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ABBREVIATIONS

1	HSBC	Health Seeking Behaviour Checklist
2	HSB	Health Seeking Behaviour
3	WH	Women's Health
4	WHQ	Women's Health Questionnaire
5	WSF	Women's Desire for Social Freedom
6	SESW	Self Esteem Scale for Women
7	SES	Socio-Economic Status
8	RMP	Registered Medical Practitioners

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ABSTRACT

Health contributes to both social and economic prosperity. India spends a huge amount on health sectors with a large number of preventive and curative schemes for women but women's health indicators still show a poor trend especially the post reproductive health. Hence the present study was undertaken with the objectives: 1) To study the health seeking behaviour among women (35-65 years of age) with respect to: personal factors, social factors, economic/productive factors, cultural barriers, educational barriers; 2. To study the relation of Health Seeking Behaviour with their: a. Socio Economic Status b. Desire for social freedom, and c. self-esteem; and 3. To devise some interventions with the help of NGO's working for Women. The study has been conducted in urban, rural and tribal areas of Jammu and Kathua Districts of Jammu and Kashmir State using multistage sampling technique to systematically select the sample. The total sample size was 600 women from urban (n=200), rural (n=200) and tribal (n=200) areas of both the Districts. Tools used for the study were Interview Schedule, Health Seeking Behaviour Checklist (HSBC), Women's Health Questionnaire (WHQ), Women's Social Freedom Scale (WSF), Self-Esteem Scale for Women (SESW) and Socio Economic Status Scale (SES).

The results reveal that most of the respondents were 49 years of age. Their average age at menarche was 14 years, age at marriage was 19 years, age at first pregnancy was 21 years, age at last pregnancy was 28 years and average age at menopause was 48 years (for those who had attained it). Most of the respondents were illiterate, homemaker, residing in nuclear families and belonging to middle socio-economic status.

The analysis of Health Seeking Behaviour Checklist (HSBC) shows that most of the respondents from Jammu show moderate level of health seeking whereas respondents from Kathua show low level of health seeking behaviour. Most of the urban and tribal respondents show moderate level of health seeking behaviour but most of the rural respondents show low level of health seeking behaviour. Health Seeking Behaviour is significantly positively related with variables such as type of family, age at marriage and

age at first pregnancy and their self-esteem whereas it is negatively related with SES and number of children a woman has.

Further findings reveal that most of the respondents of Jammu and Kathua district have moderate level of health as measured by Women's Health Questionnaire (WHQ). As age advances Somatic symptoms, vasomotor symptoms sleep problems, anxiety, and memory/concentration increase whereas sexual dysfunction, menstrual symptoms and attractiveness decrease. Health seeking behaviour is positively related to women's health.

The results show that the respondents from Jammu visualise health holistically as physical, mental, emotional and social well-being whereas respondents from Kathua lay more stress on mental health. Very few respondents from both the Districts rated their present state of health as very good or excellent. Most of the respondents from the tribal areas rated their health as poor as compared to the respondents of urban and rural areas who rated their health as good. Women believe that eating a balanced diet, doing regular physical exercise, having ideal weight, regular medical check-ups, right amount of sleep and leading a spiritual life are means to stay. Respondents from Jammu and those from Urban settings were more in favour of physical exercises to maintain their health than respondents of Kathua and those from rural and tribal settings.

Regarding utilization of health facilities, user provider relationship etc. most of the respondents from urban and rural areas of Jammu and Kathua prefer treatment in government hospitals but tribal respondents prefer treatment by nearby Registered Medical Practitioner (RMP). Respondents from the tribal areas face more difficulties in accessing medical facilities due to the bad conditions of roads and distance from the governmental health centre and they are more dependent on medicines for their routine work as compared to urban and rural areas of both districts. Most of the respondents said that there is a division of labour for household work, usually among the daughters and daughters in law, but in case of respondent's illness their husbands too substitute them. It was found that routine activities of the respondents from Jammu District and tribal areas got severely affected due to their illness. Majority of the respondents talk about their health problems with their husbands. Respondents from Jammu do not feel any social stigma is attached to prolonged illness but respondents from urban and rural areas

do feel that social stigma is attached to prolonged illness. Tribal respondents are not sure whether such stigma exists or not.

Regarding women's role in decision making it was observed that most of the decisions in the families are taken by husband and respondents jointly in the urban families whereas in tribal areas male dominance is observed in decision making about most of the matters. Most of the urban women are bank account holders and they operate their accounts too but respondents from the rural and tribal areas mostly do not hold bank accounts in their name. Majority of the respondents of Jammu and Kathua were not aware of schemes for financial assistance or health launched by the Government for women and they have never been beneficiaries of any health Schemes at any time of their life.

To understand the women's attitude towards cultural and social barriers women's desire for social freedom was studied and it was found that with an increase in desire for social freedom, or a desire to be free from taboos etc, their health seeking behaviour increases too. Respondents from Jammu show higher desire for social freedom as compared to the respondents of Kathua and this show in the health seeking behaviour and general health too.

Based on the findings strategies have been designed for Government, NGO's and women themselves to improve their health seeking behaviour.

Amratya Sen., The Nobel Laureate, says 'health, like education, is among the basic capabilities that gives value to human life.' It contributes to both social and economic prosperity. Therefore it is important to protect health through health care, besides other means of socio economic development (Ahmed, 2005). A changing demographic structure is occurring worldwide with a gradual shift towards higher proportion of older people. A declining trend in fertility and mortality rates has increased average life expectancy and created a new set of challenges in today's society. Males and females have the same life expectancy but the female advantage in life expectancy is not seen in her health (Velcoff and Adhlakha, 1998). Health is related to status in the society and women are still viewed as an economic burden. The factors that contribute to her low status in society are preference for sons, daughters' mistreatment, low educational levels and formal labour participation, low decision making power and father's, husband's or son's control.

Presently India has around 90 million elderly and by 2050 the number is expected to increase to 315 million, constituting 20% of the population (UNFPA,2012). The 2011 Census Report shows that 62.5% of India's population is 15-59 years of age and there are 62.2% are males and 62.8% are females, whereas 8% of the population is 60+, 7.7% are males and 8.4% are females. Life expectancy among females is more. In Jammu and Kashmir 65.9% of the population is 15-59 years of age, 65.1% being males and 66.8% being females. 8.4% of its population is 60+, 8.5% being males and 8.3% females. The Situational analysis shows that 48% of the elderly living in rural areas and women and 55% of them are widows (UNFPA,2012). The Global Report on Aging in the 21st Century reinforces the observations made in India that there is a multiple discrimination experienced by older persons particularly older women, including access to jobs and health care(UNFPA and Helpage India International, 2012). Further the report says that majority of people at 60+ are socially backward and economically poor.

India spends a huge amount on health sectors with so many preventive and curative schemes for women but still women's health indicators do not show a healthy trend. Most of the health programmes in India are aimed towards improving the reproductive health, but inadequate attention has been paid to the age group under study. Health related research studies show that women do not actively seek health. They are

usually the last ones to do so in their family. As they grow older their health problems multiply and they spend an uneasy life thereafter. Gender discrimination in health affects the well-being of the women and her family. The availability of physical, financial and emotional care for the elderly women is also strongly related to their marital status. According to WHO (2003), many of the women's old years may be spent in disability or illness. In developing countries, health seeking behaviours and health care services utilization patterns has been studied and determinants have been classified in physical, socio economic, cultural and political contexts (Sheikh and Hatcher, 2007). Though women generally live longer, they experience greater morbidity (as indicated in CHETNA study) and have less access to health care than men. The health needs of older women will thus become increasingly important over the next decades (Chetna, 2008).

Health seeking behaviour (a NURSING DIAGNOSIS accepted by the North American Nursing Diagnosis Association) is defined as *a state in which a person in stable health is actively seeking ways to alter his or her personal habits or environment in order to move toward a higher level of health*. Wilkinson (2001) reviewed HSB studies carried out in Cambodia in the 1990s for the Ministry of Health and the World Health Organization. He defined a number of concepts that are fundamental to the understanding of health-seeking behaviour-access, utilization, demand for service, perception of quality of care and health beliefs.

Health seeking studies acknowledge that health control tools, where they exist, remain greatly under or inadequately used. Understanding is prerequisite to change in behaviour and improved health practices (Hausmann-Muela, Ribera and Nyamongo, 2003). The findings from their study show that in order to respond to community perspectives and needs health systems need to adapt their strategies taking into account the findings from behavioural studies. According to WHO (2003) health in old age has not only to do with presence or absence of disease but availability and quality of care too are important. Women are less likely to seek appropriate and early care for diseases yet the frequency with which such care is required and the quality of care required has not been well documented in South Asia (Fikree and Pasha, 2004). The public, private and voluntary sectors contribute towards the provision of health care in India but their contribution is not without shortcomings (D'Cruz and Bharat, 2001). **At the Sixth South**

Asia Regional Ministerial Conference, Commemorating Beijing in January 2008, New Delhi, India the Ministers, Secretaries and Senior Officers of the Governments in South Asia, women's Groups /networks, civil society, and researchers from – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka, with representation from the SAARC Secretariat, acknowledged the achievements made by the countries of South Asia and the gaps and challenges identified show inadequate implementation of plans, policies and programmes relating to women due to inadequate allocation of resources, inadequate attention to eliminating harmful traditional practices that continues to infringe the human rights of women ,the increasing prevalence of HIV/AIDS among women, including exposure to infection from husbands, lack of gender sensitive policies and interventions to combat communicable diseases, anemia, TB, malaria etc and inadequate and lack of gender sensitive reproductive and sexual health information and services and care to women While the above gaps refer to women in general, they aptly bring into focus the pathetic condition of older women who are most vulnerable and marginalized among women.

The present study endeavours to understand grey area of women's health i.e. their health seeking behaviour during the menopausal transition, holistically . This area has not been given much attention, as the nation is preoccupied with reducing the Infant and maternal mortality and morbidity rates, but a visit to any gynaecological clinic or ward in the hospital shows the gravity of the post reproductive health care. The present study would be beneficial for understanding the health care system in India from the perspective of culture and psychology. The findings are beneficial for the people concerned with health care nationally and internationally as it will provide them knowledge about why women in this age group are developing health problems. A women's access to health depends on care in physical, social and psychological contexts on health beliefs and her socio economic system along with demographic background (Nayab, 2005). To reach out effectively to older people interventions must take into account the gender realities. This study would be beneficial to all those concerned with the health care both in the governmental and the private sectors. It would also be beneficial for those concerned with the study on women as it will provide an opportunity to understand the problem from a humanistic perspective. Usually the health care needs

are assessed on the basis of demographic indicators and the approach is top down, which is not acceptable to many. This research would help to understand the women's attitude towards own health. It would also be beneficial for policy planners and those responsible for implementation at grassroots to understand why these programmes are not successful.

Significance of the study

The changing demographic structure is occurring worldwide with a gradual shift towards a higher proportion of older people. A declining trend in both fertility and mortality rates has increased average life span and has created a new set of challenges in today's society (Biswas et al, 2006). Women across the world face similar situations when it comes to healthcare. India ranks 136th on the Human Development Index(2013). Though a lot is spent to raise the status of its population especially the women and children, yet the outcomes are dissatisfactory and it is only the women in the reproductive age who are much attended to. Women who are reaching their menopausal years have not been given much importance, but as the aged population in India is increasing and the women are expected to outlive men much attention is required in the coming years to look after the health care of the aged women. There is a need to understand the women's beliefs, perceptions, socio economic status, literacy status, decision making, labour participation and communication, perceived quality of health care as there is dearth of such data in India. Health policies have not been successful because they have not addressed this problem from a cultural- psychological perspective. They have not understood the barriers that women face when it comes to looking after their own self. Current societal arrangements tend to make women less powerful than men, and less able to advocate for their own health (WHO, 2003). Women, who take primary responsibility for the care of others in home and community, are the last ones to demand for health care. Gender disparities in the sphere of health seeking are the direct consequences of gender discrimination in other spheres of social well- being. Any policy targeting women's health must recognize that women's health outcomes are invariably linked to other aspects of their lives and to their unequal positions in the society. However current "uterocentric" policies fail to recognize that understanding women's health in isolation leads to an improper understanding of the issue and therefore to a clumsy and ineffective

policy planning. State policy's overemphasis on reproductive health and a total neglect of all other aspects of Indian women's lives ensures that they receive policy attention only in their child bearing years and for their reproductive functions. There is an urgent need to turn research and policy attention to health issues arising from ageing among women. Few studies quantify the extent of their contribution and the way it can affect women's own health and disability in later life (WHO, 2003). The present study endeavours to fill these lacunae by taking holistic view of health from the perspective of women.

Women's health issues at the later stage of life beyond the reproductive period are grossly neglected by the women themselves and by the policymakers in general. Gender disparities in health are direct consequence of gender discrimination in other spheres of well-being (Datta, 2003). The documentation of the reproductive period is well accomplished but there is a grey area beyond that needs ardent attention too. The present study would endeavour to look beyond the reproductive phase, beginning at the intersection i.e. the age group of 35-45 years, moving beyond that to understand women's beliefs about health and the practices they incorporate to remain healthy, and on the other hand why or why don't they actively seek health services. Nations half, i.e. the women, deserve to remain healthy if our nation is to progress in a meaningful way and the resources are to be utilized effectively. The present research would help identify the areas in women's health where more attention is required.

Objectives:

1. To study the health seeking behaviour among women(35-65 years of age) with respect to:
 - personal factors
 - Social factors
 - Economic/productive factors
 - cultural barriers
 - educational barriers

2. To study the relation of health seeking behaviour with their:
 - a. socio economic status
 - b. desire for social freedom, and
 - c. self esteem
3. To devise some interventions with the help of NGO's working for women.

International status

Phillip (1990) in his study on “Sexuality and Menopause” says that most women experience some change in sexual function during the years immediately before and after the menopause. Common sexual complaints include loss of desire, decreased frequency of sexual activity, painful intercourse, diminished sexual responsiveness, and dysfunction of the male partner. Sexual function is influenced by biologic and non-biologic factors. Sexual arousal, including sensory perception, central and peripheral nerve discharge, peripheral blood flow, and the capacity to develop muscle tension, as well as sexual desire and frequency of sexual activity, can all be influenced by ovarian hormone levels. Sexual function is also influenced by the interplay of psychological, sociocultural, and interpersonal factors. Health care professionals can play an important role in the evaluation, education, counselling and treatment of the menopausal woman.

Thorell and Suardsud (1993) conducted a study on 155 women in Kungsor who became 50 years old in 1984-1987. Results showed that women who smoked had an earlier menopause than others. Postmenopausal women had more sleep disturbances than premenopausal women. There were no significant differences in other self-rated well being, but home and family situation patience, anxiety and sleep disturbance tended to become worse with time from menopause.

Malacare et al (1994) conducted a study on urban population of Leon, State of GuanaJuate and determined 48 years to be the main age at menopause. Result showed that menopause was strongly associated with hypertension, increased frequency of obesity and an increment in sedentary habits, which occurs, in the female population, and the possible participation of hormone deprivation.

Gibbs and Fuery (1994) reviewed the literature on Black women's mental health has three goals: 1) to describe the mental health issues, needs, and adaptive behaviors of Black women; 2) to discuss the research, intervention, and public policy efforts of mental health professionals and Black women's groups to address the multiple needs of this population; and 3) to identify effective strategies by which community psychologists can improve the mental health status of Black women through efforts to reduce their environmental stressors, to increase their resources and access to services, and to

facilitate their empowerment in American society. The authors propose a number of recommendations to improve Black women's mental health, including changes in research paradigms, changes in education and training programs, and the development of culturally competent service delivery systems.

Okojie (1994) examines gender inequalities of health in Third World Countries. Health hazards are present at every stage of a woman's life cycle. Health problems which pose the greatest hardship to women in these countries include: reproductive health problems, excess female mortality in childhood, violence against girls and women, occupational and environmental hazards, and cervical and breast cancer. Many of these lead to maternal mortality which was the most focused upon indicator of women's health in the literature. Gender inequalities of health originate in the traditional society where definitions of health status and traditional medical practices all reflect the subordinate social status of women. Gender inequalities in health are manifested in traditional medical practices which attribute women's illnesses to behavioural lapses by women; differential access to and utilization of modern healthcare services by women and girls, including maternal care, general healthcare, family planning and safe abortion services. Reasons for gender inequalities in health include--emphasis on women's childbearing roles resulting in early and excessive childbearing; sex preference manifested in discrimination against female children in health and general care; women's workloads which not only expose them to health hazards but also make it difficult for them to take time off for healthcare; lack of autonomy by women leading to lack of decision-making power and access to independent income; early marriage which exposes women to the complications of early and excessive childbearing. Gender inequality in health is one of the social dimensions in which gender inequality is manifested in Third World societies. Strategies to eradicate gender inequalities in health must therefore involve efforts to improve the status of women.

Gijsbers et al (1996) in their study revealed that gender inequalities in health are a consequence of the basic inequality between men and women in many societies. Despite the importance of socio-economic factors, women's health is also greatly affected by the extent and quality of health services available to them. Both non-governmental women's organizations and feminist health researchers have in recent years identified major gender

inequalities in access to services and in the way men and women are treated by the health care system. Firstly, although women are major health care users as well as providers, they are under-represented in decision-making in health care. Secondly, no justice is done in general to existing differences in position and needs of women and men in defining quality of health care, i.e. gender aspects. Among women's organizations, there is general agreement that "gender sensitive health care should be available, accessible, affordable, appropriate and acceptable". In addition, health care for women should be adequate and not depart from a male model of health and illness. In this paper, they pay attention to inappropriate health care for women on the one hand, as illustrated by the increasing medicalization of women's reproductive life [menstruation, menopause, pregnancy and childbirth and (in)fertility]. On the other hand, they discuss gender bias in the management of serious, life-threatening diseases such as cardiovascular disease, lung cancer, and kidney failure, as a form of inadequate care. These examples are followed by a global vision on quality of care from a gender perspective, as formulated by the women's health care movement in the Netherlands and at the Fourth International Conference on Women in Beijing. If anything, the recommendations agreed upon in Beijing will have to ensure the consolidation and enhancement of good quality health care for women around the world. The final discussion, attempts to give some general recommendations for achieving more adequate (gender sensitive) and appropriate (non-medicalizing) health care for women. These recommendations pertain to health and health care research, policy, education, and organization from a women's perspective.

Craft (1997) in the paper on "Women's health is a global issue" report that all over the world, women live longer than men, up to 12 years longer in the Russian Federation. However, while women live longer, they are not necessarily living better, healthier lives. In developing countries, communicable diseases, together with childbirth-related illnesses, account for most morbidity among women. In the developed world, too, women reported experiences of higher levels of physical and psychological morbidity. While women have risk of contracting the same endemic diseases as men, both biological and social factors may increase exposure or worsen the effects. The following are discussed as affecting women more than men, regardless of where they live: poverty, birth rates and aging populations, gender, violence against women, and lack of research about women.

Issues affecting women in the developing world and in poorer areas of the developed world include education, lack of autonomy, legal status, preference for sons, traditional practices, and lack of access to health care, work and environmental health hazards, and unequal human rights. Women's health in the developed world is also considered.

Kuh et al (1997) did a study with the objective to describe the health symptoms of a large representative sample of British women at age 47 years, and to examine the influence of the menopause allowing for social factors and health in earlier adult life. A national prospective birth cohort study using information on health problems, menstrual cycle, use of hormone replacement therapy and life stress at 47 years was collected using a postal questionnaire. Information on health, smoking behaviour and educational attainment earlier in life had been collected at previous home visits. Out of a general population sample of 1498 women, 84% of those sent a questionnaire. Women who had experienced an early natural menopause had a strongly raised risk of vasomotor symptoms (hot flushes or night sweats), sexual difficulties (vaginal dryness or difficulties with intercourse) and trouble sleeping. However, there was little or no excess risk of other somatic or psychological symptoms. In contrast, all types of symptoms were more common among women who had had a hysterectomy or were users of hormone replacement therapy. Women with the least education, stressful lives, or a previous history of poor physical and psychological health at age 36 also reported more symptoms at 47 years compared with other women, but adjustment for these factors in a logistic regression model did not affect the relations between symptoms and current menopausal status. For vasomotor symptoms, postmenopausal women had an adjusted odds ratio of 4.7 (95% CI 2.6-8.5) and perimenopausal women had an adjusted odds ratio of 2.6 (95% CI 1.9-3.5) compared with premenopausal women. Corresponding adjusted odds ratios for sexual difficulties were 3.9 (95% CI 2.1-7.1) and 2.2 (95% CI 1.4-3.2), and for trouble sleeping were 3.4 (95% CI 1.9-6.2) and 1.5 (95% CI 1.1-2.0). Specific symptoms were clearly associated with the natural menopause. More general health concerns were common among women in middle life, particularly among those with stressful lives, or those who had had a hysterectomy or started taking hormone replacement therapy before they were postmenopausal. Appropriate advice and support needs to be easily accessible.

Rosenberg et al (1998) did a study to assess correlates of the use of postmenopausal female hormone supplements among Black women. Information was obtained from 64,564 U.S. Black women 21 – 69 years of age who enrolled in the Black women's Health study in 1995 by completing postal questionnaires. Included in the present analysis were 13,352 women 40 – 69 years of age who had ceased menstruating. Most resided in 10 states, with 66% from California, New York, Michigan, Georgia, & New Jersey, 41.0% had completed college. Among the 13,352 women 40 years of age or older who ceased menstruating, 49.2% reported ever use of female hormone supplements & 33.3% were using them currently. Unopposed oral estrogens accounted for 63.4% of the medications being used currently. The use of supplements was highest in the western U.S. and lowest in Northeast. The strongest correlate of use was menopause due to bilateral oophorectomy. Use peaked at 50 – 54 years of age and then declined, and was associated positively with lower body mass index, greater years of education, participation in vigorous exercise, and past oral contraceptive use. Use was associated inversely with having a positive history of diabetes heart attack or breast cancer. Some of the drug use reported was at variance with suggested guidelines: unopposed estrogen together with a progestin was taken up by some women who had a hysterectomy. These data indicate that patterns of use of postmenopausal female hormone supplements among Black women who participated in the present study are similar to those documented in White women. Women with risk factors or coronary artery disease were not more likely to use supplements than women at lower risk, a pattern that is not in accordance with suggestions that the greatest benefit of supplements may accrue to high risk women. Because users differ from non-users in important characteristics that may affect the incidence of coronary heart disease, breast cancer, and other illnesses observational studies of the health effects of these medications must control carefully for correlates of use.

Mitra and Lovell (1999) in their study on anthropological approaches to cancer prevention and control in New Brunswick concluded that gender and power can play an important role in providing decisions concerning treatment and moral dilemmas in medical care. Health care professionals need to understand the range of health beliefs in a population and be sensitive to the possibility that cultural factors may interfere with

effective communication. Multi -method approach was used. Women were found to more actively seek cancer as compared to males. Importance of comparing the experiences of men and women is suggested.

Olofsson and Collins (2000) analyzed the attitude to menopause from women's own accounts and to examine whether psychosocial factors and attitude are associated with symptom reporting .The data form part of a population-based longitudinal study of a cohort of women who have been followed annually for 5 years using psychological interviews and rating scales, health screening and hormonal characterization. The data reported here were collected at the fourth follow-up when the women (n = 148) were 53 years old. Women were classified as peri-menopausal (27%), postmenopausal (15%), Hormone Replacement Therapy (HRT) users (52%) and hysterectomized (6%), based on self-reports. More than half the women (51%) had a positive attitude to menopause, 24% had a negative attitude and 25% had a neutral attitude. Menopausal status was not associated with attitude to menopause. Factor analysis of symptom ratings yielded ten independent factors comprising negative mood, vasomotor symptoms, decreased sexual desire, memory problems, sleep-related symptoms, vaginal dryness, urogenital problems, joint pain, vitality and increased sexual desire. Only vasomotor symptoms and joint pain were associated with menopausal status. The other symptoms were more strongly related to psychosocial factors, life-style and attitude to menopause. The results support the view of the menopause as a developmental phase associated with an increased self-awareness and a stronger personal identity. More than half the women held a positive view of the menopause, whereas the remaining proportion of women had either a negative or a neutral attitude. Only vasomotor symptoms and joint pain were associated with postmenopausal status. Other symptoms were significantly related to psychosocial factors, life-style and attitude to menopause.

Sim et al (2002) examines chronic and acute diseases that are the leading cause of morbidity among African- American women age 35-64 in the country. This report finds that in the county, Pennsylvania, and the US, African- American women ages 35-64 have higher morbidity and mortality rates due to various chronic and sexually transmitted diseases than White women within the same age group. Socio economic status and racial

and gender bias plays a significant role in health status in middle aged African- American women.

Davidson and Schattner (2003) in their study on “Doctors’ health-seeking behaviour: a questionnaire survey” explore doctors’ perceptions of the acceptable limits to self-treatment and to identify barriers to doctors seeking appropriate healthcare. 896 Australian doctors randomly selected from the Health Insurance Commission database and stratified by sex, discipline (general practitioner or specialist) and location (urban or rural). Results reveal that 358 (40%) doctors returned questionnaires. More participants believed it was acceptable to self-treat acute conditions (315/351; 90%) than to self-treat chronic conditions (88/350; 25%). Nine per cent (30/351) of participants believed it was acceptable to self-prescribe psychotropic medication. A greater proportion of GPs (206/230; 90%) than specialists (101/121; 83%) believed doctors are reluctant to attend another doctor, especially if the problem is psychological. Women and GPs were significantly less likely to report that it was easy to find a satisfactory treating doctor (women, 58/140 [41%]; men, 128/211 [61%]; GPs, 106/231 [46%]; specialists, 80/120 [67%]). Being a specialist was predictive of seeking appropriate healthcare for all three vignettes. Doctors have varying opinions regarding the acceptability of self-treating chronic conditions, and perceive considerable barriers to seeking appropriate medical care. Strategies are needed to challenge the culture of self-reliance.

Fuh et al (2003) in their study on “Quality of life and menopausal transition for middle aged women on Kinmen Island” say although it seems reasonable to suggest that most women experience significant changes in quality of life (QOL) during the menopausal period, few researches have quantified these changes. A total of 1497 women (aged 40-54 years) and living on the island of Kinmen, were recruited for this survey. However 137 were eliminated leaving 1,360 for analysis. Women who used hormonal therapy or who had undergone surgically induced menopause were excluded. The subjects with incomplete data or who exhibited mental retardation or severe psychiatric disease were also eliminated. Univariate analysis demonstrated that, in general QOL scores were poorer for peri-menopausal and postmenopausal status. Comparing pre and post menopausal women, significant statistical differences were demonstrated for role limitations due to physical and emotional problems even after adjusting for age,

education level, body mass index, menarche and chronic illness. A strong association was demonstrated between menopausal symptoms and premenstrual syndrome (PMS). Women with menopausal symptoms and PMS had significantly lower scores on all SF-36 dimensions. The results of this study suggest that poorer health status is experienced by peri and postmenopausal women compared to premenopausal women.

Alexander et al (2003) discusses how sexual function is affected by menopause? Changes in circulating levels of estrogen and androgens during the peri and postmenopausal years have a far-reaching impact on sexual symptoms in some women. Many factors influence whether or not a woman experiences a symptom and whether or not she finds it distressful. Likelihood of experiencing sexual symptoms depends on age and menopausal status. For those women who do experience sexual symptoms, and where these symptoms can be attributed to reduced levels of gonadal hormones, the use of estrogen or estrogen plus testosterone replacement therapy can be successful in improving sexual function. However it is important to recognize that in addition to this biologic etiology of new-onset sexual symptoms in the postmenopausal women, several non-biologic domains influence sexual functioning as well. These domains could be thought of as being interpersonal, socio cultural or psychosocial, and psychological in nature. A women's sexual function depends on the dynamic inter play of these factors. The clinicians should identify sexual problems that are of new onset with the menopausal transition and causing distress to the women; separate biologic from non-biologic causes of symptoms, and design a treatment plan based on the dynamic interplay of these factors.

Bernard (2003) took about 1000 women between ages 36 and 45 for three years. One third had either current or past major depression, while the rest had no history of depression. Every six months, the women were interviewed and their emotional state, blood and menstrual cycles were analyzed. The results reveal that women living in poverty are 80% more likely to begin menopause early. There are several reasons for this women in poverty are more likely to be undernourished, have increased exposure to toxins, and more likely be smokers- all be factors that can lead to an earlier onset of menopausal symptoms but the key is stressful life events. Early menopausal symptoms not only impact fertility, but accelerate bone loss, sexual and cognitive problems

associated with menopause. It may also put women at greater risk of cardiovascular problems. Menopause typically begins around age 50. The effects of emotional stress on fertility-women under a lot of stress or with depression do have a much harder time getting pregnant. This study also documented the link between emotions and the hormonal system. But antidepressants don't seem to be helping with the symptoms, perhaps it's time to try psychotherapy, relaxation therapy, or other non-pharmaceutical techniques to elevate mood. This study suggests the gynaecologists to pay more attention to mood changes occurring in these women and be ready to refer them for psychological evaluation when necessary.

Desoto (2003) examined the relationship between body image, self-esteem and the severity of menopausal symptoms and assessed the influence of hormonal therapy and post menopausal estrogen level on specific complaints. The author considers self-esteem to be an important factor where as decrease in estrogen level to be a serious cause. The attempt to suppress real effects of estrogen on mental and physical health is harmful to women's health.

Hausmann-Muela, Ribera and Nyamongo (2003) found that inequality in access is associated with findings that women have to overcome more obstacles to reach treatment and sometimes the health providers too show gender bias. Other factors that were found to have significant influence on the health seeking behaviour were limited access to money, transport, decision making, and nature of women's work.

Heinmann and Saad (2003) in a study on, "Sweating attacks: Key symptom in menopausal transition only for women?" say that aging men are not as much aware of the fact as women that they too, undergo some kind of menopausal transition and they notice the symptoms rarely. The key symptom of "hot flushes/sweating" is undisputed among women. The objective of this paper is to compare the frequency of episodes of sweating across gender and age groups. A sample of 500 German males and a control sample of 153 women were asked to report about the frequency between males and females. A precipitous rise in frequency can be found in the 6th decade of life for both sexes. This applies in particular to sudden, unexpected episodes of sweating or constriction /anxiety with or without sweaty skin that occurs at night (less frequently during the day), i.e.

occurring without any obvious physical or mental stress. This seems to be an important symptom for the changes occurring at an age of over 50 years for both sexes. Sensations of sweating occurring suddenly and unexpectedly, especially at night, but also during the day seem to be similarly common among men and women.

Herey et al (2003) studied the correlation to bone mineral density and susceptibility to osteoporosis”, on 168 of the 477 postmenopausal women who were randomly recruited. The result reveals that after adjustment for potential confounding factors such as age, height, weight, years since menopause and daily calcium intake, subject with Genotype 20+ (n=64) had lower bone mineral density values and a significantly greater risk for osteoporosis when compared with subjects with genotype 20- (n=104) at the femoral neck.

Lawlor et al (2003) did the study to assess the association indicators of adverse socio-economic position from across the life course with age at menopause. It was done in the 23 British towns on 3513 women aged 69-70 years who underwent hysterectomy or oophorectomy prior to the natural menopause or who were taking HRT around the perimenopausal period. The results of the study reveal that most of the 10 indicators of adverse socio-economic position from childhood through to adulthood were linearly associated with a younger age at menopause. Adult indicators of adverse socio-economic position were similarly associated with earlier age at menopause. Age at completing full time education was not substantively associated with age at menopause. The inverse association between each of the indicators of both childhood and adulthood socio-economic position and age at menopause were not importantly affected by adjustment for other reproductive factors but they attenuated by between 6% and 21% with adjustment for adult smoking and body mass index. The study concludes that the adverse socio-economic circumstances in childhood as well as in adulthood are associated with an earlier age at menopause. The association between childhood deprivation and early menopause may at least in a part be mediated via exposures such as childhood diet, which affect both linear growth and age at menopause.

WHO (2003) states that health in old age has to do not only with presence or absence of disease. Availability and quality of care are also important. Even though all factors are

against the women yet she has a higher life expectancy in developing countries. Many of these years may be spent in the shadow of disability or illness. Current societal arrangements tend to make women less powerful than men and less able to advocate for their own health. Most research on aging has been done in developed countries. Older people in developed world may have different problems. To reach effectively to older people, interventions must take account of gender realities. The ways in which gender affects people's capacities and behaviour must be examined and addressed if they must be effective.

Amore et al (2004) in their study had the objectives to provide epidemiological data about psychological symptoms derived from a large Italian non-clinical sample, and to investigate the correlation with psychosocial factors. The study design was a cross-sectional postal survey of a sample of menopausal women recruited from the General Registry Office in Ferrara's province. 4073 women were sent questionnaire designed on the basis of the Women Health Questionnaire (WHQ). Together with the WHQ, women were asked to fill out a personal file to define social status, cultural level, family's characteristics, recent menstrual cycles, gynaecological history and operations, drug's assumption, life events in the last year and life time depression. Factors analysis resulted in 8 clusters of symptoms. Among psychiatric symptoms, three different clusters were identified depressive symptoms, depressed mood with anxiety symptoms, and anxiety. The clusters "depressive symptoms" was more evident in the postmenopausal period with respect to the premenopausal one. Hence it was concluded that the cluster depressive symptoms is significantly different in the premenopausal group with respect to the postmenopausal group, with greater levels of symptomatology in the postmenopausal group. On the contrary, the factor "depressed mood with anxiety symptoms" is present to the same extent in the pre-, peri-, and postmenopausal groups. Prior depression is the most predictive variable of subsequent depression in postmenopausal women. Factors related to more pronounce depressive symptoms are number of life events, postmenopausal status, place of residence in rural area and lower cultural level.

Avis et al (2004) in this paper examine whether menopausal status is associated with global quality of life (QOL) among women aged 40-55 and whether this association varies by race/ethnicity. They further examine the contributions of other health-related

and psychosocial factors to QOL and whether these associations vary by racial/ethnic group. Analyses are based on 13,874 women who participated in the multi-ethnic, multi-race study of mid-aged women called the Study of Women's Health Across the Nation (SWAN). Study participants completed a 15-min telephone or in-person interview that contained questions on a variety of health-related topics. Items of interest for these analyses include global QOL, menstrual history (to assess menopausal status), socio-demographics, health status, lifestyle, and psychosocial variables. Results showed that in unadjusted analyses, early peri-menopausal women reported lower QOL compared with premenopausal women, but menopausal status was no longer associated with QOL when analyses were adjusted for other variables. In multivariable models, being married and having low levels of perceived stress were associated with better QOL across all racial/ethnic groups. While there were many consistencies across racial/ethnic groups, they also found that the nature of the associations between QOL and education, marital status, perceived stress and social support varied across racial/ethnic groups.

Lindh et al (2004) assessed if regular physical exercise or oral oestradiol therapy decreased vasomotor symptoms and increased quality of life in previously sedentary postmenopausal women. 75 post menopausal, sedentary women with vasomotor symptoms were randomized to: exercise 3 times weekly over 12 weeks (15 women), oral oestradiol therapy for 12 weeks (15 women) and 45 women to three other treatment arms. Results shows that 10 women fulfilled 12 weeks of exercise. The number of flushes was rather unchanged in 5 women and decreased to 28% (range 18-42%) of baseline in other 5 women. 5 of the 10 women continued to exercise another 24 weeks, thus in all 36 weeks. The mean number of flushes decreased by about 50 % in these 5 women. In the same group a score made as the product of reduction in number and severity of flushes decreased by 92% at 12 weeks, 75% at 24 weeks and 72% at 36 weeks compared with baseline. In the estrogen group flushes decreased from 8.4 to 0.8 ($P < 0.01$) after 12 weeks of therapy and remained at this level after 36 weeks. Well-being according to different measurements improved significantly in both groups albeit more markedly in the estrogen group. Apart from many other health benefits regular physical exercise may decreased vasomotor symptoms and increase quality of life in postmenopausal women. Exercise should be introduced gradually to ensure compliance.

Shirley and Lee (2004) in their study on “Health and Sickness: The meaning of Menstruation and premenstrual syndrome in women’s lives, expresses that the concept of health and sickness associated with the experience of menstruation are an important topic of study within medical anthropology particularly as changes associated with menstrual cycle have been labelled premenstrual syndrome. This condition has been characterized as sickness, but PMS also serves as a cultural symbol that has come to represent a women’s normal functioning, part of “being a women.” Research was conducted on 43 women who volunteered for a study on women’s knowledge and understanding of menstruation and premenstrual syndrome which took place in Winnipeg, Manitoba, Canada in 1999. Intensive interviews were used to compile the data. Themes and patterns associated with specific domains were derived from interviews. Analysis was also used to understand the meaning of menstruation and PMS. Results reveal that attitudes towards menstruation ranged across a broad spectrum from extremely negative to extremely positive. Although most women accepted the PMS label and placed their changes within the realm of sickness, a small group of women were identified who conceptualized their changes in an extremely positive way thus reframing their experiences. This is not to suggest that some women do not experience severe changes associated with their cycle. However, more positive perceptions of menstrual changes may have a significant impact on the re-evaluation of menstrual cycle fluctuations as sickness without devaluing the experiences of those women with severe changes.

Subba (2004) reported that a number of ethnics have their own traditional health seeking behaviour in Nepal. The objective of the present study was to assess the practices of using modern, self and alternative medication on the basis of socio economic status. It was a cross sectional descriptive type of study. Survey was done using semi structured questionnaires containing both open ended and close ended questions on 175 households. Modern, alternative and self medication was used. Modern medicine was believed to be expensive. There was a relation between economic, educational status and health seeking behaviour.

Yip and Chan (2004) identified major risk factors, such as natural menopausal transition, physical strain to the lower back, and psychosocial and lifestyle stress, for low back pain (LBP) prevalence among non -institutional Chinese middle-aged women. A

total of 182 cases and 235 controls participated. Data were collected at face-to-face interviews and body measurements were obtained. The data included extensive criteria: descriptions of their LBP, socio demographic factors, menopausal status and reproductive factors, physical strain activities, psychosocial stress, lifestyle factors, and anthropometric parameters. The results indicated that LBP was prevalent among (a) women who experienced stressful life events in the past 12 months. (b) Women who had high psychological stress related to house work or work. (c) Women who performed some physical strain activities, such as prolonged squatting or moderate physical activities in the previous year. (d) Women who had a low waist-to-hip ratio. The results reveal that showing women how to reduce physical strain during activity and how to maintain good postures may have great potential in reducing or eliminating LBP. The findings have important implications for the development of health education as health promotion such as how to take care of their backs and how to handle psychological stress in both the home and work place.

Kimerling and Baumrind (2005) conducted a cross sectional examination of probability sample of 3,750 California women. The main indicators of access to service were perceived need, service seeking, and service use. Significant racial and ethnic variations in access to speciality mental health services were observed. It was observed that African American, Hispanic and Asian women were significantly less likely to use speciality mental health services than white women. Multivariate analyses showed that Hispanic and Asian women were less likely than White to report perceived need even after frequent mental distress had been taken into account.

Melby et al (2005) reviewed recent research on the relationship of culture and menopausal symptoms and propose a bio cultural framework that makes use of both biological and cultural parameters in future research. Medline was searched for English language articles published from 2000 to 2004 using the keyword 'menopause' in the journals-Menopause, Maturitas, Climacteric, Social Science and Medicine, Medical Anthropology Quarterly, Journal of Women's Health, Journal of the American Medical Association, American Journal of Epidemiology, Lancet and British Medical Journal, excluding articles concerning small clinical samples, surgical menopause or HRT. Additionally, references of retrieved articles and reviews were hand-searched. Although a

large number of studies and publications exist, methodological differences limit attempts at comparison or systematic review. They outline a theoretical framework in which relevant biological and cultural variables can be operationalized and measured, making it possible for rigorous comparisons in the future. Several studies carried out in Japan, North America and Australia, using similar methodology but different culture/ethnic groups, indicates that differences in symptom reporting are real and highlight the importance of bio cultural research. They suggest that both biological variation and cultural differences contribute to the menopausal transition, and that more rigorous data collection is required to elucidate how biology and culture interact in female ageing.

Nayab (2005) conclude that women's access to health depends on care in physical, social and psychological contexts. It also depends on her health beliefs and her socio economic and demographic background. In a study on health seeking behaviour in Pakistan he reports that the decision to seek health depends on women's educational and economic status, the extent to which she is worried about symptoms and interspousal communication about symptoms.

Biswas et al (2006) in their study in Bangladesh found that old age and ill health are perceived to be inseparable entities. Seeking health care from a formally qualified doctor was avoided due to high costs. Familiarity and accessibility of health care providers played a significant role in health seeking behaviour of elderly persons. Flexibility of health care providers in receiving payments was also a crucial factor.

Erdman and Cook (2006) say that the worldwide burden of reproductive and sexual ill-health falls disproportionately on women belonging to vulnerable and disadvantaged groups. Women's rights to reproductive and sexual health, as protected under national constitutions as well as regional and international human rights treaties, require that health systems account for the distinctive needs and circumstances both of and among women. The purpose of this article is to investigate what we can do as advocates to ensure that the reproductive and sexual health rights of all women are respected, protected, and enforced, both internationally and in Canada.

Li et al (2007) conducted a national survey of Medicare managed care enrolees in 2003-2004. A total of 28,724 patients who were non institutionalised, age 65 and older, and

who had self reported UI problem in last 6 months, formed the sample. Community living older women with UI problems are less likely to seek professional help than their male counter parts, but more likely to be treated after a health professional is consulted. Patient's socio economic status can affect physician behaviour and ultimately their receipt of treatment of UI especially for women.

Shaikh and Hatcher (2007) reviewed literature on the relationship of factors affecting utilization and the focus has been on Pakistan. National Health Survey Conducted in 1990-04 has been critically reviewed. Low social status of women results in a toll of unacceptable and preventable maternal deaths, one of the highest in South Asia. Women report less for health care seeking.

Boateng and Flanagan (2008) analyzed Women's physical and psychological access to health care using the 2003 Ghana Demographic and Health Survey (GDHS), a nationally representative study for monitoring population and health in Ghana. Female respondents from the 2133 cases in the couple's data set were used in this study. Women's level of education was positively related to physical but not to psychological access to health care. Residing in an urban area was positively related to both types of access. Matriliney consistently showed positive effects on physical access. In addition to these demographic factors, both physical and psychological access were positively related to women's self-determination, i.e., women's right and ability to make real choices about their lives including their health, fertility, sexuality, childcare and all areas where women are denied autonomy and dignity in their identities as women. Self-determination factors both mediated the effects of background factors on access and added explanatory power to the models.

Lukes (2008) did a study to review data from the WHI, including recent analyses, demonstrating the risks and benefits of HRT in postmenopausal women, to describe changes in menopause treatment guidelines and HRT use since publication of early WHI results nearly 6 years ago, and to identify opportunities for improving the quality of care in peri menopausal women. Early results from the WHI demonstrated that the risks of long-term HRT in postmenopausal women outweighed the benefits, leading study investigators to conclude that HRT should not be initiated or continued for the primary

prevention of coronary heart disease (CHD) in postmenopausal women. Treatment guidelines published by several professional and managed care organizations continue to advocate the use of HRT for treatment of moderate-to-severe VMS. Nevertheless, physician and patient confidence in HRT has declined, as evidenced by a decrease in new HRT prescriptions and an increase in the discontinuation rate of HRT immediately following publication of the preliminary WHI results. Recent analyses demonstrate that the risk for CHD in postmenopausal women is largely dependent upon the age of the woman and the number of years since menopause, with a lower risk for CHD in women aged 50 to 59 years and in women who experienced menopause within the previous 10 years. The highest risk for CHD was evident in women aged 70 to 79 years and in women who experienced menopause 20 or more years ago. Although these data do not support the use of HRT as a primary prevention strategy in postmenopausal women, they do suggest the need to further evaluate the benefits and risks of HRT in perimenopausal women based on patient-specific characteristics, including age and time since menopause. Menopausal women present a unique opportunity for health care providers to improve the quality of care among women, not only as it relates to the treatment of VMS, but also as it relates to osteoporosis and cardiovascular disease, 2 common co morbidities in perimenopausal and postmenopausal women.

Ward and Heidrich (2009) examined African American women's representations/beliefs about mental illness, preferred coping behaviors if faced with mental illness, whether perceived stigma was associated with treatment-seeking, and if so, whether it was related to beliefs and coping preference, and whether these variables differed by age group. Participants were 185 community-dwelling African American women 25 to 85 years of age. Results indicated the women believed that mental illness is caused by several factors, including family-related stress and social stress due to racism, is cyclical, and has serious consequences but can be controlled by treatment. Participants endorsed low perceptions of stigma. Major preferred coping strategies included praying and seeking medical and mental health care. Age differences were found in all variables except stigma.

Davison and Breckon (2012) conducted a study to determine the impact of health information-seeking behavior (HISB) and personal factors on patients' preferred role in

treatment decision making (TDM). Participants consisted of 150 men with newly diagnosed PC seen at 2 urology clinics in western Canada. A survey questionnaire was used to gather information on HISB, personal factors influencing treatment choice, and decision control. More than 90% of the participants reported a preference to play either an active or collaborative role in TDM and having either an "intense" or "complementary" HISB. No significant association was found between HISB and preferred role in TDM. Impact of treatment on survival and urinary function and the urologist's recommendation were identified as the 3 main factors influencing the treatment decision. At the time of diagnosis, the majority of men want to be involved in TDM and have access to information. Our findings suggest that the type and amount of information men want to access are dependent on HISB. Assessing factors having an impact on TDM may prove useful to guide patient-clinician treatment discussions.

Amin et al (2010) principal finding of their study on “Socioeconomic factors differentiating maternal and child health-seeking behaviour in rural Bangladesh: A cross-sectional analysis” was that a household's relative poverty status, as reflected by wealth quintiles, was a major determinant in health-seeking behaviour. Mothers in the highest wealth quintile were significantly more likely to use modern trained providers for antenatal care, birth attendance, post natal care and child health care than those in the poorest quintile (χ^2 , $p < 0.01$). The differentials were less pronounced for other factors examined, such as education, age, and the relative decision-making power of a woman, in both bivariate and multivariate analyses. Within rural areas of Bangladesh, where overall poverty is greater and access to health care more difficult, wealth differentials in utilization remain pronounced. Those programs with high international visibility and dedicated funding (e.g., Immunization and Vitamin A delivery) have higher overall prevalence and a more equitable distribution of beneficiaries than the use of modern trained providers for basic essential health care services. Implications of these findings and recommendations are provided.

Marrow and Luhrmann (2012) describe how perceptions of family honor, shame, and moral responsibility, access to psychiatric services, and cultural acceptance of biomedical approaches to mental health treatment, combine to lead Indian families to hide family members with severe psychosis within their homes (taking on the majority of caregiver

burdens), and American families to abandon them to institutions or on the streets. Chinese families may also keep family member's illness a secret in order to save face (Mak & Cheung, 2008).

Davison and Breckon (2012) examined information and decision making preferences of patients on active surveillance (AS), and the factors influencing their decision. A cross-sectional sample of 180 patients on AS for <10 years completed a survey exploring the role men assumed with their physician in treatment decision making (TDM), factors influencing their decision to go on AS, and information preferences. Thirty-five percent of patients reported assuming an active role in TDM, 38% a collaborative role and 27% a passive role. Results suggest that patients <60 years prefer to play an active role in TDM whereas, men >70 years prefer to play a passive role. Available treatment options, eating a 'prostate friendly' diet, and non-traditional therapies were identified as the top three information preferences. Patients with higher levels of anxiety wanted access to more information compared to those with lower levels of anxiety. The urologists' recommendation was rated the most important factor influencing patients' decisions to go on AS. The urologist's recommendation for treatment continues to have the most influence on the decision to go on AS. Our results suggest that age has an impact on the role patients wish to assume in TDM.

Daniel and Norris (2013) conducted a study with the aim to describe the healthcare access, beliefs, and practices of middle-aged and older women residing in Soweto. This is a cross-sectional study of the primary (female) caregivers of the Birth to Twenty Cohort, based in Soweto, South Africa. The study instrument was administered to 1 102 caregivers as part of routine annual data collection. Over half the respondents (50.7%) reported having at least one chronic non-communicable disease (CND), only a small portion (33.3%) of whom reported accessing a healthcare service in the last 6 months. Reported availability of private medical practice and government clinics was high (75.1% and 61.5% respectively). The low utilisation of healthcare services by women with CND is a concern in terms of healthcare management. There is a need to further investigate how healthcare beliefs are formed, as well as the feasibility of programmes to support the ongoing management of CND in Soweto.

National Status

Shanmuganandan et al (1992) studied “Women, AIDS and health seeking behaviour: an analysis of attitudes and awareness” with the objective to analyse the attitude and awareness of AIDS in relation to its origin, prevention, pregnancy and child birth, sexual behaviour, safer sex transmission, reducing risk behaviour, health education and health seeking behaviour in relation to supportive environments and so on; To quantify the risk factors and to explain the variable rate of perception among women. The present study is confined to an urban area of Madurai city alone and the total number of respondents was 600 belonging to Adolescent women, and working women to household women. A random sampling method was used with the help of a questionnaire survey carried out in the age group of 15-45 years and the variables were largely dealing on sociocultural, socioeconomic, environmental, behavioural and health care. The multivariate statistical tool discriminant analysis was used and discriminant scores explained the significance of selected variables in influencing the behaviour of women at large. There was a high degree of awareness among working (71%) women compared to household women. AIDS awareness was considerably noticed to be higher on AIDS origin rather than preventive aspects particularly among household women. Adolescent women (43%) were exposed to the awareness of risks of AIDS. The factors identified with the help of discriminant scores laid significance on Suggestive measures for AIDS prevention, AIDS spread and transfusion, Knowledge and Behaviour of Women, Agents of AIDS spread and preventive health care measures and curability and fear of AIDS. There is a need to tune special health education measures on AIDS suitable particularly for women and also literacy campaign for household women with the help of the voluntary health agencies and social clubs.

Khan (2001) says that women’s role in decision making process is an important factor and needs to be considered for tribal woman empowerment. Mainstreaming of women through gender specific policies is a necessary precondition for meaningful development. There is a lacuna between gender specific policies and reform agenda. He pointed out that government policies like reservation of seats, can promote empowerment and women access to development projects numerically but not practically.

Chhaya and Santosh (2002) while making a study on tribal of Maharashtra found that the number of health care personnel providing health education or health care services was insufficient, most of the staff frequently remained absent for many days. They further stated that water, harvesting, construction of small bunds and structures for conserving water should be encouraged. Tribal are found to be in a transitional phase, moving from traditional practices to mainstream, this may lead to consequences such as adoption of dowry system in place of bride price and the practice of female infanticide.

Bilquis and Madhavalatha (2003) studied the trend of Menarche in three regions of Andhra Pradesh. The study was done to analyse the mean menarcheal age of 555 rural girls belonging to three regions of Andhra Pradesh. The data reveals that heterogeneous distribution of mean menarcheal age i.e. 12, 12.5, and 13 years in Andhra, Rayalseem and Telangana region respectively

Kumar (2003) stated that even if government is undertaking various development programmes for tribal women it fails to reach its goal. Lack of awareness, control of economic resources, family problems, traditional values are various factor hindering the women empowerment.

Murari et al (2003) aimed at tracing out the effect of employment on life satisfaction of working and non-working of Kumareen Region and the influence of rural and urban background on life satisfaction of Kumarni women. To achieve the main objectives of the study, 320 women were drawn randomly from the six district of Kumaren, out of these 160 were working and 160 were non-working. In both groups, 80 were from rural and 80 women were from urban areas. Scores were obtained on life satisfaction scale by Q. G. Alam and RamjiSrivastava. Significant difference was observed in life satisfaction of working and non-working women. The result showed employment has a beneficial effect on the life satisfaction of women of Kumaun Region.

Gupta et al (2003) examine the adjustment problem of married and unmarried working women. The sample included 300 women working as teachers in different schools of Varanasi city, among which 150 were married and 150 were unmarried. The teacher adjustment inventory developed by Mangal, S.K. (1996) was administered to the total sample. T-test was applied to see the differences of mean adjustment between married

and unmarried teachers. Results reveals that married working women are better adjustment than unmarried working.

Bala and Monga (2004) found that the tribals in India have inherit aged a rich culture from their ancestors. However, with the onslaught of industrialization, urbanization and modernization and the resultant migration of tribal men, women and girls to urban centres the age-old culture of these primitive human societies is on the verge of extinction. It is suggested that all-out efforts must be made to make the tribal realize the importance of their culture and to motivate them for preserving their unique culture at any cost. The greater responsibility in this respect rests with the migrant tribal women and girls who lost contacts with the tribal people in their hinterlands.

Kulkarni (2005) in new findings on the role of estrogens in treating psychotic mental illnesses such as schizophrenia and bipolar affective disorder say that as women approach and reach menopause, there is an increased risk of relapse for those who have schizophrenia and also a risk of new-onset schizophrenia for otherwise healthy women. Therapy for women in peri menopause and thereafter should be holistic, taking into account the psychosocial, biological and hormonal changes that may well be key driving forces in the emergence of psychotic symptoms or in the exacerbation of existing psychosis. As with psychotic disorders in all women, the etiology has biological, psychological, and social components, all of which must be addressed. A woman with schizophrenia may well have experienced cognitive deficits, poor self-esteem, social disabilities, and physical ill health because of her serious mental condition, which can all be exacerbated by menopause. It is imperative that mental health clinicians be aware of and be able to recognize the special problems of women with psychosis as they go through menopause and try to help them attain a good quality of life during this transition period.

Raj (2005) conducted a study of “Pregnancy complications and health-seeking behaviour among married women in Uttar Pradesh, India” Childbirth is one of the important events affecting health of a woman, especially in developing countries likes India. According to National Family Health Survey-2 (1998-99) Antenatal care (ANC) coverage is the least in the state of Uttar Pradesh where only 34.6 per cent of women avail of any type of ANC

services during pregnancy, indicating that for most of the women pregnancy complications are neither detected nor treated. This paper is based on the data collected by NFHS-2 and examines the pregnancy complications among married women in Uttar Pradesh and also analyses the health seeking behaviour of these women.

Singh and Arora (2005) studied the “Profile of menopausal women in rural north India” with an objective to ascertain the profile of menopausal women in rural north India. Six villages were selected in a rural field practice area of Department of Community Medicine, Postgraduate Institute of Medical Education and Research, Chandigarh, north India. Results of the 558 enlisted women, 152 (27.2%) had attained menopause. Average age at menopause was 44.1 years. More than half (53%) reported seven or more symptoms at menopause. Diminished vision was reported as the most common symptom at menopause. The majority (85%) admitted that menopause adversely affected women's physical health. However, most of them (95%) considered menopause socially good for women and welcomed it. None of our respondents reported use of hormone replacement therapy. Women in rural north India viewed menopause positively. Medicalization of menopause was minimal.

Jain, Nandan and Misra (2006) conducted a qualitative study through focus group discussions in 18 villages of 3 rural community development blocks of district Agra(UP) selected on the basis of performance of RCH indicators. Multistage stratified sampling technique was used. Majority of people first try home treatment and only when they are not relieved they opt for approaching any provider. Choice of health providers depends on the elder male members or decision makers, literacy and socio economic status, past experience and perceived quality of health care also play a pivotal role in selection of provider.

Kumari et al (2005) examined change in health functioning as women progress through the menopausal transition. Prospective study of 2,489 women followed through four phases of the Whitehall II study. Health functioning was assessed with the eight subscales of the SF-36. Compared with peri- and postmenopausal women who did not experience menopausal symptoms, women who reported vasomotor symptoms or menopausal depression experienced large and significant declines on most scales of the SF-36.

Women who reported the greatest symptom severity experienced the largest declines in functioning. For example, decline in physical functioning for perimenopausal women experiencing severe vasomotor symptoms was 3.3 (standard error SE=1.1) greater than those who experienced no vasomotor symptoms. Decline in role limitation-emotional for perimenopausal women experiencing severe menopause-associated depression was 18.4 (SE=2.3), compared with those who did not experience these symptoms. Vasomotor symptom reporting was predicted by low socioeconomic position, high body mass index, and limiting long-term illness at baseline. Menopause-associated depression was additionally predicted by smoking and depression. The menopausal transition is associated with decreased health functioning in women who report menopausal symptoms. Menopausal symptoms are strongly related to all aspects of health functioning assessed by the SF-36. Socioeconomic and behavioral risk factors for menopausal symptoms and associated declines in health functioning have been identified.

Fernandes (2006) while making a study of tribal women in NE region found that among the Aka and Dimasa more men and women want to restrict higher education to boys. All the Adibasi men opt for it. However, 338 respondents favour equal opportunities for boys and girls in higher education. Only 4 men, one each Aka and Angami and 2 Dimasa, all of them above 60, said that women should not take salaried jobs as they have to look up the families.

Bhasin (2007) has carried out her study about tribal women in different geographic region i.e. Ladakh, North Eastern Region, Rajasthan and her findings show that the tribal women possess a lot of importance in tribal communities. Even the tribal communities of Rajasthan do not look upon the birth of girl child as a curse. Dowry system is not there. The girl possesses the right to choose her husband. Divorces are easy and well secured. Women play vital role in economic activities. They take joint decision along with the male counterparts. The study also reveals that women power is not extended to societal or political sphere. Their economic power is not translated in to corresponding community authority. Women supremacy is restricted with household domain and due credit and importance is not given at official level. Women have secondary importance in public affair and community decision making.

Mitra (2007) has analyzed the status of women among schedule tribes in India with comparison to main stream Hindus, in term of social and cultural practices. The study shows that isolation from main stream population for many years have been actually helped, tribal community to provide relatively high status of tribal women and there is absolutely no gender discrimination in many tribal communities. It may have occurred due to assimilation of many tribal group with main stream Hindu culture and tradition.

Jan et al (2008) Self-esteem has enormous influence on mental health of women. Self-esteem comprises self-worth and self-image, which affects women's adjustment in various spheres of life. This paper presents relation of age, family income, and family type with self-esteem among women. In this context, 100 women were selected through multistage sampling method, administering questionnaire, and 'self-esteem scale for women' (SESW) on them. The study reveals highly significant relation of family type with self-esteem in personal life of women. Significant differences are also found among women in joint, nuclear and extended families, concerning their self-esteem in family relations, career life, and overall self-esteem. Family income has also shown significant association with women's self-esteem in family relations.

Singh and Gupta (1997) conducted a study on "Health Seeking Behaviour and Healthcare Services in Rajasthan, India: A Tribal Community's Perspective". An attempt has been made to investigate the health seeking behaviour of the tribal communities in four tribal districts of Rajasthan, India, namely Banswara, Dungarpur, Udaipur and Sirohi. It was observed that people generally do not pay much attention to the routine problems during ante-natal, natal and post-natal periods, which they regard as a built in part of child bearing and child rearing. In the case of reproductive health problems and general health problems like fever and malaria, at the first stage some treatment is administered at home, followed by a visit to the bhopa (the local faith healer) and a herbalist in that order. The next stage involves visiting a nurse or an ill-qualified or unqualified medical practitioner, depending upon availability. It is only in very advanced stages of the problem that the help of a qualified medical person is sought. In the case of dental problems, as well as for cough and cold, the problem is ignored till the last minute, until the pain becomes unbearable. In the case of children's problems, they are mostly treated by giving some indigenous treatment, and in case the problem should persist after

a certain period, the help of a medical practitioner is sought, who may or may not be qualified. In some specific problems like poisoning, all people reported visiting faith healers and claimed that their treatment is very effective. In cases of abortion also, the help of a herbalist or an experienced traditional Birth Attendant (TBA) is sought, who may or may not be trained, to abort the foetus by using indigenous methods. The second part of the study deals with the community's perspective of health services and health personnel. It also looks at the issue of integration of Private Medical Practitioners (PMPs) and traditional Birth Attendants (TBAs) in improving the delivery of health services. The paper overviews the community perception about the Non- Governmental Organisations working in the health sector.

Subha (2010) in her paper on “Is menopause a health risk for Bengali Women?” says that researches suggest that people’s perception about menopause largely depends on the inherent socio-cultural context. In some of the developed countries of the west, menopause is viewed pessimistically. So, the understanding of this reproductive phase as a health risk and the approach to medicalise it are more pronounced in these countries. Some studies show that presently, to certain extent, people from developing countries are espousing menopause in a similar way like the west. The present study aims to understand the knowledge, attitude and perception of urban middle class women of West Bengal (India) towards menopause. The data have been collected on the post-menopausal women from their lived experiences. The result shows that women of this study group are not much concerned with menopause and menopausal problems and do not perceive this reproductive episode of their life as health risk. It seems that the socio-cultural perspective of the Bengali middle class epitomize menopause as uneventful. Thus, it appears that the agenda of promoting menopause as a medical model, has probably failed to penetrate the life of Bengali middle class community.

Jan (2010) found that increase in women's Desire for Social Freedom (DSF) has positive impact on egalitarian Decision Making Power (DMP) and feminine DMP in the family; while masculine DMP and familial DMP is negatively influenced by DSF. A sample of 360 women was selected through multistage random sampling method from Kashmir region of Jammu and Kashmir State in India with the objective to correlate women's Desire for Social Freedom (DSF) with their Decision Making Power (DMP). The tools

and techniques comprised two research scales namely Women's Decision Making Power (DMP) constructed by Jan (2004) and Women's Desire for Social Freedom (DSF) constructed by Bhushan (1987).

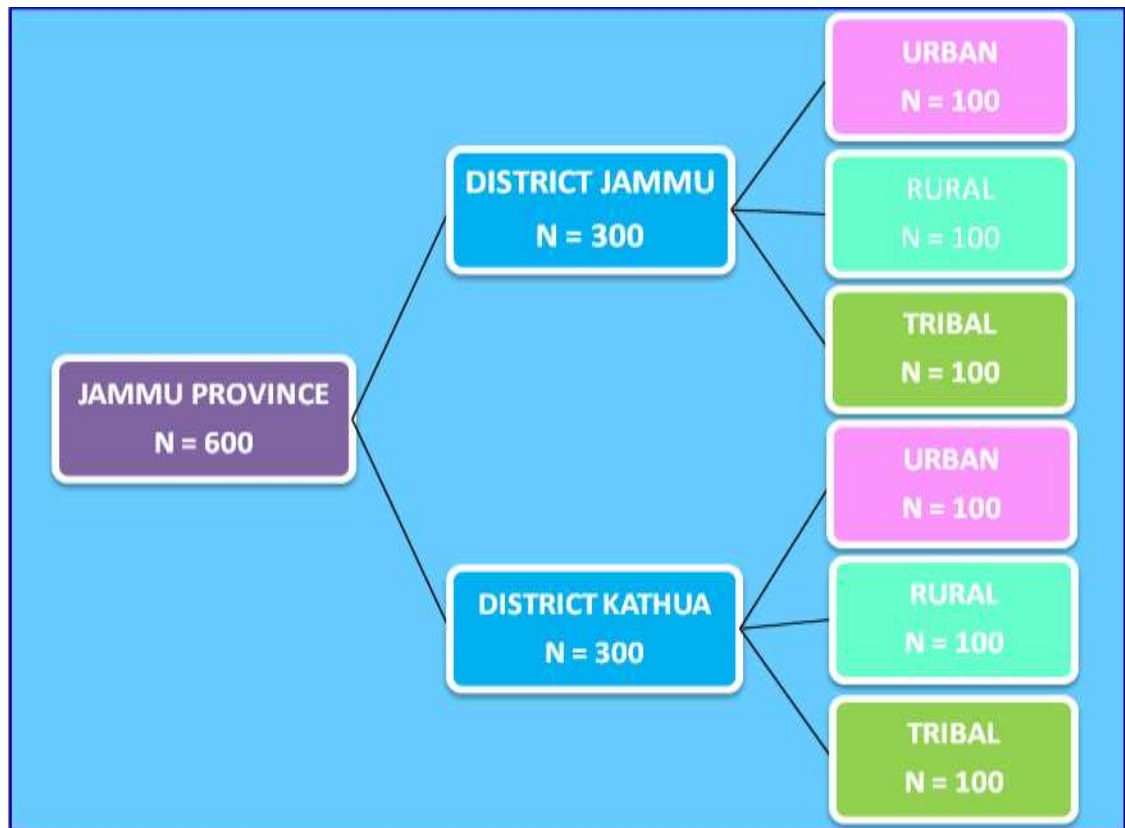
Summary of the review:

- International and national status indicates that factors that influence the health seeking behaviour are limited access to money, transport, decision making and nature of women's work.
- There are very few studies in context of health seeking behaviour among women in menopausal transition.
- There is relationship between economic status, educational status and health seeking behaviour.
- Health care providers play a significant role in health seeking behaviour.
- Choice of health providers depends on decision makers, literacy, socio-economic status, past experiences and perceived quality of health care.
- Women's health issues grossly neglected by herself and policy makers
- Documentation of reproductive period but beyond that a grey area.
- There is a need to identify areas in women's post reproductive health that require attention
- The concept of studying health seeking behaviours has evolved with the course of time and has ultimately become a tool for understanding how people employ the health care systems in their respective socio-cultural, economic and demographic circumstances.
- All these behaviours actually define social position of health and provide a better understanding of the disease process.
- It is therefore imperative to study the impacts of all the determinants, such as ethnicity, education, gender, lifestyles, or economics of a community.
- All the same, biomedical knowledge alone cannot guarantee better health.

- Health practitioners, managers and policy makers ought to reflect on social determinants while delivering services, designing health promotion interventions and developing policies.
- To build a responsive health system, there is a strong need to understand the health seeking behaviours on the demand side and that is the only way to expect improved health outcomes.

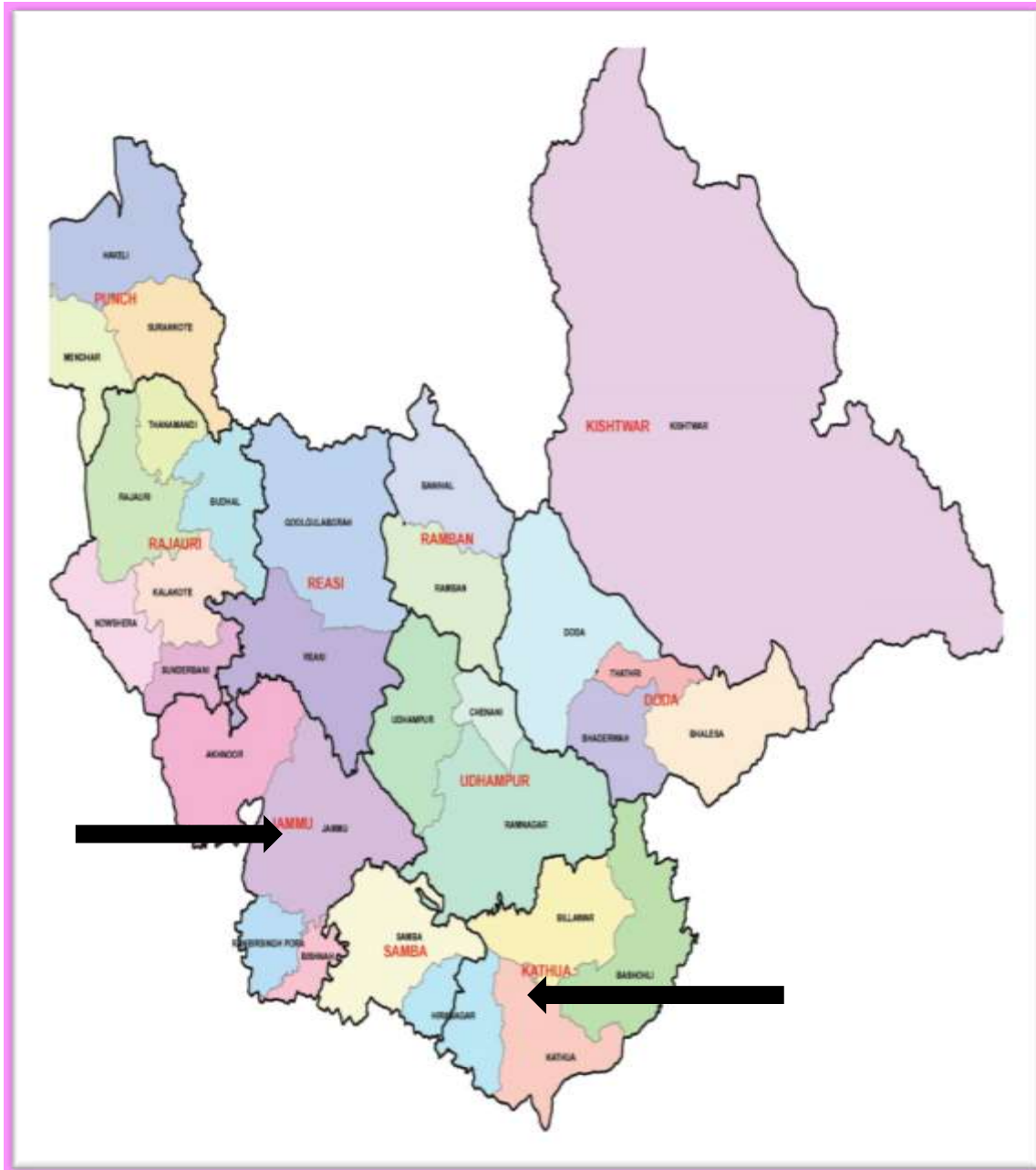
Sample: The sample size for the study comprises of 600 women in the age group of 35-65 years. The sample was equally distributed between two districts and further among Urban, Rural and Tribal areas, as shown in the following figure (3.1)

Fig. 3.1: Sample Distribution



Locale: The study was conducted in rural, urban and tribal areas of Jammu and Kathua Districts of Jammu province of the Jammu and Kashmir State.

Fig. 3.2: Showing the area under study in the Jammu Province of the J&K state.



THE CRITERIA FOR SAMPLE SELECTION:

Age: Only women above the age of 35 and below of 65 were included.

Residence: The sample was systematically selected from rural, urban and tribal areas of Jammu and Kathua district.

Health: Women having any apparent signs of physical or psychological disability were not included in sample group.

Marital Status: Only married women were selected.

Sampling Technique: Multistage sampling technique was used to systematically select the sample:

Rural: Out of four tehsils of Jammu, three were selected randomly and a list of villages was obtained. From the list, randomly 10 villages from each district were selected. From each village 10 women were selected through purposive sampling technique. In Kathua District also, there are four tehsils so similar technique was used for District Kathua.

Urban: Sample was selected from various wards of Kathua and Jammu City. There are 71 wards in Jammu and 17 in Kathua out of which 10 wards each were selected randomly from both the urban areas and from each ward 10 women were selected purposively.

Tribal: Areas having a concentration of Gujjar tribal population were identified from Jammu and Kathua tehsils. Sample was randomly selected from these areas.

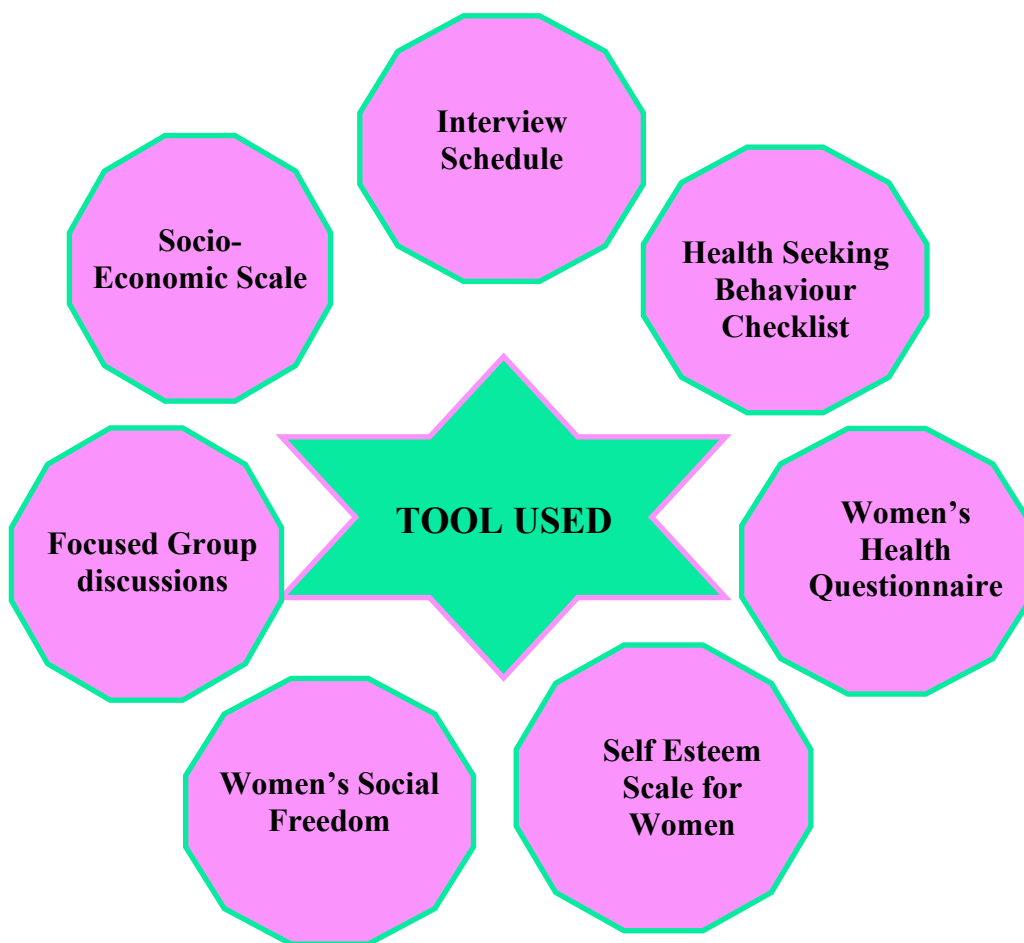
Table 3.1: Showing distribution of sample.

DISTRICT JAMMU		
RURAL	URBAN	TRIBAL
Kotli Mian Fateh	Greater Jammu	Nawabad Tower hill colony
GurdeepVihar, R.S. Pura	Kunjwani	Sunjuwa
Bishnah	Janipur	Bhithidi
Kanhal	Akhnoor	Batala
BalBagh	Lower Roop Nagar	Gujjar Nagar
ChackMohamad Zara	ShahidiChowk	Gujjar Colony Near Peer Baba
Dablehar	Trikuta Nagar	Kotbalwal
ChakBala	ChanniHimat	Jallabaghchowk
GurahBhramna	Kunjwani	
MawaKrara	Gandhi nagar	
DISTRICT KATHUA		
RURAL	URBAN	TRIBAL
Khrote	Gandhi Chowk W.No.7	Supalma
Barwal	Patel Nagar	Manayari

Dhali	Lower Shiva Nagar	Haripur
Supalma	Indira colony	Lachipur
Channmorian	Krishna Colony W.No 3	Mandala
Naroli	MandiSher Singh W.No.5	Gujjar Chak
Sample Sapla	Ward no.8	HariyaChak
Billawar	Ward no.9	Pansar
Deoli	Krishna nagar ward no. 4	NaunChak
Paddu	Shastri Nagar	ChackHanda
		ChackDeso

TOOLS USED: Keeping in mind the objectives of the research the following tools were selected / constructed for the sample.

Fig. 3.3: Showing tools used for the study



1. **Interview Schedule:** Based on Tanner and Vaseloff's (1998) systematization of risk factors for women, an open ended interview schedule was framed and then given to experts, modification and changes were suggested by the experts. After modifications it was pre-tested on 20 rural and 20 urban women from both the districts. During pre-testing, it was found that on most of the items, respondents were not able to give the appropriate answers for measuring objective No: 1, then a close ended interview schedule was prepared, and given to experts for evaluation. After some modifications interview schedule was finalized and used.
2. **Health Seeking Behaviour Checklist:** In addition to the interview schedule, a need was felt to construct a checklist which includes those items that can be used to classify the women as active or passive health seekers. After initial brainstorming, a list of items was prepared and in the form of a checklist, these forms were given to experts to rate and give their views. Modification and changes were suggested by the experts which were incorporated and the tool was pre tested on a small sample. After pre-testing, it was finalized after minor changes and used on the sample. This scale possess high reliability quotient of 0.51

Scoring: For positive scores a mark of +1, for negative -1 is assigned and then the total scores were calculated for a particular individual. The responses on all the items were put together and statistically treated. On the basis of scores obtained on the scale by respondents, the criteria was developed by calculating quartiles for classifying the levels of their health seeking behaviour.

Table 3.2: Interpretation of scores of health seeking behaviour among women based on scores

Scores	Interpretation
1-8	Low
9-12	Moderate
13 and above	High

3. **Women's Health Questionnaire:** Women's Health Questionnaire (WHQ) developed by Myra S. Hunter (2003) was used because it is a 37-item questionnaire which assesses nine domains of physical and emotional health rated on four point scale. The questionnaire measures a range of domains of symptom experience, some of which are relevant to the menopause, such as vasomotor symptoms, and others which are associated with psycho-social factors, general health and or ageing, such as sleep and sexual problems and cognitive difficulties. Applications of the WHQ have been varied and range from the evaluation of hormone treatments for menopause related problems, to epidemiological studies with populations of healthy women. The WHQ is population specific in that it is applied to women only. Consequently the WHQ can also be considered to be a 'generic' QOL measure for these mid-aged populations. Each score is scaled to give a range from 1 to 4. Higher scores reflecting a greater level of symptomatology or difficulty and low health status.
4. **Socio Economic Status:** This scale is devised by S.C. Tiwari, Aditya Kumar and Ambrish Kumar (Department of Geriatric Mental Health, King George's Medical University, Lucknow, India, 2004). The scale aims to assess the socio-economic status in rural and urban communities in India. The scale had seven profiles (House, material possession, educational, occupational, economic, possessed land / house cost, social profiles) which were rated on 10-point scale. The validity and reliability of the scale was established through a defined Visual Analogue Scale (VAS) and test-retest methods. The **validity** of the scale was high demonstrating its sensitivity to discriminate families between middle and upper classes.
5. **Women's Social Freedom Scale:** This scale is devised by L.I Bhusan (1987).The WSF-Scale consists of 24 statements that pertain to whether women should or should not have freedom in a variety of sphere life (i.e. social taboos, conventions, rituals and roles which provide them the lower status in the society).This scale possess high reliability quotient of 0.75. and construct validity has been established. **Scoring:** Positive responses scores a mark of +1, for negative-1 is assigned and then the total scores are calculated for a particular individuals. The responses on all the items were put together and statistically

treated. On the basis of scores obtained on the scale by respondents, the criteria developed by calculating quartiles for classifying the levels of their Desire for freedom.

Table 3.3: Interpretation of scores of Desire for social freedom among women based on scores

Scores	Interpretation
1-9	Low Desire for freedom
10-12	Moderate Desire for freedom
13 and above	High Desire for freedom

6. **Self Esteem Scale for women:** This scale was developed by **Kapadia and Verma (2000)**. It is a multidimensional concept which has generally been used to refer to the evaluative dimensions of the self. It is a standardized scale which was used without any modifications. This scale Possess high reliability quotient of 0.86. Concurrent and construct validity has been established.

Scoring: For positive items scores 3,2,1 are assigned to most often, sometimes and rarely respectively for negative 1,2,3 for most often, sometimes and rarely respectively and then the total scores were calculated for a particular individuals. The responses on all the items were put together and statistically treated. On the basis of scores obtained on the scale by respondents, the criteria developed by calculating quartiles for classifying the levels of Self Esteem.

Table no 3.4: Interpretation of scores of Self- esteem among women based on scores

Scores	Interpretation
1-84	Low Self Esteem
85-89	Moderate Self Esteem
90 and above	High Self Esteem

DATA COLLECTION:

The actual process of data collection was preceded by testing the viability of the interview schedule, checklist and the scales. This was accomplished by performing a pilot study.

PHASE-I:

Pilot Study: All the tools were pretested on a sample of 20 urban and 20 rural women from both the districts. Necessary modifications were made before the final data collection. In addition to the interview schedule, a need was felt to construct a checklist which includes those items that can be used to classify the women as active or passive health seekers. So a 20- item Health Seeking Behaviour Checklist was devised.

PHASE-II:

Data Collection:

At the initial stage of data collection it was not easy to get the information from females in rural as well as tribal areas. . Women were hesitant to give responses to these questions. So a local female, who was very familiar to the place and people, was requested to accompany during the interview and help in motivating the respondents. It did prove beneficial as the initial ice breaking became easier. In the urban areas women were reluctant to respond as they did not have time. Motivating them was not easy, but in the end they did complete the interview. Interview schedules were administered along with other scales and questionnaire to the women. The duration of each interview was about 1-2 hours. 2-3 visits were made for focus group discussion. Attempt was made to conduct interviews and focussed group discussion in their leisure time.

DATA ANALYSIS:

The data was subjected to both qualitative and quantitative analysis. The qualitative data was obtained through interview schedule. The responses obtained on interview schedule were analysed and categories were framed and responses were framed under these categories. After that differences were measured by using statistical techniques i.e. chi square. The data has been represented diagrammatically and graphically.

Coding of the quantitative data obtained through Checklist and Scales was done for each sample to facilitate the computer processing. The analysis was done using SPSS (Statistical Package for Social Science Research version 15.0). The data collected from the sample chosen was analysed by using frequencies and percentages, chi square, mean, standard deviation, correlation and one-way ANOVA.

Frequencies and Percentages were used to analyse Knowledge and beliefs about wellbeing and illness, user/provider relationship. Role in health at household level, decision making at household and community level, Use of service, quality of health services, social stigma. Division of labour, substitution of labour, Economic policies in relation to accessibility of service/care, availability of cash.

Mean and Standard deviation were calculated for further statistical analysis.

Chi square was also used to find out the difference between both district wise as well as ethnicity wise.

Correlation was used to find out the relationship between desire for social freedom, self-esteem health seeking behaviour and components of WHQ of women with that of the various demographic variables like Age, Education, Type of Family and Occupation.

One Way ANOVA was used to find out the association of socio demographic variables Women's Social Freedom, Self Esteem Scale Women, Women Health Questionnaire and Health Seeking Behaviour Checklist among women of rural, urban and tribal areas from both the districts.

4.1 BACKGROUND INFORMATION

Table 4.1.1: Background information of the respondents

Education	Frequency N = 600	Percentage (%age)
Illiterate	230	38.3
Primary	68	11.3
Secondary	134	22.3
Hr. Secondary	64	10.7
Graduation	57	9.5
Post Graduation	45	7.5
Technical	2	0.3
Occupation		
Service Holder	58	9.7
Business	11	1.8
Pension Holder	14	2.3
Daily Labourer	3	0.5
House Hold Work	12	2
Home Maker	402	67
Caste Occupation	100	16.7
Family Type		
Joint	288	48
Nuclear	312	52
Socio-Economic Status		
Upper	8	1.3
Upper Middle	157	26.2
Middle	274	45.7
Lower Middle	160	26.7
Lower	1	0.17

Table 4.1.1 reveals that majority of respondents (38.3%) are illiterate, 22.3% have studied upto secondary class, 11.3% have studied upto primary and 10.7% have studied upto higher secondary. Majority of the respondents (67%) are home makers, 16.7% indulge in caste occupation and 9.7% respondents are service holders. Majority of respondents (52%) are living in nuclear families whereas 48% are residing in joint families. Results further indicates that majority of the respondents i.e. 45.7% belong to middle class, 26.7% belong to lower middle class and 26.1% belong to upper middle class.

Table 4.1.2: Mean age of the respondents during transitional phases of life

Variables	Mean	Std. Deviation
Age	49.59	9.3
Age at Menarche	14.08	1.4
Age at Marriage	19.42	4.2
Age at 1st Pregnancy	21.02	4.4
Age at last Pregnancy	28.20	6.08
Age at Menopause	48.6	4.47

Results presented in the Table 4.1.2 reveal that present mean age of the respondents is 49.6 ± 9.3 years. Their average age at menarche is 14.08 ± 1.4 , age at marriage is 19.42 ± 4.2 , age at first pregnancy is 21.02 ± 4.4 , age at last pregnancy is 28.2 ± 6.08 and average age at menopause is 48.6 ± 4.47 years respectively.

4.2 HEALTH SEEKING BEHAVIOUR OF THE RESPONDENTS

Health Seeking Behaviour Checklist was prepared on the basis of focused group discussion, carried out during the pretesting phase and observations of the rural, urban and tribal areas, to get the information regarding the levels of Health Seeking Behaviour of the respondents.

Table 4.2.1: Level of Health Seeking Behaviour of respondents

Health Seeking Behaviour	DISTRICT WISE		ETHNICITY WISE			Total N= 600
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200	
Low	54 (18)	121 (40.3)	47 (23.5)	96 (48)	32 (16)	175 (29.17)
Moderate	138 (46)	126 (41.7)	91 (45.5)	70 (35)	103 (51.5)	264 (44)
High	108 (36)	53 (17.3)	62 (31)	34 (17)	65 (32.5)	161 (26.83)
χ^2	44.98**		55.64**			

Percentage in Parentheses; **significant at $p \leq 0.01$

Fig. No. 4.2.1 (a): Figurative presentation of table 4.2.1

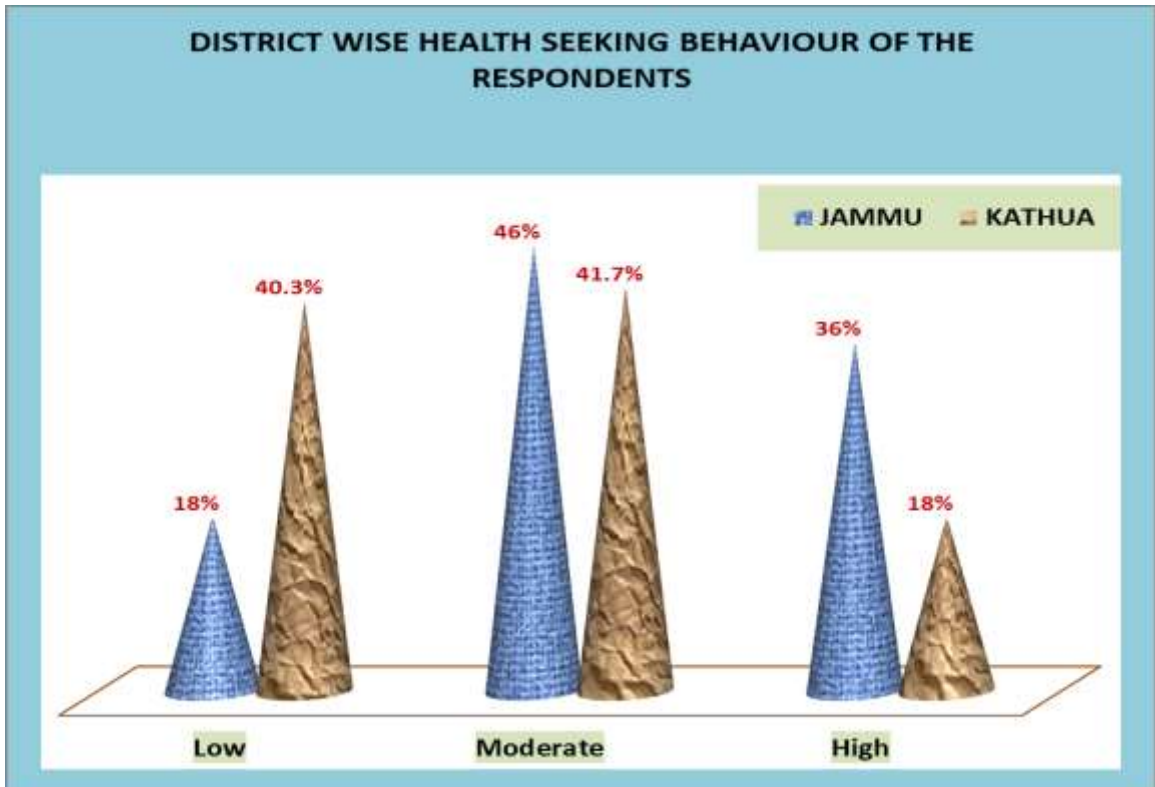
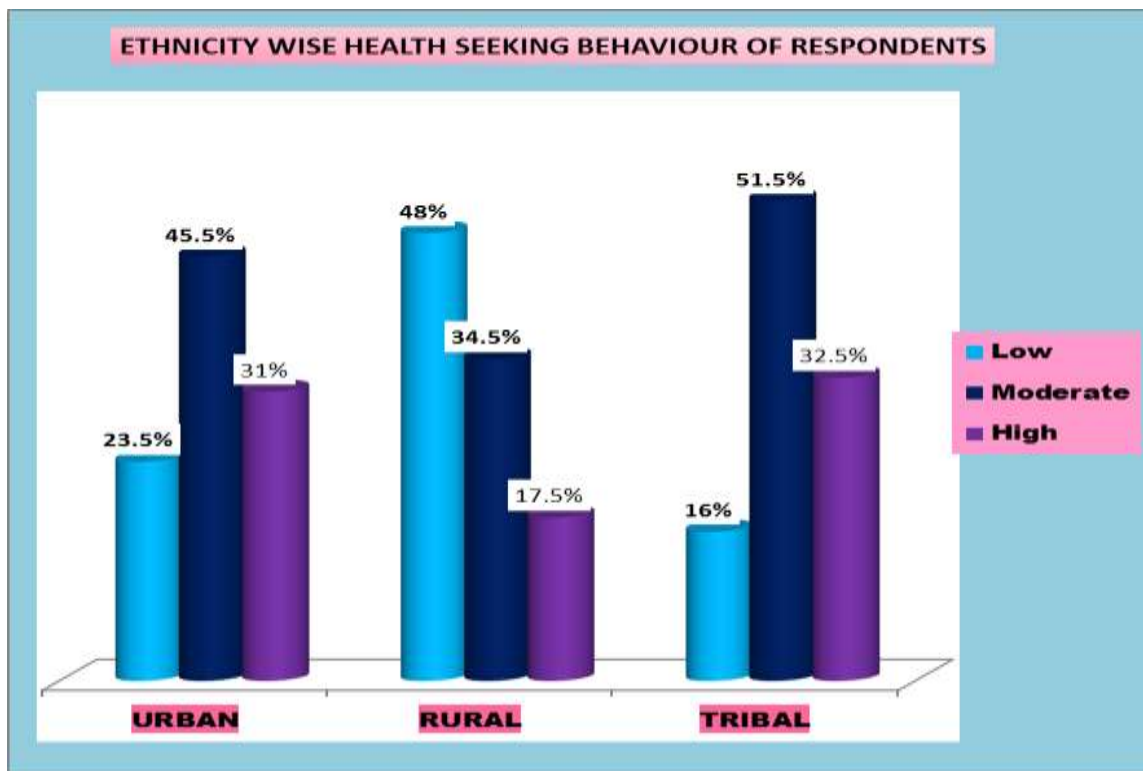


Fig. no. 4.2.1(b): Figurative presentation of table 4.2.1



Overall results in Table 4.2.1 show that 44% of the respondents have moderate level of health seeking behaviour followed by 29.17% of respondents who show low level of health seeking behaviour and 26.83% who have high level of health seeking behaviour. **District wise** results indicate that 46% respondents from the Jammu district are moderate health seekers and 36% show high level of health seeking behaviour. On the other side 41.7% respondents from the Kathua district are moderate health seeker and 40% show low level of health seeking behaviour. It can further be analysed that respondents from the Jammu district show moderate to high level of health seeking whereas respondents from the Kathua district show moderate to low level of health seeking.

Ethnicity wise results indicate that most of the respondents from urban (45.5%) and tribal (51.5%) areas are moderate health seekers whereas most of the respondents (48%) from rural areas show low level of health seeking. 32.5% tribal, 31% urban and only 17.5% rural respondents show high level of health seeking behaviour. Overall results reveal that most of the respondents (44%) show the moderate level of health seeking behaviour, followed by 29.17% who have low level of health seeking and

26.83% have high level of health seeking behaviour. **Chi-square** values reveal significant difference ($p \leq 0.01$) both district wise as well as Ethnicity wise

Table 4.2.2: Education, socio-economic status, type of family and levels of health seeking behaviour of the respondents

BACKGROUND VARIABLES	LEVELS OF HEALTH SEEKING BEHAVIOUR							
	Low		Moderate		High		Total	
	F	%age	F	%age	F	%age	F	%age
EDUCATION								
Illiterate	84	14	102	17	44	7.3	230	38.3
Upto Primary	17	2.83	34	5.7	17	2.83	68	11.3
Upto Secondary	33	5.5	66	11	35	5.83	134	22.3
Upto Higher Secondary	23	3.83	22	3.7	19	3.17	64	10.7
Upto Graduation	12	2	17	2.83	28	4.7	57	9.5
Upto Post Graduation	6	1	22	3.7	17	2.83	45	7.5
Technical	-	-	1	0.17	1	0.17	2	0.33
SOCIO ECONOMIC STATUS								
Upper	1	0.33	3	0.5	4	0.67	8	1.33
Upper Middle	39	6.5	63	10.5	55	9.17	157	26.17
Middle	86	14.3	118	19.67	70	11.67	274	45.67
Lower Middle	49	8.1	79	13.17	32	5.33	160	26.6
Lower	-	-	1	0.17	-	-	1	0.17
TYPE OF FAMILY								
JOINT	98	16.3	118	19.67	72	12	288	48
NUCLEAR	77	12.83	146	24.3	89	14.83	312	52
TOTAL	175	29.17	264	44	161	26.83	600	100

It is clear from the results given in the table 4.2.2 that 17% of the respondents who are illiterate show moderate level of health seeking behaviour, 14 % of them who are illiterate show low health seeking behaviour and 11% who are educated upto higher secondary level show moderate level of health seeking behaviour. 19.67% respondents who belong to middle socio-economic strata are moderate health seeker, 14.3% show moderate level of health seeking behaviour and 11.67 % show high level of health

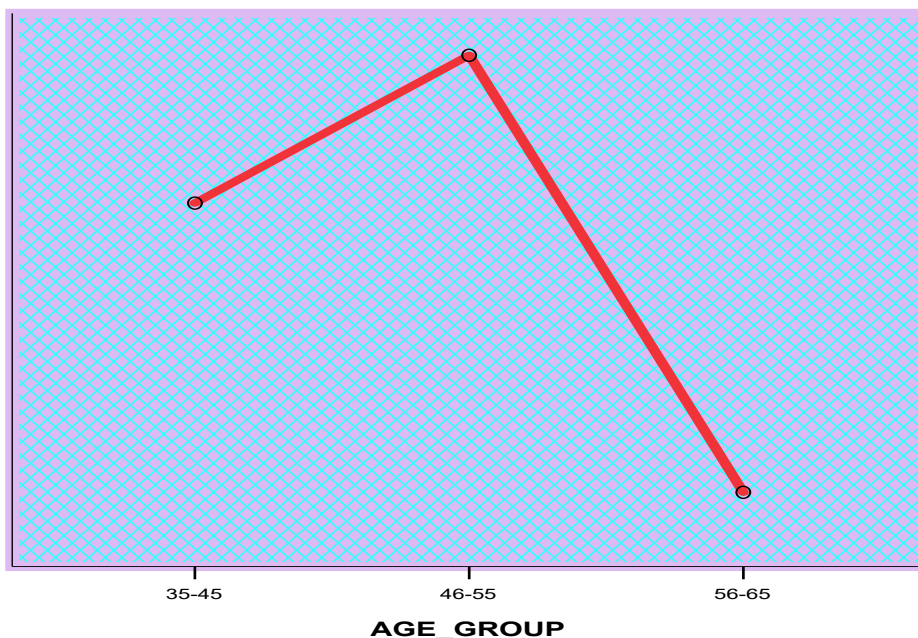
seeking behaviour. 13.17% of respondents belong to lower middle SES show moderate level of health seeking behaviour. Results further indicate that majority of respondents (52%) reside in nuclear families and 48% reside in joint families. 24.3% respondents living in nuclear families show moderate level of health seeking behaviour, 14.83% show high and 12.83% show low level of health seeking behaviour. 19.67% respondents living joint families show moderate level of health seeking behaviour, 16.3% show low level and 12% show high level of health seeking behaviour.

Table 4.2.3: Mean Scores of respondents on Health Seeking Behaviour Checklist

VARIABLE	Mean N = 600	S. Dev.
Health Seeking Behaviour	10.20	3.698

Table 4.2.3 shows that that respondent’s score 10.20, on an average on the Health Seeking Behaviour Checklist with a standard deviation of 3.698. The fig. 4.2.3 (a) given below shows that as age increases the mean scores on Health Seeking Behaviour decreases peaking around the age of 46-55 years, coinciding with the menopausal transition. The mean of the respondent’s age at menopause, who have attained it, is 48.6 ± 4.47 years in the present study.

Fig. 4.2.3 (a): Age group wise figurative representation of HSBC.



ITEM ANALYSIS OF HEALTH SEEKING BEHAVIOUR CHECKLIST

Table 4.2.4: District wise mean and t scores of the respondents

Items of Health Seeking Behaviour Checklist	DISTRICTS		
	Jammu	Kathua	't' Value
	Mean ± Std. Dev	Mean ± Std. Dev	
I regularly do physical exercise for half an hour.	0.44 ± 0.49	0.19 ± 0.39	6.920**
I sleep soundly for 7-8 hrs. daily	0.86 ± 0.34	0.74 ± 0.44	3.80**
I examine myself for lump or swelling in body once in a month.	0.43 ± 0.49	0.4 ± 0.49	.662
I regularly go for weight and B.P check up	0.58 ± 0.49	0.47 ± .500	2.71**
I go for dental check-up once in a year	0.37 ± 0.484	0.28 ± .451	2.35**
I go for cancer screening test after every two years.	0.09 ± 0.291	0.4 ± 0.19	2.63**
I go for complete health check-up once in a year.	0.30 ± 0.45	0.13 ± 0.34	4.96**
I always consult doctor for continuous hair fall.	0.44 ± 0.49	0.21 ± 0.41	6.18**
I always consult doctor before having any kind of medication.	.78 ± 0.41	0.56 ± 0.49	5.87**
I always consult doctor in case of piles.	0.84 ± 0.36	0.57 ± 0.49	7.49**
I regularly take my breakfast before 9:00 a.m.	0.65 ± 0.47	0.60 ± 0.49	1.27
I regularly take my lunch before 2:00 p.m.	0.28 ± 0.45	0.31 ± 0.46	.714
I regularly take my dinner before 8:00 p.m.	0.29 ± 0.45	0.39 ± 0.48	2.42**
I regularly take fruits and nuts.	0.56 ± 0.51	0.52 ± 0.5	.802
I drink 7-8 glasses of water daily.	0.67 ± 0.49	0.73 ± 0.44	1.65
I take milk twice a day regularly.	0.41 ± 0.49	0.53 ± 0.5	2.88**
I always wash my hands before touching any eatables.	0.96 ± 0.23	0.88 ± 0.32	3.59**
I always use fresh water.	0.95 ± 0.26	0.86 ± 0.35	3.54**
I always keep my medical records with care.	0.87 ± 0.36	0.49 ± 0.50	10.397**
I regularly watch/ hear health programme on T.V/ radio	0.54 ± 0.51	0.22 ± 0.41	8.252**

*significant at p≤0.05, **significant at p≤0.01

Table 4.2.4 depicts significant differences in Health Seeking Behaviour of respondents on the items such as physical exercise, sound sleep, weight and blood pressure check-ups, dental check-ups, cancer screening, complete health check-ups, consultation for hair fall, having medicine without consultation, consultation regarding piles, meals (Dinner), milk usage, maintaining medical record and watching health awareness programmes on T.V. among respondents from Jammu and Kathua with means favouring the respondents from Jammu. Results further indicates that that the respondents from Jammu District show higher mean scores on items such as physical exercise($t=6.92, p\leq .01$), sound sleep ($t = 3.8, p\leq .01$), weight and blood pressure check-ups ($t = 2.71, p\leq .01$), dental check-ups ($t = 2.35, p\leq .01$), cancer screening test ($t = 2.63, p\leq .01$), complete health check-up ($t = 4.96, p\leq .01$), consultation for hair fall ($t = 6.17, p\leq .01$), having medicine with consultation ($t = 5.87, p\leq .01$), consultation regarding piles ($t = 7.49, p\leq .01$), washing hands before eating anything ($t = 3.59, p\leq .01$), fresh water usage ($t = 3.54, p\leq .01$), maintaining medical record ($t = 10.397, p\leq .01$) and watching health awareness programmes on T.V ($t = 8.25, p\leq .01$) than respondents from Kathua who scored higher mean on regular dinner timings ($t = 2.42, p\leq .01$) and milk usage ($t = 2.88, p\leq .01$).

Table 4.2.5: Association of Health Seeking Behaviour with Ethnicity.

Items of Health Seeking Behaviour Checklist	Urban	Rural	Tribal	F value
I regularly do physical exercise for half an hour.	0.41 ± 0.49	0.16 ± 0.36	0.39 ± 0.49	19.35**
I have sleep soundly for 7-8 hrs. daily	0.81 ± 0.39	0.78 ± 0.42	0.81 ± 0.39	.506
I examine myself for lump or swelling in body once in a month.	0.43 ± 0.50	0.41 ± 0.49	0.41 ± 0.49	.089
I regularly go for weight and B.P check up	0.53 ± 0.50	0.48 ± 0.50	0.56 ± 0.50	1.168
I go for dental check-up once in a year	0.32 ± 0.47	0.27 ± 0.44	0.40 ± 0.49	4.22**
I go for cancer screening test after every two years.	0.08 ± 0.27	0.10 ± 0.29	0.03 ± 0.16	4.41**

I go for complete health check-up once in a year.	0.30 ± 0.46	0.16 ± 0.37	0.19 ± 0.39	6.045**
I always consult doctor for continuous hair fall.	0.40 ± 0.49	0.27 ± 0.44	0.33 ± 0.47	3.87*
I always consult doctor before having any kind of medicines.	0.68 ± 0.47	0.57 ± 0.50	0.76 ± 0.43	8.812**
I always consult doctor in case of piles.	0.75 ± 0.43	0.55 ± 0.50	0.83 ± 0.38	21.63**
I regularly take my breakfast before 9:00 a.m.	0.64 ± 0.48	0.43 ± 0.50	0.83 ± 0.38	38.52**
I regularly take my lunch before 2:00 p.m.	0.31 ± 0.46	0.20 ± 0.40	0.39 ± 0.49	8.44**
I regularly take my dinner before 8:00 p.m.	0.23 ± 0.42	0.21 ± 0.41	0.59 ± 0.49	46.15**
I regularly take fruits and nuts.	0.54 ± 0.50	0.37 ± 0.51	0.72 ± 0.45	25.61**
I drink 7-8 glasses of water daily.	0.66 ± 0.47	0.77 ± 0.46	0.67 ± 0.47	3.06*
I take milk twice a day regularly.	0.43 ± 0.50	0.37 ± 0.48	0.62 ± 0.49	14.71**
I always wash my hands before touching any eatables.	0.93 ± 0.26	0.93 ± 0.31	0.91 ± 0.29	.505
I always use fresh water.	0.94 ± 0.25	0.84 ± 0.41	0.93 ± 0.26	5.88**
I always maintain my medical records with care.	0.73 ± 0.45	0.57 ± 0.53	0.74 ± 0.44	8.17**
I regularly watch/ hear health awareness programme on T.V/ radio	0.57 ± 0.50	0.37 ± 0.51	0.20 ± 0.40	30.76**

*significant at $p \leq 0.05$, **significant at $p \leq 0.01$

One way ANOVA (Table 4.2.5) was used to find the association of Health Seeking Behaviour of the respondents with ethnicity. Results reveal significant association of ethnicity with physical exercise, dental check-ups, cancer screening test, complete health check-ups, hair fall, having medicine without consultation, consultation regarding piles, meals (Breakfast, Lunch and Dinner), eating fruits and nuts, water usage, keeping medical record and watching health awareness programmes on T.V. Results indicate that health seeking behaviour of the respondents of urban, rural and tribal respondents differ significantly on most of the items. Respondents from the tribal areas

scored higher means on most of the items, followed by the respondents from urban areas and least by the respondents of rural areas. Respondents from the tribal areas scored higher means on the items such as dental check-up ($f = 4.22, p \leq .01$), having medicine with consultation ($f = 8.812, p \leq .01$), consultation regarding piles ($f = 21.63, p \leq .01$), meals: breakfast ($f = 38.52, p \leq .01$); lunch ($f = 8.44, p \leq .01$); dinner ($f = 46.15, p \leq .01$), fruits and nuts ($f = 25.61, p \leq .01$), milk usage ($f = 14.71, p \leq .01$), maintaining medical record ($f = 8.17, p \leq .01$). Respondents from the urban areas scored higher means on the items such as physical exercise ($f = 19.35, p \leq .01$), complete health check-up ($f = 6.045, p \leq .01$), consultation for hair fall ($f = 3.87, p \leq .05$), usage of fresh water ($f = 5.88, p \leq .01$) and watching health awareness programmes on T.V. ($f = 30.76, p \leq .01$) Respondents from the rural areas scored higher means on the items such cancer screening ($f = 4.41, p \leq .01$) and drinking of 7-8 glass of water ($f = 3.06, p \leq .0$)

4.3 WOMEN'S HEALTH STATUS:

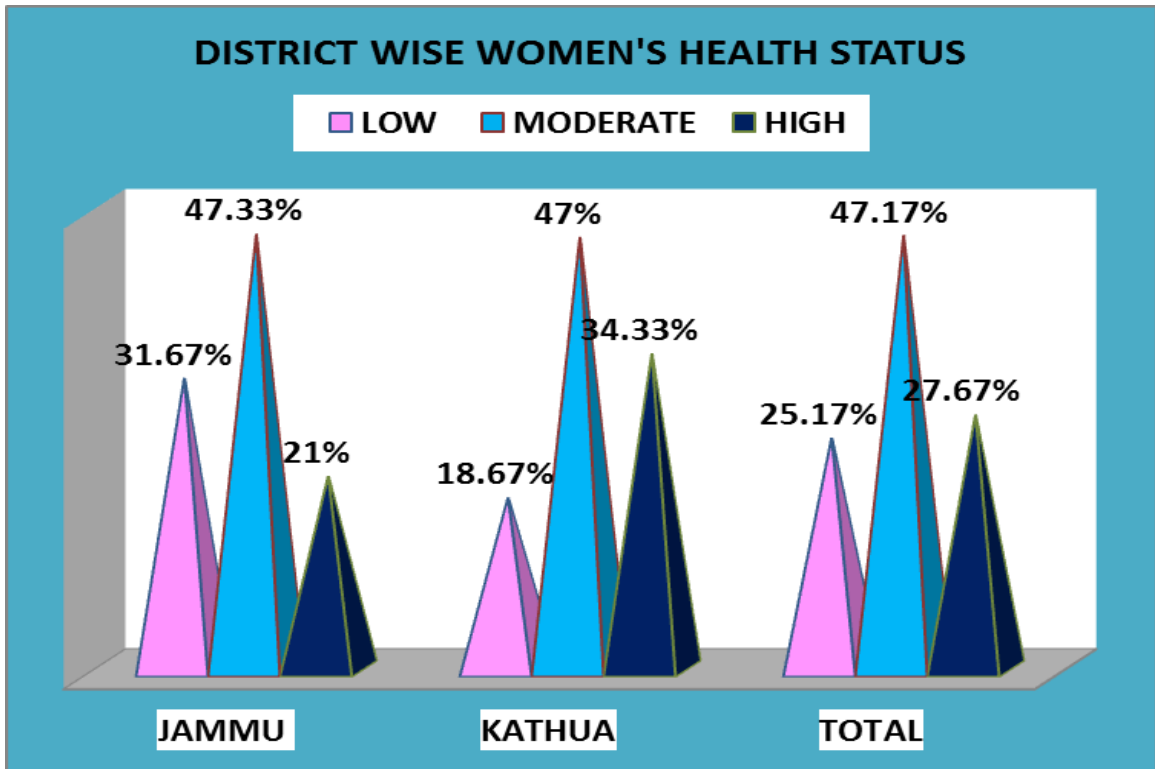
Women's Health questionnaire (WHQ) was used to assess a wide range of physical and emotional symptoms or sensations experienced by mid-aged women. It has been designed specifically to study possible changes in health and well - being during menopausal transition. Higher scores are interpreted as low health status.

Table 4.3.1: Levels of Women's Health

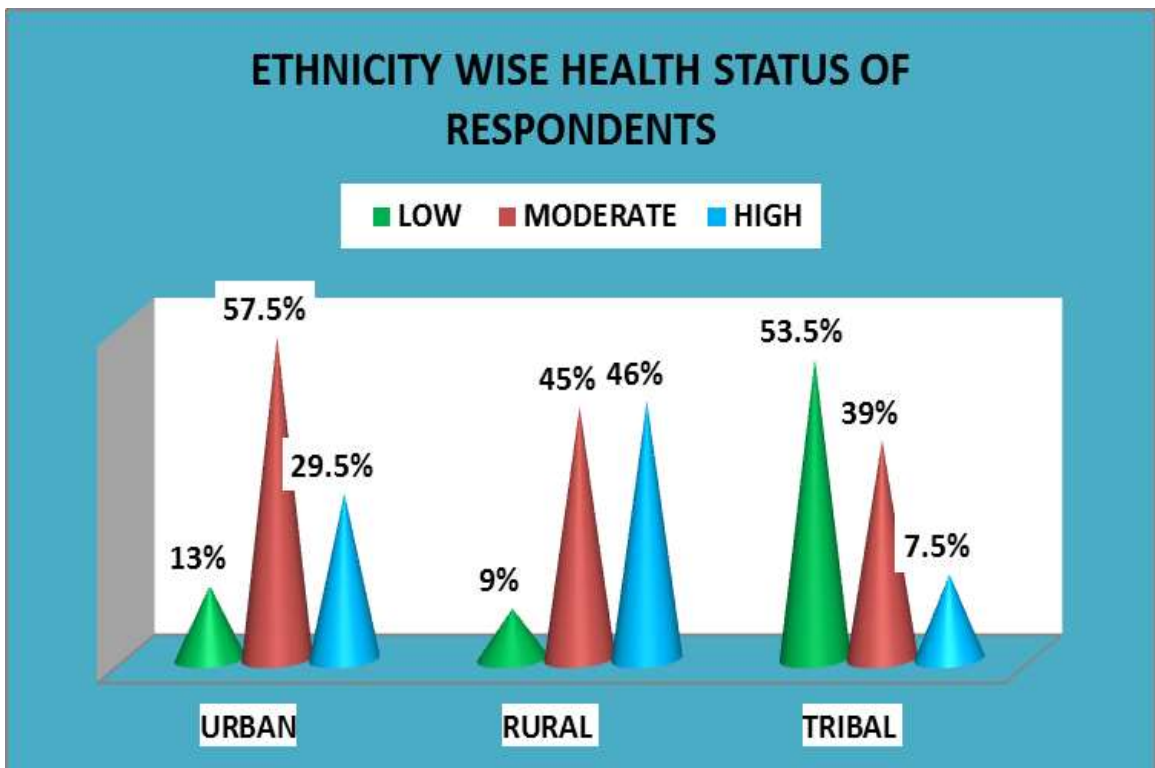
LEVELS OF WHQ	DISTRICT WISE		ETHNICITY WISE			Total N = 600
	Jammu N = 300	Kathua N = 300	Urban N = 200	Rural N = 200	Tribal N = 200	
Low	95 (31.67)	56 (18.67)	26 (13)	18 (9)	107 (53.3)	151 (25.16)
Moderate	142 (47.33)	141 (47)	115 (57.5)	90 (45)	78 (39)	283 (47.17)
High	63 (21)	103 (34.33)	59 (29.5)	92 (46)	15 (7.5)	166 (27.67)
χ^2	18.72**		153.7**			

Percentage in parentheses, *significant at $p \leq 0.05$, **significant at $p \leq 0.01$

Figurative presentation of Table 4.3.1 (a)



Figurative presentation of Table 4.3.1(b)



Overall results reveal that most of respondents (47.17%) have moderate health status followed by 27.67% having high health status and 25.17% low health status. District wise results given in the table 4.3.1 reveal that 47.33% respondents from Jammu district and 47% respondents from Kathua district have moderate health status. 31.67% respondents from Jammu show lower health status whereas 34.33% respondents from Kathua show high health status. Ethnicity wise results show that 57.5% respondents from urban, and 45% from rural areas show moderate level of health status but 53.5% of the tribal respondents show low level of health status. 46% respondents from the rural areas show high health status whereas 7.5% respondents from tribal and 29.5% from urban areas show high level of health status.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.3.2: Education, Socio-Economic Status, type of family and health of the respondents

LEVELS OF WOMEN'S HEALTH								
Background Variables	Low		Moderate		High		TOTAL	
	F	%age	F	%age	F	%age	F	%age
Illiterate	74	12.33	111	18.5	45	7.5	230	38.33
upto primary	14	2.33	36	6	18	3	68	11.33
upto secondary	27	4.5	57	9.5	50	8.33	134	22.33
upto Higher secondary	16	2.67	31	5.17	17	2.83	64	10.67
upto Graduation	13	2.17	31	5.17	13	2.17	57	9.5
upto Post Graduation	7	1.17	15	2.5	23	3.83	45	7.5
Technical	0		2	0.33				
Socio-Economic Status								
Upper	3	0.5	2	0.33	3	0.5	8	1.33
Upper Middle	38	6.33	72	12	47	7.83	157	26.17
Middle	62	10.33	120	20	92	15.33	274	45.67
Lower Middle	48	8	88	14.67	24	4	160	26.67
Low	0		1	0.17	0		1	0.17
Type of Family								
Joint	75	12.5	143	23.83	70	11.67	288	48
Nuclear	74	12.33	140	23.33	96	16	312	52
Total	151	25.67	283	47.17	166	27.67	600	100

It is evident from the results given in the table 4.3.2 that 18.5 % of the illiterate respondents show moderate health status. 9.5% who are educated upto higher secondary show moderate health status. 20 % of the respondents belong to middle socio economic status show moderate health status, 15.33% show high and 10.33% show low level of health status. 23.33% respondents living in nuclear families show moderate level of health status, 12.5 show low and 11.67% show high level of health status. 23.83% respondents living joint families show moderate level of health status, 16% show high level and 12.33% show low level of health status.

Table 4.3.3: Mean Scores on various dimensions of WHQ.

DIMENSIONS OF WHQ	MEAN	STD. DEVIATION
Somatic Symptoms	21.28	4.47
Vasomotor Symptoms	4.81	1.53
Sleep Problem	7.75	1.798
Depression	16.19	3.48
Sexual Dysfunction	5.57	2.17
Anxiety	12.96	3.07
Menstrual Symptoms	8.56	2.72
Memory / Concentration	4.57	1.70
Attraction	4.62	1.58
WHQ	85.21	14.05

Table 4.3.3 shows the mean scores of respondents on the various dimensions of WHQ. The mean score on Somatic behaviour is 21.28 ± 4.47 , on Vasomotor symptoms it is 4.81 ± 1.52 , on Depression it is 16.19 ± 3.48 , on Sleep Problem it is 7.75 ± 1.79 , on Sexual Dysfunction it is 5.57 ± 2.17 , on Anxiety it is 12.96 ± 3.07 , on Menstrual Symptoms it is 8.56 ± 2.72 , on Memory/ concentration it is 4.57 ± 1.70 , and on Attraction it is 4.62 ± 1.58 . Overall mean scores on WHQ is 85.21 ± 14.05 .

Table 4.3.4: District wise mean and t Scores on various dimensions of WHQ.

DIMENSIONS OF WHQ		DISTRICT				
		Jammu N = 300		Kathua N = 300		't' value
		Mean	Std. Deviation	Mean	Std. Deviation	
Somatic Symptoms	(28)#	21.63	4.393	20.93	4.532	1.903*
Vasomotor Symptoms	(08)#	4.65	1.364	4.97	1.660	2.553**
Sleep Problem	(12)#	7.64	1.500	7.87	2.048	1.546
Depression	(28)#	16.25	2.409	16.12	2.985	0.481
Sexual Dysfunction	(12)#	5.13	3.276	6.01	3.232	5.07**
Anxiety	(16)#	12.69	2.481	13.22	3.550	2.133*
Menstrual Symptoms	(16)#	8.36	2.266	8.75	3.108	1.756
Memory/Concentration	(12)#	4.48	1.418	4.66	1.940	1.273
Attraction	(08)#	4.25	1.39	4.98	1.68	5.79*
WHQ	(144)#	88.21	13.01	82.21	14.42	5.35**

* significant at the 0.05 level; ** significant at the 0.01 level. # Maximum Score on each dimension that can be attained are in parentheses

Results reveal that respondents of both the districts differ significantly from each other on the various dimensions of WHQ except Sleep problem, Depressed mood, Menstrual symptoms and Memory/concentration dimensions of WHQ. Results indicate that respondents of Kathua score significantly higher on the dimensions of WHQ i.e Vasomotor symptoms ($t = 2.553, p \leq .01$), Sexual Dysfunction ($t = 5.07, p \leq .01$), Anxiety ($t = 2.133, p \leq .05$), and Attraction ($t = 5.79, p \leq .05$) showing that the respondents of Kathua district have poor health status than that of Jammu on these dimensions. Overall results reveal that respondents of Jammu have attained higher scores ($t = 5.35, p \leq .01$) showing relatively poor health status than that of respondents of Kathua.

Table 4.3.5: Association of various dimensions of WHQ with Ethnicity.

DIMENSIONS OF WHQ	ETHNICITY			F value
	Urban N = 200	Rural N = 200	Tribal N = 200	
Somatic Symptoms	20.87 ±4.05	18.68±4.24	24.3±3.11	109.487**
Vasomotor Symptoms	4.63 ±1.38	4.2±1.48	5.61±1.37	52.573**
Sleep Problem	7.58 ±1.79	7.15 ±1.82	8.54 ±1.47	35.196**
Depression	15.71 ± 3.65	15.52 ± 3.54	17.32 ± 2.92	17.115**
Sexual Dysfunction	5.2 ± 2.02	5.5 ± 1.79	5.99 ± 2.62	6.98**
Anxiety	12.41±2.96	12±3.05	14.47±2.60	42.187**
Menstrual Symptoms	8.61 ± 3.07	7.53 ± 2.17	9.54 ±2.49	29.889**
Memory / Concentration	4.25±1.52	4.31 ±1.64	5.15 ±1.78	18.673**
Attraction	4.46 ± 1.46	4.73 ± 1.52	4.66 ± 1.75	1.505
WHQ	82.52 ± 12.73	78.62 ±13.50	94.49 ±10.58	89.93**

** significant at the 0.01 level.

Results (Table 4.3.5) reveal significant ethnicity wise differences on all the dimensions except attraction. On somatic symptoms mean scores are higher among the respondents of tribal areas i.e. 24.3±3.111, followed by the respondents of urban areas 20.87 ±4.046 and lower among the respondents of rural areas i.e 18.68±4.24. On Vasomotor symptoms scores are higher for the respondents of tribal area 5.61±1.37, followed by the respondents of urban areas 4.63 ±1.38 and lower for the respondents of rural areas i.e. 4.2±1.48. Sleep Problems scores are again higher among the respondents of tribal areas i.e. 8.54 ±1.47 than the respondents of urban and rural areas (7.58 ±1.795 and 7.15 ±1.81). On the dimension of Depression, higher mean scores are obtained by the respondents of tribal areas i.e 17.32 ± 2.92 followed by the respondents of urban areas i.e. 15.71 ± 3.65 than the respondents from the rural areas i.e. 15.52 ± 3.54. Mean Scores on sexual dysfunction are higher among the respondents of tribal areas i.e. 5.99 ± 2.62 followed by the respondents of rural areas 5.5 ± 1.79 and lower among the respondents of urban areas i.e. 5.2 ± 2.02. On Anxiety tribal respondents obtained higher mean scores than the respondents of urban i.e.12.41±2.96 and rural i.e. 12±3.05 areas. On Menstrual

Symptoms scores are higher among the respondents of tribal areas i.e. 9.54 ± 2.49 than the respondents of urban (8.61 ± 3.07) and rural areas (7.53 ± 2.17). On the dimension of Memory / Concentration, higher mean scores are obtained by the respondents of tribal areas i.e. 5.15 ± 1.78 followed by the respondents of rural areas i.e. 4.31 ± 1.64 than the respondents from the urban areas i.e. 4.25 ± 1.52 . Scores on the dimension of Attraction are higher among the respondents of rural areas i.e. 4.73 ± 1.52 followed by tribal respondent 4.66 ± 1.75 and least among the urban respondents. Overall results reveal that tribal respondents have attained higher scores followed by urban respondent and then the rural respondents showing that tribal respondent's health status is lower than that of the urban and rural respondents and need more attention.

4.3.6. AGE WISE FIGURATIVE PRESENTATION OF VARIOUS DIMENSIONS OF WHQ

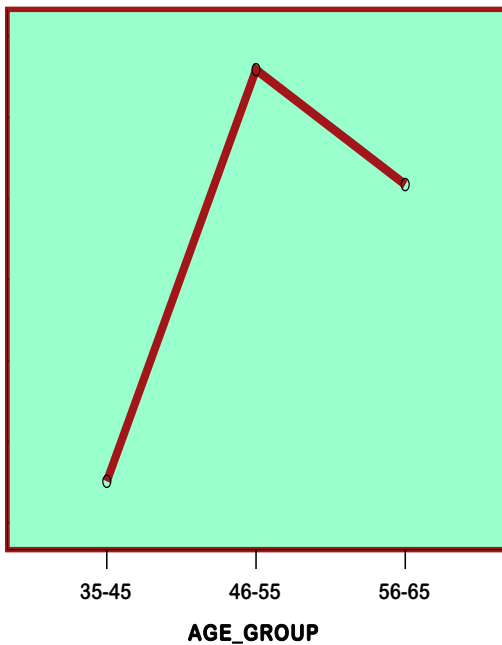


Fig. no 4.3.6. (a) Mean plot of WHQ Overall

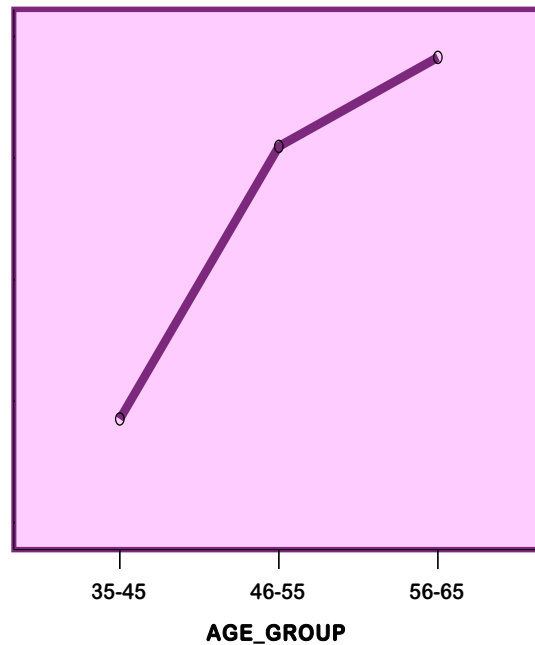


Fig. no 4.3.6. (b) Mean Plot of Somatic Symptoms

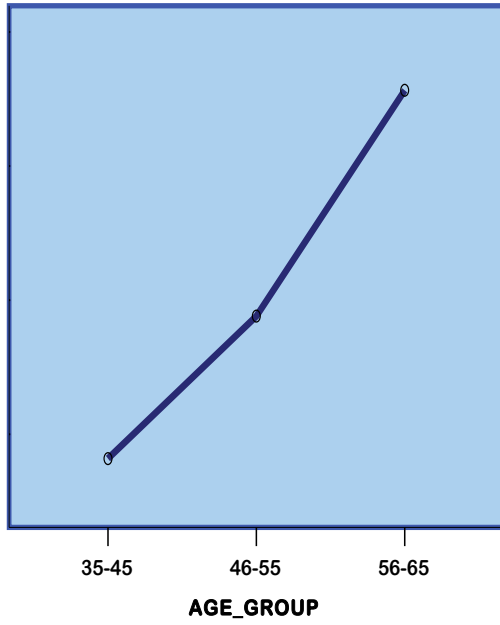


Fig. no 4.3.6. (c) Mean Plot of Vasomotor

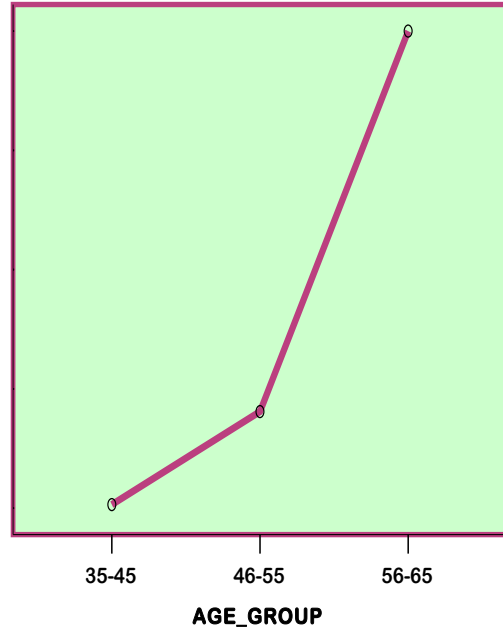


Fig. no 4.3.6. (d) Mean Plot of Sleep Problem

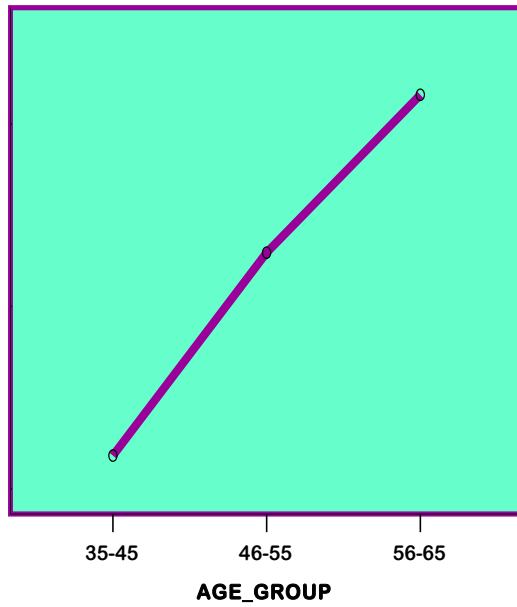


Fig. no 4.3.6. (e) Mean Plot of Depressed Mood

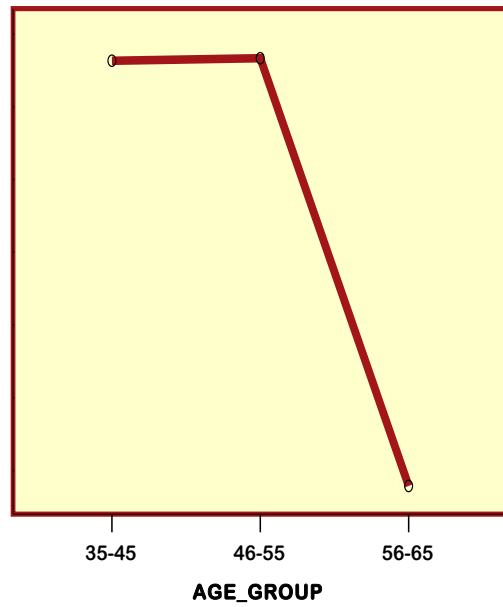


Fig. no 4.3.6. (f) Mean Plot of Sexual Dysfunction

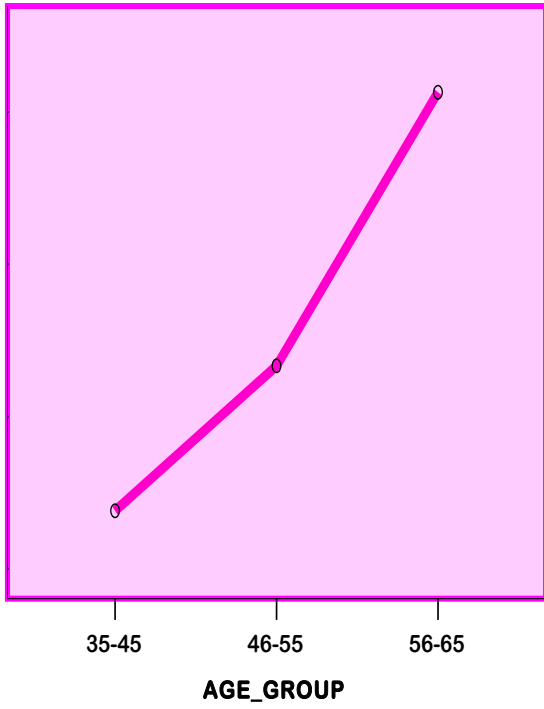


Fig. no 4.3.6. (g) Mean Plot of Anxiety

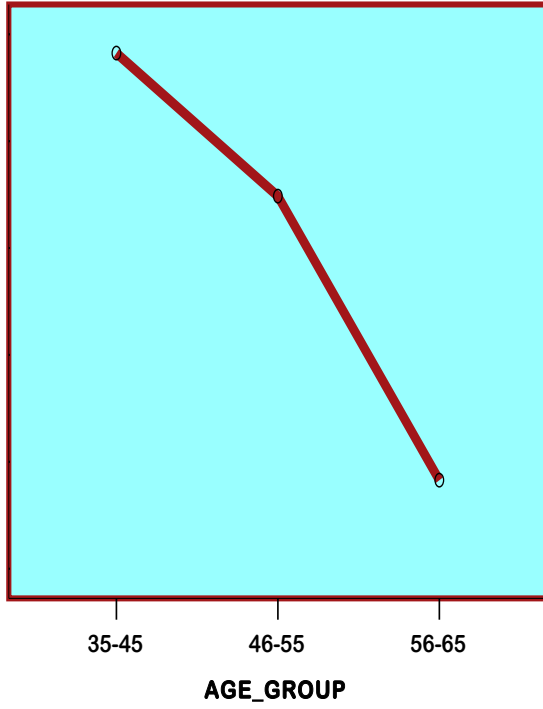


Fig. no 4.3.6. (h) Mean Plot of Menstrual Symptoms

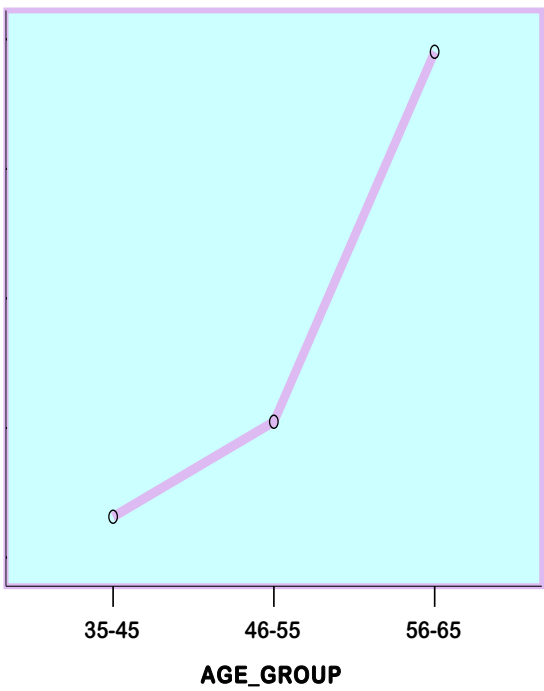


Fig. no 4.3.6. (i) Mean Plot of Memory/ Concentration

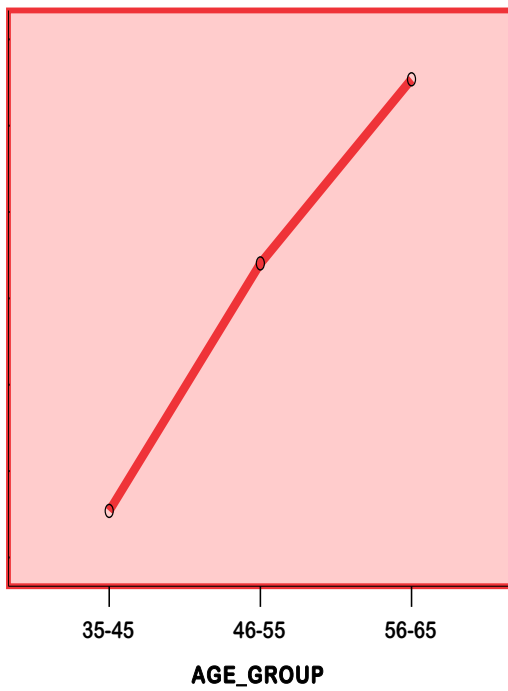


Fig. no 4.3.6. (j) Mean Plot of Attractiveness

Figurative representation (Fig. 4.3.6) of various dimensions of WHQ shows that somatic symptoms, vasomotor symptoms, sleep problems, depressed mood, anxiety, memory/ concentration increases with the increases age. Sexual Dysfunction, menstrual symptoms and attractiveness decreases with the age. Overall results reveal that women's health is better during the 35-45 years. The health problems are at peak at the age of 46-55 years i.e. menopausal transition years, then again showing a downward trend during 56-65 years.

Table 4.3.7: Levels of Health Seeking Behaviour and women's Health Status.

LEVELS OF WHQ	LEVELS OF HSBC			
	Low N = 600	Moderate N = 600	High N = 600	Total N = 600
Low	24 (4)	72 (12)	53 (8.8)	149 (24.8)
Moderate	82 (13.7)	123 (20.5)	78 (13.0)	283 (47.2)
High	67 (11.2)	67 (11.2)	34 (5.7)	168 (28)
Total	173 (28.8)	262 (43.7)	165 (27.5)	600 (100)

(Percentage in parentheses)

Results in the table 4.3.7 reveal that 20.5% respondents show moderate level of health seeking behaviour also scored moderate scores on WHQ, 13.7% show low level of health seeking behaviour have moderate scores on WHQ, and 13% of the respondents who score moderate scores on WHQ show high level of health seeking behaviour. It can be interpreted that respondents show moderate to low health seeking behaviour but moderate to high health status.

4.4 WOMEN'S HEALTH IN RELATION TO PERSONAL FACTORS, SOCIAL, ECONOMIC/ PRODUCTIVE ACTIVITIES

An interview schedule was constructed (based on Tanner and Vaseloss's (1998) systematization of risk factor for women which include: Knowledge and Beliefs about wellbeing and illness, use of service, quality of received health service, user/provider relationship, role of health at household level, decision making at household and

community level, social stigma, division of labour, substitution of labour, economic policies in relation to accessibility of service/care, availability of cash). After the pretesting on statistically significant sample (30 each from urban, rural and tribal areas) close ended form of interview schedule was finalized.

KNOWLEDGE AND BELIEFS ABOUT WELLBEING AND ILLNESS

Table 4.4.1: Respondents' beliefs about healthy person

Belief about healthy person	DISTRICT			ETHNICITY		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200	
One who..... is a healthy person						
Takes Balanced Diet	37 (12.3)	36 (12)	22 (11)	26 (13)	25 (12.5)	
Has Good Digestion	29 (9.67)	38 (12.6)	11 (5.5)	39 (19.5)	17 (8.5)	
Eats adequate food	32 (10.7)	62 (20.7)	25 (12.5)	49 (24.5)	20 (10)	
Is good looking	19 (6.3)	65 (21.7)	15 (7.5)	45 (22.5)	24 (12)	
Is free from diseases and tensions	50 (16.7)	131 (43.7)	37 (18.5)	72 (36)	72 (36)	
Has healthy relations with others	20 (6.7)	16 (5.3)	11 (5.5)	16 (8)	9 (4.5)	
All of the above	167 (55.7)	104 (34.6)	114 (57)	95 (47.5)	62 (31)	
χ^2	76.5426**			55.0212**		

Multiple responses; Percentage in Parentheses; **significant at $p \leq 0.01$

Table 4.4.1 describes the opinion of the respondents about a healthy person. **District wise** results reveal that majority of the respondents i.e. 55.7% from Jammu believe that a person taking balance diet, having good digestion, eating adequate food, good looking, one who is free from worries and tensions and one who has healthy relations with others is a healthy person. 43.7% of the respondents from Kathua believe that one who is free from tensions and worries is a healthy person, whereas 21% of them give stress on good looks and 20% on adequate food.

Ethnicity wise results reveal that majority of them i.e. 57% urban, 47.5% rural and 31% tribal respondents believe that a person, who takes a balanced diet, has good digestion, one who eats adequate food, is good looking, is free from worries and tensions and the one who has healthy relations with others is a healthy person. **Chi-square** values reveal significant difference ($p \leq 0.01$) district wise as well as Ethnicity wise.

Table 4.4.2: Respondents' beliefs about an ill or unhealthy person

Opinion about an ill/unhealthy person	DISTRICT		ETHNICITY		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Person is an unhealthy person.					
Having lot of Diseases	33 (11)	50 (16.6)	29 (14.5)	27 (13.5)	27 (13.5)
Having lot of tension and Worries	65 (21.67)	82 (27.3)	46 (23)	75 (37.5)	26 (13)
Having weak/Poor digestion	24 (8)	63 (21)	18 (9)	48 (24)	21 (10.5)
Skipping Meal	28 (9.3)	38 (12.67)	12 (6)	46 (23)	8 (4)
Unable to perform routine activities	33 (11)	39 (13)	16 (8)	34 (17)	22 (11)
All of the above	151 (50.3)	140 (46.67)	107 (53.7)	100 (50)	84 (42)
χ^2	17.396 ₅ **		46.57 ₁₀ **		

Multiple responses; Percentage in Parentheses; **significant at $p \leq 0.01$

Table 4.4.2 describes the opinion of the respondents about ill or unhealthy person. **District wise** results reveal that majority of the respondents i.e. 50.3% from Jammu and 46.67% from Kathua again give multiple responses and believe that a person having lots of diseases, tensions and worries, one who skips meals, has poor digestion and one who does not perform routine activities is an ill or unhealthy person. 21.67% respondents from Jammu and 27.3% from Kathua believe that one who has lots of tensions and worries is an ill or unhealthy person, whereas 21% from Kathua believe that one having poor digestion is an unhealthy person

Ethnicity wise results show that 53.7% urban, 50% rural and 42% tribal respondents gave multiple responses and believe that a person having lots of diseases, tensions and worries, one who skips meals, has poor digestion and one who does not

perform routine activities is an ill or unhealthy person. 27% urban respondents and 37.5% rural respondents believe that one having lots of tensions and worries is an unhealthy person whereas 24% rural respondents are of the view that one who has a poor digestion is an unhealthy person. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.3: Need for women to take special care of their health

Responses	DISTRICT			ETHNICITY		
	Jammu N=300	Kathua N=300	Urban N= 200	RURAL N=200	TRIBAL N=200	
Whether Women should take special care of their health?						
Yes	286 (95.3)	198 (66)	178 (89)	160 (80)	146 (73)	
No	14 (4.7)	102 (34)	22 (11)	40 (20)	54 (27)	
χ^2	82.71**			16.52**		

Percentage in Parentheses; **significant at $p \leq 0.01$

Table 4.4.3 shows that **District wise** 95.3% of the respondents from Jammu District and 66% respondents from the Kathua believe that women should take special care of their health.

Ethnicity wise results show that majority of respondents from Urban (89%), followed by Rural (80%), and Tribal (73%) areas believe that women should take special care of their health.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.4: Self-rating of health by respondents

Self-rated health	DISTRICT		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Excellent	5 (1.6)	7 (2.3)	4 (2)	7 (3.5)	1 (0.5)
Very Good	83 (27.7)	34 (11.3)	60 (30)	36 (18)	21 (10.5)
Good	138 (46)	100 (33.3)	78 (39)	88 (44)	72 (36)
Fair	63 (21)	77 (25.7)	40 (20)	51 (25.5)	49 (24.5)
Poor	11 (3.7)	82 (27.3)	18 (9)	18 (9)	57 (28.5)
χ^2	82.54**		60.28**		

Percentage in Parentheses; **significant at $p \leq 0.01$

Table 4.4.4 depicts the self-rated health of the respondents. **District wise** results indicate that 46% respondents from the Jammu and 33.3 % respondents from the Kathua rated their health as good. 27.7 % respondent from Jammu rated their health as very good, whereas 27.3% respondents from Kathua rated their health as poor.

Ethnicity wise the results reveal that 39 % respondents from the urban, 44% from rural areas and 36% from the tribal areas rated their health as good and 30% urban respondents rated their health as very good, 28.5% tribal respondents rate it as poor and 25.5% rural women rate it as fair. Results further indicate that very few respondents from the tribal areas reported their health as above the level of Good, which shows that their health needs more attention.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.5: Knowledge of respondents regarding measures that help to stay healthy

Measures to Stay Healthy	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Eating a balanced diet					
Help a lot	252 (84)	280 (93.3)	173 (86.5)	164 (82)	195 (97.5)
Help to some extent	43 (14.3)	16 (5.3)	23 (11.5)	31 (15.5)	5 (2.5)
Doesn't Help at all	5 (1.7)	4 (1.3)	4 (2)	5 (2.5)	-
χ^2	13.92**		25.54**		
Regular physical exercise					
Help a lot	232 (77.3)	217 (72.3)	147 (73.5)	129 (64.5)	173 (86.5)
Help to some extent	62 (20.7)	48 (16)	46 (23)	56 (28)	8 (4)
Doesn't Help at all	6 (2)	35 (11.7)	7 (3.5)	15 (7.5)	19 (9.5)
χ^2	22.82**		46.94**		
Having ideal weight for age					
Help a lot	223 (74.3)	204 (68)	141 (70.5)	120 (60)	166 (83)
Help to some extent	64 (21.3)	48 (16)	50 (25)	51 (25.5)	11 (5.5)
Doesn't Help at all	13 (4.3)	48 (16)	9 (4.5)	29 (14.5)	23 (11.5)
χ^2	23.22**		45.74**		
Regular medical check-ups					
Help a lot	220 (73.3)	195 (65)	135 (67.5)	117 (58.5)	163 (81.5)
Help to some extent	68 (22.7)	49 (16.3)	48 (24)	53 (26.5)	16 (8)
Doesn't Help at all	12 (4)	56 (18.7)	17 (8.5)	30 (15)	21 (10.5)
χ^2	33.12**		32.34**		
Getting right amount of sleep					
Help a lot	244 (81.3)	260 (86.7)	164 (82)	156 (78)	164 (82)
Help to some extent	53 (17.7)	24 (8)	32 (16)	38 (19)	7 (3.5)

Measures to Stay Healthy	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Doesn't Help at all	3 (1)	16 (5.3)	4(2)	6 (3)	9 (4.5)
χ^2	20.32**		22.74**		
Leading a spiritual life					
Help a lot	250 (83.3)	232 (77.3)	158 (79)	165 (82.5)	159 (79.5)
Help to some extent	47 (15.7)	39 (13)	40 (20)	29 (14.5)	17 (8.5)
Doesn't Help at all	3 (1)	29 (9.7)	2 (1)	6 (3)	24 (12)
χ^2	22.52**		35.24**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.5 reveals the knowledge of respondents about measures that help a person to stay healthy. **District wise:** Results reveal that majority of the respondents from both the districts are of the opinion that eating balanced diet (Jammu 84% and Kathua 93.3%), doing regular physical exercise (Jammu 77.3% and Kathua 72.3%), having ideal weight (Jammu 74.3% and Kathua 68%), regular medical check-ups (Jammu 73.3% and Kathua 65%), right amount of sleep (Jammu 81.3% and Kathua 86.7%) and leading a spiritual life (Jammu 83.3% and Kathua 77.3%) helps a lot to stay healthy.

Ethnicity wise: When ethnicity wise the data was analysed it was found that majority of the respondents from the urban, rural and tribal areas opined that eating balanced diet (86.5%, 82% and 97.5%), doing regular physical exercise (73.5%, 64.5% and 86.5%), having ideal weight for age (70.5%, 60% and 83%), getting regular medical check-ups (67.5%, 58.5% and 81.5%), getting right amount of sleep (82%, 78% and 82%) and leading a spiritual life (79%, 82.5% and 79.5%) respectively contribute a lot to staying healthy. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as Ethnicity wise on all the measures that help to stay healthy.

Table 4.4.6: Frequency and type of physical exercise done by respondents

	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Physical exercise					
YES	125 (41.7)	58 (19.3)	84 (42)	50 (25)	49 (24.5)
NO	113 (37.7)	197 (65.7)	80 (40)	110 (55)	120 (60)
Sometimes	62 (20.7)	45 (15)	36 (18)	40 (20)	31 (15.5)
χ^2	49.99 ₂ **		22.54 ₄ **		
If yes, kind of Physical exercise (Multiple responses)					
Brisk walking	113 (37.7)	66 (22)	72 (36)	52 (26)	55 (27.5)
Cycling	3 (1)	3 (1)	3 (1.5)	1 (0.5)	2 (1)
Gardening	37 (12.3)	16 (5.3)	8 (4)	22 (11)	23 (11.5)
Dancing	5 (1.7)	-	3 (1.5)	2 (1)	-
Jogging	12 (4)	4 (1.3)	8 (4)	4 (2)	4 (2)
Yoga	79 (26.3)	48 (16)	59 (29.5)	48 (24)	20 (10)
χ^2	5.17 ₅		28.02 ₇ **		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.6 describes the frequency of the respondents who practise physical exercise to maintain their health. **District wise** results reveal that that only 41.7% of the respondents from Jammu District and 19.3% from Kathua district do physical exercise to remain healthy. Majority of the respondents (65.7%) of respondents from the Kathua District said that they don't do any physical exercise to maintain their health. 20.7% from the Jammu and 15% from the Kathua districts said that they sometimes go for exercise but not regularly. **Ethnicity wise** results show that 40% of respondents from Urban, 55% from the Rural, and 60% from Tribal areas said that they don't do any physical exercise to maintain their health. Only 42% of respondents from Urban, 25% from the Rural, and 24.5% from Tribal areas said that they do physical exercise to maintain their health. These respondents said that they do enough work and hence don't need any exercise. It is

further interpreted from the results that urban respondents are more conscious about doing physical exercises as compare to rural and tribal respondents. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Further results reveal particular kind of Physical exercises respondents prefer to maintain their health. **District wise** results reveal that that 37.7% of the respondents from Jammu District and 22% respondents from the Kathua District go for brisk walking to maintain their health followed by 26.3 % from Jammu and 16 % from Kathua who said that they do yoga to remain healthy. 12.3% Jammu and 5.3% Kathua respondents do gardening, 4% Jammu and 1.3% Kathua respondents go for jogging to remain healthy. It was observed during interviewing process that the respondents do physical exercises mostly on the recommendation of their doctors or other health practitioners. **Ethnicity wise** results show that 36% of respondents from urban, 26% from the rural, and 27.5% from tribal areas said that they go for brisk walking to maintain their health. 29.5% urban, 24% rural and 10% tribal respondents do Yoga; 4% urban, 11% rural and 11.5% tribal do gardening as physical exercise to remain healthy. There is very lesser percentage of other exercises like dancing and jogging preferred by respondents. **Chi square** analysis reveals insignificant difference among the respondents from both the districts whereas ethnicity wise significant differences ($p \geq 0.01$) were observed among the respondents.

USE OF SERVICES, QUALITY OF SERVICES AND USER / PROVIDER RELATIONSHIP

Table 4.4.7: Accessibility to medical facilities

Accessibility to medical facilities	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Not at all	13 8(46)	162 (54)	119 (59.5)	116 (58)	65 (21.7)
A Little	146 (48.7)	64 (21.3)	72 (36)	73 (36.5)	65 (32.5)
Very Difficult	16 (5.3)	74 (24.7)	9 (4.5)	11 (5.5)	70 (35)
χ^2	71.32**		99.034**		

Percentage in Parentheses; **significant at $p \leq 0.01$

District wise results reveal that 48.7% respondents from the Jammu district said that sometimes it become a little difficult for them to get medical facility due to non-availability of family members at home. 54% of respondents from Kathua district said that they do not have any difficulty to get medical facility whenever needed whereas 24.7% said that it becomes very difficult for them to get medical facility.

Ethnicity wise results reveal that most of the respondents from the urban and rural areas i.e. 59.5% and 58% respectively, said that they do not have any difficulty to get medical facility whenever required whereas 35% respondents from the tribal areas said it become very difficult to get medical facility due to non-availability of transportation all the time as the areas where they reside are far away from the national and linking roads. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.8: Perception about effectiveness of medicines in preventing illness

Effectiveness of medicines in preventing illness	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Not at all	5 (1.7)	28 (9.3)	7 (3.5)	8 (4)	18 (9)
Some what	20 (6.7)	17 (5.7)	18 (9)	11 (5.5)	8 (4)
Moderately	57 (19)	76 (25.3)	46 (23)	40 (20)	47 (23.5)
Very Much	147 (49)	93 (31)	79 (39.5)	83 (41.5)	78 (39)
Extremely	71 (23.7)	86 (28.7)	50 (25)	58 (29)	49 (24.5)
χ^2	32.64**		12.78		

Percentage in Parentheses; **significant at $p \leq 0.01$

Table 4.4.8 describes the respondent's perception regarding effectiveness of medical treatment. **District wise** results reveal 49% respondents of Jammu and 31% from Kathua district were of the opinion that medicines are very much effective in preventing illness. 23.7% respondents of Jammu and 28.7% from Kathua district opined that medicines are extremely effective in preventing illness.

Ethnicity wise result reveals that 39.5% respondents from urban, 41.5% from rural areas and 39% from the tribal areas are of the opinion that medicines are very much effective in preventing illness. 25% respondents from urban, 29% from rural areas and 24.5% from the tribal areas opined that medicines are extremely effective in preventing illness.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both districts whereas ethnicity wise insignificance difference was found.

Table 4.4.9: Type of treatment preferred by Respondents

Choice of respondents regarding treatment	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Home Remedies	41 (13.7)	43 (14.3)	24 (12)	28 (14)	32 (16)
Homeopathic	1 (0.3)	-	-	1 (0.5)	-
Herbalist	2 (0.6)	-	2 (1)	-	-
Chemist	8 (2.7)	35 (11.7)	7 (3.5)	9 (4.5)	27 (13.5)
Registered Medical Practitioners (RMP)	4 (1.3)	87 (29)	9 (4.5)	17 (8.5)	65 (32.5)
Govt. Hospitals	147 (49)	69 (23)	79 (39.5)	95 (47.5)	42 (21)
Ayurvedic	11 (3.7)	2 (0.6)	6 (3)	5 (2.5)	2 (1)
Traditional Healer	4 (1.3)	0	1 (0.5)	1 (0.5)	2 (1)
Private Hospital	80 (26.7)	64 (21.3)	71 (35.5)	43 (21.5)	30 (15)
Any Other	2 (0.6)	0	1 (0.5)	1 (0.5)	-
χ^2	137.9 ^{**}		126.881 ^{**}		

Percentage in Parentheses; ^{**}significant at $p \leq 0.01$

The decision to seek out health service is a complex decision. For any study into the reason underlying health provider choices and health seeking behaviour, it is important to identify the health provider that individuals frequent. It is evident from the **District wise** analysis in the Table 4.4.9 that 49% respondents from Jammu and 23 % from Kathua prefer treatment in government hospitals, followed by 29% respondents

from Kathua who prefer to consult Registered Medical Practitioners in case of illness. 26.7 % from Jammu and 21.3% from Kathua prefer treatment in private hospitals. 13.7 % respondents from Jammu and 14.3% from Kathua prefer home remedies for the treatment of their illness and they do not consult doctors until the problem becomes severe.

Ethnicity wise the results reveal that 39.5% urban, 47.5% rural and 21% tribal respondents prefer to get treated in government hospitals in case of their illness followed by 35.5 % urban, 21.5% rural and 15% tribal respondents who prefer private hospitals. Many of the respondents (32.5%) from the tribal areas prefer to consult Registered Medical Practitioners.

The reasons for choice of health practitioner are related to easy availability, their being economical and faith in these health practitioners. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.10: Use of medical services since past one year

During past one year	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Frequency of visiting doctor's clinic as a patient in last one year					
Never	38 (12.7)	62 (20.7)	40 (20)	39 (19.5)	21 (10.5)
1-2	112 (37.3)	80 (26.7)	68 (34)	72 (36)	52 (26)
3-5	91 (30.3)	87 (29)	55 (27.5)	53 (26.5)	70 (35)
6 or more	59 (19.7)	71 (23.7)	37 (18.5)	36 (18)	57 (28.5)
χ^2	12.29 ₃ **		19.74 ₆ **		
Stayed overnight in a hospital as a patient in last one year					
Never	237 (79)	261 (87)	166 (83)	171 (85.5)	161 (80.5)
1-2	43 (14.3)	26 (8.7)	26 (13)	21 (10.5)	22 (11)
3-5	17 (5.7)	9 (3)	7 (3.5)	6 (3)	13 (6.5)
6 or more	3 (1)	4 (1.3)	1 (0.5)	2 (1)	4 (2)

During past one year	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
χ^2	7.94 ₃ **		6.2 ₆		
Been treated with alternative medicine in last one year					
Never	168 (56)	183 (61)	102 (51)	98 (49)	151 (75.5)
1-2	75 (25)	30 (10)	51 (25.5)	29 (14.5)	25 (12.5)
3-5	9 (3)	16 (5.3)	7 (3.5)	9 (4.5)	9 (4.5)
6 or more	48 (16)	71 (23.7)	40 (20)	64 (32)	15 (7.5)
χ^2	26.3 ₃ **		56.67 ₆ **		

Percentage in Parentheses *significant at $p \leq 0.05$, **significant at $p \leq 0.01$

Table 4.4.10: Use of medical services by the respondents since past one year District wise results reveal that 37.3% respondents from the Jammu district said that during the last one year they visited doctor's clinic as a patient once or twice whereas 29% respondents from the Kathua district have visited doctor's clinic as a patient at least 3-5 times during last one year. Majority of the respondents from both the districts i.e. 79% from Jammu and 87% from Kathua said that they didn't stay overnight in a hospital during last one year. 56% respondents from Jammu and 61% from Kathua said that they didn't treat their illness with alternate medicines. They prefer the prescription recommended by allopathic doctors.

Ethnicity wise results reveals that most of the respondents from the urban (34%) and rural areas(36%) said that they visited doctor's clinic as a patient during last one year once or twice whereas 35% respondents from the tribal areas visited doctor's clinic as a patient for 3-5 times during last one year. Majority of the respondents from urban, rural and tribal areas i.e. 83%, 85.5% and 80.5% respectively said that they didn't stay in a hospital overnight during last one year, and 51% respondents from urban 49% from rural and 75% from tribal areas said that they didn't treat their illness with alternate medicines. They consult allopathic doctors first before taking any medicine. For minor problems like headache/backache, stomach disturbance etc. they prefer home remedies. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise on all the dimensions.

Table 4.4.11: Dependency on medicines for performance of routine activities

Dependency on medicines	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Not at all	21 (7)	143 (47.7)	51 (25.5)	67 (33.5)	46 (23)
A Little	65 (21.3)	59 (19.7)	47 (23.5)	30 (15)	47 (23.5)
A Moderate Amount	94 (31.3)	46 (15.3)	49 (24.5)	43 (21.5)	48 (24)
Very Much	103 (34.3)	42 (14)	49 (24.5)	46 (23)	50 (25)
An Extreme Amount	17 (5.7)	10 (3.3)	4 (2)	14 (7)	9 (4.5)
χ^2	134.94**		15.248*		

Percentage in Parentheses *significant at $p \leq 0.05$, **significant at $p \leq 0.01$

District wise results given in table 4.4.11 reveal 34.3% respondents of Jammu district were very much dependent on medicine for performance of their routine daily activities whereas most of the respondents i.e.47.7% from the Kathua district were not dependent on medicine at all for their routine activities. They said that they avoid medicine for minor ailments as these medicines have lot of side effects.

Ethnicity wise result reveals that 25.5% respondents from urban and 33.5% from rural areas were not dependent on medicine at all for performance of their routine activities whereas 25% respondents from the tribal areas were very much dependent on medicine for their routine activities.

Chi-square analysis reveals significant difference at $p \leq 0.01$ among the respondent of both districts whereas ethnicity wise significant differences are observed at $p \leq 0.05$.

Table 4.4.12: Belief in faith healer or baba for the treatment of Diseases

Faith Healing	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Beliefs in Faith healers/ 'Baba'/ 'Sayana'					
Have Faith	254 (84.7)	189 (63)	134 (67)	133 (66.5)	176 (88)
Do not have faith on it	46 (15.3)	111 (37)	66 (33)	67 (33.5)	24 (12)
χ^2	36.41**		31.22**		
If yes, which diseases can be treated by 'Baba' or faith healers(multiple responses)					
Fever	13 (4.3)	48 (16)	24 (12)	21 (10.5)	16 (8)
Headache	15 (5)	104 (34.7)	24 (12)	37 (18.5)	58 (29)
Body aches	25 (8.3)	64 (21.3)	26 (13)	29 (14.5)	34 (17)
Vertigo	46 (15.3)	17 (5.7)	22 (11)	8 (4)	33 (16.5)
Fatigue	5 (1.6)	20 (6.7)	16 (8)	8 (4)	1 (0.5)
Instability of mind	83 (27.6)	67 (22.3)	54 (27)	63 (31.5)	33 (16.5)
χ^2	104.96**		78.312**		

Multiple responses, Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.12 shows respondents' belief in faith healer or baba for the treatment of Diseases. **District wise** results show that 84.7% respondents from Jammu and 63% from Kathua believe in faith healer for the treatment of ailment. **Ethnicity wise** results reveal that 67% urban, 66.5% rural and 88% tribal respondents believe faith healers for the treatment of ailment. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as residence wise. **District wise** results reveal that 27.6% of the respondents from Jammu District go to faith healers for treatment of instability of mind, followed by 15.3% who go for vertigo. Only 15.3% respondents from Jammu said that they do not have faith on these healers whereas 37% respondents from the Kathua District were also of the same opinion, 34 % respondents from Kathua said that they go to faith healers for treatment of headache, followed by 22.3% who go for treatment of instability of mind and 21% who go for treatment of body aches.

Ethnicity wise results show that 33% of respondents from Urban, 33.3% from the Rural, and only 12 % from the tribal areas said that they don't have any faith on all these healers. 27% from the urban and 31.3% women from the rural areas go to these healers for the treatment of instability of mind whereas respondents from the tribal areas (29%) usually go to faith healers for treatment of headache. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as residence wise.

WOMEN'S HEALTH AND THEIR HOUSEHOLD WORK

Table 4.4.13: Frequency of occurrence of Aches in the body

Body Aches	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Frequency of Aches in body					
Most of the time	79 (26.3)	128 (42.7)	46 (23)	62 (31)	99 (49.5)
Sometimes	196 (65.3)	131 (43.7)	130 (65)	113 (56.5)	84 (42)
Hardly Ever	25 (8.3)	41 (13.7)	24 (12)	25 (12.5)	17 (8.5)
χ^2	28.42**		33.074**		

Percentages in parentheses; **significant at $p \leq 0.01$

District wise results depicted in 4.4.13 show that majority of the respondents from both the districts Jammu (65.3%) and Kathua (43.7%) said that sometime aches occur in different parts of their body. 42.7% from the Kathua and 26.3% from Jammu district said that aches occur most frequently in various parts of their body.

Ethnicity wise results reveal that majority of the respondents urban (65%), rural (56.5%) and tribal areas (42%) said that sometimes aches occur in their body whereas tribal respondents (49.5%) reported the occurrence of body pains most of the time. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondents both district wise as well as ethnicity wise.

Table 4.4.14: Parts of body having aches

Parts of body having aches	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Head	67 (22.3)	116 (38.7)	58 (29)	68 (34)	57 (28.5)
Arms	47 (15.7)	39 (13)	25 (12.5)	35 (17.5)	26 (13)
Legs	109 (36.3)	88 (29.3)	58 (28)	88 (44)	5 1(25.5)
Back	116 (38.7)	109 (36.3)	78 (39)	94 (47)	53 (26.5)
Knees	70 (23.3)	45 (15)	36 (18)	43 (21.5)	36 (18)
Whole body	100 (33.3)	76 (25.3)	50 (25)	45 (22.5)	81 (40.5)
Not at all	8 (2.7)	23 (7.7)	9 (4.5)	9 (4.5)	13 (6.5)
χ^2	31.96**		32.412**		

Multiple response Percentages in parentheses; **significant at $p \leq 0.01$

District wise it is evident from the analysis of results in Table 4.4.14 that 38.7% respondents from the Jammu district suffer from backache, 36.3% from pain in their legs, followed by 33.3% having pains in the whole body, 23.3% in knees, 22.3% in head and 15.7% who reported pain in their arms. On the other hand 38.7% respondents from the Kathua district said they often suffer from headache, 36.3% suffer from backache followed by 29.3% who have pain in their legs, 25.3% who have pains in their whole body and 15% have pain in knees.

Ethnicity wise results reveal that 39% respondents from the urban areas suffer from backache followed by headache (29%), pain in legs (28%), whole body (25%), knees (18%) and arms (12.5%). Most of the respondents from the rural areas (47%) said that they mostly suffer from backache followed by pain in legs (44%), headache (34%), whole body pains (22.5%), pain in knees (21.5%), and only 17.5% said that they feel pain in arms. Respondents from the tribal areas mostly have pains in the whole body (40%), 28.5% have headache, 26.5% suffer from backache, 25.5% have pains in their legs, 18% in knees and 13% reported that they have pain in their arms. It is further concluded that most of the respondents from urban and rural areas of both the districts mostly suffer

from backache and headache whereas respondents from the tribal areas suffer with the pains in their whole body.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.15: Disturbance in routine household activities due to Physical Pains

Disturbance in routine household activities due to Physical Pains	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Not at all	11 (3.7)	98 (32.7)	30 (15)	48 (24)	31 (15.5)
Somewhat	54 (18)	48 (16)	37 (18.5)	47 (23.5)	18 (9)
Moderate	91 (30.3)	72 (24)	60 (30)	52 (26)	51 (25.5)
Severe	111 (37)	51 (17)	55 (27.5)	39 (19.5)	68 (34)
Extreme	33 (11)	31 (10.3)	18 (9)	14 (7)	32 (16)
χ^2	94.34**		35.58**		

Percentages in parentheses; **significant at $p \leq 0.01$

District wise results given in table 4.4.15 reveal that 37% respondents from the Jammu district said that their routine activities severely get effected by their pains whereas 32.7% respondents from the district Kathua said that their physical pains do not effect their routine activities at all. 30.3% respondents from the Jammu and 24% from Kathua district said that their pains have moderate effect on their routine activities. There were 11% from Jammu and 10.3% respondents from Kathua district said that their physical pains extremely effect their routine activities. They almost feel unable to perform their routine activities.

Ethnicity Wise results indicate that 30% respondents from the urban areas and 26% respondents from the rural areas said that their physical pains moderately effect their routine activities whereas 34% respondents from the tribal areas said that their pains severely effect their routine activities. 27.5% respondents from urban areas said that their

routine activities are severely effected by physical pains, 18.5% reported it has a little effect on their routine work, 15% said that pains do not effect their routine activities at all and only 9% said that their physical pains extremely effect their routine activities. From the rural areas 24% respondents reported that their routine work is not effected by their physical pains at all, 23.5% said that it effect a little, 19.5% said that their routine activities are severely effected by physical pains and 7% said that their physical pains have extreme effect on their routine activities. And among the respondents from the tribal areas 25.5% said that their physical pains moderately effect their routine activities, 16% said that their physical pains have extreme effect ,15.5% % said that pains do not effect their routine activities at all and only 9% said that their physical pains have a little effect on their routine activities. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.16: Sleep Disturbance faced by respondents

Disturbed sleep	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	193 (64.3)	175 (58.3)	126 (63)	96 (48)	146 (73)
NO	107 (35.7)	125 (41.7)	74 (37)	104 (52)	54 (27)
χ^2	2.31		26.72**		

Percentages in parentheses; **significant at $p \leq 0.01$

Results given in the Table 4.4.16 reveal that majority of the respondents from both the districts, i.e. 64.3% Jammu and 58.3% Kathua, face sleep disturbance whereas in WHQ more respondents from the Kathua report problem.

Majority of the respondents from urban and tribal areas i.e. 63% and 73% respectively are disturbed in sleep whereas 52% of the respondents from the rural areas said that they are not disturbed in their sleep. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondents both ethnicity wise whereas insignificant differences are observed district wise.

Table 4.4.17: Frequency of feeling of anxiousness faced by respondents

Feeling anxious	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Often	41 (13.7)	117 (39)	37 (18.5)	42 (21)	79 (39.5)
Sometimes	184 (61.3)	139 (46.3)	120 (60)	111 (55.5)	92 (46)
Rarely	66 (22)	29 (9.7)	38 (19)	36 (18)	21 (10.5)
Hardly Ever	9 (3)	15 (5)	5 (2.5)	11 (5.5)	8 (4)
χ^2	58.73**		31.56**		

Percentages in parentheses; **significant at $p \leq 0.01$

Results given in table 4.4.17 show that 61.3% respondents from Jammu district and 46.3% from Kathua district said that they sometimes have feeling of anxiousness, whereas 39% said that they feel anxious often. Symptoms of anxiety were more reported in Kathua in WHQ.

Ethnicity wise results indicate that 60% urban, 55.5% rural and 46% tribal respondents sometimes feel anxious and 39 tribal respondents feel anxious often. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

SHARING OF HEALTH PROBLEMS WITH FAMILY MEMBERS

Table 4.4.18: Persons with whom respondents share their health problems

Person with whom you share your problems	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Husband	203 (67.7)	196 (65.3)	123 (61.5)	121 (60.5)	155 (77.5)
Children	72 (24)	133 (44.3)	49 (24.5)	90 (45)	66 (33)
Mother	18 (6)	9 (3)	15 (7.5)	9 (4.5)	3 (1.5)
Mother- in - law	18 (6)	12 (4)	12 (6)	16 (8)	2 (1)
All of the above	28 (9.3)	13 (4.3)	16 (8)	22 (11)	3 (1.5)
Any other	15 (5)	8 (2.7)	10 (5)	11 (5.5)	2 (1)
χ^2	29.715**		52.210**		

Multiple responses; Percentages in parentheses; **significant at $p \leq 0.01$

District wise results reveal that majority of the respondents from both the districts, i.e. 67.7% from Jammu and 65.3% from Kathua, prefer to share their health problems with husbands. 44.3% from Kathua and 24% from Jammu also share their health related problems with children. There is very lesser percentage of the respondents who share their problems with their mother, mother-in-law or any other person.

Ethnicity wise results reveal that majority of the respondents from urban, rural and tribal i.e. 61.5%, 60.5% and 77.5% respectively share their problems with husbands and 24.5% urban, 45% rural and 33% tribal respondents share their problems with children. Remaining respondents share their problems with mother, mother-in-law, neighbourer or friends etc.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondents both district wise as well as ethnicity wise.

SOCIAL STIGMA ATTACHED TO HEALTH PROBLEM

Table 4.4.19: Embarrassment faced by respondents in sharing health problem

Do you feel embarrassed in sharing your health problems?	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	56 (18.7)	38 (12.7)	36 (18)	35 (17.5)	23 (11.5)
NO	244 (81.3)	262 (87.3)	164 (82)	165 (82.5)	177 (88.5)
χ^2	4.081*		3.962		

Percentages in parentheses; *significant at $p \leq 0.05$;

Table 4.4.19 describes embarrassment faced by respondents while sharing health problems. Both **district wise** as well as **ethnicity wise** results reveal that majority of the respondents 81.3% Jammu and 87.3% Kathua; and 82% urban, 82.5% rural and 88.5% tribal don't feel embarrassed in sharing health problems with others.

Chi-square analysis reveals significant difference ($p \leq 0.05$) among the respondent both district wise whereas insignificant differences were observed ethnicity wise.

Table 4.4.20: Social stigma attached to prolonged illness

Does prolonged illness carry a social stigma?	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	103 (34.3)	138 (46)	94 (47)	99 (49.5)	48 (24)
NO	129 (43)	79 (26.3)	72 (36)	73 (36.5)	63 (31.5)
Don't Know	68 (22.7)	83 (27.7)	34 (17)	28 (14)	89 (44.5)
χ^2	18.59₂**		65.4₂**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.20 describes respondents' opinion regarding social stigma attached to prolonged illness. **District wise** results reveal that 43% respondents from Jammu said no social stigma is attached to prolong illness where as 46% respondents from Kathua said that prolonged illness does carry social stigma.

Ethnicity wise results reveal that 47% urban and 49.5% rural respondents are of the view that prolonged illness does carry social stigma where as 44.5% tribal respondents did not reply as they were not sure of this. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

DIVISION AND SUBSTITUTION OF HOUSEHOLD WORK DURING RESPONDENTS' ILLNESS

Table 4.4.21: Division of responsibilities among family members during respondents illness

Responsibilities are divided among all family members	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	250 (83.3)	205 (68.3)	158 (79)	162 (81)	135 (67.5)
NO	50 (16.7)	95 (31.7)	42 (21)	38 (19)	65 (32.5)
χ^2	18.4₁**		11.6₂**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.21 shows that both **district wise** as well as **ethnicity wise** results reveal that majority of the respondents 83.3% Jammu and 68.3% Kathua district; and 79% urban, 81% rural and 67.5% tribal respondents said that household responsibilities are divided among all family members during their illness. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondents both district wise as well as ethnicity wise.

Table 4.4.22: Persons who help with the household chores during illness of the respondents.

Relationship	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Person who helps with the household chores during illness					
Husband	94 (31.3)	114 (38)	46 (23)	71 (35.5)	91 (45.5)
Children	139 (46.3)	168 (56)	73 (36.5)	105 (52.5)	129 (64.5)
Mother	9 (3)	5 (1.7)	13 (6.5)	1 (0.5)	0
Mother- in – law	33 (11)	29 (9.7)	28 (14)	28 (14)	6 (3)
Daughter-in-law	72 (24)	70 (23.3)	51 (25.5)	42 (21)	49 (24.5)
Herself	29 (9.7)	52 (17.3)	26 (13)	35 (17.5)	20 (10)
χ^2	7.95		68.210**		

Multiple responses; Percentages in parentheses; **significant at $p \leq 0.01$

District wise results in Table 4.4.22 reveal that majority of the respondents from both the districts i.e. 46.3% from Jammu and 56% from Kathua said that their children help them in household chores during their illness. 31.3% from Jammu and 38% from Kathua said that their husbands help them, 24% from Jammu and 23.3% from Kathua said that their daughters-in-law help them in household chores during their illness. A very lesser percentage of the respondents who said that their mother, mother-in-law or she herself performs household chores during her illness.

Ethnicity wise results reveal that majority of the respondents from urban, rural and tribal areas i.e. 36.5%, 52.5% and 64.5% respectively said that their children help

them in household chores and 25.5% urban, said that their daughters-in-law perform household chores, 35.5% rural and 45.5% said that their husbands perform household chores during their illness. Remaining respondents said that their mother, mother-in-law or she herself performs household chores during her illness. **Chi-square** analysis reveals ethnicity wise significant difference ($p \leq 0.01$) among the respondent whereas district wise insignificant differences are observed.

DECISION MAKING AT HOUSEHOLD AND COMMUNITY LEVEL:-

Table 4.4.23: Decision making at household level

Person in the family who take Decision regarding	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
What to cook					
Respondent	80 (26.7)	129 (43)	76 (38)	54 (27)	79 (39.5)
Husband	57 (19)	70 (23.3)	33 (16.5)	40 (20)	54 (27)
Husband and Respondent Jointly	114 (38)	65 (21.7)	57 (28.5)	68 (34)	54 (27)
Someone Else	24 (8)	25 (8.3)	19 (9.5)	25 (12.5)	5 (2.5)
Respondent and Someone Else Jointly	20 (6.7)	9 (3)	13 (6.5)	10 (5)	6 (3)
Decision not made or not applicable	5 (1.7)	2 (0.7)	2 (1)	3 (1.5)	2 (1)
χ^2	31.75**		28.310**		
Upbringing, education, occupation and marriage of children					
Respondent	33 (11)	61 (20.3)	33 (16.3)	22 (11)	39 (19.5)
Husband	77 (25.7)	105 (35)	46 (23)	52 (26)	84 (42)
Husband and Respondent Jointly	152 (50.7)	95 (31.7)	85 (42.5)	98 (49)	64 (32)
Someone Else	21 (7)	29 (9.7)	20 (10)	23 (11.5)	7 (3.5)
Respondent and Someone Else Jointly	14 (4.7)	9 (3)	14 (7)	5 (2.5)	4 (2)
Decision not made or not applicable	3 (1)	1 (0.3)	2 (1)	-	2 (1)

Person in the family who take Decision regarding	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
χ^2	29.25**		44.210**		
Buying /Selling of moveable immovable property					
Respondent	33 (11)	51 (17)	27 (13.5)	23 (11.5)	34 (17)
Husband	72 (24)	115 (38.3)	51 (25.5)	50 (25)	86 (43)
Husband and Respondent Jointly	154 (51.3)	92 (30.7)	83 (41.5)	95 (47.5)	68 (34)
Someone Else	21 (7)	32 (10.7)	23 (11.5)	25 (12.5)	5 (2.5)
Respondent and Someone Else Jointly	17 (5.7)	9 (3)	14 (7)	7 (3.5)	5 (2.5)
Decision not made or not applicable	3 (1)	1 (0.3)	2 (1)	-	2 (1)
χ^2	35.15**		41.0510**		
To keep monthly income					
Respondent	40 (13.3)	52 (17.3)	32 (16)	29 (14.5)	31 (15.5)
Husband	80 (26.7)	116 (38.7)	51 (25.5)	53 (26.5)	92 (46)
Husband and Respondent Jointly	138 (46)	91 (30.3)	76 (38)	89 (44.5)	64 (32)
Someone Else	21 (7)	30 (10)	24 (12)	22 (11)	5 (2.5)
Respondent and Someone Else Jointly	18 (6)	10 (3.3)	15 (7.5)	7 (3.5)	6 (3)
Decision not made or not applicable	3 (1)	1 (0.3)	2 (1)	-	2(1)
χ^2	22.75**		40.610**		
Mode of Saving					
Respondent	48 (16)	61 (20.3)	34 (17)	40 (20)	35 (17.5)
Husband	70 (23.3)	105 (35)	42 (21)	45 (22.5)	88 (44)
Husband and Respondent Jointly	139 (46.3)	90 (30)	80 (40)	85 (42.5)	64 (32)
Someone Else	21 (7)	29 (9.7)	23 (11.5)	22 (11)	5 (2.5)
Respondent and	19	13	18	8	6

Person in the family who take Decision regarding	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Someone Else Jointly	(6.3)	(4.3)	(9)	(4)	(3)
Decision not made or not applicable	3 (1)	2 (0.7)	3 (1.5)	0	2 (1)
χ^2	21.65**		49.210**		
How much to spend on daily use					
Respondent	64 (21.3)	72 (24)	42 (21)	52 (26)	42 (21)
Husband	62 (20.7)	96 (32)	42 (21)	38 (19)	78 (39)
Husband and Respondent Jointly	139 (46.3)	85 (28.3)	75 (37.5)	82 (41)	67 (33.5)
Someone Else	16 (5.3)	28 (9.3)	18 (9)	21 (10.5)	5 (2.5)
Respondent and Someone Else Jointly	14 (4.7)	10 (3.3)	12 (6)	6 (3)	6 (3)
Decision not made or not applicable	5 (1.7)	9 (3)	11 (5.5)	1 (0.5)	2 (1)
χ^2	25.85**		47.310**		
Type of gifts given to friends / relatives					
Respondent	69 (23)	69 (23)	45 (22.5)	51 (25.5)	42 (21)
Husband	59 (19.7)	87 (29)	33 (16.5)	39 (19.5)	74 (37)
Husband and Respondent Jointly	134 (44.7)	93 (31)	84 (42)	78 (39)	65 (32.5)
Someone Else	17 (5.7)	31 (10.3)	19 (9.5)	24 (12)	5 (2.5)
Respondent and Someone Else Jointly	14 (4.7)	11 (3.7)	13 (6.5)	6 (3)	6 (3)
Decision not made or not applicable	7 (2.3)	9 (3)	6 (3)	2 (1)	8 (4)
χ^2	17.45**		43.110**		

Percentages in parentheses; **significant at $p \leq 0.01$

Decision making has particular importance with regards to women's health issues as it implies important decisions that could have favourable or unfavourable consequences on the life and well-being of women. **Table 4.4.23 describes the role of respondents in decision making at house hold level.**

What to Cook:- Results given in the above mentioned table show that joint decisions by husband and respondent are taken in 38% families in Jammu, followed by 43% families in Kathua where respondents take decision themselves. 38% respondents from the urban areas and 39.5% from the tribal areas take decision solely, whereas in case of 34% respondents from rural areas the decision is taken jointly by husband and themselves.

Upbringing, Education, Occupation and Marriage of Children:- Results further indicates that regarding upbringing, education, occupation and marriage of children joint decisions by husband and respondent are taken in 50.7% families in Jammu, followed by 35% families in Kathua where husbands take decision. In 42.5% families from the urban areas and 49% from rural areas the decision is taken jointly by husband and themselves. In 42% tribal families decisions are taken by husbands only.

Buying/Selling of moveable/immoveable property:- It is evident from the results that regarding buying/selling of moveable/immoveable property joint decisions by husband and respondent are taken in 51.3% families in Jammu, followed by 38.3% families in Kathua where husbands take decision. In 41.5% families from the urban areas and 47.5% from rural areas the decision is taken jointly by husband and themselves. In 43% tribal families decision are taken by husbands only.

To keep monthly income:- It is clear from the results that joint decisions by husband and respondent are taken in 46% families in Jammu, followed by 38.7% families in Kathua where husbands take decision. In 38% families from the urban areas and 44.5% from rural areas the decision is taken jointly by husband and themselves. In 46% tribal families decision are taken by husbands only.

Mode of saving:- It is observed from the results that joint decisions by husband and respondent are taken in 46.3% families in Jammu, followed by 35% families in Kathua where husbands take decision. In 40% families from the urban areas and 42.5% from

rural areas the decision is taken jointly by husband and respondents. In 44% tribal families decision are taken by husbands only.

How much to spend on daily use:- It is observed from the results that joint decisions by husband and respondent are taken in 46.3% families in Jammu, followed by 32% families in Kathua where husbands take decision. In 37.5% families from the urban areas and 41% from rural areas the decision is taken jointly by husband and respondents. In 39% tribal families decision are taken by husbands only.

Type of gifts given to friend/relatives:- It is observed from the results that joint decisions by husband and respondent are taken in 44.7% families in Jammu, 31% families in Kathua. In 42% families from the urban areas and 39% from rural areas the decision is taken jointly by husband and themselves. In 37% tribal families decision are taken by husbands only.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise on all the dimensions of decision making at household level.

Table 4.4.24: Freedom to visit local places in community

Free to take decisions to visit	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Local market					
Alone	206 (68.7)	181 (60.3)	144 (72)	116 (58)	127 (63.5)
Not Alone	52 (17.3)	45 (15)	24 (12)	36 (18)	37 (18.5)
Never	42 (14)	74 (24.7)	32 (16)	48 (24)	36 (18)
χ^2	10.92**		9.94*		
For check-ups					
Alone	240 (80)	226 (75.3)	159 (79.5)	148 (74)	159 (79.5)
Not Alone	57 (19)	50 (16.7)	39 (19.5)	46 (23)	22 (11)
Never	3 (1)	24 (8)	2 (1)	6 (3)	19 (9.5)
χ^2	17.22**		26.64**		

Free to take decisions to visit	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Neighbourhood					
Alone	205 (68.3)	212 (70.7)	135 (67.5)	133 (66.5)	149 (74.5)
Not Alone	91 (30.3)	63 (21)	63 (31.5)	60 (30)	31 (15.5)
Never	4 (1.3)	25 (8.3)	2 (1)	7 (3.5)	20 (10)
χ^2	20.42**		31.14**		
Nearby Shrine / Mosque					
Alone	233 (77.7)	225 (75)	156 (78)	146 (73)	156 (78)
Not Alone	65 (21.7)	49 (16.3)	41 (20.5)	48 (24)	25 (12.5)
Never	2 (0.7)	26 (8.7)	3 (1.5)	6 (3)	19 (9.5)
χ^2	22.92**		23.24**		

Percentages in parentheses; **significant at $p \leq 0.01$

Local Market:- Results given in the Table 4.4.24 show that majority of the respondents from Jammu and Kathua district i.e. 68.7% and 60.3% respectively, go to local market alone. 72% respondents from urban, 58% from rural and 63.5% respondents from the tribal areas go to local market alone.

For check-ups:- Results show that majority of the respondents from Jammu and Kathua district i.e. 80% and 75.3% respectively, go for check-ups alone. 79.5% respondents from urban, 74% from rural and 79.5% respondents from the tribal areas go for check-ups alone.

Neighbourhood:- Results show that majority of the respondents from Jammu and Kathua district i.e. 68.3% and 70.7% respectively, go to neighbourhood alone. 67.5% respondents from urban, 66.5% from rural and 74.5% respondents from the tribal areas go to neighbourhood alone.

Nearby Shrine / Mosque:- Results show that majority of the respondents from Jammu and Kathua district i.e. 77.7% and 75% respectively, go to nearby Shrine / Mosque alone. 78% respondents from urban, 73% from rural and 78% respondents from the tribal areas go to nearby Shrine / Mosque alone.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.25: Information related to Social Organization joined by respondents

Member of any Social Organization	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	82 (27.3)	98 (32.7)	80 (40)	85 (42.5)	15 (7.5)
NO	218 (72.7)	202 (67.3)	120 (60)	115 (57.5)	185 (92.5)
χ^2	2.03 ₁		72.62 ^{**}		
Type of Organization					
Religious	30 (10)	79 (26.3)	44 (22)	59 (29.5)	6 (3)
Social	29 (9.7)	9 (3)	22 (11)	12 (6)	4 (2)
Women's Organization	22 (7.3)	7 (2.3)	13 (6.5)	13 (6.5)	3 (1.5)
Political	-	3 (1)	-	1 (0.5)	2 (1)
None	219 (73)	202 (67.3)	121 (60.5)	115 (57.5)	185 (92.5)
χ^2	43.94 ^{**}		84.28 ^{**}		

Percentages in parentheses; ^{**}significant at $p \leq 0.01$

Table 4.4.25 reveals both district as well as ethnicity wise indicate that majority of the respondents (District wise: 72.7% Jammu and 67.3% Kathua; Ethnicity wise 60% urban, 57.5% rural and 92.5% tribal) said that they are not member of any Organization. Those who are the members are mostly associated with religious organization.

Chi-square analysis show significant differences ($p \leq 0.01$) among the respondent ethnicity wise whereas insignificant differences are observed district wise regarding member of some organization whereas significant differences ($p \leq 0.01$) among the respondent district wise as well as ethnicity wise are observed on the type of organization.

AVAILABILITY OF CASH FOR HEALTH AND OTHER NEEDS

Table 4.4.26: Information related to bank account and its operation

Responses	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Bank account holder					
YES	187 (62.3)	104 (34.7)	144 (72)	95 (47.5)	52 (26)
NO	113 (37.7)	196 (65.3)	56 (28)	105 (52.5)	148 (74)
χ^2	45.91**		84.82**		
Operating					
YES	165 (55)	91 (30.3)	128 (64)	88 (44)	40 (20)
NO	135 (45)	209 (69.7)	72 (36)	112 (56)	160 (80)
χ^2	37.31**		79.32**		

Percentages in parentheses; **significant at $p \leq 0.01$

District wise results reveal (Table 4.4.26) that 62.3% Jammu respondents hold personal bank account but only 55% operate these accounts themselves independently whereas among respondents from Kathua only 34.7% respondents hold personal bank account and 30.3% operate these accounts themselves independently.

Ethnicity wise results reveal that 72 % urban respondents hold personal bank account but 64% operate these accounts independently whereas majority of the rural and tribal respondents i.e. 52.5% and 74% respectively do not hold personal bank account. Among rural respondents 47.5% hold personal bank account but 44% operate these accounts independently and among tribal respondents only 26% respondents hold personal bank account and 20% operate these accounts independently. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.27: Availability of cash for medicines and other needs

Availability of cash to buy	DISTRICT WISE		ETHNICITY WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
Medicine					
YES	209 (69.7)	179 (59.7)	142 (71)	125 (62.5)	121 (60.5)
NO	64 (21.3)	50 (16.7)	26 (13)	47 (23.5)	41 (20.5)
Doesn't buy herself	27 (9)	71 (23.7)	32 (16)	28 (14)	38 (19)
χ^2	23.72**		9.64*		
Clothes					
YES	189 (63)	171 (57)	129 (64.5)	107 (53.5)	124 (62)
NO	85 (28.3)	52 (17.3)	39 (19.5)	59 (29.5)	39 (19.5)
Doesn't buy herself	26 (8.7)	77 (25.7)	32 (16)	34 (17)	37 (18.5)
χ^2	34.12**		8.44		
Fruits / vegetables					
YES	165 (55)	91 (30.3)	128 (64)	88 (44)	40 (20)
NO	134 (44.7)	208 (69.3)	72 (36)	111 (55.5)	159 (79.5)
Doesn't buy herself	1 (0.3)	1 (0.3)	-	1 (0.5)	1 (0.5)
χ^2	37.72**		79.84**		
Toiletries					
YES	196 (65.3)	166 (55.3)	125 (62.5)	111 (55.5)	126 (63)
NO	76 (25.3)	49 (16.3)	38 (19)	52 (26)	35 (17.5)
Doesn't buy herself	28 (9.3)	85 (28.3)	37 (18.5)	37 (18.5)	39 (19.5)
χ^2	37.072**		5.24		

Percentages in parentheses; *significant at $p \leq 0.05$; **significant at $p \leq 0.01$

District wise results described in Table 4.4.27, show that majority of the respondents from both the districts said that cash available for them to buy Medicines (69.7% Jammu and 59.7% Kathua), Clothes (63% Jammu and 57% Kathua) and toiletries (65.3% Jammu and 55.3% Kathua). For the purchase of fruits and vegetables 55% respondents from the Jammu District said cash is available to buy these where as 69.3% from Kathua said that they don't buy fruits / vegetables themselves. Other family members help in buying these.

Ethnicity wise results shows that majority of the respondents from urban, rural and tribal areas said that cash is available for them to buy Medicines (71% urban, 62.5% rural and 60.5% tribal), Clothes (64.5% urban, 53.5% rural and 62% tribal), and toiletries (62.5% urban, 55.5% rural and 63% tribal). For the purchase of fruits and vegetables 64% respondents from the urban areas said that the cash is available and they do buy these whereas 55.5% rural and 79.5% tribal respondents cash is not available to buy fruits / vegetables themselves.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondents of both the districts on all the dimensions whereas ethnicity wise significant differences ($p \leq 0.01$) are observed on the dimension of purchase of fruits and vegetables and medicines ($p \leq 0.05$)

ECONOMIC POLICIES IN RELATION TO ACCESSIBILITY OF SERVICE/ CARE

Table 4.4.28: Awareness regarding Governmental Schemes for financial assistance.

Awareness of Schemes for financial assistance to women from Government	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	69 (23)	60 (20)	63 (31.5)	45 (22.5)	21 (10.5)
NO	231 (77)	240 (80)	137 (68.5)	155 (77.5)	179 (89.5)
χ^2	0.81		26.32**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.4.28 reveals that both district as well as ethnicity wise majority of the respondents (77% Jammu and 80% Kathua and 68.5% urban, 77.5% rural and 89.5% tribal) said that they are not aware of governmental Schemes for financial assistance to women.

Chi-square analysis shows significant difference ($p \leq 0.01$) among the respondent ethnicity wise whereas insignificant difference is observed district wise.

Table 4.4.29: Awareness of Health related Schemes of Government

Awareness of Health related Schemes for women from Government	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	96 (32)	52 (17.3)	73 (36.5)	48 (24)	27 (13.5)
NO	204 (68)	248 (82.7)	127 (63.5)	152 (76)	173 (86.5)
χ^2	17.31**		28.542**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.2.11.2 reveals that both district as well as ethnicity wise results reveal that majority of the respondents (68% Jammu and 82.7% Kathua and 63.5% urban, 76% rural and 86.5% tribal) said that they are not aware of Health related Schemes for women launched by the Government.

Chi-square analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

Table 4.4.30: Benefit from any Health related Schemes

Ever been beneficiary of any Health related Schemes for women from Government	DISTRICT WISE		RESIDENCE WISE		
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200
YES	51 (17)	23 (7.7)	35 (17.5)	28 (14)	11 (5.5)
NO	249 (83)	277 (92.3)	165 (82.5)	172 (86)	189 (94.5)
χ^2	12.081**		14.082**		

Percentages in parentheses; **significant at $p \leq 0.01$

Table 4.2.32 both district as well as ethnicity wise reveals that majority of the respondents (83% Jammu and 92.3% Kathua and 82.5% urban, 86% rural and 94.5% tribal) said that they are not ever been beneficiary of any Health related Schemes for women from Government. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise.

4.5. CULTURAL AND SOCIAL FACTORS:

To study the cultural and social factors, as perceived by Ojanuga and Gilbirt (1992) related to: inferior status of women, Women's Desire for Social Freedom Scale and Self-Esteem Scale was used.

WOMEN'S DESIRE FOR SOCIAL FREEDOM (WSF)

Table 4.5.1: Mean and t scores of the respondents on the various dimensions of WSF (District wise)

DIMENSIONS OF WSF	DISTRICTS		
	Jammu N = 300	Kathua N = 300	t
Freedom from Husband	3.67 ± 0.56	3.58 ± 0.64	1.76
Freedom from customs, taboos and rituals	12.20 ± 1.34	12.14 ± 1.48	0.519
Freedom from Marriage and Sex	8.25 ± 1.35	7.65 ± 1.38	5.38**
Economic Freedom and Social Equality	10.02 ± 1.078	9.70 ± 1.12	3.60**
WSF (Total)	11.38 ± 2.76	10.61 ± 3.166	3.160**

**significant at $p \leq 0.01$

Results in the Table 4.5.1 show that overall significant differences were found on Desire for Social Freedom among the respondents. On all the dimension of Desire for Social Freedom respondents of Jammu have higher mean scores but significant differences were found only on the dimension of marriage and sex, economic freedom and social equality.

Table 4.5.2: Association of various dimensions of WSF with Ethnicity

DIMENSIONS OF WSF	ETHNICITY			F
	Urban N = 200	Rural N = 200	Tribal N = 200	
Freedom from Husband	3.75± 0.48	3.56± 0.66	3.58± 0.64	5.944 *
Freedom from customs, taboos and rituals	12.57± 1.37	12.05± 1.36	11.89± 1.42	13.379**
Freedom from Marriage and Sex	8.66 ± 1.42	7.71 ± 1.30	7.49 ± 1.18	45.132**
Economic Freedom and Social Equality	9.78 ± 1.02	9.90 ±1.21	9.91 ± 1.09	.919

*significant at p≤0.05, **significant at p≤0.01

Results in the Table 4.5.2 show significant differences on all the dimensions of Desire for Social Freedom Scale except economic freedom and social equality. On the dimension of Desire for Social Freedom from husband respondents of urban (3.75± 0.48) have higher mean scores followed by the respondents of tribal areas(3.58± 0.64) and then respondents from the rural areas (3.56± 0.66). On the dimension of freedom from customs, taboos and rituals respondents of urban (12.57± 1.37) have higher mean scores followed by the respondents of rural areas (12.05± 1.36) and then respondents from the tribal areas (11.89± 1.42). On the dimension of freedom from marriage and sex Respondents of urban (8.66 ± 1.42) have higher mean scores followed by the respondents of rural areas (7.71 ± 1.30) and then respondents from the tribal areas (7.49 ± 1.18). On the dimension of economic freedom and social equality respondents of tribal areas (9.91 ± 1.09) have higher mean scores followed by the respondents of rural (9.90 ±1.21) and then respondents from the urban areas (9.78 ± 1.02).

Table 4.5.3: Levels of Women’s Desire for Social Freedom

Levels of WSF	DISTRICT		ETHNICITY			Total N = 600
	Jammu N = 300	Kathua N = 300	Urban N = 200	Rural N = 200	Tribal N = 200	
Low	71 (23.7)	102 (34)	65 (32.5)	74 (37)	34 (17)	172 (28.67)
Moderate	133 (44.3)	121 (40.3)	89 (44.5)	91 (45.5)	74 (37)	254 (42.33)
High	96 (32)	77 (25.7)	46 (23)	35 (17.5)	92 (46)	173 (28.83)
X²	7.55*		46.79**			

*significant at p≤0.05, **significant at p≤0.01

Figure No. (a): District wise figurative presentation of Table 4.5.3

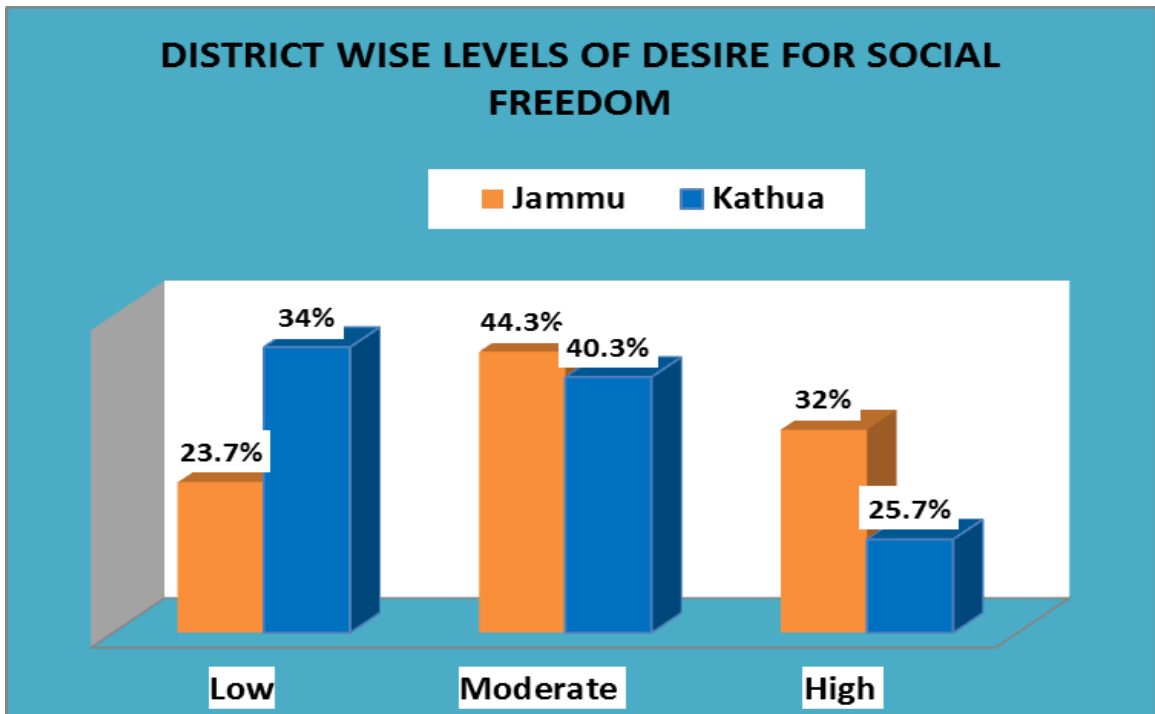
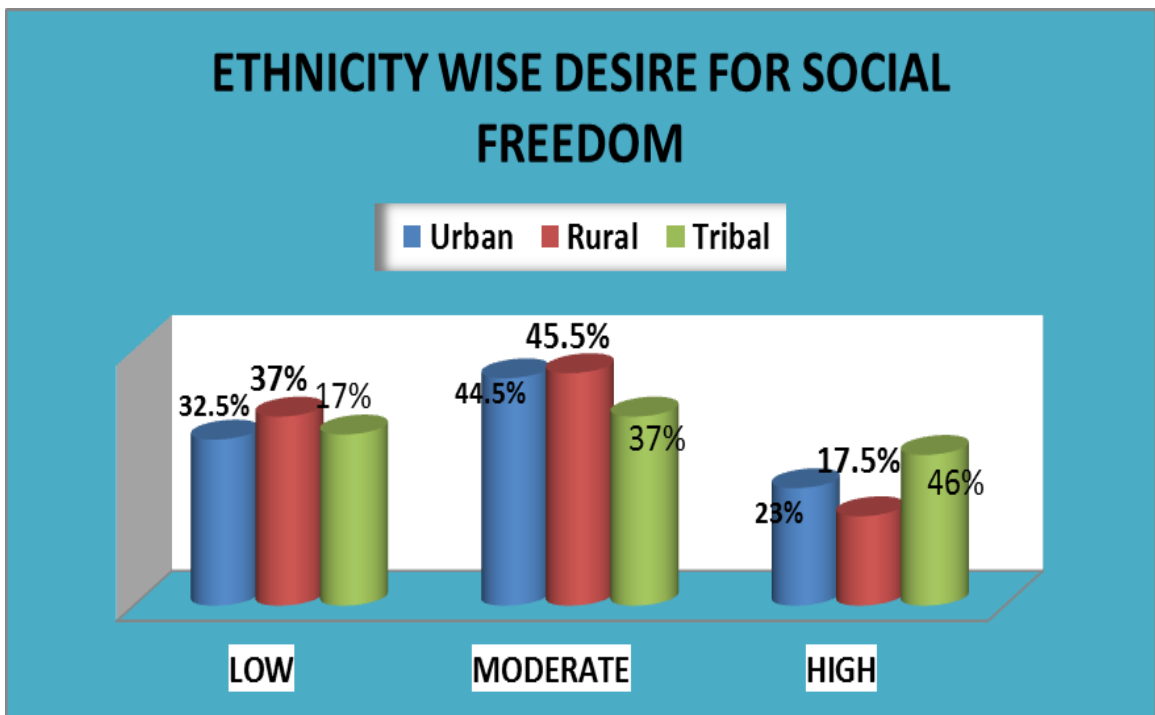


Figure No.(b): Ethnicity Wise District wise figurative presentation of Table 4.5.3



It is evident from the Table 4.5.3 that most of the respondents (42.33%) have moderate level of Desire for Social Freedom. **District wise** results (in the Table 4.5.3) reveal that most of the respondents from Jammu (44.3%) and Kathua (40.3%) show moderate level of desire for social freedom. 32% respondents from Jammu show high level of desire for social freedom whereas 34% of the respondents from Kathua show low level of desire for social freedom. 32% respondents from Jammu and 25.7% from Kathua show high level of desire for social freedom.

Ethnicity wise results reveal that most of the urban (44.4%), rural (45.5%) and tribal (37%) respondents have moderate level of desire for social freedom. Only 23% respondents from urban, 17.5% from rural but 46% respondents from tribal areas have high level of desire for social freedom. It was observed during data collection that majority of respondents urban, rural and tribal areas were satisfied with the prevailing system of society. They believe that the social bindings imposed on them are for their wellbeing only.

Chi-square analysis reveals significant difference among the respondent both district wise ($p \leq 0.05$) as well as ethnicity wise ($p \leq 0.01$).

SELF ESTEEM AMONG RESPONDENTS

Table 4.5.4: Levels of self esteem among respondents

Levels of SESW	DISTRICT		ETHNICITY			Total N = 600
	Jammu N = 300	Kathua N = 300	Urban N = 300	Rural N = 300	Tribal N = 300	
Low	69 (23)	102 (34)	46 (23)	37 (18.5)	88 (44)	171 (28.5)
Moderate	71 (23.7)	69 (23)	36 (18)	45 (22.5)	59 (29.5)	140 (23.3)
High	160 (53.3)	129 (43)	118 (59)	118 (59)	53 (26.5)	289 (48.17)
X²	9.7**		60.9**			

*significant at $p \leq 0.05$, **significant at $p \leq 0.01$

Figure no. 4.5.4(a): District Wise Levels of Self Esteem of Women

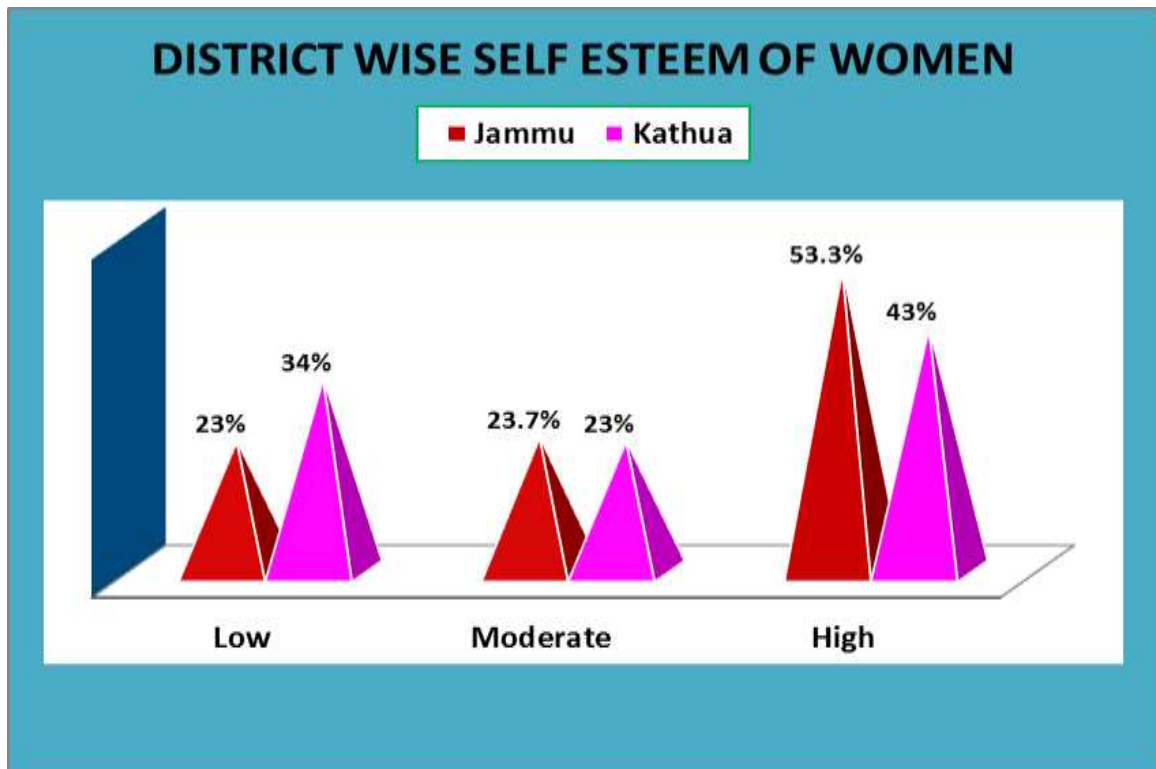
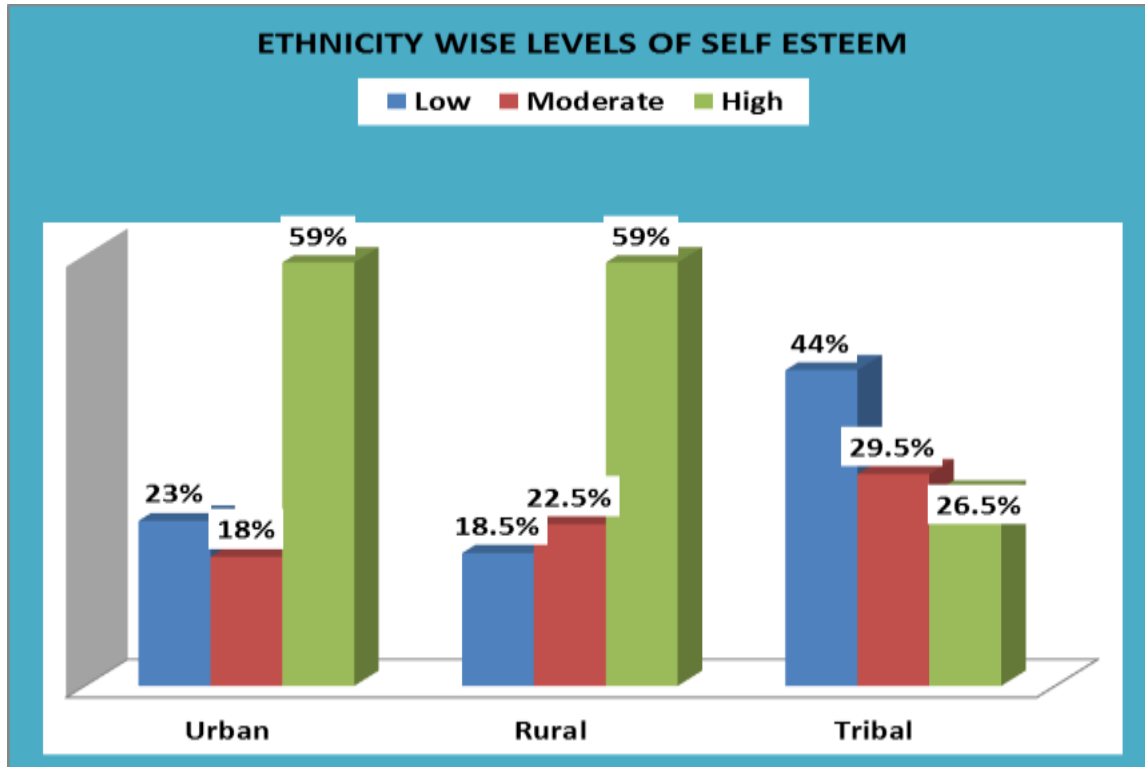


Figure no. 4.5.5 (b): Ethnicity Wise Levels of Self Esteem of Women



It is clear from the results that most of the respondents (48.17%) show high level of self-esteem. Further **District wise** results reveal that most of the respondents from Jammu (53.3%) and Kathua (43%) have high level of self-esteem. Results further indicate that respondents from Jammu have higher level of self-esteem as compared to respondents from Kathua. **Ethnicity wise** results reveal that most of the respondents from urban (59%) and rural (59%) areas show high level of self-esteem whereas most of the respondents from tribal (44%) show low high level of self-esteem. It can be clearly interpreted from the above mentioned figure no. 4.5.5 (b) that tribal women have lower level of self-esteem as compared to urban and rural women. **Chi-square** analysis reveals significant difference ($p \leq 0.01$) among the respondent both district wise as well as ethnicity wise

4.6 RELATIONSHIP OF BACKGROUND VARIABLES WITH:

- Demographic Variables
- Health Seeking Behaviour
- Desire for Social Freedom
- Self Esteem
- Women’s Health Questionnaire (WHQ)
- Various dimensions of Women’s Health Questionnaire

Table 4.6.1: Relationship among background and demographic variables

Background/ Demographic Variables	Age at Menarche	Age at Marriage	Age at 1st Pregnancy	Age at last Pregnancy	Age at Menopause	Number of children
Age	.134(**)	-.453(**)	-.249(**)	.124(**)	.156(*)	.416(**)
Education	.027	.543(**)	.376(**)	-.013	.045	-.435(**)
Occupation	-.043	-.298(**)	-.146(**)	.058	-.025	.234(**)
Type of family	-.007	.317(**)	.138(**)	-.082(*)	-.002	-.268(**)

** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed).

Table 4.6.1 reveals that present age is positively significantly correlated with age at menarche, age at last pregnancy, age at menopause and number of children ($p \leq 0.01$) whereas negatively significantly correlated with age at marriage and age at first pregnancy ($p \leq 0.01$). Education is positively significantly correlated with age at marriage and age at first pregnancy ($p \leq 0.01$) but negatively significantly correlated with number of children and SES ($p \leq 0.01$). Occupation is positively significantly correlated with number of children and SES ($p \leq 0.01$) but negatively significantly correlated with age at marriage and age at first pregnancy ($p \leq 0.01$). Type of family is positively significantly correlated with age at marriage and age at first pregnancy ($p \leq 0.01$) whereas negatively significantly correlated with age at last pregnancy ($p \leq 0.05$) and number of children ($p \leq 0.01$). Educational attainment delays the age at marriage and age at first pregnancy. Occupation positively relates to number of children whereas as higher education means lesser number of children for these respondents.

Table 4.6.2: Relationship of demographic variables with HSB, WSF,WH and SESW

Variables	Health Seeking Behaviour	Women's Social Freedom	Women's Health	Self Esteem
Age	-.071	-.023	.042	.045
Education	.204(**)	.060	-.183(**)	.182(**)
Occupation	-.117(**)	.005	.097(*)	-.116(**)
Type of Family	.117(**)	-.049	-.038	-.073
SES	-.139(**)	.024	.103(*)	-.307(**)
Age at Menarche	-.037	-.114(**)	-.095(*)	-.027
Age at Marriage	.190(**)	.046	-.121(**)	.085(*)
Age at 1 st Pregnancy	.147(**)	.080	-.135(**)	.074
Age at Last Pregnancy	-.030	.071	-.041	.070
Age at Menopause#	.053	.047	-.052	.093
No. of Children	-.117(**)	.029	.149(**)	-.062

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Data for only 271 women used who attained menopause.

Correlation analysis shows that **Health Seeking Behaviour** is positively significantly correlated with Education, Type of family, Age at marriage and Age at first pregnancy ($p \leq 0.01$) but negatively significantly correlated with Occupation, SES and number of Children ($p \leq 0.01$). **Women's Social Freedom** is positively correlated with Education, Occupation, SES, Age at marriage, Age at first pregnancy, Age at last pregnancy, Age at menopause and number of children but no significant relationship was found whereas negatively significantly correlated with age at menarche ($p \leq 0.01$). **Women's Health** is positively significantly correlated with Occupation and SES ($p \leq 0.05$) and number of children ($p \leq 0.01$) but negatively significantly with Education ($p \leq 0.01$), Age at menarche ($p \leq 0.05$) Age at marriage, Age at first pregnancy ($p \leq 0.01$) and Age at menopause ($p \leq 0.05$). **Self Esteem** is positively significantly correlated with Education ($p \leq 0.01$) and Age at marriage ($p \leq 0.05$) but negatively significantly with Occupation and SES ($p \leq 0.01$). Higher the education, age at marriage and age at first pregnancy, higher the health seeking behaviour, whereas higher the SES and number of children lower the health seeking behaviour.

Table 4.6.3: Relationship of Health Seeking Behaviour with Desire for Social Freedom, Women’s Health Status and Self-Esteem

	HSBC	WSF	WHQ	SESW
HSBC	1			
WSF	.218(**)	1		
WHQ	.185(**)	.156(**)	1	
SESW	.020	-.106(**)	-.234(**)	1

**** Correlation is significant at the 0.01 level (2-tailed).**

Results in the Table 4.6.3 reveals that Health Seeking Behaviour is positively significantly correlated with Desire for Social Freedom and Women’s Health Status ($p \leq 0.01$). Desire for Social Freedom is positively significantly correlated with Women’s Health Status ($p \leq 0.01$) whereas negatively significantly correlated with Self-Esteem ($p \leq 0.01$). Women’s Health Status is positively significantly correlated with Health Seeking Behaviour and Desire for Social Freedom ($p \leq 0.01$). Self-Esteem is negatively significantly correlated with Desire for Social Freedom and Women’s Health Status ($p \leq 0.01$).

Table 4.6.4: Relationship of Dimensions of WHQ with demographic variables

	Somatic	Vasomotor	Sleep Problem	Depressed Mood	Sexual Dysfunction	Anxiety	Menstrual Symptoms	Memory / Concentration	Attractiveness
Age	.115(**)	.115(**)	.069	.237(**)	-.256(**)	.030	-.312(**)	.107(**)	.227(**)
Education	-.107(**)	-.202(**)	-.223(**)	-.291(**)	-.151(**)	-.213(**)	-.007	-.334(**)	-.291(**)
Occupation	.121(**)	.135(**)	.163(**)	.145(**)	.146(**)	.200(**)	.074	.298(**)	.171(**)
Type of Family	-.122(**)	-.095(*)	-.058	-.048	.091(*)	-.011	.125(**)	.041	-.105(**)
SES	.050	.135(**)	.233(**)	.253(**)	.242(**)	.253(**)	.100(*)	.323(**)	.218(**)
Age at Menarche	-.117(**)	-.067	-.061	.052	.076	-.061	-.101(*)	.077	.097(*)
Age at Marriage	-.161(**)	-.213(**)	-.181(**)	-.283(**)	-.105(**)	-.204(**)	.070	-.204(**)	-.300(**)
Age at 1 st Pregnancy	-.146(**)	-.159(**)	-.193(**)	-.235(**)	-.019	-.220(**)	-.010	-.132(**)	-.151(**)
Age at Last Pregnancy	.000	.045	-.067	-.037	-.027	-.104(*)	-.105(*)	-.009	.003
Age at Menopause	-.038	-.026	-.041	-.093	-.156(*)	-.090	-.038	.005	-.060
Number of Children	.195(**)	.214(**)	.164(**)	.196(**)	-.037	.108(**)	-.104(*)	.201(**)	.139(**)

**** Correlation is significant at the 0.01 level (2-tailed).**

*** Correlation is significant at the 0.05 level (2-tailed).**

Correlation analysis reveals that Somatic Behaviour is positively significantly correlated with age, occupation and number of children ($p \leq 0.01$) whereas negatively significantly correlated with education, type of family, age at menarche, age at marriage and age at first pregnancy ($p \leq 0.01$). Vasomotor is positively significantly correlated with age, Occupation, SES and number of children ($p \leq 0.01$) whereas negatively significantly correlated with education, age at marriage and age at first pregnancy ($p \leq 0.01$). Depressed Mood is positively significantly correlated with age, occupation, and SES ($p \leq 0.01$) whereas negatively significantly correlated with education, age at marriage, age at first pregnancy and age at last pregnancy ($p \leq 0.01$). Sleep Problem is positively significantly correlated with occupation, SES. and number of children ($p \leq 0.01$) whereas negatively significantly correlated with education, age at marriage and age at first pregnancy ($p \leq 0.01$). Sexual Dysfunction is positively significantly correlated with Occupation ($p \leq 0.05$), type of family and SES ($p \leq 0.01$) whereas negatively significantly correlated with age, education, age at marriage and age at menopause ($p \leq 0.01$). Anxiety is positively significantly correlated with Occupation, SES and number of children ($p \leq 0.01$) whereas negatively significantly correlated with education, age at marriage, age at first pregnancy ($p \leq 0.01$) and age at last pregnancy ($p \leq 0.05$). Menstrual Symptoms is positively significantly correlated with type of family ($p \leq 0.01$), SES ($p \leq 0.05$) but negatively significantly correlated with age ($p \leq 0.01$), age at menarche, age at last pregnancy and number of children ($p \leq 0.05$). Memory / Concentration is positively significantly correlated with age, occupation, SES and number of children ($p \leq 0.01$) whereas negatively significantly correlated with education, age at marriage and age at first pregnancy ($p \leq 0.01$). Attractiveness is positively significantly correlated with age, occupation, SES, number of children ($p \leq 0.01$) and age at menarche ($p \leq 0.05$) whereas negatively significantly correlated with education, type of family, age at marriage and age at first pregnancy ($p \leq 0.01$).

**Table 4.6.5: Relationship of various items of WHQ with demographic variables.
Correlations**

	Age	Age at 1 st menarche	Age at marriage	Age at 1 st pregnancy	Age at last pregnancy	Age at menopause	Number of children
I wake early and then sleep badly for the rest of the night	-.016	-.059	-.025	-.028	.057	-.053	.108(**)
I get very frightened or panic feelings for apparently no reason at all	.030	-.107(**)	-.088(*)	-.096(*)	.000	-.061	.120(**)
I feel miserable and sad	.031	-.101(*)	-.084(*)	-.099(*)	-.032	-.064	.064
I feel anxious when I go out of the house on my own	.078	-.120(**)	-.014	-.075	-.022	-.036	.127(**)
I have lost interest in things	.171(**)	-.047	-.098(*)	-.067	-.023	-.043	.135(**)
I get palpitations or a sensation of "butterflies" in my stomach or chest	.006	-.108(**)	-.091(*)	-.184(**)	-.090(*)	.003	.074
I still enjoy the things I used to	.203(**)	.028	-.220(**)	-.132(**)	.015	-.058	.136(**)
I feel life is not worth living	.122(**)	.143(**)	-.047	-.100(*)	-.086(*)	.070	.009
I feel tense or "wound up"	.069	-.005	-.087(*)	-.058	-.050	-.012	.057
I have a good appetite	.068	.069	-.042	-.002	.031	-.005	.047
I am restless and can't keep still	.056	-.067	-.030	-.032	-.012	-.005	.064
I am more irritable than usual	.135(**)	-.008	-.155(**)	-.139(**)	-.068	-.126(*)	.097(*)
I worry about growing old	-.070	-.014	.082(*)	.009	-.061	-.069	-.054
I have headaches	.042	-.054	-.139(**)	-.125(**)	-.037	-.193(**)	.065
I feel more tired than usual	.078	.013	-.109(**)	-.103(*)	.017	-.063	.124(**)
I have dizzy spells	.092(*)	.006	-.109(**)	-.091(*)	.003	-.100	.097(*)
My breasts feel tender or uncomfortable	-.094(*)	.001	.065	-.008	-.075	.064	-.074
I suffer from backache or pain in my limbs	.085(*)	-.113(**)	-.208(**)	-.141(**)	-.045	-.040	.093(*)
I have hot flushes	.157(**)	.070	-.151(**)	-.101(*)	.033	-.034	.167(**)
I am more clumsy than usual	.073	-.037	-.098(*)	-.082(*)	.031	-.051	.117(**)
I feel rather lively and excitable	.090(*)	.049	-.150(**)	-.058	.008	.026	.038
I have abdominal cramps or discomfort	.069	-.110(**)	-.109(**)	-.137(**)	-.070	-.040	.066
I feel sick or nauseous	.026	-.078	-.075	-.080(*)	-.026	-.025	.070
I have lost interest in sexual activity	-.036	.006	.072	.052	.035	.079	.006
I have feelings of well-being	.152(**)	.053	-.149(**)	-.089(*)	.047	-.048	.121(**)
I have heavy periods	-.595(**)	-.087(*)	.253(**)	.165(**)	-.027	-.068	-.192(**)
I suffer from night sweats	.065	-.137(**)	-.082(*)	-.132(**)	-.057	-.024	.113(**)
My stomach feels bloated	.088(*)	-.146(**)	-.064	-.107(**)	-.015	.015	.123(**)
I have difficulty in getting off to sleep	.103(*)	-.089(*)	-.116(**)	-.172(**)	-.113(**)	.052	.096(*)
I often notice pins and needles in my hands and feet	.030	-.189(**)	-.170(**)	-.152(**)	-.010	-.027	.153(**)
I am satisfied with my current sexual relationship	-.275(**)	.048	.249(**)	.166(**)	-.033	-.038	-.175(**)
I feel physically attractive	.264(**)	.104(*)	-.322(**)	-.178(**)	-.002	-.116	.177(**)
I have difficulty in concentrating	.083(*)	-.108(**)	-.021	-.013	.004	.217(**)	.097(*)
As a result of vaginal dryness sexual intercourse has become uncomfortable	-.412(**)	-.137(**)	.256(**)	.156(**)	.028	-.057	-.091(*)
I need to pass urine/water more frequently than usual	.056	-.051	.017	.013	.007	.063	.090(*)
My memory is poor	.101(*)	.033	-.054	-.001	.023	.069	.124(**)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Correlation of various items of WHQ with demographic variables reveals that Age is positively significantly correlated with losing of interest, feeling that life is not worth living, restlessness, irritability, dizzy spells, backache or pain in limbs, hot flushes, being lively or excitable, well-being, sleep problem, and attractiveness, memory and concentration; whereas it is negatively correlated with tenderness of breast, heavy periods, satisfaction with sexual relationship, and vaginal dryness. Age at menarche is positively significantly correlated with feeling that life is not worth living and attractiveness whereas it is negatively correlated with panic feeling without any reason, miseries and sadness, anxiousness when go out of home, palpitation and sensation, backache or pain in limbs, abdominal cramps, heavy periods, stomach feel bloated, night sweats, sleep problem, pins and needles in hands and feet, memory and concentration and vaginal dryness. Age at marriage is positively significantly correlated with growing old, heavy periods, satisfaction with sexual relationship and vaginal dryness. growing old, tiredness, dizzy spells, tenderness of breast, clumsiness, well-being, heavy periods, attractiveness, whereas it is negatively significantly correlated with panic feelings without any reason, miseries and sadness, losing of interest, palpitation and sensation, still enjoying things, tense or wound up, irritability, headache, tiredness, dizzy spells, backache or pain in limbs, hot flushes, clumsiness, being lively or excitable, abdominal cramps, well-being, night sweats, sleep problems, feeling pins and needles in hands and feet and attractiveness. Age at first pregnancy is positively significantly correlated with heavy periods, sexual relationship and vaginal dryness whereas negatively correlated with panic feeling without any reason, miseries and sadness, palpitation and sensation, still enjoying things, feeling that life is not worth living, irritability, headache, tiredness, dizzy spells, backache or pain in limbs, hot flushes, clumsiness, abdominal cramps, well-being, night sweats, stomach feel bloated, sleep problems, feeling pins and needles in hands and feet and attractiveness. Age at last pregnancy is negatively significantly correlated with feeling of palpitation and sensation, that life is not worth living and sleep problems but no positive significant relationship is found with the items of WHQ. Age at menopause is positively significantly correlated with memory and concentration problem whereas it is negatively significantly correlated with irritability and headache. Number of Children is positively significantly correlated with hot flushes whereas negatively

significantly correlated with loss of interest in things, palpitations or a sensation, still enjoying the things, growing old, tenderness of breast, clumsiness, lively and excitable, abdominal cramps, , well- being , sexual activities, heavy periods, sexual relationship, attraction, vaginal dryness, pass urine/water frequently and poor memory.

Table 4.6.6: Relationship of dimensions of Women’s Desire for Social Freedom with other variables:

	Desire for Freedom from Husband	Desire for Freedom from customs, taboos and rituals	Desire for Freedom from Marriage and Sex	Desire for Economic Freedom and Social Equality
Age	.025	.014	.059	-.056
Education	.073	.072	.189(**)	.051
Occupation	-.073	-.048	-.123(**)	-.074
Type of family	.036	-.014	-.039	.073
SES	-.141(**)	-.131(**)	-.250(**)	-.015
HSBC	.017	.031	.052	.032
WHQ	-.052	-.085(*)	-.123(**)	-.063
Self Esteem	.074	.016	.064	-.017

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Result in the Table 4.6.6. reveals that desire for freedom from husband is negatively significantly correlated with Socio-Economic Status ($p \leq 0.01$). Desire for freedom from customs, taboos and rituals is negatively significantly correlated with Socio-Economic Status ($p \leq 0.01$) and WHQ ($p \leq 0.05$). Desire for freedom from marriage and sex is positively significantly related with education whereas it is negatively significantly correlated with occupation ($p \leq 0.01$), SES($p \leq 0.01$) and WHQ ($p \leq 0.01$)

DISCUSSION

Women's right to health has been strongly affirmed by the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women in 1995. According to UN Population Aging Report (2013) the older population, in this world, is predominantly female. In 2013, globally, there were 85 men per 1000 women in the age group of 60 years and over. Notwithstanding universal declaration of human rights aim to provide a common standard of living, women are by and large victims of poor health in almost every nook and corner of the world (Sen, 2012). The changing demographic structure is occurring worldwide with a gradual shift towards a higher proportion of older people. A declining trend in both fertility and mortality rates has increased average life span and has created a new set of challenges in today's society (Biswas et al, 2003). Craft (1997) reported that all over the world women live longer than men, upto 12 years longer in the Russian Federation. However, while women live longer, they are not necessarily living better, healthier lives. In developing countries, communicable diseases, to there with childbirth related illness, account for most morbidity among women. In the developed world, too, women experiences of higher levels of physical and psychological morbidity (Craft, 1997). Women across the world face similar situations when it comes to healthcare. World bank projects that by 2020 one in five women in the developing world will be 50 years or older, increasingly neglected and plagued with a host of chronic conditions. Cancer of cervix and breast claims 350,000 older women each year, osteoporosis afflicts 1/10 over 60, osteoarthritis will be the increasing cause of disability in post menopausal years. Health is one of the core components of National Common Minimum Programme and health care among the 7 thrust areas. Most of the health programs in India are aimed towards improving the reproductive health, but inadequate attention has been paid to the post reproductive health.

Though a lot is spent to raise the status of its population especially the women and children, yet the outcomes are dissatisfactory and it is only the women in the reproductive age who are much attended to. Aged women have not been given much importance, but as the aged population in India is increasing and women are expected to outlive men

much attention is required in the coming years to look after the health care needs of the aged women. With 77 million elderly in 2007 (Helpage India Research and Development), the second largest in the world, out of which 40 million are women, the situation seems grave, especially when they avoid health seeking. 80% elderly reside in rural areas, 40% live below the line of poverty and 35% marginally over it, 73% of them being illiterates out of which 42.08% are females. Out of 54% women who are 60+ 18.36 million are widows. Baliga et al (2013) say that attribution of ill health to ageing, low economic status and negative attitude of health workers towards elderly are some of the factors associated with delay in seeking health care. They also stress on the need for health care among elderly. Dominic et al (2013) say that a proper understanding of health seeking behaviours could reduce delay in diagnosis, improve treatment compliance and health promotion strategies in a variety of contexts. Olasunbo and Ayo (2013) observed a significant relationship of health actions to demographic variables. Their study showed that men demonstrate better health seeking behaviours in regard to diet and empowered to bear cost of health care. They conclude that there are strong gender differences in relation to health.

There is a need to understand the women's beliefs, perceptions, socio economic status, literacy status, decision making, labour participation and communication, perceived quality of health care as there is dearth of such data in India. Women are less likely to seek appropriate and early care for diseases yet the frequency with which such care is required and the quality of care required has not been well documented in South Asia (Fikree and Pasha, 2004). The study of beliefs about health and disease has become important to understand why people seek or do not seek health care. Health care professionals have started studying these cultural aspects of health care in order to improve health care seeking among population.

HEALTH SEEKING BEHAVIOR:

Health seeking behaviour refers to all those things humans do to prevent diseases and to detect diseases in asymptomatic stages (Mackain 2012). It means to take care of health or to lead a healthy life (Sen, 2012). This behaviour among different populations is a complex outcome of many factors operating at individual, family and community level

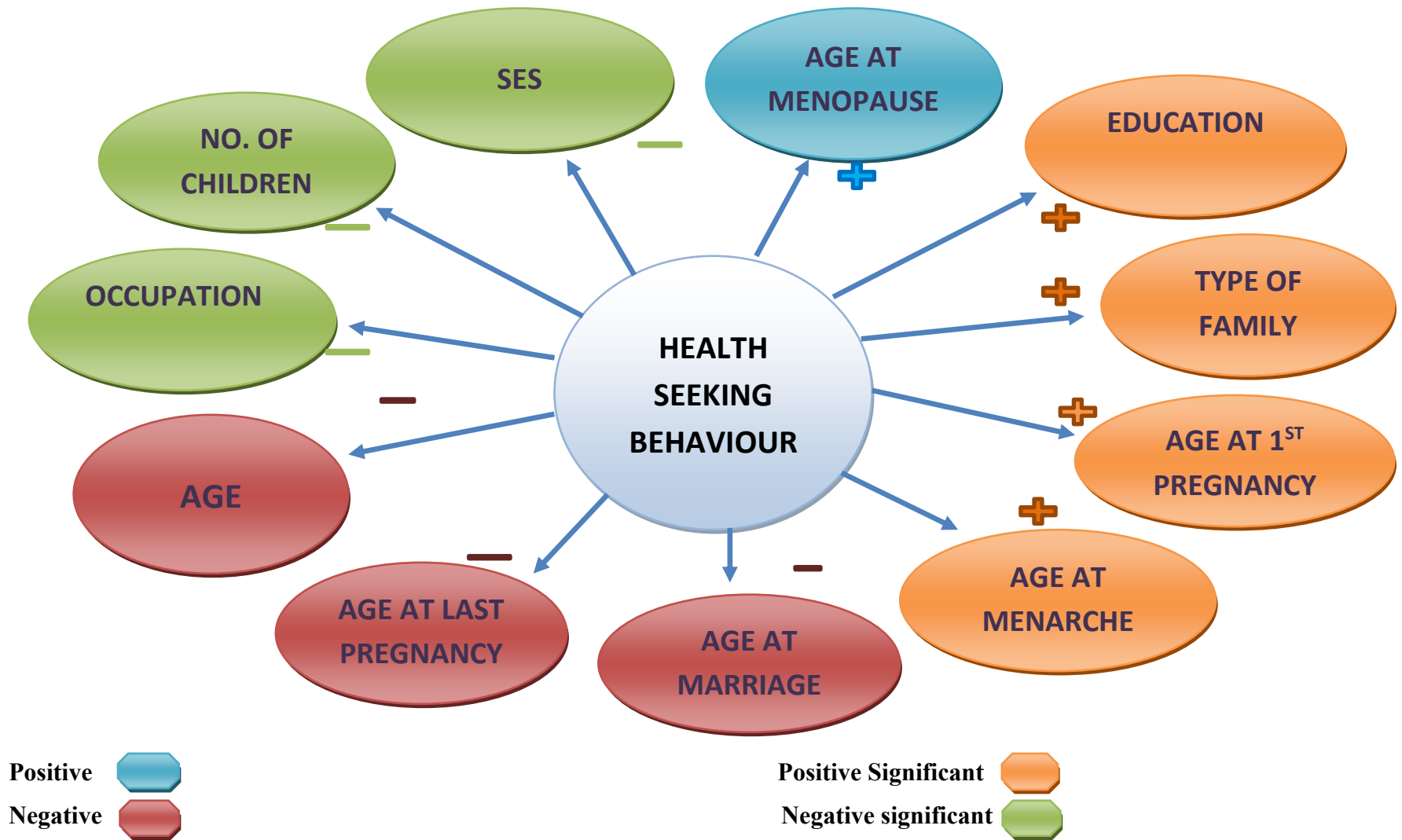
including their bio-social profile, their past experiences with the health services, influences at the community level, availability of alternative health care providers including indigenous practitioners and last but not the least their perceptions regarding efficiency and quality of the services.

To understand the health seeking behaviour of women in the menopausal transition, a study was conducted in the urban, rural and tribal areas of Jammu and Kathua districts of J&K state. Most of the respondents were 49 years of age, most of them being illiterate, not employed outside home, residing in nuclear families and belong to middle socio-economic status. Their average age at menarche was 14 years, age at marriage was 19 years, age at first pregnancy was 21 years, age at last pregnancy was 28 years and average age at menopause was 48 years (for those who have attained it).

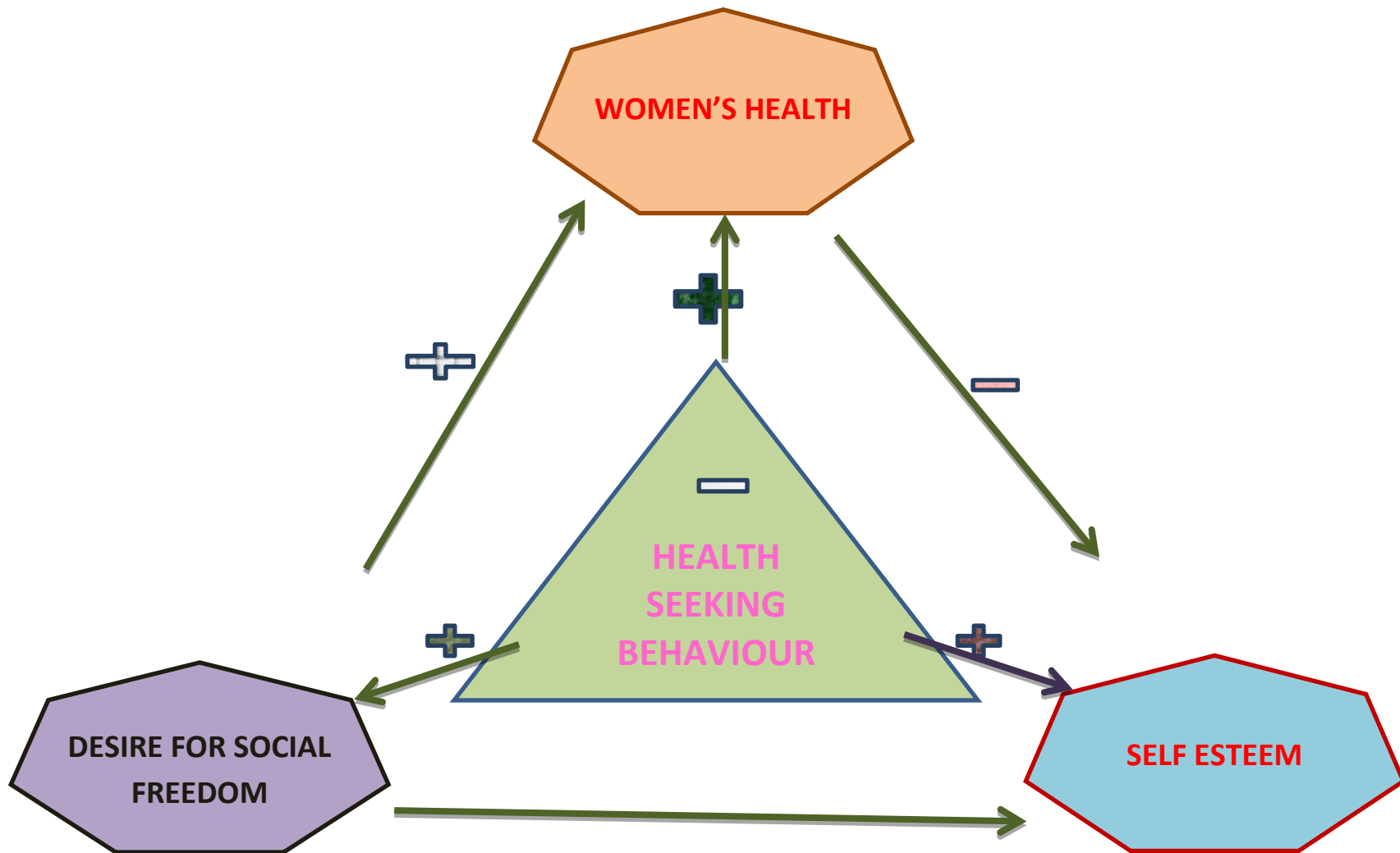
Most of the respondents from Jammu show moderate to high level of Health Seeking Behaviours whereas respondents from Kathua show moderate to low level of Health Seeking Behaviours. Majority of the urban and tribal respondents show moderate to high level of Health Seeking Behaviours but most of the rural respondents show low to moderate level of Health Seeking Behaviours. Most of the respondents were illiterate; belong to middle socio economic status and living in nuclear families show the moderate level of health seeking behaviour. It was found that health seeking behaviour was peaking around the age of 46-55 years, coinciding with the menopausal transition. Significant association of ethnicity was found with Health Seeking Behaviours such as physical exercise, dental check-ups, cancer screening test, complete health check-ups, hair fall, having medicine without consultation, consultation regarding piles, meals (Breakfast, Lunch and Dinner), eating fruits and nuts, water usage, keeping medical record and watching health awareness programmes on T.V. Respondents of tribal areas scored higher means on most of the items, followed by the respondents of urban areas and least by the respondents of rural areas. Tribal respondents show high health seeking behaviour but observation reveals that these women were living in unhygienic conditions and still following traditional life style pattern and were not seeking health care as they were saying.

Health Seeking Behaviours are significantly positively related with Type of family, Age at Marriage and Age at first pregnancy and negatively significantly correlated with SES and number of children. It was expected that SES would be positively correlated with Health Seeking but on the contrary results reveal the opposite. Dominic et al (2013) found a significant association between health seeking behaviour and demographic variables such as age education and family income. Health seeking behaviour is influenced by age, gender, education and income (Olasunbo and Ayo, 2013). In a study on elderly population of rural areas of Varanasi district Shankar et al (2014) found that factors like caste, socio-economic status and literacy did not show any significant association with health. Item analysis shows that age of the respondents was positively significantly correlated with dinner timings and use of fresh water; whereas type of family was positively significantly correlated with physical exercise, self-examination for lump or swelling, consulting a doctor for hair fall, drinking 7-8 glasses of water regularly, maintaining medical records and watching health programmes on T.V / radio regularly. The food habits of elderly studied by Olasunbo and Ayo (2013), divulged the fact that 63% eat thrice daily and 35% had a habit of skipping meal. In the present study all the respondents have three meals but their timings varied. 70.7% respondents had their breakfast before 9:00am, 62.8% Lunch before 2:00 pm and 29.7% have their dinner before 8:00 pm. Current societal arrangements tend to make women less powerful than men, and less able to advocate for their own health (WHO, 2003). Women, who take primary responsibility for the care of others in home and community, are the last ones to demand for health care. Gender disparities in the sphere of health are the direct consequences of gender discrimination in other spheres of social well-being.

Fig. 4.8.1: Relationship of Health Seeking behaviour with background and demographic variables.



4.8.2: Figurative representation of relationship of Health Seeking behaviour with WSF, WHQ and SESW



Another scale Women's Health Questionnaire (WHQ) was used to measure physical and emotional symptoms or sensations experienced by mid aged women especially during menopausal transition. Most of the respondents of have moderate health status. Most of the respondents were illiterate; belong to middle socio-economic status and living in joint families have moderate health status. Women's Health Seeking Behaviour is positively significantly correlated with their scores on Women's Health Questionnaire (WHQ). Respondents from Kathua District scored higher mean score on these dimensions of Women's Health Questionnaire (WHQ) i.e. Vasomotor, Sleep problems, Sexual Dysfunction, Anxiety, menstrual symptoms, memory and concentration problem, and Attraction, showing that they have more health problems than the respondents of Jammu District. Significant association of ethnicity was observed with nearly all the dimensions of women's Health (WHQ) i.e. Somatic, vasomotor, Sleep Problem, Depression, Sexual Behaviour, Anxiety, Menstrual Symptoms, Memory, except Attraction. Somatic behaviour, vasomotor, sleep problems, depressed mood anxiety, increase with the increase age. Sexual Dysfunction, menstrual symptoms, memory/ concentration and attractiveness decreases with the age. Okonofua et al. (1990) in a study conducted in South-west Nigeria, found joint pain and hot flushes to be the most commonly reported menopause symptom. Agwu et al. (2008) in South East Nigeria, also found the commonest menopausal symptom to be hot flushes. It is interesting to note that, in the study by Agwu et al. (2008), urinary symptoms featured prominently, compared with the findings in this study where it was the least prevalent. The findings in this study are similar to the findings by Pan et al. (2002) among postmenopausal women in Taiwan. Among these Taiwanese women, insomnia was the most prevalent menopausal symptom reported in 42% of the subjects, followed by hot flushes in 38%. Williams et al (2006) reported that in US vasomotor symptoms are associated with energy and sleep. Weight gain, mental health and vaginal dryness were some of the common symptoms discussed with health care provider. Overall the present results reveal that health of women declines with the increasing age.

Significant differences on the various items of women's health questionnaire among the respondents, both the districts wise as well as ethnicity wise, were observed. Respondents from Kathua district attained more mean scores on most of the items of

WHQ but overall results show that the respondents of Jammu attained more mean scores than respondents from Kathua district which show their poorer status of health. Relationship of various items of WHQ with demographic variables reveals that Age is positively significantly correlated with losing of interest, feeling that life is not worth living, restlessness, irritability, dizzy spells, backache or pain in limbs, hot flushes, being lively or excitable, well-being, sleep problem, and attractiveness, memory and concentration; Age at menarche is positively significantly correlated with feeling that life is not worth living and attractiveness Age at marriage is positively significantly correlated with growing old, heavy periods, satisfaction with sexual relationship and vaginal dryness. Age at first pregnancy is positively significantly correlated with heavy periods, sexual relationship and vaginal dryness. Age at last pregnancy is negatively significantly correlated with feeling of palpitation and sensation, that life is not worth living and sleep problems but no positive significant relationship is found with the items of WHQ. Age at menopause is positively significantly correlated with memory and concentration problem whereas it is negatively significantly correlated with irritability and headache. Number of Children is positively significantly correlated with hot flushes. A study by Kuh et al (1997) reveals that women who had experienced an early natural menopause had a strongly raised risk of vasomotor symptoms (hot flushes or night sweats), sexual difficulties (vaginal dryness or difficulties with intercourse) and trouble sleeping. However, there was little or no excess risk of other somatic or psychological symptoms.

Somatic symptoms are positively significantly correlated with age, occupation and number of children. Vasomotor symptoms are positively significantly correlated with age, occupation and number of children. Depressed mood is positively significantly correlated with occupation and type of family. Sleep Problems are positively significantly correlated with occupation and number of children. Sexual dysfunction is positively significantly correlated with occupation, type of family, age at marriage and age at first pregnancy. Anxiety is positively significantly correlated with occupation and number of children. Menstrual symptoms are positively significantly correlated with type of family. Memory / Concentration is positively significantly correlated with age, occupation and number of children. Attractiveness is positively significantly correlated with education,

type of family and age at marriage. In the present study having hot flushes is positively significantly correlated with number of children. A study by Ollofsson and Collins (2000) reveals that vasomotor symptoms and joint pain were associated with postmenopausal status. Other symptoms were significantly related to psychosocial factors, life-style and attitude towards menopause.

Schooley et al, (2009) found that women's decisions to seek care were often associated with their sense of self-worth and self-esteem, and women's self-esteem. Most of the respondents from Jammu and Kathua have high level of self-esteem. Respondents from Jammu have higher level of self-esteem as compared to those from Kathua. Tribal women have lower level of self-esteem as compared to urban and rural women. No significant relationship was observed among Health Seeking Behaviour and Self Esteem.

PERSONAL FACTORS:

Knowledge and Belief about health and well being

Knowledge about health and well-being is an important factor in determining health seeking behaviour. Health Care Seeking Behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained health provider, in a formally recognised health care setting. Yet a consistent finding in many studies is that, for some illnesses, people will chose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities (Ahmed et al, 2001). Thus there is growing acknowledgement that health care seeking behaviours and local knowledge need to be taken seriously in programmes and interventions to promote health in a variety of contexts (Price, 2001; Runganga, Sundby and Aggleton, 2001). Ngomane et al (2010) say that an understanding of indigenous beliefs and practices of clients regarding health issues is important in ensuring the quality of care and positive health outcomes. In Malanyen (1995) study results the respondents concept of healthy person is one who has not been sick for a long time. Doctors are consulted only when someone is ill.

In the present study attempt was made to understand respondent's concepts about health and illness. Respondents believe that a healthy person is one who is able to eat proper food, digest it, mentally healthy, has a good physical appearance, and performs

routine work adequately. They visualise health holistically as physical, mental, emotional and social well-being. Indigenous cultures tend to have a more holistic understanding of health, in which 'physical, mental, emotional, spiritual and cultural are all intrinsically intertwined and linked' (NCAHS 2009:48; Maher 1999; Swan & Raphael 1995). In the present study too health has been viewed from all these aspects. A woman is deemed to be healthy when she fulfils these criteria. Hence health has to be viewed holistically for this population and likewise health care seeking too has to be viewed keeping all these factors in mind. The respondents in the present study believe that women should take special care of their health, but on observation it was found that they take least care of their health. Their belief is different from what they practise. They may avoid seeking help from the health providers, they may visit the health provider once and then avoid going again considering it as a waste of time, some keep using their old prescriptions again and again. Similar results were concluded in the studies by Needham et al (2001); Yamasaki-Nakagawa et al (2001) that women have been found to have significantly longer delays to diagnosis than men. NFHS-3 data has suggested that health care facilities are more frequently used for the treatment of children with diarrhoea, fever, and acute respiratory infection than during and post pregnancy care. This clearly presents the picture of male-dominated society of India where women's needs are accorded lower priority by their families and themselves as well, especially in rural areas.

Women's health seeking behaviour is also influenced by how they perceive their health. Respondents in the present study believe their health to be good. Results are consistent with a study conducted by Exavery et al (2011) which reveal Self-rated health (SRH) was reported as 42.5% (51.3% men, 36.8% women) to be good, 43.3% (32.9% men, 50.1% women) moderate and 14.2% (15.8% men, 13.1% women) poor. In the present study it was found that respondents believe that pains and some life style disorders like hypertension and diabetes are normal because most women have them. They don't consult doctors or any medical practitioner unless some condition grows serious. Rural residents had the least self-evaluated health status and there by justify more of them seeking medical care than upper class in Jamicana (Bourne, 2009). In an another study by Adanu et al (2008) found that the two chief reasons for women not seeking care

were because the symptoms were not considered to be serious and because the cost of receiving care was considered unaffordable.

The means to stay healthy are viewed holistically too by the respondents in the present study. Women believe that eating a balanced diet, doing regular physical exercise, having ideal weight, regular medical check-ups, right amount of sleep and leading a spiritual life are means to stay healthy. Though physical exercise is considered important yet very few women indulge in it. Frequency of physical exercise is more in Jammu than in Kathua district and more for urban than rural and tribal respondents. Those who go for these exercises are either directed by their health provider or inspired by media. In the study on elderly population of Dagoelli division of Nairobi, Waweru et al (2003) found that walking was done by 67% of respondents as physical exercise.

It was observed that women usually delay their breakfast as they are indulging in household and religious activities. Hindu religious beliefs prescribe that early morning worship and rituals have to be performed 'Suche Muh' or without eating any kind of cereals, pulses etc. only fruits, tea, milk and milk products can be consumed. It was observed that women usually keep on having tea but avoid eating anything before performing these rituals. Then they have 'brunch' (breakfast and lunch) which creates problems in digestion. Many of them suffer from hyper acidity which later on sometimes gives rise to Ulcers.

Use of services, Quality of services and User / Provider relationship

Accessibility to health care and user provider relation are also important in women's health seeking behaviour. In the present study frequency of accessing formal health care services was assessed. During last one year frequency of visiting doctor's clinic and being treated with alternative medicine is more among the respondents of Jammu District and respondents from the tribal areas. A study by Sharma et al (2012) regarding the treatment seeking behaviour reveal that about three fourth of the subjects were taking one or the other treatment showing concern of the respondents towards health. They further found that Allopathic medicine was the most preferred treatment by majority (91%) of the respondents; however, only 39% were complying with the treatment. 'No need to take medicine' and non- availability of the medicine were the

main reasons reported by about half of the respondents, whereas high cost of treatment and forgetfulness were some other reasons reported for non-compliance to treatment (Sharma, 2012). Tribal respondents, in the present study, do face difficulty in accessing medical facilities due to poor conditions of roads and distance they need to travel to reach these facilities. These Gujjar tribals move along with their herds to upper green pastures in summers and lower areas in winters. Sometimes they have to live in the places which are not connected by roads and other means of communication. For minor ailments, and sometimes for major, they usually depend on home remedies. Similar results were observed in the studies conducted by Matthews et al. (2006) and Okojie (1994) with regards to access to maternal care where geographical distance or transportation were identified as a barrier to health care access in rural Ethiopia. For most of the respondents of Ghana (Russell, 2008) the health provider that they usually go to is the closest to their house, 80% to the cheapest one. Russell (2008) further found that there is a positive relationship between quality of the road and promptness in seeking health care.

Medicines, be it allopathic, Ayurvedic, Unani, or home remedies, are important for women to carry out their routine activities. It has been observed that women usually depend on medical practitioners 'next door' or some familiar health providers for discussing their ailments. They usually discuss about hypertension, diabetes, pains and aches but serious ailments are avoided and there is a delay in reaching out a doctor especially for gynaecological problems. Here sex of the practitioners matters much more than the specialization. This creates a barrier in health seeking and only when the problem becomes severe and sometimes out of control that the families reach out to doctors usually in the Government hospitals, Clinics or dispensaries. Here also referral is sometimes very poor and problems may remain untreated. Present study reveal that respondents of Jammu district are more dependent on medicine and believe that they are more effective for performance of their routine activities than those from Kathua district. Tribal respondents are more dependent on medicine for routine activities than urban and rural respondents. Waweru et al (2013) found that 62% of elderly respondents were buying over the counter drug and 26% consumed addictive drugs. External challenges such as poor availability of trained doctors, nurses and other health personal and number of health institutions in an area influences health seeking behaviour of women.

There is a significant difference in type of treatment preferred by respondents both ethnicity wise and district wise. Treatment in Government Hospitals is preferred by respondents of Jammu whereas respondents from Kathua prefer Registered Medical Practitioners for treatment. Urban and rural respondents prefer treatment in government and private hospitals whereas tribal prefer Registered Medical Practitioners for treatment. The choice of the health provider consulted for a symptom is linked to the perceived cause of the symptom (Ahmed, Sobhan, Islam, & Barkat-e-Khuda, 2001), the severity of the symptoms, socio-cultural influences, distance, place and cost of treatment, income, level of education and quality of health care facilities (Sullivan & O'Connor, 2001). According to the 2005-06 National Family Health Survey (NFHS) and District-Level Household Survey (DLHS) Data 85 percent population seek health facilities from private providers in Uttar Pradesh. Majority of elderly patient(77%) visited a private hospitals/physicians for obtaining treatment for hypertension in a study in urban slums of Belgaum city. In another study by Dominic et al (2013) it was found that 71.2% of the rural adults had a negative health seeking behaviour towards governmental health care facilities. Yamasaki-Nakagawa et al (2001) found women in Nepal were more likely than men to seek help from traditional healers first. Same findings are reflected in a study by Rahman (2000) in rural Bangladesh, where 86% of women received health care from non-qualified health care providers. Singh and Gupta (1997) found that the problems being faced by the people, of Rajasthan, while utilizing government health care services were inaccessibility due to lack of transportation, unsympathetic attitude of the staff dispensing the health, services, and shortage or non-availability of medicines. In a study from US Williams et al (2006) report that general practice and family practice were the specialist women talked to most often about their menopausal symptoms. They further report that women are using availability of medication to treat their menopausal symptoms including prescription over the counter supplements, herbal supplements and alternative therapy. From their study in Bangladesh, Shanker et al) reported that self-care / self-treatment with home remedies is preferred by most of the respondents followed by paraprofessional (semi qualified allopathic) and drugstore sales man (unqualified allopathic). Sen (2012) from a study in Barak Vally of Assam analysed that traditional values are preponderant in health seeking behaviour in general and women in particular. In tribal areas people rely

more on superstitious practices, keeping allopathic as last resort. But in another study by Malanyen (1995) respondents expressed more confidence in knowledge and expertise of medical professionals, than in traditional healers and would go lengths just to finance their health needs, but expressed their preference for private medical facilities and personals over government ones. Akande and owoyemi (2009) also found that traditional healers are preferred. Sharma, Thakur and Kour (2012) found that among elderly population of Chandigarh 9% preferred allopathic treatment. Dienye et al (2013) report that menopausal women in Nigeria consulted patent drug healer (51.4%) followed by health worker (44%), traditional healer were consulted least (3.8%).

Women's health problems and their effect on household

Women are known to ignore their health problems for their household work and children who are their first priority. Their own health comes at the last level of priorities. Respondents from Jammu report pain in back and whole body, those from Kathua report more pain in head and back. Those from the urban areas report pain in back, those from rural areas more in back and legs and the tribal respondents reported pain in the whole body. Shankar et al (2005) found that in the age group of 20- 59 years 30% of the respondents women from Bangladesh reported body pains or aches. Respondents from Jammu district and tribal areas feel a severe effect of pain on routine activities, whereas those from Kathua don't feel any disturbance in routine activities due to pains. Moderate effect of pain is felt by respondents from urban and rural areas. Most of respondents say that health problems do affect household work sometimes and these differences are significant both district wise and ethnicity wise. Present study further reveal that majority of the respondents from both the district have sleep Problem and sometimes get anxious over small things.

Social Factors

In the present study most of the respondents from urban and rural areas do feel that social stigma is attached to prolong illness. Tribal respondents are not sure whether such stigma exists, whereas most respondents from Jammu district do not feel that any stigma exists. Household work is divided among the family members and when the respondents are ill and unable to do the household chores, the work is performed mostly

by the children, husbands or daughters-in-law. Health problems are discussed by the respondents more frequently with the husbands. Many respondents from the Kathua share them with their children too. Respondents do not feel that any stigma is attached to sharing these health related problems. A study by Nkwo (2009) shows that women are much less embarrassed about reporting the non-genital and non-sexual complaints such as hot flushes, crawling sensation, insomnia, irritability and depression, hence the apparent higher prevalence of these non-genital and non-sexual symptoms. Information from focused group discussions however, revealed that Nigerian menopausal women experience the urinary and genital symptoms. In many settings worldwide, women are disadvantaged due to social, cultural, political and economic factors that directly influence their health and impede their access to health-related information and care (WHO, 2009). The concept of decision making has diverse connotations depending upon being discussed (Darteh et al, 2014). These are decision making as a process, as a choice and as a right. Recently scholars have moved away from using proxies such as education and employment to measure autonomy, choosing instead more direct measures consisting of a combination of observable indicators that tap into different dimensions of the concept including freedom from mobility, control over household purchases, freedom from domestic violence, participation in child related decisions etc. In fact women's autonomy measures with the above mentioned indicators is crucial to the use of health care services (Woldemicael and Tenkong, 2010). Olasunbo and Ayo (2013) say that health seeking behaviour is preceded by a decision making processes that is further governed by individual and /or household behaviour, community norms and expectations.

It was observed that joint decisions by husband and respondent are taken in the most of the families of Jammu district whereas in the Kathua district mostly husbands take decision on these matters. In tribal families husbands solely take decisions. Balk (1994), Mason (1996), and Kishor (2005) found that women's active participation in domestic decision-making is a reflection of their power within the household, and may increase their chances of making the right reproductive choices including utilizing health services. Most of the respondents, in the present study, can take decisions to visit Local Market for shopping, for medical check-ups, neighbourhood for social visits and religious places, alone, though the frequency varies both ethnicity and district wise. Most of the

respondents have not joined any religious, social women's or political organization, though a few from Kathua are members of religious organization. Women usually rely on networking for security reasons; the social groups they join provide them. Rahman et al (2012) found that gender and age play a role in making decisions in households in relation to health matters and treatment seeking. Socio- economic factors such as poor literacy and awareness, dominance of in-laws and husband, poverty, early marriage, overall standard of living, residing areas(urban/ rural) and women's decision making power account for less treatment seeking behaviour among pregnant women in Uttar Pradesh (Rastogi. 2012).

There are significant district wise and ethnicity wise differences in decision making at house hold level regarding cooking, for child rearing, children's education, occupation and Marriage of children, buying/selling of moveable/immoveable property, to keep monthly income, mode of saving, spending and giving gifts.

Economic / Productive Factors:

Socio-economic status is a strong determinant of health-seeking behaviour (Khe et al. 2002, Ahmed et al. 2003), even among the elderly (Ahmed et al. 2005). In the present study majority of the respondents from Jammu and Kathua district belong to middle socio-economic class families whereas most of the respondents from the tribal areas belong to lower middle class status. Socio- economic status was found negatively significantly correlated with Health Seeking Behaviour whereas positively significantly related with Women's Health Questionnaire. Though women's health is related to social class positively yet the actual behaviours bear negative relation to it. Contrary results have been found in the other studies. Zhang et al (2009) in their study of health seeking behaviour among Chinese women with genitourinary symptoms found significant relationship among income, education and treatment. Bourne (2009) concluded that it is not higher social class that determines health seeking behaviour but money. Those in upper class may have access to more financial resources, but rural residents have greater social network which avails them of extended economic resources. Uzoichukwu, & Onwujekwe, (2004) and Kazembe et al. (2007) identified household resources as important determinants of health seeking behaviour. In a study conducted in Bangladesh,

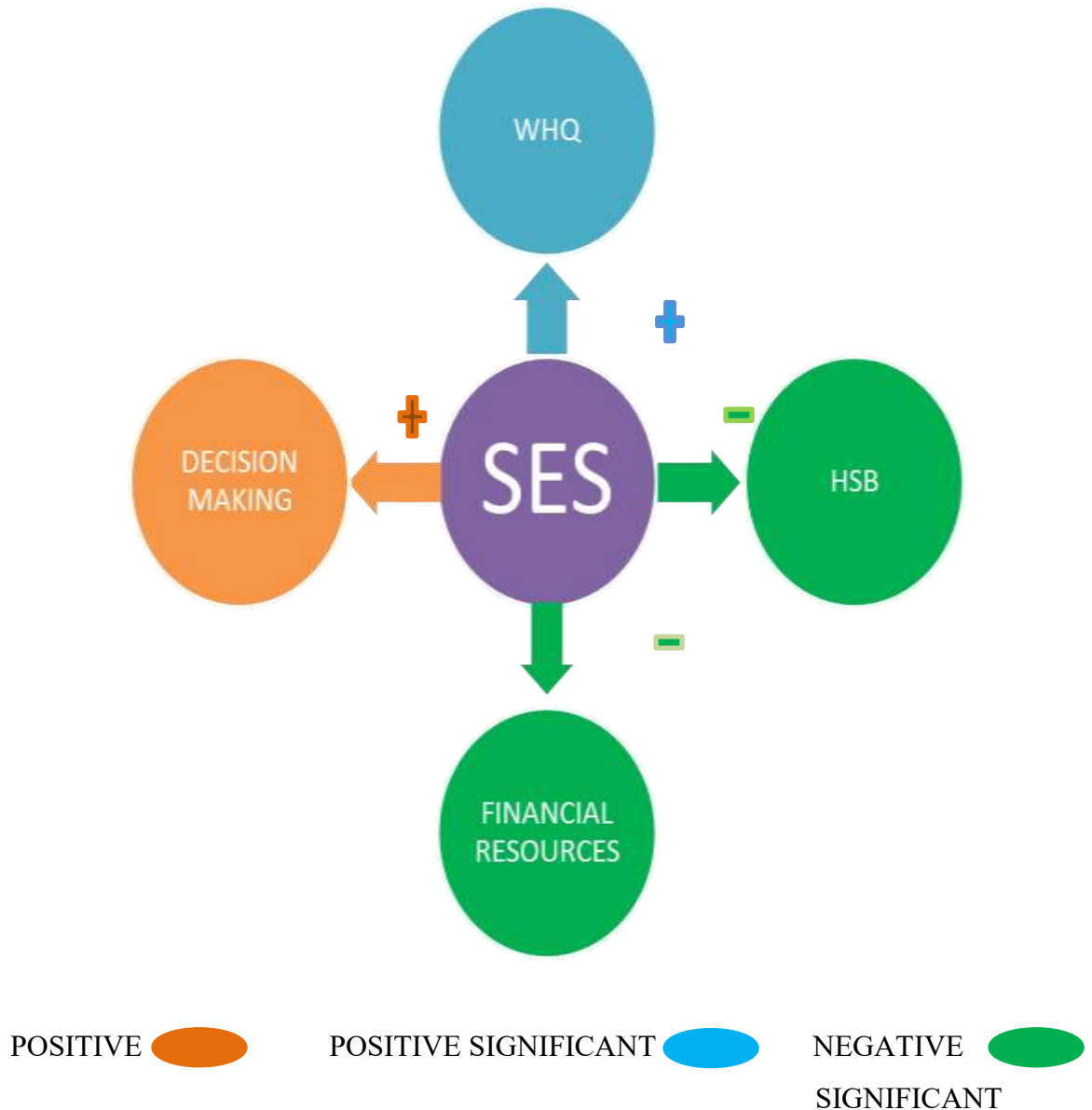
household wealth was found to have a positive relationship with the use of health services, where women from poor households had poorer health seeking behaviours. Michael et al 2007).

Factors that were found to have significant influence on the health seeking behaviour were limited access to money, transport, decision making and nature of women's work (Hausman-Muela and Nyamongo, (2003). Richest, richer and middle women as per wealth index were more likely to make decisions on engaging in sexual inter course as well as condom use as compared to the poorest (Darteh et al 2014). Reduction in poverty will go a long way to improve the women's reproduction health decisions making and hence their health (Darteh et al 2014). Ahmad et al (2005) found from their study of rural elderly population of Bangladesh that socio economic indicators were the single most persuasive determinants of health seeking behaviour overriding age and sex, health care expenditure and type of illness as well. Most of the urban women respondents in the present study are bank account holder and they operate their accounts too. Respondents from the rural and tribal areas mostly do not hold bank accounts in their name. Most of the urban respondents do have cash available for purchasing medicines and other household material, clothes and toiletries whereas rural and tribal respondents mostly don't have cash available for buying these. Women's limited time and access to money and their restricted mobility, common in many traditional societies, often delays their seeking health care. They may be allowed to decide on seeking medical care for their children, but may need the permission of their husbands or significant elders within the family to seek health care for themselves (State of the world's Children 2007; Snow, 2010; Govender and Penn-Kekana, 2010).

Awareness about developmental schemes in itself is an important factor in determining whether these services are availed or not. Government of India has launched various schemes especially for women to provide financial and health care services to them. Results of present study reveal that majority of the respondents were not aware about Schemes for financial assistance in both the districts of Jammu and Kathua. Very few tribal women are aware about Schemes for financial assistance. Similar is the case with the health related schemes for women launched by the Government. Majority of the women have never been beneficiaries of any health related schemes even during their

reproductive period. District as well as ethnicity wise significant differences were found regarding awareness about schemes for financial assistance and health launched by the Government. Results are consistent with the study by Nigussie (2004) that shows services targeted at women have an even lower coverage.

Fig. no. 4.8.3: Showing relationship of socio- economic status and HSB, WHQ, Decision making and financial sources.



EDUCATIONAL FACTORS:

Education is for instance not only considered as fundamental to the empowerment of women, but also equips them with the skills needed to make important decisions some of which revolve around their health (e.g., knowing where facilities are located, and attracting the attention of doctors and nurses). However, it is argued that simply looking at schooling is not sufficient, but also the content of education, which often reinforces gender ideology (Mason 1994). In Shankar et al's study (2005) level of education and poverty emerged as the two most significant determinants of health seeking behaviour. Lindelow (2005) found that education and physical access to health facilities at the household level are important correlates of healthcare decision making. Results of the present study also show that education is significantly positively related with Health Seeking Behaviour. Education is positively significantly correlated with Health seeking Behaviours like physical exercises, sound sleep, dental check-ups, cancer screening test, complete health check-ups at least once in a year, consulting doctors regarding hair fall and piles, use of fresh water, maintaining medical records and regularly watching health programmes on T.V/ radio. Education was found negatively significantly correlated with WHQ but relationship of education with various dimensions of WHQ reveal that education is positively related with attractiveness whereas it is negatively related with somatic symptoms , vasomotor symptoms ,depressed mood, sleep problems, anxiety and memory/ concentration. Self esteem is significantly positively related with Education.

CULTURAL BARRIERS:

According to Vaughn (2009) health attributions influence health beliefs and subsequent health behaviours. Health attributions are partly shaped by culture. In turn, cultural health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. Present study reveals that most of the respondents hold belief in faith healers known as 'Sayana' or 'Baba', in local language, especially for the treatment of headache in Kathua district and tribal areas, and instability of mind in Jammu district and urban and rural areas. Frequency of visiting these 'sayanas' is more among the tribal respondents. Even while getting treated by doctors they visit these places more frequently because of their blind faith on these faith

healers. A study by Singh and Gupta (1997) also reveals that tribal people generally do not pay much attention to the routine problems during ante-natal, natal and post-natal periods, which they regard as a built in part of child bearing and child rearing. In case of reproductive health problems and general health problems like fever and malaria, at the first stage some treatment is administered at home, followed by a visit to the 'bhopa' (the local faith healer) and a herbalist in that order. The next stage involves visiting a nurse or an ill-qualified or unqualified medical practitioner, depending upon availability (Singh and Gupta 1997). A study by Dienye et al (2013) in Nigeria on the other hand reveals that the utilization of the services of the traditional healers was poor whereas the utilization of the services of patent drug dealers was very high. Olasanbu and Ayo (2013) in their study revealed that 38% elderly went for routine medical check-ups, 89% follow doctors prescriptions but 64% are aware of orthodox health facility and 27.5% had preference for traditional health facilities.

Women's Social Freedom Scale was used to measure women's perception regarding cultural and social barriers like social taboos, conventions, rituals and roles. Analysis of the scale shows that respondents of Jammu have moderate to high desire for social freedom whereas respondents of Kathua show low to moderate desire for social freedom. Majority of respondents urban, rural and tribal areas show moderate to low desire for social freedom. Health Seeking Behaviour is positively significantly correlated with desire for social freedom means that belief in cultural and social barriers lowers the desire for social freedom and hence the lowered health seeking behaviour. On the dimensions of desire for social freedom reveal that desire for freedom from husband is negatively significantly correlated with Socio-economic status. Desire for freedom from customs, taboos and rituals is negatively significantly correlated with Socio-economic status and WHQ. Desire for freedom from marriage and sex is positively significant with education whereas it is negatively significantly correlated with occupation, SES and WHQ.

SUGGESTIONS AND PROPOSED INTERVENTION BASED ON THE FINDINGS

Analysis and interpretation of the data reveals a need to devise intervention strategies to promote health seeking behaviours of the women during the menopausal transition. The results show a general low level of health seeking behaviour among all respondents especially the tribal women. The results also show that most of the respondents were illiterate and not employed outside their home. Hence the strategy would be to reach out to these women as they may have difficulty in understanding through formal approaches and written material will not be beneficial for them.

For Self

- ❖ **Raise self esteem:** Level of self esteem of women is low. Women should have faith in themselves and their ability to look after their own health needs as well as that of their family, especially the girls.
- ❖ **Raise awareness:** Even if not educated they should try to seek knowledge to enhance their awareness regarding health issues. Their lack of knowledge about developmental transitions is a reason for their low health seeking.
- ❖ **Be assertive:** Women should be equipped with knowledge and should have assertive attitude towards their health issues in order actively pursue health seeking.
- ❖ **Prepare the Daughters:** Women should talk about oncoming developmental transitions to their daughters and prepare them well to adjust to these.
- ❖ **Do not delay Health Seeking:** Women should be encouraged to seek medical facilities during illness as their delay in seeking treatment is one of the reasons of low health status.
- ❖ **Know your health provider:** Before consulting any health practitioners be sure that they are experts in their fields. Don't put your life at risk just to avoid travelling to the Governmental Health outlets.
- ❖ **Don't use old prescriptions and consume medicines as prescribed.**

- ❖ **Prevention is better than cure:** Changes are required in the overall patterns of health-seeking behaviour and the mind sets of the people, especially with regard to preventive health.
- ❖ **Don't think that because it happens to everyone around you it is normal:** Women usually gauge themselves through the viewpoint of others. If other women around them have a certain health condition and they too are suffering from that they consider it normal.
- ❖ **Learn to be of help to other women around you as networking is very important for a woman to feel secure.**
- ❖ **Become a member of the religious or social group.**
- ❖ **Indulge in income generation activities available in your area.**
- ❖ **Learn to read labels:** This would ensure that women are able to at least read about the expiry date if they are not educated.
- ❖ **Indulge in health seeking behaviours** such as:
 - Physical Exercises like walk, jogging, running, yoga, meditation etc
 - Meals at regular intervals
 - Health checkups and follow up
 - Avoiding of fast foods which have permeated to even far of places too which are difficult to reach otherwise.
 - Sharing health problems with family and other women.

For Government, Semi Government, NGO's and Private Sector

Enabling the disadvantaged: The main stress should be to create awareness and to build self-reliance among women especially for tribal females.

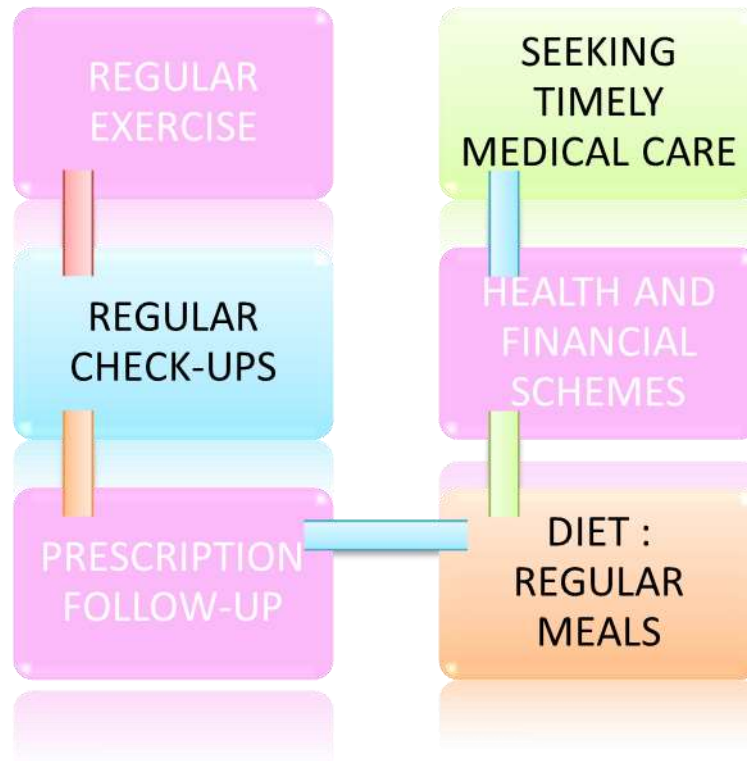
- ❖ **Education of adult women:** The low educational status of women in this area is a matter of great concern and needs to be addressed properly. It is the root cause of low autonomy among women, low power of decision making and low levels of health seeking.
- ❖ **Understand women's health issues from their perspective:** Understanding beliefs, knowledge and attitude of women regarding their health and illness.

- ❖ **Understanding women’s problems in local context:** To optimize the health care for middle-aged women, there is need to understand the process by which they describe, explain and experience menopausal transition and also to understand the factors that may shape their experiences of menarche and menopause.
- ❖ **Holistic view of health:** Women understand health in a holistic manner and hence the health provision should also cater to holistic view of health rather than a narrowed one.
- ❖ **Sensitization of health providers:** Sensitizing activities to make primary care physicians more aware about the peculiar needs of women, their explanations of problems, their mental state and thereby improving the quality of care. The health providers should maintain a congenial and facilitating aura in their centres.
- ❖ **Developing audio visual materials for health awareness:** As most of the women in this age group are illiterate, healthcare workers should be trained to use low cost audio visual materials and tools and verify the patient’s understanding through “teach backs and also for awareness generation. NGO’s and others can also contribute a lot here.
- ❖ **Strong emphasis needs to be laid to improve medical facilities to impart better services in accordance with changing needs of women from one developmental transition to the other.**
- ❖ **Policy at the Centre:** The centre should come up with a policy on post reproductive health. Reproductive health is looked after adequately but post reproductive health is grossly neglected. A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support is required.
- ❖ **Implementation of Health Policies:** Formulation of development polices for women is not so important, as that of implementation.
- ❖ **Using Media to reach out to women:** Use of newer media as well as folk media would be extremely beneficial. Television, through cable networks, has made strong inroads even to those places where roads have not reached and this can be effectively used for dissemination of information. Folk media such as folk songs

and dances performed in a particular area can also be used. Puppetry will be interesting as well as engrossing

Approaches for spreading awareness regarding need for health seeking among women

The key areas which demand **attention and awareness generation** are:



The following approaches can be used:

❖ **Individual Approach:**

- It takes a lot of time to spread messages individual to individual but this can be done by some health worker, NGO representative or a health practitioner effectively. In the present research this approach was used during data collection itself. After data collection the investigator provided information to the respondents about the importance of having- balanced diet, meals at regular intervals, exercise, regular medical check-ups, and

other similar issues for which they showed low level of knowledge, awareness and practice.

❖ **Group Approach:**

- While working in a group following strategies may be adopted:
 1. Woman to woman Approach: Women accept the message or practice given by their fellow women easily.
 2. Key informants to be identified
 3. Group leaders to be identified and roped in for awareness generation.
 4. Family and community to be involved as they play an important role in decision making about women's health

Woman to woman activities should be organized in common meeting places of women like in front of their homes, water sources, fields, work places, Anganwadi Centres, etc. The information can be transmitted through lectures by Expert, movies, role plays and focussed group discussions. Besides woman to woman strategy seminars and debates can be organized in schools, colleges and universities so that the issues of post reproductive health are deliberated and the message is absorbed early in life. Males need to be involved as they have to understand need for maintaining post reproductive health of their life partner

❖ **Mass Approach:**

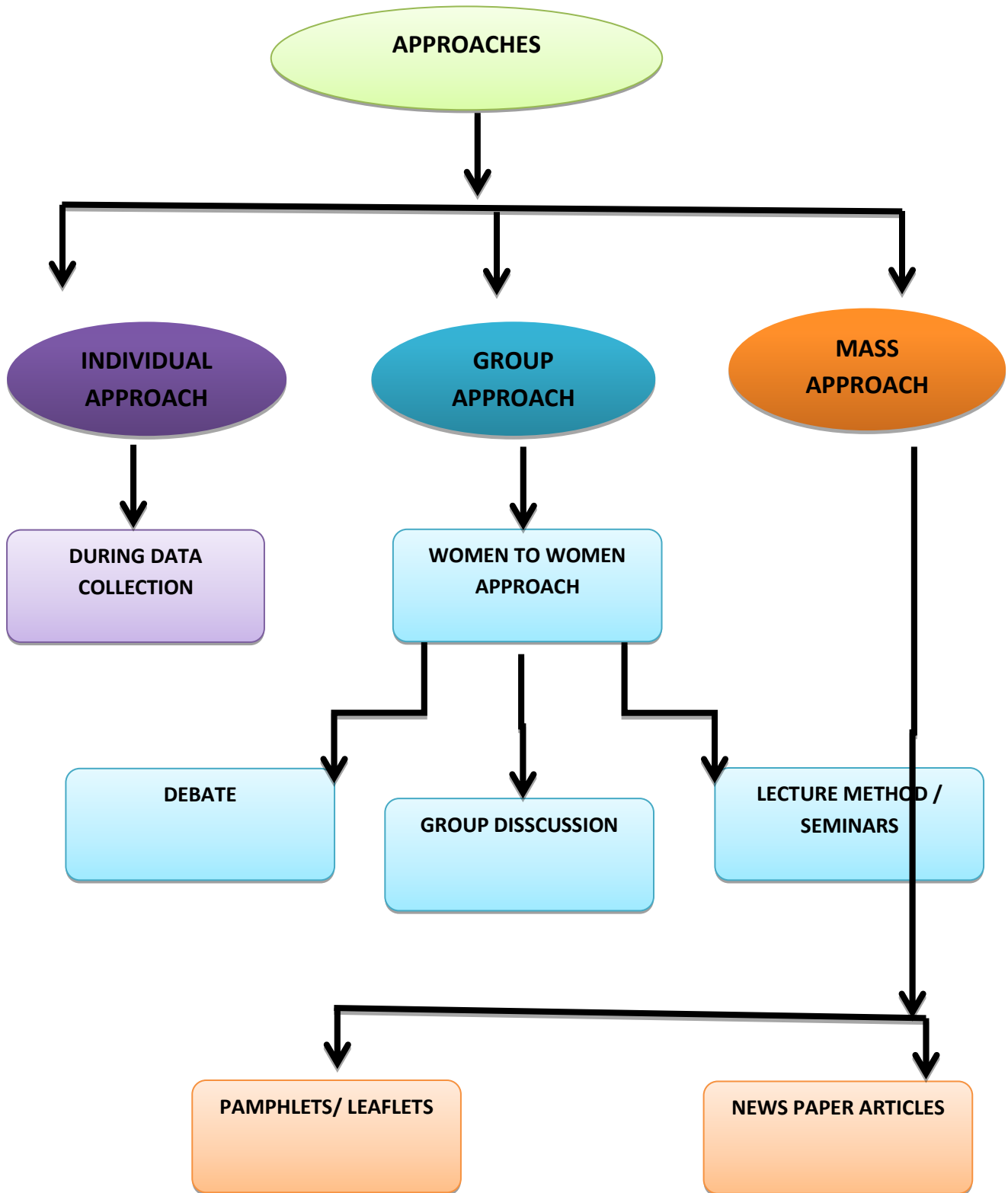
- In order to reach out the women from varied backgrounds mass approach can be used. Masses can be approached through media very effectively. Messages on newer technologies such as social networking forums, mobile phones can effectively reach out. Most of the information should be audio visual as the target group may not be able to read it. Small crisp messages have shown their effectiveness in the democracy. The information can also be disseminated by publishing articles in newspapers, journals, pamphlets/ leaflets, organising camps, rallies etc. Hoardings can be put up where maximum number of women are able to see. The employers of women need to be roped in for information dissemination.

Examples of use of the approaches and methods of reaching out to women:

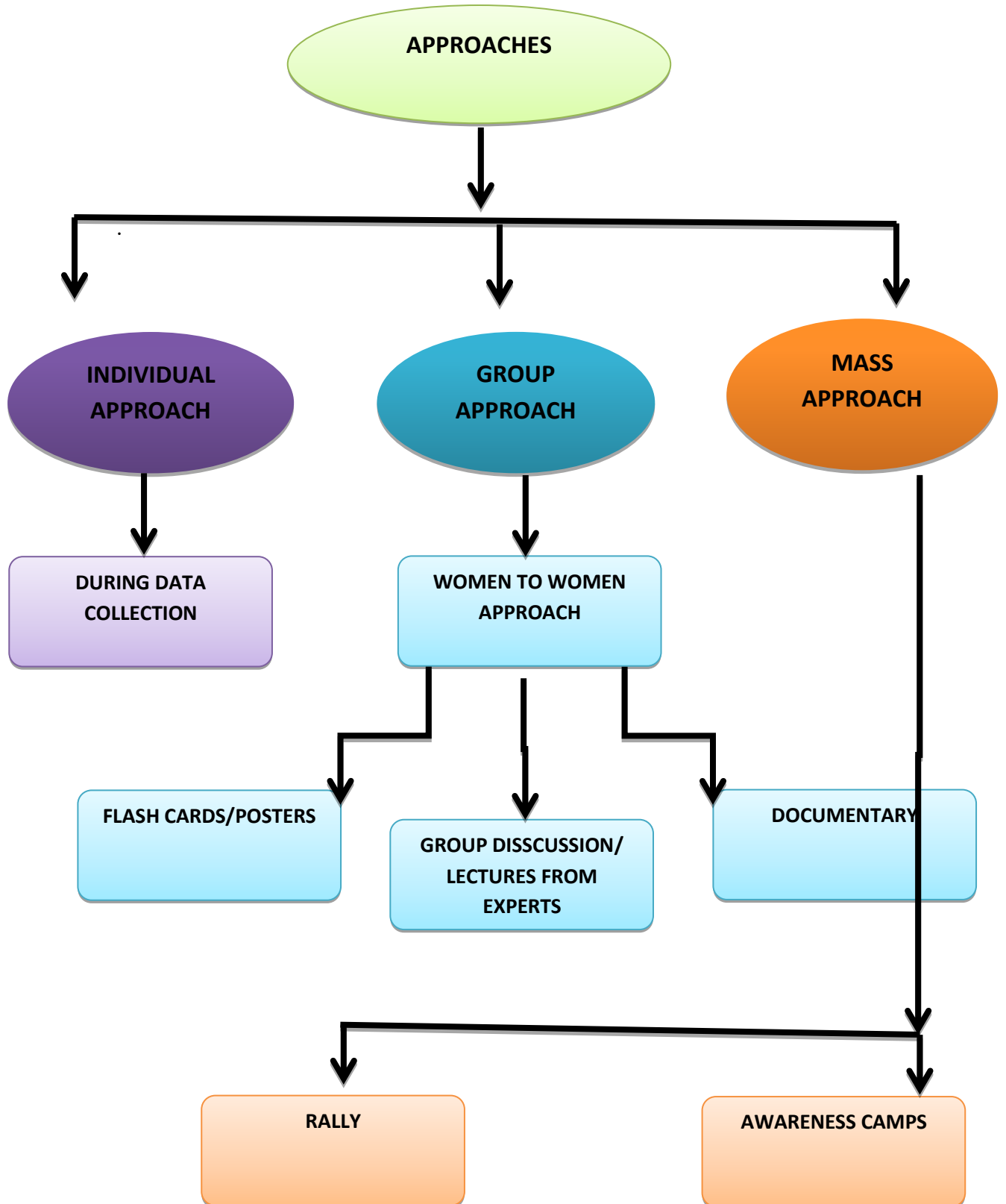
Aim	Appropriate Method	Example
<p>1. Health awareness goal Raising awareness, or consciousness, of health issues</p>	<ul style="list-style-type: none"> • Talks • Group work • Mass media • Displays and exhibitions • Campaigns 	<p>Encourage women to seek early detection and treatment of diseases.</p>
<p>2. Changing attitudes and behaviour Changing the lifestyles of Individuals</p>	<ul style="list-style-type: none"> • Group work • Skills training • Self help groups • One-to-one instruction • Group or individual therapy • Written material • Advice 	<p>Persuasive education to aware them regarding the importance of exercises, meals on proper time, health check-ups seeking treatment on time and follow up of prescription.</p>
<p>3. Improving knowledge Providing information</p>	<ul style="list-style-type: none"> • One-to-one teaching • Displays and exhibitions • Written materials • Mass media • Campaigns • Group teaching 	<p>Giving information to women about the effects of good food habits, exercise, delay in seeking treatment etc. Helping them to explore their own values and attitudes and come to a decision. Helping them to learn how to change their habits if they want healthy lifestyle</p>
<p>4. Self empowering Improving self-awareness, self-esteem, decision-making</p>	<ul style="list-style-type: none"> • Group work • Practising decision-making • Values clarification • Social skills training • Stimulation, gaming and role play • Assertiveness training • Counselling 	<p>Women identify what, they want to know about certain health issues which they need more knowledge about.</p>

<p>5. Societal/ environmental change</p> <p>Changing the physical or social environment</p>	<ul style="list-style-type: none"> • Positive action for under-served groups • Lobbying • Pressure groups • Community development • Community-based work • Advocacy schemes • Environmental measures • Planning and policy making • Organisational change • Enforcement of laws and regulations 	<p>Impart information to Community members and males members of the family to improve their understand of the needs women during post reproductive years of their life.</p>
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APPROACHES SUGGESTED FOR URBAN WOMEN: Most of the urban respondents are educated. Following approaches can be used to create awareness among them can be raised:



APPROACHES SUGESSTED FOR RURAL AND TRIBAL WOMEN: As majority of the respondents were illiterate following approaches can be used to aware them:



Health contributes to both social and economic prosperity. Therefore it is important to protect health through health care, besides other means of socio economic development (Ahmed, 2005). India spends a huge amount on health sectors with a large number of preventive and curative schemes for women but women's health indicators still show a poor trend especially the post reproductive health. Hence the present study was undertaken with the objectives: To study the health seeking behaviour among women (35-65 years of age) with respect to: personal factors, social factors, economic/productive factors, cultural barriers, educational barriers. 2. To study the relation of Health Seeking Behaviour with their: a. Socio Economic Status b. Desire for social freedom, and c. self-esteem. 3. To devise some interventions with the help of NGO's working for Women. The study has been conducted in urban, rural and tribal areas of Jammu and Kathua Districts of Jammu and Kashmir State using multistage sampling technique to systematically select the sample. The total sample size is 600 women from urban (n=200), rural (n=200) and tribal (n=200) areas of both the Districts. Tools used for the study were interview schedule, Health Seeking Behaviour Checklist (HSBC), Women's Health Questionnaire (WHQ), Women's Social Freedom Scale (WSF), Self-Esteem Scale for Women (SESW) and Socio Economic Status Scale (SES).

The results reveal that most of the respondents were 49 years of age. Their average age at menarche was 14 years, age at marriage was 19 years, age at first pregnancy was 21 years, age at last pregnancy was 28 years and average age at menopause was 48 years (for those who had attained it). Most of the respondents were illiterate, homemakers, residing in nuclear families and belonging to middle socio-economic status.

The analysis of Health Seeking Behaviour Checklist (HSBC) shows that most of the respondents from Jammu are moderate health seekers whereas respondents from Kathua show low level of health seeking behaviour. Most of the urban and tribal respondents show moderate level of health seeking behaviour but most of the rural respondents show low level of health seeking behaviour. Health Seeking Behaviour is significantly positively related with variables such as type of family, age at marriage and age at first pregnancy and their self esteem whereas it is negatively related with SES and number of children a woman has.

Further findings reveal that most of the respondents of Jammu and Kathua district have low level of health as measured by Women's Health Questionnaire (WHQ). As age advances Somatic symptoms, vasomotor symptoms sleep problems, anxiety, and memory/concentration increase whereas sexual dysfunction, menstrual symptoms and attractiveness decrease. Health seeking behaviour is positively related to women's health. Knowledge and beliefs of the respondents regarding health have also been studied. The results show that the respondents from Jammu visualise health holistically as physical, mental, emotional and social well-being whereas respondents from Kathua lay more stress on mental health. Significant differences in the opinion were observed among the respondent both District wise as well as ethnicity wise regarding knowledge and beliefs about wellbeing and illness, and, importance and present state of their health. Very few respondents from both the Districts rated their present state of health as very good or excellent. Most of the respondents from the tribal areas rated their health as poor as compared to the respondents of urban and rural areas who rated their health as good. Women believe that eating a balanced diet, doing regular physical exercise, having ideal weight, regular medical check-ups, right amount of sleep and leading a spiritual life are means to stay healthy and significant differences were observed among the respondents both District as well as ethnicity wise. Respondents from Jammu and those from Urban settings were more in favour of physical exercises to maintain their health than respondents of Kathua and those from rural and tribal settings.

Most of the respondents from urban and rural areas of Jammu and Kathua prefer treatment in government hospitals but tribal respondents prefer treatment by nearby Registered Medical Practitioner (RMP). Respondents from the tribal areas face more difficulties in accessing medical facilities and are more dependent on medicines for their routine work as compared to urban and rural areas of both districts. Majority of respondents believe that medicines are very effective in curing illness but most of them also hold belief in faith healers known as 'Sayana' or 'Baba', especially for the treatment of headache in Kathua district and tribal areas, and instability of mind in Jammu district and urban and rural areas. Percentage of those visiting these 'sayanas' is more among the tribal respondents.

Most of the respondents opined that there is a division of labour for household work and in case of respondent's illness, their husbands and children substitute them for household work. Majority of the respondents talk about their health problems with husband. Regarding women's health problems and their effect on household, it was found that routine activities of the respondents from Jammu District got severely affected due to their illness and same is the case with the respondents of tribal areas. Regarding social stigma attached to prolong health problems, respondents from Jammu do not feel any such stigma but respondents from urban and rural areas do feel that social stigma is attached to prolonged illness. Tribal respondents are not sure whether such stigma exists or not.

Regarding women's role in decision making it was observed that most of the decisions in the families are taken by husband and respondents, jointly, in the urban families whereas in tribal areas male dominance is observed in decision making about most of the matters.

Most of the urban women are bank account holder and they operate their accounts too but respondents from the rural and tribal areas mostly do not hold bank accounts in their name. Majority of the respondents of Jammu and Kathua were not aware of schemes for financial assistance or health launched by the Government for women and they have never been beneficiaries of any health Schemes for women at any time of their life.

To understand the women's attitude towards cultural and social barriers women's desire for social freedom was studied and it was found that with an increase in desire for social freedom women's their health seeking behaviour increases too. Respondents from Jammu show higher desire for social freedom as compared to the respondents of Kathua. Based on the findings intervention strategies have been designed for women themselves, for policy planners, NGO's etc.

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INTERVIEW SCHEDULE

**Health Seeking Behaviour among women (35-65yrs.)
of Jammu**

Background Information

Name:- _____

Age:- _____

Type of Family:- Joint / Nuclear**Education level:-**

1. Illiterate
2. Primary
3. Secondary
4. Higher Secondary
5. Graduation
6. Post Graduation
7. Technical

Occupational status

1. Cultivator
2. Service Holder
3. Business
4. Pension Holder
5. Daily Labourer
6. House Hold Work
7. Homemaker

ADDRESS: _____

Ph. _____

1.	Age at first Menarche	
2.	Age at Marriage	
3.	Age at first Pregnancy	
4.	Age at last Pregnancy	
5.	Age at Menopause	
6.	No. of Children	

Questions	Coding Categories
Opinion about health	Who take balanced diet 1 Having good digestibility 2 Eat adequate food 3 Good looking 4 Free from diseases / tensions 5 Having healthy relations with others 6 All of the above 7 Any other (specify) 8
Opinion/ or causes about illness	Having lot of diseases 1 Having lot of tensions & worries 2 Having weak / poor digestibility 3 Skipping meals 4 Unable to perform routine activities 5 All of the above 6 Any other (specify) 7
How important it is that women take special care of their health	Not at all 1 A little 2 A moderate amount 3 Very much 4 An extreme amount 5
Considering your age how would you describe your overall physical health	Excellent 1 V. Good 2 Good 3 Fair 4 Poor 5
Do you do any physical exercise other than the routine house hold work	Yes 1 No 2 Sometimes 3
What kind of physical exercise do you do for at least 30 minutes	Brisk walking 1 Cycling 2 Active gardening 3 Dancing 4 Swimming 5 Jogging 6 Yoga 7
Do you suffer from pains in various parts of your body	Most of the time 1 Sometimes 2 Hardly ever 3

Questions	Coding Categories
In which parts?	Head 1 Arms 2 Legs 3 Back 4 Knees 5 Whole body 6 Not at all 7
To what extent do you feel that physical pains prevent you from doing what you need to do	Not at all 1 A little 2 A moderate amount 3 Very much 4 An extreme amount 5
In the past year, how many days of illness have you had that kept you from normal activities	Never 1 1-2 2 3-5 3 6 or More 4
How much medical treatment do you need to function well in your daily life.	Not at all 1 A little 2 A moderate amount 3 Very much 4 An extreme amount 5
Where do you go or whom do you consult when you are ill: Choice of Practitioners	
Home Remedies	
Homeopath	
Herbalist	
Chemist	
Registered Medical Practitioner	
Govt. Hospital	
Ayurvedic	
Traditional Healer	
Private Hospital	
In the past 12 months, how many times have:- i) Visited a doctor's office or clinic as a patient ii) stayed overnight in a hospital as a patient. iii) been treated with alternative medicine	1 2 3 4 Never 1-2 3-5 6 or more
Overall , how effective do you think medical	Not at all 1

Questions	Coding Categories
treatment is, in preventing illness	A little 2 A moderate amount 3 Very much 4 An extreme amount 5
Which of the diseases you think can be treated by ojha/baba /religious gurus.	Fever 1 Headache 2 Body pains 3 Vertigo 4 Fatigue 5 Instability of mind 6
How difficult is it to get medical facility / care when you want it	Not at all 1 a little bit 2 very difficult 3
List of things some people think help their health , do you think each one help a person's health:- i) Eating a balanced diet ii)Getting regular physical exercise iii)Being at the ideal weight for a person iv)Getting regular medical check-ups v)Getting right amount of sleep vi)Leading a spiritually good life	1) Help a lot 2) Help to some extent 3) Doesn't Help at all i) ii) iii) iv) v) vi)
Are you troubled by disturbed sleep	Yes 1 No 2
How often do you feel tense anxious or depressed	Often 1 Sometimes 2 Rarely 3 Never 4
Who would you talk to your illness if you had	Husband 1 Children 2 Mother 3 Mother-in-law 4 All of the above 5 Any other (specify) 6
Do you have any problem which you feel embarrassed to talk to others	Yes 1 No 2

Questions	Coding Categories
In your opinion a person suffering from prolonged illness or dreadful disease carry any kind of sigma	Yes 1 No 2 DNK 3
In your family house hold responsibilities are divided among all the family members	Yes 1 No 2
If you are not feeling well who performs your routine work	Husband 1 Children 2 Mother 3 Mother-in-law 4 Daughter-in-law 5 Herself 6
Who in your family has the final say on the following :- i) What to cook. ii) Upbringing, Education Occupation & Marriages of children. iii) Buying moveable & immoveable property. iv) to Keep monthly income. v) Mode of saving. vi) How much to spend on the items of daily use. vii) Types of gifts(kind/cash) to be given to friends/relatives	Respondent 1 Husband 2 Respondent & husband jointly 3 Someone else 4 Respondent & someone else jointly 5 Decision not made or not applicable 6 1 2 3 4 5 6 i) ii) iii) vi) v) vi) vii) viii)
Do you have any bank account on your own name	Yes 1 No 2
Do you yourself operate the account	Yes 1 No 2
Do you yourself control the the money needed for the following:- i) Veg.& fruits ii) Clothes iii) Any kind of medicine for yourself iv) Toiletries for yourself	1 2 3 Yes No Doesn't buy herself i) ii) iii)

ANNEXURE- II

HEALTH SEEKING BEHAVIOUR CHECKLIST

ITEMS	YES	NO
I regularly do physical exercise for half an hour.		
I examine myself for lump or swelling in body once in a month.		
I regularly go for weight and B.P check up		
I go for dental check-up once in a year		
I go for cancer screening test after every two years.		
I go for complete health check-up once in a year.		
I always consult doctor for continuous hair fall.		
I always consult doctor before having any kind of medicines.		
I always consult doctor in case of piles.		
I always follow the prescription of doctor		
I always maintain my medical records with care		
I regularly take my breakfast before 9:00 a.m.		
I regularly take my lunch before 2:00 p.m.		
I regularly take my dinner before 8:00 p.m.		
I regularly take fruits and nuts.		
I drink 7-8 glasses of water daily.		
I take milk twice a day regularly.		
I always wash my hands before touching any eatables.		

I always use fresh water.		
. I have sleep soundly for 7-8 hrs. daily		
I regularly watch/ hear health awareness programme on T.V/ radio		

ANNEXURE- III

WOMEN' HEALTH QUESTIONNAIRE

ITEMS	Yes, Definitely	Yes, Sometime	No, not much	Not at all
I wake early and then sleep badly for the rest of the night				
I get very frightened or panic feelings for apparently no reason at all				
I feel miserable and sad				
I feel anxious when I go out of the house on my own				
I have lost interest in things				
I get palpitations or a sensation of "butterflies" in my stomach or chest				
I still enjoy the things I used to				
I feel life is not worth living				
I feel tense or "wound up"				
I have a good appetite				
I am restless and can't keep still				
I am more irritable than usual				
I worry about growing old				
I have headaches				
I feel more tired than usual				
I have dizzy spells				
My breasts feel tender or uncomfortable				
I suffer from backache or pain in my limbs				
I have hot flushes				
I am more clumsy than usual				
I feel rather lively and excitable				
I have abdominal cramps or discomfort				
I feel sick or nauseous				
I have lost interest in sexual activity				
I have feelings of well-being				
I have heavy periods				
I suffer from night sweats				
My stomach feels bloated				
I have difficulty in getting off to sleep				
I often notice pins and needles in my hands and feet				
I am satisfied with my current sexual relationship				
I feel physically attractive				

I have difficulty in concentrating				
As a result of vaginal dryness sexual intercourse has become uncomfortable				
I need to pass urine/water more frequently than usual				
My memory is poor				

ANNEXURE- IV

SELF ESTEEM SCALE FOR WOMEN

No	Statement	MO	S	R
1*	I find it very easy to start a conversation.			
2*	I like to please everyone.			
3*	I have got the things I desired			
4*	I feel afraid or anxious when I am entering a room by myself where other people have already gathered and are talking.			
5*	I do not need constant approval from others.			
6	I feel ignored.			
7	I find it hard to talk in front a group.			
8*	I am very confident about making decisions.			
9	I wish I was a boy.			
10*	I think I have been more of a success than failure.			
11	I think most women are better off than me.			
12*	I feel people like me.			
13	I need the help of others to solve my problems.			
14*	I feel I can achieve the things I want.			
15	I feel I am good for nothing.			
16*	I think I can convince people of what I believe in.			
17	Most of my friends are attractive and better looking than me.			
18*	It is simply enough for me to take decisions in everyday life.			
19	I feel flustered when things do not go asplanned.			
20*	I have the strength to act according to what is right.			
21	It is of much concern to me whether people like being with me.			
22	Life is full of pain and sorrow.			
23*	I like myself.			
24	I am continuously worrying over possible problems.			
25*	I think I am important to people who are close to me.			
26	No one seems to understand me.			
27*	I think my plans will meet with considerable success.			
28	I feel helpless.			
29*	I like to venture into the unknown.			
30	I am afraid other people will dislike me.			
31*	I can make worthwhile contribution in group conversations.			
32	I wish I was someone else.			
33	I dream of myself as being beautiful.			
34*	I find it very easy to make new friends.			
35	I have a feeling there are very few things I can do well.			
36*	People come to me for advice.			
37	I feel so discouraged with myself that I wonder whether I am a			

	worthwhile person.			
38*	I am successfully at handling social interactions.			
39	I am constantly under the fear of failing.			
40	I wish I was more intelligent.			
41	I am confused.			

MO = Most Often, S = Sometimes, R = Rarely. The items with asterisks are positive items and must be scored as 3(MO), 2(S) and 1(R). The rest of the items are scored as 1(MO), 2(O), and 3(R).

ANNEXURE- V

WOMEN SOCIAL FREEDOM (WSF) SCALE

S.No	Statement	Agree	Disagree
1	Marriage should be performed by the consent of girls.		
2	If wife wants to work outside the home, husband should interfere.		
3*	The basic responsibilities of women is to look after her home and family.		
4	Not allowing girls to go alone outside their homes is an orthodox view which should be eliminated.		
5*	Parents are more experienced and wise, so wherever they arrange the marriage, an intelligent daughter should accept it.		
6*	A virgin should be given a freedom to have sexual relations with any guy or man.		
7	The tradition of addressing married women by the surname of her husband should be abolished.		
8	A women who is financially dependent on her husband lives like a slave.		
9*	Wife should perform only such conducts and activities which may increase the fame of her husband.		
10	Like some developed countries, it should be also permissible for women in our society to live with any man like a friend without marriage.		
11*	For happy married life, a wife should perform house hold chores and a husband should perform activities outside the home.		
12	Married and unmarried mother should get equal status in our society.		
13	The freedom of love should be encouraged among guys and girls.		
14*	Women who considers her children as liability is psychologically ill.		
15	With the name of bachelor as well as a married man only, "Mr" is used, similarly "Ms" should be used with the name of all women, instead of "Miss" or "Mrs".		
16	If men after being tired by their work, drink or smoke, women should not feel ireful about such behaviour.		
17	Women should have right to revolt against such rules which deprive them to achieve equal status and freedom.		
18	Girls should participate in social work.		
19*	Bashfulness is the attraction for women which no women should eliminate.		
20	The basic quality of women is to love, so if any girl fall in love, it should not be considered resentful.		
21	Today it has become necessary to go against the old morals for the promotion of women.		

22*	Women achieves her full identity only when she becomes a mother.		
23	There is nothing wrong if a married woman has a friendship with other man.		
24	Not allowing women to do activities related to business and labour is a social crime.		

For positive items. Agreed 1; disagree 0

The items with asterisks are negative items scored as : Agreed 0; disagree 1

ANNEXURE -VI

A Scale for the Assessment of Socio-Economic Status

S.C Tiwari , Aditya Kumar & Ambrish Kumar

Department of Geriatric Mental Health , King George's Medical University , Lucknow , India
SES Scale

A-HOUSE-PROFILE

URBAN:

A.1-Land Area :- (Total area = constructed+unconstructed)

No land	Upto 750 sq.ft	751-1500sq.ft	1501-2250sq.ft	2251-3,000sq.ft	>3,000sq.ft
0	2	4	6	8	10

A.2- HOUSE TYPE:

Not Applicable	K1	P1	P2	P3	P4
0	2	4	6	8	10

Final Score:- $\frac{A1+A2}{2} = \square$

RURAL:

A.1-Land Area :- (Total area = constructed+unconstructed)

No land	Upto 1000 sq.ft	1001-5000sq.ft	5001-10,000sq.ft	10,001-20,000sq.ft	>20,000sq.ft
0	2	4	6	8	10

A.2- HOUSE TYPE:

Not Applicable	K1	P1	P2	P3	P4
0	2	4	6	8	10

K1= No brick walls / floor kuchha / chappar / hutments (jhopari) / shanty / khapraail

P1= plastered or un-plastered brick walls / floor kuchha or made up of bricks only / ordinary roof (R.B roof) or tolly roof or tin roof

P2= plastered walls/floor cemented or mosaic / ordinary roof (R.B roof)

P3= plastered walls/floor cemented or mosaic / RCC roof

P4= plastered walls/floor made up of mosaic or marble or tile flooring(excluding toilet & kitchen flooring)/RCC roof or plaster of paris roof design

Final Score:- $\frac{A1+A2}{2} = \square$

B-MATERIAL POSSESSION

URBAN:

B.1- House Hold Gadget(according to the cost of items)

None	Upto Rs 10,000	Rs 10,001-50,000.00	Rs 50,001-10,00,000.00	Rs 1,00,001-3,00,000.00	>Rs 3,00,000.00
0	2	4	6	8	10

B.2- Conveyance Facility (according to the cost of vehicles)

None	Upto Rs 5,000.00	Rs 5,001 - 50,000.00	Rs 50,001-5,00,000.00	Rs 5,00,001-20,00,000.00	>Rs 20,00,000.00
0	2	4	6	8	10

Final Score:- $\frac{B1+B2}{2} = \square$

RURAL:**B.1- House Hold Gadget(according to the cost of items)**

None	Upto Rs 5,000	Rs 5,001- 10,000.00	Rs 10,001- 50,000.00	Rs 50,001- 1,00,000.00	>Rs 1,00,000.00
0	2	4	6	8	10

B.2- Conveyance Facility (according to the cost of vehicles)

None	Upto Rs 5,000.00	Rs 5,001 - 50,000.00	Rs 50,001- 5,00,000.00	Rs 5,00,001- 20,00,000.00	>Rs 20,00,000.00
0	2	4	6	8	10

Final Score:- $\frac{B1+B2}{2} = \square$

House Hold Gadget (Approximate cost)

Radio = Rs 500.00
 Tape recorder = 1,500.00
 Two-in-one (tape + radio) = Rs 2,000.00
 B/W T.V = Rs 3,000.00
 Colour T.V = Rs 10,000.00
 Disc Antenna = 6000.00
 V.C.P= 8,000.00
 V.C.R = 15,000.00
 Jewelry = as applicable
 CD Player =Rs 3,500.00
 D.V.D Player = Rs 6,000.00
 Jet Pump = Rs 10,000.00
 Microwave oven = Rs 10,000.00
 Lap-top = 1,50,000.00
 Generator = Rs 20,000.00
 Refrigerator = Rs 8,000.00
 Pumping Set = Rs 20,000.00
 Flour mill = Rs 4,000.00
 Gobar Gas = Rs 15,000.00
 Kolhu (electricity) = Rs 40,000.00

Licensed Arm = Rs 40,000.00
 Basic Phone = Rs 3,000.00
 Mobile Phone = Rs 5,000.00
 Fan = Rs1,000.00
 Cooler = Rs 4,000.00
 Hand pump = 4000.00
 L.P.G = 2000.00
 Utensils etc. as applicable
 Other meaningful gadgets = as applicable
 Milking Animal = Rs 10,000.00
 Water Pump (Tullu)= Rs 5,000.00
 Computer = Rs 30,000.00
 Geyser = Rs 5,000.00
 A.C =Rs 20,000.00
 Inverter = Rs 8,000.00
 washing Machine = 12,000.00
 Tubewell = Rs 15,000.00
 Threshing equipment = Rs 15,000.00
 Solar Plant = Rs 6,000.00
 Kolhu (ox) = Rs 10,000.00

Conveyance Facilities :-

Rickshaw = Rs 3,000.00	Cycle = Rs 1,500.00	Moped = Rs 20,000.00
Scooter = Rs 25,000.00	Motorcycle = Rs 40,000.00	Tempo = Rs 1,25,000.00
Auto = Rs 75,000.00	Jeep = Rs 4,50,000.00	Tractor = Rs 3,50,000.00
Truck = Rs 10,00,000.00	Economic car (Maruti 800 , Fiat etc.) = Rs 2,50,000.00	
Medium value car (Zen, Palio etc.) = Rs 4,00,000.00		Luxury car = Rs 8,00,000.00
Mini Truck (DCM Toyota , Eicher) = Rs 6,00,000.00		

C- EDUCATIONAL PROFILE (FOR URBAN AND RURAL BOTH):

Family Members	0	2	4	6	8	10
1						
2						
3						
4						
5						
6						
7						
8						
9						

0= illiterate

2= just literate / religious education or upto 8th

4= upto 12th

6= upto graduation / Diploma holders

8 = upto post graduation / professional degrees

10 = Higher studies (Ph.D , MD , D.Litt , MCH , DM etc)

Final scoring = total sum of scores obtained by family members getting education or have completed education divided by number of index family members =

C- OCCUPATIONAL PROFILE (FOR URBAN AND RURAL BOTH):

Family Members	0	2	4	6	8	10
1						
2						
3						
4						
5						
6						
7						
8						
9						

0 = No gainful employment

2= Unskilled Labour (labour , agriculture labour , rickshaw puller).

4 = Class IV employee , skilled worker (tailor , black smith, carpenter, washer man, potter, barber, driver etc.) hawker, vendor, (goods less than 50,000.00) petty farmer (cultivated land <1 acre), caste occupation.

6= Class III employee , primary school teacher , high school teacher ,small businessman (having his / her own or rented shop and goods up to Rs 1,00,000.00), farmer (cultivated land 1 - 10 acres), & private contractor, insurance agent etc.

8=Class II employee / junior professionals (experience up to 5 years), intermediate teacher , principals upto intermediate colleges , farmer (cultivated land 10 - 20 acres),businessman (goods up to Rs 1,00,000 – 5,00,000.00), local public leader like corporater , Govt. contractor etc.

10= Class I employee / executives / senior professionals (experience more than 5 years), university / degree college teacher , principals of degree colleges , professors , farmer (cultivated land more than 20 acres),businessman (goods > Rs 5,00,000), leaders (MLA's , MP's etc.)

Final scoring = Total sum of scores divided by number of family members who are engaged in monetarily gainful activity =

URBAN:

E: Average per capita income per month (from all sources)

Upto Rs 5,00.00	Rs 501-3,000.00	Rs 3,001-8,000.00	Rs8,001-15,000.00	>Rs 15,000.00
2	4	6	8	10

Final scores =

RURAL

E: Average per capita income per month (from all sources)

Upto Rs 500.00	Rs 501 - 2,000.00	Rs 2,001- 5,000.00	Rs 5,001- 10,000.00	>Rs 10,000.00
2	4	6	8	10

Final scores =

F- POSSESSED LAND / HOUSE COST PROFILE (FOR URBAN AND RURAL BOTH)

Upto Rs 50,000.00	Rs 50,001- 5,00,000.00	Rs 5,00,001- 20,00,000.00	Rs 20,00,001- 50,00,000.00	>Rs 50,00,000.00
2	4	6	8	10

Final scores =

G-SOCIAL PROFILE (FOR URBAN AND RURAL BOTH)

G.1 Understanding of social issues:

None	Religious – cultural	Developmental	Educational	Health Promotional	Political
0	2	2	2	2	2

G.1 Scores : Sum of Scores obtained =

G.2 Participation in social activities:-

None	Religious – cultural	Developmental	Educational	Health Promotional	Political
0	2	2	2	2	2

G.2 Scores : Sum of Scores obtained =

Final scores = $\frac{G.1 \text{ scores} + G.2 \text{ scores}}{2}$ =

Finding out SES categories from SES scores

Profiles of SES Scale :	Total Score	Obtained score
1- House Profile	10	<input type="text"/>
2- Material possessions Profile.....	10	<input type="text"/>
3- Educational Profile	10	<input type="text"/>
4- Occupational Profile	10	<input type="text"/>
5- Economic Profile	10	<input type="text"/>
6- Possessed Land/House Cost Profile	10	<input type="text"/>
7- Social Profile	10	<input type="text"/>
Total obtained score		<input type="text"/>

Key to socio-economic status categories:

SES Category-(1-5)

S.N.	SES CATEGORIES	SCORE RANGE				
		A-I Class City	A-Class City	B-I Class City	B-II Class City	C Class City
1.	Upper Class	65-70	63-70	61-70	59-70	57-70
2.	Upper Middle Class	50-65	48-63	46-61	44-59	42-57
3.	Middle Class	35-50	33-48	31-46	29-44	27-42
4.	Lower Middle Class	20-35	18-33	16-31	14-29	12-27
5.	Lower Class	0-20	0-18	0-16	0-14	0-12

*The cities which come under different category are as follows: The list should be re-categorised from time to time as per Swamy's handbook.

- A-I Class City** • Bangalore, Chennai, Delhi, Hyderabad, Kolkata & Mumbai
- A- Class City** • Ahmedabad, Jaipur, Kanpur, Lucknow, Nagpur, Pune, Surat & Vashi
- B-I Class City** • Agra, Allahabad, Amritsar, Asansol, Bhopal, Coimbatore, Dhanbad, Faridabad, Indore, Jabalpur, Jamshedpur, Kochi, Ludhiana, Madurai, Meerut, Nashik, Patna, Rajkot, Shilong, Vadodra, Varanashi, Vijaywada & Vishakapattnam
- B-II Class City** • Aligarh, Alwaye, Amrawati, Aurangabaad, Bareilly, Belagaum, Bhawnagar, Bhilai, Bhiwandi, Bhubaneshwar, Bikaner, Chandigarh, Cuttack, Dharwad, Dehradun, Ghaziabad, Goa, Gorakhpur, Guntur, Gurgaon, Guwahati, Gwalior, Jalandhar, Jammu, Jamnagar, Jodhpur, Kolhapur, Kota, Kozhikode, Manglore, Moradabad, Mysore, Noida, Panchkula, Pondicherry, Raipur, Ranchi, Rourkela, Salem, solaur, Srinagar, Tiruchirapalli, Tiruppur, Thiruvananthapuram & Warangal.

* For this categorization, Swamy's handbook – 2006 may be consulted

ACHIEVEMENTS FROM THE PROJECT

- Project Fellow and two enumerators trained for data collection and analysis.
- Two scholars enrolled for PhD on the issue of Women's Health.
- Popular lectures on Health Seeking Behaviour were delivered in the University, rural and urban community by Principal Investigator and Co- Investigator.
- Popular Lectures Delivered :- i) Extension lecture was delivered to rural women on “ ***Health Seeking Behaviour on 13th of August 2010*** at Block Development Office, Teh. Bishanh, District Jammu. After lecture there was an interaction session on health issues by the Principal Investigator and Co- Investigator. The participants raised several queries which were answered by both of them.
- Extension lecture was delivered by Principal Investigator to urban males and females regarding “***The Need For Health Seeking In Today's Context***” in Model Institute of Education & Research (MIER) College of Education B.C Road Jammu . It was followed by an interaction session where a fruitful discussion was generated. (March,2011)
- Focus Group Discussions were conducted.
- The findings have been presented in seminars and conferences. Abstracts have been accepted in National and International level conference.
- Research paper entitled “ ***Women's Health***” presented in “7th JK Science Congress” (13th – 15th Oct 2011) organised by the University of Jammu in collaboration with J&K State Council for Science and Technology, University of Jammu, Jammu
- Abstract accepted in 2nd International Congress on Gerontology and Geriatric Medicine (ICGGM 2012) All India Institute of Medical Sciences & University College of Medical Sciences, Delhi.25th – 29th February 2012
- Abstract accepted in “8th JK Science Congress”, University of Kashmir, titled “ ***A comparative study of health seeking behaviour among women of Jammu and Kathua district***” (17th to 19th September, 2012),University of Kashmir, Kashmir
- Research paper titled “***Study of Health Seeking Behaviour of Tribal Women(35-65 years):A Case for Life Long Learning Initiatives***” presented in **National Seminar on Life Long Learning and Higher education**(9-10 March,2012), organized by the Department of Lifelong Learning University of Jammu, Jammu
- Research paper titled “ ***To study the relationship of education on health seeking behaviour of tribal women(35-65 years)in Jammu***” presented in **Annual International Conference of Comparative Education Society of India (CESI)** (October 10th -12th 2012)in collaboration with Department of Education, University of Jammu, Jammu
- Research paper titled “***Health Seeking Behaviour of women during menopausal transition(35-65 years): A comparative study of Rural, Urban and Tribal***

women of Jammu ”presented in ICSSR sponsored “National Seminar on Declining Sex ratio in North-West India (20th -21st March, 2013) organised by the Department of Sociology, University of Jammu, Jammu

- Research paper titled “*Health Seeking Behaviour of women during menopausal transition(35-65 years): A comparative study of Rural, Urban and Tribal women of Jammu* ”presented in ICSSR sponsored “National Seminar on Declining Sex ratio in North-West India (20th -21st March, 2013) organised by the Department of Sociology in collaboration with the Centre for Women’s Studies, University of Jammu, Jammu
- Research paper titled “*Women’s Health During Menopausal Transition: Need For Innovative Approach To Health Care*” presented in 101st Indian Science Congress(3rd February to 7th February 2014) organized by University of Jammu, Jammu.
- Research paper titled “*Education and Health Seeking Behaviour of women*” presented in IDEA conference..... (12th March to 14th March 2014) organized by Directorate of Distance Education Department, University of Jammu, Jammu.
- Research paper entitled “*Tribal Health Status and Environment: A Study of Women (35-65 Years) of Jammu and Kathua District*” presented in national conference on environmental issues, concerns and solutions (EICS-2014) (24th March to 25th March 2014) organized by Directorate of Distance Education Department, University of Jammu, Jammu.
- Abstract accepted titled “*Relationship of Health Seeking Behaviour of the Tribal women(35-65 years) of Jammu with some selected variables*” National Conference on **Human Development And Family Studies: Crystallizing A Disciplinary Identity In India** (October 17-19, 2013) organized by UGC-Center of Advanced Study (Phase- II) Department of Human Development and Family Studies (HDFS) The Maharaja Sayajirao University of Baroda In collaboration with International Society for the Study of Behavioral Development (ISSBD-India).
- Two publications in the international journals. One is published and another is accepted for publication

ANNEXURE VIII

23236551, 23232791, 23237721, 23234816
23238733, 23232317, 23236736, 23239437



विश्वविद्यालय अनुदान आयोग
बहादुरशाह जफर मार्ग
नई दिल्ली-110 002
UNIVERSITY GRANTS COMMISSION
BAHAURSHAH ZAFAR MARG
NEW DELHI-110 002

F. No. 37-413/2009 (SR)

Dr. Neeru Sharma
Department of Home Science
University of Jammu
Jammu-180006, J & K

11 JAN 2010

Sub:- UGC support for the Major Research Project in Physical Sciences, Bio-Sciences, Pharmacy, Medical, Agricultural Sciences and Engineering & Technology to University.

I am to refer to your application regarding Major Research Project entitled "Health seeking behaviour among women (35-65 years) of Jammu," and to inform that your project has been approved by the Expert Committee. The item-wise details is given as under:-

S.No.	ITEMS	AMOUNT APPROVED	GRANT RELEASED AS 1st INSTALMENT
A.			
1.	Date of implementation <u>1.2.2010</u>		
2.	Tenure of the project. <u>3 years</u>		
B.	Non - Recurring		Non-Rec 100 %
1.	Books & Journals	25,000/-	
2.	Equipment (Computer accessories)	40,000/-	
C.	Recurring		Rec 50 %
1.	Honorarium to Retd. Teachers @ Rs. 12,000/- p.m.	nil	
2.	Project Fellow @ 8,000/- p.m.	2,88,000/-	
3.	Chemical/ Glassware	nil	
4.	Hiring Services/ Consumable	50,000/-	
5.	Contingency	1,00,000/-	
6.	Travel/Field Work	1,00,000/-	
7.	Overhead Charges @ Rs. 10% approved recurring Grant (Except Travel & Field Work)	43,800/-	100 %
	Total (B + C)	6,46,800/-	3,77,800/-

The acceptance Certificate in prescribed format attached Annexure I may be sent to the undersigned within one month from the issue of the award letter failing which the project may be treated as cancelled.

Approval cum sanction is being issued separately to the University as a block grant vide letter no. dated.....

You are requested to approach the University in the matter.

The Registrar
University of Jammu
Jammu-180006, J & K

(Ananta Hazra)
Under Secretary



F. No. 37-1/2009 (J & K) (SR)

The Under Secretary (FD-III)
University Grants Commission
New Delhi-110002

Sub:- UGC support for the Major Research Project in Physical Sciences, Bio-Sciences, Pharmacy, Medical, Agricultural Sciences and Engineering & Technology to University.

Sir,

With reference to the recommendations of the Expert Committee regarding Major Research Project I am directed to convey the Commission's approval cum sanction of an 'on account' grant of **Rs. 28,91,500/- (Rupees: Twenty eight lakh ninety one thousand five hundred only)** as block grant against the total allocation of **Rs. 41,51,500/- Rupees: Forty one lakh fifty one thousand five hundred only** to the

**Registrar
University of Jammu
Jammu, 180006, J&K**

in r/o of Major Research Project (5) of the Principal Investigators (subject wise detail attached)

If the terms & conditions are acceptable, as per guideline which are available on UGC web-site www.ugc.ac.in the Demand Draft/ Cheque being sent may be retained. Otherwise the same may be returned in original to the commission by Registered Post in variability with in 15 days from the receipt of the Demand Draft/ Cheque.

Principal Investigators should ensure that the utilization Certificate to the effect that the grant has been utilized for the purpose for which it has been sanctioned shall be furnished to the University Grants Commission in time.

The final report of the project may be submitted in typed form as well as electronically i.e. in floppy/CD

1. The sanctioned amount is debitable to the Major Head 4. (I),A and is valid for payment during financial year **2009-10**.
2. The amount of the Grant shall be drawn by the Under Secretary (drawing and Disbursing Office), University Grants Commission on the Grants-in-aid Bill and shall be disbursed to and credited to the University **University of Jammu, Jammu** through Cheque/Demand Draft/ Mail Transfer.
3. The Grants is subject to the adjustment of the basis of Utilization Certificate in the prescribed performa submitted by the University/Colleges/institution.
4. The University/College shall maintain proper accounts of the expenditure out of the grants which shall be utilized only on approved items of expenditure.
5. The Utilization Certificate to the effect that the grant has been utilized for the purpose for which it has been sanctioned shall be furnished to the University Grants Commission as early as possible after the close of the current financial year.
6. The assets acquired wholly or substantially out of University Grant Commission's grant shall not be disposed or encumbered or utilized for the purposes other than those for which the grant was given, without proper sanction of the University Grants Commission and should, at any time the College/University ceased in function such assets shall revert to the University Grant Commission.

23226356, 23232701, 23237721, 23234116
23228733, 23232317, 23236735, 23239437



विश्वविद्यालय अनुदान आयोग
बहादुरशाह जफर मार्ग
नई दिल्ली-110 002
UNIVERSITY GRANTS COMMISSION
BAHADURSHAH ZAFAR MARG
NEW DELHI-110 002

F. No. 37-413/2009 (SR-)

1 OCT 2012
Dated:-

The Under Secretary (FD-III)
University Grants Commissions
New Delhi-110002

Sub:- UGC assistance for the Major Research Project entitled, "Health.....jammu."
Dr. Neeru Sharma, Department of Home Science, tenure of the project from 1.2.2010 to 31.1.2013.

Sir,

I am directed to convey the sanction of the University Grants Commission to the payment of **Rs. 5,19,816/- (Rupees: Five lakh nineteen thousand eight hundred sixteen only)** to **University of Jammu, Jammu -180006** for the Major Research Project of **Dr. Neeru Sharma, Department of Home Science**, as detailed below:

Purpose	Amount Allocated Rs.	Amount already released Rs.	Amount being released Rs.	Total grant sanctioned including the present instalment Rs.	Category
Books & journals	25,000/-				
Equipment	40,000/-				
* Project Fellow + HRA	5,01,333/- + 97,351/-				
Travel/Field work	1,00,000/-	3,77,800/-	5,19,816/-	8,97,616/-	Gen
Contingency	1,00,000/-				
Hiring Services	50,000/-				
Overhead Charges	43,800/-				
Additional grant for Equipment	25,000/-				
Total	9,82,484/-	3,77,800/-	5,19,816/-	8,97,616/-	

1. The sanctioned amount is debitible to the Major Head 4. (i). a (31)Rs. 4,94,816/- & 4. (i) a (31)Rs. 25,000/- and is valid for payment during financial year 2012-13 only.
2. The amount of the Grant shall be drawn by the Under Secretary (drawing and Disbursing Office), University Grants Commission on the Grants-in-aid Bill and shall be disbursed to and credited to the **University of Jammu, Jammu -180006** through Cheque/Demand Draft/ Mail Transfer.
3. The Grants is subject to the adjustment of the basis of Utilization Certificate in the prescribed proforma submitted by the University/Colleges/institution.
4. The University/College shall maintain proper accounts of the expenditure out of the grants which shall be utilized only on approved items of expenditure.
5. The Utilization Certificate of the effect that the grant has been utilized for the purpose for which it has been sanctioned shall be furnished to the University Grants Commission as early as possible after the close of the current financial year.

* As per revised rates w.e.f. 1.4.2010.

6. The assets acquired wholly or substantially out of University Grant Commission's grant shall not be disposed or encumbered or utilized for the purposes other than those for which the grant was given, without proper sanction of the University Grants Commission and should, at any time the College/University ceased in function such assets shall revert to the University Grant Commission.
7. A Register of assets acquired wholly or substantially out of the grant shall be maintained by the University/College in the prescribed form.
8. The grantee institution shall ensure the utilization of grant-in-aid for which it is being sanctioned/paid. In case non-utilization/part utilization, the simple interest @ 10% per annum as amended from time to time on unutilized amount from the date of drawl to the date of refund as per provisions contained in General Financial Rules of Govt. of India will be charged.
9. The interest earned by the University/College/Institute on this grants in aid shall be treated as additional grant and may be shown in the Utilization Certificate/Statement of expenditure to be furnished by grantee institution.
10. The University/College/Institute shall follow strictly all the instructions issued by the Government of India from time to time with regard to reservation of posts for Scheduled Castes/Scheduled Tribes/OBC/PH etc.
11. The University/College shall fully implement to Official Language Policy of Union Govt. and comply with the Official Language Act, 1963 and Official Languages (Use for Official purposes of the Union) Rules, 1978 etc.
12. The sanction issues in exercise of the delegation of powers vide Commission Office Order No. 25/92 dated May 01, 1992.
13. An amount of Rs. 3,25,132/- out the grant of Rs. 3,77,800/- sanctioned vide letter No. F. 37-1/2009 (J & K) dated 11.1.2010 has been utilized by University/College/Institution for the purpose for which it was sanctioned Utilization Certificate for Rs. has already been entered at S. No. Now we may enter Utilization Certificate for Rs. 3,25,132/- S. No. 2164... and in the U. C. Registrar at page no.
14. It is also certified from the B.C.R. that the funds are available under the scheme. Entered in BCR at S. No. 2164... The above grant is sanctioned against the budget provision of Rs. 41 Crore during the current financial year leaving a balance of Rs. under the head of Account 4. (i). a (31)Rs. 4,94,816/- & 4. (i) a (31)Rs. 25,000/-
15. The funds to the extent are available under the Scheme.
16. The University/Institution/College is strictly following the UGC regulations on curbing the menace of ragging in Higher Educational Institutions, 2009.

- Sd -
(Kanta Batra)
Deputy Secretary

Copy forwarded for information and necessary action for:-

1. The Registrar, **University of Jammu, Jammu -180006**.
Acknowledgement for the receipt of DD / Cheque / Mail Transfer for Rs. 5,19,816/- may be sent to the Under Secretary, Finance Division III, UGC,
2. **Dr. Neeru Sharma**, Principal Investigator,
Department of Home Science,
University of Jammu, Jammu -180006.
3. Office of the Director General of Audit, Central Revenues, A. G. C. R. Building, I. P. Estate, New Delhi.
- 4.


(Pramod Sharma)
Section Officer

23236351, 23232701, 23237721, 23234116
23238733, 23232317, 23236735, 23239437



विश्वविद्यालय अनुदान आयोग
बहादुरशाह जफर मार्ग
नई दिल्ली-110 002
UNIVERSITY GRANTS COMMISSION
BAHADURSHAH ZAFAR MARG
NEW DELHI-110 002

F.No.37-413/2009(SR)

Dr. Neeru Sharma
Dept. of Home Scienc
University of Jammu
Jammu-180006, J & K

1 OCT 2012

Subject:- Major Research Project – Recommendation/Comments/Suggestions of the Experts Committee.

Sir,

This has reference to your presentation before the Mid-term Evaluation Committee of the project run by you. **The Recommendation/Comments/Suggestions of the Expert Committee may be read as under ;**

1.	Extension of tenure, if any	6 months
2.	Additional Grants Sanctioned, if any	Rs. 25,000/- for Digital camera & Dictaphone.
3.,	Re-appropriation, if Any (Head Wise)	Nil
4	Comments with specific recommendation in case the tenure of the project is being reduce/cut-down	Progress is satisfactory.

You are requested to expedite the research work and submit the final documents with in the stipulated period.

Yours faithfully,


(Kanta Batra)
Deputy Secretary