WOMEN AND TURMOIL: A SOCIOLOGICAL STUDY OF HEALTH STATUS OF WOMEN IN BORDER AREAS OF JAMMU AND KASHMIR

Thesis Submitted for the Award of the Degree of

DOCTOR OF PHILOSOPHY

in

Sociology

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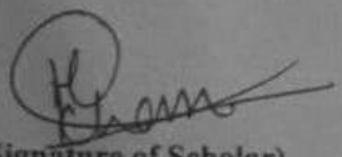
DECLARATION

I, hereby declared that the presented work in the thesis entitled "Women and Turmoil: A Sociological Study of Health Status of Women in Border Areas of Jammu and Kashmir" in fulfilment of degree of **Doctor of Philosophy (Ph.D.)** is outcome of research work carried out by me under the supervision of Dr Ganesh Digal, working as Assistant Professor, in the School of Liberal & Creative Arts (Social Sciences and Languages) of Lovely Professional University, Punjab, India. In keeping with general practice of reporting scientific observations, due acknowledgements have been made whenever work described here has been based on findings of other investigator. This work has not been submitted in part or full to any other University or Institute for the award of any degree.



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CERTIFICATE

This is to certify that the work reported in the Ph.D. thesis entitled "Women and Turmoil: A Sociological Study of Health Status of Women in Border Areas of Jammu and Kashmir" submitted in fulfillment of the requirement for the award of degree of **Doctor of Philosophy (Ph.D.)** in the Sociology/School of Liberal and Creative Arts (Social Sciences & Languages), is a research work carried out by Haseena Nighat Khan, 12021108, is bonafide record of his/her original work carried out under my supervision and that no part of thesis has been submitted for any other degree, diploma or equivalent course.

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Abstract

According to the World Health Organization (1948), “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." The Beijing Declaration Platform for Action, followed by the Fourth World Conference on Women Health Issues, provided a roadmap for gender equality and to empower women, with especially emphasis on reproductive health challenges and concerns, to ensure healthy life and also promote well-being for every woman, regardless of age criteria, the matter disclosed and discussed on a global level, and of course, the Sustainable Development Goal 3 target to provide “good health” and Sustainable Development Goal 5 to achieve “gender equality.”

Women’s health has always been a matter of concern for every society and is often confronted with numerous socio-cultural factors that negatively impact their physical well-being and access to appropriate health care services. “Health is not solely determined by biological factors; it is also influenced by social, economic, political, environmental, and cultural factors." These social factors linked with such parameters as age, income, social class, education, location, source of income and so on, have become increasingly important for women's health, specifically reproductive, which includes maternal health as well. However, these factors directly have an effect on women's health as well as on the health of the child. The condition of women in India in terms of their health issues has been worse compared to that of men and these circumstances lies due to gendered differences with respect to socio-economic status. Significantly, Indian women's health is actually inextricably connected and linked to their socio-economic position in society while determining the use and access to healthcare, which is mainly positioned and strongly correlated with their social and economic status.

The proposed study is aimed at identifying the social factors that influence women’s reproductive health and analyzing the impact of political turmoil on the maternal health of women. However, particularly in the border villages of Jammu and Kashmir, it is important to unveil the prevailing and existing factors responsible for the women’s subjugation, and it was found that no such research was taken into account before that. There is also mention of a lack of work and a reported shortfall in women’s health. The study has been organized into five chapters, each dealing with a particular aspect of the research under taken.

The first chapter is comprised of the background of the study, conceptual framework, research gap, statement of the problem, significance of the study, relevance of the study, rationale of the study, scope of the study, and included objectives of the present study. To conduct the study, three objectives have been outlined. The first objective is to identify the challenges and health issues faced by women in the border areas of Jammu and Kashmir. The second objective is to describe the pregnancy care and delivery complications in the border areas of Jammu and Kashmir. The third objective is to analyze the impact of turmoil on the maternal health status of women in the border areas of Jammu and Kashmir.

Jammu and Kashmir have unique topography and cultural diversity, since the divide between the two nations and political conflict impelled by the turbulence situation in the region has affected the lives of people, especially women and women's health specifically. Research on various aspects of women's health has revealed that there are inequalities regarding the medical system and infrastructure that reflect that women were previously excluded. They are directly or indirectly affected by the unrest situation in the border regions, and these areas are actually suffering from chaos, disturbance, and disorder in view of the fact that ongoing ceasefire breaches, random shelling, and escalation unquestionably impact women's socio-cultural, economic, and political existence.

Numerous studies address the general state of health during times of conflict, emphasizing that poor health outcomes are typically caused by a lack of access to high-quality healthcare. According to previous studies conducted about the conflicted and affected zones, high maternal health issues, a sharp decline in health-related human resources, limited access to medical facilities, a lack of basic health knowledge, a lack of health awareness programs for locals, and mental health issues are reported as the main health issues reported during the turmoil situation, which impedes barriers to their social development and their socio-economic condition stands to some limited sphere. The territorial dispute in Jammu and Kashmir affected the inhabitants' lives, especially those who lived near the border line. Since 1947, the country has been going through political unrest, areas of controversy, and disagreement that have affected the lives of women. From the point of view of existing literature, studies, and researchers in "Health Sociology" gave minimal consideration and expansion. In the present study, the researcher comprehends research and best knowledge for addressing the concept of women's health challenges and the influence of turmoil, factors responsible for various dimensions, how it has dynamically and interchangeably evolved, and its repercussions on the lives of women and the

impact of turmoil in the region. Specifically, the women's health concerns exerted and influenced by conflict are still unexplored. This study lets readers know about the women's health in border villages' despite the unsettled situation of ongoing turmoil with devastating effects.

The second chapter discussed the literature part of the study, which deals with understanding conflict from a sociological perspective, understanding turmoil, understanding health sociologically, describing women's health from a sociological perspective, describing the health and impact of turmoil on women, and disclosing the summary of the chapter. The conflict perspective discussed in connection with antagonistic and difference of opinion in thoughts between the people, as well as social inequalities that provide social problems in contemporary society, with uneven distribution within society creating chaos and conflict amongst people. On the other hand, poor and marginalized sections of society, including women, are subjected to worsening conditions. The present study highlights the border areas that lie near the Pakistani border after partition between two nations, India and Pakistan. Hence, in the border areas, turmoil is the byproduct of conflict; it is external to the local inhabitants. Here in the present study, we are looking for conflict between India and Pakistan and their identity as two independent nations, and the present study considers India and Pakistan as two separate identities, though they have similarities and differences. The border regions of Jammu and Kashmir are continuing to be in turmoil because of the India-Pakistan conflict. Turmoil, observed as an interplay and major influencing factor in the border areas of Jammu and Kashmir, creates numerous challenges to women's health.

The third chapter presents the design of the study, which has a predominantly qualitative, descriptive, and exploratory essence. The data for the present study has been collected from both primary and secondary sources of information, and a long-term field visit has been conducted. The primary data has been collected through in-depth interview schedules, focused group discussions, and the case study method. Secondary data has been collected through books, journals, Newspapers, library visits, and government reports, including the opinions and arguments of social activists, academicians, politicians, officials, etc. in the region. Due to the nature of the study and other issues and challenges in the region, the study requires a sociological perspective to understand the ground realities, like conflict and feminist perspectives. So far as sampling is concerned, the study is based on the non-probability sampling method, particularly purposive sampling. The target population coverage is reflected

in the border areas of two districts, namely Baramulla and Poonch. The sample size has been fixed at about 107 respondents, divided on the basis of age and marital status. The tools employed for the collection of data are mainly interview schedules, which are unstructured and open-ended in nature. For analyzing the data, thematic content analysis has been used for the interview schedule, and the narrative analysis method has been used for the case studies. The present study is conducted on women in border areas of Jammu and Kashmir. The present study was conducted within Tulwari, SalliKoot, and Addosa villages under the Uri block from Baramulla district and Islamabad (India), and "Balakote" (India) villages under blocks Haveli and Balakote from district Poonch.

The fourth chapter presents the analysis, findings, and discussion part of the study. followed the intersectionality approach to study the health issues of women and how variables of women, turmoil, and health were interconnected and overlapped. The approach employed to analyze the women's health issues, influenced by contextual factors, intersects (to meet and cross at a point) with each other along with the ongoing turmoil situation in the region. The notions of the approach give analytical attention to the process of shared experiences linked to their daily routine.

The fifth chapter presents the conclusion of the present study. Results showed that the impoverished are typically the ones who suffered, and the consequences of the hardship affect their lives. However, the factors responsible are political turmoil, the source of income, social status, topography of the region, environmental and climatic variations, educational profile, resources, etc. In fact, the unrest in the region disrupts the lifestyle of women and is expected to have an impact on their health. The major moderating factor in the region is conflict that promotes turmoil, reflecting the character of conflict between both nations. Every civil right and neutral position have been breached or disappeared because of the volatile circumstances in the region. Transitional determinants are health inequalities and suffering that precede the present situation with respect to poor health results and identify numerous challenges. However, within turmoil settings, the disappearance of human rights severely expose because of insecurity and fear in daily routine life, and it would be difficult to unable to protect and hold their families, they might be attacked by shell or by bullet, lack of resources, migration, loss of social relationships and networks, no means of communication living in isolation and loss of social roles, loss of opportunities provide for daily life and needs, scarcity of food because of due to infertile or barren land and they are helpless to access the resources for their

livelihood, no proper and essential health care and services includes like education, medical care, employment, sanitation system, etc. However, it is reported that the similarities in the findings noted turmoil in the border regions and the contribution of the turmoil while recognizing and identifying numerous social factors to describe the impact on women's health and create challenges and issues in the border areas of Jammu and Kashmir.

Acknowledgements

"The success of any endeavor is always reliant on inspiration and hard work".

"At the onset, all praises to Almighty (Allah) for his mercy and magnanimity". "Glorified is to Almighty (Allah), the most merciful, beneficent, supreme, and gracious, for his mercy and blessings bestowed upon me and for enabling me to be grateful to conduct this research in a righteous way".

I would like to convey a sincere acknowledgment to my worthy supervisor, Dr.Ganesh Digal, as well as my erstwhile supervisor, Dr. Keyoor Pathak (Assistant Professor) from Allahabad Central University for their support and assistance that contributed significantly throughout this endeavor. It was an honor for me and I consider it a privilege to have worked under the supervision of his and for meticulous, analytical approach, which inspired and helped me to pursue and accomplish my work. I immensely grateful to my advisor, their expertise and encouragement have been instrumental in shaping my research and academic growth. I would like to extend special thanks to Dr. Mohammad Amin Wani (Assistant Professor) from Lovely Professional University and my senior associate Dr. Sumbl Ahmed Khanday (Assistant Professor) from Aligarh Muslim University for their continuing guidance throughout the PhD journey.

Finally, special thanks to all members of my family, especially my mother who played a dual role being as mother and father as well and she faced challenges throughout the life. Despite of that she supports me every time through my whole journey and I am very thankful to my mother for their unwavering support and guidance throughout this challenging yet rewarding journey. I would like to extend my special thanks to my younger brother, Mehtab Sharief Khan during the field study for three months as I gathered relevant data by means of primary sources from remote border villages of Jammu and Kashmir. He spent many hours patiently helping me, especially during the most difficult times. I also extend my gratitude towards my siblings, niece (Aliya), and nephew (Faisal) and also to my well-wishers for their encouragement and boundless support. Thank You to everyone who has supported me along the way. Here's to new beginnings and endless possibilities.

Dedication

This thesis is dedicated to my deceased father, who has been my torch bearer during my academic ambitions. His advice was always inspirational for me throughout my academic voyage.

Acronyms and Abbreviations

AIDS Acquired Immunodeficiency Syndrome

BPL Below Poverty Line

NITI National Institution for Transforming India

PCOD Polycystic Ovarian Disorder

ICPD International Conference on Population and Development

OBC Other backward castes

MOHFW Ministry of Health and Family Welfare

UNICEF United Nations Children's Fund’s

WHO World Health Organization

NHM National Health Mission

HDI Human Development Index

UNHCR United Nations High Commissioner for Refugees

LAC Line of Actual Control

LOC Line of Control

JSY Janani Suraksha Yojana

SNP Supplementary Nutritional Programme

PMMVY Pradhan Mantri Matru Vandana Yojana

SMAS State Marriage Assistance Scheme

ASHA Accredited Social Health Activist

ANM Auxiliary Nurse Midwife

LHV Lady Health Visitor

Dai/TBA Traditional Birth Attendant

SDG Sustainable Development Goal

RTI Reproductive Tract Infections

UTI Urinary Tract Infections

NFHS National Family Health Survey

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1.0 Introduction

Chapter one is the introductory part of the thesis, which explains "Turmoil," "Women," and "Health," the specific and conceptual part of the discourse mainly discusses women's health issues and challenges associated with social factors that influence and are interlinked with their reproductive and maternal health.

Health and Illness are observed as a social phenomenon influenced by the social structure of the society. The word "illness" defines "the condition of being unhealthy," determined by the circumstances that considerably affect health. The "Sociology of Health" discussed various issues and how the existing social structure affects human health, specifically women's (Anbu, 2020).

Scholars like Muzaffar, Khan, and Maqbool describe the term "Health is determined by various social, economic, political, cultural, and environmental factors and not just by the biomedical ones". However, a woman's health status is determined by her reproductive and maternal health, which is confined to an important yardstick. In contrast to that, the most accepted factor is that accessing healthcare services often has a prominent influence on health. Michael Marmot (1999) stated that health issues of women and social determinants influence women's health. However, the environment become more significant in defining the health profile of women and considered being as influencing factor on women's social life. In addition, social practices such as rituals, ceremonies, rites of passage, traditions, and customs create long-term social deprivations in society. Due to the inequalities, exploitation, and discrimination in society in comparison between the higher and lower classes, those who belong to the lower classes are discriminated against and meet the criteria of a state of powerlessness (Khan and Maqbool, 2019).

Bhasin (2017), in her book "Understanding Gender," opined with respect to radical feminists that "Patriarchy is responsible for the exploitation and subjugation of women and accountable for their low status". Considering patriarchal ideology and structure in society, women adhered to restrictions and followed the values and norms. They mostly tolerate discrimination inside the

private sphere; they feel disgraced by the dominance of men and cannot access proper resources; they have no decision-making powers, which eventually affect their physical as well as mental health.

1.1Background of the Study

Health is multidimensional and contributes to positive health in spiritual, emotional, vocational, philosophical, cultural, socio-economic, environmental, educational, and nutritional dimensions, besides the physical, mental, and social dimensions. On the other hand, this dimension, functions and interactions with one another, each has its nature (Hassan and Shafi, 2013).

Scholars like Bloom, Fikree, Pasha, Kapungwe, Hou, Ma, Aantjes, Muzaffar, and Murugan worked extensively on the health status of women; the literature reflects on health, and health status often focuses attention on women's health issues and challenges. Since human existence in every society existing differentiation and social stratification are considered the primary sources of inequalities, distinctions, and disparities among individuals but women's health issues have always been the focus of attention. Rapidly rising issues and problems continue to exist, and the social status of women is defined by their socio-economic background and the manner of lifestyles and circumstances that affect the woman's livelihood, which are mainly responsible for creating barriers to their social development concerning health and welfare (Hamal and Dieleman, 2020).

According to the Census (2011), the total population of women in India is around forty-eight percent, still excluding women's health issues. India's status about women's health is influenced by social and contextual factors and constitutes differences in the existing society, whereas women's health concerns in rural areas observed key challenges. The present issues observed such as poor lifestyle, high fertility rate, early marriages, and lack of resources. Demographic characteristics including gender, age, livelihood status, the total number of children, educational status, caste, place of residence, etc., play a significant role in determining the social profile of women (Muzaffar, 2016). However, women living in remote or far-flung regions with no access to healthcare services are found to be most vulnerable to different diseases, infections, and other health problems, only because they do not acquire proper medical care and are deprived of many

amenities. However, there is no physical infrastructure available, most importantly the health infrastructure, there is dearth of medical infrastructure in these regions (Gul, 2014).

Scholars like Khan and Pathak (2022) opined in comparison between rural and urban women, there are differences in social class and on a large scale. Rural communities are almost embedded in traditions and customs; the remote rural areas have different strategic locations and geography and also engage with numerous challenges like illiteracy, poverty, unemployment, shortage of resources, and so on. Nevertheless, these factors play an important role in defining the conditions of living people. In India, most of the women who live in rural areas mostly suffer from many health problems and lack of appropriate concern at all times. For the most part, during the maternal period, women do not gain access to a proper diet. However, it is reported in rural areas where women during pregnancy are not concerned about medications such as vitamins, calcium, and iron folic tablets, essentially for the better health of the mother and child, and the carelessness of any woman can be a threat to women. In the state of Bihar recorded the most cases related to maternal health complications, followed by Jharkhand and also by the state of West Bengal (Subba, 2013). It is reported that women usually prefer early marriages, remain uneducated, and do not access healthcare, which affects their health. Because of this, they face many problems and suffer a lot throughout their lives, which affects their reproductive and maternal health. There have been discussions on numerous and diverse issues of women's maternal health, of which the most important factor mainly responsible for every woman's susceptibility is anemia (iron deficiency). It has an equally adverse effect on the reproductive age of women, where anemia is found to be much more challenging and predominantly found in the pregnant and middle-aged categories. Malnutrition is another serious concern for every woman that threatens their life (Zodpey and Negandhi, 2022).

According to the Ministry of Health and Family Welfare and NITI Aayog (2019) report released, Bihar ranked at the bottom concerning various health problems such as the highest fertility rate, preference for home deliveries and delivery complications, stillbirth cases, and maternal mortality (MOHFW and NITI Aayog, 2019). In continuation of the argument poor health affects the mother and also the fetus, the state of Odisha reported the highest low birth weights because of the mother's weak health (Kowsalya and Shanmugam, 2017).

Scholars like Khan and Pathak (2022) revealed in their study the different parameters of health issues of women are predominantly observed in border areas of Jammu and Kashmir, and confined the differentiation still exists in the health sector. Examine the nature of social factors that play a vital role in determining women's health concerns, like education, health status, and source of income, family structure, traditions, and beliefs. The reviewed literature disclosed about women suffering from various reproductive and maternal health issues. However, taking into consideration the drawbacks, the outcome draws closer to numerous social issues, similar to preferring early marriages, increased fertility rates, adolescent pregnancies, miscarriages and unplanned abortions, morbidities, maternal deaths, mental health issues, reported weak health during the postpartum period, and so on, further leading to the emotional strain and distress observed amongst women.

David (2017) stated that a large portion of South Asia's population has experienced various forms of protracted conflict; the region can offer important insights into the health issues that arise in conflict areas. Health has greatly suffered as a result of decades of conflict (Acerra, 2009). Scholars like Singh, Orbinski, and Mills (2007) focused on conflict and health to investigate the connections between conflict, humanitarianism, and health. Some regions of India have low intensity and protracted conflict due to their diverse ethnic, linguistic, and religious groups. However, in India there are three main areas of conflict: the state of Jammu and Kashmir; some remote northeastern states; and parts of central India where there is a Maoist insurgency. Chronic disruptions caused by internal displacement, counter-insurgency operations, and armed group violence have severely damaged the healthcare system (Ranvijay, 2010).

Scholars like Bendavid, Bodha, and Sheikh stated in their work against the aforementioned argument that the war continued to simmer in the state of Jammu and Kashmir and the political and social order remained fragile. Since 1947, there has been a historical background between the two nations, India and Pakistan, for around seven decades under the turbulence of political conflict. Going back to history, many wars have been settled between the two nations, but the matter in question is still unresolved; only destruction and chaos are produced on both sides. The disturbance in the region creates obstacles to border residents and there are numerous challenges come out in their pathway. In the context of border areas, there have been questions, debates, controversies, and differences of opinion; in fact, the region is in continuation beneath

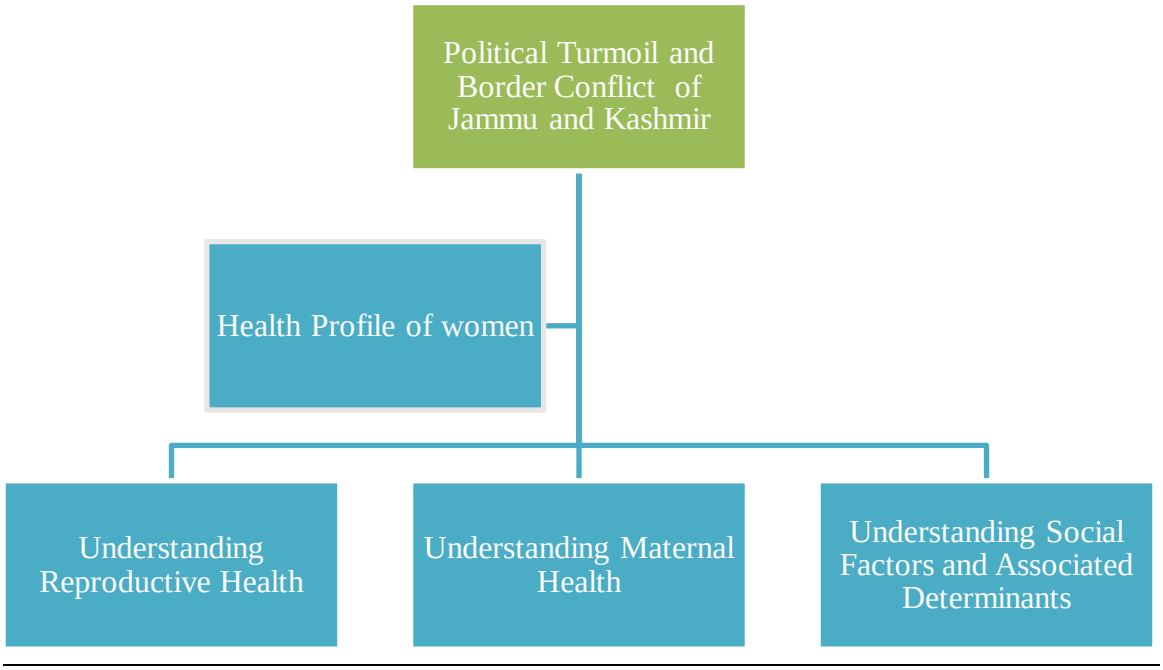
insurgencies, escalations, and interruptions of utilities. There is instability, unrest, and turmoil in the region and the relations between the two nations are disagreeable and dissatisfying. An examination of the border areas of Jammu and Kashmir was reported, especially those areas that are close to the Pakistan border line. However, because of an ongoing turmoil women are at great risk of and as long as there are no such healthcare facilities in the border villages of Jammu and Kashmir.

Jammu and Kashmir have unique ethnic and cultural values, and the strategic location has unique physical features, geographically unique landforms, and more or less rigid terrain, which attracts tourism around the globe. The region continues to be unstable because of regional competition, and it is difficult to reconcile the security issues, internal unrest, economic instability, social disintegration, and interests of the population. Jammu and Kashmir's natural landscape and boundaries are shared with the neighboring country, Pakistan. Furthermore, the topography of the region demands snowfall, which acts as a great barrier for inhabitants living in that zone for about three months (December–February) and, as a consequence, affects women's health and the general health situation in the midst of conflict. The present study highlights that access to quality health care is generally poor and not available, leading to poor health outcomes (Muzaffar, 2015).

The conflict-prone zone during a war-like situation in Jammu and Kashmir, there is a probability of raising numerous health problems, whereas the most predominant challenge is reported for maternal health. In the conflict regions, there are higher rates of social issues including health challenges compared to other non-conflict areas. It is pointed out that the border regions of Jammu and Kashmir have been an area of dispute, and there are still existing inequalities with a lack of medical infrastructure and deficiencies in the public health system; there is no proper management system; and there is the non-availability of health centers. However, especially during the period of pregnancy and childbirth, there is a great challenge for every woman because the roads are underdeveloped and almost blocked in winter due to heavy snowfall. There are treacherous journeys to access any requirements and health facilities, and inadequate healthcare services. When roads are blocked by high amounts of snow, villagers must travel dangerous distances to receive even basic health or medical care. It is admittedly said that during the winter, childbirth is dangerous for every pregnant woman. Though, it is still a dream for

every woman to access better antenatal care, and it is truly argued that good maternal health care is still a ray of hope in the border villages of Jammu and Kashmir. Maternal mortality rates have become more alarming in Jammu and Kashmir, and women in border and remote areas suffer to a great extent. Pregnancy and childbirth complications are two main reasons why women are vulnerable, and additionally, it is challenging to access maternity health care in these areas. The repercussions occur because of the lack of accessible blood, which is essential during childbirth, yet even a woman can die from it. For every woman living isolated with numerous difficulties and hurdles in border areas of Jammu and Kashmir, improved maternity health is still a hope and a dream (Adiga, 2021).

1.2 Conceptual Framework of the Study



1.2.1 Understanding Political Turmoil and Border Conflict of Jammu and Kashmir

To describe "Turmoil" sociologically, the study demands that we employ the conflict approach. In the present study, the metaphor of "Turmoil" in the title suggests turbulent, social dynamics and rapid processes of change that generate new qualities but whose outcome remains uncertain.

Scholars like Muzaffar, Hedström, and Herder discussed behind the storyline that the bone of contention starts from the disagreeable divide between the two countries, and it is very important to know that Pakistan is subject to rule with the same pursuing competing interests over union territory of Jammu and Kashmir, and the armed war destruction creates barriers to the development of society and tends to disrupt infrastructure with a mainly negative impact on the health services is the major challenge. Adding to notions of feminist perspective, research over the years has demonstrated that conflict affects women's health, adding to the complexity. It is manifest that reproductive unassertiveness contributes to higher stillbirths and maternal mortality during the war and postwar periods and the exclusion of women from decision-making on concerning issues.

1.2.2 Understanding the Health Profile of Women

Scholars like Aantjes, Bloom, Fikree, Pasha, Kapungwe, Hou, Ma, Muzaffar, and Murugan worked on the health status of women stated in the context of underdeveloped and developing countries such as India, the status of women's health has prevailed across the span of centuries. They are facing many serious challenges to their health concerns, so it is imperative to focus primarily on the given key indices: overall health includes physical, emotional, spiritual, and mental health and associated consequences includes reproductive health issues, maternal health problems, and postpartum health concerns.

Scholars like Shuja and Guruswamy (2014) stated in their work that South Asia as a whole has experienced a long period of robust suffering, but still, the region is considered a developing world today. Women's status in South Asian countries is subjugated to being more restricted by the traditions and customs inherited. Apart from the patriarchy and the traditions, political turmoil has another larger impact on women's social well-being. Asia is a region plagued by violence, depression, and human rights violations. There is history and legacies from the past regarding South Asian conflicts, whether they are considered mixed with internal divisions and external influences and the region's conflicts have other patterns and parallels. India and Pakistan are part of South Asian countries; there has been a long history of intolerance (political) and recurrent episodes of civil unrest; and there are significant patterns in India-Pakistan relations and in the conduct of their counter-insurgency operations.

Scholars like Jafree and Bhopal expressed in their work that descriptive analysis of South Asian countries' status of women is an unsatisfactory way to compare other developed countries. Asia is influenced by cultural and traditional pressures, which may be the most important factor in defining a woman's right to adopt healthy behaviors and health awareness. Cultural norms, religious beliefs, familial ties, governmental institutions, and individual preferences all limit, regulate, and direct behavior patterns. In South Asia, the social construction of physical and mental illness for women is still quite damaging. It is challenging for women, especially, to actively invest in health recovery, even when they don't access opportunities. In the border region of Jammu and Kashmir, women share common cultural practices to understand the problems collectively and overcome the improvements in health challenges. They are said to be rigid, conservative, and patriarchal in their treatment. Women's presence in society and family has usually been viewed as a burden to them, and the son preference has been given special significance due to certain social stereotypes, which have firmly stimulated women's emotions and feelings to support and take a standpoint to tolerate the number of children.

1.2.3 Understanding Reproductive Health

Women and child health received a major impetus after the International Conference on Population and Development (ICPD) in Cairo (1994), which recommended that the participant countries implement unified programs for reproductive and child health, as it was considered essential to human welfare and development. All pregnant women are expected to receive doses of the tetanus vaccine to be protected against tetanus. The situation is not much different as for the coverage for iron and folic acid tablets, which form a prophylaxis against nutritionally induced anemia among pregnant women. The higher the birth order of a child, the more adverse the effect it has on the reproductive health of the mother, as it means a repeated number of pregnancies, and it is observed that poor educational status among women is an important reason for their poor reproductive health in the region. Rural areas due to the traditional outlook prevalent in rural societies, where most of the births still take place at home and are assisted by "Dai" (traditional midwives) who are not very skilled and follow traditional practices, some of which are unhygienic (Raj and Raj, 2004).

Kaur (2018) stated in her work that socio-economic, demographic, and cultural factors are closely linked to poor women's reproductive health conditions. Factors like high fertility, illegal pregnancies, and abortions impact reproductive health. But the widespread practice of sex-selected abortions in South Asia, especially in India, highlights how widespread misogyny and patriarchy are in the area. Researchers predict that the ongoing use of selective abortions will result in 6.8 million fewer female births in India by 2030. India has been performing worse than most other countries on a global scale. However, India ranked 112th in the world in 2019 for gender disparities, placing it among the bottom five nations and performing worse (Kumari, 2021). In context of Jammu and Kashmir, women from backward castes (scheduled castes and scheduled tribes) and other backward castes found themselves poverty-stricken, and the outcomes of poor health affected their overall health more than those of women belonging to other general castes (Khanday and Akram, 2016).

Balan (2017) argued that women living in remote areas of Jammu and Kashmir are more exposed to health concerns like reproductive health, maternal health, and mental health issues. In comparison, people living in urban slums reported the same common reproductive issues because of their unhygienic living style and lack of resources. Women mostly prefer home deliveries without any trained practitioner and practice traditional remedies. The majority of the women found issues like miscarriages and stillbirths common across India. However, the early pregnancies and early childbearing are important factors contributing to the maternal mortality rate (Paned et al., 2011). However, several females are not capable of bearing the burden of fertility and childbirth; they are not physically as well as psychologically strong. While discussing menstruation, the menstrual challenges of a vast majority of women are still left out of the larger mapping of the menstrual hygiene management narrative. Menstrual health concerns and associated problems concerning contraception exacerbate the situation. However, the stage of menopause marks the end of a woman's reproductive life, which is arguably the most noticeable phase that occurs in the middle amongst women. Globally, menopause is reported at the ages of forty-five and fifty-five and primarily causes difficulties and symptoms with indications of hot flashes, coughing, and exhaustion. Infections are linked to inadequate sanitation and hygiene; there are reported high gynecological morbidities and reproductive tract

infections, and infections are also more common among urban poor women (Bhatia and Cleland, 1995).

According to the report released by the National Family Health Survey-4, thirty-nine percent (39%) of women have symptoms of reproductive tract infections, and estimations found between the ages of fourteen and forty-nine includes various sensitive infections and syndromes that cause personal embarrassment, vaginal discharge, and itching, as well as physical discomfort, menstrual cycle irregularities, crams and difficulties, excessive bleeding, etc. Women have reproductive issues, with an excessive number of reported cases in the state of Meghalaya (26%), followed by Jammu and Kashmir (23.1%), and then Mizoram (11.2%). Women ranked in the criteria of age between twenty and thirty-five years had higher odds of accessing and seeking treatment. Moreover, they have menstrual cycle-related problems like endometriosis, and leucorrhea increases with time. In rural areas, women and girls between the ages of fifteen and forty-five use cloth pads every month, which reflects poor hygiene and reports various reproductive tract infections (NFHS, 2016).

Muzaffar (2016) stated that the records from the National Family Health Survey-4 indicated data facets about Jammu and Kashmir women's reproductive health conditions and estimated that about thirty-nine percent (39%) have symptoms of reproductive tract infections frequently. In this context, Jammu and Kashmir experiences more complications during childbirth in comparison to other states in India. The border women equally reported the same problem, with seventy-three percent (73%) of women having reproductive issues and approximately fifty-nine (59%) experiencing complications during pregnancy, whereas seventy-four percent (74%) faced complications during delivery and forty-five (45%) experienced post-delivery problems. Compared to the rest of India, Jammu and Kashmir has higher rates of delivery complications. Approximately seventy-three (73%) of living women in border areas reported having problems with their reproductive health. Moreover, the greatest number of pregnancy-related and post-partum complications are reported (NFHS, 2016). According to a report released by the National Family Health Survey-3, delivery complications are significantly higher in the union territory of Jammu and Kashmir. However, prenatal or antenatal care is not much more frequently provided by ASHA (Accredited Social Health Worker) auxiliary nurse midwives in the region (NFHS, 2006).

1.2.4 Understanding Maternal Health

Muzaffar (2016) stated in her work about maternal health of Jammu and Kashmir, defined as a "woman's condition during her pregnancy, childbirth, and the post-partum period". Maternal health disparities are the result of the contextual elements that give rise to social hierarchies or stratifications in society. The contextual factors influence the outcomes of maternal health, which is a social phenomenon. The high rates of fertility in India are linked to, or worsen, many of the health issues that affect the majority of women. A mother's nutritional status deteriorates with multiple pregnancies and closely spaced births, and they also have a lower likelihood of being able to give their infants enough nutrition, food, and attention. Indeed, overall, India's total fertility rate has decreased from 2.4 to 2.1 in the past five years. However, women suffered from widespread malnutrition problems, being anemic and observed with other deficiencies; they actually witness unequal access to essential healthcare services. On the other hand, high maternal death rates are mostly caused by inadequate nutrition and a lack of knowledge about using healthcare facilities, especially during reproductive age. Women's undernourished condition generally results in poor reproductive health, and spending more and more time in the family circle works to procreate the children as well as stabilize the adults. Tribal women suffer from widespread malnutrition problems, being anemic and observed with other deficiencies; they actually witness unequal access to essential healthcare services. Health issues brought on by extreme poverty, a lack of nutritional food and a balanced diet, clean water to drink, insanitary housing condition and an unhygienic lifestyle, harsh living conditions, and an unfriendly environment. Malnutrition affects adolescent girls and women and is caused by deficiencies in vitamins, calcium, minerals, and food calories, as well as more factors connected to women's poor health.

Scholars like Kowsalya and Shanmugam (2017) opined that Indian women's survival is at risk due to severe health problems because of their lower social position, poor educational status, and reproductive biological insufficiency. However, heavy work burdens and demands in the manner of responsibilities exacerbate the nutritional profile and affect women's health, making them more susceptible to illness and ultimately increasing mortality rates. However, South Asia has one of the highest rates of anemia prevalence worldwide, and India is one of the South Asian

countries. “Anemia means iron deficiency in diet, and being undernourished has been prevalent for a long time”. It may play a role in maternal mortality because of its detrimental health effects.

On a global level, iron deficiency is the most prevalent cause of nutritional deficiency, and there is concern about the falling nutritional status, especially the growing anemia among women of all ages. In the fifteen to forty-nine (15–49) year age group, 48.9% were anemic in 2015–16; now 65.9% are anemic, and ultimately, anemia is considered to cause more feeble physical conditions (NFHS, 2020). According to a facets report released by the United Nations in 2021, there were possibly 228,000 more child deaths and 11,000 more maternal deaths in South Asian countries as a result of disruptions in health services brought on by the COVID-19 pandemic (United Nations Report, 2021).

Previous studies revealed that between fifty to ninety percent of all pregnant women in India suffered from iron deficiency. The most determinants of anemia are found among women in the state of Andhra Pradesh. In contrast, the state of Bihar found low birth weight, a high birth rate, and not merely preferred institutional deliveries showed declines, placing it at the bottom of the list. The majority of families give preference to midwife practitioners required for home deliveries with minimum medical facilities; therefore, the risk of complications and death of mothers and their infants might be increased, as well as reported reproductive infections in unhygienic and poor conditions. In India, mainly maternal deaths and infant mortality are interlinked with highly anticipated home deliveries. Compared to urban women, anemia is more prevalent in rural women, especially those who belong to the lower social categories. In developing nations, anemia remains a serious health problem for women who are of reproductive age. It is reported that women who suffer from anemia deficiency have low birth weight, higher rates of neonatal mortality, weak and poor health, decreased levels of productivity and physical activities, mental imbalance, inadequate iron stores for babies, and are prone to morbidity (MOHFW and NITI Ayog, 2019).

However, the proportion of non-pregnant anemic women in the age group of fifteen to forty-nine depicts near about 53.2% being anemic, and above that, over fifty percent (50%) of pregnant women in the same age group are anemic. In comparison to other sections of society, the most marginalized condition of maternal health found in the most vulnerable group, which is

scheduled tribes, is disadvantaged primarily in terms of the possible standards of health. Women living in socio-economically disadvantaged positions who prefer home deliveries with low educational status provide not good enough delivery services and utilization (Zodpey and Negandhi, 2022).

The data facets of the National Family Health Survey-4 revealed that in India's states and union territories, about 22 percent (22%) of deliveries in the country took place at home and found numerous complications. Because the states have diverse socio-cultural backgrounds and a large geographic expansion, it is possible to find variations in maternal mortality rates. In continuation, in the year 2017, there were about 295,000 cases reported as maternal deaths from various complications related to pregnancy and childbirth. In India, maternal mortality is still persistently higher than in many other developing countries. There is a high level of fertility associated with two health concerns: maternal mortality and morbidity, and it highly probably create disparity among women lies in their socio-economic condition and access to healthcare services that mainly contribute to maternal mortality. However, the primary cause of India's high rates of maternal death is poor living and lack of health care system. Besides that, a number of factors, including marriage age, fertility rate, family planning concept, poor spaced birth control, not preferring contraceptives and preventions, and preferring home deliveries, are linked to a higher risk of maternal deaths. On the other hand, in India, hemorrhage has an immense effect, plays a significant role in deteriorating maternal health, and is the leading cause of maternal deaths. (NFHS, 2016).

Nour (2008) opined in his work that the highest maternal mortality rates on a global level are found in Africa, and Nigeria has observed prominent number of maternal deaths. Maternal mortality is the most extreme consequence and outcome of poor maternal health. However, in the state of Bihar, Jharkhand, and West Bengal have the highest rates of maternal complications (Subba, 2013).

Muzaffar (2016) stated and classified as a result of any cause related to or made worse by the pregnancy or its management, but not accidental or incidental causes. However, with significant intra-state and inter-state disparities, India accounted for nearly one-fifth ($1/5^{th}$) of all maternal deaths worldwide in 2015. The rate of maternal death is comparatively high in northern states

like Rajasthan, Uttar Pradesh, and Assam. Maternal complications, however, are higher in all eastern states where they are in the country.

The National Family Health Survey-4 facets revealed the mortality rate and several health problems that affect the majority of women, which further exacerbate their poor health. Women who are found to be underweight and have stunting and wasting are more likely to give birth to undernourished babies. The current wide disparities among women's socio-economic status may be caused by early marriage and childbirth. It has been proposed that India's traditional customs and dominant culture are to blame for the declining nutritional and health conditions of Indian women. In actual fact poor nutrition can often affect women's health on a large scale, particularly during pregnancy and lactating time period (NFHS, 2016).

According to the National Family Health Survey 3, research indicated that in India, about 59.5 percent (59.5%) of women experience complications during pregnancy, whereas 74.4 percent (74.4%) experience delivery complications, and on the other side, 45.5 percent (45.5%) experience post-delivery complications, and on the other side, delivery complications in Jammu and Kashmir in comparison with the rest of India's other states. The data facets sheet also indicates there are several sources of antenatal care services for those who received services, around 77.2 percent (77.2%), of which 6.2 percent (6.2%) are from ANM (Auxiliary Nurse and Midwife), nurses, 1.1 percent (1.1%) from "Dai," (locally named for any professional and experienced lady), and 14.7 percent (14.7%) from no one. However, in Jammu and Kashmir, women with higher levels of education and with financial support tend to receive more prenatal care and preventative healthcare than illiterate women. The majority of women in rural areas are found to be less likely to prefer institutional delivery, which produced poorer outcomes. Nonetheless, maternal health is also related to residence, there are differences between rural and urban areas, and more than two-fifths (45.0%) of the women residing in the union territory of Jammu and Kashmir experienced post-partum complications after childbirth (NFHS, 2006).

1.2.5 Understanding Social Factors and Associated Determinants

Scholars like Jafree and Bhopal opined that descriptive analysis of South Asian countries' health status of women is an unsatisfactory way to compare other developed countries. Asia is

influenced by cultural and traditional pressures, which may be the most important factor in defining a woman's right to adopt healthy behaviors and health awareness. However, in the border areas of Jammu and Kashmir the social construction of physical and psychological illness for women is quite different. It is challenging for women, especially, to actively invest in health recovery, even when they do not access opportunities. As earlier it has been explained health determined by various factors, like biological, environmental, socio-economic, cultural, and other factors. The following moderating social determinants are responsible for women's health issues:

- Political Turmoil
- Poverty
- Illiteracy
- Health Infrastructure
- Education and
- Cultural Practices

Ritzer (1996), in his work, discussed that all spheres of human activity involve conflict, starting with the intrapersonal. Scholars such as Karl Marx, Friedrich Engels, and Saint-Simon have highlighted the role of conflict in the social lives of humans. Marx cites the phrase "the history of hitherto existing human society is nothing but the history of class struggle". The majority of authors who talk about the conflict and turmoil situation in the border areas of Jammu and Kashmir seem to agree that structural imbalances, ambiguity in social structure coordination, competition for limited resources, and differences in goals, value systems, and interests are some of the causes of conflict. Women's health issues are seen as an unresolved phenomenon; they cannot continue to live in a blissful environment, whereas ongoing poverty and hope can be addressed later on through welfare programs and schemes. Poverty triggers for the majority and the primary cause of their poor health is that women make up a disproportionate amount of those living in poverty, and their unfavorable general health situation is made worse by women's comparatively lower social status and the risks involved in reproduction (Hassan and Shafi, 2013).

Except in a few states, women in rural areas have lower social status, are more likely than men to become ill, and are less likely to seek medical attention and care before the illness is severely advanced because the women fall into the poorer segments of the population. Maternal mortality and morbidity, as well as the risks associated with childbearing, are increased because of poverty. In developing countries, it has been noticed that around ninety-nine (99%) of maternal deaths take place, with ninety-five (95%) deaths occurring in Africa and Asia alone. However, in the year 2015, two-thirds of maternal deaths happened in the world's poorest nations, with one in six of those deaths occurring in India alone (Tinker, 2000).

According to the 2011 census, in India, about 82.14 percent of males and 65.46% of females are literate, and the proportion of literate females is lower than average in several northern states. The health of mothers and children is strongly correlated with maternal education. During this period, illiterate mothers were more likely to experience negative outcomes than literate mothers because they had more children, had less knowledge about contraception, had fewer prenatal visits, and were not aware of a good nutritional diet and hygiene. An important factor in improving the health of children is maternal literacy and age identified as significant confounders for child development. Despite the notable advancements in female literacy since independence and widespread recognition of the advantages of educating females, women in the border areas of Jammu and Kashmir continue to face significant disadvantages in the field of education. Women's lower educational attainment has effects on their health, and increasing female education is essential to improving their health because there is a strong correlation between improvements in health conditions and the level of education (Imam et al., 2017).

Shuja and Guruswamy (2014) stated that in developing countries like India, the status of women and the health status of women are exposed by the lack of infrastructure and inaccessibility to health services. South Asia as a whole has experienced a long period of robust suffering, but the border region of Jammu and Kashmir is still considered a developing world because of a lack of medical facilities and a healthcare system that is not well developed. Women's status in South Asian countries is subjugated to be more restricted by the traditions and customs inherited. Apart from the patriarchy and the traditions, political turmoil has another larger impact on women's social well-being. However, the main cause for teenage girls getting married at a young age are unaware of the negative effects of early marriages, have positive attitudes toward them, and are

unaware of the social consequences of getting married young. These factors have an impact on their physical and mental health, as well as the social consequences of getting married young, like having less access to education and less control over their reproductive health and rights. Early marriage practices violate the right of a girl child to an education (Herliana, 2018). According to the National Family Health Survey-5 Report, about thirty-eight percent (38%) of Indian women aged twenty to forty-nine married before the right age of marriage (NFHS, 2021).

1.3 Research Gap

Scholars like Akram, Bodha, Bendavid, Khan, Khanday, Kaur, Kowsalya, Kumari Maqbool, Muzaffar, Pathak, Shanmugam, and Sheikh worked thoroughly on women's health issues, but their work is not confined to the lived experiences of border women and the impact of turmoil on their health. In the union territory of Jammu and Kashmir, very limited research has been conducted on women and women's health, but no research has been found specifically in the context of border areas.

There is a substantial gap and research gap in the existing literature and the results of reproductive and maternal health that are regulated by the social factors observed in border areas that are situated near the Line of Control (LOC) are not well documented in the literature. Research on the current and ongoing conflict between India and Pakistan to address the challenges among the living community has been lacking, despite announcements from humanitarian crisis relief organizations like the World Health Organization (WHO) about the importance of providing high-quality healthcare in social settings. This research is an attempt to explore and contribute to women's health in the border regions of Jammu and Kashmir. However, there is a gap in the methodology part found in previous studies, although gap is also found in the conceptual and theoretical framework, especially in conflict zones.

1.4 Statement of the Problem

The conflict between India and Pakistan has caused immense unrest and created disturbance in the territory of Jammu and Kashmir, particularly in the border regions. The political turmoil is more complicated, and because the field of study is sensitive, it is challenging to get a

comprehensive understanding of the issues and challenges that women actually faced. The border areas of Jammu and Kashmir have been a conflict-prone region, which has had an impact on people's lives, specifically women. Stories telling the difference between the women in these areas are subject to nearly every health-related metric, and their marginalization is likely to worsen according to analysis of several parameters related to their health. Literature reviewed the subjugation of women in these areas, subject to nearly health-related issues; however, they are living in distress conditions. Women's health issues are also being made worse by the chaos brought on by the unrest as well as the denial of access to healthcare. Though women residing in these regions cannot fully exercise their rights, the prolonged turmoil in the region affects women's health in general, and in particular, the state of reproductive and maternal health concerns. Women continue to have a low status and are discriminated against, and they are in peril of existing in the border villages; their social mobility and social interactions are restricted as a result of the turmoil in the region. However, the unsettled war between India and Pakistan has caused vast political and social unrest and women suffered from the proctored war situation on all levels, socially, economically, psychologically, and emotionally (Neogi, 2022).

1.5 Significance of the Study

The present study has the potential to open a wider debate and discuss it with the academic world and policymakers to understand women's health-related issues and shared lived experiences in the conflict zone. This study would comprehend research on the concept of women's health issues in conflict regions and the impact of turmoil. The present study also has the importance of elaborating on the contextual factors responsible for various challenges and dimensions, how they have dynamically (with dynamism) and interchangeably (mutually or vice versa) evolved, their repercussions on the lives of females (in a narrow sense), and the impact of the turmoil in the region (in a larger sense). The importance of the research internationally could be on the empirical model that is going to be developed out of the findings of the study, and those factors and challenges that have been hindering women's health in general and specific could be described. The present study has a significant role to play in contributing to the sociology of health, with new aspects that are included in the study. The present study aims to bridge the difference and division by examining, with analytical rigor, a social phenomenon that will pass into the next era.

1.6 Relevance of the Study

In the literature of social sciences, there is a severe dearth of studies on the topic owing to certain reasons, like the fact that the region has been a conflict zone since independence, as both countries like India and Pakistan have their claims over the territory of Jammu and Kashmir, and to maintain their claims, they have numerous times gone for direct and indirect wars. Hence, in this perpetual turmoil, researchers rarely prefer to study health issues in general and women's health problems in particular. It is needed to bring out the health issues of women who are residing in this conflict zone. The contribution of the present study to women's health has been two fold. Firstly, the study is relevant academically because health is the most important aspect of human life. The present study will contribute to a comprehensive understanding of women's health issues and the underlying social factors associated with reproductive and maternal health. Secondly, the study will also provide an in-depth understanding of the various challenges and collective opinions and thoughts as a strategy for analyzing the lived experiences of women's contextualized health issues.

1.7 Rationale of the Study

In the conflict region, women's health concerns and issues are still unexplored. The border areas of Jammu and Kashmir are demarcated as darkness, and nobody prefers to go inside the area. The unsettled ongoing turmoil situation has devastating effects on residing (local) people. Specifically, the women's health concerns exerted and influenced by conflict are still unfamiliar. After the partition, Pakistan gained considerable experience launching covert operations in the Kashmir valley and adjoining border regions. The occurrence of daily incidents of warfare conditions constantly loaded with troubles and worries gave rise to health emergencies, the most disfigured and unfinished affair linked to women's recognition. Therefore, the present study aims to describe women's lived experiences in a sociological manner and ways to explain social challenges and the impact of Turmoil on women's health with existing discourse and consequences.

1.8 Scope of the Study

In the contemporary academic world, the study of Intersectionality between Turmoil, Women and Health, unravels many issues that need to be debated and discussed from a proper sociological perspective. The present study is an inherently sociologically illustrative contribution to sociological alternatives and perspectives. Research in the field is based on analyzing health-related situations that inform sociology as well, and it is now possible to say that "Health Sociology" yields literature aimed at instructing lawmakers and medical professionals. Increasing interdisciplinary research has the potential to yield novel insights within the social sciences and other health and medical sciences. The sociology of health is likely to go in the direction of greater theoretical infusion in the future, as seen in the creation of a theoretical framework that illustrates the relationship between social inequalities linked to women's health. The popularity of using a variety of research philosophies and methods to study health phenomena is growing, and this trend is probably going to continue. The present study can be employed as "testimony" about the shared experiences and thoughts of the respondents and also bring the concerned issues into the limelight. However, after the abrogation of Article 370, this study will be considered the new study in the era of Jammu and Kashmir as confirmed union territory.

1.9 Research Questions

Why are women in border areas suffering silently?

What are the factors responsible for antenatal care challenges for women in border villages in Jammu and Kashmir?

How is border turmoil accountable for maternal health issues for women in the border villages of Jammu and Kashmir?

1.10 Objectives

In empirical research, the nature of the problem itself leads to the formulation of objectives. The practical utility of research activity is enhanced manifolds if the objectives of the study are identified. The objectives of the present study are as follows:

1. To identify the challenges and health issues faced by the women in the border areas of Jammu and Kashmir.

2. To describe the pregnancy care and delivery complications in the border areas of Jammu and Kashmir.

3. To analyze the impact of turmoil on the maternal health status of women in the border areas of Jammu and Kashmir.

1.11 Inclusion Criteria

The following participants meet the inclusion criteria for the present study:

- The respondents ought to be residents of border villages.
- The respondents should be married.
- The respondents with backgrounds in conflict-zone areas have encountered a range of problems and difficulties.
- The respondent's age group should be confirmed up to nineteen to forty years of age.

1.12 Exclusion Criteria

Exclusion criteria individuals who do not meet the below criteria are not allowed in this study.

- Women who are unmarried.
- Women who are widows.
- Women who are not the residents of border villages.

- Women aged below eighteen and above forty-one years.

1.13 Universe of the Study

The present study universe draws the districts located near the border of Pakistan and selects both districts, Baramulla and Poonch, of Jammu and Kashmir. The Baramulla district is situated on the bank of the river Jhelum, and its geographical peculiarity lies in the fact that it includes both sub-temperate and sub-tropical regions under its purview. Its coordinates are latitude 34.2 and longitude 74.3, and the region experiences extremely low temperatures and snowfall in the winter. The Poonch district is located near the line of actual control (LAC) of the de facto border with "Pakistan" and situated on the bank of the river Poonch. The elevation lies at 1,021 m, and the region experienced a humid subtropical climate, cold winters, and snowfall. However, most of the area is cut off, mountainous, and inaccessible, with very meager infrastructural facilities. Due to the disadvantages caused by geographical conditions, existence on the line of control, such as continuous border crossing, firing, and shelling across the border, people are economically marginalized.

1.14 Operational Definitions

Health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

Maternal Health: "Maternal health is defined as the duration of pregnancy up to the post-partum epoch" (WHO, 2019).

Reproductive Health: "Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when, and how often to do so" (WHO, 2018).

Turmoil: According to Cambridge Dictionary "a state of extreme confusion, turbulence, uncertainty, and disorder".

1.15 Structure of the Thesis

The thesis has been divided into five chapters. To provide a background on the study discussed in Chapter one. The chapter two comprised of comprehensively and extensively reviewed literature, the review provides the theoretical foundation upon which the research is based. Chapter three discusses the methodological framework adopted in the present study. The results of the study are discussed in Chapter four. It concludes by synthesizing the findings of the research and discussing their implications. The last chapter five explains the conclusion of the thesis.

CHAPTER-2

Review of Literature and Theoretical Explanations

This chapter explains the literature part of the thesis, divided into seven sections. The first section is enfolded with understanding conflict from a sociological perspective; section two deals with sociologically understanding India and Pakistan conflict; section three provides an understanding of turmoil; section four confers understanding health sociologically and health from a sociological perspective; section five deals with understanding women's health; section six discusses the women's health status in India; section seven discloses about the women's health status in Jammu and Kashmir; section eight reveals about the impact of turmoil on women's health in border areas of Jammu and Kashmir and section nine elucidate the summary of the chapter. However, in the present chapter the conflict perspective used to define the concept "Turmoil" in the region whereas feminist perspective used to describe the women health issues sociologically. The other perspectives used only for making theoretically understanding with respect to understanding the women issues on broader context. Because to understand the variations and challenges of women health issues it is requirement to employ the feminist perspective in broader text. How the different feminist perspectives explained the women health issues context, that's why not used any single perspective.

2.0 Understanding Conflict from a Sociological Perspective

According to sociological literature, understanding conflict is social. Scholars like Karl Marx, Lewis Coser, Ralph Dahrendorf, and Randall Collins contribute to the conflict perspective. Conflict theory, with its roots in the work of Karl Marx, is based on the assumption that society is composed of various groups struggling for advantages, that inequality is a basic feature of social life, and that conflict is the major cause of social change. Marx's perspective in conflict theory is seen in the rejection of the view expressed by structural functionalism that society is held together by shared norms and values. Weber adds, however, that social inequality is not

based on just money, property, and relationships to the means of production but also on status and political influence. Since all social systems contain such inequality, conflict inevitably results, and conflict, in turn, is responsible for social change. The conflict approach emphasizes social inequality in the quality of health and healthcare delivery. People from disadvantaged backgrounds are more likely to become ill and to receive inadequate healthcare. Partly to increase their income, physicians have tried to control the practice of medicine and to define social problems as medical problems. From a conflict perspective, Marxian theory offers a radical alternative to functionalism. Marxian theory begins with the simple observation that, to survive, man must produce food and material objects. In doing so, he must enter into social relationship with another person (Pandey, 2016).

Scholars like Oyekola and Oyeyipo (2020) stated that the conflict theory of social stratification, as an alternative explanation, posits that stratification exists not because it benefits to all individual members of society but it benefits some individuals and groups who have the privilege and power to dominate, oppress, and exploit others. Conflict theory rests heavily on the ideas of Karl Marx, especially his historical "Economic Determinism Theory". The central concern of conflict theory is the unequal distribution of scarce resources and power. Conflict theorists generally see power as the central feature of society. The conflict perspective has eminence focused on inequality in the quality of health, and it mainly emphasizes that society's disparities concerning social class, race, gender, and ethnicity are reproduced in our health. People who belong to disadvantaged sections are more inclined towards disease and illness because of a lack of resources; they access inadequate health care, which makes them more vulnerable. Health inequalities are an indication of the differences in life chances that exist and the conflict perspective focuses mainly on social inequalities that create social problems in contemporary society. Uneven distribution within society creates chaos and conflict among people. Elites who have more wealth can access resources that are largely part of society, and they control and gain dominance over resources and power. On the other hand, poor and marginalized sections of society, including women, are subjected to worsening conditions. Health issues are closely linked to the unhealthy and stressful environment that has been reported in border-prone areas of Jammu and Kashmir (Barkan and Trevino, 2018).

Allan (2006) highlights the opinion of Lewis Coser that conflict is instinctual for us, so we find it everywhere in human society. There is the conflict of war, but there is also the conflict that we find in our daily lives and relationships. He argued for two kinds of functional consequences of conflict*:* (a) conflict that occurs within a group and (b) conflict that occurs outside the group. An example of internal conflict is the tension that can exist between indigenous populations and the national government. Internal conflict is between or among groups that function within the same social system. External group conflicts are the wars in which a nation may involve itself. When explaining the consequences of external conflict, it is more violent conflict. However, the notions of external group conflicts are observed in the union territory of Jammu and Kashmir, in which both nations, India and Pakistan, have evolved and natives are suffering from the volatile situation. Dahrendorf also uses Marx's notion of political interests stemming from polarized social positions and he claims that power is the one unavoidable feature of all social relations. Like Coser, Dahrendorf sees conflict as universally present in all human relations and he argues that it is power that both defines and enforces the guiding principles of society. However, his concern is primarily with explaining class conflict within a society.

2.1 Sociologically Understanding India and Pakistan Conflict

2.1.1 Explanation before Partition

The advent and establishment of British rule were accompanied by radical changes in the political and economic structure of the country as well as intellectual life. Britain's colonial disengagement policy exacerbated the ideological differences between the Congress and the Muslim League. In the early nineteenth century, the introduction of Western ideas and English education created discontent among Muslims while Hindus eagerly accepted Western ideas, Muslims rejected English education (Harrison et al., 1999). Initially, the British adopted the divide and rule policy so that Hindus and Muslims would realize how futile it was for them to try and obtain nationhood. They wanted to demonstrate that the two sides could only live together under British rule. Yet, differences between the two sides became irreconcilable, and instead of sorting out the mess, the British handed over control hastily when the Congress of the Muslim League reached a political stalemate beyond British control (Jaffrelot and Christophe, 2002).

The issue of Kashmir is also a bone of contention. At the time of independence, there were more than a hundred princely states in undivided India, while Pakistan constituted all the provinces with a Muslim majority. The princely states had their own choice to accede to either side but princely state of Kashmir had a Hindu prince (Raja) who belonged to the Dogra tribe. The Raja decided to accede to India and did not properly consider the views of the masses, which were predominantly Muslims. Pakistan insisted that all Muslim-majority areas should be handed over to the new Muslim state. However, India was intent on demonstrating that all minorities could flourish under a secular government (Singhal and Damodar, 1972). Both nations indeed have nuclear power, in a more subtle sense and they have destabilized unfriendly relations since the partition. They do not want to confirm closely to their political dictates, and the contemporary situation is relatively unclear. Both nations want to exercise their control over the territorially demarcated area of Kashmir (Mann, 1992).

The 1948 border skirmishes discussed had the result that one-third of Kashmir went to Pakistan; while India maintained control over two-thirds of the region. However, both India and Pakistan are involved in border tensions from both sides. There are various aspects of identity; citizenship, nationality is one of them; political values and traditions; culture, history; social conditions; profession; religion; economic conditions; race; ethnicity; and friends-enemies are all different aspects of identity. Indians and Pakistanis share many of these aspects existing together for centuries, both Hindus and Muslims exchanged their traditions, and the Muslims who migrated to Pakistan carried these traditions over to the new country. However, they had been able to co-exist for a thousand years. The main reason was that they did not feel threatened by each other and they were able to maintain their religious identity as Hindus and Muslims practiced their religion freely, and at the same time, they were able to maintain their joint Indian identity. Yet, with the British policy of divide and rule, the differences between them were highlighted to the extent that they became a burden. This gulf was intensified by British colonial policy and created a fear of “Hindu domination” that resulted in the creation of Pakistan, a predominantly Muslim country (Hasan, 2023).

2.1.2 Explanation after Partition

After Independence from British rule, both India and Pakistan came into existence as two separate nation-states. They have a history of seventy-five years of existence as separate countries as compared to about a thousand years of joint existence before the British. However, their common identity revolves around aspects of shared history, geography, culture, values, and traditions and at the time of partition, only one of the identities was considered, i.e., the religious identity of the people. Over the years, common identity has often been suppressed and buried by the pressure of the conflict of identity between India and Pakistan. One expression of the conflict between India and Pakistan is the issue of Kashmir, which is an open conflict similar to the Israel-Palestine conflict and has been used for more than half a century. If we look at the tremendous upheaval that was created in society upon separation in 1947, it is hardly surprising that there were feelings of bitterness and mistrust on both sides. During partition, new boundaries were drawn up without consideration for local interests and loyalties, villages, clans, and families were split up instantaneously. In fact, irrigated land was cut away from the source of water and both countries faced an explosion of communal violence (Hasan, 2023).

2.3 Understanding Turmoil from a Sociological Perspective

Not many polished publications, especially in the scholarly discourse, have explored or analyzed the concept of turmoil in the border regions of Jammu and Kashmir. Most authors of those that do exist have considered the history of the conflict and mainly emphasize and highlight the concept of conflict, for instance: T. V. Paul (2005), S.N. Kaul (2005), Basharat Peer (2010), B.A. Dabla (2014), Daya Sagar (2014), Seema Shekhawat (2014), A.G. Noorani (2015), Avineet Prashar and Paawan Vivek (2015), Saifuddin Soz (2018), Radha Kumar (2018), Jagmohan (2019), Happymon Jacob (2018), Sumantra Bose (2021), Victoria Schofield (2021).

To describe the “Turmoil” social conflict theory employed as a theoretical framework for analyzing the conflict. Social conflict theories provide a useful analytical tool for understanding the turmoil in the region. Social conflict theories emphasize the role of conflict as an integral factor in shaping social conditions and the dynamics of social life. To elucidate the chosen theories, which ranged from traditional theories of conflict to the sociology of conflict by Karl Marx and Randall Collins as well as theories from authors who have contributed to the literature? There is no analysis based specifically on the conflict approach discussed about the

conflict between India and Pakistan. The present study employed the central idea of conflict theory found in the writings of debate as the source of Turmoil. The conflict theory takes the principle of "Dialectic as central to social life (Musielak, 2016).

Karl Marx owes Hegel the philosophy of "Dialectical Materialism," since the latter's notion of dialectic provides the foundation for Marx's theory (Popper, 1940). These principles, the laws of opposition, negotiation, and transition, explain how things oppose and contradict one another, as well as how transformation results from these oppositions and negotiations. However, these dialogues hold for both concrete and abstract realities. Marx disagrees with Hegel's thought about the statement that consciousness determines life, which favors abstract reality over the material world. It is undoubtedly stated that the individuals in a society collectively have conflicting interests; this conflict results from the regulation of mutual appropriation through exchange (Russell, 1946).

Hussain (2019) used "Dialectical Materialism" to describe the two different and opposite ideologies, and their emotional attachment among the people. In the present study, the concept of "Dialectical Materialism" is employed to describe the two nations having different ideologies, strong emotional detachment between the two opposite nations, and a profound sense of belonging among the people of the same identity. With two different ideologies, the British considered this to be the simplest route. Nevertheless, we must acknowledge and understand that Islam and Hinduism are two distinct ideologies with separate practices and beliefs. Mohammad Ali Jinnah, the founder of Pakistan, affirmed in his writings that Muslims and Hindus have different philosophies, traditions, social customs, and literature. They are members of two distinct civilizations that are founded on opposing ideologies and conceptions; they do not cohabitate or marry each other. The statement reflects the nature of conflicting ideas.

Scholar like Hasan (2023) opined that communal violence continued and a sense of separateness persists in India to this day. But we also have to acknowledge that Islam and Hinduism are two different religions with different thoughts and ideologies. The founding father of Pakistan, Jinnah, penned this:

"The Hindus and the Muslims belong to two different philosophies, social customs, and literature. They neither intermarry nor inter dine together and indeed, they belong to two different civilizations which are based on conflicting ideas and conceptions"

According to conflict theory, every pattern of action, belief, and interaction tends to generate an opposing reaction. Conflict in thoughts or ideologies between both nations, despite having the same identity and culture, creates conflict. India, with a secular ideology, is a democratic country and wants to resist Jammu and Kashmir; on the other side, Pakistan is not a democratic country and wants to take over the territory of Kashmir. Both nations represent separate ideologies and separate ideas; India is democratic, whereas Pakistan is autocratic. The present study highlights the border areas of Jammu and Kashmir between two nations, India and Pakistan. Hence, in the border areas, turmoil is the product of conflict; it is external to the local inhabitants. In this study, looking for conflict between India and Pakistan and their identities as two independent nations, the present study considers India and Pakistan as two separate identities, though they have similarities and differences. However, the border regions of Jammu and Kashmir are continuing in Turmoil because of the India-Pakistan conflict.

2.4 Origin of Sociology of Health

Bernhard Stern, who wrote extensively on historical accounts of the place of medicine in society from the late 1920s to the early 1940s, was considered the first sociologist to publish widely on health-related topics. Theoretical advancement concerning the sociological comprehension of the use, control, and phenomenological experience of the human body includes emotions and feelings. Social constructivism serves as the theoretical basis for a large portion of this work, which has been conducted primarily in Great Britain. The French social theorist Michel Foucault has been credited with inspiring one branch of social constructivism, which holds that knowledge about the body, health, and illness is subject to interpretation and change and reflects subjective, historically particular human concerns. Health sociology flourished from the 1970s to the 1980s when it attracted a large number of practitioners, academicians, researchers, and applied settings and supported a massive publication explosion of empirical research-based works. Investigators focused on many important topics, including stress, mental health, inequality and class differences in health, use of health care, managed care, and other organizational changes, AIDS

(acquired immunodeficiency syndrome), and health, gender, and women. In Britain the reputed Journal" Sociology of Health and Illness" was announced in 1978 and "Health" followed in 1999. A health sociology review was first published in 1991 by the Australian Sociological Association. Additionally, several books and textbooks appeared, and the leading textbook was William Cockerham's "*Medical Sociology,"* first published in 1978 and appeared in the 12th edition in 2012 (Cockerham, 2007).

2.4.1 Understanding Health from Sociological Perspectives

A theoretical framework is essential to the continuous development of knowledge since it directs research, establishes variables, data analysis, and so on. The Conflict and Feminist Perspectives Framework, a theoretical framework appropriate for analyzing the health concerns of women in Jammu and Kashmir, is described in the present study. The social implications of attitudes toward illness, disease, disorder, disability, and aging are at the center of the sociological approach to health. The sociological approach places a unique emphasis on how various processes impact our mental and social well-being. Life events, social settings, social roles and structures, and cultural systems are some of these various processes. Numerous sociologists and researchers, whose opinions are reflected in the existing literature, have attempted to investigate how social conditions contribute to the health status of women. The sociologically defined meaning "Health is not a biological or physical condition; it is influenced by social determinants and factors such as socio-economic, political, cultural, and environmental conditions" (Warren and Hernandez 2007).

Examining the complex relationships between societal structures, cultural norms and health beliefs, results is the focus of a sociological approach to health and illness. It examines how and why these relationships develop, as well as their evolution. The "sociology of health" had given rise to a greater understanding of health and illness, with the increased complicated functions of social factors, structures, individual, complex roles, and societal health and well-being. The sociological fields of "sociology of health and illness, health care or medicine, and health policy" are all included in the field of medical sociology, which is also known as the sociology of health and illness. The social aspects and determinants of health causes and consequences, as well as context, are the main focus of the sociology of health and illness (Daniel, 2013).

Health sociologists and other academicians became increasingly interested in health inequalities in the 1960s. Many thought that by granting more equitable access to health care, health outcome disparities could be addressed and explained because widespread health inequalities persisted even after the introduction of the welfare state, which guaranteed more equitable access to healthcare. This was made evident for the first time in the United Kingdom with the commission of the Black Report in 1977, and its official publication was in 1980. It was discovered in the outline report and demonstrates that economic inequality was the primary cause of these disparities. It was believed that people in poverty, which was devoid of basic amenities, comfortable houses, and lifestyles, were more likely to experience infectious disease risks and other health problems. Even though the theory that deals with socio-economic disparities are defined major cause of health disparities has gradually gained interest as a topic of discussion, much research is still being done on the mechanisms through which disparities actually enter human life (Marmot and Theorell, 1988).

2.4.1.1 Functionalist Perspective

The pivotal moment in the history of health sociology occurred in 1951, giving a previously practical field a theoretical orientation. Talcott Parson's theory "The Social System" first appeared in this form, and this book included Parson's theory and concept of the sick role and was written to explain a sophisticated structural-functionalist model of society. Parson's sick role formulation consists of four basic propositions that define the normative pattern of physician utilization by the sick and their corresponding social roles clearly and concisely. In terms of health and sickness, the functionalist perspective has made a great contribution to Talcott Parson's concept of the "sick role". He argued that to analyze sickness as a social role, it is not merely a biological entity and physical experience. For any society in the world, if it wants to function smoothly, there should be a need to cure sickness in such a way that every person lives a normal life and maintains their social relationships. Sickness within itself means withdrawing from normal life patterns; it may lead to deviance. Medicine plays an important role in curing disease and regulating social behavior. Sick people are legitimately exempted from the responsibilities associated with their relatives; he believed that good health and proper medical care are prerequisites for the well-being of society. Due to illness and improper health, society will not perform its function, and solidarity is hindered. Parsons emphasized the importance of

individual health for society to function properly. Furthermore, after Parson, the other notable sociologists of the era published contributions in medical sociology that strengthened the discipline's scholarly standing, especially among academic sociologists. These authors included Robert King Merton, Erving Goffman, and Levi Strauss. Medical sociology developed and became a recognized field of study in sociology between 1970 and 2000. Bryan Turner's book "Body and Society" (1984), which started the sociological investigation on the subject, was another important work. Parson's increased prominence as one of the most well-known sociologists in the world and his importance as a theorist led to the first significant theory in health or medical sociology, which attracted attention from academic sociologists in particular (Turner, 1984).

2.4.1.2 The conflict Perspective

Conflict theory greatly lessened the influence of structural-functionalism by combining the ideas of Karl Marx and Max Weber with reference to symbolic interaction. Based on the ideas that inequality is a fundamental aspect of social life, conflict is the primary driver of social change, and society is made up of diverse groups struggling for advantages in such a manner, conflict theory was developed. However, Weber also notes that status and political power play an important role in creating social inequality, in addition to money, property, and ties to the means of production. However, inequalities exist in all social systems, and conflict inevitably arises, even though conflict derives social change. The conflict approach places a remarkable emphasis on disparities in healthcare delivery and equality, and the quality of health and healthcare is characterized by social inequality. Those who come from underprivileged backgrounds are more likely to get sick and receive inadequate medical care, with the obvious conclusion that in order for humans to survive, they must produce food and material goods, and for this purpose, they interact socially with someone else in order to accomplish this. McKinlay (1984) and Waitzkin (1993) described the role of conflicting interests in health care delivery and policy as a major area of study for conflict theory in health sociology. Other areas of research include working-class health, capitalist ideologies in the physician-patient relationship, and the causes of illness and disability in the work environment (Pandey, 2016).

2.5 Understanding Women's Health from a Sociological Perspective

Scholars like Peters, Woodward, Jha, Kennedy, & Norton (2016) discussed women's health issues, which are a major concern in every society. On the global level, enhancing women's reproductive and maternal health has been a major focus of attention on the international level and steps towards initiatives to improve their health. Long-term dedication and efforts are required as long as the women's health agenda is unfinished. In support, the global strategy of the World Health Organization (WHO) has underlined the need to adopt a life-course approach to women's health and to shift the focus of the women's health agenda away from reproductive health concerns and take into consideration their health problems. The United Nations confirmed that the Sustainable Development Goals (SDGs) formed a blueprint agreed to by all the world's countries and major development institutions to improve international development and meet the needs of the poorest. Sustainable Development Goal No. 3 sets targets for 'ensuring healthy lives and promoting well-being, and Goal No. 5 targets for 'achieving gender equality and empowering all women and girls' by 2030.

White (1992), in the book "Sociology of Health and Illness," a very famous contribution to the field of health sociology, argued the assumption that unifying sociological accounts of sickness and disease is a rejection of behaviorism, the claim that we passively respond to environmental factors, as a model for human action. Health and disease are cultural products and individuals as social agents react to, transform, and are shaped by the experiences of health and disease. There is no one-way determination, from nature and biology through the individual and society. Rather, for sociologists, it is the structures of society that shape who will get sick, how they experience their condition, how they will be diagnosed and treated, and how they will recover. What looks like 'natural behavior' is, in fact, the product of social interaction?

2.5.1 Feminists Perspective

Khanyan, Krawczyk, and Wilamowski (2021) stated that since the inception of life, there has been considerable differentiation between genders. Gender is a social construction and an ascribed status, and it is very important to understand how the differences shaped by cultural factors contribute to inequalities. The feminist perspective not only examines the relationship

between gender, sex, and health but also explores the distribution of power in public health processes. Public health plays a vital role in protecting and promoting the health of the population. Some of the major concerns of public health are directed toward re-addressing the effects of poverty, domination, oppression, and discrimination on women. Why are women categorized as disadvantaged? The feminist political economy of health emerged as a term that connected a lens with a focus on health disparities among women. The analysis signifies that women have experienced health disparities because of women's social, economic, cultural, and political conditions. The feminist's political economy of health infers that material and cultural discrimination are traced as primary factors that determine the social conditions and health of women. Feminists have tried to understand the differences between sexes (biological construction) and gender (social construction) and need to explore the concept of "Intersectionality" of sex, gender, sexuality, race, and class as it shapes our experiences.

Globally, the women's health movement began in the 1950s at the United Nations. The onset of the second wave movement of American women in the late 1950s and early 1970s furthered reproductive rights, abortion, and in general women's health care. However, the advent of the women's health movement has raised many issues and made a lot of changes. The main motive and demand are for individual choice and women's health issues like reproductive rights, which shifted the focus toward women's maternal health. However, the rapid increase in intersections between the environment and political crises across the world has a direct impact on local contexts. The first wave of feminism emphasized women's emancipation and equality emerged in the nineteenth and early twentieth century as a feminist movement. Their focus was struggling for women's rights to vote and participate. Mary Wollstonecraft is considered the mother of first-wave feminism. She stated that women could be equal to men in every aspect if they were provided the same education and opportunities as men. "One World Women's Movement" is considered a very constructive survey and is critical of international debates amongst academic feminists regarding global patriarchy, race, and gender. Thus, the first wave of feminism is concerned with the inequalities, political interests, and self-determination of women. The second wave of feminists originated in the mid-twentieth century from the writings of the British feminist Juliet Mitchell, with an ideology of radicalism based on economic and social conditions. In the 1960s and 1990s, many feminists were particularly connected with social movements

against the existing division of roles between men and women. Early radical feminism, arising within the second-wave in the 1960s, typically viewed patriarchy as a historical phenomenon. The leading figures of this second wave of feminism included Shulamith Firestone, Ti-Grace Atkinson, Carol Hanisch, Roxanne Dunbar, Naomi Weisstein, and Judith Brown. In the manner of radical feminists such as Shulamith Firestone, Germaine Greer, and Julie Bindel, their writings reflect the idea that patriarchy is responsible for the marginalization of women and is linked to low-status women. Due to the patriarchal structure, women bear discrimination within their private sphere, and they have no right to decide or not make any decision. They get humiliated by the male dominance of power somewhere, and they cannot access proper resources like food, health benefits, and education. Society has a patriarchal structure that makes women adhere to restrictions and norms, and the societal structure impacts women's welfare, particularly their health; their opinion regarding health is a social phenomenon that is influenced by the structure of society (Anbu, 2020).

Furthermore, the right to self-determination (i.e., the right to choose to have an abortion) is another important theme in the women's liberation movement. The feminists mainly strived for women's reproductive rights, making abortion legalized and ensuring birth control. Moreover, they analyzed the gender difference and focused on attaining equal rights in the political and economic spheres and gaining sexual liberation as well. They focused on socio-economic issues like equality in social status, sexual harassment, and discrimination based on caste, class, race, sexuality, age, ethnicity, religion, and political consequence. The third-wave feminism movement started in the 1990s and stressed individual empowerment. The third wave of feminism emerged with the contribution of American feminist writer Rebecca Walker, which aimed at social and economic equality. Feminists mainly struggled for reproductive rights protection from violence at home and in the public sphere to provide equal social and economic rights. No doubt, the majority of feminists have focused on middle-class women and struggled for their emancipation. In the post-colonial era, it refers to techno-science in feminist post-colonial analysis to illustrate the materiality of global inequalities. They argued that knowledge and power are always inseparable, and techno-science has worked towards the emancipation of feminist goals. However, in the 19th century, the feminist movement started with the aim of struggling for better healthcare for women. At the end of the 1980s and in the 1990s, the

discipline of health and medicine was developed from the beginning of the women's liberation movement, strife to achieve preferred health for women and better access to health care. Equitably, factors such as pregnancy and childbirth withhold a great risk of mortality in developing countries. These variations and connections emerged due to the increasing global mobility of people affected by conflict, political turmoil, and poverty. In Sub-Saharan Africa, the most extensive absolute poverty exists and reported illness issues related to poverty and poor nutrition negatively impact and cause women to suffer. Feminist materialist ideology examines chaos concerning women's paid and unpaid work; it seems women's reproduction, unpaid care giving, and expressive roles are not mentioned. Moreover, feminists strongly argued that women's health is directly impacted by determinants of health such as age, income, residence, and social status; cultural and societal norms and attitudes generate ideologies that define feminine and masculine positions (Syed, 2021).

2.6 Women's Health Status in India

Muzaffar (2015) opined that "Health is a social phenomenon that is influenced by social factors and creates social hierarchies in societies that produce maternal health inequalities". Since human existence, society has a patriarchal structure that makes women adhere to restrictions and norms. The societal structure impacts women's welfare, particularly their health; their low status is intrinsically linked to the existing patriarchal society, and they often receive inadequate health care facilities. The geographical vastness and socio-cultural diversity indicate that maternal issues and mortality rates vary across the states. Poverty and unemployment are some social problems that lead to misery for women. Women in India face many challenges to their health concerns, violence against women, and unequal treatment. In India, a high level of fertility is linked to poverty, low education, low female participation, and other measures of social and economic development, and the high fertility rate raises serious health challenges for Indian women (Anbu, 2020).

Table No.1: ***Represents the comparison between urban and rural women in terms of health issues***

S. No.	Urban women	Rural women	Total
Marriage before eighteen years	2.0	5.3	4.5
Total fertility rate	1.2	1.5	1.4
Literacy Rate	81.9	71.6	74.3

Maternity Care	90.0	85.5	86.6

Source: National Family Health Survey-5

Figure 2: Graphical representation of Table No. 1

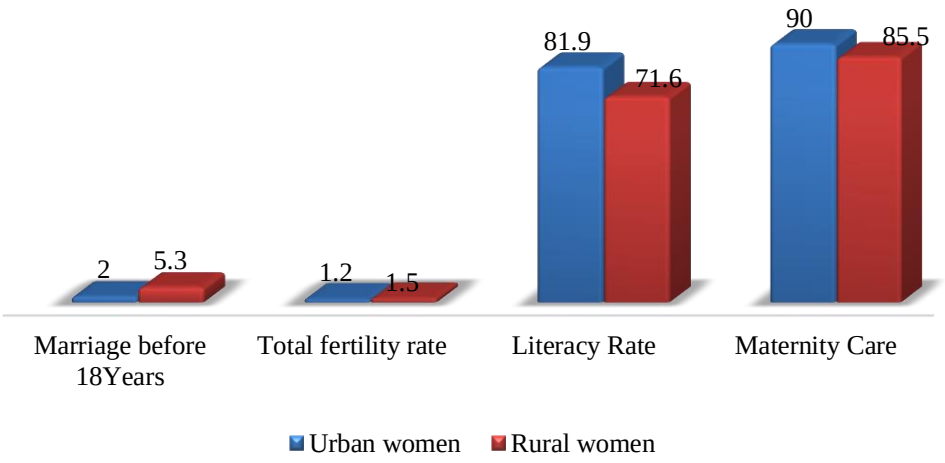


Table No. 1 explains that the marriage age of females before eighteen years is highest in rural areas as compared to urban areas. There is a lack of awareness, and the uneducated female population is more prominent in rural areas and not aware of their civil rights. There is a huge difference between rural and urban women as well. Rural communities are almost traditionally bound and adhere to customs; they have shared feelings. In rural areas, the fertility rate is much higher due to illiteracy factor and also because of no proper health care services. It is observed adolescent girls prefer early marriages, and due to the burden, women suffer a lot throughout their lives and adolescent pregnancies lead to numerous complications.

Women in rural areas, because of their household responsibilities and out of ignorance, tend to neglect their illnesses until they become too sick to move around and attend to household chores. Reproductive health is a universal concern but is of special importance for women, particularly in their reproductive years. Generally, women's standard of living is determined by their socio-economic conditions; particularly, rural women's standard of living is very low. In rural India, women fully depend on agricultural and allied activities, and they have a work burden while eating less nutritious and balanced food. Rural women do not use and practice different types of

family planning methods, showing they are not well aware of family planning methods, and almost have no awareness during pregnancy (Subramani, 2020).

According to the National Family Health Survey-4, reproductive tract infections were the highest among women at thirty-nine percent, whereas an estimated group of women aged fourteen to forty-nine reported symptoms, including sexually transmitted infections (NFHS, 2015). Women who suffer from reproductive tract infections bear discomfort, distress, embarrassment, problematic situations in the menstrual cycle, the impact of the use of contraceptives, and reported stillbirths (Anjana and Balan, 2017).The location of the slum areas is presented in the vicinity of the city, and these areas are mainly underdeveloped. Their socio-economic conditions are very poor, and there is no proper sanitation or cleanliness. In the slums region, many diseases and infections are more prevalent; women's conditions are pathetic in these areas, and even morbidities are common among women in slums (NFHS, 2016). On the other hand, marginalized sections of society in India face numerous challenges and issues in their living habitat. Due to their traditional way of life, they have myths and practices in their lifestyles and do not get proper medical facilities; they do not have a good hygienic environment or sanitation. In the tribal states of India, the number of pregnancy-related deaths is reported to be the highest, and the women's hostile lifestyles create problems for their health (Khanday and Akram, 2016).

According to the National Family Health Survey-4, the report discussed a brief exposition of the trends in a household environment and sanitation, fertility, child health and child mortality, nutrition, health, and the status of women. However, there are several issues that policymakers and program managers must take note of. Despite the implementation of the Swachh Bharat Abhiyan in the year (2014) by the Government of India, many states still lack basic household sanitation, improved sources of drinking water, and the use of clean fuel, which have direct linkages with the health of women and children. Concerning maternal healthcare conditions, a substantial improvement has been reflected in the past decade. On the other hand, tremendous inequality regarding wealth and social status is still prevailing. The use of modern methods of contraceptives remained almost unchanged at the national level and declined in several states. Hence, there is a need to reposition the family planning program with a special focus on modern spacing methods. The survey results illustrate that there are gray areas that need further attention. In particular, the pervasive inequality among socio-economic groups is a matter of great concern

and needs attention if India aims to achieve the Sustainable Development Goal by 2030 (Paswan et al., 2017).

Table No. 2: ***Represents the population and household profile, women, and children's health status***

S. No.	Indicators	Urban	Rural
1.	Total females who attended school	82.5	66.8
2.	The sex ratio of the total population	985	1,037
3.	Households with electricity facility	99.1	95.7
4.	Households with required drinking water	98.7	94.6
5.	Households use improved sanitation	81.5	64,9
6.	Women literacy rate	83.0	65.9
7.	Married women below 18years	14.7	27.0
8.	Total fertility rate	1.6	2.1
9.	Adolescents' Fertility Rate	27	49
10.	Neonatal mortality Rate	18.0	27.5
11.	Infant mortality rate	26.6	38.4
12.	Below are five mortality Rates	31.5	45.7
13.	Maternity care	75.5	67,9
14.	Nutritional Status of Women	54.0	40.2
15.	Post natal care	84.6	75.4
16.	Institutional births	93.8	86.7
17.	Home births	2.1	3.7
18.	Delivered cesarean Births	32.3	17.6
20.	Children's Nutritional Status	12.3	11.0
21.	Children under stunted	30.1	37.3
22.	Children under weight	27.3	33.8

Source: National Family Health Survey-5(2020-2021)

Table 2 explains the percentage of females who attended school at any time in urban areas and the percentage in rural areas. However, the sex ratio of the total population (females per 1000 males) in urban areas is 985, and in rural areas it is 1,037. In households with essential resources such as electricity, proper and safe drinking water, and the use of proven sanitation facilities, up to 80 percent of people in urban areas access these resources. But in rural areas, the percentage is quite low, and people are still suffering from such resources. However, women's literacy ratio in urban areas between the age groups of 15 and 49 years was found to be very high at 83.0 percent, whereas in rural areas it is only 65.9 percent, which shows that rural women are still far from education in this digital era. Women aged between 20 and 24 years married before the age of 18 years, which is not marked legally as the right age for girls, with 14.7 percent in urban regions and 27.0 percent in rural areas reported as high. Whereas, the total fertility rate of child-woman women was reported at 1.6 and 2.1 in urban and rural areas, respectively. However, the adolescent fertility rate among women in the age group between 15 and 19 years was reported at 27 percent in urban areas and 49 percent, with a huge number found in rural regions due to a lack of proper education and awareness. At the same time, the neo-natal mortality ratio is 18.0 in urban and 27.5 in rural areas; the infant mortality rate is found at 26.6 percent in urban and 38.4 percent in rural areas; and the under-five age group mortality rate is reported at 31.5 percent in urban and in rural areas as 45.7 percent. About maternal and child health care for the last birth in the five years before the survey, the mother who had an antenatal checkup is 75.5 percent in urban areas and 67.9 percent in rural areas. Mothers who have consumed proper nutrition, vitamins, and iron-folic acid are highly recommended to every pregnant female for the health of the fetus. Around 54.0 percent are found in urban areas and 40.2 percent in rural areas, with a smaller number. Postnatal care in urban regions is around 84.6 percent, and 75.4 percent is found in rural areas. In addition, women preferred institutional deliveries in urban areas at around 93.8 percent, which is a huge number, and 86.7 percent in rural regions of India. On a very low basis, women who opt for home deliveries in urban areas, which were conducted by skilled health personnel, reported only 2.1 percent, whereas in rural areas the ratio is 3.7 percent, which is high compared to urban areas. At the same time, births delivered by cesarean section and in a private health facility are also reported to have the highest number in urban as compared to rural areas. There are 32.3 percent and 49.3 percent in urban areas and 17.6 percent and 46.0 percent in rural areas, respectively. However, according to data, nutritional status among children' is highly

advanced in urban regions of India due to the number of factors responsible for about 12.3 percent, whereas in rural areas it is 11.0 percent. Due to inadequate nutrition and an improper diet, the main impact on the growth of children was that they remained stunted and underweight. Such cases are highly reported in rural areas, with 37.3 percent and 33.8 percent, respectively (NFHS, 2021).

2.7 Women's Health Status in Jammu and Kashmir

Jammu and Kashmir is an integral part of India and has unique topography and cultural diversity. Studying the different parameters of women's health revealed that inequalities exist in the health sector, which further leads to the marginalization of women. Since partition, the union territory of Jammu and Kashmir has been going through political turmoil that has put an eye on the health of women. The border areas of Jammu and Kashmir have been an area of dispute that has directly or indirectly affected the lives of people. These regions are reeling under constant escalation and ceasefire violations, and they are not able to enjoy their rights to their full extent. Women's social, economic, cultural, and political lives are impacted by turmoil; they are unsafe in border regions and discriminated against; their status remains dismal. In the present study it has been observed that there is connection between Turmoil, Women and Health. The general health issues of women are frustrated by the continuing political turmoil in the state. They are not getting proper reproductive as well as maternal care, which needs to be addressed. Moreover, they experience restrictions on their mobility and social interaction because of the turmoil and on the other side; social factors also take part in determining the health of women. The primary problems facing women are poverty, unemployment, illiteracy, ignorance, and uncontrolled fertility. They do not get a proper diet, particularly pregnant women, and suffer a lot due to the burden of work and within the bounds or limits that result in high neonatal, infant, and maternal mortality. However, they are not going for institutional deliveries, which results in negative outcomes in prenatal care, which has led to fetal distress, cases of postpartum issues, and psychological health problems (Muzaffar, 2015).

Adiga (2021) opined that it has been observed that females suffer from anemia problems, poor nourishment, and poor reproductive health. Her access to health care is poor because of her overburdened domestic chores and her mental stress due to chaos and fear. They bear household

burdens along with agriculture, pastoral work, and cattle rearing. Reproductive health issues are found in about seventy-three (73%) of living women in border areas (NFHS, 2015). The public health system still has flaws, particularly with regard to women's primary care (Bilal et al., 2017). However, the greatest number of complications during pregnancy and immediately following delivery are reported. According to data facets released by the National Family Health Survey-3, there are significantly more delivery complications in Jammu and Kashmir than in comparison to other states of India. Because the majority of women prefer home deliveries, there appear to be several sources of antenatal care services received at home, including auxiliary nurses, midwives, and nurses, but they are neither professional nor trained (Muzaffar, 2015).

Table 3: Represents the comparison between districts of Jammu and Kashmir regarding women malnutrition profile

S. No	Districts	Age	Malnutrition
1	Baramulla	15-49	16.69
2	Jammu	15-49	11.11
3	Srinagar	15-49	7.55
4	Anantnag	15-49	6.72
5	Bandipora	15-49	6.39

Source: NITI Aayog Report, 2021, Jammu and Kashmir

Figure 3: Graphical representation of Table No. 3

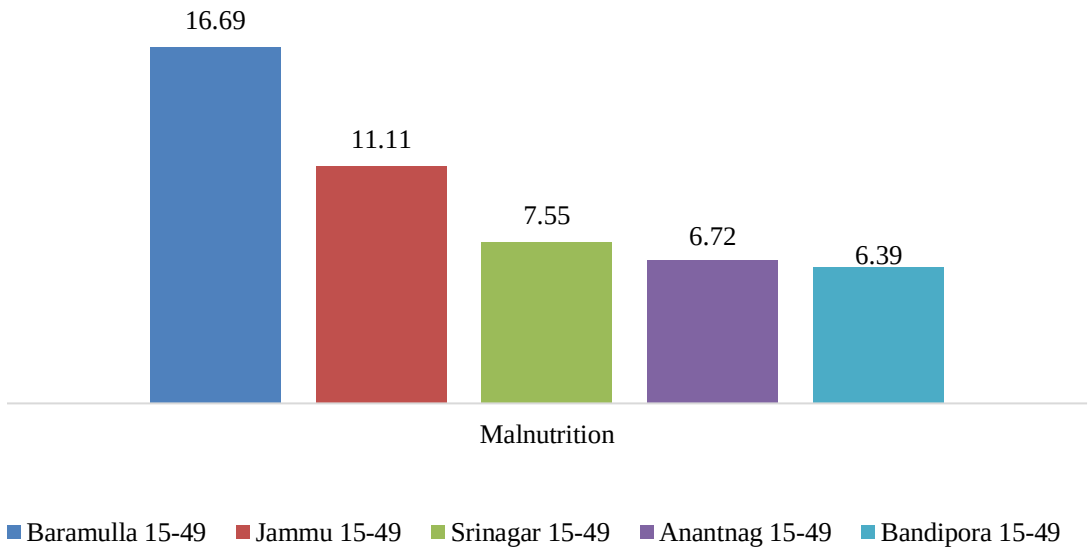


Table No. 3 represents the graphical explanation about the NITI Aayog report, which depicts the nutritional profile of Jammu and Kashmir, as more than twenty-nine lakh women are anemic and underweight. Figures show the comparison of the malnutrition status of women in the districts of Jammu and Kashmir. Due to a lack of proper diet, deficiency in nutrition, and iron deficiency, women suffer a lot. In the age group of 15–49 years, women were found to be underweight. The district of Baramulla ranked at the top with 32372 percent of women found underweight and undernourished, followed by Jammu at 21545 percent. After these two districts, the other comes in the category of Srinagar (14648), whereas 13044 were reported from district Anantnag and 12389 from Bandipora district of Kashmir division.

Table 4: ***Represents district-wise comparison of the anemia profile of pregnant and non-pregnant women in Jammu and Kashmir***

S. No.	Districts	Pregnant women Anemia	Non-Pregnant women Anemia
1	Srinagar	23.04	133.43
2	Jammu	18.39	212.45
3	Baramulla	7.95	135.56
4	Anantnag	7.53	146.25
5	Udhampur	4.43	_
6	Kupwara	_	99.60

Source: NITI Aayog Report 2021, Jammu and Kashmir

Figure 4: ***Graphical representation of Table No. 4***

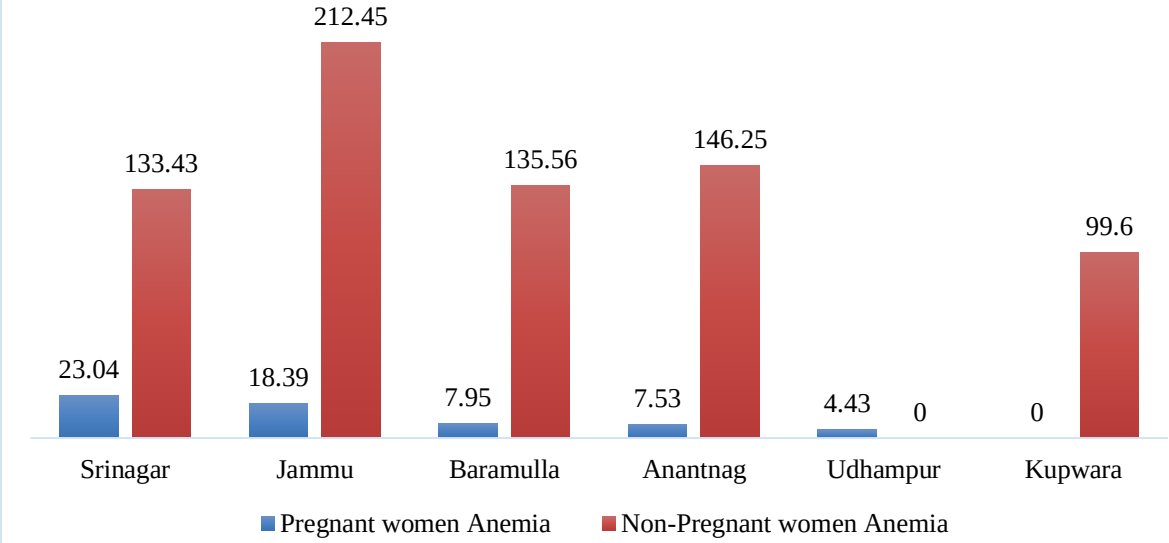


Table No. 4 graphically presents the data showing the difference between the anemic profile of pregnant and non-pregnant women in the districts of Jammu and Kashmir. However, in the category of pregnant women reporting anemia, Srinagar was at the top, with 37940 cases of women suffering due to chaos and fear of turmoil. Here are the reported 13105 anemic women. The other districts are Anantnag with such cases as 12408 and Udhampur-7306. On the other hand, the category of non-pregnant anemic women was found to be highest in the Jammu district, with 349,848 such cases, followed by Anantnag-240841. Thereafter, the other anemic cases were reported from Baramulla with 223242 and Srinagar with 219726, and at last, Kupwara is also a border district of Jammu and Kashmir with a vast majority population. Here, anemic women are reported in the non-pregnant category in 164023 cases (NITI Aayog Report, 2021).

Scholars like Neeru, Samridhi, and Ambika (2015) discussed in their study that in Jammu province; most women in the age group of 35 to 65 years suffer from the menopausal transition period. The symptoms like somatic behavior, vasomotor problems, sleep problems, depressed mood, and anxiety increase with age. On the other hand, nomad tribal women, the consistent

majority population in Jammu and Kashmir, come under the category of scheduled tribes. They are totally impoverished because of their living styles and nomadic way of life, and they usually encounter severe shortages and a lack of basic amenities. In fact, their wandering moments make them more vulnerable and the consequences of poor health for nomad women mirrored their infant mortality rate as well as maternal mortality. Therefore, because of poverty, they live in utter deprivation, which leads to early marriages, a lack of awareness, a nomadic way of life, traditional neglect, and soon. Their reproductive healthcare has been a great challenge, along with their socio-economic profile. They often bear the great burden of multiple pregnancies and unsafe abortions that create infections and complications during pregnancy. However, they have a high fertility rate, which deteriorates their health condition and leads to a high risk of maternal mortality (Gul, 2014).

Table 5: ***Represents the health status of women in Jammu and Kashmir***

S. No.	Indicators	Urban	Rural
1.	Total females who attended school	71.8	63.0
2.	Sex ratio of the total Population	958	978
3.	Households with electricity facility	99.7	96.3
4.	Households with a facility for portable drinking water	97.9	85.0
5.	Households use improved sanitation	66.2	45.9
6.	Women literacy rate	77.5	65.4
7.	Women married below18 years	4.2	10.3
8.	Total fertility rate	1.6	2.2
9.	Women achieved antenatal care	84.8	74.1
10.	Nutritional status	32.4	29.4
11.	Overall women Anemic	51.5	48.4
12.	Pregnant women Anemic	43.6	49.0
13.	Non-Pregnant women Anemic	51.9	48.4
14.	Women's decision-making power	87.5	82.5
15.	Women experienced spousal violence	6.7	10.6
16.	Women experienced violence during pregnancy	0.8	1.5
17.	Women access hygienic environment	85.0	60.2

Source: National Family Health Survey-4(2015-2016)

Table No. 5 explains that the total female population in Jammu and Kashmir is around 47.04 percent. Out of the total population in Jammu and Kashmir, the female population comprised 71.8 percent in urban and 63.0 percent in rural areas who have ever attended school. Whereas the sex ratio of the total population (females per 1,000 males) is 958 in urban areas and 978 in rural areas, it is a higher percentage than in urban areas. Households with facilities for electricity, proper safe drinking water, and improved sanitation are reported to have the highest ratio in urban areas, with 99.7 percent, 97.9 percent, and 66.2 percent, respectively. Women's education in the age group between fifteen and forty-nine years in Jammu and Kashmir, both in urban and rural areas, has a great number. With such a percentage, in urban areas, the literate women are 77.5 percent and 65.4 percent in rural regions. The above-mentioned figures analyzed the literacy rate in Jammu and Kashmir rural areas in terms of females. Women ranging in age from twenty to twenty-four marry before the age of eighteen, which is legally not accepted as the age for girl marriage. The numbers figured out here are 4.2 percent in urban areas and 10.3 percent in rural regions. Here again, the outdated percentage is markedly highest in rural areas where girls, before attaining the right or legal age of marriage, got married before it, which is not good for any female posit the fertility rate as 1.6 percent in urban areas and 2.2 percent in rural areas, which is also the highest, and the total fertility rate (children per woman) figured out (NFHS, 2016).

In the context of maternal and child care, mothers who had an antenatal checkup in Jammu and Kashmir. According to the data, 84.8 percent of urban pregnant women got proper maternity care, whereas in rural areas, 74 percent of women got proper care. However, nutrition must be necessary for every woman's development, particularly for pregnant women; it is a prerequisite for both the mother and their fetuses. Women consumed an adequate amount of nutrition, vitamins, and iron-folic acid during their pregnancy; 32.4 percent of women found in urban areas are taking a proper nutritional diet; and only 29.4 percent of pregnant women have consumed a very low number in rural Jammu and Kashmir. Nevertheless, anemia was also reported to be high among women, both in the category of pregnant as well as non-pregnant. Non-pregnant women aged from fifteen to forty-nine are anemic, with reported numbers of 51.9 percent in urban and 48.4 percent in rural regions. However, females in the category of pregnant women

aged between fifteen and forty-nine years who are anemic were found at 43.6 percent and 49.0 percent in urban and rural areas, respectively. Apart from these two categories, all women aged fifteen to forty-nine who are anemic reported 51.5 percent in urban and 48.5 percent in rural areas. However, gender-based violence was also reported in another way, women experienced spousal violence both in urban and rural regions. There are facts about married women who usually participate in household decisions, with 87.5 percent in urban areas and 82.5 percent in rural areas. 6.7 percent are found in urban areas and 10.6 percent in rural areas. For those women who have ever experienced violence during any pregnancy, there are 0.8 percent of cases reported in urban areas, which is the least number, and 1.5 percent of cases reported in rural areas. In fact, among women in the age group of fifteen to twenty-four who used hygienic methods of protection during their menstrual period, about 85.0 percent of women access hygienic methods in urban areas, whereas in rural regions, 60.2 percent of women's cases are reported. It is however concluded that most reproductive issues, like reproductive tract infections, are mostly found among women residing in rural areas (NFHS, 2016).

Analyzing the data facts released by the National Family Health Survey-4 clearly shows how females and adolescent girls are still living under chaos and suppression in rural areas due to a lack of essential resources. However, some social determinants are responsible for the susceptibility of women. Women are uneducated and have low social status, poor nutritional conditions, observed high fertility rates, and report gender-based spousal violence, which is not good for their mental health. Due to these circumstances, women in rural regions are lagging and becoming victims of early marriages (NFHS, 2016).

Table 6: ***Represents the health status of women in Jammu and Kashmir***

S. No.	Indicators	Urban	Rural
1.	Women attended School	76.0	67.9
2.	Women literacy rate	81.9	71.6
3.	Women married below18years	2.0	5.3
4.	Total fertility rate	1.2	1.5
5.	Adolescent fertility Rate	5	10
6.	Neo natal mortality	7.5	10.5
7.	Infant mortality rate	14.7	16.7

8.	Below five mortality Rates	15.7	19.4
9.	Women access antenatal care	90.0	85.5
10.	Women nutritional Status	21.6	14.1
11.	Postnatal care	89.4	82.6
12.	Institutional deliveries	98.6	90.5
13.	Women preferred home births	0.6	3.8
14.	Births in a private health facility	91.0	74.4
15.	Anemia among Children	70.1	73.5
16.	All women of age (15-49) who are anemic	61.4	67.5
17.	All women aged (15-19) who are anemic	71.5	77.5
18.	Pregnant women reported anemic	44.1	44.1
19.	Non-pregnant women reported anemic	62.5	69.0
20.	Married women experienced spousal violence	5.9	11.0
21.	Married women experienced physical violence during Pregnancy	0.3	1.6
22.	Young women between (18 and 29) experienced sexual violence	1.4	5.0

Source: National Family Health Survey-5(2019-2020)

According to the National Family Health Survey-5, the ratio of females who have attended school in urban areas is 76.0 percent, and it is 67.9 percent in rural areas. The overall women's literacy rate between the age groups of fifteen to forty-nine years in urban areas is 81.9 percent and 71.6 percent in rural Jammu and Kashmir. However, the urban ratio is 2.0 percent, whereas in rural areas, there are 5.3 percent of adolescent girls who married before attaining the right age of marriage. There are also high fertility rates in rural areas as compared to urban areas, at 1.5 percent and 1.2 percent, respectively. Nevertheless, in the union territory of Jammu and Kashmir, both in urban and rural regions, adolescents' fertility rates are also found at 5 percent and 10 percent, respectively. At the same time, the rates of neonatal mortality, infant mortality, and below-five mortality rates are shown in figures 7.5, 14.7, and 15.7 in urban regions in their respective manners. On the other hand, in rural areas neonatal cases are 10.5 percent, the infant mortality rate is 16.7 percent, and the below-five-year mortality rate is 19.4 percent, cases are quite high as compared to urban areas. However, maternal care is a matter of concern for every

society. Here in Jammu and Kashmir, women's antenatal care is reported at 90.0 percent in urban areas, which is good for women's health; in rural areas, it is reported at 85.5 percent. In terms of nutritional status, women who consumed proper nutrition, vitamins, and iron-folic acids were reported as 21.6 percent in urban and 14.1 percent in rural regions. Both in urban and rural Jammu and Kashmir, data facts revealed that the nutritional status of women is low, which affects the maternal health of women, whereas 89.4 percent of women also have postnatal care in urban areas and 82.6 percent in rural areas. In contrast to that women who preferred institutional deliveries in urban areas accounted for 98.6 percent and 90.5 percent in rural areas. In addition, women opt for home births and deliveries, with 0.6 percent found in urban Jammu and Kashmir and 3.8 percent reported in rural areas. The women having births in a private facility with expert personnel, around 91.0 percent were found in urban areas and 74.4 percent in rural areas (NFHS, 2020).

Anemia is considered a major silent killer among individuals. Among children, anemia cases are reported at 70.1 percent in urban and 73.5 percent in rural areas. However, the overall women categorized in the age group of fifteen to forty-nine years are anemic in urban areas, with 61.4 percent and 67.5 percent in rural areas, respectively. All young women in the age group between 15 and 19 years are anemic, with 71.5 percent and 77.5 percent in urban and rural areas, respectively. Women who are pregnant also reported an anemic rate of 44.1 percent in urban areas and the same rate in rural areas. Here, figures describe that the ratio of anemic women has the same percentage found both in urban and rural areas of Jammu and Kashmir. In any case, women in the category of non-pregnant are also found to be anemic; their ratios are 62.5 percent in urban areas and 69.0 percent in rural areas. Violence has roots in every society and it is observed that gender-based violence cases were found among married women in the age group of eighteen to forty-nine years who have ever experienced spousal violence, with 5.9 percent in urban areas and 11.0 percent in rural areas. However, women experienced physical violence during any pregnancy in urban areas at 0.3 percent and 1.6 percent in rural regions. Apart from this, young women experienced sexual violence, with 1.4 percent in urban areas and 5.0 percent in rural areas of Jammu and Kashmir (NFHS, 2020).

After analyzing the data released by the National Family Health Survey-5, facts revealed that in every community and society, women's issues persist. To make a comparison between the data

facts of the National Family Health Survey-4 and the National Family Health Survey-5, it has been analyzed that there were improvements in some parameters, but at the same time, women's concerns and problems are still prevalent. The structural inequalities in rural areas of Jammu and Kashmir, particularly in border areas, are not addressed in such a way. Women are facing various social problems and bear the subjugation of lower status and dominance. Anyhow, gender-based violence and discrimination are also reported. To overcome all these issues, there is a need to create opportunities for everyone that promotes equality. To provide valuable education that removes the artificial barriers that stop women, there should be a framework for policies and reports to make the best advent to social reform for women (NFHS, 2020).

2.8 Understanding Turmoil, Women and Health from a Sociological Perspective

2.8.1 Impact of Turmoil on Women's Health in Border Areas of Jammu and Kashmir

Scholars like Hamal and Dieleman (2020) discussed in their work the socio-economic status of women in society, which is confined by their social position and limits their social profile. This may have a direct or indirect impact on women's social lives, which impedes or creates barriers to their development, especially about their overall health. However, it is because in the border regions of Jammu and Kashmir has experienced various forms of protracted wars; that it can offer important insights into the health issues of women that arise in conflict areas (David et al., 2017).

Bilal (2017) stated that following the India-Pakistan separation, political unrest has plagued the union territory of Jammu and Kashmir, specifically in border areas that are only a few kilometers away and are closely located away from the Line of Control (LOC). This has a tremendous negative impact on every aspect of life for women, especially health, and on their socio-economic, cultural, and political lives, as well as being extremely uncertain. There are reportedly no better physical health infrastructure in place and no better medical treatment been provided? Women in the border villages experience various health issues like living in fear, chaos, and depression as a result of turmoil and are exploited in such a way. However, they are subjected to

a variety of hardships and knotted into kinship ties and bear the traditional responsibilities and found weak in society.

Scholars like Muzafar, Hedström, and Herder discussed behind the storyline that the controversy starts with the unsatisfactory divide between the two countries, and it is very important to know that Pakistan is pursuing conflicting objectives and interests regarding Jammu and Kashmir. It is manifest that reproductive unassertiveness contributes to higher stillbirths and maternal mortality during the war and postwar periods and the exclusion of women from decision-making on concerning issues. However, because of turmoil in the region, women are at great risk of and vulnerable to any social change. In addition to the physical, mental, and social aspects, health has other dimensions that all contribute to overall well-being. These dimensions include spiritual, emotional, vocational, philosophical, cultural, socioeconomic, environmental, educational, and nutritional. Even though various dimensions interact and function, each has a unique character (Hassan and Shafi, 2013).Scholars like Bendavid, Derek, Bodha, Sheikh, and Khuhro opined that, in opposition to the stated claim, the conflict continued and the political and social structure of the area remained uncertain. The region's interplay factor, turmoil, constitutes problems for women living there as well as having an impact on their health especially maternal health, their antenatal care, nutritional status, weak and poor health, the risk and complications associated with childbirth, delivery mortality rates, and even the highest illiteracy and poor health of their children, as has been proven (Sandiford et al., 1995).

Scholars like Sarkar, Djamilah, Herliana, Fadlyana, Fan, and Koski in their study reviewed early marriage and the chance of additional pregnancies in less than two years and how it influences the chances of becoming pregnant unintentionally or at the wrong time. Following an examination of the literature, a study conducted by Fan and Koski (2022) found that in developed America, women who married before turning eighteen years old are more likely to become weak physically as well as psychologically than those who married later in life to report having a variety of mood disorders, anxiety, and other mental illnesses reported as much as in adults. Women who married younger, below eighteen years of age, reported higher levels of depressive symptoms, in comparison to another small study done in a single country in Iran about women who married earlier and found more depressive symptoms than those who married older. The public health system especially in border areas of Jammu and Kashmir still has no

development, chiefly among women, who prefer early marriages and cannot access primary healthcare, which puts them at risk for developing fetal distress, postpartum issues, and mental health issues (Adiga, 2021).

2.9 Summary

This chapter presents an extensive literature review and comprehensive study that highlights the origins of health sociology and associated sociological perspectives. In this chapter it has been discussed in terms of sociologically understanding the conflict between India and Pakistan and the political turmoil. This study aims to identify the literature on women's health status in India and in Jammu and Kashmir and to investigate the impact of turmoil on women's health in border areas of Jammu and Kashmir. However, in the present chapter it has been observed in the border areas of Jammu and Kashmir, women health issues are influenced by Turmoil and there is linkage between the Turmoil, Women and Health.

CHAPTER-3

Methods and Design of the Study

This chapter explained the methods and design of the present study, divided into seven sections. The chapter comprised of the introduction, paradigm of the study, theoretical framework, research design, qualitative research method, research approaches, research setting and sampling, data collection process, ethical considerations in research, pilot study, role of the researcher, data analysis and interpretation, limitations and delimitations of the study, and summary of the chapter.

3.0 Introduction

"A systematic investigation and detailed inquiry of any phenomenon is called research, and its goal is to establish facts, generate new ideas and theories, and draw new conclusions."

The present study is predominantly qualitative, exploratory, and descriptive. The data has been collected from both primary and secondary sources of information, and for the long term, a field visit has been conducted. The primary data has been collected through an interview schedule, focused group discussions, and the case study method. Secondary data has been collected through books, reputed journals, newspapers, library visits, and government reports, including the opinions and arguments of social activists, academicians, officials, and other informants. Due to the nature of the study and the other issues and challenges in the region, understanding the social reality of the region requires an accepted perspective to understand, explain, and analyze the ground reality of the study area. Therefore, the study demands conflict and feminist perspectives to understand and explain the research problem. Throughout the study, an interpretive approach has been used in the research to enable the observations to create a theoretical understanding of the women. The present study describes the connection between the research paradigm (constructivism) and the philosophical foundation (ontology, epistemology,

and methodology). The relationship discussed how the constructivist paradigm relates to the ontology, epistemology, and methodology employed in the present qualitative study (Bryman 2016).

3.1 Constructivist paradigm of the study

Scholars like Merriam & Tisdell, Guba & Lincoln, and Merriam & Tisdell stated in their work that through interpretation, the experiences of the study's participants could be built into knowledge, and personal opinions play an important part in understanding the shared experiences and perceptions, even though interactions with participants in this study are crucial at this point. Such an explanation agrees that the constructivist paradigm reflects a worldwide understanding of the process of creating knowledge and how it is constructed.

Scholars like Guha and Lincoln (1989) opined that ontology, epistemology, and methodology are fundamentally linked to a research paradigm. Hitchcock and Hughes (1995) stated that "ontological assumptions give rise to epistemological assumptions, which have methodological implications for the choice of particular data collection techniques". The three aspects of the research process or philosophical foundations are ontology, epistemology, and methodology, which in turn attempt to characterize constructivism in the following sub-sections. Constructivism is viewed as an approach to qualitative research and is frequently combined with interpretive perspective, the way in which individuals achieve social reality that is subjective in nature. "Subjectivism as meaning that comes from anything but the object to which it is ascribed by its subject, and social phenomena are created from the perceptions and consequent actions of social actors"(Crotty,1998).

The present study employed constructivism theory to explain the social construction of reality by women in a naturalistic inquiry concerned with how they perceive and create social reality. In the present study, employed the social constructivist approach to learn about the thoughts, perceptions, emotions, desires, hopes, and opinions of the participants in an attempt to comprehend their social life and conditions and to understand the respondents' interpretations and experiences in subjective ways and aimed at different factors. Due to the multiplicity and diversity, the researcher chose to focus on an intersectional approach, and the aim of the research is to become as familiar as possible with the participants' perspectives and their situation under

investigation. To employ the constructivist approach in the present study, the researcher must be able to address the process of interaction among participants, recognize their social and cultural contexts, and concentrate on the particular contexts of the respondents. Because they place themselves in the research to acknowledge how their interpretation is shaped by their personal, cultural, and historical experiences, researchers acknowledge their background and influence their interpretation, and the researcher needs to make sense of (or interpret) the meanings **(**Creswell, 2018).

3.1.1 Ontology

Bryman (2012) stated that the philosophical investigation of ontology focused on the nature of reality and social entities (systems). According to Guha and Lincoln (1989), the constructivist paradigm remark about reality is multifaceted and viewed as subjective and ever-changing, with no ultimate truth recognized. Constructivism is concerned with how people interpret their own subjective experiences related to particular subjects in light of their social and historical context, and respondents create and interpret their own understandings about the world and its existence (Creswell, 2014).

3.1.2 Epistemology

Crotty (1998) defined epistemology as "the study of the theory of knowledge and how we know what we know; it reflects a particular understanding of what it means to know". Saunders (2009) defined "epistemology as concerned with the acceptance of knowledge in the study field". However, the social interactions between individuals are what give the world its meaning. In actual, many factors could influence the creation of meanings, including one's prior experience and knowledge, political and social status, gender, race, class, nationality, and personal and cultural values. In order to provide theoretical underpinnings, the present study used constructivism as the research paradigm and the epistemology that informed it (Crotty, 1998).

3.2 Theoretical Perspective of the Study

The philosophical position that guides and determines the research methodology is described from a theoretical perspective. Philosophically and sociologically, the present study demands the

interpretive approach and also other sociological theories, like the phenomenology approach, to enhance the significance of these approaches in general and how this helps to strengthen the present study. Social constructivism, feminist sociology, and the phenomenological approach are all influenced by interpretive sociology (Adorjan and Kelly, 2017).

3.2.1 Interpretive Approach

Max Weber developed the concept of interpretive sociology in his famous book "The Protestant Ethic and the Spirit of Capitalism" (1905), which emphasizes the significance of meaning and action in the analysis of social issues and problems and additionally makes a contribution to the growth of the qualitative research methodology in sociology and social sciences in general. One of the main pioneers of interpretive sociology is contemporary; that is, this theoretical framework and the associated research techniques have their roots in the German word "Verstehen," which signifies to comprehend in order to arrive at a comprehension of actors, their interactions, and human history and the interpretive roots lie beneath hermeneutics. According to this, it is first easier to understand the subjective meaning of human actions through direct observation and interpretation of texts and language, and furthermore, it advances the understanding of the fundamental causes of human behavior. Interpretive sociology is the study of social phenomena from the perspective of those who have experienced them, and understanding the meaning that people under study assign to their beliefs, values, actions, behaviors, and social relationships with other people and institutions is the main goal of interpretive sociology. By emphasizing a subjective approach, interpretive philosophy develops knowledge in a different way. The present study employed the "interpretive approach" by realizing that participants subjective experiences, opinions, and behavior are just as vital to the study as observable; this led to an emphasis on comprehending the significance of the research (Ababneh, 2020).

3.2.2 Phenomenology Approach

Edmund Husserl (1859–1938) led the founding of the phenomenology approach at the start of the 20th century. The introduction to sociology was promoted by Schutz, and his central thesis is that the social science methodology constitutes a constitutive analysis of the social world.

The world of everyday life as the realm of pragmatic actions is the paramount reality because we experience it as shared with others. According to Schutz's theory, human reality is an intricate web of interconnected life worlds that encompass a wide range of viewpoints and manifold realms of meaning, and it methodically considers the diversity of cultural worlds and different life forms. However, the argument given by Schutz's supports the present study to know about how women shared their lived experiences and thoughts about various challenges associated with their health condition, which promotes how to interpret based on their subjective experiences and how they are facing numerous challenges in the turbulent region. However, the design and method in the present study demand phenomenology as a theoretical perspective that emerged to explain human social reality and is used to analyze the phenomena of subjective consciousness, describe the social structures of subjective consciousness, and discuss social life. The phenomenology approach employed in the present study has significance for understanding their everyday life experiences (Flick, 2014).

3.3 Research Design

Ababneh (2020) stated that a research design is a strategy that you choose to investigate the study. How do conduct the study? What methods should be needed for the study? How do you address the research problem? Once the problem has been defined and the literature review is complete, design of the research will be defined. The research design varies according to the purpose of the research design, which is to provide a plan to study the research problem as well as the point of view and working procedure. The present study employed the qualitative method and followed non-experimental designs such as descriptive and exploratory research designs.

3.3.1 Descriptive Research Design

To identify, describe, and characterize the features of the variables in the scenario, a descriptive study is carried out. In this study, the researcher gathers information about a specific group of women, provides detailed characteristics and experiences of a particular subject, and collects a lot of information about the phenomenon that is studied (Robson, 2002). In the present study, the descriptive design has been followed to describe verbatim aspects of the women's health, various challenges, and how turmoil impacts their health. Since this study is regarded as a component of

or precursor to exploratory research, it is imperative to have a comprehensive understanding of the phenomenon prior to undertaking exploratory research (Ababneh, 2020).

3.3.2 Exploratory Research Design

Sekaran (2003) opined in his work about exploratory research design that allows for a more comprehensive understanding of the nature of the issue. The present study centered on examining current events, posing inquiries, looking for and exploring new perspectives, and evaluating phenomena from different parameters. However, it is about exploratory design employed when little or no information is available about the study, and exploratory research design is carried out as reflected in this study because there is a dearth of literature and no polished research has been carried out, especially in border villages of Jammu and Kashmir. There is a need to explore more data and conduct an in-depth study to highlight the issues women are actually facing. This study can be helpful in elucidating and comprehending the imprecise issues facing women in the region (Saunders et al. 2009).To identify, describe, and characterize the features of the variables in the scenario, a descriptive and exploratory study is carried out. In this study, the researcher gathers information about the specific group, which is women, and provides detailed characteristics and experiences of a particular subject (Robson, 2002).

3.4 Qualitative Research Method

Creswell (2014) opined that there are approaches that can be used in research methods to collect data: the mono method is the application of a single technique, and the multi method is a combination of more than one technique. According to the design of the present study, it followed a mono (single) research method, which is a qualitative method. It is a way to investigate and comprehend the meaning that individuals or groups attribute to social problems through qualitative research. The research methodology allows for a wide range of classifications for the study.

Miles (2014) stated that qualitative research relies on non-statistical and non-numerical data collection and analysis modes to understand concepts, opinions, and experiences. Qualitative research provides a detailed description and analysis of the phenomenon, and human experiences

like shared and lived experiences are the focus of qualitative data, which makes them essentially ideal for identifying the meanings attached to the routines and arrangements in their lives as well as for relating these meanings to the social context in which they exist. In the present study, the basis of qualitative research lies in the interpretive and phenomenological approaches (Prasad and Prasad, 2002).

3.5 Research Approach

Saunders (2009), as stated that there are two types of research approaches that have been mentioned: “deductive and inductive”. The inductive approach (specific to general) used in this study involves the collection of data, analysis, and creation of a theory based on the data analysis. It is used to discuss the influences of social factors on each other and is employed in primary data, whereas the deductive approach employs secondary data for the purpose of a literature review. The deductive (general to specific) approach was followed by developing theory and designing a research strategy. A “deductive approach” has been selected in the present study for reviewing literature, collecting secondary data by following “theoretical arguments based on existing phenomena, and generalizing the regularities in human social behavior (Blaikie, 2000).

3.6 Research Setting and Sampling

3.6.1 Historical background of the border conflict between India and Pakistan

The historic partition of India and Pakistan in 1947 left behind a legacy that includes the Kashmir dispute, but more recent problems have also warped it. The protracted conflict in Kashmir raged on for so long that it seemed irrelevant to the rest of the world and anachronistic at the same time. Mountbatten has been compelled to accept that the Princely States, which included Kashmir, would be integrated into one of the new countries due to the growing crisis brought on by intergroup violence. The United Nations mediated a ceasefire the following year and created the Line of Control after negotiations got underway following the end of the combat in 1947. It was agreed that India and Pakistan should each administer a part of Kashmir until a popular referendum could be held. Divide the region into Gilgit-Baltistan and the western most

portion of Kashmir, which were given to Pakistan, and Jammu, Kashmir, and Ladakh, which were given to India. India cites the "Instrument of Accession" signed by the former Maharajah of Kashmir as legal and tangible proof of its claim to ownership of the entire state. Pakistan felt empowered to challenge India over the controversial dispute over the Kashmir Valley. The people themselves faced increased threats as a result of the aimless shelling that occurred across the fictitious "line of control" separating Pakistan and India (Johnson, 2005).

3.6.2 Social Context of the Research Setting: Baramulla and Poonch Districts

3.6.2.1 District Profile of Baramulla

Table No 7: Represents the demographic profile of the Baramulla district

<table>
<tr><td colspan="2" rowspan="2">Name of the District</td><td rowspan="2">Total population</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>534,733</td><td>473,306</td><td>1,008,039</td></tr>
<tr><td colspan="2" rowspan="2">Baramulla</td><td rowspan="2">Literacy rate</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>77.35</td><td>55.01</td><td>66.93</td></tr>
<tr><td>Area/sq km</td><td>4,243sq. km</td><td rowspan="2">Sex Ratio</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>Population Density per sq. km</td><td>238 per sq. km</td><td>909</td><td>1000</td><td>1,909</td></tr>
</table>

Source: Census, 2011

Baramulla district is the principality of "Jammu and Kashmir's oldest and most significant town located on the bank of the Jhelum River and was considered the Gateway of Kashmir Valley" by Rawalpindi-Murree-Muzaffarabad-Baramulla Road until 27th, 1947. It covers an area of 4,243 km^2 and consists of villages. The district draws its name from the city of Baramulla, which was established in B.C. It is the largest district in the entire valley, both in terms of population and area, and it is also situated along the route leading from Muzaffarabad, which is now in Pakistan-occupied Kashmir (POK), and Rawalpindi, which is also currently a present-day town in Pakistan and the city served as a gateway to the valley. However, the district known as "Baramulla" is distinct in that it includes both sub-temperate and sub-tropical climates, as well as

sizeable areas of temperate that have experienced severe, bitter cold and snowfall during the winter.

According to the 2011 census, the district has a total population of 1,008,039, of which 534,733 are males and 473,306 are females. The overall district literacy rate is 66.93%, with males at 77.35% and females at 55.01%, whereas females have a lower literacy rate than males. The Baramulla district sex ratio is 909 females per 1000 males. However, the district is the largest producer of horticultural products, has vast apple orchards, and also has a silkworm breeding unit. Baramulla district has been providing health facilities to the public since its inception, and family welfare centers exist in all villages of the district. But there is a need to make primary health care centers and mother and childcare hospitals in the peripheries more functional and effective so that more and more patients get treated there, thus necessitating fewer referrals to the district hospitals for pregnant females and sick newborns.

Map of the district Baramulla

Source: https://www.mapsofindia.com/maps/jammuandkashmir/tehsil/baramulla.html

Table No. 8: ***Represents the administrative profile of the Baramulla district***

District Name	No. of Sub-Divisions	Tehsil	No. of Blocks	No. of Villages
Baramulla	4	15	10	524

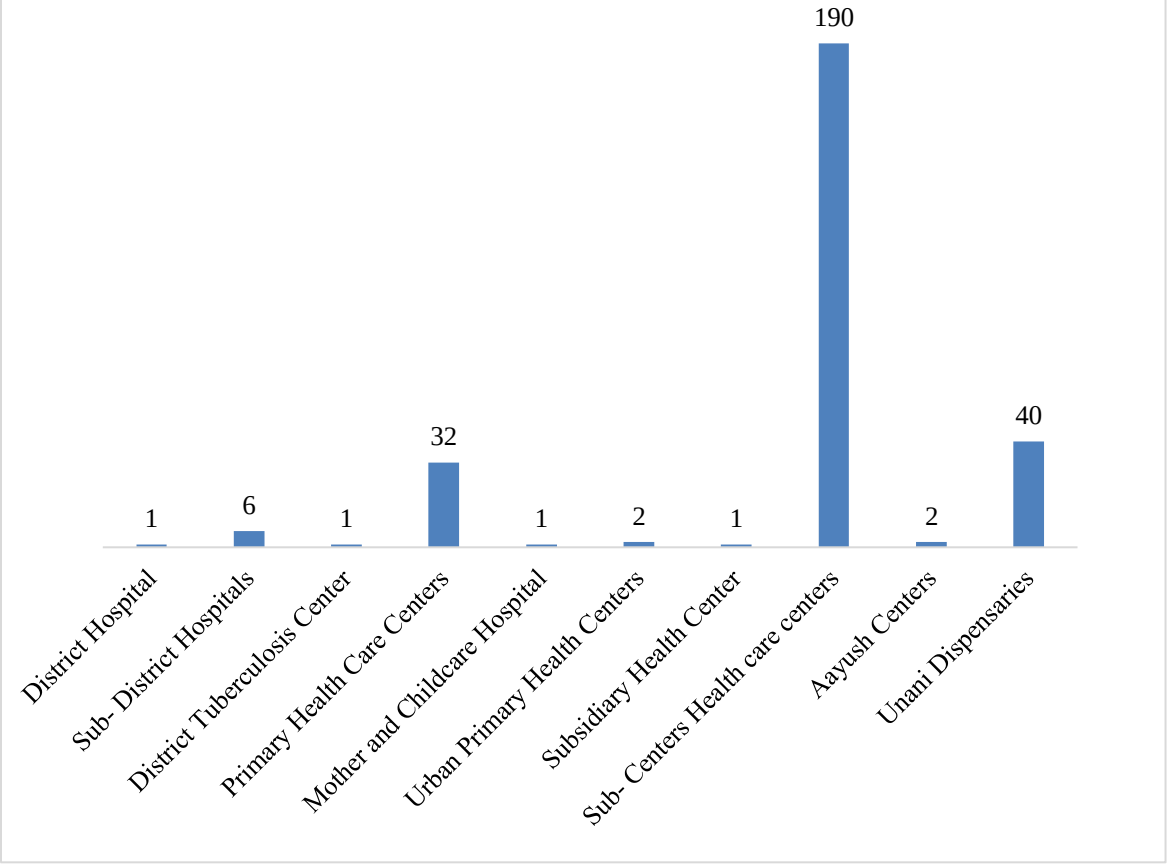
Source: *https://baramulla.nic.in/rti/*

Table No. 9: ***Represents the health infrastructure of the Baramulla district***

Sr. No.	Health Establishments	Total
1	District Hospital	01
2	Sub- District Hospitals	06
3	District Tuberculosis Center	01
4	Primary Health Care Centers	32
5	Mother and Childcare Hospital	01
6	Urban Primary Health Centers	02
7	Subsidiary Health Center	01
8	Sub- Centers Health care centers	190
9	Aayush Centers	02
11	Unani Dispensaries	40

Source: *https://baramulla.nic.in/rti/*

Figure 6: Graphical representation of Table No. 9



3.6.2.2 District Profile of Poonch

Table No. 10: ***Represents the demographic profile of the Poonch district***

Name of the District		Total population	Male	Female	Total
			251,899	224,936	4,76,835
Poonch		Literacy rate	Male	Female	Total
			77.33	50.90	54.68
Area/sq km	1,674sq.km	Sex ratio	Male	Female	Total
Population Density per sq. km	285per sq. km		893	1000	1,893
Source: *Census, 2011*					

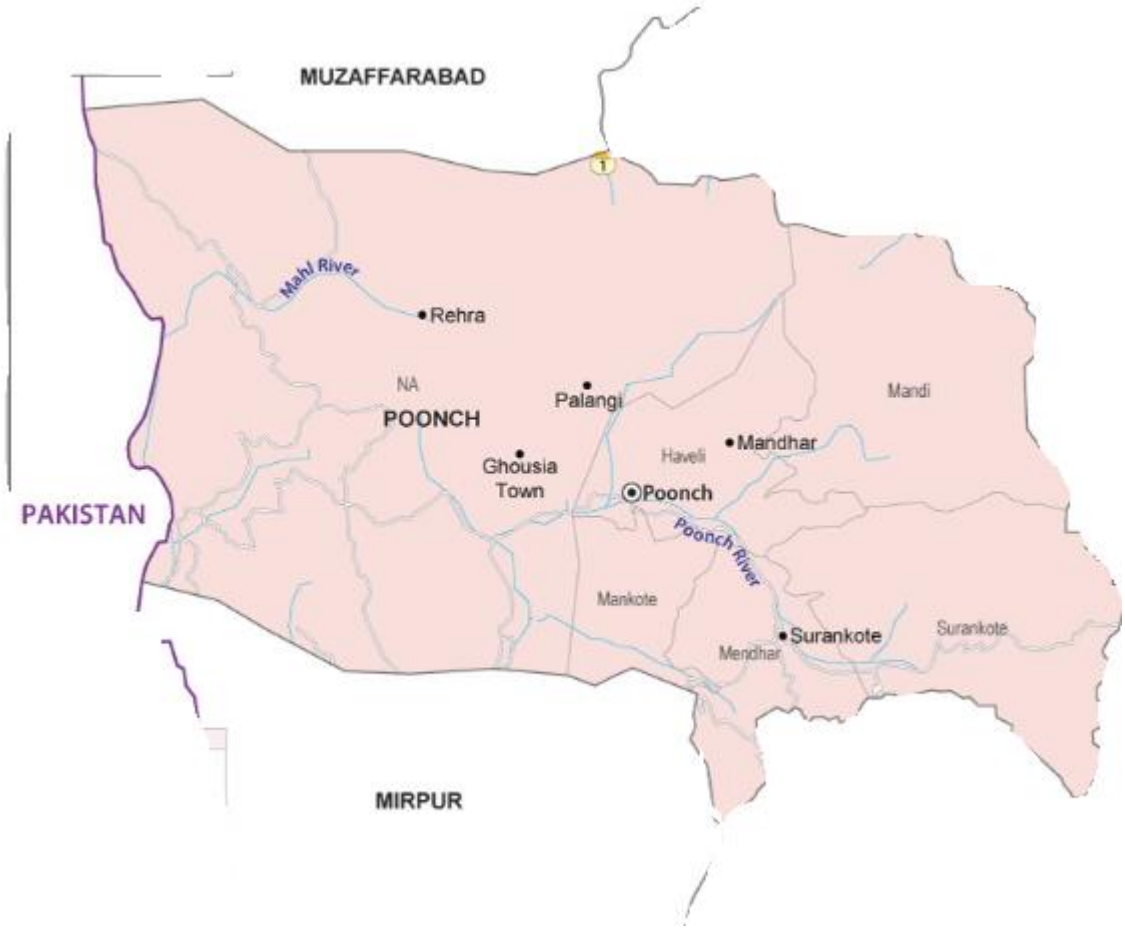
Poonch has witnessed many historical eras and emerged as a sovereign state under the rule of "Raja Nar" in the year 850 A.D. The name Poonch was also written in official records as "Punch" before the partition, but after the partition, Punch was replaced with "Poonch". The most renowned personality, Huen Tsang, well-known Chinese traveler, visited this region in the 6th century A.D. In the history of Poonch, the years 1850–1947 are referred to as the Golden Period. During Raja Baldev Singh's reign in 1901 A.D., the principality of Poonch received statehood from the British Raj. In 1947, Pakistan illegally occupied two and a half tehsils of Poonch, while the remaining tehsils became part of Rajouri and Poonch districts. Poonch is an erstwhile princely state situated in the foothills of the "Pir Panjal" range. It has a total of four Tehsils and 178 villages in this district. It has scenic beauty, shy kissing mountains, snow-covered peaks, beautiful valleys, lush green pastures, gushing streams, charming meadows, crystal-clear lakes, and waterfalls. Though there are places of interest and historical monuments that attract tourists, the district lies near the border adjoining Pakistan; even some villages in the district lie under the jurisdiction of Pakistan and are very closely connected and demarcated by the Line of Actual Control (LAC).

The villages selected for the present study are in close proximity to Pakistan territory, just around zero to five kilometers. The selected villages, namely, Balakote (India) and Islamabad (India), both lie under India. Poonch district was also part of Azad Kashmir, which has been occupied by Pakistan. It is bordered on the north by the "Bagh" district, on the east by Haveli, on the south by the Poonch district, on the west by the district Rawalpindi, which is part of the province of Pakistan, and on the south by the region known as "Azad Kashmir", which is comprised of the areas Sudhanoti and Kotli. The Rawalakot district is situated just around thirty kilometers away from the Poonch district. The district of Poonch was also part of the Kashmir dispute between India and Pakistan.

According to the 2011 census, Poonch district has a total population of 4, 76,835; the total population in rural areas is 4, 38,205; and the urban area is 38,630, whereas 251,899 are male and 224,936 are female. It is located at 1,000m (3,300 ft) above sea level. The district has a density of population per square kilometer. The overall district literacy rate is 64.68 percent, with males having 77.33% and females having 50.90%, with females having a lower literacy rate than males. The Poonch sex ratio is 893 females per 1000 males. People living in the district of

Poonch have unacceptable economic conditions. The overall majority of the village population falls under the middle class and falls under the criteria of being below the poverty line. People living in Poonch depend on multiple skills, agriculture, farming, and small pieces of land for cultivation. In rural areas, people work on agricultural land as laborers; both men and women are involved. The main agriculture specialty of the district is rajmash, chillies, maize, wheat, paddy, garlic, and potatoes whereas maize is the staple food of the people cultivated. But the frequent occurrence of calamities like hailstorms, incessant torrential rainfall, and moisture stress due to prolonged dry spells. Poverty has a negative impact on the lifestyle of people generally. The district is home to a large number of jobless or unemployed people, and the situation for women is not much better. However, there are a total of 186 health institutions across the district. The health sector of Poonch comprises three blocks, namely Mandi, Mendhar, and Surankote, and two of its blocks, Mandi and Mendhar, have a border adjoining the Line of Actual Control (LAC) with Pakistan.

Map of the district Poonch



Source: https://www.mapsofindia.com/maps/jammuandkashmir/districts/poonch.html

Table No. 11: ***Represents the administrative profile of the Poonch district***

District Name	No. of Sub-Divisions	Tehsil	No. of Blocks	No. of Villages
Poonch	2	6	11	178

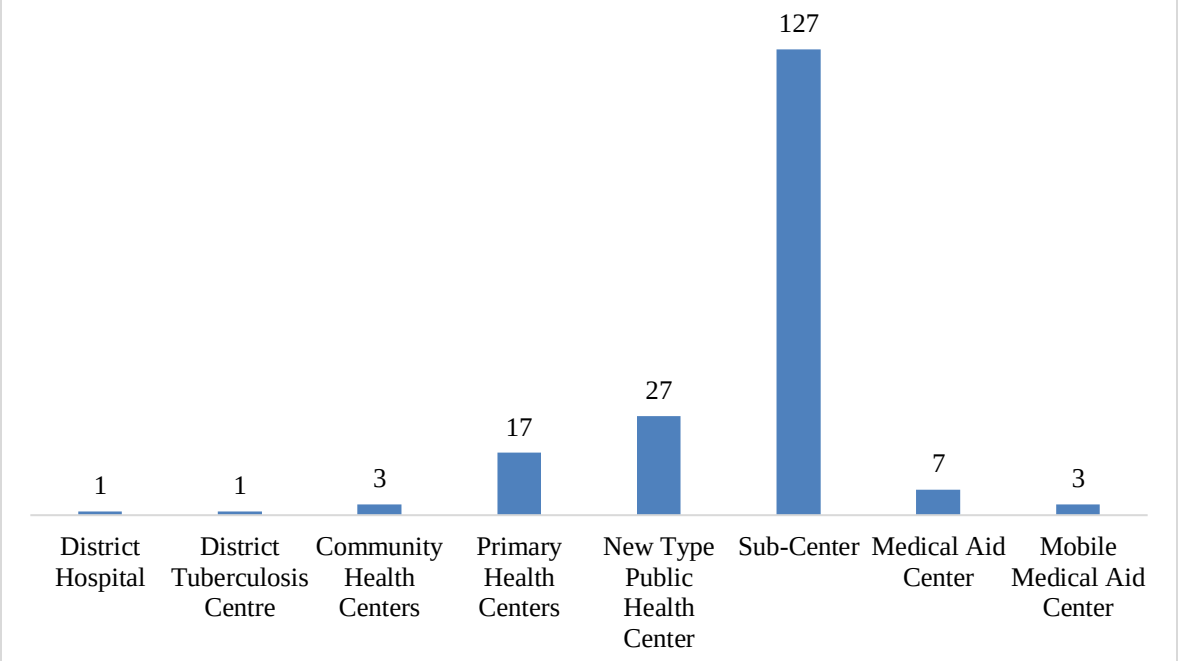
Source: *https://poonch.nic.in/about-district/*

Table No. 12: R*epresents the health infrastructure of the Poonch district*

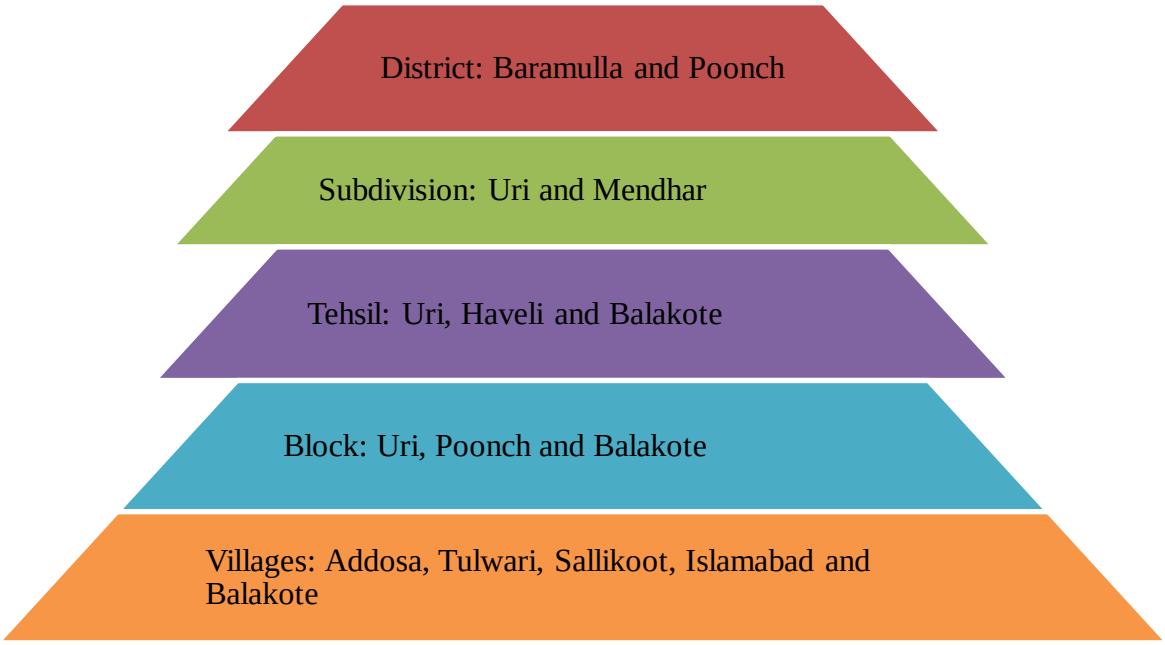
Sr. No.	Name of the Facility	Quantity
1	District Hospital	01
2	District Tuberculosis Centre	01
3	Community Health Centers	03
4	Primary Health Centers	17
5	New Type Public Health Center	27
6	Sub-Center	127
7	Medical Aid Center	07
8	Mobile Medical Aid Center	03

Source: *https://poonch.nic.in/about-district/*

Figure 8: Graphical representation of Table No. 12

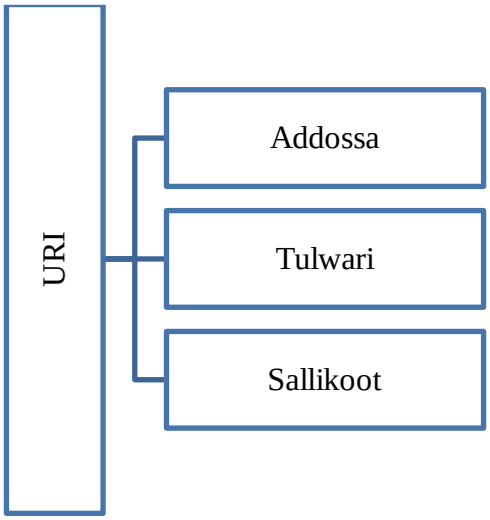


3.6.3. Sampling Framework of Districts Baramulla and Poonch



The framework for the selection of the villages and sample selected at block level from both districts, Baramulla and Poonch, it is selected from one block from Baramulla, which is Uri, and one Tehsil and one Block from Poonch district, which is Haveli and Balakote. Within the block, a selection of villages based on the target population has been made, with three villages selected from the block Uri, namely Addosa, Tulwari, and Sallikoot, and in the same manner, two villages named Islamabad from Tehsil Haveli and Balakote from block Balakote have been selected.

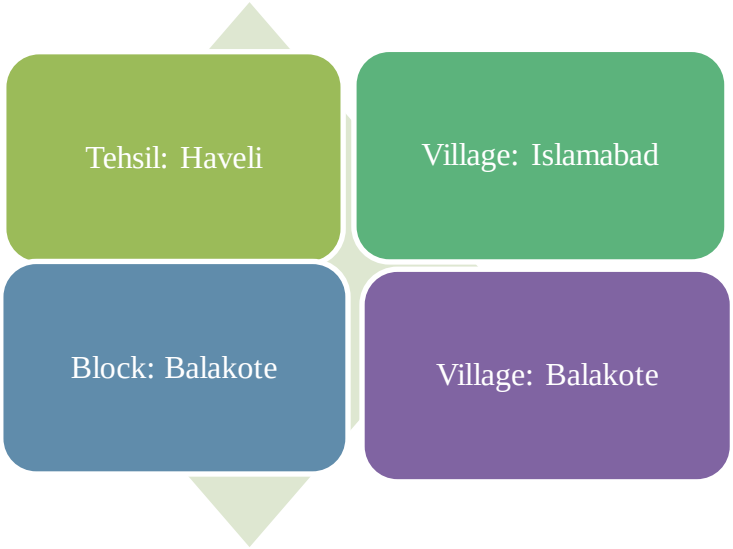
3.6.3.1 Justified Sample Block and Villages of district Baramulla



Map of border areas near block Uri

Source: https://scroll.in/latest/869279/jammu-and-kashmir-three-civilians-injured-after-alleged-ceasefire-violation-by-pakistan-in-uri

3.6.3.2 Justified sample Tehsil, Block and Villages of district Poonch



Map of Border areas near District Poonch

Source: http://www.eindiatourism.com/jammu-kashmir-maps/punch-jammu-kashmir-india-maps.html

3.7. Demography of selected Tehsil and Blocks

Jammu and Kashmir has been region-divided since independence; from that period on, the region has experienced instability, uncertainties, migration, and unrest along its border fence areas. However, cross-border firing and land mine explosions severely disrupt daily life in villages. Jammu and Kashmir are mostly in the Himalayan Mountain regions and share borders with the people to the north and east side of the Republic of China, as well as the areas governed by Pakistan to the south with other states like Himachal Pradesh and Punjab. Jammu and Kashmir has twenty districts with an area of around 222,236 sq. km and has two divisions: having mountains, peaks, unprotected monuments, rivers, and rich local cultures. Since 1947, Jammu and Kashmir, particularly border areas, have suffered a lot due to insurgencies and conflict between India and Pakistan. It decelerates the growth and development of the state, and the political insurgency in Jammu and Kashmir is the most staggering conflict in international politics. On the contrary, there has been conflict in Jammu and Kashmir and border regions, which has had an impact on the lives of people. The regions under random shelling violations, threats, and fear of firing have hampered the conditions of the area, and it is observed that unrest and disturbance affect women's social lives.

3.7.1 Demography of Tehsil Haveli

Table No. 13: ***Represents the demographic profile of Tehsil Haveli***

<table>
<tr><td colspan="2" rowspan="2">Name of the Tehsil</td><td rowspan="2">Total population</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>71,538</td><td>61,229</td><td>13,2767</td></tr>
<tr><td colspan="2" rowspan="2">Haveli</td><td rowspan="2">Literacy rate</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>69.69</td><td>51.67</td><td>61.38</td></tr>
<tr><td>Area/sq km</td><td>278.42sq.km</td><td rowspan="2">Total villages

51</td><td>Total household</td><td>Sex ratio</td><td>Languages</td></tr>
<tr><td>Population Density per sq. km</td><td>477per sq. km</td><td>25,558</td><td>856</td><td>Pahari, Kashmiri, Urdu and Gojri</td></tr>
<tr><td colspan="6">Source: Census, 2011</td></tr>
</table>

Haveli is a tehsil located in the Poonch district of Jammu and Kashmir. According to the census (2011), Tehsil Haveli is comprised of 51 total villages and 25,558 households, with a total population of 13, 2767, out of which 71,538 are males and 61,229 are females. The average sex ratio of the village is 856. The overall literacy rate of the village is 61.38 percent, whereas the total male literacy rate is 69.69 percent and the female literacy rate is 51.67 percent. Haveli has a total area of 278.42 sq. km. with an average population density of around 477 per sq. km. The majority of the population belongs to general castes and scheduled tribes, and the indigenous languages spoken here are Pahari, Kashmiri, Urdu, and Gojri.

3.7.2 Demography of Block Uri

Table No. 14: ***Represents the demographic profile of the block Uri***

<table>
<tr><td colspan="2" rowspan="2">Name of the Block</td><td rowspan="2">Total population</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>41,827</td><td>33,040</td><td>74,867</td></tr>
<tr><td colspan="2" rowspan="2">Uri</td><td rowspan="2">Literacy rate</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>64.11</td><td>33.59</td><td>50.64</td></tr>
<tr><td>Area/sq km</td><td>160.05sq.km</td><td rowspan="2">Total villages

148</td><td>Total household</td><td>Sex ratio</td><td>Languages</td></tr>
<tr><td>Population Density per sq. km</td><td>468per sq. km</td><td>12,109</td><td>790</td><td>Pahari, Kashmiri, Urdu and Gojri</td></tr>
<tr><td colspan="6">Source: Census, 2011</td></tr>
</table>

In Jammu and Kashmir, the sub-division, tehsil, and block uri are under the district Baramulla, located at an elevation of 1577 meters above sea level, approximately ten kilometers east of the Pakistan border. It is situated on the left bank of the Jhelum River. According to the census (2011), Uri Tehsil has 12,109 households with a total population of 74,867, of which 33,040 are female and 41827 are male. The average sex ratio is approximately 790. The total literacy rate is 50.64%, out of which 64.11% is male and 33.59% is female. Uri has a total area of 160.05 square kilometers, and the total villages in Uri Block are forty-eight. The majority of the population belongs to Pahari and Kashmiri castes and scheduled tribes. The indigenous languages spoken there are Pahari, Urdu, Kashmiri, and Gojri. The Pakistan border envelopes Uri Tehsil entirely,

with the majority of Uri's villages situated only within the catchment area, from zero to five kilometers from the Pakistan border. Some of the important villages close to the Pakistan border are: Addosa, Tulwari, Sallikoot, Dardkote, Churrunda, Sokar, Dachi, and Chakra. However, some villages are still under barbed wire, and most of the natives have migrated to the Uri town area; only a few houses are estimated and found in these villages. Even though no one is permitted inside these villages, only the villagers themselves are granted permission. Since the partition, there have been ongoing cross-border infiltrations, and approximately majority of the inhabitants do not prefer to live inside the villages.

3.7.3 Demography of block Balakote

Table No.15: ***Represents the demographic profile of blockBalakote***

<table>
<tr><td colspan="2" rowspan="2">Name of the Block</td><td rowspan="2">Total population</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>216</td><td>245</td><td>461</td></tr>
<tr><td colspan="2" rowspan="2">Balakote</td><td rowspan="2">Literacy rate</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>91.77</td><td>71.16</td><td>79.89</td></tr>
<tr><td>Area/sq km</td><td>574 hectares</td><td rowspan="2">Total villages

11</td><td>Total household</td><td>Sex ratio</td><td>Languages</td></tr>
<tr><td>Population Density per sq. km</td><td>80per sq. km</td><td>103</td><td>1134</td><td>Pahari, urdu and Gojri</td></tr>
<tr><td colspan="6">Source: Census, 2011</td></tr>
</table>

Balakote is a medium-sized village located in the Mendhar tehsil of Poonch district, Jammu and Kashmir. According to the census (2011), block Balakote is comprised of a total of 11 villages and 103 households, with a total population of 461, out of which 216 are males and 245 are females. The average sex ratio of the village is 1134. The overall literacy rate of the village is 79.89 percent, whereas the total male literacy rate is 91.77 percent and the female literacy rate is 71.16 percent. Balakote has a total area of 574 hectares with an average population density of around 80 per square kilometer. The majority of the population belongs to general castes, and minorities constitute the Schedule tribe population. The vernacular languages spoken there are Pahari, Urdu, and Gojri. In the same way, Balakote also lies very close to Pakistan, as the

demarcated line marked is called the Line of Actual Control (it is the military control line on both sides). Balakote has been divided into two parts: one called "India's Balakote" and the second named "Pakistan Balakote." However, some villages of the block of Balakote have been merged within the Pakistan dominion, and some parts lie under the control of India, and the whole area is known by the name "Balakote." However, the village names are not specified (Jacob, 2018).

3.8 Profile of the Sample Villages

The target villages from district Baramulla are selected at block level, as are the areas that are near the border. The block Uri that is close to the Pakistan border and selected villages of border villages are Addosa, which is about zero to five kilometers away; Tulwari, which is zero to two kilometers away; and Sallikoot, which is also situated at zero to two kilometers from the border. In fact, the village of Sallikoot lies very close to the border fence line, and half the area of this village is under Pakistan control. In the same way, for the Tulwari village location, half of the area is under Pakistan control. Both villages, Tulwari and Sallikoot, lie under the jurisdiction of India and Pakistan. However, the target villages from district Poonch are also selected at tehsil and block level and areas that are near the border Line of Control (LOC), and the selected villages from tehsil Haveli named Islamabad (India) lie within zero to one kilometer from the border, and block Balakote also located near about zero to one kilometer.

3.8.1 Profile of village Addosa

Table No. 16:*Represents the demographic profile of village Addosa*

<table>
<tr><td rowspan="2">Name of the Village</td><td rowspan="2">Total population</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td>175</td><td>205</td><td>380</td></tr>
<tr><td>Addosa</td><td rowspan="3">Literacy Rate</td><td>Male</td><td>Female</td><td>Total</td></tr>
<tr><td rowspan="2">Total Households = 63</td><td rowspan="2">74.86%</td><td rowspan="2">49.27 %</td><td rowspan="2">61.05</td></tr>
<tr><td colspan="5">Source: Census, 2011</td></tr>
</table>

According to the Census (2011), Addosa village is a block in the Uri tehsil of Baramulla district, Jammu and Kashmir. The total population of the village is 380, with 175 males and 205 females. There are around 63 households in the village, and the overall literacy rate is 61.05 percent, with males at 74.86 percent and females at 49.27 percent.

3.8.2 Profile of village Tulwari

Table No 17: ***Represents the demographic profile of village Tulwari***							
Village name	Total population			Total Households	Literacy Rate		
	Male	Female	Total		Male	Female	Total
Tulwari	253	223	476	86	47.53	66.80	57.77

Source: *Census, 2011*

According to the census (2011), village Tulwari is located in the Baramulla district's block Uri. The total population of the village is about 476, of which 253 are males and 223 are females. There are a total of 86 households in the village. The village's overall literacy rate is 57.77 percent, with 47.53 percent male and 66.80 percent female.

3.8.3 Profile of village Sallikoot

Table No. 18: ***Represents the demographic profile of village Sallikoot***							
Village name	Total population			Total Households	Literacy Rate		
	Male	Female	Total		Male	Female	Total
Sallikoot	91	103	194	33	75.77	71.84	80.22

Source: *Census, 201*Source: *Census, 2011*

According to the census (2011), the village Sallikoot is in block Uri of Baramulla district. The village's overall population is around 194, with 91 males and 103 females. There are only 33 households in the village. The village total literacy rate is 75.77 percent, with 80.22 percent male and 71.84 percent female.

3.8.4 Profile of village Islamabad

Table No. 19: ***Represents the demographic profile of village Islamabad***

Village name	Total population			Total Households	Literacy Rate		
	Male	Female	Total		Male	Female	Total
Islamabad	1727	850	877	341	69.42	49.02	59.51

Source: *Census, 2011*

Islamabad is the village that has been targeted in the present study. It comes under Tehsil Haveli and block Poonch of district Poonch. Islamabad (India) is a large village with 341 families living in Haveli tehsil of district Poonch, Jammu and Kashmir. According to the 2011 census, the total population in the village is around 1727, with a male population of 877 and a female population of 850. The village has a total of 341 households, and the majority of the natives belong to the scheduled tribe caste. In comparison to others, Islamabad has a lower literacy rate; it accounts for a total of 59.51 percent, with a male literacy rate of 69.42 percent and a female literacy rate of 49.02 percent. However, the village of Islamabad is also located near Pakistan fence, and the name of the village in itself resembles the name of Pakistan's state capital, "Islamabad," present in Pakistan. The name of the village that is located in India is derived from Pakistan's state name before partition and still continues with that. The village has been divided into two parts: half under the control of Pakistan and half under the control of India.

3.8.5 Profile of village Balakote

Table No. 20: ***Represents the demographic profile of village Balakote***						
Village Name	Total Population			Total Households	Literacy Rate		
	Male	Female	Total		Male	Female	Total
Balakote	216	245	461	103	79.89	71.16	67.16

Source: *Census, 2011*

Balakote (India) is a small to medium village with 103 families living in it, situated in the district of Poonch in Jammu and Kashmir. As per the 2011 census, the total population is about 461, with 216 males and 245 females, and the village has a total of 103 households. The overall literacy rate is 67.16 percent, whereas the male literacy rate is 79.89 percent and the female literacy rate is 71.16 percent. The same region has been divided into two parts, with half of it under the control of Pakistan (that region is also named Pakistan Balakote) and the other half under the control of India.

3.9 Social Geography of the Villages

Source: Field work

The villages and border areas of district Poonch are situated in the “Pir Panjal” range of Jammu and Kashmir. It is bordered by the line of control adjoining Pakistan. The topography of the Poonch district is mountainous, rugged, and hilly. The chief crops are wheat, rice (paddy), walnuts, garlic, pumpkin, potatoes, onions, rajmah, etc. The texture and profile of the soil are a little fertile, snowfall occurs at high altitudes during the winter months. Due to geographical terrain and climatic conditions, people have been suffering and do not prefer migration due to poor socio-economic conditions. The villages lying close to the border are Khardi, Kharmarda, Gulpur, Dagwar, and Islamabad. These villages are very remote from district Poonch and suffer from a lack of facilities like underdeveloped roads, transport, no developed health infrastructure, communication facilities, and electricity. The villages remain excluded for a minimum of two months during harsh winters due to heavy snowfall. The area remains covered in snow, and people face many hardships, but they still walk on foot to take food items to their houses. However, it is observed that only municipalities or town areas are developed.

Source: Field work

The topography of Uri tehsil/block in the Baramulla district is mountainous, hilly, and rough terrain. The major crops include rice, wheat, potatoes, garlic, etc., and the soil texture is a little sandy. Due to geographical terrain and climatic conditions, productivity is not much higher, and it is observed that many people have migrated to the town area because of disturbed lives. The villages are remote; they suffer from various problems such as network communication,

electricity, medical services, etc. In fact, it has been found that these regions remain cut off for a minimum of two to three months because of heavy snowfall. However, people still use mules to go outside the home in the absence of transport availability.

Source: Field work

The Uri block villages have been divided, with half lying under Pakistan; the village names are Tulwari and Sallikoot. Though one village named Charunda is still under army defense, locals have identity cards to enter the area, but nobody is allowed to enter the village. Because this village is half under India and half under Pakistan, both countries are meeting and showing interest in the same area.

3.10 Sampling Procedures and Sample Size

3.10.1 Sampling Design

Qualitative samples tend to be more purposeful than random. Sampling is the selection of objects or items that are taken from a larger population, called a sample, to represent the entire population. In the present study, the process of sampling and selection of sample size tends to be more strategic and purposeful. The present study is mainly descriptive and exploratory, conducted among married females in selected rural border villages of the districts of Baramulla

and Poonch in Jammu and Kashmir. However, the selected sample size is 107 to gather the data; forty-nine (49) samples were chosen from the district of Baramulla and fifty-eight (58) from Poonch district. The parameters for selecting the sample size are based on inclusion criteria based on location (border villages), age (19 to 40 years), and marital status (Cherry, 2022).

3.10.2 Approaches to Determine the Sample Size

Babbie (2010) stated in his work that non-probability sampling relies on purposive (judgmental) sampling, in which researchers rely on their judgment when choosing the target population to participate in their survey. Knowing the population, its components, and the purpose of the study should be taken into consideration when choosing a sample. In the present study, the approach is to determine and choose the sample size procedure through the purposive sampling method (Bullen, 2013). The purposive sampling method is used to deal with situations where it is not possible to identify a particular population, i.e., where there is no available list of population elements. Depending on the particular research questions being investigated, it would be possible to contact and interact with situations where it is not possible when there is no justified list of population available and to identify the specific population (Blaikie, 2000).

However, used purposive sampling methods in the present study for the selection of the target population and for the selection of samples in border villages (women) categorized. The extensive coverage for the selection of sample size has been reflected in the border villages of two districts, namely Baramulla and Poonch. It has been selected one block from Baramulla, which is Uri, and one tehsil and one block from Poonch district. The target villages from the block uri, namely Addosa, Tulwari, and Sallikoot, purposefully chosen within the blocks based on their target populations. In the same manner, two villages named Islamabad and Balakote has been selected from district Poonch.

3.10.3 Universe of the Target Area

Table No.21: ***Represents the universe area of sample***

S. No.	Village Name	Total Household	Total female population	Sample
1	Addosa	63	205	14
2	Tulwari	86	223	23
3	Sallikoot	33	103	8
4	Islamabad	341	850	44
5	Balakote	103	245	18

Source: Data from village Panchayat

3.10.4 Factors Influencing the Decision to Sample

3.10.4.1 Size of the Population

Blaikie (2000) opined that "It is the absolute size of the sample, not some ratio of the population size, which is important in determining sample size." The parameters of the homogenous population can be estimated with much smaller samples. The size of the smallest community becomes significant if the target population has migrated, and there must also be a sufficient number of individuals.

Singh (2019) stated if the population is small, the researcher may decide to include all in their study. On the other hand, if the size of the population is large, the researcher may decide to select a limited number of respondents from the target population. Whether the investigator regards it as a small or large population, or when the population is finite, the present study, the size of the population is small, finite, and has homogenous characteristics in nature. In the study, the target village areas are also small, and the researcher interacts with all the target population and selects a few respondents who meet the inclusion criteria of the study.

In the present study, it is not possible to ascertain beforehand to determine the sample size because the study demands the border villages that are nearly close to the fence area near the Pakistan border. However, time, resources, and social contextual factors may inevitably put some

restrictions on the sample size. On the other hand, regarding the records of officials such as Anganwadi Center data and informants like the village head (Sarpanch), they guided the further selection of samples and how to approach the target female population of the villages, which was found below the government record. After visiting the villages, many households have migrated and settled in town areas or anywhere else. The migrated people changed their addresses and records; very few are still staying in the villages, and they are in government records that show the natives of the village. Some people have migrated, but their household records are still linked with the same village, recorded on a local level. On the contrary, the village Islamabad is a larger area compared to others, but within this village, the researcher selected the sub-village part from which the sample met the inclusion criteria, and it was also observed during the field study that mostly people migrated from the village because of turmoil and found very few households from where the researcher selected the target sample.

3.11 Data Collection Process

3.11.1 Tools of Data Collection

The data has been collected from both primary and secondary sources. The tools used to collect primary data are as follows:

- Interview Schedule
- Focus Group Discussions
- Case Study

3.11.1.2 Pilot Study

Inn (2017) as stated the first step in the entire research protocol is a pilot study, which is generally a smaller-scale study that helps with planning and modifying the larger study. A pilot study is conducted with all the procedures of the main study and validates the study's feasibility by evaluating the inclusion and exclusion criteria of the participants. It also provides the information needed for the assessment of the research design, the research method, the process of data collection, and evaluating all other aspects of the study. Through the pilot study, researchers learn about the research processes used in the main study, which helps them choose the research

approach that is suitable to address the research question. Obtaining the preliminary data needed to determine the sample size for the main outcomes is one of the main reasons a pilot study is necessary. Nonetheless, concern must be taken when estimating the sample size needed for the primary examination.

The pilot study is important for the improvement of the quality and efficiency of the main study. To obtain high-quality outcomes, a good research study with a relevant design and accurate performance is required. Thereafter, the researcher has created a suitable framework for the interview schedule in order to collect the responses from the selected participants, and with due course of time, the researcher assumed about the framework observed with similarities and believed that the responses of the participants should be relevant and merely valuable for the inquiry.

3.11.1.3 Ethical Considerations in Research

Falk (2020) stated in his work that planning and conducting field research in a responsible way requires ethical concerns. It is critical to have a general understanding of the structure of the topic and its order before drafting a proposal. However, it is crucial to follow moral guidelines at all times during the data collection and research. In the present study, during collection of data the researcher promotes integrity and solidarity amongst the respondents, and the interviewees have agreed to participate and work ethically by making rapport with the target population on the field. There is no kind of constraint applied against consent and respect for the norms and traditions represented in this research in contact with participants. Although women's health issues can lead to sensitive questions or discussions during the interviews and are considered when preparing for the interviews, there should be research ethics to protect respondent's privacy and the researcher's ability to ensure the accuracy of collected data and social knowledge. The researcher's beliefs and thoughts about non-discrimination, to avoid discrimination and also to not be biased based on sex, race, ethnicity, caste, class, and other factors that are not related to their competence and integrity, to maintain and improve the skills that help promote competence in research, and also to know and obey relevant laws, institutional data, and governmental policies. In the present study, equal chances are given to every respondent, and they were actively participating in the research study while during field work. In the present study, to avoid

exploitation of participants, the researcher showed sympathy, equal treatment, and intimacy with all respondents because their involvement showed their interest in the study. The researcher followed their ethical duty to safeguard the participant's privacy and the informal conversation involved during data collection process and how it should be utilized in the study.

3.11.1.4 Interview Schedule

Babbie (2010) stated that open-ended interview schedules are more popular in research because they provide a greater uniformity of responses and are more easily processed than closed-ended questions. For the present study, the tool for collecting empirical data is open-ended questions designed in such a way that the researcher makes good rapport with the respondents and listens carefully to what participants perceive about their lived experiences, present situations, and social phenomena in their social settings. In the interview schedule, unstructured questions that have been prepared by the researcher themselves serve as a guide for interviewers to help in collecting information about a specific issue. It is a procedure under the self-reporting technique of individual data collection where the researcher makes face-to-face communication with the respondents, which provides flexibility to the interviewer, leads to more responses, and accurate information can be collected. Because of the open-ended and unstructured questions prepared, the researcher has the opportunity to change the questions and modify the answers of the respondents. An open-ended question has no limits on the response available to the interviewee and questions in which the respondent is asked to answer are provided by the researcher. During the field study, the researcher took responses using the interview schedule method, and while interviewing, the behavior of the respondents can be observed. To follow this method for this research has great significance to comprehend women's lives experiences in border areas of Jammu and Kashmir regions and contexts. The questions can, in this way, be more open-ended, involve the interviewee, and allow for a discussion with them (Falk, 2020).

3.11.1.5 Focus Group Discussion

Singh (2017) opined in his work and discussed about focus group discussion are a useful tool for gathering relevant data in social research, as they allow participants to share their own opinions and views as well as data generated through interaction. The interviewee and the interviewer

engage in an open-ended verbal conversation and express themselves verbally as well as non-verbally to spark new thoughts and present insightful information. It is a research method that brings together a small group of people to answer questions in a moderate setting. It is frequently used as a qualitative approach to gain an in-depth understanding of social issues. In the present study, the focus group discussion involves gathering information from similar backgrounds and experiences to discuss a specific phenomenon and asking questions about their perceptions, emotions, beliefs, opinions, and ideas. In a focus group discussion, participants are free to talk within the group members. In the present study, a focus group discussion has been conducted amongst married women in the target areas, especially at hospitals and labor rooms, and in Anganwadi centers, where a number of women disclosed their problems related to their reproductive and maternal issues, the impact of turmoil in the region, and other influencing social factors on their overall health and stimulating activities, which can provide the researcher with useful insights. Employing this method in the present study aims to obtain data from a purposefully selected group of respondents and help in gaining insights into respondents' shared understanding of everyday life and how they are influenced by others in a group situation.

3.11.1.6 Case Study

Blaikie (2000) opined that, throughout the history of social research, case studies have been regarded as a method of data collection. The credit for introducing this method to the field of social investigation goes to Frederic Le Play, who used it as a handmaiden to statistics in his studies of family budgets. In the words of Charles Horton Cooley, case study deepens our perception and gives us a clearer insight into the life of the respondent. In the present study, case studies are used as a research method on one single respondent for a researcher to study one aspect of a problem in some depth and gain an understanding of a specific issue in its real-life context (Yin, 1989).The case study method has significance for describing, comparing, evaluating, and understanding different aspects of a research problem, and this method is essentially important for an intensive investigation in the border region of Jammu and Kashmir. The present study demands the case study method because it is observed that there is "intersectionality" found between castes, culture, and its relationship with the social factors and forces involved in its surrounding environment. Through case study methods, a researcher

obtains a real record of personal experiences, inner strivings, emotions, tensions, and certain patterns of behavior and gains an in-depth study of the woman's life history (Cherry, 2022).

3.12 Data Analysis and Interpretation

The two approaches followed in the present study to analysis the data.

3.12. 1 Thematic Content Analysis

Flick (2014) stated in his work that the process of finding themes in the data that convey meaning pertinent to the research question and possible connections between these themes and associated sub-themes is known as thematic content analysis. The researcher can find patterns in the data by using and connecting research questions linked to conceptual and theoretical concepts in one way, and also by examining the link between data and thematic analysis to preserve the connection of data to their original context. The methodical (systematic) process of identifying themes can be part of a qualitative approach to data analysis.

Yin (2015) opined that qualitative data analysis used the "Thematic Content Analysis" approach to analyze the data without coding; only themes were generated and transcripts were written. The data in the present study has been analyzed manually, in which transcripts should be read and re-read numerous times, and the researcher needs rigorous knowledge to draw the themes. The steps involved in the present study are as given below:

1. Compiling
2. Disassemble Data
3. Re-Assemble Data
4. Interpreting Data
5. Conclude

1. Compiling: The very first step involved in the present study is compiling notes prepared from the fieldwork, data collection, and then putting the data in order.

2. Disassemble Data: The second step involved assembling the compiled data into smaller fragments, confirmed as the disassembling process. To assign themes to the fragment

data, then re-organize the disassembled fragment data into a sequence that falls in the original notes. Therefore, in the present study, non-coding data has obtained by following the disassembling procedure involved to identify the text from the original database and create a new set of substantive notes.

3. Re-assemble Data: This step involved in the study when, at the time of the disassembling phase (when data is not coding), the researcher should be aware of potentially broader patterns in the data. The reassembling procedure involved "playing with the data," which means considering them under different arrangements and themes and then altering and re-altering the arrangements and themes until output emerges that seems satisfactory. That means emerging patterns should make sense and patterns should relate to the concepts in the study.
4. Interpreting Data: The fourth step involved in the study is re-arrangement and re-combinations, which are facilitated by depicting the data graphically or in tabular form. The next phase involved using the reassembled data to create a new narrative with accompanying tables and graphics, which became the key analytic portion of the draft manuscript. This phase considered interpreting the re-assembled data.
5. Conclude: The fifth step involved the concluding phase, and to draw conclusions from the study, such conclusions should be related to the interpretations of the study. Therefore, in the present study, the conclusion is overarching statements that raise the findings of the study.

3.12.2 Narrative analysis

Flick (2014) stated the most commonly used method in qualitative studies are narrative analysis, and highlighted alternatives to categorizing analysis in case study or disclosing oral narrative stories that are purely based on non-fiction attributes and are predominantly factual representations. In order to create a picture of a unique individual, the holistic approach prioritized and also placed emphasis on comparing, evaluating, contrasting, and being involved in special cases. The approach is to know the in-depth issue of an individual, discuss the topic holistically, sum up additional exceptions and portraits, and categorize the analysis into case study reports. In the present study, the narrative analysis process used, especially in explanation

of case study, confounded that claim by describing case studies as presenting a holistic portrayal of the individual.

3.12.3 Data Interpretation

3.12.3.1 The Intersectionality Approach

Creenshaw (1989) introduced the concept of "intersectionality" in her ground-breaking analysis of United States anti-discrimination laws, pointing out that these laws neglected to recognize black women's particular experiences of sexism and racism as occurring simultaneously and intertwined. In the health sciences, "intersectionality" theory has recently come into the limelight as a critical theoretical and methodological approach to qualitative research. The approach is also used as a qualitative analytical framework that was created in the latter half of the 20th century. It describes how interlocking power structures impact the most marginalized sections of society. For instance, Dalits, Blacks, the working class, Scheduled Castes, and Scheduled Tribes, but amongst all, they are especially focused on women. The idea has been used in feminist research on the ways women are positioned as women and as individuals. The approach also acts as a theoretical foundation that helps to make social realities more apparent, and it acts as a mapping tool for geographic and social movements and social disparities. It is observed that the social identities that overlap and intersect can be oppressive as well as empowering. However, it intervenes in the existing paradigms in relation to the political unrest and social inequalities in the border areas and associated challenges to women's health. By challenging discourses about social hierarchies, inequalities, the dispassionate distribution of resources, the state's controlling mechanism, and class and caste categories, it intervenes in the current paradigms of social differentiation that trace a long history about border regions of Jammu and Kashmir to reproduce knowledge (Lindstrom & Rushton, 2013). In the present study, this approach used as a conceptual basis offers a framework to explore and examine social factors, hierarchies, discrimination, inequalities, contextual and structural determinants, and the subjugation of women. This study employed "intersectionality" to map out the various intersections and overlaps with each other that need to be differentiated and to investigate the health challenges among women in the border areas; however, it is also an approach used as a framework for

examining the impact of political turmoil on the lives of women living in border villages in Jammu and Kashmir (Chaulagain and Pathak, 2021).

3.13 Role of the Researcher

The "emic and etic" approaches have been employed by the researcher for this study because they are qualitative in nature. The researcher focused on an individual or any group or community's lived experiences, behaviors, and thoughts within a culturally contextualized framework, acting in both Insider and Outsider roles.

In order to frame the situation and the research questions, which frequently require researchers to explain themselves and try to understand the situation in their own terms, the "emic and etic" approaches served as the theoretical foundation. The position and role of the researcher during the study, as well as how to apply reflexivity throughout, are addressed by the "emic and etic" approach, which offers the framework and instructions for tackling the idea of positionality.

3.13.1. Positionality

Smith (1993) stated that "social researchers should recognize their own positionality in research in order to explore the phenomenon under study with no or few researchers' interruptions". Researchers in the social sciences are often required to explore and explain their positionality, as, in the social world, it is recognized that their ontological and epistemological beliefs influence their research. Positionality "reflects the position that the researcher has chosen to adopt within a given research study". Positionality is normally identified by locating the researcher in about three areas: (1) the subject under investigation, (2) the research participants, and (3) the research context and process.

Being a Kashmiri Muslim female and local to the study area, especially conducting studies in one's own community in a home environment, is always a challenging task. However, by following academic ethics, discipline, and guidelines, the study has been conducted. However, framing the research questions and research objectives the researcher neither followed the religious identity nor gender identity nor being local to the study area have any kind of prejudice. In the present study, as the literature survey, data collection, and analysis have been done by

employing scientific methods. Being an insider helped the researcher establish good rapport and interactions between the researcher and the respondents throughout the process of the study. However, during Pilot study it provides the pathway to frame the research questions and research objectives in a righteous manner.

During a field study, it has been observed that something is similar and something can be different in the region. Biologically, females are the same, and their health issues are the same at some and may not be same at some moment. If we can examine in the Middle East countries, women's health issues are the same, though in the border region has the same cultural values and shared lived experiences about social circumstances and effect on health because of turmoil. In the present study, the role of positionality and purpose is to help researchers to better understand the study (Calabrese Barton, 1998).

3.13.2 Reflexivity

Reflexivity is the concept that researchers should acknowledge and disclose themselves in their research, seeking to understand their part in it or their influence on it. Reflexivity is necessarily required in the present study by the researcher with regard to their cultural, political, and social context because the individual's ethics, personal integrity, and social values, as well as their competency, influence the research process (Bryman, 2016).

Danielewicz (2001) describes "reflexivity as an act of self-consciousness that can lead to a deepened understanding of the phenomenon." Reflexivity is all about what you learned and what you unlearned during the study process. In the present study, reflexivity helped the researcher to make an in-depth inquiry into the study, to address it, and to identify the limitations of the study design in understanding women's issues in a culturally sensitive society. Sociologically, the concept of communities is fundamental, and in the border villages, they have similar characteristics such as we-feeling, specific territorial region, homogeneity, sharing a common way of life, sharing common customs, and a strong sense of community sentiment. It is also reported through secondary sources that the distance of the villages reported was five kilometers away from the Pakistan border, but in the field, the researcher observed there was less distance within two or one kilometers and in some villages within zero kilometers as a ground reality.

3.13.3 Researcher Role as Insider

In the present study, the researcher discussed the benefits of having an insider position, including how it makes it easier to obtain information about the culture under study and how it allows one to build rapport and familiarity with the respondents over time. It aids the researcher in posing queries, looking into issues, and learning about thought-provoking conversations and questions. Being an insider in the community or target group was advantageous for the researcher. The insider is someone who has lived familiarity and prior knowledge of the group being researched because of their personal biography, which includes information about their gender, caste, race, religion, language, class, and so forth. Since the researcher is more reliable, answers from them might be more truthful and consistent. The language, including that of the indigenous people, and non-verbal clues are easier for the researcher to comprehend. Even so, the border region is specific and shares similar shared experiences and cultural values. In this study, reflexivity assisted the researcher in gaining a thorough understanding of the study's inquiries, addressing them, and recognizing the study design's limitations in comprehending women's issues in a culturally sensitive society. Sociologically speaking, the idea of a community is fundamental, and border villages share many traits, including homogeneity, a shared way of life, shared customs, and a strong sense of community sentiment.

However, it was observed during field study that respondents are completely illiterate; aside from their native languages of Pahari, Kashmiri, and Gojri, they are also unable to speak in Hindi, Urdu, or English. Additionally, secondary sources reported that the villages distance from the Pakistan border was confined within five kilometers; the field researcher actually observed that the actual distance was very close, near about one to two kilometers, and in some cases, it was as close as zero kilometers as a ground reality.

3.13.4 Researcher Role as Outsider

Being an outsider or someone who is not a part of the community or the same socio-cultural group, the researcher does not have any prior intimate knowledge of the target group, their circumstances, culture, or other factors. It is always a difficult, challenging, and uncertain task for a researcher to conduct research in border regions that are close to the Line of Control (LOC). This is an area where people always fear for their lives because they do not have the courage to

go near the horrific incidents that happen in their daily lives, such as unexpected random shelling and mine explosions. Because no one knows where the land mines have been fixed, there is an increased risk of researching and entering certain villages that are covered in them. Certain villages remain under security control, and no one is allowed to enter, even with permission from the authorities.

Nonetheless, the researcher has encountered and experienced all such difficulties and challenges during the fieldwork. Due to security reasons, it was observed that, mostly in the villages, there are no milestones available for showing directions to identify villages. The researcher followed work ethics by building rapport with the target population on the ground and respondents had given their consent to participate in the study. The researcher promoted integrity and cooperation among the respondents in order to increase participant's involvement. For the purpose of preserving participant privacy and guaranteeing the accuracy of data collection and social knowledge, research ethics should be followed in the present study.

3.13.5 Field Work Experienced

During the field study, it has been observed that the geographical location is purely difficult, hilly, mountainous, and tough terrain. In the village, there is also a tribal population, mainly Gujjars and Bakerwals, observed as a nomadic community whose primary occupation is cattle rearing for the means of their livelihood. Every year, with the onset of summer, these tribes go to the higher reaches of the Pir Panjal mountains with their cattle, sheep, goats, and buffalos, particularly in winter when pastures are reduced. While Gujjars are semi-sedentary goes to the lower or middle mountains with their cattle, their occupation is selling milk and milk products. The majority of the population has Kaccha houses and mainly dependent on agriculture and pastoral cattle rearing only for their livelihood. The social factors such as poverty, ignorance, illiteracy, lack of resources, low income, unemployment, early marriages, no infrastructure, especially health infrastructure, no development, no benefit of government schemes observed in the region, still there is always a fear of turmoil in these villages.

Regarding the social and cultural composition of the region, people can be said to share mechanical solidarity, and society is closed off. Since people interact with each other a lot,

society has a high moral density. The residents are from lower socio-economic classes and disadvantaged groups. Their primary and allied occupations, such as handicrafts such as knitting, embroidery, basket making, pottery, etc., are their main pursuits, or we can say that because of their heavy household responsibilities and mental stress from chaos and fear, they have limited access to health care. In the target villages in Uri block, the researcher observed that there is no such primary health center, dispensaries have been established, no health workers are available, and even there is no Anganwadi center existing. The researcher also observed during focus group discussions with the respondents that the majority of the women are still unaware of government schemes and their policies.

Researcher dialogue with Informant (Asha Worker) acknowledges all of the concerns and affirms that border villages are experiencing various issues and have hardships in their lives. Even though, during the COVID-19 pandemic, they suffered a lot with minimum resources and faced other health challenges. Many of the women from the far-flung border villages walked about 20 to 30 kilometers to the district hospital for medical concerns because hospitals are located in the town area and far away from border villages.

3.13.6 Observations and Barrier during the Field Study

It is difficult to conduct research in border areas and challenging due to various factors such as geo-political location, topography, and security concerns. The field study, which lasted almost three months, presented challenges for the researcher, who also occasionally fell ill. There is no reliable transportation system, and the terrain is very rough, rugged, harsh, and steep. In addition, the researcher undertook a long-distance walk for around 20 to 25 km by foot. However, the researcher was terrified to carry out research in border regions that are very near the Line of Control (LOC). Some villages have underground land mines, while others have entrance restrictions based on security concerns. At the moment, nobody knows where the mines are beneath the earth, so it is risky for anyone not familiar with the layout of the village to try to enter. There are, nevertheless, some locations without any landmarks that can be used to guide the way. The researcher encountered further challenges in identifying the village because border areas are erratic with thick forest ranges, and there is also issue of wild animals and mine explosions happen instantly and shelling occurs randomly.

3.14 Limitations of the Study

One major limitation of the present study included only reproductive and maternal health and social factors associated with various challenges to women's health. However, a qualitative study could inevitably have some limitations because the quality of the research greatly depends on the researcher's interpretation and analysis. The researcher's interpretation can readily and unintentionally have an impact on this kind of subjective research. Despite the fact that every attempt and effort has been made to adhere to the information provided in the participant stories that were recorded, the limitations of any qualitative study must be taken into account when interpreting the findings of the investigation. Conducting research in border areas is hectic with respect to geo-political location, security issues and other factors. However, in the present study, the border village selected those very close to Line of Control (LOC).There is always a fear for anyone to do research in border zones that are very near to Pakistan and nobody prefers to go inside these areas.

3.14.1 Delimitations of the Study

- In the conflict-ridden area and this perpetual turmoil, researchers rarely preferred to study. The present study has been widely delimited.
- The selected districts lie near the Line of Control.
- It covers the villages from the Tehsil and Blocks of both districts of Jammu and Kashmir, namely Baramulla and Poonch.
- The extent of the study has been confined to the concept Turmoil, Women, and Health in a broader context.
- The locale of the present study mainly covers rural areas of Jammu and Kashmir.
- The selection criteria for sample size are confined to only marry females.
- The present study is restricted to only border villages of Jammu and Kashmir.

3.15 Summary

This chapter discusses the philosophical concepts of epistemological and methodological stances that are necessary for the study to provide findings that reflect the actuality of the world and the phenomena being studied that represent the research paradigm. The research process is directed by theoretical perspectives; methodological research includes research design and techniques. Followed the constructivist approach to analyze the perceptions and subjective thoughts of the respondents about the context of the study and, more subtly, to conduct a more thorough organizational study to employ the phenomenology approach and put forth as a qualitative method, social setting and sampling, role of the researcher, and to followed ethics should be must for every research. However, thematic content analysis and narrative analysis were both employed to comprehend the characteristics, discussions, and findings of the study.

CHAPTER-4

Results and Discussion of the Study

4.0 Introduction

This chapter deals with the results, analysis, and discussions of the study. It deals with the data interpretation and analysis of the results on the health status of women in the study area in Jammu and Kashmir.

- Section 1: represents the participants' demographic details.
- Section 2: highlights the challenges pertinent to health issues and challenges experienced by women in the study areas of Jammu and Kashmir.
- Section 3: represents findings related to problems of pregnancy care and delivery complications in the study areas of Jammu and Kashmir.
- Section 4: explains the impact of turmoil on the maternal health condition of women in border areas of Jammu and Kashmir.
- Section 5: represents the case study of the respondents in the study areas of Jammu and Kashmir.

For data analysis, primary data has been systematically designed for qualitative analysis. Thematic content analysis approach used as a qualitative method, and Microsoft Excel also used for frequency distribution to find the percentile on socio-economic issues affecting women's health. Further narrative analysis was done to describe the case study of the participants. By following this method, the three main objectives of the study has been qualitatively analyzed.

4.1 Demographic profile of the Respondents

Table No. 22: ***Represents the demographic profile of the participants included in the study (N=107)***

S. No.	Demographic Variables	Variables Parameter	Frequency	Percentage (%)
1	Gender	Female	107	100%
2	Age Groups	Minimum	19	17.75%
		Maximum	40	37.38%
3	Marital Status	Married	107	100%
4	No. of Children	Minimum	4	3.73%
		Maximum	7	6.54%
5	Caste	General	63	58.87%
		Scheduled Tribes	44	41.12%
6	Education Status	Primary	43	40.18%
		Middle	13	12.14%
		Higher	Nil	Zero
		Uneducated	51	47.66%
7	Socio-economic Status	Upper Class	Nil	Zero
		Middle Class	5	4.67
		Below Poverty Line	102	95.32%
8	Widow	No	Nil	Zero
9	Family Type	Joint	89	83.17%
		Nuclear	18	16.82%
10	Locale	Rural Areas	107	100%
11	Structure of the House	Kaccha	60	56.07%
		Pacca	11	10.28%
		Semi- Kaccha	17	15.88%
		Both Kaccha and Pacca	19	17.75%
12	Religion	Islam	107	100%

Source: Primary Data

4.1.1.1. Gender: The total selected number (107) of respondents is mainly female. In the present study, there is only female participation.

4.1.1.2. Age of the Respondents: The age of the respondents is categorized into two groups, i.e., the minimum and the maximum. The minimum age is fixed at 19 years, whereas the maximum age is 40 years. The total 107 respondents have been interviewed.

4.1.1.3. Marital Status: In the present study, only married women up to 19 to forty years of age have been selected from the border villages of Jammu and Kashmir.

4.1.1.4 Number of Children: In the present study, the minimum ratio of children is up to four and the maximum is seven.

4.1.1.5. Caste of the Respondents: In the present study, the majority of the respondents, 63 (58.87%) out of 107, belong to general castes, viz., Pahari and Kashmiri, followed by 44 (41.1%) out of 107 respondents belonging to scheduled tribes (Gujjar and Bakarwal).

4.1.1.6 Educational Status: The data reflects from the given above table that the majority of the respondents have varied educational backgrounds; around 51 out of 107 (47.66%) are uneducated, 43 (40.18%) respondents have up to primary education, and 13 (12.14%) have attained middle-level education and found no higher education; it remarks at zero (0%). It reflects that the majority of the participants meet uneducated criteria.

4.1.1.7 Socio-Economic Status: The table highlights the respondents' socio-economic background. In the study, not much respondent belongs to the upper class, and with the very least selected respondents, only 5 (4.67%) out of 107 belong to the middle class, but predominantly respondents, 102 (95.32%) out of 107, belong to those below the poverty line, have poor living styles, and have low resources.

4.1.1.8 Widow: In the present study, no widow participant has been included; they meet the exclusion criteria.

4.1.1.9 Family Type: The type of family in which a woman lives may also affect her health. Generally, it is seen that a woman living in a nuclear family may have more freedom to exercise

her own decisions and choices, which may not be possible for a woman living in a joint family. The family type is considered an important variable in sociological analysis. On the basis of the type of family, the respondents are classified into two categories: joint and nuclear. The table disclosed that the majority of the respondents, 89 (83.17%) out of 107, have a joint family structure, whereas respondents 18 (16.82%) out of 107 have nuclear families. The above data fact reflects that the majority of the respondents do not prefer nuclear family structures.

4.1.1. 10 Locale: The table depicts that the target respondents total 107 (100%) belong to rural areas in the border villages of the districts of Baramulla and Poonch and have resided in the specified area for a very long time.

4.1.1.11 Structure of the House: The house type of the respondents is also an important variable to know the living condition of the respondents. Hence, the respondents are categorized into three categories: 1) Kuccha house 2) Pucca House 3) Semi-Kaccha house 4) Both the Kaccha and Pacca houses. Due to a lack of resources, the majority of the respondents have Kaccha houses, around 60 (56.07%), followed by 11 (10.28%) who have Pacca houses, 17 (15.88%) who have a semi-Kaccha house pattern and 19 (17.75%) who have both Kaccha and Pacca houses. It reflects from the data that a very small number of respondents have a Pacca house structure, and a small number of respondents have both Kaccha and Pacca houses.

4.1.1.12 Religion of the Respondents: Religion tends to be an important characteristic, as it is often tied to customs, beliefs, and traditions. The above table data depicts that all respondents, 107 (100%) out of 107 of the border village community, can be broadly classified into one religious practice, which is Islam.

4.2 Section 2: Represents the findings for the objective highlighting the challenges and health issues faced by women in the border areas of Jammu and Kashmir has been summarized into broad themes and sub-themes as presented in Table No. 23.

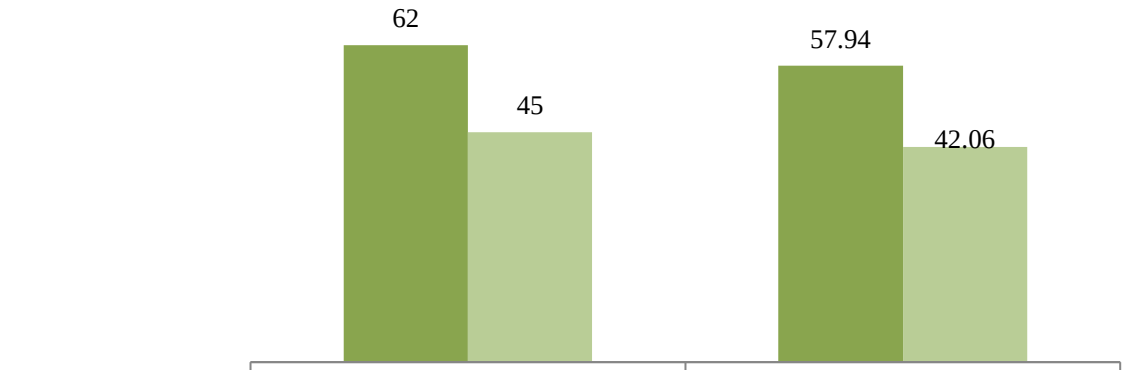
Table No. 23: ***Represents the objective one, themes and sub-themes of the study***		
Objective	Themes	Sub-Themes
To identify the challenges and health issues faced by the women in the border areas of Jammu and Kashmir.	1. Geographical factors	1. Strategic Location
		2. Climate
	2. Socio-Economic Challenges	1. Illiteracy and Educational status.
		2. Occupation and financial Insecurity
		3. Poverty
		4. Role of Governance
	3. Physical Infrastructure	1. Road and Connectivity
		2. Health Infrastructure
	4. Cultural Practices and Beliefs	1. Traditions and customs
		2. Early Marriages
		3. Son Preference

TableNo.24:*Represents the description of respondents with respect to Theme one (Geographical Factors) N=107*

Theme	Sub-Themes	Frequency	Percentage
Geographical Factors	Strategic Location	62	57.94
	Climate	45	42.06
Total		107	100

Table No. 24 explained the geographical factors. Geographical factors play an important role in any kind of health issue or challenge. Broadly, the geographical location and climate of the location have an impact on women health. Findings infer that the majority of the respondents, 62 (57.94%), revealed that the strategic location, topography, and mountainous terrain are the biggest challenges, followed by around 45 (42.05%), who outlined that climate is another major moderating factor and not satisfactory in the region, especially during winters.

Figure 17: Graphical representation of Table No. 24



	Frequency	Percentage
Strategic Location	62	57.94
Climate	45	42.06

Strategic Location

Turmoil anywhere in the world definitely disturbs the lives of people. The region is totally bordered by Pakistan's border line. There is about 75-year-old rivalry, dispute, and unrest in border areas, which is not safe for everyone. Every day, they have to prepare to face random shelling and insurgency issues.

Although there is one border named the Attari-Wagah border in the Amritsar district of Punjab, here the circumstances are different; there is no random shelling or insurgencies observed. Inhabitants are living peacefully, and here in Jammu and Kashmir, circumstances are different because both nations have mutually antagonistic thoughts and contention and have contradictory opinions and claims over the territory of Kashmir and due to this, there is continued unrest in the region. In fact, during the field study, it was observed that some villages are under the control of the Indian Army and covered by barbed wire, located just at the zero line from Pakistan. However, some villages are divided into two parts: one part lies under the jurisdiction of Pakistan, and the other part is under India. In these villages, roads are mostly used for Army services, not for local people. Majority of the women residing in these villages experienced various challenges because of turmoil situation and problems in their daily routine, and they found themselves helpless.

Therefore, turmoil has a severe impact on women's health; they are unable to avail timely treatment, which has negative consequences for their health, and at the time of cross-firing, they are not able to go outside anywhere and remain inside the home, which is a great challenge every time women are facing it. Turmoil creates a fearful situation and also has effects on a woman's mental health because of random mortar shelling. It creates a more drastic sound in the village, and then an explosion of shelling somewhere creates another tension. Sometimes shelling explodes near their houses within a zero to one kilometer catchment area, especially during escalation and firing from both sides of the border. The mortar-shelling situation is really fearful, and if anyone goes in front of that zone, they might die. The distress in the border villages makes the women social lives disturbed and leads to a more stress-prone lifestyle. During the field study, it was observed that there are security issues for the inhabitants, especially for women, because of their fear of the army and external forces; they are deprived of many opportunities. In the region, when there is continued attack by Pakistan mortar shelling to destroy their crops and attacks on domestic cattle and animals when they are grazing, suddenly injured due to firing or shelling, sometimes cattle die and even occasionally humans become victims, and some death cases are reported during shelling. Respondents have opinions about tension and stress linked to and influenced by the turmoil, both unintentionally and spontaneously, that the circumstances provide, even if they are not capable of carrying it.

Respondent No. 2, age 34, stated, "In the year 2019, my brother was sitting outside our home when suddenly there was a mortar fired from Pakistan's side, and it hit the head of my brother. My brother died on the spot, and it was a bad incident for my family. At that time, I was six months (24 weeks) pregnant, and I was under stress. Later, I was diagnosed with an anxiety issue. Due to shelling, many people got injured in our village while working in the fields or at the time of cross-firing".

The above statement revealed the heart-wrenching, destructive incident that really experienced an unacceptable moment. The participant shared what happened to their family, how she became victimized by this occurrence, and the consequences for her mental health, diagnosed with anxiety only because of the turmoil. Moreover, the same events happened in the villages where the inhabitants became victims since the partition between the two nations.

From the interview with the respondent, it is clear that turmoil has had a severe impact on women's lives since marriage. Women are still suffering and encountering challenges as well as threats from circumstances like fear and stress. They always prefer to hide inside their houses; even they do not go outside their homes for many days because of the fear of random shelling and cross-firing. It was observed from the respondent's interview that sometimes army personnel searched the area, including their house, in search of infiltration. During the field study, it was found in one village some houses were set on fire. Due to continuous fear and threat, most of the households have been migrated to the town area and the village is until now under barbed wires, and half of the area is under the control of Pakistan and half is lying with India. From here, analysis is subjected to how villages are near Pakistan, and this is the major reason for insurgency, infiltration, and smuggling, which pose a challenging life to women. Turmoil, seem to agree that structural imbalances, uncertainties, ambiguity in social structure coordination, competition for limited resources, differences in the social system, and interests are some of the causes (Hassan and Shafi, 2013).

Climate

The present study area lies within a unique geographical territory, both geographically and politically. The region lies on horrendous geography and rough terrain that is very rugged, hilly, and mountainous. During the field study, it has been noticed that both topography and climate are major challenges for local residents due to the hectic and fearful environmental cataclysm and irrevocable impact of climate change. They are facing many problems, like leakage on the terrace, because the majority of people have Kaccha houses. On the other hand, during winter, snowfall is a major challenge, which results in water on roads and creates difficulty while walking. During field study, it was observed that the landforms are interconnected with both nations, such as mountains and rivers, and one example of a tributary of the river named "Haji Peer Nala" from the Pakistan side is flowing into the Khardii-Kharmarda village of district Poonch and also flowing into the villages Tulwari and Sallikoot in Uri block, and they returned to Pakistan after flowing in these villages of Jammu and Kashmir, India.

Sheikh (2016) revealed that climatic variations create challenges for women living in border areas, along with ongoing political turmoil. In fact, respondents revealed they were affected by

landmine blasts because of the heavy rain and snowfall, the under-earth landmines are moved from their initial location, making it challenging to find and deactivate them, and in some cases, they are moved towards the village area, where they cause life loss and damage.

Respondent no. 44, age 37, during the conversation says, *"I have a kaccha house. We don't have a grocery store near our house. There is a problem during snowfall, and we are suffering from the issue of water during rainfall. Rainfall water comes inside the home, and we kept awake some nights due to this. In winter, due to climatic change, our lives are not meant to be stable for around three months. We observed a harsh cold, and almost all of us fell ill."*

From the above statement, it is stated that the respondents are really facing hardships in the region, taking climate variations as the biggest challenge because mostly people have kaccha houses, and in winters there is the highest snowfall rate noticed. Because of the torrential rainfall, the water gets inside their houses, making it difficult to stay inside, and there is no other choice for inhabitants to go anywhere. Besides this, there is no healthcare availability and a lack of other resources observed.

Respondent no. 7, age 33, revealed that "During the winter season, at snowfall, my family kept inside our homes for at least two months, and we remained in the home during snowfall. Only my husband goes outside for food items and other things. There is no electricity for more than one or two months, and we live in darkness and burn candles, or "Chullahs" and "Diyas." In our village, there is no local bus, car, or auto available, and roads are not developed."

The above statement was revealed by the respondent about the problems faced during the winter. In the region, they faced various issues, such as electricity and road connectivity, which are the major problems. They used to light the candles or use traditional sources to overcome the electricity issue, but mostly they prefer to keep them inside the house because nobody wants to go outside in harsh and severe cold and underdeveloped and complicated ways with trenches and horrendous terrain.

Dimitrov (2019), in rural areas, geographical topography is always inhospitable, and women are vulnerable to climate changes that affect their daily routine. Women affected by climate change are mostly affected, which is always compared to their vulnerability. However, the ecological

vulnerability in the aftermath makes women move in search of food and fodder for their livelihoods due to the changing environment, and the climatic conditions and strategic locations make them difficult in many ways.

In the border areas, there are factors such as geo-political strategic location, mountainous landscape, and unfavorable climate, and prevailing circumstances like random shelling and deployed land mine incidents are being considered as leading challenges. Hence, it is observed that no outsider government official prefers to come inside the region which is near to Line of Control. The majority of the respondents also expressed that in their region there is no proper transport facility, which is the one of the major reasons that pregnant women cannot walk in hilly and mountainous areas to visit the distribution centers like Anganwadi.

In the winter, due to heavy snowfall roads are remain blocked for several months and that time the locality are facing challenges and unable to move outside to access health benefits. Nevertheless, the respondents expressed due to difficult landscape and unfavorable climate condition all the sponsored schemes for women's wellbeing, especially women's health are being not materialize at the grass roots level. However, the foremost challenge in the region is security issues and because of security reasons, in some areas nobody allowed to enter because these are under control by security forces. People need special permission and every local resident having pass card and they have proper fixed time to go outside.

Interpretation

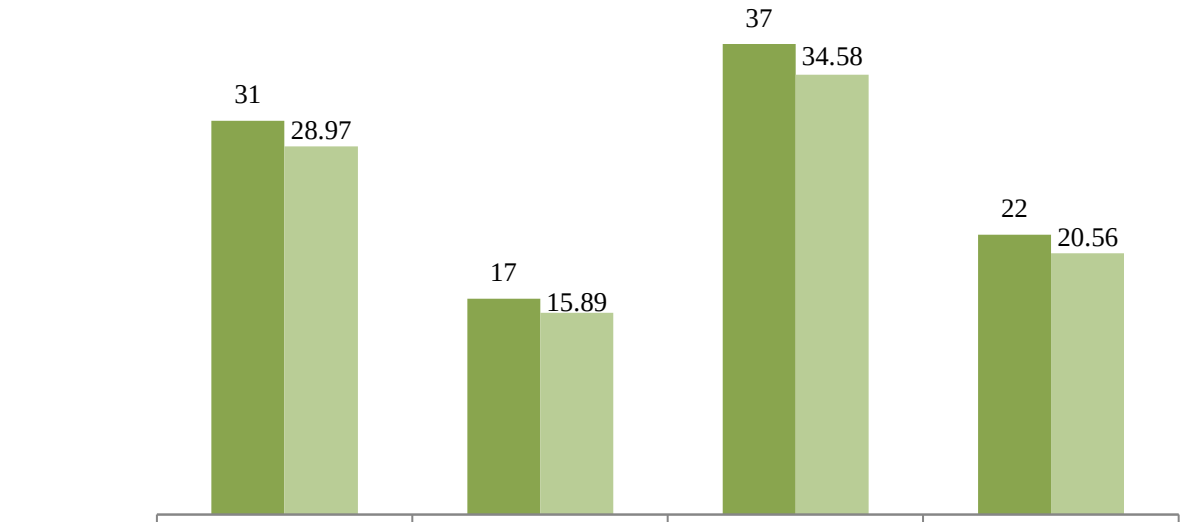
The everyday lives and lived experiences of women in the study area were affected by turmoil, horrendous geographical location, and climatic variations in numerous ways. They bear various challenges because they live on hilly and rough terrain, which has the impact of seasonal variations. From the above narratives, it is observed that life in the border areas is not safe; each moment there is a threat that negatively affects the health of every woman. They become more vulnerable because of the ongoing turmoil in the area. It is clear that the turmoil is, in fact, harmful for the living inhabitants, mainly women in the region.

Table No. 25:*Represents the description of respondents with respect to Theme two (Socio-economic challenges) N=107*

Theme	Sub-Themes	Frequency	Percentage
Socio-Economic Challenges	Illiteracy and Educational Status	31	28.97
	Occupation and Financial Insecurity	17	15.89
	Poverty	37	34.58
	Role of Governance	22	20.56
Total		107	100

Table No. 25 reflects the data about socio-economic indicators of the respondents, and it depicts that the majority of the respondents, 37 (34.58%), revealed that poverty is the major and most dominant challenge in the region, while the majority falls below the poverty criteria, followed by 31 (28.97%), who disclosed that being uneducated makes life more difficult for women, and around 17 (15.89%) revealed that financial crises and economic dependency affect women's health in numerous ways, whereas 22 (20.56%) respondents revealed the problems faced because of the deficient role of governance in the region.

Figure 18: Graphical representation of Table No. 25



	Illiteracy and Educational Status	Occupation and Financial Insecurity	Poverty	Role of Governance
Frequency	31	17	37	22
Percentage	28.97	15.89	34.58	20.56

Illiteracy and Educational Status

"Socio-economic status is a complex concept that involves education, income, overall financial security, occupation, living conditions, resources, and opportunities afforded to people within society." During the field study, it was found that low socio-economic status has a major role in influencing the health conditions of women; there is no proper economic development; women have low social status; and the majority of the women are uneducated and dependent on their spouses. The majority of the respondents experienced various health problems because they do not know about overall health concerns, their diet during pregnancy, were unaware of maternal care and health, had knowledge about food to eat, and were not aware of biomedical care. Even though they do not have the right to make decisions because of their low or nil education, they are unable to participate in any decisions. The majority of the women revealed during the field study, they remained silent throughout their lives and accepted the prevailing circumstances, and this is the foremost reason why women do not access good health care.

Scholars like Imam, Chohan, Murtaza, Qamar, Zahra, Shahab, Khalid, and Ismail (2017) discussed how the health of mothers and children is strongly correlated with maternal education.

However, illiteracy is another dominant factor in the region and found profoundly. Illiterate mothers were more likely to experience negative outcomes than literate mothers because they had more children, used contraception less frequently, fewer prenatal visits, and less knowledge about good nutrition and hygiene. An important factor in improving the health of children is the maternal literacy rate, and ages have been identified as significant confounders for child development. The majority of the respondents agree that illiteracy impacts women's health because an uneducated woman has low exposure to contextual factors. In border villages, the unmet need for family planning is too high, majority of the women do not prefer and no exposure and even they may not discuss family planning with their husbands.

Scholars like Shabuz, Haque, Islam, and Bari (2022) stated that unmet needs vary between rural and urban areas of Bangladesh. It was observed that women from rural areas generally had a higher risk of unmet need (delay or limit pregnancy) for family planning than women from any economic group in urban areas; the unmet need for family planning was higher than that of women from rural areas. Notwithstanding, it is observed during field study that many women do not know their ages; they are totally illiterate, or we can say that women received very little or no education, and the majority of them have no education. Due to their low education, they do not understand their health issues in general, especially reproductive and maternal issues. An uneducated woman is not fully aware of family planning and fertility, and it is found in the present study that there is a high fertility rate and more children, which really affect their physical and mental health in many ways. However, both illiteracy and high fertility intersect and overlap with each other equally. Although, during the field study, it was also observed that the minimum criteria for having children is four and the maximum is seven. Besides this, one specific reason is multiple pregnancies, and many women go for unsafe abortions that lead to their weak health, but only in these regions.

Occupation and Financial Insecurity

In the border villages, poor health care is observed, and mainly women are found to be economically dependent. For economic reasons, they are dependent on agriculture, pastoral cattle rearing and selling milk, eggs, poultry, and organic vegetables like garlic, onion, pumpkin, cucumber, spinach, etc. for their livelihood. Some women do knitting work to earn money, but

one other issue during the field study has been reported regarding wild animals come from the forest (jungle) at late evening and eat the crops, finishing and destroying the fertile agricultural lands converted into wasteful and barren land. In some cases, both spouses are dependent on agriculture and pastoral farming, and because of the shortage of land, their productivity remains small. For this reason, the majority of the spouses are agricultural workers and labor workers.

However, there is rough and dry land, but women are still involved in subsistence farming and fall ill due to the maintenance of the land, even terrain is responsible for women's health issues. Because of the economic crisis, they may not be able to afford to go for any medical checkup. Sometimes, they do not have money to purchase medicines, so they sacrifice themselves, and in response to that, it indirectly impacts their health. Financial issues equally impact their health due to unequal access to basic health services and healthcare, and it is really impossible to go for a medical checkup and to cover other expenses, even so they are unable to fulfill their basic needs. Mostly, they prefer to take traditional home care for any health problem; they do not have enough income to afford good medical health care.

In the same manner, it is also observed during field study in the border regions most of the population falls under scheduled tribe groups in Jammu and Kashmir and lives below the poverty line. They are nomads in occupation, and because of their wandering way of life, women come across an acute shortage of basic health facilities. They are living in utter ignorance, facing poverty; they are totally illiterate, economically backward, highly traditional and custom-bonded, prefer early marriages, and neglect the social structure of society. They genuinely suffer from poor health conditions, which reflect on their social status.

Gul (2014) stated that nomad woman's issues in Jammu and Kashmir suffering from reproductive health care and it is a great challenge, along with their socio-economic profile. They often bear a great burden of numerous pregnancies and unsafe abortions that create infections, stillbirths, infant mortality, and various complications during pregnancy. However, they have high fertility rate, which deteriorates their health condition and leads to a high risk of maternal mortality.

Poverty

Poverty is a dominant factor in the region and because of poverty, women suffer from various socio-economic problems; they are not living a normal life as compared to other high-class people with limited resources who only compromise their desires and wishes. It is the same notion observed and found during field study due to poverty before and after the marriage: being born into a poor family and also married into a poor family in the same village. Because the majority falls under poverty line and this is the same as in traditions; they cannot afford to go to a private hospital for better treatment with the required facilities as such. Poverty challenges in such a way: women cannot have good food to eat, improper care, nutritional deficiency, prefer home remedies, poor lifestyle. During field work, it was found that women remained underweight before marriage and is still facing the same issue after marriage, whereas the same issues were disclosed due to poverty before and after marriage. However, due to poverty with minimum resources, poor women cannot take a nutritious and balanced diet; this is the main reason and has negative consequences for their health.

Tinker (2000) stated that women health issues are seen as an unresolved phenomenon; they cannot continue to live in happiness; there is ignorance under the model of development that generates ongoing poverty; and they hope that they can be addressed later on through welfare programs or poverty reduction schemes. Health behavior is also considered to be influenced by socio-economic background and education level, which in turn impact women's overall social status and especially their health status. It is observed and analyzed that the factors overlap, interlinked and intersect with each other. In the region, poverty is considered one of the major social factors influencing a woman's life, creating various challenges associated to their health. It is also observed that more or less all families are below the poverty line with minimal resources, so they cannot access better opportunities, resources, and healthcare services.

Rizvi (2020) opined that in South Asia, when men decide to migrate to earn stable incomes, they leave the women behind to take care of the children, the home, and the land, in an attempt to preserve patriarchal sentiments and safeguard family honor. This makes them more vulnerable to food insecurity and overall hardships. The age of the woman, whether she is currently pregnant, and how many children: these factors would affect the efficiency and health of women when

faced with added workloads caused by location and climate change. It is commonly found in border areas of Jammu and Kashmir where women with younger children and pregnant women also suffer from greater stress and anxiety due to compounded uncertainty and insecurity for themselves and their children's lives. They carry a considerable burden of domestic work and responsibilities, agricultural production, and livestock maintenance.

Role of Governance

The findings of the present study infer that most of the respondents revealed that poor governance records in the region. During the field study, it was observed that the majority of the respondents revealed information about the governance and implementation of government schemes in the region. As a welfare state, the government of India has been implemented many welfare programs and policies for its citizens. During the field study, it was observed that respondents disclosed that though government benefits are available for their welfare but are not reached to the beneficiaries, in particular to women. Therefore, it has become clear that prevailing social factors such as no health infrastructure create challenges for the women to avail the benefits.

On the other hand, some of the respondents revealed that there is lack of awareness and are still deprived of various government schemes and policies that are confined to women's interests. However, they also disclosed that they are not availing benefit of government schemes like the National Health Mission (NHM), whose basic goal is to improve health and access to quality health care. The other schemes are Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vndana Yojana (PMMVY), Supplementary Nutritional Programme (SNP), Ayushman Bharat, and Ladli Beti, which were launched in 2015 by the state government, particularly for below-poverty line people whose parent's income is below seventy-five thousand per annum. However, this scheme is especially for girl children, to stop female feticide, and to also provide for marriage assistance.

Recently, in the union territory of Jammu and Kashmir "State Marriage Assistance Scheme" (SMAS) was re-structured in 2022, with the objective of the scheme being to upliftment of the poor girls. The main objective of this scheme is to stop child marriage among adolescent girls

and provide financial assistance to poor girls before marriage. Moreover, their responses are not satisfactory regarding benefits from any government schemes that aim to provide essential medical care and services; their lifestyles have remained poor and impoverished. From the field it has been observed that the respondents were worried and concern about the socio-economic crisis and the unemployment in the region.

Interpretation

It is observed that a lack of resources and opportunities coupled with economic dependency are the main factors responsible for the suppression of women in border areas. It is a fact that social background influences the social class that makes the difference in individual behavior with others. However, the respondents disclosed that the region has been in chaos for the last many years from random shelling and infiltration across the Line of Control, which has resulted in the deaths of innocent civilians and damage to physical infrastructure such as homes, educational institutions, and health infrastructure.

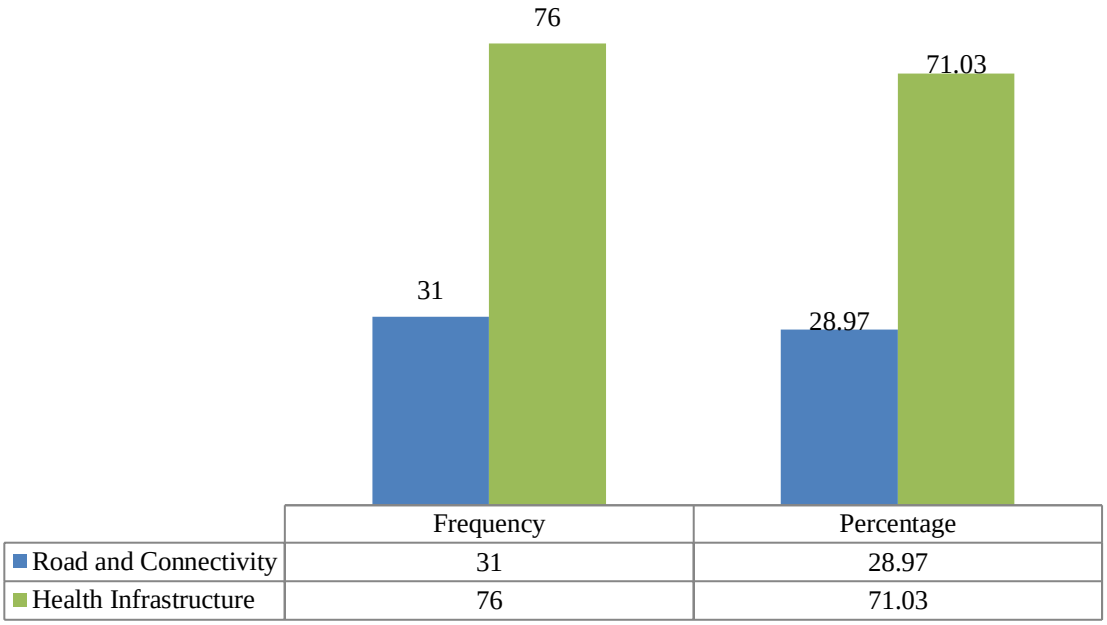
However, in actual fact, there is no doubt that the government is trying its best to make things normal in border areas through its diplomatic process, but the resentment and fear of the locals are greater than their efforts. There is a special ministry for women and child development since the independence Government of India has been launched, implementing various welfare policies regarding women and health. To analyze the difficulties in putting plans and policies into action inside the border areas, it is observed the proximity of the areas to the Line of Control(LOC) is the biggest challenge.

Table No. 26:*Represents the description of respondents with respect to Theme three (Physical Infrastructure) N=107*

Theme	Sub-Themes	Frequency	Percentage
Physical Infrastructure	Road and Connectivity	31	28.97
	Health Infrastructure	76	71.03
Total		107	100

Table No. 26 discusses physical infrastructure, and it depicts the majority of the respondents 76 (71.03%) revealed the problems faced because of the lack of health infrastructure, followed by 31 (28.97%) who revealed that in the border villages there is no proper connectivity and no transport services in the region; they mostly walked by foot.

Figure 19: Graphical representation of Table No. 26



	Frequency	Percentage
Road and Connectivity	31	28.97
Health Infrastructure	76	71.03

Road and Connectivity

There is a dearth of infrastructure in the border areas of Jammu and Kashmir. It has been observed during field work, road connectivity and physical infrastructure in the villages are completely paralyzed. Due to poor connectivity, it directly led to an increase in anger, chaos, and hopelessness among women. Roads are not developed and no proper transport facilities. People walk on foot and use animal power for ferrying essential commodities; sometimes they took mules to go to the market to load the heavy things. Otherwise, they mostly walk around thirty kilometers or more from the village for resources. At some places, roads are underdeveloped; they are in process but there is no transport service available, even though the mobile network and electricity shut down in the winter, especially. These circumstances including lack of medical care negatively affects women's health.

Respondent 56, age 31, shared her experience that *"road connectivity is not in our village; there is no link road, no transport. The roads within the villages are only for defense purposes and for army personnel, but the real problems arise in winter as the roads get closed owing to heavy snowfall. Our children go to school by foot and take around two hours to reach school. When they come back to school, it will take them two hours to reach home. It is a total of four hours per day, and after they come back, their health condition feels bad because they walk in a highly mountainous region".*

The above statement revealed the experiences shared by the respondent regarding road connectivity in the region. She stated that there is no transport availability for the locals; it is only for defense personnel, and the locals' faced problems during the winter when snowfall formed and the ways closed, which created enormous hurdles and problems for the people of the remote border villages. However, their children cover the most distance by foot in their daily routine; it is almost four hours per day and definitely affects their health because they are walking on such hilly and rugged terrain in the locality.

It was observed during the field study that in the winter season, snowfall is a big challenge. There are like snow palettes locally named "Kora." It is very slippery in nature on the roadways; there are only trenches. It is a very fearful situation to travel, and due to this condition, they do not prefer to go to the market or anywhere. In the region, the harsh winters, coupled with the fact that road connectivity gets cut off for a minimum two to three months, add more complexity. Therefore, need quality life and healthcare has forced people to migrate both temporarily and permanently.

Health Infrastructure

The majority of the respondents in the region agree that accessing better healthcare is a prerequisite for improved health, but findings from the above data indicate that due to the dearth of health infrastructure and no proper healthcare system in the border villages of Jammu and Kashmir, mostly women are suffering from numerous issues and have poor health conditions. There is no doubt that just because of the strategic location of the border zone, they suffered from prenatal health issues because of the lack of medical services, especially for pregnant

females. There are no facilities for primary health care centers, no Anganwadi center providing services, and as such, no proper medical aid is provided to women during pregnancy, which impacts their health. If they find in some villages where a dispensary is available but there is no ASHA (Accredited Social Health Activist) worker available and doctor availability is another issue, on condition that someone or children fall ill or women, they are not able to find a doctor in the village. If anytime women get ill or sick, it is very hectic to arrange transport and how to take them to the hospital; they cannot find transport, and there is no bus service. In some villages, there was no dispensary, no Anganwadi center, and even no pharmaceutical medical shop for seeking assistance.

During the field study, it was found that in two villages there is only one Anganwadi center, but it is very far and there is no proper assistance they are providing to the needy, and it has been observed that they have no proper management system. During the winter season, the climate is not supportive, and a harsh climate is observed. Most of the women suffered at that time, especially during the delivery period, and even could not go to access proper medical care for around two months because of snowfall and a severe cold winter. These local community-level healthcare centers remained closed. In fact, the density of the snowfall observed at high levels and ways becomes blocked in all directions, making it very difficult to go outside.

Interpretation

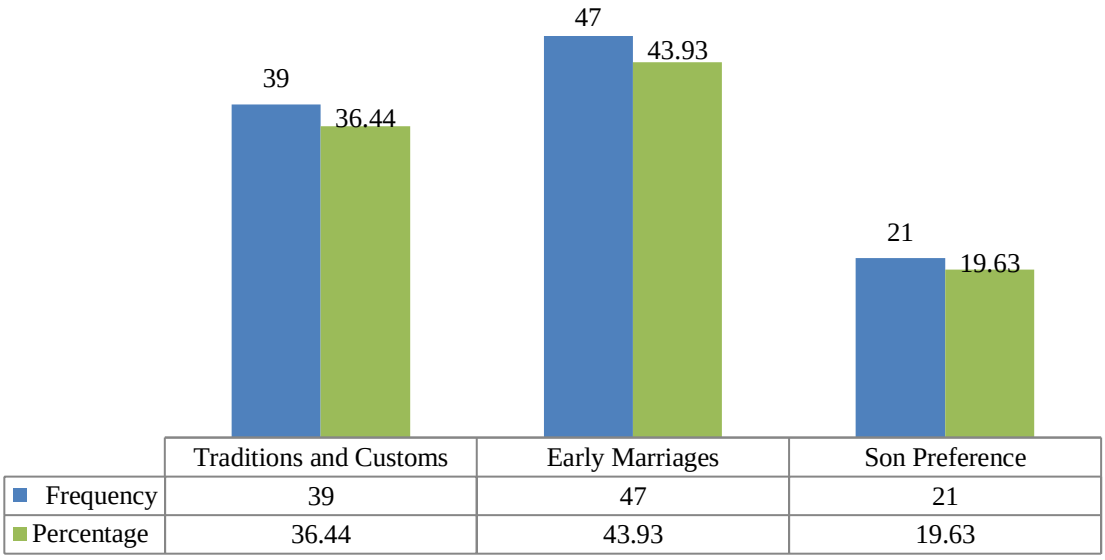
From the above narratives, it is observed that because of the location, the region is near the Pakistan border, and it is not possible to build any infrastructure here at the border location; there is a fear of random shelling from both sides, India and Pakistan. Because of security reasons, no one prefers to build any kind of infrastructure like a primary health care center or a community healthcare center in that locality because it can be destroyed by random shelling at any time. But in some villages, there are certain local-level health centers that are observed, but workers do not adhere to their duties and punctuality. It is clear that the respondents' problems show facing various issues because of road and transport connectivity and the proper health care system in the region.

Table No. 27: ***Represents the description of respondents with respect to Theme four (Cultural Practices and Beliefs) N=107***

Theme	Sub-Themes	Frequency	Percentage
Cultural Practices and Beliefs	Traditions and Customs	39	36.44
	Early Marriages	54	50.47
	Son Preference	14	13.09
Total		107	100

Table No. 27 depicts cultural practices and beliefs, which are very important parts of social lives and directly affect the health status of women. The majority of the respondents, 54 (50.47%), believed that due to turmoil, parents and elders prefer early marriages for their daughters, followed by 39 (36.44%) respondents who adhere to traditions and customs and are more bonded with cultural practices, and around 14 (13.9%) revealed that in the region, certain family choices for son preference led to more fertility and health concerns.

Figure 20: Graphical representation of Table No. 27



Traditions and Customs

Living in border areas, there are limitations for security purposes. Girls and women need protection, but they are living happily in the culture; they are very traditional people, socially and

emotionally bonded and with one another, and they should maintain the customs at their homes. During the field study, it has been observed that most of the respondents were adhering to their customs and traditions and their kinship relations are well intertwined. Women from birth until marriage still lived in the same situation and occupied the same cultural practices. They inherited all the traditions of the society where they were born, and after marriage, they followed the same, not being allowed to make independent decisions. In this somewhere, Turmoil is the hidden cause, in their opinion, because their parents keep them always secure from the army personnel and any disturbance. They are very traditional and customary, and they live by the guidelines of their elders and in-laws. Even though they are not permitted to leave the house without elders' consent, they have limitations in every sphere of life, and they possess strict and orthodox ideologies. The majority of the respondents have the opinion that every society has its own traditions and customs, but they are not saying that the minimal cases mentioned argue that cultural norms impact their health.

Emile Durkheim (1893) stated in his first major contribution, "Division of Labor," about two forms of solidarity: mechanical and organic. Living in undifferentiated social cohesion, social integration, and the common beliefs and values that constitute a collective conscience are very cultural and isolated in nature."

During fieldwork, it was observed that respondents are very culturally and traditionally bonded and have a respectful nature towards in-laws, husbands, and elders. However, they do not raise questions about any restrictions or any decision taken by the family because they are uneducated. The majority of the respondents revealed that they do not have the right to take any decision without the consultation of their husband, in-laws, or elders. In fact, it is observed that in the region, parents prefer early marriage, and they do not allow or support the girl's education.

Respondent no. 106, age 34, revealed, *"When I was pregnant, I lived with in-laws, and I never asked for anything because of their fear. I had low weight during pregnancy, and my in-laws asked for home remedies. I even did not allow myself to go anywhere because my family had not allowed me, and I never asked for permission. At delivery time, the experienced old midwife helped me, and she was not trained well, but my family and in-laws called her, and I was remaining silent".*

The above statement revealed that mostly women have restrictions on their social lives; they have to live inside the home and are not allowed to go anywhere without the prior permission of their elders and spouses. They are not permitted to take any decision or to ask for any demand because their families have homogeneous characteristics and a highly traditional nature, and mostly the cycle of their lives is run by customs. Women preferred home remedies for making their health better, and because of the lack of opportunities and healthcare practitioners, their overall health has been affected.

Muzaffar (2016) stated that culture has a significant impact on both health and illness. There are culturally accepted beliefs, customs, and rituals about health and medical procedures in India because when a husband does not take care of the feelings of his wife, she remains silent and bears the dominant character of a husband. But it indirectly impacts women's mental health, which further affects their physical health.

Respondent no. 98, age 34, disclosed, *"We are living in remote villages far from the town, and we are living in a joint family. My in-laws have not allowed us to go outside the home or market because, in our community, we should get permission from the husband and in-laws. We are living under some restrictions, and the whole day we are doing domestic work, raising cattle, and taking care of children and elders. We are not allowed to disturb while talking; my husband and in-laws and we should keep silent."*

The above statement reflects that respondents' lives are regulated by the customs, rituals, and traditions, and they are more customarily bonded with having restrictions on their social life, but they are not opposing their ways of living and traditions; they have inherited all the cultural traits; and they have also observed that the community is in a patriarchal social order where women adhere to their elders and spouse decisions, but respondents are resistant to that and in no case give voice against patriarchy. Even though they are very cooperative with their families and live with the same conditions that are imposed on them, they have no issue with that kind of restriction and social control.

Early Marriages

During the field study, it was found that because of social factors such as political turmoil, poverty, woman dependency, financial crises, and unemployment, the majority of the women in the villages prefer to marry at a young age. Turmoil in the border village is the main reason and their parents prefer early marriages. The challenges identified because of early marriages include high fertility rates, adolescent and multiple pregnancies, unplanned abortions, and psychological issues with work burdens and domestic responsibilities. In the present study, it has been observed that poverty is another important reason for early marriages in the region. They have very little or no education because of early marriage. They are not taking education, which is really needed for every girl child; most of the respondents are uneducated.

Respondent no. 7, age 40, revealed that *"I belonged to the same village before marriage. I see all the chaos and circumstances, and my parents want to marry me at an early stage because they do not want to take the responsibility of the girl child because of the disturbance in the region. I married at a very early stage when I was about fifteen years old, and it affects my health because of the work load, and I am suffering from anxiety issues and stress feelings sometimes."*

The above statement revealed by the respondent outlined the preference for early marriage in the region; it was a new issue that was noticeably observed during the field study. The girl from the same village with the same living conditions married inside the village or another village with the same circumstances as those maintained before marriage. Even though they are aware of all situations, they have to marry at an early stage because of their parents will, and it is part of their culture. In fact, because of the early marriage, the respondents shared their opinions about physical and psychological health effects.

The majority of the girls prefer early marriages, even though it has been observed girls are not capable, but they have to marry because of the prevailing situation of conflict and chaos. Parents prefer early marriages; according to their opinion, the maximum age should be fifteen years as a result of turmoil, unrest, and insecurity in border villages. They, having a poor lifestyle and

being economically backward, decided to marry their girl child at an early age and pulled out of school unwillingly to accept the decision of marriage.

During the field study, it has been observed that the majority of the parents have an opinion that taking responsibility for the girl child in the border region is difficult for them, and they have continuous security issues for the girl child. Although in some cases observed, women marry at an early stage of their choice due to the influence of culture, the villages practice the tradition of marrying a girl at an early age and followed the same. Childbirth immediately after marriage is another challenge for every girl married at a premature age because it is compulsory for every girl after marriage to have children. Because it is in traditions and in the villages, every woman after marriage should have children.

Respondent no. 43, age 35, shared her experience. *"I married at an early age; even though I did not know about household work, pastoral cattle rearing, or agricultural work, my parents fixed my marriage. Because my family was very poor and we have a kaccha house with only one room, and because of the situation in the village, parents did not take responsibility for the girl, they asked me about marrying, and I agreed, and my physical health became weak, and now I am still underweight."*

The above narration was revealed by the respondent, and she stated that the culture of the village, turmoil in the region, and poverty are the major factors contributing to the preference for early marriages in the border areas. Because of poverty, parents are not able to take care of their children, and they just let them marry at an early stage; they are living in ignorance. On the other hand, the turmoil situation in the region also fuels the miseries of the residents because, all in all, it completely affects women's health status after marriage.

Scholars like Geltore and Anore (2021) stated about child marriage, which is common in developing nations, nearly one-third of girls get married before reaching the right age. It is common because the issues are motivated by various factors such as poverty, social conditions and practices, societal pressure, etc. It has become a more significant social issue because of rising concern about women's reproductive health. It draws forth negative effects for young women to get married too soon that further lead to numerous challenges, such as dropping out of

school, the major concern for every girl, and attaining education, which is a civil right for everyone. Another concern is the health risks associated with early intercourse and adolescent pregnancy, as well as reproductive tract infections, being unable to take on the responsibilities and work burden, and even furthermore, suffering from anemia, malnutrition, and underweight issues. In addition to that, early marriages deny the fundamental rights of the spouse and depiction them to undesirable behaviors of the spouse, like social control, exploitation, intimate partner abuse, and violence.

Muzaffar (2016) stated that because of cultural, religious, and financial factors such as poverty, where parents cannot afford to provide education and a better lifestyle to their daughters, they decided to marry them at a young age. These conditions put the young girls through various health problems and pregnancy-related complications, which ultimately led to a difficult time. Even so, the majority of married women who are under legal age are more frequently reported in rural areas compared to urban areas.

Son Preference

The table highlights data reflects for the son preference in the border villages are like as such stereotype observed in few families not reported much more. Of course, old age's ideology and parents' opinions always used to say there should be a first preference for boys after marriage. During the field study, it has been observed that in every household there are an equal number of children, both boys and girls. Some cases found women bear more chances for sons, making their reproductive health weak. Women are facing a lot because of the myths and traditional thinking of the elders that their son will be the owner of the property, and all these ideologies make it an issue for women's health. In some cases, there are around four to five girl children and in-laws putting stress on their daughter-in-law for having a boy child because, according to their ideology, a boy child is the landlord of wealth and property, and the generation is recognized by the male lineage.

During field study it has been observed, if women have no sons, relatives make arguments like, why do you not have a son? In response to that, women led to bear more children for the sake of their sons, and she (women) became victims of unwanted pregnancies and unplanned abortions.

If they had earlier three or four girl children, their in-laws would have provoked their sons, but belief in the Almighty was the last hope for every woman. In some cases where there is only one son, in-laws, elders, and relatives suggest taking the chance for another son. But in some cases where women have up to two or three sons, they do not bear any kind of issue regarding son preference because, as per their opinion, the region is facing unrest and it is very hard to live peacefully. In fact, any child born, either girl or boy, is welcome in their home in these prevailing circumstances. Besides, in some cases, women are taking multiple chances for a son, and they have had unplanned abortions, they are not taking any precautions, such as any contraceptives. However, the respondents revealed about major role of stereotypes in the family are influenced by the mother-in-law on a large scale. After marriage, they used to torment her daughter-in-law for the birth given preference to son, and many women revealed they were facing the same issue after marriage.

Interpretation

The data facets revealed that respondents believed in traditions and were more bonded towards customary practices. It was observed during the field study that old-age ideologies and unethical folklore influence women's social lives, especially their overall health. Cultural practices such as traditional beliefs, religious fallacies, ceremonies, rituals, etc. are also observed; they follow and obey the decisions and suggestions of the elders, in-laws, and spouses. They are living under restrictions, and they have to maintain their limits within the premises of the house. These situations might affect women's freedom and their behavior, which is maintained by social control.

It is an ideology that is abstract in nature, and the village structure includes customs, old-age opinions, myths, superstitious beliefs, etc. Because of the myths and traditional thinking of the elders, the son will be the owner of the property, and the consequence of the ideology is various issues for the woman's health that are obstacles to accessing skilled professionals, especially at the moment of delivery. It is actually a fact observed that in the region there is a shortage of trained practitioners, and almost their family called the midwife, locally named "Dai" to provide services to women. It is noticeably found that the majority of the women marry before legal age, and the new issue also evidently noticed that the girls marry within the same village with the

same circumstances, and they have an opinion in their region that no outsider prefers to marry them because of their socio-economic profile. It was also found during the field study that there is a culture in the village where parents prefer to marry girls at an early age, and early marriages and son preference affect social life of the women. Both issues in border areas are responsible for the high fertility rate, unplanned abortions, miscarriages, stillbirths, uterus rupture cases, and the fact that women's reproductive age and health are becoming more and more poor and unhealthy.

4.3 Section 3: The findings for Objective 2 to describe the pregnancy care and delivery complications in the border areas of Jammu and Kashmir have been summarized into broad themes and sub-themes as presented in Table No. 28.

Table No. 28: ***Represents the objective two, theme and sub-themes of the study***

Objective	Theme	Sub-Themes
To Describe the Pregnancy care and Delivery complications in the border areas of Jammu and Kashmir.	Factors associated with Pregnancy Care and Delivery Complications	1. Geography and Location 2 Medical Infrastructure 3 Prefer Home Deliveries 4 Reproductive Health Issues

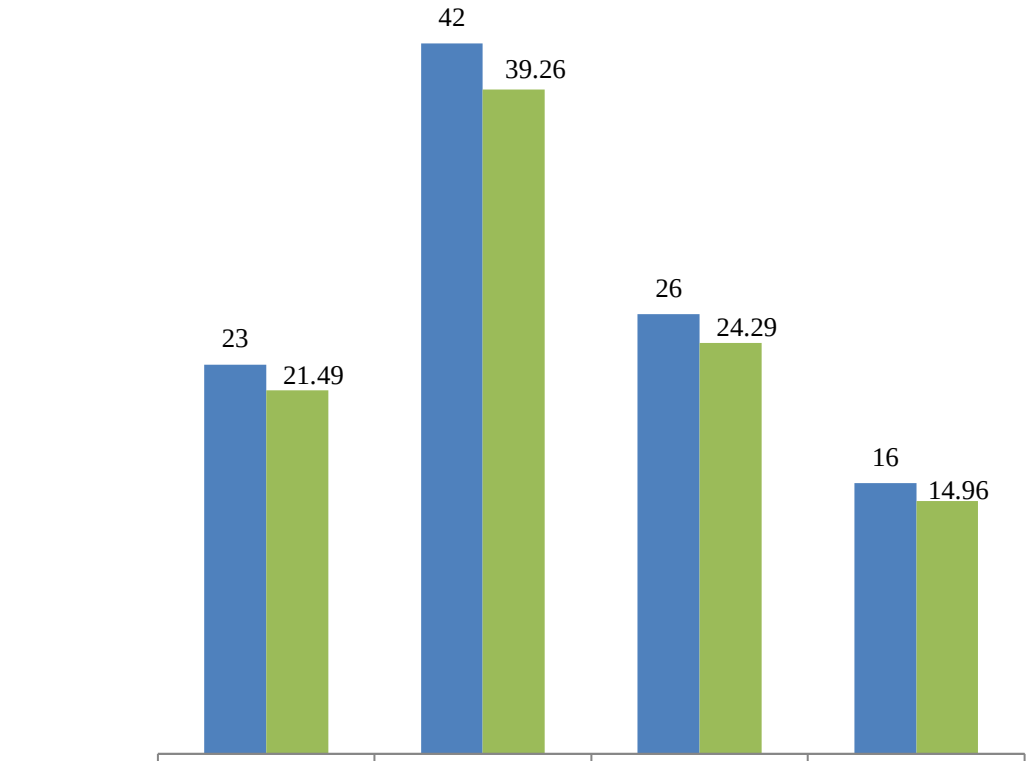
Table No. 29: ***Represents the description of respondents with respect to Theme (Factors associated with pregnancy care and delivery complications) N=107***

Theme	Sub-Themes	Frequency	Percentage
Factors associated with pregnancy care and delivery complications	Geography and Location	23	21.49
	Medical Infrastructure	42	39.26
	Prefer Home Deliveries	26	24.29
	Reproductive Health Issues	16	14.96
Total		107	100

The findings from Table No. 29 infer the various factors responsible for creating obstacles to taking antenatal care that further led to delivery complications. The data facets from the above table reflect the majority of the respondents; 42 (39.26%) revealed that the dearth of medical

infrastructure and no health facilities have immense hurdles in the region. Consider the major factor that contributes to obstacles for the inhabitants of the region. There are around 26 (24.29%) respondents revealed they mainly prefer home deliveries and do not opt for institutional deliveries followed by 23 (21.49%) revealed that geographical features and strategic location observed rugged, hilly, and tough terrain are difficult in the region, and 16 (14.96%) respondents revealed that they suffered from reproductive health issues.

Figure 21: Graphical representation of Table No . 29



	Geography and Location	Medical Infrastructure	Prefer Home Deliveries	Reproductive Health Issues
Frequency	23	42	26	16
Percentage	21.49	39.26	24.29	14.96

Geography and Location

In the border region, representation about women's pregnancy care and delivery complications is infinite. During the field study, it was found that pregnancy care is really difficult because the influence of social determinants on health is complicated. The location of the regions closely

adjoining Pakistan, encompassing all around the border of Pakistan, for the most part includes villages located near Line of Control (LOC) just a distance of around zero kilometers. Due to the disadvantages caused by strategic location, existence on the line of control, continuous cross-firing, and shelling across the border, Women living in area of dispute over the territory led to the turmoil situation, which has directly affected the lives of people, especially women, and they are more exposed to health issues. The reproductive health issues of women are frustrated by the continuing political turmoil in the border areas.

A substantial percentage of the respondents shared their experiences with delivery complications in the region. Because it is difficult for pregnant women to go on foot to get medical assistance from the hospital, the situation is really difficult because, during pregnancy, it is not possible to walk on foot for around twenty to twenty-five kilometers in hilly, rough, and mountainous terrain. It is observed that mostly women are under stress because of climatic variations and conditions, especially in the winter. They are under stress about expecting delivery in the summer and not in the winter because during the winter there is a high rate of snowfall and they have no health facilities in the village.

Respondent no. 78, age 35, revealed that *"our village location is on the top hill of the mountain. It is very difficult to walk in that type of region. It creates difficulty at the time of delivery, and childbirth is a great challenge for us living in this area because we cannot go outside because the snowfall has deep density. This is the major issue we are* facing*, and childbirth is difficult during snowfall. I became serious during my delivery, and I have been taken to bed to reach the dispensary or hospital. But the moment was really difficult for me."*

The above statement discloses that the location of the region is highly mountainous and rigid. It creates obstacles for residing people, especially for pregnant women. During the delivery period, they faced a great challenge; they are actually unable to move anywhere, and particularly in the winter, childbirth is really difficult for everyone because at that time they cannot access medical services, and if any emergency case is found, it is difficult to take them to the hospital.

Medical Infrastructure

During the field study, majority of the respondents revealed that in the region there is a dearth of medical infrastructure and no hospitals, maternity care centers, or even primary health centers available, but in some villages primary health centers are available, but they are not providing proper services. It is very difficult for every woman to access the antenatal care that is really needed for every pregnant woman and any assistance for others. Because of the early pregnancy-related complications, much more was found, which ultimately created hurdles for childbirth and led to various psychological issues and stress, and women were not ready to bear the work burden at such an early stage. However, it has been observed whenever women bear abdominal or labor pain, they prefer home remedies or natural ways to treat any illness, and the majority of the women prefer home deliveries.

The respondents outlined the information that in some villages there is no Anganwadi center, no primary health care center, no dispensary, and no maternity care center available, but if some villages found Anganwadi center, dispensary, and primary health center availability, they are not providing accessible services; there is no ASHA (Accredited Social Health Activist) worker or any doctor available in this center; it is just infrastructure. When a woman is not taking regular checkups; what happens inside the womb, no one knows and without scanning or ultrasound, it might be reason for complications during delivery and after due to their hardships and poor living conditions, on the other hand? Because of not taking proper medical care and medical checkups, it is reported mainly. There are some important causes, including adolescent pregnancy and lack of awareness, multiple pregnancies, no antenatal care, and a proper medical checkup, which are equally responsible for creating complications during delivery. In addition to that, the other consequences include overweight (obesity), underweight, and undernourished cases, but the prevalence of being overweight or obese among women aged between ninety and forty years of age is not found in the present study.

Prefer Home Deliveries

During the field study, it has been observed that in the region, respondents are culturally more connected, and religious beliefs are much more prevalent. Preferring early marriages in the

villages are considered a customary tradition. However, due to adolescent marriage the repercussions faced adolescent pregnancy; in some cases, it is found women bear the burden of multiple pregnancies because of son preference, which further culminates in weak pregnancy and leads to complications during childbirth found prevalent in the region. In addition to that, the pregnancy and work burden affect women's health, both psychologically and reproductively, and more psychological pressure, along with the burden of pregnancy and work load, is reported to be the highest.

During the field study, it found the highest percentage of women preferred home deliveries, which led to several delivery complications and many cases observed in border villages in Jammu and Kashmir. In fact, the locality (rural) was found to have an effect on women's pregnancy care in the border regions. During the field study, it seems the trajectory of triangulate relations among pregnancy care, delivery complications, and childbirth is interlinked, intersects, and overlaps with each other; none is independent of the other. There is no nearest maternity care center, which negatively affects women's health linked to antenatal care. The data revealed that delivery complications are considerably more common in the union territory of Jammu and Kashmir than in other states of India.

Muzaffar (2016) stated that women received antenatal care from ANM (Auxiliary Nurse Midwife), LHV (Lady Health Visitor), and Dai/TBA (Traditional Birth Attendant), the majority of women in Jammu and Kashmir, but this was this was not observed in border villages. During this time period, women prefer home deliveries, with numerous difficulties taking help from a local, experienced midwife locally named "Dai". In some cases, the midwife performed a cesarean with an untrained pattern, which further led to various difficulties for women, like difficulties during pregnancy and after delivery. In a few cases, it was observed that when women got more serious, they had to be taken to the hospital, and that moment was also really difficult when women were fighting for their lives. In extreme cases, a woman might be tragically killed, or it would be dangerous for her health and for her fetus too.

However, it is also found that with the highest number of participants not preferring institutional deliveries because of the financial crisis and lack of resources, going for expensive medical care and for institutional deliveries is very difficult for every poor woman living in the border villages

to prefer institutional delivery, especially during snowfall. Amongst all respondents, a minority found it preferable to take advantage of governmental facilities for pregnancy care, but that was not satisfactory. From the findings, it has been clear that the majority of the participants do not prefer institutional delivery.

Respondent no. 66, age 39, shared her experience "*During the conflict situation, there was going to be random shelling near the village and just keeping inside the home and not going anywhere. At my delivery time, I faced a difficult phase, and I have done all home deliveries and suffered from blood deficiency, but only belief in Allah makes me strong and provides faith in myself."*

The above statement revealed that mostly women are not going for regular checkups and are not taking proper medication courses, and at delivery time they need assistance like medicines, blood emergencies, etc. During the turbulent situation, everything went under restriction, and it is impossible to go outside the home or anywhere.

Aftab (2012) opined in his work with similar arguments that were found in the present study that there can be numerous factors, with poor economic conditions like poverty, unemployment. The major factor is the economic condition, which creates challenges for not going to institutional deliveries. They usually opted for unskilled "Dai" for delivery and did not prefer regular visits or checkups, which promote complications during pregnancy. However, the repercussions of home delivery preferences include the highest number of miscarriages, unplanned abortions, stillbirth cases, infant mortality, and premature delivery cases. Amongst all, the average number of stillbirth cases reported the highest.

Respondent age 37, *"she revealed after marriage I have continued stillbirth cases. The symptom I got before was pain in my abdominal portion, and I was just taking it as normal and used to take home remedies. My first three infants died, and after that, at the next time of delivery, I again found a fetus born, and thereafter, after 5 minutes, my infant died. As the doctor said, it is due to the blood pressure."*

The above statement revealed that women living continuously in danger, and they are suffering from major and sensitive health problems. The mishap showed that they are not taking proper medical care and go on with the same issues. In fact, in the literature, it is found that the majority

of the women suffered from hypertension issues and also had severe attacks on the fetus, but no routine checkups or home remedies, along with carelessness, led to the women's woes.

Scholars like Kumari, Mengi, and Kumar (2013) opined that contextual factors like socio-economic and environment also impact maternal age and the outcome of pregnancy. The two main types of pregnancy waste are stillbirths and early pregnancy losses, or abortions, which are more prevalent. The majority of these unfavorable results can be avoided if early identification of the issues and prompt remedial action are taken. By raising public awareness about maternal health issues and promoting a better healthcare system, the concerns can be further improved.

Reproductive Health Issues

In the present study, the respondent's opinions and findings outline the reproductive health issues that affect women's health. During the field study, it has been observed that high fertility with numerous pregnancies and unexpected abortions impacts reproductive age and health. However, unsafe abortions, a serious health issue found in the region, caused numerous problems like bleeding, infections, or even damage to the reproductive organs of the woman. Women's health is significantly at risk from unsafe abortions, especially with limited access to safe and legal procedures. In the region, illiteracy is more prevalent, and the majority of participants are not aware of family planning, birth control measures, or the use of contraceptives to prevent unplanned pregnancies. However, unmet family planning needs are more prevalent among those with low socio-economic status and those with poor access to family planning services, although prior studies identified a significant intersection between low educational levels. This is another paramount dominant factor found among border-residing women who are silently prone to delivery complications.

Reproductive tract infections are syndromes that cause acute physical discomfort, personal embarrassment, itching, and contraceptive side effects of miscarriages, stillbirths, and abortions because of the loss of fecundity and productivity of the woman (Anjana and Balan, 2017). In one study, it is discussed that providing universal access to reproductive healthcare has been recognized by the United Nations as a priority global health area, included in the Millennium Development Goals. Women's access to reproductive healthcare is well established in developed

countries. However, in developing countries, women's health services, particularly reproductive health services, are often not provided at a level of quality that meets human rights standards (Mariania et al., 2017). Therefore, it has been observed the same findings in their study, which reported the highest cases of unplanned pregnancy and no usage of contraceptives, which lead to various reproductive issues such as multiple abortions. It is observed that mostly women suffer from urinary tract infections such as itching, vaginal discharge, discomfort, fungal infection, skin rashes around sensitive parts, etc. (Srivastava, 2011).

During the field study, it has been observed that in the border region of Jammu and Kashmir due to the turmoil situation, women experience restrictions on their mobility and social interaction because of the turmoil, they cannot access healthcare, which effects their health repeatedly through abortions, miscarriages, and stillbirth cases, which have worse effects on women's reproductive health. The findings are similar to existing literature, and the contributions support the findings of the study. There is an impact of the conflict on women's reproductive health, and they faced an issue that may have both immediate and long-term effects on women's health (Bosmans et al., 2008).

Respondent no. 43, age 33, said, "*At the time of delivery, my condition was complicated, and my family took me to the hospital. My infant had already died, and I was feeling pain in my abdominal portion before delivery. I was suffering from an infection inside the uterus, and I was not taking a serious concern seriously, so I did not go for regular checkups. Whenever I feel pain, my choice is for home remedies such as herbs that are easily available in my village, which I used to take for pain."*

Supporting the above discussion, it reflects that women are living in ignorance and no knowledge about health; they are not much more concerned about their health issues; they suffered from reproductive problems and diagnosed the issues during the delivery period; besides this, they do not prefer any medicines; their preference is only traditional remedies; they are more inclined towards cultural practices.

Respondent 77, age 25, revealed that *"During snowfall, I faced issues for at least two months in January and February. During my pregnancy, I had low and high blood pressure issues. While*

walking on hilly land, I slipped away, got injured and miscarriage my unborn baby. I went for an abortion, and after the miscarriage and abortion, I was not feeling well because the doctor said your uterus became weak and you do not carry a heavy work load, but I am still working in fields, pastoral work, etc. I have been suffering from urine infection for two years."

Supporting the above narrative revealed by the respondent, it reflects that the location of the region is also responsible for women's issues because of the lack of transport connectivity, especially in the winters, and they suffered from a difficult phase. Women bear health issues such as stillbirths, miscarriages, and abortions, but despite that, they feel pain and tolerate all suffering, and the consequence comes in the form of reproductive health challenges like urinary tract infections that affect their reproductive age. Somehow, they still remain inside the home because of the unavailability of resources and opportunities.

According to the National Family Health Survey-4 statistical data released on women's reluctance to seek medical attention for these symptoms, the issue is made worse by the prevalent culture of silence; around seventy-three percent of women in border areas have reported problems with their reproductive health (NFHS, 2016).

Interpretation

It is observed that more or less all women have the same issues regarding pregnancy care and delivery complications. They revealed that the topography of the region affects their social as well as mental health. Because of the environment, embedded practices, beliefs, and varying climatic variations, women are more vulnerable than men. Reported high fertility rate issues are more than early marriage-related complications reported to make women's health poor. The idea of 'unmet need' discussed the condition of fecundity of women of reproductive age who either wish to postpone the next birth or who wish to stop childbearing but are not using a contraceptive method. But in the region observed, women have no idea about the concept of unmet need because of ignorance. The fertility rate reported high, and behind this is low or nil female education observed in these villages. There is no right to take decisions regarding the size of the family and its consequences found on women's reproductive age and health.

4.4 Section 4: The findings of Objective 3 to analyze the impact of turmoil on maternal health in border areas of Jammu and Kashmir have been summarized into broad themes and sub-themes as presented in Table No. 30.

Table No. 30: ***Represents the objective three, themes and sub-themes of the study***

Objective	Themes	Sub-Themes
To Analyze the impact of Turmoil on maternal health status of women in the border areas of Jammu and Kashmir.	1. Social Activities and Lifestyles during Maternal period	1. Food Habits 2. Work Activities 3. Medications
	2. Turmoil and Maternal Health Profile	1.AntenatalCare Challenges 2. Nutritional Status of Women 3. Oral Health Issues 4. Sanitation 5.Psychological Health Issues 6. Post-Partum Profile

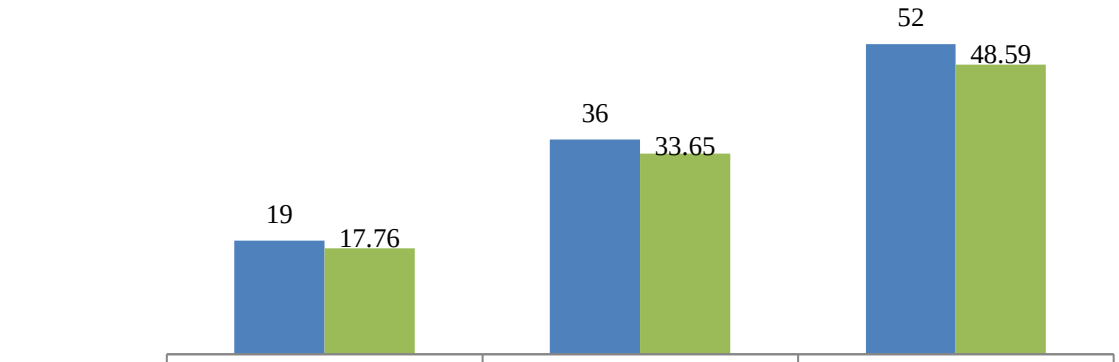
Table No. 31: ***Represents the description of respondents with respect to Theme one (Social activities and lifestyles during maternal period) N=107***

Theme	Sub-Themes	Frequency	Percentage
Social activities and Lifestyles during Maternal Period	Food Habits	19	17.76
	Work Activities	36	33.65
	Medications	52	48.59
Total			100

Table No. 31 depicts the figures regarding the maternal period and what kind of social activities and lifestyles respondents opt for, and the data reflects a lower number of respondents: 19

(17.76%) revealed their food habits, and they mostly prefer traditional food during the maternal period, followed by 36 (33.65%) respondents who disclosed their work activities, and the majority of the respondents, 52 (48.59%), revealed their opinions against not taking medications and proper healthcare.

Figure 22: Graphical representation of Table No. 31



	Food Habits	Work Activities	Medications
Frequency	19	36	52
Percentage	17.76	33.65	48.59

Food Habits

The location of the region witnessed constant political turmoil, insurgency, infiltrations, and unrest over the territory of Jammu and Kashmir. Due to poor financial living conditions, it is restricted for women to acquaint themselves with or fulfill their desires and choices regarding health, food, lifestyles, etc. Rural food habits vary from living styles to urban areas, but in the present study, a smaller number of respondents revealed that the majority of the respondents have no issue with the food items. It was observed during the field study that respondents revealed their experiences during the maternal period. They normally take normal food and usually prefer to eat normal local food, such as maize food locally named “Maaki ki Roti” with green chilli (Chutney) and yogurt shakes locally called “Lassi.” In the region, organic and natural fruits are observed and available in their fields, such as pear, apple, apricot, and walnut. They do not prefer to eat fast or junk food; even they have no knowledge about that kind of food. But they opposed the ongoing turmoil in the region, where they cannot access more facilities. A few respondents also argued that because of the turmoil, they prefer and are satisfied with normal

food, so they cannot go to the market anytime to access more nutritious food or any kind of food items that are actually needed during the maternal period.

Work Activities

It was observed during the field study that respondents shared their experiences and thoughts about work activities; they had no issue with work burden during the maternal period or the rest of their lives. The data facets present clearly show that a very small number of respondents expressed food habits because the majority of the respondents inclined towards traditional food. It was found during the field study that women having heavy work burden; they mostly indulge in domestic chores, agricultural and field work like sowing of the seeds, planting, and harvesting of the crops, go for cattle grazing, and sell the milk and poultry. Some women do knitting, basket making, embroidery locally named ("Suzni") work, and carpet weaving. They do not have any objections to work; they feel comfortable with all these responsibilities and such types of work activities. The majority of the women working in agricultural fields, especially logging the paddy fields, mostly do subsistence farming. Most of the women go into the forest area to collect wood during pregnancy, and the whole day they used to spend in the forest without taking a proper diet. Respondents revealed that they are dependent on forests for wood for cooking purposes, and women take drinking water from the springs and mostly go to the river to wash their clothes. They do all the work during pregnancy, not taking any rest or precautions.

Scholars like Geltore and Anore (2021) stated that health risks are associated with pregnancy; if these are not appropriately managed during this time, the outcome may be a low birth weight, stillbirth, abortion, preterm delivery, and complications. There is no doubt that work burden impact women's health; they feel weak for a long time.

Respondent 89, age 38, revealed that *"During pregnancy, I brought the lodges and wood from the jungle near our village and went for the cutting of grass and collecting fodder for cattle, and I also made a mud house with the clay for cattle. Sometimes, I did not take food because of my work load, and I also went for cattle grazing. The whole day I spent near the jungle side and even did not take water."*

The above statement revealed that women living in border areas are highly underworked; they have not taken proper food and care, especially during the maternal time period. Because of their ignorance, they are not supposed to take proper food, medicines, and health care. They have a work load, and they are in tune to this lifestyle. Being pregnant and going inside the forest to take wood and lodge is not possible for every woman. But they adopted the lifestyles because of their circumstances and the prevailing conditions.

Respondent no. 69, age 37, revealed that *"Because of the work burden, I am suffering from backache problems. I do pastoral cattle rearing and farming work, and I sell milk. During pregnancy, I went to the jungle to take wood for cooking food and for burning purposes in winter; we took coal into a "kangri" (earthen pot) to get warm. In fact, during labor pain, I was sowing the seeds in the field, and I am still underweight and feel weak."*

The above statement revealed about the women shared experience with respect to pregnancy because of their poor life; usually they always indulge in domestic chores, agricultural and pastoral cattle rearing, and farming works for their livelihood; and also because of the social environment they opt for and living in the same pattern as their elders followed; they are still living in ignorance; they possess lack of knowledge about health issues; and they also reported many challenges at and after delivery or throughout their lives.

Medications

It reflects from the above data that respondents revealed and shared their experiences of not consuming proper nutrition, vitamins, calcium, and iron-folic acid medicines, which are really inevitable during their maternal period and must be done for the better health of the mother's and fetus. In the present study, very few cases were found to consume these types of remedies, but the number is very low. Women are very poor in terms of their health due to a lack of proper medical care. Most of the women do not prefer to take medicines during their maternal period, and the repercussions come in the form of various problems such as anemia (iron deficiency) and vitamins, calcium deficiency, malnutrition, underweight imbalance, blood pressure, and stress. It has been observed and examined during field study mostly women suffered from Anemia (iron deficiency) problem is observed highest both in the category of pregnant as well as non-

pregnant. On the other side health issue observed, like hypertension (blood pressure), every single woman suffered from the problem because she lived in a turbulent region that influenced her mental health, evoked stress, and was associated with other factors. The prevalence of blood pressure was reported to be moderately high among women because of the chaos and unrest in the region, and they shared their thoughts, always living in fear situations. They articulate in such a way about blood pressure that it fluctuates every time, sometimes going high and sometimes going low, and it is the most prevalent issue. The estimation and prevalence observed for hypertension included adult women aged between nineteen and forty years of age.

According to the NITI Aayog Report (2021), released and conducted, the statistical fact reflects many women suffering from the anemia issue in Jammu and Kashmir. An investigation into women's nutritional profiles was carried out in Jammu and Kashmir by using the age criteria of the total number of women in the age group of fifteen to forty-nine years of age. The total number of women reported was 1, 93,874, who were found to be underweight and malnourished overall. Baramulla district, which is the target area of the present study, reported 32372 at the top of the position, and the pregnant women who faced anemia problems were 13105. On the other hand, among women who are non-pregnant and experiencing anemia problems, there are 223242 cases reported of anemia in Baramulla district and 164023 cases reported in Kupwara, another border district (NITI Aayog Report: 2021).

Another issue observed is malnutrition deficiency, which further makes women weak and in more vulnerable conditions. During the field study, it was observed that a larger number of respondents suffered from the problem, and they are still undernourished because they are not taking any supplements along with food; even their food habits disclosed that they are taking normal and routine food, and further undernourished conditions connect with underweight. It was also observed that some of the respondents were underweight, and this is also linked to and affects fetal health because of a mother's food habits and weak health impact on the unborn child.

In the region the most important concern about the issue that is calcium deficiency and it is also equally observed with other issues but the major factor behind the problem revealed by the respondents that is climate; there is no or less exposure of sunlight and women suffered from

calcium deficiency and further at extreme position identify osteoporosis or arthritis because climate and it can be generally described by the respondents and also observed during field study it is found “cool in the spring and autumn”, “moderate in the summer” and severe and harsh “cold in the winter” and at hilly and mountainous regions received torrential rainfall and snowfall for about maximum three to four months and they are not getting more exposure to the sun. Women revealed that they are facing various symptoms because of the disease osteoporosis, such as prickling in arms and legs, bone-related injuries, lower back, shoulder, ankles, wrists, legs, and joint pain.

According to the NITI Aayog report depicting the facts about the nutrition profile in Jammu and Kashmir, twenty-nine lakh women are reported to be underweight and anemic. Figures showing the comparison of the malnutrition status of women on the district level show that due to a lack of an improper diet, insufficiency in nutrition, and iron, women suffer a lot. In the age group of 15–49 years, women were found to be underweight. With a percentage of 32372 women found to be underweight and malnourished, Baramulla district ranked top, followed by Jammu at 21545 percent. Due to inadequate nutrition and an improper diet, the main impact on the growth of children remained wasted, stunted, and underweight. Such cases are highly reported in rural areas, with 37.3 percent and 33.8 percent, respectively.

Respondents 33, age 29, revealed that *“I suffered from a blood pressure problem during pregnancy, and at delivery, “Dai” told to my family that my child had died, and then my husband took me to the hospital, and the doctor said that this already happened because of blood pressure issue that I did not know about, and I have no knowledge.”*

In the above statement, the respondent revealed a major health concern: hypertension that fluctuates during the maternal period. Another issue observed that fewer means of resources and opportunities, and mostly they do not prefer regular checkups, medical care, or even institutional delivery. They also access unskilled local midwife practitioners. Moreover, women are uneducated, and due to a lack of awareness, various health concerns were found that impacted the fetus.

Interpretation

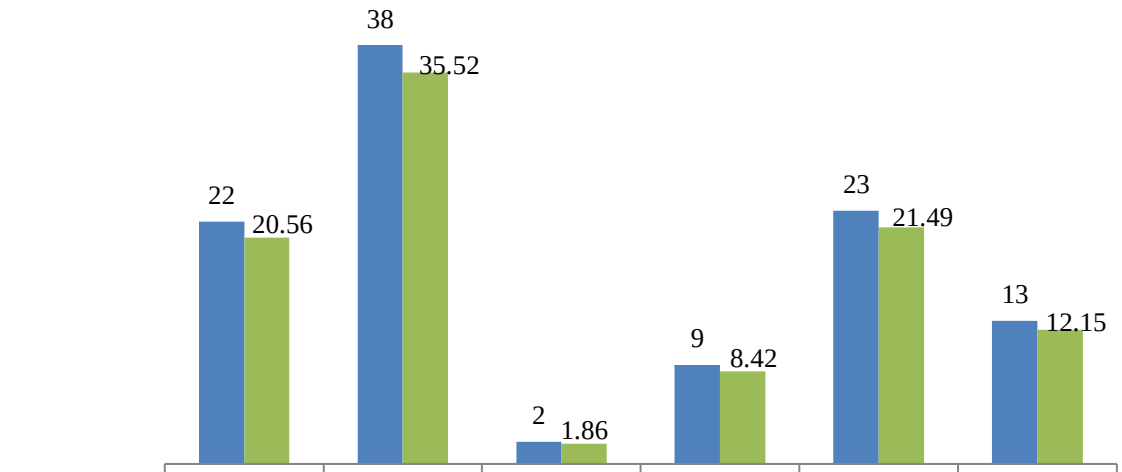
In the border areas, factors such as terrain, lack of resources, and other factors responsible for women's health concerns caused them to experience health issues during the maternal period because they were not taking proper food, medicines, and care. The majority of the respondents preferred not to take medical courses during pregnancy and further suffered from various challenges such as anemia, hypertension (blood pressure), and osteoporosis because of the location of the region. The other major factor is the turbulent situation that influenced the social life of every woman living in these villages. The climate in the high mountainous regions of Jammu and Kashmir is reported to be mostly cold as it is situated at a high altitude and receives very little sunlight. Due to all these issues, mostly women received health problems.

Table No. 32:*Represents the description of respondents with respect to Theme two (Turmoil and Maternal Health Profile) N=107*

Theme	Sub-Themes	Frequency	Percentage
Turmoil and Maternal Health Profile	Antenatal care challenges	22	20.56
	Nutritional Profile	38	35.52
	Oral Health Problems	2	1.86
	Sanitation	9	8.42
	Psychological Issues	23	21.49
	Post-partum Profile	13	12.15
Total		107	100

Table No. 32 The impact of turmoil on maternal health and the facets depict that the majority of the respondents, 38 (35.52%), have a nutritional profile that is unsatisfactory, followed by the respondents, 22 (20.56%), who have antenatal care challenges in the region, whereas 23 (21.49%) have various psychological issues because of the turmoil situation, followed by the 13 (12.15%) respondents who revealed about the post-partum issues after childbirth, with a very small number of respondents (9 (8.42%) disclosing about the sanitation problem, and at the very least, the minimum number of respondents (2.86%) outlined their opinions against oral health conditions during the maternal period.

Figure 23: Graphical representation of Table No. 32



	Antenatal care challenges	Nutritional Profile	Oral Health Problems	Sanitation	Psychological Issues	Post-partum Profile
Frequency	22	38	2	9	23	13
Percentage	20.56	35.52	1.86	8.42	21.49	12.15

Antenatal care Challenges

"It is the care that women receive during the pregnancy time period."The theme of the objective reflects the impact of turmoil on maternal health, refers to the respondents' dissatisfaction with their own experiences regarding the turmoil situation in the region that creates challenges during maternal health. Respondents revealed, they face numerous issues regarding health and medical care facilities every time they stand against the challenges, fear of random mortar shelling, any explosion, or any kind of disturbance. During the field study, it was found and revealed by the respondents that mostly women receive a lack of basic health facilities and also a concern about the lack of advanced, well-developed health infrastructure such as hospitals, the non-availability of trained staff, sub-hospitals, no maternity and childcare hospital or center, no primary health care centers, and even no pharmacy shop in the villages.

However, it was also observed during the field study that the majority of the respondents are not going for routine or regular checkups, even though they are not going to take any immunizations, especially the tetanus vaccine, which is mostly recommended by doctors and needed for pregnant women. In fact, they do not have any knowledge or awareness about the immunization system during the antenatal time period. The majority of the respondents disclosed their opinions and opined that they do not prefer institutional deliveries, which negatively affects prenatal care.

Moreover, it has been observed, and also respondents revealed about childbirth are a difficult phase during random shelling and disturbance. The majority of the respondents revealed that in the village where Anganwadi center is available but it does not work properly, they did not take any assistance from the center. Admittedly, it was observed during a field study in one village where one primary healthcare center was found, but the issue was that there was no doctor, nurse, or even an accredited social health activist (ASHA) worker available in the center and no proper medical checkups or care provided to them.

Scholars like Geltore and Anore state in their work that "antenatal care refers to planned examination, observation, and guidance provided to expecting women from the time of conception until the postnatal period to provide comprehensive health supervision to pregnant women prior to delivery." The time leading up to pregnancy offers a significant opportunity to identify health risks to both mother and unborn child, as well as to receive postpartum health issues. Therefore, they are not receiving enough antenatal care, as the majority of fetal complications happen during or soon after delivery. As a result, having a qualified and skilled obstetrician present during delivery is essential. The disparities in the use of antenatal care, labor pain and delivery, and postpartum services between high- and low-income countries as a result are quite different. While in comparison studies, only sixty-five percent and fifty-three percent of pregnant women in developing nations use skilled and trained obstetric care services, respectively, ninety-seven percent of pregnant women in developed nations receive antenatal care and ninety-nine percent use trained personnel during delivery.

Respondents also revealed that, apart from other challenges, they faced other problems such as vomiting, nausea, and mood swings during the maternal period. It is observed that most women suffered from vomiting until six months; some suffered from both vomiting and mood swings, but it was revealed by the respondents that the major factor behind the mood swings was turmoil and unrest in the region. Almost every respondent faced mood swing issues on a large scale. Very few women's faces experience nausea, usually experienced only during travelling. Women are feeling headaches and dizziness, because they feel weak and have a work burden; they also feel lethargic due to not taking proper medication. It has been observed during the field study, there are a few cases of maternal death; those women who cannot reach the hospital at a time when they really need medical service and care then die before reaching the hospital or any

health care center. Women have illusions and myths about medicines and are mostly uneducated; they do not have knowledge about that and have also possessed some kind of misconception about medicines, revealing an opinion that medicines might have side effects that are not good for health to take on a regular basis; they thought traditional remedies were more than enough good for maternal health. In fact, in the region, there are a few cases of maternal death also observed.

Respondent 45, age 28, revealed that *"when I was pregnant, I did not know about maternal health care or the medications and all. There is one dispensary in our village; it is far from my house. In the dispensary, there is no doctor or nurse available, and in my village, there is no medical shop available. I did not go for routine checkups and I have done home deliveries for all children to follow the natural way for treatment at home. There is one "Dai" in our village that helps me during my delivery."*

The above statement revealed that the women are not taking proper antenatal care because of inadequate health facilities in the village, and they are not taking medical care. In spite of that, they are using home remedies. Mostly, they are not going for institutional delivery, and they access local health practitioners locally named "Dai" who help them at the time of delivery.

Interpretation

It has been observed in the region that women living in isolated border areas are not receiving better maternity care and access to proper health services. They have dreamed they might need and access basic healthcare facilities. In fact, it is also noticed that locals are more traditional and intact with their customs, and their belief in using traditional remedies during the maternal period is highly adequate for their health condition. All these conditions increased the chances of maternal morbidity and mortality, whereas it was found to be the major moderating factor in the region, and behind all these conditions, the major responsible factor is turmoil in the region.

Nutritional status of women

"Dietary habits include vitamins, minerals, proteins, carbohydrates, water, fats, and dietary fiber." During the field study, it was observed and clearly reflected in the data that the majority of the respondents suffered from undernourished conditions, reported the highest cases, and received symptoms such as fatigue, weakness, headache, body ache, and feeling a work burden. However, it has been disclosed because of not taking a proper, balanced, and nutritious diet along with the recommended medical care. The major factor affecting women's nutritional status is the turmoil in the region. Apart from that, because of low education, poor lifestyles contribute to an impact their health; in fact, it is observed that spouse illiteracy is also equally responsible for their health condition. During the field study, it was found that the burden of workload, along with poorness and ignorance, and not taking a proper nutritious diet, had been outlined and revealed by the respondents. They mostly work the whole day in fields and go usually with cattle for grazing during pregnancy until delivery, which results in the mother's being underweight and undernourished and affect the unborn fetus as being born underweight.

Respondent no. 54, age 23, revealed that *"I was not taking food at the time; I took only "Makki ki roti" with "Chutney" and "Lassi," and I was also not taking calcium and vitamin tablets. I was working in the fields and went for cattle grazing the whole day. I suffered from tension and problems like sweat on my face, weakness, and low blood pressure during my maternal period, and I did not go for a regular checkup; only two times I went for a checkup."*

The above statement revealed that women are not serious about their health; despite taking a balanced and nutritious diet, they usually prefer to take staple foods; they are living in ignorance, and they are just involved in domestic work such as agriculture, and pastoral cattle rearing. It is very important for every woman to take calcium, vitamins, iron, and folic acid medicines, and they reported health concerns and symptoms.

Respondent no. 86, age 27, revealed that *"I was pregnant and I ate uncooked food sometimes, because at that time there were continuing shelling in our village, and we all underwent and hidden inside the home for some days; no one preferred to go outside, and I did not find proper*

food in the home. Whatever was available, I took only that; after delivery, I found my child was underweight, and I also suffered from anemia and an undernourished condition."

The revealed statement by the respondent stated that in the region, because of turbulence, women bear health problems and have an impact on their child's weight because of their mother's carelessness. The respondent disclosed about their health condition, where they suffered from anemia and were also undernourished because they were not taking balanced, nutritious food, which indirectly affected their fetal health. The turmoil creates challenges for the residents of border villages.

Respondent no. 34, age 21, revealed that *"I was not taking food at the time; I used to go into the jungle for collection of woods during pregnancy, and I have low weight, and I ate a normal diet because we are very poor, and I did not take any medicines, and I never went for medical checkups. In our village before two years, one of my relatives died because of a landmine burst, and I was pregnant at the time. I also felt tension, and I was thinking about my delivery because of the disturbance in the region."*

The statement revealed that poverty and turmoil both play a dominant role in women's social lives and are interlinked and overlapping with their health conditions. They are not able to access resources in the form of balanced food and medical services and routine checkups during their maternal period, and the consequences observed on their health. From the above narration, it appears that the respondent bears the underweight problem during her maternal period journey, and the hidden factor is ongoing unrest in the region that constrains their minds and social life and some kind of social control.

Interpretation

In conclusion, regardless of whether they reside in rural areas or not, women's access to resources such as a balanced diet, medical facilities, and health care is the primary factor contributing to the disparities in women's nutritional status. It is to be said that women's nutritional profile is not satisfactory and affected by contextual factors such as the environment, political turmoil, and poverty in the region. They cannot access resources and health services that they actually need during their maternal period.

Oral Health

The data facets revealed that very few respondents disclosed their concern about oral health, and it clearly reflects that it is not a major health issue in the region. Respondents revealed that with such inadequate services, women's concerns are important, and they are suffering from oral health issues like gum problems during their lifetime. There is a very important need for medical care, especially oral care, but during the field study, it was observed that in the region there is no medical infrastructure and not even dental clinics and specialists in the border villages. It was found throughout the field study that women during the maternal period prefer painkillers without knowing their side effects, and in extreme cases, in one or two cases, they have removed the teeth during pregnancy. It was due to not taking oral health hygiene, but some respondents viewed that they bear gum issues and teeth pain because of eating habits that are unhygienic; they are not maintaining proper hygiene. Though very few respondents argued because of calcium deficiency but never disclosed it to others because of their tolerance, with no services available in the village and especially during disturbance situations, they could not access the proper medical treatment.

Respondent 60, age 24, revealed that *"During my maternal period, I was suffering from tooth pain. I bear pain very much. I took painkillers, and after delivery, my child was found dead. I did not know that my child was dead, but after delivery, I came to know. My teeth pain problem was started before marriage, and it continued after marriage, I reported the same issue, but I never went to the doctor because of the prevailing conditions, sometimes because of snowfall, sometimes because financial crisis, and sometimes because of a turbulent situation."*

The above statement revealed about the oral health condition of the respondent disclosed all factors, such as climatic variations, financial crises, turmoil, and unrest in the region, is responsible and it is kind of obstacles to not taking medical care. More interestingly, it is observed that the same issues women faced at a young adolescent age and reported the same after marriage. She revealed that lack of knowledge and ignorance; along with other factors mentioned collectively have equal impacts on their fetal.

Interpretation

In the border areas, inhabitants are more likely to have a poor lifestyle, a lack of resources, financial insecurity, and poverty with such limited accessibility and resources. From the above discussion, it is clearly mentioned that very few cases found regarding oral health; at the lowest level, cases observed and reported cases suffered from gums and minor teeth problems, but they did not prefer any medical treatment because of some social factors, and the outcome is in the form dead fetal inside the womb, which is the most heartfelt incident for any woman.

Sanitation

During the field study, the researcher observed very minimum number of cases from the majority have sanitation issues like poor hygiene and cleanliness and revealed practices of agricultural tasks, farming cooperatives, subsistence farming, and pastoral cattle rearing, quite visible parameters that create challenges. They revealed that they usually prefer to go near a river or a streamside for washing clothes and sometimes take utensils for washing purposes, and that access to poor protection and inadequate washing facilities may increase susceptibility to infection. They are unhygienic during the menstrual cycle and usually prefer clothes and not sanitary pads, which become less important as they carry the risk of susceptibility to reproductive tract infections (RTI). It has been observed during the field study that respondents suffered from various reproductive tract infections like itching, irritation, inflammation, genital ulcers, white discharge, discomfort, and so on.

Respondent no. 103, age 24, said, *"I am suffering from infection inside the vagina, but I was not aware of that, and also from reproductive infection for the last five years. My husband is a laborer, and we do not have a washroom; go for open defecation into the fields. It is very difficult during the menstrual period, I used clothes and homemade napkins, washed them off after use, and then again re-used the same cloth."*

The above statement describes the reproductive tract infections caused by unhygienic conditions. In the region, cases are observed at a negligible level, but the reported cases suffered from infections, and they do not access better hygienic availability because of a poor lifestyle, and

they became victims, especially throughout the menstrual period. They do not prefer sanitary pads, and they usually access an unhealthy pattern that further impacts their reproductive health.

Interpretation

It has been noticed that very lowest cases observed against sanitation and poor hygienic conditions. The region has a clear and pollution-free environment with natural landscapes and beauty. In the context of this, the unhygienic situations observed are very uncommon and unhygienic environment linked to women's menstrual cycle. When they re-used cloth, easily washable, and convenient to dry outside, may contribute to the acceptance of unsanitary menstrual practices, and it also has not well for their health.

Psychological Issues

During the field study, it was observed that the maximum number of respondents revealed they are suffering from mental health issues being as residents of border villages. Every time living in stress and tension, always had a fear of firing and accidental shelling prevailing in the region, which is a very horrific and fearful moment for them. In the region, there are restrictions on locals every time they are not allowed to go outside, especially after evening. In fact, it was observed during the field study that some villages are equally divided between India and Pakistan, and both nations have control located just zero kilometers from the border. Some villages are still under barbed wire by the Indian Army, and they have an isolated environment.

During the field study, it was disclosed by the respondents that from the year 2019 to 2021, they faced bullet explosions, mortar shells, and continuous firing, and they were still living in very fearful and drastic conditions. However, some respondents revealed their maternal period journey and outlined their narration profoundly: being pregnant, they were unable to go outside the home, and they are not supposed to go for a medical checkup or to take medicines or food items. In fact, some of the respondents revealed that a bullet and random shelling just exploded near their houses, and the explosion sound and fearful moment put them under stress. They suffered from anxiety and stress problems during delivery; they faced complications and mostly had home deliveries, helped by local unskilled practitioners.

It is found that mostly women have anxiety, stress, and depression issues because of the prevailing turmoil situation, and during pregnancy, taking more stress can impact their mental health. It is outlined by the majority of the respondents that living in border villages is not possible for everyone; poor resources and poverty do not allow them to go anywhere. Sometimes, in these areas, random shelling and firing start in the morning and sometimes start in the evening, with no electricity or telephone connectivity accessed during that time. They revealed that they could not even talk to anyone or their relatives. Respondents were profoundly exposed to political turmoil and unrest in the region, and it was also disclosed during the field study that during the maternal period, women took stress about their delivery and mostly observed hypertension problems because of the disorder. Even though they have a poor lifestyle with limited resources, no access to proper medical care also makes them distressed.

Respondent No. 58, age 34, revealed that *"Sometimes I feel more fear and tension, and during pregnancy I was always thinking about my delivery; I have a fear of shelling. Sometimes, when my children went to the fields to play, I was remaining in tension. Because of the conflict situation and living on the border, it is always a fear for us."*

The narrative statement disclosed about the turmoil and location of the region: that being residents of border villages is always a threat to them and a fear of random shelling. They are living under fear, tension, and stress that influence their mental health, and turmoil has a significant negative impact on women's mental health and the emergence of psychological issues like depression. However, the locality and turmoil both intersect and overlap on women's health, which affects their social lives.

Scholars like Saleem, Rizvi, and Bashir stated that the territorial dispute between India and Pakistan after the 1947 partition has been the source of ongoing political turmoil, insurgency, and unrest in Kashmir. Poverty, economic insecurity, uncertainty, and unemployment are some of the major and significant consequences of the conflict that become apparent. It has been discovered that these conditions are linked to serious mental health problems. Political unrest in the border regions has created an abundance of uncertainty, which has a negative influence on local people's lives in many ways, including their mental health.

Interpretation

It is observed that the turmoil and strategic location are interlinked and influence the women's mental and emotional well-being status. They are deprived of many opportunities, and they are unable to access medical services and healthcare because they are residing in border areas. There are restrictions and limitations that bind and control their behavior. Living in stress and fear is always not good for human health, but they are forced to bear it automatically, not intentionally, because the circumstances of the border region make them to accept the cultural traits and survive within social bonds; they are not allowed to live in freedom.

Post-Partum Issues

The data revealed not so many cases observed against the post-partum issues, but there are some cases observed. During the field study, it was observed that women living in impoverished conditions, taking poor diets, having no routine checkups and medical care, having a poor lifestyle, being illiterate, and having a significant impact of turmoil on their social lives further led to various issues after delivery and childbirth, such as anemia, deficiency of calcium, iron, and vitamins, being underweight and undernourished, and instability of their mental health. These issues intersected with each other and linked their connections and consequences come at post-partum period.

A significant portion of the respondents have no knowledge of family planning and unmet needs; postpartum women make up this group. Women who have amenorrhea or are pregnant are regarded as having unmet needs because of their unplanned or inappropriate pregnancy. If women do not use contraception after giving birth, they are likely to become pregnant again, and effects come in the form of post-abortions and miscarriages. They have just undergone abortion or miscarriage, which may require additional reproductive health services such as RTI (reproductive tract infections) and UTI (urinary tract infections), as noticed and revealed by the respondents.

It was also observed during field work that the majority of the women revealed that early marriages and adolescent pregnancies had impacts and suffered from reproductive tract infections and issues such as urinary tract infections, uterus and vaginal inflammation, etc. At the

post-partum stage, due to early marriages with multiple or adolescent pregnancies, one other major reason might be the diagnosis of various issues at the later stage of reproductive and psychological health, such as uterus rupture cases, stress, insomnia problems, sleeplessness, anxiety, and also post-partum depression. However, during the field study, some other factors were disclosed about postpartum issues amongst women, such as numerous and unwanted pregnancies and unsafe abortions, both of which were considered major contributors.

An informant interviewee (a senior nurse) shared her experience about women suffering from the issue of postpartum hemorrhage. The cases of "eclempsia" (high blood pressure) problems reported mostly involved the patient becoming unconscious at that time. There are a few cases reported of maternal mortality after childbirth or at the time of delivery. In the present year 2022, two or three cases happened in the district hospital Poonch, and the victims belonged to border villages. One patient died three or four days after surgery due to a heart attack. In fact, some diseases are not diagnosed during the maternal period or at delivery, mainly diagnose after delivery.

Respondent No. 7, age 39, revealed that *"During pregnancy, I suffered from infection for the first three months because of poor hygiene; I do not have private washrooms; me and my family usually went for open defecation; and after childbirth, this issue has been continued and reported as a fungus infection, but I did not go for a medical checkup, only to follow home remedies because I have a money problem."*

The discussion of the above statement opined that the causes of post-partum issues started varying from the woman's life before and after marriage; instead of this during the maternal period, the sticking point starts and is thereafter disclosed at the post-partum period. Similarly, the respondent's narration reflects their health condition derived from the maternal time period, and because of poverty, poor sanitation, and carelessness, they become sufferers from reproductive infections.

Interpretation

Turmoil in the region impacts women's health in numerous ways, including access to inadequate medical care and checkups, especially during the maternal period, which further leads to various

complications and consequences reported, reflected, and observed in the post-partum period. However, it is very important to take care during the maternal time period or throughout life, but their circumstances are not in their favor. Every time they face challenges and fear of conflict that influence their social life and all other parameters are also affected by the prevailing turmoil condition, they are still living under fear and chaos in the border villages of Jammu and Kashmir.

4.5 Section 5: The Section Presents Five Case Study from Both Districts of Jammu and Kashmir

4.5.1 Case Study from Village Balakote of District Poonch of Jammu and Kashmir

To discuss the narrative of a married woman resident of village Balakote, district Poonch. Noor Jahan (name has been changed): To preserve anonymity, her age is around thirty-nine years. She is a married housewife with three daughters and three sons. This case study begins by outlining the experiences shared by the women who reside in the border village within zero to one kilometer away from the Pakistan border line. The village is divided into two parts: one part is under the control of India, and the other half is under the jurisdiction of Pakistan. Under Pakistan is also named Balakote (Pakistan). She revealed that the village, located approximately zero kilometers in front of the Indian boundary on the Line of Control, was taken over by India during the war and divided into two sections, with the areas on each side going to India and Pakistan. She has participated and shared experiences and thoughts about Turmoil in the region, the challenges and issues faced, and the impact on their health.

Asked the questions regarding socio-economic condition, Noor Jahan replied that her family total income is around 10,000 rupees per month, but they are extremely poor. Her husband is a laborer who has the responsibility of nine family members, including two elderly family members who are dependent. She faced many problems because of living in a hilly and mountainous location. Their house structure is made up of mud and stone; it is called “Kaccha House” and it is difficult to adjust for the extended family where they shared only two rooms. They have no water connectivity and no private washrooms; they just go for open defecation, and it is not possible at evening or mid-night to go outside the home. Because of this system, her health was affected, and she suffered from an itching problem that is a reproductive infection.

On being asked about the health issues, she revealed that in her village there is no health infrastructure availability; there is only one dispensary opened and found no proper service. There is no ASHA (Accredited Social Health Activist) worker, no nurse, and no community doctor available at the time, similar to the case for the Anganwadi center in the village. Noor Jahan replied that she faced difficulty with routine checkups and that she did not prefer regular visits during the maternal period, even though she did not receive antenatal care. However, she bears labor pain at home and does home deliveries for all the children. When she falls ill or is in critical condition, she can go to the district hospital or prefer to go to another adjoining primary health center nearby, which is about thirty kilometers away. Noor Jahan stated that she could not afford to buy medicines and had no access to health care because of a financial crisis. There were numerous challenges related to pregnancy care and delivery obstacles she had faced. She gave more preference to traditional remedies in spite of medical care because of their strategic location and far distance from the hospital. She also revealed that during pregnancy, she had problems with her teeth and gums and had to bear the pain.

On being asked which health problems she was actually facing, she replied that cultural norms and patriarchy affected her health because she was living in an extended family after marriage, which was hectic for her. She used to do work the whole day, bearing work load like agricultural tasks, pastoral work, went for cattle grazing, and involved in paddy fields, harvesting of wheat and maize, along with domestic chores. It makes her health very weak and sick because she was married at a very young age, which had an impact on her physical health and she revealed that it was difficult for her to give birth at an early stage. But according to culture and elders ideology, girl should have children immediately after marriage, with the ideal gap between two children being about one year. She is totally illiterate and stated that the main cause of fertility and the reason for son preference that is important for family lineage. She opined that the ignorance and low education of my husband are also responsible for high fertility.

On being asked a question about contraceptive usage, she showed a shy gesture and replied, “I even do not know about contraception and precautions” she replied. Then she revealed that only followed the natural way, like preventive care. As a result, Noor Jahan revealed that because of multiple pregnancies, she still suffered from anemia issues because of an inadequate and poor

diet and not taking iron and calcium tablets, and she got symptoms such as fatigue and hot flashes sometimes.

Noor Jahan revealed her particular life incident occurred last year when she became the target of a mortar shell locally named “GOLA” attacking her, which had a terrible impact on her general health and left her unable to act. Her left leg was the victim of a shell that entered into her left thigh inside the skin and stayed for a brief moment before abruptly removing itself and taking her skin with it as it shot outside, and she suffered more, which resulted in a long-term illness condition. After this incident, she spent the whole year on bed but she had strong belief, and with just faith in the Almighty (Allah), her continued survival is truly a miracle. After that incident, “she went through an operation or surgery, and she also lost her skin from the right leg (thigh) part that needed to be fixed to the hollow place where the mortar attacked. Surgery was extremely challenging, and the situation was really heartfelt for her, for her family, and even for the whole village.” However, she disclosed that there is no bunker (a protective embankment or room that protects during war and conflict time) available in their village; she said government recently provided one bunker, but it is like as only one room, which is not sufficient for the whole village to adjust.

She revealed about their weak psychological health: she said suffering from anxiety and feels stress every time because fear of shelling and taking sleeping pills to get better sleep. It is because of the mortar shell that it creates a kind of stress and social stigma for her, and she should always remain in fear; it is only because of the turmoil in the region.

She disclosed about her postpartum period, revealed that always has pain in the body and is taking painkillers and other medicines for this problem. Due to this, she further developed other problems such as stomachaches, kidney pain, headaches, and anxious feelings. She has continued backache like heavy pain after the attack, and her period stopped at the age of forty years. It is very early due to the attack of mortar shell and because of taking medicines in high amounts and injections; painkillers for the problem make her in a more impoverished condition.

Regarding schemes related to women’s health policy in the border villages, they revealed that they are not getting any benefit from any government scheme because their location not

permitting them to reach the Anganwadi center and she revealed their village terrain is extremely rough and there is no proper transport facility available, they are still underprivileged.

4.5.2 Case Study from village Islamabad of district Poonch of Jammu and Kashmir

This is another narrative story conducted with the common objective of describing the impact of Turmoil in understanding within the context of interpreting and embedded to understand the narrator in relation to weak maternal health impact on their fetal. It is the description revealed by the respondent of the village of Islamabad (India) in the district of Poonch. Mehr-un- Nisa is a thirty-three-year married woman with two daughters and five sons. This case study begins by outlining the experiences shared by the woman who resides in the border village within zero kilometers from the Pakistan border line demarcated and called Line of Actual Control (LAC) in Islamabad block Haveli of district Poonch. The village is divided into two parts: one part is under the control of India, and the other half is under the jurisdiction of Pakistan. The village name is similar to Pakistan's capital, Islamabad.

Mehr-un-Nisa revealed that the strategic location is hilly, very rugged, and mountainous; no road has been developed, and there is no transport availability in the village. However, no health infrastructure is available, like hospitals, sub-hospitals, dispensaries, or maternity care centers, and even though there is only one Anganwadi center, it almost remains closed. She did not go for regular and routine checkups because the hospital was far away and there was no transport availability in her village. When critical situations arise, her family arranges a special car or avails of bus service to go to the hospital, or sometimes, when she feels very sick, she is forced to walk by foot with pain. During pregnancy, she used to walk on foot for around twenty or thirty kilometers whenever she had plans for the market. But most of the time, her in-laws give directions and guides for everything; she only needs to do household work inside the premises of her home.

On a question asked about Turmoil in the region, she replied that unfortunately, it creates the biggest obstacle for me. In the region, she has experienced the violence of shelling and firing. Many times, when she was working in the agricultural field, random firing or shelling blows from the border side directly diffused in close proximity to their fields. The moment was really

fearful, as they were always deterred by the threat of conflict. Mehr-un-Nisa's parents prefer to get her married for security purposes at a very young age; she was sixteen years of age. Subsequently, she faced an infinite challenge with a work burden and, after marriage, had to take a chance on children immediately. In her village, there is a perception that after marriage, women do not have children; people are talking badly about the woman for not having children. So, she prefers to take early chance for children; there should be one or two years of gap amongst children.

Mehr-un-Nisa has an economic issue; she does not have money to purchase medicines. She has suffered from urinary tract infections (UTI) for the last five years, but she does not prefer to go to the doctor; she usually prefers traditional home remedies. Although she suffered malnutrition issue, had a low weight during pregnancy, and also experienced hypertension problem. She also revealed about her mental instability and health condition, suffering from stress because of the turmoil in the region, and about her disabled daughter.

She revealed her story of facing health issues such as anemia and being underweight. She said having no knowledge about diet and care, and even took normal food during the maternal stretch of time. On being asked another question by Mehr-un-Nisa: Do you find any sign of the child because of your weak maternal health? She replied in a sorrowful manner, yes, my one daughter was born with paralyzed legs; there is no movement of the legs; her girl always remained in an inactive position. She revealed that the doctor said this happened because of her mother's poor nutritional diet and not taking supplements during pregnancy. In spite of the repetitive surgeries during their early years, her health was affected, and she was unable to perform the work tasks. She said that people in the village have social stereotypes regarding her paralyzed daughter, and she is experiencing stress, hypertension issues, and mood swings and always feels that nature is changing.

Mehr-un- Nisa is totally illiterate and not aware of health issues, particularly women's maternal and reproductive issues. On being further questioned about challenges, she revealed that illiteracy is the main cause of high fertility in her village, whereas she has seven children, of whom one is paralyzed. She also disclosed that never prefer to take any contraceptives, and she

has faced three unwanted pregnancies and unsafe abortions. From that period until now, she has continued to have backaches and weak physical health.

Mehr-un-Nisa shared her thoughts on the causes of maternal mortality and deaths in the village. She revealed that in her village, no road or transport system has been developed yet. In extreme conditions, women used to walk on foot to reach the district hospital. Two or three women have lost their lives at this moment in their village, by general criteria; very few cases of maternal deaths have been reported. On being asked the question about the government scheme like "Pradhan Mantri Surakshit Matritva Abhiyan" which aimed to provide essential medical treatment for pregnant women during their pregnancy for three to six months in rural areas, she revealed I have done all home deliveries with the help of local "Dai" and she has no knowledge about the scheme.

4.5.3 Case Study from village Tulwari of district Baramulla of Jammu and Kashmir

This is another narrative story conducted with the common objective of describing health issues and challenges. The participant from the border village named Tulwari, block Uri of Baramulla district, located within zero to one kilometer from the Pakistan border fence. Shahzada's age is about thirty-eight years. She is a married woman with three daughters and two sons. Her husband is a tenant, and she has a poor lifestyle dependent on mainly agriculture. Shahzada revealed something about her mother: when she was three years old, her mother died. She is a single girl and has no siblings. Thereafter, her father's married again after two years, and her upbringing was handled by her stepmother.

On being asked a question about early marriage and how it impacts your psychological health, she replied that because of the ongoing turmoil in the region, her parents let her marry at fifteen years of age, before she reached legal age. It is a belief in their village, and this is just a kind of tradition: there should be children immediately after marriage. However, even her children's have a one-year gap each. Otherwise, their elders and village women tease or pass comments about not having children after marriage. She was not able to bear the burden of early pregnancy and childbirth, along with the work load and maintenance of pastoral and cattle rearing; she usually took cattle for grazing, along with the responsibilities of home, and she revealed that

because of all these circumstances, her health became weaker. She revealed their psychological issues, such as stress and tension, though she did not share her feelings with anyone and always bear the load and stress on her mind and body, she remained silent, and consequences came out in the form of depression, and now she is taking medications to overcome the sleeplessness issue.

On being asked the question about the domination of in-laws and patriarchy, Shahzada replied that she lived in a joint family and stated the argument about her husband first: her husband is older than her by around fifteen years. There is an issue of compatibility and understanding between the spouses because of differences in ideologies; they have no mutual understanding between them. Her husband is only adorable to their parents and always respects his parents' decisions and is never opposed their parent's decision and orders because his husband is a devout person whose beliefs are influenced by religion. She said because of in-laws' pressure, and husband is not so supportive to her in any decision-making, and even she is not able to take any decisions by itself. She said that her mother-in-law deliberately put the burden of work on her, and the whole day she always trying to indulged her in working.

Shahzada revealed the major issue, which is climatic variation such as snowfall. It is very difficult to manage during snowfall because, for around three months, her family wants to remain inside the home; nobody prefers to go outside due to the severe and harsh climate with no opportunity. Though in her village, no road developed and she used to walk by foot on mountainous terrain, it is very far from town. She revealed that they walk for about two hours in one round to reach the market and return home it is also estimated to take two hours minimum on the same day. The total calculation is about four hours a day. Regardless of how difficult it is to walk on foot for around four hours during pregnancy.

On the question about turmoil in the region, she replied that turmoil is the major influencing factor in the region and impacts women's health in various ways. She shared her experience. "I saw a shelling attack near my house; at that time, I was pregnant and even did not go for regular checkups. I was kept inside the house and was deterred by the threat of conflict." The other reasons she disclosed were a financial crisis and a shortage of resources. She revealed that she has done all home deliveries; to call one old, experienced woman locally named "Dai" and she

helped during delivery. She never prefers routine checkups and institutional delivery and is not taking proper care, and because of her carelessness, she has reported five fetal deaths and one fetal born who died after seven months. Because of the infection, there are germs, and she also has cysts inside the uterus. After the incident of five fetal deaths, she has gained very poor physical health as well as feeling psychologically weak.

She suffered from anemia during pregnancy, and still underweight. She did not prefer any medicine such as calcium, vitamins, or iron supplements. She has been suffering from calcium and vitamin deficiency, and due to this, she is having symptoms such as joint pain in her arms and legs and sometimes feels more pain in her joints. She did not take a proper diet the whole day because of her working schedule. Shahzada disclosed one new argument: that before marriage and also after marriage, she is suffering from teeth problem. She removed more than four or five teeth, and this is a hereditary problem within their family because she has done cross-cousin marriage.

Shahzada is a totally illiterate woman and stated that high fertility is caused by the low or nil education of spouses and, somewhere, religious dogmas to have more children for security and generation. She has no knowledge about contraceptives or any precautions that prevent birth control; she is not taking any measures, even though still not taking any measures to control birth. On the question about causes of maternal mortality in the village or any case reported until now, she replied that very few cases happened because of hemorrhage. The silent cause of maternal deaths is hemorrhage, the problem of blood at the period of delivery because of not taking maternity care with a proper diet, and it is difficult to take care in the villages due to a lack of resources with prevailing disturbances.

Shahzada replied about the weak maternal health impact on children: her infant was born underweight, and up to thirteen years later, they remain underweight. Her one child is suffering from the morbidity condition, has issues with blood platelets, and his physique is very thin; he is not able to go to school and always feels sick because, at his time, she did not eat food for a minimum of six to seven months. She only eats sometimes homemade recipes like “suji halwa” and drinks water. She has an opinion that weak maternal health impacts the fetus’s health.

She has had four abortions, and after inside her uterus, an infection was found and replaced by their actual own position, which became weak, and her uterus was removed by surgery. After removing the uterus, her menstruation cycle has been stopped. She said at a very early stage her uterus has been removed, and also case was complicated. As per doctor suggestions, the reasons are early marriage, multiple pregnancies, work burden, and mental stress.

Shahzada revealed her story about the post-partum stage. She reported depression, and both her physical and mental health found to be very weak. She said that facing the issue from marriage time to until now. She said that because of her marriage life did not find mental stability and even did not take care of herself because of the numerous reasons all through her life went from the worst situations, and she experienced various challenges and obstacles throughout her life. However, she revealed the situation after the abrogation of Article 370 on August 5, 2019, sharing her opinion regarding the turmoil situation in the region. There is disturbance, but the commitment regarding the ceasefire has been changed to some extent but not fully. Though we people in the village faced an insecurity issue and a fearful condition.

4.5.4 Case Study from village Islamabad of district Poonch of Jammu and Kashmir

The narration disclosed by another respondent, Jahan Ara, shared experiences and thoughts in the context of being a childless woman and was enclosed to understand their narrative in relation to their health and the impact of political turmoil in the region. The respondent is a married woman, age thirty-five, without a child, and belongs to village Islamabad (India) in district Poonch. This case study begins to sketch out the experiences shared by the woman; a local resident of a border village located at zero kilometers away from the Pakistan border in Islamabad block Haveli of district Poonch. However, the village has been divided into two parts: one part is under the control of India, and the other half is under the jurisdiction of Pakistan.

Jahan Ara disclosed that because of the location, there are continuous cross-border firing, landmine burst cases reported, and bullet explosions near houses or inside the village, and there are also some cases of infiltration observed in the region. She revealed that during any suspension, the army enters into their houses for searching without their permission; even on the village side patrolling is still continued.

On a question asked about mental health, she replied that living in the same village with the same status as before and after marriage. Because of firing and random mortar shelling, there is only one bunker available to hide and protect them during shelling. Before one year, there was one incident of continuation of shelling from Pakistan side, and all villagers are usually kept inside the home. Some people just keep inside the bunker, which is only one room size, and it is not possible to adjust the whole population of the village. That moment was very drastic in nature, imagined full of fear, and even nobody prefers to go outside. But sometimes we need to go outside the home for items because they are poor and dependent on wood for cooking purposes, but due to insecurity and time-bound restrictions, sometimes they are not allowed to go for taking wood from the forest. But there is fear of mines deployed under earth by the Army for protection from the enemy alien from Pakistan; there is a time restriction in these areas. So, that's why they always feel insecure because they live in a sensitive region and are not allowed to go anywhere at any time.

She revealed that turmoil has a significant impact on women's social as well as mental health. Jahan Ara revealed that all circumstances and insecurity make every day a challenge for her, and lives under tension, fear, and stress, but she has no child yet, and has been bearing the tension for around fifteen years. She revealed that being childless does not gain respect and is blamed by her husband and in-laws; they usually provoke and taunt her for having no child. It is always announced that infertility is not considerably that being childless does not gain respect and is blamed by her husband and in-laws; they usually provoke and taunt her for having no child, in their case her family members are not accepting and they always realized their generation and inheritance have not extended. Jahan Ara disclosed that in every cultural practice she has been rejected, and even though hit by the fear of divorce because of her inability to give birth, and she remained disgrace and lived in a distressed condition. She revealed that besides all these, there is societal pressure and customary bondage on her; she is labeled and stigmatized for being infertile, as supposed to be claimed by the family, relatives, and neighbors; she faces social rejection and feels shameful in the village, child preference is the first priority. She has only believes in God (Allah), having religious belief, and still faith for children.

On being asked about the cultural practices, traditions, and customs, she replied, yes, of course, old age's ideology and her parents always used to say there should be children after marriage,

and she lived under stressed conditions, and in fact agreed that there should be children after marriage. She also stated that there is a cultural expectation that girls have children after marriage, with a preference for male children. She said that in their village and within the family, in-laws and elders possessed traditional thinking, and sometimes women could not speak or disclose their health issues.

On being asked a question about illiteracy and lack of awareness and impact on women's health? She replied, "Yes" Illiteracy impacts women's health, and in their case, been suffering for fifteen years, and proclaimed because of her lack of education, she was not aware of the health issues before and after the marriage. She attributed the high fertility rate in remote border areas linked to illiteracy and lack of awareness, stating that women in border regions are uneducated and unaware of health issues. In her case, she suffered from both issues such as anemia and underweight.

Jahan Ara revealed about the non-governmental organization and role of civil society and said that in fact, schemes related to women's health were implemented, and she took advantage of the hospital when she went for a medical checkup, but in the village, they are not supposed to take any benefit. She also disclosed that the area's topography does not allow everyone, and even our local leaders are residing in the town area, and because of sensitivity in the region, very rarely officials visit. During the field study, she said that you are the first lady who visited in our village before you, nobody visited in our area, and that was unsatisfying.

4.5.5 Case Study from village Sallikoot of district Baramulla of Jammu and Kashmir

This is the narrative story conducted with Mumtaza Begum to describe the health challenges and impact of political turmoil on residents of border village Sallikoot within zero to one kilometer from the Pakistan border. She belonged to Uri block from district Baramulla and her age is thirty-five years old and has two daughters and four sons. Her husband is a laborer and being poor lifestyle, dependent on agriculture. This case study begins to explain the shared experiences of women local to a border village within a zero-catchment area approximately away from the Pakistan fence.

On being asked about the impact of political turmoil in the region, she replied that their half village is under Pakistan control and many times, mortar shells explode in their fields near their house, and it was a fearful moment for them. She disclosed one incident that "last year one milk seller died because of land mines" and even their cattle crossed the fencing and died because, on zero line, the land mines were deployed under earth, and it is very difficult to protect the livestock. Mumtaza Begum revealed that in their village there is no proper transport availability; they just walk on foot if they want to go anywhere, but roads are only for army traffic. Their village is a far-flung region covered with dense forest and far away from the town.

On being asked a question about early marriage, Mumtaza Begum replied about her marriage age and revealed she married before seventeen years of age because of the marriage faced psychological issues at a very young stage due to the overburden of work load and responsibilities. She said taking so much stress and every time living in distress because of the turmoil. She revealed the geography of the village and half of the area went under Pakistan control, and their village is also under the barbed wires and control of Indian army personnel, and without permission from the Army personnel, they cannot go anywhere.

On the other side, there is another fear of wild animals; sometimes, people recognize the claws of lions and bears in the fields in the morning. Mumtaza Begum revealed to faced stress throughout the pregnancy time period and said that living in a disturbance condition provides fear always, and it is stressful routine life for everyone in the border region, and now at the post-partum stage, diagnosed with depression for the last year. She never disclosed her emotions and choices to their family members. However, she experienced stress, but there is still fear about firing in the zone because of the prevailing circumstances. She does not go for regular checkups and mainly prefers home deliveries. Eventually, they should accept all the circumstances and adjust to their daily routine. On being asked about the impact of weak maternal health and impact on child after delivery, she replied, yes! During pregnancy, "I did not take balanced and proper diet and suffered from anemia and calcium deficiency". She revealed that to take blood injections at seven months of pregnancy, and the sign come out as an infant born underweight. Also, during lactating period, she did not take a reasonable diet, which affected her physical health, and revealed that sometimes her infant behaves sick when not getting proper feed. Therefore, after delivery, she observed a cardiac issue, and the doctor said this was only because of taking stress

and fear throughout life. She disclosed one incident during delivery where her blood vein stopped for a while and there was a net blockage in the heart, and after treatment she got relieved.

She revealed about poor hygiene; they have no private washroom because of poorness and cannot afford to make the infrastructure. Their family prefers open defecation inside the fields, or near the river area or mountain side. However, at late night they cannot go into the fields because of fear of wild animals and any insurgency in the region.

Mumtaza Begum revealed their reproductive age disadvantages and sufferings. She got married at an early age and thereafter was burdened with work and all responsibilities, along with the decision of the elders that there should be children immediately after marriage. She observed continued pregnancies, and has three miscarriages and two stillbirth cases because of regular pregnancies and not taking any contraceptives or any prevention because of illiteracy and ignorance of her spouse too. Because living in ignorance, illusions and myths regarding contraceptive pills. She disclosed about a local health trainer named "Dai." She even not takes medicine to control birth because it affects women's health, and also, in their culture, there is an ideology that every girl after marriage should have children, which leads to the promotion of generations.

She disclosed reproductive health issues because of a miscarriage incident. After the birth of first child reported a miscarriage and went through a prolonged reproductive infection. Thereafter, with two children, again reported another miscarriage and then again reported the same incident; repeatedly and comes out with three miscarriages. However, apart from this, she also found stillbirth cases; experienced two stillbirths where the fetus was already reported to have died; these cases occurred after the fourth child and suffered from weakness. She revealed that because of the financial problem, never preferred institutional delivery or went for routine checkups, and there was also a little bit of fear of the shelling and feeling insecure during the night or late evening. After these incidents, she felt pain inside the uterus and found Cyst (Ovarian). She faced symptoms like a bleeding issue, and also disclosed about taking stress because of the cyst and went for an operation for the cyst, and now her uterus rupture issue has been reported. On being asked questions about post-partum issues, revealed about her health issues, such as feeling

lethargic, calcium deficiency, blood deficiency, etc., and because of cyst operations, miscarriages, and stillbirths observed continued backache, weak and poor health, as well as suffering from psychological imbalance.

The researcher asked a question about the "Mahila Shakti Kendra" scheme, which was approved by the government of India in November 2017 for its implementation to empower rural women through community participation. The scheme aims to provide an interface for rural women, but Mumtaza Begum said "I do not know about the scheme, and in their village, there is no awareness or knowledge about this scheme."

4.6 Summary

It presents an analysis of the findings of the respondent responses with support from existing literature. It examines the inequalities in their health profile in general and in their thoughts and perceptions about the issues, and it explores the demographic and social factors that may be associated with the inequalities. After a brief description of the response, there are major contextual factors linked to health: descriptive, exploratory, and perceived opinions. The narrative inquiry includes revealing the trajectory of various issues in the context of a particular geographical region. Living in the border village, rural women experience poorer health outcomes and have less access to health care, and significant health disparities exist in the border regions of Jammu and Kashmir.

Political turmoil has had a major impact on women's health in the border villages of Jammu and Kashmir. The findings indicated that the impact of turmoil on women's health led to their social status diminishing. The present study findings revealed that political turmoil has a psychological impact on women even after their birth and marriage. They suffer from stress, fear, anxiety, sadness, and a sense of instability in their daily routine life. The majority of the women are yet to be confined and marginalized by disgraceful consequences just because they belong to the border area and are below the poverty line in society.

The social factors that become more significant for maternal health are age, income, education, geographical terrain, climatic variations, health infrastructure, nutritional status, food habits, and social class. In the region of border villages going through political turmoil and insurgency

experiencing distress, it put its marks on women's health. It has been observed that there is no proper medical care and health care system; women suffer during the maternal period; antenatal care challenges exist; there is no better accessibility of health services; and they only face issues with minimal resources and opportunities. In order to implement targeted corrective actions, an attempt should be made to determine the prevalence of maternal risk factors and their relationships with pregnancy waste. The present study findings contribute evidence supporting the notion that the majority of women still experience varying issues like anemia and being undernourished, poor sanitation, oral health problems, reproductive infections, hemorrhage and hypertension, mental health issues, and postpartum issues that are to blame for unfavorable and unsatisfactory women's health outcomes. The findings outlined describe the various challenges and impacts of turmoil on women's maternal health and well-being as a means to understand the lived experiences of the respondents.

In the present study, the findings suggest that despite women's multiple roles in the household, their positions are quite unfavorable. Despite that, there has been no progress in increasing the use of antenatal care or access to health care facilities. The vast majority of women prefer to deliver at home under the supervision of a traditional birth attendant and report no medical facility for assistance. Women are negatively affected by socio-cultural elements that include traditional beliefs and customs, religious rites, early marriages and their impact on adolescent health, a lack of awareness, and distorted social constructions of mental distress.

On the other hand, there are significant obstacles to receiving healthcare services because of deficiencies in the public and private sectors, and because of poverty, the majority prefers folk medicine and traditional healers. It was also observed during the field study that the majority of the women married within the same village with the same traditions; they are highly custom-bonded by nature, and they mainly prefer to marry within the same manner. However, their parents and elders do not prefer to go outside or to another village because they are much closer to their cultural values and beliefs. Religion plays a very vital role in framing the attitude, lifestyles, and thoughts of the local residents of the border villages. The majority of the respondents revealed that informants from the Anganwadi centers, health centers, local leaders, and non-governmental organizations headed by government official personnel are working on ground level to promote and fulfill the objectives of various schemes and policies as such

implemented in the town areas. They are more deeply committed to their work and more willing to remain in service. On the other hand, the border areas with multiple issues are not providing such a platform to commit such tasks.

CHAPTER-5

Summary and Conclusions

5.0 Conclusion

The present study addresses the health issues of women and their adverse health effects in the border areas of Jammu and Kashmir. The contemporary situation in the border villages is unclear and undefined. Conflict is a permanent variable found in the region since it declines strategies and attempts. There is no question that wars cause profound devastation to the entire population. There is data-based evidence that turmoil leads to disturbances that harm women, their social relationships, and poor health outcomes.

Similarly, in the context of Jammu and Kashmir, with reference to the conflict approach, there are antagonistic thoughts between the two nations, India and Pakistan, and the continuation of conflicting interests and attempts to pursue with the same interest of Pakistan over the territory of Jammu and Kashmir. The area adjacent to the border line demarcated as Line of Control (LOC) is in perpetual suffering due to ceasefire violations and random shelling. The region is in a state of turmoil, and living in a conflict-prone region is always fraught with chaos and disruption. Due to political unrest and turbulence, women confront restrictions on their social interactions and mobility, are unsafe in border regions, and deal with unfair treatment somewhere else. The women's health profile is not satisfactory in Jammu and Kashmir, and the maternal problems and challenges are high. Women on a large scale are deprived of basic, adequate needs and results showed people have fewer and limited resources and no proper access to healthcare in the border areas. Generally, women's standard of living is determined by their socio-economic conditions and particularly the rural border women's standard of living is very low as compared to urban women. They mostly depend on agriculture and allied activities and they are doing hard work and taking less nutrition food, so the female health is physically weak. During the field study, it has been observed in the reproductive age group, most of the respondents suffered a lot from health problems. However, it is found in the present study that

social factors such as unemployment in the region, poverty, illiteracy, climate variations, cultural practices, and beliefs are more common.

Admittedly, there are differences and variations between rural and urban women; their circumstances differ from each other with respect to their socio-economic conditions, cultural settings, social lives, patterns of lifestyles, etc. Historically, rural communities have been more enclosed, follow traditions, are more customarily bonded, and value shared experiences. Because of geography, location, isolated areas, and other parameters, there is a lot of differentiation between the two societies. If it is examined in remote border villages, the local residents suffered from numerous problems like illiteracy, unemployment, poverty, lack of knowledge, ignorance, early marriages, lack of economic resources, low social class, and lack of education, as well as a shortfall in health infrastructure and availabilities. However, the data facets released by the National Family Health Survey-5 highlight the indicators of urban and rural areas of India that cast a shadow on women's education and health. Specifically, in rural areas, factors such as less resources, geographical terrain, social differentiation, and less mobility mean that mostly women have unmet needs for their development. People who belong to disadvantaged sections are more susceptible to disease and illness. Because of a shortage of resources, they access inadequate health care, which makes them more vulnerable.

Health inequalities are an indication of the differences in life chances that exist. Health issues are closely linked to the unhealthy and stressful environment that has been found in the study area. However, the unequal distribution of limited resources and a lack of opportunities were observed in the border villages of Jammu and Kashmir. In the region, they are mainly dependent on agriculture for their livelihood, but because of the climatic variations, their effects on natural resources and their economic sources paralyzed at some point, and they usually faced various obstacles and the distribution of the resources was not functional, most probably disrupting their way of life. It is a very popular debate, and the topic of discussion is migration. However, inherited in human nature, people who want to live in a civilized manner must relocate to highly developed and peaceful areas. Because of political unrest and insurgency, some families migrated, or, we can say, shifted, towards town areas or anywhere else to acquire a safer environment.

The social and cultural factors affecting maternal health in rural border villages of Jammu and Kashmir are multidimensional and interlinked, but include the interplay of the following factors: pregnant women's heavy workload, division of labor within the household, women's unfavorable position in the household and limited access to and utilization of health care. The participants often said that they worked longer hours, which were not necessarily fully occupied by their tasks. The overall expansion of fragile maternal health services is a result of the lack of implementation of maternal health programs at the village level. It is not observed immunization drive observed during maternal time duration. There should be no proper service or availability of specialists in rural border areas. However, there is no availability of skilled and trained practitioners for pregnant women at the community level, especially during the delivery time period. When asked what they thought was detrimental to their health during pregnancy, the participants agreeably reported that their daily activities were too strenuous and that they could not get sufficient rest even as they approached their delivery date.

Unfortunately, the major disparity has been seen in institutional deliveries, which are the most important component of maternal healthcare services for reducing complications and maternal mortality. Similar inequity is reported by literacy status in access to maternal healthcare utilization and awareness about health. Inequalities in maternal healthcare utilization led to a higher unmet need for family planning among poor and non-literate women in the region. It is important to understand and address these inequities in order to improve maternal health in border areas of Jammu and Kashmir and to bring about a significant reduction in various health challenges. To address these disparities, there is a need for adequate infrastructure, primary or community health centers with the availability of qualified trained staff, and there should be provision of dispensaries that helps during any health emergency and in providing quality services.

Findings indicate that women's inability to take antenatal care services due to fear, armed encounters, confinement, and mobility restrictions contributed to the lower condition of antenatal care coverage because of unrest and significantly contributed to higher rates of maternal and postpartum issues. According to the information revealed by the key informants and local leaders, the major factors are political turmoil, obstacles to women's health care, and, in addition to that, their low educational achievements in the region, poor economic structure, geographical

barriers, early marriages, psychological strain, and an inclination towards cultural norms. However, the unrest in the region made conditions worse, increasing the number of cases of poor maternal health and postpartum health challenges. Women also face many problems during pregnancy and delivery with complications reported and various incidents such as stillbirths and fetal deaths found to be the highest. However, social issues like early marriages have also been more widespread in the border areas.

Culture is shared by all; in society, traditions, customs, values, and norms are its unique components. It is an incredibly intricate system that has a significant impact on women's health outcomes in the region. It is truly believed that the facets of health, healthcare, and other health-related issues are greatly influenced by culture. They have particular traditional beliefs and customs that play a role in the development of and influence their thoughts within the culture. A certain number of opinions and habits are related to or have an impact on women's health. They embrace religion to various extents as an essential part of their way of life, and it is customary for them to invoke certain ceremonial rites about their health. Women faced inequalities and living in dominance under their elders because of the supremacy of social control and patriarchy, observed in the border region. However, the concept of patriarchy and its influence on women's lives highlighted in the present study is minimal because the majority of the respondents adopted the same conditions and is not against patriarchy because they possessed the same socio-economic conditions and educational status and mostly observed more religiosity in their nature.

For this reason, fertility rates are observed as towering in the border areas because of ignorance and illiteracy that are interconnected with their common thoughts and religious beliefs. The explanation of women's fecundity position and its effects on maternal health found in the region is very poor and also connected to multiple pregnancies. However, it reflects in the findings that the majority of the women do not prefer contraceptive measures, and even though they have no knowledge about family planning, they only gave preference to more fertility, which is also influenced by religious thoughts. This finding shows the lack of decision-making autonomy and economic independence among women. Women's decision-making autonomy may be explained in relation to their lack of education and limited influence over material resources. Other traditional practices based on patriarchal beliefs also affect women's psychological and physical health.

The findings revealed that those women's preferences for male children and reliance on customs and traditions have largely replaced their desire to remain closely connected to their families, increasing the array of signs and moments that hinder their psychological as well as physical health. Nevertheless, allied to this milieu, the overarching narratives of women's shared experiences and collective identities are often in a state of chaos and confused with their thoughts. Comparably, multiple births, particularly close together, may raise the risk of obstetric complications and subsequent morbidities, stillbirths, mortality deaths, and postpartum issues. With no use of contraceptive measures and poor knowledge about that, most women experienced unnecessary pregnancies, unsafe abortions, and miscarriages due to a lack of skilled health personnel, whose effects came in the form of weak health, and they also suffered from reproductive tract infections. The results revealed that, because of the improper sanitation system in the region, women are having more and more problems during pregnancy. Sanitation coverage, which ought to be a way of life to safeguard health, is inadequate in border areas; access to hygiene facilities is still a challenge; and women are prone to various reproductive diseases.

The "intersectionality" approach in the present study acts as a framework and helps to explain the distinct experiences of many oppressed women living in a matrix of dominance with interlocking oppressions, especially women who reside in the border regions of Jammu and Kashmir, close to the Pakistan border line. It makes the argument that various facets of social life, including social structures, hierarchical structures, differentiation, social class, dominance, and oppression, intersect and are somehow mutually interwoven and interlinked. But it is observed that women emerged stronger from their struggle for survival, and the vast majority of them are now in charge of households with numerous responsibilities. There is an intersection between contextual factors influencing women's health. Poverty is considered the greatest impediment to their health and is prone to vulnerability to reproductive and maternal health concerns; it limits access to opportunities and means of livelihood and, hence, poor socio-economic conditions. For many women, poverty is strongly correlated with early marriages, which leads to adolescent pregnancies and child-bearing burdens with various psychological issues that are also correlated with a lack of educational attainment and no decision-making power in the family. However, since early marriages are associated with more pregnancies, girls

who married before turning eighteen are more likely than those who married later to encounter these events.

Moreover, according to respondent's opinions, explosive attempts can destroy the health infrastructure or any other physical infrastructure in the region and have serious consequences for women's health during pregnancy and childbirth. Women, despite being plunged into extreme situations, have shown an unwavering capacity to challenge the prevailing situation with embedded traditional roles to which they have historically been submitted and overcome many of the barriers that prevent them from achieving greater autonomy in their personal lives. During turmoil situation the physicians may feel pressured to relocate to provide healthcare to the needy. Depending on the extent of conflict, physical barriers, such as transportation blockades, may explicitly prevent individuals from accessing any available healthcare. Even with such barriers, fear for personal safety may result in a negative correlation between healthcare seeking and the number of conflict-related challenges in the region. Prolonged conflict in the region caused widespread poverty, continual instability, and the failure of development by the state as well as local and regional powers. However, government schemes have been implemented in a very well-mannered way and are also working on a grass-roots level also found some achievements, but they have been observed in town areas not subject to border areas. Although the conflict situation between the countries has been declining, there are still antagonistic thoughts and violent and threatening attempts within border areas. Nonetheless, no change was observed in their socio-economic lives, and no transformation was observed in health infrastructure and services after the abrogation of Article 370 and over the last two years.

The comparison between the border villages of both districts, "Baramulla" and "Poonch" observed similarities in the findings, which noted turmoil in the border regions and the contribution of the turmoil while recognizing and identifying numerous social factors to describe the effects on the health of women and concerned issues. Moreover, the present study highlights the similarities in various perspectives that are integrated and analyzed. Given the regional dynamics and the impact of the turmoil in an appropriate way, there are limitations because of the conflict-prone area, security issues, and war at any time. Externally, nobody wants to live inside the area; there are prescribed restrictions in the villages and zones, with landmines deployed beneath the ground to prevent infiltration from the border. It is not possible to go inside

the dangerous area; we need to restrict the study to limited areas where permitted. The major moderating factor in the region is conflict, and the outcome of conflict is turmoil, reflecting the character of conflict between nations, India and Pakistan, and the loss of women's rights. A number of issues, including health disparities and psychological distress brought forth by the circumstances and exhibited as poor health outcomes, are considered intermediate determinants. In the conflict region, everyone, in one way or another, is vulnerable.

Considering the connection between women's health and extreme stress, particularly as it relates to contextual determinants, the relationship must be examined closely. The combination of deprivations in both districts contributes to poor health and an inability to manage everyday challenges. The present study concluded with similar findings to previous research on women's health issues because of conflict. In a state of turmoil, the primary cause of obstacles in providing health services to women needs to be an examination to their challenges and to remove the unfair treatment of those who belong to downtrodden sections of society. The assessment of diverse aspects pertaining to women's health in the union territory of Jammu and Kashmir demonstrates they faced many hurdles in nearly every health-related metric and are susceptible to any social change. In a nutshell, it has been concluded that the lack of comprehensive health services in general and reproductive and maternal healthcare services in particular is a major drawback of all the women's health issues in the region. Turmoil continues to have an impact on their social, economic, cultural, political, and environmental spheres.

5.1 Recommendations

This study investigates women's health issues with respect to reproductive and maternal health and also associated social factors that influenced the health of border village's women in Jammu and Kashmir. The investigation aims to unveil and highlight the perspectives of the respondents regarding numerous realities of their lived experiences, thus providing enhanced comprehension and disclosing the health issues and challenges facing women living in remote border areas. The outcome of the study would provide policy suggestions, a framework, and a contribution in the field of health sociology, which would enable the formulation of amicable strategies to bring women's health issues into the limelight. The implications of the study for women, healthcare professionals, and policymakers at the local, national, and international levels make it valuable.

The issues revealed in the present study not only include academic interest but have national and global ramifications as well.

In the border areas, one major obstacle is the political system, and state autonomy has been assumed to be unpleasant politics in the region. The radius of military striking power between both nations is far greater than that of state political control. Turmoil situations and power subsume weak physical infrastructure and economic growth, and people residing in border areas are exploiting them because of territorial disputes. This can all be done through the proper implementation of policies and welfare schemes to address social factors that may lead to a dismal status for women and make them vulnerable. To provide civil rights to every woman, provide education in general and in particular regarding health, make women participate, and create awareness for their empowerment. These are such initiatives for gender equality and the development of any nation, in particular women's health in the border regions of Jammu and Kashmir.

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CD, Division of Research and Development

SOAS University of London | University of Chittagong Bangladesh | Indian Institute of Human Security and Governance India | S.R.K.P. Govt. P. G. College, Kishangarh, Ajmer, Rajasthan, India

IIHSG INTERNATIONAL CONFERENCE 2021

on

GENDER SECURITY & GLOBAL POLITICS

25th & 26th February, 2021

CERTIFICATE OF PRESENTATION

This is to certify that Prof./Dr./Ms./Mr./Mrs. **HASEENA NIGHAT KHAN, PhD Research Scholar** of **LOVELY PROFESSIONAL UNIVERSITY, JALANDHAR** presented paper on/chaired a session on **COVID-19 PANDEMIC AND DOMESTIC VIOLENCE : AN UNFINISHED AGENDA** at **IIHSG International Conference 2021** on **Gender Security & Global Politics,** organized by the Indian Institute of Human Security & Governance, Delhi, India in collaboration with the Centre for International Studies and Diplomacy, School of Oriental and African Studies, University of London, United Kingdom and Department of International Relations, University of Chittagong, Bangladesh.

Dr. Nandini Basistha
Convener
IIHSG International Conference 2021
Executive Director
Indian Institute of Human Security
& Governance, Delhi, India

Dr. S.R. Choudhary
Co-Convener
IIHSG International Conference 2021
Associate Professor (Poltical Science)
Govt. P.G. College Kishangarh, Ajmer
Rajasthan, India

Dr. Sujit Kumar Datta
Organizing Secratary
IIHSG International Conference 2021
Associate Professor
Dept. of International Relations,
University of Chittagong, Bangladesh

VET Institute *of* Arts and Science

(Co-education) College

An Institution run by Vellalar Educational Trust
Affiliated to Bharathiar University
Thindal, Erode, TN - 638 012.

CERTIFICATE OF PRESENTATION/PARTICIPATION

This is to certify that Mr. / Ms. **HASEENA NIGHAT KHAN**

RESEARCH SCHOLAR, DEPARTMENT OF SOCIOLOGY, LOVELY PROFESSIONAL UNIVERSITY, PHAGWARA 144411

has presented the paper on **MENSTRUAL PRACTICES AND CHALLENGES AMONGST MARGINALIZED WOMEN: A STUDY OF BORDER AREAS OF JAMMU AND KASHMIR**

in 2-day South Asian Conference on **"Menstrual Health and Hygiene: Menstrual Waste Management"** on 20 & 21 September 2022 organized by Department of Sociology, VET Institute of Arts and Science (Co-education) College, Thindal, Erode, Tamil Nadu, India in Collaboration with District Social Welfare Office, Erode, Tamil Nadu, India.

Dr.Yasir Ashraf	Dr.V.P.Nallaswamy	Dr.R.Saravanan	Thiru.S.D.Chandrasekar
Organizing Secretary	Dean Academics	Principal	Secretary

Department of Islamic Studies

Baba Ghulam Shah Badshah University

Rajouri, Jammu & Kashmir - 185234

CERTIFICATE

This is certified that .....HASEENA NIGHAT KHAN, RESEARCH SCHOLAR,..... ...SOCIOLOGY, LOVELY PROFESSIONAL UNIVERSITY, PUNJAB:..... attended one-week ***Research Methodology Workshop in Social Sciences and Humanities*** from ***31st of October to 6th of November 2022.***

Dr. Naseem Gul	***Dr. Shams Kamal Anjum***	***Prof. Iqbal Parwez***
Coordinator Dept. of Islamic Studies	Associate Dean School of Islamic Studies & Languages	Dean Academic Affairs

LOVELY PROFESSIONAL UNIVERSITY

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INDIAN ACADEMY OF HEALTH PSYCHOLOGY REGD.NO.1107 (ESTD. 2015)

Certificate No. 273411

Certificate of Participation

This is to certify that **Dr./Mr./Ms. Haseena Nighat Khan** of **Lovely Professional University, Punjab** has presented a paper on **Women and Conflict : Lived Experiences on Mental Health Challenges and Wellbeing in the Border District of Kashmir** in the International Conference on **"Holistic Health & Well being: Issues, Challenges & Management"** held from **2nd to 3rd June, 2023** organized by School of Education & Department of Psychology at Lovely Professional University, Punjab.

Date of Issue : 03-06-2023
Place : Phagwara (Punjab), India

Prepared by
(Administrative Officer-Records)

Convenor

Organizing Secretary