IMPACT OF EDUCATION ON WOMEN HEALTH: A SOCIOLOGICAL STUDY OF RURAL WOMEN IN KASHMIR

Thesis Submitted for the Award of the Degree of

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in

Sociology

By

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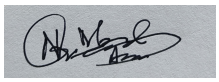
DECLARATION

I hereby declare that the thesis entitled "Impact of Education on Women Health: A Sociological Study of Rural Women in Kashmir", submitted in fulfilment of the requirements for the award of the degree of Doctor of Philosophy (Ph.D.) in Sociology, is the outcome of my own independent and original research carried out under the supervision of Dr. Ganesh Digal, Assistant Professor, Department of Sociology, Lovely Professional University, Punjab, India. The work embodied in this thesis is a genuine contribution to the existing body of knowledge and has been conducted with utmost sincerity, integrity, and adherence to the academic and ethical standards prescribed by the University. In keeping with the norms of scholarly research, I have duly acknowledged the contributions and findings of other researchers wherever applicable. I further declare that this thesis has not been submitted, in whole or in part, to any other university or institution for the award of any degree, diploma, or any other academic qualification.



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This is to certify that the thesis entitled "Impact of Education on Women Health: A Sociological Study of Rural Women in Kashmir", submitted by Akeel Naveed Raja, to Lovely Professional University, Punjab, in fulfilment of the requirements for the award of the degree of Doctor of Philosophy (Ph.D.) in Sociology, is a record of original and independent research work carried out by him under my supervision. The research presented in this thesis is authentic, has been carried out with scholarly rigor, and makes a valuable contribution in research and literature. The work has not been submitted, either in part or in full, to any other university or institute for the award of any degree, diploma, or any other academic recognition.

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ABSTRACT

Education is one the greatest factors which has direct and indirect influence on health. The research has found and recognized the fact that social factors have great influence on health outcomes and education is the one the most predominant factors which intervenes in health outcomes. Various factors associated with education contribute directly or indirectly to different health outcomes. Education imparts knowledge and raises awareness about disease prevention, develops skills for managing health, and increases awareness of available provisions and facilities, all of which influence health outcomes. Additionally, social factors that significantly impact women's empowerment and welfare are closely tied to education. Education significantly enhances the social status of women, empowering those who have been dominated, discriminated against, and marginalized within society. Through education, these women gain the tools and confidence to challenge societal norms and assert their rights. This empowerment is intrinsically linked to their health status, as improved social conditions lead to better health outcomes. Education equips women with the necessary resources and skills for effective health management, prevention of illnesses, and overall health improvement. Additionally, educated women are more likely to advocate for healthier environments, access healthcare services more efficiently, and make informed decisions about their well-being. This holistic approach not only benefits their personal health but also contributes to the health and prosperity of their families and communities, fostering a cycle of positive social and health developments. The women get social support with the additional social networks which they communicate in educational institutes, training centers, workplaces and also in other social domains. Educated people are more likely to get engaged with paid jobs rather than the family chores and care work which remains

unpaid. The women engaged in the domestic care work are more at the risk of health distress where their own health gets ignored and they themselves are conditioned to take care of the other family members and in comparison, the educated women are less likely to be engaged in more unpaid labor due to the more engagement in formal and informal sectors of workplaces or educational institutes in which these educated women have more chances of opportunities to be engaged with. Economic assistance is directly connected to health outcomes, as the costs associated with managing health and receiving treatment need to be affordable. Access to economic assistance is often linked to paid employment, which is significantly enhanced for women through education. Educated women have more opportunities to secure well-paying jobs or launch their own businesses. With better qualifications, they can pursue higher-paying positions and entrepreneurial ventures, providing them with the financial resources necessary for healthcare. This financial stability enables them to afford medical treatments, preventive care, and healthier lifestyles. Moreover, economic empowerment through education enables women to cover treatment costs, utilize superior healthcare facilities, and address their families' health needs. The educated women with the opportunities of economic assistance are less dependent on others for their financial needs required for the management of health. This comprehensive support system results in better health outcomes for women, as they can access timely and effective medical care, engage in preventive health measures, and maintain healthier lifestyles. A healthy attitude is crucial in maintain good health. education develops positive health behavior and the women with education are likely to adopt the positive health behaviors which is better for their own health as well as for the family and generally for the social environment surrounding them. Education influences the conditions and social life of women to enhance their standard of life and challenge the social issues which impacts the health outcomes for the women particularly in rural areas. In rural Kashmir the importance of

education for women can be recognized as in the rural setup women face more discrimination and domination. The limitations imposed by a constricted social environment serve as a driving force for the onset of health-related distress. In contexts where social interactions, opportunities, and resources are restricted, individuals are likely to experience heightened levels of stress and adversity, leading to negative health outcomes. This constrained environment can exacerbate existing health issues and create barriers to accessing adequate healthcare and support systems, thereby amplifying the overall burden of health distress within affected populations. In case of non-communicable disease women are more vulnerable to health distress due to the association of social factors in the conditions of these ailments. The knowledge, awareness and maintenance supported by socio economic factors in cases of non-communicable diseases play an important role which is directly or indirectly linked with education. In cases of non-communicable diseases like diabetes and CVDs it is crucial to monitor normal levels of blood sugar, blood pressure or heart rates on regular bases and adopt the healthy behavior by bringing changes in the lifestyle, food choices and nutritional requirements. These processes of prevention and rejuvenating health are better understood by the educated women. Women who receive education, gain a significant boost in confidence and develop enhanced abilities to articulate their thoughts and feelings. This empowerment allows them to more openly and effectively communicate their health needs and concerns. Educated women possess greater skills and awareness, which facilitates better access to healthcare services. They are also more knowledgeable about government provisions, health schemes, and various facilities available to them. This crucial awareness, which stems from their education, enables them to fully utilize these benefits and improve their overall well-being. Educated women are better equipped to confront social evils and combat violence. In many situations, education significantly enhances the quality of life for women, especially

in rural areas, leading to improved health outcomes. With education, women gain the knowledge and skills to advocate for their rights and challenge discriminatory practices. They become more empowered in family and larger society which brings positive impact on mental and physical health. Furthermore, education provides women with better economic opportunities, which can lead to financial independence and access to better healthcare resources. This holistic improvement not only benefits the women themselves but also has a positive ripple effect on their families and communities. In understanding the phenomena, the research has been done to find the link and impact of education on rural women in Kashmir which is concluded in finding the impact of education directly and indirectly with influencing factors on the health outcomes.

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INTRODUCTION

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1.1 Background of the Study

Kashmir, often dubbed "Paradise on Earth," is celebrated for its stunning scenery, rich cultural tapestry, and intricate socio-political backdrop. Despite its allure, Kashmir, especially its rural sectors, grapples with notable socio-economic hurdles that significantly affect women's health. Women in rural Kashmir frequently find themselves marginalized and face considerable barriers in accessing healthcare services. The insufficient healthcare infrastructure, coupled with inadequate facilities and challenging terrain, impedes timely medical care. This issue is further aggravated by cultural norms and socio-political turmoil, which restrict women's movement and hinder their access to education and employment opportunities (Srinivasan, 2018). Furthermore, the situations of conflict in the area have severely impacted mental health, with women disproportionately affected. Many suffer from anxiety, depression, and posttraumatic stress disorder (PTSD) due to constant exposure to violence and loss (Khan & Shabir, 2019). This psychological burden is often intensified by economic difficulties, as the conflict disrupts livelihoods and deepens poverty (Dabla, 2012). Nutritional deficiencies represent another major problem for women in rural Kashmir. Due to poverty and limited access to nutritious food, many women experience anaemia and other malnutrition-related health issues (Dar, 2020). This is particularly alarming for pregnant women, as it heightens the risk of complications during childbirth and negatively impacts both maternal and child health (Bashir et al., 2017). In addition, gender-based violence remains a significant concern in the region. The socio-political instability has led to a rise in domestic violence and other forms of gender-based violence, further affecting women's physical and mental well-being (Rashid, 2016). The stigma associated with reporting such violence often prevents women from seeking help, trapping them in a cycle of abuse and deteriorating health (Ahmed, 2015).

1.1.1 Socio-Cultural Context

The socio-cultural fabric of Kashmir is intricately interwoven with patriarchal norms and traditional values that have long curtailed women's autonomy and access to resources. As noted by Kukreja (2017), Kashmiri society is hierarchically structured, with rigidly defined gender

roles that largely confine women to domestic spheres. The deeply entrenched patriarchal norms and socio-political challenges in Kashmir greatly hinder women's access to education and healthcare. The prevalent practice of early marriage and the limited mobility of women further amplify their vulnerability, significantly hindering their access to education and healthcare (Yasin et al., 2019). In rural Kashmir, women encounter a wide range of socio-economic challenges that further entrench their marginalization. The prevailing societal expectations prioritize women's roles in household responsibilities over their personal and professional development. Consequently, this emphasis severely limits their access to educational and career opportunities, preventing them from achieving greater autonomy and economic independence. This dynamic perpetuates women's economic dependence on male family members, constraining their ability to make independent decisions about their health and wellbeing (Dar, 2020). Additionally, the socio-political instability in the region have exacerbated the difficulties faced by women. The conflict scenario often disrupt access to healthcare services, creating dire circumstances for those requiring medical attention. Mental health issues, including anxiety and depression, are rampant among women due to the persistent threat of violence and the loss of loved ones, underscoring the urgent need for comprehensive healthcare interventions (Khan & Shabir, 2019). The cultural stigma linked to seeking assistance for gender-based violence remains a major hurdle. Many women suffer quietly due to the fear of social exclusion and the lack of support networks. This perpetuates a cycle of abuse and adverse health outcomes, highlighting the necessity for community-based programs that raise awareness and provide safe havens for women (Ahmed, 2015).

1.1.2 Educational Landscape

Despite efforts to bolster educational infrastructure in Kashmir, achieving equitable access to education remains an uphill battle, especially for women. The Jammu and Kashmir Economic Survey (2018-19) underscores the disparity in female literacy rates compared to the national average, with rural and conflict-affected areas bearing the brunt of this discrepancy. The Jammu and Kashmir Economic Survey (2018-19) highlights the gap in female literacy rates relative to the national average, with rural and conflict-affected regions experiencing the most significant disparities. In addition to socio-economic inequalities, the inadequate availability of transportation facilities significantly hinders girls' education, especially in remote areas (Ahmad & Bhat, 2016). Additionally, cultural obstacles persist in obstructing girls' education

in Kashmir. Conventional gender roles and societal expectations frequently favour boys' education over that of girls, sustaining a cycle of inequality. The prevailing of conservative attitude conservative views on female education restricts opportunities for girls, resulting in lower enrolment rates and higher dropout rates (Ganai, 2018).

1.1.3 Education and Health Nexus

Education acts as a catalyst for change, empowering women to take charge of their health and well-being. According to Mistry et al. (2020), education plays a crucial role in enabling women to make informed choices regarding their health, including decisions about reproduction, accessing healthcare services, and preventive measures. By providing women with knowledge and critical thinking abilities, education strengthens their ability to navigate complex healthcare systems, enhances their autonomy, and empowers them to assert control over their health.

Furthermore, education promotes economic self-sufficiency, thereby reducing women's susceptibility to health risks associated with poverty and socio-economic disadvantages. With access to education, women can pursue meaningful employment opportunities, secure financial stability, and avail themselves of improved healthcare services, leading to better health outcomes (UNESCO, 2016). Tackling educational inequalities is crucial for diminishing health disparities and promoting sustainable development in Kashmir. Education serves as a societal equalizer, closing gaps in access to healthcare services and health information. It empowers women from disadvantaged communities, including those in rural and conflict-affected areas, to advocate for their health rights, oppose discriminatory practices, and demand accountability from healthcare providers and policymakers (WHO, 2018). Moreover, education promotes health behaviour, critical thinking and also the civic participation, this enables women to actively engage in community health initiatives and contribute to policy discussions on healthrelated issues. Amid socio-political unrest, education emerges as a beacon of hope, providing pathways for social transformation and resilience. Sofi (2018) highlights the transformative potential of education in promoting peace, tolerance, and social cohesion in conflict-affected regions like Kashmir. Education serves as a deterrent to radicalization and violence, offering young women alternative viewpoints, skills, and opportunities for constructive engagement. Education bolsters psychosocial well-being and resilience by equipping women with coping mechanisms to navigate adversity and trauma. By fostering a

sense of belonging, identity, and purpose, education alleviates the negative impact of conflict-induced stressors on women's mental health and social integration (UNICEF, 2017).

1.2 Statement of the Problem

The rural women in Kashmir like the rural women in other parts of India face challenges and issues within a social setting. The rural areas of Kashmir are featured with scenic beauty and cool atmosphere, but women still face social issues as in rural communities the culture and tradition are operative with the patriarchal mode in the social realm. In rural Kashmir, Women autonomy is constrained and gender-based discrimination is perpetuated by patriarchal norms (Bhat et al., 2017). The rural women in Kashmir due to facing the restricted norms and the dominant control of men, lag behind several accessibilities, remain discriminated in several opportunities and resources effects their overall wellbeing as the unequal treatment hurdles their competencies. In rural Kashmir, the access to education, employment opportunities for women and the process of decision making are limited by the norms (Malik et al., 2016). The women are wedged in a situation where they sometimes face violence and their social life emerges like a trap for them, particularly in rural areas of Kashmir. Several women in their homes face physical, psychological and emotional abuse as domestic violence is prevailing is rural Kashmir (Mushtaq & Gull, 2019). The socio-economic status of women in rural Kashmir is driven by the traditional norms in which the authoritative position in household decision makings and the ownership of land and assets in primarily entitled to men. The barriers of accessing land, credit and other resources hinder the economic independence in rural Kashmir (Khan & Firdous, 2018). Women's dependence on male members in the family is perpetuated due to the unequal distribution of resources (Najar & Yasin, 2018). The men in the society have always been provided better resources than women. The Census report of 2011, like other statistical data also shows men literacy rate of 76.75% better than women which was lower at 56.43% depicting 20.32% of gender gap in literacy rate in Jammu and Kashmir. In rural areas the disparity can be observed higher and the resources for women as more limited. The social issues faced by women are more predictable to influence their health outcomes as social factors are responsible for altering the outcomes of health. In case of rural women in Kashmir the social attitude and the marginalization of their social class exert more pressure on them and on a big scale has a decisive role in effecting health outcomes.

The women residing in rural areas of Kashmir can be observed facing issues in health management and outcomes due to several reasons. Firstly, the social conditions dominated limit their circle which brings health impacts driven by social factors. The geographical conditions have a great influence of health services in rural areas. The remoteness of areas, lack of facilities and weather conditions hurdle in health services timely and efficiently. The geography of Kashmir with the features of mountainous terrain and variable climate particularly in rural and remote areas likely impact the access to healthcare for women. (Gupta et al., 2020). The availability of quality services is undermined due to Shortage of trained healthcare professionals and inadequate health care infrastructure facilities (Kumar et al., 2018). In rural Kashmir it can be observed that the health of the women is at risk due several reasons like patriarchy, traditional attitude towards women and the context prevailing in the rural setup of Kashmir like social limits in women autonomy, social pressure, lack of economic assistance, inadequate healthcare facilities due to the geographic conditions and lack of infrastructure and services. In such conditions the health management is a challenge for women residing in rural areas of Kashmir. Education is an influential tool which uplifts the life conditions of women, enhances the better health results and provide skills in managing health, knowledge and awareness about the prevention and management of diseases, developing positive health behaviours as reviewed in the literature of research findings related to the impact of education on health. The social, economic, geographical and other barriers hurdle the health management in cases of non-communicable diseases as the lifestyle diseases, the conditions in which the daily diagnosis, treatment, management skills, economic assistance and healthcare facilities are important. The women who face the social barriers and lack the resources have to face health issues. Its pivotal to investigate the influence of education in enhancing health for the rural women in Kashmir facing issues and challenges in maintaining and managing health needs.

In cases of non-communicable diseases social factors have an influential impact and even the factors like social burden, lack of nutritional support, lack of proper knowledge of prevention can lead to more cases of non-communicable diseases and those who suffer need more awareness, skills, finance and support worsens the health and ignoring or not managing conditions like these lead to the dangerous consequences. The women health in relation to NCDs has been investigated by collecting the secondary source of data from NCD Clinic Yaripora of District Kulgam in which it has been found in their monthly reports that women are more diagnosed with these NCDs as compared to men and had to come for follow-up

accordingly due to the health issues they face. In the month of august 2023 out of the 9 newly diagnosed for diabetes the 7 including them were women and also the 1 woman only diagnosed newly for hypertension and among the 332 patients suffering from diabetes 239 had come for the follow-ups and out of the 69 follow-up patients suffering from hypertension 47 were women. In the month of September out of the newly diagnose 6 patients, 5 were women who were newly diagnosed for diabetes and also the number of the patients advised for follow-up was higher among the women. At the block level it was also found that women were more suspected for the NCDs as per NPCDCS reporting for the medical block yaripora of district Kulgam for the month of August and September 2023. This gives an idea about the health conditions which women suffer from and in managing the ailments and such conditions, education plays an important role in providing awareness, skills, monetary stability and facilities to cope up with these issues.

1.3 Concept of Rural Women

In the discourse of sociology, women are not only characterized by their biological distinctions from men, but also by the societal expectations, behaviours, and roles attributed to them. Feminist theory emphasizes the mechanisms by which women's identities and roles are shaped and governed by cultural norms, institutional frameworks, and societal customs. This perspective draws attention to concerns surrounding gender disparities, power dynamics, and the intersectionality of women's experiences with other social divisions like race, socioeconomic status, and sexual orientation (Connell, 2009).

Within the realm of sociology, rural women are understood in the context of their unique socioeconomic and cultural environments, which create distinct challenges and opportunities compared to those faced by urban women. The experiences of rural women are heavily influenced by their geographical location and social environment. They often engage in farming and informal economic work while also taking on domestic responsibilities. Despite their substantial economic contributions, they frequently face restricted access to land ownership, financial capital, and market opportunities (Agarwal, 1994). Gender norms and expectations are typically more rigid for rural women, who often encounter higher levels of gender-based discrimination and violence. They have fewer educational opportunities and face significant obstacles to political and social participation (Kabeer, 1994). Access to essential services like healthcare facilities and education is particularly more limited for rural women. This situation is worsened by inadequate infrastructure, including poor transportation and limited

communication technologies, which further marginalize them from economic and social opportunities (Desai & Thakkar, 2007).

1.4 Concept of Health and Education

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). This definition has been used in several research in health studies after it was articulated in the constitution adopted by World Health Organization in 1948. The concept of health is not only related to the presence or absence of any disease but as per the WHO definition when a human being is physically fit, mentally sound and socially balanced can only be termed as a healthy human being. In a social setup the health of an individual is determined in social environment which effects the wellbeing of members of society. The concept of health of an individual is comprehensive in such situation where along with physical fitness the individual must be socially adjusted with the provision of social capital in a social setup and also sufficient social and emotional support is prerequisite for the mental wellbeing which needs to be accessible for the members of the society to be termed as healthy. Social, cultural and environmental factors influence the health and wellbeing (Walsh, 2004). Women who face inequalities are more in risk of health distress. Where there are inequalities, the health differences are found between social classes and also between occupations (Acheson, 2001). The women particularly in rural areas can be understood in more discrimination and their social class can be observed as depicted as lower social class and being dominated by the male members of the society. Mental health problems can be found more in lower social classes (O'Brien et al., 2002). As women are deprived of their social rights and positions as recognised in the seminal feminist works all around the world their mental health as well as physical health remains at risk. Deprivation influences the mental as well as physical health of those groups who are socially excluded (Micheal Nash, 2014). social empowerment for the women is pivotal for their overall wellbeing. The risk factor of different non communicable is higher for women due to the social issues faced by women in our society. From the three last decades the noncommunicable diseases have been the major cause for the deaths worldwide for the women and also one among the three deaths of women are due to the non-communicable diseases (R Lozano et al, 2010). In case of non-communicable diseases, the management and prevention are always a challenge for women. In dealing with such disease's women lack the social environment of resources and support as compared to men. There are several barriers faced by women like socio-cultural barriers, economic and geographical barriers and also, they lack

resources and accessibility to healthcare due to which they are not able to afford the quality of care needed for non-communicable diseases (R Bonita & R Beaglehole, 2014). The NCDs being the lifestyle diseases are a major threat to the health of women who are particularly surrounded by a strict life condition in a social setup particularly in family life under the influence and control of men. There is now a shift from infectious diseases to noncommunicable diseases like Diabetes, cancer, chronic respiratory diseases and primarily the cardio-vascular diseases. (R Bonita & R Beaglehole, 2014). The health of the women as along with all the humans is the complete wellbeing where women who are physically fit need to be mentally sane and socially appropriate. The women in social and mental pressures are particularly at the risk of non-communicable disease in response to which they have to deal with several issues to prevent and manage these ailments.

Education is a pivotal tool in the process of social transformation and key to women empowerment. As per the statement of M. Phule "It is education which differentiates good from the evil". Considering the above definition, it is clear that education has been the base in all the revolutions taken place in the world history (R A Bhat, 2015). Education as a resource for women in terms of qualification is that social capital which upgrades the life of women by providing the different socio-economic benefits for the educationally qualified women. This is fact that higher education as a return has been as large as compared to the return to the conventional forms of capital and among all the investments the returns to the education has been more attractive (T W Shultz, 1961). Education particularly higher education is important in social and overall developments. The highly educated individuals tend to have better health in comparison with less educated individuals (Cutler & Lleras-Muney, 2006). The women who pursue higher education are likely in a position of better social conditions as compared to those women with low academic qualifications. The high levels of education for women enhances them with social skills and interpersonal abilities by which success in their social interactions is contributed (DiPrete & Buchmann, 2013). Higher education boosts self-confidence for women in asserting opinions and advocating their needs (Buchmann & DiPrete, 2006). Higher education often makes women accessible to the broader social circle (Coleman, 1988). The education which is in the form of qualifications gives access to a needful social exposure and imparts skills and adds resources as economic and other status factors are also linked with formal education. With formal education women develop communication skills, thinking

abilities also cultural competencies with which diverse connections with individuals and groups are provided (Pascarella & Terenzini, 2005).

The fact is evident that education in the form of formal education influences the health outcomes for women particularly in rural areas where more marginalisation of women class is found. The term health can be understood as wellbeing in physical, mental as well as in social form for an individual and in case of women the health management, maintenance and treatment is crucial in dealing with NCDs as in such situation the social factors have an unavoidable decisive influence in the same.

1.5 Impact of Social Factors on Health

The impact of social factors on health outcomes has been recognized in social science research as in various research it has been found that social factors have a pivotal influence on the overall health for a member of society. Emile Durkheim in his notable work "suicide" found the degree of social integration and regulation as decisive factors which determined the rates of suicide (Durkheim, 1987). The work of Durkheim gave new insights to the social inquiry regarding health studies in social science research. The social integration concept of Durkheim affirmed the importance of social factors impacting health (Mills, 2000). The importance of social structure and social relations as determinants of health outcomes has been highlighted by Durkheim (Wilson, 2012). The fact has been found and considered that various social relations and social encounters faced in a social setup by the members of society have a profound effect on their overall health. Social environment plays an important role in bringing different health outcomes depending upon the nature of the social networks of the individual members of the society. There is a profound impact of social environment on health outcomes which influences accessibility of resources, health behaviour and wellbeing of individuals (Phelan et al., 2010). Social ties have a link with physical morbidity and mortality (Berkman and Syme, 1979). Those who are engaged in their social gatherings and remain engaged with society are found in better health in different studies than those who are not engaged with society (Cohen, 2004). Health of the people who participate in their community is found better as compared to those who remain isolated (Bell, LeRoy and Stephenson, 1982). Those who remain in isolation are always at the risk of different ailments and disorders. The social relationships play a proactive role in health which is evident (Cohen et al., 2000). It has been found that those who are more socially integrated has less chance of getting heart attacks (Kaplan et al., 1997). In overall health and

wellbeing social factors are widely responsible for bringing different health results. The social conditions exert mental burden and also intervene in healing the depressive symptoms. Those who are socially disintegrated are at a high risk of obesity, high blood pressure, developing habits of cigarette smoking (House et al., 1988). The fact is evident that social factors have a great influence in health maintenance and outcomes for an individual being a member of the social setup. A human without a society cannot be imagined and for the necessity of life a human being has to be a social being. In the context of community social relationships provide sense of belongingness, identity and understanding of self (Leary, 2010). Women in rural areas face challenge, marginalization and discrimination on the bases of gender (Bell et al., 2019). Women being marginalized social class particularly in rural areas are more constrained in the social setup. Women face different inequalities in life opportunities, status, resources and accessibilities as highlighted in different feminist works have a limited social environment and most of the times a selective form of social relationships where they are in many instances subordinated to the male members of the society. The women have disguised their image as like servants and slaves similar to the oppressed people (Simone De Beauvoir, 1949). The women are kept in subordination by men with designing of violence against women (MacKinnon, 1978). The social factors which surround the women and social situation faced by them in the form of subordination and inequality in different societies of the world impact their overall social and mental wellbeing resulting in different health outcomes as it is evident from the research that social factors greatly influence the health outcomes.

Women are marginalized in several aspects of life in our society. Women are worst hit and are considered to be the most vulnerable segment of society in Jammu and Kahmir (S B A Gul, 2015) The attitude towards the women more or less is same all around the world as it is in India, the change of surname for newly married women is still prevalent even today (U S Goswami, 1993). The women are dominated in several aspects where they face discrimination from men in the society as they are been understood as subordinated to men where they are used to obey the male members of the society. When the women refuse to obey their husbands and act to resist, they face domestic violence (Jones, 2000). The women remain limited to the circle of their family, lack the freedom of expression also most of the times they are engaged in the domestic household chores which traditionally have been labelled as the responsibility of women. The girls of the rural areas of Jammu and Kashmir are supposed to be the household servants (Gul & Khan, 2013). The women in rural areas face more social limitations. The social

life of women living in rural part of our society lack the accessibilities to good education and healthcare functionalities as compared to urban areas which makes their social life more stretched with additional control on their life within the limitations of household are found. Women in rural areas of Jammu and Kashmir are deprived of basic facilities and education and their restriction to household chores can be found (Zulafqar Ahmed, 2021). The limited social environment for rural women leaves them isolated from the general society at large impacting their degree of social relations, deprival of basic education, resources, social and emotional support leading to the impact on the health outcomes. The achievement of education for girls is also hurdled in social issues due to which continuation of education for girls remains a challenge for them. Girls in rural areas are found with lower enrolment rates and disparity of higher dropout rates in comparison to boys (Mishra & Pandey, 2020)

Among all the social factors education has a decisive impact in shaping and progression of life and welfare of an individual member of society. Education is the most powerful tool for improving the role of women in society (Srivastava, 2014). Education plays an important role in social integration by bringing wide range of networks and by providing a better social status with which positive social integration can be achieved which is a necessity for the women who are left in isolation with the nature of social conditions prevailing in our society. Low level of education is the greatest risk factor for women dominance (L Gerstein, 2000). Education is responsible for providing socio-economic resources and a vast range of social networks which impact the health managing skills and influence health outcomes. The health awareness of women is enhanced with education making them able to be informed decisions regarding their own life (Gakidou et al., 2010). Education has direct and indirect impact on the wide range of social factors which influence the health of an individual particularly the health of the women. The social life for women determines their welfare and concludes towards their health outcomes as simply understood the health is the complete social and mental wellbeing along with physical fitness. The social factors which influence women life in a society where they face domination, and discrimination leads to the wellbeing of the women impacting the health outcomes. For the rural communities, investment in the education of women has benefits which are beyond health which includes the reduction of poverty, social and economic development, and progress to rural communities which are resilient and healthy (Gupta et al., 2014).

1.6 Education and Social Determinants of Health

Various factors are linked with the health outcomes which are enhanced with education. Education plays a very crucial and deciding role in relation to the social factors which ultimately influence the overall health directly and indirectly.

1.6.1 Knowledge and Skills

The education has been considered as a "social vaccine" which improves women health by enhancing the knowledge of women regarding the prevention of diseases, better services of health and better health behaviours (WHO, 2013). Education has an important impact on the daily life of women with being the powerful tool in managing and dealing with the needs and prerequisites of the body and overall health. In this connection a woman needs to be well aware and knowledgeable about managing good health and well skilful in dealing with health distress which is better possible with the achievement of education. Educated women are better in understanding the proper nutrition, good sanitary practices and health hygiene which reduces the chances of diseases (UNESCO, 2014). The knowledge of better nutrition and healthy food, better sanitary management and understanding about the consequences on health and also the knowledge of symptoms of different ailments is crucial in early diagnosis and care of diseases. Women with formal education are more reasonable to provide balanced diet to their children in comparison to those who are without formal education (Singh et al., 2014). Education is evident in providing skills and knowledge to the women which brings better health outcomes. The different reports of UNICEF have shown educated women giving birth to the healthier babies and the survival rate for the children of educated women is better than those mothers who are illiterate (UNICEF, 2015).

In case of non-communicable diseases, the knowledge and skills are crucial in management and dealing with the lifestyle diseases which require management and treatment on regular bases. In cases of non-communicable diseases like diabetes, hypertension and other cardiovascular diseases, it is important and must unavoidable routine for those who are suffering from such diseases to maintain proper nutrition, regular diagnosis and proper treatment failing which will bring dangerous health results for them. This is possible with education which enables knowledge and skills. The studies have found the women with formal education are better able to understand health requirements and are able to adopt the information which are related to non-communicable diseases (Sen et al., 2002). Educated

women response faster in treatment for conditions such as diabetes and hypertension (Smith et al., 2012). In conditions of NCDs for those who suffer from chronic diseases, it is always a challenge for them to manage their health on regular basis. A woman who is diabetic needs to be well aware about the blood sugar levels, normal HBA1C levels and proper nutrition. It is recommended for both type of diabetic patients whether they are on insulin or not to monitor blood glucose on daily basis (American Diabetes Association, 2020). Same is the case with hypertensive women who have to be skillful and knowledgeable in maintain normal blood pressure levels on daily bases along with the awareness of nutrition and understanding the importance of physical exercises which is also crucial for managing other non-communicable diseases. The guidelines of American Heart Association have highly recommended the monitoring of blood pressure on regular basis for those suffering from hypertension to aid the medication in maintaining blood pressure (Whelton et al., 2018). Monitoring and regular checkup of blood sugar levels and also blood pressure is important in preventing more complications and risk of strokes or other serious issues (Yusuf et al., 2004). Those who are educated adhere treatment schedules prescribed to them which leads to better NCD management and health results for them (Lange, 2017). The managements and abilities of health and wellness are developed with education which provides knowledge and skills in response to these conditions of health for women in general and rural women in particular who are left with limited social environment and limited accessibility of health care institutes.

1.6.2 Socio-Economic factors

Health challenges are faced by the rural women in respect of nutrition, healthcare facilities and rates of maternal mortality in comparison to the urban women (WHO, 2015). Socio economic status influences health for rural women particularly who remain in many situations marginalized and discriminated in our society. Lower socio-economic status has been linked with higher morbidity and mortality rates (Adler & Newman, 2002). Education has crucial impact on the socio-economic factors particularly for rural women. The women who are educated likely participate more in the labour market which boosts their earnings with which they contribute to the household and also to the economies of nation (Psacharopolos & Patrinos, 2004). Health management needs economic assistance and social skills which are crucial for the health care and also dealing with different diseases without which the health maintenance cannot be achieved. Education uplifts these socio-economic conditions to bring positive impact on the health outcomes. Higher educated women are likely to have desirable economic status

and are accessible to healthcare facilities and nutrition's which results in better health results (Adler & Newman, 2002).

The women who are suffering from non-communicable diseases need socio-economic support to manage the symptoms and effects of the diseases from which they suffer as the daily management is needed in such cases. The NCDs prevalence has been found higher in countries which are of low and middle income (Hosseinpoor et al., 2012). In the maintenance of health in case of NCDs it is crucial to be regular in checkups and diagnostics which requires economic assistance to afford the cost of the treatment and monitoring and managing the desired levels of body functioning's. those who are poor are unable to pay in order to treat NCDs (Levesque et al., 2007). Women education is important in providing the socio-economic status which makes them able to manage the health needed to be maintained in the condition of NCDs. Education improves socio-economic status of women, enabling them resources and the power of decision-making essential for the management of NCDs (Subramanian et al., 2020). This is evident that in cases of the health distress where the daily management is needed, the socioeconomic status plays a deciding role and most important fact to notice is that education uplifts the socio-economic status for women particularly crucial in rural setup. Education brings economic empowerment which makes women able to afford the nutritious food, medications and health insurance leading to health improvement (Das et al., 2016).

In history women are given responsibility of domestic chores, care and emotional services (Hochschild, 1989). The domestic work and caregiving services of women have been labelled traditionally as the work of women and particularly the women who are less educated and likely not to be engaged with formal labour force or educational institution due to which they remain engaged with domestic chores which remains unpaid. In production of labour force unpaid labour provides the services of labour force like childcare, the elderly care and domestic chores which remain without compensation of monetary benefits (Federici, 2020). In comparison with the less educated women, the highly educated women spend less time in domestic chores (Bianchi & Milkie, 2010). This unpaid labour impacts the health of women directly and indirectly. The domestic unpaid work impacts the physical health of women. The daily high level domestic tasks like cooking, washing, care of children likely leads to the disorders of musculoskeletal like strain injuries, back and joint pain (D'Ovidio, Mariani & Vergnano, 2017). The women are vulnerable to health distress like the problems of obesity, hypertension and CVDs due to having less time for the management of health and selfcare (Artazcoz et al., 2009).

The women who are less educated and likely to be engaged in unpaid domestic work face psychological distress also and their own health needs get ignored. Due to the domestic responsibilities the women engaged with unpaid work face stress and anxiety (Artazcoz et al., 2007). The domestic responsibilities consume time and remain without monetary benefits for those who are busy in household and care work which makes them to unable to find much time and lack of assistance for themselves. The women busy in unpaid labour are hindered in healthcare services for them as they likely prioritize the family members health over their own needs (Kim et al., 2004). Education is a pivotal tool to defend the health consequences of unpaid labour as women who are engaged with educational institutes, workplaces with recognised social status and economic backup are found to be less engaged with unpaid labour and more settled socio-economic status which are likely to bring better health results as evident from the research works.

1.6.3 Social Networks

Social networks are the relationships between the nodes and ties (Wasserman & Faust, 1994). An individual is surrounded with network of ties which can be understood as social networks. These social networks impact the wellbeing of individuals at personal levels as well as in the social life interacting with the larger society. The analysis of the structure of social networks can be done at individual interpersonal relations at small scale to larger society at large scale (Granovetter, 1973). Social networks have multiple functions which include social support, social influence and formation of identity (Tajfel & Turner, 1986). Social networks have important impact on health outcomes which includes mental and physical health and also utilization of healthcare services (Berkman & Syme, 1979). Less social networks resulting in social isolation and loneliness in associated with the risk of psychiatric disorders and worse mental health outcomes (Holt-Lunstad et al., 2015). Social networks influence the utilization of healthcare and treatment (Berkman et al., 2000). Social networks have an impactful influence on health results particularly for rural women who experience limited social environment with lack of social and emotional support. Women are likely to face barriers in marginal communities in accessing healthcare resources and social support network which results in health outcome differences (Hankivsky et al., 2010). Women in marginalized communities with limited social networks can face disparities in accessing healthcare and also in health outcomes (Berkman et al., 2000). With social networks more social and emotional support is gained which is linked with the impact on health outcomes. Social support is the

availability of empathy, assistance and others companionship which are the key components of social networks which has a profound impact on the health of women (Thoits, 2011). It has been indicated in research that strong networks of social support are linked with health outcomes of women throughout their life (Uchino, 2004). Those women who find social support have less chances of experiencing anxiety, depression and illness related to stress (Cohen & Wills, 1985). Lack of social support or facing social isolation are barriers for women to access healthcare services which includes financial limitations, issues of transportation and help seeking stigma (Perry et al., 2018). The women connected with community organizations, support groups, professionals in healthcare are benefitted in accessing health education, screening and treatment (Valente, 2010). Educated women gain skills and accessibility of healthcare systems with the prevalence of larger social relations.

Education provides sources for social networks by giving wide range of networks. Educational institutes provide additional social networks with more social interaction and sources of social and emotional support. Girls, young women find friendship, mentoring relations and systems of support which extends beyond the setting of classrooms (Ostrove & Long, 2007). The platform is provided by colleges and universities for events, development workshops and also alumni associations which connects women with like-minded individuals, role models and mentors (Turner & Bowen, 1999). The social circle of women is expanded in coordination with research projects, study programs, internships which increases their social circle (Hakim, 2006). Educated women develops communication skills and thinking abilities which provides them confidence in social interactions (Archer & Yamashita, 2003). The impact of social networks on health outcomes is evident and these social networks are boosted and expanded with education which is prerequisite for the rural women who face limitations in their social life and risk of health outcomes in their daily lives.

1.6.4 Health Behaviour

Health behaviour incorporates several intensive actions of individuals and their choices which they make regarding their health like diet, physical activities, healthcare prevention, diagnosis and treatment. The studies have revealed, the level of education is associated with health behaviour and health outcomes (Cutler & Lleras-Muney, 2010). There is co-relation between education with healthy lifestyle (Mirowsky & Ross, 2003). The health behaviour of people differs with education. The high level of education is linked with the early detection of diseases, more awareness of measures of prevention of diseases and treatment (Aguirre et al., 2019). The

acquisition of knowledge and awareness is the key process through which education contributes the development of positive health behaviour. Education provides individuals with the necessary information and understanding of health risks, benefits of healthy behaviours, and strategies for disease prevention. Highly educated individuals likely possess skills, health literacy which enables them to accurate interpretation of health knowledge and their health-related decisions (Berkman et al., 2011). This empowers the knowledgeable individuals to opt for healthy behaviours and develop positive health attitude like choosing proper healthy diet, regular exercise and medical treatment at times of need. Education is linked to socioeconomic status, as high level of education often linked with more resources, social networks, and healthcare access (Link & Phelan, 1995). With more resources enhanced with education positive health attitude and behaviour is more expected. With improved access to resources and higher levels of education, rural women in Kashmir are poised to foster favourable attitudes and behaviours towards health. Education acts as a catalyst in empowering these women, furnishing them with essential knowledge and skills necessary for making informed choices about their well-being. As rural women gain education, their awareness of preventive healthcare measures, reproductive health rights, and the importance of seeking medical assistance, when necessary, expands substantially. Those will with low education levels likely face social and economic barriers which hurdles them in adopting health behaviours like balanced nutrients, facilities of recreation and health care accessibilities (Adler & Stewart, 2010). In managing health and dealing with the disorders and distress it is very important to understand the health needs and to be aware about the symptoms and dangerous consequences of different diseases and disorders in the process of managing health the attitude towards self-health and wellness is important. The people with high education are more likely to exercise and less likely to smoke, often wear seatbelts and take part in cancer screenings (Grossman et al., 1997). Attitude towards health is important in healthcare and management and education is an important source for developing positive attitude towards health particularly for the rural women who experience limited social environment with lack of facilities in comparison to the others. The women who are educated are likely regular in physical activity, balanced diet, and avoid alcohol and tobacco like harmful substances (Jafar et al., 2020). self-control and sense of personal management is important in managing and maintaining health and wellness. Self-control enhances health behaviour and attitude in developing health attitude. The people who are with good self-control have more knowledge about health and most likely adopt preventive behaviours like restriction from smoking and alcohol consumption and better health is self-

reported by them in comparison to the less self-controlled ones (Seeman & Seeman, 1988). Educated women likely access medical care, timely treatment and proper health services bringing better health outcomes for them (Stepurko et al., 2016). Education provides knowledge and also the skills in the maintenance of health. The less educated women are not much aware about the symptoms and effects of different disorders due to which the various ailments are likely to remain unreported. The underreporting of illness by patients have been linked with low levels of education (Mackenbach et al., 1996). The healthcare initiatives taken by the government and other welfare organizations are likely to be better accessed by the educated women as compared to the less educated women. Educated women affirm their healthcare rights which advocate programs and policies which promote health and well-being of women (Wong & Thomas, 2020). Women with participation in educational programs not only acquire knowledge related to health but also gain social support and social networks which reinforce positive behaviours and attitudes regarding health (Yaya et al., 2021). The process of decision makings in healthcare are likely participated more by educated women with timely medical care and adoption of healthy lifestyle not only for themselves but also for their families as well (Tofani et al., 2020). This is now an observable fact that women health behaviour is influenced by education which not only impacts the health outcomes and health management for themselves but also for their family members and finally the overall society.

1.7 Integrative approach: Insights from Sociological Perspectives

Education plays an important role in shaping health by affecting individual behaviours, societal norms, and public policies. The link between education and health is complex and has a big impact on both personal well-being and society as a whole. Sociologists have studied this connection in detail, offering different theories to explain how education influences health outcomes. Key ideas like structural-functionalism, conflict theory, and symbolic interactionism simplifies to understand various aspects of this relationship.

1.7.1 Structural-Functionalism: Education as a Promoter of Health

In view of Structural-functionalism, education is an important part of society that helps to maintain stability and well-being. Education is been viewed as a way to prepare people to be part of society by teaching them important values, norms, and skills. Talcott Parsons, a key figure in this perspective, expressed that education helps people learn how to live in society by

socializing them (Parsons, 1951). In terms of health, education gives people knowledge about things like hygiene, nutrition, and preventing disease, encouraging healthier behaviours. Émile Durkheim, another important thinker, introduced the idea that education also teaches moral values. Schools help instil discipline and a sense of responsibility, which are important for the health of both individuals and the community (Durkheim, 1922). Schools that include health education help students understand the importance of healthy behaviours, precautionary steps, exercise, and eating well. This not only benefits the individuals but also the whole society at the wider level, as educated students are more likely to develop the behaviour which is beneficial in terms of health and are a positive factor for the health and hygiene of the society. Students can be seen in participating in health campaigns also that help protect their communities from diseases. Herbert Spencer, with his theory of evolution, saw education as a way for people to adapt to changing social needs, including health challenges (Spencer, 1861). Education helps individuals to stay updated on new health risks and also makes them aware about the advancements in healthcare. Lifelong learning enhanced with education allows people to understand and compete with the emerging health threats, like pandemics and also education contributes in making new medical technologies useful and functioning with the knowledge and skill development fostered with education. This ongoing process of education is very vital in helping people to respond to arising health, this ensuring that society remains resilient to face new challenges.

Robert Merton's idea of manifest and latent functions also applies to education and health (Merton, 1949). Merton expressed that education has both clear, intended purposes (manifest functions) and unintended side effects (latent functions). The main purpose of education is to teach knowledge and prepare people for work. However, it also helps build social connections and cooperation, which indirectly supports public health. With education there is link of economic factors which enhances good health as with good economic backup one can afford the healthcare expenses and needs of nutrition's pivotal for body growth and the prevention of diseases. The education can be linked with social connections which unintendedly are developed with the education pursuance in formal institutes, and these relations gets attached in educational institutes or workplaces which are vital for mental health providing social and emotional support. Overall, education is crucial for both individual and societal health. It provides people with the knowledge they need to make healthier choices, adapt to new health challenges, and work together to improve public health. Through socializing individuals, teaching values, and promoting social cooperation, education helps create a healthier, more

stable society. Education not only helps people in their daily lives but also strengthens communities by encouraging in participation of health programs and supporting public health efforts.

1.7.2 Conflict Theory: Education and Health Inequalities

Conflict theory, based on Karl Marx's ideas, focuses on how power and social inequality influence institutions like education and healthcare. Marx argued that society is divided into social classes, and those in power which are usually those having resources, use their influence to keep social structures in place and maintain control of the system. When it comes to education, this theory suggests that unequal access to education keeps health disparities alive by creating gaps in resources and opportunities. For example, people from privileged backgrounds typically receive better education, which leads to better health, while marginalized groups often face barriers to education and experience worse health outcomes. Karl Marx's theory of class struggle helps us understand how education can make these inequalities worse. Education often helps reinforce class differences by giving advantages to wealthier people. Those with money have access to better schools, higher education, better jobs, and higher incomes, which then help them live in healthier environments and access better healthcare. In contrast, people from lower-income backgrounds face obstacles like limited access to quality schools, financial constraints, and social biases, which often lead to poor health. This creates a cycle where disadvantaged people are less likely to access the education and resources which they need to maintain good health. Pierre Bourdieu's theory of cultural and social capital further explains how education helps maintain social inequality. According to Bourdieu, education acts as a way to keep powerful groups in control by valuing certain kinds of knowledge and cultural practices that align with the elite's values (Bourdieu, 1986). People from wealthier backgrounds are more likely to possess cultural capital in the form of skills, knowledge, and social networks which gives them an advantage in the education system. This helps them succeed in school and get higher-paying jobs, which leads to better healthcare and healthier living conditions. On the other hand, people from marginalized communities often don't have the same cultural capital, making it harder for them to succeed in education due to which they are not able to access resources that promote good health, like healthy food, hygiene management, safe living spaces, and healthcare services. Antonio Gramsci's theory of cultural hegemony also helps to explain the relationship between education and health inequalities. Gramsci's idea of cultural hegemony refers to the dominance of certain cultural

values and beliefs that benefit the ruling class (Gramsci, 1971). In terms of health, this theory suggests that educational institutions promote mainstream health beliefs and practices, alternative approaches like holistic or traditional medicine are being often ignored. These mainstream health practices are usually more accessible to wealthier individuals who can afford to navigate the healthcare system. In contrast, the alternative health practices which are more likely to be culturally appropriate for marginalized communities, are often overlooked. This exclusion keeps disadvantaged groups restricted from accessing the potentially more relevant or effective health practices which further deepens the health inequalities. Nancy Fraser's work on justice, particularly her ideas which are about redistribution and recognition, provides another valuable perspective in understanding how education and health interact with social inequalities. Fraser argues that justice has two key parts: redistribution, which means fair sharing of resources like education and healthcare, and recognition, which focuses on recognizing and respecting the identities and experiences of marginalized groups (Fraser, 1997). In terms of education and health, Fraser's ideas highlight how systemic barriers like classism, racism and sexism prevent marginalized groups from accessing both education and healthcare. For example, women in particular and minority groups in general are often excluded from educational opportunities due to gender and racial biases, which limits their ability to get the health information and resources they need. As a result, they experience disproportionately poor health, which is worsened by the lack of recognition of their specific health needs and experiences.

Link and Phelan's fundamental cause theory further explains the effect of education on health outcomes. According to this theory, people with higher levels of education are better able to access health-promoting resources, like healthcare services, healthy food, and safe living environments, because they have the social and economic capital to navigate these systems and make better health choices (Link & Phelan, 1995). Educated individuals are also more likely to practice those behaviours which promote health, such as they are likely to exercise on regular basis and usually seek preventive healthcare, because they have the knowledge and resources to do so. In contrast, those people who are with less education face greater challenges in accessing these resources which leads to poorer health outcomes. Link and Phelan's theory shows how education is a "fundamental cause" of health inequalities, as it affects several factors like income, social support, and access to healthcare which influence overall health. By emphasizing the role of power, class, and cultural dominance, conflict theory explains how unequal access to education continues to fuel disparities in accessing health. The ideas of

theorists like Bourdieu, Gramsci, Fraser, and Link and Phelan further show the complex ways education and health are tied to social inequality. To reduce these inequalities, it is necessary to improve the access to education for marginalized groups while also addressing the cultural and systemic barriers that prevent these groups from fully participating in both education and healthcare systems. Only by tackling these structural inequalities we can be able to reduce the health disparities that persist in society.

1.7.3 Symbolic Interactionism: Micro-Level Perspectives on Education and Health

Symbolic interactionism offers a distinctive perspective to examine how everyday interactions within educational settings influence individuals' health-related identities, perceptions, and behaviours. It highlights the role of socialization, labelling, and societal expectations in shaping individual approaches to health and well-being.

George Herbert Mead's theory of the self emphasizes how people learn behaviours through social interactions (Mead, 1934). These interactions in the primary levels with family and in school environments learn about health and hygiene and understand about the processes and patterns which are linked with education which on broader scale impact the overall health. In schools, students learn about hygiene, fitness, and mental health by interacting with teachers, classmates, and school activities. Peer discussions about healthy food and unhealthy eating habits can shape the perception of health among these students. Over time, these interactions influence how students perceive themselves and their choices about being healthy. Howard Becker's labelling theory explains how the labels given to students, like "gifted" or "troublemaker," can affect their self-esteem and behaviour (Becker, 1963). Positive labels can make students feel good about themselves which will encourage them to study more and work hard to upgrade their educational performances and to take care of their physical and mental health. On the other hand, negative labels can cause stress and lead to unhealthy coping methods, such as overeating or withdrawing from others and remaining isolated or getting disinterested in achieving the academic goals. Labels not only shape the way students see themselves but can also block their access to the support they need. Erving Goffman's idea of impression management shows how students try to meet social expectations about health and appearance (Goffman, 1959). In schools, students may change their behaviour or looks to fit in with peers or avoid criticism. For example, they might follow fitness trends or dress a certain way to gain acceptance. While some students develop good habits, others may feel stressed or

unhappy trying to meet unrealistic standards of appearance or health. Rosenstock's health belief model explains how schools influence and how students see health risks and benefits (Rosenstock, 1974). Students learn about healthy practices, get aware about the positive and negatives of health, learn to make better choices which impact their health. Access to mental health support, counselling, and physical activities also helps students handle challenges and develop healthy habits for life. Symbolic interactionism shows how small, everyday interactions shape health behaviours for individuals. But these interactions don't happen in isolation, but important factors like family, culture, and access to resources play influential role.

1.7.4 Feminist Perspective on the Impact of Education on Health

The perspective of Feminism has also drawn attention towards the intertwined nature influence of education and health. The perspective analyses how gendered norms and systemic inequalities influence health outcomes. Education operates as both a determinant of health and a space where inequalities of gender, race, and class are perpetuated, affecting physical, mental, and social well-being. Inequalities in accessing education and difficulties and social barriers faced by women in availing equal opportunities of education and the factors associated with it impacts the health outcomes for the women.

Feminist theorists like bell hooks and Simone de Beauvoir critique the patriarchal structures within education that marginalize women, limiting their access to health resources and opportunities (hooks, 1994; Beauvoir, 1949). Patricia Hill Collins (2000) shows how gender, race, and class combine to create unique challenges for some students. For example, African American girls in poorly funded schools often face both racism and sexism. This can limit their access to health education, counselling, or after-school activities that support their well-being (Crenshaw, 1989). These challenges can lead to stress and poor health, such as anxiety or obesity (Geronimus, 1992). The exclusion of diverse experiences from health curricula further alienates marginalized students, creating a disconnect between their lived realities and the information imparted in schools (Evans-Winters & Esposito, 2010). Feminist scholars advocate for culturally responsive teaching methods that address these disparities and tackle systemic barriers such as healthcare access and environmental racism (Morris, 2016). Bell hooks (1994) frames education as a liberatory practice that can empower individuals to challenge oppressive structures that impact health. The schools along with imparting the knowledge and skills

beneficial in health outcomes directly and indirectly can also expose students to inclusive and critical health education programmes. Programs addressing issues like sexual violence, mental health stigma, and food insecurity have demonstrated their potential to reduce health disparities in underserved communities (hooks, 1994; Gilligan, 1982). Nancy Fraser (1997) talks about two kinds of fairness: redistribution and recognition. Redistribution is about making sure resources, like financial resources to achieve academic goals and funding for schools to upgrade the mode of teaching. Recognition means valuing everyone's identity and experiences. For example, schools in poor neighbourhoods often don't have enough money for quality education and health programs, leaving students without important knowledge about topics like nutrition and mental health. Fraser's ideas suggest that schools need both better resources and more respect for diversity to improve health outcomes (Fraser, 2008). The feminist and intersectional examination of education's impact on health reveals how systemic inequities in accessing education and prevailing in the educational in schools perpetuate broader health disparities.

1.7.5 Globalization, Technology, and the Evolving Role of Education

Globalization and technology have changed how education influences health. According to Manuel Castells' network society theory, digital platforms help share health knowledge and connect education with healthcare (Castells, 1996). However, not everyone has equal access to technology, leaving some groups behind particularly the marginalized ones who face barriers and unequal opportunities. Ulrich Beck's risk society theory explains that education helps people handle global health problems like pandemics and climate-related health issues (Beck, 1992). By teaching important skills and knowledge, education plays a key role in helping people navigate a connected and changing world. This can be understood that those lagging behind the accessibility of technology due to the lack of social and economic support which is linked with education or the lack of knowingness in accessing technology leads to the health disparities.

1.8 Theoretical Framework

Theoretical framework presents a guide and model for the study to take insights from. The theoretical framework offers a structured lens through which research problem can be examined; it ensures that the study is grounded in a coherent scholarly tradition (Grant & Osanloo, 2014). Theoretical frameworks often rely on established theories that have been tested

and validated within their respective fields. However it very beneficial to use the **integrative approach**, which combines theories and concepts from various disciplines to form a more comprehensive framework. This approach is especially beneficial for tackling complex research problems that cut across multiple fields, as it enables researchers to merge different perspectives and create a more nuanced understanding of the phenomenon being studied (Berkowitz & Siemsen, 2020).

1.8.1 Structuration theory by Anthony Giddens

Anthony Giddens' structuration theory provides a comprehensive framework for understanding how structure and agency interact to shape social life of individuals. Introduced in his influential book "The Constitution of Society" (1984), the theory of structuration suggests a dynamic relationship between agency and structures. The agency reproduces and transforms the structure and in turn this structure constrains and influences the individual. “Agency” are the individuals with their capacity to act. Individuals make their choices and act within the limits of social structure. “Structure” refers to the pattern of relations, norms and institutions which play a decisive role in shaping the life of individuals within a social setting. As per Giddens there is reciprocal relationship between agency and structure which is referred as "duality of structure". In this interplay of duality, the structure is produced and reproduced by action and an actor is constrained by that structure. The structure comprises of the rules and resources which are utilized by the actors. Giddens concept of "duality of structure," highlights that structures are not external to individuals but emerge and evolve through their actions. In simple terms, individuals create social structure and in turn this social structure influences and constraints them, of which they are a part. The social order or the nature of institutions or norms can be understood as dynamic and can be changed with the acts of the individuals.

In case of education impacting the health of individuals, theory of structuration offers a delicate framework and model of study. The individuals make choices in the form of acquisition of educational attainment which in turn impacts their health. Less educated individuals by lacking education face health distress. In a social setup individual with educational achievement gain knowledge, choose health behaviours, get access to healthcare facilities, and adhere to the needed screening and treatments which forms the pattern of structure for them and in turn this structure influences in bringing health outcomes for them.

1.8.2 Social capital and Cultural capital by Pierre Bourdieu

Social Capital

Pierre Bourdieu's exploration of Social Capital Theory is a significant contribution to the comprehension of social dynamics, relationships, and the impact social capital in various forms on individuals and communities. Pierre Bourdieu's seminal work "The Forms of Capital" (1986) offers a detailed examination of functioning of social capital within diverse social settings. In Bourdieu's framework, social capital encompasses the resources accessed by individuals within the social networks to enhance their social status, these are assets to achieve goals, and these navigate within different social domains. social capital is rooted and connected in relationships depending on the networks which are established over time by individuals. As per Bourdieu the social capital accrues through the cultivation of social ties, reciprocity of interactions, trust and adherence to norms, which foster community cohesion and cooperation within a social setting. The essence of Bourdieu's Social Capital Theory revolves around the concept of "habitus," which encompasses the deeply ingrained tendencies, inclinations, and behaviours acquired by individuals with the process of socialization within specific social milieus. The influence of Habitus is on the individual's development of perception, understanding, and their engagement with the world surrounding them. This process shapes individual's interactions and the accumulation of social capital. Bourdieu argues that individuals from various social backgrounds possess distinct habitus, which in turn affects their ability to access and make use of social capital. Bourdieu's Social Capital Theory illuminates the processes of evolution of social capital, its endurance, and its transformation within a social structure. The distribution and utilization of social capital are significantly shaped by social networks and the functions of institutions. The social networks are being highlighted as significant in providing support, resources and exchange of knowledge which enhances social capital for individuals. The concept expresses that social exclusion and social stratification can be perpetuated due to the unequal accessibility of social capital. individuals with higher social capital have better prospects in life by accessing resources and opportunities by using the possessions acquired by social capital. The social capital is the possession of social resources which provide accessibility and social mobility and social status for the individual members of society and contributes to their overall wellbeing.

Cultural Capital

Pierre Bourdieu's theory of cultural capital suggests that an individual possess wide range of cultural capital in the form of knowledge, skills and competencies particularly developed in educational institutes and family setups. These abilities which form capital for an individual are acquired by them through the process of socialization. The concept of cultural capital has been elaborated extensively in his work "Distinction: A Social Critique of the Judgment of Taste." Cultural capital are the assets for an individual in the form of knowledge, educational attainment and cultural skills which makes individuals able in development of personality, social mobility and differentiates individuals by enhancing social status. The two forms of capital identified by Bourdieu are: embodied and institutionalized cultural capital. Embodied cultural capital are those assets which are acquired by the individuals through the process of socialization. These are the habits formed over time, knowledge of culture and communication patterns internalized by individuals in a social setup. Those who belong to the higher social class acquire more of embodied cultural capital which enhances their social status in a society. Institutional cultural are acquired through institutionalized in the form of formal educational qualifications, achievements as associations with organizations. These forms of cultural capital are cultivated through the institutionalized channels for individuals. These channels are schools, colleges, universities and cultural institutes where the qualifications and abilities are acquired in a formal process. These achievements are recognized by the society and individuals are valued within a society. These assets bring several opportunities for the socio-economic development of the individuals and enhances overall development of wellbeing. The unequal distribution of cultural capital within a society perpetuates social inequalities which leads to distinctions of social status within a society. The differences in social status brings different opportunities, positions and conditions of life. Bourdieu's concept of cultural capital in has a significant place in sociological research. The concept of cultural capital is significant as model of study in analysis of several phenomena particularly the impact of education in bring different results in wellbeing of the individuals.

The concepts of social capital and cultural capital denotes the social and cultural resources as possessions or assets for individuals. The social networks and support, formal education and cultural knowledge are denoted as capital for individuals, all of which are related to educational achievement and health impacts. In the present study the education impacting the health can be corelated with the theory and these concepts serve as model of study. The education is as a

resource with the features of knowledge and awareness, skill development, social value, more social networks and opportunities in economic fields which enhance the wellbeing of individuals by improving the health outcomes for them.

1.8.3 Ecological Systems Theory by Urie Bronfenbrenner

Ecological Systems Theory developed by Urie Bronfenbrenner (1979), describes how a person's development is shaped by various interacting environmental systems. The theory divides these systems into five levels: Microsystem, Mesosystem, Exosystem, Macrosystem, and Chronosystem. These levels represent different types of environments, from close surroundings like family and school to broader cultural and societal influences. The theory highlights how these systems influence an individual. Education has a strong impact on women's health by improving their knowledge, health habits, and access to medical care. Urie Bronfenbrenner's Ecological Systems Theory (EST) helps explain this relationship by showing how different environmental factors, from personal to societal, influence development. The theory views human growth as being shaped by multiple layers of influence, and it can be related with education affects women's health at individual, family, community, and societal levels.

1. Microsystem

The microsystem is the closest environment in a person's life, involving interactions with family, friends, and schools. Education at this level helps women improve their understanding of health, making them more aware of healthy habits and encouraging positive attitudes toward their own and their family's health. Women who are more educated are better at understanding and practicing preventive healthcare, which leads to better physical and mental health.

2. Mesosystem

The mesosystem involves the relationships between different microsystems. For example, the connection between a woman's family and her school can greatly impact her education. When families are supportive and involved in their children's education, it leads to better learning experiences, which can also improve knowledge about health and healthy behaviors. Schools that include families in health education create a better environment for women to learn about health issues. The connection or interaction between schools and healthcare providers is also important because the health education programs can take place which can make it easier for women to access health services and adopt healthy habits.

3. Exosystem

This layer includes larger social systems that do not directly involve the individual but still influence their development. While individuals do not interact directly with these systems, they are still impacted by them. The exosystem includes social factors that affect women's health in indirect ways, such as parents' job profile, community health services, government rules. Women's education can influence these factors leading them to better health outcomes. For instance, educated women are more likely to find good jobs and get health insurance, which improves them in affording healthcare, and this results in better health not only for themselves but also for their families.

4. Macrosystem

The macrosystem is the outermost layer of a person's environment. It includes cultural elements like social values, customs, and laws. This layer influences individuals by shaping the beliefs and ideas found in the other systems. The macrosystem involves societal and cultural factors, including policies, laws, and cultural norms that shape attitudes about women's education and health. Societies that support women's education and gender equality often have better health outcomes for women. Policies that provide universal access to education and promote gender equality help reduce health gaps. These policies create environments where women can make informed choices about their health and well-being.

5. Chronosystem

The chronosystem involves changes that occur over time, such as social transitions, policy changes, and evolving roles. The increase in educational opportunities for women has significantly impacted their health in the long term. Higher education enhances women's knowledge and access to health resources, allowing them to express their health needs more confidently and navigate healthcare systems more effectively. The historical changes in policies supporting women's higher education can be found leading to better reproductive health outcomes and a decreasing the maternal mortality rates.

This framework, based on Ecological Systems Theory, shows that education affects women's health through various environmental factors at different levels. These levels include personal experiences, family dynamics, community resources, and broader societal norms. Each of these factors interacts with one another, creating a complex network that influences women's health outcomes.

1.8.4. Capability Approach by Amartya Sen

Amartya Sen's **Capability Approach** provides a compelling philosophical and analytical lens for exploring how education shapes women's health outcomes. Rather than evaluating well-being merely through economic indicators or service access, this approach centres on what individuals are genuinely able to be and do, that is, the real freedoms and opportunities available to them. In this sense, development is not just about resource distribution but about expanding human potential and agency.

At the heart of the Capability Approach are four foundational concepts:

- **Functioning's** refer to the various states of being and activities that constitute a person's well-being—such as being healthy, being educated, or being safe. These represent the tangible achievements in a person's life.
- **Capabilities** are the actual freedoms or real opportunities to attain these functionings. While functioning's describe outcomes, capabilities reflect the potential to achieve them. For instance, a woman's capability to be healthy depends not only on her physical condition but also on whether she has access to knowledge, services, and autonomy to seek care.
- **Agency** is a key pillar of this framework, emphasizing a person's ability to act deliberately and pursue goals that they value. It recognizes individuals as active participants in shaping their lives, rather than passive recipients of aid or policy.
- **Freedom** in Sen's terms is both an end in itself and a means to broader development. It encompasses the freedom to make choices, to live with dignity, and to access the resources necessary for a meaningful life.

When applied to the context of women's education and health, these concepts reveal how education becomes a transformative force. Education is not simply a medium for acquiring knowledge it is a gateway to expanding capabilities. Educated women are better equipped to understand their health needs, make informed decisions, access medical services, and adopt preventive health behaviours. In this way, education enhances the capability to achieve and maintain good health a vital functioning.

Moreover, education fosters a stronger sense of agency. Women who are educated tend to have greater control over their bodies and lives, making autonomous decisions regarding reproduction, contraception, family planning, healthcare-seeking behaviours, and able to

access the healthcare facilities. They are also more likely to challenge oppressive traditions or social norms that negatively impact their physical and mental health.

Education also plays a crucial role in promoting freedom not merely in the abstract sense, but in everyday practical terms. A literate woman, for example, can navigate healthcare systems, interpret medical information, and participate meaningfully in family and community decision-making. This freedom empowers her to prioritize her health and well-being, both individually and collectively.

Importantly, Sen's approach highlights the interconnectedness of capabilities. The enhancement of one capability, such as education, often leads to improvements in others like economic empowerment, political participation, and of course, better health. For example, educated women are more likely to secure employment, which increases their financial independence and access to quality nutrition and healthcare for themselves and their families. At the same time, good health enables continued learning, productive work, and broader social engagement.

1.9 Conceptual Framework

1.9.1 Defining Conceptual Framework

A conceptual framework is an essential part of research which acts like a roadmap that guides researchers through the entire study. It provides a clear structure for understanding the relationships between important concepts which helps researchers to collect and analyze data effectively. In social science research, a conceptual framework is a system of connected ideas, assumptions, beliefs, and theories that provide direction for a study. It highlights the key factors, concepts, or variables that the research focuses on and explains how these elements are connected. As Miles and Huberman (1994) define it, a conceptual framework is "a visual or written product that explains, either graphically or in narrative form, the main things to be studied—key factors, concepts, or variables—and the presumed relationships among them."

Rather than just being a random set of ideas, a conceptual framework combines theoretical knowledge and real-world data to build a structured outline for the study. In essence, it helps researchers:

1. Focus their research questions or hypotheses,

2. Set the boundaries of the study,

3. Justify their research methods, and

4. Link theory with the data they are investigating.

Elements of a Conceptual Framework

A conceptual framework usually includes the following key elements:

1. Concepts or Constructs: These are the main ideas or topics the research is trying to understand. Concepts are abstract and need to be clearly defined based on what previous studies or theories say about them.

2. Variables: Variables are the measurable parts of the concepts. Variables can be independent (the cause) or dependent (the effect).

3. Relationships: A key aspect of a conceptual framework is figuring out how the variables relate to each other. These relationships are often shown in research questions or hypotheses.

Importance of a Conceptual Framework in Social Science Research

1. Focuses the Research: A well-constructed conceptual framework helps researchers to stay focused on what's important. It makes clear which concepts and variables to prioritize, ensuring that the study stays on track and doesn't get sidetracked into irrelevant areas. This improves the overall clarity and relevance of the research.

2. Guides Data Collection and Analysis: The conceptual framework provides a logical plan for collecting and analysing data. It helps researchers decide which data to gather and how to interpret it. For example, if the framework suggests that social networks influence political participation, the researcher will focus on data that captures these social connections and political behaviours.

3. Links Theory with Real-World Data: Social science often relies on theories to make sense of complex social issues. A conceptual framework connects these theories with real-world research, allowing researchers to apply theoretical ideas to practical situations. Ravitch

and Riggan (2017) argue that conceptual frameworks “frame the approach to inquiry and influence how the researcher interacts with participants and interprets findings.”

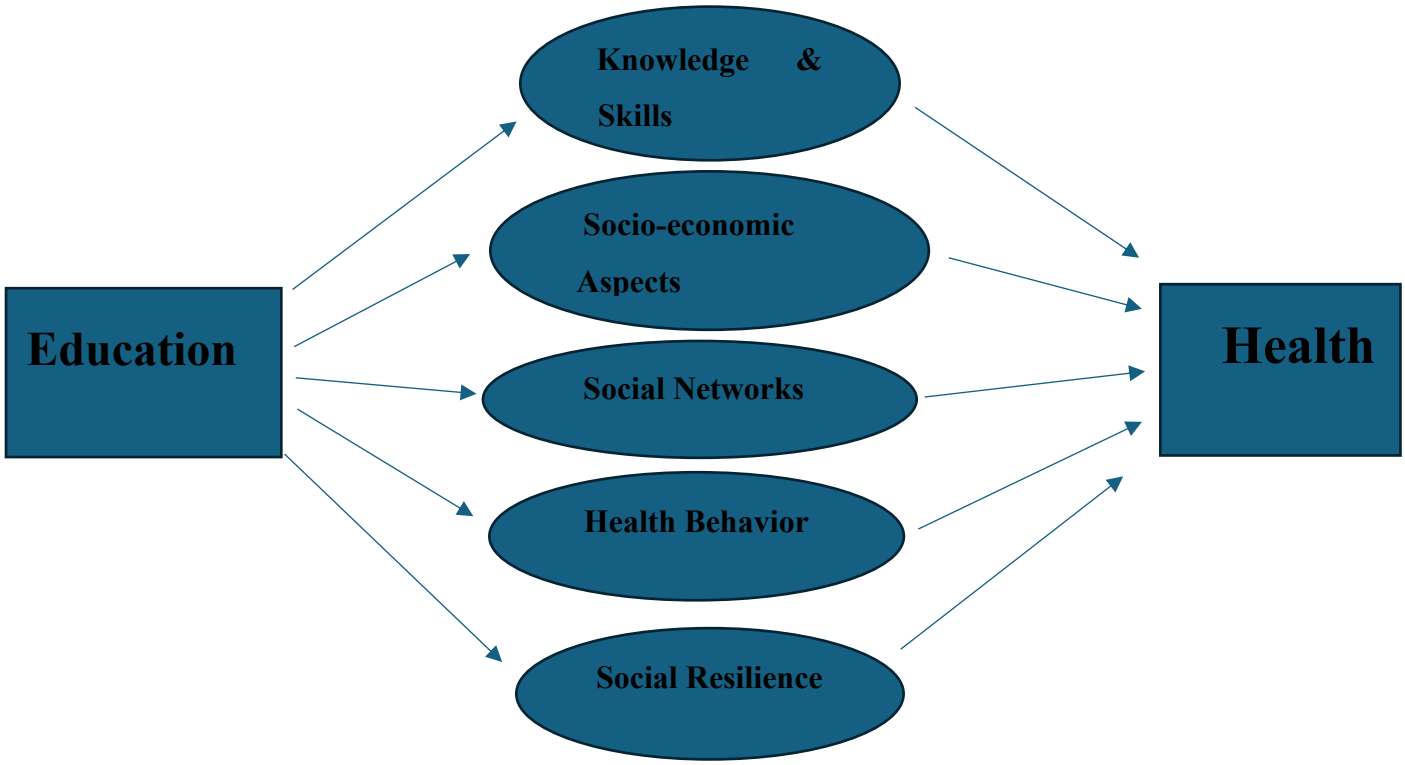
4. **Improves Research Validity and Reliability:** A strong conceptual framework strengthens the validity (accuracy) and reliability (consistency) of a study. By providing a clear plan for the research design, it ensures that the research questions are well-founded and the methods are appropriate. Maxwell (2012) notes that a good conceptual framework helps researchers avoid biases and misinterpretations by rooting the study in solid theoretical ideas.

5. **Encourages Rigor and Transparency:** In social science research, thoroughness and openness are important for ensuring the findings are credible. A clear conceptual framework shows how the research was planned and carried out, from developing research questions to analysing data. This transparency makes the research more trustworthy.

A conceptual framework is an essential tool for guiding social science research. It provides a clear structure for defining the research problem, forming hypotheses, and guiding data collection and analysis. By linking theoretical ideas with real-world data, the conceptual framework enhances the accuracy and transparency of the research. Developing a well-constructed conceptual framework is critical for producing meaningful research that contributes to social science knowledge.

1.9.2 Conceptual framework for this research

Education is widely recognized as a vital factor which influences health, particularly women are impacted. The connection between education and health is complex, as education affects many aspects that indirectly shape health outcomes. This framework looks at the independent variable (education), the mediating variables (knowledge and skills, socioeconomic factors, social networks, health behaviours, and social resilience), and the dependent variable (women's health outcomes).



Independent Variable: Education

Education is the independent variable in this framework, and its effect on health is multifaceted. It includes different aspects: formal schooling, the quality of education, and opportunities for lifelong learning. In this context, education is not just about the number of years in school but also about the quality and relevance of what women learn. Educational achievement can be measured by formal qualifications (like primary, secondary, or tertiary education). One significant way education impacts health is by enhancing literacy and cognitive skills. Women with more education generally have a better understanding of health-related information, such as nutrition, hygiene, and disease prevention. These skills enable women to comprehend medical advice, access healthcare services, and make informed decisions about their health and their families' health. Education helps women to understand complicated healthcare systems and speak up for better services. Education opens up economic opportunities that are essential for health. Educated women are more likely to find better-paying jobs and are less likely to experience poverty. Financial stability can improve health outcomes by providing access to nutritious food, safe living conditions, and preventive healthcare services. Education also fosters financial independence, allowing women to have more control over health-related decisions and expenses.

Mediating Variables: Pathways Linking Education and Health

Education influences health through several mediating variables, which explain how the independent variable affects the dependent variable. This framework highlights five key mediating variables: knowledge and skills, socio-economic factors, social networks, health behaviours, and social resilience.

1. Knowledge and Skills: One of the most immediate effects of education is gaining knowledge and skills, especially in areas important for health. Educated women are more likely to be informed about health risks, disease prevention, and healthy behaviours. Education improves women's ability to understand and follow medical advice, including availing health systems, understanding medical procedures, and recognizing and finding early signs of illness. Health literacy is the ability to obtain, process, and understand basic health information and this is a crucial skill which is learned through education. Women with higher health literacy can better manage chronic conditions like diabetes or hypertension and are more likely to participate in preventive healthcare, focus on screening and clinical investigations.

2. Socio-economic Factors: Education significantly boosts the socio-economic status of women, which is a major determinant of health. By increasing access to better-paying jobs and providing financial stability, education plays an important role in managing and taking care of health. Women with financial security can afford nutritious food, healthcare services, engage less in unpaid domestic responsibilities which are essential for better health outcomes.

3. Social Networks: Education provides social networks which impacts health for women. Education helps women build social networks by connecting them in schools, workplaces, and community organizations. These connections offer both social and emotional support, enabling women to share health-related information and motivate one another to make healthier choices. This impacts the health of women by providing the healthy social networks.

4. Health Behaviours: Education plays a crucial role in shaping health behaviours. Educated women are more likely to engage in health-promoting activities, such as eating a balanced diet, exercising regularly, and avoiding harmful substances like tobacco and alcohol. In cases of non-communicable diseases, the health behaviour plays a crucial role and educated women are more likely to take preventive steps and adopt the healthy behaviour. The educated women are more likely to take timely treatment, monitoring and screening.

5. Social Resilience: Education equips women with the problem-solving skills and resilience needed to face health-related challenges. Educated women are generally better prepared to develop coping strategies for stress, illness, and adversity. Educated women are more likely to challenge harmful cultural practices that affect their health, such as early marriage, domestic labels and can be more able to demand better healthcare services while engaging in public health initiatives.

Dependent Variable: Women's Health Outcomes

The health of women is thus influenced with various factors linked with education. Education provides more knowledge and skills which impacts overall health and develops health related illness. Education intervenes by developing better socio-economic condition which improves the affordability and social conditions related to health management and care. Education boosts social networks which are pivotal in socio-psychological support resulting in better health outcomes. Education provides social resilience in dealing with social barriers which hurdle in better health outcomes. All these factors have an impact on health and education plays an important role by enhancing the better version of these factors for them.

1.10 Objectives of the Study

1. To study the relations between the level of education and health outcomes for rural women.
2. To analyse the factors that impact the health outcomes of rural women.
3. To understand the health behaviour of rural women.
4. To find out the challenges of rural women regarding health.

1.11 Significance of Study

The study is focussed on the marginalized class of the society inquiring their health impacts and various factors which play influential role in overall health status of rural women. The study provides significant contribution in betterment of women health in rural environment by highlighting various factors which are interlinked with education to determine the health status of women in rural areas. It is very crucial to understand the health disparities faced by the women in rural areas and the study has highlighted the unequal health accessibilities based on the traditions, socio-economic status, inadequate facilities and unequal opportunities of education. The study provides the detailed link and influence of various factors with the health and wellbeing of the women. The women in particularly rural settings are less accessible to the

health care services and due to the responsibility of family and care work they do not find the time and support for themselves in respect to the health needs and management. It is very significant in women welfare to highlight the ignorance of health distress of rural women and their unequal access and inequality in healthcare access. The study has been focussed on the causes of ignorance of symptoms of diseases and issues faced in the management of health during health distress among the women living in rural Kashmir. The study is important in presenting the social burdens which deteriorate the health of women like domestic work which is without the economic assistance, patriarchal mode of society preferring men over women, limited environment lacking the needed facilities. The study highlights education as the solution to overcome these barriers and enhancing the women development in factors which influence and most of the times determine health. The study focusses on the impact of education in developing health behaviour among women. The adoption and developing habits of health preventive measures are important for the health of women and overall community surroundings to develop a healthy environment, all this accounting to the welfare of mankind and society. The study is significant in highlighting the issues faced by rural women which lead to the negative health results for them and recognising education in providing competencies in countering the health challenges faced by rural women. The study is significant in understanding the process of social change in the direction of women development, providing the inquiry of social contains and education in response as the tool of health promotion for the women in rural demography of Kashmir.

1.12 Research Question

Do the education has an impact on the health outcomes for rural women in Kashmir in relation to the social determinants of health is the research question for this work. The study has been done accordingly to find the impact of education on health outcomes of the rural women residing in Kashmir and the link of education with social factors has been examined accordingly.

1.13 Structure of the Thesis

The thesis work starts with the introduction chapter in which the impact of health on education has been discussed in the from the insights of theorists, research and concepts which are related to the subject of inquiry. the concept has been understood in the chapter 1 with emphasizing the importance and scope and aim of the study. The next chapter 2 deals with the literature

which provides more resource to the study in which the work of several researchers has been reviewed to benefit the study. The chapter 3 expresses the methodology which has been applied to find the fact followed by the chapter 4 which presents the results and their process of analysis for the study. In the final Chapter 6 of the theses the research findings have been concluded, and some suggestions are presented for the future work and development. The theses in the reference section credits the researchers for their findings and the sources of data is revealed from where the secondary source of data has been collected.

CHAPTER 2:

REVIEW OF LITERATURE

CHAPTER 2

REVIEW OF LITERATURE

2.1 Introduction

The review of related literature in research work has a pivotal influence on the fact findings as it provides the proper guidance and structures the ideas and inquiry to enhance the research in a methodical way. The researchers get familiar with the context of their research work by reviewing the literature. A literature review furnishes researchers with an extensive summary of pertinent theories, concepts, and discoveries. within the existing body of knowledge, it enables researchers to position their work appropriately (Fink, 2019). The research gaps are identified by Analysing the related literature and the areas which need to be addressed in related inquiry which a researcher aims to explore can be highlighted with the review of literature. By synthesizing the existing literature, researchers can pinpoint the extensively un-explored areas or the existence of contradictory findings with which new opportunities of research directions can thus be highlighted (Tranfield et al., 2003). Literature review guides in formulating the research design and adopting proper methodology to undergo the research. The insights can be drawn by the researchers from previous studies in selecting proper methodology for the objectives of their research (Greenhalgh & Peacock, 2005). It is important for the research before it is initiated to search the facts which are been recognized and the results of research findings and studies which have been accomplished in the related field. These findings provide a design and proper approach to reach the conclusion which is significant for the researchers to limit the subjectivity and proceed in scientific manner. The theoretical model for research study is enhanced with the literature review of the related research. The new theoretical models or the existing theories can be integrated by the researchers on the bases of insights which they gain from literature (Webster & Watson, 2002). The review of existing literature enables researchers to avoid delicacy or the repetition of the already research done previously. It enhances new additions to the research and filling the gaps of research with new insights, updates and validation. With the help of review of literature, the researchers are ensured with prior awareness of finding of research enabling them to build up the existing knowledge instead of revisiting the familiar ground (Boote & Beile, 2005). The research is compared with the existing findings and its validity can be assessed with reviewing literature which is related to

research. The reliability and consistency of research findings can be assessed by the researchers in light of the previous research work (Creswell, 2017).

2.2 Insights from Indian Sociologists

In the context of India, the relationship between education and health has been a topic of significant interest among sociologists. Education has been found to positively influence in various aspects of health, from individual health behaviours to overall societal health outcomes. The contributions of Indian sociologists have been instrumental in understanding the link between education and health, particularly in rural and marginalized communities.

Indian sociologists have long explored how education acts as a fundamental determinant of health. In a society marked by social stratification and inequality, education has been recognized as a powerful tool for improving health outcomes. C.N. Shankar Rao, examined the role of education in reducing health disparities. He argued that educated individuals, particularly women, are more likely to access healthcare services, understand health-related information, and adopt healthier lifestyles (Rao, 2000). M.N. Srinivas pointed out the role of education in social mobility, which includes improved access to healthcare. He emphasized that educated individuals are not only more likely to adopt modern health practices but also possess the ability to challenge traditional norms that limit access to healthcare, thus enhancing overall health (Srinivas, 1966). Maternal health is one of the most evident areas where education significantly influences health outcomes. According to K.L. Sharma, maternal education has a direct impact on maternal and child health. Sharma's research illustrated that educated women are more likely to seek prenatal care, deliver in healthcare facilities, and make informed choices regarding family planning (Sharma, 2002). This results in lower maternal mortality and improved child health, especially in rural areas where access to healthcare can be limited. Shah and Joshi (2006) also highlighted the positive effects of maternal education on child health, pointing out that children born to educated mothers were more likely to receive vaccinations, proper nutrition, and timely medical interventions. These health-promoting behaviours, linked to maternal education, reduce infant mortality rates and contribute to better health outcomes for the next generation.

Education also plays a pivotal role in shaping public health knowledge. Sociologists like T.K. Oommen have underscored how education enhances individuals' understanding of public health issues such as sanitation, nutrition, and disease prevention. Oommen (1997) suggested

that educated individuals are more likely to engage with public health initiatives and adopt health-promoting practices, which can have a positive ripple effect on community health. B.K. Nagla's (2013) work further explored how education impacts health awareness in rural areas, where access to health information is often limited. Nagla found that educated individuals in rural India are more likely to practice better hygiene, seek medical help when needed, and understand health risks, thus improving their personal and family health outcomes.

Education is often linked to improved socioeconomic status, which in turn improves access to healthcare. G.K. Karanth (2004) explored how education facilitates economic mobility, providing individuals with better job opportunities and the means to access healthcare services. Karanth argued that educated individuals are more likely to afford medical treatment, health insurance, and preventive care, which leads to better health outcomes. Furthermore, V.B. Jugale (2016) highlighted the economic benefits of education, particularly for women. Educated women, especially in rural areas, are more likely to enter the workforce, achieve financial independence, and have better control over their health decisions. Financial autonomy empowers women to seek healthcare for themselves and their families, leading to better overall health.

Gender inequality in health outcomes remains a significant issue in India. Sociologists like Veena Das have explored how education can help address these disparities. Das (2001) pointed out that educated women are more likely to take control of their reproductive health, seek medical care, and engage in family planning. Education enables women to challenge traditional norms that may restrict their access to healthcare, leading to improved maternal health and reduced gender-based health disparities. G.S. Ghurye (1969) also discussed the role of education in overcoming gender-specific health challenges. Ghurye argued that education serves as a means of empowerment for women, enabling them to challenge social norms and improve their health outcomes. Educated women are more likely to understand and manage issues like menstruation, reproductive health, and maternal care, thus improving their overall well-being.

The work of Indian sociologists has shown that education has a profound impact on health, both directly and indirectly. Educated individuals, particularly women, tend to have better health outcomes due to increased health knowledge, access to healthcare, and improved socioeconomic conditions. The research of these sociologists can be taken as insights for

examining the critical role of education in improving health in rural India and reducing health disparities. However, challenges such as gender inequality, poverty, and limited educational opportunities for women still persist, limiting the full potential of education to improve health outcomes. Addressing these barriers through targeted policies and interventions can help maximize the health benefits of education in India.

2.3 Literature Review of Previous Research

There is a determinant link between education and health outcomes. The studies have revealed that education has a very influential impact on health results particularly of women who face social discrimination and remain a dominated social caste with limited accessibilities. Education enhances social status and provides economic resources and develops skills and knowledge which intervenes in outcomes of health. The studies related to the association of education with health provide a wide range of knowledge and guidance in the same and associated research to make addition in the research findings and to fill the gaps of existing research developed earlier. the review of literature has provided the proof for the reliability of the data.

1. In Lesly Doyal book *"What makes women Sick, gender and political economy of health"* (1995) gender inequalities have been highlighted which explore the impact on health of women due to these inequalities. The work has revealed that women are treated less in social status as compared to men. The cultural position of women as domestic workers for adds mental stress for women. The burden of care work and risks faced by working women at workplaces has been highlighted in the work. Women are observed in dealing with social issues in which they face the economic barriers as well as cultural and social hurdles due to which they are unable to meet their needs.
2. Catherine E. Ross and Chia-ling Wu in their research work *"the links between education and health, (1995)"* found the impact of education on health. The research has been analysed after the data collection which is done via telephone in two terms by interviewing the respondents. The fact has been concluded that different levels of education bring different health outcomes. The study highlights the correlation between education and health, suggesting that well-educated individuals tend to enjoy better health outcomes compared to their less-educated counterparts. This association is attributed to various socioeconomic factors associated with education. Employed individuals generally exhibit better health than those who are unemployed. The research indicates that well-educated

individuals are more likely to secure employment with higher income, leading to a greater sense of control over their lives. Additionally, they tend to have stronger support systems and are less prone to unhealthy habits like smoking and excessive drinking. Overall, the findings underscore the direct and indirect impact of education on health, emphasizing the role of economic and social resources in promoting healthy behaviours and lifestyles. The study also identifies health inequalities stemming from disparities in education, which influence economic opportunities, work conditions, social support networks, and psychological well-being.

3. In their work *"Rural Women in India: Assessment of Educational Constraints and the Need for New Educational Approaches"* (1997), Rajika Bhandari and Frank J. Smith explored the educational status of women in developing nations, focusing particularly on rural women in India. The study sheds light on the various benefits that literacy can bring to women, enabling them to achieve social and economic stability, which in turn contributes to the well-being of both them and their families. The researchers collected data from a sample of 102 women aged between 15 and 35 from three villages in Madhya Pradesh. The findings reveal that husbands typically assume the role of decision-makers, while women are primarily engaged in domestic duties. Furthermore, only two-thirds of the population utilize health facilities, with approximately 33% of women either unaware of or not accessing these facilities. The study identifies prevalent reasons for women dropping out of school, including financial constraints, early marriages, and family obligations. Financial crises often lead to daughters being withdrawn from school, while family economic circumstances and social duties hinder rural women from completing their education.
4. In K. Buckshee's 1997 study, *"Impact of Roles of Women on Health in India,"* the focus was on understanding how women's roles in society influence their health outcomes in the Indian context. Buckshee delved into the complexities of this relationship by analysing data from various sources, aiming to shed light on the challenges women face in maintaining their well-being. The research explored the intersection of gender roles and health, examining factors such as social expectations, economic participation, and access to healthcare. The study sought to emphasize the diverse influences that shape women's health in India, highlighting the need to address structural inequalities. Through a thorough examination and analysis, the study provides insights into the ways societal norms and gender dynamics impact the health of Indian women. The study emphasizes the importance of addressing these issues to enhance the overall health outcomes and well-being of women

throughout the country. The women literacy level has been explored as impacting the reproductive behaviour, child upbringing, infection prevention, health and hygiene. Healthcare providers who are women play a crucial role in shaping the healthcare landscape of society.

5. In *"Women's Health in India"* (1998) by Victoria A. Velkoff and Arjun Adlakha, an analysis of the health status of women in India is presented. The study correlates women's health with their societal status, highlighting prevalent issues such as the preference for sons over daughters and the continued perception of women as burdens within families. According to the researchers, women in India face low levels of education and formal labour force participation, coupled with limited autonomy compared to men. The study primarily focuses on five key issues: reproductive health, violence against women, nutrition status, HIV/AIDS, and gender disparities in family dynamics. However, it notes that certain critical aspects such as maternal health during pregnancy, family planning, and access to safe contraceptive methods are not adequately addressed. Domestic violence and other social factors significantly impact women's health, with reported instances of dowry deaths. The researchers highlight the correlation between maternal education and child malnutrition, noting that mothers with at least a high school education exhibit better practices in child nourishment and overall health. Moreover, HIV/AIDS poses a significant risk, particularly among female sex workers and during pregnancy due to negligence and lack of awareness. The study underscores the unequal treatment of girl children in India, leading to adverse health outcomes.
6. In the study titled *"Social Relationships and health: Challenges for measurement and and intervention"* (2001) by Sheldon Cohen et al., social relationships have been found important in treatment of diseases, health maintenance and overall wellbeing. Various approaches have been analysed with theoretical explanation of different researchers highlighting and recognizing the impact and importance of social relationships in relation with health outcomes and wellbeing of individuals. The study highlights various ways through which health is influenced by social relationships. In this study various intervention models have also been discussed.
7. In *"Returning a Favor: Reciprocity between Female Education and Fertility in India"* (2002) by PN Mari Bhat, the study delves into the complex interplay between female education and fertility dynamics within the Indian context. the research examines how the educational level of women influences fertility rates and conversely, how fertility decisions

may impact women's access to education. The study offers insights into how educational attainment shapes women's reproductive choices and family planning behaviours, while also exploring the potential impact of fertility patterns on educational opportunities for women. Limited fertility derives focus on education of females in the family as with the importance of knowledge about contraceptive measures the fertility rates are being regulated which has impacted positively for the girl education and reduced the burden of females with excessive responsibility of younger siblings in India. Overall, the research provides a nuanced understanding of the reciprocal relationship between education and fertility in India, shedding light on the intricate dynamics at play.

8. The study titled *"Does literacy mediate the relationship between education and health outcomes? A study of a low-income population with diabetes"* was conducted by Dean Schillinger et al., in 2006. Its aim was to explore the correlation between education levels and health outcomes within the diabetic community. A sample of 395 diabetic patients in public hospitals in the US has been taken in the study. The HBA1C level of the patients and the literacy level of the sample have been analysed. The result has shown that literate people with glycemic control. The low-income population with a low level of education reported a high level of HBA1C. The study has been concluded with the direct impact of education on health.
9. In their work *'What Does Education Do to Our Health?'* (2006) "Wim Groot and Henriëtte Maassen van den Brink highlight the relation between the levels of education with the health outcomes. In this research various studies have been analysed to spot the influence on health by education. The research has provided the evidence from different studies that higher education brings better health outcomes and reduces the mortality rates and enhances better healthcare services. The work has highlighted the importance of education in developing the health behaviour and practices which contribute to better health. The literates are shown as adopting healthy lifestyle and are able to make decisions regarding their health betterments. The study recognizes education being the determinant of health by providing socio-economic status which contributes to better health results.
10. BA Dabla's (2007) study, "Multi-dimensional Problems of Women in Kashmir," offers a thorough examination of the intertwined challenges faced by women in the conflict-ridden region of Kashmir. According to the study, the persistent conflict and heavy militarization have exposed women to widespread violence, psychological distress, and considerable restrictions on their movement. Displacement has uprooted many from their homes, causing

a loss of livelihoods and disrupting social and family networks. The economic toll of the conflict is profound, leading to high rates of unemployment and poverty, with women, particularly those who are the primary breadwinners, experiencing severe financial hardships. Traditional gender roles further constrain women's economic prospects, often relegating them to household duties. Access to healthcare is severely disrupted, significantly impacting maternal and reproductive health services. The constant exposure to violence and instability has led to prevalent mental health problems, including anxiety and depression. The conflict environment has worsened gender-based violence, such as domestic abuse and sexual violence. Girls' educational opportunities are significantly obstructed by frequent curfews and violence, leading to high dropout rates and limited educational achievements. Cultural norms and safety concerns often prioritize boys' education, thereby deepening gender inequalities. Patriarchal norms deeply embedded in society restrict women's roles and freedoms, often confining them to traditional, subordinate positions. Women, especially those who are widows or survivors of violence, often face social isolation. Legal protections against violence and discrimination are insufficient, leaving women vulnerable to abuse and exploitation. The conflict has led to numerous human rights violations, including arbitrary detentions and disappearances, with women being disproportionately affected.

11. As per the study *"Role of female literacy in material and infant mortality decline"* (2007) by Alpana Kateja, there is a strong relation between the literacy of women and their use of reproductive and maternal health services. The literacy of the women is directly associated with the women social status, economic status and accessibility to health care facilities. The female literacy improves employment opportunities for women, knowledge and awareness about of nutritional requirements and the better health care of children. The study focuses on the women empowerment by education enhancing benefits to broader society specifically importance of female education has been highlighted in the improvement of infant and maternal health outcomes.
12. Leland K. Ackerson, Ichiro Kawachi, Elizabeth M. Barbeau and S V Subramanian in their study *"Effects of individual and proximate educational context on intimate partner violence: A population-based study on women in India"* (2008) examine the role of women's education and proximate education on intimate partner violence. The research analyses the understanding of association between levels of education and intimate partner violence. The research has investigated the fact that educational attainment at personal level

and the educational environment influences the intimate partner violence in India. The intimate partner violence has been considered globally a serious health concern leading to poor mental and physical health outcomes for women. The sample of 83627 married women aged 15 to 49 years from 1998 to 1999 from Indian National Family Health Survey has been examined. The results have confirmed the effects of women's own education and proximate education on intimate partner violence.

13. Catherine E. Ross and John Mirowsky in *"Gender and the health benefits of education"* (2010) develop a theory which states that for women the education improves their health more than the health of men. With the increase in the level of education for women there is decrease in physical impairment for women more than men. The employment and income with the link of education benefits both men and women but education as per the study improves health of the women more than men. Education develops habits, skills, motivation and skills which develop human capital and as far as the women are concerned the recourses are limited for them as compared to men which are expanded with education
14. The work of K. Mallikharjuna Rao, N. Balakrishna, N. Arlappa, A. Laxmaiah & G.N.V. Brahmam titled *"Diet and nutritional status of women in India, (2010)"* considers women as vulnerable to under nutrition in India. It has been highlighted that malnutrition is a serious issue which Indian women face mostly during pregnancy. The literacy level of women as per the study can affect their reproductive behaviour, the health of their children, the upbringing of their children, the hygienic practices, and their employment status. The literacy level of women in India affects the overall status of women. The unavailability of health recourses and poor health leads to the birth of unhealthy children. The nutritional status of women has been analysed by using the data collected by the National Nutrition Monitoring Bureau (NNMB) under the aegis of Indian Council of Medical Research (ICMR) surveys during 1998-99 and 2005-06. The sample has been collected from rural and tribal populations in the survey. The results have found that the food intake is lower than the level recommended by the ICMR. Pregnant women and lactating mothers are found not taking a proper diet and found with deficiency of vitamins and minerals. However, the tribal women are found more vulnerable to health due to the undernutrition as compared to the rural women. The result of the study has revealed the inadequate level of nutrition among women during pregnancy and lactating mothers.
15. Ashok Kumar and M E Khan in their work *"Health status of women in India: Evidences from National Family Health Survey-3 (2005-2006) and future outlook"* (2010) elaborate

the link of health with the status of women in India. Among the several challenges faced by the women the main factors which impact the health of women in India are violence against women, challenges of reproductive health, gender inequality and the inadequate nutrition. The fertility control has been an important factor in development of women health status. The NFHS-3 data has shown violence against women as mostly impacting negatively the health of women in India.

16. *"Associations between noncommunicable disease risk factors, race, education, and health insurance status among women of reproductive age in Brazil- 2011"* (2011) by Jonetta Johnson Mpofu et al., is a work which shows the health status of women in Brazil impacted with some important factors including education as an important factor intervening women health outcomes. The results show that the less educated women in comparison to the more educated women were found at high risk of noncommunicable diseases with inadequate intake of nutritious foods and less likely to take part in physical activities.
17. Kathy Offet-Gartner in her work *"Rewriting Her story: Aboriginal women reclaim education as a tool for personal and community, health and wellbeing"* (2011) found among the Canadian women that the institution of education is associated with their pleasure, pain, personal and community wellbeing. As per the study the women respondents considered education as the major tool for, healing and strength.
18. *"Education, Income, and incident heart failure in post-menopausal women"* (2011) by Rashmee U shah et al., is a study aimed to find the effects of education and income on incident of heart failure hospitalization among the post-menopausal women. The low levels of education and income self-reported by women were found as associated with high risk of incidents of heart failure incidents.
19. As per the study *"Gender disparity and policies of inclusion: A case study of women's education in Jammu and Kashmir"* (2011) by Fayaz Ahmad Bhat, Fouzia Khurshid & Nazmul Hussain there exists gender difference in literacy of rural women in general and in particular among the urban women also. The low enrolment rate of girl students and high rate of school dropouts have been found. There are several initiatives by the government for decreasing the gender disparities and further literacy programs are needed as per the study
20. Catherine E. Ross, Ryan K. Masters & Robert A. Hemmer in their work *"Education and the gender gaps in health and mortality"* (2012) examined the relations between education

and health among men and women. The men mortality rates are found higher than men, but the health outcomes are reported worse of women. The education has an important part in women health as the socio-economic status of women is linked with education bringing health outcomes. For those who are disadvantaged education provides recourses which are important for the health outcomes. The education reduces the gender disparities in the context of health.

21. *"A study of factors influencing the nutritional status of lactating women in Jammu, Kashmir and Ladakh regions, (2012)"* by Yasmeen Majid Khan and Asmat Khan highlights the nutritional status of women who are lactating mothers influenced by different factors. The sample has been taken from four districts in Jammu and Kashmir. The results show that the women with a nutritional deficiency in all the three regions (Jammu, Kashmir, and Ladakh). The study found differences between these three regions with respect to sociodemographic and health status. Most of the population was found lower and middle class in economic aspects. 16.9% of women were found with chronic energy deficiency, 56.4% of women were found with nutritional deficiency, and 49% of women were found anemic. A low level of literacy rate, low level of employment, and other social conditions are important factors in women's health.
22. David M Cutler and Andriana LIeras-Muney in *"Education and Health: Insights from international comparisons, (2012)"* have studied the relationship between education and health. The link between education and health has been examined by combining and comparing data between various countries. The data from developed and developing Nations has been collected from various surveys conducted by different organizations. The data of the developing countries has been collected from the demographic and health surveys (DHS); the data of Europe has been collected from Euro barometer Surveys and the data from the US have been collected from the Behavioural Risk Factor Surveillance System (BREFS) of 2004 to 2009. The relation between education and health has been analysed. Poor countries have been found as characterized by a mix of undernutrition and overnutrition. Education has been found important factor in nutrition intake. Less educated people are found underweight and anaemic. The relationship between education and health has been examined by the impact of health on education also. Poor health also leads to poor education. The DHS survey reports strictly on women in the age group 15-49 has been analysed in which poorly educated women are seen with poor health. The evidence of the causal effect of education and health has been discussed by reviewing the literature showing

the link between education and health. Various theories have also been reviewed in this work related to the link between education and health.

23. Tom S Vogl has reviewed the relationship between education and health in his work *"Education and health in developing economies, (2012)"*. There are different pathways that link education and health in different phases and life cycles. Education affects children in their stage of schooling. When children visit schools for education their health is improved and also the good health has been seen as improving the education. Various studies have been reviewed in this work to show the evidence of school-going children being healthy and good health of children has been found as a good factor in increasing the number of school children. The adulthood stage in which education is linked with health outcomes has been discussed in this work. Life expectancy among adults and their health impacting children has been linked with education. In poor countries due to the income disparities, the link is more evident. The work, patience, and attitude toward health behaviour in developing countries are determined by the education which leads to the health outcomes in these countries. The health of the parents is also important for the health of the child and the education of the parents is found important for the health of their children.
24. In the study *"Health Status of Marginalized Groups in India"* (2012) by Zulufkar Ahmad Khanday & Mohammad Akram the problems faced by marginalized groups in India have been highlighted. It has been expressed as some particular social groups are being pushed into edges. Women face violence and burden, and their needs are not fulfilled. Women are treated inferior to men. The scheduled tribes and scheduled castes live in poverty and disadvantaged from several health benefits with adverse life conditions. The persons with disabilities also face worse conditions of life. As per the study these marginalized sections of the society get unfair treatment in many instances.
25. Lisa M. Bates, Lisa F. Berkman and M. Maria Glymour in their work *"Socioeconomic determinants of women's Health: The changing landscape of education, work, and marriage"* (2013) observed social factors as shaping the health and wellbeing of women throughout their life. Education has been found as increasing life expectancy and decreasing mortality rates among women in USA. The diseases like hypertension, diabetes, heart diseases, and stroke are found common in less educated ones and education has been found as influencing health through different mechanisms. The study highlights other social factors like employment and social relationships which are also linked with education and influencing the health outcomes for women.

26. As per the study of Kavita Suri titled "*Empowering Women Through Education: A Study of Rural Jammu and Kashmir (2013)*", The literacy situation in Jammu and Kashmir (J&K) reveals a significant gender disparity, particularly in rural areas, where challenges persist despite government initiatives. According to the 2011 Census, female literacy in J&K stands at 58%, below the national average, with districts like Ramban displaying notably low rates, especially among females. This discrepancy underscores broader issues such as societal traditionalism, economic constraints, and the enduring conflict in the region, all of which impede progress in educating females. Traditional societal norms, particularly prevalent in rural areas, where customary gender roles often dictate that girls remain at home until marriage, pose a significant obstacle. Economic hardships also contribute to families prioritizing the education of male children over females. Moreover, apprehensions about safety due to the ongoing conflict further dissuade parents from sending their daughters to school. Inadequate infrastructure exacerbates the situation, with many schools lacking proper facilities and operating in unsuitable premises. Teacher absenteeism is widespread, especially in rural areas, where schools frequently shut due to supervision shortages. Geographical challenges, such as rugged terrain and isolation, further hinder access to education. Addressing these challenges requires a comprehensive approach, including empowering rural women through education, raising awareness, and integrating gender sensitivity into teacher training programs. Expanding early childhood care facilities can also help ease the burden of caregiving, enabling more girls to attend school. Community mobilization efforts should concentrate on enrolling out-of-school girls and improving the educational outcomes of those already enrolled. Financial backing from both governmental and non-governmental sources is crucial for funding literacy programs and improving infrastructure. Additionally, rendering education more appealing to women through innovative teaching methods and incentives can enhance enrolment and retention rates. As per the study, mitigating the obstacles facing female education in rural J&K demands collaborative efforts from various stakeholders. Prioritizing girls' education, raising awareness, and enhancing infrastructure and teacher training are imperative steps toward achieving gender parity in literacy rates and empowering rural women for a brighter future.
27. Emily Zimmerman and Steven H Woolf in their work *"Understanding the relationship between education and health, (2014)"* explain the link between education and health. In this work, the influence of education on health has been explored. The work shows that

there are several social factors that determine health, but education is the most predominant. Education benefits the health of the individuals and impacts the individual in various situations. As per the study, education impacts the range of skills and provides human capital which results in good health. The study shows that education increases social and economic resources. Employment and social support affect health outcomes. The benefits of education at the community level bring good health outcomes in the neighbourhood and in the community the food access, physical activity, health institutional availability, environmental sustainability are maintained with education. The researchers have found education as the greatest source in which the policy for the society the beneficial for the health of the people can be framed.

28. *"Women and violence: A study of women's empowerment and its challenges in Jammu and Kashmir"* (2015) by Showkeen B A Gul focuses the violence against women of J&K. women discrimination in Jammu and Kashmir has been discussed and considering them as vulnerable. The women as the section of society in J&K facing the political conflict zone have been considered as worst hit and at risk of mental distress. The cases of violence has been highlighted which occur in domestic and broader socio-political scenario for women in Jammu and Kashmir. The intervention in women issues have been suggested through counselling, religious and community advocations, Governmental and Non-Governmental organizations.
29. Nadiya Muzaffar (2015) in her work *"Maternal health and social determinants: a study in Jammu and Kashmir".* This paper delves into the maternal health situation in Jammu and Kashmir, India, with a focus on social determinants. It contrasts biomedical theories, which emphasize biological aspects, with social determinant theories, which stress the impact of social circumstances. Emphasizing the Ottawa Charter of Health Promotion, it highlights the significance of peace, education, income, and social justice for overall health. Based on data from the District Level Household and Facility Survey (DLHS-3), the paper underscores that socio-cultural factors such as education, income, and place of residence significantly influence maternal health outcomes, rather than just the place of delivery. It notes a positive correlation between higher education levels and wealth with increased institutional deliveries, while also pointing out a notable rural-urban gap. Despite relative prosperity, anaemia remains a noteworthy factor affecting maternal health in Jammu and Kashmir. The paper advocates for policy interventions aimed at empowering women and promoting principles of freedom, peace, justice, and inclusion to effectively enhance

maternal health in the region. The concept of social determinants of health encompasses socio-cultural and socio-economic conditions that shape health disparities among different groups. These factors include income distribution, access to resources, and the influence of prevailing political ideologies manifested in public policies. The study identifies various factors associated with heightened maternal mortality risk, such as age at marriage/delivery, birth frequency and spacing, economic circumstances, and the utilization of antenatal and postpartum care services. It emphasizes the importance of addressing these factors, as evidenced by data from DLHS-3 and NFHS-3, to drive improvements in maternal health outcomes in Jammu & Kashmir.

30. According to the study *"Women education in rural India, (2017)"* by Paras Jain, Rishu Agarwal, Roshni Billaiya, and Jamuna Devi there are social, cultural, and economic reasons for the unequal treatment of girls regarding health, support, and education as compared to the boys in rural India. Families usually prefer their sons instead of daughters to get educated. The daughters as per them are seen as a burden or dowry which is to be sent to their husband's house. The financial restrictions and lack of modern technology like transportation in rural make it difficult for the girls to join the schools regularly as they are busy with domestic works also. The lack of education for girl's leads to the lack of female teachers is a reason for girls not continuing their studies. The data has been collected from different secondary sources which show parents' preference, family responsibility, early marriages, and other social reasons for the causes of discontinuation of education in rural women.
31. *"Knowledge, attitude and beliefs regarding cardiovascular diseases in women"* (2017) by C. Noel Bairey Merz et al., is a work depicting the survey conducted by World Health Alliance to determine the knowledge, beliefs and attitude of women towards the cardiovascular diseases. The awareness of cardiovascular diseases among women in United States has been found inadequate. Social stigma regarding body weight has been a barrier for women and they are less likely to discuss and take actions regarding the risk factors of cardiovascular diseases.
32. As per the work *"Study on economic empowerment of Indian women through education – an enabling factor for women labour force participation"* (2018) by Ayushi Ghosh and Shivani Mehta, Education is considered as basic guide which benefits with learning and provides knowledge for all. The education of girls has been considered as pivotal for gender equality the literacy rate and overview of education in India has been provided in the study.

Disparities in literacy rate on the bases of education in different regions of India has been highlighted. Role of education has been highlighted in providing the women participation in labour force and economic assistance. The association in labour force with levels of education has been discussed by showing the influential link in between. High levels of education have been found related with employment for women. As per the study education is the key factor to ensure the women empowerment and contribution of education in labour force of women has been found in the study.

33. Ab. Hamid Mir, & Showkat Ahmad Bhat (2018) in their study "*Health status and access to health care services in Jammu and Kashmir state*" has stated that Jammu and Kashmir (J&K) has made substantial progress in establishing a comprehensive healthcare system, boasting an impressive network of 3972 health institutions, comprising hospitals, dispensaries, and public health centres. The region has consistently outperformed national averages in various health indicators, showcasing notable achievements in life expectancy, birth rates, death rates, infant mortality, and institutional births. Notably, the life expectancy for both males and females has surpassed the national average, while the crude birth rate and death rate have significantly decreased. The total fertility rate has also declined below the replacement level, signalling a positive demographic shift. Furthermore, the infant mortality rate has decreased over time, reflecting improved healthcare access and services. Moreover, the proportion of births occurring in health facilities and assisted by trained healthcare professionals has increased. Despite these accomplishments, there are still some challenges that need to be addressed, including a declining sex ratio and inadequate sanitation coverage, particularly in rural areas where a significant portion of households lack access to toilets, leading to a higher risk of open defecation. Overcoming these challenges will be crucial for maintaining and improving overall health outcomes in J&K.
34. As per the study *"Knowledge, attitude, and practice of family planning services among healthcare workers in Kashmir – A cross-sectional study"* (2019) by Rabbanie Tariq Wani, Imrose Rashid, Sheikh Sahila Nabi, and Hibba Dar most of the women who are in their reproductive age have no knowledge awareness and accessibility of methods of family planning. The women as per the study are mostly unable to understand how to use the methods or where they can get them. The women are aware about the family planning methods but were least aware about their use. Healthcare workers need to be intervening in imparting knowledge and guidance regarding the family planning methods.

35. In the study titled “The three-dimensional role of education for women empowerment” by Yilikal Muche Engida, the researchers have revealed education as most pivotal constitutional right which reduces inequality and enhances social and overall development. The conditions of the life of women are improved with education. Various indicators have been highlighted to show the empowerment of women through education. Personal empowerment is enhanced with women education as women get self-confidence, better opportunities of jobs, awareness and skills. Education provides relational benefits for the women as per study. The women in contact of others and in participating social gatherings get benefited. According to the study social development is possible with education.
36. In the study titled *Role of education in the empowerment of women in India”* (2023) by Harun Al Rasid Mondal, Women education has been shown as important for the development and progress of the Nation. As per the study the women contribute to the society being strong and powerful resource for a Nation. Awareness of rights with education makes women able to face problems and makes women productive citizens. Several findings of the studies have been highlighted which focus on the women role in empowerment of women. The study has concluded with the statements like deprivation of opportunities for women in accessing proper nutrition, employment and education. The study has found women being considered inferior to men in India. The overall empowerment of women is found associated with education.
37. As per the study titled “*Impact of domestic violence on maternal and child health and wellbeing in rural India”* by Bushra Sabri et al., (2023), In rural India, where maternal and neonatal mortality rates are among the highest globally, domestic violence significantly contributes to adverse health outcomes for women and children. This study explored the profound impact of domestic violence on the health of women and children during pregnancy and after childbirth in rural areas of India. It also examined how domestic violence, along with other factors, affects women's access to healthcare services during these critical periods. The research revealed the various ways domestic violence negatively affects women's physical health, leading to increased risks of miscarriages, abortions, and repeated pregnancies due to pressure to have male offspring. Children born into these situations also suffer from inadequate care and neglect. Factors such as restrictions imposed by spouses and families further hinder women's access to healthcare. In summary, the study emphasizes the urgent need for interventions to raise awareness about domestic violence and its impact on maternal and child health in rural India. It calls for the implementation of

screening and intervention programs targeting domestic violence during pregnancy and after childbirth. These efforts are essential for reducing maternal and child mortality and improving health outcomes for vulnerable populations in rural areas.

38. The work of Swathi Ramesh & Kalpana Kosalram (2023) titled "*The burden of non-communicable diseases: A scoping review focus on the context of India*" offers a thorough examination of the global prevalence of non-communicable diseases (NCDs), emphasizing the significant challenge they pose to healthcare systems worldwide. In India, there has been a noticeable decrease in communicable diseases alongside a simultaneous increase in NCDs over time. To tackle this rise, it's crucial for low- and middle-income countries (LMICs) to establish effective monitoring systems and utilize the collected data to enhance control strategies. While much focus is placed on finding cures for NCDs, prevention and management strategies are equally important. NCDs are a leading cause of disability, illness, and death globally, with prevalence rates expected to rise without intervention. In India, there's a need for a coordinated framework and comprehensive policy tailored to NCDs, involving sectors beyond healthcare such as agriculture, regional development, education, and trade, which have underlying factors contributing to NCDs. The National Multisectoral Action Plan for the Prevention and Control of Common NCDs (2017–2022) serves as a guiding model for India's efforts. However, the lack of reliable NCD surveillance and research data impedes effective planning for prevention and control. To address this, a robust surveillance system capable of providing accurate and timely data
    is crucial. Current NCD programs have limited coverage, necessitating strategic investments, actions at both individual and community levels, primary prevention through screening, improved diagnostic capabilities, enhanced management capacities, and universal access to healthcare services. The success of NCD prevention and control depends on integrated management, a strong surveillance system, and public awareness campaigns, ensuring widespread availability of services throughout the country.
39. In the study "*Chronic non-communicable disease burden among reproductive-age women in India: evidence from recent demographic and health survey"* by S K Singh, K Chauhan & P Puri (2023) it has been stated that, recent findings from the National Family Health Survey (NFHS) conducted between 2019 and 2021 reveal a significant risk of multimorbidity among women in their reproductive years, especially those aged 30 to 35. This age group is increasingly susceptible to multiple chronic illnesses, highlighting the

need for targeted healthcare interventions. The survey emphasizes focusing on women from lower socio-economic backgrounds, promoting education about behavioural factors leading to multimorbidity, and addressing long-term health impacts. This approach aims to better align self-reported health issues with actual prevalence rates, thereby minimizing discrepancies in health reporting. While current health programs often concentrate on the elderly, there is a pressing need to address the growing burden of multimorbidity among women of reproductive age. Particular attention should be given to managing obesity and diet-related non-communicable diseases (NCDs) among women from affluent households. Neglecting these concerns could precipitate a widespread multimorbidity crisis in India. The study underscores that the rising incidence of multimorbidity among reproductive-aged women not only impacts their health but also significantly affects the health and development of their children. This complex issue calls for urgent and strategic actions from policymakers to mitigate the growing threat of multimorbidity. Comprehensive interventions are crucial to managing and reducing these risks, thus ensuring better health outcomes for both mothers and their children and averting a potential future health crisis.

40. The study *"Socio-economic empowerment in rural India: Do financial inclusion and literacy matters?"* By Niyaz Panakaje et al., (2023), set out to investigate how financial literacy impacts financial inclusion and how this, in turn, influences the economic empowerment of rural communities in Karnataka, India. The results emphasise a clear and significant connection: financial literacy directly promotes financial inclusion. Additionally, it shapes better financial decision-making and management behaviours, further driving financial inclusion. When examining the broader effects, the study found that financial inclusion substantially boosts socio-economic empowerment. For rural populations, particularly those living in poverty, financial literacy is a crucial tool. It empowers them to make sound financial decisions before engaging with complex financial products and services provided by formal financial institutions. Given their precarious financial situations, the ability to assess and choose the right financial options is critical for their survival and prosperity. Financial literacy is more than just understanding financial products; it's about making informed decisions that lead to greater savings and overall wellbeing. Individuals who are financially literate are better equipped to evaluate and utilize financial services effectively, leading to enhanced social and economic empowerment. The study concludes by expressing that there is a pressing need to actively promote financial literacy among rural communities. Doing so will improve their financial

decision-making and management skills, contributing to inclusive and sustainable economic growth. This approach is essential for achieving balanced regional development and ensuring that rural areas are not left behind in the progress toward economic empowerment.

2.4 Research Gap

The women empowerment is an important aspect in overall development of the society. The health of women cannot be ignored as it is not only concerned about their own betterment of life but also a concern of humanity and an important derived need for the welfare of whole family and generally the whole society. There is a great scope to further uncover the hidden facts and investigate more in the field of women health implications. There are numerous studies on education and health of women but very few investigations imply on impact of education on women health in rural settings. The earlier research has been done on rural women in Kashmir but there is more scope and need to investigate the women health in the influence and impact of education. There is more need of inquiring the factors in which education plays an important role for the betterment of health among the rural women in Kashmir. The social conditions need to be highlighted on a big scale which leads to health results in rural context of Kashmir. The social barriers in managing lifestyle diseases and their daily care skills and awareness among rural women in Kashmir is a prerequisite in women wellbeing research. The burden of unpaid labour on rural women effecting their health directly and indirectly is also an important aspect which is needed to be highlighted for women particularly in rural context in association with status of education. It is very important to analyse role of education in eradicating the social barriers and development of access to institutional facilities in rural areas for women in Kashmir, as the women are wedged in social constraints and inadequate resources in rural places. In relation to the non-communicable diseases there is less explored regarding the social factors which are enhanced with education determining the health outcomes. It is very crucial to focus on the social conditions which impact the rural women of Kashmir in their social setting which can be altered with education. The direct impact of education on results or betterment of health has not much been explored in the rural settings of Kashmir. In this descriptive approach study the focus is more on adding the new facts to the existing theories of knowledge related to the research. In a crucial to examine the impact of education related with several social aspects to find additional facts and to understand the fact.

CHAPTER 3:

RESEARCH METHODOLOGY

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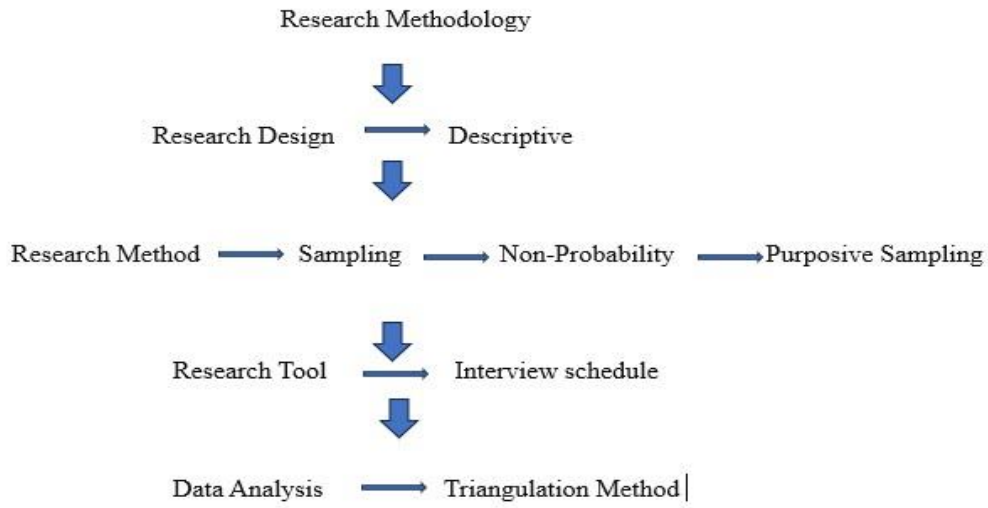
3.1 Concept

Research is the process of finding the relevant answers of the inquiry which develops knowledge, generates theoretical explanations and validates the knowledge and existing findings. Research is the process involving the collection and analysis of data which increases knowledge about an issue or a topic (Creswell, 2017). Research involves the process of systematic, controlled, empirical, and critical investigation of hypothetical propositions about the anticipated connections among natural phenomena (Kerlinger & Lee, 2000). In any scientific investigation a fundamental framework is provided by research methodology which structures the study in methodological approach in collection and analysis of data for fact findings to draw the conclusions. In social science field the research methodology has a significant place with careful examination and procedures as the nature of phenomena in social science research is complex and dynamic. Research methodology comprises the principles and procedures of conducting scientific inquiry. Creswell (2017) has highlighted the key components which comprise research methodology, these components comprise research design, process of sampling, collection of data, analysis of data, and ethical considerations. Every element related to methodology is important is research outcomes. The validity and reliability of the findings can be enhanced by researchers by using appropriate techniques and methods (Neuman, 2014). The process of research is thus a methodological procedure in approaching the enquiry and in social science research due to the nature and complexity of phenomena the social inquiry needs to be systematic and organized in controlled manner. Research methodology guides researchers in making decisions regarding selection of tools, sampling, methods of data collection which ensures that data is relevant to objectives and research questions (Bryman, 2016).



3.2 Research Design

Research design is a strategy and a plan of procedure in conducting research. It involves systematic framework for the selection and application of proper technique for data collection and relevant methods of analysis of data. Research design is a structure and outline of various processes to be carried out in conducting research. Research design is a strategy and a plan of procedure in conducting research. It involves systematic framework for the selection and application of proper technique for data collection and relevant methods of analysis of data. Research design is a structure and outline of various processes to be carried out in conducting research. It is a blueprint, a design for collection, analysis and interpretation of data required in scientific inquiry initiated for finding facts. Research design, with its crucial role, ensures that a study yields accurate and dependable outcomes by minimizing bias, error, and confounding variables. It establishes a structured approach for managing external influences and ensures that the conclusions genuinely represent the phenomena being studied (Neuman, 2014).

Descriptive research design has been used for this research work. Descriptive research design, along with experimental, quasi-experimental, survey, case study, longitudinal, and meta-analysis designs, compose the diverse methodological landscape of social science research (Trochim, 2005). The descriptive research design is that systematic process in which a phenomenon is described and observed without bringing a change in it. In proceeding this type of design, the subject of inquiry gets highlighted, and its nature and implications get uncovered in further findings of research. Research to solve a particular problem in descriptive research

design is conducted to clarify the characteristics of certain phenomena (Babbie. 2020). Descriptive research design offers a snapshot of the present state of affairs and clarifies the characteristics of certain phenomena to tackle particular research issues and (Neuman, 2014).

3.3 Universe of Study

The universe of study in sampling method of research denotes the entire domain or population aimed by researchers to investigate within a particular research setting. It is vital for researchers to understand the universe od study for as it delineates the scope and limits of their research inquiry, informing choices regarding sampling, data collection, and analysis. (Neuman, 2014).

The universe of study for the research is rural Kashmir. Kashmir is the part of Union Territory of Jammu and Kashmir. The UT of J&K comprises of 2 divisions, Jammu division and Kashmir division comprising 20 districts, 10 from both divisions (jk.gov.in). The Kashmir division comprises of 3 parts known to be North Kashmir, central Kashmir and South Kashmir (jkpolice.gov.in). The research has commenced with the application of sampling method for the data collection to be analysed for conclusion of fact findings.

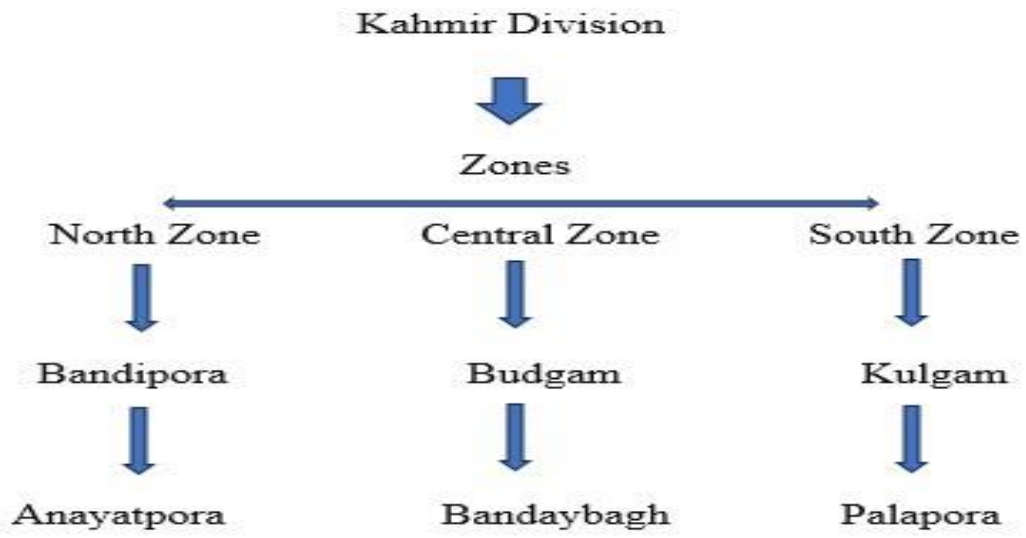
3.4 Sampling

Sampling involves the process of selecting a subset of larger population to be included in research study (Maxwell, 2012). Sampling is selection of subset of individuals or cases from a larger population which represents that population in a study (Yin, 2014). To reach each characteristic and element of larger population is not appropriate and not allowed by the consideration of time and economy. The desirable approach to research the population characterised by homogeneous elements is to choose a subset of it which represents the whole part of the population. Sampling provides reliable estimate of the characteristics of population (Cochran, 1977). It is important to choose a representative sample of the population and that subset must be representing the true population. A good sample is the fair estimated representative of the population (Kothari, 2004). The findings from the research can be generalized to the whole population with the technique of sampling. A subset of population taken from the population to be studied represents the whole and its findings are generalized to the whole unit of study. The sampling approach can be probability or non-probability type of sampling. There is an equal chance of getting selected for each unit for sample in probability sampling (Levy & Lemeshow, 1999, p. 23). In non-probability sampling the random selection is not done but the elements of population are selected on the bases of convenience or

judgement by the researchers (Creswell & Creswell, 2017, p. 206). When the population is huge, it is not possible to select each and every unit of population, in such cases the nonprobability sampling is more desirable in taking time, cost and efficiency in consideration.

The non-probability sampling approach has been used in the study. The type of non-probability sampling used in the study is "Purposive sampling technique." In purposive sampling, which is also known as judgemental or selective sampling, individuals are selected on the bases of specific criteria which is based research objectives (Patton, 2002). To fill the purpose of the study in choosing a subset of population the purposive sampling technique has been used to choose the three villages of Kashmir.

The sampling unit has been reached by stepping in stages. The three villages have been selected as representative elements of population from three districts distant from each other from three distant geographies of division Kashmir so that the whole population should be related, and the most possible relevant data should be purposively included. The division of Kashmir (Rural) is the unit of study. As per the census of 2011, around 72.62% of the total population of Jammu and Kashmir live in rural areas. In the first stage the division is divided into three known zones: North, central and south zones of Kashmir. There are total of Ten districts in Kashmir divisions geographically in the North, central and south of the demography. District Kupwara, Baramulla, Bandipora are considered in the North zone. District Srinagar, Budgam and Ganderbal considered to be in Central Kashmir zone. District Anantnag, Pulwama, Kulgam and Shopian lying in the south zone of Kashmir. In the first stage considering three distinct geographical positions, Three Zones have been formed as North Kashmir, Central Kashmir and South Kashmir. In the second stage one district has been selected from each of the three zones. The district with least literacy rate as per the census 2011 has been selected (District Bandipora, Budgam and Kulgam from North, Central and South Kashmir respectively). To fill the purpose of research without going into further complexities, in the third and final stage, three villages have been selected as per highest literacy rate as per the data of census 2011 including the villages: Anayatpora (Bandipora), Bandaybagh (Budgam), Palapora (Kulgam). The total population of women in these villages as per census 2011 is 1778.



3.5 Sample Size and Sampling Unit

The size of the sample has been taken as of 180 women. The sample size has been formulated by using arbitrary approach selecting approximately 10% of women population of the selected three villages and also the level of saturation point has been taken into consideration. The data has been collected from 60 women in each village from four different categories (45 women of each category) on the bases of educational qualifications. The following are the characteristics of the sampling unit:

Total Number of women participants: 180

Age group: 30 – 60

Educational Qualification Categories: 1. Illiterate and less than primary, 2. Primary and Secondary literates, 3. Higher secondary and graduates, 3 postgraduates and above.

The pregnant women have been excluded to be constituted in the sample due the several reasons as during the pregnancy particularly as in relation to non-communicable diseases which they suffer due to the biological complications particularly during pregnancy.

3.6 Data Collection

Data collection is that systematic process in which information or evidence is gathered to achieve research objectives or address research questions (Neuman, 2014). The data collection is important for the fact findings after it has been analysed to reach the conclusion.

The data for this research has been collected from the sample representing the field by using "Interview schedule" as the tool of data collection. The semi-structured type of interview schedule has been formulated and used in the research. Interview schedule is a structural plan of conducting interviews. It contains predetermined questioned organized and systematically framed to collect information from participants (Babbie, 2020).

The data has been collected by using semi-structured interview schedule consisting both close ended question and open-ended questions. The quantitative data has been collected by using questions which are close ended questions in which the respondents had to choose one of the options asked in the interview. The open-ended questions were asked to collect the data of qualitative nature where the respondents were open to narrate their situations and conditions.

The secondary sources of data have also been used in the form of different literature available from different sources like journals and other publications to review literature and get benefited from early findings related to the study. The statistical data from governmental reports and health institutes has also been navigated and integrated accordingly.

3.7 Data Analysis

Data analysis is a critical phase of the research process as researchers draw inferences and uncover the relationships and pattern within the data related to phenomena under study (Denzin & Lincoln, 2018). In data analysis, the data collected is processed, interpreted and synthesised to analyse the facts in order to draw conclusions. The data can be in quantitative or qualitative form. Quantitative data can be quantified by using statistical methods (Smith, 2017).

Mixed approach of research has been employed in the research analysis with integration of Quantitative and Qualitative methods. Mixed method research encompasses the sequential collection and analysis in a single study of both qualitative and quantitative data (Creswell & Plano Clark, 2018). Patterns in participants experiences are identified through participant coding (Brown, 2020). The following approaches have been used in data analysis:

1. SPSS
2. Narrative Analysis
3. Thematic Analysis

SPSS (Statistical Package for the Social Sciences) is a statistical software commonly utilized for analysing data across various research disciplines. Through the frequency percentage method, SPSS provides an easily accessible platform to compute and present the frequency and percentage distribution of categorical or numerical data. The quantitative data has been analysed through frequency percentage method.

Narrative analysis is a research method used to understand how people create meaning through the narrations which they communicate during the research. This type of analysis looks at how these stories are structured, what they contain, and the context in which they are told. This approach helps researchers explore personal experiences, social connections, and cultural influences. Riessman (2008) explains that narrative analysis focuses on "the ways in which people tell stories to create order and meaning in their lives." The narrations of the respondents in the form of qualitative data have been observed and analysed which enabled to understand the social situations of the respondents which also helped in generation of themes.

Thematic Analysis is a foundational qualitative research method designed to identify, analyse, and interpret patterns or themes within data. It is a versatile and adaptable approach applied across various social science fields. By systematically organizing data into meaningful themes, researchers can generate insights that reflect participants' experiences and perceptions (Braun & Clarke, 2006; Nowell et al., 2017; Guest et al., 2012). Through thematic analysis, researchers focus on identifying recurring patterns or themes in qualitative data, such as interview transcripts or textual responses. These themes encapsulate significant insights pertinent to the research questions. This method proves particularly valuable for examining complex social phenomena or exploring subjective experiences (Boyatzis, 1998).

Key Steps in Thematic Analysis

1. **Familiarization with the Data:** The first step involves researchers immersing themselves in the data, thoroughly reading and re-reading to understand its content. Initial observations and potential patterns are noted during this process (Braun & Clarke, 2006; Yin, 2016).

2. **Generating Initial Codes**: Researchers systematically assign codes to significant data segments, labelling them with descriptive tags. These codes form the foundation for further analysis by highlighting key elements of the data (Saldaña, 2016; Guest et al., 2012).
3. **Searching for Themes**: The codes are then examined for patterns that can be organized into broader themes. At this stage, researchers identify relationships among codes and categorize them into meaningful clusters (Braun & Clarke, 2006; Nowell et al., 2017).
4. **Reviewing Themes**: Potential themes are reviewed for coherence and relevance. Researchers refine, merge, or eliminate themes as needed to ensure they accurately represent the data (Boyatzis, 1998; Guest et al., 2012).
5. **Defining and Naming Themes**: The refined themes are given clear definitions and descriptive names to reflect their essence. These definitions connect the themes back to the research objectives (Braun & Clarke, 2006; Saldaña, 2016).

   The qualitative data after collected through the narrations of the respondents was familiarised and coded initially after which the themes emerged.

3.8 Ethical Considerations

the study has been taken with adherence to ethical considerations. The study has been conducted with a strong focus on ethical principles, ensuring that the rights, dignity, and well-being of all participants are respected and protected throughout the entire research process. A key ethical aspect of this study was obtaining informed consent from all participants. Each participant was provided with clear and detailed information about the study, including its objectives, the specific procedures, the data that would be collected, and any possible risks or benefits associated with their involvement. Importantly, participants were also informed about their right to withdraw from the study at any time, without facing any negative consequences, ensuring that their participation was entirely voluntary. This transparent approach allowed participants to make an informed decision about whether or not to take part in the study, knowing exactly what it would involve.

In addition to obtaining consent, the study placed great emphasis on protecting the privacy, confidentiality, and anonymity of all participants. Any personal information and sensitive data collected during the study were handled with the highest level of care and attention. To ensure anonymity, all identifiable information was removed or altered, meaning that participants could not be recognized or traced back to their responses. Sensitive information needs to be

securely stored, with strict measures taken to prevent unauthorized access and negative consequences while dealing with sensitive factors. The study made a clear commit ent that no personal data would be shared or disclosed without the explicit permission of the participants. Furthermore, the findings of the study have been presented in an aggregated form, which further protects participants' identities and ensures that no one can be identified from the results.

CHAPTER 4:

DATA ANALYSIS

CHAPTER 4:
DATA ANALYSIS

4.1 Introduction

Systematic data analysis is crucial to generating insights into social phenomena (Bryman, 2006). This approach of data analysis integrates both quantitative and qualitative methods which enables the researchers to examine patterns, connections, and shifts within social contexts. The validity and reliability of research findings are enhanced through data analysis (Creswell, 2013).

The analysis has been done with the application of mixed methods approach analysing both quantitative and qualitative data. The data was collected using semi-structured interview schedule which comprised both close ended and open-ended questions providing both quantitative and qualitative data. The quantitative data has been analysed in the form of frequency percentage by using SPSS which has shown the level of percentage of responds being analysed. The qualitative data has been analysed by using narrative analysis by which the narrations of the respondents have been closely analysed and understood and accordingly the thematic analysis has been used after familiarising with narrations and coding them which led to the emergence of themes in the case of qualitative data mentioned in the analysis section. The frequency percentage has shown the degree of impact on health with the influence of education directly and indirectly. The themes have been emerged after analysis of narratives communicated with the participants. the analysis has been systematically done by using "Convergent design" with the merging of quantitative and qualitative data to draw a valid conclusion. The process has been formulated with obtaining objectives of study under the titles of themes and sub themes mentioned in the analysis.

4.2 Objectives of the Study

1. To study the relations between the level of education and health outcomes for rural women.
2. To analyse the factors that impact the health outcomes of rural women.
3. To understand the health behaviour of rural women.
4. To find out the challenges of rural women regarding health.

4.3 Socio-Demographic Profile

No. of participants: 180

Sex: Females

Table T1: Age group: (30 – 60)

Age between	No. of participants (N = 180)	Percentage
30 – 36	**36**	**20.00**
37 – 42	**39**	**21.66**
43 – 48	**31**	**17.22**
49 – 54	**45**	**25.00**
55 – 60	**29**	**16.11**

Table T2: Educational Qualification

Qualification	No. of participants (N = 180)	Percentage
Illiterate and less than primary	**45**	**25**
Primary and secondary literates	**45**	**25**
Higher secondary and graduates	**45**	**25**
Postgraduates and above	**45**	**25**

Table T3: Occupation

Nature of Occupation	No. of participants (N = 180)	Percentage
Home Makers (Unpaid Work)	**101**	**56.11**
Paid work (Job/entrepreneurship/artist, etc)	**72**	**40.00**
Others (Study, Project, Volunteer work)	**7**	**3.88**

Table T4: Marital Status

Marital Status	No. of participants (N = 180)	Percentage
Married	**119**	**61.11**
Un-married	**58**	**32.22**
Widow/Divorced	**3**	**1.66**

Table T5: Family structure

Type of Family	No. of participants (N = 180)	Percentage
Nuclear	**64**	**35.55**
Joint	**116**	**64.44**

Table T6: Family Head

Head of the Family	No. of participants (N = 180)	Percentage
Male	**148**	**82.00**
Female	**32**	**17.77**

4.4 Results and Discussions

4.4.1 Relation between level of education and health outcomes

4.4.1.A Quantitative Data

1. **Health Outcomes**

The relation between the level of education and health has been examined by assessing the direct health outcomes of the respondents and the data has revealed the level of education showing positive health outcomes for the respondents.

Table T7: Health Outcomes

Educational Qualification	No. of Respondents suffering from any disease/disorder	Total No. of Respondents	Percentage

Illiterate and less than primary	**16**	**45**	**35.55**
Primary and secondary literates	**11**	**45**	**24.44**
Higher secondary and graduates	**9**	**45**	**20.00**
Postgraduates and above	**6**	**45**	**13.33**

The data has shown a declining shift in negative health outcomes with the upward level of education. Those participants who are less than higher secondary literates reported more incidences and diagnosis of diseases in comparison to those participants who are higher educated. Around 30 % respondents among those who are less than higher secondary literates reported more suffering from ailments like hypothyroidism, hypertension, Diabetes etc. The less responds constituting around 16.66% in comparison are reported by higher secondary and above qualified levels respondents. The data has depicted the levels of education related positively with the health outcomes with the shift at each level of education framed in categories.

2. Role of Educational Institutes

The respondents reported about the importance of role of educational institutes in health management, the data analysis has shown the high percentage of respondents believing in positive outcome of education in health management.

Table T8: Education Institutes

Educational institutes play important role in health management	**No. of respondents (N = 180)**	**Percentage**
Yes	**126**	**70**
No	**18**	**10**
No Idea	**36**	**20**

Among all the respondents who participated in the research, the majority of them believed that educational institutes have a pivotal role to play in the management of health. The 70% of the respondents expressed their observation in opining of the imparting of knowledge and behaviour learned in the ambits of educational institutes which gives a positive return in the form of better health outcomes.

3. Awareness of Diseases

In a condition of health distress, the ignorance of symptoms leads to the dangerous consequences. The timely treatment and preventive steps are crucial in dealing with ailments. The respondents were asked about awareness of the ailments which they or any of their family member suffers from. The responds again were differential on the bases of educational qualifications.

Table T9: Awareness of Diseases

Aware of the diseases/disorder of Self/Family member	Illiterate and less than primary (N=45)	%age	Primary and secondary literates (N=45)	%age	Higher secondary and graduates (N=45)	%age	Postgraduates and above (N=45)	%age
Completely aware	**6**	**13.33**	**9**	**20.00**	**23**	**51.11**	**31**	**68.88**
Partially aware	**21**	**46.66**	**24**	**53.33**	**18**	**40.00**	**11**	**24.44**
Unaware	**16**	**35.55**	**8**	**17.77**	**2**	**4.44**	**0**	**0**
No such condition	**2**	**4.44**	**1**	**2.22**	**2**	**4.44**	**3**	**6.66**

The awareness of the diseases or disorder which the respondents or any of their family member suffers from differs with the level of education. The data shows higher secondary and above qualified respondents are more aware about the ailments near to them and 60% of these respondents reported that they are completely aware about the diseases/disorder which they

suffer from or their family members are diagnosed with. However, 33.22% has partial knowledge about the same among the high level educated respondents. The highest responds of unawareness of diseases/disorders which they or their family members suffer from, are found in the data from illiterate and less than primary literate category which constitutes around the 35.55% and is the least percentage of unawareness responds. This data presents a clear picture how education with several factors impact the health outcomes and makes individuals able to deal with the health distress particularly in rural areas where there are less accessibilities of healthcare facilities and rigid social context for women.

4. **Awareness of Healthcare facilities:** The women participants were asked about the awareness of health services available for them in the nearest places. The highly educated respondents were found more aware about the healthcare facilities.

Table T10: Awareness of Healthcare facilities

Awareness about healthcare facilities	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Completely Aware	**29**	**32.22**	**45**	**50.00**
Partially Aware	**37**	**41.11**	**38**	**42.22**
Rarely Aware	**10**	**11.11**	**6**	**6.66**
Completely Unaware	**14**	**15.55**	**1**	**1.11**

The data presented in table T10 shows the level of education as influential in awareness of the healthcare facilities with higher secondary level and above literates found more completely and partially aware about nearby health structures. 50% of the respondents with higher secondary and above level qualification reported that they are completely aware about the healthcare facilities near them and 42.22% responded that they have partial knowledge about the healthcare facilities near them. The percentage of awareness of nearby health facilities is less among the less educated respondents among which 15.55 % of them reported to be completely unaware about the health facilities which are available near them and 11.11% are rarely aware regarding the same. The data has shown the impact of education in respect of awareness of

health facilities and educated respondents are likely to be more accessible to health facilities.

4.4.1.B. Qualitative Data

1. Health Literacy:

Source of Knowledge: The knowledge of prevention and management of health has also been found as facilitated with education. The respondents were asked about the source of their knowledge about the health care and management to which they responded differently.

Table T11: Source of Knowledge

Knowledge of health mainly gained from	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Family/Friends	**31**	**34.44**	**9**	**10.00**
Books/School/college	**24**	**26.66**	**30**	**33.33**
Internet/Mass media	**26**	**28.88**	**41**	**45.55**
No Knowledge of health	**9**	**10.00**	**0**	**0**

The respondents reported different sources through which they gain knowledge about the health and wellness. In order to observe and categorise the data, the respondents were asked to name the particular source which they believe is the main reason for their knowledge of health and wellness which they have acquired of which they are aware about. The responds recorded were coded initially into categories. Those who named their father, sister, colleague or a close friend from which they get aware about health has been categorised in the heading of "family/friends", similarly the knowledge gained from websites, informative videos, social networking sites and other pages that were recorded through the respondent's reports has been coded into the category of "Internet/Mass Media" as presented in table T11.

The responds of not knowing about health were only given by the less educated ones as 10% of the below higher secondary literates responded that they have no idea about the health and wellness. Those who were higher secondary literates and more than that responded with having some knowledge about health and among these respondents 45.55% reported internet and mass

media as their primary source from which they became aware about health and 33.33% reported that they learned about health prevention and management through books and educational institutes. The respondents who were less literate than higher secondary school level also talked about different internet sources and stages of educational institutes but in less percentage than highly educated ones as among them the 28.88% respondents reported internet and mass media being their primary source of knowledge about health and 26.66 believed books and school education educating them about health and wellness.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I don't know much about health; all I know is what my health has gone through these years of my life. In critical situations I have to visit the health centre to get treatment."

Case 2 (Qualification category: Less than primary): "I am an illiterate woman and don't have knowledge about health as the time has changed and the new generation looks weak. The food that was supposed to be healthy brings obesity and other illness."

Case 3 (Qualification category: Primary/Secondary): "My brother is a medical professional, and I usually discuss health issues with him. I have learnt a lot from him."

Case 4 (Qualification category: Higher Secondary/Graduation): "I read about health and hygiene during the classes in schools and through science books I have read about diseases and their modes of transmission."

Case 5 (Qualification Category: Higher Secondary/Graduation): "YouTube videos give lot of information, and I watched videos which provided me ample of information about my health needs."

Case 6 (Qualification Category: Higher Secondary/Graduation): "I am a staff nurse by profession, and I have learned primarily from studies."

Case 7 (Qualification category: Post graduation/Above): "I search on internet to read/find about different health needs and issues then accordingly I respond."

The respondents reported about the primary source which mainly provides them knowledge about health or has educated them about the health requirements and management. In their reports the data has shown that education has an important factor in the accessibility of health knowledge and awareness. The sources of knowledge are found to be the books, studies in

schools/colleges, the knowledgeable educated/professional persons or the sources of internet which are being used in electronic gadgets mainly with the operation of mobile phones. This reveals the fact that education is also providing the source of knowledge through different mediums of providing education which gives them knowledge about health and hygiene. Additionally, education enables them with skills and make them accessible to health awareness and management as it is evident that educated women are more skilful in dealing with mobile phone, different sources of internet and other gadgets. Those who are highly educated have more sources of knowledge available for them which plays important role in health outcomes, management and care skills. The narrations of the respondents depict that among the less educated respondents some of them are completely unaware about the overall concept of health. The data is evident in supporting the role of education in providing health literacy by enhancing different sources of knowledge regarding health.

Nutrition Knowledge:

The respondents were inquired as do they possess any idea/information about the nutritional compositions of different foods which are consumed by them or known to them. The respondents talked about the benefits of different foods or the unawareness of the nutrition's in foods. The data after been familiarized was coded initially. The responds were categorised as per the data. Those who named some fruits and their nutritional composition has been categorised as "benefits of fruits" known to the respondents. Similarly, the knowledge about consuming chicken or mutton has been categorised separately as the "benefits of non-veg" reported by the respondents. Accordingly, all the categories listed in the following table has been derived from the relative terms which have been used by the respondents in communication with the interview conducted.

Table T12: Nutrition Knowledge

Talked about	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Benefits of fruits	**2**	**2.22**	**14**	**15.55**
Benefits of vegetables	**5**	**5.55**	**18**	**20.00**

Benefits of non-Veg food	**2**	**2.22**	**13**	**14.44**
Benefits of cereals /Pulses	**3**	**3.33**	**16**	**17.77**
Benefits of milk and diary	**7**	**7.77**	**11**	**12.22**
Disadvantages of sugary and processed foods	**2**	**2.22**	**6**	**6.66**
No information	**72**	**80.00**	**37**	**41.11**

In this cross-tabulation (Table T12), the categories shown are analysed by counting the number of respondents talking about the particular thing. Some of the respondents talked about the benefits of several things and accordingly each that respondent is counted in all the categories which she has talked about. If a respondent has talked about fruits as well as vegetables, she has been counted in both the categories which makes her count to two. So, the table shows each category reported the number of times by the respondents.

As per the data gathered and familiarized with it has been found that the more educated are more aware about the nutritional benefits of different kind of foods. 80% of the respondents possessing less than higher secondary level of education had no idea about the nutritional composition of different foods. However, the percentage of unawareness about the nutritional compositions of the food is less among the highly educated respondents among those 41.11% respondents are unaware which shows that at some level there is more knowledge of balanced diet among the more educated ones. Similarly, among the more educated ones 14% have talked about different nutrients of fruits, 20% have talked about different vegetables and also the benefits of other kind of food are talked more by the educated respondents.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I don't know anything regarding this."

Case 2 (Qualification category: Primary/Secondary): "I know that food is healthy but I don't know what is contains."

Case 3 (Qualification category: Higher Secondary/Graduation): "Proteins are in chicken chest piece and the green leafy vegetables contain iron."

Case 4 (Qualification category: Higher Secondary/Graduation): "Milk has protein which is good for hair growth and has calcium also."

Case 5 (Qualification Category: Higher Secondary/Graduation): "Palak (Spinach) has iron and Vitamin C is in oranges, banana has potassium and cereals, Moong and other dhals and Channa (beans, chickpea) contains protein."

Case 6 (Qualification Category: Post/Above graduation): "All I know is we should consume healthy food like meat, vegetables, eggs, milk and avoid the junk and fast-food which is unhealthy."

Case 7 (Qualification category: Post graduation/Above): "Apple has fibre in it, orange has vitamin C and milk has calcium."

Case 8 (Qualification category: Post graduation/Above): I don't know exact terms about the nutrition's, but I usually know that fruits and other diet is healthy but sugary, fatty and oily food can lead to the worsening of health."

The highly educated women were found with better knowledge of nutrition's composed in food which is usually consumed or needs to be consumed. The less educated respondents are more unaware about the nutrition's in food. The education directly and indirectly provides knowledge about the different benefits of food and the importance and understanding of a balanced diet for healthy living. The data has shown educated respondents more aware about different terms of nutrients and therefore are more aware about the nutritional benefits which plays an important role in health outcomes, management and prevention, treatment of ailments. With the knowledge about healthy diet, we can assume that a woman can take care of her health as education develops knowledge about the healthy diet among them and in broader understanding develops health literacy among them.

Diseases Awareness:

The respondents were asked about their knowledge regarding non-communicable diseases and their responds were different when considering the group of their education level. To understand in a specific way the responds were recorded and placed in two groups which differentiates them broadly in terms of education. The respondents talked about the diseases like diabetes and hypertension in terms of their normal and abnormal levels. The respondents narrated about different clinical investigations which are related to NCDs. The food to be

consumed and avoided has also been talked by them and also the importance of walk and other forms of exercises have been narrated by the respondents. The narrations of respondents are categorized after the gathered data being coded has been formulated as shown in the table T13.

Table T13: Diseases Awareness

The terms related to NCDs	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Normal and abnormal levels of blood sugar/ blood pressure/ heart rate	**24**	**26.66**	**62**	**68.88**
FBS/RBS/HBAIC/LIPID Profile	**11**	**12.22**	**21**	**23.33**
Symptoms of different NCDs	**5**	**5.55**	**14**	**15.55**
Food intake in case of NCDs	**19**	**21.11**	**23**	**25.55**
Importance of physical activities	**7**	**7.77**	**12**	**13.33**
Info about cancer and strokes	**0**	**0**	**4**	**4.44**
Consequences of NCDs	**0**		**6**	**6.66**
Unaware about NCDs	**35**	**38.88**	**6**	**6.66**

Those respondents who were less than higher secondary literates gave less information about the noncommunicable diseases as compared to the more educated respondents. 35% among less than higher secondary literate respondents reported that they are unaware about the NCDs, however only 6.66% respondents among highly educated ones were unaware about the NCDs. The respondents with higher level of education narrated better about the normal and raised levels of blood sugar, blood pressure, heart rates and also the terms like the clinical diagnosis/investigations including fasting/random

bool sugar tests, HBA1C, lipid profile etc. The different symptoms of diseases like diabetes and hypertension were more talked by the highly educated respondents. The knowledge about cancer and strokes was also narrated by the more educated ones. the consequences of NCDs were also only narrated by the higher secondary and above level respondents.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I don't know about NCDs."

Case 2 (Qualification category: Primary/Secondary): "In diseases like sugar (diabetes) we have to stop the usage of sugar in food and in case of Pressure (hypertension) we have to reduce the salt intake."

Case 3 (Qualification category: Primary/Secondary): "Monitoring of pressure (blood pressure) is important to find whether the pressure (blood pressure rate) is normal or high."

Case 4 (Qualification category: Higher Secondary/Graduation): "Diabetes is the condition when the body glucose level is high and in cases of hypertension the blood pressure level is high. We can monitor them with taking tests like FBS, RBS and monitoring with BP apparatus or digital BP machine."

Case 5 (Qualification Category: Higher Secondary/Graduation): "I am suffering from diabetes and I have to take medicines and refrain from taking food which is high in carbohydrates. I take tests (clinical investigations) like Fasting blood sugar, random blood sugar and also HBA1c which determines my sugar levels."

Case 6 (Qualification Category: Post graduation/Above): "During my pregnancy I suffered from both diabetes and hypertension. It is crucial to be cautious about the normal levels otherwise the abnormal levels will bring dangerous consequences to the body."

Case 7 (Qualification category: Post graduation/Above): "NCDs are the lifestyle diseases. Diabetes is the condition due to lack of insulin in the body. It can be of type 1 or type 2 diabetes. Hypertension is the condition where human heart pumps blood at other than its normal level."

The knowledge enables individuals to adopt the preventive measures and deal better with health distress of their own or of their family members suffering from these diseases which are dangerous for their overall wellness. The data has revealed that education provides more knowledge about the diseases, symptoms of diseases, consequences, management and screening as those who are more educated are more aware about

noncommunicable diseases. This is observable from the data that education is an important factor which provides awareness about the diseases, particularly the NCDs in which the knowledge of symptoms, proper management, screening, monitoring and treatment on time and sometimes on regular bases is a prerequisite in such conditions. With the awareness about diseases the education literate about health.

Support Awareness:

The respondents were asked about the information of various Governmental initiatives and schemes which benefits woman. The women with high levels of education narrated more about the nomenclature and details of various schemes which are framed by the Government for the welfare of the women which are presented in table T14 as mentioned by the respondents regarding their knowledge about the benefits provided by the government for the women or girls.

Table T14: Support Awareness

Mentioned about	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
JSSK	**6**	**6.66**	**28**	**31.11**
JSY	**2**	**2.22**	**37**	**41.11**
ASHA	**6**	**6.66**	**2**	**2.22**
Beti Bachao Beti Padhao (BBBP)	**12**	**13.33**	**33**	**36.66**
Sukhanya Smridhi Yojna	**10**	**11.11**	**21**	**23.33**
ICDS	**8**	**8.88**	**14**	**15.55**
Poshan Abhiyan	**0**	**0**	**7**	**7.77**
State Marriage assistance scheme (SMAS)	**14**	**15.55**	**21**	**23.33**
No Benefits for woman	**27**	**30.00**	**4**	**4.44**

No idea	**16**	**17.77**	**4**	**4.44**

Among those with level of education less than higher secondary, 30% reported that there are no benefits for woman, 17.77% are unaware about any provision or scheme available for them.

Those who are higher secondary or above level literates narrated more about the various schemes like JSY mentioned by 41.11% , JSSK by 31.11% , Beti Bachao Beti Padhao (BBBP) 36.66% and some other mentioned schemes as tabulated in table T14 shows more support awareness among them than the less educated ones. The high level educated women narrated about the various schemes like Janani Shishu Suraksha Karyakram (JSSK), Janani Suraksha Yojana (JSY), integrated child development services (ICDS), Sukhanya Samridhi Yojna etc which shows the level of awareness about the schemes among the highly educated women and more chance of getting benefited for these welfare schemes.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "Anganwadi centres give nutritious food to pregnant women."

Case 2 (Qualification category: Primary/Secondary): "women don't get any benefit from government schemes."

Case 3 (Qualification category: Primary/Secondary): "ASHA workers assist the pregnant women and also the pregnant women have free tests at government hospitals."

Case 4 (Qualification category: Higher Secondary/Graduation): "there are several schemes like JSY, Marriage assistance scheme."

Case 5 (Qualification Category: Higher Secondary/Graduation): "JSK, JSSY, ICDS and BBBP are some schemes by which women can be benefited."

Case 6 (Qualification Category: Post graduation/Above): "Beti bachao beti padhao (BBBP), Sukhanya Smridhi scheme, marriage assistance scheme, are some of the schemes which I know about."

Case 7 (Qualification category: Post graduation/Above): "we have JSK, JSSY, Poshan Abhiyan, ICDS, Marriage assistance schemes for the benefits of women. I have read them during my exam preparation for Supervisor recruitment."

The welfare program can be only successfully implemented when it is accessed by the masses and the access of these benefits are obvious from the narrative analysis being accessed by the high level educated women. The less educated ones were found with less awareness about the schemes and initiatives for the women particularly for the betterment of health. The data shows the level of awareness with respect to the level of education. We can conclude this by finding education an important factor in developing awareness about the governmental welfare initiatives available to the women which makes these initiatives accessible to them.

With these findings it is observable that education provides health literacy with proving sources of knowledge about health, disease awareness and support awareness.

⟹ **Findings of previous studies:**

Bhatia et al., (2021) stated that the households which have illiterate heads were found at risk maternal deaths as per the NFHS-4 data analysis. V Raghupathy & W Raghupathi, (2020) in their study concluded that higher educational attainment correlates with improved health outcomes, including decreased infant mortality rates, increased life expectancy, and fewer years of potential life lost due to early death. As per the study of E Gakidou et al., (2010) Educational attainment, especially among women, has far-reaching benefits that extend across generations. Educated mothers are more inclined to engage in health-promoting behaviors and utilize healthcare services more effectively. According to the findings of Berkman et al., (2011), Education significantly enhances health literacy, enabling individuals to understand health information and make informed decisions regarding their health. Those with higher educational attainment are more likely to participate in preventive healthcare practices, including routine check-ups, vaccinations, and health screenings. This proactive approach facilitates early detection and treatment of diseases, ultimately contributing to better health outcomes.

4.4.2 Factors associated with education impacting health

4.4.2.A Quantitative Data

1.Financial-Support

The women participants were asked about the monetary requirements which are important in managing health and without which the health needs cannot be fulfilled. The respondents reported about the economic assistance in which the majority of highly educated respondents were found as engaged with paid jobs or art/work with monetary assistances.

Table T15: Financial Support

Educational Qualification	No. of respondents engaged in paid work	Total No. of Respondents	Percentage
Illiterate and less than primary	**5**	**45**	**11.11%**
Primary and secondary literates	**13**	**45**	**13.00%**
Higher secondary and graduates	**22**	**45**	**48.88%**
Postgraduates and above	**31**	**45**	**68.88%**

Among all the respondents 71 (39.44) reported to be engaged in any form of paid work. The data has shown the dependency of women for economic assistance on male members of the family. However, those who are getting economic assistance are mostly among the highly qualified ones.

2. Healthcare affordability

The respondents were asked about affording the health expenses. The respondents who have higher secondary level of education and above than that responded more of themselves as paying for health expenses. 46.66 % of respondents who are postgraduates and above qualified were found as able to take their health expenses. Only 8.88% of the respondents who were illiterate and less than primary level literates reported that they pay for their health expenses on their own and 75.55% of them were found as dependent on the male members of the family for the economic assistance in managing health.

Table T16: Healthcare affordability

Health expenses are paid by	Illiterate and less than primary (N=45)	%age	Primary and secondary literates (N=45)	%age	Higher secondary and graduates (N=45)	%age	Postgraduates and above (N=45)	%age
Respondent herself	4	8.88	7	15.55	20	44.44	21	46.66
Male member of the family	34	75.55	29	64.44	16	35.55	20	44.44
Female member of the family	4	8.88	8	17.77	7	15.55	4	8.88
Others	2	4.44	1	2.22	2	4.44	0	0
No One	1	2.22	0	0	0	0	0	0

The data is evident in showing the link of education with the economic aspect of the health management and expected outcomes. Lack of economic assistance has been found as the hinderance in health checkups, fulfilling health needs and heath management as per the respondents.

3. Economic Hurdle

Respondents were inquired about any obstacles they faced in managing their health, particularly in affording and meeting their healthcare needs. This involves assessing whether they encountered difficulties in paying for medical expenses, accessing necessary treatments, medications, or other health-related services, and the extent to which these financial barriers affected their ability to maintain and improve their health.

Table T17: Economic Hurdle

Lack of economic assistance hindered health management	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Always	**12**	**13.33**	**2**	**2.22**
Mostly	**29**	**32.22**	**10**	**11.11**
Sometimes	**33**	**36.66**	**42**	**46.66**
Never	**16**	**17.77**	**36**	**40.00**

The majority of the Higher educated respondents reported that they were not mostly hindered in managing health due to the reasons of economic assistance. 40% among those who are higher secondary or more level literates reported that they never face any economic hardship in managing health. The less educated respondents reported more hindrance due to lack of economic assistance as per the data shown in table T17. The educated women are likely to find more jobs and generating other means of income due to being more skilful which results in the availability of monetary assistances. The treatment processes and health needs require economic assistance which is more likely to be accessible to the educated ones. Additionally, the status of women plays an important role in better condition of life. The less educated women are likely to be dominated in the family which makes them unable to express their health needs and when in such situations she is completely dependable to other members of family to which she can't openly ask it can easily be predicted that the health management in such situations can be very difficult.

4. Support Networks

The respondents were asked about the social and emotional support provided in educational institutes or workplaces where they find people to interact with and the majority of the respondents believed that educational institutes and workplaces give more support in social life.

Table T18: Support Networks

How often Social & Emotional support is provided at educational institute/workplace	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Always	**16**	**17.77**	**27**	**30.00**
Mostly	**25**	**27.77**	**29**	**32.22**
Sometimes	**29**	**32.22**	**25**	**27.77**
Never	**6**	**6.66**	**5**	**5.55**
No idea	**14**	**15.55**	**4**	**4.44**

The respondents who are more educated and found more engaged in educational institutes and workplaces reported that educational institutions and places of work provides them social and emotional support and even less educated respondents also believe that these contexts are good for the additions of social networks which are beneficial for the overall health outcomes for them. 15.55 % of the less educated than higher secondary level literates had no idea regarding the same. 62.22% of the respondents categorised as the level of Higher secondary or above literates reported that educational institutes and workplaces provide always or mostly the additional social and emotional support.

5. Social Isolation

The Participants were asked as, how often they feel isolated and need social and emotion support. The responds were different on the bases of differences in levels of education.

Table T19: Social Isolation

Social Isolation is felt	Illiterate and less than primary (N=45)	%age	Primary and secondary literates (N=45)	%age	Higher secondary and graduates (N=45)	%age	Postgraduates and above (N=45)	%age
Always	**13**	**28.88**	**11**	**24.44**	**5**	**11.11**	**3**	**6.66**
Mostly	**8**	**17.77**	**14**	**31.11**	**7**	**15.55**	**6**	**13.33**
Sometimes	**18**	**40.00**	**9**	**20.00**	**23**	**51.11**	**15**	**33.33**
Never	**5**	**11.11**	**11**	**24.44**	**10**	**22.22**	**21**	**46.66**

The data has shown the less educated respondents feeling more isolated and need of social and emotional support than the highly educated respondents. 46.66 % of the respondents who were postgraduates and above level qualified reported that they never feel isolated and they find social networks for the emotional support. 28.88% respondents categorised as illiterates and those with less than primary level of education reported that they always feel isolated. The difference can be observed as the highly educated respondents are more connected to social networks and get support more than those who are less educated. social support is a pivotal factor in health outcomes as social isolation leads to serious mental and overall health effects.

6. Unpaid Work:

The domestic work remains without economic assistance and domestic workers are engaged in the work for several hours of the day which also impacts negatively on the overall health. The respondents were interviewed about the domestic work and their responds reveal that more educated are less engaged in domestic unpaid work than the less educated ones.

Table T20: Unpaid Work

Most of the domestic work in the family is done by	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Respondent herself	**57**	**63.33**	**35**	**38.88**
Any other female member of family	**30**	**33.33**	**52**	**57.77**
Any other male member of the family	**2**	**2.22**	**1**	**1.11**
Paid worker	**0**	**0**	**2**	**2.22**

The 63.33 % of the respondents with less than higher secondary level of education reported that they are mostly responsible for the domestic chores in the family while as in comparison, the respondents who were more educated were found less engaged in unpaid domestic chores. The domestic chores are found to be done by the women of the family and most part of the work is assigned to the less educated ones who are less engaged and associated with educational, training institutes and formal workplaces.

4.4.2.B Qualitative Data

1. Health Management

The respondents were asked as who manages their health when they are sick. There were some common narrations about the persons managing health needs. The names of parents and husband was commonly narrated by several participants, but the self-management of needs differed largely with the difference of education as shown in table T21.

Table T21: Health Management

Health managed by	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Father	**17**	**18.88**	**15**	**16.66**
Mother	**4**	**4.44**	**7**	**7.77**

Husband	**32**	**35.55**	**23**	**25.55**
Brother	**12**	**13.33**	**5**	**5.55**
Sister	**2**	**2.22**	**2**	**2.22**
Myself	**13**	**14.44**	**37**	**41.11**
No one	**10**	**11.11**	**1**	**1.11**

There was not much difference among all respondents in dependency on the other members of the family particularly on the male members, but the higher educated respondents reported to be more in a condition to manage their health on their own than the less educated respondents.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "My husband takes the responsibility of the family and my health when I am sick."

Case 2 (Qualification category: Primary/Secondary): "My husband accompanies me to hospital when I am sick and purchases medicines for me."

Case 3 (Qualification category: Primary/Secondary): "I am so busy in my household work and childcare that I can't find much time for myself. When I am extremely ill then I visit the doctor alone but usually no one manages my health."

Case 4 (Qualification category: Higher Secondary/Graduation): "My brother helps in during my sick days and takes me to the doctor and buys medicines for me."

Case 5 (Qualification category: Higher Secondary/Graduation): "I myself take manage my health needs. I am a tailor so I get money for my work with which I can afford the health requirements."

Case 6 (Qualification Category: Higher Secondary/Graduation): "My mother manages my health."

Case 7 (Qualification Category: Post graduation/Above): "I myself manage my health and also take care of my family members."

Case 8 (Qualification category: Post graduation/Above): "My father takes care of my health and always support me in my needs."

Sometimes the symptoms of diseases remain unreported or ignored which is due to the lack of management of health or lack of knowledge and skills. The educated women are more skilful to manage their health like to visit the health facility alone or afford the health expenses or express their needs on their own.

2. Needs Disclosure

The respondents were asked as with whom they share their body needs. The respondent's narrations were different as per the education level which they possess. The narrations of the respondents were found in mentioning different relations or none of anyone which are presented in table T22.

Table T22: Needs Disclosure

Needs are shared with	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Parents	**19**	**21.11**	**27**	**30.00**
Husband	**26**	**28.88**	**32**	**35.55**
Friend's	**5**	**5.55**	**8**	**8.88**
Siblings	**3**	**3.33**	**9**	**10.00**
No one	**37**	**41.11**	**14**	**15.55**

41.11% of the less educated respondents reported that they are not able to share their different needs of body. The more educated ones are found better in expressing their body needs in terms of health. In comparison the highly educated respondents reported better in expressing their needs freely.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "with whom should I share? I usually ignore my needs."

Case 2 (Qualification category: Primary/Secondary): "I don't talk about my needs with anyone."

Case 3 (Qualification category: Primary/Secondary): "I discuss everything with my sister."

Case 4 (Qualification category: Higher Secondary/Graduation): "sometimes I have to know many things for which I talk to my friend who is a healthcare profession."

Case 5 (Qualification category: Higher Secondary/Graduation): "I share my needs openly with my husband as he takes care of me.

Case 6 (Qualification Category: Higher Secondary/Graduation): "My mother manages my health."

Case 7 (Qualification Category: Post graduation/Above): "I share with my parents and ask for their help if there is any such need."

A significant 41.11% of respondents with lower education levels reported difficulties in conveying their body needs, particularly in relation to women's health issues such as reproductive health, menstrual care, and maternal health. This challenge may arise from a lack of understanding of health concepts and insufficient access to health education resources. In contrast, those with higher education were more successful in articulating their body needs. This advantage likely results from their increased exposure to health topics and enhanced critical thinking skills. The disparity in educational backgrounds highlights the need to improve health literacy among less educated individuals, empowering them to express their body needs and seek appropriate care.

3. Social Pressure

In finding if the respondents feel any stress of anything, narratives were analysed in which the less educated women mentioned more about the household care and family responsibilities. Some respondents who are below higher secondary level literates mentioned the domestic difficulties and issues faced by them. In comparison the more educated ones talked less about care work and domestic issues as presented in the table T23.

Table T23: Social Pressure

Cause of any stress	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Domestic issues	**24**	**26.66**	**8**	**8.88**

Health related	**15**	**16.66**	**12**	**13.33**
Financial issues related	**19**	**21.11**	**15**	**16.66**
Job or carrier related	**0**	**0**	**14**	**15.55**
Childcare or child future worries	**20**	**22.22**	**22**	**24.44**
No stress	**12**	**13.33**	**19**	**21.11**

The observable fact from the narrations of the respondents is that there is social pressure among the women, and they feel stressed of several issues. The difference is that the more educated reported less in percentage of worries discussed by the respondents and face fewer domestic issues as compared to less educated respondents who reported 26.66 % as stressed due to the domestic issues.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I am suffering from back pain but I have to do all my household chores alone."

Case 2 (Qualification category: Primary/Secondary): "yes I am stressed about financial issues of our house."

Case 3 (Qualification category: Primary/Secondary): "family issues and my husband's behaviour towards me is the reason behind all my stress."

Case 4 (Qualification category: Higher Secondary/Graduation): "my children future and care make me anxious."

Case 5 (Qualification category: Higher Secondary/Graduation): "I am stressed about my father's health issues."

Case 6 (Qualification Category: Higher Secondary/Graduation): "With the Gods grace I have everything, so I have no tension at all."

Case 7 (Qualification category: Post graduation/Above): "I am desperate to get a job which is my only stress."

The narratives analysed reveal that respondents experience varying degrees of stress depending on their educational background. Women with lower educational levels, particularly those who have not completed higher secondary education, tend to emphasize their concerns about household care and family responsibilities more frequently. They often mention the domestic difficulties and challenges they face on a daily basis, such as balancing childcare, managing household chores, and handling family expectations. In contrast, women with higher levels of education report less stress related to domestic duties and care work. Their narratives are less centered around household responsibilities and more focused on broader aspects of their lives, including career aspirations, personal development, and social interactions. This suggests that higher education provides women with better access to resources, knowledge, and skills that enable them to manage or delegate household tasks more effectively. As a result, they are likely to experience less burden from domestic responsibilities, allowing them to focus on other aspects of their well-being. Despite these differences, it is important to note that all women, irrespective of their educational background, report feeling stress related to social issues. However, the nature and intensity of their stress differ based on their educational levels. Women with lower education levels are likely to experience stress due to limited opportunities, social discrimination, or family pressures, while those with higher education might encounter stress related to professional challenges, societal expectations, or navigating gender roles in the workplace. Education emerges as a crucial factor in mitigating the impact of social issues on women's lives.

4. Social Discrimination

The respondents were asked as does the domestic work which remains unpaid and labelled for the women discriminate them which they responded with several statements which after being familiarized with were examined, categorised and formulated as shown in table T24.

Table T24: Social Discrimination

Domestic work discriminates because it is	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Unvalued work	**8**	**8.88**	**14**	**15.55**
Free of cost work	**12**	**13.33**	**13**	**14.44**
day consuming work	**19**	**21.11**	**9**	**10.00**
Labelled for women work	**15**	**16.66**	**29**	**32.22**
Double shift work	**0**	**0**	**8**	**8.88**
Risk for health	**12**	**13.33**	**13**	**14.44**
Responsibility/duty of women	**17**	**20.00**	**2**	**2.22**
No Idea	**7**	**7.77**	**2**	**2.22**

The respondents reported that domestic work is a source of discrimination for various reasons. They expressed that household chores and caregiving responsibilities are often perceived as "unvalued work", meaning that despite the effort and time invested, their hard work is not recognized or appreciated by society and is looked like they have done nothing. It is always a "free-of-cost work", which means it lacks monetary assistance. Domestic and care work requires a substantial amount of time and energy, leaving little room for other pursuits like education, employment, or personal interests as it is a "day consuming work" which discriminates woman. Domestic work is "labelled as women's work" as no one will assist a woman even if she is the only woman in the family. Woman despite of other responsibilities have to do this work. The working women feel that after returning or before joining from their paid work they have to complete the household work and hence had to do the "double-shift of work" which is a discrimination. Domestic work is also felt as risk for health particularly worsening it during health distress and adverse for recovery and broader health outcomes. As far as 20% of the less educated respondents are concerned, domestic work is the work of woman and as per them it's their duty so they must do it, which shows their perception of the women to be the only responsible persons for all the domestic stuff.

However as per the narration's transcripted, coded and tabulated as shown in table T24 the more educated respondents are found to be more voicing against the social discriminations which emerge in the form of the nature of unpaid work faced by the women in our society.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "the domestic work takes full day, and I cannot do any other thing."

Case 2 (Qualification category: Primary/Secondary): "yes the domestic work is not valued as men think that women don't do anything."

Case 3 (Qualification category: Primary/Secondary): "The domestic work is the responsibility of women, and it has to be done by us."

Case 4 (Qualification category: Primary/Secondary): "I have multiple discs due to which I suffer from backpain, and doctor has advised me to take rest, but I can't take rest as there is no option other than doing my domestic chores

Case 5 (Qualification category: Higher Secondary/Graduation): "The load of domestic work impacts health."

Case 6 (Qualification category: Higher Secondary/Graduation): "it's an extra work as before going to my workplace I have to cook for the family and do other domestic chores and when I come back, I have to do my household work. So, it's like a double shift for me."

Case 7 (Qualification Category: Post graduation/Above): "The domestic work is not valued as it is an unpaid work."

Case 8 (Qualification category: Post graduation/ Above): "Yes the domestic work discriminates women as it should not be solely considered as women work."

Education can significantly reduce the discriminatory aspects of domestic work. With education woman can develop positive mindset and awareness which can able them to question the rigid traditional gender roles that forces women to get confined with the domestic duties in any situation. The domestic work burden and labelled women work is not good for their health and wellness.

Findings of previous studies:

Tamborini et at., (2015) found that Education is closely linked to higher income. People with greater educational attainment often obtain higher-paying jobs, which enhances their financial stability and grants better access to healthcare services. I Kawachi et al., (2001) in their study found that high level of education is linked with increased social networks and additional social support which leads to positive impact on health. S. Srinivasan & A. S. Bedi, (2007) found that time spend by women on unpaid domestic work effects their reproductive health.

4.4.3 Health behaviour influenced by education

4.4.3.A Quantitative Data

1.Habits and Addiction

The respondents were asked about tobacco or any other intoxication in which majority of the respondents denied of having any of the ill habit.

Table T25: Habits and addiction

Indulgence in tobacco addiction or any other intoxication	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Yes	**1**	**1.11**	**0**	**0**
No	**83**	**92.22**	**89**	**98.88**
Sometimes	**6**	**6.66**	**1**	**1.11**

Respondents with education level of higher secondary or above reported not engaging in tobacco use or other forms of addiction. Their responses reflect greater awareness of the health risks associated with such habits, as well as stronger self-discipline in avoiding them. On the other hand, a small number of respondents with lower educational backgrounds admitted to engaging in these addictive behaviours as presented in table T25. This difference is likely to be due to the lack of awareness about the harmful effects of substance use or limited access to health education. Education provides individuals with the knowledge and skills needed to make informed choices, resist peer pressure, and adopt healthier coping mechanisms, thereby lowering the likelihood of substance abuse.

2. Physical activities

The difference in the attitude towards health has been found on the bases of education. The importance of physical activities like walking and exercise was asked to the respondents. The well-educated respondents reported better attitude than those with less qualification as comparison to them.

Table T26: Physical activities

Walk and Exercise	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Daily	**20**	**22.22**	**32**	**35.55**
Once/twice in a week	**27**	**30.00**	**30**	**33.33**
Once/twice in a month	**10**	**11.11**	**8**	**8.88**
Never	**33**	**36.66**	**20**	**22.22**

As per the reports of respondents it has been found that the respondents with high level of education have better focus on the healthy behaviours than the less educated respondents. The difference can be seen in the table T26 as among higher secondary and above level literates 35.55% reported walk and exercise done on daily bases and 33.33% do it in once or twice a week among the less educated than these the percentage lowers to 22.22 as reported being daily going for walk or performing exercises and 33% never doing it.

Education plays a pivotal role in shaping positive attitudes toward health by raising awareness of the numerous benefits associated with physical activities and encouraging healthier lifestyle choices. Through education, individuals learn the importance of regular exercise in preventing diseases, maintaining a healthy weight, and improving mental well-being. This knowledge fosters a deeper understanding of how small changes in daily habits can lead to long-term health benefits, promoting a more proactive approach to self-care. As a result, educated individuals are more likely to prioritize physical activity and adopt behaviours that reflect a strong commitment to their personal health and overall well-being.

3. Access Barriers

The respondents were also asked that who purchases menstrual products for them. The responds again were different with the difference of education.

Table T27: Access Barriers

Menstrual products are purchased by	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Respondent Herself	**27**	**30.00**	**55**	**61.11**
Family Member	**46**	**51.11**	**30**	**33.33**
Others	**4**	**4.44**	**2**	**2.22**
No one	**13**	**14.44**	**3**	**3.33**

The data in the table T27 shows that 61.11 % highly educated women purchase menstrual products by themselves and among the less educated women only 30 % reported that they themselves purchase these products. The less educated respondents were found more dependent on others than themselves.

Education plays a vital role in empowering women to take charge of their health and wellbeing. Women with higher education levels tend to purchase menstrual products on their own, reflecting greater confidence and awareness of their personal health needs. In contrast, women with lower education levels are less able to do so independently, which indicates barriers such as limited knowledge or restrictive social norms. promoting education is essential not only to enable women to make informed health decisions today but also to ensure that in future the woman in our society have the confidence, ability and freedom to prioritize their well-being and they advocate for their needs.

4.4.3.B Qualitative Data: -

1. Preventive Measures

The respondents were also inquired as if they take any steps in prevention of lifestyle diseases like diabetes and hypertension. The narrations of the highly qualified respondents were better than the less educated respondents as presented in table T28 in which the responds in categories are shown as the statements stated the no. of times by the respondents.

Table T28: Preventive Measures

Preventive measures mentioned	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	
Reduction of salt and sugar in food	**14**	**15.55**	**34**	**37.77**
Avoiding junk/oily/ fatty foods	**9**	**10.00**	**12**	**13.33**
Engaging in physical activities	**7**	**7.77**	**17**	**18.88**
Screening/ monitoring/diagnostics	**23**	**25.55**	**36**	**40.00**
Healthy food	**2**	**2.22**	**9**	**10.00**
No such measures (due to different reasons)	**61**	**67.77**	**18**	**20.00**

The Higher secondary literates and above that level of qualification responded in lifestyle modifications. 37.77% among them talked about the reduction of salt and sugar particularly for those who are at risk or suffer from these non-communicable diseases while in comparison the less educated than them who talked about these lifestyle modifications were 15.55% only. The importance of healthy foods was narrated by 10% Among the highly educated respondents, 40% reported they go for screening or monitoring of blood pressure, blood sugar, heart rates and body parts functional tests or tri-glycerides level or some other clinical investigations. The 61% among the less than higher secondary respondents in aggregation responded that they do not take any measure in prevention of NCDs.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I don't know anything about this so what measures can I take."

Case 2 (Qualification category: Primary/Secondary): "we have both sugar and pressure (diabetic and hypertensive) patients in the family, and we all prefer reduction in sugar and salt."

Case 3 (Qualification category: Primary/Secondary): "I have tried to reduce the spices in food, but my family do not like the food which is not spicy. So, I can't do anything in that."

Case 4 (Qualification category: Primary/Secondary): "we work in home and in our fields, orchards. Those who work will not get sick."

Case 5 (Qualification category: Higher Secondary/Graduation): "I always advice my family to use salt less in quantity and avoid sugary foods."

Case 6 (Qualification category: Higher Secondary/Graduation): "we consume sugar, salt, oil in limit and even do a complete body profile test at least once a year."

Case 7 (Qualification Category: Post graduation/Above): "every day in the morning I walk for 2 to 3 kms and I am working on my weight loss because obesity is a risk factor for several diseases."

Case 8 (Qualification category: Post graduation/ Above): "monitoring of blood sugar and blood pressure is very important. Whenever I feel like some symptoms, I prefer monitoring and checkups."

Respondents with higher levels of education tend to take more proactive preventive measures against non-communicable diseases (NCDs) like diabetes, hypertension, and heart disease. With a deeper understanding of risk factors, they are more likely to adopt healthy lifestyle practices, such as balanced diets, regular exercise, and routine health check-ups, avoiding of junk foods or fatty and oily foods which can result in worse health outcomes. This shows how education plays a key role in promoting disease prevention and long-term health management.

2. Managing Skills

Feminine Competency

It was asked to the respondents that what they know about the menstrual hygiene management, to see how they manage their health. The responds in difference with educational qualification are shown in table T29.

Table T29: Feminine Competency

Knowledge about menstrual hygiene management	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	
Use of sanitary pads	**3**	**3.33**	**26**	**28.88**
Taking rest during periods	**5**	**5.55**	**8**	**8.88**
Disposal of sanitary pads	**0**	**0**	**2**	**2.22**
Healthy food intake/Precautions	**8**	**8.88**	**18**	**20.00**
No information	**79**	**87.77**	**48**	**53.33**

Those respondents who were less than higher secondary literates were shy in sharing details about menstrual health. The less educated women responded with very few information about the menstrual hygiene management. Those respondents having higher secondary and above level of education narrated more about the importance of sanitary pads and also talked about taking rest during the menstrual periods. Some (2.22%) of the highly educated respondents also stated about the disposal of sanitary pads. 79% respondents among the less than higher secondary level of education did not share any information about menstrual hygiene management. In contrast, among the higher secondary and above level literates the percentage of no information given about menstrual hygiene management remains less (53.33%) in comparison to the less educated ones. 26% of higher secondary and above level of educated woman talked about using sanitary pads and only 3.33% among the less than higher secondary literates talked about the same.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I can't talk about that."

Case 2 (Qualification category: Primary/Secondary): "I don't know much about that."

Case 3 (Qualification category: Primary/Secondary): *"I don't know. I just manage as others do."*

Case 4 (Qualification category: Primary/Secondary): "A women should not bath during her cycle days and should take healthy food."

Case 5 (Qualification category: Higher Secondary/Graduation): "I can't tell a man about that."

Case 6 (Qualification category: Higher Secondary/Graduation): *"Use of sanitary napkins is hygienic than using cloths."*

Case 7 (Qualification Category: Post graduation/Above): "Use of sanitary pads is important to prevent any infection and then these pads must be disposed properly after being used."

Case 8 (Qualification category: Post graduation/ Above): "during the menstrual periods women should not work but should take rest."

Educated women emphasized the importance of using sanitary pads, maintaining a nutritious diet, and getting adequate rest during menstruation. They recognized that high-quality sanitary pads enhance hygiene and comfort, helping to prevent infections and alleviate menstrual symptoms. They also highlighted the benefits of a balanced diet rich in iron, vitamins, and minerals, which can ease menstrual discomfort and promote overall health. Highly educated women acknowledged the necessity of rest, understanding that it is vital for managing fatigue and other symptoms during their menstrual cycle. Educated women somehow expressed greater confidence in discussing their menstrual health needs and concerns compared to less educated women, who felt more shy or hesitant to address such topics. This openness allows them to advocate for themselves and contribute to breaking down stigmas surrounding women's health issues. Overall, educated women have more managing skills in menstrual health management, prioritizing hygiene, nutrition, rest, and open communication.

Medical Proactivity

The respondents when asked about visiting any clinical laboratory for diagnostics or clinical investigation gave somehow common responds that when the doctor advised them of any of the investigation, they did the same. However, some of the highly educated women narrated

about the self-investigations for the prevention of health as shown in the table T30. This shows the positive health behaviour enhanced with education.

Table T30: Medical Proactivity

Previously visited the clinical lab for investigation	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	
When doctor advised	**41**	**45.55**	**47**	**52.22**
Self-investigation / body profile investigation	**8**	**8.88**	**24**	**26.66**
FBS/ RBS/ TSH due to co-morbidities	**20**	**22.22**	**17**	**18.88**
Not visited from a long time	**21**	**23.33**	**2**	**2.22**

Among the less than higher secondary level literates 23.33% reported that they have not visited any clinical laboratory from a long time and among the higher literates only 2.22% reported the same. 26.66% of higher secondary and above level of literates reported that went for self-investigations which shows their health managing ability better than the less educated ones.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "before a month I was sick, and the doctor asked for some tests which I did at the hospital."

Case 2 (Qualification category: Primary/Secondary): "I am suffering from hypothyroidism, and I visit the laboratory after every three months and then show my test report to the doctor."

Case 3 (Qualification category: Higher Secondary/Graduation): "I had fever for several days before 10 days and I was worried, so I went for typhoid test."

Case 4 (Qualification category: Higher Secondary/Graduation): "I am diabetic, so I frequently check my Fasting and random blood sugar. In the morning, I did my FBS test with glucometer."

Case 5 (Qualification Category: Post graduation/Above): "I was worried due to my weight gain, and I thought of Tri glycerides, so went for the lipid profile test before a week."

Educated women are more likely to seek clinical investigations compared to those with lower education levels. This proactive behaviour comes from a better understanding of health issues and the importance of regular check-ups. Their education provides them with the knowledge to identify symptoms and health concerns, motivating them to pursue timely medical assessments. Educated women tend to be more aware of the advantages of preventive care, leading them to prioritize clinical investigations or routine checkups to keep track of their health. This engagement with healthcare services shows their commitment in maintaining wellbeing and effectively managing health issues. Their ability to navigate the healthcare system and to prioritize their own needs highlights the essential role that education plays in fostering positive health behaviours.

3. Healthy environment

The respondents were asked about their suggestions which they give to those who fall sick in their family. The respondents however reported mostly that they suggest them to visit the nearby health facility to consult a doctor, but the higher literates responded with better health procedures. The data has been coded and presented in table T31 showing the kind of suggestions mentioned in number of times by the respondents in this cross tabulation.

Table T31: Healthy environment

suggestions to those who fall sick	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Consultation of concerned specialist	0	0	8	8.88
Visiting the nearby doctor/health facility	45	50.00	67	74.44
Purchasing drugs from nearby chemist	26	28.88	7	7.77
Taking rest and medication	9	10.00	16	17.77
Clinical investigations/diagnostics	6	6.66	23	25.55
No suggestion	11	12.22	2	2.22

The respondents narrated about what they suggest to those who fall sick in their family. It was only mentioned by the 8.88% of the respondents with qualification of higher secondary and above level that they suggest of visiting the concerned specialist like if a woman has irregular menstrual cycles the woman should visit the gynaecologist and if someone is having pain in joints or bones then it is better to suggest them to the orthopaedical specialist. 28.88% among less than higher secondary level respondents reported that they suggest of bringing medicines from medical shops, which can be sometimes worse for the health outcomes. The suggestions of visiting the nearby doctor or health facility were almost given by the majority of the respondents but the highly educated ones mentioned more (74.44) about visiting the nearby health facility to consult the doctor than the less educated one who mentioned less (50%) about the same as compared to the highly educated ones. the advice of clinical investigations/diagnostics were also mentioned more (25.55%) by the respondents having higher secondary or above level of education than the less (6.66%) educated ones.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "If anyone is sick in the family, I tell them to purchase medicines from the medical shop".

Case 2 (Qualification category: Primary/Secondary): "I always tell them to visit the doctor."

Case 3 (Qualification category: Primary/Secondary): "I tell them to go to the hospital and bring some medicines."

Case 4 (Qualification category: Higher Secondary/Graduation): "If someone falls sick in the family, I advise them to visit the doctor and do the concerned tests (clinical investigations) and take care of their food also."

Case 5 (Qualification category: Higher Secondary/Graduation): "healthy diet is important for recovering from illness and I ensure that the sick person takes the medicine on time as prescribed by the doctor."

Case 6 (Qualification Category: Post graduation/Above): "first of all we have to look at the symptoms and accordingly suggest for clinical investigation and consulting the doctor."

Case 7 (Qualification Category: Post graduation/Above): "It depends upon the kind of illness they suffer from and accordingly I advise them to visit the concerned specialist like general physician, orthopaedic, dermatologist etc to take the treatment."

Case 8 (Qualification category: Post graduation/ Above): "I advise them to consult the doctor, take treatment and take rest till they recover and advise them to take healthy food."

Woman with higher education tend to give better advice when someone is sick in their family or surroundings, such as suggesting a visit to the doctor, getting medical tests, and following proper treatment. Their understanding of health helps them recognize the importance of early medical care, which encourages others to take action quickly. This leads to better health and less spread of diseases in the community. On the other hand, less educated people may not be as familiar with these practices, which could result in delayed treatment and worse health outcomes. This shows how education enhances to create a healthier community by promoting smarter health choices and habits to develops a healthy environment.

5. Healthcare Accessibility

Table T32: Healthcare Accessibility

Visiting heath facilities	Less than Higher secondary level literates (N=90)	Percentage	Higher secondary level and above literates (N=90)	Percentage
Always during health distress	31	34.44	57	63.33
Less due to domestic responsibilities	20	22.22	14	15.55
Less due to economic hardships	10	11.11	3	3.33
Less due to lack of facilities	10	11.11	4	4.44
Less due to Self-treatment/Medication	12	13.33	5	5.55
Less due to lack of family support to take them to these facilities	7	7.77	2	2.22
Less due to the double shift od work	0	0	6	6.66

The respondents were asked as how often they visit the health care facilities during their health distress. Those with less than higher secondary qualification narrated some of the difficulties in availing healthcare facilities and stated about the family responsibilities which hinders them in visiting the health centres frequently. Some of them also narrated about the economic hardship, the lack of economic assistance to pay for the treatments frequently. The higher educated respondents gave positive response than the lower educated respondents in availing the healthcare facilities. They narrated that they visit the healthcare facilities during their health distress and this narration came mostly from these respondents having more education levels in comparison to the less educated women respondents.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "I don't go to the hospital usually because I remain busy in my household work and my husband also brings medicines for me if I am sick."

Case 2 (Qualification category: Primary/Secondary): "When I am sick, I visit the hospital which is near to us."

Case 3 (Qualification category: Primary/Secondary): "The nearby health centre doesn't have sufficient facilities, and the hospital is very far from my house which takes a full day to take treatment. I have to do my household work and don't find time to usually go to the hospital."

Case 4 (Qualification category: Primary/Secondary): I visit the hospital when I am sick, but sometimes if there is no one who will accompany me to the hospital then I am unable to visit the hospital."

Case 5 (Qualification category: Higher Secondary/Graduation): "I visited the nearby health centre yesterday to bring the folic acid and iron tablets which are provided free for us."

Case 6 (Qualification category: Higher Secondary/Graduation): "If I am accompanied by any family member, I visit the hospital whenever needed."

Case 7 (Qualification Category: Post graduation/Above): "Whenever I feel symptoms of anything I visit the nearby health facility."

⟹ **Findings of previous studies:**

Cutler & Lleras-Muney, (2010), found that education has negative link with smoking. People with higher levels of education tend to have lower smoking rates than those with less education. Darmon & Drewnowski, (2008) found that healthy food is consumed by highly educated individuals. More nutritional food is preferred; sugar and fats are avoided by the highly educated individuals. The study of Kripalani et al., (2007) discovered that individuals with lower levels of health literacy, which are frequently associated with lower levels of education, faced challenges in comprehending medication instructions and following treatment plans, resulting in worse health results.

4.4.4 Challenges faced by rural women related to health management

4.4.4.A Quantitative Data

1. Psychological barriers

Do the respondents find it difficult to visit the healthcare centre alone was asked to them and their responds varied with the differences of level of education.

Table T33: Psychological barriers 1

Finding difficult to visit healthcare facilities alone	Illiterate and less than primary (N=45)	%age	Primary and secondary literates (N=45)	%age	Higher secondary and graduates (N=45)	%age	Postgraduates and above (N=45)	%age
Yes	18	40.00	11	24.44	9	20.00	3	6.66
Sometimes	19	42.22	17	37.77	14	31.11	8	17.77
No	8	17.77	16	35.55	22	48.88	34	75.55

Some respondents from all the categories reported that they find it difficult to visit the healthcare facilities alone but the percentage of respondents who are dependent on others for availing the health facilities is more among the lower level of educated respondents. As per data tabulated in table T33, 82.22 % of the respondents including illiterates and less than primary literates sometimes or always find it difficult to visit the healthcare facilities alone. In contrast 75.55 % respondents who are postgraduates and above qualified reported that they don't face any difficulty in visiting the healthcare facilities alone. Similarly, the data has revealed the difficulty of availing healthcare facilities alone is faced differently with the difference of educational achievements.

Do the respondents feel shy in expressing their health needs in the family was asked to them and their response has again been found with the influence of education.

Table T34: Psychological barriers 2

Feel shy of expressing health needs in the family	Illiterate and less than primary (N=45)	%age	Primary and secondary literates (N=45)	%age	Higher secondary and graduates (N=45)	%age	Postgraduates and above (N=45)	%age
Always	14	31.11	10	22.22	8	17.77	3	6.66
Mostly	12	26.66	15	33.33	8	17.77	6	13.33
Sometimes	12	26.66	11	24.44	16	35.55	10	22.22
Never	7	15.55	9	20.00	13	28.88	26	57.77

57.77 % of the respondents who were illiterates or less than primary literates reported that they always or mostly feel shy in expressing their health needs in the family. In the table T34, it can be found as per the data the educated women at elevated levels feel free to express their health needs in the family. The data is evident that education has a pivotal and influential role in the psychological development and enhancing social position in the way of managing health.

2. Social Discrimination

As per the majority of the respondents the needs of the men are more fulfilled than the needs of women in the society. The data in the table T35 shows the opinion of the women respondents on the social barrier which they face in the society.

Table T35: Social Discrimination

Needs of men are fulfilled more than of women	Respondents (N = 180)	Percentage
Yes	113	62.77
No	55	30.55
No idea	12	6.66

Among all the participants 62.77 % of the respondents believed that the needs of women are underestimated as compared to the needs of men in society.

4.4.4.B Qualitative Data

1. Social Barriers

Educational Disparities

The respondents were asked as if the education of sons is preferred more than the education of the daughters. Majority of the respondents reported that equal treatment is given in educational opportunities and some of the respondents reported that the girl's education is not preferred much as boys of the family in some cases. To find the validity of the fact the question was asked about the highest qualification in the family so that to crosscheck the focus on the education with respect to gender. The narrations revealed that majority of the male members are more focussed and provided more educational support.

Table T36: Educational Disparities

Highest qualification in the family (Age group above 18)	Respondents (N=180)	Percentage
Male having highest qualification in the family	**108**	**60.00**
Female having highest qualification in family	**41**	**22.77**
Equal qualification	**31**	**17.22**

Among all the respondents 60% reported that the male member of their family is having the highest qualification in the family and only 22.77% reported that females are having the highest qualification in the family. As per 17.22% respondents there is equal qualification of both males and females of the family.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "My brother-in-law in studying in university and other females have discontinued their study."

Case 2 (Qualification category: Primary/Secondary): "My son is perusing MBA in Chandigarh, and my daughter is going to be married this year has discontinued her studies."

Case 3 (Qualification category: Primary/Secondary): "My husband is more educated than me and we have small school going children"

Case 4 (Qualification category: Primary/Secondary): My Husband has done Post graduation and is a govt. employee and I discontinued my studies as I have taken the household and field or orchard work responsibility since my childhood and still the whole household runs by me."

Case 5 (Qualification category: Higher Secondary/Graduation): "My brother is a PHD scholar, and I have done GNM."

Case 6 (Qualification category: Higher Secondary/Graduation): "My husband and his brother have both completed Post graduation which is highest in our family."

Case 7 (Qualification Category: Post graduation/Above): "I have completed my MA education and B-ED and my brother has done MCA."

Case 8 (Qualification Category: Post graduation/Above): "I have completed my MA Sociology from IGNOU and my both younger brothers are enrolled in colleges, one for the BA and other is pursuing his lab tech course outside J&K."

The narrations mentioned more about girls' education to be discontinued or less than the male members of the family. The inquiry was made to check overall trend of educational focus and investments in females of the society. In the narrations it has been observed that male members of the family are sent out of the station for studies and very few females went for out of the territory. We can simply conclude that it reveals the more focus on male education as compared to the female education. This inequality is likely to impact their health and wellness as education plays an important role in overall health outcomes, skills of management, treatment processes, the understanding and awareness of health-related facts.

Gender inequality:

The respondents were asked about some of the main reason for the discontinuation of girl's studies in the society. The respondents mentioned different reasons related to the categories presented in cross tabulation below in the table T36.

Table T36: Gender inequality:

Common reasons for the discontinuation of studies for girls	Respondents (N=180)	Percentage
Early marriage / discontinuation after marriage	**78**	**43.33**
Domestic responsibilities	**51**	**28.33**
Lack of economic support	**20**	**11.11**
Lack of interest	**23**	**12.77**
Family not focussing on girl education	**16**	**8.88**
No idea	**20**	**11.11**

As per the 43.33% of the respondents the early marriages are the main reason for discontinuation of girl's studies. The women have to disenroll themselves from educational institutes after getting married as they cannot study after being burdened with responsibilities and child care. Around 28.33% respondents opined that domestic work is day consuming work and with the responsibility of family and children the women do not find time to study or enroll themselves in any educational institute. Lack of economic support due to the bad financial condition at first costs girl's education as per 11.11% of the respondents. 12.77% believe in lack of interest of girls in education and for 8.88% respondents it is the discrimination of the family in focusing education of girls.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "My mother died when I was a child due to which I had to take the responsibility of home and was unable to continue my studies. Similarly, the women who discontinue studies is due to family responsibilities."

Case 2 (Qualification category: Primary/Secondary): "the financial conditions of the family impact the girl's studies."

Case 3 (Qualification category: Primary/Secondary): "those who have degrees are unemployed. The girl's loose interest in studies as they have to work at home also."

Case 4 (Qualification category: Primary/Secondary): "the girls after marriage have to take care of the family and after their marriage they can't study".

Case 5 (Qualification category: Higher Secondary/Graduation): "Early marriage is the reason for discontinuation of studies of girls."

Case 6 (Qualification category: Higher Secondary/Graduation): "The girls are considered as housewives, and they are not able to go out of the house to stay for nights on rented places like boys who are free to go even out of the state to study."

Case 7 (Qualification Category: Post graduation/Above): *"Marriage and family responsibilities on women make them to quit their studies."*

Case 8 (Qualification category: Post graduation/ Above): "it can be lack of money, early marriage or families less focus on the girls."

The reasons girls stop their education like getting married early, taking on household chores, not having enough financial support, and the lack of focus on their education highlights the problem and prevalence of gender. These challenges not only limit girls but also hold back progress for society as a whole. Education is a strong tool for change, helping girls gain confidence, improve their job opportunities, and enhance their overall health. Educated girls are more likely to make better choices about their health and their families' health. They often prioritize getting medical care, plan their families effectively, and seek help when they need it, leading to better health outcomes for themselves and their children. By focusing on girls' education and working to change attitudes that support gender inequality, we can build a generation of women who have the skills and knowledge to overcome these obstacles and who can live a healthy life.

2. Accessibility issues

The respondents were asked about the issues faced by them in health management which they responded, and their responds are being categorised in table T37 which shows the particular group of reasons mentioned the no. of times by the respondents in the cross tabulation.

Table T37: Accessibility issues

Issues in health management	Respondents (N = 180)	Percentage
Burden of domestic chores and childcare	79	43.88
Lack of financial assistance	56	31.11
Unable to visit the health facilities alone	21	11.66
Lack of health facilities	44	24.44
Lack of facilities to reach health centres	27	15.00
Illiteracy/ lack of knowledge	13	7.22
Unable to express	6	3.33
Double shift work	12	6.66
dependency on males	2	1.11
Complications during pregnancy	8	4.44
No such issues	5	2.77

As per the 43.88% respondents the women face issues in health management because of the domestic responsibilities and child care work in the family which hurdles them in accessing the proper healthcare management. For 24.44% respondents the health facilities related to women are not adequate which is hurdle in health management. 31.11% respondents agreed in pointing financial issues as reason for the lack of health management. The 15% of the respondents mentioned about the lack of facilities to reach the healthcare centres like lack of connectivity or remoteness. The 6% of the respondents feel the household work in addition to the paid work as one of the hurdles in managing health. 7.22% respondents reported that unawareness and lack of knowledge or being illiterate makes it difficult to understand the requirements and management of health. 11.66% respondents reported that visiting a health centre alone is difficult for the women and due to the dependency on others it is difficult at times to manage health. 3.33% believe that inability to express the needs is one of the reasons which hurdles health management for woman. 4.44% respondents talked about the complications which occur during pregnancy which are hard to manage.

Some notable narrations:

Case 1 (Qualification category: Less than primary): "women don't have much time due to the family responsibilities to take care of their own health".

Case 2 (Qualification category: Primary/Secondary): "The money is not always available for the treatment."

Case 3 (Qualification category: Primary/Secondary): "Sometimes the family do not support or ask for the health needs and a woman cannot take care of her health alone."

Case 4 (Qualification category: Primary/Secondary): "If no one in the family is available to take me to the hospital I can't visit a doctor alone".

Case 5 (Qualification category: Higher Secondary/Graduation): "A woman face some health issues which she cannot openly express."

Case 6 (Qualification category: Higher Secondary/Graduation): "I work in a hospital, and I found women facing issues of non-availability of female professionals like several women are uncomfortable in performing their ECG by the male professionals."

Case 7 (Qualification Category: Post graduation/Above): "The working women have to do the double shift of work at home and at the office which exhausts them and impacts their health."

Case 8 (Qualification category: Post graduation/ Above): "there are various issues faced by women in our society. They are dependent on men for financial and other support. During pregnancy they don't get proper nutrition and during their menstrual cycle several women have the load of work which effects their health."

The various issues in health management for women—such as the burden of domestic chores and child care, lack of financial support, limited access to health facilities, and low levels of education—show the significant challenges they face. These problems often prevent women from getting the healthcare they need and make it hard for them to speak up for their own health. The inability to express themselves, double shifts of work, reliance on men, and complications during pregnancy make their situations even more difficult. Education is key to address these issues. It empowers women with the knowledge and skills as they are more likely to understand health information, navigate healthcare systems, and communicate their needs effectively. Education helps women achieve financial independence, reducing their reliance on

men. This financial stability allows them to invest in their own health and that of their families. By breaking the cycle of illiteracy and ignorance, education leads to better job opportunities and improved access to healthcare services. Investing in women's education is crucial for tackling health-related issues. By promoting education for women, we can empower them to overcome barriers, improve their health, and enhance their overall quality of life.

3. Structure and facilities

The respondents were asked about their level of satisfaction about the availability of healthcare facilities. The narrations have mentioned about the lack of specialist facilities in nearby healthcare facilities as compared to the urban setup. The unavailability of medicines and other medical stuff needed in emergencies has been narrated by the respondents. The un-availability of female staff in all the facilities has been mentioned by some of the respondents who find it difficult to express some of the health issues and services from male staff. The educational system was also demanded to be more formal like in urban setups. The respondents narrated that those with good economic support enrol their children in better educational institutes which are far from the villages. The school education quality should be uniform for all as in the urban areas as per the narrations of some respondents observed in the research work. However, there was no such unequal treatment reported in educational institutes on the bases of gender, and it was narrated that there are equal opportunities of enrolment and education in the educational institutes for both boys and girls as per the narrations of the respondents. The table T38 shows the level of dis-satisfaction or satisfaction, or some issues needed to be overcome for their betterment in which these viewpoints given by the respondents are counted in each category of which they talked about.

Table T38: Structure and facilities

Viewpoints about the facilities	Respondents (N = 180)	Percentage
Lack of specialists in the health facilities	**43**	**23.88**
Lack of female or other technical staff in nearby health facilities	**27**	**15.00**
Lack of free drugs/services	**15**	**8.33**

Lack of instruments in health facilities	**28**	**15.55**
Lack of standard schools/mode of education	**18**	**10.00**
Lack of better connectivity/ remoteness	**25**	**13.88**
Satisfied with the facility	**36**	**20.00**
Unaware about the facilities	**16**	**8.88**

Some notable narrations:

Case 1 (Qualification category: Less than primary): *"The hospital is far away from our locality."*

Case 2 (Qualification category: Primary/Secondary): "The doctor for bone treatment (orthopaedic doctor) is not available in our nearby hospital."

Case 3 (Qualification category: Primary/Secondary): "I am satisfied as hospital is available where we get treatment, and many schools are available for the study of children."

Case 4 (Qualification category: Higher Secondary/Graduation): "The female staff must be available in all facilities of health centres."

Case 5 (Qualification category: Higher Secondary/Graduation): "The health centre near us must be having the facilities like the hospital."

Case 6 (Qualification Category: Post graduation/Above): "The specialist doctors like dermatologist, urologist, cardiologist should be available at sub district hospitals also and as far as the education system is concerned the government schools still lack the standard as of the private institutes."

Case 7 (Qualification category: Post graduation/ Above): "The reputed private schools are at a good distance for children and in this competitive time we need good institutes which are easily accessible to the children."

Case 7 (Qualification category: Post graduation/ Above): "the gynaecologist is not available particularly in the night times a woman can't find a gynaecologist in the hospitals freely."

The various viewpoints about health facilities reveal significant challenges for women, including the lack of specialists and female or technical staff, unavailability of free drugs and services, insufficient medical instruments, poor educational standards, and limited connectivity due to remoteness. While some women express satisfaction with the existing facilities, many remain unaware of the resources available to them. Education can play a vital role in addressing these issues specifically for women. By educating women about the health services available to them, they can learn about the resources they have and how to access them. This awareness can encourage more women to engage and get trained in health care services which can help women to reduce the difficulties faced by women. Raising educational standards for women can lead to better training for healthcare workers, allowing more women to join the medical field and provide care that meets their specific needs.

⟹ **Findings of previous studies:**

Subramanian & Kawachi (2004) discovered that social disparities, encompassing obstacles related to caste, socioeconomic status, and geographical placement, substantially impact women's ability to reach healthcare facilities in India. It underscored that among marginalized women, discrepancies in healthcare accessibility contribute to unfavourable health outcomes. Acharya et al., (2010), The study revealed that adherence to traditional gender roles, the stigma attached to reproductive health matters, and women limited decision-making authority impede their access to reproductive healthcare services, thereby leading to negative health consequences. S. Prinja et al., (2012) in their study investigated the difficulties in delivering healthcare in rural India and concluded that the absence of healthcare infrastructure, encompassing hospitals, clinics, and adequately trained medical personnel, substantially hampers rural communities' accessibility to vital healthcare services.

CHAPTER 5:

CONCLUSION AND SUGGESTIONS

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5.1 Conclusion

the research has found the fact that education is pivotal and influential in overall health of the rural women in Kashmir. The women with more elevated levels of education have been found with better health outcomes in comparison to the less educated women. Education provides knowledge and skills which enhances the health management of rural women. The importance of educational institutes and other institutes which are linked with educational achievements have been recognized as crucial for the management of health. The women with education have more awareness about the prevention and dealing with diseases. In cases of non-communicable diseases, lifestyle modification and proactive responses are important in dealing with different ailments. The educated women at higher levels are more able to deal with the diseases/ disorders which they or any of their family member suffer from. The less educated women find it difficult to understand the normal levels of blood sugar, blood pressure and heart rates which hurdles their health care and management and takes to the risk of worse health outcomes. The lack of knowledge leads to the ignorance of symptoms of diseases and health needs which proves dangerous for the health of these women. The educated women are able to deal in a better way in conditions of health distress. The highly educated women are more able to have access to electronic media and other internet sources giving them ample of information regarding health and wellness. The highly educated women are found with better knowledge of balanced diet as compared to the less educated women. The women who are better in education have better access to healthcare facilities and are more aware about the initiatives and provisions provided by the government for the health benefit of the women. Due to the lack of knowledge less educated women do not avail benefits of the services and facilities available to them. The economy is linked with education. The well qualified women are more likely to get paid with the access to jobs and other forms of business opportunities. The less educated women are more engaged in domestic work which remains unpaid and discriminates their life. Due to the domestic burden the women find less time for them in considering their own health needs and managing their requirements. The highly educated women are found more engaged with paid work and the for the less educated women lack economic assistance has been a hinderance in fulfilling their health needs. The process of health management constitutes the healthy diet,

diagnosis and treatment which is most of the time costly and requires monetary assistance. The women who lack education are dependent on others for monetary assistance are not able to manage their health. The women who are associated with educational institutes, training centres, workplaces are more connected to the people. The more social interaction gives them more social networks. Educated women at high levels have been found with more social and emotional support enhancing the better mental and overall health. Less educated women are found more isolated and lack the social and emotional support which is important for being healthy. The women with high level of education have been found with more social freedom. The less educated women find difficulties in sharing their body needs and are not able to express their health distress freely. the health behaviour of the highly educated women has been found as better than the less educated women. The women at the elevated levels of education are better focused on physical activities, balanced diet and health hygiene at their day-to-day life. The well-educated women are more aware about the menstrual health management and are more skilful to manage health. These women provide a good healthy environment surrounding them. The less educated women also face difficulties to visit the healthcare facilities alone. The health care facilities are more accessed by those women who possess high level of education. Women in rural areas face difficulties and limited social environment in which they are discriminated and marginalized which poses serious threat to their health and wellbeing. The research has found the fact that education enable women to overcome the crises and social pressure and provide knowledge and abilities to manage health and develops positive health behaviours and in conclusion provides better health outcomes for women in rural areas of Kashmir.

5.2 Suggestions

1. Education of the girls needs to be prioritized as it is crucial for the women empowerment and overall wellbeing.
2. Health literacy is important in bringing better health results. The women should be made more aware about the health management in rural areas with the proper implementation and communication of health literacy schemes.
3. More awareness programs should reach the rural population as several benefits and availabilities remain non-accessible due to the lack of awareness.

4. The domestic work labelled to be the work of women needs to be valued. The implications and consequences of unpaid work should be highlighted in society.
5. The female staff should be provided at the healthcare facilities where women hesitate to express their needs.
6. The workshops should be initiated in providing knowledge about menstrual hygiene management and other health issues where women are shy to express their needs.
7. More facilities should be advanced in structures like infrastructure and equipment, services in healthcare and connectivity to the rural setups.
8. The value of education in health outcomes needs to be communicated to the masses.
9. Mobile health clinics needs to be promoted in rural areas.
10. Counselling of people is pivotal in promoting education.

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APPENDICES

APPENDICES

INTERVIEW SCHEDULE

OBJECTIVES OF THE STUDY: -

1. To study the relation between the level of education and health outcomes for rural women.
2. To analyse the factors that impacts the health outcomes of rural women.
3. To understand the health behaviour of rural women.
4. To find out the challenges of rural women regarding health.

ETHICAL CONSIDERATION: -

Greetings

My name is AKEEL NAVEED RAJA (Research Scholar Lovely Professional University). My research is titled as "Impact of education on women health, a sociological study of rural women in Kashmir". The research needs your valuable time and factual information regarding your health, education and social life.

May I have your permission to use this information provided by you in this interview? May I use this gathered data in research analysis, research outcomes and publications? This information is purely needed to gather the facts inquiring the link between education and health among the rural women in their social setup. Your details are ensured with privacy and confidentiality and will not be exposed in public domains.

Are you comfortable in giving me some time and answering few questions related to your personal health, its management and outcomes in this regard?

Details of Agreed Respondent

Name…….……

Address…….

Socio-Demographic Profile

Level of Educational Qualification: -

Illiterate & less than primary

Primary & secondary literates ☐

Higher secondary &graduates

Postgraduate & above ☐

Kindly mention the Qualification also ……

Age: - 30 – 40 ☐ 41 – 50 ☐ 51 – 60 ☐

Occupation: - Home Maker ☐ Paid Work ☐ Other ☐

Marital Status: - Married ☐ Unmarried

Family structure: - Nuclear ☐ Joint

Family Head: - Male ☐ Female ☐

1. Relation between the level of education and health outcomes for rural women.

Q1: - Do you suffer from any disease/disorder?

Yes ☐ No

Q2: - How aware are you about the disease which you or other member of your family suffers from?

Completely Aware ☐ Partially Aware ☐ Unaware ☐ No Such condition

Q3: - How aware are you about the various services available for you in nearest health center?

Complete Aware ☐ Mostly Aware ☐ Rarely Aware ☐ Completely Unaware

Q4: - What do you know about non-communicable diseases (Diabetes, Hypertension and other CVDS etc.)?

……

……

Q5: - Do you have any idea about the level of normal blood sugar, blood pressure and heart rate?

……

……

Q6: - What do you know about various Government initiatives/Schemes framed for the welfare of women and girl child?

……

……

Q7: - What do you know about the various governmental initiatives/schemes framed for the welfare of women?

……

…….

Q8: - Are you aware about the work/facility of ASHA available in your locality?

Yes ☐ No ☐ Not Available

Q9: - From where do you get knowledge about health and wellness?

……

…….

Q10: - Do you have any idea about nutritional compositions of different foods?

……

…….

Q11:- What do you know about balanced diet?

……

……..

Q12: - Does educational institutes play important role in management of health?

Yes ☐ No ☐ No Idea ☐

2. Factors impacting the health outcomes of rural women.

Q13- Who manages your health needs when you are sick?

……

…….

Q14: - who pays your health expenses?

Myself ☐ Male Member of Family ☐ Female Member of family ☐ Others ☐
No One

Q15: - With whom do you share about your body needs and health distress?

……

……

Q16: - How often you feel isolated for which you need emotional and social support?

Always ☐ Mostly ☐ Sometimes ☐ Never ☐ Q17:

- Do you feel stress of anything?

……

…….

Q18: - Does educational institution/workplace give more social and emotional support than being at home?

Always ☐ Mostly ☐ Sometimes ☐ Never ☐ I don't know

Q19: Does lack of economic assistance hinders your health checkups and needs?

Always ☐ Mostly ☐ Sometimes ☐ Never

Q20: - Who does most of your family's domestic work?

Myself ☐ Other females of family ☐ Males family members ☐ Paid worker

Q21: - Does domestic work which remains unpaid & labeled for women, discriminate their life?

……

…….

3. Health behaviour of rural women.

Q22: - Do you indulge in tobacco addiction or any other intoxication?

Yes, ☐ No ☐ A few times ☐

Q23: - Does lifestyle modification have any part in management of NCDs like diabetes, Hypertension etc.?

……

……..

Q24: - What steps do you take in prevention of these lifestyle diseases like diabetes and hypertension?

……

……..

Q25: - How often you visit the health facilities during your health distress?

Always ☐ Mostly ☐ Sometimes ☐ Never

Q26: - When was the last time when you visited any clinical laboratory for diagnostics/investigations?

……

……

Q26: How frequently you take part in physical activities like walking and exercise? Daily

Once/twice in a week ☐ Once/Twice in a month ☐ Never Q27: - What ☐

you suggest to those who fall sick in your family?

……

…….

Q28: -what do you know about menstrual health management?

……

……

Q29: - who purchases menstrual products for you?

My Self ☐ Family Member ☐ Others ☐ No one ☐

4. Challenges of rural women regarding health.

Q30: - Do you find it difficult to visit the healthcare centre alone?

Yes ☐ No ☐ Sometimes

Q31: - How often you feel shy in expressing your health needs in the family?

Always ☐ Mostly ☐ Sometimes ☐ Never

Q32: - Do you feel that the needs of the women are not fulfilled as compared to men in a family?

Yes ☐ No ☐ Idea ☐

Q33: - Do you feel education for sons is preferred over daughters?

……

…….

Q34:- What the highest qualification among the female members of your family?

……
……

Q35: What is the highest qualification among the male members of your family?

……
……..

Q36: - Any Disenrollment from educational institute of any member of family. If yes, Mention reason?

……
……

Q37: - What is the main reason for discontinuation of studies for girls?

……
……..

Q38: - How satisfied/dissatisfied are you with the education system/facilities available for women near you?

……
……

Q39: - How satisfied/dissatisfied are you with the healthcare facilities available for women near you?

……
…….

Q40: - Are there any common reasons due to which women are not able to maintain good health?

……
……

Form 3A

National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for NCD Clinic at Community Health Centre (CHC)/ Sub District Hospital(SDH)

Name and Address of the SDH / CHC /Block/ Taluk/ Mandal/ Zone____Yaripora_____ District_____kulgam_____State_____J&K_____

Month__ August _____ Year_____2023

Indicator		During the Reporting Month		
		Male	Female	Total
		159	470	629
I. Common NCDS under NPCDCS				
2. No. newly diagnosed with	A. Diabetes Only	2	7	9
	B. Hypertension Only	0	1	1
	C. HTN & DM	0	1	1
3. No. of persons suspected and referred for	A. Cardiovascular diseases	0	0	0
	B. Stroke	0	0	0
	C. Oral Cancer	0	0	0
	D. Breast cancer	0	0	0
	E. Cervical cancer	0	0	0
	F. Other cancers	0	0	0
4. No. of newly diagnosed patients initiated on treatment	A. Diabetes Only	2	7	9
	B. Hypertension Only	0	1	1
	C. HTN & DM	0	1	1
5. Patients on treatment Follow Up	A. Diabetes Only	93	239	332
	B. Hypertension Only	22	47	69
	C. HTN & DM	42	140	182
6. Total No. of persons referred to District Hospital/ Higher Centres		0	0	0
7. No. of persons counselled for health promotion & prevention of NCD		94	151	245
333				
8. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (5A+5C)]	A. No. of known TB cases on ATT	0	0	0
	B. No. screened for TB Symptoms	30	52	82
	C. No. suspected for TB & refered to DMC/ PI	0	0	0

Signature:
Name and Designation Dr Shahnawaz Bandh (Physician NCD)
Date of reporting_____26-07-2023_____

**This report should be generated from CHC OPD screening data.*
This report should be verified and signed by Medical Officer I/c CHC.
This report should be sent to District NCD Cell by 7th day of every month.

Dr Shahnawaz Ahmad Bandh
General Practitioner
Reg. No. MCI-13-50492
J&K-12971

Form 3A

National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for NCD Clinic at Community Health Centre (CHC)/ Sub District Hospital(SDH)

Name and Address of the SDH / CHC /Block/ Taluk/ Mandal/ Zone____Yaripora_____ District_____kulgam_____State_____J&K_____

Month__ September _____ Year_____2023

Indicator		During the Reporting Month		
		Male	Female	Total
		178	517	695
I. Common NCDS under NPCDCS				
2. No. newly diagnosed with	A. Diabetes Only	1	5	6
	B. Hypertension Only	1	0	1
	C. HTN & DM	0	1	1
3. No. of persons suspected and referred for	A. Cardiovascular diseases	0	0	0
	B. Stroke	0	0	0
	C. Oral Cancer	0	0	0
	D. Breast cancer	0	0	0
	E. Cervical cancer	0	0	0
	F. Other cancers	0	0	0
4. No. of newly diagnosed patients initiated on treatment	A. Diabetes Only	1	5	6
	B. Hypertension Only	1	0	1
	C. HTN & DM	0	1	1
5. Patients on treatment Follow Up	A. Diabetes Only	108	297	405
	B. Hypertension Only	17	33	50
	C. HTN & DM	45	125	172
6. Total No. of persons referred to District Hospital/ Higher Centres		0	0	0
7. No. of persons counselled for health promotion & prevention of NCD		98	160	258
333				
8. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (5A+5C)]	A. No. of known TB cases on ATT	0	0	0
	B. No. screened for TB Symptoms	40	62	102
	C. No. suspected for TB & refered to DMC/ PI	0	0	0

Signature:
Name and Designation Dr Shahnawaz Bandh (Physician NCD)
Date of reporting_____26-07-2023_____

**This report should be generated from CHC OPD screening data.*
This report should be verified and signed by Medical Officer I/c CHC.
This report should be sent to District NCD Cell by 7th day of every month.

Dr Shahnawaz Ahmad Bandh
General Practitioner
Reg. No. MCI-13-50492
J&K-12971

Form 5B
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)
Reporting performa (Institution Level)

Name and Address of the District NCD Cell
CHC Yaripora
Month Of.....August .....Year 2023

Block____Yaripora_____ State____J&K_____

Part A : Screening for HTN and Diabetes

Source Of Data	Total NCD Checkups Done			No. of new persons Suspected for DM and refered			No. of new persons Suspected for HTN and			No. of known cases of DM on Follow-up			No. of known cases of HTN		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Compiled data from all CHC's	579	710	1289	19	26	45	22	26	48	100	126	226	18	219	219

PART B: Screening for Common Cancers

Source of Data	No. of persons screened for Cancers			No. of persons suspected with Cancer and refered to PHC/ CHC/ other GH					No. of Known Cancer patients		
				Oral			Breast	Cervical	Total			
	Male	Female	Total	Male	Female	Total				Male	Female	Total
Compiled data from all CHC's	362	483	845	0	0	0	0	0	0	3	5	8

B1. Other Programme Markers (Compiled data of Population based Screening (PBS))

	Indicator	During the Reporting Month			Cummulative since April (Finanacial Year Data)		
		Male	Female	Total	Male	Female	Total
Total NCD Checkups Done							
Total No. Of Persons Suspected and refered for	Diabetes only	47	150	197	195	321	516
	Hypertension Only	58	54	112	259	257	516
	HTN & DM (Both)	76	152	228	292	287	579
	Oral Cancers	0	0	0	0	0	0
	Breast Cancers	0	0	0	0	0	0
	Cervical Cancers	0	0	0	0	0	0
	Other Cancers	0	0	0	0	0	0
No. of diagnosed patients on follow up in PHC and Sub centres	Diabetes only	97	134	231	346	439	785
	Hypertension Only	162	188	350	749	584	1333
	HTN & DM (Both)	48	53	101	344	230	574
	Oral Cancers	0	0	0	0	0	0
	Breast Cancers	0	0	0	0	0	0
	Cervical Cancers	0	0	0	0	0	0
	Other Cancers	0	2	2	0	2	2

Signature:
Name and DesignationSheikh Muzaffar (BMEO)
Date of reporting_____26-09-2023_____
*This report should be generated by compiling data of Form 3B of all Blocks/Mandals/Taluks under the District
This report should be verified and signed by District Nodal Officer.
This report should be sent to State NCD Cell by 10th day of every month.

Sheikh Muzaffar
Block Monitoring & Evaluation
Officer Yanpora
08/09/2023

Form 5B
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)
Reporting performa (Institution Level)

Name and Address of the District NCD Cell
CHC Yaripora
Month Of... September .....Year 2023

Block____Yaripora_____ State____J&K_____

Part A : Screening for HTN and Diabetes

Source Of Data	Total NCD Checkups Done			No. of new persons Suspected for DM and refered			No. of new persons Suspected for HTN and			No. of known cases of DM on Follow-up			No. of known cases of HTN		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Compiled data from all CHC's	597	708	1305	6	12	18	13	18	31	84	122	206	184	223	407

PART B: Screening for Common Cancers

Source of Data	No. of persons screened for Cancers			No. of persons suspected with Cancer and refered to PHC/ CHC/ other GH					No. of Known Cancer patients		
				Oral			Breast	Cervical	Total			
	Male	Female	Total	Male	Female	Total				Male	Female	Total
Compiled data from all CHC's	294	325	619	0	0	0	0	0	0	3	5	8

B1. Other Programme Markers (Compiled data of Population based Screening (PBS))

	Indicator	During the Reporting Month			Cummulative since April (Finanacial Year Data)		
		Male	Female	Total	Male	Female	Total
Total NCD Checkups Done		264	377	641	2449	2497	4946
Total No. Of Persons Suspected and refered for	Diabetes only	6	15	21	201	336	537
	Hypertension Only	14	18	32	273	275	548
	HTN & DM (Both)	6	6	12	298	293	591
	Oral Cancers	0	0	0	0	0	0
	Breast Cancers	0	0	0	0	0	0
	Cervical Cancers	0	0	0	0	0	0
	Other Cancers	0	0	0	0	0	0
No. of diagnosed patients on follow up in PHC and Sub centres	Diabetes only	59	117	176	405	556	961
	Hypertension Only	153	196	349	902	780	1680
	HTN & DM (Both)	26	25	51	370	255	595
	Oral Cancers	0	0	0	0	0	0
	Breast Cancers	0	0	0	0	0	0
	Cervical Cancers	0	0	0	0	0	0
	Other Cancers	0	0	0	0	2	2

Signature:
Name and Designation Sheikh Muzaffar /BMEO
Date of reporting_____26-09-2023_____
*This report should be generated by compiling data of Form 3B of all Blocks/Mandals/Taluks under the District
*This report should be verified and signed by District Nodal Officer.

Sheikh Muzaffar
Block Monitoring & Evaluation
Officer Yanpora