FACT SHEET, JAMMU AND KASHMIR
NATIONAL FAMILY HEALTH SURVEY, 1999

Sample Size

Households	2,786
Ever-married women age 15–49	2,744

Characteristics of Households

Percent with electricity	90.1
Percent within 15 minutes of safe water supply[1]	62.3
Percent with flush toilet	22.2
Percent with no toilet facility	49.0
Percent using govt. health facilities for sickness	49.8
Percent using iodized salt (at least 15 ppm)	52.9

Characteristics of Women[2]

Percent urban	21.5
Percent illiterate	69.8
Percent completed high school and above	11.9
Percent Hindu	41.6
Percent Muslim	56.5
Percent Sikh	1.5
Percent regularly exposed to mass media	74.4
Percent working in the past 12 months	42.4

Status of Women[2]

Percent involved in decisions about own health	55.5
Percent with control over some money	58.1

Marriage

Percent never married among women age 15–19	91.5
Median age at marriage among women age 20–49	18.7

Fertility and Fertility Preferences

Total fertility rate (for the past 3 years)	2.71
Mean number of children ever born to all women 40–49	4.79
Median age at first birth among women age 25–49	20.3
Percent of births[3] of order 3 and above	50.3
Mean ideal number of children[4]	2.7
Percent of women with 2 living children wanting another child	30.9

Current Contraceptive Use[5]

Any method	49.1
Any modern method	41.7
Pill	3.3
IUD	3.0
Condom	4.8
Female sterilization	28.0
Male sterilization	2.7
Any traditional method	6.8
Rhythm/safe period	1.8
Withdrawal	4.9
Other traditional or modern method	0.6

Unmet Need for Family Planning[5]

Percent with unmet need for family planning	20.0
Percent with unmet need for spacing	7.4

[1]Water from pipes, handpump, covered well, or tanker truck
[2]Ever-married women age 15–49
[3]For births in the past 3 years
[4]Excluding women giving non-numeric responses
[5]Among currently married women age 15–49

Quality of Family Planning Services[6]

Percent told about side effects of method	9.1
Percent who received follow-up services	79.5

Childhood Mortality

Infant mortality rate[7]	65.0
Under-five mortality rate[7]	80.1

Safe Motherhood and Women's Reproductive Health

Percent of births[8] within 24 months of previous birth	24.9
Percent of births[3] whose mothers received:	
Antenatal check-up from a health professional	83.0
Antenatal check-up in first trimester	47.9
Two or more tetanus toxoid injections	77.7
Iron and folic acid tablets or syrup	70.8
Percent of births[3] whose mothers were assisted at delivery by a:	
Doctor	33.8
ANM/Nurse/midwife/LHV	6.7
Traditional birth attendant	50.0
Percent[5] reporting at least one reproductive health problem	60.5

Awareness of AIDS

Percent of women[2] who have heard of AIDS	31.9

Child Health

Percent of children age 0–3 months exclusively breastfed	41.5
Median duration of breastfeeding (months)	29.5
Percent of children[9] who received vaccinations:	
BCG	85.6
DPT (3 doses)	72.3
Polio (3 doses)	74.3
Measles	68.9
All vaccinations	56.7
Percent of children[10] with diarrhoea in the past 2 weeks who received oral rehydration salts (ORS)	47.5
Percent of children[10] with acute respiratory infection in the past 2 weeks taken to a health facility or provider	76.2

Nutrition

Percent of women with anaemia[11]	58.7
Percent of women with moderate/severe anaemia[11]	19.4
Percent of children age 6–35 months with anaemia[11]	71.1
Percent of children age 6–35 months with moderate/severe anaemia[11]	42.0
Percent of children chronically undernourished (stunted)[12]	38.8
Percent of children acutely undernourished (wasted)[12]	11.8
Percent of children underweight[12]	34.5

[6]For current users of modern methods
[7]For the 5 years preceding the survey (1994–98)
[8]For births in the past 5 years (excluding first births)
[9]Children age 12–23 months
[10]Children under 3 years
[11]Anaemia–haemoglobin level < 11.0 grams/decilitre (g/dl) for children and pregnant women and < 12.0 g/dl for nonpregnant women. Moderate/severe anaemia –haemoglobin level < 10.0 g/dl.
[12]Stunting assessed by height-for-age, wasting assessed by weight-for-height, underweight assessed by weight-for-age

SUMMARY OF FINDINGS

The second National Family Health Survey (NFHS-2), conducted in 1998–99, provides information on fertility, mortality, family planning, and important aspects of health, nutrition, and health care. The International Institute for Population Sciences (IIPS) coordinated the survey, which collected information from a nationally representative sample of 90,303 ever-married women age 15–49 from all 26 states of India at the time of the survey. These states comprise more than 99 percent of India's population.

IIPS also coordinated the first National Family Health Survey (NFHS-1) in 1992–93. Most of the types of information collected in NFHS-2 were also collected in the earlier survey. In addition, the NFHS-2 questionnaire covered a number of new or expanded topics with important policy implications, such as reproductive health, women's autonomy, domestic violence, women's nutrition, anaemia, and salt iodization.

The sample for the survey in Jammu and Kashmir was originally designed to provide estimates for the whole state, for its urban and rural areas, and for its two administrative regions of Jammu and Kashmir. However, due to national security concerns, all of the selected primary sampling units (PSUs) from the Rajouri, Poonch, and Doda districts in the Jammu region had to be replaced with PSUs from the remaining districts of the same region. In addition, the single selected PSU in the Kargil district of Kashmir had also to be replaced for the same reason. Thus the sample which was finally implemented is not strictly representative of the entire state of Jammu and Kashmir. In addition, estimates for the Jammu region are not representative of the region as a whole, since only three of its six districts (65 percent of the region's population) were covered by the survey.

In Jammu and Kashmir, NFHS-2 field staff collected information from 2,786 households between 22 April 1999 and 20 September 1999, and interviewed 2,744 eligible women in these households. In addition, the survey collected information on 1,107 children born to eligible women in the three years preceding the survey. One health investigator on each survey team measured the height and weight of eligible women and young children and took blood samples to assess the prevalence of anaemia.

Background Characteristics of the Survey Population

Seventy-nine percent of the Jammu and Kashmir population lives in rural areas. The age distribution is typical of high-fertility populations that have recently experienced some fertility decline, with relatively high proportions in the younger age groups and a slightly smaller proportion age 0–4 than age 5–9. Thirty-seven percent of the population is below age 15 and 5 percent is age 65 and above. The overall sex ratio for the *de facto* population is 955 females for every 1,000 males. The sex ratio is 969 in rural areas and 902 in urban areas, suggesting that rural to urban migration in Jammu and Kashmir has been dominated by males.

The survey provides information on a variety of demographic and socioeconomic background characteristics. In the state, 53 percent of household heads are Muslim, 45 percent are Hindu, 2 percent are Sikh, and less than 1 percent are of other religions. Fifteen percent of household heads belong to the scheduled castes, 11 percent belong to the other backward classes (OBCs), and 3 percent belong to the scheduled tribes. Seventy-two percent of household heads do not belong to any of these groups.

Questions about housing conditions and the standard of living of household members reveal that 90 percent of households in Jammu and Kashmir have electricity, 59 percent have piped drinking water, and 22 percent have flush toilets. Seventy-one percent of households in urban areas have a flush toilet compared with only 7 percent in rural areas. While the vast majority (80 percent) of households in the Jammu region do not have any toilet facility, a similar majority (82 percent) of household in the Kashmir region have toilet facilities, mostly pit toilets or latrines. Access to piped drinking water is also more common among households in the Kashmir region than in the Jammu region.

Sixty-nine percent of males and 45 percent of females age six and above are literate. The corresponding provisional estimates from the 2001 Census for male and female literacy rates for Jammu and Kashmir as a whole are 66 and 42 percent, respectively. Eighty-four percent of children age 6–14 currently attend school. Girls lag behind boys in school attendance at all ages and this disparity in school attendance by sex grows with increasing age of children. At age 6–10, 91 percent of boys and 82 percent of girls attend school. By age 15–17, 70 percent of boys attend school, compared with only 47 percent of girls.

Women in Jammu and Kashmir tend to marry later than women in India as a whole. In Jammu and Kashmir, only 8 percent of women age 15–19 are already married, compared with 34 percent in the country as a whole. Older women are more likely than younger women to have married at an early age: 32 percent of women who are now age 45–49 married before they were 15, compared with only 1 percent of women who are now age 15–19. Although this finding indicates that the proportion of women who marry young has declined rapidly, approximately two out of five women in Jammu and Kashmir still marry before reaching the legal minimum age of 18 years. Even among women currently age 20–24, one-fifth were married before age 18 years. On average, women are five years younger than the men they marry.

As part of an increasing emphasis on gender issues in NFHS-2, the survey asked women about their participation in household decisionmaking. In Jammu and Kashmir, the vast majority of women (88 percent) are involved in decisionmaking on at least one of four selected topics. Over half the women (56 percent) are involved in making decisions about their own health care but only one-fourth make these decisions by themselves. Only about one-tenth of women do not need permission to go to the market or to visit friends or relatives. Women's labour force participation is limited. Only 42 percent of women do work other than their own housework, and only 31 percent of working women work for cash. Two-third of the women who earn cash can decide independently how to spend the money that they earn. One-fourth of working women who earn cash report that their earnings constitute at least half of total family earnings, including 5 percent who report that the family is entirely dependent on their earnings.

Fertility and Family Planning

Fertility continues to decline in Jammu and Kashmir. At current fertility levels, women will have an average of 2.71 children each throughout their childbearing years. By contrast, women who are currently age 40–49 have an average of 4.79 children each. Efforts to encourage the trend toward lower fertility might usefully focus on groups within the population that have higher fertility than average. In Jammu and Kashmir, women from households with a low standard of living, women who belong to the scheduled tribes, the scheduled castes, and the other backward classes, and illiterate women have higher fertility than other women. The fertility rates in the

Jammu and Kashmir regions of the state are similar (2.9 and 2.7, respectively). Although fertility differentials continue to exist between various population groups, there is evidence that significant strides are being made. Studies in India and elsewhere have shown that health and mortality risks increase when women give birth at young ages—both for the women themselves and for their children. Among women age 25–49 in Jammu and Kashmir, the median age at first birth is now 20.3 years (one year higher than the average for India as a whole), and women age 15–19 account for 8 percent of total fertility.

The appropriate design of family planning programmes depends, to a large extent, on women's fertility preferences. Women may have large families because they want many children, or they may prefer small families but, for a variety of reasons, may have more children than they actually want. For 16 percent of births over the three years preceding NFHS-2, mothers report that they did not want the pregnancy at all, and for another 16 percent of births, mothers say that they would have preferred to delay the pregnancy. Thus, one-third of all births in the state in the three years preceding the survey were either not wanted or were mistimed. When asked about their preferred family size, 43 percent of women who already have three living children and 29 percent of women with four or more living children said that they consider the two-child family to be ideal. This gap between women's actual fertility experience and what they want or would consider ideal suggests a need for expanded or improved family welfare services to help women achieve their fertility goals. In Jammu and Kashmir, 88 percent of women want at least one son and 83 percent want at least one daughter. A strong preference for sons is indicated by the fact that 40 percent of women who have no daughters want no more children, whereas only 17 percent of women who have no sons want no more children.

If women in Jammu and Kashmir are not using family planning, it is not due to lack of knowledge. Knowledge of contraception is virtually universal. Women are most familiar with female sterilization (98 percent), followed by male sterilization (almost 94 percent), the pill (82 percent) and the condom and the IUD (each 77 percent). Fifty-four percent of women know of at least one traditional method. Although knowledge of all methods is widespread, there remains a sizable gap between knowledge and use.

Forty-nine percent of married women are currently using some method of contraception, about the same as the NFHS-2 national level of 48 percent. Contraceptive prevalence is higher in urban areas (68 percent) than in rural areas (44 percent). Female sterilization is by far the most popular method: it is used by 57 percent of all current contraceptive users. The prevalence of female sterilization is much higher in urban areas (38 percent) than in rural areas (25 percent). Overall, only 3 percent of women report that their husbands are sterilized. Use rates for the pill, IUD, and condom remain low at 3, 3, and 5 percent, respectively. Seven percent of women report that they are currently using traditional methods, mostly withdrawal.

There are notable variations in contraceptive prevalence among socioeconomic groups. Contraceptive prevalence increases with education and even more sharply with household standard of living. It is much higher for urban women, Sikh women, women with three living children, and scheduled-caste women than most other women. Sikh women, more educated women, urban women, women from households with a high standard of living, and women with one or two children with one son are more likely than other women to use the three modern spacing methods (pills, IUDs, and condoms). However, no more than 34 percent of women in any socioeconomic group use these methods.

Given the strong emphasis on sterilization, women tend to adopt family planning only after they have achieved their desired family size. As a result, contraceptive use can be expected to rise steadily with age and with the number of living children. In Jammu and Kashmir, contraceptive use does indeed go up with age, peaking at 67 percent for women age 35–39. Use also goes up with the number of living children, peaking at 65 percent for women with three children. Son preference appears to have some effect on contraceptive use. Women who have one or more sons are generally more likely to use contraception than are women who have the same number of children but have only daughters. For example, among women with three living children, current use of contraception rises sharply from 37 percent among those with no sons to 79 percent among those with three sons.

Seven percent of currently married women are not using contraception but say that they want to wait at least two years before having another child. Another 13 percent are not using contraception although they do not want any more children. These women are described as having an 'unmet need' for family planning. The unmet need is highest (43 percent) for women age 15–19 who have a strong interest in spacing their births. Notably, women with one living child also have a high unmet need (25 percent), due primarily to the need for spacing. These results underscore the need for strategies that provide spacing as well as terminal contraceptive methods in order to meet the changing needs of women over their lifecycle.

For many years, the Government of India has been using electronic and other mass media to promote family planning. In Jammu and Kashmir, 99 percent of rural respondents live in villages that are electrified but only 6 percent live in villages that have a cable connection. Although only 2 percent live in villages that have a community television, about two-fifths of rural households and the majority of urban households own a television. Among the different types of media, television and radio have the broadest reach across all categories of women. Overall, 58 percent of ever-married women listen to the radio at least once a week and 55 percent watch television at least once a week. Nevertheless, 26 percent of ever-married women are not regularly exposed to television, radio, or other types of media. Sixty-one percent of women saw or heard a family planning message in the media during the few months preceding the survey. Radio, television, and wall paintings or hoardings are the primary sources of these messages. Exposure to family planning messages is much lower than average for women from households with a low standard of living, women in the Kashmir region, Muslim women, illiterate women, scheduled-tribe women, and women who have never used contraception.

Sixty-nine percent of women who use modern contraception obtained their method from a government hospital or other source in the public sector and 23 percent obtained their method from the private medical sector. More than four out of five female and male sterilizations are conducted in the public medical sector. The private medical sector is the major source for pills, and is also an important source for IUDs and condoms. In general, the private medical sector has a larger role in urban areas (where it is the source of modern methods for 29 percent of users) than in rural areas (where it is the source of modern methods for only 20 percent of users).

An important indication of the quality of family planning services is the information that women receive when they obtain contraception and the extent to which they receive follow-up services after accepting contraception. In Jammu and Kashmir, only 16 percent of users of modern contraceptives who were motivated by someone to use their method were told about any other method by that person. Moreover, at the time of adopting the method, only 9 percent were

told by a health or family planning worker about possible side effects of the method they adopted. Eighty percent of the users of modern contraceptive methods received follow-up services after accepting the method. However, this high rate of follow-up is due primarily to high follow-up for sterilization (88 percent) than for other modern methods (55 percent).

From the information provided in NFHS-2, a picture emerges of relatively late marriage, considerable contraceptive use especially among women with two or more children, and a falling fertility rate in Jammu and Kashmir. Nonetheless, younger women still have high unmet need for spacing, contraceptive use is dominated by sterilization with a relatively low median age at sterilization (28 years), one-fourth of births take place within 24 months of a previous birth, and the desire for more children and contraceptive use appear to be strongly affected by son preference.

Infant and Child Mortality

NFHS-2 provides estimates of infant and child mortality and factors associated with the survival of young children. During the five years preceding the survey, the infant mortality rate was 65 deaths at age 0–11 months per 1,000 live births, about the same as for India as a whole (68). The neonatal mortality rate at 40 per 1,000 live births and the child mortality rate at 16 deaths at age 1–4 years per 1,000 children reaching age one are both lower than the respective all-India averages. Nonetheless, 1 in 15 children in Jammu and Kashmir die in the first year of life, and 1 in 12 die before reaching age five. All rates except the neonatal mortality rate, are higher in the rural areas than in the urban areas. Child-survival programmes might usefully focus on specific groups of children with particularly high infant and child mortality rates, such as children from other backward classes, children from households with a low or medium standard of living, and children of illiterate and less-educated women. Infant and child mortality rates do not vary much by region.

Along with various socioeconomic groups, efforts to promote child survival need to concentrate on very young mothers, mothers whose births are closely spaced, and children born at birth orders four or higher. Infant mortality is at least 28 percent higher among children born to mothers under age 20 than to older mothers. Infant mortality is at least three times as high among children born less than 24 months after a previous birth as among children born 48 months or more after a previous birth. Clearly, efforts to expand the use of temporary contraceptive methods for delaying and spacing births would help reduce infant mortality as well as fertility.

Health and Health Care

Promotion of maternal and child health has been one of the most important components of the Reproductive and Child Health Programme of the Government of India. One goal is for each pregnant woman to receive at least three antenatal check-ups plus two tetanus toxoid injections and a full course of iron and folic acid supplementation. In Jammu and Kashmir, mothers of 83 percent of the children born in the three years preceding NFHS-2 received at least one antenatal check-up (much higher than the national level of 65 percent), and mothers of 66 percent of children received at least three antenatal check-ups. Seventy-one percent of women received iron and folic acid supplementation during their pregnancies, the majority receiving an adequate supply and consuming the supply they receive. An even higher proportion of mothers received the recommended number of tetanus toxoid vaccinations (78 percent). Women in disadvantaged

socioeconomic groups, in particular, illiterate women and women with a low standard of living, are less likely than other women to be covered by each of the three recommended types of antenatal care. Although there is not much difference by region in antenatal care coverage, women in the Jammu region are somewhat less likely than women in the Kashmir region to have received an antenatal check-up.

The Reproductive and Child Health Programme encourages women to deliver in a medical facility or, if at home, with assistance from a trained health professional and to receive at least three check-ups after delivery. During the three years preceding NFHS-2, only 36 percent of births in Jammu and Kashmir were delivered in a medical facility. Fifty-one percent were delivered in the woman's own home and 12 percent in her parents' home. Trained health professionals assisted with the delivery in 42 percent of cases. Fifty percent of deliveries were assisted by a *dai* (a traditional birth attendant) and 7 percent were attended only by relatives, friends, and other persons who were not health professionals. Only 11 percent of births delivered at home were assisted by a health professional. Postpartum check-ups are not common for noninstitutional births in Jammu and Kashmir. Only 28 percent of births that took place outside a medical facility were followed by a postpartum check-up within two months of delivery. Overall, these results show that health services during pregnancy are reaching a large majority of women in Jammu and Kashmir; however, most women are not receiving health services during delivery and in the postpartum period.

The Government of India recommends that breastfeeding should begin immediately after childbirth and that infants should be exclusively breastfed for about the first four months of life. Although breastfeeding is widely practiced in Jammu and Kashmir, only 21 percent of infants begin breastfeeding within the first hour after birth. A much higher percentage (59 percent) begin breastfeeding within one day of birth. For 77 percent of births, mothers squeeze the first milk (colostrum) from the breast before breastfeeding begins, thereby depriving the baby of natural immunity against diseases that colostrum provides. Only 42 percent of children under four months of age are exclusively breastfed, as recommended at that age. The median duration of breastfeeding is 30 months, but the median duration of exclusive breastfeeding is two months. At age 6–9 months, children should be receiving solid or mushy food in addition to breast milk. Only 39 percent of children age 6–9 months receive the recommended combination of breast milk and solid/mushy foods, however.

NFHS-2 uses three internationally recognized standards to assess children's nutritional status—weight-for-age, height-for-age, and weight-for-height. Children who are more than two standard deviations below the median of an international reference population are considered underweight (measured in terms of weight-for-age), stunted (height-for-age), or wasted (weight-for-height). Stunting is a sign of chronic, long-term undernutrition, wasting is a sign of acute, short-term undernutrition, and underweight is a composite measure that takes into account both chronic and acute undernutrition.

Based on these measures, 35 percent of children under age three years are underweight, 39 percent are stunted, and 12 percent are wasted. Despite the fact that all of these measures are lower for Jammu and Kashmir than for India as a whole (47 percent, 46 percent, and 16 percent for underweight, stunting, and wasting, respectively) poor nutrition remains a serious problem in Jammu and Kashmir. Undernutrition is much higher in rural areas than in urban areas and is particularly high among children from disadvantaged socioeconomic groups. While underweight

and wasting is more common in the Jammu region, stunting is more common in the Kashmir region. Boys are slightly more likely to be malnourished (as indicated by the three nutritional status measures) than girls. Findings from NFHS-2 also suggest that iron deficiency is a serious problem in Jammu and Kashmir. Seventy-one percent of children age 6–35 months are anaemic, including 39 percent who are moderately anaemic and 4 percent who are severely anaemic. Although there are some differentials in the prevalence of anaemia among groups, a large majority of children in every subgroup of the population are anaemic. Anaemia prevalence is highest for scheduled-caste children (83 percent) and children whose mothers are moderately anaemic (79 percent). Notably, 78 percent of children in the Jammu region are anaemic, compared with 65 percent in the Kashmir region.

Child immunization is an important component of child-survival programmes in India, with efforts focussing on six serious but preventable diseases—tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. The objective of the Universal Immunization Programme (UIP), launched in 1985–86, was to extend immunization coverage against these diseases to at least 85 percent of infants by 1990. In Jammu and Kashmir, only 57 percent of children age 12–23 months are fully vaccinated, another 33 percent have received some but not all of the recommended vaccinations, and 10 percent have not been vaccinated at all. Eighty-six percent of children age 12–23 months have been vaccinated against tuberculosis, 72 percent have received three doses of DPT vaccine, 74 percent have received three doses of polio vaccine, and 69 percent have received the measles vaccine.

One reason why immunization coverage is relatively low in Jammu and Kashmir is that dropout rates for the series of DPT and polio vaccinations remain a problem. For both the DPT and polio series, 86–88 percent of children received the first dose but a much smaller percentage, 72–74, received all three doses. A lower proportion of children age 12–23 months have received all the vaccinations in rural areas (53 percent) than in the urban areas (73 percent) and in the Kashmir region (53 percent) than in the Jammu region (61 percent). Notably, male children are much more likely to have received all vaccinations than female children (61 percent compared with 50 percent).

In addition to full immunization, it is also recommended that children under age five years should receive oral doses of vitamin A every six months starting at age nine months. Thirty-six percent of children age 12–35 months have received any vitamin A supplementation, and only 23 percent received a dose of vitamin A in the six months preceding the survey.

NFHS-2 collected information on the prevalence and treatment of three health problems that cause considerable mortality in young children—fever, acute respiratory infection (ARI), and diarrhoea. In Jammu and Kashmir, 39 percent of children under age three were ill with fever during the two weeks preceding the survey, 22 percent were ill with ARI, and 33 percent had diarrhoea. The majority of the children who became ill with ARI (76 percent) or diarrhoea (81 percent) were taken to a health facility or health provider. Knowledge of the appropriate treatment of diarrhoea is also quite high. Seventy-three percent of mothers of children age less than 3 years know about oral rehydration salt (ORS) packets. However, about one-third of mothers believe incorrectly that when children are sick with diarrhoea, they should be given less to drink than usual. In addition, only 41 percent of mothers know at least two signs of diarrhoea that indicate the need for medical treatment. Two-thirds of children with diarrhoea received some

form of oral rehydration therapy (ORT), including 48 percent who received ORS. The use of ORS is more widespread in the Kashmir region than in the Jammu region.

Based on a weight-for-height index (the body mass index), 26 percent of women in Jammu and Kashmir are undernourished. Women in the Jammu region are more than twice as likely as women in the Kashmir region to be undernourished. In addition, nutritional deficiency is particularly serious for younger women, Hindu women, and women in disadvantaged socioeconomic groups. Women who are undernourished themselves are also much more likely than other women to have children who are undernourished. Overall, 59 percent of women in Jammu and Kashmir have some degree of anaemia, and 20 percent are moderately to severely anaemic. Anaemia is a serious problem among women in every population group.

Sixty-one percent of currently married women in Jammu and Kashmir report some type of reproductive health problem, including abnormal vaginal discharge, symptoms of a urinary tract infection, and pain or bleeding associated with intercourse. Among these women, about two out of three have not sought any advice or treatment. These results suggest a need to expand reproductive health services, as well as information programmes that encourage women to discuss their problems with a health-care provider.

In recent years, there has been growing concern about domestic violence in India. NFHS-2 found that in Jammu and Kashmir, three-fourth of ever-married women agree that the beating of wives by husbands is justified under some circumstances. Twenty-two percent of ever-married women have experienced beatings or physical mistreatment since age 15 and 9 percent experienced such violence in the 12 months preceding the survey. Most of these women have been beaten or physically mistreated by their husbands.

The survey collected information on the prevalence of tuberculosis, asthma, malaria, and jaundice among all household members. Disease prevalence based on reports from household heads must be interpreted with caution, however. The survey found that 2 percent of the population suffers from asthma, and less than 1 percent suffered from tuberculosis. About 1 percent each had malaria during the three months preceding the survey and jaundice during the 12 months preceding the survey. The prevalence of asthma and tuberculosis increase substantially with age, whereas malaria and jaundice prevalence vary little with age.

Only about half of the households in Jammu and Kashmir (53 percent) use cooking salt that is iodized at the recommended level of 15 parts per million. The consumption of adequately iodized salt is highest, 80 percent or higher, in large cities, among Sikh households, and among households with a high standard of living.

Half the household respondents in Jammu and Kashmir said that household members usually receive treatment from the public medical sector when they get sick and the remaining half said that they usually receive treatment from the private medical sector. Use of the private medical sector is much higher in urban areas and rises sharply with household standard of living. NFHS-2 also asked women about the quality of care received during the most recent visit to a health facility. Most respondents are generally satisfied with the health care they receive. Virtually all women received the service they went for on their last visit. Women had to wait an average of about 29 minutes before being served (30 minutes in the public sector and 29 minutes in the private sector). Ninety-five percent said that the staff spent enough time with them. However, a smaller proportion (66 percent) said that the staff talked to them nicely. Only 57

percent rated the facility as very clean. Seventy percent of those who said they needed privacy during the visit said that the staff respected their need for privacy. Ratings of the quality of services are consistently lower for public-sector facilities than for private-sector facilities. Overall, only 1 percent of women received a home visit from a health or family planning worker during the 12 months preceding the survey.

NFHS-2 also collected information on selected lifestyle indicators for household members. According to household respondents, 45 percent of adult men and 9 percent of adult women smoke, 10 percent of men and less than 1 percent of women drink alcohol, and 7 percent of men and 1 percent of adult women chew *paan masala* or tobacco.

The spread of HIV/AIDS is a major concern in India. Less than one-third (32 percent) of women in Jammu and Kashmir have even heard of AIDS. Awareness of AIDS is particularly low among women from households with a low standard of living, women who are not regularly exposed to any media, and illiterate women. Women in the Jammu region are more likely than women in the Kashmir region to have heard of AIDS. Among women who have heard of AIDS, 86 percent learned about the disease from television and 46 percent from the radio, suggesting that government efforts to promote AIDS awareness through the electronic mass media have achieved some success. Sixteen percent of women who have heard of AIDS learned about it from newspapers or magazines and 18 percent learned about it from friends and relatives. With one in four women not regularly exposed to mass media in Jammu and Kashmir, AIDS programmes will have to find innovative ways of reaching these hard to reach women. Among women who have heard of AIDS, 52 percent do not know of any way to avoid infection. NFHS-2 results suggest that health personnel could play a much larger role in promoting AIDS awareness. In Jammu and Kashmir, only 2 percent of women who know about AIDS learned about the disease from a health worker. The most frequently mentioned way of avoiding AIDS is to have only one sex partner. Only 16 percent of women who have heard of AIDS (5 percent of ever-married women age 15–49) mention that using condoms is a way of avoiding AIDS.