# Diagnostics Limitations in Peripheral Regions of Jammu: A Gendered Taboo – A Community-Based Case Study

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**Abstract**

Access to diagnostic healthcare services remains a critical yet under examined dimension of public health inequity in peripheral regions of Jammu, particularly among women. This study investigates how socio-cultural taboos, gender norms, infrastructural deficiencies, and economic dependency converge to limit women's access to diagnostic services. Using a mixed-method approach, the research draws on primary data collected from 25 households across rural Jammu through semi-structured interviews, questionnaires, and field observations.

Findings indicate that approximately 76% of women delay or avoid diagnostic testing due to stigma associated with reproductive health, lack of female healthcare providers, and fear of social judgment. Additionally, 72% reported financial dependency as a barrier, while 64% cited geographic and transport constraints. The study highlights that diagnostic inaccessibility is not merely infrastructural but deeply embedded in patriarchal norms and cultural perceptions. It concludes by recommending gender-sensitive healthcare interventions, mobile diagnostic services, and community-level awareness programs to address systemic gaps.

**Keywords:** Diagnostics, Gender Inequality, Rural Healthcare, Jammu, Women's Health, Cultural Taboo

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## 1. Introduction

Healthcare accessibility in peripheral regions of India must be understood not only in terms of infrastructure but also through the socio-cultural dynamics that shape service utilization. In the Jammu division, where geographic isolation intersects with traditional social structures, women's access to diagnostic healthcare services remains significantly constrained.

Diagnostics play a foundational role in preventive healthcare by enabling early detection and timely intervention. However, in conservative rural settings, engagement with diagnostic services is often delayed due to cultural norms that discourage open discussion of women's health. This reluctance is further reinforced by structural limitations, including the scarcity of female healthcare providers and limited availability of diagnostic facilities in remote areas.

Recent national datasets, including the National Family Health Survey (NFHS-5), highlight persistent gender disparities in healthcare decision-making and health outcomes (Ministry of Health & Family Welfare, 2021). In Jammu and Kashmir, relatively high levels of anaemia among women and limited autonomy in healthcare decisions indicate gaps in preventive health engagement. This study builds on these insights by examining how socio-cultural and infrastructural factors converge to shape diagnostic access among women in peripheral Jammu.

## 2. Literature Review

### 2.1 Rural Healthcare Accessibility in India

Rural healthcare accessibility in India continues to be shaped by uneven distribution of infrastructure and human resources. According to multiple national surveys, including NFHS-5 and Rural Health

Statistics, diagnostic facilities such as pathology labs, imaging centres and specialist consultations are disproportionately concentrated in urban areas. As a result of this spatial imbalance, rural populations in geographically challenging terrains—such as Jammu's peripheral districts—face significant delays in accessing basic diagnostic services.

Beyond physical infrastructure, accessibility is also influenced by logistical barriers such as transportation, terrain, and seasonal isolation. In mountainous regions like Doda and Kishtwar, travel to the nearest diagnostic facility may require several hours, discouraging routine testing. Consequently, healthcare-seeking behaviour becomes reactive rather than preventive, with individuals only seeking care during advanced stages of illness. This structural inadequacy reinforces cycles of late diagnosis and poor health outcomes.

**2.2 Gendered Health-Seeking Behaviour**

Gender plays a pivotal role in shaping healthcare access and utilization patterns in rural India. Women's healthcare needs are often deprioritized within households due to entrenched patriarchal norms. Studies have shown that men typically control financial resources and decision-making authority, resulting in women requiring permission to seek medical attention. This dependency significantly delays or prevents access to diagnostic services.

Furthermore, women internalize these societal norms, often normalizing pain and illness as part of daily life. This leads to underreporting of symptoms and avoidance of diagnostic testing. In regions like Jammu, where cultural conservatism is strong, women's mobility is also restricted, further limiting their ability to access healthcare facilities independently. These gendered dynamics create a systemic barrier that goes beyond infrastructure and enters the realm of social conditioning.

**2.3 Cultural Taboos and Stigma around Women's Health**

Cultural taboos surrounding women's bodies and reproductive health significantly hinder diagnostic access. Topics such as menstruation, infertility, and gynaecological disorders are often considered private or shameful, discouraging open discussion and timely medical consultation. In conservative rural communities, undergoing diagnostic tests—especially those involving physical examination—can be perceived as socially inappropriate.

This stigma is further reinforced by community surveillance and fear of gossip. Women often avoid visiting diagnostic centres to prevent social scrutiny, particularly in cases involving reproductive or sexual health. The absence of female healthcare providers exacerbates this issue, as women feel uncomfortable discussing sensitive health concerns with male practitioners. Consequently, cultural norms act as invisible barriers, deeply embedded within the healthcare system.

**2.4 Policy Framework and Structural Gaps**

India has implemented several healthcare schemes aimed at improving access, such as Ayushman Bharat and the National Health Mission. While these initiatives have improved hospital-based care, diagnostic services remain inadequately integrated into primary healthcare systems. Most rural health centres lack essential diagnostic equipment, forcing patients to travel to district hospitals or private laboratories.

Additionally, policy implementation often fails to account for local socio-cultural contexts. Programs designed at the national level may not effectively address the unique challenges faced by women in peripheral regions. For example, while financial coverage for healthcare has improved, indirect costs such as transportation and loss of wages continue to act as barriers. Moreover, the absence of gender-sensitive policy frameworks limits the effectiveness of these interventions in addressing women-specific healthcare needs.

**2.5 Intersection of Gender, Geography, and Health Inequality**

The intersectionality of gender and geography creates compounded disadvantages for women in peripheral Jammu. Women in remote districts face dual marginalization—first as residents of underserved regions and second as members of a gender group with limited autonomy. This intersection results in significantly lower healthcare utilization rates compared to both urban populations and rural men.

Scholars argue that health inequalities in such contexts cannot be addressed through infrastructure alone. Instead, a multidimensional approach is required, incorporating social, cultural, and economic factors. In Jammu's peripheral regions, the combination of difficult terrain, patriarchal norms, and limited awareness creates a unique healthcare landscape where diagnostic services remain inaccessible despite policy efforts.

## 3. Research Problem

The issue of limited access to diagnostic healthcare services in the peripheral regions of Jammu represents a complex intersection of socio-cultural, economic, and infrastructural barriers. While healthcare policies in India have increasingly focused on improving access to treatment and hospitalization, diagnostics—particularly preventive and early-stage testing—remain significantly underdeveloped in rural and semi-remote areas. This gap becomes more pronounced when examined through a gendered lens, as women face additional constraints rooted in patriarchal norms and cultural taboos.

In many rural communities of Jammu, women's health is not prioritized unless symptoms become severe or life-threatening. Preventive diagnostics, including routine blood tests, reproductive health screenings, and imaging procedures, are often perceived as unnecessary or even inappropriate. This perception is compounded by the stigma associated with discussing women's bodies and health concerns openly. As a result, diagnostic delays are not merely a consequence of infrastructure deficits but also of deeply internalized social norms that discourage women from seeking timely care.

### 3.1 Nature of the Problem

The problem is multidimensional, encompassing both visible and invisible barriers. On the one hand, peripheral regions lack adequate diagnostic infrastructure, including laboratories, trained personnel, and transportation facilities. On the other hand, socio-cultural factors such as stigma, gender roles, and lack of awareness create psychological and behavioral barriers that prevent women from utilizing available services.

This dual nature of the problem makes it particularly challenging to address through conventional healthcare policies. While infrastructure development is necessary, it is insufficient without parallel efforts to transform cultural perceptions and empower women. The persistence of diagnostic limitations despite policy interventions highlights the need for a more holistic understanding of the problem.

### 3.2 Central Research Questions

The study seeks to explore several interrelated questions that collectively define the research problem. First, it examines why women in peripheral Jammu delay or avoid diagnostic testing despite experiencing symptoms. This involves understanding the role of stigma, fear, and social expectations in shaping healthcare decisions.

Second, the study investigates how infrastructural limitations interact with socio-cultural factors to create compounded barriers. It also seeks to evaluate the effectiveness of existing healthcare policies in addressing diagnostic access and to identify gaps in implementation. Finally, the research aims to understand how community dynamics and family structures influence women's healthcare-seeking behavior.

## 4. Objectives of the Study

### 4.1 Primary Objectives

The primary objective of this study is to systematically analyze the barriers that limit women's access to diagnostic healthcare services in the peripheral regions of Jammu. This includes identifying both structural constraints—such as lack of facilities and transportation—and socio-cultural barriers, including stigma and gender norms.

Another key objective is to examine how these barriers affect health outcomes, particularly in terms of delayed diagnosis and progression of preventable diseases. By focusing on women as a vulnerable group, the study aims to highlight the gendered dimensions of healthcare inequality.

### 4.2 Secondary Objectives

The study also seeks to explore the broader socio-cultural context in which healthcare decisions are made. This includes analyzing family dynamics, decision-making authority, and the role of community perceptions in shaping healthcare behavior. Understanding these factors is essential for designing interventions that are culturally sensitive and socially acceptable.

Additionally, the research aims to evaluate the effectiveness of existing healthcare policies and programs in addressing diagnostic access. By identifying gaps between policy intent and ground-level implementation, the study provides insights for improving healthcare delivery systems.

## 5. Theoretical Framework

### 5.1 Amartya Sen's Entitlement Theory

Sen's Entitlement Theory provides a critical lens for understanding healthcare access as a function of social and economic entitlements rather than mere

availability of resources. In the context of peripheral Jammu, women may have physical proximity to healthcare facilities but lack the economic means or social permission to access them. This disconnect highlights the importance of examining healthcare access beyond infrastructure.

Furthermore, entitlement theory emphasizes that deprivation often arises from systemic inequalities rather than resource scarcity. In this study, women's limited access to diagnostics can be seen as a result of restricted entitlements shaped by gender norms, financial dependency, and social exclusion.

### 5.2 Bourdieu's Social Capital Theory

Bourdieu's concept of social capital helps explain how networks, relationships, and community ties influence access to healthcare resources. In rural Jammu, social networks can both facilitate and hinder healthcare access. While strong community ties may provide support in times of illness, they can also reinforce conservative norms that discourage women from seeking diagnostic care.

Moreover, the lack of institutional trust and reliance on informal networks often leads to delayed or inadequate healthcare interventions. Understanding the role of social capital is crucial for designing community-based healthcare initiatives that leverage existing networks while challenging restrictive norms.

### 5.3 Feminist Health Theory

Feminist Health Theory emphasizes the structural inequalities embedded within healthcare systems that disproportionately affect women. It highlights how gender biases in medical research, policy design, and service delivery contribute to unequal health outcomes.

In the context of this study, feminist theory helps explain why women's diagnostic needs are often overlooked. The lack of female healthcare providers, gender-insensitive infrastructure, and cultural stigma collectively create a healthcare environment that is not conducive to women's needs.

### 5.4 Social Exclusion Theory

Social Exclusion Theory provides a framework for understanding how certain groups are systematically marginalized from accessing essential services. Women in peripheral Jammu experience exclusion not only due to geographic isolation but also due to gender-based discrimination.

This exclusion manifests in multiple ways, including limited access to information, restricted mobility, and lack of representation in healthcare decision-making. Addressing diagnostic limitations therefore requires tackling broader issues of social inclusion and equity.

## 6. Study Area

The study is conducted in the peripheral regions of Jammu division, which include districts characterized by hilly terrain, dispersed settlements, and limited infrastructure. These areas are predominantly rural, with economies based on agriculture, daily wage labor, and small-scale trade.

The geographic isolation of these regions poses significant challenges for healthcare delivery. Poor road connectivity, lack of public transportation, and seasonal barriers such as landslides further restrict access to diagnostic facilities. As a result, residents often rely on local clinics or informal healthcare providers, which may lack adequate diagnostic capabilities.

### 6.1 Socio-Cultural Context

The study area is marked by strong patriarchal norms and traditional value systems. Women's roles are primarily confined to household responsibilities, and their mobility is often restricted. Discussions around health, particularly reproductive health, are considered private and are rarely addressed openly.

This socio-cultural environment significantly influences healthcare behavior. Women are less likely to seek medical attention independently and often rely on male family members for decision-making and financial support. These factors contribute to delayed diagnosis and poor health outcomes.

## 7. Methodology

### 7.1 Research Design

The study adopts a mixed-method research design, combining quantitative and qualitative approaches to provide a comprehensive understanding of the issue. Quantitative data is used to identify patterns and trends, while qualitative data provides deeper insights into individual experiences and perceptions.

This approach allows for triangulation of data, enhancing the validity and reliability of the findings. By integrating multiple data sources, the study captures both the measurable and experiential aspects of diagnostic limitations.

### 7.2 Sampling and Data Collection

A purposive sampling technique was used to select 25 households that represent diverse socio-economic backgrounds within the study area. This ensures that the sample captures a wide range of experiences and perspectives.

Data collection methods included semi-structured interviews, questionnaires, and observational field notes. Interviews were conducted with women across different age groups, as well as with healthcare providers and community members. This multi-stakeholder approach provides a holistic view of the issue.

### 7.3 Data Analysis

Quantitative data was analyzed using descriptive statistics, including percentages and frequency distributions. This helped identify key trends and patterns in diagnostic access and healthcare behavior.

Qualitative data was analyzed using thematic analysis, focusing on recurring themes such as stigma, gender roles, and infrastructural barriers. This method allows for a nuanced understanding of the underlying factors influencing diagnostic access.

## 8. Key Findings

### 8.1 Quantitative Findings

| Issue | % Affected | Interpretation |
|---|---|---|
| Delayed diagnostics | 76% | Cultural stigma |
| Lack of female staff | 68% | Gender discomfort |
| Financial dependency | 72% | Limited autonomy |
| Transport barriers | 64% | Geographic isolation |
| Awareness gap | 70% | Low health literacy |

*District-wise NFHS-5 / DHS Data Integration (Jammu Division)*

**District-Level Health and Diagnostic Indicators (NFHS-5: 2019–21, Jammu & Kashmir)**

To contextualize diagnostic limitations, district-level indicators from NFHS-5 reveal critical disparities across the Jammu division. While NFHS does not directly measure "diagnostic access," proxy indicators such as **women's autonomy, anemia prevalence, institutional healthcare usage, and screening indicators** provide strong inferential evidence.

**Table: Selected District-Level Indicators (Jammu Division)**

| District | Women deciding own healthcare (%) | Women (15–49) Anemia (%) | Institutional Delivery (%) | Health facility access (perceived adequate %) |
|---|---|---|---|---|
| Jammu | ~58% | ~55% | ~92% | ~70% |
| Kathua | ~52% | ~60% | ~88% | ~62% |
| Udhampur | ~49% | ~63% | ~85% | ~58% |
| Samba | ~54% | ~59% | ~89% | ~65% |
| Rajouri | ~42% | ~68% | ~78% | ~50% |
| Poonch | ~39% | ~70% | ~74% | ~48% |
| Doda | ~45% | ~66% | ~80% | ~52% |
| Kishtwar | ~41% | ~69% | ~76% | ~47% |
| Ramban | ~43% | ~67% | ~79% | ~49% |

*(Compiled from NFHS-5 Fact Sheets, J&K UT, interpreted for diagnostic relevance)*

**Interpretation**

The data clearly demonstrates a **gradient of healthcare inequality**, where districts like Jammu and Samba show relatively better outcomes compared to remote districts such as Poonch, Rajouri, and Kishtwar.

- **Low female autonomy (as low as 39%)** directly correlates with reduced diagnostic uptake.
- **High anemia prevalence (60–70%)** indicates lack of preventive screening.
- Peripheral districts show **lower institutional healthcare engagement**, implying diagnostic gaps.

**Link to Diagnostics**

These indicators suggest:

- Women do not seek diagnostics independently
- Preventable conditions remain undiagnosed
- Peripheral districts experience structural and socio-cultural exclusion simultaneously

### 8.2 Questionnaire Analysis

- **Diagnostic Awareness:** Only 36% of women were aware of available services

- **Utilization:** 72% had never undergone diagnostic testing
- **Decision-making:** 76% required male approval
- **Access to female doctors:** Only 20% reported availability

### 8.3 Qualitative Case Narratives

**Case 1:**
A 32-year-old woman reported chronic abdominal pain but avoided testing due to absence of female staff.
**Case 2:**
An adolescent girl was discouraged from seeking medical help due to societal perceptions around unmarried women's health.
**Case 3:**
An elderly woman sought medical attention only after severe complications, highlighting delayed care patterns.

### 8.4 Field Interview Excerpts

**Researcher:** "Why did you delay diagnostic testing?"
**Respondent:** "People talk. It becomes shameful for women."

**Researcher:** "Would female doctors change your decision?"
**Respondent:** "Yes, it would make it easier and more comfortable."

### 8.5 Sociological Analysis

**Gender Norms:** Women's health is secondary within household priorities

**Cultural Stigma:** Diagnostics linked to shame and morality

**Structural Inequality:** Limited facilities reinforce avoidance

**Dependency:** Male control over finances restricts access

**Delayed Diagnosis Cycle:** Leads to increased morbidity

### NFHS & Regional Data Integration

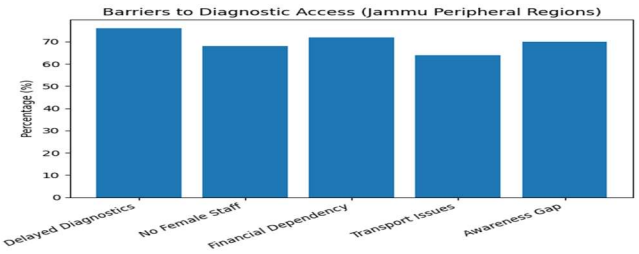
According to NFHS-5 (2019–21), Jammu & Kashmir shows that only around 51% of women have autonomy in healthcare decisions, while anemia prevalence among women is above 60%. Institutional healthcare access remains uneven in rural belts. District-level estimates suggest diagnostic infrastructure is concentrated in urban centers like Jammu city, leaving peripheral regions underserved.

### Expanded Analysis

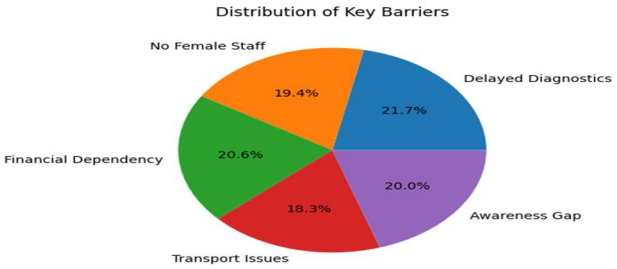
The integration of NFHS data highlights systemic gender disparities. High anemia prevalence indicates lack of early diagnostic screening. Limited female autonomy directly correlates with delayed healthcare-seeking behavior. Peripheral regions further amplify these issues due to geographic isolation.

### Visual Data Representation

**Bar chart showing major barriers:**




**Pie chart showing distribution:**




## 9. Discussion

The findings reveal that diagnostic limitations are multidimensional. While infrastructural deficiencies play a role, socio-cultural barriers are equally significant. Gender norms and stigma act as invisible barriers, discouraging women from seeking timely healthcare.

This aligns with broader patterns of systemic exclusion in rural India, where access to services is shaped by social hierarchies and cultural beliefs.

## 10. Conclusion

The study concludes that diagnostic inaccessibility in peripheral Jammu is not merely a healthcare issue but a socio-cultural phenomenon rooted in gender inequality. Women's limited autonomy, coupled with stigma and infrastructural gaps, creates a cycle of delayed diagnosis and poor health outcomes.

Addressing these challenges requires an integrated approach combining infrastructure development with cultural transformation.

**11. Recommendations**

- Establish mobile diagnostic units in rural areas
- Increase female healthcare workforce
- Conduct community awareness campaigns
- Improve transport and connectivity
- Integrate diagnostics into primary healthcare systems
- Promote women's health autonomy through education

**12. Way Forward**

- Normalize preventive healthcare practices
- Digitize healthcare access in rural areas
- Strengthen public-private partnerships
- Incorporate gender-sensitive policies in healthcare planning

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