**Background:**

UHC is conceptually straightforward; translating it to a feasible metric is quite intractable. Generalizable metric such as service readiness index is paramount as it can indicate the capacity of facilities to provide essential care and furthermore, estimation of metric at sub national is imperative for effective evidence based policy.

**Study Area:**

Case study is conducted in remotest district of Jammu and Kashmir state in India. It is fragile area with heavy military deployment as it is bounded by Line of Control with Pakistan and is embroiled in militancy and cease fire violations. Also, it is bearing brunt of double whammy of geographical inaccessibility due to mountainous topography and backwardness in terms of Human Development Indicators.

**Objective:**

The objective of the study is to evaluate the service availability and readiness of health facilities and ascertain the supply side barriers in service provisioning

**Methodology:**

Mixed method design via concurrent triangulation is employed. Facility survey encompassing 138 facilities at various hierarchies conducted to ascertain supply side readiness. Compendium of checklist designed in tandem with WHO’s SARA methodology conjunction with IPHS standards. Information elicited by canvassing questionnaire and scorecard generated for each facility. Health service readiness index calculated via amalgamation of average scores across six dimensions. Further, multidimensional statistical data reduction technique of principal component analysis employed for parsimonious composite indices. Stakeholder analysis conducted for nuanced qualitative information. Myriad techniques like key informant interviews, discussions and FGD’s conducted with various players such as leaders, adopters and laggards.

**Result:**

Basic amenities, infrastructure, medicine availability were suboptimal in health facilities. Readiness score of health facilities was 0.47 and 0.50 for medicine and basic amenities respectively. Scores for availability of equipment and diagnostic capacity were low 0.57 and 0.53 respectively. Service provisioning (adolescent health, delivery, neonatal and child health, non-communicable etc.) ranged from 0.47 for newtype Primary health centers with rudimentary infrastructure to 0.71 for district hospital. First two component amongst secondary care facilities explained 38% common variance characterized by service provisioning. For primary health centers, single principal component explained 24% common variance characterized by newborn care. Lack of incentives for retention in remote and shelling prone areas for staff members, unavailability of staff quarters, inaccessibility of roads, political interferences and prevalence of internal adjustments in the form of transfer/attachment of health workers, inhibitions of skilled staff in serving militancy prone areas, nonchalant attitude of policymakers identified as major barriers for service provisioning based on stakeholder analysis.