RESEARCH REVIEW JOURNALS
Volume-03
Issue-11
November -2018

ISSN: 2455-3085 (Online)
RESEARCH REVIEW International Journal of Multidisciplinary
www.rrjournals.com [UGC Listed Journal]

Reproductive Health and Gujjar Women: A Study among Nomadic Dhodi Gujjars in Jammu District

[1]Dr. Hema Gandotra & [2]Ms. Ruhi Gupta

[1]Sr. Assistant Professor, Department of Sociology, University of Jammu (India)
[2]Asstt. Professor in Sociology, GCW, Parade Ground, Jammu (India)

ARTICLE DETAILS

Article History
Published Online: 10 November 2018

Keywords
Reproductive Health, Nomadic Dhodi Gujjars, Patriarchy, Contraception, Antenatal care, Postnatal care, Indigenous medicines.

***Corresponding Author**
Email: gandotrahema[at]gmail.com

ABSTRACT

Reproductive health is an essential component of the long dawn process of the empowerment of women. The entire reproductive process extends from menarche to menopause; the intervening periods are marriage, pregnancy, childbirth and contraception. These conditions are determined by socio economic and cultural factors and available health care facilities. The present paper attempts to understand the various factors i.e. social, cultural, religious and economic that affect the reproductive health of the Nomadic Dhodi Gujjar women. The present research has understood and identified various factors affecting the Gujjar women reproductive health, the levels of utilization of the reproductive health services. In a society, where reproductive rights and choices are socially and culturally defined and governed through patriarchy, a woman has very little freedom to exercise her sexual reproductive rights and choices. The patriarchal structure restricts women's movement and lack of education and awareness deprive them of any related information. Women are at risk of complications from pregnancy and childbirth. The issues of reproductive health are rarely discussed openly, often leading to ignorance and misconceptions. The variables like education, age at marriage, religion, patriarchy etc. have been taken into account for the present study.

1. Introduction

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to reproductive system and to its function and process. The Pan American Health Organisation and World Health Organisation have defined sexual and reproductive health as "the experience of the on-going process of physical, psychological and socio- cultural well being related to sexuality. Thus, no discussion of women's health would be complete without paying careful consideration to women's sex-specific health issues – those related to sexuality and to reproductive health, including fertility, contraception, pregnancy, abortion and childbirth. (WHO, 1958)[1]

The International Conference on Population and Development programme of Action(1994) states that reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if ,when and how often to do so. Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and child birth they also face risks in preventing unwanted pregnancy ,suffer the complications of unsafe abortion .Among women of reproductive age,36% of all healthy years of life lost is due to reproductive health problems such as unregulated fertility ,maternal mortality and morbidity.

The ICPD Programme of Action clearly states that all countries should strive to make reproductive health care-including family planning counseling, information, education, services for prenatal care, safe delivery and post-natal care accessible to all through the primary health-care system. Reproductive health-care programmes must involve women in the leadership, planning, decision-making, management, implementation, organization and valuation of services. Community participation in reproductive health-care services should also be promoted by decentralizing the management of public-health programmes. (Neelam,2011)[2]

In the International Conference on Population and Development (ICPD) 1994, about 180 representatives from different countries agreed to improve male participation in the Reproductive and Child Health (RCH). It has also been pointed out and accepted in several international, national and state level conferences and meetings that equality and equity based gender partnership in the field of RCH and family planning should be increased. It was universally and unanimously recognised that supportive and effective partnership of males can contribute to the women status, education, health, and overall development and welfare. As outlined by the ICPD definition, reproductive and sexual health (RSH) is not merely about reproduction. RSH must be viewed as three interconnected domains that include universal rights, women's empowerment and health service provision. Firstly, RSH promotes a universal understanding that is premised on the fact that RSH a basic human right to be fulfilled by all government. Secondly, RSH seeks to address the underlying causes of gender inequality and inequity to promote women's empowerment. Thirdly the provision of universal access, utilization and quality of RSH services addresses issues of sexual and reproductive ill-health and possibly death. (Neelam, 2011).[3]

Reproductive health is a crucial feature of healthy human development and of general health. It may be a reflection of a healthy childhood, is crucial during adolescence, and sets the stage for health in adulthood and beyond the reproductive years for both men and women. Reproductive life span does not begin with sexual development at puberty and end at menopause for a woman or when a man is no longer likely to

have children. Rather, it follows through out an individual's life cycle and remains important in many phases of development and maturation. At each stage of life, individual reproductive health needs may differ. However, there is a cumulative effect across the life course, and each phase has important implications for future well-being. An inability to deal with the reproductive health problems at any stage in life may set the scene for later health problems. This is known as the life cycle perspective for reproductive health. (Sarkar and Acheampong, 2010) [4]

Women anywhere in the world have to suffer from some inbuilt advantages, compared to man, because of certain biological reasons. They have to put up with menstruation, pregnancy, child-birth, lactation, child-rearing and menopause and their various complications. Physically, they are less strong. They are also more vulnerable to sexual aggression and abuse. The different cultural, social and economic situations in India have given different focus to these biological disadvantages of women. These situations also influence the way these biological disadvantages affect the health of the women and Girl-child (Yadava and Mishra,2003)[5]

In our society, as in most societies, women not only bear children. They also take primary responsibility for infant care, spends more time with infants and children than do men, and sustain primary emotional ties with infants. When biological parents do not parent, other women, rather than men, virtually always take their place. Though fathers and other men spend varying amount of time with infants and children, the father is rarely a child's primary parent. (Chodorow, 1978)[6]

The health of women in the years from 15 to 45 is predominantly influenced by their reproductive and maternal roles. This is also the period when are more likely to suffer from illnesses related to their reproductive roles such as sexually transmitted diseases, anaemia and complications resulted from childbearing. Globally, 51 per cent of pregnant women and a one- third of women of reproductive age who are not pregnant are anaemic. This causes fatigue reduces productivity and lowers their resistance to disease. In pregnancy and childbirth it means greater risk for the life and health of both mother and child. (Kumar, 2006).[7]

Dhodi Gujjars are true pastoral nomads who continue to depend on milch cattle like cows, buffaloes etc, they move higher in the Himalayan forests and spend their summer months in the wilderness with their kids and cattle. The orbital movement between highland and lowland pastures is the communities ecological response to the temporally varying spatial distribution of the resource base. There are two space – specific resource bases which alternately active during different seasons of the year, one in the lower foothills south of the Pir-Panjal and the other in high altitude pastures of the Greater Himalayas. The alpine pastures become snowbound during winter and hence their resource value for the pastoralists becomes seasonally dormant. That is why the herders cannot stay from October to April and so it becomes ecologically imperative for the herders to move down to lower and warm altitudes (Khatana, 1992)[8]

As the Gujjars are mostly nomadic and semi-nomadic, they spend days in steep ignorance and age old backwardness. The condition of most of the people of these tribes, especially the nomadic, on the whole is altogether deplorable and pitiable. Nomadism affects their way of life in more than way. Their constant life of movement from one place to another keeps them untouched by the forces of modernization operating in the society. Hence, they live mostly in primitive conditions. They are weak financially, educationally and vocationally. They are usually bankrupt as they are burdened because of their ancestral debts. They do face economic handicap as they have to pay normal grazing fee as well as other requirements of the petty officials. All these factors are the major causes of their poor economic condition. Hence, they remain generally under debt in order to meet their daily expenditure (Charak, 1983).[9]

According to Patnaik (2011)[10], traditionally the Gujjars have a patriarchal family set up. The status of the women is low in Gujjars. She plays a considerable role in the economic activity of their pastoral economy. She milks the cow, makes ghee, paneer, khoya and other milk preparation and often also takes them to the market. This shows that women actively participate in the distribution and sale of milk and milk products. This becomes very interesting to study as in a community which is predominantly patriarchal and male dominated, women are participating in the public sphere activity too which is an earning source of the family.

Sharma and Niranjna (2001)[11] argued that since women are central in the process of reproduction and they live under specific social and cultural conditions underlying the social structure, their social status and behaviour is conditioned by the value structure of a society. The status of a women herself, especially in a patriarchal society, is dependent on the man, family and the social structure. In the modern human society, social status of an individual depends on a multiplicity of factors. They argue that that the status of women, besides their economic and prestige attributes, also depends upon the social and cultural milieu in which they are placed. It, therefore, implies that in defining the status of women as high and low the cultural values associated with the female in a given social structure are of considerable importance. The present study has analysed the status of the Dhodi Gujjar women in her community in order to see the fertility behaviour and her reproductive health.

During the field visits, it has been found that among the Gujjar community, not only the medical facilities are meager, but they hardly exist. The socio-cultural dimension also constraints women in exercising their choices in relation to various health facilities. The patriarchal structure and religious taboos restrict women's movement and lack of education and awareness deprive them of any related information. Therefore, the present study seeks to access that whether and up to what extent the Gujjar women are able to participate in the decision-making process in general and regarding reproductive matters in particular in their families.

Women's health is mediated by a number of factors such as women's lack of power, lower status in the family and society, discrimination, lack of knowledge, biased cultural practices based on patriarchy and lack of safe and empathetic services. All these factors find manifestation in women's early marriage and early child-bearing age, multiple and short-spaced pregnancies making them very vulnerable to get physical and mental strain. Although gender discrimination is said to be relatively unknown among tribals, girls tend to receive less attention than their brothers which has serious implication on their health and nutritional status. The nutritional

biasness leads to some of the rampant incidence of diseases like stunted growth and chronic anemia which are associated with pregnancy, childbirth and other gynaecological problems. In addition, other factors like cultural and traditional practices, which are often antithetical to women, also aggravate their nutritional deficiency particularly during pregnancy. (Nagla, 2015)[12]

Human fertility is not only a biological process but also a social one. It is the social character of human life and human reproduction that differentiates human societies from those of animals. Fertility is a very important demographic process which is largely responsible for the replacement of population for the continuation of society. Human fertility has always been socially controlled (Sandhu, 1996)[13]. Therefore, the present research paper has made an attempt to understand the relationship between the socio-cultural factors and reproductive health because an analysis of the socio-cultural factors will help one to understand the health and the reproductive health in a better manner.

2. Methodology

The proposed study has been carried out in the Jammu District. The respondents for the present study have been identified through purposive and snowball sampling. The data has been collected from both primary and secondary sources. For secondary sources besides books, journals, articles and reports, other documents in the form of any archival material and written stories will be consulted. For collecting primary data, field work has been conducted in the area of study by using qualitative and quantitative methods. The interview schedule designed for the present study has been used to record the first hand information given by the respondents and will consist of both the open-ended and closed-ended q uestions regarding respondents name, age, caste, living conditions, working conditions and socio-cultural aspects. Observation is a deliberate study through the sight and may be used as one of the methods for scrutinizing collective behaviour and complex social institutions as well as the separate units comprising of totality. It has been used to study the living conditions of the nomadic Dhodi Gujjar women.

The following attributes have been looked into while exploring the field:

Education and Reproductive Health

Education plays an important role on the matters related to health and reproductive health. Education contributes immensely to a person's awareness improving his/her chances of seeking timely medical treatment. Women need to be aware about their health and nutrition. They need to understand their reproductive health system and health care in a mature manner. Such understanding and awareness facilitated by education will have a positive influence on their health seeking behaviour.

Sandhu (1996)[14] has argued that education especially of the women not only changes the outlook of the person regarding the value of children and ideal number of children preferred, but also leads to greater acceptance of family planning. It also raises the age at marriage, thus cutting down the reproductive span of the women.

According to Dreze and Sen (2002)[15], Women's education in general and higher education in particular has often been highlighted as the most important factor towards restoration of their social, economic, legal and reproductive health rights .Education also makes the horizon of vision broader, helps to disseminate the knowledge of family planning. The promotion of female literacy, women's employment opportunities, family planning facilities, can enhance the voice and decisional role of women in family affairs and also bring about radical changes in the understanding of justice and injustice. Female literacy has a strong impact in reducing child mortality rates, and also contributes to reduce fertility.

When the respondents were asked about their educational level, it was found during the field work that the female respondents were mostly illiterate but were sending both their sons and daughters to school. There were mobile schools opened for the Gujjars and mostly the schools were up to the primary level. The female respondents even argued that women become more aware and better understand their rights and role in the family and society through education so they whole heartedly support education of their children. The respondents hold the view that education is responsible for the development of the human personality and there was a change in their mindset regarding education with changing time. Education forms an important component of reproductive health because women who take to primary and secondary schooling are less likely to go into childbirth during adolescent years. It has also been observed that the low level of education among the respondents was responsible for the lack of awareness regarding various contraceptives and birth control technologies as well as their inability to make decisions about the number and spacing of children.

Age at Marriage and Reproductive Health

Age also plays an important role in determining the reproductive health. The role and the status of women changes with the change in age. The factor of age is extremely important in dealing with the question of reproductive health of women because the role and responsibilities of women vary significantly in different periods of life. In the sample for investigation, the women from different age groups were included in order to trace how far their problems are different.

Siddiqui (2001)[16] has argued that the younger the women marry, the early they start child bearing and longer they are exposed to conception. They lose the chance of longer schooling and of employment, and they enter in to marriage with less motivation and fewer resources to plan their families successfully. In addition, early marriage means a shorter gap between successive generations, significantly the birth rate increases.

Sandhu (1996)[17] has argued that age at marriage is one of the most important demographic variables which influence fertility in India. A women's reproductive span is spread between 15 and 45 years on an average. Marriage at an early age means early initiation into the reproductive process and lengthier exposure to reproduction. On the other hand, higher age at marriage reduces the length of the reproductive span. Age at marriage of a woman itself depends upon her education and working status. Sandhu considered it as an important determinant of fertility in India.

Early marriage, early pregnancy and too many

pregnancies are common among the Nomadic Dhodi Gujjar women. Majority of the respondents delivered their first child before and at the age of 18 years. Delivering the child at the very early age also resulted in more number of children among them. Some even reported of miscarriages as they were very young to carry their first pregnancy. Marriage at an early age increased their birth rate. Since they married early, so even miscarriages didn't bother them because at the back of their mind, they had the notion that they can bear more children and they even kept on doing so, without realizing its effect on their health in general and reproductive health in particular.

Economy and Reproductive Health

In the poor and undeveloped countries, economic factor plays a major role in fertility determination. This is because children are both producers and providers of economic security in various ways. For women, it is even more important to have children who provide both social status and economic protection. (Bajpai and Mishra, 2007)[18]

Women's disadvantaged social position, which is often related to the economic value placed on familial roles helps perpetuate poor health, inadequate diet, early and frequent pregnancy, and a continued cycle of poverty. From infancy, females in many parts of the world would receive less and lower-quality food and are treated less often when sick, and then only at a more advantaged stage of disease. In countries where women are less educated, receive less information than men and have less control over decision- making and family resources. They are also apt to recognize health problems or to seek care. (Sarkar, Acheampong, 2010)[19]

It was observed during the field work that the daily income of a single household was found to be Rs. 200 on an average. Their living conditions were very pathetic. Dhodi Gujjars live mostly in Kacha houses. They have low level of standard of life as they cannot afford to have basic facilities of life. They have very low source of income and cannot afford to have good house, good food and better health facilities. Females are the major contributor of this occupational activity to take place. Females wake up early in the morning, feeds the animals, take milk from the cattle and then take it for distribution along with their husbands. They supply milk mostly in tea stalls, sweet shops and in the houses. Their meals were mainly comprised of cereals and milk products. Non-vegetarian food is very rare in their dietary pattern as according to them it is very expensive. Sometimes they took loan either from their relatives or friends. Majority of the respondents did not earn enough to meet the expenses of the household, the women even work during their pregnancy period because of the financial stress of the household. The discrimination faced by the women in the economic sphere reinforces their low status as their contribution goes unrecognized and their work always remains undervalued.

Delivery Pattern, Traditional Indigenous Medicines and Reproductive Health

The data regarding the place of delivery revealed that majority of the respondents had their deliveries in their homes only. A comparatively higher percentage of them were assisted in delivering their children by their neighbours followed by their mother-in-law who take care of antenatal care and postnatal care and also attend to deliveries. Majority of the female respondents incurred no expenditure on their deliveries. Some of the respondents accepted that the institutional deliveries are definitely safe but due to their nomadic way of life, deliveries in the hospitals are not possible. The young women at the age of 20 or so even reported that their deliveries were sometimes attended by doctors and nurses in the hospitals.

Tribal communities possess a unique health care approach concerning the acceptance and rejection of modern medicine. They have retained much of their traditional health care during pregnancy and post delivery period. The relationship between a tribal woman and traditional health care is based on trust, responsibility, charity, power and respect from which she expects more than skill-based interventions as treatment. It is also observed that, reproductive health of tribal population is comprised of supernatural beliefs related to illness and treatment, strong role of traditional medicine men or shamans, community involvement in disease control and treatment, mixed interventions of traditional and modern health care . It has been observed from recent study that there is a keen inclination among the tribal women towards modern medical facilities if accessible . WHO (1978) also recommends that some traditional medical resources, such as some medicinal plants could be used after an evaluation where the beneficial resources should be selected and those considered harmful to health should be discarded. Traditional tribal social-religious practices also can be adversely affected their women's reproductive health as well as tribal's general health, such as alcohol consumption during pregnancy. (Chanu, ArunKumar, 2015)[20]

The Nomadic Dhodi Gujjar women prefer traditional indigenous medicines due to their nomadic way of living. Majority of the population of this community inhabit a very difficult mountainous terrain, lacking transportation services and hospitals services. Therefore, they use the shrubs for the treatment. Modern day health care is not accessible. They have deep rooted knowledge of medicinal use of biomedical resources. They prefer herbs like *Simloo* found in Srinagar. *Patris* i.e. Aconitum heterophyllum, *Choru* are used by them. *Rasonth* which is an extract of *Simloo* are available in Ayurvedic medicine shops. *Chatiyal,* and *Chrutijar* were also collected by the Gujjar women during their pregnancy period. They collect these herbs and boiled it in water. Mathuri, *Chikana* i.e. Country mallow and *Sansspore* i.e. White musli are also some of the shrubs used by the Gujjar women. These herbs help them in relaxing the muscles and deliveries take place easily. They used to take ghee at the time of their delivery.

It was surprising to note that a number of participants mentioned health problems, yet they did not seek medical treatment from trained personnel for any of the illnesses. As the Gujjar women are poor, they have little or no money to spend on health care. They also think that being women, any ailment is a part of their daily life and not worth bothering about. They often try to ignore the illness and try to bear as long as it does not affect their work. They do not consider their ailments important enough to take timely medication.

Living Conditions and Reproductive Health

For women living in a marginal existence, anything that adds to their burden adds to the risks for health. Because women are faced more directly than men with the problems of

water supply and sanitation, they can be a substantial driving force behind the installation and maintenance of facilities. Nevertheless, 1.2 billion people are still without access to good water and probably 1.9 billion still live with inadequate sanitation. The implications for women's health are sobering. (Smyke, 1991)[21]

The living conditions were not friendly for the Nomadic Dhodi Gujjar women. The healthy living conditions are important for having a healthy society. Both the physical and social factors play an important role in determining their reproductive health. For example, when families migrate from hilly areas to low plains, the high cost of living results in low purchasing power for conveniences, unsanitary conditions and infections. These unhygienic conditions affect the health of the women especially the reproductive health which ultimately results into various diseases. As they were facing the acute shortage of water at their places, this may be one of the reasons of their unclean habits, so women has to face a lot of problem during the menstrual periods. These people do not have a shelter to protect them from the sun and the rain.

When the living conditions of the Nomadic Dhodi Gujjars were explored, it was found that their life is very miserable, the huts and shelters of these people (Kotha) at the highlands as well as at their lower hills and plains are in a very dilapidated condition. Charak (1983) has also argued that the Kothas of the nomadic Dhodi Gujjars need proper repair and maintenance; these houses are made up of pralis (a kind of dry grass). Regular migration does not induce them to invest much on their housing. Most of them cannot afford to spend. There is also no denying that they have no time to devote attention towards their housing problems. They are accustomed to living in such huts consisting of one room with the close company of their cattle, sheep, goats and kitchen.

Decision-Making Power and Reproductive Health

Sharma and Niranjna (2001)[22] argued that decision-making was further extended to the area of bearing of children. The decisions regarding the number of children the family should have are not exactly consciously affected by anyone in the family. But their husbands and their parents-in –law do prevail over. A woman remarked that it is basically the social pressures or expectations of the community which are reflected through their husbands and they go in for additional child.

Gujjar women were not empowered to take their own decision in the reproductive choice. The respondents revealed that the decisions regarding a number of children and the sons a family should have were either decided by their husbands or it is in the hands of God and they don't have any planning for the first and subsequent pregnancies. The study revealed that most of the women don't have any knowledge about the contraceptive devices. This clearly indicated the lack of awareness among the respondents and which affected their reproductive health. A very small number of the couples were found to have had planned their family size before begetting the children as compared to 90 per cent of the couples. Inter-spouse communication about fertility matters is indicative of women's status in regulating her fertility behaviour. In my study, it has been found that the Nomadic Dhodi Gujjar women grow up maintaining a 'culture of silence' as according to them reproductive life is very personal, private and secret matter in our society. Some respondents even reported that articulation of reproductive choices and exercising their rights is a distant dream even sometimes their basic provisions are neglected.

At the social and cultural levels male dominance is clearly felt at all stages of the reproductive process. Numerous studies have shown that the factors like son preference, lack of consideration for women's health, ignorance, subservience to taboos that prevent proper communication with wives and so on have combined to reduce women to being mere producers without have any say in matters that concern them closely.

Becker (1996)[23] has argued that family planning communication between husbands and wives is a pre requisite for better and responsible reproductive health behaviour. Couples can make better reproductive decisions if they discuss family planning matters more openly and frequently. Whether to practice family planning or not, which methods to choose, when to start conception, and the choices regarding the number and timing of children are all outcomes of inter-spousal communication. Inter-spousal communication enables husbands and wives to know each other's attitude towards family planning and contraceptive use. It has been found that the Gujjar women earlier had no knowledge of contraceptive devices but with the passage of time, the electronic media is an important source for information on the reproductive health services. The media might similarly be used to bring about changes in people's approaches to the use of modern medical services.

Patriarchy and Reproductive Health

Women experience discrimination and unequal treatment in terms of basic right to food, health care, education, employment, control over productive resources, decision-making and livelihood not because of their biological differences or sex, which is natural but because of their gender differences which is a social construct. "Sex is considered a fact- one is born with either male or female genitalia. Gender is considered a social construction- it grants meaning to the fact of sex. Conversely, it could be said that only after specific meanings came to be attached to the sexes, did sex differences become pertinent." (Geetha, 2002)[24]

Gender based differences and exploitations are widespread and the socio-culturally defined characteristics, aptitudes, desires, personality traits, roles, responsibilities and behavioural patterns of men and women contribute to the inequalities and hierarchies in a society. Gender differences are manmade and they get legitimized in patriarchal society. Patriarchy manifests itself in various forms of discriminations, inequalities, hierarchies, inferior status and position of women in society. (Geetha, 2002)[25]

It has been seen during the field work that men are the primary decision makers in their families and the authority is their hands so they even prefer to give their wages to them and if at all they refused to give they were beaten by their husbands. The issues regarding the spacing between children, number of children, taking care of children was all influenced by patriarchy and it therefore affected the health and reproductive health of the nomadic Dhodi Gujjar women.

During interaction with these respondents, it was also observed that the women respondents have somewhere internalised this patriarchal structure and were happy with the kind of life they were living.

Son-Preference and Reproductive Health

Sonalde Desai (1994)[26] argued that gender inequality in Indian society constrains women's reproductive choice and health. Indian women's reproductive and marital choices are particularly circumscribed by their social and economic circumstances. In particular, women's choices are severely curtained by the absence of socially accepted alternatives to marriage and a high degree of reliance on sons for old-age support.

The primary expectation from a married woman is that she will become pregnant soon and bear children. Typically, a woman knows of no acceptable role for herself than that of wife-mother. Childbirth dispels immediately the stigma of barrenness of a couple, especially that of a wife. The first child's sex is secondary, more important is the couple's fertility (Patel,1994). The religious rites a woman participates in are also predominantly related to increase her fertility. A woman requires to bear children to prove her womanhood, and a man desires children to attain fully manly state and hence dignity. Even grandparents are eager to have grandchildren as their status gets enhanced in a society. The whole family is desirous of having children. By bearing children, it is fulfillment of both social expectation and personal desires. (Oakley,1982). It is not only that motherhood brings status to a woman but it is also an attribute without which she is useless. She justifies her existence and is privileged only as a mother of son/s. Sons are regarded as critical for continuing the family line, for family's religious rites and rituals, especially to light the funeral pyre of parents. It is through sons that parents can anticipate a relaxed old age with daughter-in-law to run the household and look after them on how disconcerting and disheartening births of 'daughters only' can be. Sons are also important to take on the responsibility towards the sisters and daughters of the family. It is not just dowry at the time of wedding, but a continuous flow of gifts that a daughter and her children and others in her conjugal family receive from her parents and brother/s. (T.Patel,1994)[27]

During the field work, it has been found that son preference is an important factor influencing their fertility behaviour. Perceptions about the male as the bread winner and the sole source of support for parents in the old age in a society where post marital residence is largely patrilocal makes it important for the couple to have at least one son. Maximum of them had just son preference and said that at least two sons are necessary but some preferred both the sons and the daughters. Therefore, desire for son was somewhere directly proportional to the number of children.

Spacing and Reproductive Health

Spacing was still an alien concept for the women Nomadic Dhodi Gujjar women. Less spacing adversely affects the health of the women and also led to many gynecological problems. It has been found that the women who were just at the age of 30 had five daughters and one son. It has also been observed that majority of the respondents had five or six children and a few were having three children. Marrying at an early age and lack of education and awareness was an important factor for having more children among the respondents and also believed that they are God's gifts. Another prominent and important factor was the desire of son and even the lack of communication on reproductive matters was also the reason for more children among them. Therefore it affected the reproductive health of the women and even more children and less spacing led to more miscarriages.

So gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. From socio-cultural and economic perspectives, women in India find themselves in subordinate positions to men. They are socially, culturally and economically dependent on men. Women are largely excluded from making decisions, have limited access to and control over resources, restricted in their mobility and are often under threat of violence from male relatives. (Jejeebhoy and Sathar, 2001)[28]

3. Conclusion

The poor health condition of the Nomadic Dhodi Gujjar women is reflected in the status of their reproductive health correlated with individual and household social and economic conditions. Reproductive health also represents the overall health condition of a population. Moreover, women are central to various social and economic activities in tribal communities requiring reciprocal interactions with the contributing factors of reproductive health. Hence, the present study focuses on the reproductive health of Nomadic Dhodi Gujjar women to understand the overall condition of the Nomadic Dhodi Gujjar women.

Women experience discrimination and unequal treatment in terms of basic right of food, health care education, employment, control over decision-making and livelihood not because of their biological differences or sex, which is natural but because of their gender differences which is a social construct. A Nomadic Gujjar women spends 15- 20 years of her reproductive life in pregnancy and lactation, yet no specific health programme was ever introduced for this group of women. The entire reproductive process from pregnancy and childbirth to child rearing, which concerns women the most, these issues really need to be addressed. The social, health and nutritional factors have direct effect on reproductive health of mothers. Rather than being a medical problem, reproductive health has to be considered as a combination of several underlying factors in which social, economic, health and nutritional factors play a major role. Biologically the women bear the burden of reproduction; women alone have to go through all the problems and discomforts related to pregnancy and delivery. Women face various barriers in visiting a health centre to seek maternal and reproductive health care. This include cost of care, access to clinics, cultural factors, quality of care, and a lack of health awareness and use of any type of family planning. Physical access is an important barrier as longer distances entail higher transportation and opportunity costs. The health of the women especially the reproductive health is affected as she is forced to go for repeated pregnancies. So empowering women and stimulating mother's education would produce greater results in better reproductive status.

End Notes

1. World Health Organization (WHO). 1958. Women's Empowerment and Development. New Delhi.
2. S. Neelam. 2011. Sexuality, Health and Human Rights. Delhi: Manglam Publications
3. Ibid.
4. Sarkar and Acheampong. 2010. Gender, Poverty and Sustainable Livelihood. New Delhi: Arise Publishers.
5. Yadav and Mishra. 2003. Gender Issues in India. New Delhi: Radha Publications.
6. Chodorow. 1978. *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender.* Berkeley: University of California Press.
7. A. Kumar. 2006. Health and Nutritional Status of Indian Women. New Delhi: Anmol Publications.
8. R.P. Khatana. 1992. *Tribal Migration in Himalayan Frontiers.* Haryana: Vipin Jain Publishers.
9. S.K. Charak. 1983. *History and Culture of Himalayan States.* New Delhi : Light and Life Publishers.
10. Patnaik, Soumendra Mohan. 2011. *Culture, Identity and Development*. Jaipur: Rawat Publications.
11. Sharma and Niranjna.2001. *Social Structure and Fertility Behaviour*. New Delhi: Rawat Publications.
12. M. Nagla. 2015. 'Status of Health and Healing Practices Prevalent among Tribal Women: An Analysis, in S.N. Chadhuary (ed.), *Tribal Women : Yesterday, Today and Tomorrow.* Jaipur: Rawat Publications.
13. J. Sandhu. 1996. Sociology of Fertility. New Delhi: Rawat Publications.
14. Ibid.
15. Dreze, Sen. 2002. *India Development and Participation.* New Delhi: Oxford University Press.
16. Siddiqui, G.A. 2001. *Fertility Status of Women*. New Delhi: Rawat Publications.
17. J. Sandhu. *Op.Cit* Ref.13.
18. Bajpai and Mishra. 2007. *Women, Empowerment and Reproductive Behaviour*. New Delhi: Classical Publishing Company.
19. Sarkar and Acheampong. *Op.cit* Ref.4.
20. Chanu, Arunkumar. 2015. 'Traditional Reproductive Health Care Practices and Knowledge: A Case Of the Thadou of Manipur. IOSR Journal of Humanities and Social Science, Vol. 20(7): 86-88.
21. P. Smyke 1991. 'Women and Health'. London: Caledonian Publications.
22. Sharma and Niranjna. 2001.*Op.Cit* Ref. 11
23. Becker. S. 1996. '*Couples and Reproductive Health: A Review of Couples Studies'*. Studies in Family Planning, 27(6): 291-306.
24. Geetha. V. 2006. *Theorizing Feminism.* Kolkata: Graphique International Publications.
25. Ibid.
26. S. Desai. 1994. *Gender Inequalities and Demographic Behaviour*. New York: The Population Council Inc.
27. T. Patel. 1994. *Fertility Behaviour: Population and Society in a Rajasthan Village.* New Delhi: Oxford University Press.
28. Jejeebhoy and Sathar. 2001. *'Women's Autonomy in India and Pakistan: The Influence* of *Region and Religion'* Population Development Review, 27: 687-712.

Bibliography

1. Agarwal, Sutapa; *Active and Passive Elimination of Girl Child,* New Delhi, 1983.
2. Ahuja, Ram; *Research Methods*. New Delhi, 2001.
3. Anand , Meena; *Dalit Women Fear and Discrimination,* Delhi, 2005.
4. Andal N; *Women and Indian Society*, Jaipur, 2002.
5. Bajpai and Mishra; *Women, Empowerment and Reproductive Behaviour*, New Delhi, 2007.
6. Becker. S. *'Couples and Reproductive Health: A Review of Couples Studies'*, Studies in Family Planning, Vol.27(6), 1996, pp. 291-306.
7. Bedi and Alamgeer; *Impact of Modernism on Contemporary Muslim Women,* New Delhi, 2011.
8. Charak, S.K; *History and Culture of Himalayan States,* New Delhi, 1983.
9. Chanu, Arunkumar; *'Traditional Reproductive Health Care Practices and Knowledge*: A Case Of the Thadou of Manipur, IOSR Journal of Humanities and Social Science (IOSR-JHSS), Vol. 20(7), 2015, pp 86-88.
10. Chodorow, Nancy; *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender,* Berkley, 1978.
11. Dak, T.M.; Sociology *of Health in India*, New Delhi, 1991.
12. Desai and Thakkar; *Women in Indian Society*, New Delhi, 2001.
13. Dreze, Sen; *India Development and Participation,* New Delhi, 2002.
14. Dube, Leela; *Anthropological Explorations in Gender: Intersecting Fields.* New Delhi, 2001.
15. Geetha. V; *Theorizing Feminism.* Kolkata, 2006..
16. Gupta. J.A; *New Reproductive Technologies, Women's Health and Autonomy; Fredom or Dependency ?* New Delhi, 2000.
17. Hussain, Sabiha; 2003. Gender and Reproductive Behaviour: The Role of Men. *Indian Journal of Gender Studies*, Vol. 10 (1), 2013 pp 45-76, New Delhi.
18. Khan, Masood Ali; *Women in Islam*, Jaipur, 2006.
19. Khatana, R.P; *Tribal Migration in Himalayan Frontiers,* Haryana, 1992.
20. Kothari, C.R; *Research Methodology, Methods and Techniques,* New Delhi, 1985.
21. Krishnaraj, Sudarshan and Shariff; *Gender, population and Development,* New York, 1998.
22. Kumar; *Health and Nutritional Status of Indian Women*, New Delhi, 2006.
23. Magray; *Tribal Geography of India,* Jammu, 2003.
24. Mandlebaum, D.G; *Human Fertility in India*, Berkeley, 1974.
25. Memoria, C.R; *Agricultural Problems of India*. Allahabad, 1957.
26. Menon, Latika; *Gender Issues and Social Dynamics*, New Delhi, 1997.
27. Nagla, Madhu. (e .d.), *Sociology of Health.* New Delhi, 2014.
28. Neelam. S; *Sexuality, Health and Human Rights,* New Delhi, 2011.
29. Patel, Tulsi; *Sex-Selective Abortions in India*, New Delhi, 2007.
30. Patnaik, Soumendra Mohan; *Culture, Identity and Development*, Jaipur, 2011.
31. Rahi, Javaid; *The Gujjar Tribe of Jammu and Kashmir*, Kashmir, 2011.
32. Ram, Unissa, Sekher, (e.d.), *Population, Gender and Reproductive Health,* New Delhi, 2011.
33. Sandhu, J; *Sociology of Fertility*, New Delhi, 1986.
34. Sharma and Niranjna; *Social Structure and Fertility Behaviour*, New Delhi, 2001.

35. Shashi, S.S; *The World of Nomads*, New Delhi, 2006.
36. Siddiqui, G.A; *Fertility Status of Women*, New Delhi, 2001.
37. Singh, Surijit; *The Great People of Jammu and Kashmir,* Jammu, 2008.
38. Tapan, Neeta; *Need For Women Empowerment*, Jaipur, 2000.
39. WHO; *Reproductive Health Strategy*, Department of Reproductive Health and Research, 2004.
40. Yadav, M; *Gender Issues in India*, New Delhi, 2003.
41. Yadava. K.N.S; *Status and Fertility of Women in Rural India,* New Delhi, 1995.

