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A STUDY ON HEALTH STATUS OF GUJJAR TRIBES IN ANANTNAG DISTRICT OF KASHMIR VALLEY

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Abstract
Despite remarkable world-wide progress in the field of diagnostics and curative and preventive health, still there are people living in isolation in natural and unpolluted surroundings far away from civilization with their traditional values, customs, beliefs and myth intact. They are commonly known as "tribals" and are considered to be the autochthonous people of the land. Health is a prerequisite for human development and is an essential component for the well being of the mankind. The health problems of any community are influenced by interplay of various factors including social, economic and political ones. The common beliefs, customs, practices related to health and disease in turn influence the health seeking behaviour of the community. Health of indigenous or tribal people is the perception and conception in their own cultural system with less awareness of the modern health care and health sources. In India, tribals are most depressed and under drowned people, especially in rural areas they don't even have a permanent work and sufficient income and they do not acquire an adequate service of health. The Gujjars and Bakerwals tribes form the third largest ethnic group in Jammu and Kashmir after Kashmiri and Ladakhi, constitute more than 20 per cent population of the State are living below poverty line. They are the state's most populous Scheduled Tribe contains the population of more than 20 lakh as per the 2011 census and one forth of them are living nomadic life. The both groups of Gujjar community are without sufficient food, fodder for their animals. They lack basic facilities like proper shelter, health, drinking water, and education. The health condition of Gujjar and Bakerwal tribes in Jammu and Kashmir is the worst, because of lack of education, lack of awareness about health programs and their way of living nomadic life. These tribes do not have basic knowledge towards health care and preventive measures and they don't have a proper health care service too. The central government, state government, NGO's and local bodies are jointly working for the improvement of Gujjar and Bakerwal health conditions. The main focus of the study is: to study the health problems of Gujjars tribe and to identify the background characteristics that determines the health status of Gujjar tribes in Anantnag district of Kashmir valley.

Key words: Health, Gujjar Tribes, Awareness.

Introduction

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." It is well recognized that health is not the exclusive domain of medical science because every culture, irrespective of its simplicity and complexity, has its own beliefs and practices concerning diseases. No culture works with a meaningless approach in its treatment of diseases. Every culture evolves its own system of medicine in order to treat diseases in its own way. Thus, treatment of disease may vary from group to group. To understand health and health related problems in a proper perspective, it is very important to consider the socio-cultural issues, economic dimensions and environmental aspects. This is more relevant in the context of tribal people, particularly living in the rural areas. Although the National Health Policy, 1983 accords high priority to extending organized services to those residing in the tribal, hilly and backward areas as well as to the detection and treatment of endemic diseases affecting tribals, yet they continue to be one of the fragile population, mainly due to their poor health and disease management. Tribal health is one of the important areas for action in the health sector. The major contributors to the increased disease risk amongst tribal communities include - (i) poverty and consequent under nutrition; (ii) poor environmental sanitation, poor hygiene and lack of safe drinking water leading to increased morbidity from water and vector-borne infections; (iii) lack of access to health care facilities resulting in the increased severity and duration of illnesses; (iv) social barriers and taboos preventing utilization of available health care services; (v) vulnerability to specific diseases like G-6 PD deficiency, yaws and other endemic diseases like malaria etc. Also, the tribal population, being heterogeneous, there are wide variations in their health status, access to and utilization of health services.

The different tribal communities in India, represents a heterogeneous group. There is considerable variation in the context of socio-economic life, custom and tradition and behaviour and practices. Similarly, variations are also there in the context of demographic features. There is one factor common among all tribal communities except North-east tribals; it is low literacy rate and poor health status and indigenous method of disease management. The tribal illiteracy has a close link between health and disease management. The common beliefs, customs, traditions, values and practices connected with their health and disease have been closely associated with the treatment of diseases. In most of the tribal communities, there are number of folklores related to health. Knowledge of folklore of different socio-cultural systems of tribals may have positive impact,

which could provide the model for appropriate health and sanitary practices in a given eco-system. Tribal health system and medical knowledge over ages known as 'Traditional Health Care System' or 'Indigenous Health Practices' depend both on the herbal and the psychosomatic lines of treatment. While plants, flowers, seeds, animals and other naturally available substances formed the major basis of treatment, this practice always had a touch of mysticism, supernatural and magic, often resulting in specific magico-religious rites. Faith healing has always been a part of the traditional treatment in the Tribal Health Care System, which can be equated with rapport or confidence building in the modern treatment procedure. Certain practices are suggested to avoid illness or diseases, while some are prescribed to have better health. These should not be ignored as mere folk-beliefs, but need careful attention. There are different folklores to avoid illness, during illness, regarding food and so on. It has also been noted that among the tribals there is high incidence of communicable diseases, like: Tuberculosis, Hepatitis, Sexually Transmitted Diseases (STDs), Malaria, Filariasis, Diarrhoea and Dysentery, Jaundice, Parasitic infestation, Viral and Fungal infections, Conjunctivitis, Yaws, Scabies, Measles, Leprosy, Cough and Cold, HIV/AIDS, etc due to lack of sanitation and unhygienic living. The acute diarrhoeal problems were basically due to poor environmental hygiene, lack of safe drinking water, improper disposal of human excreta, aggravated by low literacy, socio-economic status coupled with blind cultural belief, lack of access to medical facilities leading to serious public health problems.

The state Jammu and Kashmir lies in Northern India. It is located mostly in the Himalayan Mountains, and shares a border with the states of Himachal Pradesh and Punjab to the south. Jammu and Kashmir has an international border with China in the north and east, and the Line of Control separates it from the Pakistani-controlled territories of Azad Kashmir in the west and northwest respectively. The state has special autonomy under article 370 of the constitution of India**. (**http://en.wikipedia.org/wiki/Jammu_and_Kashmir**)** The total population of Jammu and Kashmir has 1, 25, 41,302 (1.25 cr.) with a territory of 2, 22,236 sq.km. representing about 3.20% of total area of the country. The Gujjars and bakerwals are the third biggest ethnic groups in Jammu and Kashmir constitutes more than 11.9% of the total population of the state (Census, 2011); scheduled tribe is the only community, which maintain its culture and heritage throughout ages. In the Indian state of Jammu & Kashmir, the concentration of Gujjars is observed in the districts of Rajouri and Poonch, followed by, Anantnag, Udhampur and Doda districts. It is believed that Gujjars migrated to Jammu and Kashmir from Gujarat (via Rajasthan) and Hazara district of NWFP. And the Bakarwal has a place with the same ethnic stock as the Gujjars, and intermarriages openly happen among them. The constitution of J&K has notified twelve communities as the scheduled tribes vide two (Scheduled Tribes) order (Amendment) Act. Eight communities- Balti, Beda, Bot, Brookpa, Changpa, Garra, Mon and Purigpa, among them were given this status in 1989; And Bakerwals, Gujjars, Gaddis and Sippis were notified as the scheduled tribes vide the constitution (Scheduled Tribes) order (Amendment) Act, 1991. Gujjars and bakerwals constitute the greater part of them with 69% of tribal population. Scheduled tribes are socially all that much depictable by moving, religious customs and traditions and so forth. They entirely take after their old traditions and conventions. The tribals herd animals like sheeps, goats and buffalo. Semi-nomadic people of Gujjar community are in the habit of migrating to upper parts of Himalayas along with their cattle during the summer season and back to the plains with the onset of chilly winter. The both groups of Gujjar community are without sufficient food, fodder for their animals. They lack basic facilities like proper shelter, health, drinking water, and education. The survey conducted by Tribal Research and Cultural Foundation (TRCF) further revealed that more than 71 percent of nomads were not aware of the schemes of the state and central governments for their upliftment under Scheduled Tribe category. The Gujjars-Bakerwals were listed in constitution of India in 1991 under ST category and schemes were launched by state and central governments to uplift them socially, economically, educationally and culturally. The Gujjars and Bakerwals in the state are the poorest, living in sordid conditions, had no access to education as they are of migratory characters. There is need to formulate a sustainable poverty eradication programme for migratory tribes as they deserved special attention due to toughest lifestyle, lacking economic freedom, health facilities and food security owing to low income and deficiency of resources.

The health problems need special attention in the context of tribal communities of India. Available research studies point out that the tribal population has distinctive health problems which are mainly governed by their habitat, difficult terrains and ecologically variable niches. The health, nutrition and medico-genetic problems of diverse tribal groups have been found to be unique and present a formidable challenge for which appropriate solutions have to be found out by planning and evolving relevant research studies. Primitive tribal groups of India have special health problems and genetic abnormalities like sickle cell anaemia, G-6-PD red cell enzyme deficiency and' sexually transmitted diseases (STD). Insanitary conditions, ignorance, lack of personal hygiene and health education are the main factors responsible for their ill health (Basu, 2000). ST populations continue to carry high burdens of 'diseases of the poor', namely under nutrition and infectious diseases. High levels of chronic under nutrition have been observed among child and adult populations (Bose et al., 2006). Micronutrient malnutrition is also a major problem among STs, including anemia and iodine deficiency disorders (Ghosh & Bharati, 2003; Arlappa, et. al, 2009). Malaria persists, particularly among tribal populations living in forested areas and the prevalence has

been found to be rising in some areas (Singh, et. al, 2003; Singh & Dash, 2009). Prevalence of tuberculosis varies across tribal populations. A number of studies have found that the prevalence and patterns of TB does not differ significantly from non ST communities, but that TB control programs for STs require special attention due to difficult terrain and limited drug supplies in many tribal areas. Geographical isolation and limited interactions with other communities has limited exposure of HIV/AIDS among ST communities and among some tribal groups prevalence rates remain low; however in some areas, STs are emerging as a high-risk group for HIV/AIDS as they migrate driven by displacement or for employment opportunities (Naik, et al, 2009). Social determinants of health are the economic and social conditions under which people live which determine their health. They are "societal risk conditions", rather than individual risk factors that either increase or decrease the risk for a disease, for example for cardiovascular disease and type II diabetes. As stated in Social Determinants of Health: The Solid Facts (WHO, 2003).

Objectives of the Study

1. To study the health problems of Gujjar tribes **2.** To identify the background characteristics that determines the health status and the health problems of Gujjar tribes in Anantnag district of Kashmir valley.

Material and Methods

The researcher has selected Anantnag district of Kashmir valley for this study work because according to Census 2011 the highest scheduled tribe population is found in that district. Descriptive as well as analytical research deigns is made to use for the purpose of this study work. The sample for the present study comprises of 420 Gujjar households from two blocks viz. Kokernag and Dachanipora blocks of Anantnag district by using stratified random sampling. The sample consists of 255 Gujjar respondents in Kokernag block and 165 Gujjar respondents in Dachanipora block. For achieving the above given objectives this study was based on both the primary and secondary data, the investigator has collected the primary data directly from the respondents, using the structured interview schedule. The pattern of questions in the interview schedule was both structured and open-ended related their socio-economic conditions, Health conditions /Health care, Educational Status and social awareness of welfare programmes aspects. The researcher has used Statistical Package for Social Science (S.P.S.S) and the multivariate techniques have adopted to analyse the collected data.

Result and Discussions

In the present study, respondents have been asked about their present health condition as an ascribed status which may be cross-checked and confirmed by the chronic disease as unhealthy status and without disease as healthy status. Thus the researcher just describes the health condition of the respondents by frequency table and detailed explanation of health care activities with the help of cross-tabulations and chi-square test of significance. Finally, the major determinants of the respondents' health status across the background characteristics have been analyzed with the help of a multivariate model.

Table 1.1: Percentage Distribution of the Respondents by their Heath Problems in Block Wise

Block	Health Problems		Total No. of Respondents
	Percent	No. of the Person Affected	
Breng / Kokernag	55.3	141	255
Dachanipora	44.7	74	165
Total	51.2	215	420
χ^2 – Value; Sig. Level	**4.375; p< 0.01**		-----

Note: Percentages for each category of the variables have been calculated by Row-wise. -- = Not Applicable.

The considering fact that the scheduled castes and scheduled tribes are vulnerable to avail the basic amenities like food, water, shelter and health care in general and Gujjar tribes in particular. For instance (Table: 1.1) in Breng block, 55 per cent of the respondents suffer from health problems and in block Dachanipora 45 per cent of the respondents are suffering from varying health problem. In this study, it was found that in both the blocks those Gujjar tribes who are living near to villages or those tribes who are settled in villages their lifestyle was better than those Gujjar respondents who are living in higher reaches of Pir Panjal mountains or those Gujjars who are living semi-nomadic life. The respondents who are near to villages are gaining the health care facilities easily, because of the close proximity of hospital in those areas. Distance is one of the policy variables to determine poorer health care. The result of the chi-square test shows that the block wise distribution of health has high level of significance. The chi-square test is being employed and the test has confirmed that there are differences between the blocks with respect to availing health care facilities at the 5% level of significance.

Percentage Distribution of Gujjar Tribes Major Health Problem

Table 1.2 shows the major health problems of the respondents. Those health problems are closely related to their food habits, housing conditions, daily practice and smoking/answer dependency on addictive substances. In it most of the respondents except few works as grazing cattle's and agriculture workers. They are receiving money after some months and do not have the habit of savings and taking proper diet. As grazing the cattle is too much difficult task that they have to walk full day, so they use the money for other habits such as smoking, Naswer, chewing tobacco and majority of the Gujjars are expenditure their money on family food and fodders to their cattle. Others work for daily wages in works such as construction work, Carpenters, Masons and shopkeepers; they receive money towards the end of their work every day. Respondents without a proper and balance diet, but having bad habits, are mainly responsible for their health problems. In this study, it was found that 16 per cent of the respondents is having ulcer / gastric problems and 13 per cent of the respondents reported that they are suffering from kidney/lung problems. Other problems are related to one another and there is a slight difference in percentage. Other minor health problems (Nee, Joint, Eye, Body pain, skin problem) are named as others in the table; it is reported by 15 per cent. These problems are directly related to their work and work burden. Respondents do hard physical work for a whole day without proper rest and adequate food. Thus, after a certain years of work, most of the people are affected by any of the health problem. Thus the respondents say that the work burden and poverty are the main reasons for their addiction.

Table 1.2: Percentage Distribution of Gujjars by their Major Health Problem

Name of Diseases	Health Problems	
	Percent	**No. of Person Affected**
No Health Problem	48.8	205
Kidney Problem / Lungs Problem	12.9	54
Blood Pressure / Sugar	8.1	34
Ulcer / Gastric	15.7	66
Others	14.5	61
Total	**100.0**	**420**

Note: Percentage for each category of the variables have been Calculated by Row-Wise

Differential Distribution of Gujjar tribes Background Characteristics for Selected Aspects across their Health status

In this section, an attempt is made to analyse and discuss the differentials in respondents' health; which is being affected by the chronic health problems that is a continuous illness. It helps the researcher to understand the health status of the respondents as a consequence of socio-economic conditions of the respondents. The results turn out to be significant differentials in the health problems by most of the variables taken under consideration (Table 1.3). Age is important policy variable which turn out to be significant. There is a positive relationship between the age and the health problem. Age is playing a critical role in the health status of every person. In other words the lower is the age, lower are the health problems and the higher is the age, higher the percentage of health problems are. The respondents are classified into three groups by their age for better understanding of the health conditions. For instance, 59% of the of the senior citizens are affected by varying health problems at the age group of 45 and above years whereas, 54% of the people who are at age group of 31 – 45 years are affected. At the same time 41% of the people of age group of below 30, have less health problem than other two age groups. Therefore, the lower the ages are, the lower the risks are, and the higher the age there is will be higher the risks. It's all by the respondents' habits and their living conditions, in this study most of the male respondents are suffering from kidney and body pain problems while as female respondents suffers from stomach pain and heart problems. *Variable 2 of Table 1.3* shows that 52% of both the male and the female are affected. It shows that sex does not play a main role in health problems. In the rural area, the female are play a dual role in the sense that they have to do household as well as agriculture work. Women have many hardships to bare namely, a work burden, an economic inadequacy and the family problems which affect their health. Hence, the health problem is more or less responds in the same proposition by both genders thus the statistical results has turns out as lesser extend of significance. *Variable 3 of Table 1.3* shows the marital status of the respondents with regard to their health status. Fifty seven per cent of the respondents who are widows, separated or divorced are affected by health problems as compared to those who are married; again it is an influence of age factor and the χ^2 – test results in this regard emerged as lesser significant ($p<0.10$). *Variable 4 of Table 1.3* shows that more than half of the respondents (57%) are illiterates who reported more health problems as compared to those who are educated (31%). In reality, an illiterate is suffering a lot than the literates (those who have a basic educational qualification) it is also highly significant in influencing the health status of the respondents. There is a positive relationship between education and health problems ($p<0.001$). This shows that lower the education, higher the health problems and the higher the education, health problems will reduce

gradually. It means that the respondents are educated about health, health care and treatment it will reduce the risk of health problems automatically.

Occupation and income are more a deciding factor of lifestyles in the present study *variable 5 & 6* of Table 1.3 shows that 77% of the respondents who are working in agriculture suffers more from health problems, 61% are those respondent who are grazing their cattle are also troubled by health problem whereas 45% of the respondents who are skilled workers reported health problems and 20% of the respondents working in Government jobs. Hence most of the respondents who are grazing cattle and working in agriculture are highly distressed by health problems. This is followed by other working groups. The chi-square results turned out as highly significant ($p<0.001$). It means that the suffering is also increasing gradually while an income is low; the study proved it as true by highly significant determinants as far as reality is concerned. The higher the income lowers the risk of health and vise-versa. The respondents use huge amounts for their family expenditure and fodder for their cattle's and they do not have the habit of savings. Thus it is due to the all results in poverty and health problems. So, the health problem is highly related to their age, occupation and income status, these variables give high significant values in chi-square tests.

The environment has a huge influence on the health conditions. Thus the researcher tries to explore their circumstances and its impact on health. *Variable 7 & 8* of Table 1.3 shows that the respondents living in Katcha house have higher percent of health problems (55%). Respondents in rural huts, have a great challenging task to lead a healthy life. It is followed by the respondents living in semi-pucca (45%) and (42%) in Pucca homes with slight differences in percentage. The major cause of the health problems is not having a proper drainage system and toilet facilities and also lack of their knowledge about disease and prevention. The chi-square test in this regard have also exhibited a highly significant association ($p<0.001$). The preference of the hospital and performance of preventive measure are all calculated by using chi-square techniques and it give significant differentials in health problem. Fifty seven per cent of the respondents prefer government hospital for treatment. They are not interested to spend a large amount for treatment as they are economically poor not to prefer private hospitals and they make a proper use of the government concessions.

In this study *variable 9 of Table 1.3* shows that when the larger the family size; the higher the number of health problems. Here, the respondents having five or six family members (54%) are suffer more health problems than those respondents who have three or four family members. Generally the Gujjar community has larger family system because in the transhumant society larger family is the necessity for keeping livestock and the fact is that most of the respondents do not adopt the family planning method. The chi- square results in this regard have exhibited a moderately significant ($p<0.05$). *Variable 10 of Table 1.3* shows that, higher the earning members in the family lesser (45%) would be the health problems; lesser number of earning family; the higher (54%) the health problems. Generally, in a Gujjar community where there is less number of earning member are unable to take care of family members due to low income while as the family having more earning members have the opportunity to take care of others members as they are earning more income. Moreover, the chi-square test have also been turned out as moderately significant ($p<0.05$).

Table 1.3: Percentage Distribution of Gujjar Tribes Background Characteristics for Selected Aspects across their Health status

Background Characteristics	Health Status				Total	
	Healthy		Unhealthy			
	%	No.	%	No.	%	No.
1. Current Age (in Years)						
Up to 30	59.2	84	40.8	58	33.8	142
31 – 45	46.0	58	54.0	68	30.0	126
45 +	41.4	63	58.6	89	36.2	152
χ^2 – Value; Sig. Level	***9.769; p < 0.001***					
2. Gender						
Male	49.0	147	51.0	153	71.4	300
Female	48.3	58	51.7	62	28.6	120
χ^2 – Value; Sig. Level	***0.015;p<0.10***					
3. Marital Status						
Married	49.5	188	50.5	192	90.5	380
Single / Widow / Divorce	42.5	17	57.5	23	9.5	40
χ^2 – Value; Sig. Level	***0.704; 0.10***					

4. Educational Status						
Illiterate	42.9	139	57.1	185	77.1	324
Literate	68.8	66	31.3	30	22.9	96
χ^2 – Value; Sig. Level	***19.804; P < 0.001***					
5. Occupational Status	39.0	39	61.0	58	23.8	100
Grazing Cattle	45.0	63	77.0	98	33.3	140
Agriculture Workers	54.4	49	45.6	133	21.4	90
Skilled Workers / Business	80.0	28	20.0	7	8.3	35
Govt. Employees	47.3	26	52.7	31	13.1	55
Housewives						
χ^2 – Value; Sig. Level	***19.184; P< 0.01***					
6. Monthly Income						
Up to ≤ 3500	36.9	65	63.1	111	41.9	146
3501 – 5500	49.6	65	50.4	66	31.2	138
5501 +	66.4	75	33.6	38	26.9	136
χ^2 – Value; Sig. Level	***24.532; P < 0.001***					
7. Type of House						
Katcha	44.5	114	55.5	142	61.0	256
Semi Pucca	54.9	73	45.1	60	31.6	133
Pucca	58.1	18	41.9	13	7.4	31
χ^2 – Value; Sig. Level	***4.904; p< 0.01***					
8. Preference of Hospital						
Govt. Hospital	78.1	57	21.9	16	17.4	73
Private Hospital	42.7	148	57.3	199	82.6	347
χ^2 – Value; Sig. Level	***30.302; p< 0.001***					

(Continued…

Background Characteristics	**Health Status**				**Total**	
	Healthy		**Unhealthy**			
	%	**No.**	**%**	**No.**	**%**	**No.**
9. Total Family Members						
3 – 4	47.6	30	52.4	33	15.0	63
5 – 6	45.5	76	54.5	91	39.8	167
7 +	52.1	99	47.9	91	45.2	190
χ^2 – Value; Sig. Level	***1.590; p< 0.05***					
10. Total No. of Earners						
1	45.7	126	54.3	150	65.7	276
2 +	54.9	79	45.1	65	34.3	144
χ^2 – Value; Sig. Level	***3.212; p< 0.05***					
11. Inability to Work						
Yes	44.8	162	55.2	200	82.2	362
No	74.1	43	25.9	15	13.8	58
χ^2 – Value; Sig. Level	***17.278; p< 0.001***					
12. Reduced Income						
Yes	44.3	162	55.7	204	87.1	366
No	79.6	43	20.4	11	12.9	54
χ^2 – Value; Sig. Level	***23.558; p< 0.001***					
13. Managing Disability						
Friends / Relatives	40.2	66	59.8	98	39.0	164
Selling Cattle	41.0	55	59.0	79	31.9	134
Taking Loan	59.7	37	40.3	25	14.8	62
Managing within their salary	78.3	47	21.7	13	14.3	60

χ^2 – Value; Sig. Level	***31.912; p< 0.001***					
14. Preventive Measures						
Following Diets	66.7	48	33.3	24	17.1	72
Proper check-up / Medicine	82.8	72	17.2	15	20.1	87
Never mind about it	32.6	85	67.4	176	62.1	261
χ^2 – Value; Sig. Level	***76.878; p< 0.001***					
Total	**48.8**	**205**	**51.2**	**215**	**100.0**	**420**

Note: Percentages for each of the categories of the variables have been computed by Row-wise

In this study *variable 11, 12, 13 & 14* of Table 1.3 reveals that more than half of the respondents (55%) say that their working capacity is down due to the health problem, the chi-square test have also been turned out as highly significant ($p<0.001$). It was also noticed that 55 per cent of the respondents says that it reduces their income and they manage with the support of others (friends/relatives) or selling their cattle's and it is statistically highly significant ($p<0.001$). In this study it was also observed that Sixty seven percent of the respondents are never worried about health status and the respondents do not follow any preventive measures to secure their health status. Conversely, only a minimum 17% number of the respondents are getting medicine from the medical shop at the time of ailments and take rest until they get cured and 33 per cent of them are following diets. Generally in tribal areas mostly they use more traditional methods for treatment or get medicine from the medical shop at the time of ailments and taking rest until they get cured. The Gujjar tribes in the Kashmir vary is the worst, because due to the lack of education, lack of awareness about health programmes and their way of nomadic life. Most of the nomads were not aware of the schemes of the state and central governments for their uplifment under Scheduled tribe category.

Findings & Conclusion

In Breng block, 55 per cent of the respondents suffer from health problems and in block Dachanipora 45 per cent of the respondents are suffering from varying health problem. In this study, it was found that in both the blocks those Gujjar tribes who are living near to villages or those who are settled in villages their lifestyle was better than those Gujjar respondents who are living in higher reaches of Pir Panjal mountains or those Gujjars who are living semi-nomadic life. The respondents who are near to villages are gaining the health care facilities easily, because of the close proximity of hospital in those areas. Distance is one of the policy variables to determine poorer health care. In this study, it was found that 16 per cent of the respondents is having ulcer / gastric problems and 13 per cent of the respondents reported that they are suffering from kidney/lung problems. Other problems are related to one another and there is a slight difference in percentage. Other minor health problems (Nee, Joint, Eye, Body pain, skin problem) are named as others in the table; it is reported by 15 per cent. These problems are directly related to their work and work burden. Respondents do hard physical work for a whole day without proper rest and adequate food. Thus, after a certain years of work, most of the people are affected by any of the health problem. Thus the respondents say that the work burden and poverty are the main reasons for their addiction. Age is important policy variable which turn out to be significant. There is a positive relationship between the age and the health problem. Age is playing a critical role in the health status of every person. In other words the lower is the age, lower are the health problems and the higher is the age, higher the percentage of health problems are. The low level education and illiteracy making them to gain less basic knowledge about the health and hygienic care as they are in need of other's help for their healthy behavior. Therefore majority of the respondents that is to say about 77 per cent of respondents are being affected by the health problems. Occupation and income are more a deciding factor of lifestyles in the present study about 77% of the respondents who are working in agriculture suffers more from health problems, 61% are those respondent who are grazing their cattle are also troubled by health problem whereas 45% of the respondents who are skilled workers reported health problems and 20% of the respondents working in Government jobs. Hence most of the respondents who are grazing cattle and working in agriculture are highly distressed by health problems. This is followed by other working groups. It means that the suffering is also increasing gradually while an income is low; the study proved it as true by highly significant determinants as far as reality is concerned. The higher the income lowers the risk of health and vise-versa. The respondents use huge amounts for their family expenditure and fodder for their cattle's and they do not have the habit of savings. Thus it is due to the all results in poverty and health problems. So, the health problem is highly related to their age, occupation and income status. In this study that more than half of the respondents (55%) say that their working capacity is down due to the health problem. It was also noticed that 55 per cent of the respondents says that it reduces their income and they manage with the support of others (friends/relatives) or selling their cattle's. Sixty seven percent of the respondents are never worried about health status and the respondents do not follow any preventive measures to secure their health status. Conversely, only a minimum 17% number of the respondents are getting medicine from the medical shop at the time of ailments and take rest until they get cured and 33 per cent of them are following diets. Generally in tribal areas mostly they use more traditional

methods for treatment or get medicine from the medical shop at the time of ailments and taking rest until they get cured. Finally, it was concluded that the Gujjar tribes in the Kashmir vary is the worst, because due to the lack of education, lack of awareness about health programmes and their way of nomadic life. Most of the nomads were not aware of the schemes of the state and central governments for their uplifment under Scheduled tribe category. In spite of the tremendous advancement in the field of preventive and curative medicine, the health care delivery services in these primitive tribal people are still poor and need to be strengthened in order to achieve the goal of Health for all in the country

References

1. Arlappa, N. et.al. (2009). Prevalence of Anaemia among Rural Pre-School Children of West Bengal, India. Ann HumBiol, Pp. 1-12.
2. Bose, K. et.al. (2006). High prevalence of under nutrition among adult Kora Mudi tribals of Bankura District, West Bengal, India. Anthropological Science, 114, Pp. 65-68.
3. Ghosh, R., & Bharati, P. (2003). Hemoglobin Status of Adult Women of two Ethnic groups living in a peri-urban area of a Kolkata city, India: a micro-level study. Asia Pacific J Clin Nutr, 12, Pp.451-59.
4. Gul, Showkeen Bilal Ahmad (2014). "Assessment and Understanding of Gujjar and Bakerwal Women's Health in Jammu and Kashmir", Journal of Business Management and Social Science Research 3(3): 37-43.
5. Jana, Narayan Chandra, Anuradha Banerjee & Prasanta Kumar (2014) "Comparing Patterns and Variations in Health Status between Tribes and Non-Tribes in Odisha of Eastern India with Special Reference to Mayurbhanj District", Journal of Geography and Earth Sciences 2(2), 49-69.
6. Mishra, Manish (2012). "Health Status and Diseases in Tribal Dominated Villages of Central India", Health and Population -Perspectives and Issues 35(34): 157-175.
7. Salil Basu, (2000). Dimensions of Tribal Health in India. Health and Population - Perspectives, 23(2), Pp. 61-70.
8. Shankar. R and S. Manimaran (2013) "Socio – Economic Conditions of Pachamalai Tribes", International Multidisciplinary Journal 1(1): PP. 112-118.
9. Singh N, et. al., (2003).Forest malaria in Chhindwara, Madhya Pradesh, Central India: A case study in a tribal community. Am J Trop Med Hyg, Vol. 68, Pp.602 - 607.
10. Singh, N., & Dash, A.P. (2009). Fighting malaria in Madhya Pradesh (Central India): Are we losing the battle? Malaria Journal, Vol.8, Pp.93.
11. Naik E, et.al., (2009). Rural Indian Tribal Communities: An Emerging High-risk group for HIV/AIDS. BMC Int Health Hum Rights, Vol.5, Pp. 1.
12. WHO (2003) *The World Health Report*, Geneva.