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Family Dynamics, Health Inequities, and Human Rights: Analyzing the Marginalization of Transhumant Gujjar Women in Jammu and Kashmir

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ABSTRACT

The Transhumant Gujjars of Kashmir are a semi-nomadic pastoral community known for their seasonal migrations. They move with their livestock between high-altitude summer pastures in the Himalayas and low-altitude winter pastures in the plains. This lifestyle significantly impacts their socio-economic conditions, access to healthcare, and educational opportunities. The challenges they face include limited access to consistent medical services, nutritional deficiencies due to economic constraints, and educational barriers, particularly for women and children. These factors collectively influence the overall well-being of the community. This study explores the impact of family dynamics on the health of tribal women, focusing on the Transhumant Gujjars of Kashmir. The Gujjar community's patriarchal structure, migratory lifestyle, and traditional practices shape the health outcomes of its women. Family roles, characterized by heavy workloads and lower social status for women, contribute to physical and nutritional health challenges. Limited access to healthcare, exacerbated by seasonal migrations, and reliance on traditional remedies, adversely affect women's health. Nutritional deficiencies arise from food distribution practices that prioritize men and children, further compounded by economic hardships. Low literacy levels and limited empowerment restrict women's ability to seek and utilize healthcare services effectively. Early marriages and high fertility rates pose significant reproductive health risks, while the extended family system, although providing social support, imposes additional responsibilities on women. This study underscores the need for targeted interventions, including mobile health services, nutrition programs, educational initiatives, and culturally sensitive health policies to improve the health and well-being of Transhumant Gujjar women. By addressing the unique socio-cultural and

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economic factors within the Gujjar community, these measures can foster better health outcomes for tribal women in Kashmir. By putting these encounters within a human rights context, the paper highlights the invisibility of Gujjar women in policy discourses and the disappointment of prevailing schemes to endorse constitutional, International, and universal rights pledges. It contends that traditionally sensitive, rights-based interventions to be incorporated. The nutritional and educational programs, mobile health units, and other women's empowerment initiatives that identify the exclusive experiences of transhumant Gujjar women. Addressing these biases and inequities is important to understanding health not merely as a medical worry, but as a fundamental human right grounded in equity, dignity, and justice.

Keywords: Women, Transhumant Gujjars, Tribals, Jammu and Kashmir, Family Dynamics, Health, Human Rights.

INTRODUCTION

The lived experience of transhumant Gujjar women portrays a close intersection between human rights violations, marginalization, and neglect from both the state and the patriarchal structure of their community. When analyzed within the human rights framework, the challenges and marginalization women of the community face are not only paramount but also violate the very basic aspects of the universally recognized human rights. There is a close connection between the socio-economic status and human rights (McAuliffe, 2022). They are not only complementary but also mutually reinforcing. The denial of socio-economic opportunities translates into the violation of basic human rights. The same is true that the protection of human rights creates viable conditions for the socio-economic well-being of the individuals.

The Gujjar belong to the Scheduled Tribes communities of Jammu and Kashmir, which practice transhumance activity. Transhumance involves seasonal movements from winter to summer regions tracking through the mountainous regions of the state. They do not establish permanent settlements instead reside in temporary tents. This allows them to move frequently in search of green pastures and herding their livestock which is their main income source. Throughout

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India, pastoralists have a low human development index with high relative deprivation index (Kapruwan et. al, 2024). They remain outside the ambit of any government policies due to the absence of any permanent residence, poor communication, uncertain civil status and often perceived with low priority. Tribal's of the Jammu and Kashmir constitute the significant part of the population. According the 2011 census of India, the tribal population constitutes 11.9 percent of the population of the erstwhile state of Jammu and Kashmir (census, 2011). Among them the Gujjar community are the third largest ethnic and linguistic group, constituting more than 20 percent of the population. But they are socially, economically and politically backward. Despite several constitutional provisions available, the community still lags far behind the mainstream population in every aspect of the socio-political and economic life. They have remained by and large untouched by the modernity (Bhat, 2019). They have yet to developed basic facilities such as shelter, healthcare and means of communication. Their main income sources are through the earnings of animals especially sheep, goat, buffaloes and horses. The transhumant Gujjar women are living at the margins of socio-economic strata of the society. Therefore, this study deals with the Gujjar community's patriarchal structure, migratory lifestyle, and traditional practices shape the health outcomes of its women.

Women Living on the Margins

Economic development plays a significant role in the empowerment of a marginalized community. In this respect, the transhumant Gujjar population is the most vulnerable section compared to the mainstream population (Ahmad 2020). Although women from this community have been working shoulder to shoulder with men to contribute to the household economy. From physical labour such as tracking thousands of miles for the heading animals and at the same time taking care of family and the children, yet have no role in the decision making, especially about how and when to spend the money (Sharma 2015). They may contribute economically to the family, but are not allowed to spend the money. It is always men who make decisions on their behalf. Most of the time, it has also been observed that when they get ill or have any severe diseases, they do not get access to health care for several reasons, but one of the prominent reasons is that it is not their tradition to spend money on health care (Rahi, 2018). They consider spending money on modern healthcare to be useless and harmful. Instead, they rely on herbs or medicinal plants and more often on spiritual people (Rahi, 2018). Due to limited access to financial resources, the absence of credit facilities, lack of market

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opportunities, among other factors that hinder their ability to improve their socio-economic conditions. They lack the modern knowledge about how the market determines the demand and supply in order to get benefit from the opportunities it provides, even in selling their livestock. Due to illiteracy, they do not know how to exploit modern technology for economic gains, such as digital media or others. Thus, they remain outside the spectrum of modernity, which in turn has a harmful impact on their education, health and social well-being (Bhat, 2019).

Health care status

Given their lifestyle, the community faces multiple challenges in accessing modern health care services. Poverty and discrimination have a deleterious impact on their health. They have the highest infant mortality rates. According to the National Family Health Survey, the infant mortality rate is 60 deaths per 1000 live births (NFHS-5, 2019). Transhumant women have the highest rate of malnutrition; undernutrition, vitamin deficiencies, hypertension, diabetes mellitus and thyroid issues are found among the transhumant Gujjar women (SKIMS, 2020). Many children are born underweight or stunted. It has also been observed by various studies that rough terrain and rudimentary infrastructure play a huge role as barriers to accessing healthcare (Ahmad, 2020). Even if they would like to visit the nearest healthcare clinic but by the time they reach the healthcare centre, it is either closed or doctors are not available. A transhumant Gujjar woman, Amina, also stated this:

When I was pregnant, I would rarely go to the hospital for a medical check-up, because that would take me a whole day," said Amina. "The hospital is far from here, and the local dispensary has no facilities." My first pregnancy was a nightmare as I had to travel many kilometres to Kangan, a nearby village, to find the doctor. I would be in severe pain and dependent on painkillers, which I took without any prescriptions. (Nabi, 2020)

They have no understanding of how hospitals work. Given their luck, they may get a chance to see a doctor, but are not in a position to pay for medicine because government-run clinics either have a shortage of supplies or there is no medicine available at all. A 2019 study revealed that, on average, public health centres had only 51 per cent of the required physical infrastructure. Health workforce shortage was bound to be the greatest impediment in accessing healthcare, the study further stated (Verma, et. al., 2019).

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Affordability is another significant factor that hampers the transhumant community from seeking health care. Apart from the costs of drugs and consumables, diagnostic charges are also high for these communities; a good sum of money goes to transportation for both inpatient and outpatient (Verma, et.al., 2019). Incurring those costs hampers the community in seeking medical help.

One of the serious issues yet to be debated thoroughly has been the acceptability issues the community, particularly transhumant women, are facing. Once they make it to the healthcare and are willing to spend money but they are still not being treated fairly by the health attendants and the doctors. They are stereotyped, dehumanised, and often called as unclean and unhygienic. For instance, a recent study revealed that more than 37.2 per cent the people had issues nonchalant attitude of the medical staff and said that they are not being reassured and comforted or properly communicated about their illness and symptoms (Verma, et.al., 2019). Women from this community are mistreated in public places, especially in hospitals. Thus, accessibility, affordability and acceptability do impede a smooth processing of the right to medical health.

Menstrual health and marginalisation

The transhumant Gujjar women are most ignorant regarding menstrual health. Navigating through the tough terrain, women suffer a pernicious state of menstrual and postpartum health crisis. During pregnancies, they keep doing the same work and tracking through the same terrain. They deliver babies on the way and in severe healthcare issues, even die before reaching to nearby healthcare facilities. Due to a lack of menstrual knowledge and ignorance, transhumant women have unhygienic menstrual practices, which often result in vaginal infections, discharge and complications (Mugloo, 2022). A study found that more than 96 per cent manage their menstruation very poorly by relying on use of dirty cloths, improper use of used cloths and inadequate drying mechanisms. Ignorance, poverty and neglect are the main reasons for inadequate menstrual hygiene. Dr. Shabnam, a medic at a central Kashmir hospital who treats tribal people and runs menstruation awareness camps, says: “The most important factor is poverty and lack of knowledge. They know nothing about hygiene (Mugloo, 2022).

If unattended, such infections lead to pelvic inflammatory disease (PID) which results infertility among women. These issues, among others, get intensified with malnutrition and a

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weak health status. Transhumant women also have multiple pregnancies with no ligation in between. Contraceptives, abortions, and family planning is staunchly prohibited by both tradition and the male-dominated society. "Tribal women do not use contraceptives," said Dr. Javaid Rahi, founder of the Tribal Research and Cultural Foundation. "Instead they use a type of wild grass that they believe is an anti-pregnancy pill but is not effective at all." (Nabi, 2020) Women from these communities have even no say in their decision making. They are not even allowed to take decisions with respect to their bodies either. For instance, if they do not want more children, they can't do anything in this regard. Men from their community put pressure on women by internalizing the belief that more the children will eventually be more hands to help their family in earning more. According to Rahi "If any woman refuses to have more children, the men in the community simply opt for another marriage since marriage is a very low-key affair in this community" (Nabi, 2020).

Another study done by the Sher-i-Kashmir Institute of Medical Sciences (SKIMS) found that 33% had some form of thyroid dysfunction (24.1% subclinical hypothyroidism; 6.8% overt hypothyroidism) and about 30% had urinary iodine concentration (Azmat, 2023).

Poverty and Health

Economics and health are interconnected and interrelated. Already discussed above about how low economic opportunities are affecting transhumant Gujjar women's health by not affording modern health care. In this section, an overview is given on how poor accommodation have deleterious impact on health care. The transhumant Gujjar women practicing nomadic and semi-nomadic pastoralists reside in kacha (mud) huts or make shift tents during migration. These huts and tents are poorly ventilated, damp and prone to insect infestation. These makeshifts with no proper ventilation and waste disposal systems are the breeding ground for bacteria, parasites, and insects, leading to frequent infections and allergic reactions for women who have to cook there and rear livestock in the same space.

These huts and tents are often overcrowded. They cook, sleep and give birth in the same tents, making women more susceptible to health issues. Indoor cooking using firwood causes chronic diseases such as lung cancer and bronchitis, and increases the chances of respiratory diseases, including allergies and asthma. They give birth in the same tent. They take care of the newborn in the same tent where she cooks by burning wood.

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Analysis under the Human Rights perspective

Th above paragraphs illustrate that there is a profound intersection between gender-based discrimination, tribal marginalisation and structural neglect by both state and the society. When analysed within human rights framework, these challenges do not only reflect the socio-economic issues, but clear violations of the universally recognised rights enshrined under Universal Declaration of Human Rights (UDHR) and Fundamental Rights under Indian Constitution under chapter iii. Take for example affordability of healthcare. The transhumant community particularly women face huge obstacles in affording modern health care facilities due to cost of reaching hospitals purchasing sanitary pads or accessing antenatal care. This violates Article 12 of International Covenant on Economic, Social and Cultural Rights (*ICESCR)* and Article 21of *Indian Constitution* as interpreted in *Bandhua Mukti Morcha v. Union of India* case. article 12 of ICESCR lays stress on that the right to health includes of availability, accessibility, acceptability, and quality of health services (ICESCR, 1966). In *Bandhua Mukti Morcha v. Union of India* case, the supreme court held that the "Right to Life" under Article 21 does not merely mean survival or animal existence rather it includes the right to live with human dignity, free from exploitation, and with access to basic necessities of life, such as: health care, education, clean environment and decent working conditions ESCER-NET, 2015).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often called the international bill of rights for women. It obliges states to under article 12 to "Eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning" (UN, 1979). Further, Article 12 of CEDAW emphasises on inclusive right extending to timely and appropriate services for pregnancy, childbirth, and postnatal care, with core obligation to states to ensure that women are not denied access to healthcare because of distance, poverty, or cultural barriers.

As highlighted above transhumant Gujjar women are stereotyped by officials and medical staff and often called "backward" or "unclean". The social and class bias breach *Articles 14, 15, and 17* of the Indian Constitution, which guarantee equality and prohibit untouchability-like discrimination. As elucidated earlier that physical and geographical factors have a role to play

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in accessing healthcare by the transhumant Gujjar women. Non-availability of nearby government health care centres where most of this community stay during migration is both an administrative failure and also violates the international human rights law that guarantees to safe motherhood and bodily integrity of pregnant women. There are no reproductive health services and immunisation support available to them when they transit from one place to another.

CONCLUSION

Despite constitutional guarantees and policies both from the state and the centre regarding the tribal population of Jammu and Kashmir, the transhumant Gujjar community remain outside these schemes. Their lifestyle, male-dominated social structure, and poverty, among other factors, combine to deny them access to heart care services. Their marginalisation and deprivation of basic amenities, such right to health, is both structural and systemic. Transhumant women navigate the marginalisation both in private life- marginalisation and deprivations at home, and public spaces-stereotyped and discriminated against at hospitals and other public places. These marginalities at various levels also pose an ongoing threat to physical and mental health. These factors, coupled with tough physical workloads, malnutrition, poverty, and unhygienic menstruation practices, with no knowledge of pre- and post-natal healthcare services, further aggravate their vulnerabilities. Their affordability, accessibility, and acceptability remain major hurdles in accessing healthcare. Therefore, from the human rights perspective, transhumant marginalization exemplifies the failure of both the state and the society. State failure by not ensuring conditions where rights are not just guaranteed but also realized by fully implementing the various international and state conventions regarding right to dignity. Healthcare of transhumant women cannot only be seen through the prism of modernity but through perspective of justice, rights and more significantly the dignity of being human. Human dignity supersedes all other factors and issues related to being a human.

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Conflict of Interest

The authors declare no conflict of interest.