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# Marginalization of the Marginalized: Analysis of Cultural Determinants of Health and Gender-based Response among Tribals in Kashmir Society

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**ABSTRACT**

Generally, there exist certain set medical standards of the physical, social and mental health of women which every society or culture has ensured, rather guaranteed. It is because of the fundamental importance of the role of women in procreation and continuity of human race and society. It is not something extra which the women deserve in society. In reality, as man's health conditions are determined by social, economic, cultural, educational and other factors, women's health too is shaped by these crucial factors in addition to biological and hereditary factors. However, women's health is characterized with particular features because of female body organism and particular requirements which must be fulfilled necessarily. Though the biological factor has a basic role in the women's health, the importance of culture also emerges as one of the dominant and determining factors, especially with the advancement in age after birth. In-fact at advanced stage of life, culture turns to be the single most important factor. In this study I have emphasized

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the crucial and critical role of cultural context of women's health, especially in the under developed society like that of the Kashmiri tribal society.The study is empirically oriented, it depends mainly on empirical methods/techniques,especially questionnaire, interview and observations. All major propositions in the study are based on the gained information and data from one of the tribal block in the Union Territory of Jammu and Kashmir in India during the year 2023-2024, and conclusions are drawn accordingly.

**Keywords:** Gender health, Cultural symbols, Folk healers.

## Introduction

India rightly has been described as a "melting pot" of races and tribes. The ancient and epic sacred literatures, the Vedas, the Puranas, the Ramayana and the Mahabharata emphasize that India is inhabited by several types of tribes or people. The word "tribal" or Adivasi brings to our mind a picture of half-naked men and women, with arrows and spears in their hands, feathers in their heads, and speaking an unintelligible language. Even when majority of the communities in the world kept changing their cultures very quickly to keep pace with the "progress" of the world, there were communities still living in line with their traditional values, customs and beliefs, where they could continue to live in peace with nature and their unpolluted environment. The mainstream world, so called civilized people branded these communities variously as natives, uncivilized people, Aboriginals, Adivasis, Tribals, Indigenous and uncontacted people etc. In India, we mostly refer them as Adivasis/Girijans. Since tribals are indigenous people of India and indigenous people all over the world are historically subjugated and socially disadvantaged, which is explicitly and implicitly affecting their access to the resources, life expectancy and health status (Xaxa: 2014). They usually live within geographically distinct territories; tend to maintain distinct social, economic, and political institutions within their territories; and self-identify as indigenous or tribal (Abdullah N.A: 2014). India has the second largest tribal population in the world with a total of 84.33 million scheduled tribes, constituting 8.6% of the population of the country (Butt & Gupta: 2014). In Indian context tribal people have far worse health and sanitation indicators than the general population. Most tribal people live in remote rural hamlets in hilly, forested or desert areas where illiteracy, trying physical environments, malnutrition, inadequate access to potable water, and lack of personal

hygiene and sanitation make them more vulnerable to disease. This is compounded by the lack of awareness among these populations about the measures needed to protect their health, their distance from medical facilities, the lack of all-weather roads and affordable transportation, insensitive and discriminatory behavior by staff at medical facilities, financial constraints and so on. Government programs to raise their health and sanitation awareness and improve their accessibility to primary health care have not had the desired impact. Not surprisingly, tribal people suffer illnesses of greater severity and duration, with women and children being the most vulnerable. The starkest marker of tribal deprivation is child and maternal mortality, with rates among rural tribal children remaining startlingly high. Statistics speak loudly and clearly, Census 2011 illustrates that in terms of basic amenities such as Housing Conditions, Availability of Drinking water, Sanitation Facility, type of Fuel used, Electricity, Communication facilities and Percentage of households possessing bank account and few durable assets, the Scheduled Tribes are lagging behind the general population, thereby affecting the former's ability to reach their potential. According to Census 2011, across India, 40.62% of STs live in Good condition houses and 6.2% live in dilapidated houses compared to 53.1% and 5.35% respectively of that of the All Social groups (which includes the ST's also). 19.72% of STs have drinking water source inside their premises whereas 33.59% have it away from their premises. All India level only 46.9% of all households out of which 22.6% of ST households have latrine facility within the premises. 0.3% of total household and 0.1% of ST households continue to use the method of night soil removal by human especially women folk. While 49.8% of total households go for open defecation, 74.7% of ST households are still going for open defecation. At the all India level 42% of all Households and 17.3% ST Households have bathing facility within the premises. Only 6.1% of ST households have waste water outlet connected to closed drainage compared to 18.1% of that of the households of all social groups.

## The Scenario of Jammu & Kashmir Union Territory

Jammu and Kashmir (J&K) has a substantial proportion of tribal population and constitutes 11.9% of the total population (Census of India: 2011). Gujjar tribe is the largest tribe in J&K. Gujjars are not original inhabitants of J&K but started their migration in 9th and 10th century from plain areas such as Gujarat, Kathiawad, and Jodhpur where they have been even in power. Bakarwal is a nomadic pastoral tribe known for livestock farming as the main source of

livelihood and is the second largest tribe in the Union territory. The combined population of Gujjar and Bakarwal community is around 10,93,852 constituting 69% of the total tribal population of J&K (Census of India: 2011). Traditionally, the socio-economic status of Gujjar and Bakarwal community has been quite different from the rest of the Kashmiri society. The tribal population of J&K mostly lives in scattered clusters across hilly, inaccessible terrains due to which, they have remained beyond the realm of the general development process, lacking the basic facilities like access to healthcare, pure drinking water, and education resulting in the extremely poor socio-economic conditions. The tribes have also been suffering from various forms of social discrimination and political isolation (Sharma: 1995). It is an admitted fact that there is significant scarcity of data on this population, especially on the services and basic amenities of life available to them. One such under-noticed evaluation is the status of the health of historically marginalized community of women among these tribes.

## Methodology

This study stands for a scientific, sociological and empirical study of women's health among tribals in Kashmir. In an attempt to carry out an objective analysis of the social phenomena, varying theoretical perspectives were applied partly to arrive at scientifically verifiable propositions and conclusions.The main theme of this study is to observe and assess, scientifically and sociologically, all past and present aspects of women's health and to suggest ways of improvement and perfection in future. The focus of this is to investigate empirically the social, cultural, economic and other dimensions of women's health. In other words, the study is oriented to analyse the input-output processes and causes-consequences of the most crucial component of the society. The study has qualitative as well as quantitative dimensions and generally pursued inter-disciplinary approach. The general and broader universe of this study is the Kashmir province in Union Territory of J&K having ten administrative districts. Out of ten administrative districts one particular district (Budgam) in this region has been made particular unit of study. I have purposively chosen this particular district because this backward district can provide a realistic picture about existing and changing health conditions among women in these tribal hamlets. The actual field investigation was carried out in one of the block namely block "surasyar".

The schedule tribe population details about the district as per census 2011 are given below:

Total ST population in the district is 23912, out of whom 12932 are male and 10980 are female.

In surasyar block the population of ST is 3089 as per tribal affairs department J&K.

Since study is empirically oriented, it depended mainly on empirical methods/techniques, especially questionnaire, interview and observation. The other methods employed for gaining information were non participant observation, Official and non-official documents and sources including periodical reports of survey and studies [carried out regularly by international and national agencies, organizations and institutions], other research documents, books, research papers and newspaper-magazine articles. In addition to the above the one more method adopted for seeking information about the reality of health problems and issues in the past and present times was the oral methods in which real and correct information was gathered in the informal oral sessions with respondents, experts, professionals, scholars, researchers and others concerned held in different areas and different situations. So all major propositions in the study are based on the gained information and data, the field observations were collected from block surasyar of district Budgam in J&K during the year June 2023 to June 2024 and conclusions are drawn accordingly.

## Review of Relevant Literature

The functionalist theorist Talcott Parsons (1951) in his book "The Social System" devised the first major theory within sociology that explored the role of health and illness in social life. Parsons argued that being ill was not just a biological condition, but also a social role with a set of norms and values assigned to the role. In his book "Medical Nemesis; The Expropriation of Health (1975)", Ivan Illich argues that modern medicine, more than having reduced human suffering, is actually the cause of much contemporary ill health. This focus on the social determinants of health has since been taken up by political philosopher and bioethicist Norman Daniels, a former student of John Rawls. In his Boston Review article "Social Justice is Good for Our Health," Daniels and colleagues argue that the social conditions under which we live influence how healthy we are. Another work published in the year 1976, by Thomas Mckeown "The Role of Medicine: Dream, Mirage, or Nemesis?" was McKeown's most explicitly debatable use of historical data. The book documented a recapitulation of his familiar arguments about the relative contributions of medicine and economic

progress to the health of society. Peter Conrad's book entitled as "The Médicalisation of Society" deals with the issues which were previously regarded as normal human events and common human problems such as; birth, aging, menopause, alcoholism, and obesity among others and are now viewed as medical conditions. For better or worse, medicine increasingly permeates aspects of daily life. Cecil Helman, a South African trained physician, wrote a compact book entitled as "Culture, Health and Illness" whose primary purpose was to bring the insights of medical anthropology to biomedical professionals. The essential message of this work is to respect the world's wide-ranging cultural diversity in health and medical practices. The primary question which lies at the heart of the book entitled as Health Dynamics and Marginalised Communities by Mohammad Akram is that "Despite the long standing commitment to "Health for All", enormous health disparities continue to prevail among Indian masses. Henry W. Wright in his book entitled as "A More Excellent Way To Be In Health" focuses most of his attention on the improbable spiritual roots of illness, usually (but not always) disregarding environmental causes to illnesses by looking at spiritual causes, including the sins of one's parents, especially the fathers or patrilineal line. The book "Health Care under the Knife, edited by Howard Waitzkin and the Working Group on Health Beyond Capitalism" extends marxism to the healthcare by relating persisting and more recent problems in health sector with the developments and permeation of capitalism in all aspects of social life. Jose Boban K in his book "Tribal Ethno medicine (1993)" explored the health status of the Muthuvan and the Mannan tribes located in the Idduki district of Kerala. The author of this book has studied the ethno medical practices found among these two tribes and the extent to which their system has changed as a result of the influence of modern medicine. The book "Cultural Correlates of Tribal Health" by A.B Hiramani (1997) looks at the health of the tribals, more from their cultural point of view i.e., whether the tribals attach more importance to their cultural values than any other external factors which are not parts of their culture par se. Robin D. Tribhuwan, (1998) in his book : "Medical World of the Tribals-Explorations in Illness Ideology, Body Symbolism and Ritual Healing" illustrates that illness and responses to it can be related to the structure and maintenance of a social system, a system of interactions among the members of a society and systems that is linked to its environments. The book "Tribal Medicine written by Burman JJ. R. (2003)" unveils the extent of dependence on different medicinal practices that exists in six tribal villages and a few small towns of

Sikkim including Gangtok. The book Tribal health and Medicines, edited by "A.K. Kalla and P.C. Joshi ( 2004)" is a collection of papers contributed by various experts in the field of health and society. Papers on health and diseases of tribes from all over India, including tribes from Nagaland, Manipur, Gujarat, Central India, Arunachal Pradesh, etc,. find attention in the book. Udai pratap singh in his book "Tribal Health in North East India: A Study of Socio-cultural Dimensions of Health Care Practices (2008)" explores that the health is not only a state of physical and mental well being, but also in true sense it involves the socio-cultural and environmental factors. The book edited by Ravindran, Reenu and V prasad entitled as "Health Among Tribal Communities in India (2023)" is a compilation of findings from three studies across four states of Indian society viz. Assam, Chhattisgarh, Jharkhand, and Kerala. It aims to understand and explain the diverse nature of health inequities existed along with processes and historical contexts which still create, configure, and sustain health inequities among tribal populations in India. Verma et.al in their study Traversing the margins: Access to healthcare by Bakarwals in remote and conflict-prone Himalayan regions of Jammu and Kashmir Pastoralism state that despite government interventions promising mobile health clinics in the pastoral tribals hamlets of the region, the issue of availability still persists because the provision of healthcare services to transhumant pastoralist tribes is expensive and logistically complicated. Ghulam Gilani and Maqbool Ahmed(2023) in their study entitled as "Comprehensive Review on Tribal Health Status in Poonch District of Jammu and Kashmir" highlight the myriad challenges encountered by pastoral communities in Poonch district of J&K. They argued that the characteristics of the district's tribal population are similar to other pastoral communities residing in different districts of Jammu and Kashmir. Their shared culture, financial, educational status, geographical isolation, limited healthcare infrastructure, seasonal migration, low awareness, limited financial resources, lack of transportation, scarcity of medical status, gender disparities, spiritual belief, and environmental factors that collectively hinder their access to essential healthcare services. Ahmad, B. S. (2014) in his study Assessment and Understanding of Gujjar and Bakerwal Women's Health in Jammu and Kashmir reveals that the focus of this study was on the assessment and understanding of the Gujjar and Bakerwal women's health in J&K. The objectives of the study were, to understand and explore the Gujjar and Bakerwal women's health conditions; to explore the determinants and factors of their poor health; and to know the

status of awareness among them about government schemes. Vaida, N. & Hamid, T. (2017) in their study entitled as "A Study on Nutritional Status of Scheduled Tribe (Gujjar and Bakerwal) Women of Kashmir" accessed the nutritional status of Gujjar and Bakarwal women of Kashmir. Khan, A. D & Khan, S. (2020) in the study entitled as "Health Status of Tribal Women in Jammu and Kashmir" reveal that the health status of most of the Gujjar and Bakerwal women of J&K is very poor. These women live in utter deprivation due to poverty, illiteracy, early marriage, nomadic way of life, superstitions, traditional neglect and were facing various types of domestic violence, which adversely affects their health.

## Discussion and Findings of the Study

From the above review of literature it is evident that health is determined by several factors including genetic inheritance, personal behaviors, access to quality health care, and the general external environment (such as the quality of air, water, and housing conditions). In addition, a growing body of research has documented associations between social and cultural factors and health. For some types of social variables, such as socioeconomic status, robust evidence of their links to health has existed. For other kinds of variables—such as social networks, marginalization and social support—evidence of their links to health has accumulated over the past thirty years. The purpose of this review of literature and content analysis was to provide an overview of the social variables that have been researched as inputs to health (the so-called social determinants of health), as well as to describe approaches to their measurement and the empirical evidence linking each variable to health outcomes. After this review of literature I hereby emphasize at the outset that the sociocultural determinants of health can be conceptualized as influencing health at multiple levels throughout the life course. Thus, for example, culture can be conceptualized as an exposure influencing the health of individuals at different levels of organization—within families or within the neighborhoods in which individuals reside. Moreover, these different levels of influence may co-occur and interact with one another to produce health. For example, the detrimental health impact of growing up in a tribal family may be potentiated if that family also happens to reside in a disadvantaged geographical location e.g. in hilly terrains. Furthermore, culture may differentially and independently affect the health of an individual and community at different stages of the life course (e.g., in utero, during infancy and childhood, during pregnancy,

or during old age). In short, the influence of social and cultural variables on health involves dimensions of both time (critical stages in the life course and the effects of cumulative exposure) as well as place (multiple levels of exposure). The contexts in which social and cultural variables operate to influence health outcomes are fertile questions of further sociological investigation. So this research "Marginalization of the marginalized: : Analysis of Cultural determinants of health and gender-based response among tribals in Kashmir Society" will be a valuable addition to the existing literature and may fill the void. The major findings of the study are discussed as:

## 1. Ignorance And Gender Health

Despite the fundamental importance of gender health in the society, this field faced either the situation of ignorance or situation of negative differentiation and discrimination. It has been observed during the field work that normally gender health has often been ignored consciously and this practice had a common character. In this particular conservative background, women's health in general was ignored in terms of leaving aside their health needs, avoiding and delaying their normal treatment, and keeping their health problems unattended leading to their multiplicity and deterioration. It has also been established during the observation by researcher that women health problems were not treated properly, timely and completely. This may be explained partly in terms of illiteracy, poverty, ignorance, non-availability of doctors, facilities and medicines and partly be cultural lag, cultural ethos and cultural practices. In that ideal situation, if a male fell ill, he was normally treated medically, necessarily and immediately. On the other hand, if a female fell ill, she was not rushed to the then experts immediately and necessarily. The latter's cases were often delayed or ignored which deteriorated their condition. They were used to send to the then available health expert of institution at the last. These extremely negative gender health conditions prevailed in all these tribal communities of researched block. Though, a considerable degree of change has been experienced in the contemporary times in other communities but these tribals are in the same cultural experience.

## 2. Gender Health And Kashmiri Tribal Culture

Like other traditional cultures in the Indian sub-continent, the Kashmiri tribal culture in the distant past did not treat women equal, as a result of which they developed different, often unequal, status

and role. They were generally differentiated, discriminated and maltreated. Their activities were restricted to the domestic jobs. The consequent attitudes and behavior patterns reflected at the broader societal level. The common practice in those pre-independent days was that while gender health was not responded properly and completely and most of its problems were not attended but kept pending, deferred or forgotten. The rationale provided to this kind of gender health treatment was explained in terms of heavy economic dependence of women on eldest male member of the family, absolute and dominant male authority, unequal role and status between male and female, cultural limitations and so on. Thus a social environment was created whose last preference was the gender health. In that situation, while women were not treated medically in time and properly, there was no goal fixed related to women's health improvement. It was particularly bad for women's health as there existed no common health facility and there was no doctor available. So, women had to opt for folk or faith-healing practices in which majority of them suffered damages in their health. Moreover, a general situation in which women were teased, harassed and tortured continuously and systematically and with some ideological and cultural support, women developed several mental and physical health problems. These could neither be diagnosed in time and properly nor treated completely by their male family members. Even they were not allowed to go independently to avail the available medical treatment and facilities. In brief, the traditional cultural ethos in Kashmir in the distant past provided not a just and needed health care to women and they were not also allowed to avail the medical facilities. In addition, that situation has not been even condemned and was not considered undesirable.

### 3. Gender Health and Cultural Symbols-Practices

It is now clear that gender health was totally affected by the cultural phenomena such as cultural notions, concepts, orientation, values, norms and practices. Even superstitions played a role and were practically detrimental to the ideals of gender health. It was observed that conscious and organized negation of gender health facilities were justified and legitimized on the basis of cultural notions and views which were practiced through the application of related values and norms. Even value oriented words like 'maa', 'behan', 'betee', 'biwi' and' bahu' revealed differential treatment of heath care to them. Three particular examples will this differential treatment with women which follow:

(i) The women in the past in these tribal hamlets believed that their respective husbands were "dekka" [forehead], meaning like a crown (taj) and king without whose association her existence meant nothing. They reserved all honours and regards for that "taj". They also believed that their husbands must be always at top of hierarchy and must always be preferred irrespective of their social positions even at their cost.

(ii) In these tribal hamlets women used to occupy back seat after their husbands inside as well as outside their family. They never claimed first, superior or equal status to men. This crudely reflected in their habit of not consuming the fresh food with other male members of family and not at the same time at which male members consumed it. In many cases and on all special occasions like Eid and local festival, when there used to be a variety of special foods prepared for the occasion/s, they used to consume either after the males consumed or consume the male's left- over food.

(iii) In the cultural context of thse tribes in Kashmir, even some gender health care has been deteriorated to such a level that it did not benefit the women nor could they avail it in ideal conditions. This was revealed through the practical aspects of Kashmiri tribal culture which again can be explained in three particular ways:

(a) when women fell ill, they usually go to their parent's home and get the treatment there on their expenses.

(b) women usually go to parent's home voluntarily before the time of delivery and stay there till she gets perfectly well.

(c) when the women feel tired or overburdened in in-laws home, they usually go to their parent's home for relaxing and entertaining. In cases of divorce and separation also, the women sufferers are provided shelter, security, support and help by the parents and their paternal/maternal relatives.

## 4. Culture and Religion in Kashmir

Like in other societies in the Indian sub-continent, religion was used in Kashmir society in general and among these tribals in particular directly or indirectly for gender health care in a particular way and through different methods and techniques. In this connection, I may mention about conventional and non-conventional methods of this

gender health treatment in Kashmir. On the one hand, the conventional methods include religious, psychological and folk healing methods. On the other hand, the non-conventional methods include all traditional and modern forms of medical treatment. In the cultural background of Tribal Kashmir, women have utilized more conventional than non-conventional methods in treating different diseases and other health problems. The result is that their health has suffered and these conventional methods were not fully effective and realistic. Consequently, they had to opt for non-conventional methods for speedy recovery of diseases and from other health problems.The field investigation reported the following:

(i) The most common conventional method of gender health treatment was "Peer-Faqir Illaj" which has strong cultural and religious connotation. It has been observed during research that treatment is strongly embedded in women cases, its effects have also shown positive impact and significant improvement in many cases. Thus both conventional and non-conventional ways of treatment are in vogue in Tribal Kashmiri society, still a considerable number of women patients go for conventional ways of treatment, especially when modern medical facilities are not available fully. But, the emerging trend in this regard convey that increasing number of women in rural and urban areas are moving towards modern methods of health care, which otherwise is not the case in these tribal hamlets and they still follow the conventional methods. The conventional particular religious type health care revolves around some practices ordered by Peers and Faqirs and followed by women health sufferers. These practices include the following distinctive practices explored during field work:

   (a) Making a 'taveez'(amulet) and put/hang it on any particular or directed part of the body;

   (b) Reciting some Quranic recitations and give the patient an air wave of it;

   (c) Giving a cup on which some religious statements are written by the Peer with a pen of blue or black colour. The patient is directed to wash the cup with water and consume that water.

   (d) Some dry fruits, especially badaam, kishmish, and other items like shreen, sugar pieces, and so on are given to the

women patients to consume as per the orders of the peer and faqir.

(e) Some Quranic text on a small piece of paper [ say around from 3 x 4 to 4 x 6 inches] is folded and given to women for burning it in Kangdi [local firepot] and take its smoke on her body;

(f) Some Peers, especially senior and experienced ones, go for 'jadoo' [ magic ] technique. As per this practice in health the concerned woman has to take some serious oral or physical act in order to restore normalcy or negate the undesirable physical or psychological condition. The peers' belonging to the Shia sect of Muslim community are considered more experienced and expert in this field.

(h) There is one 'jinn-pari syndrome' in which a woman is caught mentally and physically and she performs abnormal acts. The particular type of 'peers' have to work very hard in order to liberate these women from those non-human entities. While this disease is limited to the women, its treatment is available with the religious oriented 'peers' only. Modern treatment is still irrelevant for this kind of female disease.

(h) The other conventional type of gender health treatment is carried out by the folk practices and folk healers. Folk healers have power like lowest degree of charisma through which they treat women. Sometimes, they adopt religious oriented and religious ordained treatment to women health seekers. They ask for doing certain practices repeatedly. This action on the part of folk healers has a limited effect in practice. Normally, this treatment does not continue for longer period and these tribal women usually return to the medical treatment for speedy recovery and stable health.

(i) It seems important to note here that these conventional and folk practices of gender health care have been distorted and exploited by some shrewd individuals . These folk peers and faqirs use these healing techniques for personal and financial gains. As a result, these practices got debunked, deteriorated and degenerated. Some fake-identity individuals use it for sexual purpose also. In reality, all these individuals involved in these practices stand for fraud, evil and criminal elements. Though the job of these fake peers and faqirs has been

delegitimized, they still continue with these practices, especially in these remote hamlets of tribal population.

## Gender Health, Heavy Workload and Inter-Sex Cultural Practices

(i) It has been explored that, in the cultural background of Kashmir, there is heavy burden of domestic work especially among these tribal hamlets. In the tribal areas, they have the further responsibility of activities related to agriculture, domestication of animals and collection of timber etc from forests. This is in addition to child-bearing and child-rearing practices performed by them. Even if there is separation between the couple, the 'duties' are performed by women only. This seems interesting to note that, in the traditional cultural context, women are not involved in heavy work load by men only but by women also. Thus even in the intra-sex relationship and work allocation, the women emerge as the main burden taker and sufferer. That explains the complex relationship between daughter-in-law and mother-in-law, in which the latter, league with elder male-female members of the family, impose heavy load of domestic work on the former. The sister-in-law too help her brother to impose heavy burden on his wife. In this way, women always suffer at the hands of their own and opposite sex.

(ii) It follows that in totality women have been assigned heavy workload which has affected their health adversely. In this kind of cultural environment, women felt compelled to undertake all sorts of work at the cost of her health, especially in in-laws context because women want to please them always. It was in this type of cultural environment that married women generally took refuge in the parental home in order to take complete rest or relaxation or to avoid odd jobs.

## Gender Health and Age at Marriage

(i) It was also found that one of the important culturally determined factor, i.e. age at marriage, affects the gender health condition in general. It follows that age of marriage in society, early or late, affect the entire process of health maintenance and reproductive behavior in the negative way. If the average age is due and proper, it will also affect but in positive way and will ensure proper reproductive cycle. It was observed during the

field research that in the Tribal Kashmiri society while in majority of female cases, marriage was performed at earlier age, these practices had negative physical and mental health implications. Moreover, they had to face several complications in the reproductive health. On the other hand, only minority, though significant, of women had married at the normal and proper age. This kind of marriage practice had comparatively better physical and mental health implications for the entire life.

## Gender Health And Cultural-Religious Attitudes

Culture, with the support of mass religion, created an environment in the tribal Kashmiri society which had clear negative implication for gender health. This reflects in the common cultural-religious attitude to avoid and to resist/oppose the exposure of their bodies in front of unknown and unrelated doctors. Consequently, they are not able to get proper and timely treatment of their diseases and other health problems in the absence of female doctors and other concerned professionals. This type of attitude in its extreme form hurt women at large at the time of their delivery. This complex problem aggravated and deteriorated the health condition of women in the situation characterized by shortage of female doctors and para-medical staff [especially nurses] in the speciality of gynecology and obstretics at all health centres in these hamlets and for all women. In totality, the culture-imposed restrictions on male-female interaction have created several structural and functional limitations and difficulties for women for their medical treatment. In that situation, there was neither any possibility of forced/imposed interaction between female patients and male doctors-professionals nor their former could expose before the latter.

## Gender Health And Food Habits

It has been observed that socially the traditional food habits of these tribals do not go in the best interests of the health of the people, especially of the female health. It follows that the general pattern of food habits in Kashmir had not contributed to the betterment of gender health.

The first argument in this regard is that present food habits in these tribal hamlets are neither scientific nor balanced. The people, including women, consume heavy quantity of rice in the lunch and dinner which has had negative health implications on the consumers,

especially women. Most of the local people, especially women in their marriage days and during pregnancy days, consume huge doze of spices which, after some limit, turn anti-body components and sources for dreaded diseases for them. Thus they develop complex problems which never allow their bodies to reach desirable standards of health.

Second, there is hardly any fruit-consumption tradition in these tribals. People generally eat less or very less fruits or didn't eat at all. It is occasionally said here that people used to eat fruits at the time they fell ill and on the advice of doctor or hakim(folk healer).

Third, women in large numbers consume salt tea [which is boiled with the soda to the highest, even dangerous level] in large quantity, say 2 – 4 cups at a time in the morning and in the afternoon [ at 4.00 p.m.] This tea consumption has spoiled the stomach system of more women than men. Because men usually remain out of home for work and consume in lesser quantity.

## Summary and Conclusion

The most important aspect of this entire discussion is that a radical but partial type of change has been experienced in the gender health in Indian society in general and Kashmir society in particular and allied health sector too. In reality, the educational, economic, and social changes in post-independence period provided the basis for change in attitudes and behavior towards health and nutrition. In other words, people in general and women in particular started giving due attention to their physical and mental health needs in the recent past. This gave rise to a gender-based response towards health and family welfare. This was also because the state after 1947 started taking concrete steps and introducing-implementing schemes and programmes for total gender health betterment. As a result of all these conscious and organized efforts by the government, we have a situation now with minimum gender health facilities available in urban, rural and tribal areas and certain sections and groups of women utilize these fully according to their needs and problems. These groups are from middle-upper classes from rural and urban background. However, a large number of women from lower classes and communities and particularly from tribal areas still wait for gender health facilities, expert doctors and professionals, health education and medicines in order to fulfill their basic health needs. And moreover the cultural determinants of gender healthcare has further deteriorated the health of women folk in these tribal hamlets.

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