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Health and Customary Practices among Tribal women: A concern towards Marginalization

DR. NEHARICA SUBHASH

CENTRE FOR STUDY OF SOCIAL EXCLUSION AND INCLUSIVE POLICY

UNIVERSITY OF JAMMU

Abstract: Various studies on tribals give rich ethnographic details about their cultural practices, perception and behavioural aspects. Despite all these studies, very few studies are conducted on the health of tribal women especially their reproductive and Nutritional health. This paper will help policy makers to develop realistic health plans based on the felt needs of tribal women. The present paper is an attempt to examine the health and customary practices among tribals with special reference to women. Health is a function, not only of medical care but also of the overall integrated development of society i.e., cultural, economic, educational, social and political situation. Each of these aspects has deep influence on health, which in turn influences all these aspects. In order to understand the customary practices & dimensions of health, it is necessary to examine briefly the basic social, economic, cultural, religious and educational concerns and aspirations of the tribal women. This paper explores the role of tribal women in the socio-economic development of their families and how it effects their health in reciprocation.

Keywords: Health, Tribal, Women, customary practices, educational concerns, development

Introduction: Tribal women's status in Indian society is accompanied by a variety of strictures, which define how women are expected to behave. In general status of women, which reflects the type of society, and culture they live in, depends very much on the level of their health, education, income, employment, rights, as well as their role in the family, community and society at large. The social and cultural determinants of female role and role expectations (predominantly Hindu, patriarchal, patrilocal and patrilineal) are generally rooted in their lives at family and social levels. Within the family as well as the community, the position of women is equal to men. She is an active participant of family life, and there is a visible and dignified pattern of division of labour between the sexes. Economically women are equal and hardworking partners alongside of the males. Many scholars working on tribal issues have noted that the women in these communities have traditionally enjoyed higher status compared to their non-tribal counterparts (Chaudhuri 1992). The status of women differs in each tribal community. Women as active

workers constitute a large section of tribal labour force in particular and women's labour force in general. They act as bread earners or active producers at home. Besides agricultural activities like sowing, weeding, transplanting and harvesting, the tribal women collect minor forest produce, fodder and firewood for household purpose and selling. In the field of animal husbandry and poultry farming also women's contribution is no less than men.

Large number of women suffers from under nutrition and iron deficiency and thus it is expected that a woman losses her daily energy intake by just fetching water and carrying it to their houses especially during dry season (Ray, 2007). A tribal woman participates in both economical and non-economic activities. They are extremely hard working and at times they work more than men (Bhasin, 2007). A study on the nutritional assessment of Korku tribes of Madhya Pradesh reports the mean nutritional intake of both the male and female of the tribe is less than the recommended dietary allowances mainly due to extreme poverty and consumption of their meals only once in a day (Das, 2010). Iron deficiency anaemia is at high prevalence among the tribal women (Chakma etal. 2012). Regional disparities in child health care program and its influence on child morbidity was studied by Prakasam (2013). Tribes have been at the lower end in all indicators dealing with the living conditions and household assets (Bhagat, 2013). A study carried out in the rural parts of Odisha to understand the effect of open defecation on the pregnancy outcomes found that around one-third of the women have had poor outcomes which includes pre term births, low birth weight child, spontaneous abortion and stillbirths. It found that practicing open defecation have more chances of adverse pregnancy outcomes (Bagcchi, 2015). Under nutrition among children is not only because of less intake of food but also because of frequent bouts of gastro infections. Therefore, the trouble lies more in lack of sanitation facilities than food security (Dobe, 2015). Manhas.S (2015) Most females of the Gujjar community were married young with little or no education. Becoming mothers at a tender age with no family planning and limited access to health care puts both their and their unborn child's life at danger. The nutritional status of the Saharia tribe in Rajasthan was studied by Monika etal. (2018). Based on the review of the earlier studies it is clear that most of these studies were carried out at macro level for understanding the reproductive health of women especially in the tribal communities. Given that the reproductive health of women especially tribal married women have been inadequately covered with multi factorial aspects.

Population: As per the Census India 2011, Bani Tehsil has 8096 households, population of 45996 of which 23889 are males and 22107 are females. The literacy rate of Bani Tehsil is 44.27% out of which 57.16% males are literate and 30.34% females are literate. Gaddi population according to census 2011 mostly depends on agriculture, cultivators, agricultural labourers and engagement in plantation, livestock, forestry, gout fishing, hunting and allied activities. In Bani Tehsil out of total population, 22,282 were engaged in work activities. 69.1% of workers describe their work as Main Work (Employment or Earning more than 6 Months) while 30.9% were involved in Marginal activity providing livelihood for less than 6 months. Of 22,282 workers engaged in Main Work, 11,718 were cultivators (owner or co-owner) while 73 were Agricultural labourer (http://censusindia.gov.in/pca/pcadata/pca.html).

Aim: The present study has made an attempt to understand these issues at micro level with the following objectives to understand the profile of the tribal married women in terms of social, economic, demographic and cultural aspects. To assess the nutritional status of the tribal married women. To understand the marriage process and practices of the tribal married women. To understand the involvement of tribal married women in decision making on their reproductive health matters. To understand the nature and extent of autonomy of the tribal married women within their marital homes and the relation they have with their husbands. To know the health seeking behaviour of tribal married women and their utilization of existing health care facilities. To understand the factors associated with the reproductive health of tribal married women. To evolve effective measures, which have policy and programme relevance for better reproductive health and welfare of the tribal married women.

Research Questions: The following are the research questions expected to be answered in conducting the present study: What is the family background of the tribal married women, in terms of, socio-economic and health status of other members of their family? To what extent the tribal married women are knowledgeable in the areas of health concerns. How are the tribal married women utilizing the existing health care services in the community? What are the gaps in health services as desired by the tribal married women and those in existence for their utilization?

Methodology: The research methods are explorative, participatory and observation based (during field visits). Mainly focus group discussions (FGD); Observation; Interviews, and analysis of government data has been an important component of this action-research to describe present health status and state. The primary data was collected from 100 Gaddi female respondents from Bani. Purposive sampling method was used in selecting the respondents with the criteria of availability and willingness to respond in detailed manner without hesitation. Secondary data was collected from digest of statistics, books, internet, reports in order to substantiate literature survey and primary information.

Analysis and discussion: Health is an important factor in economic and social development because disease creates vicious circle of depleting human energy, leading to low productivity and poor earning capacity, deteriorating quality and quantity of consumption and standard of living, put simply the quality of life. Thus, in order to understand the existing health condition of Gaddi women, an analysis of her socio-economic condition is necessary.

Age: Age is an important variable, which determines the socio-economic and health status of women. It is found that the perception and attitude regarding health of young and old women are different and also educational and health status of women shows a big variation between both the groups.

Table 1 Socio-economic profile

Age	Respondents
Below 20	19 %
21-30	39%
Above 30	42%
Marital Status	
Un-married	10%
Married	78%
Others	12%
Age at Marriage	
Below 16	15%
16-25	73%
Above 25	12%
Education	
Not educated	15%
Primary level	13%
Middle level	47%
High school	17%
Higher secondary	6%
Graduate	2%
Reasons	
No interest	9
Financial crunch	26
Far off from home	47
Family responsibility	18
Occupation	
Work in own field (cultivators)	69
Unskilled labour Service	12
NHPC projects	nil
Health worker	1
Anganwadi teacher	3
Household chores	15

It is evident from the data that women from age group 21-30 (19%) and 30 and above (42%) were more open in answering the queries raised by the researcher during interview schedule. It has been found that the tribal women in rural areas get matured much earlier than the non-tribal community women.

Marital Status: Gaddi Tribes claim themselves to be Hindu of high cast but their marriage culture is slightly different. They call Bride as *Laadi* and Groom as *Laada* in Gaddi Dialect. They avoid doing marriage in relatives (same *gotra* relatives). They practice three days' marriage. First day is called *Mehandi Raat* (Night). All the relatives gather for this occasion and sister's designs her brother's or sister's hand and feet with Mehandi. Next day *Jani* (barat) has to leave for brides house, all relative and friends accompany groom to bride's home. After performing about 7-8 hrs continues pooja (including pheras) by priest, they become a couple. The bride is bid adieu from her house to a new household, the ritual is known as *Pacheki*. On this day both bride & groom with their relative come back on the next day. Dowry cases are not seen in this community. They favour birth of a girl child as compared to boy. Daughter's birth is celebrated as welcoming lakshmi goddess into their home. Father feels proud of in performing *kanyadaan* as compared to son's marriage. Few cases of polygamy were recalled by older women but still modern generations avoid it. It has been shown in the data that 78% women were married and only 9% were widow which shows that believe in marital relations is strong among the tribal women. Only 1% women were divorced and because of early death of husband 2% women were remarried which shows adherence towards the sanctity of marriage and piousness of relationships were being maintained by the Gaddi community.

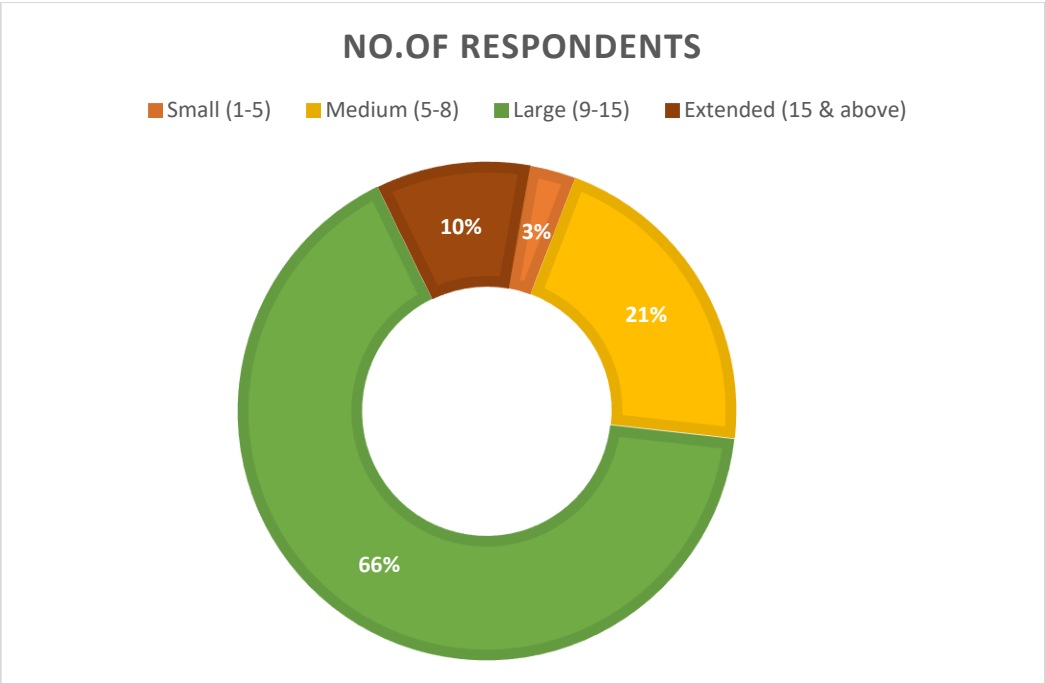
Age at Marriage: Age at the time of marriage is an important factor in conception of child and women's health. Childbirth closely follows marriage, which generally occur at young ages between the age of 15 and 19. Childbearing during adolescence poses significantly greater health risks to women along with closely spaced pregnancies. Usually births occur within two years of the previous birth, endanger both the health of the mother and the infant and older siblings. The above table reveals that both early marriages and late marriages are a rare phenomenon in the tribal life. According to the sample, 73% women got married in the age group of 16-25 years. The appropriate age of marriage is considered between 16 to 25 years in the village under study. It further indicates that average age of boys getting married is 19-25 years. Age gap between the couple is very normal.

Educational Status: Literacy rate is regarded as one of the indicators of socio-economic development and it also determines the health status of the community. Women's educational level is a key to improving their health. It is also found that education was not a serious concern for women of older age but young women feel the need of education and it is becoming a part of their life. The percentage of illiteracy among Gaddi women in only 15% which is among the older women who helps in household chores only. The Gaddi women 47% have attained education up to middle level the reason behind is the distance between the village and high educational institutions. However, 17% women have studies 10^{th} and 6% reached higher secondary. It has been observed that there is no social discrimination on the basis of gender but other factors were for not attaining higher educational levels. As far as the husband's level of education shows slight difference and the percentage of men who attended higher educational level is bit high (62%) and 5% of them even could make up to college. The level of education of the family members of the women shows that the younger generation is getting into the mainstream educational system.

Reasons for dropout: After the observations it has been found that 9% have no interest in education with 18% having family responsibility. Around 47% women lack education because of distance and insecurity to send a girl child far off. Other reasons for dropouts like financially 26% respondent were facing, as the land has been sub-divided between large family members it is not possible to bear the expenses of travel so both boys and girls were unable to attain higher education. And mostly it is the distance which binds them from educational attainment at higher levels.

Dietary habits: Gaddi people eat a proper diet. They were well known for their strength. The mostly have milk and milk products such as butter, ghee etc in surplus form. Their special foods are *Cherrawdi* (Sweet noodles), *Satrawa* (salty noodles), *Babru* (poori) etc. The main crops are paddy, maize, pulses and vegetables. Another economic occupation is pastoral activity. Families have got goat, sheep and cows. Cattle are taken care with the same affection that they have for family members. Goats are also offered as sacrifice to the gods and goddesses. The religion and rituals occupy a prominent place in the economic organization of the Gaddies. The size of land holding among the Gaddi has varied considerably from time to time. The process of division of land among the sons lessened their land ownership as the family size is large in Gaddi tribal group. So many of men from tribals community are working as labourers in skilled and unskilled jobs (74%). Gaddi women and men are equal partners in agriculture and cultivation on their own land. By and large women also depend on unskilled agricultural labour (12%), women have become health workers and joined as Anganwadi worker also. Data reveals that 69% women are working as agricultural labour on their own chunk of land like sowing, weeding or harvesting.

Family size: The family system is patrilineal but the father and mother have an equal status in the family. Men and women both take the decisions in the family together. The average size of the Gaddi family is medium (5-8 family members) and mostly large as they have the notion that larger families shows fruitfulness of the clan. The data in the above table reveals that 66% tribal community lives in joint family system and consist of large families. With the modernization they have also switched to nuclear and medium families but only who have migrated from the native villages.

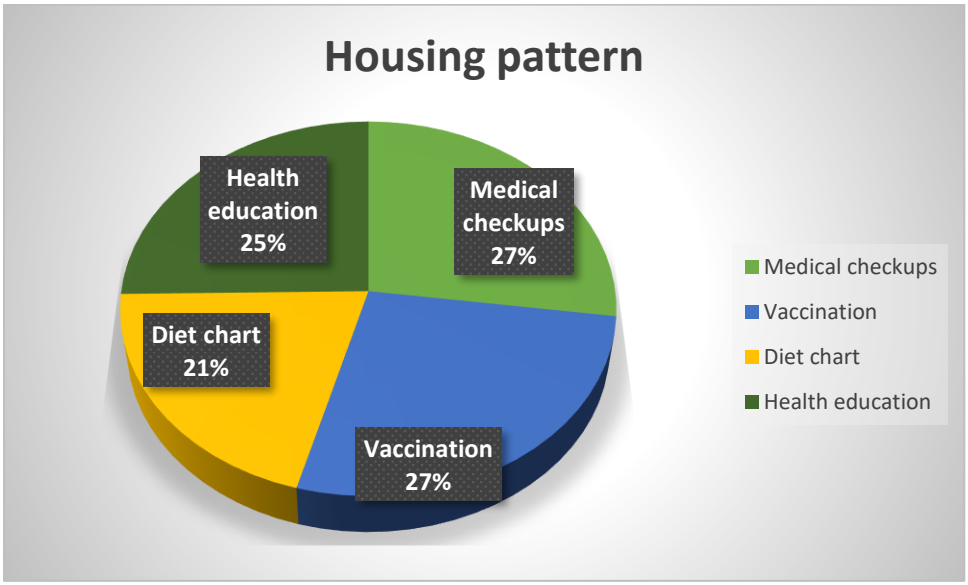


Factors Affecting the Health of the Gaddi community

The factors affecting the health of the Gaddies can be divided into two broad categories, viz; protective and curative measures. The former category includes those factors, which are responsible for fostering diseases like habitat, dietary habits and nutritional status, lack of sanitation, lack of proper medication while the second category comprises all such factors, which affect the health of the people in an indirect way including attitudes, beliefs and customs of the community.

Basic amenities: People have access to drinking water through natural resources. During rainy season, water becomes muddy and people drink the same water. There are many cases of Diarrhoea and worm infestation in this season and specially children are more susceptible to these sicknesses. Regarding sanitation, there is no proper sanitation facility in both the villages. Only 4 percent have got bathroom and 2 percent toilet facility in both the villages. Almost all the houses have got little place in the comer of the house to take bath, mostly made of sticks and covered with sack or cloth. Only a few houses have got toilet facility. Adults normally go to the field or nearby forest or isolated places to respond to the call of nature. Women have to adjust themselves early in the morning or late in the evening so that their privacy is maintained. Children urinate and defecate in the house or in the little place in front of the house and generally mothers dispose it little far.

Housing: Proper housing is important for physical and mental health of the people. The Gaddi housing settlement is compact. The houses are scattered. All the members of the family, relatives and neighbours participate in raising a house and accomplish the task within a few days. Most of the tribal people now live in *pucca* type houses. Usually, a single structure accommodates, in different sections, the family members, their livestock and poultry, cooking and various food processing implements and storing containers. For most of them, house is mainly a place for cooking, eating and sleeping and the verandas and front yard of the house is the place for rest and recreation. People spend most of their time outdoor working and they hardly stay indoors except in the night. Many of the household are being benefitted by the PM Awas yojna also. According to the data 52% Gaddi women are aware of the health education and go for medical check-ups also, 21 % adhere to the diet chart recommended by the doctor and 27



Environmental Sanitation: It has been observed that in the villages of bani sub-division as the sanitation is poor. Garbage is usually disposed near the houses and none of them have drainage for wastewater disposal due to hills. The cattle sheds are filled with cow dung and urine. The organic manure pit is adjacent to the house only. In most of the houses chicken also is kept inside the house and apparently house becomes more dirty. In addition, since the houses open field and dust enters the house even with little breeze although the weather is quite good because of hill slopes. It is also noticed that people spit anywhere in the house. Children play in the mud and stay with the animals freely. During monsoon mosquitoes breed from the stagnant water and the cattle shed. Various types of skin diseases and malaria are common due to these factors. According to the data, 34.4% of the families of the women in the sample of our study do not use any preventive measure to control malaria. The common indigenous method opted is to put smoke in the house usually with neem leaves and dried cow dung cakes. Around 81 % of the families put smoke while only 8 % use mosquito net to prevent mosquito biting. There are 63 % families using mosquito nets apart from burning neem leaves and cow dung cakes to keep away mosquitoes. Personal body cleanliness includes cleaning of teeth daily. Besides that, due to weather conditions they take bath, cleanliness of the hair, washing of clothes and frequency of changing clothes depends upon the weather conditions. Gaddi women in general very few times take bath daily due to climate conditions as most of the time cold weather is being observed in the areas of bani sub-division. Mostly the body is cleaned only with water and sometimes soap is used. Hair is washed only occasionally.

One of the most important aspects of public health is dental hygiene. The teeth play a significant role in the human body. The above table shows that a vast majority of the Gaddi people (74%) clean their teeth with *dathan,* indigenous brush of a twig of *akhrot or neem tree*. It is an indigenous brush used for cleaning teeth. The twig is made into a brush by chewing one end of it and the fibrous end is then used as toothbrush. After brushing the teeth, mouth is rinsed with water. Cleaning teeth with *dathan* is a common indigenous method among almost all the tribal groups. Only few people use toothpaste where as 22.4% use both *dathan* and tooth paste to clean their teeth. Mostly women are particular about cleaning children's teeth mostly by toothpaste now a day.

Patterns of Food and Dietary Habits

Gaddi community eat food twice a day, in the morning and evening. In the morning, they take tea (desi local tea) with the maize roti (*todda*) of the previous night and those who can afford take some bakery products too.

Smoking Habits: Smoking of bidis (indigenous cigarette) and eating tobacco is common among the Gaddi community. It has been observed that consumption of tobacco causes cardio-vascular diseases, respiratory diseases, gastro- ulcer, lung cancer and other types of cancer. The data reveals that 40.4% of the families of the respondents consume tobacco on daily basis and 2.8% take it sometimes. But a good number of the families, i.e., 56.8 % do not use tobacco at all. People believe that it has improved the health status of the people.

In totality it has been observed that ritualistic measures are common among the Gaddi community in context of the health. These functions are organized both at the individual and community level. It is believed that ancestors may become displeased if they are not given proper ceremonial respect. People believe that the wrath of supernatural beings, including various deities and ancestral spirits, is the most common cause for most of the sicknesses. Further they also opine that the supernatural powers may punish men for sins committed in their life or in some previous existence. It is therefore believed that by keeping the ancestors or village deities (chandi mata; Nag devta) satisfied, health could be maintained and protected from various diseases. The village deities are worshipped on certain occasions and at certain months in a year. Irrespective of religion, education and economic status people believe in these supernatural factors attributing to health sometime or the other.

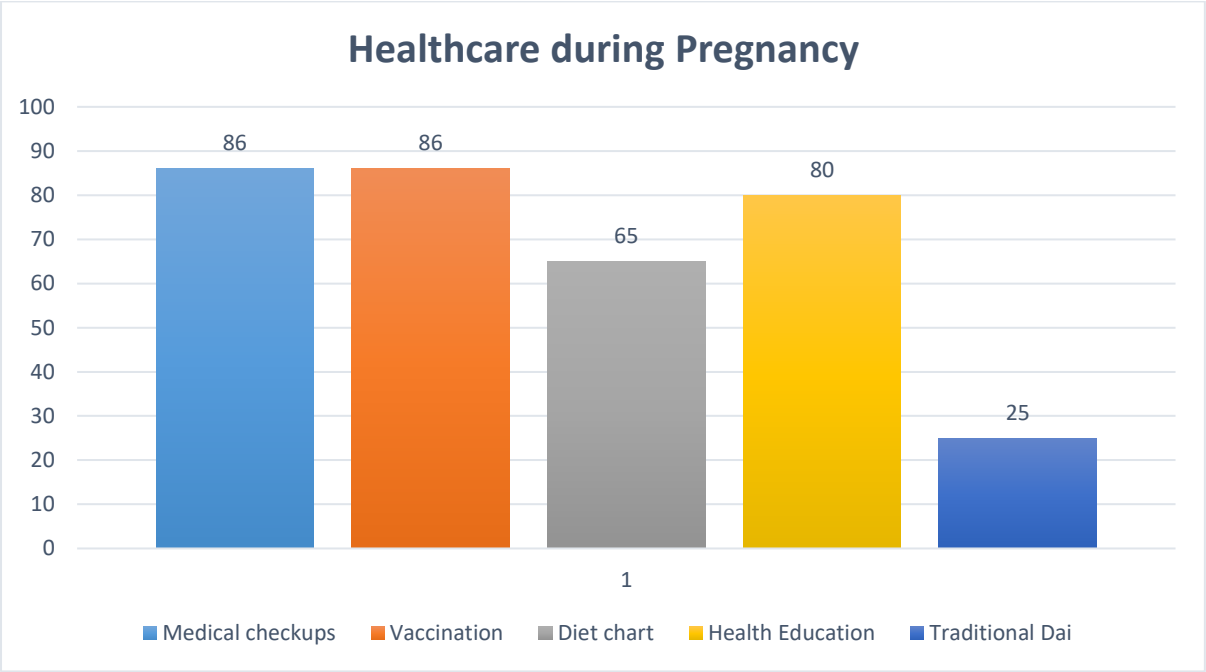
Women's poor reproductive health is affected by a variety of socio-cultural and biological factors. There are certain prohibitive customs set for menstruating women. They are allowed to carry on only certain activities and are banned from certain activities. Women during the menstruation period are not supposed to carry on their normal daily activities like filling water, cooking and grinding, they are not supposed to go near the place where the family gods are installed; neither can they participate in any religious ceremonies. Not surprisingly women are allowed to work in the field and collect forest produce or do other laborious works. Once the menstruation period gets over women are supposed to bathe properly and they can resume their daily chores only after this purification bath.

Food consumption of the women in the sample covered revealed lack of awareness about balanced food and nutrition, which is not surprising. On the whole rigid traditional food habits, poor economic condition and lack of awareness are the main reasons for under-nourishment. Whatever occasional vegetable and fish or meat supplements do not provide the required nutrition. It may be mentioned that hard work, inadequate rest and lack of nutritious food, unhealthy habits and surroundings are the primary reasons for most of the health problems that women are facing in the villages. In the final analysis, inadequate nutritional intake resulting in wide spread anaemia among women have serious implications for women's productive and reproductive health status.

A Gaddi female known as *Gaddan* delivers a child in Gaushala (cattle shed) and stays in there for ten days. She is taken as impure during this period and can enter into house only after purification is done. It is very interesting to note that a *Gaddan* is not provided other than milk and a Manda (same as Dosa) for ten days. On the twelfth day the mother with her baby come out from Gaushala (cattle shed) and takes blessing of lord Surya Dev (Sun). This occasion is very popular among Gaddis & in Gaddi Dialect it is known as Barowhla. Almost all relatives and native villagers attend this special day.

Health Care: It is observed that there is a direct relationship between age, literacy and antenatal care. Those who belong to the age group of 50 and above said that they have not received any of the health care services during pregnancy due to the absence of proper health care facilities in their time. It is noticed that those who are educated follow medical check-ups and other traditional health care services like consulting Dai (a local delivery women). But now health workers also visit the villages and she takes the regular weighing of the

pregnant women, supplements iron and folic acid tablets, and distributes pulses and *jaggery* to the pregnant women apart from imparting health education.



The above table reveals that 86% Gaddi women are well aware about the medical facilities received medical check-ups during pregnancy. Immunization is carried out by the sub-district hospital free of cost in the village and in this context it is interesting to note that majority of Gaddi women have got vaccination against tetanus along with that women have taken iron/folic acid tablets. Many women believe that if they take the tablets they can eat any food; otherwise it is not safe to eat more. Gaddi women have received health education during their pregnancy. Only health care services are a matter of serious concern as in case of medical complex they have to reach either Kathua or Jammu for further treatment. In the village also they have to reach sub-district hospital before time due to difficult geographical hilly slopes.

Family planning: Continuous childbirth drains the energy of women and adds to their misery of poor health and further deterioration of economic condition. It is observed that family planning is not a normal phenomenon for the Gaddi community. The Health workers aware people about family planning but the community has the notion that large families shows the fruitfulness of the clan. The data from the sample villages reveal that only 25.7% couples use contraceptives for family planning without the knowledge of elders in their families.

Conclusion: It is observed during fieldwork that there are some women who silently put up with all their health problems rather than seeking cure. In short, the above findings reveal that extra workload, lack of proper diet, lack of awareness and education are some problems affecting the health of Gaddi women. Diseases and treatment are intimately associated with their belief in different religious faiths. However, the influence of supernatural powers and ancestral spirits are still dominant in the causation and treatment of sicknesses of Gaddi women. The above study shows that impact of modernization has given momentum to change in the Gaddi society like any other tribal communities and the awareness and practice of allopathic treatment is gaining ground among the Gaddi women instead of their traditional methods of treatment. The findings of this study is an effort to gauge the socio-cultural dimension of health of Gaddi people in general

and women in particular and thus cannot be held fully representative and therefore it would be difficult to come to definite conclusions and generalizations.

Social implications: Women are the prime targets of programmes that aim at improving maternal and child health and achieving other desired demographic goals. Due to variety of reasons, tribal health is less optimal as compared to the health of general population. And, women need to be empowered to bridge the gap in different spheres.

Recommendations:

- The mean age of marriage is less than 18 years. Therefore, the young tribal girls should provide awareness related to legal age at marriage of girls.
- Highest percentage of households use open water sources. Safe drinking water facility needs to be provided.
- Majority of the households have no toilet facilities. Swachh Bharat Mission (SBM) should implement to eliminate open defecation in the study area.
- Household are not receiving food grains through ration shops. Effective implementation of "Public Distribution System (PDS)" is very much needed in this area.
- Household decision making is there but it needs to be enhanced by introducing Self Help Groups (SHG) and cooperatives related to women.
- The highest majority of the population reported no health centre in their area. Since, Primary Health Centre (PHC) is a fundamental need with each village should be provided PHC services.
- The traditional healer called as Bhagat/Dai provides all types of health care services which sometimes lead serious conditions for the people. Therefore, to control this type of practices the community needs awareness programmes.
- Utilisation of Government Hospital by women during pregnancy shows less in this population. Therefore, health workers like ANM's and ASHA workers need to encourage the women to utilise the services of government hospitals.
- Rural connectivity, modern agricultural methods, village committee and other related sectors needs to be strengthened for their welfare to achieve well-being.

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