OPERATIONAL DEFINITIONS

HEALTH SEEKING BEHAVIOR: Health seeking behaviour refers to all those things humans do to prevent diseases and to detect diseases in asymptomatic stages (Mackain, 2012). This behaviour among different populations is a complex outcome of many factors operating at individual, family and community level including their bio-social profile, their past experiences with the health services, influences at the community level, availability of alternative health care providers including indigenous practitioners and last but not the least their perceptions regarding efficiency and quality of the services.

ADULTHOOD: The time of life when one is expected to take responsibility for one’s own actions and well-being. The period can be further divided into:

- **Young Adulthood**: A person aging from 20 to 40 years.
- **Middle Adulthood**: A person aging from 40 to 64 years.
- **Late Adulthood**: A person aging from 65 years and above.
1.1 INTRODUCTION

Health is a basic human right. A healthy person is an asset to the society. If a person is physically, mentally and socially well, only then can he/she be considered as healthy. A person is healthy only when she is free from diseases and all the organs of their body function normally as per age and sex. He/she should be able to understand emotions, instincts and the tendencies, which further lead to understand other’s emotions, trait and behaviour. A healthy person is the one who has regular and qualitatively healthy interaction and relationship with family members, friends and other concerned individuals of the society. Efforts are being made to promote and improve the health of the people by increasing awareness, mobilizing community action and improving or creating the conditions required for better health (Yadav, 2016).

Health of an individual also depends on Health Seeking Behaviour exhibited by her / him. The health seeking behaviour of a community determines how they use health services. Health-care-seeking behaviour has been defined as any action undertaken by individuals who perceive themselves to have a health problem for the purpose of finding an appropriate remedy (Olenja, 2003) or as a sequence of remedial actions that individuals undertake to rectify perceived ill health (Fomundam et al, 2012). It can also be described as the process of remedial actions that individuals accept for improvement of their perceived disease (Bahrami et al, 2014 and Atashbahar et al, 2013). Health-care-seeking behaviour is believed to be a summation of individual characteristics, the nature of the environment in which a person lives, and the interaction between individual and environmental factors. It includes issues of whether, when, and from where care is sought for an illness (Chomi et al, 2014). Studying health seeking behaviours has become a tool to understand how people engage with the health care systems in their respective socio-cultural, economic and demographic circumstances. Health not only means physical but also includes mental health. Mental health and wellbeing are important factors for physical health. WHO describes mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her
community” (WHO, 2005). Mental Health is not just the absence of mental illness. There are multiple associations between mental health and chronic physical conditions that significantly impact people’s quality of life, demands on health care and other publicly funded services, and generate consequences to society (WHO, 2004). The WHO states that “there is no health without mental health” (WHO, 2004).

Chandrashekhar (2014) states that “Women’s health is an integral part of overall health system of any country”. They are the one who take care of the health of the whole family. Good health of the children, to a greater extent, depends on the good health conditions of the mother. Women are the foundation of health system, status of family and community. The woman is the pivot around which the family, the society and humanity itself revolves. Women’s health and nutritional status is inextricably bound up with social, cultural and economic factors that influence all aspects of their lives, and it has consequences not only for the women themselves but also for the well-being of their children (particularly females), the functioning of households, and the distribution of resources. As Jawaharlal Nehru also aptly remarked that ‘one can tell the condition of a nation by looking at the status of its women’. Thus, women’s stable and good health is the top indicator of any country’s overall development (Chandrashekhar, 2014). The health of Indian women is intrinsically linked to their status in society. Research on women’s status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens (Kamalapur and Reddy, 2013). The factors that contribute to their low status in society are preference for sons, daughters’ mistreatment, low educational levels and formal labour participation, low decision making power and father’s, husband’s or son’s control. Health and wellbeing are affected by many factors, and those that are associated with ill health, disability, disease or death are known as ‘risk factors’. Risk factors may be coexisting and they interact with one another. Age is one of the important factors in women’s life especially during the transitional years of adulthood when they need to seek more attention towards their health issues. Major developmental transitions for women, happen during the three stages of development: Early Adulthood, Middle Adulthood and Late Adulthood. Early Adulthood i.e. Reproductive years, are generally defined as the period from ages 25 to 40.
years. Middle Adulthood i.e. Pre-menopausal to post-menopausal (Peri-menopausal) stage, is generally defined as the period from ages 40 to 65 years. Late Adulthood i.e. Post-Menopausal stage is generally defined as the period from 65 years on. During Late Adulthood physical changes continue to occur at a rapid pace, and the brain also begins to lose neurons, resulting in memory loss and other changes (Boundless, 2015).

Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low-weight infants. They also are less likely to be able to provide food and adequate care for their children. Several studies have found that one of the reasons for the poor health of Indian women is the discriminatory treatment girls and women receive compared to boys and men (Das Gupta, 1994; Desai, 1994). The most chilling evidence of this is the large number of “missing women” (i.e., girls and women who have apparently died as a result of past and present discrimination). Estimates placed this number at approximately 35 million (The World Bank, 1996). In other words, there is a deficit of 35 million girls/women who should be part of the population but are not. This deficit of females is due to higher female than male mortality rates for every age group up to age 30 (IRG, 1996a). Finally, a woman’s health affects the household economic well-being, as a woman in poor health will be less productive in the labor force (UNICEF, 1995).

The 2011 Census Report shows that 62.5% of India’s population is 15-59 years of age and there are 62.2% are males and 62.8% are females, whereas 8% of the population is 60+, 7.7% are males and 8.4% are females. Life expectancy among females is more. In Jammu and Kashmir 65.9% of the population is 15-59 years of age, 65.1% being males and 66.8% being females. 8.4% of its population is 60+, 8.5% being males and 8.3% females. The Census 2011 report further shows that the total female sex ratio in India is 940 per 1000 males and the female child sex ratio is 944 girl children per every 1000 boy children of the same age group. The overall female sex ratio has increased by 0.75 % in the Census 2011 as compared to the previous Census of 2001 (Maps of India, 2011). Total Fertility Rate (TFR) measures average number of children born to a woman during her entire reproductive period. Total Fertility Rate for the country remained stationery at 2.6 during 2008 to 2009. As compared to 22.5 birth rate at national level, Jammu and
Kashmir has a birth rate of 18.3 followed by a death rate of 5.7, fertility rate of 2.2 and infant mortality rate of 43; as compared to 7.3 per cent, 2.6 per cent and 47 per cent respectively at all India level. Similarly, as compared to 72.90 per cent institutional deliveries at the all India level and 67.2 per cent safe deliveries, 61 per cent full immunization and 71.5 per cent children vaccinated with DPT; Jammu and Kashmir has 80.9 per cent, 82.9 per cent, 66.6 per cent and 77 per cent respectively. Jammu and Kashmir has lower birth, death and infant mortality rate in comparison to the all India ratio (Jammu and Kashmir-National Rural Health Mission, 2013) (https://www.jknrhm.com).

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. From 1990 to 2013, the global maternal mortality ratio declined by 45 per cent – from 380 deaths to 210 deaths per 100,000 live births, according to UN inter-agency estimates. The number of women and girls who died each year from complications of pregnancy and childbirth declined from 523,000 in 1990 to 289,000 in 2013. These improvements are particularly remarkable in light of rapid population growth in many of the countries where maternal deaths are highest. Still, about 800 women are dying each day from complications in pregnancy and childbirth, and for every woman who dies, approximately 20 others suffer serious injuries, infections or disabilities. Almost all maternal deaths (99 per cent) occur in developing countries (WHO, 2014). Morbidity is a measure of disease, illness or injury within a population. Like infant mortality, conditions resulting from prematurity and low birth weight are strongly associated with infant morbidity. In 2009-2010, 12.1 percent of infants in a 30-state area were reported to have been admitted to a Neonatal Intensive Care Unit (NICU) and more than 7 percent of infants stayed in the hospital for 6 or more days. The proportion of infants with the longest hospital stays varied by maternal age, education, and race/ethnicity factors (Teune et al., 2011).

According to Azad India Foundation (2016) India's maternal mortality ratio (MMR) is highest in South Asia: 540 deaths per 100,000 live births or one woman dying roughly every five minutes. An estimated 1, 36,000 women die in India every year due to pregnancy related setbacks. The number of maternity-related deaths which
occur in a week in India is equivalent to what occurs in a whole year in Europe. However government has not taken any effective measures till date. Despite the fact that an high fatalities occur among women in a year due to poor reproductive health practices no one is exercised enough to create a movement for improving women's health. One of the reasons is lack of timely transportation to the nearest hospital (Azad India Foundation, 2016).

Analysing the condition of poor health of Indian women it becomes imperative that their health seeking behaviours be studied and understood in context of the culture. This understanding of psychology of health will help the planners to plan effective need based policies, not blanket policies which are ineffective culturally. It is important to protect health through health care, besides other means of socio economic development. A women’s access to health depends on care in physical, social and psychological contexts on health beliefs and her socio economic system along with demographic background (Nayab, 2005). Health seeking studies acknowledge that health control tools, where they exist, remain greatly under or inadequately used. Understanding is prerequisite to change in behaviour and improved health practices (Muela et al, 2003). The findings from their research show that in order to respond to community perspectives and needs health systems need to adapt their strategies taking into account the findings from behavioural studies. The roles, rights, responsibilities and status assigned to women by society may leave more women vulnerable to unwanted and unprotected sexual intercourse, poor nutrition, and physical and mental abuse; they also limit women’s access to healthcare (Reproductive Health Outlook, 2004). Therefore, gender based inequality has a direct bearing in sexual decision-making and its impact on health (UNFPA, 2002; Helman, 2000). Furthermore, gender discrimination at each stage of the female life cycle contributes to health disparity, sex selective abortions, neglect of girl children, reproductive mortality, and poor access to healthcare for girls and women (Fikri and Pasha, 2004).

The Millennium Development Goals (2000) (www.un.org) were able to achieve the target of improvement in maternal health and combat HIV/AIDS, malaria and other diseases partially. Sustainable Developmental Goals (2016) (www.un.org) envisage to
ensure healthy lives and promote wellbeing for all at all ages. Globally adolescent girls and young women face gender based inequalities, exclusion, discrimination and violence (UNDP, 2016). The International Conference on Population and Development (ICPD, Cairo, 1994) and the Fourth World Conference on Women (FWCW, Beijing, 1995) both clearly emphasize the need to promote gender equity and equality in reproductive health policies and programs, and to promote and protect human rights. Furthermore, the United Nations Population Fund (UNFPA, 2006) also supports a gender-and rights-based approach to reproductive and sexual health that empowers women throughout their lives. They recognize that reproductive rights become tangible only when reproductive health services offer a high quality of care and are made widely available (UNFPA, 2006). Health problems are more prevalent among women than among men and certain health problems are unique to women/affect women differently than men (Kumar and Devi, 2010).

Despite the attempts from all sectors early marriages are still prevalent in Indian Societies, especially in same social groups. The problem with early marriage and childbearing is that young girls are often not adequately prepared with information regarding reproductive and sexual health issues, including sexual intercourse, contraception, sexually transmitted infections and diseases (STIs and STDs), reproductive tract infections (RTIs), pregnancy and childbirth (Pande et al., 2006; Gangakhedkar et al. 1996). Reproductive tract infections (RTIs) and STDs are increasingly being recognised as a major public health problem in India. These infections significantly increase the risk of contracting other fatal health problems such as cervical cancer and HIV infections (Pande et al., 2006; Gangakhedkar et al., 1996).

The focus of women’s health researchers and health policy planners has shifted towards postmenopausal women also since recent trends suggest an increase in their number and life expectancy (World Health Report, 1998; WHO, 2000). A total of 130 million Indian women were expected to live beyond menopause by 2015. Under current demographic trends, menopausal and postmenopausal health has emerged as an important public health concern in India owing to improved economic conditions, rapid lifestyle changes, and increased longevity (Sengupta, 2003). Generally, women have more
complex and stressful aging process as men do, as a consequence of hormonal changes that occur during menopausal transition (Morrison et al, 2006). The onset of this physiological development not only marks the end of women’ reproductive function but makes them more vulnerable to a new set of health problems including cardiovascular diseases, osteoporosis and so on (Shakhatreh and Mas’ad, 2006). Menopause (as defined by the World Health Organization) is the permanent cessation of menstruation due to loss of ovarian follicular activity. This definition uses both, a symptom that can be identified by a woman (the end of menstruation) and a sign that can be measured (loss of follicular activities resulting in changes in levels of hormones). Presently India has around 90 million elderly and by 2050 the number is expected to increase to 315 million, constituting 20% of the population (UNFPA, 2012). According to Sengupta, and Srinivasan (2010) with rapid demographic changes, the number of elderly population is gradually rising and the ratio of elderly and young adults is expected to reach 1:4; and by 2020, the actual number of women aged more than 50 will be nearing 150 million in India. The situation in the developed countries is more alarming with the ratio reaching 1:2, showing a high dependency rate. Thus, menopausal health assumes greater significance especially for those who suffer symptom and substantial morbidity. Moreover, menopausal health which signifies overall health and well-being status of a woman during and beyond middle age is also linked to various socioeconomic, cultural, physiological as well as psychological factors. Though physiological alteration in the cyclical ovarian function begins early at the commencement of climacteric period i.e., around 35 years of age but morbid conditions such as vasomotor instability, psychosexual problems, mental-physical exhaustion, anxiety-palpitation or genitourinary discomfort, bony pains in general and osteoporosis, diabetes and coronary arterial disease in particular are commonly seen later during and/or after menopause. They are generally ignored in rural, sub-urban as well as urban India, even if they suffer from symptoms silently (sengupta, 2003; WHO, 2000; Bush, 1990; Flint et al, 1990; Kaur et al, 2004).

Despite programmatic policies, reproductive health in India is very poorly understood (Pande et al, 2006; Population Council/CARE India, 2004; UNFPA, 2006; RHO 2004). Primarily, in the Indian context, socio-cultural norms, beliefs and practices
play a bigger role in making women more vulnerable to reproductive health problems and post reproductive health is still not a public health concern, because due to purity and prohibition followed during the menstrual periods women welcome menopause and don’t pay much attention to their bodily changes.

Findings of this study would be beneficial to all those concerned with the health care both in the governmental and the private sectors. It would also be beneficial for those concerned with the study on women as it will provide an opportunity to understand the problem from a humanistic perspective. Usually the health care needs are assessed on the basis of demographic indicators and the approach is top down, which is not acceptable to many. The findings would help to understand the women’s attitude towards own health. It would also be beneficial for policy planners and those responsible for implementation at grassroots to understand why these programmes are not successful especially for pastoral women, women from disadvantaged sections for example: tribal women, fisher women.

Today, nearly 200 million nomadic and transhumant pastoralists throughout the world generate income and create livelihoods in remote and harsh environments where conventional farming is limited or not possible (WISP). This number rises sharply when extensive agro pastoralists are included (MARAG, 2011). Pastoralists represent a significant proportion of the population in the dry lands, which are particularly vulnerable to desertification. The nomadic system, however, has proven to be an efficient way of managing the sparse vegetation and relatively low fertility of dry land soils, and has enabled pastoralists to adapt to their unpredictable environment. The wellbeing of millions of the world’s poor is based upon pastoral systems, which support a wide range of globally valued services and products, including biodiversity and raw materials. (UNCCD and IFAD, 2007)

According to Rota et al (2012) The Global Gathering – the first of its kind took place in Mera, a rural area of India in the Province of Gujarat, in November 2010. Sponsored by IFAD, the event brought together more than 100 pastoral women and men from 31 countries across the world. The goals were to work towards empowering women
pastoralists to participate equitably in decision-making within their communities and in government and other national, regional and international forums, and to raise awareness of the specific challenges faced by women pastoralists in the shifting social, economic and ecological environment. Global Gathering of Women Pastoralists (2010) was an important opportunity to: (i) highlight specific challenges faced by women pastoralists; (ii) promote the exchange of experiences and learning to strengthen the role of women pastoralists in decision-making (including policymaking); and (iii) contribute to the development of a global forum for identifying major social, economic, political and ecological challenges facing women pastoralists. Key themes identified by participants and discussed in interest groups included: Natural resource management, climate change, Access to markets, Women’s decision-making at home, in their communities and more widely, Advocacy, Engaging men, Women’s health, Education and Human rights (Rota et al, 2012) but the paper didn’t show any representation of pastoral women of Jammu and Kashmir. Gujjar & Bakarwal one of the most populous tribe of Jammu and Kashmir. Hence the women from Gujjar tribe of Jammu and Kashmir has been selected for the present study.

1.2: GUJJARS: A NOMADIC TRIBE OF JAMMU AND KASHMIR

Gujjars, are one of the ancient tribes of India. This community is believed to have migrated from Central Asia to India before 6th century AD and settled in Gujarat and Rajasthan. During 7th century, a devastating drought occurred in Rajasthan and Gujarat and some of the Gujjars migrated to the Shiwalik hills i.e; the outer Himachal Pradesh, Uttar Pradesh, Haryana and other Himalayan areas. In Jammu and Kashmir, after Kashmiri Muslims and Dogra Hindus, they are the third largest ethnic group. It is said that initially the Gujjars were Hindus but they adopted Islam during the reign of Mughal King Aurangzeb. They speak Gojri which is different from Dogri and Kashmiri, the major languages of the state. Gujjars are classified as a Scheduled Tribe. According to the 2011 Census of India, Gujjars are the most populous Scheduled Tribe in Jammu and Kashmir, having a population of 763,806. Around 99.3 per cent population of Gujjar and Bakarwal in Jammu and Kashmir follow Islam. According to the Tribal Research and
Cultural Foundation, Gujjars constitute more than 20% of total population of the state. They mainly live on cattle rearing. They are seasonal migrants, in the summers they live in the higher reaches of the state, and migrate down to the plains in winter (The Hindu, 2010).

From the occupation point of view the Gujjars, living in the area of study, are divided into three main categories:

1. *Dodhi Gujjar* (Buffalo keeper, producing and trading milk and milk products)
2. *Zamindar* (practicing arable agriculture along with livestock rearing)
3. *Other Professionals* (Shepherds, nomadic grazers and other professionals)

A study conducted by Koundal (2012) shows that a large population of nomad Gujjars in the states of Jammu and Kashmir and Himachal Pradesh alone are living below the poverty line. The survey says the Gujjars of Himalayan ranges are without sufficient food, fodder for their animals and lack basic facilities like proper shelter, health, drinking water, education, etc. Moreover, most of the nomads are not aware of schemes operated by the State and Central Governments for their upliftment and poverty eradication.

The status of any social group is determined by its levels of health-nutrition, literacy education and standard of living. The tribal women, constitute like any other social group, about half of the total population of Gujjars. About 89 per cent Gujjar women are illiterate in Jammu and Kashmir (TRCF, 2008). TRCF further says that early marriage, illiteracy, extreme poverty and nomadic way of life was casting dark shadows over the future of lakhs of nomadic Gujjar women residing in the most backward, hilly and border areas of Jammu and Kashmir. The study was conducted in 1000 houses of nomadic Gujjar and Bakerwal tribals in Poonch, Rajouri, Baramulla and Kupwara districts. However, their health is more important because they work harder and family’s economy and management depends on them. Higher Infant Mortality Rate among the tribal compared to national average; low nutritional level of the tribals; lower life-expectancy than the national average; high incidence of sickle cell disease and glucose - 6- phosphate enzyme deficiency in some tribal societies ; and higher fertility rate
compared to the national average have been reported by various studies (Singh, 1993). Hence it is important to understand the health seeking behaviour among these tribal women as it may have lifelong repercussion, which can be altered by early interventions (Tribal Affairs Statistics Department, GOI)(www.tribal.nic.in).

1.3: STATISTICAL PROFILE OF TRIBALS OF JAMMU AND KASHMIR

Jammu and Kashmir is one of the border states of India having a population of 1,25,41302 including male population of 66,40662 and female population of 59,00640. The 12 Scheduled Tribes in Jammu and Kashmir have a population of 14,93,299 which account for 11.9 per cent of the total population of the State (Census 2011). As per Census 2001, out of twelve Scheduled Tribes, Gujjar and Bakkarwal tribes form 69.1 percent of the total ST population of the state. These twin tribes also form the third largest community in Jammu and Kashmir, the third largest ethnic group in Jammu and Kashmir after Kashmiri and Ladakhis, and constitute more than 20 per cent population of the State. They are the state’s most populous Scheduled Tribe having a population of more than 20 lakh as per the 2011 Census and one fourth of them are living nomadic life. Out of the total nomadic Gujjar and Bakerwals, 66 percent population of nomad Gujjar-Bakerwals who fall under Scheduled Tribe groups in the state of Jammu and Kashmir are living Below Poverty Line, revealed a survey conducted by Tribal Research and Cultural Foundation (TRCF), a frontal organization working for the cause of Indian tribes. The Gujjar and Bakerwal women’s health 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. Like many other places Gujjar and Bakerwal women’s position in Jammu and Kashmir has been central in the upbringing of children, grazing their goats and sheep’s and managing domestic affairs (Gul, 2014).
1.4: JUSTIFICATION

Health is one of the core components of Sustainable Developmental Goals (2016) (www.un.org). Gender discrimination in health affects the wellbeing of the women and her family. Women are less likely to seek appropriate and early care for diseases yet the frequency with which such care is required and the quality of care required has not been well documented in South Asia (Fikree and Pasha, 2004). According to WHO (2003), many of the women’s old years may be spent in disability or illness due to lack of attention to health during reproductive phase. A large body of evidence confirms that many people in the developing world go without health care from which they could benefit greatly. The poor in developing countries are even less likely than the better off to receive effective health care (O’Donnell 2007). Gender attitudes and roles are particularly important determinants of Health Seeking Behavior. Raising access to maternal, reproductive and child health interventions is a major challenge within societies that restrict the public lives of women. Women across the world face similar situations when it comes to healthcare. There is a need to understand the women’s beliefs, perceptions, socio economic status, literacy status, decision making, labour participation and communication, perceived quality of health care as there is dearth of such data in India. Health policies have not been successful because they have not addressed this problem from a cultural- psychological perspective. Influence of health status of adult women during one stage of life to another (Early to Middle and middle to Late) has not been studied yet. Much research has been done on the status of women relating to their socio-cultural problems, their economic rights, their participation in management, their access to employment, food, health, etc. yet health seeking behaviour has not been studied effectively. Issues during adolescence, reproductive years or elderly have been researched, yet a holistic view is lacking. The status of any social group is determined by its levels of health-nutrition, literacy education and standard of living. The tribal women, constitute like any other social group, about half of the total population. Reviewed literature has revealed a number of studies on the tribes, their culture and the impact of acculturation on the tribal society yet studies on the status of tribal women in Jammu and Kashmir have received lesser attention especially in relation to Health Seeking Behaviour.
from the developmental perspective during adulthood among tribal women. In the view of above the present study has been designed to understand the Health Seeking Behaviour of tribal women in context of developmental stages as well as living style. Focus will entirely on tribal women of Gujjar community as it is one of the important tribe of Jammu and Kashmir and the lifestyle of this tribe is quite different from others as they are the seasonal migrants. The women contribute actively to the economy of their families and tribe, but the health related information about them has received meager attention.

![Developmental Perspective of women’s health](image)

The present study has aimed to fill in the gap in existing literature especially among the disadvantaged group of the Gujjar Tribal adult women of Jammu. It follows up the UGC Major research project on ‘Health Seeking Behaviour among women (35-65 years) of Jammu’ where it was found that more focused study needs to be done on Tribal Gujjar Women of Jammu, whose Health Seeking Behaviour was found to be low. It has tried to look at the relationship of Physical and Psychological Health with their Health Seeking Behaviour in context of Developmental Stages of Adulthood and Living Style i.e. Nomadic/Semi-Nomadic and Settled.
1.5: OBJECTIVES OF THE STUDY

I. To study the Health Seeking Behaviour of Gujjar adult women of Jammu Province in context of: Physical and Psychological health

   Developmental Stages (Early, Middle and Late adulthood)

   Living Style (Settled and Semi-Settled / Nomadic)

   Self Esteem

II. To know the health beliefs of sample women and investigate their access to health care services

III. To study the health care facilities available to them.

IV. To suggest supportive health seeking interventions specific to sample group wherever necessary.

1.6: HYPOTHESES

1. Health Seeking Behaviour, health beliefs and access to health care of Gujjar women will be, in part, a function of their developmental stages, living style and levels of self esteem

2. Health Seeking Behaviour will be positively related to physical and psychological health of tribal adult women.

1.7: STUDY AREA

For the present study, Jammu Province of Jammu and Kashmir state was chosen as unit of the study. The broad area of study is Women’s health in Adulthood and the study was conducted on Gujjar tribal women living in Jammu Province with a focus on developmental changes in their Health Seeking Behaviour.