**Transhumance, Armed Conflict and Healthcare Services: A Study of the Bakkarwals of Jammu and Kashmir**

*Thesis submitted to Jawaharlal Nehru University*
*in fulfillment of the requirement*
*for award of the degree of*

# Doctor of Philosophy

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JAWAHARLAL NEHRU UNIVERSITY
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2022

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## Declaration

This is to certify that the dissertation/thesis titled, "***Transhumance, Armed Conflict and Healthcare Services: A Study of the Bakkarwals of Jammu and Kashmir***" submitted by Mr. **BHAT IQBALL MAJEED** in partial fulfilment of the requirements for award of degree of Ph.D. of Jawaharlal Nehru University, New Delhi, has not been previously submitted in part or in full for any other degree of this university or any other university/institution.

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# Acknowledgement

I am grateful to my destiny for this memorable journey which started more than a decade ago at Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. My initial years at JNU invoked in me curiosity to work on nomadic Bakkarwals. I am highly thankful to all my faculty members at CSMCH for nourishing such a wonderful academic culture. I am indeed grateful to Prof. Mohan Rao for keeping the patience to engage, listen, discuss and reflect on the work that I have been doing. Prof. Rao provided unrelenting support throughout this journey in many ways. I must admit Prof. Rama.V.Baru was extremely generous for agreeing to be my supervisor after the retirement of Prof. Rao. I am indebted to her for supporting me in completing this thesis. This thesis was completed only because of her continuous push to stick to the deadlines. Many thanks, to Prof. Baru and Prof. Rao for their guidance. I thank Indian council of Medical Research (ICMR) for providing fellowship at the inception of this research.

The non-teaching staff of CSMCH has always been forthcoming and supportive. Thanks to *Jeewan Lata Pattak, Satinder Rawat, Satish Ji* and others. I am indebted to Dinesh Ji for his unwavering support all the time.

It would be unethical and snobbish on my part as a researcher if I do not mention with a very honest thanks to the people who as a community are known by names like nomads, *Bakkarwals* and *khanabadosh*. I say it with no hesitation that this research would have been impossible without a close study of their social bodies and linkages. So, a very big thanks to each and every member of this generous and brave-hearted community with whom I interacted, and whose life, whose culture, whose stories of struggle and survival became the texts for this research. Talib Hussain Fambda, deserves all appreciation for letting me to be part of his family. I am grateful to him for ensuring my stay with his family and other bakkarwal deras at various locations in Jammu and in warwan valley. I am thankful to his family, his brothers, his sisters and all other relatives for hosting me, listening to me and being available to me every time. Each one of yours contribution is immense!

Some people whose names indeed deserve the mention for the contribution they made in completion of this thesis, I pay my thanks to them:

Prof. Manoj K Jha for his unrelenting support and graciousness

Harsh Gupta, a dear friend and student, for being my photographer and companion in my visits to pastures

Er. Muzaffar Rasool for his wonderful companionship

Shahied Fazal Chouhan for his unwavering positive engagement at every meet

Suvaid Yaseen for helping, managing access to numerous readings as and when required

Manzoor Reshi for his suggestions and critical comments

Gujjar Desh Charitable trust Jammu for providing access to their library

Javaid Rahi, for his engagement with Bakkarwals and giving me access to his work

Prof. Khawaja Zafar for pushing me in completing this work

Nisar Ahmad for being banker to me

Hilal Bhat (UNICEF) for his support at various levels

Dr. Ranvir Singh friend, colleague, for technical help and Comradeship

Thanks to Prof. Renu Nanda, Prof. Kavita Suri, Prof. Pamela Singla, Prof. Archana Dassi, Prof. Zubair Meenai and Dr. Chakreveti Mahajan for their academic support and encouragement.

I thank my colleagues at Department of Social work, Central university of Jammu for their support.

I am thankful to Dr. Dharmendra Singh for having recommended my leave to complete this thesis, but feel pained losing him to the dreadful Covid pandemic.

Friends are an important part of my life and I thank all of them for their assistance. Few names I would like to take: Yasir Hamid, Basarat Hassan, Manik, Manmeet kour, Shweta verma, Syed Ishrat, Dr. Abid, Sajad Ahmad, Rafiya Farooq, Faizan, Lateef, Tanveer, Junaid, Asif Ali, Rabinder Singh, Javaid Rashid, Kevailya Desai, Mahendaran, Sudhir Maske, Shafat Naseem, Shafat Nazir, Sheikh Mudasir, Rayees, Shakoor, Abid Parray, Sheraz, Javaid Nabi, Jamiel,Dolma, Cathleen and many others……

The prayers and best wishes of my parents (Mr. Abdul Majeed and Hameeda), have been impulsive in the completion of this research project. I am indebted to both of them.

I am grateful to my father in law (Mohd Idrees Tak) and mother in law (Tehmeena) for supporting my wife and child while I was writing this thesis.

I am thankful to my sister (Chasfeeda Majeed) and brother in law (Er. Gowhar Ahmad) for always believing in me.

I would like to name my family members who have been source of motivation and encouragement for me during this long research endeavor: Arshid, Abid, Altaf, Areeba, Arushma, Hamza Ali, Muhammad Mubashir Gatoo, Shazia Idrees, Falak, Geeran, Mussadiq and Muawiz.

I owe my gratitude to my wife **Insha Idrees** for reading many drafts of this thesis, editing them, bringing in the legal framework and of course being an inseparable partner to every joy and sorrow of ours.

I am grateful to almighty for bringing **Khuraim**, my son into my life during this journey

Stay Blessed

Bhat Iqball Majeed

**July 2022**

*'Bakkarwals bruised by state,*
*Discriminated by society and*
*Neglected by academicians'*

*I dedicate this thesis*
*to the Nomadic Bakkarwals;*
*to their men, women, and kids*
*who live a very harsh life.*

*Wish you all*
*peace,*
*dignity,*
*progress,*
*transformative power,*
*and a better life.*

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# Abstract

The development of reason and thought is the unique attribute that human beings have been bestowed through their creation. It is the power of reasoning and thinking that has led to exploration and production of knowledge in the world. Diversity of human beings in terms of thought process has further augmented the knowledge production process. The search for new inventions and discoveries has continued over the period of time and has given rise to varied forms of lifestyle. The very nature of diversity has led human beings to adapt different lifestyles; nomadic and settle. Both these forms of lifestyle are still existing though there have been onslaught of dominant form of lifestyle; settle form over the nomadic one. But nevertheless nomadism has resisted, struggled and exists in various parts of the globe. This thesis generated out of the initial exposure of the researcher towards the nomadic community during his earlier study on the Armed Conflict and Health Services in Jammu and Kashmir. Jammu and Kashmir as prominent region of India shows diversity in many ways be it language, food, religion or weather. To all this diversity peculiarity is added by the presence of nomadic community known as Bakkarwals.

Bakkarwals are sheep and goat rearing community living in Jammu and Kashmir and practice transhumance in all three regions; Jammu, Kashmir and Ladakh. This thesis is actually documenting the lived experiences of the nomadic Bakkarwal community. While the idea of researching on them generated out of researchers own lived experience in Jammu and Kashmir. However, it was shaped and refined by the initial academic training at Jawaharlal Nehru University. Bakkarwals as a community is embedded within the larger identity of Gujjars recognised as scheduled tribes by the constitution of India in 1991. While we witness that there has been tremendous advancement in progress of human beings at every front but at the same time marginalisation of some communities continues to exist. Bakkarwals in Jammu and Kashmir is one such community which has been *criminalised by state, discriminated by settle population and neglected by the academicians*. Such a situation gave further impetus to the researcher for engaging with this community in a more rigorous way. Therefore an idea was conceived, developed in the form of a doctoral study so as to bring forth nuances of the life of Bakkarwals. Owing to some important considerations the thesis located itself in the engagement of bakkarwals in negotiating healthcare under the garb of state induced development and

persistent armed conflict. While developing this proposal of working on nomadic bakkarwals it was found important that there needs to have a historical understanding of the community and then how they have located themselves in the larger discourses prevalent in Jammu and Kashmir. Thus this thesis brought in historical aspect and then the conceptual framework of transhumance as described by numerous scholars working in the domain of nomadic studies. The thesis undertook a comparative analysis of how scheduled tribes have figured across various indicators in comparison to other scheduled tribes in India. Besides this how scheduled tribes in Jammu and Kashmir and rest of the population figure in the data sets has been shown in the thesis. The idea is basically to contextualise the notion of why there is need to study Bakkarwals. The thesis examines the identity assertion by bakkarwals amid the continuous tussle of modernity and tradition. The continuous onslaught of forced sedentarisation and the changes occurring globally and its response by the bakkarwals has been captured in the thesis. The thesis documents experiences of how bakkarwals negotiate their health needs in transhumant phase and also during their stay in pastures. A special focus has been given to the transhumant movement of bakkarwal and how it takes place. The thesis captures narratives of the bakkarwals which describe their engagement with the healthcare institutions and also their own use of faith based and traditional health care practices. The essential feature of bakkarwal existence i.e mobility has been extensively described by way of capturing some moments through images.

The thesis gains significance for the fact that it adds to the knowledge repository about one of the most neglected and under researched communities of Jammu and Kashmir. It is important to mention that in Jammu and Kashmir we witness tremendous challenge in terms of availability of literature and studies with respect to nomadic communities particularly bakkarwals. This is further complicated by the complete absence of studies pertaining to bakkarwals and more so when it comes to health aspect. There have been interventions by state and other organisation to look into the aspect of education of the bakkarwals but health per se has not received much attention. The thesis brings in newer perspective of how healthcare service delivery is being managed by countries having nomadic populations. Therefore the idea of '*One Health'* has been adapted from African context and same has been proposed as a means to deliver effective healthcare to the bakkarwals. Locating Bakkarwals in the policy mechanism of '*One Health'* is an important outcome of this study.

The thesis is significant also in the sense that it opens the debate of how policy formulation has to envision for nomadic communities. The thesis can be evaluated for its contribution in terms of reigniting the debate of sedentarisation, mobile healthcare services and the reemphasis it is laying on creating and developing sensitive health systems. While adding to the knowledge treasure of tribal studies this thesis is limited in its own context as it is located within a specific nomadic group in Jammu and Kashmir. Besides this the intricacies of diversity within the bakkarwal community which may be location specific have not been captured in the thesis per se. Therefore completely generalising it to all nomadic communities in the Jammu and Kashmir would be unfair. However, the thesis would serve the purpose of revisiting the whole policy perspective of how nomadic communities should be provided effective healthcare services.

# Contents

# Introduction

## Preface

Human beings have inhabited different locations across various regions of the globe. The diversity of lifestyle patterns has been an important characteristic of human existence. Nomadism as a form of lifestyle has been practised by numerous groups throughout the globe. There have been various strands of nomadism thriving in the world. With the advent of time and changes in the social organisation of human societies, nomadic lifestyle has come under tremendous pressure. In some places onslaught on the nomadic lifestyle has led to settle form of life with its own consequences. But many groups irrespective of tremendous challenges are still continuing their nomadic lifestyle by negotiating the entire crisis. The everyday experiences and struggles of these groups are worth to be explored and documented. It is mostly the nomadic groups of African continent which has got much required attention of researchers and policy groups. The nomadic groups living in Asian continent remained mostly untouched when it came to the policy group studies and development organisation interventions.

In India nomadic groups unfortunately had to face colonial wrath, partition brutality and indeed larger negligence from the state itself. Even though post-independence nomadic communities have been even constitutionally recognised as scheduled tribes, however the saga of their criminalisation and marginalisation continues. The state has either been indifferent to plight of nomadic tribes in India or has shown extreme push for sedentarisation of such nomadic tribes. Though many nomadic communities have been forced to settle lifestyle and many other communities are at the verge. This doctoral project was conceived out of the idea of understanding the nomadic bakkarwals who practice transhumance in Jammu, Kashmir and Ladakh. This ethnic group of nomadic people have been practising nomadic lifestyle since ages and are still continuing that though drastic changes have occurred. These nomadic bakkarwals have been rearing goat and sheep along the low lying plains of Jammu and thereafter proceed to upper reaches of himalayan pastures during summer months to stay along with their livestock. Jammu and Kashmir as a geographically and politically sensitive region has been at receiving end of contestations between India and Pakistan. In this whole volatile environment various communities living in Jammu, Kashmir and Ladakh have been witnessing drastic changes and challenges at

every front. The nomadic bakkarwal communities are also facing the challenge of negotiating their existence amid persisting armed conflict, communal tensions and government enforced restrictions. The nomadic bakkarwal community is unique in the sense that their expanse of relationship is varied as they practice transhumance all through three regions Jammu, Kashmir and Ladakh earlier used to be under one government structure. The Bakkarwals are the only group living in Jammu and Kashmir whose expanse of living is such huge and thus they face challenges too many in keeping this tandem of association going. It is important to note that nomadic bakkarwals as a community is also numerically insignificant which further adds to their invisibilisation as they remain out of the power corridors of Jammu, Kashmir and Ladakh. They have been criminalised by the british colonial occupation, neglected by the state, discriminated by the society and marginalised by the intelligentsia.

**Background**

This doctoral project was conceived out of my lived experience and also shaped by the study undertaken during Mphil programme. Jammu and Kashmir (Including Ladakh) has been extensively in the discussion for all the reasons owing to armed conflict persistent in region and also to the recent abrogation of Article 370 by the union government on 5$^{th}$ August, 2019. However it is mostly dominant narratives that have usually shaped discourses pertaining to erstwhile state of Jammu and Kashmir. The nomadic bakkarwal community has mostly remained hidden in this larger discourse for reasons probably their numerical strength and also weak economic and social capital and much importantly their nomadic lifestyle. It is in this backdrop that this doctoral study tries to bring to forefront the lived experiences of nomadic bakkarwal community in current state of existence. This doctoral study has been envisioned to study bakkarwals in their natural locations by traversing along with them to pastures. The study focuses on documenting experiences of the bakkarwal community concerning the issues of accessing healthcare services. The study has tried to look to question of how Bakkarwals negotiate their health amid their nomadic nature, armed conflict and state induced developmental initiatives. The study has used an ethnographic approach to understand everyday living of Bakkarwals particularly interms of negotiating their health needs. The study tries to explore notion of health among Bakkarwals and how they negotiate their heath needs through intersecting with the healthcare service delivery mechanism of the state.

The study has been designed keep in view mobility aspect of the nomadic bakkarwals. The ethnographic approach has been used to understand bakkarwals at various locations alongside during their transhumance. Ten deras (households) of nomadic Bakkarwals have been selected for the purpose of the study. Further to add to the particularities of the study, settled gujjars and bakkarwals have also been added as respondents in the study so as to capture the changing aspect of nomadism and the influence of sedentarisation process, that is taking place.

**Overview of Thesis Chapters**

The chapters of this thesis begin with three background chapters that introduce and describe the subject, Review of literature, Methodology, Conceptual framework and relationship between Modernity, State and Nomadism. This is followed by narratives of the walk, and field data. The thesis ends with a chapter on Discussion and Conclusion.

***Chapter 1: Health, Nomadism and Armed Conflict: Introduction***

This chapter basically draws upon the conceptual understanding of health and nomadism. In this chapter understanding about health as a broader category has been emphasized. The chapter lays emphasis on making distinction between clinical concept of health (medicine) and the public health. The chapter draws from the data of the world bank to show how Indian health sector has figured in comparison to smaller countries like Srilanka. The chapter tries to bring in the debate of socio, economic and political influences on the health of the nation. Besides this the chapter tries to weave the relationship between health, nomadism and armed conflict by looking into intersects of these categories. The chapter makes use of global data and studies to show how armed conflict is affecting the health of various nations and then particularly the nomadic populations. The chapter has a special mention on the history of Jammu and Kashmir in context of the persisting armed conflict. The chapter also does a comparative analysis of various health indicators of scheduled tribes in Indian with respect to overall population.

***Chapter 2: Profile of Scheduled Tribes, Review of Literature and Research Methodology***

This chapter majorly focuses on the comparative analysis of scheduled tribes in India and Jammu and Kashmir. The chapter brings forth the data related to various health indicators for assessing the condition of scheduled tribes in Jammu and Kashmir. The chapter also undertakes the literature review in the domain of nomadism and health at various levels.

The literature review has been done at global level, national level and also specifically on the studies pertaining to bakkarwals of Jammu and Kashmir. The chapter at the end describes the methodology that has been adopted for the study. The chapter ends by mentioning the limitations and ethics issues with respect to the study.

***Chapter 3: State, Modernity and Nomadism***

This chapter describes the role of state within the ambit of modernity in relation to the nomadic lifestyle. The chapter looks into how nomadic communities have been dealt historically in India by colonial rulers and then by constitutionally empowered independent state. The chapter traces the emergence of criminality notion of the nomadic tribes and then goes on to see the influence of modernity as induced by state and reciprocated by the nomads. This chapter particularly locates bakkarwals in the broader framework of state induced modernity. The chapter brings forth the lived experiences of bakkarwals in Jammu and Kashmir under the garb of development and modernity. Besides this the chapter also looks to the question of how identity assertion has emerged among the bakkarwals in the recent times.

***Chapter4: Narratives of Walk***

This chapter describes the transhumant movement of the bakkarwal community. The chapter documents lived experiences of bakkarwals throughout their transhumant journey. The chapter mentions the engagement of bakkarwals with different settle communities and also the health institutions of the state. Moreover the chapter describes what sort of challenges the bakkarwal have to face in continuing their lifestyle and also how state responds to the nomadic lifestyle. The chapter specifically captures the challenges that bakkarwals have to face while catering to their health needs. The chapter make use of various field narratives from different categories of respondents to show the engagement of bakkarwals with state health institutions. Besides this the chapter also lays emphasis on the overall 'Health Culture' of the community by looking to the use of traditional health practices and also the influences of many other factors in seeking healthcare.

***Chapter 5: Discussion and Conclusion***

This chapter summarises field data and makes inferences about what it means to live the life as a nomad. The discussion part of the chapter brings in the notion of assertion of identity and the struggle of nomadic community to exist even after the heavy onslaught.

The conclusion part of the chapter also brings to the fore various recommendations that policy formulators and governments can think of taking into consideration while looking to the issue of nomadic communities. Moreover the chapter ends by also raising certain unexplored issues and questions related to nomadic bakkarwal community which can be taken as a starting point for further exploration by other researchers.

Chapter 1

# Health, Nomadism and Armed Conflict

## 1.1 Introduction

Homo sapiens sapiens (modern-day human being) has evolved through various evolutionary stages from wanderer to the civilization stage. History is testimony to the fact that human beings have shown remarkable advancement technologically and culturally throughout evolutionary ladder. From hunter-gatherer to settled lifestyle journey has been incredible. There have been divergent lifestyles that human beings have adapted over time. Nomadism or pastoralism is one of those divergent lifestyles that humans adapted across different regions of the world. Pastoralism has been one of the important phenomena associated with history of human beings from early times. For nomadic communities human-nature relationship assumes significance and that too for nomadic pastoral communities as their livelihood is hinged on their animals and obviously the pastures. It is important to mention that these communities always remain in a symbiotic relationship with nature and regard nature and themselves as a single entity. For them nature is source of their existence as it provides them all resources they need for their survival. Such an understanding is embedded in their cultural systems. Their culture, is a guiding force for their existence, provides a knowledge base that helps them to sustain their livelihoods and to manage the ecology as well.

Pastoralism is one of the main and necessary production systems in various drylands across the globe. Pastoralists have been practicing transhumance from times immemorial. Transhumance is simply defined as the periodic movement of people along with their animals from one fixed location to another for optimal use of pastures. As mentioned by Roger Blench (2001) that the large scale pastoral production is taking up the 25% of the total land area of the world and thereby generates around 10% of the meat which is consumed by humans and in return provides livelihood to around 20 million households. With the withering away of the centralised economies of Central Asia, there has been increase in the number of people who are dependent on pastoral production in the twentieth century. It is important to mention that pastoral production contributes approximately one-quarter of global beef output, one-third of lamb, and around one-fifth of milk (FAO, 2009).

Pastoralism does persist in most parts of the world but there have been be numerous changes. The characteristic feature of mobility is on decline in many countries as is mentioned by Food and Agriculture Organisation in its various reports. Pastoralism still exists in many parts of the globe, however it has undergone tremendous change and the span of mobility is shrinking in many countries. The declines in mobility are basically an outcome of the amalgamation of push and pull factors; factors that discourage movement and factors that encourage settlement. Transhumant pastoralists show differential variations in terms of the practice of transhumance across the globe. However, the characteristic feature of transhumant groups is that animals are taken away for grazing by the men and only lactating females are kept at the location to be taken care of by other members of the community usually by women.

With the advent of time and development of science and technology, there has been a remarkable change in the practice of transhumance. With the introduction of modern means of transport transhumant groups have started taking use of trucks and trains. For example, wealthy gujjars and bakkarwals of Jammu and Kashmir rather than following traditional transhumance routes now carry their herds in trucks. Trautman (1985) argues that with advent of modern means of transport there have been phenomenal changes in the practice of transhumance in many regions of Eurasia. In North Africa many pastoralists make use of trains or trucks for sending their animals during transhumant movement. Even the practice of transhumance in britain has witnessed a new trend. The sheep are being carried on trucks for shifting them to different grazing pastures between highland and lowland areas. Besides this, because of the introduction of newer technology in various fields of life, many transhumant groups have either become settled or have taken to newer forms of earning a livelihood.

The introduction of heavily mechanized capitalistic development has led to the shrinking of spaces for these transhumant groups and thereby affecting their livelihood. The livelihood of nomads is absolutely dependant on the health of their animals, environment and of course the nature. Nomadic pastoralists possess sufficient knowledge and are conscious about the demand availability of fodder and water, more so their existence is strongly intertwined in their knowledge of ecology (Evans-Pritchard, 1940). For instance, the Van Gujjars of Uttarakhand, who are herding buffalos, are having 15 indicators pertaining to change of seasons. Any change in season is responded by buffaloes by becoming restless as and when there is shortage of resources (Rollefson, 2007). Nomads

are facing a tough time in continuing their lifestyle. Globally we witness a trend of sedentarisation but still then nomads survive and continue. In this tussle of sustaining their livelihood nomads are facing difficulties in accessing the service delivery institutions of modern nation-states particularly health and education. It is interesting to note that modern nation-states are dominated by settled populations and hence public policy formulation is done from settlers perspective. All the service providers of modern nation-states are particularly meant to serve the settled populations thereby letting nomads unattended at fringes. The 'settlers bias' is very much evident in the functioning of modern day nation states. The settle versus nomadic dichotomy is continuing and its impacts are visible when we look at the conditions of nomadic communities.

It is indeed the biggest misfortune that modern democracies have not been able to provide justice to the nomadic populations. The biggest concern that we witness currently is access to modern service delivery institutions like health and education. Healthcare services are not catering to the needs of nomadic or pastorals groups owing to the very nature of their mobility. The health indicators of the transhumant groups present a very dismal picture globally and similar is the case in India. Adequate healthcare is a matter of basic rights, still a dream for nomadic people in India. Nomadic populations and particularly transhumant groups who reside in remote pastures of Greater Himalayas are facing numerous challenges in accessing the basic healthcare facilities available around them. Bakkarwals find it extremely difficult to respond to the healthcare facilities that are being provided in the health institutions in and around settled populations. There are numerous reasons for not being able to utilise the modern healthcare facilities by nomadic groups like bakkarwals.

### 1.2 Transhumance and Healthcare Services: Global Context

Transhumance is weaved in complex environmental, socio-economic and political contexts. Transhumance is diverse and dynamic along with changing time and space. The characteristic feature of mobility in transhumance ensures adaptability to the scattered and unpredictable natural resources. Moreover the mobility also allows responding to climate suitability for the livestock. Not all countries support pastoralism some even discourage it by not supporting through legislative and policy frameworks. The role of countries towards pastoralism or transhumance is very dubious. We do find countries which are completely discouraging transhumance however even the countries which seem favouring transhumance are doing it in a

very conditional manner through an incomplete understanding of nomadism or pastoralism. Food and Agriculture Organisation mentions that by dint of vast grazing systems, pastoralism manages to provide foods like meat and milk which are having high nutrition value, in lands where the growing of crops is not easy or productive owing to requirements of high fossil fuel and water. These foods are extremely nutritious and required for healthy development of children. In reality, it is predicted that pastoral systems provide higher protein output per unit of feed input than intensive livestock systems; for example, for every unit of feed input, Kenya and India produce 21.16 and 4.3 units of protein, where as Brazil and United States of America produces 1.17 and 0.53 units respectively (FAO, 2011). However, changes at global level are creating issues for pastoralism. It is important to note that increased demand for animal products from highly developed nations and rich economies are pushing for extreme intensification of livestock production thereby generating issues of sustainability (Gerber et al., 2013).

Across the globe we find nomadic groups similar in many aspects as their livelihood hinged on livestock, effective mitigation of difficult terrain and extreme climates, resistance to ill health and strong social linkages within their communities and independent (suspicious) of governments. Mostly we witness that nomadic people are far behind the settle populations in education and access to public services. Besides this, nomadic groups while lacking political power are having meagre representation across governmental institutions. The policy formulations at national level do not provide sufficient attention to nomadic populations owing to their geographical marginalisation, poor communication systems and not being seen as priority (Cohen, 2005). Healthcare of nomadic populations has been a challenging area for governments and policymakers. There has been increasing knowledge generation concerning health-seeking behaviour and healthcare services of nomads. The African region is one of the most explored and researched when it comes to transhumant populations.

The World Health Organisation argues that within Africa, for various preventable conditions nomadic groups still have higher rates of morbidity and mortality (Gele, A,A., Bjune, G., & Abebe, F. 2009). From 1970's when smallpox eradication program began, whose success is attributed to herd immunity, nomadic pastoralists have been on the focus. (Kaplan, E, H., & Wein, L, M. 2003). The demographic invisibility of nomadic pastoralist populations is specifically salient in view of the Sustainable Development Goal (SDG) 2030 targets for which accessing the reach of indicators is the requirement of accurate denominator data (Wild, H., Glowacki, L., Maples, S., & Mejía-Guevara, I *et al*. 2019).

Emergence of non-communicable diseases along with the spread of infectious diseases among nomadic populations has been an area of concern for policymakers. Nomadic communities usually have poor health status. The nomadic communities are usually infested by varying diseases as per the region they reside in. However some common non-zoonotic infections like tuberculosis (TB), acute respiratory and gastrointestinal (GI) infections, sexually transmitted diseases and parasitic infections are found in most of the tribal communities (Schelling *et al.* 2005). The modern healthcare institutions have not been able to respond to the demands and felt needs of nomadic populations. It is important to mention that the delivery of healthcare services and other initiatives to nomadic populations is difficult. It is generally held that mobile health clinics or the establishment of fixed health centres in specific locations are the options that can cater to the health demands of nomadic people. The fixed health centres are seen as an effective approach for nomads who remain sedentary for some period of year at a specific location. However, the mobile health clinics are more effective for nomadic groups who are in continuous movement. 'Even with efficient fixed or mobile clinics, significant barriers may still exist to health delivery including mistrust, low perception of health priorities by nomads, and preference for traditional medicines/treatments', (Zinsstag, J., M, Ould Taleb., & P, S, Craig. 2006, p, 567 ).

We do witness many innovative experiments that have been carried out in many countries of Africa for enhancing the health outcomes of nomadic groups. The countries like Chad, Kenya, and Somalia have witnessed the implementation of the concept of 'ONE HEALTH' where the human health services have collaborated with animal health services. One health as a concept evolved from the Calvin Schwab's concept of 'One Medicine'. The concept of 'One Health' uses the services of both veterinary and allopathic services together. There have been campaigns where the immunisation and vaccination services have been provided jointly for the animals as well as nomads together. This has shown remarkable results in countries like Chad and Kenya. However, at the same time initiatives like 'One Health' also showed that in lieu of mobility and systemic factors nomadic populations may not be catered by formal health care systems (Schelling, E, W,D., & Bonfoh, B. 2008). In the case of India, we are yet to use these experiments at a large level for nomadic pastoralists. However many non-governmental organisations like ANTHRA at Pune in Maharashtra have been trying the concept of 'One Health' for pastoral communities like Dangars. Their experience reveals promising effects of 'One Health' initiative.

### 1.3 Health Scenario in India:

Health is considered one of the important factors for the growth and development of a nation. Health is to be understood from a broader perspective of wellbeing of a community. The notion of wellbeing entails various indictors which are linked directly or indirectly to the health of a community. The idea of being free from disease and illness limits the definition of health to clinical understanding only. Therefore the socio-economic, political and psychological aspects are considered important indicators of health. The recent development in the understanding of health has led to the exploration of the social determinants of health. This term social determinants of health include economic, political, cultural and environmental factors as the determinants of health. These are basically the contextual conditions in which people exist all over the globe (WHO, 2013). According to this view, the larger health inequities that exist in the populations are contributed by factors like occupation of a person, educational status, income, social capital and the status in society. These circumstances are further augmented by a vast array of forces, including economics, social policies, and politics. Individuals and even families can affect some of these factors by their urge to achieve particular outcomes, while some other vast forces are outside the control of individuals. It is worth to mention whether people take any action to prevent from getting ill or utilise the services for treating illness is determined by the social and economic situation of the people (WHO. 2013). According to the World Health Organization (WHO), 'the social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries' (WHO. 2013. p, 14).

Thus there are various determinants that define or categorise the health of an individual or a community. The allopathy sees health from an individualistic view point which is devoid of social context. Such an understanding has a flawed contextualisation about the health of communities. Health is to be understood from a wider prism of various determinants which have a profound impact on it. The socio economic context strongly determines the health of the communities. It has been found out that it is mostly the poor people who are having health issues as compared to the rich people in a community. The socio economic conditions of the poor people are indeed miserable as compared to the elite people in community, therefore directly indicating about the relation between socioeconomic factors and the health. Therefore to develop a nuanced understanding of health it is important that health has to be differentiated from illness paradigm. The concepts of healthcare and health service delivery only try to look to a narrow question of understanding the

complexity of health as a broader concept. Moreover it is important to locate the people's perspective in the contextualisation of the health.

Various anthropological and public health studies have shown that there varies the understanding of health when it comes to different communities and cultures. This is where the concept of health culture which is being made operational to look to address the question of health of the communities attains significance. As stated by Banerji, D. (1975), 'every community has a health culture of its own- its own meaning of its health problems, its health practices and its corps of practitioners' (p, 70). Health culture as a concept entails the understanding of how people contextual the concept though their cultural structures. The health seeking behaviour also forms the part of the health culture of a community. For example what would be seen as an illness by the members of a given community will determine whether or not they will utilise the healthcare services. Healthcare is defined as a host of services provided to individuals and communities by health service providers or practitioners for improving, maintaining, and restoring their health. The service may include consultation, physical examination, surgical procedures, and diagnostic services, etc. It is a rare service that people need but does not necessarily want to avail (Berry & Bendaupudi, 2007). However, globally as well as at the national level there has been a tremendous rise in number of medical care providing facilities (hospitals, nursing homes, diagnostic centres, clinics) and the people visiting these facilities for improving and restoring their health. Healthcare services in India are provided by the government as well as private players, with the latter playing a dominant role. It is important to note that private doctors, nursing homes, private run hospitals, charitable hospitals, and local chemists etc are all part of the private sources of treatment. When India attained independence the private sector at that time accounted for only 5-10% of patient care (Rao, 2012). However, ever since then, there has been a significant increase in the share of patient care provided by the private sector. As argued by Das J., Hammer J., & Leonard, K. (2008), 'Private health care in India, however, is not only expensive but also suffers severely from a lack of trained and skilled manpower as compared to the public sector(p, 105). According to the National Sample Survey (NSS) 71st round on social consumption (2014), the private sector was used to treat more than 70% of illness episodes (72 percent in rural areas and 79 percent in urban areas). The single most important source of care in both sectors was private physicians. In both rural and urban settings, private doctors do about 50% of the treatments. At the national level in India, the

proportion of public hospitals providing outpatient care has significantly increased. Between 2004 and 2014, the increase in rural areas increased from 22% to 28%, whereas the increase in urban areas increased only slightly, from 19% to 21%. It is also seen that private hospitals play a prominent role for hospitalised treatment accounting for 58% and 68% of hospitalized treatment in rural and urban India respectively. However it is important to notice that share of private hospitals in hospitalized treatment remained unchanged at 58% in rural India whereas in urban India there has been a slight jump from 62% to 68 % in the same period. Although the private healthcare system is playing a dominant role in providing healthcare to the people of India, the importance of the public healthcare system is paramount. India, a country of more than 1.3 billion people, with more than 20% of the population living below the poverty line, is quite distant from universal health coverage. It is interesting to look at the comparative health indicators of India and Srilanka.

**Table 1: Comparative Health indicators India and Srilanka**

| Indicator | India | Srilanka |
|---|---|---|
| Infant Mortality Rate | 27 | 6 |
| Maternal Mortality Rate | 145 | 36 |
| Life Expectancy at Birth | 70 | 77 |
| Prevalence of Stunting, Height for Age( % of Children below 5 yrs of age) | 30.9 | 16 |
| Immunization DPT( % of children 12-23 Months) | 85 | 96 |
| Hospital Beds Per 1000 Population (year 2017) | 0.5 | 4.2 |
| Unmet need for contraception(% of married women ages 15-49) (year 2016) | 13 | 8 |
| Current Health expenditure( % of GDP)( year 2019) | 3.01 | 4.08 |
| Out of Pocket Expenditure(% of current Health Expenditure)(year 2019) | 54.07 | 45.64 |

*Source: https://data.worldbank.org year 2020*

It is important to note that India has 1.2% of GDP on Public health expenditure whereas Srilanka has 1.6 % of GDP on Public health expenditure. Since the independence, Sri Lanka has been providing free healthcare to all citizens. The government owned and run hospitals provide healthcare free of cost, while as privately owned and run hospitals are providing healthcare on a fee levying basis. Every year tens of millions of people in India

fall into poverty because of devastating health expenditures. Although India is called pharmacy of the global south, 68% of the people have limited or no access to essential medicines (Selvaraj., Farooqui., & Karan. 2018). Diseases like Tuberculosis and Kalazar are prevalent even after 70 years of Independence. Hence, in light of these facts, the existence of the public health care system in India becomes indispensable. However, mere existence is not going to be the panacea, quality, and quantity of care provided is also going to be pivotal. Moreover, the target of universal health coverage as envisaged in the National Health Policy (2017) cannot be achieved in the absence of a strong and vibrant public healthcare system. Also, the degree of effectiveness of the various government schemes for improvement in health outcomes significantly relies on the reach and performance of the public healthcare system.

There are 23,582 government hospitals having 710,761 beds in the country. Out of these, 19,810 hospitals are in a rural area with 279,588 beds and 3,772 hospitals are in urban areas with 431,173 beds (National Health Profile, 2018). Having said this it is important to mention that the public health system with three tier structure i.e Primary Health care, Secondary Health Care, and Tertiary Healthcare, is indispensable for effective and efficient service provisioning. Unfortunately, the biggest challenge is the health financing which makes most of these structures dismal and thereby hindering the service provisioning. Transhumant groups are essentially dependant on the public health system for catering to their needs. For the very reason, that transhumant groups like bakkarwals reside in remote locations and usually abode the upper reaches of himalayas that private health system doesn't find them at all profitable. Therefore inadequacies of the public health system are taking a heavy toll on their health as they have to look for alternate means for healthcare services. The alternate means are usually found in terms of local pharmacists, quacks, and other remedies which again are disastrous for them.

The roots of the existing primary healthcare system in India can be traced to the recommendations of the Bhore Committee, 1942. The committee recognised the then existing rural-urban disparities in availability and accessibility of healthcare facilities. It called for the development of health services delivery structure in the short and long run centred on the tenets of equal access, regardless of financial means, with a focus on rural areas, and offering complete preventive and curative services; and, a cooperation of people should be sought. For the development of rural health infrastructure, the Committee recommended the development of Primary Health Centres (PHCs) and that there should be

one PHC for a population of 40,000, which was to be manned by two doctors, one nurse, four public health nurses, four midwives, four trained Dais, two sanitary inspectors, two health assistants, one pharmacist, and fifteen other class fourth employees.

The Bhore Committee's recommendations demanded that the then-healthcare system undergo fundamental modifications leading to creation of new structures. If the recommendations of Bhore Committee would have been implemented it would have brought significant changes and would have drastically shaped access to health care and thereby bringing a remarkable change in the health status of Indian people particularly people residing in rural areas. It is indeed an embarrassment for country like India that even after so many decades we do not have yet an evidence of any development of health care services to a level as was considered and regarded minimum decent standard by Bhore Committee (CEHAT, 2005). It is with pain and shame to write that nation like India is still to achieve the health infrastructure as was suggested by the Bhore committee. As stated by Banerji, D. (2004), 'The report of the Bhore Committee, submitted in 1946, is to this day regarded as an authoritative document, not only because of its distinguished authorship but because many of its proposals and recommendations continue to be valid. It contains many 'seeds of hope.' It was guided by such lofty principles as "nobody should be denied access to health services for his inability to pay" and the need for a focus on rural areas, with emphasis on preventive measures and training of what it called "social physicians"' (p, 130).

### 1.4 Healthcare for the Scheduled Tribes in India

Although there is a paucity of studies exploring the health of tribal population in low-income regions of South-Asia and Sub-Saharan Africa, scholars argue that there is enough evidence to suggest that the indigenous people tend to have lowest health outcomes world-wide (Zinsstag, J., M, Ould Taleb., & P. Craig. 2006). In the context of India the constitution provided for affirmative action to improve their lives however, they continue to remain at the margins of development goals. Despite India's impressive economic performance inequalities in access to health care and health continue to exist and have rather increased across states and also in rural and urban areas along within communities. Literature on state of health in India highlights that three key forms of inequity have dominated status of health. First, the historical inequities rooted in colonial policies, many of which continued to be pursued in post-colonial India, second, inequality because of

prevalent caste structure, class differentials, religion and gender differentials and aided by inequity in terms of utilisation of health services which is marked by acceptability, availability and affordability.

In Indian society caste an endemic category is an essential determinant of socio-economic inequality in all spheres of well-being. Both Scheduled Castes and Scheduled Tribes are placed at bottom of social hierarchy and constitute respectively 16 and 8 percent of the total Indian population. Scheduled Tribes like Scheduled Castes suffer social and economic deprivations. National Health Family Surveys (NFHS) have highlighted that sharp regional and economic divide in health outcomes, with SCs, STs and less developed states bearing the burden of mortality and other health care challenges disproportionately.

India is home to a large number of tribal groups spread across all states and regions. According to the census 2011, tribals constitute 8.6 per cent of the total population of India. Diversity is the key feature of tribal populations in India even though numerical strength is low. The tribal population of India shows tremendous variations concerning language, ecological settings in which they live, physical features, the extent of acculturation, livelihood, and social stratification. Tribal population is found all across the India east, west, north and southern region. There is no uniformity in the territorial distribution of tribes in India. The majority tribal population resides in the eastern, central, and western belt covering the nine States of Odisha, Madhya Pradesh, Chhattisgarh, Jharkhand, Maharashtra, Gujarat, Rajasthan, Andhra Pradesh, and West Bengal. North eastern region has around 12 per cent tribal population followed by southern region with five per cent, and northern states having three per cent tribal population (Tribal Health committee report, 2014).

Having faced the wrath of colonial excesses, tribals expected a bright future post-independence in terms of safeguards and provisions. Even though constitutional safeguards and provisions were granted to tribals but still their dismal picture has not improved to the expected level. When it comes to levels of poverty, tribes are among the poorest and also the most marginalized sections of Indian society. The tribal health in India assumes significance for the fact that tribals are most marginalised when it comes to healthcare. The dismal health indicators concerning tribals are evident examples of the situation of healthcare of tribals in India.

**Table 2: Key Health Indicators of Schedule Tribes & Total Population (India)**

| Indicators | ST | India (total) | Source |
|---|---|---|---|
| Sex Ratio | 990 | 943 | Census, 2011 |
| Child Sex Ratio | 957 | 914 | Census, 2011 |
| Literacy rate | 59 | 73 | Census, 2011 |
| Infant Mortality | 44.4 | 40.7 | NFHS-4 |
| Under Five Mortality rate | 57.2 | 49.7 | NFHS-4 |
| Neo-natal Mortality | 39.9 | 39 | NFHS-3 |
| Post-natal Mortality | 22.3 | 18 | NFHS-3 |
| Child Mortality | 35.8 | 18.4 | NFHS-3 |
| Under Five Mortality | 95.7 | 74.3 | NFHS-3 |
| Under Five Stunted | 43.8 | 38.4 | NFHS-4 |
| Under Fiver Severely Stunted | 29.1 | 23.7 | NFHS-3 |
| Under Five Wasted<br>Under Five Severely Wasted | 27.4<br>9.3 | 21<br>6.4 | NFHS-4<br>NFHS-3 |
| Under Five Under Weight | 45.3 | 37.5 | NFHS-4 |
| Under Five Severely Underweight | 24.9 | 15.8 | NFHS-3 |
| Full ANC Checkup of Women % | 14.7 | 18.8 | NFHS-3 |
| | 15.0 | 19.7 | RSOC-2013-14 |
| Institutional Deliveries % | 68.0 | 78.9 | NFHS-4 |
| | 70.1 | 78.7 | RSOC-2013-14 |
| Child Vaccination (Full Immunization) % | 55.8 | 62 | NFHS-4 |
| | 55.7 | 65.3 | RSOC-2013-14 |
| No Vaccination % | 9.2 | 6.0 | NFHS-4 |
| | 7.4 | 6.6 | RSOC-2013-14 |
| % Households Covered by a Health Scheme/Insurance | 2.6 | 31.9 | NFHS-3 |
| Prevalence of any Anaemia (<12.0g/dl) in Women age 15-49 | 59.8 | 53 | NFHS-4 |

From the data, it is very much evident that except for the sex ratio and child sex ratio, the tribals lag in all the health indicators in comparison to the national average level. It becomes obvious that tribal healthcare demands a thoughtful exploration as to why the indicators are so poor even after governments claiming that there is a heavy emphasis on tribal healthcare. The data vividly shows that child mortality is almost double when it comes to the scheduled tribe population as compared to the national average. Similarly, the percentage of institutional deliveries is yet to reach the level of the national average even after too much emphasis on it after NFHS 3. The National Family Health Survey

2015-16 (NFHS-4) shows the following: 45.9 per cent of scheduled tribe members were in the lowest wealth bracket compared to 26.6 per cent of scheduled castes, 18.3 per cent of other backward caste, 9.7 per cent of other castes, and 25.3 per cent of those whose caste is unknown. There has been a 4 percentage point drop in the percentage of scheduled tribes in the lowest bracket as compared to a decade ago, from 49.9 per cent in 2005-06 to 45.9 per cent in 2015-16. Further, 70.7 per cent of scheduled tribe fall in the lowest two wealth brackets compared to 37.6 per cent of other backward castes and 24.8 per cent of other castes.

Children born in SC and ST families have a higher risk of dying than others. "The risk is higher for children born in scheduled tribe (ST) families as compared to scheduled caste (SC). For example, a child born to an SC family has a 13 per cent higher risk of dying in the neonatal period and an 18 per cent higher risk of dying in the post-neonatal period, as compared to others. Similarly, a child born to an ST family has 19 per cent higher risk of dying in the neonatal period and 45 per cent risk of dying in the post-neonatal period"(NIMS., ICMR., & UNICEF. 2012).

Keeping in view the marginalisation of tribal communities, several committees and commissions have been formed by various governments to analyse the situation of tribals and suggest measures to be put in place for the overall welfare of the tribal communities. Some of the committees and commissions constituted had specific mandate to investigate the condition of tribals. The committees like Elwin Committee, post 1947., U.N. Dhebar Commission, 1960., Lokur committee, 1965., Shilu Ao committee, 1966., Bhuria Committee, 1991., and the Bhuria Commission, 2002-2004, Bandopadhyay Committee, Mungekar Committee, and High-level Committee on Socioeconomic, Health, and Educational Status of Tribal Communities of India, 2014 headed by Virginis Xaxa. All these committees looked at the general welfare of the community particularly focusing on state intervention.

In comparison to national average, the tribal community are behind in several vital health indicators and that too with women and children being the most vulnerable. Various studies have shown presence of high level of malaria and tuberculosis (TB) cases in tribal communities. Besides this, many of the tribal areas are also considered as malaria endemic. (Kumar, M, M., Pathak, K,V., & Ruikar, M., 2020). It is mostly believed that tribals hardly suffer from major non communicable diseases like cancer,

diabetes, or hypertension. However, in recent time's presence of such diseases have been noted among tribals. The prevalence of sickle cell disease (SCD) has been noted in tribal communities and is considered as a significant public health issue (Saxena, D., Yasobant, S., & Golechha, M. 2017).

Chronic malnutrition, increased levels of morbidity and mortality and lower provision of antenatal and postnatal services among tribals that too in the PVTGs has been shown by various studies on maternal health. It is astonishing to know that under-five mortality rates among rural tribal children remain high. The reproductive health services in tribal areas do not receive adequate attention which is a cause of concern when it comes to women health. Even if abortion and contraception do not conform to the category of 'illnesses', but they form an essential aspect of reproductive health of tribal women. Due to the heavy advance of market economy in consonance with discrimination and continued exploitation tribals have been experiencing and showing visible mental health issues. The presence of severe anxiety, distress and other disorders has been reported by tribal populations (SAMA, 2018).

The vulnerability to mental health issues has emerged among the tribals however; there is no adequate health care available to be accessed. The poor health conditions of tribal communities owe itself to the poverty present in tribal communities which is further aided by migration, displacement, food insecurity and more importantly the lack of access and availability of health services. When it comes to the public health infrastructure, tribal areas show similarity with rural areas except for the population ratio differences. Tribal communities are usually underserved ones, with gaps evident in human resources and infrastructure. The Rural Health Statistics (RHS) data has remarkably shown the deficient human resources like doctors, specialists and paramedical staff at all the levels of health care delivery system in tribal areas.

As shown by SAMA (2018) study, this situation of deficits in human resources aided by non-availability of drugs and diagnostics has led to high out of pocket expenditure (OOPE) on health care and thereby increasing the indebtedness of tribal population which further renders to ill health. Besides this, absence of adequate transportation facilities in tribal areas hampers access to health care. Further, it is quite evident that tribal communities usually have a lived experience of witnessing undignified and unfriendly behaviour by the health personnel, which comes from a social prejudice

developed against the tribal population. Besides this barrier in terms of language further aid to the low utilisation of the existing health care services in Scheduled Areas (SAMA, 2018).

The parliament of India adopted The National Health Policy (NHP) in 2017. The policy makes mention of the fact that there are health inequities existing in various indicators such as IMR and MMR, when it comes to different states, Union Territories particularly remote and isolated tribal areas. The policy recognises that even in the states where health indicators are showing an improvement, the tribal communities still lack behind. The policy advocates that territorial and infrastructural challenges of tribal areas should be considered and measures are taken to bring change and improvement in the health services pertaining to these areas. For this, The National Health Policy suggests the establishment of Mobile Medical Units (MMUs), etc so as to increase reach of public health services. The policy endorses the view that there is need for developing research and validation pertaining to tribal medicine so as same can be included in the public health sector later on. The NHP stresses the role of states in providing health services; however it also lays emphasis on engagement of private sector to adopt tribal areas under corporal social responsibility for raising health care awareness and providing services. It is pertinent to mention that public–private partnerships (PPPs) that are being promoted is in a way absolving state from providing services to the people and particularly to vulnerable tribal communities. In this amalgamation of PPP model there is no overall plan for reorganising public health system nor is any foresight as how to regulate private sector, enforce patients' rights or ensure fair practices.

The increasing burden of diseases and the unavailability of healthcare services in tribal areas is a major challenge that the Indian state is currently facing. The dismal health indicators of tribals are indeed an area of concern. When there is a heavy shift of public to private healthcare services, the tribal population becomes a big casualty. What we witness is that insurance induced private healthcare is not going to render the services to the tribal areas owing to their geographical remoteness and low-income levels. This decreasing public health services and an increase in the private healthcare is detrimental to the cause of tribal healthcare in India. Nomadic tribes are one of the most marginalized communities in India. Most of the nomadic communities are facing extreme socio-economic, cultural, and political problems in India because they do not

stay in one place. It is often seen that nomadic people are devoid of essential and mandatory documents such as ration card, caste certificate, voter card, and so on. Not possessing these documents renders the tribal people from availing the various services which are specifically run for them mostly in poverty reduction programmes. The total nomadic population is not precisely known in India. The reality is that even today many nomadic groups are not even part of the census and remain surprisingly invisible and unenumerated as citizens (Rao and Casimir, 2003). These people are not living dignified lives and also they do not have documentary evidence to prove themselves as the real citizen of India. The non-availability of data pertaining to the health of nomadic communities is one of the biggest challenges to establish the gravity of the situation. Even the health policies and planners have miserably failed to cater to the health needs of the nomadic populations particularly in the Himalayan region. The nomadic communities remain outside the framework of the policies and programmes that are designed for the larger population. It is interesting to note that concerning education there have been efforts like mobile schools and residential schools that have been tried to provide education to children of nomadic families like Bakkarwals in Jammu and Kashmir; however, when it comes to health there are no such examples which can be portrayed. Nomadic populations like Bakkarwals have been completely left out of healthcare planning. There has not at all an effort to cater to the health needs of the groups.

### 1.5 Armed Conflict and Healthcare Services

Armed conflict[1] has been one of the major challenges to the present-day nation-states. History is witness to huge devastations that have occurred because of the two major world wars. The Second World War was even more destructive with deaths alone estimated to have exceeded 60 million, including 32 million civilians. This resulted in a population decline of more than 10% in nations including Germany, Latvia, Lithuania, Poland, and the Soviet Union. It also claimed the lives of 500,000 Americans, 2.5 million Japanese, and 10 million Chinese elsewhere. (Eliss, 1993 cited

[1] Currently, there is a lot of disagreement on what constitutes an armed conflict. Armed conflict is defined by "The Heidelberg Institute for International Conflict Research" as "a clash of opposing interests or positional differences over national values and issues like independence, self-determination, borders and territory, access to or distribution of domestic or international power." This definition is used in the current study. A conflict must involve at least two sides (states, groups of states, organisations, or organised groups) who are adamant about pursuing their interests and succeeding in their cause, and it must be of some duration and magnitude. State is at least one of the parties.

in Jacoby, 2008). The interesting case of Poland is worthy to study in terms of the consequences of armed conflict on the populations. Poland had 32.9 million inhabitants in 1939 and the same reached the figure of 23.9 in 1946. This decline of 8.4 million, of a quarter of the population, has been attributed to the combined result of the Nazi holocaust, high mortality due to hunger and epidemics, the drop in the birth rate, and the eviction of Germans from western Poland (Sillanpa 2002).

'The World Health Organization's World Report on Violence and Health reveals that currently, 1.6 million people die each year because of violence, including collective violence such as conflicts within or between states. A large number of people who lose their lives because of militarized conflict are non-combatants' (Iqbal, 2006).

We have often seen that armed conflict not only kills and maims people; it destroys the infrastructure, agricultural fields, and property. In addition to direct deaths and injuries as immediate consequences, armed conflict also results in conditions that contribute to poor nutrition, inadequate water, and sanitation, disrupted livelihoods, and general indigence (Iqbal, 2006). It results in a huge diversion of public resources from social services (e.g. away from health services) towards military spending, affecting the poor disproportionately (Murshed, 2002). For instance, in Ethiopia, in 1973-1974, the government was spending 11.2 per cent of its annual budget on military expenditures, which has increased to 36.5 per cent in 1990–1991, while during the same period the share of the health budget declined sharply, falling from 6.1 per cent to 3.2 per cent (Kloos, 1992). It affects welfare levels, breaks educational trajectories, determines occupational choices by disrupting the social arrangements that promote economic activity, security, social relationships, etc. – all domains which are difficult, if not impossible, to disentangle and understand (Verwimp, Justino & Brück, 2009).

In Nicaragua, the low-intensity war of 1983 (which continued up to 1987) had a wide-reaching impact on health, health services, and health economics in that country. Due to economic restriction and contra destruction, the war has cost the Nicaraguan health system about 200 billion Cordoba (which is approximately equal to the value of two years of the entire health budget). Due to the decreased number of staff and services of the Nicaraguan public medical system, approximately 10 per cent of the population was left without access to health facilities (Garfield, 1989). Armed conflicts generally create the conditions conducive for the existing socioeconomic disparities to thrive and

flourish. Therefore, the impact of armed conflicts on the health of the population can never be underestimated. In other words, it can be argued that the impact of armed violence and its linkage with the health of the population cannot be expressed only at macro-level but also needs to be verified at multiple levels (meso & micro), as effects become embodied in individual experiences, which could be explored in narratives of suffering reported by affected individuals. Armed conflict generally influences many aspects of peoples' health and well-being, and at times their abilities to utilize the care needed. Both their physical, psychological, and overall well-being is often severely compromised in times of conflict

The accessibility and availability of health services are greatly decreased in conflict zones (Garfield, 1989). There is clear inference in the literature about the incompetency of states to meet the health needs of their populations owing to violent conflicts which leads to damage and destruction of infrastructure including hospitals. In the occupied Palestinian territory, 31, 426 people were injured between 29 September 2000(the beginning of the second intifada) and the end of May 2007, of whom 8112 were injured by live ammunition, 7101 by metal bullets, and 6740 by gas (PCBS, 2007).

Although the Marburg haemorrhagic fever outbreak in Angola was the greatest and deadliest on record, it wasn't the only illness outbreak to accompany a conflict situation (WHO, 2007). More frequently cholera assails a debilitated population while measles takes a toll on young children. The majority of infant and child deaths are related to under-nutrition, diarrhoea, and upper-respiratory infections, a testimony to bodies starved by conflict and humanitarian neglect.

Armed conflict has, across the globe, lead to the overall destruction and shattering of the infrastructure and property of the people engulfed by it. Thus we would often see that most of the regions which are engulfed by armed conflict show remarked disparity in terms of various indicators like mortality, morbidity, etc among different groups. The problem further gets aggravated when certain groups that are facing historical marginalization get engulfed in an armed conflict situation. The pertinent example that can be cited is the badakshan province of Afghanistan. Badakshan province in Afgahnistan has recorded the highest maternal mortality ratio (Bartlett *et al.* 2005). Furthermore, Scholte *et al*, (2004), have shown that in Afghanistan, a setting of

prolonged and at times intense armed conflict, rates of post-traumatic stress disorder and depression symptoms were found to be 20 per cent and 38.5 per cent of the population respectively. The persistent conflict aided by vast levels of poverty has led to the emergence of highest maternal mortality ratios in Afghanistan at approximately 1600 per 100000 live births in 2002 (WHO, 2006).

The presence of armed conflict and urban-centric, capitalistic oriented development in the third world and developing countries have led to severe marginalization of some groups in these countries. Armed conflict further aggravates the problem because it not only leads to an increase in the number of deaths but it increases the marginalization within the groups in a society differentially. Historically it is a proven fact that some of the groups across the globe have been the worst victims of marginalization be it the blacks of America, Dalit's of India or the Gujjars and Bakkarwals of Jammu and Kashmir.

The marginalization can be seen in wider forms especially in terms of inaccessible state institutions, welfare institutions, and geographical marginalization and further not to forget the economic marginalization[2]. However there remains a need for a study and to document the nature of the effect on many indicators like maternal mortality, infant mortality, literacy rate, etc of the Gujjar Bakkarwal community. Though the data that is accessible and available is most of all the scheduled tribe of Jammu and Kashmir there is a need for differential analysis concerning each tribe.

In terms of geographical marginalization, it is an evident fact that places in which the gujjar bakkarwal community are in majority (Rajouri and Poonch) are border areas and highly backward areas. Poonch and Rajouri are the two districts that have the highest percentage of gujjar and bakkarwal population approximately 36.9 and 36.2 per cent respectively (Census, 2011). These are the border areas which have always remained tense due to hostile relations between India and Pakistan post-partition. Therefore the brunt of cross-border firings and usual shelling have always made the life of the gujjar bakkarwal community miserable and harsh. Due to border skirmishes, the cultivable land possessed by this community remains barren because of the regular shelling from across the border. One must make a mention here that marginalization and armed

[2]For detailed analysis of the marginalization of Gujjar Bakkarwal community please refer to the sub-heading ST's in Jammu and Kashmir.

conflict share a strong linkage. This marginalization can be noticed through the availability and accessibility to the number of state institutions in specific areas having a specific ethnic population. Furthermore, the structural imbalance that one can see in many of the sectors in countries like India is a harsh reality. In this context, it is important to note that those geographical zones which are considered poor are not simply ostracised or out casted rather they are being dominated by other zones historically and thus further the marginalisation process. This particular phenomenon of domination of tribal zones by other zones has led to socio-economic impoverishment and cultural isolation in marginalised zones. This historical marginalisation has brought in a shift in the land structures and also the pauperisation of the population living in these zones thereby further increasing their dependence on dominant zones.

The armed conflict in kashmir, although commencing only in 1989, has its historical legacy in the british colonial rule itself. The state of Jammu and Kashmir at present is the only muslim majority state under the Indian federal structure. Tracing the political history of Jammu and Kashmir one comes across different periods of brutal rule that the erstwhile state of Jammu and Kashmir, especially the kashmir region has seen. Mughals, Afghans, Sikhs, Dogras were all part of this brutal history. The partition of India in 1947 which redefined the boundaries again did not end the suffering that Kashmiris were facing historically. The partition although helped to calm the struggle for some time but when it erupted again, it erupted in a very violent form.

It is the treaty of Amritsar executed on 16$^{th}$ March 1846, signed between East India Company and Gulab Singh, a former vassal of the Sikh kingdom of Lahore which led to the creation of Jammu and Kashmir (Rai, 2009). Jammu and Kashmir was created by bringing together different territories and varied ethnic groups. Ladakh, in the east, was ethnically Tibetan and the population practiced Buddhism; Jammu, in the south, was a mixed area of Hindus, Sikhs, and some Muslims; the Vale of Kashmir was predominantly Muslim, but there was an influential Hindu minority, the Pandits; Punch, in the west, was Muslim but different ethnicity from Kashmir; and of the two sparsely populated northern areas, Baltistan was ethnically related to Ladakh but practiced Shia Islam, and the Gilgit Agency was an area of diverse, mostly Shi'ite, groups. As argued by Rai, although awkwardly created Jammu and Kashmir state was able to survive till 1947 (Rai, 2009). With the formation of Muslim Pakistan and

Hindu majority India in 1947, all the princely states were given an option to accede to any one of these. Kashmir however remained sovereign and did not accede to any of these dominions. Had Kashmir been awarded on the same terms as the provinces of British India, it would have been assigned to Pakistan (Thorner, 1949). It was only after the tribal invasion from the side of Pakistan that on 22nd October 1947 that Kashmir's sovereignty came under threat. It is from that time, so-called Azad Kashmir area came under Pakistan control, Kashmir came under Indian's hand and both of these are still the holding erstwhile Jammu and Kashmir.

The Maharaja[3] supposedly signed a controversial Agreement of Accession to the dominion of India on the 26 October 1947 and the Indian Army was airlifted to Srinagar Airport on the 27th of October 1947 "without the permission and sanction of the Kashmiri people" (Munshi, 1995). It was only after the United Nations intervention that ceasefire came into operation from first January 1949 and both the nations Pakistan and India accepted it. After this systematic erosion of Jammu & Kashmir's special autonomous status[4] (under the 370 article of Indian constitution) by the Indian Union had further alienated the Kashmiris**,** who had not reconciled to the territorial integration of their region with India. Moreover, a new generation of highly politicized young Kashmiris saw Sheikh Abdullah's compromise deal (Kashmir accord-1975) with India as a betrayal of Kashmiri nationalist sentiments of the question of Kashmiri self-determination as per the United Nations resolutions.

It is from the period of 1989 militant struggle started in Kashmir to which the Indian state also responded with the military might. The Jammu and Kashmir Liberation Front (JKLF) started the first armed struggle in Kashmir, which was countered by India with the deployment of a large number of troops in Kashmir. In this struggle, a war-like situation existed in Kashmir and that made the people go through all the worst forms of crimes like torture, rape, disappearances, and the irreparable loss of death. This on-going armed struggle in Jammu and Kashmir has been a big setback to the pastoralists of the state.

[3]Maharaja Hari Singh was the Hindu ruler of the undivided state of Jammu and Kashmir prior to partition.
[4]For more details please read 'Achievable Nationhood: A Vision Document on Resolution of the Jammu & Kashmir Conflict.' by Lone, S. G. (2006). Retrieved December 15, 2009, from scribd.com: http://www.scribd.com/doc/16354847/Achievable-Nationhood

Bakkarwals who have been practising transhumance for ages are now facing a serious challenge in terms of accessing the resources. The upper ranges of the Himalayas which are the abode of pastures have become almost inaccessible to the bakkarwals as they have been taken over by the Indian army. Where ever now they are allowed to use pastures it is completely at the mercy of the army and the government authorities. This scenario has forced many of the bakkarwals to look for alternate livelihood opportunities like daily wage labourers and so on. Besides this, the armed conflict in Jammu and Kashmir has also made the lives of these people very susceptible owing to tremendous searches and surveillance which hinders their movement in the valley. The bakkarwals have to live their life in a constant struggle of staying neutral as they are often labelled both by the Indian army and by militants for acting against them. This struggle is in itself very dehumanising and demeaning for Bakkarwals who are such hardworking people.

### 1.6 Healthcare in Jammu and Kashmir

Jammu and Kashmir lies at the extreme north of India. It is situated between 32° 17' N and 37° 6' N latitude, and 72° 40' E and 80° 30' E longitude. Jammu and Kashmir state (J&K state was bifurcated on August 5$^{th}$, 2019, into two union territories, Jammu and Kashmir as one UT and Ladakh as another UT) is strategically very sensitive and important region owing to its sharing of borders with neighbouring countries.

Jammu and Kashmir shares its border with Afghanistan in the north-west, and on west side with Pakistan, and China and Tibet are on north-east side. The total geographical area of the Jammu and Kashmir including Ladakh is 2, 22, 236 square kilometres. Out of this 78,114 sq. km are under Pakistan's occupation, and 5,180 sq. km were handed to China by Pakistan, and 37,555 sq. km lay under occupation of China[5]. Excluding area under Pakistan & China, the total geographical area is 1, 01, 387 sq. km, accounting for 3.20 per cent of the total area of India, makes it the 11th largest state in the country (Directorate of Economics & Statistics J&K, 2008).

According to census 2011, Jammu and Kashmir rank 19$^{th}$ in India with a population of 12548926 people, constituting approximately 1.04 per cent of the country's population with a decadal growth rate of 23.71 per cent (Registrar General of India, 2011). With a

[5] Annual Report (2011-12). MSME-DI, Jammu and Kashmir.

population density of 124 persons per square kilometre, Jammu and Kashmir is ranked 30th populous state of India (Registrar General of India, 2011). In India, Jammu and Kashmir comes under regions which are most educationally backward. As per the 2011 census, in there has been 13 per cent increase in literacy rate of state in last decade. In the 2011 census, the literacy rate has increased up to 68 percent (7,245,053 persons) among which 78 percent (4,370,604 persons) are males and 58 percent (2,874,449 persons) are females, continues to be lower than the national level, i.e., 82.14% males, 65.46% females, and 74.04% total at all India level (Registrar General of India, 2011).

As per census data 2011, there has been a drastic fall in the child sex ratio of the state from 941 females per 1,000 males (0 to 6 years of age) in 2001 to 859 females per 1,000 males in 2011. However, for the population aged 7 and above, the ratio has increased from 884 in 2001 to 887 in 2011, indicating the slightest increase of 0.3 percent compared to the 2001 census (Registrar General of India, 2011). The sex ratio total population has also drastically fallen from 892 in 2001 to 883 in 2011.

As per the latest special below poverty line (BPL) survey which was conducted in 2008 in all 22 districts of Jammu and Kashmir before UT formation by the Directorate of Economics & Statistics, 22.68 percent of the total population (26.14% in rural and 7.96% urban areas) of Jammu and Kashmir fall under below poverty level with distribution of 17.76 per cent Muslims, 4.63 per cent Hindus, 0.20 per cent Buddhists, 0.08 per cent Sikhs and 0.01 percent Christians. At a regional level, in the Kashmir region, 21.37 per cent % of the population (both Rural and Urban) live below the poverty level with the highest percentage in Kupwara (32.55%), followed by Bandipora (31.09%), Budgam (26.64%), Baramulla (26.49%), Pulwama (26.18%), Ganderbal (24.3%), and Kulgam (22.59%). The highest percentage of urban poverty is in district Kulgam (15.83%) followed by district Pulwama (14%) and district Ganderbal (13.87%). In Ladakh region, Kargil (31.9%) has been identified as the poorest district followed by Leh (22.07%). In the survey, Reasi (37.93%), Ramban (37.73%), Kisthwar (37.72%), and Poonch (33.67%) districts of Jammu division have been identified as the poorest. Overall, the survey shows that about a fifth of the State's population fell below extreme poverty. This means that out of every five persons, one falls Below Poverty Line (Directorate of Economics & Statistics J&K, 2008).

Jammu and Kashmir has shown remarkable progress in terms of health indicators compared to all India levels. The data below is a clear indication of the same.

## Table 3: Key Indicators J&K and India

| Indicators | J&K | India |
|---|---|---|
| Life Expectancy at Birth | 67.2 | 73 |
| Sex Ratio | 972 | 991 |
| Child Sex Ratio | 921 | 919 |
| Women age 20-24 years married before age 18 years (%) | 8.7 | 26.8 |
| Women age 15-19 years who were already mothers or pregnant at the time of the survey (%) | 2.9 | 7.9 |
| Total fertility rate | 2.0 | 2.2 |
| Infant mortality rate (IMR) | 32 | 41 |
| Underweight children % | 16.6 | 35.8 |
| Teenage pregnancy(15-19 yrs old mothers) % | 2.9 | 7.9 |
| Full Immunisation % | 75.1 | 62 |
| Current Use of family planning methods % | 57.3 | 53.5 |
| Women (18-29 yrs) married exact at age 18 yrs % | 9.2 | 27.9 |
| Under-five mortality rate (U5MR) | 38 | 50 |
| Literacy Rate (in per cent, 2011) | 67.2 | 73 |
| Women who are literate (%) | 69.0 | 68.4 |
| Men who are literate (%) | 87.0 | 85.7 |
| Households using improved sanitation facility (%) | 52.5 | 48.4 |
| Households with improved drinking water source (%) | 89.2 | 89.9 |
| Women having a bank or savings account that they themselves use (%) | 60.3 | 53 |
| Gross Enrolment Ratio* | 8.7 | 26.8 |
| Birth rate* | 15.4 | 20.2 |
| Unemployment rate per 1,000 population (Usual status), Rural male * | 22 | 17 |
| Unemployment rate per 1,000 population (Usual status), Rural female * | 30 | 17 |
| Unemployment rate per 1,000 population (Usual status), Urban male * | 41 | 30 |
| Unemployment rate per 1,000 population (Usual status), Urban female * | 190 | 52 |
| Poverty rate (percentage, based on MRP consumption)* | 10.35 | 21.92 |

*Source: National Family Health Survey (NFHS-4), 2015-16, except indicators marked with an asterisk (*). Data marked with an asterisk are from Economic Survey 2018-19 and RBI Handbook of Statistics on Indian States, 2018-19, quoting Census, NITI Aayog, and NSSO data.*

From the data, it becomes visible that Jammu and Kashmir has figured well as compared to all India levels. However, it is important to dissect the statistical data more in-depth to see how various groups figure. The disaggregated data will give us a clear picture as to how groups like Schedule Caste, Scheduled Tribes figure in this whole data set. The general statistical number should not be taken as a real picture of the whole population. There are various communities in Jammu and Kashmir whose healthcare is a big question mark. The nomadic tribals groups like Bakkarwals are having serious healthcare issues in Jammu and Kashmir.

Chapter 2

# Schedule Tribes in Jammu and Kashmir: Background

## 2.1 Introduction

Jammu and Kashmir is predominantly a rural Union Territory, where 72.79 percent of the population resides in villages. Out of the total population of previous territory of Jammu and Kashmir (now UT), only 27.21 percent live in urban areas (Census, 2011). The Scheduled Tribe population too dwell in rural habitations. It is seen that the rural areas are marginalized as compared to the urban areas; the Scheduled Tribe population face this marginality as well. The problem gets further aggravated because almost the entire population of scheduled tribes resides in mountainous regions, where there is the least accessibility as compared to the people living in plain areas of the valley. Therefore they suffer from double marginality. Initially vide the Constitution (Jammu & Kashmir) Scheduled Tribes Order, 1989 eight tribal communities were recognised as scheduled tribes and later on more four communities namely Gujjar, Bakkarwal, Gaddi, and Sippi were notified as the Scheduled Tribes vide the Constitution (Scheduled Tribes) Order (Amendment) Act, 1991. Thus making it total 12 communities to be registered as scheduled tribes. It is in the census 2001 that all tribal communities in erst while Jammu and Kashmir state were enumerated for first time.

**Table 4: Figures of Scheduled Tribes and overall population in Jammu and Kashmir**

| State/ Region | Total Population | ST Population | % ST Population |
|---|---|---|---|
| Jammu and Kashmir (Including Ladakh) | 12,541,302 | 1,493,299 | 11.9 |
| Kashmir | 6,888,475 | 464,306 | 6.74 |
| Jammu | 5,378,538 | 810,800 | 15.07 |
| Leh | 274,289 | 218,193 | 79.54 |

*Source: Source: Census, 2011*

As per census, 2011, the percentage of total tribal population of Jammu and Kashmir comes to 11.9 which is 1.3 per cent of the total tribal population of India. However, activists from gujjar bakkarwal community argue that they have been underestimated in the census data (The Tribune, 6th March 2017). They argue that since bakkarwals are mostly nomadic and census takes place during that time when they are in upper reaches of the Himalayas, they do not get enumerated. 95.3 per cent of the total tribal population in

J&K reside in villages. Kargil (86.88 per cent) has the highest proportion of Scheduled Tribes followed by Leh (71 per cent), Poonch (36.9 per cent), and Rajouri (36.2 per cent). While Leh and Kargil are now part of Union Territory of Ladakh, therefore making Poonch and Rajouri two districts with the highest proportion of Scheduled Tribe population in the Union Territory of Jammu and Kashmir. In the erstwhile state of Jammu and Kashmir, the two districts of Leh and Kargil were the ones that had a population of ST category more than 50 percent. The districts of Poonch and Rajouri have more than 30 percent population of STs and districts of Doda and Udhampur have more than 10 percent population of STs. The literacy rates of these districts are comparatively worse, the predominance of the ST population being one of the factors.

The district wise population of Scheduled tribes in Jammu, Kashmir and Ladakh is shown below in the tables:

**Table 5: Scheduled Tribe Population (Jammu Division)**

| District | Total Population | ST Population | % of ST Population |
|---|---|---|---|
| Doda | 409, 936 | 39, 216 | 9.56 |
| Jammu | 1,529,958 | 69,193 | 4.52 |
| Kathua | 616,435 | 53,307 | 8.64 |
| Kishtwar | 230,696 | 38,149 | 16.53 |
| Poonch | 476,835 | 176,101 | 36.93 |
| Rajouri | 642,415 | 232,815 | 36.24 |
| Ramban | 283,713 | 39,772 | 14.01 |
| Reasi | 314,667 | 88,365 | 28.08 |
| Samba | 318,898 | 17,573 | 5.51 |
| Udhampur | 554,985 | 56,309 | 10.14 |

*Source: Census 2011*

**Table 6: Scheduled Tribe Population (Kashmir Division)**

| District | Total Population | ST Population | % of ST Population |
|---|---|---|---|
| Anantnag | 1,078,692 | 1,16,006 | 10.75 |
| Bandipora | 392,232 | 75,374 | 19.21 |
| Baramulla | 1,008,039 | 37,705 | 3.74 |
| Budgam | 753,745 | 23,992 | 3.17 |
| Ganderbal | 297,446 | 61,070 | 20.53 |
| Kulgam | 424,483 | 26,525 | 6.24 |
| Kupwara | 870,354 | 70,352 | 5.08 |
| Pulwama | 560,440 | 22,607 | 4.03 |
| Shopian | 266,215 | 21,820 | 8.19 |
| Srinagar | 1,236,829 | 8,935 | 0.72 |

*Source: Census 2011*

**Table 7: Scheduled Tribe Population (Ladakh Division)**

| District | Total Population | ST Population | % of ST Population |
|---|---|---|---|
| Kargil | 140,802 | 122,336 | 86.88 |
| Leh | 133,487 | 95,857 | 71.80 |

*Source: Census 2011*

The Gujjars are the most populous group of all the tribes residing in Jammu, Kashmir and Ladakh, with 763,806 people, hence making it 69.1 percent of the total ST population. With a population of 96, 698, Bot is second major group among the tribes, followed by Bakkarwal with population of 60,724 and Brokpa with population of 51,957. The Gujjar, Bot, Bakkarwal and Brokpa together constitute 88 percent of the total tribal population whereas Balti, Purigpa, and Gaddi having population ranging from 38,188 down to 35,765 form 10.2 percent of the total ST population. All the remaining five (5) tribes, Sippi, Changpa, Mon, Garra, and Beda along constitute the residual proportion of 1.9 percent total. Beda is the least numerous group of all the tribes in Jammu, Kashmir and Ladakh with population of just 128 members.

### 2.2 Bakkarwals as Tribal Community: Historical Trajectory

Among the twelve recognised Schedule Tribes in Jammu and Kashmir (pre union territory), gujjars and bakkarwals are the largest group in terms of number. Bakkarwals are numerically very less, however, a strong similarity with gujjars when it comes to cultural, linguistic and other affiliations, makes these groups twined together. Bakkarwals are usually associated with the gujjars for these similarities and in 1899 the bakkarwals were first recognised as a separate group. Therefore historical journey of bakkarwals is not devoid of gujjars and hence it becomes imperative to look into the history of gujjars and bakkarwals together to understand the genesis of bakkarwals completely. Furthermore, many scholars and activists have been continuously arguing that the difference between gujjars and bakkarwals is only in terms of the rearing of livestock. The literal meaning of the word bakkarwal is ‘Bakri’ (goat) and ‘wal’ (one who rears goat) and thus bakkarwals are sheep and goat herders. Gujjars very often keep and rear buffalos. There are no other major differences between gujjars and bakkarwals. Thus the historical origin of bakkarwals is related to gujjars only. It is generally believed that gujjar’s first entered Jammu and Kashmir from Punjab and the North West Frontier Province (Census of India, 1941). Owing to various phases of displacement and migration thereby leading to develop newer adaptations to respond to new ecological and economic environments an emergence

of professionally specialised and preferentially endogamous sub groups has been witnessed. Aparna Rao (1995) mentions that in the historical sources mention of bakkarwals to have been documented for first time in 1899. She goes on further to state that it is believed that they migrated to Jammu Kashmir from the Hazara region in NWFP of Pakistan, from the valleys of Kunhar and Allaiwal. According Rao in pastoral societies for balancing the labour and resources, either the resources are redistributed or sedentarisation of population happens (Rao, A. 1995)**.** Even on the historical origin of bakkarwals they are categorised in two categories: Kanahari and Allayvali. Kanahari bakkarwals are believed to have migrated from the valley of Kanhar, Bogadmung, and Konish, all lying to the north of Hazara. It is after the name of the river valleys (Kanhara) where from this sub-tribe has come that they are called as Kanahari Bakkarwals. Kagan mountain region is the origin of river Kanhara and it joins river Jhelum between Muzaffarabad and Kohala. Thus those bakkarwals who originally came from this general area north of Hazara have, were given the name as Kanhari Bakkarwals. The Alai, Nandhar, Rajadnari, Kaladhaka Kohistan, and Swat regions in western Pakistan are where the Allayvals sub-tribe originated. These regions were heavily influenced by Pakhtoon language and culture due to their geographic location; hence they have some dialectal differences from the Kanhari Bakkarwal (Khatana, 1991). As argued by Chowdhary, there are varying versions of the origin and history of Gujjars but most historians agree on their Central Asian origins (Chowdhary, 2011). Some others believe that the gujjars are of Indian origin and inhabited the regions around Mount Abu in western Rajasthan, Malwa, and Gujarat. Warikoo (2005) is of the opinion that many of the names like Gujarat, Gujranwala, etc are only after the name of the gujjar community which predominated in these areas. Donell while citing the annual report of the forest department of Jammu and Kashmir 1899 writes, “Gujar in Jammu and Kashmir are attested for long, but the first explicit documentary reference to the Bakkarwal here is dated 1899 (Mc Donell, 1899 cited in Rao, A. 2005, p, 4). Aparna Rao, whose scholarship on pastoralism in the Himalayas is widely acknowledged, writes that the term bakkarwal was initially used to refer to a professional category of ‘people with goats’ as opposed to, ‘people with cattle’. Only around 1912 did official records transform this professional category into an "ethnic" one, differentiating between "locals," who had migrated and lived within the state's borders for at least one generation, and "foreigners," who were viewed as undesirable new immigrants (Rao, 1999). In Jammu and Kashmir, all gujjars are muslims and except for a few hundred families, they are nomads, semi-nomads, pastoralists. According to Negi &

Raha (1982) gujjar and bakkarwals of Jammu and Kashmir can be divided into the following three groups according to their mode of subsistence:

1. The Gujjars who are now more or less settled agriculturalists.
2. Dudh Gujjars who are semi-agriculturalists and pastoralists. They raise the stock of cattle and buffaloes and trade in milk products.
3. The Bakkarwals who raise flocks of sheep and goats and lead an almost completely nomadic life.

Bakkarwals, considered as a part of the same larger family of gujjars, started mobilization to protect their identity and culture especially their language, Gojri. They comprehended their socio-economic and political backwardness. Apart from the language issue, it was the issue of underestimation of a population of the gujjar-bakkarwal community in official documents that mobilized these two communities as this underestimation had a direct bearing on development. In the 1970s, the mobilization intensified and this evoked a response from political leadership. Sheikh Mohammad Abdullah announced the "Gujjar Bakkarwal Welfare Board", in 1975 with a mandate to ensure the development and welfare of these two communities. This mobilization and establishment of the Gujjar Bakkarwal Welfare Board resulted in various positives steps towards development. In the education sector, mobile schools and hostels for gujjar and bakkarwal students were started. Like the model of mobile schools, mobile dispensaries were also opened for these communities. On the cultural front, a new impetus was given through the creation of Gujjar Section in Jammu and Kashmir Academy of Art, Culture, and Languages, and Gojri programmes were started in Radio and Television. These were all important steps but not enough for the overall development of these communities. The struggle had to continue to fight for their socio-economic and educational rights and recognition of cultural rights. It was the struggle to get the Scheduled Tribe status that was gaining prominence. They had tried several times to achieve the ST status but failed. It was during Chander Shekhar's short tenure as Prime Minister that gujjars and bakkarwals were granted the Scheduled Tribe status in year 1991. When eight communities of the Ladakh region were granted the status of Scheduled Tribes in Jammu and Kashmir in 1989, it was difficult to deny gujjars and bakkarwals the ST status for long. There were two more communities, namely Gaddi and Sippi which were also demanding the ST status. When

the ST status was approved for gujjars and bakkarwals, these two communities were also granted the ST status.

### 2.3 Schedule Tribes of J&K: Saga of Marginalisation

Tribals in India are facing social exclusion by being the poorest and most backward. The levels of poverty along with dismal indicators of health, literacy, and employment increase the marginalisation. When it comes to Jammu and Kashmir tribals are not much different from the rest of the country. In Jammu and Kashmir among all the social groups Schedule Tribes have the poorest indicators. Moreover, the geographical remoteness, political invisibilisation, and social discrimination are the added elements of the vulnerability that tribes in Jammu and Kashmir face.

**Table 8: Key Indicators Scheduled Tribe and overall Population (J&K)**

| **Indicator** | **ST** | **J&K** | **Source** |
|---|---|---|---|
| Population | 1493299 (11.9%) | 12541302 | Census 2011 |
| Sex Ratio | 910 | 883 | Census 2011 |
| Literacy Rate | 50.6 | 68.74 | Census 2011 |
| Infant mortality rate (IMR) | 38 | 32 | NFHS-4 |
| Full Immunisation % | 69.0 | 75.1 | NFHS-4 |
| No Vaccination | 5.2 | 3.5 | NFHS-4 |
| % of Children not receiving any treatment for Diarrhoea | 21 | 12.4 | NFHS-4 |
| % of Children with Any Anemia <11.0 g/dl) | 49.4 | 41.9 | NFHS-4 |
| % of households using Iodized salt | 87.1 | 96.7 | NFHS-4 |
| % of women who are Obese(BMI ≥30) | 3.3 | 8.1 | NFHS-4 |
| % of men who are Obese(BMI ≥30 | 1.2 | 3.7 | NFHS-4 |
| % of women who are moderately or severely thin (BMI ≤ 17) | 7.1 | 3.3 | NFHS-4 |
| % of men who are moderately or severely thin (BMI ≤ 17) | 5.3 | 2.5 | NFHS-4 |
| % of women with Any Anemia <12.0 g/dl) | 37.9 | 41.0 | NFHS-4 |
| Percentage of women(age 15.49) covered by any health scheme or health insurance | 0.5 | 1.1 | NFHS-4 |
| Percentage of men(15-49) covered by any health scheme or health insurance | 3.6 | 2.5 | NFHS-4 |

The data depicts that health indicators are low as compared to the J&K average. The only promising indicator is the sex ratio where scheduled tribals are ahead of the total average of Jammu and Kashmir. Some of the indicators like infant mortality rate, no vaccination and immunisation are a clear indication of how basic health services are not effective in catering effectively to tribal groups. The data here clearly augments the argument that Scheduled Tribes in Jammu and Kashmir are the most marginalised group. One must remember that it is gujjar andbBakkarwal which constitute around 73 per cent of the total tribal population of Jammu and Kashmir. Thus the data is a clear indication of the fact that the Scheduled Tribes in Jammu and Kashmir are at a disadvantage. It is important to mention that the disaggregated data would tell the picture of marginalisation more perfectly as there is variation within the tribal groups also when it comes to poor health indicators. Some of the tribal groups are having a more abysmal condition than the others. Therefore it would be inappropriate to draw the complete picture unless the disaggregated data would not be available about all tribal groups. Though we largely do not have disaggregated data available for tribal groups for all the indicators, however few tables below would help in making an argument more clear.

**Table 9: Sex Ratio of Scheduled Tribes in Jammu and Kashmir**

| Age group | All ST's (J&K) | Gaddi | Bot | Balti | Brokpa | Gujjars | Purigpa | Bakkarwals |
|---|---|---|---|---|---|---|---|---|
| All ages | 910 | 948 | 941 | 936 | 916 | 908 | 903 | 868 |
| 0-6 (Years) | 979 | 989 | 965 | 994 | 938 | 985 | 1019 | 928 |

**Table 10: Literacy Rate of Scheduled Tribes in Jammu and Kashmir**

| Literacy Rate | All STs | Balti | Bot | Purigpa | Brokpa | Gaddi | Gujjar | Bakkarwal |
|---|---|---|---|---|---|---|---|---|
| **Persons** | 37.5 | 62.1 | 61.3 | 60.9 | 55.5 | 37.3 | 31.3 | 22.5 |
| **Female** | 22.5 | 45.4 | 50.3 | 44.2 | 38.6 | 19.6 | 20.4 | 12.8 |

*Source: RGI, census 2001*

When it comes to the sex ratio, it is evident from the data that Bakkarwals have the most skewed sex ratio among all the tribes in Jammu and Kashmir. Since they have also the lowest literacy rate therefore there seems a plausible link between the two.

Bot, Balti, Purigpa have more than 22 percent literates who are matriculates, implying that every 4th literate of these tribes are matriculates. Bakkarwals have the lowest proportion of secondary level literates (7.8 percent) as per the Census Data, 2001. From the data, it is clear that Bakkarwals are the worst off when it comes to the educational level. Even for that matter, the percentage of graduates and above among the literate in Bakkarwal community comes to one per cent only. Such a dismal picture points towards the backwardness and discrimination the community is facing. As per census 2001 tribals in J&K have 37.5 percent literacy where as it is 47.1 percent for STs at national level. Similarly the male and female literacy rates for tribals of J&K is 48.2 percent and 25.5 percent respectively which in comparison to male and female rates at national level for tribals comes to 59.2 percent and 34.8 percent respectively. This is clearly showing that tribals of J&K figured poorly when compared to tribals at national levels. Among all the tribes in J&K it is Balti, Bot, Purigpa, and Brokpa who have shown higher literacy rates whereas Gujjar, Gaddi, and Bakkarwal have shown lower literacy rate than that of the national average. Same trends have been witnessed when it comes to female literacy also. Among the ST literates, 34.9 percent of tribal literates are either without any educational level or have attained education below the primary level. The primary level literates constitute 26.2 percent followed by literates up to the middle level (22.1 percent). The persons educated up to matric/secondary/higher secondary constitute 14.7 percent whereas two percent only are graduates and above. Non-technical & technical diploma holders form a negligible percentage (0.1). At the level of individual tribe, Bot, Balti, Purigpa have more than 22 percent literates are matriculates, implying that every 4th literate of these tribes are matriculates. Bakkarwal have the lowest proportion of secondary level literates (7.8 per cent).

Jammu and Kashmir is engulfed by the armed conflict that has caused havoc in the state over last three decades. The regular loss of human lives, damage to property, and infrastructure has been followed by changing patterns of livelihood across various ethnic groups. The Bakkarwal has also been the victim of this conflict. This ethnic group is one of the socially isolated and economically backward groups in the union territory of Jammu and Kashmir. Having to live their lives in the upper reaches of the Himalayas, these people

have to face hardship not only from nature but from the dominant structures. Historically bakkarwals have been pastoralists who always add to the economic production in terms of providing raw materials in the form of wool, meat, milk, and the cattle at large. However, because of the dominant influence of modernity in terms of technological interventions and globalization, these people are facing numerous problems. The problems are both at the level of changing livelihood patterns and the breaking down of their socio-cultural milieu. As revealed by the review of literature this is not a unique case with the pastoralists in Jammu and Kashmir only, rather it is found almost in every part of the world (Rao, A., & Casimir, M, J. 2003). Nomads globally are facing the problem of sustenance of their livelihood, accessing the health and education facilities. However, gujjars and bakkarwals of Jammu and Kashmir have to face a violent armed conflict that has been persisting in the union territory for the last three decades. The presence of armed conflict has led to suffering for people at large. The presence of army and paramilitary forces along with the renegade groups and militants has led to the complexity of problems concerning gujjar and bakkarwal community. The welfare measures operated by the government in terms of tribal sub plans are also not devoid of the larger political context of the state. However, having said this one cannot make an argument as to how far have presence of armed conflict made an impact on the overall health and education indicators of bakkarwal community. There are no studies so far available which could mention the extent of the impact of armed conflict on the bakkarwal community. There still remains the need to find out any direct linkage with respect to the key health indicators and presence of armed conflict. But one should not hesitate in stating that the presence of armed conflict has led to the sufferings for the gujjar bakkarwal community, some of which is individual and some collective. The worsening condition of the scheduled tribe population in Jammu and Kashmir is mostly of the gujjar and bakkarwal community. Some of the key indicators that have been compared between Scheduled Tribes and the total population in Jammu and Kashmir also point towards the discrimination of the community as such.

The history of Jammu and Kashmir is incomplete without mentioning gujjars and bakkarwals. Gujjars and Bakkarwals are an important part of the historiography of erst while state (now UT). However, the dominant identities have always left the gujjar bakkarwal community at the fringes. While running through pages of history of Jammu and Kashmir, there has always been visible marginalization of this group. The worst

victims of the partition of 1947 have been the gujjars and bakkarwals of Jammu and Kashmir. Most of the members of this ethnic group are now residing in the Pakistan Occupied Kashmir (POK) and parts of Gilgit and Northwest Frontier (Majeed, B, I. 2018). The partition of Indian subcontinent created volatile borders between India and Pakistan, thereby making life miserable for gujjar and bakkarwal community. The continuous volatility at the borders led to tragedies like cross firings, landmine blasts, and night bombings. Just after the partition, the Indian side of Jammu and Kashmir start to usher a ray of hope for developing a prosperous Jammu and Kashmir. However, the destiny of these people didn't change much as they remained only vote bank community to be lured by false promises written in election manifestoes. Just for a miniscule of elite representations in the political power corridors, the larger population of gujjar and bakkarwals continued to live and suffer in destitution. The elite members of this group did nothing except keeping their poverty intact to bargain out of that. The underdevelopment of this group in terms of low levels of literacy, high poverty, high mortality rates, and poor infrastructural facilities kept rising with the advent of time.

The poverty-ridden gujjars and bakkarwals live a very miserable life because of a lack of modern facilities. These people have to face both natural tragedies as well as human-induced tragedies. Due to historical marginalization, these people have had to face several health problems along with the increased burden of poverty and changing livelihood issues. The Gujjar lung disease has been discovered only after an extensive study of the effects of impoverished housing on the Gujjar and Bakkarwal people. "The entity 'Gujjar Lung'[1] came into existence in medical literature in 1991 when Dhār & Pathania from Government Medical College associated Chest Diseases Hospital Srinagar studied 46 Gujjar patients who had a history of exposure to pinewood smoke inhalation since an early age in the dwellings, with radiological evidence of milliary mottling and reticulonodular shadows, who were empirically put on therapeutic trials of anti-tuberculosis treatment, but the shadows remained same or increased in density. Finally, lung biopsy revealed features

[1] *Gujjar lung is a form of chronic lung disease as a result of indoor air pollution with pinewood smoke in Gujjar community - a social and ethnic group residing at hilly regions of the Indian sub-continent. These people live in ill-ventilated mud hoses called "Kothas" and use pinewood for heating and cooking purposes throughout the year, with daily exposure to smoke averaging 12 to 16 hours. A high oleoresin containing part of the wood called "Lash" is used for lighting purposes adding further to the indoor air pollution.*

of anthracotic nodules, carbon-laden macrophages and fibrosis to Gujjar community" (Hassan et al, 2006, p, 166)

## 2.4 Review of Literature

The literature review is an essential component of any research and its contribution is there in the whole process of research. The literature review helps in critically evaluating the research studies that have been done before and then deduce interpretations for use in the current research study. For any research study, it is important to review the previous relevant studies that have been conducted. Therefore a review of literature helps in identifying the gaps that exist in knowledge production concerning the group one is trying to study. Moreover, a review of literature also brings in the element of familiarity and hence repetitiveness of study gets eliminated.

Medical systems of any society are rooted in their culture, the traditional health care system of tribal groups existed ahead of implementation of western innovations in health care. Tribal communities have strong belief system towards the health. For tribals health and treatment are closely Inter twined with environment, mostly the forest ecology. For tribal's health seeking behaviour is basically a process of recognising illness and also the measures to respond to it. This is important to understand that tribal constructions of illnesses are outcome of belief and knowledge that is contextualised within time and space. Most of the tribal societies the cure and treatment is based on use of different herbs and medicinal plants along with faith based rituals. As argued by Sonowal, J, C., & Praharaj, P. (2007), 'Tribal societies have developed their own medicine system and some simple knowledge base of medical techniques including the diagnosis of the disease at individual level. Tribal people use both magico-religious and herbal medicine for their treatment' (p 136).

Various social, economic and developmental activities affect tribal populations potentially exposing them to high rates of malnutrition and health problems. The lower literacy rates and lack of access to education further exacerbate health status of the community. Some scholars have emphasised that inaccessibility to health care and reluctance to seek help for various health issues still is the major public health concern in nomadic tribal areas (Omar, M. 1992). There is enormous effort and resources required for bringing the health awareness and attitudinal change towards health issues in tribal communities. Vulnerability to diseases is generally high in tribal communities, and more so in primitive

tribal groups. It is mostly found that primitive tribal groups are usually neglected, exploited and thus increasing the vulnerability to diseases. Owing to geographical remoteness, political marginalisation aided by high levels of poverty malnutrition is quite evident in tribal communities. The poor man's disease namely under nutrition and infectious diseases are common in tribal communities. There are high levels of chronic under nutrition among child and adult populations, including anaemia and iodine deficiency disorders (Jain, Y *et al*. 2015).

Looking at the literature on health of tribal population in India, we find that there has been focus on two aspects of health care. One group of scholars has focused attention on the morbidity and mortality trends among the tribal population. This literature provides analysis of the burden of diseases in different tribal communities. It helps to understand what has been the response of public health interventions towards the disease burden in tribal communities. The explanations regarding morbidity and mortality trends in tribal communities focus largely on health care practices of the communities and attribute these trends to beliefs that tribal people possess and their misconceptions about health and health care practices. While such explanations are in tune with the colonial discourse, as is evident, however they still figure and exist in the studies and literature developed after decolonialisation. The explanations that the knowledge of the tribal communities on health constitutes the dependence on the belief in contrast to the expert scientific 'biomedical knowledge' predominate the contemporary understanding of health situation of the tribal communities in India. Good Byron (1994) elaborately analyses consequences of this belief-knowledge framework and the challenges this framework puts towards the medical anthropology. Biswamoy Pati (1998) rightly argues that such kind of framework explanations creates an irrational unscientific image of indigenous people towards the healthcare. Dixit, Mishra and Sharma (2008) also argue that it is necessary to go beyond such kind of frameworks and approaches. The second group of scholars emphasize that lack of access to modern health care facilities because of ill equipped health facility, physical inaccessibility of such facilities and other such reasons for not accessing health facilities lead to incidences of diseases. While there can be many reasons for lack of access to health facilities, however, literature is dominated by observations that attribute the lack of access to customary and erroneous health beliefs of the community. Studies providing a more holistic understanding of health situation of tribal community are lacking. Scholars like Howard (1994) and Millard (1994) emphasize that in understanding

the health situation of tribal communities' larger socio-economic context needs to be taken into account to develop a more holistic understanding of their health situation. As Mishra et al (2011) argue studies on tribal health take an evolutionary approach believing that the traditional knowledge systems of tribal communities will pave way to modern as they process more proactively in the development and modernization process. There is however, a need to understand the experiences of tribal communities with health care providers and why, when and how certain practices are followed and not others and the notions of health and illness in the collective life of these communities.

With respect to nomadism or transhumance, we usually find enough body of literature that has been produced in the African context (Zinsstag, J., M. Ould Taleb., & P. Craig. (2006). Most of the studies on nomads and pastoralists have been conducted in the African region. In Asia and particularly in India, the studies on nomads are not so wide. When it comes to nomads in Jammu and Kashmir there is seriously a dearth of research studies. If at all nomads or pastoral groups in India have been studied mostly from a cultural perspective. We hardly find extensive studies on the healthcare of nomads in India. Bakkarwals in Jammu and Kashmir have also not been extensively studied when it comes to healthcare. If we look at the major extensive works that have been produced with respect to bakkarwals in Jammu and Kashmir we find an anthropological exploration by Aparna Rao mostly on the cultural aspect of lived experiences of Bakkarwals. Apart from her work there are some doctoral studies conducted by scholars from sociology and education departments of university of Jammu mostly and sparsely by university of Kashmir. Even the independent research by non-governmental organisation is missing when it comes to the gujjars and bakkarwals of Jammu and Kashmir. Moreover, the scarcity of data is another factor that is a reality of bakkarwals in Jammu and Kashmir. Therefore pressing needs of this research most review studies have been taken from the African context. Nomadic pastoralists of Africa have been extensively studied and when it comes to healthcare many experimental initiatives have been undertaken by International organisations like World Health Organisation (WHO) and other development organisations. When it comes to the Indian context very few studies and ministerial reports pertaining to nomadic healthcare are available. The review of literature has been organised not on a thematic basis but in terms of the studies that have much relevance to the current research study. The literature review here has been put under three headings which are as follows:

## 2.5 Studies from Global Context:

As has been already mentioned earlier that much of the research related to the field of nomadic pastoralism has been undertaken in the African context, therefore understanding the nomadic communities in the Indian context would be helpful if one looks at African knowledge production**.** Some of the much prominent studies are as below:

1. Victoria M. Gammin, Michael R. Diaz, Sarah W. Pallas, Abigail R. Greenleaf, and Molly R. Kurnit in their paper, "Health services uptake among nomadic pastoralist populations in Africa: A systematic review of the literature", have brought interesting results to the fore. They reviewed 102 full papers for their systematic review of the above titles paper. They have categorised the results into the following major headings;

    a) Distance and Geographical Access: it has been seen that among nomadic pastoralists geographical factors are posing challenge to uptake of health services, as in 66 (65 per cent) papers.

    b) Health Service Quality: it has been found that poor quality of health services rendered to nomadic pastoralists was identified as a barrier to uptake health services in 58 (57 per cent) papers.

    c) Structural factors impacting the quality of services included deficient infrastructure, equipment, supplies, and health products.

    d) Knowledge of disease and awareness of health services: Researchers identified nomadic pastoralists' limited knowledge of specific diseases, including due to lack of education more generally and limited familiarity with, and value of, formal health services to prevent and treat disease as barriers to health services uptake in 38 (37 per cent) of papers

    e) Costs to nomadic pastoralists: Health service-associated costs were identified as a barrier to uptake in 23 (23 per cent) papers. These costs included direct medical (e.g., out-of-pocket payments for health services, informal fees at health facilities, medications), non-medical costs (transport to and from health facilities, paying someone else to shepherd while seeking care, paying for water point access near health facilities), and the indirect (or opportunity) costs of time and domestic

productivity losses due to care-seeking (e.g., travel and waiting time at health facilities)

f) Social structure and gender: Recognizing the heterogeneity of nomadic pastoralist ethnic groups in Africa, the respective roles of societal structures (e.g., the agency associated with age, gender, marital or social status) emerged clearly as a theme. Some element of nomadic pastoralist "social structure" was identified as a barrier to formal health service uptake in 29 (28 per cent) papers. Of these, 19 (19 per cent ) identified gender norms that impede health care access, e.g., the time demands of childcare, or those that prevent women from unaccompanied travel

g) Nomadic pastoralist beliefs, behaviours, and attitudes: In 41 (40 per cent) papers, the beliefs, behaviours, and attitudes ascribed to the particular nomadic pastoralists studied were identified as barriers to the uptake of formal sector health services offered at fixed-post health facilities or through outreach. Examples included nomadic pastoralists' reported preferences for self-treatment and traditional medicine/healers. Studies did not always clarify, however, if this preference may have been related to factors such as cost, distance, knowledge, or quality/efficacy of formal sector health services, misconceptions about or perceived risks of "Western medicine" (e.g., rumours about vaccine side effects), or suspicions around mass outreach activities (e.g., that health gatherings are a ploy to enable taxation)

2. J. Zinsstag, M, Ould Taleb, and P, S, Craig. (2006), in their paper, "**Health of nomadic pastoralists: new approaches towards equity effectiveness**", Published by European Journal of Tropical Medicine and International Health (vol.11, Issue 5) argue that many nomadic populations lag behind the settled population in education and access to public services. They also argue that nomadic population are often underrepresented in government institutions and hence lack political empowerment. The paper deciphers that the health perspective of nomadic pastoralists is divided between traditional approaches and influences of modern medicine by taking an example of nomadic pastoralists in Mauritania and Chad. Here in the paper, the authors argue that it seems appropriate to pay specific attention to health care for nomadic pastoralists who lead an archaic lifestyle in the age of Internet and nanotechnology, using ecosystems that could hardly be habitable or productive

without livestock. The authors also emphasise the fact that we should not forget that nomadic pastoralist systems are under tremendous pressure and over several decades they have been tremendous changes in their lifestyle. The authors also point out that it is indeed difficult to deliver health care services to nomadic populations. There have brought to the fore that there is only choice either mobile clinics or fixed health centres placed in strategic towns. The authors argue fixed health clinics work effectively with seasonally active nomads, who will be sedentary at certain times of the year, e.g. the 'winter pastures' of Tibetan and Mongolian nomads. While mobile clinics may make more sense for continually moving populations such as nomadic pastoralist groups in the Sahel, though they may not be more cost-effective than fixed clinics. Even with efficient fixed or mobile clinics, significant barriers may still exist to health delivery including mistrust, low perception of health priorities by nomads, and preference for traditional medicines/treatments.

3. Cohen D (2005) in their paper on, "**Providing nomadic people with health care**" published by British Medical Journal, (Vol. 331, issue. 720) argues that health and poverty initiatives at the national level neglect nomadic populations because of their geographic isolation/remoteness, poor communications, logistic requirements, uncertain civil status, and their perceived low priority. In return, a barrier to the use of available services is a mutual distrust between nomadic groups and governmental structures. The nomadic way of life makes access to dispensaries in villages difficult, as groups with animals have to avoid areas with crops, and visits to markets often exclude the most vulnerable – women and children

4. Smith and Swift (2012) in their study reveal that pastoralism is an economically viable strategy for best use in harsh environments. It requires considerable knowledge and skills. Although it is often seen as archaic practice without a future, in reality it is more productive than modern western ranching, operating under similar conditions. The major issue of pastoral society remains in their inadequate statistical representation. The statistics towards their number and their contribution to national economies remain non-existent and deeply flawed. There is a need for greater visibility of pastoralists at a statistical level

5. Schelling *et al.* (2003) in their paper on, "**Brucellosis and Q-fever seroprevalences of nomadic pastoralists and their livestock in Chad**", published by Preventive

Veterinary Medicine, 61(4) have looked at the morbidity of nomadic pastoralists and their livestock together. They have shown that the vaccination coverage of livestock exceeded the vaccination of children which was almost zero. Thereafter the pilot project campaigns of joint human and animal vaccination were taken up in two provinces of Chad. These joint campaigns showed positive results by reducing the costs by 15 per cent and also increasing the coverage.

6. Zinsstag, J., Schelling, E., Waltner-Toews, D., & Tanner, M. (2011) in their paper, **"From "one medicine" to "one health" and systemic approaches to health and well-being"** published by *Preventive veterinary medicine*, *101*(3-4) talk about the relationship that exists between the human and animal health. This paper establishes the significance particularly to the health of Nomads which is inextricably linked to the health of their animals. In this paper, the authors have looked at the concept of one medicine given by Calvin Schwabe. The concept of 'One Health' recognises that there is no difference of paradigm between human and veterinary medicine and both disciplines can contribute to the development of each other. The paper traced the history of the development of one health concept. The paper has shown that the concept of one health is the most emerging when it comes to the nomadic pastoralists. The one health concept has made a remarkable difference in the health outcomes of nomadic pastoral communities.

**2.6 Studies from Indian Context:**

India with rich diversity has tribal populations spread across all the states. The tribal population living in India is also varied in many ways. However, the commonality among the tribals in India is the dismal health indicators augmented by poverty, malnutrition, and displacement. Therefore the tribal healthcare in India itself is a broad area of concern and needs to look at its specificity. There are tribals who are forest dwellers, nomadic pastoralists, and peripatetic. Some of the important tribal healthcare studies that have looked into the question of healthcare are as follows:

1. Prashanth Nuggehalli Srinivas et al in their study, "**Towards Health Equity and Transformative Action on Tribal Health (THETA)** study to describe, explain and act on tribal health inequities in India: A health systems research study", published by *Wellcome open research*, *4* (202) argue that poor tribal health status in India mirrors a global pattern of worse-off health status among indigenous populations. In this study,

they noted that a comprehensive meta-analysis of health outcomes in 104 million global tribal populations found that health, education, and development indicators of Indian tribal populations are consistently poorer across the country, despite overall improvements in population health across Indian states. Furthermore, they argue that poor tribal health is an outcome of a complex interplay of socio-political, economic, and cultural conditions that contribute to this situation. In this study, they have been able to show that there are disparities within the tribal communities when it comes to health come. They argue that dismal health outcomes in tribal communities are partly attributed to poor availability and quality of information on access and utilisation of health services, illness profiles, and health-seeking behaviour. The interesting outcome of this study is that it has depicted the lack to plan and devise contextually relevant public health interventions. The study argues that it is less understood as to whether remoteness is more responsible or social disadvantage when it comes to poor health outcomes of tribals. The study emphasises the fact that it is important to examine to what extent social disadvantages influence the healthcare behaviour of tribals so as we can achieve the desired health outcomes.

2. Jai Prakash Narain (2019) in his paper, "**Health of Tribal Populations in India: How long can we afford to neglect?**" published by *Indian Journal of Medical Research*. 149 (3) paints dismal picture of tribals by making use of NFHS-4 data. In the paper, he has shown how even in developed states like Kerala the disparity of health indicators between tribal communities and other groups is alarming. Besides, the paper has shown how diseases like tuberculosis and malaria are still consuming lives in tribal regions across India. He argues that there is a need to frame tribal health policy and put in place a coordinated team for the implementation of the national programmes for tribals. The paper argues that until there is no increase in the funding specifically for tribal healthcare, it is very hard to witness any prominent change in the health status of tribals in near future.

3. A study by SAMA (2017-2018), "**From the Margins to the Centre: A study on the health inequities among the tribal communities in selected districts of Chhattisgarh, Jharkhand and, Odisha**", shows although abortion and contraception do not conform to the category of 'illnesses', they are important in the context of sexual and reproductive health of women in tribal communities but do not receive much attention. Similarly, tribal communities experience distress, severe

anxiety, and other mental health issues due to displacement, the onslaught of a market economy, conflict, discrimination, exploitation, and unemployment. They are highly vulnerable to mental health problems but are challenged by the lack of remedy due to the unavailability of requisite health care. These dismal health conditions of tribal communities are the result of poverty induced by large-scale displacement, increased migration, and frequent conflict, coupled with food insecurity, poor access to potable water and lack of sanitation, poor living conditions, and, most importantly, the lack of access to health services. Further, tribal communities often experience discriminatory and unfriendly behaviour by the health personnel, which stems from deep-rooted biases held against the tribal population, and language barriers, leading to low utilisation of the existing health care institutions in Scheduled Areas. There is substantial evidence that points to the close association of distress, exacerbated in situations of poverty, conflict, and other humanitarian crisis, and mental health issues of depression and anxiety. Several tribal communities are challenged by forced displacement and migration due to the loss of access to livelihoods, forests, rivers, and other natural habitats that are central to diverse aspects of their lives, culture, and health. Although it is generally believed that tribal populations seldom suffer from diseases like cancer, diabetes, and hypertension, there is increasing evidence of the incidence of such non-communicable diseases (NCDs) among them. Sickle cell disease (SCD) is also prevalent in tribal communities and is acknowledged as a significant public health issue. Several studies on maternal health show chronic malnutrition; higher levels of morbidity and mortality, and lower provision of antenatal and postnatal services among tribals, particularly among the PVTGs. Under-five mortality rates among rural tribal children remain startlingly high. Although abortion and contraception do not conform to the category of ‘illnesses’, they are important in the context of sexual and reproductive health of women in tribal communities but do not receive much attention. Similarly, tribal communities experience distress, severe anxiety, and other mental health issues due to displacement, the onslaught of the market economy, conflict, discrimination, exploitation, and unemployment. They are highly vulnerable to mental health problems but are challenged by the lack of remedy due to the unavailability of requisite health care

4. The High Level Expert Group (HLEG) report on Universal Health Coverage (UHC) for India (HLEG Report) instituted by the Planning Commission of India in 2011 is yet another policy framework to look into while discussing tribal health issues. It emphasises that the tribal areas remain mostly underserved when it comes to human resources, making the people in those areas extremely vulnerable. The necessity of well-functioning primary health care teams, which could potentially work towards the promotion of health equity and the value of empowering communities to participate in their health and well-being is also argued for by the report. The report also draws attention to the need for higher financial allocations to states that have districts with significantly high tribal populations to meet the need for special dispensations of health infrastructure and human resources.

5. Dr. Abhay Bang chaired an expert committee report, "**Tribal Health in India: Bridging the Gap and a roadmap for the future**", Ministry of Health and Family Welfare & Ministry of Tribal Affairs (2013) has in detail presented the picture of tribal health in India. The report mentions that tribal communities face the 'triple burden' of disease. Apart from high rates of malnutrition and communicable diseases (TB, leprosy, HIV, etc), the advent of rapid urbanisation, and changing lifestyles and environment, has led to a rise in non-communicable diseases as well (cancer, diabetes, and hypertension). These are both in addition to the burden of mental illness and subsequent addiction. The report highlighted a significant gap in the lack of healthcare professionals that are available to work with tribal communities. The report mentions that healthcare professionals view postings in tribal areas as a 'punishment' of sorts, and are hesitant to go, much less stay, there. The report emphasises the need for a significant mind set change, but more importantly, points to the opportunity that lies in motivating and training tribal people themselves to join the health force. "If we work with the communities, we will find that tribal youth are an excellent resource, and inducting them into healthcare will be a more feasible, sustainable, long-term solution." (p, 12) The report also stresses the need to train traditional birth attendants under a Safe Motherhood Programme besides increasing the outreach of health insurance along with PPP based healthcare in tribal areas. The report also states that traditional healers within tribal communities should be recognised and utilised. There is no dearth of health-related folklore in tribal communities, and tribal people rely

heavily on naturopathy, using medicinal leaves, roots, fruits, and seeds from their surrounding ecosystems. The lack of spirituality and emotionality in the modern healthcare system is a factor that sometimes keeps people away from public health systems; including traditional healers in healthcare, programmes could begin to address this issue. t is important to look at tribal health problems as separate and distinct, and clubbing them together with the issues faced in general by rural populations negates the vastly different context within which tribal communities exist. The committee identified 10 health issues that affect tribal people disproportionately. These are malaria, malnutrition, child mortality, maternal health problems, family planning and infertility, addiction and mental health issues, sickle cell disease, animal bites and accidents, low health literacy, and poor health of tribal children in *Ashramsalas*.

6. The National Health Policy (NHP) was endorsed by the Parliament of India in 2017. The policy recognises the inequities in health indicators, such as IMR and MMR, between states, especially in remote and tribal areas. It acknowledges that even in states where overall health indicators are improving marginalised communities like the tribal communities continue to fare poorly. It suggests that geographical and infrastructural challenges of tribal areas should be recognised and special efforts should be made to provide improved health services in these areas. For this, the policy advocates enhanced outreach of public health care through Mobile Medical Units (MMUs), etc. The policy also upholds the need for research and validation of tribal medicine in the public health sector. While the NHP upholds the state's roles in providing health services, it also underlines the need to engage the private sector, through the adoption of tribal or backward areas, in rising health care awareness and providing services as part of their corporate social responsibility. These public–private partnerships (PPPs) that are being promoted are a part of the abdication of the State's responsibility towards market forces and alliances, without any plan for the overall reorganisation of the health system, any regulation of the private sector, any system to rationalise practices or costs and any mechanisms to enforce accountability or patients' rights

7. A High Level Committee of seven members was set up in 2013, to develop a position paper on, "the current socio-economic, health and educational status of the tribal communities across the country, and formulate policy initiatives and outcome-

oriented measures to promote public service delivery to the Scheduled Tribes". Professor Virginius Xaxa, an eminent sociologist from the Indian Institute of Technology (IIT) Kanpur, who has written extensively on tribal communities in the country, was the Chairman of the Committee and along with other experts drafted the report that looked into a wide range of issues. The Xaxa report included the administrative framework, employment status, education, health, land alienation, displacement, enforced migration, and legal and constitutional issues. The report tracked the historical developmental trajectory of all these issues from the pre-independence era to present-day India and delineated highly nuanced recommendations to address them holistically and sustainable manner. The Ministry of Tribal Affairs (MoTA), Government of India, published the Xaxa report in May, 2014. Despite the recommendations in the report by the Committee, little has changed in terms of the reality of the tribal communities.

8. Pant (2004) unveils that nomadic people comprise to be landless and homeless people. They do not possess identity cards, voter cards, ration cards, and other official documents. They form underprivileged groups of people who lack basic civic rights, affirmative action, and safeguards. Due to a lack of basic rights, they do not have the say in the making of social policies and other affairs too. They tend to be excluded citizens. They face social indignity and harassment. Since these people do not follow the norms as followed by settled societies, they are viewed with suspicion. They continue to be ostracized, stigmatized, and marginalized.

9. Actionaid (2014) in published report '***crisis of commons'*** reveal that the majority of the nomadic communities remain invisible in India. They are mentioned only in a few research reports and anthropological documents. Also, there is no Census data available about their number.

*10.* Gandhi (2014) while discussing the educational status of 'Denotified Tribes' of Andhra Pradesh reveals that they are not covered during Census enumeration and other surveys. There are rough statistical estimations only. It is one of the major reasons for their neglect and isolation. The study also reveals that they are not only neglected and isolated; they are also socially discriminated, and stigmatized; mostly faced by those who are located on the outskirts of the villages. They constitute to be extremely poor groups who lack basic facilities of life

11. Kratli (2000) in his study reports that pastoralist people take pride in their identity. Despite the daily encounters with hostile situations or unpleasant experiences, the pastoralists enjoy their identity. The study also reports that the education provided to pastoralists transforms them into something else, which they think they are not. The government, if it is no more trying to sedentarize them, is still trying to transform them into "something else". The study also mentions that education (directly or indirectly) is seen to introduce the nomadic pastoralists to a sedentary lifestyle; thereby affecting their livelihood. In availing educational facilities, they have to stay either near the settlements or they have to go without formal education. Also, it is believed that because of the obsolete way of life and conservatism, the governments fail to provide them a viable education. Moreover, the study reveals that in reality there are no provisions for educating nomads and it is not the fault of nomadic communities to remain uneducated, rather there are structural inadequacies of education itself that are responsible for keeping them educationally backward. The study further mentions that there is a need to reverse the notion of seeing education as "a path towards development" over "development seen as a path" to education.

**2.7 Studies Related to Bakkarwals of Jammu and Kashmir:**

Bakkarwals the most marginalised tribal community in Jammu and Kashmir has been neglected both in data enumeration processes and also in academic research. There is indeed a serious dearth of research particularly on healthcare concerning Bakkarwals. Some of the significant studies related to Bakkarwals are as follows:

1. Verma et al (2019) in the paper "*Traversing the margins: Access to healthcare by Bakarwalls in remote and conflict-prone Himalayan regions of Jammu and Kashmir"* Published by Pastoralism, 9(11) discuss the outcomes of the study concerning the healthcare scenario of Bakkarwals of Jammu and Kashmir. The study explores themes about access and utilization of health care services embedded in Penchansky's framework, viz. availability, affordability, accessibility, acceptability, and accommodation, in conjunction with Anderson's model of healthcare utilization among the Bakkarwals residing in Pir Panjal Range of Jammu and Kashmir. This study unravels the health-seeking behaviour of Bakkarwals by analysing the determinants of the decision to use healthcare when ill. This study has addressed the factors impeding access to healthcare amongst the pastoral community of Jammu and

Kashmir. In the last few decades, Bakkarwals have undergone a transformation as many have sedentarised owing to the conflict in the area, forest laws regulating the grazing land, and inaccessibility of public goods like education and health care in higher pastures. The study has shown that morbidity amongst the Bakkarwals is much higher than the sedantarised, out of the total sample who reported illness only 68 per cent of them sought care and 325 of them did not seek either of the formal or informal care resorting to self-treatment or neglect. Accessibility poses a major barrier to healthcare utilization amongst Bakkarwals as long geographical distances impede utilization of healthcare services. However, accessibility does not necessarily translate to the availability of staff as the study says that the availability of staff/drugs/infrastructure even when the facility is geographically accessible poses a great challenge. Healthcare expenditures are stated as a barrier in general and acceptability issues in terms of staff behaviour, inconvenient hours, contact constraints, organizational structures, and appointment issues are challenges faced by transhumance. The mobile groups reveal that they are unsure about the day and opening and closing times on which health sub-centres and primary care centres would open as they operate upon the discretion and convenience of health workers leading to inconvenience for the community to reach the centres on time. Geographical and time-related accessibility problems are compounded when the pastoralists migrate to summer pastures which are more remote with no motorable roads and they often do not seek formal ambulatory care. The study also unravels the decrepit standards in service availability and low health facility readiness. There was also a shortage of medicines and consumables owing to the supply-side constraints in the facilities as only 42.2 per cent of the medicines from the essential drug lists were available on the date of the survey. The performance of secondary and tertiary care facilities is also dismally poor, especially in terms of service provision and physical infrastructure and amenities with only one-third of the norms being satisfied.

2. Kumar (2007) in his study mentions that although the Gujjars and Bakkarwals are culturally rich they remain non-existent at a local and national political domain. They are given the least priority in the development programmes. They have been dispossessed of their local and political rights. The major reason for their invisibility is due to the availability of inadequate data and also very few studies have been done so far. The study also acknowledges that for the betterment of this community, special

attention is needed from the state and civil society. Also, the study suggests that there is a need to devise educational programmes which are in harmony with socio-cultural aspects of the community.

3. Anita Sharma (2018), in her paper '*Nomadism and the Frontiers of State'*, published by Anthropology Society of Oxford, 10(1) argues that with state induced network of roads and increased residential areas, Bakkarwals are pushed to migrate through difficult and congested roads bearing the wrath of heavy traffic and incurring heavy losses each year. She brings forth in her paper based on her fieldwork the bottlenecks Bakkarwals have to face during their transhumant movement every year. She mentions that Bakkarwals have to face many accidents resulting in the loss of their animals or even the limbs of some of their members. Besides this, the Bakkarwals have to tolerate the abuses from state-appointed authorities like forest officials, traffic police, and even settled people who view their migration as indulgence. The enclosure of forest lands by forest officials and an increase in the settled population is squeezing Bakkarwals from both sides. Moreover, new high-altitude roads are often constructed on the migratory corridors and routes established by the Bakkarwal, who are then unable to claim their traditional rights to these passages.

4. A study conducted by Handu (1977) reveals that the Gujjars and Bakkarwals continue to live under the most unhygienic conditions. Their houses are not built on scientific lines. They use their houses for their accommodation as well for the accommodation of their cattle. It is the main cause of their health problem mostly seen in the form of Asthma, Cold, and Bronchitis. The study also reports that most of the Gujjars and Bakkarwals remain out of schools; hardly 4 per cent of the children attend schools.

5. Gupta and Aslam (2014) in their study report that the Gujjars and Bakkarwals live in abject poverty. They are economically backward. They lack the basic amenities of life. In education too, they are bereft of the basic facilities. Above all, the study also reports that the Gujjars and Bakkarwals are considered to be orthodox. They follow their traditions and customs which hinder their overall growth and development.

6. Kithan (2015) while working with pastoral nomads reports that physical movement is not only crucial for livelihood but it also shapes the socio-cultural and psychological aspects of the pastoral nomads. The study also reveals that the pastoral nomads have a strong belonging to the memories and lived experiences gained through these physical

movements. It provides them an identity that is based on the traditions, experiences, and knowledge acquired from earlier generations, thereby making them unique. The study further reveals that with technological advancement and modernity the pastoral nomads face many problems. The major problem is seen of sedentarization; wherein the state is seen to intrude into the traditions, customs, and beliefs that are being followed by the pastoral nomads. The state is seen to settle the pastoral communities so that they are easily controlled and governed.

7. Shah A, et al. (2015) in their paper on, "New ethnomedicinal claims from Gujjar and Bakkarwals tribes of Rajouri and Poonch districts of Jammu and Kashmir, India have shown that medicinal plants are frequently employed by Gujjar and Bakkarwal tribes in Rajouri and Poonch districts of Jammu and Kashmir, India for treatment of various ailments in humans and livestock. In this paper, they argue that the Bakkarwals have resourceful knowledge concerning the use of medicinal plants for treating specific ailments of their livestock as well as for themselves.

8. Sharma et al (2003) in their paper on, “Pastoralism in India: An Introduction”, argue that nomadic pastoralism is the under-researched area in tribal studies in India. This under researching is also due to the difference in the social organisation scheme, for instance, the usurpation of the pastoralists in the case hierarchy in the Indian villages is what starkly differentiates the Indian pastoralists from the African & Middle East counterparts. The Pastoral groups utilise the resources in two ways – they either use the difficult terrain otherwise inaccessible seasonally or they make use of the land resources with other agricultural activities to supplement the pastoral activity. Nomadic Pastoralism in India is concentrated in the Western parts of India around Rajasthan and Gujarat, the Deccan plateau, or the Himalayan region where the pastoral groups practice fixed oscillation – cyclic and vertical, between high and low altitudes. For the pastorals in western India, migratory pastoralism is a strategy of survival to deal with landlessness. They are historically believed to have immigrated to India from Afghanistan, Baluchistan, and Pakistan. The article also discusses the various dimensions of the pastoralist groups like their size, location, migration pattern. It talks about Bakkarwals as a sub-group of the Gujjars rearing the small livestock such as goats and sheep. The Gujjars, a tribe closely associated with Bakkarwals is a large ethnic group inhabiting eight states of India. There are two grand theories of their migration into India – one is that they were nomads from

Central Asia who came to India in the 5th or 6th century AD, the other is that they are originally Indians who inhabited the parts of present-day Gujarat and Rajasthan from where they moved to Punjab and north-west areas around 16th century. Being pastoralists, Gujjars are known for herding large cattle-like buffaloes and small stock like goats and sheep. The group of Gujjars that tends to buffaloes is called Dodhi Gujjars and the small stock herders are called Bakkarwals. The inadequacy of resources in Jammu and Punjab region caused the outward migration of the Dodhi Gujjars to other parts like Uttar Pradesh, Uttarakhand, and Himachal Pradesh. The time of this outward migration is unclear but believed to be 100 or 150 years ago. Gujjars belong to both Hindu as well as Muslim folds albeit with particular differentials like state location and status of nomadism. While the Muslim Gujjars are either agro-pastoralists or pastoralists, the Hindu Gujjars are sedentary agriculturists. Dera is a primary functional unit in the pastoral Gujjar household and an important site of social, economic, religious, and reproductive activities. The common Gujjar clan names are Khatana, Chechi, Kasana, Poswal, etc. Their migration pattern is largely transhumance with oscillation made between the fixed summer and winter pastures between the summers and winters involving 15-20 days of the journey. The increasing control of the forest areas has been resulting in a lesser number of deras doing the seasonal migration and in other cases emergence of partial semi-nomadism where some members of the family take the flock to the pastures while some others stay back.

9. Florentina & Grazia, conducted a study on the lifestyle of tribal people living on upper reaches in Rajouri district, discuss the various challenges faced by the tribal people living far away from cities in the upper reaches of Pir Panjal mountain range generally referred to as ‘Dhoks’. The lack of resources makes life challenging as there rely on natural resources more like the use of firewood in cooking, solar lights, locally grown herbs in place of medicines, etc. Childbirth is mostly managed in the households as the healthcare facilities are out of reach for them. The lack of educational facilities despite mobile schools scheme by the government pushes children away from the fold of formal education and they continue with the traditional herding lifestyle like their older generations. There is also general ignorance regarding the various government schemes and programmes started for their welfare. However, due to challenges involved in faraway living, the tribals in dhoks have a strong

community support system where living in groups is preferred more than living in scattered individual households. The disputes are settled through a community-based dispute resolution system headed by community elders. (The Gujjars, Vol.6:9-21)

10. Aparna Rao (2005) in her article, "From Bondsmen to Middlemen: Hired Shepherd & Pastoral Politics**",** explores the institution of hired shepherding among the Bakkarwals which has been a historical phenomenon. The hired shepherding has also evolved from time to time among the Bakkarwals. Rao has identified five phases of its evolution - from being religious dependents to that of unequal agents, then more of an insider by joining the family folds as a Karjawai (resident son-in-law) to an employee due to monetization of the economy in the later 20th century. As the author describes, the institution of hired shepherding is common in the pastoral societies where the labour available is minuscule as compared to the resources available. Herding in Bakkarwal society is treated as a male job, women assist the herd-related activities in the day. Children start assisting the fathers in the herd related activities from the age of seven or eight years. By 15, they are expected to shoulder full-fledged responsibility of the family herd.

From the literature review, it is evident that nomadic pastoralists are facing serious challenges in terms of accessing healthcare facilities. The continuous burden of diseases along with livelihood challenges is not getting proper attention from the health policy planners. Barring few experimental interventions the nomadic pastoralists have been almost left to seek healthcare from the institutions which hardly fit their lifestyle. Within the Indian context, the dismal picture of the healthcare of tribals is also surfacing very poignantly in the studies and reports of committees. The unfortunate fact of healthcare planning in India is that tribal health has never been contextualised to its local specificities. A similar case we are witnessing concerning Bakkarwals in Jammu and Kashmir. The non-availability of disaggregated data and misfit healthcare for Bakkarwals is the reality even today. The literature review does point out the marginalisation of Bakkarwals in general but there are visible gaps that still need to be comprehended by the conduct of rigorous studies about accessibility, affordability, and acceptability of healthcare by Bakkarwals. The nomadic communities in general and the Bakkarwals, in particular, remain invisible to the policy practitioners, therefore through rigorous studies, the need is to bring them to the limelight and hence get policy contextualised to the needs of this community. Besides this, the literature review shows that the focus of the studies

in case of Bakkarwals has remained on one aspect i.e the educational aspect mostly attending schools or not. The other aspects the health and culture mostly remain untouched. There is dire need for holistic studies which capture the lived experience of bakkarwal life comprising of their everyday struggles negotiating between the nature and the state.

### 2.8 Conceptual Framework of the Study and Concepts

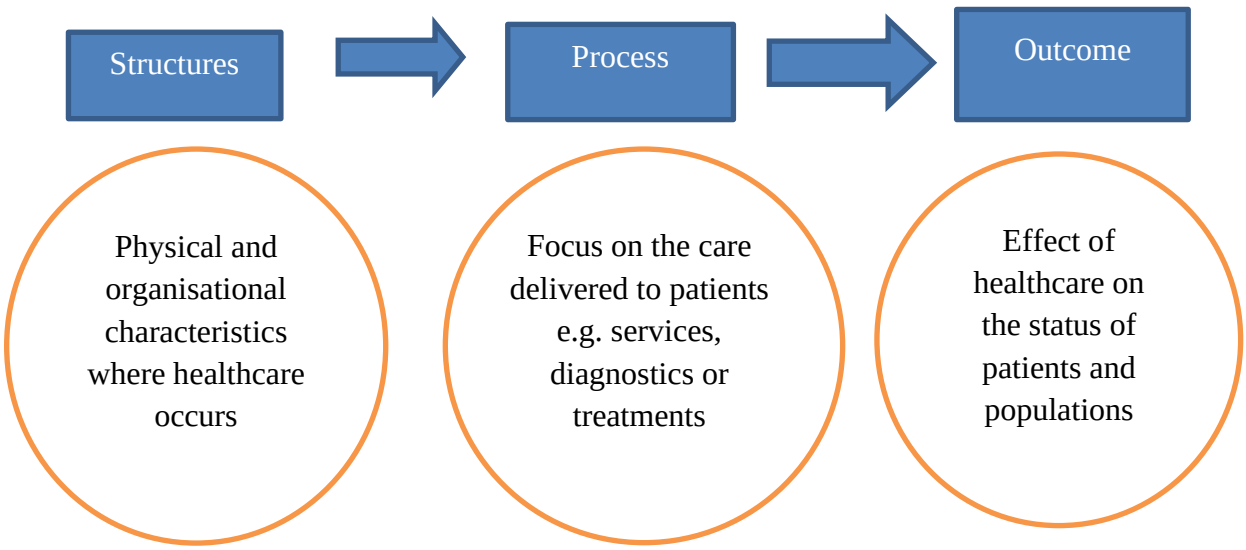
The study has been undertaken from perspective of the response of state institutions to mobile populations particularly to the transhumant groups. This study entails within itself a framework of mobility and ownership. Talal Asad's idea of ownership for subsistence is being used for understanding the Bakkarwals as a nomadic group. The idea of the forms of ownership of animals and of territory is essentiality of the nomadic character. Mobility as a category is considered to be a determining factor for a group to contextualise its relationship with the state institutions. The idea of mobility is to be seen as an alternative lifestyle divergent to a settled pattern of lifestyle. The mobility of the group will form the base of its transhumant nature. What sort of mobility is practiced by the group will determine its association with the institutions of the state. However, it is also to be mentioned that mobility as a category is not to be seen simply as a spatial movement rather it has to be located in a social context. Thus in the framework of this study bakkarwals are to be located in the space-time continuum. The framework weaves into it the concept of affordability, availability, and accessibility as markers for looking into the healthcare of bakkarwals. This study thus frames this mobility within the concept of intersectionality thereby drawing linkages that mobility has with other identities of the group. Within this framework, an Intersectionality approach has been brought in to look into the elements of how gender, class, and ethnicity relate with the above markers of healthcare of bakkarwals. The idea of settler bias which is often posed as an impediment for policy initiatives for nomads has been built in the framework. It is this backdrop framework that brings the social context as an important element for the healthcare of bakkarwals. This research study has adapted much from two prominent models; Andersen's behaviour model of health service use and the Danobedian model of quality healthcare. Both of these models have been adapted to the methodology and tools of data collection. The Andersen model lays emphasis on health service utilisation from socio-demographic perspective. An adaptation of this model for the purpose of this research has

been done. Andersen's model brings out that certain characteristic factors contribute to and determine use of health services. This model distinguishes these factors into following categories: a) predisposing Characteristics; 2) Enabling Characteristic and 3) Need based Characteristic.

Predisposing Characteristic- these are individual characteristics e.g age, sex, social status. Enabling Characteristic- Resources which are needed by individual to utilise health services are called as enabling characteristics. These enabling factors can be at the family or at community levels. Family resources include income (economic status) and location of residence. At, community level the resources include availability of health facilities and health personnel to be used by an individual. Need based Characteristics- Includes perceived needs and the evaluation of the need. The perceived need is how individuals perceive the illness and its severity or the probability of an illness occurring; while the evaluated need is how the needs are evaluated by a health professional. Therefore, the perceived need is the stimulus for the use of health services

The Danobedian Model focuses on three things; Structures, Process and Outcomes. Structures lay emphasis on attributes of the service provider. Process signifies the procedures and processes of the working of the system. Outcomes include various things like reduced mortality or experience of the patient.

**Figure 1: The Danobedian Model**

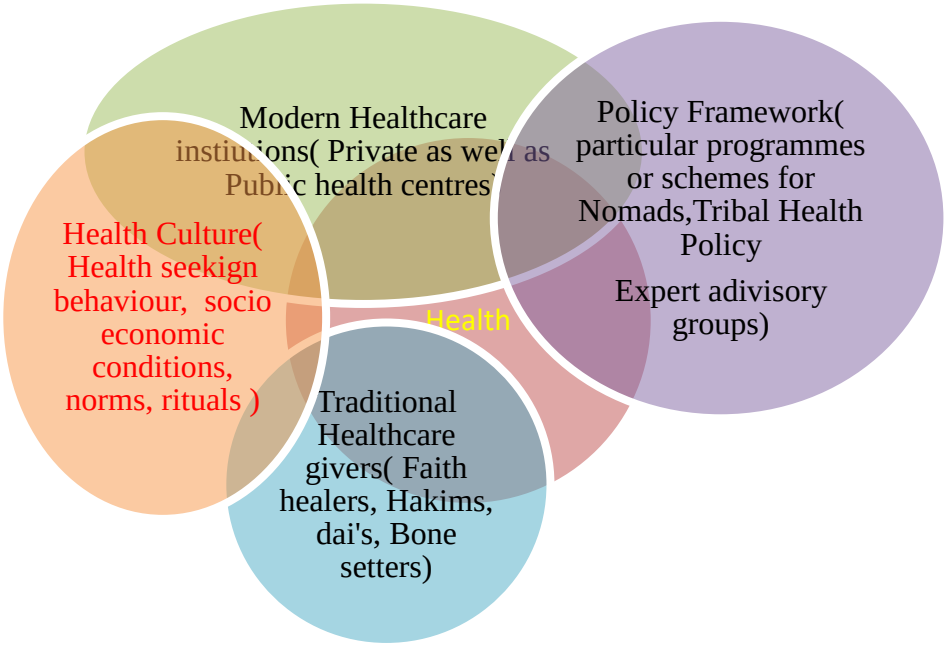



Both the Andersen's model and the Danobedian model were used to frame the Focussed Group Discussion (FGD) guiding questions and the interview schedule.

## 2.9 Conceptualisation of Nomadic Health

Nomadic health or health of tribes is to be understood form a broader perspective of culture, environment and the social structure. The interplay of this triad determines the health of the tribal community. The mere clinical aspect of health in terms of illness and the use of healthcare services is not adequate for understanding tribal health per se. Among the tribes health is understood more in functional terms than clinical (Kshatriya 2004). It is generally observed among the tribals that withdrawal from work is an indication that they are not well. Hence among tribals ill health or an affliction by diseases is to be taken as an incapacitation of a person form performing his/her regular or routine task which is expected to carry out in society. Such an understanding of health often makes tribal people neglect common symptoms such as cough, cold, headache, weakness etc., as not serious. This neglect comes from the fact that these symptoms have no bearing on the daily routine functioning in terms of performing the work by the individual. Thus what we witness is that there is perplexing understanding about tribal health where intersections of both modernity and tradition fuse into each other. The modernity influences on one hand and there are traditional beliefs and practices which also pave way into the health seeking behaviour of tribal community. As a result there is a kind of conflict between the two opposing forces of 'tradition' which people believe has worked in the past and the 'modern' which considers new as superior to old. Nomadic Health is to be understood as an interplay of both traditional aspects of their culture and also the influence of modernity. Therefore conceptualisation of health of nomads has necessary to entail the cultural elements. The cultural factors ofcourse have a strong linkage with the question of acceptability when it comes to the utilisation of healthcare services. Therefore the conceptualisation of nomadic health would be incomplete if tradition or modernity is seen in isolation. Therefore in the conceptualisation of the study a framework has been evolved where in both tradition and modernity has been encapsulated in it. The vienn diagram has been laid out in order to see the Intersectionality of nomadic health.

**Figure 2: Venn diagram depicting how nomadic health is basically contextualised**




The sphere of influence of each of the circle on the health determines the role on determining the health of nomadic tribal bakkarwals. From the diagram it is clear that the health of bakkarwals is intersected by four major elements, which are, 'Health Culture, Modern Health Care Institutions, Policy Framework and Traditional Healthcare Givers'. It is quite evident form the depiction of venn diagram that modern healthcare institutions and traditional healthcare givers have almost same significance in defining the health of the nomads. And at the same time both of these elements are strongly shaped by the Health culture of the nomads. The policy framework has role only in associating with the modern healthcare institutions in terms of certain programmes. Generally we notice that there is no significant specific policy provision for health of nomadic bakkarwals. What is to decipher from this Venn diagram is the interplay of the concept of Intersectionality in the determining the health of nomadic Bakkarwals. Intersectionality as a phenomenon clearly brings to us the questions of class, gender, ethnicity, territoriality as broader markers of health for nomads.

### 2.9.1 Nomadism

Nomads form a group of people whose identity and culture is based on nomadism. The term 'nomad' does not include displaced persons and refugees who are removed involuntarily from their homelands, residence and societies (Philips, 2001). Nomadism is often misunderstood with migration but both are different. Migration involves a shift from

one location to another and at times permanently. On the other hand, nomadism is periodical or cyclical movement where people generally return to their previous location at regular intervals (Bhasin, 1998). Nomad as term was historically used for people who took animals to different pastures. Today the term 'Nomad' is used to refer all the societies whose life is necessitated on the need to travel for ensuring livelihood and sustenance. They support themselves by using the resources of pastures that majority of the people do not, or cannot use (Philips, 2001). To be nomad is not to be seen a wandering without any objective or purpose, rather nomadic movement is purposive and targeted with specific goals (Galaty and Johnson, 1990). People are nomadic within a known territorial span, of which they have a knowhow and familiarity and also a political claim with collective ancestral rights (Galaty and Jhonson, 1990; Rao and Casimir, 2003). Diversity is quite evident among various tribal communities. Traditionally, de-notified, nomadic, and semi-nomadic communities are engaged in various occupations. In the literature they have been classified under four major categories: 1) pastoralists and hunter-gatherers, mainly shepherds, cowherds, and hunters of small game, 2) goods and service nomads, such as blacksmiths, stone workers, weapon makers, salt traders, basket makers, and so on, 3) entertainers including dancers, acrobats, snake charmers, monkey trainers and wrestlers, and 4) religious performers, ascetics, devotional singers, minstrels, and astrologers. The proper enumeration and classification of de-notified and nomadic communities is one of the important issues still existing.

Bakkarwals define their nomadic character through the use of specific word '*Khanabadoshi*'. For bakkarwals, khanabadoshi is about not having a permanent location all throughout the year. The understanding of nomadism for bakkarwals comes in relation to the settle peoples understanding of belonging to a place, owing the land and being able to trade it. Besides this, bakkarwals have an understanding that animals are an essential attribute to be considered as a nomad. Therefore for them it is animals which specify them as nomad and they exist as nomad only because they have to sustain their livestock. They define a nomad as someone without a fixed residence or acreage, and they also attribute their nomadism to their animals, in keeping with their 'bakkarwali' identity. Many Bakkarwal families brought land and thus got settle and therefore no more are nomadic now. The khanabadoshi (nomadic) lifestyle is a system which creates structures for sustaining itself. The regular periodic movement which is essential feature of nomads

ensures the adequate availability of fodder and other requirements for animals and thereby sustaining the livelihood also.

Bakkarwals by dint of their transhumant movement spend winters in low laying plains of Jammu and summers they abode the upper pastures of Himalayas all through Jammu, Kashmir and Ladakh. This practice ensures their livelihood and sustains the nomadic economy. Khazanov, a leading authority on the historical study of nomadism, argues, “the term nomad is a difficult but at the same time crucial one to be defined. He has divided nomads into two categories – one, as a mobile group living life irrespective of any economic enterprises and another - as the group engaged with pastoral activities ancillary to their mobile life” (Khazanov, 1994. p, 15).

Spooner (1973) argues that universality of features when it comes to culture or social organization is not a distinctive characteristic of nomads nor is those features universal which are specifically present among nomads. The question that follows is why nomadic communities—peripatetic, hunters-gatherers, foragers, entertainers, acrobats, travelling salesmen, and a host of other communities that practise spatial mobility as a somewhat permanent and frequently "traditional" lifestyle for reasons of sustenance—remain a subject of discussion and some academic scrutiny. Is it possible that the term "nomad" is still relevant because many people employ perpetual mobility as a particular cultural identity, or because nomads use mobility to set themselves apart from others?

Analysing the factors like social, economic and political Asad (1978) doesn’t subscribe to the view that mobility and pastoral production as the key factors essential for categorising or classifying nomads. He insists on the absence of accumulation (pastoralists can only grow their herds according to the carrying capacity of their pastures) and argues for production mainly for their own consumption as the most important feature of nomads, owing to which ‘there cannot be an essential pastoral nomadic society’ (p, 59). Asad, notes that it is their social life amid the total system and role they have played historically in larger economic systems. According to Asad, the concept of subsistence also enables independence from wealth assessments based on the market. In fact, he appears to point to a specific formula inside nomadic-pastoral economies that sets them apart from other economies: the notion of territorial and animal ownership forms.

There is a relationship that needs to be contextualized about place and mobility. The meaning attached to nomads is weaved in the space-place binary. Attaching the context of

placelessness to nomads relinquishes the whole construct of nomadism. Therefore we must reconceptualise nomadism as a concept concerning both place and mobility and not just one or the other.

### 2.9.2 Transhumance

Transhumance Pastoralism is a social system fixed firmly and deeply in the social, cultural, spatial, and environmental structures and institutions. Transhumance involves periodical seasonal movements of people along with their livestock between lands situated at different elevations and having different climatic conditions. It involves reciprocal seasonal and periodical movements typically in mountain regions from winter to summer ranges. Transhumant communities do not live in permanent structures; they reside in temporary shelters located in different zones throughout the year. Transhumant pastoralism can be seen as an effective strategy to sustain the livestock by adapting to the ecology through optimal utilisation of natural resources over a period.

## 2.10 Research Idea

Jammu and Kashmir always attain prime time slots in the media discourses of Indian television channels for very political reasons. Often we see Jammu and Kashmir being evoked either in the speeches of politicians or used as beautiful imagery by bollywood. In this gamut of visualisation the complex nuances of Jammu and Kashmir is completely invisible. In generating pseudo nationalism in the name of Jammu and Kashmir the real issues get completely obfuscated. This biggest victim of this chaos becomes already marginalised communities who further get subsumed in the discourses which only give space to the dominant identities of Jammu and Kashmir. It is either Jammu versus Kashmir and sometimes Ladakh or it is Kashmiri Muslims vs Dogra Hindus. This whole gamut never brings within its domain many other ethnic or tribal communities that also form the mosaic of Jammu and Kashmir. It is very rare, that people in many states of India know Jammu and Kashmir beyond the presence of two dominant identities. This enforced and intentional invisibilisation of communities like nomadic bakkarwals pushed me for undertaking doctoral research on them. Moreover, my own lived experience of analysing social categories and their transactions influenced me to include Bakkarwals as a prime group for my research. Having grown up in a rural remote location of south Kashmir, there was always a consistent interaction with this community and a kind of

curiosity about the way they were being treated in everyday engagements. The demeaning of their language, the cursing of their occupation, the stigmatising their identity, and the otherisation of their being was so compelling for me that I could not resist bringing them as a primary part of my doctoral studies.

My interaction with bakkarwals exposed me to the marginality and its invisibilisation within the larger academic discourses. It is from here that I began to explore the areas to be researched to bring them to the forefront. The political armed conflict that prevails in Jammu and Kashmir further aggravates this invisibility as it pushes it to the margins. The political issues become prominent and thus the discourse and research also get prioritised in that way. However, my upbringing and then a much-desired exposure at Jawaharlal Nehru University strengthened my resolve to work with bakkarwals.

My training in public health and social work infused in me an idea to weave transhumance of bakkarwals, armed conflict, and healthcare services in a framework for doctoral research. Besides this, healthcare is one of the pressing and neglected areas that demand a nuanced exploration to a much deeper level. Education among Bakkarwals has been researched to a certain level and much experimentation like mobile schools have been tried in Jammu and Kashmir. However, healthcare remains completely neglected as per the felt needs of the community. It is mostly the healthcare designed for a settled population that is also being made to deliver services to Bakkarwals and the results are indeed not successful.

### 2.11 Rationale of the Study

The idea of this study stemmed from the researcher's M.Phil fieldwork experience. During M.phil fieldwork (while visiting many of the rural villages for undertaking the study on the armed conflict) the researcher felt that there is a pressing need for studying Gujjars and Bakkarwals in depth. From the lived experience of twenty-five years in the same society, the researcher believes that gujjars and bakkarwals are one of the groups that are highly marginalized in Jammu and Kashmir. All the discourses related to Jammu and Kashmir have made gujjars and bakkarwals almost invisible. While going through the academic exercise of a literature review concerning the gujjar and bakkarwal community, the researcher found that there are hardly any exhaustive studies done barring journalistic reports in various newspapers and magazines. Furthermore, the researcher does believe that because of the historical and tragic partition of British India, this group became the

worst sufferers. Most elite members of this tribal group went to the other side of the border currently under Pakistan's control. Partition made these people residents of borders which are always tense and volatile. While the researcher himself remains a witness to the fact that this group has been excluded and marginalized not only from the dominant state structures but also from the social relations of the society. To this day, this tribal community is regarded as a kind of outcaste in informal ways in the existing social relations of Jammu and Kashmir.

This tribal community has been witnessing marginalisation from everywhere, whether dominant identities or political structures. Bakkarwals have face negligence from development initiatives pushed by different government regimes and at the same time they have remained as outcastes in the larger social organisation of Jammu and Kashmir. The interlinking of marginalization and wellbeing within the prevalent armed conflict in Jammu and Kashmir has made things complicated for this community. This community is one of the most backward tribal groups within Jammu and Kashmir. The literacy rate, health status, economic condition all show very abysmal results. They face the wrath of both nature as well as human power structures. Still, Kashmiris have prejudices concerning this group in terms of marriage and many other social rituals. They are still regarded as inferior and treated as a backward species. Hence the researcher believes that there is a moral commitment as being a member of the same society for understanding all the nuances of the gujjar and bakkarwal community.

It is extremely difficult to find separate date pertaining to health and access to healthcare for various tribal groups. When it comes to data regarding bakkarwals, they are almost invisible. There is indeed a dearth of serious research to be undertaken concerning nomadic populations like bakkarwals of Jammu and Kashmir. It is in this backdrop that this study assumes significance.

### 2.12 Importance of the Study

Already being at the fringes of territorial limits of Jammu and Kashmir and bearing the wrath of the intermittent fight at the border between the two armies of India and Pakistan, Gujjar and Bakkarwals have had to negotiate for the safety of their lives too often. The researcher strongly believes that the well-being of this group has been affected not only by the already existing marginalization but further by the issues of identity and armed conflict. Hence the need was felt to dissect the linkages between on-going armed conflict, marginalization, and

wellbeing. The researcher believes that while analysing linkages between these armed conflict, marginalisation and wellbeing, issues like the role of state and identity will come up throughout the study. Thus this study is important not only in the sense that it studies the group which is marginalized by the formation of the nation-states but also by the human relations in general. At large this research will help in contextualising the issues and challenges that the bakkarwals encounter in availing the healthcare services.

### 2.13 Broad objective of the study:

This study, keeping in view the gaps in the literature and the scholarship that is available about this community, documents the lived experience of this community with focus on the aspect of negotiating the health needs through interaction with institutions and structures (formal as well as informal) that respond to their needs. The study brings forth the lived experiences of the transhumant Bakkarwal community under the prevailing conditions of armed conflict in Jammu and Kashmir. The study documents experiences of the bakkarwal community concerning the issues of accessing healthcare services. While studying the broad objective, the study attempted to look at the following objectives:

- **The response of healthcare services to the mobility of bakkarwals**
- **Role of identity in negotiating healthcare services**
- **Familial and social relationships that mediate their accessibility to health services**
- **Sedentarisation of the bakkarwals under the garb of state induced modernity**

Within the framework of these objectives the research study is emphasizing upon the following questions:

Q. How is marginalization visible in the community?

Q. What has been the role of state vis a vis development of this community especially post tribal status notification?

Q. What are the major issues in terms of accessibility, availability, and utilisation of health institutions confronting the Bakkarwal community per se?

Q. How does Bakkarwal identity operate within themselves?

Q. How has transhumance got affected post the emergence of armed conflict in Jammu and Kashmir and amid the legal and constitutional safeguards like tribal status and so on?

Q. Is sedentarisation inevitable in the current circumstances?

Q. How does bakkarwal community respond to the abrogation of article 370?

## 2.14 Methodology:

Owing to the unique nature of this study a strong emphasis has been laid to develop an apt methodology that would capture all the nuances of the study. The study developed a framework that seemed appropriate for this study. The research study used a qualitative approach by making use of an ethnographic method for studying the transhumant group. The study is an ethnographic account of the transhumant Bakkarwal community of Jammu and Kashmir. The study documents the lived experiences of the community. Owing to the very nature of being a nomadic community, a study has utilised a nuanced approach to undertaking multi-sited ethnography. The research design followed by the study is exploratory and descriptive thereby trying to focus on bringing to fore experiencing knowledge of the people and describing already existing knowledge at a much deeper level. The multi-sited ethnographic approach was primarily used in undertaking this research. For this research study, the selection of respondents became a crucial factor as that would also determine the tools of data collection. Keeping in view the nuances of this study, three categories of respondents were selected for the study; transhumant bakkarwals, sedentary bakkarwals, and prominent people from gujjar and bakkarwal personalities. All three categories of respondents helped in capturing the data related to the objectives of the study. The commonality of the three groups of respondents was that all of them belonged to the same ethnic group of Gujjars and Bakkarwals. The description of the groups of respondents is as under:

### 2.14.1 First group (**Transhumant Bakkarwals**)

This group of respondents known as transhumant Bakkarwals is those people who practice transhumance and thus form part of pastoral nomadism. They live at different locations throughout the year in Jammu, Kashmir and Ladakh. During summers they reside in the pastures of upper himalayas in Jammu, Kashmir and Ladakh along with herds of goat and sheep. For winters these people come to abode low laying foot hills of Jammu region to avoid the harsh climatic conditions. This group undertakes the seasonal migration for going to upper reaches (pastures) and them coming back. The seasonal migration of this group is a unique characteristic feature of their lived experience. Bakkarwals are the people who have been following two important routes for their transhumance. One of them is Jammu-Banihal- Jawahar tunnel- Doru-Anantnag and Pahalgam. The other one is Jammu-Banihal- Jawahar tunnel-Kulgam-Shopian-Srinagar and Sonamarg. Ten

households known as deras of this group were taken for the study. These 10 deras of bakkarwals were followed in Kashmir as well as in Jammu and even during their transhumant movement. Multi- sited ethnographic approach has been followed by engaging with respondents at Jammu and in Kashmir during different periods over the years apart from accompanying them during their seasonal migration along the designated route. Purposive sampling method was used for selection of bakkarwals deras keeping in view the accessibility of the pasture, time availability, previous engagement and economic considerations. These ten deras were taken who lived in Jammu during winters and then migrated to Warwan in the summers along Jammu, Banihal, Anantnag, Warwan route. The study has purposively taken around 10 deras of Bakkarwals who practice transhumance between Jammu and Warwan valley of Kashmir via Anantnag. This kafila of 10 deras has been followed by the researcher throughout their transhumant movement along their designed route. It is with this group that multi-sited ethnography was used as a method. Here the researcher used participant as well as the nonparticipant tool of data collection.

### 2.14.2 Second Group (Sedantarised Bakkarwals)

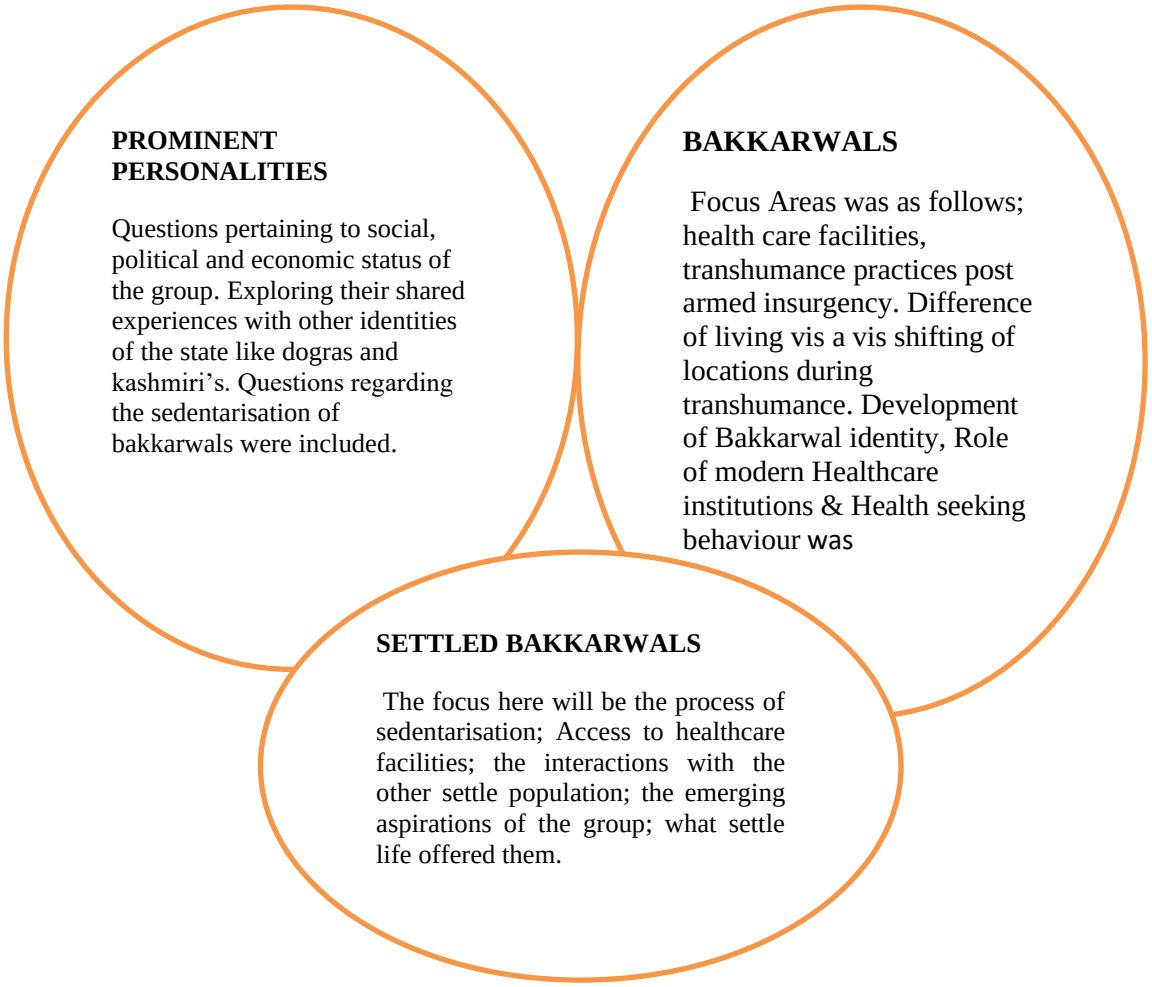
This group of respondents includes those bakkarwals who were earlier transhumant but now are no more transhumant rather they have undergone sedentarisation. This group was undertaken for study at Udhampur, Rajouri and Anantnag respectively. The respondents of this group are mostly people who are into daily wage earnings, government services, and some are engaged in daily labour market. Focussed group discussions (FGDs) were conducted with the respondents of this group. The total number of the respondents was kept flexible for the purpose of focussed group discussion. Eight group discussions were done with this group. The focussed group discussion was done separately with women, young members, and elderly members of the group. The maximum number of respondents in each focussed group discussion was kept at 15.

### 2.14.3 Third group (Prominent Gujjar & Bakkarwal persons)

This group of respondents includes twenty people from gujjar and bakkarwal community who are engaged in various occupations. Some of them were into electoral politics, some were activists, and some into Jammu Kashmir administrative services, some as medical doctors,

pharmacists and also students and researchers were part of this group. The researcher tried to include some of the women figures within these twenty people. The detailed in-depth personal interviews were conducted with all of these people to have a nuanced understanding of the Gujjar and Bakkarwal community. This is the only group of respondents which included Gujjars also. The purpose of taking respondents from Gujjar community was to collect data regarding the political identity formation and the larger context of identity politics in Jammu and Kashmir. Besides this, the reason was to understand how an influential and elite group within Gujjar and Bakkarwal community experience their interaction with the other identities present in the state of Jammu and Kashmir.

**Figure 3: Categories of Respondents**



The methodology that has been adopted for undertaking this study needs to take care of certain important factors like memory lapses, validation of the collective and individual memory and, also the time factor. The research would try to minimize the individual memory lapses by trying to fix the time period to the last fifteen years only. However, in the case of collective memory events, the validation could be done by drawing out the most common features from the events as narrated by the respondents.

### 2.14.4 Methods of Data Collection

Data collection is an important part of every research. The effectiveness and efficiency of research depend on how accurate the methods of data collection have been utilised in the given research. Therefore it becomes imperative for the study that apt methods of data collection must be utilised which will collect the data needed for the study. The data collection tools used for this study were as follows:

### 2.14.5 Observation

The researcher utilised the ethnographic method and hence staying with the transhumant Bakkarwals in their deras at various locations and traveling with them was an important element. The researcher used participant observation as well as non-participant observation methods for data collection purposes. During transhumance, the researcher observed the overall social pattern and living behaviour. Moreover, on many occasions, the researcher participated in various tasks like stacking the luggage while on the move. During stay with the community in their deras at all locations be it summer pastures or winter locations, researcher participated in all the events of the community like marriage functions, death of a community member or any other daily or season routine event in the community. Besides this, the researcher observed the people of this community while they make their way into the health institutions by accompanying them on many occasions. Observation becomes an essential information and data gathering tool while witnessing the day-to-day engagements of Bakkarwal community with people from other communities and also with state institutions like hospitals, pharmacy stores, or in the market. It is the observation that brought out many nuanced understandings that would have otherwise remained unnoticed.

### 2.14.6 Participatory techniques like PRA

Many Participatory Rural Appraisal techniques like mobility mapping and dream mapping were used for getting the information with respect to use of healthcare services by the respondents. The PRA tools provided a unique opportunity of increasing the participation of Bakkarwals in the study and also gathering information in unique way.

### 2.14.7 Focus Group Discussions

FGDs as a tool of data collection are considered effective in knowing the community's perspective of things. This tool helps in bringing to limelight the community's feelings per se and its relational aspect. Hence in qualitative studies, FGDs are considered very essential. FGDs were conducted with the Bakkarwal community members separately with females, young male members and the elderly population of the community, to know about their everyday lived experiences and aspirations. This method of data collection was used with the group of Bakkarwals who are in process or have sedentarised. The FGDs did bring out many profound elements of social relationships that exist and also the broader spectrum of how they envision themselves in the current state of affairs. Six FGDs were held at Doru with different age and gender groups, two FGDs were conducted at Udhampur and three FGDs at Rajouri. The FGDs were conducted on different occasions over two years' time period. The maximum number of participants in each FGD was kept at 15. The time for each FGD was two hours. All the FGDs were conducted in their setting and much to the pleasure of the participants. No audio visual recording of FGDs was done. However, photo documentation of FGDs was done except three FGDs conducted with females.

### 2.14.8 Interview Schedule

The interview schedule as a tool of data collection is used mostly with the literate individuals for collecting the information. The interview schedule in the study was framed by including questions related mostly to political, social, and economic aspects. The social factors in the schedule included caste, gender, and social relations, economic dimensions included livestock assets, utilization of institutional services (health institutions), ownership of pastures and land, and political dimension included adult franchise, the notion of ethnicity, political representation, and armed conflict. The interview schedule was used to gather data from the twenty prominent gujjar and bakkarwal personalities. The

interview schedule helped in gathering responses to important issues and also bringing in the debate of settled vs nomadic lifestyle. The interview schedule helped in gathering data related to prominent concerns like the role of the state, inter-community conflicts, sedentarisation, and many other important phenomena like marginalization, wellbeing, and armed conflict. For revisiting the data many interviews with the respondents were conducted again to know the view regarding the abrogation of article 370.

### 2.14.9 Sources of Data

At the very outset, it is important to mention that existing literature concerning transhumant populations like Bakkarwals in Jammu and Kashmir is very scarce. There are hardly any major studies available that could serve as a repository of knowledge for researchers. Besides this, the factual data on various indicators are not available on the Bakkarwals. The sample registration survey data, mortality, or morbidity data is not available or is insignificant. Therefore the impediment of scarce literature and data poses a major challenge for researching this group whereas on other hand it also brings an opportunity to bring forth the unexplored elements on the table. Keeping all this in view the major source of data for the study is the primary data gathered from the fieldwork undertaken by the researcher over a period. Apart from this the other sources of data include:

- Census Data of Government of India
- Newspaper reports and newspaper write-ups
- Government documents like ministry reports, commission documents, circulars, orders, and special committee reports.
- Academic journals, magazines, online portals, and books
- Reports of non-governmental organization and voluntary groups
- Reports of independent researchers
- Interviews of prominent personalities, unpublished diaries and notes, biographies, and autobiographies of known persons

## 2.15 Ethical Issues

The ethical challenge as is usual in every research, but in the case of an armed conflict zone, this is acute. The right to decline participation, anonymity of individual identities in datasets, and confidentiality difficulties are all basic ethical considerations that cannot be compromised (Ford *et al* 2009). The information gathered can create further conflict in the

community therefore confidentiality is more than protection of privacy. The researcher may, end up in a dilemma as on one side there is obligation to protect respondents identity whereas on other side the information and findings could be essential for creating peace and enhancing reconciliation (Barkat., & Eliss. 1996). The number of actors involved in an armed conflict makes it imperative for the researcher to be cautious in maintaining neutrality on the field, however difficult this might be. Keeping in view the seriousness of the issue of armed conflict it is imperative for the researcher to keep the names of respondents confidential. Besides this, at the outset, while developing rapport, the detailed purpose and plan of the study has been explained to all respondents, and oral as well as written consent taken from them. Care has been taken by the researcher to respect the sentiments and emotions of the respondents. Care has been taken so that every respondent feels free to narrate his or her experience to the extent he or she wanted to. It is highly unfortunate to mention that the scholarship concerning the transhumance of Gujjar and Bakkarwals is very poor. The scholarship about this ethnic group has been heavily affected by the partition of India as the most prominent and learned men of this community went to the other side of the border. Therefore whatever local oral narratives regarding historical events one could get, it was extreme difficult to verify and check them for complete authenticity, however only those narratives were included which found resemblance with the maximum respondents. The community is regarded to be religiously and socially conservative. Therefore the researcher remained sensitive to the range of issues such as religious beliefs, cultural and social values, the legal environment, and gender issues. In this context permission for every small engagement was every time taken from the elders of the community. The proposal of this study was confirmed by School Board of JNU in 2013 and not reviewed by the Institutional Ethics Review Board (IERB), JNU. However, SOP issued by the IERB in 2014 was carefully read and due care was taken to adhere to these guidelines while conducting field or writing the thesis.

### 2.16 Limitations of the Study

Since the study at the large documented the shared lived experiences of Bakkarwal community, therefore most of these are individual accounts and hence cannot be generalized for the whole group. Besides the small sample size of the study also acts as a limitation in terms of generalizing the outcomes of the study. The spatial context of the study areas would also make a difference in the outcomes of the study. Thus any attempt in drawing inferences from the outcomes of the study needs to take care of the spatial

context of the study done**.** The uniqueness of this Bakkarwal community makes it specific in terms of the challenges they face as compared to the rest of the nomadic communities in the country. Thus the approach that has been followed for this study may not necessarily be suitable for any other nomadic community in the country.

# Chapter 3
# State, Modernity, and Transhumance

## 3.1 Introduction

Nomads always have had a troubled relationship with nation-states. Owing to this troubled relationship there always have been attempts by state to discourage every form of nomadism and force all nomadic populations by direct or indirect ways to settle. The creation of nation-states with defined territorial limits is in contrast to the very concept of a nomadic way of life. In his extensive work on the concept of the war machine, Deleuze argued how nomads used war tactics to oppose the state apparatus. Drawing from the research of Pierre Clastres, Deleuze argues that when it comes to nomadic societies the war is not seen as a measure to create or preserve the state power rather it was seen as a strategy to be implemented against the threat of the state. Deleuze tries to make a point that nomads are averse to using warfare against the actual existing states however they put to its use only to resist any kind of state intervention in their own societies. War, as Deleuze argues, was a mechanism suitable to keep nomadic groups dispersed and mobile so as no centralisation of society can happen, which in a way would lead to emergence of any form of state apparatus. The ultimate motive of the war used by nomads, Deleuze argues, is not a battle itself, nor is it against the state itself or for achieving any political purpose. The only ulterior motive is to wade off any initiative for state formation or any other process that follow from the formation of state (Reid, J. 2003). It is important to remember that nomadic societies cannot subsist without the existence of non-nomadic societies in other economic systems. The functioning of nomadic society is possible only till the external world not only exists but ensures reciprocity of social, political and cultural elements. The mobility of nomads is an essence of their existence and any attempt to restrict this mobility is a kind of onslaught on this lifestyle. Therefore nation-states were seen with a suspicious eye by nomads. We do have examples of how this suspicion turned into reality and borders became impervious for nomads. The cross-border nomadism began to shrink over time. Every nation-state began enforcing the settle lifestyle on nomadic populations through use of state institutions and coercive policies. The bias of nation-states against a nomadic way of lifestyle created a whole lot of disadvantages for these people and pushed them to the margins. It is indeed interesting to note that nation-states considered nomadism as a threat. The policies and laws as enacted by nation-states have never been in favour of nomadic

populations. Besides this, the very existence of institutions of state never gave prominence to the existence of a nomadic lifestyle. It is in this backdrop there exist a dismal picture when it comes to role of modern institutions like health and education concerning nomadic populations. The policy formulation of nation-states completely neglected nomads or rather the policies pushed nomads towards sedentarisation. The enactment of wildlife sanctuaries, national parks are all considered as an approach for restricting nomadic pastoralists to use forests and thereby creating numerous hurdles before them. Historically state in every part of globe has made efforts to sedentarise nomads but has never succeeded in it completely. It has been seen that during the reign of Reza Shah (1925-1941) in Iran sustained efforts were made to settle pastoral nomads along with measures to completely wipe out their culture like language, dress, and other structures (Digard, 1990 Cited in FAO, 2001). Way back in 1910, there have been efforts by King Abdul Aziz to settle Bedouin in Saudi Arabia by bringing in Hijra schemes (Chatty, 1996 Cited in FAO, 2001). Such schemes have been also replicated throughout the African region under different governments. Resettlement has had a similarly bad record in the Horn of Africa. For example resettlement schemes in Northern Kenya and Southern Somalia were started with best of intentions and failed as it could not provide any alternative form of employment effectively for nomads. It was after the draught of 1973-1974 in Somali, the government tried to bring in large scale settlement schemes for nomads (Samantar, 1991, cited in FAO, 2001). In contrast to typical patterns of tenure in the area, the impact was to grant land tenure to those participating in the scheme. However, because the task itself was viewed as demeaning, practically all males of working age went back to herding or took advantage of their easier access to employment abroad. The settlement plans then resembled dry-season encampments with a predominance of children, women, and the elderly. The fact that nomads are frequently reluctant to settle shows that it is generally harmful, with the exception of after some near-starvation crucial point (especially given the importance of opportunism and adaptability in the decision-making process). In general, harsh conditions push pastoralists to stray farther and farther from home. This is how pastoralists would settle if it were advantageous for them to do so. Even with the case of Bakkarwals there has been a heavy push in many indirect ways for nomads to look to alternate means and ways of livelihood. The state at times has been indifferent to the plight of bakkarwals or at times has directly put in measures and policies which led nomads to discontinue their lifestyle. While interacting with the bakkarwal community, in an FGD at Jammu, it has come to fore:

*With the advent of time and increasing utilisation of common property resources like forests, rivers, state lands, our life has been made difficult. We find it difficult now to find space for our livestock. Every now and then there are numerous restrictions that are imposed on us on the name of conservation. We are being seen with suspicious eye as if we are misusing the resources. It is Gujjars and bakkarwals who take care of forests as they know it is their home. Our generation has been forced by state to give up this nomadism. The non-availability of facilities and welfare measures is giving setback to the hopes and aspirations of this community. We used to live in synchrony with nature by taking its care and being cared by nature. Now ruthless development in the name of sanctuaries, reserve forests, hydroelectric dams, parks, herbal gardens all is leading to the shrinking of space for nomads. Neither state nor the settle people seem to favour nomadism. Thus we end up being the victims of our honesty, hard work, and destiny.*

### 3.2 British Colonialism and Transhumant Pastoralists in India

The colonialism across Asia and Africa had a devastating effect on the nomadic lifestyle. Nomads posed a tough challenge to the imperialist expansionism policy of colonisers in India. As the colonisers found it difficult to manage nomads they made every attempt to limit their mobility by all means. A very rich scholarship has been produced regarding struggle of nomads during the colonisation of Asia and Africa. British colonialism in India is a rich case to understand how nomads were dealt during the period of colonialism. Colonisation has left a criminalising and stigmatising identity construction of nomads in India. The colonial state believed in a fixed society because it made it simpler for the state to manage its subjects and regarded itself as carrying out a civilising mission. Indeed, the colonial masters had a difficult time to deal with nomads in their own nation. They perceived nomadic communities in the colonies as being static as a result of their dread of nomadism. In addition to discouraging nomadism, the endeavor to settle these groups led to their merciless repression. Many nomadic communities lost their customary occupation in the process. Some of them were compelled to turn to dacoity as a result. Dacoity was considered a communal activity during colonial authority, and the Criminal Tribes Act (CTA), passed in 1871, designated communities that engaged in dacoity as criminal tribes (Bhukya, B., & Surepally, S. 2021). The policies implemented by britishers have encouraged and led to the establishing of settle life by nomadic populations (Balland, 1991). The nuanced discourse with regard to property which britishers introduced in India lead to sedentarisation. ‘This discourse celebrated proprietorship and viewed all forms of societies through two important categories: proprietor and tenant’ (Bhattacharya, 1995. p, 58). It is important to note that this new property rule also was made compulsory for common land and grazing runs. This new rule for property ownership did not do justice to

nomads and hence they could not use common lands any more. ‘The right to pasture was appended to the right to revenue-yielding agricultural land’, (Bhattacharya, 1995, p, 66). Meena Radhakrishna (2001) clearly showed how in colonial times britishers considered tribals and nomads as the biggest threat to the empire. To control nomads, the britishers brought them under the Criminal Tribe’s Act and later made them settle at one place. The nomads were considered as criminal tribes and hence state surveillance was increased over them. It is from that time the precarious condition of nomads in general began and the criminal tribe’s nomenclature emerged. The British believed that nomads are acting as communicators and secret agents for rebels who challenge the authority of colonisers. Therefore, there was heavy onslaught on the drama, songs, dances of nomads and thereby pushing them to settle down. The year 1871 is a considered as watershed moment in the history of nomadism in India as it is the year when britishers brought heavy measures to make nomadic people to settle down by restricting their mobility. This all was achieved through the enactment of Criminal Tribes Act, 1871, which by legal means ensured that mobility of nomads is to be considered as criminal act if undertaken without permission. This also brought a massive change in the livelihood of the nomads. The Criminal Tribes Act was used against "wandering groups, nomadic petty traders and pastoralists, gypsy types, hill- and forest-dwelling tribals, in short, against a wide variety of marginal’s who did not conform to the colonial pattern of settled agricultural and wage labour" (Arnold, 1985 cited in Singh, B, P. 2008. p, 34). The Criminal Tribes Act of 1871 made it mandatory for all those communities who have designated as criminal tribes to get themselves registered in respective local police stations. Thereafter they have had to be put in designated villages, and violation of the act meant nomads to be fined, punished, and put in reformatories. Several works discuss stigmatisation of nomadic tribes. The works of Yang (1985), Simhadri (1991), and D’Souza (2001) are worth mentioning in this context. Their works prominently deal with the criminalisation of these communities and resultant exploitation, bringing out entire process of criminalisation and victimisation of the nomadic people. Their focus is more on the victimisation of the nomadic tribes due to the laws enacted by the colonial british government in India and they do not cover the issues of the prejudice on the part of the investigators while identifying criminal tribes and the societal discrimination of the nomadic tribes. The real motive behind the enactment of the Criminal Tribes Act, 1871, has also been discussed by other scholars as well. There were several conceptions of the construction of criminal tribes and the criminal tribes act (CTA). The perception of crime and criminality in europe particularly in britain and power

relations, was at the root of the foundation of CTA. The Act was mercilessly misused by the police and local officials. The Criminal Tribes Act resulted in the discrimination, abuse, and socio-economic marginalization of nomadic communities. Tribal communities were deprived of the forest rights by the enactment of the Indian Forest Act of 1878 and 1927. It is irony to state that the Land Acquisition Act of 1894 made land acquisition legal for colonial government. The colonial administration was given power by virtue of this act that they can get any land form private parties including tribals and same can be registered in the name of company or used for public projects. Such an undue power further increased land loss issue (Ghosh, A, K. 2012). Post-independence India could not do much for the welfare of nomads except getting the criminal tribes' act repealed. However, the stigma and social isolation brought by this act still exist. Although the independent Indian state replaced the CTA with the Habitual Offenders Act, 1952, criminalization both by the police and wider society with regard to tribal communities did not vanish. The impact of criminalization is extreme, as various studies make it clear (Bhukya, B., & Surepally, S. 2021). The Government of India, Renke Commission Report of 2008 highlights, "The Denotified as well as the Nomadic communities suffer the stigma of criminality and nomadism. The society at large views them with suspicion, and thanks to the colonial as well as post-Independence rulers a people who were living with dignity and honour have become stigmatised. The denotified and nomadic communities are hounded or chased out not only by the 'mainstream communities' but also by the revenue, police and local self-government, and municipal administration or officials. They neither belong to the rural nor the urban areas. Rather, they are made out to be 'nowhere people' by all sections of the people and also by the government machinery. As a result, they do not possess ration cards, voting rights, caste and identity certificates, and residential address. In short, they have become denizens" (Ministry of Social Justice & Empowerment, GoI. 2008, p, 23). After independence, the CTA was repealed on 30 August, 1952. The criminal tribes were denotified by repealing the CTA. Therefore, these communities came to be known as denotified Tribes (DTs). But this repeal has not changed the conditions of DTs. Repealing of the CTA has not been successful in wiping out or removing the "social stigma' of criminality. The modern states see nomadic pastoralists only as a threat and fail to take into account the fact that pastoralists usually live on land that is too fragile or unstable to be used intensively and that they also serve as a substantial source of pastoral products for farmers and urban residents. Due to administrators' predominately agricultural backgrounds, government policy favours the agriculturalist, and faith in technical help

provided to farmers is bolstered by racial stereotypes (Horowitz., & Little. 1987). In addition to living in the most hostile conditions, the nomadic pastoralists suffer in various other forms as well. They suffer from entrenched negative stereotyping and discrimination. They are considered as backward, irrational, conflictual and environmentally destructive. They suffer from lack of natural resources and land dispossession. Their space for mobility is seen diminishing rapidly everywhere around the world (Jensen, 2009). In certain cases they are being evicted from areas which they have lived in and utilised for centuries. The governments have taken control of the rangelands, pastures, forests and natural resources on which pastoralists depend therefore alienating them from their natural rights. This in turn, had affected their livelihoods, nature and culture, including the values and dignity of the pastoralists (Ministry of Social Justice and Empowerment, GOI, 2008).

### 3.3 Modernity, Identity and Healthcare Services: An Intersectionality Approach

A good deal of connection has always existed between politics, society, and the economy and health (Sen, 1999). These forces develop an obvious policy frame that not only influences the health of communities but also shapes their course of action. Availability and accessibility to food, shelter, a dependable and sustainable livelihood, quality of education, and more importantly a sense of safety and security from all forms of violence (including physical, sexual, and psychological) within one's own community, control over one's life, and above all a sense of equality are important determinants of health (Marmot., & Wilkinson. 2000). Changes in these systems by any means ascertain the population's state of health. Since some countries and population groups consistently have worse health than others due to poor social policies and programmes, unfair economic arrangements, and bad politics, poor health is not the unfortunate victim of bad luck, nor is it the unfortunate result of a cluster of random events or differences and variations in individual behaviours; rather, it is the result of a toxic combination of these deeper social structures (CSDH Final Report, WHO. 2008). With time, sociologists- particularly the adherents of post-modernity began to critique the very foundation of enlightenment modernity. No doubt the colonial state – with its english education, administrative policies, economic policies, and a legal network did give us the structure of modernity. But, then the experience of colonial modernity – because of its innate violence, asymmetry, and exploitativeness, its arrogance and skepticism towards our cultural practices were often traumatic and violent (Pathak, 2006). The word 'Identity' has been originated from the

Latin word “Identitas” which refers to the fact of being what a person is. “Men and Women are not born with an identity. We have to identify to get one. Identify presupposes identification. It is employing a series of identifications that identity is constituted”, (Pathak, 2006. p, 121). The term identity gets more complex when associated with the socio-cultural dimensions of a people which make them as community and it gets vaguer and complicated when referred to the identities that are manipulated politically. From the last several decades questions regarding identity of bakkarwals have gained prominence not only in political circles but also in terms of academic discourses. The question of gujjar bakkarwal identity has got entangled in complexity because of polarization of Jammu and Kashmir along communal lines. Numerous testimonies indicate how the polarisation of Jammu and Kashmir is playing out not only in political terms but also in social transactions. In this whole communal polarisation, the worst victims are gujjars and bakkarwals. This polarisation has infused a renewed identity crisis within the gujjars and bakkarwals of Jammu and Kashmir. Thus what can be seen is the reconstruction of gujjar bakkarwal identity in Jammu and Kashmir. As we know that Rajouri and Poonch are the two districts with maximum tribal population and the assertion of tribes is these two districts started becoming visible from last two decades. The testimony to this fact can be seen in the recent demand of giving Baba Ghulam Shah Badshah University[1] a tribal university status. The concept of identity refers to the attachments people have to certain groups, lifestyles, belief systems, or behaviours that are essential to their conception of or understanding of themselves. People usually mean when they say something is vital to their identity, whether it be a practise, a location, or an activity, that it reflects something significant about their sense of self or that they would be unable to recognise something significant about themselves without access to it. They imply that they understand themselves in part in terms of an ascriptive attribute, such as their race, gender, or ethnicity, when they say that it is important to their identity. In the sense that people may not identify with features of what, in any given social context, their relation to a group is typically understood by others to entail, even ascriptive aspects of identity, such as gender, ethnicity, or race, have significant non-ascriptive dimensions, it is important to note that even these aspects of identity are not fixed. People frequently do not adhere to what Anthony Appiah (2005) refers to as the "scripts" of the collective identities that establish

[7]*This University is one of the state universities in Jammu and Kashmir which is located in Rajouri district, which second largest Gujjar bakerwal population in the state of Jammu and Kashmir. This university was opened in the year 2002 only.* http://www.bgsbuniversity.org/

the contours of potential personal narratives. Or people alter these scripts to fit their needs and become tied to certain groups in ways that are both of their own making and challenging to change without actually harming themselves. Amartya Sen (2006) makes a similar point when he claims that identities present people with options that engage their capacity for reason rather than being prior to it. Because identity refers to the unique way that individuals or groups come to see themselves in a social environment, there is a relationship between identity and respect for humans. During one of the FGD's held at Rajouri it was narrated by respondents,

> *Gujjars and bakkarwals were never respected in Jammu and Kashmir. We were seen as inferior, uncivilised, unhygienic by everyone. It is only form past decade that we have asserted ourselves at every level. See even respect for community comes only when it becomes conscious of its own existence. Our community members were earlier very subservient. They used to bear everything, poverty, malnutrition and disrespect by other people. Our identity was nowhere, nor would our children prefer to be categorised as Gujjars. Things have changed, we are now proud of our identity, we wear our dresses with respect, our children are proud of their surnames, and this is how we have established ourselves. We know we are still poor; we are still illiterate, we have still many other issues but we are now happy to be identified as bakkarwals and Gujjars* (FGD, Rajouri, 2018)

Thus when one looks at the emergence of the assertion of the gujjar bakkarwal identity in Jammu and Kashmir, one cannot keep eyes shut to the political reality amidst the armed conflict. This is so because as argued by Charles Taylor, "Identity is the background against which our tastes and desires and opinions and aspirations make sense' (Taylor, 1994. p, 42). Identity stands for the understanding of self in relation to others. Identity is a psychological need for human beings. Amartya Sen (2015) in his famous book, *Identity and violence; the illusion of destiny*, brings in the concept of multiple identities as possessed by human beings. Sen argues that the each identity brings with it the richness and warmth but also the constraints and freedoms. Sen goes on to argue that it depends on various attributes how we construct our identity in a particular context and at a particular point. The cultural identity as shown by Jennifer B Unger (2011) influences the ways in which people make decisions about performing behaviours that ultimately influence their health.

Muzafar narrated, about his Bakkarwal identity,

> *We trust the doctors and nurses who come from our community when they come to visit us whenever there is any programme. We listen to them carefully and they advise us what to do and what not to do. We also cooperate with them and never say no to them.*

The search for identity has been one of the most cherished desires of human beings since the inception of civilization. Identity has become dearer and essential to modern individuals, states, and communities. It is a basic requirement for both individual and collective life and is formed in the process of interaction and relationship with others. Although the identity of a human being is inclusive, comprehensive and multi-layered universal, and natural but still the process of identity construction and reconstruction have been an unending process and will remain so. The former expands the shared space because of its inclusive nature whereas the latter erodes the same by constructing new identities, which are exclusionary, angular, and binary.

Jamal Hussain narrated,

> *We are almost invisible in the power structures of Jammu and Kashmir. Nobody cares for us nor has an interest in us. Our destitution and struggle is not their concern as we don't belong to them. Both Kashmiris and Dogras have this understanding that we are inferior to them so we don't exist for them. They decide for us and we hardly have any say anywhere.*

This idea of seeing as other has a historical genesis and it has to lead to the emergence of identity assertion in bakkarwals. Over the past decade, we have witnessed the consolidation of gujjar bakkarwal identity across all the regions of Jammu and Kashmir. This consolidation can be seen as promising hope for the bakkarwals. A noted scholar, Balraj Puri (2000) argues, "Growing quest for gujjar and bakkarwal identity is a sign of modernization and progress of the community. As they get educated, they become aware of their heritage. As communications grow they can maintain contacts with the scattered members of their respective communities. As development causes greater prosperity, it also improves their means to consolidate their identity" (p, 12)

This consolidation of identity assumes significance for healthcare services.

Talib Hussain argues,

> *We ever we have our own people in the institutions it becomes much easy for us to access them. They know our situation very well and they treat us nicely. We feel comfortable when doctors and paramedical staff from our community are*

> *present in hospitals. It gives us confidence as we don't get humiliated. We feel dignified and respectful when the doctor speaks to us in our language and makes us understand in detail all the things about our health.*

In the pre-modern age, identities were given and normative and there was no question of construction and recasting of identities. Identities by and large remained confined to the socio-cultural fabric of society. Human beings used to enjoy autonomy in socio-cultural matters and there was no threat in these affairs from any quarter whatsoever. It was the modern age and to be more precise the modern state, which has politicized the identities by way of transferring them from private to the public domain. Initially, identity studies focused merely on the individual identities but gradually it started bringing group identities within its purview- for instance as understood in the marxist perspective of 'class consciousness' that refers to the we-ness of a group that talking of the similarities or shared attributes around which group members come together to develop group consciousness leading to the formation of communities. As a result, identity is generally relocated in collective identities, with race, ethnicity, gender/sexuality, class, and caste forming the major pillars. The infamous kathua rape and murder case where an eight-year-old nomadic bakkarwal girl became a victim is a case in point to understand how identity assertion changed the course of relations between bakkarwals and the settled dogra community. The consolidations of identities on ethnic and religious lines lead to segregation and even boycott of services between the communities. The bakkarwals were completely boycotted by local settlers and even the milkman gujjars were banned from coming to dogra villages for selling milk. Many household refused to buy milk form the Gujjars post kathua incident owing to their muslimness. This social boycott even made its presence felt in terms of gujjars and bakkarwals being refused treatment by pharmacists and private practitioners at many communally sensitive places like hiranagar, kathua. Such segregation indeed had larger repercussions in terms of the provisioning of services. The formation of Hindu Ekta Manch post Asifa rape and murder gave an open call to boycott the gujjars and bakkarwals.

Mohd Yousuf narrated,

> *We are very scared now and fear for our lives. We are not sure what will happen to us in the coming days. We don't now buy things from these shopkeepers. I went to the city last week and got medicines from there. The local pharmacists take us now with suspicion and they don't even sell medicines to us. We are facing tough times. We are now every time looking for places where people from our communities are serving.*

It is important to mention here that in kathua rape and murder case, one of the local pharmacists was also arrested on charges of selling sedatives over the counter that were used in the gruesome incident. After this incident, nomadic bakkarwals became very fearful about their existence in the places where they transact for their needs with the local populace. The biggest worry for bakkarwals comes in fulfilling their health needs particularly during emergencies and for that matter; they are mostly dependant on the local pharmacists rather than formal healthcare institutions.

Jamal Hussain narrated

> *It is now difficult for us to visit hospitals in Samba, Kathua or Jammu where Dogra community members are working. We are being looked at with suspicion. Our identity has become a marker for us to be identified. We now have to choose where to visit and where not to.*

However, many believe that the construction of identity is not a simple process of acquiring identity based-loyalty from an individual towards an identity-based group. There is a dynamism in which the collective defines the self and the self also contributes to the formation of collective identity. To quote Avijit Pathak, "One is not born with an identity. Identities are socially constructed. And this seems to be the reason why identities, no matter how 'natural' they look can be transcended. As a matter of fact radical politics, like feminism and marxism often perceive alternative cultural practices through which one transcends socially imposed, particularly stigmatized identities and seeks to become more universal and humane" (Pathak, 2006. p, 102). In the context of the debate in which the process of identity formation is seen from varied perspectives, it becomes imperative to understand the way identity operates and impacts the people and society. It raises several questions – for instance, does identity present itself as a stable entity or not? If we see the concept of identity in terms of it being 'constructed' despite it being 'given' then it means identity is always in a situation of 'flux'. It is this nature of identity in the postmodernist context that makes it different from other perspectives. Scholars like Anthony Giddens (1991) in his book, *modernity and self Identity*, analyses the concept of identity in the context of modernity. For him, identity is an issue of the modern age. Earlier, in pre-modern societies identity was not considered as a matter of any discourse and it hardly was discussed or debated upon as it was not considered as problematic. People did not undergo an identity crisis. The whole idea of identity crisis is a modern concept. Identity becomes fluid, mobile, multiple, narrower, personal, self-reflective, and subject to change. It comes

out clear from many writings like anthropological folklores which perceive identities as solid, stable, and fixed. The identity here was defined in terms of the social customs, dictums, and roles that existed from times immemorial and which were predefined and thus shaped identity and concerned paradigms. The traditional and customary realities provided religious and other social sanctions. Such rules decide and determine what position and place one would have in the world or the society and it was only such social interaction and training which influenced the sphere of thought and behaviour. People were born into a particular identity-based group such as a member of a particular tribe or clan within a fixed kinship system. Bakkarwals have adapted to many societal norms and modes of adjusting. Without a doubt, the gujjar and bakkarwal people of Jammu and Kashmir have opted to Islam, and as a result, they differ from their counterparts who have lived in other areas of the state in terms of their dress, way of life, marriage, and kinship. Their gojri language and dialect are essentially related to Rajasthani. They dress traditionally, just like the Pushto people of Pakistan. The bakkarwal community has a distinct language and cultural identity. Naturally, it is necessary to understand the many facets of their culture in terms of their geographical contexts. The bakkarwals have a culture of adaptation to their particular environment because they have lived in seclusion for so long. However, over the last few decades, industrialization, urbanisation, and a number of other influences, such as the unrest in the state over the last thirty years, have transformed the tribal indigenous culture.

The point of concern aroused from this kind of perspective is the relationship between modernity and identity. An important question one can ask then is: what changes has modernity brought that led to the sharpening and assertion of identities? As people are caught up or engaged in several conflicting and contradictory roles it becomes difficult for them to recognize themselves. Another important question that comes to the forefront is: has modernity brought about more confusion and dilemmas? And if it is so then identity presents itself as a quite complex and problematic discourse in modern times. (Mooya, 2001).

However, the belief that in pre-modern society's identity was stable and therefore blaming modernity for bringing about a plethora of unstable identities is itself questioned and contested by many (Taylor, 1994). Many scholars support the argument of stable identities in modern times as well. The fact identities that are often seen as 'given' or 'ascriptive' acquire their significance only through carefully evolved cultural practices. As Pathak says, "I may be born in a 'Brahmin' family, but whether or not I acquire a 'Brahmin' identity

depends on the way I am socialized and trained to separate myself from non-Brahmins. In other words, it is important whether I see myself belonging to a subjectively self-conscious community that establishes rigid criteria for inclusion into and exclusion from the group. Likewise, the potency of one's ethnic identity depends upon the intensity of cultural practices. I often recall the way one grows up as a 'Bengali' in West Bengal. The specific festivals and ceremonies like Durga Puja, Bengali New Year, and Tagore's birthday reinforce one's 'Bengali' identity. At school one is constantly reminded of the distinctiveness of the Bengali language, its pride, and history. One is told about its heroes and icons: Khudiram, Vivekananda, and Netaji: One grows up with this self-perception that celebrates visible cultural markers, one knows that one is 'different' from say, a 'Bihari' and 'Oriya' or a 'Madrasi' " (Pathak, 2006. p, 108). While looking at how bakkarwals were engaging with their identity construction it is mostly visible that they were mostly non-existent in the discourses in Jammu and Kashmir. Whom they belong to, who their heroes are and whom they would look to was confiscated by not have adequate representation of people from bakkarwal community either in institutions of state or in literature. It now recently that doctors, administrators and other officials belonging to bakkarwal community are now coming raising voice and generating as identity assertion among the community, which further encourages the demand for the state intervention with respect to this community.

It comes out clear that many are of the view that identity is not a static or stable phenomenon. On the contrary, it is fluid; one may recognize one specific identity at a time while becoming alien to it the other time. Identities may be formed around various dimensions- global, national, regional, sub-regional, religious, cultural, lingual, gender-based, interest-based and caste-based, etc. Some of these identities may be mutually contradictory as well making it difficult for individuals to identify with all these identities at a time as one identity becomes dominant at one point of time while others remain dormant at the same point of time. This gives space to the debate as to whether identities are given and/or pre-determined or they are structured in a particular time and space in different social, political, or economic contexts. Therefore, for some, identities are primordial or 'given', while for others, they are constructed. Given-ness of identities is based on the presumption that it is something 'natural'- something a person is born with. For example, one's gender identity is often, arguably, regarded as innate or given. Constructed identity, on the other hand, proves this presumption false with the claim that

identities involve some institutionalized agencies like leadership and elites to artificially construct them for some political program and gains. Studies undertaken in disciplines like anthropology and sociology vindicate such an assertion.

Thus the question of identity not only gains prominence as a phenomenon to be understood for national integration as any political scientist will argue, but for a public health professional identity assumes a different significance. One can never hesitate in making a preposition that identity of course determines the accessibility and utilization of health care services in any defined geographical territory. For a public health researcher, the question of identity will nevertheless be a meaningful endeavour for analysing the issue of utilization and accessibility of health services in a certain defined geographical location. It has often been seen that certain social realities like caste do act as a barrier to the utilization of health services by specific communities. Similarly, in the case of bakkarwals of Jammu and Kashmir, the social inferiority from the dominant identities of the state does hinder them to access the health services. “A bear can be more faithful than the Gujjar”, is a common adage that prevails in kashmiri society. Therefore the discrimination based on identity not only shows up as institutional marginalisation but also as marginalisation on a social level. The number of medical health professionals from the community of gujjar and bakkarwal is yet far from satisfactory level. Therefore members of the community are largely at the receiving end of discrimination. Thus identity does refer to how social characteristics are ingrained in a person's perception of himself (Appiah, 2005), or fundamental to who they are, such as their nationality, gender, ethnicity, language, religion, life goals, and moral principles (Copp, 2002). When it comes to the healthcare services in Jammu and Kashmir, the question of representation becomes important. Throughout my engagement with the bakkarwals, it has come out very vividly that representation in human resources of health is minimal from the gujjar bakkarwal community. This minimal human resource has a bearing on healthcare services. Bakkarwals are very much aware of the fact that doctors and paramedical staff are not sensitive to their culture and identity. However, where ever there are human resources in healthcare institutions from their community they understand them very well.

Muzaffar narrated this,

> *When we happen to see a doctor from our community we feel confident enough. They treat us very effectively and give us respect. Most of the time, we have to look around and search for doctors. I still remember the time when I had to take*

> *my uncle to Chest Disease hospital in Srinagar for a checkup. He was suffering from tuberculosis. As I hardly knew people there and we had been referred from Anantnag hospital to there. It was such a terrible time for me to get my uncle admitted. I begged everyone for help. I spent a lot of money on everything but all in vain. My uncle would have survived if the doctors could have provided timely treatment and effective one. On every visit in Anantnag and then in Srinagar we were never guided properly and just it was a superficial check-up. To all my misfortunate I hardly knew anyone and I became completely helpless.*

Identity becomes crucial in a diverse society for a fact that it also helps in building trust in modern healthcare institutions. From bakkarwals perspective you will see identity as an indicator for acceptability for healthcare services become prominent. The settle gujjars and bakkarwals in places like Rajouri place more trust in healthcare institutions and they own them owing to fact that their people are serving in these institutions. The human resources in health institutions at places like Rajouri come from settled gujjars and bakkarwals develops a sense of trust among people in utilising the services. The mistrust on public health institutions which is otherwise very high gets minimised when bakkarwals see the human resources from their own community.

In an FGD at Rajouri it was narrated,

> *We very often visit the hospitals and get ourselves treated there. Doctors and paramedical staff are from our own community and they guide us well. We have confidence in them, they are intelligent people. We can easily communicate with them and they listen to us properly. We find no problem in accessing services here. (FGD, Rajouri, 2021)*

The emergence of gujjar bakkarwal identity can be also visualised as an assertion of the rights that this community claims. We do witness that proactiveness because of this identity assertion has also lead to the accountability of the institutions in Jammu and Kashmir. The incidents of nomadic bakkarwals being mistreated in health institutions are immediately raised in media and also through protests by the proactiveness of the young generation of the community. The immediate protest and use of media both social and print by the community members at large and activists in particular ensures attention of the government towards the issues of the bakkarwals. The evident examples of the 19th January 2019[2] incident at famous maternity 'Lal Ded' hospital in Kashmir, a woman from the gujjar community gave birth to a baby on the road outside. This incident evoked strong criticism in the whole valley and strong resentment emerged over it in print and electronic media. The government was forced to take action by constituting an inquiry and immediate

[2] https://www.outlookindia.com/website/story/india-news-doctor-shouted-at-me-called-me-gujjar

suspension of on-duty doctor was ordered. This became possible by the emerging identity consciousness among bakkarwals themselves and thereby forcing other communities to support them. However, having said this, identity construction has had also political overtones which have been used by the groups and state machinery for its ill designs. For example, separatists have always referred gujjars and bakkarwals as active partners in the movement. On the other hand, mainstream political forces have always demonized their involvement as a kind of talibanisation. Gujjars and bakkarwals of Jammu and Kashmir are all the followers of Islam and that too of the Sunni sect. Within scholarly and societal discourses, the issue of their identity has consistently remained unsettled. It has been discovered that on the one hand, because they are muslims, they have a muslim identity of which they are fully aware and which other people, like kashimiri muslims, associate with them.

Jamal Hussain narrated,

> *We share a bond of brotherhood with Kashmiris but only inside the mosque. It is the only because we share religious identity with them and hence nobody can stop us from this. However, once we come out of the door of the Mosque we become Gujjars for them; inferior, dirty, uncivilised, and other. They no longer associate us as their own. No brotherhood exists in the social reality in outer space.*

On the other hand, the state and numerous other groups have successfully exploited their ethnic identities as gujjars and bakkarwals. The ongoing armed movement in Jammu and Kashmir emphasises this disjuncture and identity fluidity even more. When Sheikh Abdullah tried to unite the kashmiri-speaking muslims of Doda with the muslim districts of Rajouri and Poonch in a "greater Kashmir" in the late 1970s, the Gujjars first rose to political prominence. Mrs. Indira Gandhi devised new electoral arithmetic which calculated Dogras and Gujjars new counterweight to the Kashmiri Muslims. A conscious decision seems to have been taken to arouse the ethnic Gujjar as opposed to a religious Muslim consciousness of this community (Hussain, 1994).

Gujjars were first made politically relevant, according to Navnita Chadha Behara (1996), in the 1970s when Prime Minister mrs. Indira Gandhi fostered and supported them as a potential counterbalance to the valley Muslims. The adoption of the gojri language and the provision of airtime for its programming on J&K radio represented the first step in this direction. Gujjars have faced a conundrum in the broader language of political action. Due to their muslim identity, the Indian state has not fully acknowledged them as nationalists.

Their muslim identity has always been linked with the muslim character of the resistance movement in Kashmir. The Amaranth land row in the year 2008, the infamous kathua rape and murder is evidence that the Jammu region's hindu people violently persecuted gujjars for nothing more than their fault of belonging to muslim identity. In places like Samba and Kathua of the region of Jammu, the hindu mobs set their homes on fire and torched their livestock. Otherwise, these people have been using the Jammu province as their winter pastures due to harsh climate in Kashmir valley in the winters for decades.

Fazal Hussain narrated,

> *We used to live in harmony everywhere but now it is suspicion everywhere. People in Jammu, Kathua, Samba see us being closer to Kashmiri Muslims, thus doubtful about us. They don't like us anymore and don't allow us to access common resources easily. The relationship has changed drastically. Politics has ruined this harmonious relationship. And to our disadvantage, we are only scapegoats. We have nowhere to go. Neither have we opposed anything nor do we support. We are just mute spectators watching and waiting and at times remaining witness to our miseries and sufferings.*

Additionally, gujjars and bakkarwals continue to live in poverty and privation and are conveniently, though not unintentionally, left out of the increasingly communalized binary geographies of hindus and muslims that support the dominant discourses of the freedom movement, according to Sanjay Chaturvedi's argument in his 2005 book, 'Politics of Autonomy'. The voices of the gujjars frequently challenge nationalist accounts of history and identity because they lack a political vision of their own and are situated on the edge and peripheral of contemporary nation-states. Many authors who have written about kashmir argue that they have been active followers of the jihad. 'The muslim gujjar community of Jammu and Kashmir at present is faced by two different phenomena, Gujjar consciousness, and Muslim consciousness. The Gujjar voluntary organizations are making Gujjars conscious of their ethnic identity while the Islamic organizations and institutions are endeavouring to promote Muslim consciousness' (Rao, A. 1999. p, 64). The framework of the resistance movement can be used to understand allegiance to the greater gujjar identity, which is frequently espoused by political regimes in Jammu and Kashmir that uphold the status quo. The apt example of this can be seen when gujjar community of Jammu and Kashmir went to provide support to the Rajasthan gujjar community on their demand for reservation in jobs. Many of the gujjar and bakkarwal community representatives went to Rajasthan during krirori bansla time for tribal status and addressed the protesting gatherings. Recently for the implementation of the Forest Rights Act, 2006 a

seminar was organised in Jammu at Gujjar Desh Charitable Trust where president All India Gujjar Samaj addressed the gathering. Such kind of associations with covert political overtones has been attempted to push the gujjar conscious as a counter weight to muslim consciousness. There have been efforts to let the identity consciousness of being ethnic gujjar emerge so as not to make gujjars part of the larger armed movement going on in kashmir. However, there is also a reality of these gujjars being socially excluded from the larger kashmiri identity of the majority of muslims in the state (now UT). Until now gujjars and bakakrwals are socially ostracised by categorising them as uncivilised (Jahil) and hence out casted within Jammu and Kashmir. Kashmiris only associate with gujjars and bakkarwals by way of their muslim identity. Though this community was also considered as being informers of Indian by larger kashmiri community however the formation of Gujjar Liberation Tigers in1991 (Asia Watch, 1991) depicts their role as part of movement.

### 3.4 Nomadism, and Healthcare Services: Contextualising Bakkarwals

Numerous tribes on the Indian subcontinent practise nomadic pastoralism, which is distinguished from current settled populations territorial commitments by its fluidity and diverse methods of demarcation. They engage with non-humans, forests, and animals as family members in a spiritual rhythm that is significantly different from 'regular' existence. Nomadism a divergent lifestyle though hindered by the push and pull factors continue to persist and exists in many regions of the world. Himalayan ranges have been inhabited by several tribes practicing transhumance in the northern part of India for example Bhotiyas in Uttarakhand, Changpas in Ladakh; Gaddis in Kanets, Kaulis, and Kinnauras in Himachal Pradesh and Gujjar Bakkarwals scattered over parts of Jammu and Kashmir. In Himalayas historically during summer season transhumant groups migrate to upper pastures and even come down to low laying foothill plains. Since the independence of India, owing to the political and economic restructuring pastoralists have also been forced to witness changes in their lifestyle. The changes have become evident in their migration practice, social organisation and economic structure (Bhasin, 2013). Due to the neglect by state and policymakers, transhumance pastoralists have a low human development index and high relative deprivation index. They are politically insignificant thereby leading to their under-representation in government. The health status of these nomadic pastoralists is dismal as the health and poverty initiatives at the national, state-level neglect these groups. The depressing state of health of pastoralists is due to multiple

factors; their geographical isolation/remoteness, poor communication, logistic requirements, uncertain civil status, and perceived low priority. The World Health Organization on strengthening health systems has reported that mobile pastoralist populations do not even find mention among the under-privileged populations (Zinsstag et al., 2006). However, in the Indian context, the National Commission for Denotified, Nomadic and Semi-Nomadic Tribes in its report proposed various programmes on education, development, and health including access to the public health facilities by nomadic pastoralists (Ministry of Social Justice and Empowerment, GOI. 2008). The different and inconsistent access to health care services is more prevalent amongst the transhumant groups due to proximity and mobility issues combined with accessibility and availability hindrances as tribal communities often lack sources and money to travel long distances for treatment or to purchase prescribed medicines. Very often, the tribals during the medical emergency have to walk for longer distance which further complicates the situation and thereby result in poor health outcomes. The nomads globally are facing a very tough challenge of maintaining their lifestyle particularly confronting the decreasing pasture lands and increasing demand for healthcare services. Providing affordable and acceptable healthcare services to nomadic and transhumant groups are the biggest challenge. Studies have shown that health is the biggest concern for transhumant groups globally. Owing to their divergent lifestyle, the transhumant groups globally have dismal health indicators. While the health system's pyramidal structure serves settled groups well, it is inadequate to serve the demands of nomadic communities living in regions like the Himalayan upper ranges. This is a result of a variety of problems, including the unattractiveness of rural positions, the difficulties of recruiting health professionals to these locations, the difficulty of accessing services due to vast distances, and poor infrastructure. The very context and nature of transhumance gives rise to unprecedented challenges when it comes to the effective delivery and geographical accessibility of health care services.

In one of the focussed group discussion which was conducted with young bakkarwal community members at doru, Anantnag, it was revealed,

> *Bakkarwals used to manage their lifestyle much effectively before three decades. The Bakkarwal people at that point were always having good knowhow of their own surroundings and the exigencies that could happen. The inbuilt resilience within the elder population would always act as an important knowledge hub for dealing with adverse situation. The health emergencies were dealt by elders themselves and in rarest cases the need for a doctor was felt. In most of cases local traditional healers would be the priority health care givers.*

> *The situation has now completely changed. The local traditional healers including faith healers have almost gone in oblivion, and mostly ill knowing ones who are fake are now prevalent. Besides this the intrusion of allopathic drug stories in the villages has also penetrated into the Bakkarwal behaviour. Most of the Bakkarwals now rush to the local pharmacists for getting pills to cure the ailments. The continuous and unabated use of allopathic medicine on the prescription of local pharmacists is regular practice and increasing day by day. The Bakkarwals are now dependant on these local pharmacists instead of faith and traditional healers. The Bakkarwals strongly believe that these pharmacists give them medicines as and when they need without too much hesitation (FGD, Doru 2021)*

Bakkarwals move to very remote/isolated areas in search of pastures thereby leading to issue of affordability as it entails not only huge transportation costs but also time costs. To counter this challenge Bakkarwals have to render on local traditional medicines, herbs and shrubs. The nomads arsze generally characterised by poor health outcomes with reproductive health becoming the worst causality. Earlier it was thought that nomadic populations mostly suffer from infectious diseases however non-communicable diseases like hypertension are increasing drastically in nomadic communities. The engagement with Bakkarwals in pastures validates the point that increased blood pressure levels are a common complaint coming nowadays.

Jamal Hussain narrated,

> *We have to keep some painkillers with us. The local doctors (pharmacists) give us very effective medicine and we keep that with ourselves. Whenever we get a headache or pain in the body we use that pill and it is effective.*

It has been observed that the selling of these painkillers like paracetamol and diclofenac is very common. Every Bakkarwal dera buys these medicines and keeps a stock with them. They have a good know-how of these medicines now. They usually identify them by the colour and the shape whenever they buy over counter drugs from local pharmacists.

The issue of a toothache is also much prominent among the Bakkarwals. Since regular checkups are not a feature of the Bakkarwal community, we do find that over years their dependence on allopathic medicines has increased. The older generation of Bakkarwals was mostly using the local herbs and getting treatment by traditional methods. However, the influx of modern medicine has made Bakkarwal also accustomed to its use. Very often it has been noticed that the Bakkarwal men and women carrying strips of medicines in their pockets. Having a look at these clearly shows that these are all painkillers.

Talib Hussain mentioned,

> *Nowadays all of us buy painkillers from the local doctors (pharmacists) and carry them in our pocket. Whenever we have a headache we take a pill and get quick relief. The use of the medicines has relieved us from the tiredness. Our elders still make use of traditional methods and local herbs*.

Bakkarwals have been transforming their rich genetic potentialities into phenotypic realities for centuries (Kumar., & Kumar. 1998). The knowledge of ethno medicinal plants has led to emergence of effective use of traditional practices, which has served as boon for bakkarwals. The bakkarwals are in possession of a vast collection of medicinal plants that are used to treat a variety of non-chronic conditions like fever, the common cold and cough, gastrointestinal issues, and abdominal pains as well as numerous chronic conditions like rheumatism, skin issues, high blood pressure, respiratory and reproductive disorders. In-depth ethno botanical studies of the medicinal plants used by this society have been carried out throughout the state of Jammu and Kashmir, and they have highlighted the significance of this tribe's use of traditional and ethno medicine (Rashid, 2013., Dangwal *et al*. 2014). However, the unaffordability and pronounced inaccessibility of modern health services and formal institutional care centres have caused a heavy morbidity burden and has rendered patients non-compliant with treatment and follow-ups

The demand for healthcare services among transhumant populations is increasing owing to the spread of various infectious diseases as well as non-communicable diseases. The rearing of livestock by pastoral nomadic communities makes them susceptible to many zoonotic diseases which they often get from their livestock. Besides this, there have been emerging felt needs found among pastoral nomads for the increased response to modern medicines for effective and quick remedy. Therefore the pastoral nomads are being eagerly waiting for the services to be made available to them. Bakkarwals in Jammu and Kashmir are also facing a serious challenge to make use of healthcare services provided by the state. As we know that healthcare services in India are rendered by both private and public service delivery mechanisms, Bakkarwals are also entangled in this. Nomadic bakkarwals in Jammu and Kashmir live at two different locations during the year; therefore their utilisation of healthcare services is also dependant completely on the place they reside in. Bakkarwals healthcare can be looked at in three different ways which are in relation to the place they are residing at:

**Healthcare services during winter location (low laying areas of Jammu Province):** Since bakkarwals are the nomadic group therefore during the winter season they, along with their livestock, reside in the low lying plains and hills of Jammu province. Their transactions with the settled population increases during winters and hence they frequently also access the cities and towns. During the winter time bakkarwals are much closer to the cities and towns and therefore it becomes comparatively easier for them to reach the healthcare institutions. The healthcare of nomadic bakkarwals can be analysed from three major headings;

I. **Acceptability:** It is an indicator that describes how the population responds to the existing healthcare facilities either public or private. The presence of hospitals and healthcare centres in the towns and cities has been providing services to the people with a legal mandate of access to all and everyone. However, what we witness in practical terms is something different. It is often argued that modern healthcare institutions are not preferred by the tribals in India, which I found is not correct about Bakkarwals. The Bakkarwals have no problem with the modern healthcare institutions; rather they do visit these institutions when in an emergency. Acceptability as a dimension of access to health care and is important to be considered for patient-centric healthcare, especially in trans-cultural societies. Bakkarwals face numerous issues when it comes to the question of acceptability of health care services as provided by the state. The bakkarwals have developed mistrust on the ability of the service providers. Bakkarwals see this mistrust as a major impediment towards non utilisation of services whatever is available. The neglect which is been witnessed by bakkarwals aids to this mistrust and thus further widens the gap that exists in the already utilisation sphere. A significant proportion of Bakkarwals talk about the mistreatment, biases, and behaviour of the medical staff towards their community.

Jamal Hussain narrated,

> *When a Bakkarwal comes to the health centre or hospital, staff and doctors treat them differently. Most of the time doctors are reluctant to touch them as they are being considered unhygienic and stinky and are compared with cattle. Sometimes stinky unhygienic and Bakkarwals are considered synonymous to each other.*

II. **Affordability:** The covering of geographical distance amid all other hindrances like non- availability of transport facilities, continuous strikes and seeking permission for travel from security forces and so on are posing a challenge to Bakkarwals like other population for accessing healthcare services.

Mohd Hussian narrated,

> *In 2019 my 26 years old wife heavily pregnant awoke to this momentary silence. Her water had just broken, and she was going into labour. We were putting up near the outskirts of Kokernag area of Anantnag, she got into much pain. Though we waited for it finally we decided to go to the hospital. We somehow got a vehicle after so much trouble and reached to Larnoo hospital. To our misfortune, the doctor there without any proper check referred us to Anantnag maternity hospital. The driver of the vehicle started bargaining with us for an increased fare as he was not ready to take us to Anantnag. To our destitution, we agreed to pay as per his demand. As we started our journey towards Anantnag, just a few kilometers away from Larnoo, we were stopped at a security checkpoint and starting checking identity cards and only allowing two people to go with patients and others to go back. I tried to explain to them [the security personnel] that we had an emergency, and we need more people with us. They did not listen to me at all and finally, others had to get down so we could go ahead. Just at another five kms another security checkup stopped us and again the same questions. I literally begged them to kindly allow us without many hurdles as we are running out of time. Finally, after much struggle, we reached to maternity hospital Anantnag*.

An elderly Bakkarwal narrated,

> *Hospitals are very important; there you get a cure on time and save a life but what to do. We usually don't get to reach the hospital and also we are not able to reach on time.*

III. **Availability**: this is one of the important indicators of the healthcare utilisation by the bakkarwals. The very nature of bakkarwals being mobile makes them hard to reach groups. The hard to reach category as conceptualised by the government policy documents mentions that providing health care services to bakkarwals is a difficult task. The non-availability of services to bakkarwals especially during their stay at summer pastures hinders their access to services. Most of the bakkarwals could not net their health needs owing to non-availability of healthcare service delivery mechanism. While government justifies this with the fact that these groups

are sparsely populated and highly mobile therefore availability of services at each and every location is a tedious task. However bakkarwals argue that government can provide alternate means and ways like mobile health clinics for providing health services to them.

An elderly person narrated,

> *Government has all the means and resources to provide the services to bakkarwals, but it depends only on their will. Earlier government had put mobile schools to teach our kids even in pastures, so they can also provide us healthcare services like that. They can train some people from our community who can be engaged in mobile health clinics.*

### 3.5 Armed Conflict and Transhumance of Bakkarwals:

The persistent political armed conflict in Jammu and Kashmir has been affecting each sphere. This armed conflict popularly known as the Kashmir conflict has shown its impact on all the people living in the Kashmir region. Bakkarwals have also become victims of this armed conflict for the obvious reasons of their movement across Jammu and Kashmir. The spread of militancy and the intrusion of the Indian troops into hilly areas including pastures have put at stake the livelihood of this community. This community is struggling with militancy and Indian troops in their day to day living. The nomadic movement of the community is under severe threat because of the security concerns that these people have to face. Gujjars often found themselves sandwiched between the militants and the security forces and are hit from either side. As described by Suri (2014), 'If they won't listen to the ultras, they were bound to be hit by militants bullets and if they were caught helping the militants, then the security related agencies would not leave them' (p, 6). During the militancy, gujjars and bakkarwals were exploited for food, shelter, and directions across the remote areas. "Militants used them to 'carry their ammunition and equipment for sneaking past the security forces'. 'This exposed the tribal population to further vulnerability and more retaliation of the hands of the militant cadres resulting in many of them abandoning their age-old practice of pastoralism and stopped moving as part of their annual migration for fear of guns"(Suri, 2014. p, 7). Gujjar bakkarwals were killed for various reasons including the allegations that they are working with security related agencies and also for not obeying their diktats. 'Whenever a militant was killed, the finger of suspicion fell on the gujjar family living nearby. They were also killed for participating in the elections against the diktats of the militants or simply for the reason that they formed

Village Defense Committees (VDCs) with the objective to protect them and their families against the terrorists who would swoop upon their villages' (Suri, 2014. p, 8). Apart from this, because of the conflict situation, various pastures used by the Gujjars during their summer migration to the higher reaches were closed down (Suri., & Hooda. 2014). Anita Sharma argues, "It is important to note here that the bakkarwal continued their migrations up and down the Pir Panjals and Himalayas despite the daunting odds imposed by the intensive insurgency of the 1990s and early 2000s, not for no good reason, but most significantly because pastoralism continued to offer them the highest returns to labour. This ability to switch between forms of production and types of division of labour (male-female) allowed them to 'find routes' through this difficult period" (Sharma, A. 2020. p, 54). This ethnic community not only has the threat to their lives but also fear a loss of their livestock. It has been found that Indian troops and militants very often take away the sheep from these people without paying them. Moreover, milk products like ghee are also not left for these people.

Muzaffar Ahmed narrated,

> *We are silent victims of the Kashmir conflict. After this armed insurgency, we are completely at the mercy of the Indian army. Some of our pastures are in their control and they completely restrict our movement. It is on their whims and wishes were to allow us or not. We have to live in subservience to them. They have been also helpful to us. In case of emergencies they do help by providing medicines and arranging things for us.*

As bakkarwals live in the higher pastures above 3000 mtrs and these pastures are also manned by the Indian army for controlling the movement of militants. Thus what we witness is the creation of the hurdles for bakkarwal movement which earlier used to enjoy a lot of freedom. Anita Sharma in her ethnographic account of Warwan valley mentions how only after the eruption of armed struggle in Kashmir the pastures like Warwan valley become battle ground for militants and the Indian army. Before this, the bakkarwals used to have complete freedom. She argues, "During the whole period of the insurgency in Kashmir, the movement of the bakkarwal was drawn directly into opposition to the state and into ways of avoiding, as much as possible, both the state and the militant groups that often occupied areas that intersected with nomadic routes, that is, areas that were difficult for the state's forces to access. We might see valuable inflections of this relationship between the state and the nomads in the fact that, from the very beginning, the Bakkarwal, like other nomadic-type populations, were also viewed by the state for their ability to

access resources found only in difficult and remote terrain. Similarly, the Bakkarwals were seen as useful to the state because of their access to certain medicinal herbs, high altitude routes, and in the past few decades, their acting as guides and spies for the army" (Sharma, A. 2020. p, 62).

Many accounts as revealed by bakkarwals also see the Indian Army as a mechanism of safety for themselves.

As Shahid narrates,

> *People feel safe in the presence of Army. When we are in transhumant movement heavy deployment of security forces ensures a sense of security to us. Army always comes to our rescue. They provide us immediate help whenever we are in need during our transhumant movement and we never hesitate in seeking their help.*

During one of my field trips to Warwan valley in July 2014, I witnessed the role of the Indian army in the pastures. Since July is the month when Amaranth yatra is in its full swing and we were on our trek to Warwan valley after our day-long trek from Inshan to Sukhnoi village, we finally reached the pass where we had to trek for further half an hour for reaching the deras of our hosting bakkarwal family. The unit of Indian army stationed there had put up camp in the meadows to safeguard the pass which was joining Warwan with Panjthirthi on way stop of Amaranth yatra route via Pahalgam. The incharge captain of the unit enquired from us our purpose of visit and offered us breakfast. After breakfast, he denied our trek to the bakkarwal deras stating that they have information about the presence of foreign terrorists in the area so you can not be allowed. "We can't put your life in danger", he said. "If anything happens we will be held responsible so I cannot allow you to go beyond this point", said the young Indian Army officer. Even after our persuasion, nothing moved and I along with my two other fellows had to retract. This kind of interference in the pastures was not there earlier. Bakkarwals now have to report their movement and also notify about the presence of any guests they host. Such restrictions have now altered the very nature of bakkarwals in pastures and have also curtailed their movement in pastures. These restrictions were unknown to bakkarwals and now they have to live with it. It is also important to note here that post the Kargil war of 1999 many pastures around Kargil were completely banned for the bakkarwals. This had severe consequences on many families of bakkarwals who had hereditary grazing rights over those pastures. It is important to remember that bakkarwals have hereditary rights over the grazing ground which they use regularly, therefore if any bakkarwal family loses their

pastures because of armed conflict or any other government intervention; it becomes difficult for them to attain new pastures. Hence pasture rights assume survival significance for bakkarwals. Thus the armed conflict has impacted bakkarwals more in terms of restricting their movement and the loss of pastures. Because of this armed conflict, an environment of suspicion has been created. The trust between the communities has become fragile and now no one trusts each other easily. There has also emerged a certain kind of suspicion between the kashmiri population and the transhumant bakkarwals. Most of the kashmiris have the opinion that bakkarwals are spies of the Indian Army and that they have assisted in the killing of many militants. The common belief among kashmiris is that bakkarwals are informers (mukhbir). This notion that has developed has led to the worsening of informal relations between bakkarwals and kashmiris.

Talib Hussain argues,

> *We are caught between the Army and Militants. We are extremely vulnerable to both. We live in such a precarious situation that a single mistake would be too costly for us. Kashmiris see us as informers and others see us as shelter and food providers for militants. We have to stay cautious as we are not in a position to take sides. Our vulnerability is being played by every group in Jammu and Kashmir. However, for gratifying our needs at times we do depend on the Indian army. When the government leaves us at our mercy, we have to look for our own means. Therefore our cordial relations with the Indian army serve us our purpose of getting much-needed medical care in pastures. Our precarious lives are becoming tough with each day owing to the negligence of the state.*

Many Bakkarwals believe that armed conflict has been a big contributing factor in pushing them towards sedentarisation. After the emergence of armed conflict and amid this threat of existence, there has been a change in the livelihood patterns of these people. Many bakkarwal families have either reduced the size of the flock and have entered into labour market. We must remember that there is a class dimension to this changing pattern of livelihood. Literature reveals that rich bakkarwals are now hiring the poor ones for rearing their sheep and goats and themselves have got settled in the towns and low lying plains. Aparna Rao in her paper "From Bondsmen to Middlemen, Hired Shepherds and Pastoral Politics" (Rao, 1995) has shown that most of the wealthy gujjar and bakkarwals take people from poor families and make them bonded shepherds known as Ajadi. Rao argues that this change has happened only after the eruption of armed struggle in the state of Jammu and Kashmir. This change has arisen out of fear as was propagated by the Indian

Army and militants present in the upper reaches of the Himalayas which happen to be the pastures of this community.

Muzaffar Ahmad narrates,

> *Ten years before we used to have around 1000 sheep and goats, but now it has come down to 300. My two younger brothers no more come with us and they are doing labour work in Kashmir. They work with a contractor in Kashmir. They are no more in this occupation, so we have been forced to reduce the size of our flock. Many Bakkarwal families have reduced their flock size owing to significant changes taking place continuously. Many Bakkarwals now mostly rear the goats and sheep of very rich families. Thus the change in ownership of this flock is seen as a disturbing trend and it is mostly families who cannot afford to be part of any other occupation that they have to continue with the Ajadi system.*

The persisting armed conflict and the hostile relations between India and Pakistan makes the borders more volatile. The mobility patterns of bakkarwals have seriously been disturbed by the kashmir dispute as the bakkarwal pastures are mostly situated at the line of actual control i.e. boundary between India and pakistan administered kashmir. The volatility of the border creates a major challenge for bakkarwals who raise their flock around border areas of kupwara, rajouri, and poonch.

> *The intermittent firings along borders and the heavy deployment of the forces along the borders has direct impact on us. We are not allowed to raise our flock and have movement near the border pastures. Besides this, the increasing landmines that have been put in place in the border areas have also become a troubling factor for us. We are facing many difficulties when borders become tense. The peaceful times are a pleasure for us. Peaceful times bring joy to us as we could see the hope of living without fear* (FGD, Rajouri, 2021)

The central government, after the revocation of article 370, put out a narrative that tribal communities only stood to benefit from the new scenario with the implementation of the Forest Rights Act, reservations in promotions, and so on. However, the revocation of special constitutional status failed to provide a solution to eliminating corruption, eradicate the armed insurgency, and empower the marginalized sections. Tribal communities of Jammu and Kashmir expected the situation to change with new change but to their dismay, they are yet to see the fulfilment of the rights granted by the Forest Rights Act or benefit from the reservation in promotion. Though article 370 didn't directly contribute to the welfare of the transhumance of Jammu and Kashmir, it still generated a certain fear of competing with more people from the outside state in education, employment, and other job opportunities which will probably lead to further marginalization.

Guftar Choudhary the prominent social and political activist argues,

> *The narrative that is being floated that Gujjars and Bakkarwals are happy with the abrogation of Article 370 is flawed and full of vested interests. This is purposively being crafted to create a wedge between people in Kashmir and other places who are protesting against the abrogation and Gujjars and Bakkarwals. The Article 370 is as important to us as it is for many other people including Kashmiris. Nothing has stopped the government for doing things and implementing laws in Jammu and Kashmir. Many laws and policies were implemented in quick span and without any changes as and when desired by the government. For example the recently GST was implemented in J&K in a quick span. Therefore the argument that Article 370 was an impediment for implementing laws concerning to tribal communities is a blatant lie. We must understand that it is simply a façade to show that tribals of J&K are happy with this change but in reality this is not true. Tribals are as much in need of article 370 as others, it is our identity and we do want to preserve and uphold it.*

The aftermath of the revocation of article 370 and the complete communication blackout in the valley had added to the miseries of bakkarwals. Post the abrogation of article 370 the precarious lives of bakkarwals became more vulnerable. The issues of affordability indeed became a serious concern pertaining to the closing down of markets during curfews and politically volatile and sensitive times in the area, leading to perturbed treatment for patients.

Haroon narrates,

> *After the revocation of Article 370, even to visit private providers became difficult. My brother who because of medical emergency had to be taken to a hospital as stroke has struck him, his condition deteriorated after a long tiring travel, we managed to get into a private hospital which charged hefty price for treatment, to the surprise even consultation fee was three times more than what is their during normal days.*

The journey, stay, and reaching to health centres in the volatile times induced by the state machinery after the revocation of article 370 proved damaging to the life of bakkarwals, especially those who are suffering from severe ailments as they had regular need for medicines and more so they had to do regular follow ups in their treatment.

### 3.6 Locating Bakkarwals in Settled Lifestyle:

It is worthwhile to mention that the bias in terms of designing policies from the perspective of settlers' is indeed rendering difficulties to nomadic lifestyle like that of bakkarwals. The modern nation-states hardly bring in their priority the nomadic lifestyle. Thus institutions providing health and education are designed with the idea of the settled population's needs. What we witness is the dismal indicators of health when it comes to

bakkarwals. The very notion that has been built in and carried across all institutions of modern states is that the nomadic lifestyle is rudimentary and uncivilized. This understanding has crept deep in our society and hence influences the behaviour and attitude of people working in many state institutions. Health institutions have also not remained aloof from this bias. Human resources working in health institutions particularly doctors and paramedical staff usually consider nomadic populations as illiterate and rude. They hardly respond to the people of this community ethically. This has led to the development of distrust among the service users from this community. Bakkarwals do not lay their faith in the health institutions owing to the maltreatment they receive at the hands of doctors.

Jamal Hussain one of the older Bakkarwal narrated,

> *These people (doctors) think we are filthy and they often tell us that we stink. They don't check us properly. They believe we are illiterate and we only know how to tender the animals. Everyone doctor wants to see us from a distance as we are considered uncivilised and unhygienic.*

Such a kind of social discrimination in institutions is a common ordeal of bakkarwals whether in Jammu or Kashmir province. Their social discrimination does not go away with the place they reside however its form may change. Bakkarwals while in Kashmir province also face social discrimination whenever they access the institutions. It is a common adage in kashmir that "*A bear is more faithful than Gujjar or Bakkarwal*". In everyday conversations of people in kashmir and jammu, Bakkarwals are perceived as unreliable and dirty. Such notions run too deep in a common understanding of the dominant group ethnic kashmiris and dogras. This understanding indeed determines the very nature of interactions of bakkarwals with others. While in kashmir province their only advantage is that they belong to the muslim faith and to which the kashmiri population responds very nicely. However, in Jammu, their affiliation because of language increases, and their communication becomes easier and pronounced. However, their muslim identity makes them vulnerable due to the building up of communal polarisation overs the years, supported endlessly by the political groups. The infamous kathua rape and murder incident is an apt example to understand the dynamics of a relationship that exists between nomadic bakkarwals in their winter pastures and the local settled population. Before the kathua case, the Amarnath land row[3] in 2008 also evoked a communal response across the then

[3] *Amarnath land row is basically a wide spread agitation which was started in 2008 against the decision of congress led government in J&K state to transfer land to Amarnath shrine board. This agitation become communally charged leading to widespread protest and communal clashes across J&K with the fall of the*

state of Jammu and Kashmir. However, unfortunately, every time the bakkarwals have to face the brunt of this communal polarisation. During the Amarnath land row, many bakkarwal deras were targeted in kathua and samba, their hutments burnt down though fortunately, no riot or killings took place. It is imperative to mention that bakkarwals are targeted as an immediate reaction to everything that happens in kashmir province. As bakkarwals are a kind of connecting link between hindu dominated Jammu province and muslim dominated kashmir province, their identity runs in fluidity. In two districts of Rajouri and Poonch where gujjars and bakkarwals are in majority there exists an interesting dimension. Bakkarwals can assert themselves in these two districts. It is in these two districts that they find it much convenient to access institutions of the state as they find a representation of people from their community. This representation gives them a sense of confidence that they will not be humiliated nor abused which in reality turns out to be true. At all other places, bakkarwals find it extremely difficult to access the hospitals for the fact that there is a negligible representation of these people in the institutions. An interesting example of the only full-fledged university BGSBU in Rajouri is a case in itself. While having a conversation with one of the faculty members at university who had shifted from another university in Jammu to BGSBU, he narrated,

> *The reason I shifted is simply not because I belong to Rajouri but it is more than that. While I was in Jammu, it was tough for me to assert myself. I was all time mere a workhorse without any say in the matters and affairs of the department. This is simply because my voice was not significant at all, neither was I required to be asked for any opinion. If at all I would raise my voice the consequences of it would be severe. Here I can express my identity without any humiliation or fear. A gujjar here is respected and there it was a curse, an uncivilized illiterate border dwelling entity.*

The change of livelihood pattern among this community can also be seen in terms of the bakkarwal community members working in various occupations. Many of them are now working as labourers in agricultural sector, horticulture sector and some work as casual workers in cement factories, construction sites, and so on. This change is a kind of enforced on them due to the armed conflict and also due to indifferent approach of the state. The pastures at the upper reaches of the Himalayas have become an abode for both militants as well as Indian forces. In this constant danger of life, this community has stopped going to these upper reaches along with their herd. However, those people who

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*government.https://www.hindustantimes.com/india/amarnath-land-row-chronology/story-4DHZ4IrR2TvqcdlzLmbm3H.html*

could not find any other means for their sustenance are still using the same pastures and have complained of harassment from all the stakeholders. Indian army forces these people to become informers and militants label them to be acting as informers. Thus in this dilemma, these people are suffering a lot. Since this community has been socially marginalized and economically backward, lots of other problems still haunt them. They are still far from dreaming of modern education and health facilities. However the government has always played politics in the name of welfare for these people. Most of the scholarship argues that giving tribal status by the Indian government to this community in 1991 was a political move rather than a welfare measure. It is being argued that since the emergence of a sponsored militant movement in 1989 and its gaining of indigenous community support alarmed the Indian state. Thus a kind of divisive politics in the name of welfare was played out by the state. Hence the gujjar and bakkarwal community was provided with tribal status. It was propounded that tribal status to these people will lead to general welfare and development. The influx of money in the name of tribal sub-plans was either grabbed by the leaders of this community which happen to be part of the larger political elite of the Jammu and Kashmir. With some mere opening of gujjar and bakkarwal hostels, larger conditions for these people remained the same. However, Sarva Shiksha Abhiyan had to some extent helped in providing primary education to the children of these people by reviving defunct mobile schools. The effect of these schools needs to be ascertained. The National Conference (political party in Jammu and Kashmir, which ruled Jammu and Kashmir for a long period) has always made political gains out of the welfare policy. Since Sheikh Abdullah's wife happened to be from the gujjar community, that card has always been played out by the National Conference (Rao, 1999). One can see nothing substantial has been done for the welfare of this community. Bakkarwals is still downtrodden and has not been able to serve their cause with the policy of reservation. They have remained out of the purview of these constitutional safeguards. They remain oppressed and backward socially, politically, economically, and educationally. As a result, voices are being raised that mere provision of Scheduled Tribe status and the present benefits out of it are not sufficient. Therefore, the demand for political reservations is being made to improve their condition. According to the constitution of India provisions concerning the Scheduled Tribes, they are entitled to the reservation in jobs and other welfare benefits. Gujjars are now asking for political reservation for getting due seats in the legislative assembly as is proportionate to their population, though abrogation of article 370 promised the same, and

expectations are high in the community. However it is only the test of time to see whether the results will be there.

The marginalization further aggravated the eruption of armed struggle in Jammu and Kashmir because of the destruction of infrastructure and the weakening of welfare services. Gujjars and bakkarwals have been the active supporters of the resistance movements though hardly recognized by the popular kashmiri resistance leaders. The fact of the matter is that even Hurriyat[4] amalgamation has not been able to recognize them in their larger framework of resistance. However, history is witness to the fact that early in 1992, the Gujjar Liberation Tigers was formed (Asia watch, 1996). Thus what one can see is that bakkarwals has suffered like other communities when it comes to armed conflict. However this conflict has made bakkarwals particularly nomadic ones vulnerable to exploitation more by pushing to labour market in cities and towns.

[10]*Hurriyat is an association of various separatist /pro-freedom parties that exist in the summer capital of J&K.*

# Chapter 4
# Walking with Bakkarwals: Transhumance

## 4.1 Introduction

Transhumance is an essential feature of Bakkarwal existence. The seasonal migration between pastures is a prerequisite for the survival of Bakkarwals and their animals. Bakkarwals spend a good amount of time on the practice of transhumance. It usually consumes two to three months for Bakkarwals during a year on their transhumant movement from winter to summer pastures and back. There are designated routes which Bakkarwals use for their migration along with livestock. It is very often understood that Bakkarwals practice transhumance for the very necessity of providing food and a liveable environment to their livestock. Bakkarwals migrate along with their livestock comprising mostly goat, sheep, and horses from Jammu province to hilly areas of Jammu, Kashmir, and Ladakh province. This transhumant movement of Bakkarwals usually takes place on foot and some even use modern transport to carry their livestock. This year the department of Tribal Affairs, Government of J&K, has also initiated the process of providing transport facilities for carrying the livestock of Bakkarwals from Jammu to Kashmir by hiring trucks[1]. The movement is undertaken along the designated routes traversed by the respective kafilas of Bakkarwals seasonally. The routes pass through towns and finally reach pasture highlands. During transhumant movement Bakkarwals communicate and interact with settled populations along the routes they traverse. The exchange of communication between Bakkarwals and settlers during travelling involves business transactions whereby many meat traders of local towns in kashmir enter into negotiations for buying livestock. The negotiations keep continuing while traveling and sometimes it may go for a travel of more than three kilometres. It is important to mention here that the transhumant movement of Bakkarwals is most difficult part of their lifestyle. It is during transhumance that they have to be vigilant and cautious about their livestock. Very often Bakkarwal kafilas during their transhumant movement face natures as well as human wrath. The weather sometimes plays foul and wreaks havoc in terms of torrential rains thereby taking a heavy toll on their livestock. Many stories have come out where Bakkarwals lost their livestock due to sudden snowfall in pirpanjal region during their

[1] https://indianexpress.com/article/cities/jammu/jammu-and-kashmir-provides-load-carriers-for-transportation-of-nomads

journey towards Kashmir from Jammu and at times while coming back. This chapter describes transhumant journey of Bakkarwals from Jammu to the warwan valley via kashmir. The ethnographic exploration of transhumant movement of Bakkarwals has been captured in this chapter. The exploration has been described from the start of the walk till reaching to the designated pastures of warwan valley.

### 4.2 The Field

Field is a primary unit of analysis in ethnography. The engagement with the field is not only in terms of being physically present in a geographical area but more to be in fluidity with the field. The field essentially becomes more a method of study, to which people and locations stand interconnected. It is important to mention that ethnography does not aim at creating a "holistic knowledge" of a foreign culture rather it emphasizes on building a contextual understanding about people in a given locations and their engagements. The field indeed is an amalgamation of various sites, processes and relations which may be physically distant from each other but linked in many ways and through different scales and intensity. Therefore field has to be seen beyond territorial demarcations involving dynamic elements through active engagement, process, and complexities. Engaging with Bakkarwals during their transhumant movement is no less than a thrilling experience. Following the Bakkarwal deras all through their journey from Jammu to the warwan valley provided insight into numerous struggles, challenges, and opportunities that become part of lived experience. The field is amazing for the fact it changes with each inch covered by the kafila of Bakkarwals as they move. Thus to become part of a field which is so dynamic and fluid is itself a challenge for a researcher. Traversing along the roads with heavy vehicular traffic, surpassing busy markets, and finally crossing hilly terrain to reach lush green pastures are everyday events that the field throws up during transhumance. Bakkarwals begin their journey from winter abode around middle of April; Baisakh. For Bakkarwals, to move is not an ordinary physical ritual but a process entailing their very existential essence. Mobility is the feature of their lifestyle. Therefore to be mobile is to be a nomad; any hindrance to movement is seen as move challenging their very existence as a living entity. Therefore mobility of Bakkarwals is significant and needs to be experienced, visualised and performed to witness what life of a nomad means in current times.

### 4.3 Entering the Travelling Journey (Transhumance): A Thrilling Experience

During the initial days of the research work, gathering information about Bakkarwals from every source was a routine task. Out of this endeavour the idea of walking with Bakkarwals through their transhumance movement emerged. For this idea to materialise, began the search as how to, when to and where to get entry into the kafila of Bakkarwals. Bakkarwals as a community is close knit and it is not easy for an outsider to become part of their journey unless one has had established rapport. Moreover travelling with them requires an already well built rapport and communication with the deras. With the change in weather at winter pastures in Jammu, Bakkarwals begin their preparations for their movement towards the Warwan valley. They began to prepare themselves for the journey a week before actual start. Fortunately one of my close friends Talib Hussian, a well-known Bakkarwal activist introduced me to one of his relative's family who lived at surinsar, Jammu. Though earlier I had stayed on various occasions in the tents with the family of Talib Hussain at chewda, mansard, Udhampur. These short stays had already accustomed me to some of the intricacies of nomadic bakkarwal life. However travelling with Bakkarwals was indeed a different experience to be witnessed. Finally family agreed to host me along with them for a wonderful journey to warwan valley. It was the second week of April when the deras began their journey from surinsar. I reached overnight to the place and stayed with them so as we could together begin the journey early morning next day. Witnessing closing of dera (household) and packaging of the stuff for first time was a learning experience. The expertise of female members to pack stuff with great speed and efficiency was indeed thrilling. The women were more experiential and active in the packaging of the stuff and managing the children. This activeness indeed questioned gender norms that entrenched my mind but that in no way took away the fact that bakkarwal families are of course highly patriarchal. The whole stuff including cooking utensils, beddings and other essentials got packed and loaded on the specific horses. The kafila[2] comprising of 10 deras began to travel along their designated route of dhar road towards National Highway (NH44). Staying with them in the tents was different and unusual experience. After having dinner in which the dal and rice was served in commonly used aluminium utensils (khurasan bartan), it was now the time to go for sleep. The Bakkarwals go for early sleep as they also have to wake up early in the morning. Adjacent to the tents a bit down I went for urination along with few elder members of the dera. The

[2] *The kafila comprise deras, who share a common lineage*

open defecation is the only source of responding to natures call for the Bakkarwals during their transhumant movement as well during their stay in upper pastures. Thereafter the bedding was laid on the ground inside the tent and four of us got inside the tent for sleeping. The barking of the ferocious bakkarwal dog was intermittently going on and irritating for me. Sleeping in the tents reminded me of our trekking expeditions which we used to take sometimes to cherish the vacation period in kashmir. The purpose of both these experiences indeed is different. Staying in tents with Bakkarwals was a lifestyle and as a trekker it is a luxury to enjoy nature. Dog a specific breed known as 'Bakkarwali Dog' is a precious animal who keeps on guarding the tents and the livestock throughout the night by making regular rounds circumferencing territory comprising the livestock and the Bakkarwals. Bakkarwals are used to the regular barking of their dogs and are also quite well versed to immediately notice any danger which is signalled by the dogs by way of barking. However, I could not get proper sleep due to the sound of the barking dogs. Somehow the night surpassed and the early morning rise began. As usual the bakkarwal women and men got up early and just after washing their faces in the open, the morning salted tea (nun chai) was prepared and served and thus beginning of new day started.

The movement of Bakkarwals takes places in groups knows as kafila for the purpose of safety and strength. Moreover during the movement it becomes essentially important to have more people to manage the herds along the route and during the transition. It would usually take more than a month for a kafila to reach to their pastures. Therefore it requires a proper planning to start the journey. It is important to remember that travelling phase is very crucial for bakkarwals. Every dera has to do effective packaging of their stuff along with carrying essentials required throughout the journey. The Bakkarwals do the packaging of their respective deras. A very unique and effective packaging system for Bakkarwals is the use of chatts (it is a saddle used for holding all utilities while are then put on the horseback). Most of the stuff is laden on the horses back during the travelling. In conversation with one of the elder members of the travelling Bakkarwal kafila Jamal Hussain narrated,

> *Suppose we have to start moving in the morning. You see we have all the stuff packed. If there are horses, then put the Zeen on horses, then Kaathi, then Chatt. Our tents, all foodstuff everything we carry with us. So wind up from here and move to next location*

Bakkarwals, during their transhumance, prefer moving along rather than staying at one place. 'Dera torna' is basically the terminology that Bakkarwals use while they are in the

transhumant journey. Dera torn includes the start of the Journey, then transitions and till reaching to the pastures. Therefore dera torna is a very significant phenomenon in the life of bakkarwals. Bakkarwals follow the fixed routes for their transhumance which is customarily recognised by the governmental both at state level and local ones. Transhumance along the customarily recognised routes ensures free passage to nomadic bakkarwals and ensures also these routes are protected unless diverted by the state for its own purpose. These routes allow the transit and access to resources and also aid in smooth transhumant movement. While on the move, women become an essential part of the movement, on whose back rests smooth movement of the deras.

Fatima, the only vocal female respondent said,

> *Our men are mostly with the livestock, Elderly men and all women have the responsibility to be with the horses. Besides this the women also have to do all other work of packaging the stuff, preparing the chatt which then needs to be put on the horses. Women usually have to do most of the work like cooking the food also and men just eat that. we know where we have to halt , so as and when our herds reach to that location the men along with herds rest there. Till the whole dera reaches to the halting place men just manage the herd. Soon after halting women unpack some stuff, start cooking so as the men can be served the meal or tea. The men don't care anything about except for the herds. Everything else be it horses, cows has to be managed by the women. Even if we are exhausted during the journey, we have no respite but to starting cooking and prepare meals for everyone. Next morning we have again to close all the belongings, pack them in same and follow the routine travelling. Packaging the stuff and managing all this during travelling is a skillfull task. It needs a careful management and adequate utilisation of space. What to pack first, how to pack things all needs to be done carefully. See it has to put in the chatt which is to be laden on the horses. So it has to be comfortable for our horses also else their life is in danger. During journey if utensils make too much sound on the horses back, they may get scared and get scared and canter off. Maintaining proper balance is also essential and must while doing the packaging. So you see this all is so aptly done by us without any major support from our men. We also have to manage our kids during travelling. Most of the times we keep our small kids on the back of horses and then hold the horses noose in our hands. This all is to done to ensure safety of the children while riding on the horses. Travelling even after all these measures and carefulness can sometimes be ill fated for us. If horses get scared because of vehicle or due to some other reasons they run fast, thereby leading to risk of the child who is on the horses back. We have to do all our tasks with extra care and precision. Women are more skillfull and apt for managing the travelling than our men. By our sheer experience we are able to know how to balance the weight on horses, how to ride our children on them and also how to manage the horses even during travelling. Rest is all upto Rub (Allah), who is the protector of ours*

**Image 1:** Bakkarwals halting for a stay during transhumance (Pic Credits: Bhat Iqball Majeed)

### 4.4 Traversing the Routes

The transhumant journey is indeed most challenging aspect of the bakkarwals. The timing of journey is determined by various factors which are mostly not under control of the bakkarwals. Availability of forage and the weather itself is precursor for the travelling to begin. It is with the coming of April month most bakkarwals begin the preparation for travelling. By the middle of April most of the bakkarwals would have already started their journey towards summer pastures. All the members of the dera walk with their livestock except for some elderly person. Even children most of the times accompany their families during walking. The stuff is loaded on the horses and all other members have to follow the livestock along the designated routes. It takes no less than month and a half or more to reach along with livestock to the pastures. Only those nomadic bakkarwals reach too early in few days who take their livestock in trucks. Usually a bakkarwal kafila would cover around 15 kms in any given day. The dera knows the spots where to halts which depends on factors like availability of water, grazing option for animals, safe from any threats and so on. If there any unfavourable weather conditions the kafila takes a break from travelling and continues to stay back.

The bakkarwal kafila took their journey through the designated route from Jammu, Udhampur, Ramban, Banihal, Jawahar Tunnel, Doru, Kokernag, Daksum, Margan top and Warwan. The journey started with the preparation of their all stuff loaded on the horses back and thereby moving ahead. The journey is discontinued during the night time by

halting at a designated place. The role of women becomes very crucial throughout the journey. Whenever halting taking place, women have the responsibility to unpack the stuff and also start cooking meals for the members. It does not matter how tired the women are, the role of cooking and feeding has to be fulfilled and it is never to be done by the men of the community. The male members including young children boys and girls take care of the livestock. Travelling along the routes is the most difficult phase of the bakkarwals migration. Travelling is both dependent on the nature as well as human elements. Many a times if weather plays foul it can create a lot of trouble for bakkarwals. There have been numerous incidents where bad weather has created huge destruction during the transhumant movement. In one of the incidents reported in local newspapers a family of bakkarwals lost around 50 of their livestock to the bad weather and torrential rains during their movement along the infamous mughal road.

One of the respondents narrated,

> *It gets tough for us if it rains more, sometimes even snowfall can happen. For the routes, we traverse there is no arrangement for us. Two years before my brother lost 10 goats as a cloud burst struck them. We incur too much loss as we couldn't do anything at that time. We survive only on the mercy of the almighty. Bad weather is most horrible thing we are afraid of. We do carry safeguards with us but sometimes it either rains too much or even it may snow then we are absolutely helpless. Mostly those portions of our routes which are uninhabited are the risky ones if weather plays foul. It is getting more difficult with each year to deal with the bad weather as our routes are also shrinking in terms of the space and there are now no barren land were we could stay for couple of days before the weather improves. We are always in hurry to reach the pastures as soon as possible so as all hurdles that we have to face from authorities, local people are overcome.*

Besides this, during their travel through the national highway connecting Jammu with Kashmir, bakkarwals face various problems. Since they travel in daytime only, therefore, they have to manage their herds along the highways very carefully. The rush of vehicles running through these highways poses risk for bakkarwals. Apart from this as they travel through highways the traffic jam becomes inevitable and which further increases their vulnerability. Very often bakkarwals themselves and their animals fall prey to accidents along the national highways.

One of the respondents narrated,

> *Travelling on the national highway is getting difficult for us. We have to remain vigilant throughout the travel on highways. The vehicles are in hurry and they continuously buzz the horn on our kafila. Sometimes our livestock also gets irritated and run amok. Moreover people don't understand that like them we*

*also need to travel on these highways. And they know it very well that we travel on specific time period but still they couldn't digest our travelling along these highways. We only travel twice a year on these roads. Still, these people abuse and create problems for us. We get exhausted while traveling on this highway. We have to be vigilant for our animals. If we do not stay vigilant the drivers will kill us. Sometimes we have to even fight with the drivers as they literally become impatient. Thankfully administration at times comes to our rescue and paves the way for us to get our livestock through tunnels and narrow areas of the highway.*

***Image 2:*** *Bakkarwals walking along the NH44 during their transhumant Journey (Pic Credits: Bhat Iqball Majeed)*

Transhumant movement poses a tremendous challenge before Bakkarwals. This challenge is increasing due to the massive construction of highways, an increase in traffic movement, and more so due to the closure of various routes earlier used by bakkarwals. Erecting of enclosures in the name of protection of forest area has induced newer problems for the bakkarwals. These enclosures have restricted travel of bakkarwals and have forced them to use local roads and national highways for their transhumance. Furthermore, the unabated so-called developmental projects for the construction of railways, highways between Jammu and Kashmir provinces have aggravated vulnerability of the bakkarwals. The persisting landslides and heavy rush of traffic have forced them to make their movement continuous thereby making them more exhausted and tired. It is also important to mention that the state completely lacks any policy concerning nomadic population and thus no significant approach is seen for facilitating their movement and decreasing their vulnerability.

One of the known political and social activists Talib Hussain narrated,

> *Governments only use Gujjars and Bakkarwals as vote bank. Everything is only on paper for these people. In reality, no one has affection for Bakkarwals. If we Bakkarwals could have got united then something might have changed else it will be like this only. All these welfare boards are of no use and just a publicity stunt.*

Since Gujjars and Bakkarwals constitute around 73 per cent of the total tribal population of Jammu, Kashmir, and Ladakh, and Bakkarwal population is not more than 10 per cent of the total tribal population in J&K. The erstwhile state of J&K now Union Territory hardly has given any thought towards the nomadic population like bakkarwals. Except for mobile schools which are almost defunct now, we hardly see any major policy intervention for the welfare of bakkarwals. Mobile schools which once were considered as an innovative approach to let education reach doorsteps of nomadic populations have not brought any desired result owing to the government's apathy and faulty implementation. In terms of health scenario of Jammu and Kashmir, nomads like bakkarwals are at receiving end. The health institutions are not responding to the felt needs of bakkarwals. As we know these people are living in hilly areas and pastures with geographical remoteness, so making them hard to reach groups. The state health department has not made any concrete effort for reaching out to bakkarwals. This indifferent attitude of health department very often pushes these people to seek health services either at local pharmacist's door steps or quacks. During the fieldwork in the warwan one of the people who has been providing healthcare services to the bakkarwals in the pastures had erected tent housing medicines. During the interaction with the person, he narrated,

> *Every summer I come here and put up my tents for providing the services to the Bakkarwals and other travellers. I myself basically reside in the kokernag area of Anantnag district. Bakkarwals are now known to me and we share a good rapport. I have been providing my services to Bakkarwals from 12 years. I come in the month of June and stay here till late August. Thankfully I am making my living and also providing help and relief to the Bakkarwals. I usually keep the essential medicines mostly treating common ailments like cough, fever, body and joints pain, diarrhoea, stomach ache so on. The Bakkarwals mostly come to me for problems related to the pain in the body, headache, stomach ache and tooth pain. In severe cases and in dire need I suggest them to visit the hospital. Many of the cases I have suggested to go to major health institutions like SKIIMS Soura or GMC Srinagar. After every 15 days I get the stock of medicines from kokernag. I am a science graduate and have been running a medical shop at kokernag from last two decades.*

These quacks are operating their medical services in various pastures across the valley. During my personal trekking expedition in the district kulgam to the pastures of

‘Zachimarg’, I have come across such quacks that are providing medicines mostly to the bakkarwals and also to local kashmiri shepherds (known as phool) in the pastures. This is pertinent to mention that bakkarwals and local shepherds do take services of these people because of unavailability of any other nearby service. The bakkarwals are happy with the services being rendered by these people. They visit them for taking injections during emergencies and these people respond them quickly. Bakkarwals have lot of trust on these people as they are always available for them. Moreover bakkarwals out of their constructed notion based on their lived experience believe that doctors in public health centres do not have a liability of the cure. Bakkarwals generally see doctors in public health centres as ones who do not have concern for the cure what they are given. The private players, local pharmacists and quacks have an engagement which ensures the liability and they build a wonderful rapport with the nomads. This building of rapport also ensures continuous engagement of bakkarwals with local pharmacists for gratification of their health needs. Bakkarwals generally consider the local pharmacist as a doctor, for them anyone who prescribes the medicine is to be understood as a doctor. However this is no way means that bakkarwals do not have idea of who actually the doctor is. But their lived experience augments the fact that they are usually attended and get cured by the local pharmacists. What is important to understand is that local pharmacists or medical practitioners or even quacks engage with the bakkarwals in a dignified manner. This is what Jan breman also writes, “qualified allopathic doctors generally adopt a haughty attitude towards their patients, diagnosing and prescribing without debate. Quacks are different; they are more interactive with their patients, debating the problem and negotiating the treatment. They sell their medications, making them seem efficacious and they may even bargain. This makes them more approachable for people such as the Gujjars” (Cited in David Hardiman, 2007. p, 1407).

There have been numerous incidents of bakkarwals losing their lives due to inaccessible health services or due to indifferent attitude of health institutions. Thus, for various reasons, the nomads prefer the traditional system of medicine. Access to healthcare is a tremendous challenge that bakkarwals encounter during the transhumant movement. Even after accessing the healthcare service, being able to utilise that during transhumance is itself a tough task. For example if any member of the dera falls ill during the journey, taking him to hospital for treatment without letting the dera to halt is a major concern. Very often it is only two or three members who can accompany the ill person to the

hospital and be with him or her while others continue the journey. The journey cannot wait for anyone; it has to proceed even at times when there is birth or death of any member. It is interesting fact to know that bakkarwals during their journey bury their dead member along the route they are travelling.

One of the respondents narrated,

> *We don't like going to the hospital. Doctors don't check us properly and we also have to get medicine from outside only. They make us sit far off and then start writing a prescription from there only. They don't even check our pulse. We don't like this at all. These people consider us filthy. We go to the doctor outside in the market; he gives effective medicine and also checks immediately. We feel humiliated in hospital and we go to the hospital in extreme need only.*

The health of animals and humans becomes most important concern of these people during movement and all through their life. Animals are extremely dearer to bakkarwals; they are attached to their animals. They are tender to their livestock with much responsibility and also render extreme love, care and affection towards their animals. However during their transhumant journey they have to take extra care and have to be cautious for ensuring smooth journey including the safety of their animals. What has often been witnessed is that during transhumant movement bakkarwals would often get tired and complain of aching body and fever. For these ailments, they make use of their traditional herbs and preparations but also immediately rush to the nearby pharmacist who gives them over counter drugs mostly comprising pain killers' paracetamol/diclofenac tablets for immediate relief. These pharmacists have got an experiential understanding of what is to be given to any bakkarwal approaching them during their transhumant movement. The local pharmacists over the years now know it well what are the common complaints that bakkarwals come up with during their movement.

One of the local pharmacists during transhumance at Kokernag said,

> *These people (Bakkarwals) come to me while during their movement both when they are coming and also at the time of leaving towards Jammu. I know they need paracetamol or diclofenac as they are mostly tired with aching head and body. They very often have complaints of increased blood pressure also. Over the years I have come across numerous Bakkarwals whom I have found suffering mostly from gastric problems, decaying tooth and anaemia. I very well now know what they want. I give them over counter drugs for usually two to three months and they are highly satisfied with it. They trust us more than hospitals here.*

The local registered pharmacist often gives them the dose of pain relieving tablets which they keep using whenever they have any kind of ache in the body. The pharmacist without listening much to them quickly starts getting out the medicines and charges money from bakkarwals. Generally bakkarwals do not visit the hospitals during their transhumant movement rather they prefer to consult the roadside pharmacist who so ever it may be, owing to indifferent approach of hospitals towards bakkarwals. Even at times it is the bakkarwals who themselves go to roadside medical shop/drug store and would ask for tablets. The bakkarwals will keep these tablets in their pockets and then consume them as and when they feel tiredness or aching in the body. During the transhumant movement I had even suggested one of kafila member who were suffering from fever and ache, to visit the hospital which was nearby instead of pharmacist, but he could not get convinced. Even after my insistence he refused and the kafila head Jamal said,

> *Oh sahib, we don't have that much time, they will make us wait and then we will have to go here and there to see the doctor and finally get medicines again from the pharmacy outside. They don't even check us people properly, as we are not Kashmiris. They always look down upon us. For them we are unclean, illiterate and miserable people. We don't go to the hospital often until it is too much required. The doctor does not listen to what we are saying and always curse us for everything. The doctors are very egoistic people; they don't see us worth to be treated. They always think we are dirt filled people and carry disease.*

***Image 3****:Bakkarwals along with their livestock passing through villages in Anantnag, Kashmir (Pic Credits: Bhat Iqball Majeed)*

Finally crossing the last habitation of Larnoo block, bakkarwals felt at ease. This was the time when bakkarwals started moving with calmness free from all the anxieties. Leaving behind the settle population and approaching the uninhabited regions removes the anxiousness of bakkarwals. The bakkarwals now were moving all along with their herds without any fear of traffic or the administrative hassles or of the local habitations. This phase of their movement is the most relaxing one. Neither the hustle bustle of towns nor the encounters with local populace is there. It is only bakkarwals, their herds and the serene nature. They began telling me this is the abode to which bakkarwals belong. We feel it belongs to us and we belong to this place**.**

As I have argued **(**Majeed, B, I. 2020) in my paper, "We belong to nature and nature belongs to us: Ensuring transhumance during the Covid-19 pandemic", "Poets compose pastoral elegies in poetic form to represent the sad events and pain of pastoral life. I present this story as a sort of a pastoral elegy to illustrate how hope is generated through group work. I reiterate Jamal Husain's words: "After all, we belong to nature, and nature belongs to us."(p, 8). Reaching to the final destination of warwan pasture indeed is worth living for the bakkarwals. The serene nature, lush green pastures, freedom filled surroundings, cool breeze and the sound of running waters streams make pastures a wonder in itself. Bakkarwal kafila immediately settle down to their place and things were put into their place and thus ended the transhumant journey. The joy to reach to the destination narrated by Jamal Hussain as follows

> *See, who will not miss these pastures. We are waiting for all these months for sight of these pastures. We and our herds cannot live without them. They offer us what no governments, no cities, no place on earth can offer us. We want to be at peace in these pastures without ever been controlled, put under surveillance or bounded by anyone. This cool air, these vast meadows, the sound of running water and the coming out of such a good sunshine all is what makes us healthy and keeps us happy. We do not want any government to disturb us here like they do us during our travelling and winter stay. We do not fell ill here, almighty take care of us and our animals. Till the time we are here the mercy of Allah is with us and we remain healthy and grow here. We manage everything here. Our children are born here, we have graves of our ancestors all way through these meadows, and we are part of this wonderful natural mosaic.*

***Image 4**: Bakkarwal women with children in warwan (Pic credits: Harsh Gupta)*

### 4.5 The Everyday of Bakkarwals

Traversing with Bakkarwals as a researcher, I had no choice but to witness everyday of bakkarwal life, which was very different from my usual routine. The life of researcher staying late nights in hostels and hardly ever witnessing early morning was challenged by the early rising bakkarwals. A day in a bakkarwal dera starts early in morning, usually by 5 a.m. As we know that a dog is the most loved creature bakkarwals possess and they are very much dependant on dogs for their security, bakkarwal dogs are ferocious. In the morning bakkarwals after getting up first chain their dogs. The ferocious bakkarwali dog can otherwise rip muscles apart of any person approaching the dera. Then the morning salted tea (Nun Chai) is prepared by the women and is served to everyone in dera. Bakkarwals are fond of salted tea known as nun chai. The males then leave with livestock further away for herding. The males of the bakkarwal dera graze their sheep and goats in the pastures by moving even to far ends, and also providing herd with leaves cut from trees. The men remain with their herds throughout the day, only coming back in the evening. The animals are taken care of by males during day and are taken to nearby water source for drinking water. Even during day, the animals are kept under surveillance as they should not be left behind while coming back to dera. Proper counting takes place before getting herds back to dera to ensure no animal is missing. Bakkarwals have their unique ways of counting animals either through the pairs or through colour coding or their

certain marks on their body. Bakkarwals also are fully aware of their herd as they know which sheep or goat tends to be left out and so on.

***Image 5:*** *Bakkarwals herding their sheep in warwan (Pic credits Harsh Gupta)*

According to Jamal,

> *Knowing our sheep is very important for us. Bakkarwals are skillfull in their techniques of remembering each animal thoroughly. We can even identify our sheep or goat from a very huge flock. I fully know my flock, with each one of them. I can easily identify each one of them through various marks like colour or any other mark. In my flock I know how many are milch, how many non milch and respective ages. Just like a literate person know what is written on the paper and can read it, similarly we know about our animals. We can easily distinguish our animals no matter how big size of the herd is. With the age and time we learnt all the techniques of identifying our animals and also counting them. We have to cautious as we need to counting all our animals when we get them back after grazing so as to ensure no one is left. So learning the counting techniques is a skill must for us.*

Therefore what we see is that knowing the counting is a mastered technique. As the herd is being brought back after grazing in the evening, it has to be ensured that counting is done and no one is left behind**.** Owing to the vast size of summer pastures bakkarwals find it easy to graze their sheep and goats. Whereas in winter, it is difficult for bakkarwals as pastures are not so being, there is human interference and also the infesting of poisonous plants in the locations.

Imran narrates,

> *Our daily routine is completely shaped by our livestock. We have nothing to do except to be with our livestock and graze them. We have no other additional task to perform like settle people have. While in upper reaches we are usually at ease and having enough time to relax. In winters we are more occupied, have to ensure fodder for our livestock, make sure we get fallow lands for our animals; all this keeps us on toes. Also during winters we have to be vigilant for thefts and other issues as we are stay close to settle people.*

In the words of Fatima,

> *Everyone is after Bakkarwals; Knowing we don't care about them at all*

There is nothing to surprise that gender differentials do exist even among bakkarwals just like patriarchy in our societies. The life of bakkarwal men is indeed different from the women. From the field engagement it has come to the fore that bakkarwal women have to do number of tasks as compared to men. However, much of the work that bakkarwal women do goes unnoticed in the whole process. The everyday kitchen work, cooking of food, washing the clothes, taking care of cows, dogs and kids and elderly is all the work that women have to do. It is only the work of taking the herds to grazing which men are supposed to do. It is worth to mention that getting the water every day to dera is an important task that women have to do along with the firewood which can be brought anytime during the week. Therefore what we witness is that it is very rare when bakkarwal women complain of not being able to do any work. The ability to not perform the task by the women is not taken well by the family. Either it is seen as not being well or it means disobeying the traditional value system of the community.

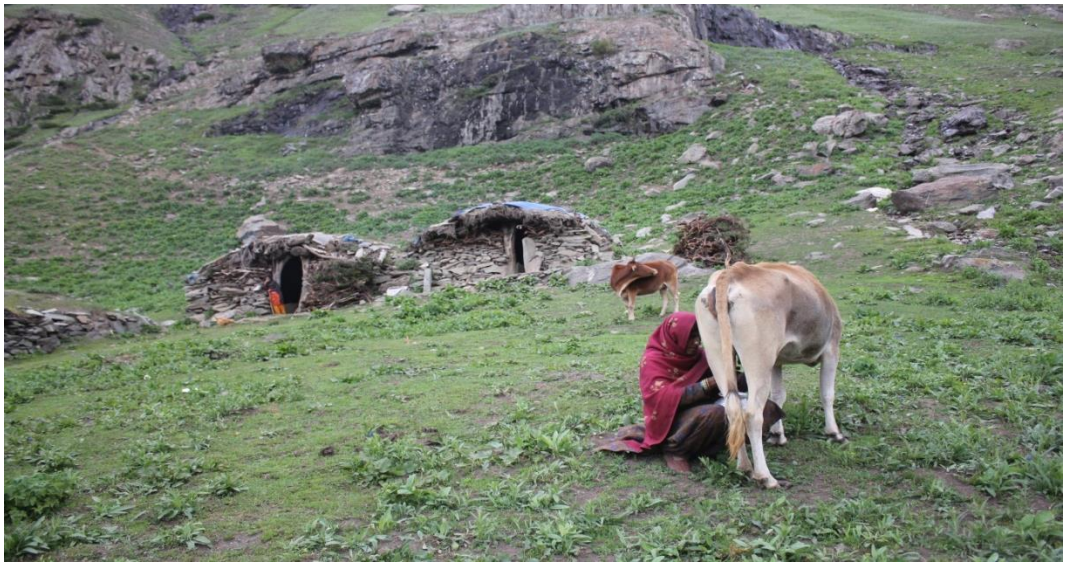

***Image 6**: Bakkarwal women milking Cow (Pic Credits: Harsh Gupta)*

### 4.6 Abrogation of Article 370: Gujjars and Bakkarwals in Frame

The latest event leading to recent unprecedented clampdown was August 5, 2019, when a Presidential Order, G.S.R.551 (E) C.O. 272 - The Constitution (Application to Jammu and Kashmir), 2019 was passed by the President of India allegedly in exercise of the powers conferred by clause (1) of article 370 of the Constitution. This order supersedes the Constitution (Application to Jammu and Kashmir) Order, 1954 by which special status had been granted to J&K. It also therefore does away with Article 35A which protected laws relating to the rights and status of Jammu and Kashmiri Permanent Residents from constitutional challenge by other citizens of India. The Rajya Sabha, on the same day i.e. August 5, 2019 passed the Jammu and Kashmir (Reorganisation) Bill, 2019, unanimously. This reorganised the state of Jammu and Kashmir into: (i) the Union Territory of Jammu and Kashmir with a legislature, and (ii) the Union Territory of Ladakh without a legislature. The Union Territory of Jammu and Kashmir will be administered by the President through an Administrator appointed by him known as the Lieutenant Governor. The Union Territory of Ladakh will be administered by the President, through a Lieutenant Governor appointed by him. On August 6, 2019, a Declaration, G.S.R.562 (E) C.O. 273 was issued by the President under Article 370 (3) of the Constitution of India by which Article 370 while remaining on the text of the Constitution was effectively nullified and abrogated. The Jammu and Kashmir Reorganisation Act, 2019 received presidential assent on August 9, 2019 and it will be effective from October 31, 2019. (http://egazette.nic.in/WriteReadData//.pdf)

The historical decision of abrogation of the much contested Article 370 by the Indian Parliament on the 5$^{th}$ of August 2019 brought varied ramifications in Jammu and Kashmir. The creation of two Union Territories in the state of Jammu and Kashmir; UT of J&K and UT of Ladakh completely shifted the political and administrative structure of the erstwhile state. The abrogation of article 370 apart from its political ramifications also brought a major shift in the legal structure of Jammu and Kashmir. The Scheduled Tribes particularly bakkarwals and gujjars owing to their muslim character were shown enthusiastically (was propagated) welcoming this historical decision. The reason put forward was the implementation of many central acts in the Union Territory of Jammu and Kashmir after this abrogation. The two major acts which were propagated to be a game changer for tribals particularly for bakkarwals and gujjars are; The Forest Rights Act, 2006 and the provision for political reservation for Scheduled Tribes in the assembly

elections. This was seen as a welcome step for the larger welfare of gujjars and bakkarwals. However, a mixed response came into public domain from different quarters of gujjar bakkarwal community. Some people publicly welcomed this decision and even went ahead saying that justice with tribals has been done after a wait of over seventy years. However, there were many others who saw this decision as politically divisive and bereft of any logic.

Guftar Chowdhary a young Gujjar Bakkarwal activist said,

> *Abrogation of Article 370 is the most unjustified act done by the current BJP led government at the centre. It will only dispossess people from the hard fought land rights and will open J&K for sale. My community people should understand that it is not going to benefit them in any way. They are only using us a tool to rip us from taking away the land. 370 is our pride and it should be restored back.*

While doing an FGD in Rajouri following came to the fore,

> *Gujjars and Bakkarwal have been deprived of many benefits for the last several decades. We are suffering at the hands of the political regime in Jammu and Kashmir. We are the poorest community in Jammu and Kashmir. The abrogation of article 370 is not in our favour. They are only making it tool to let Jammu and Kashmir have divisions. If they are concerned about our community, they could do this even without abrogating article 370. There have been numerous central acts which have been implemented in Jammu and Kashmir, so they could have implemented acts which are for us. We don't want that our land and other resources should be given to any other person from outside the state.*

The general perception of the people from Gujjar Bakkarwal community was that the abrogation of article 370 is a political decision and it has nothing to do with larger welfare or the development of community. The change in constitution is not done from welfare or development perspective rather it has severe political overtones. In order to grab the political power the current regime made sure to bring a drastic change and that is what is seen in the form of abrogation of article 370. The slogans of article 370 being the hindrance towards development of J&K are all politically hollow slogans propagated. Jean Dreze argued that article 370 helped in reducing poverty in Jammu and Kashmir. He also did a comparison of many indicators between Gujarat and J&K and showed how J&K is ahead. Therefore the abrogation of article 370 is more used a publicity stunt to justify that it would overcome the difficulties faced by tribals of J&K, which is yet to be seen and is also voiced by many people from bakkarwal community.

**Table 11: Indicators of Gujarat and J&K**

| Selected Indicators 2015-2016 | Gujarat | J&K |
|---|---|---|
| Life Expectancy at Birth (Years) | 69 | 74 |
| Under Five Mortality Rate (%) | 33 | 26 |
| Total Fertility Rate( Children Per Woman) | 2.2 | 1.7 |
| % of Girls Aged 15-19 with 8 Years of Schooling | 75 | 87 |
| % of Under Weight Children | 39 | 17 |
| % of Adult Women With Low BMI | 27 | 12 |
| % of Children Fully Immunised | 50 | 75 |
| % of Rural People Below Poverty Line, 2011-2012 | 22 | 12 |
| Wages of Male Rural Labourers, 2011-2012 ( RS/Day) | 116 | 209 |
| *Source: NFHS-4, National Sample Survey Sample Registration System* | | |

*(Adapted from The Telegraph)*

From the data it is obvious that J&K is well ahead in most of the indicators in comparison to Gujarat. Therefore the rational of current abrogation of article 370 has been done in lieu of ushering new development in J&K to which article 370 was posing hindrance seems bereft of any logic. Faridi, A (2021) argues that there has been continuous propaganda by the central government claiming that abrogation of article 370 has led to the empowerment of tribals whereas what is being witnessed is increased marginalisation and disenfranchisement. Furthermore, the idea of ushering newer rights to the tribals by way of claim over their traditional pastures and forest rights seems completely hoax as now non-natives are also claiming rights over various resources of J&K, just to emphasise that even as other states like himachal pradesh has protected native rights by bringing domicile law.

### 4.7 The Process of Sedentarisation: Bakkarwals as Witness

Nomadism globally has been under severe challenge for its survival and sustenance. Nomadic lifestyle for the myriad reasons is not preferably desirable for the growing capitalistic states. The advancements in technology and influence of market over state institutions are used as a means to discourage the nomadic lifestyle. Government wants to sedentarise mobile populations through fragmentising, enclosing and privatising shared lands. The other pretext that is often used for sedentarisation is the concern for spreading of zoonosis and contagious infections and also the animal health. Therefore there is a state induced push to sedentarise the people who are mobile. Pant (2004) reveals that due to

changing socio-economic conditions of the society, the lifestyle of nomadic people is considered to be old fashioned and out dated. They are forced to surrender their lifestyle from being peripatetic to settled communities. They lack most of the basic facilities and fall out in meeting their shelter, security and livelihood. Hatfield and Davies (2006), reveal that mobile pastoralism is contemplated to be archaic and economically irrational because of the drive to settle the nomadic communities. The pastoralists are considered as political threat and sedentarisation is seen as a way out to control pastoralists. The process of sedentarisation in Jammu and Kashmir is also not far behind. Bakkarwals are continuous witness to this process of sedentarisation. While on one hand there is an assertion of bakkarwal identity and at the same time there is visible sedentarisation happening. This whole process of sedentarisation has generated varied response within the bakkarwal community and the larger intelligentsia of Jammu and Kashmir. Most of the scholars from settle lifestyle argue there is state induced push for sedentarisation and that is responsible for bakkarwals shifting to settle life style. Afreen Faridi (2021) argues, 'A confluence of State, market, and social factors has made the practice of transhumance increasingly unviable and unsafe for the Bakarwal tribal community, forcing them to find alternate and spatially immobile livelihoods, without commensurate protection against exploitation. At this rate, the future of Nomadism in the region seems to be mutating from cohabitation with nature to confinement in urban jungles. The 'Khanabadoshi' identities of the Gujjar-Bakarwal are at risk of being subsumed into 'Dehari' labourers trying to eke a living in urban areas' (p, 4). It is been argued that market oriented and capitalistic driven development is not going in favour of bakkarwals. The state run developmental initiatives like construction of hydroelectric dams, national highways and other institutions are being built over the lands used by bakkarwals for their sustenance and hence they get displaced from their abodes. There are multiple such examples which clearly support this argument. AIIMS Jammu was built on the land used by the gujjars and so does Central University of Jammu. The coming up of these institutions in forest lands has created lot of hurdles for the bakkarwal families who were using them as their winter abode. Now due to the construction and enclosure of these forest lands bakkarwals are completely left as belonging to nowhere. In this process of becoming placeless, the bakkarwals look for alternate pastures and thereby also push their younger generation to look for alternate occupation. These kinds of measures in the name of development for settle population erodes the existence and survival of nomadic people. The government also shows

completely callous approach and disregard to the nomadic bakkarwals existence by not doing anything for their displacement.

Mumtaz Choudhary, a known Bakkarwal activist narrated,

> *The state while going for many developmental projects never thinks of Bakkarwals. The construction of Baglihar Hydroelectric power project, Central University of Jammu, all were the places where Bakkarwals used to reside during winters. Once such projects are undertaken it severely affects the Bakkarwals. Finding a new pasture is extremely difficult as there are ancestral grazing rights. Most Bakkarwal families then give up their occupation. Moreover government never rehabilitates the Bakkarwals after displacing them. They are left completely to their own fortune and to Almighty's mercy. Such apathy of government creates lot of hindrance in continuing this occupation. Many Bakkarwal families are now shifting to settle life because of harsh conditions and completely government indifference towards them. Bakkarwals now find it necessary to work as labourers instead of bearing the sufferings of dispossessions year after year. Bakkarwals are not sure even if they shift to newer pastures after lot of struggle when they will be dislocated from there. In such kind of existential crisis they always look for a settled life style.*

Besides this, there are numerous other policy interventions through which state sponsored sedentarisation process is evident. The natural environment and forest conversation philosophy as is adapted by the governments also augments this whole process. The generation of debate of overgrazing and thus introduction of forest protection policy and thereafter demarcation of wild life sanctuaries and national parks brings a drastic impact on nomadic populations. Aparna Rao in her paper, "Pastoral Nomads, The State and A National Park: The Case of Dachigam Kashmir", published in Journal Nomadic Peoples in 2002, clearly showed how the demarcation of dachigam national park created problems for bakkarwals during the 1980s. She clearly showed what chaos it led to; with eruption of violence between bakkarwals and the authorities. Finally, over a period, the Bakkarwals had to abandon that place and look for newer pastures. Afreen faridi (2021) that delayed implementation of the forest rights act, the transformation of the Jammu and Kashmir Forest Corporation into a 'for-profit' company, and the proposed dilution of environmental safeguards via the draft Environment Impact Assessment 2020, are all measures basically put in place to pave way for private sector to exploit the precious resources be it land , forests or rivers of Jammu and Kashmir.

The other debate that goes on with the process of sedentarisation is about Bakkarwals themselves willing to settle owing to their right to have access to modern facilities. Many Bakkarwals are of the opinion that nomadic lifestyle keeps them away from various

opportunities that exists in modern nation states. The affordable healthcare, education, opportunity to work, all becomes possible in a settled life style. Therefore many bakkarwals are no more inclined towards the nomadic life style. They find a nomadic lifestyle not a feasible option in current times.

Muzaffar narrated,

> *This nomadic lifestyle (khanabadoshi) is now a difficult one. We are not happy with it, and most of our young boys do not want to continue with it. They want to work in cities rather than go for this occupation. Even most of the young girls' from our community prefer to marry boys who work in towns and cities. There is much demand for such boys as compared to the ones who are into this occupation.*

There is general belief among young members of Bakkarwal community that nomadism is no more a viable option. They find it now challenging at their individual levels to adhere to this lifestyle. They argue that khanabadoshi demands strength, patience and resilience to face the difficulties arising from the nature and state interventions.

Talib Hussain said,

> *Our elder generation is very strong and skilled in carrying with this occupation. They have strength and resilience to travel and live in the pastures. We cannot match their strength and patience. We are weak physically as compared to them. We do not want to be in this occupation anymore. It is because of our elders that we have to accompany them to pastures. We would prefer to work as labourers in cities than going with livestock to pastures. Earlier it was a good lifestyle, and everyone would go together and live together. However, now social solidarity is getting weak and everyone is at his own will. Earlier we had community relationship but they are now diminishing day by day. To the outsiders it seems a thrilling occupation, the one which allows freedom, fresh air, serene nature but all this comes with many challenges. Most of the Bakkarwals who are still in this nomadic lifestyle are the ones who are poor and illiterate. They are finding it difficult to sustain this lifestyle owing to challenges that state interventions and markets have thrown. Spaces are shrinking, routes are getting shifted and barter system is dying and thus all these are creating hurdles for the Bakkarwals.*

Many prominent bakkarwal personalities generally remarked that a settled life style is far better indeed than a nomadic one. The facilities of providing adequate healthcare, housing and education to children are possible only in a settled life style and thus it has to be encouraged as compared to being nomadic.

The prominent Gujjar advocate Shah Muhammad Choudhary argued,

> *The Government should take all efforts and measures to settle the nomadic Bakkarwal community of J&K. The government should allot plots to them and construct houses so as they can live a comfortable life and provide better education to their children.*

The other opinion that is also making rounds is that there should be no forceful sedentarisation rather their choices should be valued. The government should provide all basic facilities to the nomadic population and should give due priority to them. It should be left to their wit whether they want to settle or not. There should be no push or pull factors that could lead to sedentarisation.

Inadequate healthcare has been seen as a major impediment when it comes to the nomadic life style. The issues of accessibility and availability have been at the forefront of nomadic health care. The government has been unable to resolve issues of accessibility and availability of healthcare services for the nomadic populations. Very often nomadic people are not able to avail health facilities regularly and also in emergency because of these issues. The inability to provide accessible healthcare services cannot be simply denied on the pretext of nomadic life style, there have to build up measures to suffice the health needs of nomadic populations. There are many countries like Chad, Ethiopia who have run successful and wonderful initiatives for their nomadic populations. The use of '*Mobile Health Clinics*' and the concept of '*One Health*' have shown remarkable results. The mobile health clinics have ensured accessible healthcare to nomadic populations in far off pastures. The experiment of mobile schools in J&K was a good move but lacked government effectiveness. So similarly the implementation of mobile clinics can prove a good step towards meeting the health needs of the bakkarwal community if government implements it in right direction. The government can train people in basic health courses and appoint them at mobile clinics as primary skilled health care givers. This will cater to many emergent issues among the bakkarwals. The concept of one health is of course a wonderful initiative that suits to the demand of the nomadic lifestyle. This concept embeds the human health and animal health together in one service domain. The concept of '*One Health'* was derived from Calvin Schwabe 'One Medicine' and it has been replicated in many countries like Kenya and Chad having significant nomadic population. The evaluation of 'One Health' programme in these countries has shown remarkable results. Through this one health initiative they have been able to bring down infectious diseases like tuberculosis and many others. Even in India in Pune, Anthra a non-governmental organisation has initiated the one health concept. The government can use one health as a policy mechanism and help in providing adequate health care to animals and humans engaged in nomadic lifestyle. The linking of veterinary and human health departments

can be initiated for providing healthcare to bakkarwals in Jammu and Kashmir. This linking can be done from the perspective of the public health policy measures.

The exchange of relations between various identities in Jammu and Kashmir can be seen from two lenses; one is from social frame and other from politico-religious frame. Bakkarwal identity which is nomadic scheduled identity has an amalgamation of both social relations and politico-religious frame when it comes to exchange of relations with various other identities in Jammu and Kashmir. Bakkarwals are the only group whose interactions are very diverse owing to their transhumant movement across the Jammu, Kashmir and Ladakh. The bakkarwals during their stay in winter pastures at Jammu used to have had amicable relationship with settled population a decade ago but it has now drastically changed. They used to rear their herds on the fallow land of the settlers and also used to work as labourers in their fields. The exchange was dominated by sharing of the social spaces and the social solidarity used to be very strong.

In one of the FGD's it was revealed,

> *In Jammu the Bakkarwals used to share a cordial relationship with the settled community which is mostly a Hindu population. Bakkarwals used to live peacefully and never ever the rumours would bring any rift between the communities. The bond was strong more than they had in Kashmir. Bakkarwals would share space easily with settled population and would communicate freely with all due to language affinity. Bakkarwals used to take lot of things on credit in Jammu province. Everyone believed that Bakkarwals have patience and resilience and that is what brings them closer to the people. There used to be no rifts between the communities* (FGD, Jammu, 2019)

***Image 7**: Focussed Group Discussion (Pic Credits: Bhat Iqball)*

However over a decade now the politico-religious frame has emboldened and thus the exchange of relations between bakkarwals and settled populations has drastically changed. The religious identity has overshadowed all other identities. Unfortunately the incidents of Amarnath land row and Asifa rape and murder case has widened the subtle fissures that were existing in the relationships. The animosity has become too grave, thereby hindering the coexistence and putting stringent bottlenecks in the survival of the Bakkarwals. This discord in relationships has severely affected in fulfilling various felt needs of Bakkarwals and particularly the health needs. The Bakkarwals are now facing problems in reaching out to local pharmacists for the immediate fulfilment of health necessity. Even at the local health centres Bakkarwals find it difficult to get themselves properly checked. Various incidents like a pregnant Bakkarwal women dying in the Kathua hospital for want of medical attention highlight the strained relations.

As narrated by Shahid,

> *We are now totally left on our own by the local population. After the Asifa case there is general aversion by the majority community to forge linkages with us at any level. The strain in social relationships has also overarched in the market relationships. We find it extremely difficult now to even utilise the services of local pharmacists, chemists or druggists. There is extreme suspicion filled in the majority community towards us. The local pharmacists hardly respond to us. To our utter disgrace even the government institutions are showing very callous attitude when we reach to them for taking services. The persons manning these institutions pretend not to treat us at the expense of one or the other faults, either doctor has just left or the staff person is coming and many such reasons given. The health care institutions are also showing due negligence in providing us the due treatment. The worst suffers of this entire are the poor Bakkarwals. We have now to go to Jammu city to get ourselves treated or we always wait to see if there is any Muslim doctor, then we go with a hope that we may get treatment. The situation has become very pathetic. This is an evident social boycott added by subtle avoidance at all other spheres be it market or government institutions.*

The relations of bakkarwals in Kashmir were not particularly cordial as they lived more in isolated pastures. They are not in continuous touch with the local populace there and it was occasional exchange relations that used to happen between them and local populace. However many bakkarwals narrated that from last one decade the exchange of relationship with local populace in kashmir has undergone a major shift. Kashmiris have become more sympathetic by responding in a more caring way owing to the situation in Jammu. In a FGD at Doru Anantnag it came to the fore,

> *We are now seen as victims of religious divide and therefore more sympathetic approach is coming in our exchanges. The politico religious frame is now also*

> *emboldening the relationship exchange with the local populace in Kashmir* (FGD, Doru, 2020)

One of the prominent lawyers from Bakkarwals community argues,

> *We have become the victims of nasty politics that is going on in Jammu and Kashmir. We are completely caught is subtle divide of politico religious and social frames. We are entangled in such a situation that complexity of web of relationships is becoming more volatile for us. Taking sides can prove extremely detrimental for our existence and survival at any point of time. The element of neutrality is also not going to completely work in our favour. Now what seems evident is that we need to build ourselves up as a community and thus assert our own tribal identity and negotiate all relationships from that very identity* (Personal Interview, 2021)

### 4.8 Struggles of Everyday Life: Survival, Aadat and Contradictions

The life of Bakkarwals is challenging and thrilling for varied reasons. They have the opportunity to witness nature unpolluted and utilise it for survival. The fresh air, lush green meadows, serene pastures, calm surroundings all add to the thrilling life they witness and live. However this thrilling life is not devoid of struggles that come with it. The struggle to sustain this life style is itself a challenging task. The struggle to negotiate their survival, fulfilling their basic needs and responding to the emergencies is what bakkarwals have to deal with. The most basic need that often generates anxiety among bakkarwals is adequate healthcare. The aloofness and isolation of their pastures during summers, when they are in the higher reaches of himalayas is when fulfilling heath needs becomes a herculean task. For fulfilling health needs there is always a need of skilled and trained personnel. To find skilled and trained personal is a big challenge and a thereafter requisite medicine is an added one. Even when it comes to the accessing of health centres in the settle locations near to pastures the issues of availability is a big factor. Very often the healthcare institutions located in remote places like villages on the foot hills are devoid of trained health personnel. Besides this, there is also inadequate supply of essential medicines or equipment's at these health centres. The issue of doctors not going to these locations even when they are posted there is a big concern. Posting at such locations for health functionaries is always considered as a kind of punishment. To the utter logic of market, private health sector never finds its way to these locations as they see them as no profit zones.

One of the kafila member, Jamal Hussain narrated,

> *There are hardly any doctors available in these health centres ever. The other paramedical staff also comes for few hours and leaves before time. Moreover staff which is posted in our health centres is usually not so skilled and trained. Efficient doctors (kabil doctor) are never posted here. Whosoever gets nowhere or has no good connections is posted in our area. They never ever take it as a serious posting. They are always in searching of shifting from this place at the earliest. We are not at all relying on these health centres and even the staff also pushes us not to visit these centres. They often advise us to go to district hospitals in hope of getting good treatment.*

For minor ailments bakkarwals are well equipped and skilled in making use of local herbs and traditional methods to meet their health needs. However, for major health needs they always have to look for a trained allopathic practitioner. The earlier generation of bakkarwals had adequate knowledge of traditional methods and local resource for their use but now this knowledge base is diminishing. Treating of ailments like cough, cold, fever, headache, body ache, toothache all was done by the use of traditional knowledge and local resources like herbs, grasses and so on. Even the managing of child births among bakkarwals was done by women of the community themselves. The bakkarwals collect the medicinal herbs form the pastures keep them in their possessions for treating many health ailments. Even for their animals they have good traditional knowledge repository for treating them also in case of any ailment. They also feed their herds with requisite medicinal herbs whenever they find anyone in need for the same. Bakkarwals are wary of the forest department who often accuse them of collecting medicinal herbs, which is not permitted as per law. However what has been observed is that possessing this traditional knowledge is not a so common phenomenon as it seems. It was found out that only few bakkarwals have the adequate traditional knowledge of the use of these medicinal herbs and grasses. Most of the bakkarwals are devoid of this knowledge system. And when it comes to the young generation they almost immediately make their preference for modern medicine. The kafila of Jamla Hussain during their transhumant movement brought and kept different medicines for their use during the times they are in upper Himalayan pastures. I found it very common that most of the male members of kafila have painkillers in their pockets. They keep adequate stock of these painkillers and frequently consume them. This phenomenon of use of drugs is become too common now among bakkarwals. This has also made them susceptible to drug resistance.

Moreover bakkarwals out of their constructed notion based on their lived experience believe that doctors in public health centres do not have a liability of the cure. Bakkarwals generally see doctors in public health centres as ones who do not have concern for the cure

what they are given. The private players, local pharmacists and quacks have an engagement which ensures the liability and they build a wonderful rapport with the nomads. This building of rapport also ensures the continuous engagement of bakkarwals with local pharmacists for gratification of their health needs.

The most common ailment that has been reported among Bakkarwals throughout the fieldwork is the tiredness and weakness (Kamzoori). While speaking to many pharmacists and even to bakkarwals, it has come to fore that almost every bakkarwal who approaches the local chemists has reported tiredness and weakness. The issue of getting adequate nutritious diet is of course the one important reason for all this. The bakkarwals are exposed to mountain climbing and hard physical labour throughout the year. This tough exposure of body to extreme conditions indeed demands a good supply of nutrients. The bakkarwals are usually compensating their body for nutrients in the form of milk and milk products like ghee. They hardly consume other kind of nutritious food like meat and proteins. They take extremely less quantity of meat and that too not so frequently. The malnutrition was quite visible in among all the members of the kafila. Women along with children showed visible signs of malnutrition. The weakness was apparent in the form of the body mass index. It is out of sheer habit (Aadat) that women even with their fragile weak bodies would do lot of work than their men. The women are extremely hard working and perform all major functions like cooking, washing and milking the herd. Issues of women health and reproductive health demand an in-depth exploration. The reproductive health is also one of the concerns pertaining to the women. In one of the field trips in Rajouri, one of my fieldwork assistants accompanying me had a chance to speak to women of the gujjar and bakkarwal community. The interesting revelations were brought fore in that discussion and personal interviews.

One of the women narrated,

> *I don't want to have children now. Is there any way I can do that*

This women respondent had three children and she was just 25 years old. The fragile weak body clearly showed the signs of nutrition deficiency. She was desperate for fulfilling unmet family planning need. When asked about use of condom by her husband she said it is not possible. She was desperate for some contraceptives like pills to be used by her only. The inaccessibility of women from the community to the health care institutions is

generating a demand for unmet needs among them. The child spacing and birth control mechanism are the most unmet needs that women are desperate for. Besides this there are other issues of reproductive health that demand immediate attention.

It is important to mention that in the FGDs with women, it came out that the marriage is being done in early age in bakkarwal community. By the age of 20 years the girl is already the mother of two or three children. The number of children is usually very high. The average number of children has been found four. Having two wives is also not a surprising characteristic in the bakkarwal community. It has been found that two wives is a generally accepted norm among bakkarwals. The bakkarwals usually having many children can also be attributed to the very occupations they are engaged in. More children would mean more hands at work. This is evident also from the fact that bakkarwals who having large herd size tend to have more family size. Also the influence of peer system and the way religious teachings related to family planning are brought to bakkarwals determines the family size. Bakkarwals are stringent believers and followers of sunni faith and do not adhere to the family planning. They usually see it sin to go for any kind of family planning measures. Chakrevti Mahajan (2021) mentions, 'There was a woman in the nearby village. Against her elder's wishes, she went to a local hospital. The doctors there performed a tubectomy operation (nasbandi) on her. But immediately after the operation, she died. Her dead body was buried in a local graveyard. But the grave did not accept women's dead body (qabar ne kabool nhi ki lash) (p, 166).

Such kinds of narratives running in the community are also strongly empahsied by the religious leaders and preachers during their sermons; thereby making the community behaviours more stringent towards the issue of birth control measures.

While conducting fieldwork in Rajouri a female assistant who would generally undertake interview of female respondents had interesting narration to share. The female respondent said to her,

> *can you tell me how to control the birth of babies?*

This statement thereafter leads to the following detailed conversation:

> The female respondent was 25 years old lady having three children, two boys and one daughter. She was very weak and fragile in the appearance. Her weight was very low and she seemed to be malnutrient and anaemic. She was very desperate not to have more children and was searching for the means to control

> the pregnancy. She was very fearful of the fact that if her husband comes to know that I do not want children anymore, she would be look down and cursed. She wanted to avail the services of family but which should be easily available and without letting her husband know. She said our men don not allow birth control as they say it is against the will of God and doing this is sinful.

Aliya Bashir and Rahina Maqbool in their story, '*High in the Himalaya, Family Planning Services Inaccessible to Nomadic Women'*, published in Global Press Journal on 6th May, 2019 have mentioned about the reluctance of the gujjar bakkarwal community towards family planning . Quoting one of the respondents they write, 'Discussing birth control is taboo, even for married women. Women have as many babies as they can. Even if someone dies by giving birth, it is considered to be an honor for that woman. Birth control is seen as an interruption of nature."(p, 3).

The outside factors indeed pose a challenge to access to healthcare however internal factors like culture can be more persistent (Sachdev B, 2012). Poor response to the reproductive health services is a major impediment for providing such kind of services to tribals (Nduba J et al, 2011).

Religion is an important part of the health culture of bakkarwal community. Influence of religion on the health seeking behaviour is also evident from the fact that many immunisation programmes or vaccinations drives had initially poor response in the bakkarwal community. Bakkarwals are very particular when it comes manhood. To be a potential offspring producing man, is seen as a sign of proudness and any weakness in the sexual potency is shame. Marrying young and having children is indeed a great sign of honour in the bakkarwal community. This notion is deep entrenched in the community and is also religiously glorified. Any defiance to this norm of the community is seen as violation to the command of the God. It was very often heard from the people of gujjar bakkarwal community that any person not being able to have off springs is like a sterile buffalo who is considered as not worthy. So producing off springs and having children is always seen as symbol of honour by bakkarwals.

Mohammad Hanief an elderly bakkarwal in his 50's narrated,

> *Children are the gift of almighty (Rub), it is Almighty (Rub) who sends them and also ensures their survival (razik). Whosoever is to be born will be born will be, there is no control of ours on it. Rather we should do not think about it. It is always better to have a family. There is no value to a person without a family. Only Almighty (Rub) is and will be without family. Our prophet also had a family and children'* (Personal Interview, 2019).

It was very often heard during fieldwork that government is using providing various services measures for birth control. There have been even suspicious programmes which are being run for sterilisation of the people, as was stated by people during conversation. The distrust on immunisation and vaccinations programmes often stems from the rumour of attacking the sexual potency of males. Chakraveti Mahajan (2021) describes a narrative of Dr. Sharma whom he had interviewed during his study, he mentions, 'A few years back, I was in charge of an immunisation programme in the area. I organised a polio vaccination camp in a nearby Gujjar settlement. I kept waiting for the parents to bring their children for vaccination the whole day. However, none of the households turned up to get their children vaccinated. I sent my staff on duty to enquire from the local people the reason for not sending their children for vaccination but to utter surprise, the people responded with threats. They told us to leave the campsite. I panicked and contacted the local police station. With the help of a police party, my team managed to complete the vaccination drive. Later I learnt from the Gujjars that a Maulwi had dictated to them that after vaccination, their children will become impotent (p, 164).

It seems that there is historical collective memory of India's brutal family planning programmes that resurfaces among the populations often. The collective memory of forced vasectomy and sterilisations has created distrust on many health initiatives that are being taken for the general welfare. Community information through oral history retains significance among the Bakkarwals. The passing down of information from generation to generation in the form of storytelling exists strongly in the bakkarwal community. The bakkarwals strongly held the opinion of how government has at times used deceitful ways of birth control.

While interacting with the community one of the elderly community member, Mohd Hanief narrated,

> *It is good that government is providing services for us. Government should provide us with medicine and all facilities which we need to stay healthy. But sometimes government also does many things which we don't like. Our elders were very suspicious of these injections and other medicines as it was all provided free to control our population. They wanted us not to produce children. But nothing will happen until almighty does not want. We have faith on him and he is our creator and destroyer* (Personal Interview, 2019).

Besides this the anxious role of religion also adds to this and thereby further strengthening distrust and hence aversion to any such mass immunisation and vaccination programmes. It is only after massive campaigning and use of religious preachers that bakkarwals make use of immunisation and vaccination programmes. In a conversation with one of the doctors at a District hospital in Rajouri, he narrated,

> *There has been an increased attention to reach out to the people in the far off places. We have particularly being able to do so in various programmes like polio immunisation drive. Health department officials have ensured to cover each and every household during the immunisation drive irrespective of the distance. Even mobile health units have been pressed in service for the polio immunisation. This is how we have been rendered successful. I must also admit that civil society and community itself has provided support to the immunisation drive. All stakeholders have actively supported the health department's initiative in making such drives successful. Any hesitation out of suspicious and rumour mongering narratives have been countered by effective support of the religious and spiritual leaders of the community. Many people of the Gujjar Bakkarwal community were raising questions about malafide intentions of the government particularly in terms of birth control measures being pushed through vaccinations. All such narratives have been cleared by massive campaign at various levels. The religious leaders have through their sermons and contacts ensured people to get vaccination done as it for our better health (Personal Interview, 2021)*

### 4.9 State, Nomads and Healthcare: Negotiation by Bakkarwals

Nomads and state historically have had a very critical relationship. This has indeed become more critical after heavy influence of market over the functioning of the state institutions. In this whole gamut, the formation of policies has been in resonance to the demands and needs of the settled populations. Nomads have been left out with the assumption that it is because of their lifestyle they are not able to access the healthcare services as provided by the state. Due to their lifestyle and geographical remoteness they are even designated as hard to reach groups by the state. Negotiating healthcare has been a tussle for the nomadic Bakkarwals. Looking from the perspective of Andersen's behaviour model of health care services utilisation and the Danobedian model of healthcare many interesting factors have come to light. It is to be mentioned that historical inequities, socio-economic inequities and inequities in provision and access to health services are seen to be key elements when it comes to differential health outcomes. Therefore for improving the population health availability, accessibility and affordability of health services are essential components.

### 4.9.1 Socio-Cultural Context (Acceptability):

Health culture becomes an important aspect of understanding the boarder concept of health in tribal nomadic communities like bakkarwals. Nomadic communities are usually intricate and in close knit when it comes to many cultural practices. This strongly defines the prominence of health culture in a community. In bakkarwals it is often seen that being physically fit and able to work is considered as a healthy. Thus health is seen as a physical condition which is not impacting the mobility and work of an individual. The weakness, pain and fever is what is mostly considered as not be fit. They bakkarwals usually considered weakness as 'kamzoori' and thus define it as being not healthy. However it is still not a condition which they can term as being ill. Illness is generally seen by bakkarwals as a condition which is characterised by the presence of fever and heavily impacting the mobility of the individual. It is in such a case the illness is then seen as a condition which will require the attention of a trained medical practitioner and not necessarily the doctor. Bakkarwals generally consider the local pharmacist as a doctor, for them anyone who prescribes the medicine is to be understood as a doctor. However this is no way means that bakkarwals do not have idea of who actually the doctor is. But their lived experience augments the act that they are usually attended and get cured by the local pharmacists.

Religion plays an important role in determining how bakkarwals would negotiate their health needs. The influence of pirs (religious saints) among bakkarwals is very strong. The pir (religious saint) is often consulted for all matters related to the health and wealth of the family. Anything which will be restricted by the pir has to be completely followed by the members. Faith becomes an integral part of the health seeking behaviour of bakkarwals. Very often taweez (religious worn thread) and khatem (religious praying ceremony) is being used to treat ailments like skin diseases, or long term ailments. Even for the issues related to child birth, pregnancy faith takes prominence. Almost all the bakkarwals have a strong pir system and they follow it very stringently. Religion is completely embedded in the socio-cultural milieu of the community. It has been seen that religious preachers (pirs) also coincide to act as faith healers at times. The pir makes use of traditional medicinal plants and herbs and treats many ailments. They are highly respected in the community and it only after their permission the community members approach to local health centres.

Muzafar narrated,

> *Our pirs are very pious and they are khuda ka Banda (Gods own people). They have cure for most of our illnesses and diseases, not only for us but for our herds also. We always look to them for our safety, guidance and treatment. They never deceive us and we should have their mercy on us. If they get angry with us, for sure something bad is going to happen to us*.

It is important to mention here that bakkarwals are extremely religion adhering group embedded in performing many rituals, from birth to death. The concocted stories or tales of Jinn are commonly running in the folklore of bakkarwals. The stories around the *jinn* are part of oral history of bakkarwals. This folklore aids in cultural memory and defines their health seeking behaviour. Hardly any nomadic bakkarwal evades the faith healing system present in the community. The lived experiences of bakkarwal members being held by the *jinn*, revolve around the notion of fear, of weakening of the body. Bakkarwals generally hold the belief that rivers, spots water in pastures, graves and *astaan* (religious shrines) are the places which are housed by spirits and any disregard to them would lead to possession of the body of a person by the spirit. Witnessing the incident of a bakkarwal male being possessed by the jinn was a unique experience. During stay in warwan with family of Jamal hussain, following incident happen,

> Jamal Hussain's younger son muzaffar had been facing health issue from last nine months. He would fell unconscious all of sudden at any given day. Such occurrences of getting unconscious had increased more from last few months and would almost every week happen once. Besides this muzaffar has been getting physically weak (Kamzoor) and also preferred to sit alone often. Muzaffar had also been complaining of not getting proper sleep during night. The family was visited by a pir sahib, who would come to their deras almost every summer. The pir sahib had family ties with the family and has been visiting them from last three decades. Pir sahib belonged to Kashmiri community. This time his visit has been specially for treating muzaffar. Pir sahib communicated the family that muzaffar is being possessed by a Jinn. In the late evening pir sahib started his process of religious invocation to overcome the jinn from his body. Muzaffar was made to sit in front of pir sahib and as pir sahib began chanting religious verses with the water filled pot in front of him, muzaffar started crying loudly. Pir sahib continued his chanting with intermittent water from pot sprinkled on the face of muzaffar. After sometime muzafar got unconscious and pir sahib ordered every one of us to leave the tent. After 5 minutes the process completed, and we were allowed to come inside muzaffar had regained consciousness and was sitting in front of pir sahib. After this pir sahib gave taveez to muzaffar and told him to tie it around his right forearm and keep it safe. The pir sahib narrated an evil jinn had possessed his body and was giving pain to muzaffar. Now he will be fine and nothing to worry.

The notion of *nazr* (understood as evil eye) is interlinked to bad tidings in the complex web of what constitutes and contributes to the suffering caused by the *jinn*. According to Laughlin (2015), in folk Islam, jinn are spirits invoked for magical purposes and are often held responsible for miraculous or unusual events and for a wide range of illnesses, which are popularly believed to have been caused by an imbalance between internal and external jinn. Extrapolating the understanding of 'jinn chadna' (being possessed) is medicalised in the contemporary medical terms as being mad or depressed. The complex webbed understanding of spiritual – religious is hinged on the understanding of being possessed by the spirit which requires a process of healing. The healing provided is intercalated by the pir who possesses the rich knowledge and goodness to talk to the jinn and provide ease to the pained soul and tethered body which is caged by the jinn. This can be understood through the ease mentioned in the divine scriptures. Very often Bakkarwal people are wearing the taveez around their neck or arm to wave off the evil eye or safeguard themselves form the Jinn. It is pertinent to mention that even I witnessed the taveez being put around the neck of some animals, mostly the lactating cow. This practice of visiting the pir for getting taveez is common among bakkarwals. Initially even for health elements bakkarwals will go first to pir and then only take recourse to the allopathic medicines.

One of the respondents Junead narrated,

> *This taveez was given to me by our pir sahib. Earlier i used to have headache and I was very often having pain in my legs and also used to get unconscious. Since the time I wore this taveez I don't get any headache and other complications. Pir sahib has the power to control the jinn and thus keep us safe. They are very pious and knowledge and can cure every disease*.

This kind of faith healing in some cases leads to the deterioration of their health condition. Some, who are in need of medical consultation for psychiatric or somatic disorders take recourse to faith healers instead.

Illness which is not physically evident is very hard to be referred to the public health centres by the religious faith healers of the community. The pirs (faith or spiritual healers) have strong influence on determining the acceptability of healthcare services that are rendered by the health departments for the population. Immunisation and vaccinations programmes would be completely rendered ineffective unless they are given effective support by the pirs of bakkarwal community. There has been stiff resistance to the family planning initiatives from the pirs of bakkarwal community.

One of the doctors at sub district hospital, Kokernag, narrated,

> *Birth control measures are not effectively being utilised by the people from bakkarwal community due to strong adherence to religious rituals. Most of the people form this community oppose birth control measures on the pretext that it is sinful. Pirs who are religious figures highly revered by the community are not advocating for birth control measures and hence it is difficult to convince community for the same*

The resistance comes from the religious understanding that birth and death are upto the Allah. It is decided by Allah who is to be born and die and at what time and which place. The destiny is in the hands of Allah and therefore any disobedience to his commandment is sin in the eyes of pirs and hence disapproved by the community.

### 4.9.2 Affordability of Healthcare Services:

Nomadic Bakkarwals have one of the poorest indicators when it comes to health and wealth. Financial difficulties in terms of no easy flow of money are the biggest hurdle for affording healthcare services. Since the onset of armed conflict in Jammu and Kashmir, the diminishing phenomenon of nomadism has been witnessed and now only the poor bakkarwals are continuing this occupation. Aparna Rao in her work on bakkarwals has shown how the new phenomenon of 'Hired Shepherds' has emerged among the Bakkarwal community. She argues that affluent and rich bakkarwals who used to have big herds are no more practising transhumance themselves. They usually now hire the poor bakkarwals who are tendering to their big herds and they themselves have opted for a settled lifestyle. This phenomenon she has termed as hired shepherds.

Jamal Hussain narrated,

> *The rich bakkarwals are having everything. They send their maal (herds) in big trucks to Kashmir and then from there they reach to warwan in two days. They can easily afford this, we don't have so much money to pay for travel, and thus we go by foot. We do not have money to buy essential items for ourselves where form we will give money to take our herds in trucks.*

Even the rich bakkarwals have hereditary grazing rights over the pastures and continued to keep them. Sometimes poor bakkarwals have to be on the mercy of rich ones for providing them access to the pastures owned by them. They have most of the pastures in their control, leaving very few for the poor ones. The class difference is very much evident when it comes to the Bakkarwals who are nomadic and the ones who have settled. The question of affordability of healthcare services is a concern for the nomadic Bakkarwals.

They do not have means to bear the out of pocket expenditure for their health. For the minor ailments they visit the local pharmacists with whom they can negotiate to get medicines in the bare minimum amount. Nomadic Bakkarwals hardly access the private healthcare services for the fact that they are not able to afford it. Even going to hospitals and seeing the doctor and then buying medicines form outside market is not seen as possible. Therefore utilisation of healthcare services depends on affordability. It is only when the illness or diseases becomes unmanageable or suffering increases that they approach the government healthcare services.

The prominent doctor Choudhary Zia described the scenario as below,

> *From the last one decade I have treated many people from nomadic Bakkarwal community at the prominent hospitals of Jammu and Kashmir. Most of the patients form this community reach to the tertiary or secondary level healthcare services after a prolonged illness. I have noticed that they have had taken treatment mostly form the local chemists at their nearby locations. Whenever they reach us, it is usually a grave situation; the damage is too much there. The problem is also that they do not have even money now to do some urgent tests from outside the market. As the waiting period for tests to be done at government facility is long, these people then have to suffer again. I have witnessed their suffering is at multiple levels. They are poor, they have no social capital, and therefore they have no way but to be at the mercy of doctors and hospital or the Almighty.*

Nomadic Bakkarwals have to bear unaffordability to the worst of their destiny, which even ends up losing oneself to the otherwise curable disease. The intricacies of affordability can be fully understood through the lens of Intersectionality. The historical marginalisation of nomadic Bakkarwals has led to web of factors interlinking in creating the unaffordability element. Nomadic Bakkarwals being financially poor do not have the material assets in their possession. They also lack the social capital. They do not have linkages or networks on which they could rely for utilisation of the health services. Being illiterate and unaware about various government initiatives like insurance they cannot even take advantage of that. The social discrimination, geographical isolation, institutional marginalisation all add to the already existing poverty in acting as a big hindrance for the affordability of the healthcare services.

> Haroon is a young Bakkarwal in his thirties married having two wives and three children. He is the most active person of his dera comprising of 12 members. His younger brother is studying in class 5$^{th}$ at gujjar bakkarwal hostel in Jammu. Haroon is completely illiterate and has never attended the school. Right from his childhood he has been involved with his father in the practice of nomadism. Being the eldest among his siblings he got married at the age 19 and

then had second marriage at the age of 25. They are having 200 flock of sheep and goats. They are practising transhumance every year along with these herds. They have been using traditional route for transhumance. Haroon is highly experienced and well versed with the practice of transhumance. He effectively manages his herds along with his father. Owing to his activeness he often accompanies his relatives to hospitals for treatment and checkups. Haroon has been to all the major health institutions like government medical college and hospital, Jammu and Sheri Kashmir institute of medical sciences, soura Kashmir. Haroon has been at skims soura for treatment of his father who was suffering from stomach ulcer.

Haroon narrated,

> *It is very difficult for us to go to health institutions because we do not have that much money to travel and also do not know the process. It is our last resort to go to the institutions. I took my father to soura because he was unable to digest anything and was in too much pain. Earlier we have given his local treatment and also shown him to the local doctor but nothing worked. Even our peer sahib had given him taveez and water but still the pain continue. And finally I took him to the soura. I had to spend fourty thousand rupees for almost two months and thereafter he got some relief. Everywhere it is your network that helps and we have nothing of such and thus have to wait for days and days to get our test done. Even we struggle for accommodation because it is not easy to get cheap accommodation there. Then costly medicines are the biggest trouble for us and we have to run pillar to post to arrange money for the medicines*.

### 4.9.3 Availability of Healthcare Services

It is very often seen that gujjars and bakkarwals are mostly living in regions which are geographically marginalised and also thereby infrastructural marginalised when it comes to availability of healthcare services. In order to meet the emergent health needs like child birth many untoward incidents have happened with them. In one of the incidents the person even lost her life.

During an FGD at Rajouri the respondents narrated,

> *You must have heard about the incident that happened at Lal Ded hospital, the biggest maternity hospital in Kashmir valley. One of the pregnant ladies from our community gave birth to a child on the road side and unfortunately the child couldn't survive. This all happened when she was denied access to the hospital and was not attended there. This is merely not fallout of inefficient institution's and service delivery mechanisms but something more. It is an outcome of a socialisation that is embedded in racism and casteism. This incident is an outcome of a culture of social discrimination against Gujjars and Bakkarwals. We are being denigrated as gujjar an uncivilised creature, a filthy soul and resemblance is made no less than being a wild animal* (FGD Rajouri, 2019).

This incident at Kashmir's biggest maternity hospital Lal Ded, is to be seen from this idea of discrimination and marginalisation which entails in it historicity. It is pertinent fact all those places where gujjars are settled in kashmir are marginalised zones which depend heavily on other places even for their basic needs like public distribution ration system and healthcare. The state has miserably failed in overcoming marginalisation of these zones by not providing them basic health care facilities. Even if the structures are available presence of expert human resource is a major issue as none of the trained professionals is ready to serve in these marginalised zones. The geographical marginalisation is augmented further by social marginalisation which is embedded in our socialisation. Right from the birth to death we witness ridiculing of this community in our day to day engagements. Moreover so the unavailability of functional and effective healthcare service system in the zones where bakkarwals and gujjars live is a biggest hurdle for meeting the health needs. When it comes to nomadic bakkarwals the issue of availability becomes grave owing to very nature of their mobility, which augments to the already struggling healthcare system in J&K.

Animals are an essential characteristic of the nomadic life of bakkarwals. The survival and sustenance of nomadic bakkarwals depends on where their animals can survive and sustain. Therefore the locations which provide adequate sustenance and survival to the animals are where they stay. During summers bakkarwals take abode in the pastures of upper himalayas and in winters they reside in the low lying foot hills of Jammu province. Summer pastures are of course geographically remote, isolated and least traversed by people. The summer pastures of bakkarwals are the remotest places in terms of availability of services. Winter locations are usually near to the habitations of settled populations. Generally what we see is that bakkarwals live and reside at the fringes during winters and are completely isolated during the summers. Therefore the issue of availability of healthcare services becomes an important one. The government healthcare centres in the peripheries are very limited.

In one of the FGDs at Rajouri it came to the fore,

> *The government does not care about we people. Hardly there are good healthcare services available. Even if there is building of PHC or a sub centre in any area, it is in dilapidated condition. No employee will ever want to serve in that centre. There are no doctors and staff posted in the health centres. And also in those centres where there is staff, there is scarcity of medicines and other facilities. No government officials visit them and no accountability is being held. Every now and then there is change of staff in these health centres. No body want to serve there and why will they serve when it has got not facilities* (FGD Rajouri, 2019).

The bakkarwals at summer pastures have extreme difficulty as it becomes almost impossible for them to even access the nearest health centres. From the pastures of warwan it almost takes a day to reach to the nearest health centre. Travelling such a distance for accessing healthcare services makes no sense. This lackadaisical approach of the government of not making services available is the biggest hurdle for non-utilisation of services. The failure of the governments to make healthcare services available to the bakkarwals at their location is generating the demand for the quacks. In Warwan I have witnessed many people from Kashmir are running temporary medical shops during summers. One of the persons operating such temporary shops narrated,

> *Every summer I come here and put up my tents for providing the services to the Bakkarwals and other travellers. I myself basically reside in the kokernag area of Anantnag district. Bakkarwals are known to me and we share a good rapport. I have been doing this from 12 years. I come in the month of June and stay here till late August. Thankfully i am making my living and also providing help and relief to the bakkarwals. I usually keep the essential medicines mostly treating common ailments like cough, fever, body and joints pain, diarrhoea, stomach ache so on. The bakkarwals mostly come to me for problems related to the pain in the body, headache, stomach ache and tooth pain. In severe cases and in dire need I suggest them to visit the hospital. Many of the cases I have suggested to go to major health institutions like SKIIMS Soura or GMC Srinagar. After every 15 days I get the stock of medicines from the kokernag. I am a science graduate and have been running a medical shop at kokernag form last two decades.*

Most of the bakkarwals utilise the services of these people for fulfilling their health needs. The concern is that all these people who run these medical stores are unregistered practitioners and are more like quacks. There have been initiatives globally like mobile health clinics and one health concept which have been used as measure to provide healthcare services to the nomadic populations has been operational in my countries. However any such initiative is completely missing when it comes to the nomadic bakkarwals of Jammu and Kashmir. It is worth understanding and analysing as to how bakkarwals are able to manage complex child births in summer pastures. Though they have traditional dais within their own communities who are efficient enough to do the task but tackling the complicated pregnancies is a concern. Most of the cases the women and the infant have to pay the price of not being able to survive.

Living at the fringes and marked by social discrimination health of bakkarwals is not influenced by availability of health care facilities only but is also strongly influenced by socioeconomic factors. Nomadic bakkarwals of Jammu and Kashmir are facing severe

challenges and the results are dismal when it comes to indicators like literacy rate, income and wealth and so on. These factors strongly influence the overall health of bakkarwals. The nomadic bakkarwals have poor health as compared to the settle bakkarwals and gujjars.

While conducting an FGD at Doru, Anantnag, the following come to the fore,

> *Health and Education are two important needs for our communities for which we have now become dependent on the state institutions. In our earlier times our community was healthier as we used to live in meadows filled with fresh air, water. We would suffice ourselves with all the produce from our herd only. Form last two decades most of us are finding it difficult to continue with transhumance as a stringent control and surveillance is hindering our occupation. As we have now come to kind of semi nomadism, we are trying to access the education and health facilitates more like other people. However, we have also fallen prey to many illnesses which earlier were not there with us. Now our people also are more like others and have to visit often to the health centres. Earlier we would get hardly be kamzoor and if ever we get fever just within a day we will be fine with our own known mechanism (desi alaaj). Our children are now going to schools and we are focussing on their education. We want them to study and take up jobs and live a settle life. This nomadic life is no more a feasible option anymore. Neither the government wants us to be nomadic nor does our child find it any more lucrative to be in this occupation. It is now only few of us, who are continuing in this occupation as we have no other means to survive* (FGD Doru, 2021).

What can be argued that nomadism as a form of lifestyle for bakkarwals needs to be responded by the state. The state must make use of policy mechanism to ensure that bakkarwals do not remain hard to reach group and doesn't suffer for the want to treating the elements that can be done. Establishing a coherent policy perspective which stresses and encourages nomadism must shape the health care delivery system in Jammu and Kashmir.

# Chapter 5
# Discussion and Conclusion

## 5.1 Discussion and Conclusion

Human excellence and growth is marked by inventions, discoveries, advancements in knowledge production and scientific developments. The underlying purpose of technology and knowledge production is human welfare. Human welfare can't be seen in segregated indicators but in a holistic manner comprising of progression in our engagement with fellow beings and environment. It is in this context that the current research has brought forth various discords that are currently engulfing the nomadism and the people engaging in nomadic pastoralism.

Pastoralism or nomadic lifestyle is seen as an adaptive and divergent lifestyle meant for providing feasible environment to the livestock. Nomadism is seen as an alternative means to overcome the difficulties that arise because of harsh climate and to ensure availability of fodder for the livestock. But this understanding about nomadism limits it only as an adaptive strategy and takes away the people who are important constituents of the whole process of nomadism. As Davies and Hatfield (2007) argue, "perceiving pastoralism solely from the organisational and strategic aspects of its adaptive potential, its 'direct and indirect values' and/or its appropriateness for utilising a widespread and extensive natural potential would omit a discussion about the people that are involved" (p, 12). This understanding of conceiving nomadism only from the perspective of adaptability to the climate for survival has resulted in seeing nomadic lifestyle as rudimentary and non-profitable. It is this understanding which has also been seen prevalent in the policy formulation when it comes to Bakkarwals.

This study has clearly witnessed that state is working from this perspective when it comes to the welfare of Bakkarwals. The state is utilising and developing all those means and measures which directly indirectly are leading to vanishing of nomadic lifestyle. Even the legal processes are modified in such a way that there is no respite to the people who have adapted and who are supporting nomadic lifestyle. The approach of marginalisation and neglect is one that indeed defines the precarious condition of the Bakkarwals in Jammu and Kashmir. The study has clearly shown as to how this precarity of nomadic life is entrenched in marginalisation of various types. The geographical marginalisation inherent

to very nature of Bakkarwal lifestyle is now augmented by social, political and institutional marginalisation. The marginalisation is woven into the web of neglect driven by state policies. The apathy is such that public policy formulation completely ignores the existence of the nomadic Bakkarwals. However from the field data it has come to fore that there is emergence of another kind of approach now too common offered as a panacea to the nomadic people's problems and it is 'modernisation and development'. This approach of modernisation and development brings significant effects on nomadic people.

The pundits of modernisation and development discourse are skilfully crafting newer discourses of reengaging with nomadic lifestyle. Not to any surprise modernisation and development approach again bring back Garret Hardin's concept 'tragedy of commons'. This concept of Garret Hardin is nowadays gaining pace and most of the policies are adhering to this notion. The issue of growing land pressure, over grazing and depletion of forest covers are seen as an outcome of nomadic lifestyle. Therefore privatising the common property resources like land and settling nomadic communities is considered as a panacea that is offered by development practitioners and policy experts who are hired by the governments funded by business empires to shape policies.

Aiding to the whole gamut of modernisation and development framework through tragedy of commons is the emergence of climate change debate. The propounders of climate change debate are now vehemently arguing for rescuing and rejuvenation of nature. The nomadic lifestyle is seen as generating a pressure on the forests and pastures through overgrazing and depletion of forests. Nomads are being held responsible for depletion of forests and therefore movement is to be restricted through settling the nomads or creating forest reserves, national parks and sanctuaries. When it seems easier to attribute negative events to climate change, development practitioners, consultants, decision-makers, and regional planners have a tendency to overlook social and political repercussions (Kelkar, et al. 2008., Kohler., & Maselli. 2009).

Like Jack Ives said of the Himalayan Dilemma, one day we might regret the conceptual muddle known as the "climate change dilemma" It was a development paradigm that misunderstood the relationship between cause and effect, led to the misuse of significant financial resources, and neglected some of the true demands of the populace. There were efforts taken to address a problem that either did not exist or had been greatly overstated. As a result, "growth" was misrepresented, and the recognition and prioritisation of

situations that required attention were put off (Ives, 2004). Bakkarwals in Jammu and Kashmir already faced numerous evictions under the grab of this preservation debate and now it is climate change discourse that is again hampering them.

Since rivalry between mountain farmers and pastoralists increased the demand for grazing lands, while at the same time environmental conservation and the privatisation of common properties are lowering their degrees of freedom, the space left for pastoral activities has been decreasing even more. It is possible that the concept of a "drama of the commons" will become more relevant in an era of resource expropriation and land grabbing, when customary rights are easily violated and community customs are ignored (Ostrom et al. 2002 cited in Kreutzmann, H. 2012) is much more appropriate. The Bakkarwals are in continuous puzzle as to what shape the coming times will give to their very existence of nomadic lifestyle. The push for settling down and also aspirations of the young generation is indeed garnering the space for imminent shrinking of the nomadic lifestyle. It has been clearly found out that the state is in no mood to give any kind of support to say by whatever means for creating a favourable environment for nomadic lifestyle. The two most important institutions of state, health and education are not at all catering to the felt needs of the nomadic community. The utilisation of health centres is marred by issues of social discrimination, geographical marginalisation and of course by institutional administrative apathy. Whereas at one end the demand for health needs is increasing with advent of time, at other end there is continuous refusal of meeting the demand. This demand supply gap is putting Bakkarwals at a very disadvantageous position resulting in significant effects. The ineffective public health sector which Bakkarwals have been trying to access is not fulfilling the need. Whereas, increasing private sector is leaving out Bakkarwals owing to its issue increasing medical costs and non-availability in the areas accessible to Bakkarwals.

The increased out of pocket expenditure of Bakkarwals, non gratification of health needs leading to illnesses and prolonged diseases and increased mortality rates are the outcomes of this demand supply gap. Further it is clearly visible that this demand supply gap is creating a space for others to fill. The established private sector does not venture in fulfilling this demand supply gap because it is not viable and sustainable for them from profit perspective. Therefore it leaves a comfortable space for quacks, non-registered practitioners, traditional healers, and faith healers to fulfil the created gap. The study has clearly brought forth the evident role played by many traditional healers and faith healers

in providing the healthcare services. Furthermore the nonregistered medical practitioners and quacks also pave their way in providing healthcare services to the nomadic Bakkarwals. All this comes with its own significant disadvantages. However the Bakkarwals are not averse to all these healthcare providers who are fulfilling the gap even knowing that they are not so well skilled and qualified. This is for the simple reason that Bakkarwals find it appreciable that they are getting atleast something in the times of need and that too when no state apparatus is seen anywhere.

The study has clearly shown that no major experiments or innovative efforts have been tried by the government when it comes to provisioning of healthcare services to nomadic populations. Though, globally it has been witnessed that countries like Chad, Somalia, Kenya, Ethiopia has tried various innovative programmes like '*Mobile Health Clinics*', '*One Health'* concept and so on for providing healthcare services to nomadic populations. Nothing of this has even been yet thought in case of nomadic Bakkarwals of J&K. Such indifference on the part of state is clearly pointing towards the apathy of diminishing government health sector in India. The study has shown that vaccination and immunisation programmes have found extensive reach when it comes to the provisioning of healthcare services. The public health sector does make efforts to ensure vaccination and immunisation reaches even to remotest of the locations and thus nomadic Bakkarwals are benefited through it. The vaccination and immunisation programmes are usually time driven, mission mode programmes and hence Bakkarwals find themselves lucky to get covered by it often. Though, we do not have numbers who may even get left out instead of all such efforts simply because of them being nomadic.

Socio- cultural aspects have been found quite vital and important when it comes to the relationship of nomadic peoples with state institutions. The data in the form of narratives from the field clearly depicts that healthcare service utilisation is dependent on the sociocultural factors. The historical and persisting social discrimination with respect to Gujjar Bakkarwal community is also a major impediment in utilisation of healthcare services. The issues of accessibility and availability of healthcare services which are major ones when it comes to nomadic Bakkarwals are augmented by the acceptability factors. Bakkarwals usually reside in areas which are remote and hence marred by availability of adequate healthcare institutions. Besides this the issues of access to nearest healthcare centres are also affected by available means of transportation. Many other factors like timings are adding to the issue of accessibility. To this all the social discrimination which

has now been sufficed by religious discrimination is adding a new layer of problems in availing the healthcare facilities. The study has shown that from the last one decade religious polarisation has drastically affected the Bakkarwal community. Right from accessing the common property resources near settled villages in Jammu region, availing healthcare services has become a tedious job. The wedge that has been created in Jammu and Kashmir is severely affecting Bakkarwals in fulfilling their needs both in Jammu and as well in Kashmir. It is pertinent to mention here that discrimination is not at social level only rather it has percolated down at institutional level. The study has shown through field data that Bakkarwals find it difficult to avail health services in healthcare institutions just because of their two identities one as a Bakkarwal and the other as a Muslim. Bakkarwals are facing social inferiority from dominant identities of J&K thereby hindering their access to health services. "A bear can be more faithful than the Gujjar", is a common adage that prevails in Kashmiri society. Discrimination on the basis of identity not only manifests in terms of marginalization at social level but its repercussions can be seen at institutional level. The insensitiveness of doctors and other service providers in Kashmir towards this community is not merely an incident but a practice which sometimes ends up in disastrous incidents.

The study has clearly shown that there is a caste as well as class bias with regard to Bakkarwals. Gujjar and Bakkarwal respondents revealed that kashmiris consider them as their fellow beings only inside doors of mosques and outside sphere is completely different. "Inside a mosque we are Muslims 'part of ummah' but outside we are Gujjars who are to be ridiculed and ostracised" as was narrated by a respondent. Public spheres are witness to the fact that Gujjars and Bakkarwals never had an inclusionary space within kashmiri society. The persisting social discrimination runs deep at all levels in the society and institutions. It becomes as major impediment for utilisation of health care services by Bakkarwals. The study has clearly shown that where ever healthcare providers are from the same community the utilisation of healthcare services increases and provisioning of healthcare services has been easy. It is clear from most of field narratives that Bakkarwals feel comfortable whenever they access the institutions where people from their own community are service providers. The data from the field clearly pointed towards institutional bias with respect to Bakkarwals and thereby pushing them further to margins. Unfortunately, the institutional bias operates in a very informal way.

As we know that institutions are governed by legal framework and within that framework formal procedures of working are there for every institution. So whenever we speak to service providers they completely deny of any kind of bias towards any community. They would always give a response that hospitals are for everyone, we work as per law, no discrimination, and no humiliation. It is very often we would hear from doctors and paramedical staff saying we work without any bias; we follow rules and medical ethics in our working. However, what has come to fore in the research is an existing informal way of discrimination towards Bakkarwals operating in institutions. The historical social discrimination of Bakkarwals being uncivilised and unhygienic is embedded deeply in the very being of Kashmiri service providers of public health centres. This is felt (as shown by this research) by Bakkarwals at all levels of health service delivery system. The presence of service providers from Bakkarwal community generates a sense of blood and belongingness among Bakkarwals. This belongingness creates a hope of being responded, looked after and treated properly. The private service providers are seen by Bakkarwals as ones who are there to earn money and hence they take extra care of not letting discrimination become obvious. Private providers are well aware that Bakkarwals have to be given due care and attention as they are source of income and any feeling of mistrust is going to hamper the business. However, that is in no way a measure to say that private providers do not discriminate against Bakkarwals. The findings of the study clearly show that private providers like pharmacists provide over the counter drugs to Bakkarwals at an exorbitant price.

What seems general panacea for the nomadic health is the strengthening of the public health system. The strengthening of healthcare systems and achieving the goal of universal health coverage would greatly benefit the nomadic Bakkarwals. The study has shown that Bakkarwals are dependent on the traditional healthcare practices and faith healers are an important part of health culture. Therefore there is a need to integrate and develop a model of healthcare service delivery which will integrate the modern healthcare service providers and traditional system. Integrating the two would help in achieving desired health outcomes among the nomadic populations.

It has also seen that poverty acts as a major impediment is seeking quality healthcare. The data clearly shows that reaching to tertiary care health services is the lost resort of the Bakkarwals when all their means of seeking affordable healthcare ends. They find it extremely difficult even to access public tertiary healthcare because of financial burdens.

Very often financial burden becomes too heavy for them to continue with treatment. Moreover no having a requisite social capital in cities where most of these tertiary health care institutions are established also hinders Bakkarwals from accessing these institutions. The out of pocket expenditure incurred pushes them back to faith healers (pirs) as a last measure. This often leads to maltreatment of the illness and thus increased morbidity and mortality. Ameliorating the financial burden through universal health coverage funded by government would improve access and bring positive changes in the health outcomes of the impoverished communities like the Bakkarwals.

Identity as an important marker for utilisation of healthcare services has come out as a remarkable factor. Bakkarwals see themselves as distinct from other hegemonic identities existing in Jammu and Kashmir. This identity as a marker for healthcare service utilisation is prevalent because of the very phenomenon of 'otherisation'. The social discrimination which has led to the otherisation of Bakkarwals is indeed now influencing their health service utilisation in public health system. The otherisation of Bakkarwals is now an evident phenomenon which is visible and noticed in daily vocabulary and also in many other discourses that surround the everyday lives. The visible outcome of this can be seen in street slogans where word Gujjar is nothing less than a mukhbir or a collaborator.

In Jammu and Kashmir, Gujjars and Bakkarwals had to face the wrath of colonial modernity along with worst burden of partition. This ethnic group is one of the politically insignificant, socially isolated and economically backward groups in the state of Jammu and Kashmir. Having to live their lives in the upper reaches of Himalayas, these people have to face hardship not only from nature but from dominant structures of the state. The dominant structures and identities both at the level of state and social groups have left this ethnic identity grappling with numerous problems under the grab of development. The problems are both at the level of changing livelihood patterns and the breaking down of their own socio-cultural milieu, thus creating societies, which Ulrich Beck calls '*Risk Societ*y' (Beck, U. 1992) In Risk Societies the concept of social justice, reasoning is overwhelmed by reducing the risks of breaking traditions, cultures, job insecurity and environmental degradation. Gujjars and Bakkarwals are continuously facing social marginalization, political insignificance, and geographical invisibility. Places in which Gujjar and Bakkarwal community are in majority (Rajouri and Poonch) are border areas and highly backward areas. These are border areas which have always remained tense due to the hostile relations between India and Pakistan post partition. The brunt of cross border

firings and usual shelling have always made the life of Gujjar and Bakkarwal community miserable and harsh.

Due to border skirmishes the cultivable lands as possessed by this community remain barren. This marginalization can be noticed through the availability and accessibility to the number of state institutions in specific areas having specific ethnic population. Furthermore the structural imbalance that one can see in many of the sectors is a harsh reality. The state has failed in delivering adequate healthcare to nomadic Bakkarwals, thereby limiting their access to Right to Life as envisioned in Article 21 of the Indian constitution.

**5.2 Recommendations:**

The study after thorough analysis of the data gathered from field would like to propose following recommendations for policy makers and planners to be considered

1. Nomadic Bakkarwals should be allowed to use traditional routes during their transhumant movement without any hindrance and should be provided basic facilities enroute to their pastures. The government should ensure that nomadic people be provided facilities which can safeguard them and their livestock from the natural hazards like torrential rains and snow during transhumant movement.
2. The state should ensure that pastures access to pastures should be protected within the Forest Rights Act, 2006. State should ensure effective implementation of Forest Rights Act, 2006 so as nomads don't face evictions and harassment from government institutions and local settle populace.
3. There is a need to draft as comprehensive policy for nomadic tribes of Jammu and Kashmir. The policy framework should include dimensions of health, education, and livelihood. The concept of "One Health" needs to be introduced into the policy framework for nomadic tribal health. The One Health phenomenon would ensure integrative approach for tackling the issue of health of tribals as well as their animals. The effectiveness of one health approach has shown remarkable results in many African countries and therefore its efficacy would be boon for nomads in Jammu and Kashmir. The study has clearly shown that Nomadic bakkarwals value the health of their animals and their own health on similar lines. For them health of their animals is as important as and rather more important than health of their own. Thus providing them an integrative health approach through utilising services of human health and animal health institutions would be effective.

4. There is also a need to develop a robust database for tribals in general and for nomadic Bakkarwals in particular. The data base would facilitate in observing various trends and help in further planning. Besides this the data base would help in segregate analysis of issues and concerns of different tribes which otherwise is difficult as such.
5. Many of the programmes like vaccination and immunisation has been even made possible to cover hard to reach groups because of the effective implementation of the programmes at grassroots level. Therefore it becomes imperative that for providing access to healthcare services there is need to have sufficient human resources available in all those health centres and institutions which serve the tribals.
6. The policy frame should also ensure that effective linkage between modern allopathic system and traditional healthcare providers including faith healers like hakims. This linkage will help in building the trust on the state institutions and also increase people's participation. Moreover such an approach will also help in lessening the burden on health institutions and also augmenting to achieve the desired health outcomes.

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