

Assessing the Trickle Effect in Attitudes Related to Women's Health among Tribal Gujjars

Rajni Dhingra^{1*}, Archana Bhat² and Manpreet Kaur

P.G. Department of Home Science, University of Jammu, Jammu and Kashmir, India
Telephone: ¹<0191-2552674>, ²<01923207991>, Mobile: ¹<09419104644>, ²<09596668908>
E-mail: ¹<rajni.dhingra@rediffmail.com>, ²<archanabhat83@yahoo.co.in>

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ABSTRACT The present study was conducted to assess the trickling of attitude from mothers to their daughters in context of health of adolescent girls. The sample comprised nomadic and semi-nomadic tribal (Gujjar) adolescent girls in the age group 13-15 years and their mothers. A total of 200 girls were selected using random sampling technique from various areas around Jammu district. Though, the trickling of attitudes was observed from mothers to daughters, certain amount of trickle in the reverse direction could also be found. However, significant differences in attitude of mothers and daughters in most of the aspects revealed changes taking place in the attitudes of the younger generation. Results revealed no significant difference in the attitude of mothers and their daughters in regard to reproductive health. The scores of both the generations revealed a positive attitude (153.5 and 158.9 were mean score of sample girls and their mothers respectively) towards various dimensions of reproductive health. The dimension in which attitude towards reproductive health were assessed included family life education, family planning, sexual behavior and health. The findings have implications for the researchers, planners and welfare agencies working in the aspects related to reproductive health of women.

INTRODUCTION

Reproductive health as defined by WHO and adopted by the program of action of the International Conference on Population and Development (ICPD 1994) means a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. The reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couple with the best chance of having a healthy infant. Adolescence is a bridge between the asexual child and the sexual adult (Rosenthal and Feldman 1999). It is a time of sexual exploitation and experimentation with sexual fantasies and realities, of incorporating sexuality into one's identity (Christopher 2001). Adoles-

cence is a period of rapid changes- physical, social, emotional and sexual. As adolescents attain puberty, they are considered as mature beings and expected to take on adult roles. Their needs and changes are often overlooked by their family members, especially their need for knowledge. Sex education as taught in school, has a limited scope unless the attitude of family is permissive enough to encourage communication about sexuality. It has been observed that there is inadequate understanding of reproductive health and sexual issues during adolescence which is found to be the main cause for the absence of focus on services, information and research related to adolescent reproductive health (UNFPA 2000). Adolescents especially girls, are traditionally married at early age and are exposed to greater risk of morbidity and mortality. The knowledge they have, is reflected in their behavior and practices.

Trickle down relates to economic theory that financial benefits accorded to big businesses and wealthy investors will pass down to profit smaller businesses and consumers. Trickle effect describes situation in which something that starts in the high parts of a system spreads to the whole of the system. When applied to social sciences, with advancement people have changed and organized themselves and this has trickle down effects on all sorts of social behav-

*Corresponding author

ior (Guerin 2002). Adolescent girls constitute a vulnerable group not only with respect to their social status but also in relation to health. Primarily poor personal hygiene and unsafe sanitary conditions result in gynecological problems (Bhatia and Cleland 1995). Lack of awareness regarding the health hygiene and changes related to puberty could be an important influencing factor for poor practices which further may result in poor health. Improving the status of girls especially Gujjar girls must firmly and simultaneously deal with hurdles such as social customs and cultural traditions that impede with health status of women (Gul 2014). Mothers play an important role in the early socialization of the girl and are responsible for her personality development and gender socialization. A change in the consciousness and attitudes of mothers would be constructive in building a supportive home environment for the girl child (Baligar 1999). Daughters learn their beliefs about women's role and establish their own work role identity while growing up through their mothers' instructions and examples (Moen et al. 1997). Even growing up years are important years for the transmission of social norms and values which trickle from mother to their daughters (Badyar and Brooks 1991). Mother, sisters and friends have been found to be major sources of providing information in a study of adolescent girls of Rajasthan (Khanna et al. 2005; Deb and Mishra 2004). Thus, maternal attitudes are relevant to the development of sex role attitudes among daughters (Smith and Self 1980). Most of the intergenerational influence found was transmitted through the mothers' attitude, rather than her experiences or behavior (Thornton et al. 1983). Since mothers have been found a major source for imparting information related to reproductive health issues, their own attitude towards these issues is generally expected to trickle down to the next generation. In this context, it was found vital to assess the attitude of mothers and daughters towards these issues. The present study was designed for the females (including adolescent girls and their mothers) of Gujjar tribe from Jammu and Kashmir (J&K) region of India, one of the tribes known for being educationally backward and unexposed to modern influence, with following objectives: 1. Assessment of Attitude of tribal (Gujjar) adolescent girls towards imparting family life education in schools and homes, family planning, sexual behavior and overall health. 2. Assessment of Attitude of tribal (Gujjar) mothers towards re-

productive health issues indicated above. 3. Determination of trickle effect by Comparing the attitude of mothers and their daughter.

METHODOLOGY

The entire sample for the study was divided into two groups. Group I included the core sample for the present study comprised of nomadic and semi-nomadic tribal (Gujjar) adolescent girls in the age group 13-15 years. A total of 200 girls from this group were selected using random sampling technique from various areas around Jammu district and Kashmir state. Group II comprised of the mothers of the selected adolescent girls. The sample size of this group II was 200. The sample was drawn from Gujjar tribe of J&K, residing in and around Jammu district. The areas from where the sample was drawn included R.S.Pura, Akhnoor, Nagrota and Bari – Brahmana of Jammu district. Since the sample group is nomadic, these were the areas of their temporary settlement at the time of the present study. A combination of snowball and random sampling technique was used for the selection of the sample group. The technique used for the selection of the sample is given:

Group I – since Gujjar house clusters are located in fields/open areas in far flung areas, initially these clusters were identified and information related to the availability of the adolescent girls was obtained. A list of families with at least one adolescent girl in the age range of 13-15 years was prepared. Then by random sampling technique (lottery method) the desired sample was drawn. The total sample comprised of 200 girls.

Group II – mothers of selected 200 adolescent girls were also included in the sample to form group II.

Tools for the Study

Modified version of the rating scale "Attitude towards reproductive health" devised by Hakim et al. (1991) was used to obtain data related to attitudes of respondents (both mothers and daughters). In addition, interview guide focused on the below mentioned aspects mainly for data supplementation and triangulation

RESULTS

After administering the above tools, responses were obtained from mothers and their daughters. The findings are categorized and dis-

cussed under various headings presented as follows:

A. Attitude towards Family Life Education

This component of the scale helps to assess attitude of mothers and their daughters related to imparting family life education in schools and homes. The scores obtained (Table 1) revealed that both mothers and girls show positive attitude towards imparting sex education in schools. They strongly believed that male and female teachers should impart such education separately to boys and girls. The mothers wanted that girls should have proper knowledge about their reproductive organs, processes and onset of menarche. They believed that with changing times there was no harm in imparting sex education to their child. It was felt that parents should also play positive role in imparting right kind of such education and guidance to their child. However, mothers felt embarrassed in discussing issues with their child, they claimed that family life education should only be imparted when their child was on verge of entering into family life and it should be the job of teachers to communicate such ideas. The result of t-test revealed that there was no significant difference found in the attitude of girls and their mothers in regard to family life education.

B. Attitude towards Family Planning

Under this category of the scale, the respondents' attitude towards family planning and the importance of using fertility control methods was assessed. Mothers scored higher than their daughters on this component (Table 1). Both the groups believed that multiple pregnancies are harmful to health. They were in favor of normal deliveries than caesarian one. They both showed positive attitude towards creating gap

of at least one year between the children as this was in favor of mother's and child's good health. There was significant difference in mean score of mothers and girls as shown by t-test with regard to this attitude.

C. Attitude towards Sexual Behavior

The items included under this category consisted of decision making about the birth of the child, right of females in relation to delivery of the child, correct knowledge and awareness related to general and reproductive health of females. The mothers scored higher than their daughters on this aspect and the difference was significant (Table 1). Overall, the scores on this dimension revealed positive attitude towards females' participation in sexuality related decisions, termination of pregnancy, safe delivery and reproductive rights.

D. Attitude towards Health

This component of the scale included statements related to the care of health of women. The items under this component were attitude regarding child delivery and care, factors affecting women's health and nutrition. The data obtained revealed that more mothers believed that home was the best place for delivery while their daughters preferred hospitals for this purpose. Both groups however emphasized proper medical checkups and health care by pregnant women. Result of t-test reveal that there was significant difference in attitude of girls and their mothers towards the various aspects related to the health of women.

On the basis of scores obtained on the Attitude scale (Table 2), the attitude of girls and their mothers were assessed as acceptors and rejectors. The cut off values for the scores of mothers were 161 and above, hence mothers scoring

Table 1: Mean score distribution of attitude of girls and mothers towards reproductive health

Components (max possible score)	Girls (n=200) Mean/SD	Mothers (n=200) Mean/SD	Calculated value ot "t"
Family life education(20)	12.0 (2.1)	12.1 (2.3)	0.4
Family planning(140)	84.34 (7.1)	86.08 (8.0)	2.2*
Sexual behavior(40)	27.41 (3.1)	29.11 (3.7)	4.8*
Health(40)	29.27 (4.1)	31.91 (3.6)	6.8*
Overall score(240)	153.5 (10.9)	158.9 (10.2)	5.14*

t-value = 1.645 at 0.05; df = 398

*significant difference

Table 2: Frequency distribution of scores in "Attitude towards family planning scale"

<i>Class interval</i>	<i>Frequencies mothers (n)</i>	<i>Frequencies girls (n)</i>
121-130	1	4
131-140	5	16
141-150	30	74
151-160	88	60
161-170	50	32
171-180	19	11
181-190	7	3
Total	200	200

Mothers: Q1=145, Q3=161

Girls: Q1=154, Q3=166

these values were placed in category of acceptors while 145 and below scorers were categorized as rejectors. The cut off values for the scores of daughters on the scale were 166 and above. These daughters were in category of acceptors, while, 154 and below scores were rejectors. These values represent Q3 and Q1 values. The Q3 and Q1 values are calculated from the total scores of 400 respondents (200 mothers and 200 daughters).

CONCLUSION

It was concluded that tribal respondents of this research study had positive attitude towards various aspects of reproductive health issue but However, it was also observed that when the responses were cross checked with the data obtained through the other tools (observation and interviews) a discrepancy was found between their formal responses to data team and their real practicing. The answers given by majority of respondents were those answers which were socially acceptable. Though trickling of attitudes was observed from mothers to daughters, certain amount of trickle in the reverse direction could also be found. However, significant differences in attitude of mothers and daughters in most of the aspects revealed changes taking place in the attitudes of the younger generation which may be attributed to more awareness among younger generation due to education. Similarity in attitude and level of thinking in both mothers and their daughters seem to be result of upbringing and trickling of attitude and practices from mother to daughters in family tree.

RECOMMENDATIONS

Family Life Education

Family life education should be able to address all aspects of life especially the real life situations that adolescent find themselves while taking into consideration the age, level of exposure, socio-cultural and religious belief of the child.

Mothers should provide more detailed explanation about sex and sexuality to their children because children naturally tend to confide in their mothers. It is this relationship of trust, friendship and confidence.

It is also recommended that some awareness programs about family education and health hygiene for adolescent girls should be done.

Family Planning

It is recommended that education to the community on importance of having smaller families should be intensified.

Campaigns to raise awareness on importance of modern contraceptives among males should be emphasized and should go along with those involving women. This could be through involvement of males in family planning programs.

Campaigns to empower women such as emphasis on their education, discourage gender biasness, attitude towards position/status of women in a household and in a society as a whole should be strengthened. This would improve their participation in household decisions and family related decisions.

Sexual Behavior

Information through various programs in schools and hospitals especially community medicine and through Aganwari workers regarding awareness of health and reproductive issues among women should be emphasized.

Mothers should be part of these programs and aware their daughters about good health and hygiene.

Overall Health

Improving Gujar women's health requires a strong and sustained commitment by

Government and various agencies to provide such policies which favour the target group.

Not only policies and facilities help the target groups but most important is that the

Gujjar women should be made aware of them and their benefits.

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