

Reproductive Health of the Matrilineal Khasis of Meghalaya

LORNA B. BANG

Introduction

The study of reproductive health has gained popularity mainly under the initiative of certain international agencies, but there is no denying the fact that this is an important subject of research cultural anthropologists have virtually ignored for reasons best known to themselves. The subject is particularly important from the point of view of women, as there is growing awareness about the importance of reproductive health throughout the world.

Women bear by far the greatest burden with regard to reproductive health problems. They are at risk of complications arising from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the responsibility of contraception, and are exposed to contracting, and suffering the complications of reproductive tract infections, particularly STDs (Sexually Transmitted Diseases). Among the women of reproductive age, 36 percent of all healthy years of life lost are due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity, and STDs including HIV/AIDS. By contrast, the equivalent figures for men are 12 percent to that of women (POPIN 2004).

Biological factors alone do not explain women's reproductive burden. Their social, economic and political disadvantages have a detrimental impact on their reproductive health. The reason why we chose to study the reproductive health in the context of matrilineal Khasi society is to examine the veracity of the common assumption that women in matrilineal societies have better reproductive rights and therefore better reproductive health. Issues related to sex and sexuality have never been dealt with openly in this society, and discussing some aspects of sex publicly are still considered to be taboo. However, such discussions may take place amongst close friends. Such matters are even considered to be a rebellion against the ethics and moral code of the

Dr. Lorna Barbara Bang completed her PhD degree from the Department of Anthropology, North-Eastern Hill University, Shillong.

Khasi people (*ka tipbriew tipblei*). For most of the people in Khasi society sex and sexuality are considered to be unclean and impure and it is meant for procreation purposes only.

This paper starts with a historical overview of the area of reproductive health. The definitions and concept of reproductive health as a human right are introduced in the following sections. A description of reproductive health as it applies to Khasi society is then presented, which is followed by a discussion on changes taking place in Khasi society.

Historical Overview

The concept of reproductive health emerged in the 1980s with a growing movement away from population control and demographic targets towards a more holistic approach to women's health (Sen 1994). It was not until the International Conference on Population and Development Programme of Action (ICPD) in 1994 and the Fourth World Conference on Women (FWCW) in 1995 that the concept gained international acceptance and was heralded as a turning point for women's health. The ICPD brought to international recognition two important guiding principles of Reproductive and Sexual Health (RSH):

1. Empowering women and improving their status are important ends in themselves and essential for achieving sustainable development, and
2. Reproductive rights are inextricable from basic human rights, rather than something belonging solely to the realm of family planning.

The FWCW reaffirmed and strengthened the consensus that had emerged at the ICPD.

The ICPD conference was instrumental in formalizing the paradigmatic shift in how women's health was conceptualized and how services were delivered. The way in which reproductive health was viewed began to change the focus from sexual morbidity to the promotion of healthy reproductive lives. Not only were there changes in the kinds of programmes that were delivered, but also in the intended recipients and manner of delivery of programmes. For example, men were recognized as having an important role to play, child survival was emphasized, the integration of RSH services into

primary health care rather than their being offered as a separate service was advocated and the need for reproductive health services in separate facilities was advocated. The need for reproductive health services specifically designed for refugees and Internally Displaced Persons (IDPs) was also recognized. Overall, it called for a fundamental rethink on health service provision.

Definition of Reproductive Health

The United Nations Population Network (POPIN) has defined “reproductive health” as:

(A) state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity in all matters relating to the reproductive system and its functions and processes. 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 of when and how often to do so. Implicit in this last condition are the rights of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning, as well as other methods of their choice for regulation of fertility, the rights of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.

Thus, reproductive health is viewed in relation to three interconnected domains that include universal rights, women’s empowerment and health service provision. Firstly, it promotes a universal understanding that is premised on the fact that it is a basic human right to be fulfilled by all governments. Secondly, it seeks to address the underlying causes of gender inequality and inequity to promote women’s empowerment. And thirdly, the provision of universal access, utilization and quality of reproductive health services address issues of sexual and reproductive health and possibly death.

The three concepts of rights, women’s empowerment and equality, and services must work in unison in order for individuals to achieve healthy reproductive and sexual lives. The first concept of reproductive health is basically rights based. This means that everyone is entitled to the rights and freedoms set out by the Universal Declaration of Human Rights, which includes the right to health and education without distinction based on race, sex and religion. Universal reproductive and sexual rights must be supported and upheld by governmental policies and laws, specifically the right for couples and

individuals to decide if, when and how many children they would like to have as well as access to information to enable them to make these choices.

The second concept of reproductive health deals with women’s empowerment, which is based on the fact that norms, values and laws create an environment that influences the extent of women’s equality and power within a society. Broadly, this means addressing issues of gender inequality and empowering women: ensuring men’s participation in decision making and understanding their responsibilities, eliminating all forms of discrimination against female children, and prevention from accessing education. It is widely known that education has an effect on health and healthy decision making. In terms of reproductive health, it can contribute to reductions in fertility and morbidities. It is also known that the education of girls contributes greatly to the empowerment of women and is associated with postponement of the age at marriage, reduction in the size of families and increase in a child’s survival possibilities. This second arena of reproductive health addresses how social and sexual behaviours and relationships affect healthy and satisfying sex lives or how they can create ill-health. Furthermore, reproductive health does not affect women alone and must not be solely promoted as women’s issue. Men also have reproductive health needs in addition to the fact that the involvement of men is an essential part of protecting women’s reproductive health (Jacobson 1991:6).

Therefore, in promoting women’s empowerment and addressing issues of equality and equity, relationships must not only be viewed in the context of those between men and women, but also of the individual and wider community. Attitudes and norms surrounding sexuality and gender carry profound meanings in every society or culture. The dynamics of knowledge, power and decision making in sexual relationships, between service providers and clients, and between community leaders and citizens all affect an individual’s reproductive and sexual health status.

The last concept of reproductive health deals with service provision. Not only does this include the ability of public and private service providers to provide a variety of quality services as outlined by the three areas of service provision, but also addressing factors that may inhibit an individual from accessing and utilizing these services. This may include ensuring widespread information on services and methods of family planning and safe sex, affordability, confidentiality, convenience, treatment of service providers and availability of suppliers.

However, the definition falls short of comprehensive perspective on reproductive health as it provides only a slight modification of WHO's definition of health. There is a need to include other important aspects of reproductive health. It should include the other members of society apart from women who are married like adolescents, single women, divorcees, couples who are living separately, widows, old women and children. Men are also to be included as they cause the greatest single hazard to reproductive morbidity and several other problems throughout their lives. Thus, in 1998, WHO set several goals to improve the inadequacies. The goals state that reproductive health does not start from a list of diseases or problems - sexually transmitted diseases, maternal mortality or from a list of programmes - maternal and child health, safe motherhood and family planning. Reproductive health instead must be understood in the context of relationships fulfilment and risk, the opportunity to have a desired child or alternatively, to avoid unwanted or unsafe pregnancy. Reproductive health contributes enormously to physical and psychosocial comfort and closeness, and to personal and social maturation. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy and death. The most significant achievement of the Cairo Conference was to place people firmly at the centre of development efforts, as protagonists in their own reproductive health and lives rather than as objects of external interventions (United Nations 1994). The aim of interventions is to enhance reproductive health and promote reproductive rights rather than population policies and fertility control. This implies empowerment of women (through better access to education), the involvement of women and young people in the development and implementation of programmes and services, reaching out to the poor, the marginalized and the excluded, and assuming greater responsibility for reproductive health on the part of men.

Reproductive health requires good basic health and nutrition, protection from violence, environmental health hazards and livelihood security throughout the lifespan. While the concept of reproductive health applies to both women and men, it has far greater impact on women than on men and, as such, requires preferential utilization of resources to women's health in particular, to reduce health risks. Where reproductive health is poor, reproductive rights become an issue and therefore a rights-based perspective has been adopted in this paper.

Reproductive Health as a Human Right

Reproductive rights and health are an integral part of human rights and are

essential for enjoyment of one's full human potential, mental, emotional and physical well-being (Jayapalan 2002:113). It also includes enhancement of relationships, women's empowerment and achievement of gender equality. Respect for women's reproductive rights and provision of reproductive health services also provides the basis for neo-natal health and survival for the health and development of children and for the overall well being of the family.

Reproductive rights embrace certain human rights that are already recognised in national laws, international laws and human rights documents and other consensus documents. The rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsively the number, spacing and timing of their children. To have information and means to do so and the right to attain the highest standard of sexual and reproductive health and the right to make decisions concerning reproduction that is free of discrimination, coercion and violence.

Reproductive rights also include the rights of individuals to control their own bodies, to have sex that is consensual, free from violence and coercion and to enter marriage with the full and free consent of both the parties (United Nations 1994). Reproductive rights are essential for women's exercise of their right to health and include the right to comprehensive, good quality health services that ensure privacy, that are fully informed and have freedom of consent, confidentiality and respect.

A healthy reproductive health and sexual life is now considered to be a basic human right for all, including refugees and other forcibly displaced persons and is protected by three bodies of human rights law, refugee law and humanitarian law (United Nations 1994). The foundations of reproductive rights were first established in the two fundamental human rights treaties, the United Nations Charter, adopted in 1945, and the Universal Declaration of Human Rights, adopted in 1948, which ensured an individual's right to health. In 1951, refugee law came into effect with the United Nations convention relating to the status of refugees. In 1949, the Geneva Convention with respect to the protection of civilians in the time of war provided the basis from which reproductive health was addressed under humanitarian law. Although not addressing reproductive health specifically it made reference to protection and special assistance to 'maternity cases' as well as protecting women 'against rape, enforced prostitution or any form of indecent assault' (United Nations 1949: 2-4).

In 1976, the international community agreed on an additional covenant

which provided more detail to the rights embodied in the Human Rights Declaration and the Convention of the Status of Refugees, with implications upon issues of gender, reproductive health and refugees including those individuals not lawfully within a host country. The International Covenant on Economic, Social and Cultural Rights (ICESC), Article 12 goes beyond the Universal Declaration's Right to Health and states: 'right to everyone to the enjoyment of the highest attainable standard of physical and mental health' and then outlines steps to the realisation of this goal. While there is no specific mention of reproductive health rights, some of its provisions, such as Articles 10(2) and 12(2a), address reproductive health issues (United Nations 1976:178). However, the subsequent UN General Comment No. 14 on Article 12 (United Nations 2000) states: 'the right to the highest attainable standard of health, it specifically addresses reproductive health rights of all individuals with specific reference to women, to adolescents, the inclusion of refugees, asylum seekers, illegal immigrants and internally displaced persons, as well as state responsibilities to uphold these reproductive rights'.

In 1979, the United Nations International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) set clearer definitions and standards than the earlier covenants with respect to gender equality. It expanded the protections against discriminations and called for increased attention to vulnerable groups including refugees and migrants. CEDAW is the only human rights treaty that addresses women's reproductive health rights with acknowledgement of pervasive social, cultural and economic discrimination against women. In particular, Article 12 of the Convention requires States to 'eliminate discrimination in access to health services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement, and the post-natal period' (United Nations 1979:1-2). In 1999, CEDAW General Recommendations 24 on Women and Health (Article 12) made further recommendations according to the fact that 'access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women' (United Nations 1999). It comprehensively addresses violence against women, safe motherhood, provision and access to services, and quality of services provided, and declares that all of these are to be addressed by the participating states as provision of basic human rights.

The 1989 Convention on the Rights of the Child (CRC), equally guarantees children access to basic human rights including health and access to reproductive health information and services. The 2002 Optional Protocol

of the CRC was extended to include the sale of children for prostitution, which endangers their reproductive health status.

Framed within the human rights and refugee law, a Humanitarian Charter and a Minimum Standards of Care in Disaster Assistance were developed by a larger group of agencies in 1997. This Charter describes core principles of humanitarian actions in order to reaffirm the rights of affected populations, as well as pointing out responsibilities of warring parties or states. The Charter formed the bases of the Sphere Handbook, which sets out minimum standards of care for multi-sectoral disaster responses. In 2004, an updated version came into effect, which, in addition to other cross-cutting themes, addresses reproductive health-related issues of protection, gender, children, HIV/AIDS, and people living with HIV/AIDS (The Sphere Project 2009).

Programmes dealing with various components of reproductive health exist in some form almost everywhere but they have usually been delivered in separate ways, unconnected to programmes dealing with closely interdependent topics. For example, the objectives, design and evaluation of family planning programmes were largely driven by a demographic imperative, without due consideration to tolerated health problems such as maternal health or STD prevention and management (POPIN 2004). Evaluation was largely in terms of quantity rather than quality - numbers of contraceptive acceptors as opposed to the ability and opportunity to make informed decisions about reproductive health issues. In general, such programmes exclusively targeted women, taking little account of the social, cultural and intimate realities of their reproductive lives and decision making powers. They tended to serve only married people, excluding, in particular, young people. Services were rarely designed to serve men even though they have reproductive health concerns of their own, particularly with regard to sexually transmitted diseases. Furthermore, the involvement of men in reproductive health is important because they have an important role to play as family decision makers with regard to family size, family planning and use of health services.

A reproductive health approach would differ from a narrow family planning approach in several ways. It would aim to build upon what exists and at the same time to modify current narrow, vertical programmes into ones in which every opportunity is taken to offer women and men a full range of reproductive health services in a linked way. The underlying assumption is that people with a need in one particular area, like treatment of

sexually transmitted diseases, also have needs in other areas, in this case family planning or antenatal/postpartum care. Such programmes would recognize that dealing with one aspect of reproductive health can have synergistic effects in dealing with others. For example, management of infertility is difficult and expensive but it can be largely prevented through appropriate care during and after delivery and prevention and management of STDs. Promotion of breast-feeding has an impact on reproductive health in many ways: it helps prevent certain postpartum problems, delays the return to fertility, may help prevent ovarian and breast cancer, and improves neonatal health (POPIN 2004).

Another important difference between existing programmes and those developed to respond to the new concept of reproductive health is the way in which people, particularly women and young people who are the most affected by reproductive health concerns, are involved in programme development, implementation and evaluation (POPIN 2004). When women become more involved in programmes it becomes clearer that they have health concerns beyond motherhood and also that dealing with reproductive health involves a profound rethinking of the behavioural, social, gender and cultural dimensions of decision-making which affect women's reproductive lives.

Reproductive Health, Rights and Laws

As already stated, the concept of reproductive health was evolved during the 1994 ICPD conference at Cairo as an offshoot of the family planning programme. However, any conceptual models revealing the possible causal relationship between various factors, directly or indirectly influencing reproductive health, do not accompany the existing conceptual frameworks on reproductive health (Mahadevan 2000: 3). Women suffer from several problems with the key aspects of sexuality and reproductive health such as reproductive tract infections, infertility, morbidity due to childbirth and violence against girls and women. Protection of women against indecent representation, unequal remuneration, *sati*, *devadasi* system, forced abortion, lack of maternity benefits, violence against women, dowry deaths and rape are all recognized by the Indian Penal Code (IPC) (Diwan and Diwan 1994).

Conservative and traditional upbringing of many women influences a great deal battered women to tolerate such violence (Madhurima 1996). The Constitution of India provides protection of women from discrimination and

denial of equal protection under the law (Pachauri 1999). However, the effectiveness of these laws in protecting women from social problems is doubtful.

The government of India appointed a commission to inquire into the conditions of women working in the unorganised sector. This commission produced a detailed report describing the conditions of women in India in 1975. Several efforts have also been made to discuss women's invisibility in the data. However, the greatest invisibility of women pertains to health issues. Health is the basic need of a human being and therefore denying women their health needs has seriously affected their productive and reproductive role. Health and well being of all members of a family are also far more dependent on the productive capacities of the woman than that of any other members of the family (Karkal 1996: 1). At the Alma Ata Conference in the USSR, in 1978, primary health care was exclusively discussed by 134 countries where access to family planning, maternal and childcare and prevention of common diseases was accepted as a basic human right (WHO 1978: 33).

Since the mid 1970s, women's organisations, social activists and community based organisations have raised their voices against the contradictory positions taken by the government on population and family planning. While on the one hand the Bucharest Conference espoused that "development is the best contraceptive", back home family planning measures were intensified with women becoming the focus of sterilisation. The first glimmer of doubt at the government level emerged in the 1980s when the approach paper to the Eighth Five-Year Plan stated 'in spite of massive efforts in the form of budgetary support and infrastructure development, the performance of the family welfare programme has not been commensurate with inputs' (Ramachandran 1996: 160-61). By this time, many women activists and NGOs had either distanced themselves from the government's programme and the population control lobby or had begun to oppose it. There was little or no positive dialogue between them. The moderates, who argued for a more balanced view of population, women's health and poverty linkages, were either silent or found their campaign/ advocacy ineffective.

Agreement on the central role of women was not even an issue at the ICPD (United Nations 1994). The debate focussed on a woman's control over her own body, the need to empower women, provide them with more choices, expand their access to health services and education, skill development and employment, and ensure their full involvement in policy and decision-

making at all levels. The ICPD Programme of Action facilitated reforms in population/family planning programmes wherein targets, incentives and coercion were no longer to be used. Integrated approaches, quality services and informed free choice in all matters related to sexual and reproductive life were upheld as core principles. Finally, in addition to the long-established basic right to family planning, the universal right to sexual and reproductive health was affirmed.

An important contribution of the ICPD was that it changed the language to include hitherto un-mentioned words such as sexuality, reproductive and sexual health and reproductive rights. Experts replaced words such as “population control” with “population stabilisation” to stress the voluntary nature of the actions sought. The terms “reproductive and sexual health”, “women’s rights”, “sustainable development” “quality of life”, “quality of care” and “informed choice”, reflect the shift from the quantitative achievement to a holistic vision of individual well-being (Petchesky 2000: 17).

The Indian government affirmed its commitment to the principles of the ICPD in 1994, but there is still a limited understanding of the concept of reproductive and sexual health among policy makers, programme managers and the public in India. Despite some progressive changes, there is a continuing focus on stabilising population growth rates and a lack of unity of goals among women’s rights advocates, service providers, and policymakers. What continue to be missing are policies and programmes that promote not only health but also rights and the empowerment of women. Without a strong focus on these, India’s reproductive health policies and programmes may become like “grass without roots” (Pachauri 1999: 125).

Reproductive health care strategies to meet women’s multiple needs include education for responsible and healthy sexuality, safe and appropriate contraception and services for sexually transmitted diseases, pregnancy, delivery and abortions (Sai and Nassim 1989). The use of targets, incentives and experimental contraceptives in the context of deepening poverty and patriarchy makes family planning a tool for women’s victimization rather than liberation. When we look into the WHO definition we find that it ignores the reproductive health of women who do not wish to accomplish reproduction. It makes fertility regulation mandatory as a part of health and puts major emphasis on maternity and related situations and very little is said about other conditions that seriously affect women’s health.

Understanding key policies and programme issues based on empirical

research and field experiences are important factors for better outcomes in reproductive health, especially in a country like India (Pachauri and Subramanian 1999). This is because India is a country with multiple cultures and ethnic backgrounds. It is also a male dominated society and there is huge disparity in gender equity. Therefore, it is important to ascertain the extent to which ongoing fertility transition has contributed to the reduction of disparities and socially valued outcomes. For example, the positive relationship between women’s education and fertility decline where female education is low, fertility declines sharply with education and where fertility levels are low the link between education and fertility is less marked. Thus, there should be a redistribution of resources to promote women’s education in states that have low female literacy and high fertility (Jain 1999: 3-41). An equal health service for both men and women is a positive way to improve any health policy (Piet-Pelon, Rob and Khan 1999).

Standardised quantitative methods are needed to study the occurrence and timing of violence in relation to pregnancy and to study the context in which pregnancy occurs. The right to life enables women to enjoy privileges, which come along with motherhood, and also to prevent maternal mortality (Ballard 1998: 274-276).

Reproductive choice includes abortion and family planning (Shalev 2000: 39-59). Though the term “sexual rights” has been widely used, its concrete scope has not yet been fully defined. The viewing of “reproductive rights” as a subset of “sexual rights” has led to the negligence of individuals in considering themselves as rights holders, especially the men, thus leaving many outside the framework of human rights protection in the context of sexual behaviour (Miller 2000: 67-69).

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. They also include the rights of all to make decisions concerning reproduction free of discrimination, coercion and violence. Interpretation of sexual rights by different stakeholders during the development of the Beijing Programme of Action and within the South African Development Community (SADC) illustrated a lack of understanding that sexual rights in the African context results from poverty as well as gender inequality particularly in sexual relationships whereas in the European context sexual rights claims are motivated

specifically in relation to sexual orientation (Klugman 2000: 145-69).

The “Double Discourse” which exists in the majority of Latin American nations has led to a wider choice for citizens on reproductive and sexual choices than the official policies would lead one to believe. It can lead to an increase in illegal abortion, unsafe methods to prevent pregnancy and other high risk public health factors, especially in women inflicting a great deal of self harm (Shepard 2000: 111-36). It is commonly seen in India as well where, for example, among the Khasis illegal abortions are carried out in a clandestine manner especially among well to do families. This is because families do not want to tarnish their clan name or spoil the reputation of their children in the society and the church they belong to. Another example of the “Double Discourse” in a society is the use of contraceptives or family planning methods. Many women in Khasi society will deny the fact that they use any contraceptives due to religious sanction against same. Moreover, the fear of being ridiculed in society in their own families or by elders has led these women to deny using any kind of contraceptives.

Therefore, there is an emphasis on ethical principles in women’s rights to reproductive health and freedom where the fundamental principles are “liberty”, which guarantees freedom of action, “utility” which defines moral rightness by the greatest for the greatest number, and “justice” which requires that everyone has equitable access to necessary goods and services under this framework. As a consequence of this, governments have an obligation to provide information and services for women to exercise their right to reproductive freedom (Mahadevan 2000: 3-57).

Gender Differences in Reproductive Health

Accepted wisdom in medical sociology and social epidemiology states that in industrialised societies men die earlier than women, but that women have poorer health than men (Macintyre *et al* 1996: 617-24). Detailed inspection of papers (Raju *et al* 2000: 303-324) on gender differences published in the last decade reveals that the findings reported by many researchers are not unique, but that a relatively undifferentiated model of consistent sex differences has nevertheless continued to predominate the literature. Therefore, the topic of gender differences in health needs periodic re-examination.

Men are often neglected in programmes related to reproductive health. In the past, the fact that reproduction takes place through heterosexual relations was generally ignored. A review of conventional demographic and family

planning literature illustrates that the population field has neglected issues related to sexuality, sexual decision-making, and gender relations (WHO 1985: 34). The focus has largely been on outcomes such as fertility decline, unwanted pregnancy and more recently on infection with HIV and other sexually transmitted diseases but because these issues are politically and culturally sensitive they have been avoided in the past. As men, women and especially young people are being exposed to unwanted pregnancy and infections, these issues can no longer be ignored. However, in many cultures men are the decision makers even when it comes to sexual and reproductive health. Therefore, research focussing almost exclusively on women and downplaying men’s role is likely to have limited impact, a fact that ironically has been ignored by past programmes. Ignoring these important factors may explain in part why past family planning programmes have not been successful. Men, therefore, should be considered and involved in reproductive health issues before implementing any health issues. This might enable policies to be successful (Armstrong 1999: 902-05).

Health care researchers like Cleland, Khongsdier, Mahadvan, Pachauri, Russell and others have documented that, in many settings, male social prerogatives powerfully condition women’s relationship to health care systems. Particularly in the area of reproductive health care, the decision-making privileges enjoyed by men fundamentally affect women’s health status. Yet population policy and reproductive health programmes have been slow to respond to this insight. Unrecognised or unacknowledged assumptions about women’s “natural” responsibility for childbearing and childrearing, coupled with an acceptance of the rights of men to make family health care decisions, have impeded policy responses to these research findings. By accepting these static characterisations of men, rather than understanding that gender relations are dynamic and that men’s roles are able to change, just as women’s roles are, research and programmes have often implicitly accepted men’s power and women’s subordination. Effective reproductive health care programmes need to recruit men’s support and participation in creative ways (Greene 2000: 49-59).

A survey of 6,549 married men in Uttar Pradesh, India, made by Bloom, Tsui, Plotkin and Basset during 1986-2003 investigated factors contributing to men’s knowledge in the areas of fertility, maternal health and sexually transmitted diseases (Bloom *et. al* 2000: 237-51). Results of this survey showed that very few of the respondents had basic knowledge in any of these areas. The likelihood of reporting knowledge was associated with a set of

determinants that differed in their magnitude and effect across the areas of reproductive health explored. In particular, men's belief about the ability of an individual to prevent pregnancy showed an independent association with men's knowledge about reproductive health. After controlling for factors such as age, parity, educational and economical status, men who believed that it was not possible to prevent pregnancy were less likely to know when, during the menstrual cycle, women would become pregnant. Furthermore, they tended to know little about STDs but were able to name two or more symptoms of serious maternal health conditions.

Reproductive Health in Khasi Society

Discussion on reproductive health in the matrilineal Khasi society is still a very new idea and some aspects of reproduction and related subjects are avoided in public discussions. Women may be considered promiscuous or "loose" if they openly speak about sex and sexuality. Sex and sexuality are considered to be unclean and impure subjects especially by the Catholic Church.

Khasi society is a matrilineal society, predominantly controlled by patriarchal values. Though children take their mother's clan name, the head of the household is the father. Women often have no authority in the household and absolutely no authority in the traditional political arena. Customary laws have defined the roles assigned to men and women. In traditional Khasi society men are warriors and protectors, tillers, hunters, administrators, priests, etc. Their roles and duties are in the domains outside the home. Women have the roles of mothers, housekeepers, custodians of family property, helpers in the fields and groves. A woman is considered as *Ka Blei Īng* (deity of the house), the mother ancestress, *Ka ĩawbei*, is revered as one of the ancestral triad consisting of herself, her husband and her brother (War 1992: 13). In traditional Khasi families each daughter is helped to set up the home by gifting her some land when she marries. However, this is only in cases where the family is wealthy. The youngest daughter, *Ka Khatduh* remains (even after marriage) in the house of her parents and becomes the custodian of family wealth and property. The Khasi women enjoy considerable freedom in matters pertaining to themselves. Women are not taken as sex objects, but are a part of *ki kur-ki jait* (matrilineal relations), *ki kha-ki man* (relatives from the father's side) and *para Khasi-Khara* (the Khasi race), against whom any kind of assault would be considered sacrilegious.

Women in Khasi society are treated as equal to men. They perform social roles as mothers and as custodians of religion and property. Today's

Khasis, however, are experiencing significant changes in family relationships, in attitudes and values, and in kinship relationships. Conversion to Christianity, education, profession, urban living and contact with other cultures has given Khasi women new options. Much of the traditional and religious practices in which the matrilineal kin group plays a dominant role are no longer adhered to. Social interactions with their own kin are less frequent. This has greatly weakened the effectiveness of the matrilineal kin group and has affected the attitude and behaviour of the wife towards her kinsmen and husband. She is no longer regarded just as a kinswoman or a clan-woman. Her status is dependent on her own social position and that of her husband.

In Khasi society, as a general rule, the youngest daughter or the *Khatduh* inherits all the properties, including *Ka ĩng Seng* (foundation house/ancestral property) (Gurdon 1966). She also becomes the custodian of the family property and has no authoritative power to sell it in any form. The *Jaiñtias* belong to the same racial and cultural stream as the Khasis and are also known as *Pnars*. They share the same religion, although the *Jaiñtias* are more influenced by Hinduism. However, in the southern slopes of Meghalaya constituting the areas inhabited by Wars, the customs regarding inheritance are somewhat different from the customs prevalent among the *Khyriam* Khasis and *Pnars*. Amongst the Wars, for instance, sons and daughters have equal share of the property of their parents and grandparents with the lion's share going to the youngest daughter. However, if the youngest daughter dies or refuses to claim the ancestral property the same goes to her own youngest daughter and if she is without any daughter her elder sister inherits it. In some cases, if there is no daughter in the family the property reverts to the mother's family, that is, to the mother's sister.

Most women in Khasi society are at times left to take sole care of a large number of children. This happens when husbands abandon the family or when they do not feel responsible towards their children, as they do not take their clan names. This behaviour can usually be seen in rural areas. The principal duty of women has been viewed as bearing children and serving as the foundation of families. The cost to women's health in discharging these duties goes unrecognized.

Changes in the Khasi Matrilineal System

With the onset of modernisation, urbanisation and conversion to Christianity the Khasis have to deal with pressures that force the traditional matrilineal system to go through multifarious changes. The constant interaction with

patrilineal societies is also another factor which is having an impact on Khasi society as a whole.

The role of the youngest daughter (*khatduh*) is changing. With conversion to Christianity, much of her traditional religious obligations in terms of *ka niam iing* and in bone confinement ceremonies (*thep shyieng*) are no longer expected of her. The Khasi woman is still expected, however, to fulfil her social obligations towards her maternal kinsmen. She remains the central figure of the clan if not the only important one (Syiem 1992: 22-35).

It is also possible to see some changes among the Jaiñtias as well. In traditional Jaiñtia society, the husbands were “visiting husbands” and this added to the responsibility of women to look after the children. This has changed with time and husbands no longer visit their wives at night only but are staying with them. The Jaiñtia women have the same role to play with regard to ritual and religious ceremonies like the Khasi women do. One also notices a pull between the avuncular and paternal authorities in Khasi society. The emergence of the father figure as a dominant personality is also clearly observed (Gassah 1992: 37-46).

The attitude of Khasi men and women towards some of their customs and practices has changed with the spread of modern education and other forces of modernisation (Pakyntein 1999: 171-82). The preference for a female child was strong in the traditional Khasi society. It still carries some importance in modern Khasi society. However, reverence of the female progenitors has diminished in importance though the mother’s clan name continues to be adopted by children as before. Matrilineal inheritance also continues but women depend less on the male relatives of the clan (*kur*). They manage their affairs independently or with the help of their husbands. Even the men have acquired a new sense of confidence about themselves. They have tended to show increased disapproval of the interference of the wife’s brothers and other relatives concerning their family matters (Lamin 1999: 97-108).

Modernisation and urbanisation have brought about a sea change in perception and attitudes among the Khasi people especially the women. Education is looked upon as a major asset and both sons and daughters are given equal opportunities for education. This has led to a desire among the males to form a neo-local family rather than staying with their in-laws (Das Gupta 1995) Women also prefer to set up neo-local families along with their husbands as they understand that their husbands feel insecure with their wives’ relatives.

Conclusion

Concluding on reproductive health in the matrilineal Khasi society can be difficult, as it is still a very new idea and many aspects of reproduction and related subjects are avoided in public discussions. This is complicated by the significant changes in family relationships, in attitudes and values and in kinship relationships in Khasi society. Moreover, conversion to Christianity, education, profession, urban living and contact with other cultures has given Khasi women new options. Much of the traditional and religious practices in which the matrilineal kin group plays a dominant role are no longer adhered to.

Changes due to modernisation and urbanisation are also taking place in their perception and attitudes towards the women. An example of the changing society is the desire of the men to form neo-local family structures, which are not objected to by their wives. All these changes are likely to erode some of the status associated with women in this society and are therefore likely to impact on the reproductive health of Khasi women as well.

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