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# WHEN THE HEN CROWS: OBSTACLES THAT PREVENT INDIGENOUS WOMEN FROM INFLUENCING HEALTH-CARE POLICIES – A CASE STUDY OF SHILLONG, MEGHALAYA, INDIA

## Empowerment of Women and Girls

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## **Introduction**

Meghalaya is a landlocked and largely agrarian state in northeast India with an approximate population of three million. Various government surveys report that roughly half the state lives below the poverty line. Most people live in rural areas, but in recent years Meghalaya has experienced rapid population growth and urbanisation: between 2001 and 2011, Meghalaya's cities grew 20 per cent. This has put increasing pressure on urban areas. Today, one out of five people in the capital of Shillong are slum dwellers.

Meghalaya is part of India's 'tribal belt', with a predominantly indigenous population (86 per cent), of which the Khasi constitute slightly more than half. The Khasi are one of the largest matrilineal cultures in the world, with distinct political institutions that coexist alongside India's modern state system. Identities in the indigenous group are closely linked with maternal lineage: the children take the name of their mother's clan, and traditionally, the youngest daughter in a family inherits the ancestral land of her family.

Despite living in a matrilineal society, when it comes to health and education, women in Meghalaya lag behind their peers in other northeastern states. The state has some of the worst maternal health indices and the highest unmet contraceptive need in India. One of the reasons for the women's low status is the position of Khasi women in their communities – they do not participate in traditional political decision-making, which historically is a male domain. Khasi women are barred from even attending decision-making processes. There is an old saying among Khasis: '*Ynda kynih ka 'iar kynthei, la wai ka pyrthei*' or 'When the hen crows the world is coming to an end.' It is taken to mean that if women take part in politics, the world is doomed.

This paper examines how the Indian state prioritises health needs, and how and whether poor and indigenous women are able to participate in decisions about their sexual and reproductive health. The focus is on the indigenous Khasi population in Meghalaya, with its traditional systems of governance that exist in tandem with India's modern institutions. Literature and document reviews, documented participation through interviews and focus group discussions at these different levels in Shillong help explain what opportunities and barriers women have for political participation.

## **Lack of evidence-based urban planning**

In Shillong, government health services are available and relatively easy to access. The poor benefit from insurance programmes and free or low-cost national urban and rural health programmes. Meghalaya's health indices, however, are consistently near or at the bottom of the charts compared to the rest of India, with poor programme planning and lack of funds cited as reasons. In the decade 1999–2009, there was a steady decline in health expenditure, from an 8 per cent share of total spending in 2001/02 to 3.9 per cent in 2008/09.

Another challenge is that annual targets for health indicators in Meghalaya, which the state sets, are actually developed based on indicators from national-level data that often represent much larger states, ones that differ socially, culturally and politically. Just as problematic in terms of planning is the fact that accurate and pertinent data with regard to sexual health among slum dwellers generally does not exist in Meghalaya. Overall, there is very little health research addressing the specific issues in the state.

## **Reasons why poor women do not seek health care**

Despite the close proximity of government-run Urban Health Centres and the availability of health insurance, some women living in slums reportedly hold back from seeking health care for fear of tallying up out-of-pocket expenses. The researchers found that women often deprioritise their own health in favour of supporting the needs of others. Many internalise notions of being second-class citizens, which prevents them from asserting their rights. Despite the matrilineal family structures, some women are subordinate to spousal decision-making when it comes to reproductive health.

There is also limited awareness among women from the slums in Shillong about availability of choices and possible health conditions when it comes to sexual and reproductive health. This lack of knowledge is reinforced by a scarcity of service provision for sexual and reproductive health. In general, people in the community are uncomfortable discussing these topics. Societal norms and notions of 'good manners', together with a lack of pertinent words in the Khasi language, contribute to the silence on sexuality within the community. One hurdle is the lack of appropriate words in the local language to discuss sexual and reproductive health.

## **Indigenous governance institutions and their influence**

Governance structures in Meghalaya are complex. Indigenous Khasi institutions exist alongside India's state government machinery in addition to the constitutionally created autonomous district councils (ADCs), specifically designed for the country's tribal areas.

At the village level, Khasi men choose their own village headman (*rangbah shnong*) and his council of executives (*rangbah dong*) to look after judicial and administrative affairs. Only men can participate. Notionally and traditionally, the local councils (*dorbars*) are accountable to *syiems*, dynastic rulers of kingdoms formed from grouping village clusters. The ADCs were created to preserve the traditional system of governance. Yet the result has been multiple, parallel power structures, which have led to confusion and even paralysis in governance in some instances. The relationships between traditional institutions and state authorities, including municipal authorities, are highly contentious, especially with regard to land.

## **Khasi women are barred from most traditional systems of governance**

In Khasi society, women have been traditionally discouraged from participating in political matters, a sentiment echoed by participants in this study. In the Khasi governance system, Khasi women – both rich and poor – are excluded from voting and holding office, and *seng kynthei*, the traditional women's organisation in the community, has a limited role in decision-making on community matters.

Within the state governance system, the opportunities for Khasi women are relatively better, as women can vote and hold office at every level. Indian political parties typically have a women's wing, such as the Mahila Congress Committee and the women's wing of the Hill People Union. Despite the relative lack of political voice in the state, women turn out in large numbers to vote; however, only a handful of women were elected to the 60-seat legislature in 2013. The reasons cited for so few women being in politics are a lack of interest among women and an unwillingness of political parties to field women candidates.

## Conclusions

Health planning in Meghalaya faces multiple challenges. The state lacks solid health-based statistics upon which public policymakers can design programmes and positive health outcomes. As a result, health planning is not based on community needs, especially from slum areas in Meghalaya. This potentially hides health inequalities between and within communities, and obscures poor people's lack of access to health services.

The status of women is particularly troubling. They have little input into developing policy and prioritising health needs in Meghalaya. Despite the Khasi being a matrilineal and matrilocal society, women are largely excluded from local indigenous political systems and processes. In the traditional institutions in Shillong, women have no representation in the *dorbar* nor are they allowed to attend *dorbar* meetings. The tradition of public politics and administration being a man's domain is strongly embedded in the Khasi society.

As a result, women's views and perspectives are often not heard. Gender norms and inequalities are barriers to women in making decisions about their own reproductive health, which can then serve to limit their access to sexual and reproductive health services. Women reinforce their own exclusion by subordinating to a headman, who is also in many ways powerless in his relationship with the national government. The question is: when women's voices are never heard, can their sexual and reproductive health and rights be a priority?

## Recommendations

- Fund and improve research at sub-national/local levels on gender, governance and health to inform policy and programme decisions.
- Facilitate and improve transparent civil participation processes that engage with men and women as recommended in the National Urban Health Mission (NUHM). Use locally meaningful labels to replace the Hindi terms that are currently used when implementing central programmes.
- Develop feedback mechanisms between state and civil society, including women's indigenous groups.
- Fund specific awareness/sensitising programmes on gender issues and gender inequalities that involve men in the health sector and other areas.
- Document women's attitudes and voices on what constitutes empowerment within the indigenous cultural and governance context.
- Develop pilot programmes to improve governance processes for direct access by women to state benefits and services through indigenous and state institutions.
- Facilitate social audits of the health system and improve human capacity of civil society groups, including indigenous groups, for undertaking social audits, and monitoring and evaluation. Develop quality assurance units and appropriate grievance redress mechanisms at health facilities.