

REPRODUCTIVE HEALTH CONCERNS OF RURAL MEO-MUSLIM WOMEN FROM HARYANA

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Women empowerment and improving the agency of empowerment is crucial to achieving a multitude of health and development outcomes. In this light, giving prominence to women's own socio-cultural perspectives and existing healthcare seeking behaviour and practices is imperative to address their typical health needs. The present paper echoes the reproductive health concerns of Meo-muslim women based on an ethnographic study carried out in a village in Haryana, India. A constructivist approach has been employed to analyse and understand women's shared meanings and subjective viewpoints on issues pertaining to puberty and menstruation; marriage, and fertility; contraception and family planning; pregnancy and child birth. Data for the study was primarily drawn through key informant interviews, focus group discussions and individual in-depth interviews with purposively selected women respondents in the age group of 15-49 years. The findings that figured prominently were incidence of early marriage, limited inter-spousal communication, negligent usage of any kind of contraceptives, multiple and closely spaced pregnancies, poor awareness on menstrual hygiene and frequent reproductive tract infections. It was recognized that in this traditional, patriarchal community, most of the women were reticent and secretive about their reproductive health needs, which were beleaguered by a plethora of contextual marginalities as well as preconceived socio-cultural-religious norms and beliefs, all embedded in the web of gender specific vulnerabilities.

Keywords : *Reproductive health, Women Empowerment, Healthcare, Meo-muslim, Haryana*

Introduction

Reproductive health has been defined as 'a state of complete physical, mental and social well being, and not merely an absence of reproductive disease or infirmity, in all matters relating to reproductive system and to its functions and processes' (United Nations, 1994, p.2). The unique position held by women by virtue of their biological progression from conception and pregnancy to birthing and nurturing children, situates them at the centre stage of the reproductive health agenda. Implicit in this position, are their sexual and reproductive health rights - to be aware of reproductive health issues, and have access to acceptable, safe, efficient and affordable methods of family planning and the right to avail highest standard of reproductive healthcare services. However, it is not surprising that in many parts

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of the world, women are denied these rights due to myriad economic, socio-cultural, religious and political reasons (De Jong, Jawad, Mortagy & Shepard, 2005).

Despite the explicit focus on women's health, Hessburg et al. (2007) assessed that worldwide, one-third of the total load of diseases among women is attributable to poor sexual and reproductive health. The condition is appalling in developing countries where millions of women are forced to endure risks of sexually transmitted infections due to unsafe sexual practices, unintended pregnancies, pregnancy-related complications, long-standing morbidities and untimely deaths in the course of child-birth (Glasier, Gulmezoglu, Schmid, Moreno, & Van Look, 2006). In India, several statistical indicators harvested from nationwide surveys, also point out at the deprived status of women's reproductive health. The National Family Health Survey (International Institute for Population Sciences, 2015-16), NFHS-4 data indicates a greater prevalence of anaemia amongst women aged 15-49 years (53 per cent), incidence of early marriage in women aged 20-24 years (32 per cent), a lower percentage of women having full antenatal care (21 per cent), a mere 20.9 per cent being aware of HIV/AIDS and, so on.

It is notable that women's disparate health burden cannot be explained only in terms of biological or medical factors. Cook (1995) ascribed that a woman's reproductive health is also influenced by her status and empowerment as an individual. In concurrence, Jejeebhoy and Rao (1992) also recognized the general devaluation of women, large family size norms, closely spaced pregnancies, lack of health awareness, fears about privacy and judgemental provider attitudes to be impinging on women's reproductive health. This makes it clearly evident that the social determinants such as gender, class, caste, education, economic status etc. regulate women's articulation and negotiation of health needs and participation in decision making relative to reproductive rights, besides markedly influencing their utilization of reproductive healthcare services.

The reproductive health related programmes in India have evolved from population control and family planning (in 1952) to mother and child health programme (in 1995) to the unambiguous and specific focus on women's reproductive health as envisaged in the landmark document of the National Health Policy, 2000. It is pertinent to note that the mounting prevalence of sexually transmitted diseases and HIV/AIDS may have also sparked further discussions on sexual and reproductive health in the national health policy discourse. With the launch of the National Rural Health Mission in 2005, the Reproductive and Child Health (RCH) programme efforts got further boost. Presently,

the Government of India has an integrated agenda towards stabilizing population and meeting the reproductive health needs of adolescents and women, altogether addressing reproductive rights, gender equity, human dignity and sustainable development. The conditional cash transfer schemes like *Janani Suraksha Yojana* have also been launched for promoting institutional deliveries and to help address economic barriers in accessing reproductive health services (GoI, Ministry of Health and Family Welfare, 2011). However, Qadeer (1998) has fittingly pointed out that most of these programmes have been target oriented rather than socially oriented and have never really examined either the epidemiological foundation of reproductive health or the explanations behind women's silence over reproductive health problems.

It is a fact that every culture and community has its own connotation and understanding of health and illness. The cultural factors influence women's healthcare seeking behaviour through prescribed societal norms and coping mechanisms for different disease or illness conditions. However paradoxically, the public health discourse in line with the biomedical ideology, largely concentrates on provisioning and strengthening of healthcare facilities in resource limited settings, often undermining the cultural, contextual and gender related constraints. With regard to reproductive healthcare needs of women, their own perspectives, decisions and preferences often remain overlooked and shrouded in silence. This calls for a detailed contextualized analysis of the influences on women's reproductive healthcare, based on their situated knowledge (Haraway, 1988) and focusing on their context and individual perspective and positionality as determined by gender, class, ethnicity, religion etc.

Literature review

A review of pertinent published literature was carried out using books, journal articles and electronic databases. It was found that the magnitude of reproductive health problems in South Asia was first highlighted in the pioneering work of Bang and Bang (1989). Subsequent to the holistic understanding of population health and women's empowerment in the International Conference on Population and Development (1994), an increased number of research studies emerged on the reproductive health issues. In India, such studies have been predominantly analysed in terms of gynaecological morbidity (Inamdar, Sahu & Doibale, 2013; Reddamma, Reddy & Rani, 2002), fertility issues (Ganguly & Unisa, 2010), maternal mortality (Badrinath & Karekal, 2015; Murthy, Murthy & Prabhu, 2013), and, health and hygiene practice (Biswas & Kapoor, 2005; Kshatriya & Basu, 2005; Pandey, 2002) etc. Scores of articles were also observed to be based on data from the National Family Health Surveys, while a relatively lesser

number of sociologists and anthropologists were found to have explored the area of sexual and reproductive health by following the qualitative realm through community based studies (Bang & Bang, 1991; D'Souza, Karkada, Somayaji, & Venkatesaperumal, 2013; Jeffery & Basu, 1996; Paul et al., 2015).

In terms of utilization of reproductive healthcare services, Singh, Srivastava and Singh (2017) purport its linkages with women's autonomy in taking strategic decisions and making life choices. Upadhyay et al. (2014) also found positive associations between women empowerment and lower fertility, longer birth interval and lower rates of unintended pregnancy. Further, in a qualitative study by Griffiths and Stephenson (2001) in Maharashtra, access to maternal health care was found to be impeded by financial constraints. A study by Indian Institute of Population Sciences (2007) showed that home births remained the most common practice in rural areas with merely 29 per cent of the deliveries taking place in a health facility. Additionally, Das et al. (2010) observed that as opposed to cost, customs and traditions were the most common reasons given for delivering at home. In rural agricultural communities, Mamdani (1972) found that contraception and small family norms remain meaningless and do not find approval since women and children, especially sons, are seen as a key source of labour.

Considering gender as a vital structural determinant influencing women's reproductive health, findings from several studies show that women's place in the household (Saikia & Singh, 2009; Allendorf, 2010) and in the community (Chacko, 2001; Hall, Stephenson & Juvekar, 2008) influence their access to contraception, use of services for termination of a risky pregnancy, and antenatal and post partum health care-seeking behaviour. The tradition of child marriage can also be viewed as stemming from biased gender norms in the Indian society, limiting a woman's autonomy to take any decision related to her health. Studies by Sahoo (2011) and Singh, Rai & Singh (2012) also show that marriage at a young age is related to lesser autonomy, meagre usage or unmet need for contraceptives, poor use of maternal healthcare and an elevated threat of maternal mortality.

Sanneving, Trygg, Saxena, Mavalankar and Thomsen (2013) suggested that considering the wide disparities in the women's reproductive health status in India, the inequities in healthcare access need to be analysed at the state and district levels, which calls for additional research focusing on specific geographical locations or specific groups within the population. The authors further stressed on the need for qualitative research to answer questions related to the interplay of social determinants in influencing accessibility and utilization of

reproductive health services in a specific community setting. This serves as the rationale for the present study and in tandem, the paper attempts to understand the individual and collective views of women from Meo-muslim community, on their reproductive health concerns and healthcare seeking experiences.

Research setting

This paper is the product of a research study undertaken at Village Ghasera in Nuh district (erstwhile Mewat) in the southwest Haryana. The Nuh district spanning around 1500 Sq Km, is predominantly rural with majority of Meo-muslim population (70.9 per cent). The Meos have been recognized and notified as a backward class community. There is also statistical evidence indicative of the region's socioeconomic vulnerability, such as notably high population density (729 persons per sq km), an overall low literacy rate (56.1 per cent), significantly lower female literacy rate (36.6 per cent) and a low sex ratio of 906 (Census of India – Haryana, 2011).

The District Level Household Survey, Round 4 (International Institute for Population Sciences, 2012-13) data also indicates a poor status of women's reproductive health. The unmet need for contraception has been reported as 54.8 per cent in Nuh as compared to 9.3 per cent in Haryana. Among all married women, only 23.5 per cent reportedly used contraception, with just 0.5 per cent relying on oral pills. The state has also failed to provide adequate maternal healthcare in this region as only 22.4 per cent women availed at least three antenatal visits and there have been lesser institutional deliveries at 51.2 per cent compared to state average of 80.5 per cent.

According to Census of India - Haryana (2011) village level data, Ghasera occupies an area of 887 hectares, housing a total population of 15,147 with 7,179 females. Also, almost 98 per cent of its 2,052 households belong to Meo-muslims. The female literacy rate in this village is reported to be appallingly low at 27.90 per cent. The village lies close to the state highway and is one of the largest and oldest villages of Nuh.

Research design and methods

The underlying philosophical position in designing and conducting this study is based on a constructivist paradigm, wherein 'the researcher tends to rely on the participants' views of the situation being studied' and there is a dialogue between the researcher and subjects, who construct the reality together (Creswell, 2003, p.8). This paradigm draws on the individuals' and groups' subjective meanings and experiences and focuses on how these meanings control people's routine, behaviours and life choices. Correspondingly, the data furnished in

this paper is based on the ethnographic fieldwork carried out in Village Ghasera, over a period of six months, from July-December, 2017. In an ethnographic study, the researcher explores the daily routines and activities that people perform in the context of a culture in a natural setting and makes meaning of their behaviour and social world (Hammersley & Atkinson, 2007). The usefulness of an ethnographic methodology has been demonstrated in the study of health, illness and healthcare systems by several researchers like Fetterman (2010), and, Roper and Shapira (2000). The choice of this qualitative research methodology was guided by the fact that carefully listening, understanding and meaningfully interpreting the often overlooked voices and views of women participants on their reproductive healthcare was central to the objectives of this study.

In view of this qualitative methodology, purposive or judgemental sampling (Creswell, 2003) was used to select women respondents across the age group of 15-49 years. Women participants' inclusion in the study was primarily guided by their expressed, lived experiences related to research objectives, their willingness to participate as well as based on the advice of key informants. The methods employed for data collection were informal interviews with the key informants, focus group discussions and semi-structured, in-depth interviews with 20 women respondents. Due to sensitive, personal and emotive nature of the research topic, it initially took a couple of weeks for rapport formation, trust building and unpacking the sensitizing concepts with the women in the village, who were initially reluctant to open up. The researcher made a foray into the community through ASHA (Accredited Social Health Activist) and subsequently, participated in women's family activities, community events, and general discussions at homes and health centres to observe their life situation and the diverse conditions they were exposed to in their reproductive decision-making. Since majority of women were illiterate, they were verbally explained about the intention and details of the study and subsequently, verbal consent was taken from them. Their right to voluntary participation as well as to withdraw from the study at any time was also made clear. The researcher also ensured confidentiality and anonymity to the participants and the interviews were carried out at *Aanganwari* (child daycare) centres or in the privacy of their homes, at a suitable time when men folk had gone out for work and women were relatively free. It is significant that none of the participants opted out of the study, apparently because it provided them with an unusual opportunity to share their problems and perspectives. Validity in the study was established by corroborating the chosen themes with the key informants.

Data collection was followed by transcription and translation of interviews and field notes. The analysis embraced reading through

the transcripts multiple times, marking significant statements, sorting these under categories and sub-categories, and finally identifying the underlying themes. Applying a constructivist approach, codes, categories and eventual themes were developed primarily on the basis of participants' own descriptions. Accordingly, verbatim and quotes from the interview transcripts, wherever appropriate, have been used under pertinent themes.

Results and discussion

A. Socio-demographic characteristics of the study participants

The respondents (N=20) were married Meo-muslim women, staying in Ghasera village of Nuh District in Haryana, for over two or more years. They were between 17 to 42 years of age, falling in the predetermined reproductive age group. The husbands of five women owned farm lands, two worked as heavy vehicle drivers, while the rest were agricultural or casual labourers. Joint family system was observed in case of farming households and the monthly family income reportedly ranged from Rs.8000- 25,000. The family size varied from 5-23 members, with mean number of children being four per couple. Out of the 20 women who were interviewed, only four had attended primary school and the rest had no formal education. They all however, could read an urdu language *Qaida* (primer), having learnt it at home from parents or grandparents or at *madarsah* as it facilitated their reading of the holy *Quran*. The women could also sign their names in urdu.

All the women worked at home, taking care of domestic duties, bringing up children and contributed to the upkeep of livestock, but were financially dependent on the male members of the household. It was observed that women spent an enormous amount of time and energy in meeting the fundamental needs of their family such as arranging for clean and potable water, collecting fuel wood for cooking and heating, gathering *nihhaar* (grass and fodder) for cattle etc. The work overload and the lagging educational and occupational status of women point to their low level of autonomy and negligent role in household decision making, which could apparently also be thwarting their healthcare decisions as well as utilization of healthcare services.

The respondents stayed in pucca houses but all homes did not have toilets. Those women found it difficult to go to the vacant lands for ablutions, particularly during menstruation. The electric power supply in the village was intermittent lasting for 3-4 hours a day only. The potable water was also purchased every fortnight. The houses were equipped with underground or over ground *Tankas* (tanks), which were filled with the water procured from the tankers. Women from poorer households filled up and carried urns and buckets to and fro from the community faucets installed at Government water chambers.

There were eight small *Johads* (ponds) in the village, which mostly got dried up during peak summers and whatever water remained in them was not considered fit for consumption or any domestic usage. Two of the ponds were leased by the *Sarpanch* (village chief) for fish culture. The entire burden of water collection and storage rested on women's shoulders, sometimes assisted by children. Overall, with paucity of water, the personal hygiene of women also got compromised to some extent, which at times led to skin rashes, allergies and itching.

The media reach in the village was observed to be meagre as hardly any television or radio sets were seen or reported in any of the visited houses. Some of the male members, particularly, younger generation used mobile phones, while a few older men read urdu newspapers. When asked about using any mode of information or entertainment, a woman respondent argued *"Meonis have no time to breathe, we are first to get up at dawn and last to sleep...there is always some or the other work at home or jungle (farm)...cattle also needs more care than a child... our children provide enough entertainment...we don't want them to get spoilt by these media influences. Also, most of the times there is no power supply, what will we do with a blank TV?"*

In current times, when health information is being delivered worldwide at the touch of a button through technology and internet, there was a notable gap in delivery of health communication messages to women in this village, who were reportedly, always at the mercy of the ever occupied community health workers, elderly ladies, traditional *dais* (midwives) and faith healers. The women expressed that their health related concerns, doubts and problems mostly remained unheard and unattended.

B. Perspectives on reproductive health concerns across different life course stages

The women reported several types of reproductive health problems such as menstrual irregularities, urinary tract and vaginal infections, incontinence, lumps in the breast etc. Interestingly, some of them attributed these problems to lifestyle and food habits also. Most of the women did not seek medical treatment for these illnesses, which is a revelation of their lack of awareness about the consequences of non-treatment. Their description and statements around major reproductive health challenges were slotted under the following categories -

- ***Puberty and menstruation***

The onset of menarche is a significant and critical milestone in the life of any woman. The respondents opined that it was a marker of their capability to get married and bear children. They looked at

menstruation as preparatory to conception and raising children. Notwithstanding its importance, the women revealed that at the onset during their early adolescent years, they never openly discussed about it even with their mothers. The elderly ladies got to know through stained clothes put up for washing or drying. The problems encountered and doubts regarding the monthly periods were discussed among peers and friends in the neighbourhood.

Some women complained of physical discomfort and abdominal or back pain that accompanied monthly cycle but did not perceive the irregular/scanty/excessive bleeding as signs of an impending illness. One of the respondents endorsed that "*eating foods with hot effect such as chillies, jaggery, cumin etc. leads to excessive bleeding*". There was also a variation in responses related to use of menstrual hygiene products, with younger brides sometimes using sanitary napkins and older ones relying on old rags or reusable cloth. Many women despised the usage of any kind of underwear or sanitary absorbents, considering them as responsible for breeding germs harmful for cervical health. One woman, 40 year old and mother of five, cited, "*No woman in my generation used any pads or even cloth. In my days of flow, I keep changing my pyjama (pants) every few hours, wash it and dry it in sun. When stains get difficult to remove, I dig the cloth in the mud ground or use it in a gudri (a woven mat). The present generation of girls are spoilt for choice and throw husband's money in such wasteful and harmful things.*" In contrast, the ANM (Auxiliary Nurse Midwife) was quick to mention that insufficient protection and inadequate washing of clothes soiled with menstrual blood may increase susceptibility to infections in such women.

It was also revealed by most respondents that although menstruation was considered normal, women in their monthly cycle adhered to the religious norms and did not touch the *Quran* or offered *Salat* (five prescribed prayers) during their period. They also abstained from indulging in sex and could resume their religious duties when bleeding completely stopped and after they had undertaken a purifying *ghusl* (bath).

- **Marriage, marital relationship and fertility issues**

It was noted that the marriage in *meo* families was conducted in ones' own *gotra* or clan (like *mev, sakka, nai, kasai, miraasi* etc.) and as dictated by the Islamic tenets, replete with *nikaah* ceremony and *mehr* (bride price). The dowry system was also seen to have a strong presence and the girls were married outside their parental village. Almost all the women reportedly got married around 15-16 years of age, which was illegal and against the legally prescribed age of 18 years. This is in line with Census of India (2011) data which also reported that in the

age group of 10–19 years, almost 17 million young people were already married and 76 per cent of those were girls. The elderly women justified early marriages as they feared about the safety of pubescent girls. A high value was placed on safeguarding the virginity of girls prior to marriage, which translated into restricted mobility and sheer absence of interaction and intermingling with boys or men, other than family. The girls, as young as 4-5 years, wore veils and were conditioned to always keep their heads covered and play separate from boys.

It is known that the age at marriage has a direct association with sexual and reproductive health of women. Garcia-Moreno (1999) attributed powerlessness and difficulty in expressing reproductive choices among girls, to early marriage. This further influences the age at motherhood and the total number of children a woman is likely to have. Over three-fourths of women also informed to have initiated sexual intimacy with their spouses, soon after marriage, which consequently led to frequent pregnancies and large number of children. These findings emphasize that early marriage and early child-bearing are a consequence of deep-rooted patriarchal norms in this meo-muslim community.

It is without doubt that the spouses, i.e. the husband and wife together form the core of the family and must share a cordial relationship to promote well being of themselves and their children. When probed about relationship with their spouse, one of the respondents explained "*It is there in our Quran that we must serve our husbands at all times. We can't say no to their advances, even if we are busy with cooking or some other household chores, we have to leave everything aside and oblige. Any woman who deprives her husband (of sex), goes to jahannum (hell) after death.*" This indicated that women in all their earnest were physically serving the husbands but did not expect any emotional or other support in return. Some women also expressed helplessness and fear of divorce or polygamy, if they failed to sexually gratify their spouses. Thus, in meo community, the process of socialization entailed encumbering women to carry out their reproductive obligation towards their husband, at all cost. In concurrence, Merghati Khoei, Whelan and Cohen (2008) have also found that sexual obedience within marriage is regarded as symbolic of an idealized Muslim femininity, modesty, and self-respect and demonstrates women's high level of religious commitment.

In many cases, where husbands went out for work, the women themselves toiled and took care of domestic and farming turf, as they were financially dependent on the spouse. It was observed that in joint or extended families, open communication with husbands was further compromised, especially in the presence of the elderly. It came to light

in a few cases that women were also beaten up sometimes if they ever raised their voice, though it was also indicated that verbal and emotional abuse were more common and frequent as compared to physical abuse. In contrast, in certain cases, the husbands were supportive of their wives' decisions pertaining to limiting family size or seeking healthcare.

Though satisfying ones' husband through sexual relationship was considered socio-culturally and religiously obligatory for a meo woman, it was found that one of the respondents, a 21 year old, had a relentlessly distressing marital experience to narrate. Having married at a tender age of 14 years, when she hadn't even started her menses, the woman faced repeated marital rape and succumbed to 7 miscarriages, once every year, in her seven year marriage. She narrated her ordeal "...It was heartbreaking to collect my dead undeveloped foetus in my cupped hands, carry it in polythene and bury in mud. I did this not just once but many times... It was the seventh time, I was lying unconscious in a pool of blood, and my mother-in-law verbally abused me and my parents, I was screaming with extreme pain...it was neighbours who pitied and carried me to Nalhar Hospital where my torn bachhadani (uterus) was removed" The woman, due to multiple miscarriages and abortions, had become extremely anaemic and her severely ruptured uterus had to be removed to prevent the spread of infection. Having lost the prospect of bearing children and on the pretext of her being barren, the husband deserted her and remarried.

Two respondents, 19 and 20 years old respectively, were also seeking treatment for swelling in the uterus, due to which they were reportedly not able to conceive. Only one of them got an ultrasound done and consulted the Nalhar Medical College and Hospital at Nuh, the other was diagnosed by the local *dai* and was taking herbal medicines. Both were also observed to be wearing a black band with *taabeez* (amulet) that local *Maulvi* (religious cleric) had given after reciting *duas* (prayers) from the *Quran*. It was clearly evident that although these two women were quite young, nevertheless having been married since 3-4 years, they were expected to bear children in a year or so after marriage as a social norm. Being unable to do so, they had to bear the wrath of mother in laws and other elderly females in the family, and were pressurized in making multiple efforts to establish or resume their fertility.

- **Family planning and contraception**

During the discussion held at *aanganwari* centre, the younger women were initially observed to be keeping silence on the issues of contraception and family planning, though older women voiced their angst against these. An older lady put forth that "*A human being's arrival and demise are in the divine hands of Allah... Our Quran states*

that the purpose of marriage is to have children and increase the numbers of Ummah. Contraception, whether through drugs or permanent methods, is forbidden in Islam. We know what these young brides are upto." It was interesting to observe that after her departure, many women claimed to have used Mala-N and intrauterine device like Copper-T for spacing. Omran (1992) also affirmed that non-permanent methods of contraception are allowed in Islam provided that they are safe and accepted by both husband and wife. It was found that the oral contraceptive pills were distributed through ASHA workers, while minor procedures were being conducted at the delivery hut itself or referred to the hospitals at Mandikhera or Nuh. The women, who had upto 4-5 children, were keener to avoid further pregnancies. The ANM opined that contraceptive pills were less effective and caused side effects in these severely anaemic women, which often resulted in their discontinuance. She also pointed out at the limited usage of condoms, being taken by women only, from the health centre. In addition, it was divulged that a few women had undergone tubectomy at far away hospitals in Gurgaon, Sohna or Alwar districts, by taking their husbands into confidence and to avoid themselves being stigmatized.

- ***Childbearing and delivery***

The ANM reported that *meo* women have high fertility rates and endure close spaced and multiple pregnancies. It was observed that most women sought out reproductive health facilities only in critical cases while pregnancy and childbirth were considered routine affairs that could be handled at home. The women reportedly carried out their daily activities unhindered for the whole of gestation period. They were even commonly observed to be lifting heavy water filled vessels and bundles of fodder and firewood on their heads. When enquired about food and diet during pregnancy, the women cited that they consumed more *anaaj ki roti and chiknai* (wheat bread and white butter) towards the last trimester, to help foetus gain strength and slip towards cervix. Otherwise, they stuck to routine diet or even less because of loss of appetite, apparently owing to malnutrition and anaemia.

The ANM complained that pregnant women did not take antenatal checkups seriously. The weight of these women was reportedly on lower side even in the last trimester and TT injections were also reluctantly taken after much persuasion by ASHA workers. The staff nurses divulged that despite a delivery hut within the village, many women still preferred home deliveries. Most of the traditional *dais* were reportedly trained and conducted deliveries in the privacy of women's homes with assistance from other women in the neighbourhood. The

social ties among women were found to be strong as they supported each other in dire times. It was further revealed that the lack of female doctors at Nalhar Hospital led them to prefer home deliveries as it was considered culturally inappropriate being touched by a man other than ones' spouse. This also points out at the shared values of sacredness and shame associated with female body. Also, it was noticed that due to restricted mobility, the women were always accompanied by their husbands or mother in laws to any healthcare facility.

A woman who had delivered her fifth child at home presented her argument that "*At the delivery hut and hospitals, the placenta is thrown away, but when delivery happens at home, we dig it in the mud in the compound of our home. The placenta if gets in wrong hands, can wreak havoc or bring bad omen in child's life, so we carefully dig it deep. Also, there is more comfort at home with family around, while nurses at the hospital make fun of our multiple conceptions, they are unsympathetic and rude*". Another woman added "*Even if a woman undergoes an institutional delivery or an operation, she takes discharge in few hours and rushes back home.*" Although ANM mentioned the availability of round the clock ambulance at the village delivery hut under *Janani Suraksha Yojana* to ferry critical cases to the district hospital, some women complained that they were charged money to avail the services, which the Government claims to be providing free of cost.

Most women also reported having faced 1-3 foetal miscarriages for various reasons, the most commonly cited one being *upar ki hawa* (negative vibes). There was also a consensus against abortion except when absolutely essential to save the life of mother or in the case of high risk pregnancy, permitted up to 120 days after which it was stated by a respondent that "*foetus develops a soul and it would be sinful to kill it*". Such complicated or risky cases were referred by the ANM or staff nurse to the Community Health Centre at Nuh, District Hospital, Mandikhera or Medical College at Nalhar, wherever convenient to the family of the concerned woman.

- ***Post partum care***

The respondents were vocal about the importance of adequate diet and rest after childbirth. The breastfeeding was reportedly initiated after *aazaan* (prayer) was spoken in the child's ears by a learned *maulvi*. The women cleaned their nipples and discarded the colostrum prior to breastfeeding the child for the first time. The women informed that it was customary to take hot water head bath, the next day after the delivery. Also, for those residing in joint families with supportive kin, they were placed in separate room and allowed to rest for *sawa maheena* (45 days). They also received a specially cooked diet of *dalia with ghee*

(broken wheat roasted in fat) and in a watery consistency. This was believed to help women cope with weakness and increase their milk production. As a cultural norm, the husbands were not allowed to sleep on the same bed as *jachha* (lactating woman) to restrict them from copulation. The women also were supposed to remove their bangles in this duration and were allowed to resume dressing up, wear bangles and cook in the kitchen, only after the bleeding subsided and they became *paak* (pure).

C. Other reproductive health problems and access to healthcare services

In the key informant interviews, it was further found that there were 11 ASHAs, 1 ANM and 5 staff nurses posted in Ghasera village, who provided reproductive health services. The ANM found it difficult to cater to the needs of female population single-handedly, in this large village and was overworked. ASHA workers had distributed *mohallas* (neighbourhoods) among themselves and did home visits, diligently motivating women to obtain appropriate healthcare. Distribution of nutrition supplements, contraceptives and maintaining a record of pregnant and lactating women in the community was undertaken by them. Four of these ASHA workers had previously worked as *dais* and had also undergone proper training. These elderly ladies were respected by all village women and their advice was paid heed to.

It was seen as an advantage that the village was close to the state highway and the hospitals were available at a distance of 5-10 kms. There was also a 24 hrs open, delivery hut within the village, where nurses worked round the clock on rotation. It was housed in a three room government building and well equipped with medical essentials and catered to almost 20-25 nearby villages. One of the nurses informed that around 200 deliveries were conducted every month in this 4 bedded facility, with an average of 6-8 deliveries per day. The nurses also grumbled that the monetary benefit for institutional delivery as declared by the Government, was however never given, as it never arrived, though women accused them and ASHAs to have siphoned off that money. Despite the presence of healthcare facilities, a majority of women confided during discussion that they personally did not approve of medical intervention for normal life course events like pregnancy and childbirth.

The awareness and knowledge about HIV-AIDS and other sexually transmitted infections was found negligent among women. A nurse also cited that a great majority of women never got any blood test done, even when they came for delivery. The ultrasound was also prescribed only in critical cases. The essential and stipulated diagnostic tests were never done as women delivered at home or rushed to the

delivery hut towards the end stage of their labour. The nurses boasted of having handled cases like breach babies or twins, with expertise and without any need for caesarean operation. Alongside, they also marvelled at the patience, tolerance and courage of *meonis* in bearing and delivering children several times.

During discussions on other reproductive health problems prevalent in the community, most women also complained of the white vaginal discharge (*safed paani*) and ensuing *Kamjori* (weakness and discomfort). Due to cultural inhibitions, only some of them had sought help from the ANM, while others resorted to home remedies like having buttermilk or curd to counter it as they assumed that it was due to excessive body heat. A few women also considered it as an internal problem unrelated to external hygiene of private parts. However, the ANM opined that frequent sexual intimacy, closely spaced and multiple pregnancies and poor genital hygiene among both men and women were the main reasons for frequent vaginal infections among women. Similar findings were also noted by Bang and Bang (1991) in their study among women in rural Maharashtra. The nurse also related vaginal infections and discharge in certain cases, to probable promiscuity of men who, being truck or JCB heavy construction vehicle drivers, travelled long distances and returned home after several months and transmitted infection to their wives unknowingly. However, it was affirmed that no diagnosis for other sexually transmitted infections was ever sought.

Concluding remarks

This paper attempted to put forth the socio-cultural perspectives of rural meo-muslim women on their reproductive health issues and related healthcare seeking. It was found that their reproductive health was beleaguered by a plethora of contextual marginalities such as insecure familial livelihoods, curtailed educational opportunities, ignorance and lack of awareness as well as preconceived socio-cultural-religious norms and beliefs promoting early marriage, frequent child bearing, and multiple pregnancies etc. all embedded in the web of gender specific vulnerabilities. In concurrence with Ahmed (1992), it was found that the egalitarian philosophy of Islam was also being distorted by the patriarchal forces in this community and religion was used as a shield to legitimize differing positions on gender and reproductive preferences.

Despite the presence of government run healthcare centres, any formal or informal mechanism to educate and motivate the community members on critical reproductive health issues was conspicuous by its absence. Consequently, the Meo-muslim women were reticent and secretive in enunciating their reproductive health needs. It was found

that the high prevalence of anaemia and reproductive tract infections also resulted in failure of contraception and family planning measures. In light of this, it is proposed that the reproductive health interventions in this community must be designed and implemented in a culturally appropriate and sensitive manner, giving priority to the concerns of *meonīs* and enabling them to initiate a dialogue and reflect on their healthcare decisions so that they can lead productive, fulfilling lives. Alongside, there is a pressing need for community mobilisation programmes and health education interventions to purposely engage men and promote their involvement in facilitating women's reproductive healthcare seeking.

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Rural women: striving for gender-transformative impacts. About this online discussion. In March 2018, at the 62nd Commission on the Status of Women (CSW), once again the spotlight will be focused on addressing the specific challenges and opportunities faced by rural women and girls.Â political, social and cultural dimensions, as rural women and girls also face the additional threat of being subject to gender-based violence within the home and outside (Subhalakshmi Nandi, Santosh Kumar Mishra). Almost everywhere, women face more severe constraints than men in accessing productive resources, markets and services (Muhammad Raza). Reproductive health It is essential for women to have reproductive rights to assert their individuality, and. proper reproductive health care facilities are of paramount importance to exercise their reproductive rights. Women in Mewat, however, are often denied such rights.Â The involvement of women ensures the prioritization of the problems concerning health and education due to its direct implication on womens life.2 5. Capacity Building of Village Health and Sanitation Committees Program The Capacity Building of Village Health and Sanitation Committees (VHSC) Program. aims to improve the functionality of these committees at village levels.Â Documents Similar To Empowering Rural Meo-Muslim Women in Mewat-Final (1). Carousel Previous Carousel Next. Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. UN agencies claim sexual and reproductive health includes physical, as well as psychological well-being vis-a-vis sexuality. Reproductive stage of women At reproductive age (Domestic Violence in the form of sexual (marital. rape), psychological, emotionally and physically tortured by intimate. partner and his family members).Â It revealed the status of women in Haryana on a selected set of GDI (Gender Development. Indicators) i.e. sex ratio, education, women health and violence against women in Haryana. The most striking. feature about Haryana has been a strengthening of male biased (patriarchal) norms and values across all castes, class and religion.