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## Understanding unmet contraceptive needs among rural Khasi men and women in Meghalaya

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There is a global push for increased access to contraception to respond to unmet contraceptive needs. Meghalaya state, with a majority of Indigenous people, has one of the highest unmet contraceptive needs and the lowest contraceptive prevalence rates in India. This qualitative study explores the reasons for the low uptake of contraceptives among Khasi people in a rural district. While policy makers assume that individuals may not be practising family planning because of religion and lack of education, couples actually do use a variety of ‘natural’ or ‘traditional’ contraceptive methods to obtain their desired family composition and size. Health providers focus on the provision of hormonal contraceptives, such as the pill, and on technologies such as IUDs and tubectomies that require regular follow-ups by trained medical staff. Health concerns, distrust of contraceptive technologies, the inadequate local health system and a desire to have more than two children are important factors in the low uptake of available contraceptive technologies. Contraceptive choices in rural areas are shaped by the historically problematic political engagement of Indigenous people with the central state, with policy implementation taking place on the basis of widespread assumptions rather than on evidence from contextually relevant behavioural sciences research.

**Keywords:** reproductive health; Indigenous people; contraception; India; health system

### Introduction

Access to contraceptives for family planning is widely viewed as essential to a variety of development goals. These include improved child health, reduced poverty and hunger, universal education, environmental sustainability and reduced maternal mortality and morbidity (especially due to unsafe abortions). Governments, UN agencies and non-government organisations therefore emphasise the need to improve access to contraceptive technologies (Disease Control Priorities Project 2007; Lloyd and Mensch 2008; Smith et al. 2009; Cates 2010). In many countries, even those contraceptive technologies that are available remain inaccessible to certain categories of women, such as teenagers and widows, because the individuals concerned are not supposed to be sexually active. Meanwhile, for the world’s poorest people, cost is a serious barrier to contraceptive access. The estimated 370 million Indigenous people in the world (United Nations Department of Economic and Social Affairs 2009) are ‘behind everyone, everywhere’ (Stephens et al. 2005, 10). Health systems all over the world are unable to respond effectively to the reproductive health needs – including contraceptive needs – of Indigenous and minority peoples (Rogow and Horowitz 1995; Oosterhoff, White, and

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Aggleton 2011; Oosterhoff, White, and Huong 2011; Both, Etsub, and Moyer 2013; Dijk van et al. 2013; Kwagala 2013). This study aims to contribute to an understanding of the persistent reproductive health gaps between one Indigenous people and the majority population in mainland India.

Contraceptive technologies are not the only means of family planning. Natural methods, such as withdrawal and rhythm methods, are practised by couples in various parts of the world (Okun 1997; Kulczycki 2004; Wiebe et al. 2004). While research is scant, some findings suggest that in certain contexts these methods when combined may only be slightly less effective than the proper and consistent use of male condoms (Rogow and Horowitz 1995; Miller 2003; Hatcher et al. 2007; Jones et al. 2009). Because such natural methods do not protect against STIs, including HIV, their promotion raises practical and ethical questions for reproductive health programmes in many countries. Reliance on withdrawal or rhythm methods is also risky for certain high-risk populations. Yet these methods could provide men and women with low-cost contraceptive options in areas with poor health facilities and weak distribution of contraceptive technologies.

Conventional analyses of barriers to service utilisation often overlook the ways in which services fail to engage with local preferences and cultural differences (White, Oosterhoff, and Huong 2012; Dijk van et al. 2013; Kwagala 2013). Recent research in Asia, Africa and Latin America suggests that increasing married women's access to modern contraceptive methods alone will not satisfy their unmet need for contraception (Sedgh and Hussain 2014). Married women often want to plan pregnancies, but they may have concerns about health risks and side-effects that prevent them from using contraceptive technologies even when they are available. They may prefer to use traditional or natural contraceptive methods, such as withdrawal or rhythm methods. It is necessary to acknowledge married women's concerns, and to understand their preferred methods of birth control, in order to reduce their unmet need for contraception.

Besides concerns over health risks, women from socially, politically or geographically marginalised groups may decline to use state-provided contraceptives as part of a broader display of resistance to central power structures. Such opposition can reflect long colonial histories in which groups have escaped the colonial and post-colonial state. In South Asia, this sort of resistance to the state by marginalised groups, such as scheduled tribes and lower castes, has been richly documented in the work of the Subaltern Studies Collective. Similar resistance has been extensively described by James Scott (2009) across the upland communities of the region he terms 'Zomia', a mountainous area stretching from northeastern India through southern China and Southeast Asia. Scott argues that that many of the stateless Indigenous and ethnic minority groups in this area have fled the central lowlands to escape state control. Indigenous women's refusal to embrace state-prescribed contraceptives may be analogous to practices such as shifting cultivation and the absence of a written script, which Scott (1990, 2009) views as strategies to avoid state control that resist government efforts at development. Critics of Scott's views, such as Abu-Lughod (1990, 41), warn against the 'romance of resistance': the tendency of academics to project their own privileging of subversion and opposition onto the poor. Other scholars (Michaud 2010) have argued that Scott's sweeping claims regarding Zornia are poorly grounded, given the region's extreme diversity and the paucity of historical and anthropological studies of its 120 million inhabitants.

However, anthropologists and historians agree that scholarly overemphasis on the more powerful surrounding states of South and East Asia has resulted in what van Schendel (2002, 647) called a 'geography of ignorance' with regards to the upland societies. State formation in this part of the world has been problematic and contested for

many centuries. Indigenous and minority people as diverse as the Tibetans, Hmong, Shan and Karen all struggle for recognition of their land rights, often at the same time as they face in-migration into their territory by majority populations (Fischer 2008; United Nations Department of Economic and Social Affairs 2009; Oosterhoff et al. 2012). These histories of local contempt and distrust towards central states are part of the broader political context in which marginalised groups respond to family planning.

There is a paucity of qualitative studies on contraceptive preferences or attitudes and experience with state reproductive health providers among the Khasi people. This qualitative study examines views on contraceptive technologies and family planning among Indigenous Khasi people in Meghalaya state in north-east India, which has the highest reported unmet contraceptive needs of any Indian state (Institute for Population Sciences (IIPS) 2009).

### *Khasi people and the state*

India is home to 98 million Indigenous people, who comprise 8% of the national population (Census of India 2001) and thus almost a quarter of the world's total Indigenous population. Indigenous people in India are often known as 'scheduled tribes' and are recognised in the national constitution as historically disadvantaged. Meghalaya state is part of the 'tribal belts' in the predominantly rural mountainous north-eastern part of India, with a predominantly Indigenous population (86%). The Khasi people constitute 57% of its population of the state's total population of approximately three million.

The Khasi people differ from many cultural groups in India in having a matrilineal and matrilocal family structure, in which the children take the name of the mother's clan and identities are closely linked with maternal lineage (Kyndiah 1990; Bareh 1997). Regarding decision making for the woman's own healthcare needs, 87.5 % of women in Meghalaya say they are empowered to do so, compared to the national average of 62.2%, and 69.8% of men in Meghalaya feel that women should have a say in family decision making compared to 49.7% of men nationwide (IIPS 2007, 467). Traditionally the Khasi people have no dowry system. Couples marry by choice, and children born out of wedlock are generally accepted into society. While most Khasi today are practising Christians, cohabitation without a formal ceremony or registration is still widely recognised. These significant cultural differences are not well understood in mainland India, where the media employ a variety of stereotypical misrepresentations of Indigenous women and men, including accusations that their women have loose sexual morals or oppress their men. Research in a university setting, however, shows that young adult Khasi students – like their counterparts in mainland India – practice a culture of silence and are ignorant about basic issues of sexual health, contraceptives and sexual rights. Sex education was appreciated by these students (War and Albert 2013). Although Khasi women do have customary land inheritance rights, these are limited to the private sphere. Traditionally, women do not participate in the political decision-making process; public decisions – including the allocation of public land – are traditionally male domains, which affects women's ability to advocate for their rights (Nongbri 2000; Subba 2008). The Khasi and other Indigenous groups hold key government positions in the state.

Because the Indian national government is not able or willing to impose taxes on 'tribal peoples', the Khasi – both rich and poor – do not pay income tax. At the same time, the central government imposes economic restrictions on local organisations, such as a ban on directly receiving international funds that limits commercial and social-service initiatives by local people and organisations outside the control of the state. In recent

years, both migration of non-Indigenous people from other states and rising land ownership for commercial purposes – including mining – by outsiders are perceived to be increasing. This has resulted in protests and demands to regulate the entry of outsiders into the state (Rining 2013). Although Meghalaya is one of the most stable states in the North-East, there are some violent political conflicts, notably the demand of Indigenous Garo activists for an autonomous Garoland separate from Meghalaya. This demand reflects growing Garo discontent with Khasi political leadership and control over the distribution of state power and resources.

### *Family planning, contraceptive technologies and choices in Meghalaya*

The central government of the federal union of India initiated the world's first government population stabilisation programmes in 1951. Since the 1970s, average fertility rates in India have fallen by half, and use of contraceptive technologies (sterilisation being the most important) has tripled. Family planning programmes in India gained notoriety as a result of a focus on targets in sterilisation programme for men in the early-1970s. According to official policy, men with two children or more had to undergo free vasectomies, but in practice many poor or uneducated men with fewer than two children were believed to have been sterilised in order to meet the targets, even if they were unmarried (Elder 1974). The national government vasectomy programme is blamed for creating a public aversion to family planning, with a particular reluctance to involve men and a focus on women as those responsible for determining family size (Basu 1985).

Today's national family-planning programme, led by the Ministry of Health and Family Welfare, focuses largely on promoting female sterilisation, condom use, intra-uterine devices (IUDs) and the contraceptive pill. The concept of 'contraceptive needs' is thus equated by the state with improving access to modern contraceptive technologies.

The implementation of the policy in the 29 states is shared between the union and the states, but results vary widely between states. Meghalaya state receives central government technical and financial support for its reproductive health programmes. Policies are made and budgets are allocated in Delhi and have to be implemented by the state.

According to the recent district-level family health survey (DLHS-4) conducted in 2012–2013 (Ministry of Health and Family Welfare 2014), the majority (55.5%) of women in Meghalaya have an unmet need for contraception. The total unmet need for family planning includes those with unmet need for limiting (39.7%) and spacing (15.8%) births. Unmet need for spacing includes fecund women who are not pregnant, not using any method of family planning and who say they want to wait two or more years for their next birth or are unsure whether they want another child or who want another child but are unsure when to have the birth. Unmet need for limiting family sizes includes fecund women who are not pregnant, not using any method of family planning and who want no more children (Ministry of Health and Family Welfare 2009, 2014). The total unmet need has thus increased from 39.7% in the DLHS-3 of 2007–2008. According to the National Family Health Survey 2005–2006, the contraceptive prevalence rate among currently married women aged 15–49 years is the lowest of any state in India at 24% (IIPS 2009, 8). Female sterilisation is the most popular contraceptive technology offered by the state and is used by 8.3% of currently married women (Ministry of Health and Family Welfare 2014, 3). According to the DLHS-4, most people rely on 'any method' (Ministry of Health and Family Welfare 2014, 3) rather than on modern contraceptive technologies. There is poor health awareness; only 26% of women knew that consistent condom use can reduce

the chances of getting HIV, and the fertility rate of 3.8 is one of the highest in the country (national average: 2.7).

Contraceptive services are provided free of cost in public health clinics/service centres. They tend to be spread thin and understaffed due to a serious human resource shortage. According to a recent review in the *Lancet* on human resources for health in India, Meghalaya has just 2.5 health workers per 10,000 residents, the lowest rate of any Indian state (Rao et al. 2011). While the government has invested in the infrastructure of health facilities (in the form of buildings, equipment and beds), Meghalaya state has a serious shortage of trained health staff. All community health centres claim to be open 24 hours a day, but only 14.3% have an obstetrician or gynaecologist (Ministry of Health and Family Welfare 2014, 7). The vast majority of primary health centres (94%) have at least four beds and a residential quarter for medical officers, but most do not actually have a medical officer (IIPS 2007; Ministry of Health and Family Welfare 2009). For rural citizens, important primary healthcare providers are the estimated 10,000 traditional healers in the informal sector. A health camp approach – with health staff providing services in mobile settings, such as tents in public spaces – is used to address these primary health-system shortages. To make good shortages in the health system, local accredited social health activists (ASHA) are employed as extension workers in villages and work within a broader Mother and Child Health Programme context.

The health data show that the state does not meet the reproductive and contraceptive needs of the Khasi people adequately. However, as qualitative research on contraceptive attitudes that helps to understand what the data mean is rare, it is not clear what central and state governments should do in addition to or in lieu of existing efforts. With this research, we hope to suggest culturally appropriate interventions that reduce the unmet contraceptive health needs among Khasi people living in rural areas.

## Methods

This qualitative study uses the results of research conducted between early-2012 and July 2013 using multiple tools that allow for validation and triangulation.

Secondary data were gathered through a literature review of published material using Scopus, PubMed and the Directory of open access journals using the keywords ‘India’ and ‘Khasi’ separately and combined together, and a search in the library of the Royal Tropical Institute using the same keywords. We also collected unpublished reports on demographic, health and Indigenous development issues produced by international agencies and published government data such as DLHS. We searched for additional academic articles using combinations of the keywords ‘family planning’, ‘Indigenous people’, ‘male involvement’, ‘contraceptive technology’ and ‘traditional contraceptive methods’, and collected additional references from the articles found.

Field studies were then conducted by an international research team, with six Indigenous Khasi social-science research assistants who conducted action research in three Khasi villages in Pynursla Block in the East Khasi Hills, all of which had high unmet contraceptive needs. The team conducted eight focus-group discussions in the Khasi language, using participatory techniques and tools and semi-structured question lists on ideal family size and composition, usage and preference for contraceptive methods, fertility decisions and male and female reproductive body functions. The team spoke with more than 75 men and women of reproductive age (>18 yrs old) and with <10 older people, in three villages. Most families had 4–6 children, with a few outliers; the largest family had 13 children, two women had no children and some young women of <20 had

one or two children. Researchers interviewed health staff at Pynursla Community Health Centre (CHC) and informal health providers (ASHA workers). The research team was trained in interview techniques and facilitating focus-group discussions and on reproductive and sexual health. Training was hands-on and included buying contraceptives, talking about them in a group in English and Khasi and drawing pictures of male and female reproductive organs. All study tools were pre-tested and refined prior to fieldwork.

Given language barriers, Khasi research assistants interpreted for the lead researchers. All data were transcribed, translated into English and analysed for thematic areas. Emerging themes were checked by looking at the scripts during joint analysis. These findings were then used to guide a deeper analysis of the transcripts and data.

A preliminary analysis of the results was presented to policymakers at the state level, to obtain their feedback and to start a discussion of gaps between policy and practice.

We also used the results of a participatory rural appraisal (PRA) among 51 traditional healers conducted in Khasi, led and directly supervised by one of the authors. Two Khasi researchers conducted the PRA in 15 village clusters of the Pynursla block between 2008–2009, using transect walks, free listing of general health conditions, short listing of primary health conditions and listing criteria for prioritisation or ranking of health conditions. Five of these healers were interviewed with a Khasi translator during the fieldwork in 2012.

Understanding of the issues was deepened during fieldwork practice on family planning, contraceptive use and preferred family sizes. This took place during a hands-on course on qualitative research methods for Indigenous Khasi Martin Luther Christian University (MLCU) university faculty and doctoral students in 2013, led by the lead authors.

Ethical approval of the research was obtained from the Ethical Review Board of MLCU, in conformance with universal ethical principles.

The study has several limitations. Studying Indigenous rural people in India can be difficult due to cultural and political sensitivities related to the marginalised position of Indigenous people. Research permission is required from Indigenous leaders in the villages themselves; permissions obtained at urban research institutes are not recognised in villages. The fieldwork team benefited from the long-term relationship between the local university and village leaders. However, using these leaders as gatekeepers may have created biases in how the researchers were perceived. Villages were on roads, or within a few kilometres walking distance from a road. The Khasi language has few words to describe reproductive organs and sexual acts, and people are not used to discussing sexuality with each other. Finally, this was a small sample that cannot claim to be representative of the entire Khasi community.

## Findings

### *Lack of capacity in the formal health system*

Intra-uterine devices, combined contraceptive pills and sterilisation are the main contraceptive methods that the state promotes, but it is difficult for rural Khasi women to find trained staff who can provide these safely. In Pynursla Block, residents can visit an upgraded community health centre for the insertion of an IUD or sterilisation. Respondents pointed out that without a car, motorbike or bicycle, it can take them up to eight hours' travel to get to town. Some respondents reported that women have gone to the

hospital only to find it empty, and that they fear going to a hospital without somebody to fetch food and take care of them.

The state government is aware of this health service gap. One response has taken the form of health promotion campaigns ('health camps'), during which health staff provide primary healthcare services out of tents or stalls, including hormonal contraceptives, condoms, information and some essential medicines. Services are provided free of charge and offered during daytime in town. This means that it is difficult for people who work to attend:

It is far to go to town for people who have to farm. People mainly go there to get some medicines for fever and pain. Sick people can send another person to get pills for them. (Ibor, male, FGD, Nongmadan Mawpran)

During specialised family-planning services such as 'population stabilisation fortnights', health staff insert IUDs and sterilise women and men in a few weeks across the state.

Additional family-planning services within villages are provided by ASHA, women selected from the village itself. They are generally accountable to the village for promoting awareness of health and its social implications. After a two-week training course, ASHA workers seek out pregnant women and mothers of children under five. Men and young unmarried Khasi women are not targeted. Accredited social health activist workers inform mothers about vaccination, nutrition and other simple primary health issues. They have with them a kit with some drugs and basic health materials, such as paracetamol, iron and folic acid tablets, Oral Rehydration Salts, combined hormonal pills (Mala-D), Betadine and a thermometer. Accredited social health activist workers receive a financial incentive for their activities, which may include promoting institutional delivery. They learn about contraceptives through a standardised curriculum, which focuses on the promotion of IUDs.

The ASHA workers we interviewed seemingly focused on promoting institutional deliveries and immunisation, while contraception services were less of a priority. Their knowledge of different contraceptive technologies was also variable (limited) and some of them were uncomfortable with discussing the topic. Surprisingly, natural or traditional contraceptive methods for family planning, such as the withdrawal or rhythm methods that most Khasi families use, are not part of the training curriculum. Accredited social health activists organise meetings for married pregnant women or mothers of children under five years old, and make house calls to women:

Mostly I give information to young mothers about how to keep their child healthy. I have contraceptive pills with me. When women want I can tell them where to get an IUD. I do not give information to their husbands because they are not coming to the meetings. (ASHA worker, Siatbakon)

Given the lack of capacity of the formal health system, the long distances and rough terrain, it is not surprising that traditional healers play an important role in primary healthcare in villages in these rural areas. Many villagers must also travel to see a healer, as not all villages have one. Family planning is not a priority health service for healers. These men and women are a highly diverse group, each with specialised skills and approaches to specific diseases and illnesses. Some are specialised in bone setting, others in back and skeletal pain management using massage and/or herbal treatments.

Of the 51 healers involved in the PRA, only three mentioned reproductive health-related topics. They had been visited by people for the treatment of continuous bleeding or

infertility, and one performed midwifery. The most important diseases that people visited healers for were diarrhoea, cough, gastric problems and fever.

There are clearly many barriers hindering villagers from accessing the contraceptives that are supported by the state. But to decide whether there is in fact an unmet contraceptive need, one must also know whether women are fecund and sexually active, are not using any method of contraception and do not want more children at the moment.

### *Fertility decisions and the logistics of managing sexual activity*

While the state promotes small nuclear families with two children each, Khasi respondents argue that the ideal family has between 4 and 6 children, including at least one girl. There were wide ranges in preferences, but only a handful of women would like a small nuclear family or a family with more than six children. Rather than fertility, infertility is the problem:

In a family without children there will be no one to preserve the genes and the clan. (Iba, female, 26, FGD, Siatbakon)

Infertility is not just a problem because of economic or lineage reasons such as preserving the clan land through inheritance. It is also – and perhaps even more – an emotional issue. Many respondents said they enjoy having large families, because they are more lively and warm and suggested small families are sad and lonely. Some respondents thought childless couples needed to seek medical treatment and, if that fails, accept childlessness. Others argued that adopting a girl can be a way to preserve the lineage and land inheritance:

If it is not possible to have children through treatment, a woman can adopt her sister's child, because they are blood relatives. (Aihun, female, 25, FGD, Siatbakon)

When we discussed the different notion of ideal size family between the state and the Khasi community, urban policymakers and health staff all indicated that religion is very important for the fertility decisions of Khasi people living in rural areas. They felt religious beliefs impacted on the promotion of and low uptake of family planning, implying that it is thus not within the government's powers to resolve this discrepancy. Some suggested the Khasi people have large families because they think children are God's gift, and are not able or willing to act themselves. While rural men and women often declared (with a smile) that children are a 'gift of God', they also said that it is the couple who decides the number of children they want. When men and women were asked to draw Venn diagrams visualising who decides on the number of children, they, without exception, showed two equal circles for husband and wife. God, the church, religious leaders, the health system and the state were all conspicuously absent. Discussing these diagrams, respondents elaborated on how they might discuss the issue with friends or a family member, but ultimately it was the couple who decided how many family members they wanted.

Couples' fertility decisions typically take into account their financial situation, the health condition of the mother, the need for labour, land ownership and their ability to provide education, love and food. Birth spacing is desired. Three years between children allows parents and children to manage the physical demands of childbirth on the mother, and other work such as childcare and chores.

It is common in villages to see men carrying babies and small children on their back while doing daily activities, such as food shopping or chopping wood. In large families,

older girls in particular have to help with household chores. Avoiding this burden on children is a factor in familial fertility decisions:

Too many children will create a big burden on the first child. Then he or she cannot have a happy life and I don't want to make the first child suffer. (Lawan, female, 34, Siabatkon)

Both male and female participants said that they normally did not talk about sex with each other, but enjoyed the opportunity to do so. Most rural couples live with their children in thin-walled houses on stilts, and women and men giggled when they described the management of their sexual relations:

When you have no children it is easy to be together when you like. And when the children are babies they mostly sleep. But once they are around six years old they will know. From that age on, it gets more difficult for the parents to enjoy themselves. (Banjop, male, 34, FGD, Mawlyndun)

When you have a few children who are old enough to know we have to be careful. We have to be like thieves in the night. (Dahun, female, Mawlyndun)

Although men and women agreed that men take the initiative to have sex, women must consent, and they expect sex to be pleasurable.

### ***Family planning using natural methods and perceptions of other methods***

To achieve the desired family size and spacing between children, Khasi people living in rural areas practice primarily so-called natural or traditional methods. Couples may have children sleep between them in order to avoid sex, or build an extension to the home where they can have sex. They reported using a form of rhythm method. However, they calculated the safe period for intercourse based on an inexact approximation of 10 to 12 days after menstruation.

Khasi women breastfeed up to two years, but they do not mention that they do this as a family-planning strategy. When we showed respondents in group discussions the contraceptives offered by the state – IUDs, pills, injectables and condoms – they did not respond positively. None had seen an IUD before, and the men were particularly concerned about the effects of this form of contraception on a woman's body:

This does not look natural and it may not fit well in the body. In our community women have to work very hard in the field and orchards, and she has to move around. We are concerned that such an object will harm a woman's body. How does she get it out if there is a problem? (Iban, male, 32, Nongmadan Mawpran)

Only a handful of younger women had used the contraceptive pill, and then typically for only a few months. Men and women did not like the idea of having to take a pill for decades. They reasoned that pills are for sick people, might not be healthy for babies and are easy to forget about after a long day of farm work. Injectables are easier, but are currently not provided by the public healthcare system. Some women did express a preference for long-acting injectable contraceptives. The long distance to the CHC and the lack of follow-up care in the village was also raised as a concern for sterilisation of women. Several men stated that if the alternative were for their wife to have to use an IUD, they preferred to have a vasectomy at the CHC. But men disliked vasectomies, as they feared it would make them fat and lazy. They associated it with the local practice of castrating pigs.

They also said that no one had clearly explained the duration of the operation or the post-operation consequences to them:

We are not sure. Nobody comes to give us information. Therefore we have to use our own brains and experiences. We have never seen a man who had a vasectomy. We would like to meet him and hear his experiences. (Banshan, male, 38 years, Nongmadan Mawpran)

Most men had seen condoms, but had not learned how to put them on. They complained about the lack of feeling and found them technically complicated.

Women who had experience complained of condoms getting stuck inside them. They also raised practical problems, such as the safe and discreet disposal of used condoms in villages.

Men and women would like to receive biomedical information about their bodies and about traditional or natural family planning methods as part of the state's family planning programmes, in addition to information about contraceptive technologies.

### **Discussion and conclusion**

In this part of India, current centrally planned and locally implemented family planning policies are failing because they do not match the fertility desires, contraceptive practices and reproductive health needs of the Khasi people in Meghalaya. Rather than fertility, infertility is seen as a problem. Most Khasi actively limit and space their pregnancies, mainly by using natural contraceptive methods.

Compared to the national average, Khasi women have greater decision making power about their health and about family matters. However, this empowerment does not extend to independent decision making about contraception, as a third of the rural women in Meghalaya report having an unmet need for contraception. This suggests that traditional contraceptive practices are not working flawlessly. The poor understanding of the traditional method based on safe-period calculation among participants in this study, suggests that enhancing appropriate use of these methods could help in alleviating unmet contraceptive needs.

The contraceptive choices offered by health workers, especially IUDs and pills, are regarded with suspicion as 'foreign' objects that may harm women. Some of this suspicion may be due to a lack of information about these technologies. However, Khasi men and women are not opposed to receiving information on contraceptives and sexual or reproductive health. Rather, men and women resent not receiving adequate information about contraceptive options. They may not be used to having discussions on sexuality, and the Khasi language does not have words to describe certain body parts and sexual acts.

Villagers' suspicion of contraceptive technologies is related to the scarcity of trained health staff, long travel times to health facilities and the fact that the national government and the local state incentivises health staff to increase the number of institutional deliveries, rather than to promote safe assisted delivery at home or improve family planning. Our findings confirm findings elsewhere in India that the quantity and quality of the training in practice for ASHA workers must be improved in order to improve performance (Bajpai and Dholakia 2011). Distrust of IUD insertion may be a rational response to a poorly functioning health system where, according to the DHLS-4, 14.3% of all CHS have a trained obstetrician or gynaecologist. One might echo the critique of maternal health in India, levelled recently by a UN special rapporteur on human rights, that a policy that incentivises women to use facilities that do not actually have the services they need is 'offensive, unethical and in violation of their right to the highest attainable standard of health' (United Nations 2010, 13).

Khasi people's reluctance to adopt government-promoted contraceptives does not appear to be rooted in resentment of the national state as such. Rather, local people want more and different sexual and reproductive health services, with staff who support them in improving the natural contraceptive techniques they prefer and also increase their knowledge of other options. This confirms findings by another study that found fear among women who never used any contraceptives to adopt these and that more than a third (37.3%) of the women either do not like the existing methods or find them difficult to use (Deb 2010).

Sex-positive family planning should also engage with men and unmarried young people. The provision of context-specific sexual and reproductive health services will require radical reform of the current health system. Given the current political context and system of government, in which policies shaped and paid for by the central government are merely implemented by Meghalaya state, such a responsive, well-resourced and rights-based public-health system will be a challenge to develop. The national government's lack of financial resources, and its restriction of their opportunities for independent economic development initiatives, are part of a much longer history of the difficulty of state-making in the Indigenous highlands. Low contraceptive prevalence among the Khasi people is partly a result of a lack of responsiveness of the state towards these communities. Health service delivery mechanisms are poor and are left to informal and traditional health providers. Couples are abandoned to create their own contraceptive options. Low awareness, distrust of modern contraceptive technologies and a preference for natural contraceptives derive at least in part from inadequate and insensitive healthcare delivery mechanisms.

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## Résumé

Des pressions mondiales s'exercent en faveur d'un accès plus important à la contraception afin de répondre aux besoins en la matière. Dans l'État de Meghalaya, avec sa population majoritairement autochtone, les taux de besoins en contraception non satisfaits et de prévalence du recours à la contraception figurent, respectivement, parmi les plus élevés et les plus faibles de toute l'Inde. Cette étude qualitative explore les raisons pour lesquelles le taux d'utilisation des méthodes contraceptives est faible dans la population Khasi vivant dans une zone rurale. Alors que les décideurs politiques partent du principe que les individus pourraient ne pas pratiquer le planning familial à cause de leur religion ou de leur faible niveau d'éducation, en fait, les couples ont recours à diverses méthodes de contraception « naturelles » ou « traditionnelles » pour contrôler la composition et la taille de la famille qu'ils souhaitent obtenir. Les prestataires de soins cherchent avant tout à proposer des contraceptifs hormonaux, comme la pilule, et des technologies comme les dispositifs intra-utérins (DIU) et les tubectomies qui exigent des suivis médicaux réguliers. Les préoccupations en matière de santé, la méfiance vis-à-vis des technologies contraceptives, l'inadéquation du système de santé local et le désir d'avoir plus de deux enfants sont des facteurs importants associés au faible recours aux technologies contraceptives disponibles. D'une manière générale, le recours à la contraception dans les zones rurales est déterminé par l'engagement politique historiquement problématique des personnes autochtones vis-à-vis de l'État indien, et l'application de sa politique dans ce domaine, basée sur des hypothèses largement répandues plutôt que sur des preuves apportées par la recherche comportementale contextuellement pertinente.

## Resumen

Existe un esfuerzo en todo el mundo para que los anticonceptivos estén al alcance de más personas para responder así a las necesidades de contracepción no cubiertas. El estado de Meghalaya, donde vive una mayoría de pueblos indígenas, tiene una de las tasas más altas de necesidades de contracepción no cubiertas y uno de los niveles más bajos del uso de anticonceptivos en la India. En este estudio cualitativo analizamos cuáles son los motivos de este bajo uso de anticonceptivos entre el pueblo Khasi en una región rural. Aunque los responsables políticos dan por hecho que las personas no practican la planificación familiar debido a la religión o la falta de estudios, en realidad las parejas utilizan toda una variedad de métodos anticonceptivos "naturales" o "tradicionales" para conseguir una familia con la composición y el tamaño que desean. Los profesionales de la salud se ocupan principalmente de suministrar anticonceptivos hormonales, tales como la píldora, y de tecnologías como el DIU y la ligadura de trompas, métodos para los que es necesario que un profesional médico cualificado haga un seguimiento regular. Algunos de los principales factores que

explican el bajo uso de las tecnologías contraceptivas disponibles son las preocupaciones por los riesgos para la salud, la desconfianza por las tecnologías contraceptivas, un sistema sanitario local inadecuado y el deseo de tener más de dos hijos. Las decisiones contraceptivas en zonas rurales están muy relacionadas con la participación política, históricamente problemática, de los indígenas en el Estado central y con la introducción de políticas basándose en suposiciones generalizadas en vez de evidencias que proceden de estudios científicos contextualmente relevantes sobre el comportamiento.