

AN ABSTRACT OF THE THESIS OF

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This ethnographic study was conducted among the Meo community of north India to understand cultural norms, prescriptive behaviors, and practices associated with conceptions and contraception among Meo women and men living in five neighboring villages in the region of Mewat. The study goals were to collect ethnographic data on fertility-related practices among the Meo and to examine possible associations of these beliefs and practices with fertility regulation and risks of sexually transmitted infections (STIs). In addition, the study explored the role of spiritual healers in providing health care in the Meo community. Both qualitative and quantitative methods, including participant observation, in-depth interviews, focus group discussions (FGDs), were used for data collection.

The results of this study suggest that Meo culture emphasizes fertility and its manifestation, and that spiritual healers play a significant role in the health culture of the community. These findings provide a strong basis for developing health intervention programs aimed at promoting condom use and prevention against STIs.

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Conception to Contraception:
An Ethnographic Study Among the Meo in North India

by

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Conception to Contraception: An Ethnographic Study Among the Meo in North India.

Chapter 1: Introduction

This ethnographic study examines perceptions, attitudes, and practices related to topics of conception and contraception among members of the Meo community living in Mewat areas, around New Delhi, the capital city of India. Over the past two decades, programs directed at population control and at preventing the spread of sexually transmitted infections (STIs) have failed to promote widespread condom use among the people in this community. The available literature suggests that prior programs did not take into account the larger medical, social, cultural, legal, religious and political underpinnings of the condom use in the community (UNDP, 2003). By understanding the intricate relationship between Meo beliefs and practices related to conception and contraception, this study will provide an informed basis for effective planning and implementation of culturally-informed programs for promoting condom use for contraception and for prevention against sexually transmitted diseases in the urbanizing Meo community and in other similar urbanizing communities of northwestern India. This research will explore the following questions:

1. What specific ethno-medical beliefs and practices related to conception and contraception currently exist among members of the Meo community?
2. How are these beliefs and practices influenced by gender?
3. What roles do these beliefs play in people's opinions and practices related to fertility regulation and prevention against sexually transmitted diseases?

4. What roles do local shamans and spiritual healers play in influencing people's perceptions of sexuality, fertility, and contraception?

A substantial body of research suggests that practices related to contraception are intricately connected with the cultural milieu and are relative to cultural beliefs associated with sexuality, gender, and reproduction (Friedman et al., 2002; Green, 1994; MacCormack, 1994). Although traditional methods of contraception have been practiced within the family unit for a long time, a lack of knowledge of "modern" contraceptive methods or a source of supply, cost and poor accessibility are the barriers that exist in many communities in South Asia. Research also suggests that condoms are increasingly used not only as a means of birth control, but also as a mechanism of protection against STIs, especially HIV/AIDS (Friedman et al., 2002). More importantly, several studies show increasing acceptance of condom use as a preventive measure against STIs as compared to its contraceptive function (Green, 1994).

Recent reports suggest that about 25 % of all new HIV/AIDS infections occur amongst women (UNDP, 2003), and that this number is growing as a result of gender inequalities (Foreign Affairs, 2003). In the context of a male-dominated social system, which allows women limited control over their sexuality, it is important to examine women's perception on regulation of their fertility and their inability to negotiate with their partners about the use of condoms. Understanding the socio-cultural context is, therefore, crucial for planning and implementing programs aimed at promoting condom use in any community.

This research investigates the cultural context, especially beliefs and practices, of contraception and conception among members of a rapidly urbanizing Meo community living in the border areas of Delhi, Haryana and Rajasthan. Although the Meo community is distributed throughout the region of Mewat, North West India, especially in and around the state of Haryana (Peoples of Haryana, 2003), this research has focused on the Meo community living around New Delhi.

Rationale for the Study

Over the last two decades Meo community has experienced rapid urbanization. This change has brought new employment opportunities for the people of Mewat, but also negatively impacted the community by exposing it to trafficking of women for prostitution (The Tribune, 2000).

For the most part, Meo families have remained financially weak. The average family size is 9.5, with over 60 percent of the households in the region living below the poverty line and over 30 percent of children aged 10–15 involved in different occupations (World Vision of India, 2002). Literacy rate among adults in the region is around 25 percent and literacy rate among women is only 3 percent. Although school enrollment of children in the age group 6–11 years is around 50 percent. 85 percent of girls are withdrawn from school after primary level (Samuel, 2003).

The influence of spiritual healers such as Mirasis, Maulvis and Hakeems is well demonstrated in Mewat. In recent years these healers have become actively involved in health promotion and intervention programs. In 1995, spiritual healers of Mew in Gurgaon district were involved in ensuring 100 percent immunizations

in the Pulse Polio Campaign. This model can also be extended for the promotion of contraception, gender equality, and prevention of sexually transmitted diseases and HIV/AIDS, but before going for that a comprehensive ethnographic understanding of Meo community is required. This study therefore, examines the relationship of Meo beliefs and practices related to fertility regulation and treatment of STDs. The study also focuses on role of spiritual healers in fertility regulation and prevention against STI/HIV/AIDS.

This community's close proximity to New Delhi – one of the rapidly expanding urban areas in India – provides an opportunity for comprehensive understanding of culture change and its influence on the community's perceptions and practices related to conception and contraception and sexually transmitted diseases.

The Meo Community: Ethno-historical Context

By current estimates, there are one million Meo living in rural and urbanizing areas in Haryana, Rajasthan and New Delhi. The Meo community, living in and around the New Delhi-Haryana Border, provides an excellent setting to study how the continuity and change in Meo cultural practices relate to conception and contraception.

The Meo community in India embodies a unique blend of Hindu and Muslim cultural characteristics. The Meo version of the Hindu epic, *Mahabharata*, which is also known as the *Pandun ka Kara*, was composed in the early 18th century by two Meo Muslim saints (Mayaram, 1997). The current cultural milieu of the larger Meo community reflects characteristics associated with a socio-religious

movement (*tablighi jamayat*). The portrayal of local shamans and healers – named *maulvi*, *hakeem*, *mirasi* and *fakirs* – in the *Mewati* epic suggests a complex and overlapping identity of the healer as a *jogi* or *faqir* who is simultaneously a “Hindu renouncer” and a “Muslim ascetic” (Mayaram, 1997). Meos believe that self-sacrifice and meditation (*tapas*) give them healing powers and the ability to regulate fertility. Meo healers – *Maulvis* and *Mirasis* – are not only capable of curing common health problems, but also possess the spiritual powers to grant a child and to ensure the birth of a son (Hasan, 1998; Mayaram, 1997). In a recent study of the Meo kinship system, Nora Scott (2003) suggests that in terms of family, kinship, and associated ceremonies, myths and legends, the Meo have long been regarded as unusual among Indian Muslims. The Meo forbid patrilineal parallel-cousin marriage and cross-cousin marriage, and follow north Indian, Hindu kinship rules. Earlier research suggests that Meo cultural characteristics reflect the larger patriarchal structures observed among other north Indian peasant communities. Meo patriarchal social system restricts women’s access to health care, education, income-generating activities, and contributes to the “trading” of girls – a practice that exposes the youth in the community to risks for STIs (Mamdani, 1972; Kumar, 1983). Meo girls’ education is limited to religious education (*deeni taleem*) and school dropout rates are as high as 90 percent in Mewat – an area predominantly inhabited by the Meo (Mewat Development Agency, 1999), which corners their health needs as a secondary issue. In the strict patriarchal context of the Meo community, there is considerable silence over issues related to sexuality and sexual practices (John and Nair, 1999).

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Sociological and epidemiological research in the Meo community suggests that 62 percent of the rural Meo households in the Mewat region live at or below the national poverty level (National Census Report, 1991), and that the overall literacy rate of the region is 23.1 percent (Mewat Development Agency, 1995). The government of Haryana State has declared the Mewat region to be an economically backward region (Jatrana, 1999). These studies also suggest that condom use in the Meo culture is very limited. Meo women tend to have limited decision-making powers in the matters related to sexuality, selecting a sex partner, and the timing of the sexual encounter (Clark, 1998). According to recent estimates by the International Programs Center (2000), the risk exposure rate for STIs in this region has doubled from 2.5 percent to 5 percent between 1998 and 1999. Low age at marriage has been found to be a significant cause of the deteriorating state of maternal and child health in the Meo culture (Jatrana, 1999).

Anthropologists have paid little attention to the Mewat region, in general, and the Meo community, in particular. Our understanding of the Meo culture is especially limited in terms of cultural beliefs and practices related to conception, fertility regulation, and community health. The proposed ethnographic study is the first attempt to understand the cultural and demographic context of conception and contraception in this unique community. The study attempts to understand the role played by cultural beliefs and practices associated with conception and contraception, especially investigating how gender relations, women's educational status, religious beliefs and other related factors influence decisions and practices associated with the use of contraceptive methods.

Islamic Influence on the Meo women: Real or Virtual?

Islam practiced in the Meo culture has strong influence of Hinduism, the religion which was prevailing there before coming of Islam in the region. The rituals, beliefs and practices in the everyday life amongst Meos resemble more to the Hinduism than Islamic directives prescribe in the Quran and the Hadith (Mew, 1999). Until recently, Meos used to celebrate religious festivals of both; Hindus and Muslims. Their rituals on marriage, divorce and child birth are still like their neighboring agrarian Hindu caste people, such *jat* and *gujars* (Shakoor, 1947). They have proud of being followers of the dual tradition and proudly project themselves as a 'secular Muslim.' This unique culture is blend into every aspect of Meo culture and clearly can be seen (Mayaram, 1999).

The gender roles in the Meo culture are also influenced by the so called patriarchy of Islam and Hinduism. In result, several good aspects of both the religions have been misunderstood which directly affect health of the Meo women as well as family health. Roles of women are important because women are often the "producers of health"—in other words, women are in charge of health issues on the household level (Brown, 1998).

Their attachment with the two religions at a time brought a totally different social out comes. Meo women, perform '*chak bhat*' in marriage, '*kuan puja*' after the birth of son, which are purely Hindu practices, while at the same time they wear veil (*hijab*) and avoid interaction with the non-relative men (*ghair mahram*) which is strictly recommended in Islam.

The mass illiteracy and ignorance of the Meo community specifically amongst women, had distorted the understanding of these religions, more specifically about Islam. The system of veil led them to bring culture of mobility restriction and remaining aloof from other sociopolitical life as men do in the Meo culture. Consequently, status of women in the Meo community became secondary and their participation in education, health, income generation and other civic activities reduced substantially. It is essential here to understand that Meo women in are basically Muslim and their rights in the light of Islam which can be reinforced at least within the household.

Islam has provided Muslim women social and political rights to lead her life independently. Some of their rights mention in the Quran and the Hadith are illustrated below:

- Right to maintain personal respect
- Right to have respectable married status
- Right to have authority and maintenance for their children, custody of their children after divorce
- Right to negotiate marriage terms of their choice, also to refuse any marriage that does not please them i.e the right to obtain divorce from their husbands, even on the grounds that they can't stand them
- Right to have independent property of their own
- The right and duty to obtain education
- The right to work if they need or want it
- Equality of reward for equal deeds,

- The right to participate fully in public life and have their voices heard by those in power

According to Islamic laws Muslim men and Islamic governance are bound to ensure the rights of women.

During my fieldwork I have collected the following information among Meo families:

1. General household characteristics,
2. Information on education, occupation, and gender role attitudes across generations, especially on contraception,
3. Desired family size,
4. Knowledge and use of contraceptive methods,
5. Knowledge of the most common STIs, including HIV/AIDS.
6. Knowledge and use of condoms for protection against STIs.

My prior knowledge and experience of working in the same geographic and cultural area facilitated expeditious fieldwork and allowed me to collect sensitive information related to conception and contraception. I conducted fieldwork in three phases. In the first phase, I created strong rapport with the stakeholders, opinion leaders and services providers of selected Meo villages. In the second phase, I conducted household surveys to collect detailed demographic information. In the third phase, I used ethnographic research tools (participant observations and individual/group interviews) to study a stratified proportionate sample of reproductively active Meo men and women (18-45 years) for specific information on education, gender role attitudes, desired family size and composition,

knowledge and use of contraceptive methods and knowledge of STIs and related topics.

Since this study is related to human subjects, prior approval from the Institutional Review Board, Oregon State University was taken before the start of fieldwork. All participants involved in any of the methods of data collection in the study were informed regarding goals, objectives, methods to be used, risks and benefits from this study verbally as well by providing written documents (Appendix-1&2). They were also told that all possible effort to maintain confidentiality will be made by the study team.

This thesis is divided into five chapters. The first chapter explains a comprehensive introduction to the Meo community, research questions, hypothesis and rationale of the research. The second chapter reviews extensive literature on demographic features of Mewat, its cultural background and customs and traditions related to marriage, fertility, conception and contraception. In the third chapter details of research methods have been given. The fourth chapter discusses the results and analyzes the data collected. The final chapter offers the conclusion and recommendations for effective culturally-informed planning and implementation to improve reproductive and sexual health in the Meo community and several other similar communities of north India.

Demographic Features of Meo Culture

The region of Mewat lies between 26° and 30° north latitude and 76° and 78° east longitude (Haryanaonline.com). It covers a portion of the Indo-Gangetic plain to the west of Yamuna River and south-west of Delhi, in the southern part of Haryana and north eastern part of

Rajasthan (Mewat

Development Agency,

2005). It is spread over an area of 3000 sq. miles, comprised of

six blocks in two districts of

Haryana (District *Gurgaon*:

Nuh, Taoru, Nagina, Ferozpur

Jhirka and Punhana blocks and

District *Faridabad*: *Hathin*

block). In *Rajasthan*, Meos

are spread over 8 blocks of two districts (District *Alwar*: *Tijara, Ramgarh,*

Kishangarh, Laxman Garh and *Govind Garh* blocks and District *Bharat Pur*:

Pahari kama and *Dig* blocks). These blocks are known as Mewat (Mew, 1999).

The *Mewat* region includes 491 villages, located along the *Aravalli* mountain range. The total population of the *Mewat* region is 1-1.2 million. About sixty-five per cent of the population in the region is *Meo* Muslims, the largest concentration of Muslims in any district in North India (Census of India, 2001).



Figure 2.1 Map of India

Most of the people here depend on agriculture and have small land holdings.

Education and health facilities are considerably poor in the *Mewat* region (VHAI, 2004; Narayan, 2004). The table below provides details of health, education and demographic in Mewat.

Table 2.1 Profile of Mewat

Components	Status
Area	3000 sq miles
Total Number of villages	491
Population, Census	1007800
Males	577934
Females	500066
Rural Population	92.93
Males	537035
Females	464834
Urban Population	7.06%
Males	40898
Females	35233
Sex Ration	861
Literacy	26.93%
Male	42.49%
Female	8.65%
Health Facilities:	
Community Health Centers (CHCs)	4
Primary Health Centers(CHCs)	15
Sub Centers	76
Ayurvedic	26
Homeopathic	11
Educational Facilities:	
Primary Schools	425
Middle Schools	72
High Schools	82
Hr. Sec. Schools	12
Bal Bhawan	3
Colleges	3
Teachers Training Institute	1
Source: Mewat Development Agency, Gurgaon, 2004	

Cultural Background

The *Meos* trace their roots to the early Aryan invasion of northern India and identify themselves as warriors (*kshatryas*), the marshal caste of Hindu caste system who are historically powerful (Shakur, 1947). In Hindu caste hierarchy, the marshal caste is number two after the priests (*Brahmins*). This community was perceived differently at different points of time. To the *Mughals*, the *Mewatis* were "rebels." To British ethnographers, they were "criminal tribes." To the modernizing princely rulers of eastern Rajasthan in the first half of the twentieth century, Meo were "Muslims." To the group of priests (*tablighi jamayat*), who were trying to make them better Muslims after 1947, the *Mewatis* were the "ignorant" (*jahiliyya*) of pre-Islamic Arabia and in "urgent need of reform" (Mayaram, 1997).

Historically, the region has been extremely turbulent and has been subjected to repeated invasions and resultant plundering throughout the post-Vedic period, largely due to the situational peculiarity of the area and the non-subjugated attitude of the people (The Deccan Herald, 2000). The destruction and devastation over the centuries resulted in backwardness and gross under-development of both the area and its proud people.

Cultural Identity of Meos

Like some Hindu castes in the region, such as *Jats*, *Gugars* and *Rajputs*, the Meo maintain a strong institution of *gotra* and *pal* (Imam, 1975). The Meo community is divided into twelve clusters (*pals*), and fifty-two clans (*gotras*). The sense of solidarity and unity among the members of the same *gotra* or of the same *pal* is usually very high. In everyday interaction, the *Meos* rely on help from

members of their pal or gotra (Mew, 1999). In local terms it is called '*barah-bawan*' i.e. "twelve-fifty-two", which refers to twelve *pals* and fifty-two *gotras*. It is interesting here to note that around twenty five *gortas* of Meo completely resemble the *gotras* of Hindu *Jats*, *Rajput* and *Chamars* of North India. In terms of their individuality and group identity, this system also regulates the institution of marriage in their culture.

Traditionally, Meos practice early marriage (Planning Commission, 2001). The average age of marriage for the girls is fifteen to sixteen years, while in case of the boys, it is one to two years later (Manocha et al., 1992). Cases of child marriage are frequent in Meo culture (UNESCO, 2001). The marriage agreements between two families happen even when the children are five or six years old. This custom is known as 'parental will' (*gauna*), and is prevalent among the Hindus of the region (Mew, 1999). Solemnization of marriage among Meos is not complete without both, the mutual agreement by the couple as practiced in Islam (*nikah*) and the circling of fire (*agni parikarma*) as among Hindus (Government of Hayana, 2005). Meo marriage is done on the basis of exogamy. Under this principle, marriage can only take place between individuals belonging to two different clans. The Meos also practice village exogamy. The boys and girls raised in the same village are considered siblings (Khan, 1968).

Conception and Traditional Meo Culture

Conception is more a cultural than a biological construct among Meos; it carries individual, familial, religious, economic and cultural meanings in this community. Even for the same Meo couple, different pregnancies carry different

meanings; the meaning of the first pregnancy can be entirely different compared to the second or third pregnancies (Villarreal, 1998).

An infertile couple is looked upon as the most unfortunate in the Meo community. It is even worse for the women as it is directly attached to her status in the family (Mamdani, 1974). Usually, the first pregnancy signals proof of the couple's fertility. In the case of women, it proves her womanhood, productivity and status of being "normal." After the first pregnancy, the other pregnancies carry a different meaning and are related to the notion of strength and economic production of the family. A woman who doesn't bear a child in this community is considered unholy (*ashubh*). Often she is prohibited from practicing in family festivals, such as practicing customs and rituals in the marriages of relatives. Also, a woman who conceives is liberated from the fear and pressure of rejection from her husband.

An infertile Meo woman is labeled fruitless (*banjh*), a derogatory term for a woman in this culture (Gulati, 1998). The demand for children encourages early marriage and early pregnancies. This has been described as one of the reasons for teen pregnancies in the Meo community (Shashtry, 1993).

Conceptions are also considered as signs of increasing economic status of the household in the Meo community. More than ninety percent of the Meo population lives in rural areas and their main occupation is agriculture (Mewat Development Agency, 2003). Farming thus is a family occupation. A large family tends to be more cost effective, an important factor that encourages Meos to have large families and to appreciate more conception. As a whole, "conception" is a sign of prosperity to the Meo family.

Strong families are a desired aspect of a rural agrarian culture, such as Meo culture. It further extends the strength of a village to dominate over another village in the neighborhoods. Recent changes in the political system, including the development of self-government institutions (*panchayati raj*) working at the levels of village and district, have further influenced the Meo desire to have large families. These changes have linked families directly to village and district level politics.

In most of the north Indian cultures birth of sons are preferred to ensure strength and power of the family due to patriarchal interference. In order to assure son, couple have been using ultra-sonography in the private health clinics to identify the sex of fetus, and abort female fetuses. Meos too want big families with more sons. However, in spite of their son preference, they do not practice sex selective abortions or female infanticides. Abortion is considered a sin in this culture.

Meo's religious beliefs reinforce the need of families to assure the survival of the children. They believe that God will make arrangements for the survival of whoever is born on earth. This belief doesn't allow Meos to consider fertility regulation or to maintain space between the births of two children. Overall, conception is highly significant in the Meo culture and the common belief related to conception in the Meo culture is that it brings happiness and prosperity to the family.

Contraception and Traditional Meo Culture

Contraception has more connotations beyond the concept that it is simply a method of birth control in the Meo community. The Family Planning Commission of India has stated that the targeted approach that was adopted to implement the family planning program in the 1960s and 1970s, such as forced sterilization, is the major cause of distraction from Meo support of the family planning program. During early implementation, the Meo community became hostile over the government's policy to put pressure on them to use contraceptives for limiting family size (Family Welfare Department, 1989).

There were several other reasons for them to react negatively to the program. In the Meos' perception the family planning method was made to restrict only their population (i.e. limit, or reduce the number of Meos). The first and foremost cause for their resistance was that the family planning and its methods, contraceptives, were introduced to them without proper preparations, such as environment building and cultural understanding, that would have made them understand the importance of family planning. The impacts of these loopholes are still with them. Even today, their knowledge of contraception is very limited. Now, they despise knowing much about family planning since they are negatively sensitized over the issue. These past episodes have made them hostile toward contraceptives and this is continuing today.

In addition, the Meos were given limited choices beyond the available contraceptive option, which was to have either vasectomy or tubectomy. In both cases, they would have to undergo surgery and the procedure would be irreversible.

This created fear and caused the Meo people to reject family planning. This notion about contraception led the Meo to believe that the state-sponsored family planning program was an imposition.

The worst part of the contraceptives campaign in the 1960s and 1970s was the communalization of the contraceptives in the Meo community (Dharmalingam and Morgan, 2004). The Meo religious and community leaders labeled contraception and family planning as anti-Islamic. So the Meo, who were already less interested in adopting contraception, had an easy excuse to avoid using contraceptives. Because of this, Hindu political groups blamed the Meos for not behaving in the larger interest of the nation and for not agreeing to control their population growth. This resulted in political and economic marginalization of the Meos and further retaliation by the Meos to completely reject the national family planning program (Panandiker and Umashankar, 1994).

Talking about sex and sexuality is strictly prohibited in the Meo culture. The roots of these norms came from the religion, Islam, which states it is promiscuous. Although this notion exists in almost every Indian culture, in Meo culture it is complicated with political distortions and moral compulsions. Throughout Meo society, women feel it is difficult to express their contraceptive needs to their husbands (Dyson and Moore, 1983). The most common roots of this behavior are religious and moral sanctions that come in the form of gender roles. Since religion also prohibits fertility regulation through blocking or spacing pregnancies, it is difficult to introduce contraception in a closed culture like the

Meo culture. Thus, any kind of communication or action in support of contraception is called promiscuous in this culture.

The other big factor preventing contraceptive usage in the Meo culture is prevailing myths and misconceptions related to it (Family Health International, 1996). For almost every type of contraception, there are myths and misconceptions prevailing in this culture. For example, many believe that vasectomies lead men to become weak and that tubectomies lead women to become fat. They also believe that taking oral pills causes women to gain weight and that their daughters may become infertile after attaining puberty, and that condoms reduce sexual pleasure (Mehra, 2002). Because of the above factors, acceptance of contraception in the Meo community is relatively less than the other communities of north India.

Health-seeking Behavior in Meo Culture

According to the World Health Organization (WHO), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Most rural communities of the third world don't have the same vision of health that is projected by the World Health Organization. In practice, the health seeking behavior of the people is weak and the health care delivery system is unorganized. The Meo community is one of these communities; they have shown poor health-seeking behavior for a long time. Although, the meaning and concept of health-seeking behavior changes as culture changes, a standard health need has been identified and prescribed by the World Health Organization for the health of the people of certain regions in the world. Also, it

has been observed that the connotation of health-seeking behavior changes even from subculture to subculture (Manderson, 2003).

Health in any region largely depends on environmental conditions, economic status, education and gender. It also depends on availability and quality of services. Meo culture's health-seeking behavior is influenced by all the above mentioned parameters of health-seeking behavior.

In general, it is believed that providing knowledge about the causes of ill health and choices available will help to promote a change in individual behavior, and toward more beneficial health-seeking behavior in a community. However, the *explanatory model* of illness in different cultures delineates that not only two cultural factors, awareness and availability, but a series of culture-related concepts and facts that are responsible for the desirable health-seeking behavior of any community. At present there is evidence of a growing sensitivity about health in the Meo community but still it is at slow pace. However, development agencies, governmental and non-governmental, exclusively focus on the individual as a purposive and decisive agent in the Meo community. It has been advocated by many scholars that factors promoting good health-seeking behaviors are not rooted solely in the individual; they also have a more dynamic, collective, and interactive element with the culture (Filmer et al., 1997). The knowledge and importance related to health-seeking behavior is often given little value from health and development professionals. In fact, health-seeking behavior is not even mentioned in medical textbooks (Steen and Mazonde, 1999).

Two basic approaches are helpful to understand the health-seeking behaviors of the Meo community. The first approach is to explore the issues surrounding the Meo culture's lack of attachment to the formal health care delivery system and its non-utilization in relation to fertility and sexually transmitted diseases. The second approach is to determine the magnitude of illness responses and sensitivity to avoid fertility and sexually transmitted infection.

Utilizations of Health Care Delivery System:

It is essential for an ethnographer to take every healing system into consideration when health-seeking behavior of any culture is measured. In the Meo community, numerous alternative healing systems are available. Besides availability of modern healing systems, homeopathic, herbal and spiritual healing systems are intermingled with the Meo culture. The role of spiritual healers, such as *maulvis*, *mirasis*, *ojhas*, *fakir* and *aughars*, are blended into the life of common Meo people (Mayaram, 1999) and they also influence the Meo people's perspectives about their health. The government health delivery system is multi-tiered in Mewat. Four community health care centers (CHC) are located at block the level; each of them covers a population of roughly a hundred thousand people. The community health care centers deliver primary and secondary health care services with the help of four to seven specialized medical officers. They also have beds for patients and provision of pathological tests. There are fifteen primary health care centers working in the Mewat areas. They are established for every twenty thousand people. Their major functions are first aid, services to combat

diseases and referring complex cases to the community health centers at block level. In addition, there are 76 sub-centers established for every 2000 people. These centers are mainly for the management of community health with special focus on reproductive and child health issues (Mewat Development Agency, 2005). Although health components, like self care, visits to traditional healers and unofficial medical channels, are not recorded, they are often seen and included as important aspects of health-seeking behavior (Ahmed, et al, 2001) in the Meo culture.

Despite these available infrastructures, the health-seeking behavior of the Meo community is not up to the desired level (Mewat Development Agency, 2004). The low social status of women directly influences the health-seeking behavior of the family because most often health related decisions in the household are governed by women (Brown, 1998). The pervasive patriarchy and non-decisive attitude of women lead to incidents like early age at marriage and early first pregnancy in the community, which, later, contribute to the serious and complex issues of mother and child health.

Sensitization and Response to Illness:

Sensitization and response to illness depend on the cultural factors. Awareness about disease, economic status of people and physical distance from the health care center are closely associated with this. Reference say health-seeking behavior is something that is rooted especially in the psyche of the people. Knowledge of Meo people about health issues related to conception and

contraception is still very poor (National Commission on Population, 2001). In addition, high poverty prevalence in the region stops Meo people from even thinking about better quality of health (The Tribune, 2001). These situations clearly indicate why Meo culture is not responding properly for health seeking. A number of 'social cognition models' (Conner and Norman, 1996) have been developed to predict possible behavior patterns of cultures. Later, these patterns are analyzed in the broad framework of demographic, social, emotional, perceived symptoms and access to health care (Conner and Norman, 1996). In those models, marginally poor Meos show restricted health-seeking behavior due to their lack of awareness of health care which is accompanied with poverty, over-population and low literacy rates (UNDP, 2001).

For women, their health-seeking behaviors are more of the traditional way of disease management; they do not go outside the premises of their house due to mobility restrictions in Meo culture. This cultural notion of their life prevents them and their children from accessing health facilities, even those that are close to their houses (Planning Commission, 2001).

The concept of viewing the disease is also an influencing factor for the reduced health-seeking behavior of the Meos. Diseases are often given attention on the basis of their morbidity while ailments, like headaches, fevers or colds, are considered natural and are not treated with any kind of medicine. For some diseases, known as lethal, or for injury, they visit the medical service providers. Conception and pregnancies are supposed to be natural in this culture and they do not want to

access modern ante-natal health care facilities around them. They visit spiritual healers if their problems relating to conception and pregnancy become complex.

In summary, it can be said that the low status of women in the household and restricted economy directly influence the sensitization and response to illness in the Meo community (Jatrana, 1999).

Theoretical Foundations: Anthropology and Sociology

In an analytical framework, a “theory is a set of interrelated concepts, definitions, and propositions among variables in a systematic view of events or situations by specifying relations among variables in order to explain and predict events or situation” (Glanz, Lewis and Rimer, 1996). A theoretical basis is essential for any ethnography. Its relevance becomes more important if the culture studied is transforming from rural to urban such as in the case the Meo culture. Theories not only provide the perspective for investigating a culture but also provide directions to critically associate the energizing traits of a particular culture with traits of other cultures to predict future developments.

For understanding the Meo communities in the broader anthropological framework of health and culture, four theories have been adopted for this study.

Theory of Social Facts:

Emile Durkheim (1858-1917) was among the first anthropologists who defined the factors that influence the dynamics of individuals and groups within a culture, such as behavior, attitude, understanding, action and perception. He called these ‘Social facts’. He recognized that there were specific approaches and traits

belonging to a culture or subculture that affected human relationships. These views of Durkhiem are demonstrated in the Meo culture. Existing patriarchal norms and practices related to gender are excellent examples of this. Durkheim argued that social facts are real and practical because their effects can be felt. People are compelled to live according to the norms and values of their own culture. Meo resistance towards change from a traditional agrarian lifestyle to a modern urban lifestyle illustrates Durkhiem's argument. "The common ground for discovering examples of 'social facts' can be found in general rules of behaviors allotted by a culture for example informal rules about what is appropriate to eat and how to eat" (McGee and Warms, 2000). The Meo institution of marriage that prescribes strict cultural norms and customs is explaining the social laws that are made by the culture.

By referring to 'social fact,' Durkhiem referred to the concepts, expectations, sanctions and perceptions that come, not from individual responses and preferences, but 'collectively' from the culture which socializes each of its members to act in a particular manner. This is shown in the Meo culture in the form of their health and gender related beliefs and practices. The misconceptions and myths related to conception, fertility and contraception prevailing in the Meo culture may not be supported scientifically but for them these are facts. Durkheim referred to cultural factors as a strong connotation of 'law' and spoke in terms of its executing mechanism. He did not perceive these 'laws' in a legal sense; he referred to the general rules of behavior that people unconsciously follow. These rules are internalized through growing up in the culture. Mobility restriction on

young women is a law created by the Meo culture. The individual or family who breaks this law is punished in this culture. Again these punishments are not enforced by law but are enforced in the form of rejection from relatives and friends or through mechanisms such as shaming, ridicule, and ostracism (McGee and Warms, 2000).

Durkhiem's social current can also be seen in the Meo culture in the form of their reactions to different issues. The hostility against adopting family planning, during the sixties and seventies, was a social current and was so powerful that no of Meo family opposed it. A social current differs from social fact; it is nothing but the momentary emotions sweeping a crowd, whereas social fact is more static. Modern anthropologists call this process enculturation and believe that it is largely unconscious. It is because of the unconscious internalization of the cultural constraints imposed on people during childhood, not because of conscious, rational choice (McGee and Warms, 2000). In spite of heavy industrialization in the neighborhood, Meos still adhere to their traditional lifestyles. This behavior is due to their enculturation which influences their choice of living.

Theory of Historical Particularism:

This study is inspired by Franz Boas' (1858-1942) theory of historical particularism, which states that every culture has its own unique historical development and must be understood based on its historical context. This was the first moment when ethnography was accepted into academia. Until Boas presented historical particularism, many anthropologists believe that societies develop

according one universal order of cultural evaluation. The belief, called Unilinear Evolution, explained cultural similarities and differences among societies by classifying them into three sequential stages of development known as egalitarian, barbaric and civilized. Boas criticized this belief as it is based on insufficient evidence. Boas argued that this ordering is merely an assumption because there is no historical evidence or way to demonstrate its validity. He blamed armchair anthropologist who recognized second-hand data in unsystematic manners to fit their preconceived ideas.

Based on his principle that cultural theories should be derived from concrete ethnographic information, Boas strongly advocated conducting fieldwork to understand any culture. Fieldwork is the only basis of this ethnographic research. This fieldwork includes interactions, interviews, discussions and observations to draw findings about conception and contraception related issues in the Meo culture. Boas developed the method of participant observation as a basic research strategy of ethnographic fieldwork. Based on this his method of observation, a large amount of data has been collected on conception and contraception related issues from the Meo culture. During participant observation data was collected on various socio-demographic domains which are focused on attitudes, practices, history and politics of fertility, conception and contraception in this community. Primary data and secondary data collected during the fieldwork were cross-verified, and gaps found were removed with the help of further participant observation.

Using detailed ethnographic studies Boas argued that a culture is understandable only in its own specific cultural contexts, especially through its historical process. Boas's approach is essential aspect of this study. Understanding Meo culture from Meo perspectives is the major focus of this ethnography. Behavior related to conception and contraception is a private in the Meo community and should be understood only on the basis of their views.

Theory of Critical Medical Anthropology:

Medical anthropology is one of the youngest and most dynamic of the various fields of health and culture. Furthermore, critical medical anthropology has evolved in the late 1990s with the perspectives of establishing connections between the macro-level of the capitalist world and the micro-level of the patient's beliefs and experiences with health problems.

This theory can be defined as an effort to understand and respond to issues of health, illness and treatment in terms of the interaction between the macro levels of political, economic, health care delivery system, popular folk beliefs and actions and the micro level of illness experience, behavior, and meaning, human psychology, and environmental factors (Bear et al., 1996; Scheder, 1988; Singer, 1990).

In the context of conception and contraception in the Meo community at the macro-level and at micro-level, this theory paves the way to analyze and correlate understanding and pattern of services of the providers of family planning programs,

for example Government of India and ethno-medical beliefs of receivers of service, i.e. the Meos community.

Understanding the roles of spiritual healers is significant because the Meo people have belief about shamans and the traditional modes of treatment. Critical medical anthropology as one of the approaches of investigation has provided insight to view the relatively strong influence of spiritual healers within the Meo culture compared to other forms of healing. In the light of this theory, the roles of spiritual leaders such as *maulvi*, *hakeem*, *Mirasi* and *fakir* in the fertility control and pregnancy management have been analyzed.

Spiritual Healers: A Potential Change Agent

Spiritual healers believe that people must take responsibility for their own health by practicing healthy behaviors and maintaining positive attitudes instead of relying on health care service providers (Daniel, 2004). They also believe that physical disease has behavioral, psychological, and spiritual components. These spiritual components can be explained by understanding the relationship between beliefs, mental attitude, and the immune system.

A person's religious convictions or life philosophy enhanced the average effects of the relaxation responses in three ways: firstly, people who chose an appropriate focus, that which drew upon their deepest philosophic or religious convictions, were more apt to adhere to the elicitation routine, looking forward to it and enjoying it. Secondly, affirmative beliefs of any kind brought forth remembered wellness, reviving top-down, nerve-cell firing patterns in the brain that were associated with wellness. And thirdly, when present, faith in an eternal or life-

transcending force seemed to make the fullest use of remembered wellness because it is a supremely soothing belief, disconnecting unhealthy logic and worries (Benson and Strak, 1999).

Although there are no collaborative programs involving traditional and western-trained practitioners neither in the Meo community nor in the surrounding areas, global experiences with the African cultures depict a strong correlation between treatment and traditional healing practices. Survey of African spiritual healer attitudes and limited programmatic experience have consistently shown willingness on the part of traditional healers to learn more about orthodox biomedicine and to cooperate and collaborate with western-trained practitioners (Messing, 1976; Hall et al., 1977; Osbrone et al., 1977; Rubel and Sargent, 1979; Green and Makhubu, 1985). The program reinforce that , prestige and recognition appear to be fundamental incentive underlying healers' willingness to cooperate (Green, 1994).

In spite of willingness and interest on the part of African healers, there are powerful obstacles in the way of establishing educational programs for traditional healers. Their readiness to take on sensitive issues, such as fertility, sexually transmitted diseases and HIV/AIDS were substantially less. Initially, educational programs were aimed at upgrading the skills of traditional healers or birth attendants, the technologies transferred to indigenous practitioners have been of the most rudimentary kind, primarily homemade sugar/salt solution to prevent dehydration from infectious child diarrheal disease, or non-prescriptive contraceptives, such as condom. Later, emphases were made to establish referral

mechanisms from grassroots to the trained biomedical practitioners. The inclusion³¹ of sexually transmitted diseases and HIV/AIDS happened in the latter phases of the programs when trust and strengths between traditional healers and community were tested as strong and unbreakable.

In the Meo community, presence of traditional spiritual healers such as *mirasi*, *maulvi*, *hakeems*, *fakirs*, and *jogies* and their influence over the healing mechanism in the community suggests that they can be an effective change agent if they are trained and involved on the basis of global experience for addressing the issues related to fertility, conception, contraception, and sexually transmitted disease.

Chapter 3: Research Methodology

Ethnography

The roots of ethnography lie in anthropology. The early anthropologists of the mid-nineteenth and early twentieth centuries literally 'lived among the natives' for a prolonged period of time (Malinowski, 1922) to understand the perspective of the native culture. The influence of Malinowski and his instructions to potential ethnographers is evident in the later writings of Hammersley and Atkinson (1995). According to Malinowski, the key goal of ethnography is to understand the native's point of view and thus to treat situations and settings as 'anthropologically strange' (Hammersley & Atkinson, 1995). Malinowski (1922) suggests that the scene, the actors and the performance must be described. All these details are then integrated to achieve a 'sociological synthesis' (Malinowski, 1922). More recently, researches acknowledge that the term 'ethnography' encompasses different traditions and activities. Engaging in fieldwork and observation have been described as key strategies to achieve the goal of attempting to understand people and their lives in a given culture. The dynamic nature of ethnography and the ongoing methodological debates surrounding it are also well documented in literature in anthropology and beyond (Hammersley and Atkinson 1995, Brewer 2000, Taylor 2002).

I have used "ethnography" as the primary methodology for investigating and understanding Meo culture, especially from the point of conception and contraception. In doing so, I have included both qualitative and quantitative methods of data collection. Qualitative data consist of detailed descriptions of

situations, experiences, events, interactions, and observed behaviors; to show the authenticity of information, direct quotations from the people about their attitudes, beliefs and thoughts (Patron, 1980) have been used.

Three qualitative research methods, participant observation, focus group discussions and in-depth interviews were the main tools of data collection in this study. These methods were used to provide contextual information for data collected by using three quantitative methods, namely, household survey/reproductive history structured interview forms, and secondary data collection.

Preparation and Process of Data Collection

In the beginning of my fieldwork, I visited to stakeholders and various institutions working in the areas Mewat. The rapport with the community stakeholders proved very useful for procuring basic information about the study population as well as socio-cultural information regarding Meo culture. After sufficient rapport building with major stake holders in the Meo community, I developed research tools based on the research questions and guidelines for data collection. Household survey/ reproductive history questionnaire, which was aimed for understanding milestones of reproductive and sexual health of the Meo women in their life was administered on the 50 married women from 50 different households of the study population.

Other than me five more individuals (two male and three females) have been involved as survey team. These volunteers were educated up to college level and

had 2-3 years working experience community health in the neighborhood communities of Mewat.

Orientation of Survey Volunteer:

A two-day orientation was conducted (4th and 5th October, 2004) on conception and contraception issues and on recording of survey information on the survey questionnaire to the survey volunteers.

Pre-testing:

As survey questionnaire was in English which is not the language of Meo community so the biggest fear was wrong translation by the volunteers to the participants. It was translated in to local language, Hindi, by the volunteers and mock survey with three Meo women was conducted for testing whether they understand the real meaning of questions asked or not. On the basis of learning from pre-testing required changes were done.

After survey, in- depth interview questionnaire and guidelines of the focus group discussion were developed. The pre-testing of the in-depth interview and focus group discussion were also done on the similar fashion as of survey questionnaire. The in-depth interview questionnaire was pre-tested with the three individuals, one male, and one female and with one health care service providers. Testing of FGD-questions was done with a group of women. And finally data collected by both the methods sample plan. One male volunteer and two female volunteers other than me were involved for the data collection through in-depth interview and focus group discussion.

I gathered detailed information on the following characteristics at the individual, household and community levels:

Table 3.1 Domains with Descriptions

S.No	Domain	Description
1	<i>General Household Characteristics</i>	Data on general household characteristics, such as information on age, sex, family size, education of the members of the family, occupation, family income, attitudes on gender roles across generations, were collected to inform the embeddedness of attitude and practices related to conception and contraception in the Meo community.
2	<i>Reproductive Health</i>	Information on attitude and practice related to fertility, menarche, menopause, myths and misconceptions related to fertility and conception, safe motherhood practices, availability and use of prenatal care, institutional and non institutional deliveries.
3	<i>Knowledge and Use of Contraceptive Methods</i>	Knowledge of people on available contraceptives and its accessibility, opinions of people related to fertility regulation and barriers for the contraceptive in Meo culture have been carried out.
4	<i>Desired Family Size</i>	Information on family size, son preference, and desired number of children by married couples.
5	<i>Sexually Transmitted Diseases and HIV/AIDS</i>	Knowledge of STI/HIV/AIDS, modes of transmission, protection, access to the health care and knowledge and attitudes toward condom use.
6	<i>Access to Health Care</i>	Types of health facility available, cultural factors related to access, gender issues in relation to health access.
7	<i>Role of Spiritual Healers</i>	Beliefs related to fertility regulation and protection from STI/HIV/AIDS.

Sampling

Population:

The study focuses on a sample of urbanizing Meo families living in five semi-urban villages at the border of Haryana, Rajasthan and New Delhi. The study sample drew from approximately 850 urbanizing Meo households in the three villages- Chundika, Sunari and Nizampur from the Tauru block of Gurgaon district in Haryana; and two villages,- Dhidara and Ghatal,- from the Bhiwari block of Alwar district in Rajasthan.

These villages were selected because of their proximity to the commercial and industrial centers of Haryana and Rajasthan, large concentration of Meo household in villages, availability of basic facilities like primary health centers & sub-centers, schools and village health centers(Aganwadi centers)in each village, and representatives of local self-government institutions (*Panchayati Raj Institution*)in each village.

For the purpose of this study household is defined as a unit whose members share their income and eat from the same kitchen. Table 2 presents basic demographic information on the study villages.

Table 3.2 Demographic profile of sample households

S No	Villages	No of Households	Population
1	Chundika	120	800
2	Sunari	190	1000
3	Nizampur	212	1200
4	Dhidara	250	1400
5	Ghatal	65	450
	Total	837	4850

Sampling Frame:

The study stratified according to following criteria:

- a) Married men (18-45 years)
- b) Married women (18-45 years)
- c) Unmarried adolescent boys
- d) Unmarried adolescent girls
- e) Parents/key stakeholders/opinion leaders: teachers, representatives of local self-government institutions
- f) Health service providers: medical officers, paramedics and village health workers

Samples were drawn according to Table 3, which presents a profile of the total study sample and methods used for the data collection.

Table 3.3 Sample Frame

S. No	Categories	Household Survey	In-depth Interviews	Focus Group Discussions
1	Married Men	0	10	2
2	Married Women	50	10	2
3	Unmarried Young boys(15-25 years)	0	10	2
4	Unmarried Young Girls(15-25 years)	0	10	2
5	Parents/Key stakeholders/Opinion leaders	0	5	2
6	Health Service Provider	0	5	2
	Total	50	50	12

Research Tools

1) Participant Observation:

As part of ethnographic fieldwork, participant observation involves long term interaction and proximity with the group being studied. An important reason for the need of participant observation is its success at understanding the subtleties of culturally coded messages. In this study, participant observation allowed me to:

1. Formulate survey questions and to phrase them appropriately.
2. Develop an intuitive understanding in the context of this study, which allowed me for a meaningful interpretation of the findings.

Qualitative information consisting of detailed descriptions about situations, events, people, interactions, and observed behavior, as well as direct quotations from people about their experiences, attitudes and beliefs has been collected in this ethnography. In addition to this information, a bulk of verifiable quantitative information was collected through interview and survey methods.

2) Household survey/Reproductive History Questionnaire:

I used a household survey/reproductive history questionnaire (see Appendix 1) to collect information on household features and complete reproductive history of married Meo women. The need to conduct this survey emerged because no separate secondary data were available on reproductive health issues among the Meo community. The major areas of information sought in the survey are as follows:

- Demographic features of the Meo community, such as level of education, household income, family size, etc.

- Reproductive history of Meo women from the onset of menarche until menopause.
- Health-seeking behavior, health related beliefs, basic health facilities and their utilization by Meos.

3) In-depth Interview:

The role of in-depth interview is critical in ethnography to reach and understand a culture in a more in-depth manner. I used in-depth interviews to understand beliefs and opinions associated with conception and contraception among the Meo informants. The informants for the in-depth interview were categorized as married men, married women, unmarried young people (15-25 years), parents/key stakeholders/opinions leaders and health service providers.

(A copy of the interview questionnaire has been attached in Appendix 2)

4) Focus Group Discussions:

FGDs constitute a flexible to collect detailed information of informants' opinions (Ervin, 2000). Twelve focus group discussions were conducted with stratified groups of the Meo informants. Six to twelve participants took part in each focus group session. Focus group participants were identified on the basis of their status and role in the community and shared knowledge. Focus group participants discussed specific issues related to conception and contraception with special reference to gender and reproductive rights. The focus groups were often constituted on the basis of peer groups within the village e.g. workmates or classmates.

In this study, focus groups also helped in pre-testing the questions of in-depth interviews. The flexible nature of the FGD format allowed the moderator, usually volunteer, to rephrase questions that were misunderstood or less clear to the target audience.

These focus group discussions were useful in establishing “face validity” (verifying whether the researcher and subject are talking about the same thing) and internal triangulation, i.e. verifying perceptive (Ervin, 2000).

(A copy of the guideline for the focus group discussion undertaken in this study has been attached in Appendix 3)

5) Secondary Data Collection:

Secondary data were collected from various government and non-government agencies. These included periodic statistical releases by the Ministry of Health, India, and international agencies (UNICEF, UNFPA and World Bank).

Additionally, I collected relevant secondary data from:

1. Local hospitals (on contraceptive methods, such as condom usage, usage of pills and utility of other contraceptive methods);
2. Education departments (data on school in the area, drop outs rates and male-female ratio in the educational institutions,
3. “Mewat Development Agency” (data on resources available in the region).

Data Analysis

In order to understand perceptions and practices associated with conception and contraception in the urbanizing Meo community, data was analyzed at various levels of comparisons and cross-checking. The most current version of the

Statistical Program for the Social Scientists (SPSS-12) has been used for analyzing the qualitative data, while for the quantitative data were analyzed with the help of software named NVivo-II. Initially, the information gathered by each method was analyzed separately and later all the information was categorized for the interpretations. The purpose of doing a separate analysis of each method was to ensure the highest level of validity and reliability for the data collected. The triangulation among data collected, demographic trends and socio-political understanding of stakeholders was done at the end of the fieldwork to check the authenticity of all qualitative and quantitative information.

Primary data are a rich source for any research and sometimes they are used in conjunction with data collected from other sources (Ervin, 2000). In the first phase of the fieldwork, the secondary data about demography and reproductive and sexual health of the Meo people were gathered from various governmental and non-governmental institutions. The collection of the secondary data was important because of number reasons; first it provided an outline for understating about distribution of Meo population and other macro- level information like occupational pattern, gender status, health facility, school, and education level. Second, through the collection of this data ready-to-use information was procured without devoting much time and money. The collected primary data was benchmarked by comparisons of various categories.

The results of participant observation were also arranged through coding, interpreting and matching the information gathered by the primary data and by survey methods. In a similar way, sessions of focus group discussions were

transcribed and categorized on the various related issues of the research questions.

The conclusion on the research findings were made only if each finding confirmed the parameters of two or more methods used for the study and its acceptance by Meo stakeholders.

Limitations of Methods

Although detailed data have been collected through a combination of ethnographic and survey methods, there are some methodological and interpretive limitations inherent to this study. First, this research was conducted over a period of six months; therefore, time constraints in the data collection were unavoidable. Second, a small sample size has been used to generalize about the Meo culture. Therefore, the findings of the study are open to contradictions and alternate outcomes. Third, the questionnaires were made in English and interviewers had to translate it in to in the local language, Hindi, at the time of interviewing. In many instances, the translated version did not adequately clarify the questions and might have contributed to some misunderstanding. Fourth, in the absence of official or school records of age, family income, or use of contraceptives, I could not independently validate the responses of my informants. Finally, the reproductive age range in the data collection has been selected as 18-45 years. But in some cases, especially among Meo women, the reproductive period begins earlier than 18 years of age. Thus, the representation of adolescent mothers in the reproductive history form may be limited in the present sample.

Chapter 4: Results and Discussion

In this ethnography, both, quantitative and qualitative research methods were used for the information gathering. At the beginning of fieldwork secondary data (Table-4) were collected from numerous local and regional governmental and non-government organizations and a strong rapport was established with the authorities and key stakeholders in the Meo communities in the study villages.

Table 4.1 Overview of methods, sample size and categories of respondents

S.No	Methods	Number	Categories of respondents
1	Household survey/ reproductive History Questionnaire	50 households	Married Meo women
2	In-depth Interview	50 people	Unmarried young girls and boys, married women and men, active parents, key stakeholders, opinion leaders, health service providers
3	Focus Group Discussions(FGDs)	12	Unmarried young girls and boys, married women and men, active parents, key stakeholders, opinion leaders, health service providers
4	Secondary Data collection		Government and non-governmental

Fifty households were surveyed from fifty different house hold in the five different villages for information related to general household characteristics, including household members, income level, etc. In-depth interviews and focus group discussions were conducted among members of the Meo communities in the study villages on the issues related to contraception and conception, gender, sexually transmitted disease, including HIV/AIDS, and the role of spiritual healers in the

community. Data analysis was aimed at triangulating information collected from all research methods.

General Demographic and Socio-cultural Characteristics of Meo Households

Family Size:

The majority of sample households constitute joint and extended families in which several generations live together and share resources. This is one of the typical characteristics of the north Indian family system. The eldest men are generally the heads of the family. Ninety six percent of the respondents stated that in the event of the death of the father, the next older brother becomes the head of the family. The average family size among the sample was found to be 8.5 individuals per family, which is much higher than the national average, 5.3 individual per family (Labor Bureau, government of India, 2004). In more than 40 percent of the Meo households, family size was either 10 or more individuals.

Large families are widely prevalent in the Meo community. Fifty-eight percent of informants believe that the large family size reflects the need to maintain a labor intensive agricultural lifestyle; to increase family income; and to provide political strength in the region. However, another opinion also prevailed among the rest of the sample participants, that 'large family by default' is due to lack of awareness regarding family planning methods among Meo couples.

Occupational Patterns and Family Income:

Although the region of Mewat is increasingly becoming an active commercial center because of heavy industrialization and urbanization in the

surroundings, almost 60 percent of the study participants continue to engage in agricultural activities. The household survey revealed that the remaining participants were either engaged in small-scale business activities or in job-related works. Thirty percent of the sample households have annual incomes less than Rs.10000 (\$ 230), and 42 percent annual incomes between Rs.10000-Rs.20000 (\$ 230-\$460). The Government of India defines poverty level at annual income below Rs.20000 (\$460). By this definition, almost three fourths of the sample households are below the poverty level and only 14 percent households have annual income levels between Rs.20000 and Rs.50000 (\$460-\$1150). The remaining 14 percent households are relatively better in terms of their economic status with annual incomes above Rs.50000.

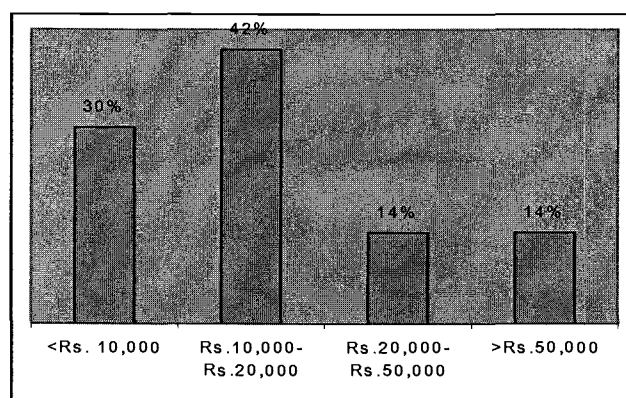


Figure4.1 Meo population at various income levels

Sixty-eight percent of the households are below poverty level; which is almost three times the national average (Planning Commission of India, 2002). This indicates that industrialization and urbanization in the region of Mewat has had only marginal impact on the lives and economic status of the Meo community.

Literacy Level:

The overall literacy of the sample participants in the in-depth interview is 24 percent. Eighteen percent informants are educated up to the primary school level; four percent up to middle school; and two percent up to high school. Only 16

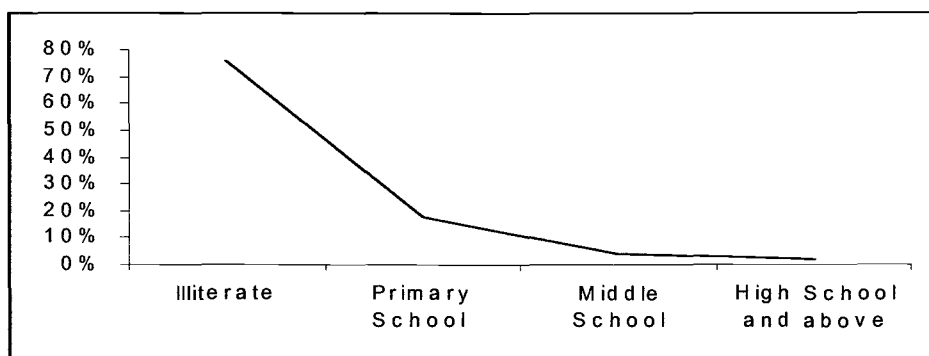


Figure 4.2 Educational status among married Meos

percent of the sample Meo women are literate as compared to 32 percent literate men. Literacy level among the sample Meo men and women combined is less than half of the national literacy level (Census of India, 2001). The majority of the women participants believe that culturally prescribed restrictions on their mobility and expectations of household work are the primary causes of their low literacy.

Cultural Perceptions of Puberty/Adolescence:

Physical growth and development among Meo girls during adolescence, considered as signs of emerging sexuality by the community, emerged as topics of concern during focus group discussion among Meo informants. Meo girls felt that they experience a sudden change in the behavior of family members toward them often resulting in strict regulations on the girl's activities outside the household and

restrictions on her mobility. No such restrictions are imposed on adolescent Meo boys.

In general, Meo girls and boys were shy and reluctant participants in discussions related to sexuality and fertility. However, focus group discussions with this group of informants revealed misconceptions related to sexuality, menstruations, conception, and related issues. Meo boys consider talking about sexuality as “dirty talk,” and held the opinion that they will learn about sexuality after they get married. Meo boys consider masturbation and nocturnal emission as sexually transmitted diseases and seek help from spiritual healers, such as *maulvi*, *hakeems*, and *mirasis*.

Numbers of Children:

In a question regarding who determine the number of children per couple in

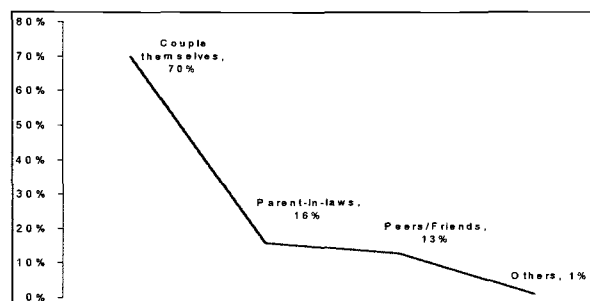


Figure 4.3 Influencing groups on couples to have more children

the Meo culture, most of the interview respondents, 70 percent, believed that only couples decide family size. Significantly, 16 percent of the respondents believed that mother-in-laws influence the number of children in the Meo Household. Some of the respondents, 14 percent, believed that peers and relatives influence the number of children by persuading couples to have more children.

Opinions to have less number of children are coming up among new generation

Meo people. But, still couples choose large family size because of the influence of elders such as parents and parent-in-laws. Mother-in-laws (*saas*) hold a big stake in the family over determining the number of children to her son and daughter-in-law in the Meo culture.

Meos strongly believe that God will provide monetary income when it is needed due to more number of children in the family. A group said 'when god has given mouth then he will provide foods also,' (*Jab upper wale ne chonch diya hai to chuga bhi dega*). Thus, feelings of extra requirements associated with child birth were observed as insignificant in the Meo culture.

The majority of married women in a group discussion reported that just after a few months of their marriages, in-laws, parents and other relatives started expecting them to be pregnant. They used to enquire symbolically saying '*kab kushkhabri suna rahe ho?*' i.e. when you are telling us good news? That happens so many times during those periods that newly married couples find it difficult to consider delaying pregnancy.

Conception, Childbirth and Health Care

Menarche, Menstruation, and Menopause:

The average age of menarche reported by the sample women is 14.5 years, considerably more than 12.5 years, the national average for India (NHFS-II, 2001).

The onset of menarche brings several changes in the life of the women in the Meo community. Girls are considered adults (*baligh*) after they start their periods.

Family members impose strict restrictions of the girl's mobility and begin actively

planning for her marriage. The majority of Meo parents held the view that the longer a girl stays unmarried after puberty, the higher are the chances of her having “affairs” with boys. It is important to note that casual relations between young boys

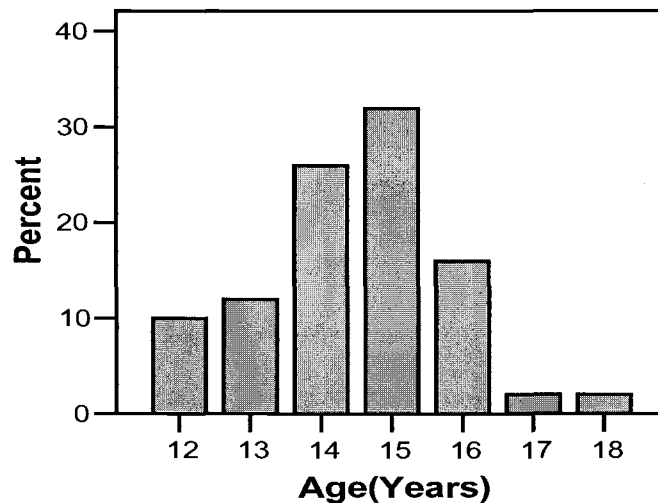


Figure 4.4 Age wise distribution of onset of menarche

are girls are strictly forbidden in Meo society and a girl who has a reputation of being “friendly with boys” will not be able to marry. The strict normative behavior expected from adolescent girls can be further seen in restrictions on mobility and interaction imposed on them. A menstruating girl is expected to remain within the house and to not interact with men at all. Meo girls are expected to follow strict directions of behavior during menstruations.

About 41 percent of the sample women believe that menopause is a disastrous event in the life of a woman as it results in the loss of a women’s ability to conceive. Twenty-three percent of the sample women defined menopause as a natural phenomenon, while 38 percent did not know about menopause.

Marriage and Fertility:

In general, Meos prefer early marriage for girls – a cultural characteristic typical of other agrarian communities in northwestern India. The tradition of early marriage allows Meo parents to avoid the risk of “sexual misadventure” on the part of an adolescent girl and provides an opportunity to forge alliances with other families in the larger community. Although the legal age of marriage for girls in India is 18 years, seventy percent of the sample women got married before attaining the legal age. The average age of marriages among the sample women is 16 years as compared to 17.8, the national mean age of marriage for women (Statistical Report, 1996). Meo informants believe that for a boy 15-16 years is the most appropriate age for marriage and for girls 13-14 years. They also report that if a boy exceeds 18 or 20 years of age or a girl exceeds 16 or 17 years of age, then the chances of their getting married are considerably reduced. Clearly, Meo men and women are marrying at a relatively early age.

On the average, married Meo couples in the sample have 4.16 children. This number of children per married couple is much higher than 3 – the national average (Population Policy of India, 1996). This can be explained on the basis of considerably low awareness and acceptance of family planning methods among Meo couples in Mewat (*Mewat Development Agency*, 2002). Focus group discussions revealed that Meo society considers fertility as an important social symbol defining the prosperity and strength of the family and that of the larger village community. Married Meo women are respected in society on the basis of their expressed fertility. Therefore, having children is a vital aspect of Meo

womanhood. Infertile women have low social status and are often abandoned by their husbands and families. An infertile woman is called a "*banj*" – a derogatory term for a woman. In discussions with local health care providers, it was estimated that a Meo woman on average gives birth to 10-12 children during her fertile life, but due to high infant mortality rates in the area, only 4-7 children survive.

Age at First Conception:

The mean age of first conception among sample women was found to be

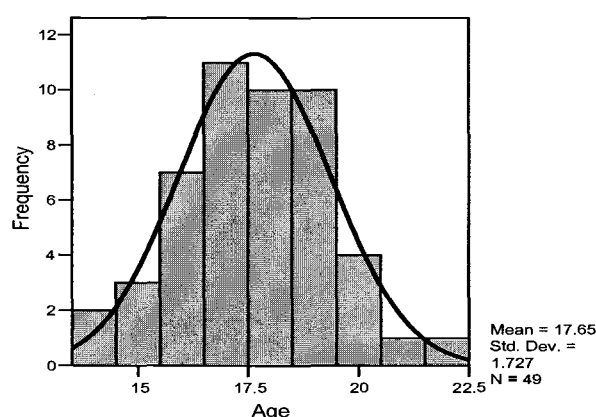


Figure 4.5 Age wise distributions at first pregnancy in sample women

17.6 years. Fifty-one percent of the sample women reported that their first conception was before the age of 18 years. This suggests that the majority of women got pregnant during their late adolescence, which is considered to be a high risk age for pregnancies (Mehra, S., Agraval, D., 2004)

In depth interviews and focus group discussions further revealed that the Meo place high cultural value on early marriage and pregnancy. These culturally prescribed preferences reflect their agrarian lifestyle and are indicative of their efforts to resist rapid assimilation into the rapidly urbanizing world of Mewat. Although some informants were of the opinion that both marriage and first pregnancy should be

delayed by implementing state-sponsored programs aimed at improving the education status of Meo women.

Health Care Practices Related to Child Birth:

In general, Meo women prefer to deliver babies at home. Among the Meo women who participated in the study, only 18.4 percent used the available medical services for childbirth. This proportion is much below the national average of 31.8 percent (NHFS, 1999). Almost 80 percent of babies were delivered at home during

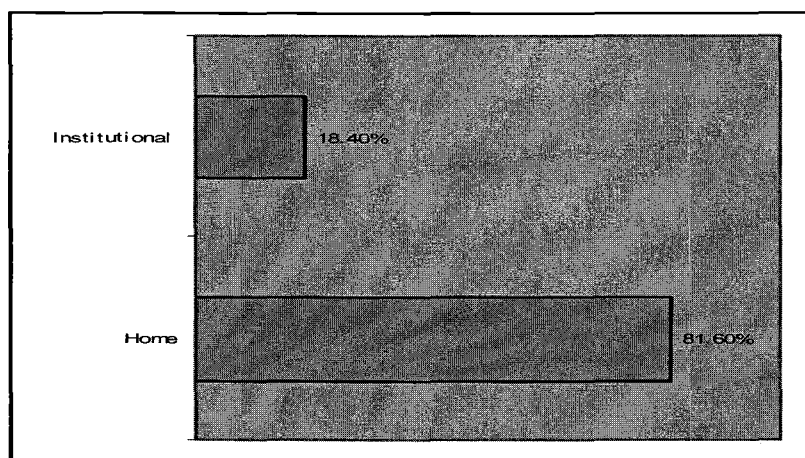


Figure 4.6 Places of first deliveries in the Meo community

the last calendar year. Of these, 44.9 percent of deliveries were supervised by a traditional birth attendant (TBA), usually a low caste woman. In some cases, elderly women in the household or neighborhood supervised the delivery. Although traditional birth traditions and practices are well-developed among the Meo, in the absence of appropriate training and immediate access to professional health services any childbirth related complication could have serious implications.

The most reported reason for not using the available professional childbirth services, state-sponsored or privately run, by the sample women was distance and lack of transportation. Around 52 percent of the total respondents stated that health care centers were too far away. Some Meo women also pointed out that strict restrictions on their mobility and cost associated with childbirth in a private clinic prevent them from using professional birthing services. Most sample women who did visit health care centers were accompanied by a family member, usually husband (54 percent) or mother-in-law (32 percent).

Access of Health Care during Pregnancy:

In recent years, state-sponsored programs aimed at providing prenatal care have considerably increased their outreach into the communities. As a result, 72

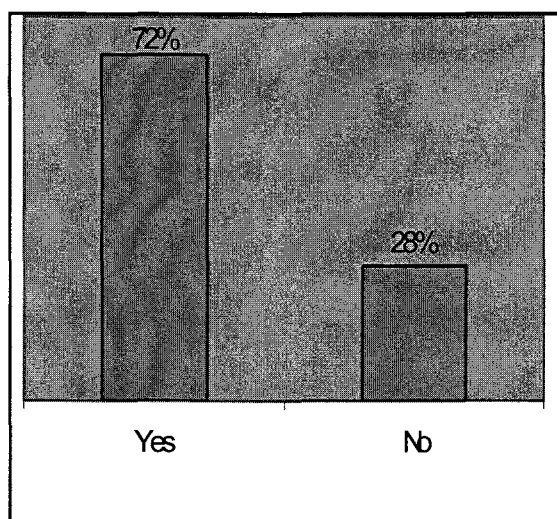


Figure 4.7 Prenatal cares received during first pregnancy

percent of the Meo women who participated in the study had received some kind of prenatal care. However, only 13.2 percent of the women received the complete

prescriptive package of prenatal care, including anti-tetanus shots, iron supplements, counseling services and regular gynecological check ups. Seventy-six percent of women received tetanus shots and iron supplements during their pregnancies. Nearly half of the sample women (47.5 percent) accessed prenatal services within their own villages delivered by the village health workers (*aganwadi workers*). At the village health centers, women typically received standardized prenatal care and are referred to the government hospitals in case of any complication. Only thirty percent of women who are referred to hospitals by the village level center staff visit the nearest hospital, almost 23 percent women visit private clinics, and a large majority of women (about 50%) either avoid seeking professional health care or seek health care from traditional healers in the village.

Elderly members of the Meo community generally discourage women from seeking professional medical care because of their beliefs in the power of traditional healing.

Role of Spiritual Healers in Fertility, Conception, Contraception:

Spiritual healers are highly respected in the Meo community and play an important role in providing traditional health care, including fertility-related problems. Forty percent of the respondents believe that *mirasis* as spiritual healers can evoke the divine powers through their songs (*miras*), which glamorize the strength of ancient Hindu spiritual heroes, *Kauravas* and *Pandavas*. The community identifies *miras* as a popular folk song and a symbol of Meo identity.

Other spiritual healers, *faqirs* and *jogies*, also have the power to regulate fertility by praying or suggesting spiritually sanctioned codes of behavior or diet.

Almost every Meo woman informant had visited a religious/spiritual healing (*maulvis*), at least once during pregnancy. *Maulvis* are believed to have the power to protect the pregnant woman and her fetus from 'evil eyes' and to ensure a safe normal delivery. Meo women also visit and pray at the graves (*dargah*) of local Muslim saints for their blessings to ensure the birth of a healthy child or to seek a son. Herbalists or (*hakeems*) provide herbal medicine for physical and mental ailments and treat such problems as infertility, STIs, and general ill health. In response to a question, 'what spiritual healers provide to them,' 42 percent of respondents stated that spiritual healers suggest religious practices for conception, while another 40 percent stated that the spiritual healers provide herbal medicines. Ten percent of respondents believe that spiritual healers perform magic to cure infertility or to improve chances of conception. About 8 percent of my informants rejected the significance of services provided by spiritual healers.

Contraceptives, Perceptions and Practices

Availability and Use of Contraceptive:

Although traditional beliefs and practices surrounding conception and fertility regulation are widely practiced in the community, the Meos are aware of the availability of "modern" contraceptive methods, such as condoms, oral pills, and sterilization. When asked regarding the knowledge about prevalence of contraceptives in the Meo community, 38 percent of the participants reported that the Meos use condoms for contraception. Twenty-eight percent of informants

suggested that the Meos use more permanent methods of fertility regulation, namely tubectomy and vasectomy. About 14 percent of the respondents suggested that Meo women use oral pills and eight percent said that women use intra uterine

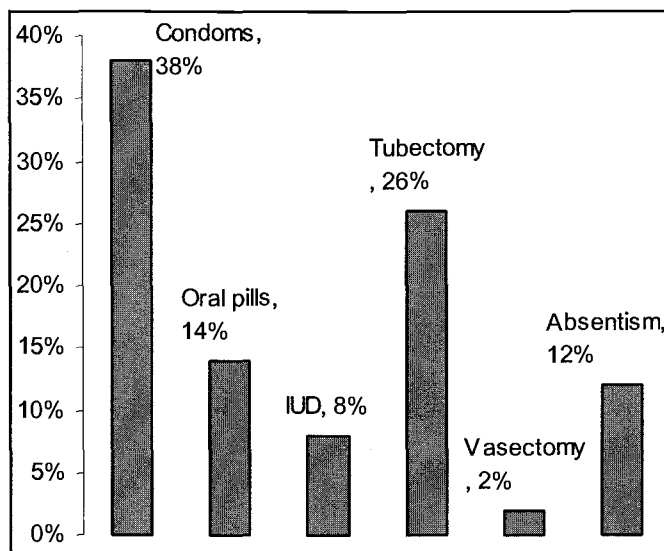


Figure 4.8 Knowledge about the prevalence of contraceptives in the Meo community

devices (IUDs). Almost 27 percent of Meo women who participated in the study have used tubectomy as a permanent method of contraception and 16 percent reported using oral pills as a temporary method of contraception. Interestingly, 31 percent of the respondents reported that the Meo practice abstinence and withdrawal as a method to avoid conception.

The Meo beliefs of conception and fertility as divine and natural events considerably influence their perceptions of the available contraceptive methods. These community perceptions also make it difficult for the Meo to access the contraceptives available at the village health centers, hospitals, or pharmacies in the area. A group of young boys reported that they feel a sense of shame when

purchasing condoms from a local pharmacy (*dukan se nirodh mangne mein sharam aati hai*). The access of contraceptive methods becomes even more problematic for young women who are expected to get married and conceive at an early age and to not discuss views on sex and sexuality.

The study participants in general considered fertility regulation as maladaptive for the Meo because the community needs to increase its population for political power in the area. These views reflect the historical strategy adopted by the Meo community to maintain its identity and seek political representation and power in a multiethnic environment.

For the Meo, child birth is a “gift of God” (*Allah ki deen*),” and any attempt to go against the wishes of the god could invoke the wrath of divine spirits. Conception and childbirth are considered to be ways to please the Meo gods. A group of women participants reported that they do not favor contraception because they believe that god will take care of the needs of the newborn (*kidi ko kan aur haathi ko man kudha hi deta ha*). Meo men feel that condoms reduce pleasure of sex and hinder the natural process. They reported that vasectomy weakens the male sexual ability and that men are unable to perform heavy work. Women informants reported that tubectomy makes women fat and lazy and oral pills can render women infertile.

Among 54 percent of married couples both husband and wife make the decision to use a particular contraceptive method. About 40 percent of the couples reported that only husband makes the decision about the contraceptive and family planning. Only 4 percent of the couples reported that mother-in-law decides about

the contraceptive use, and 2 percent stated that the woman decides on the method⁵⁸ of contraception. Among those couples who use contraceptive methods, 84 percent of the women reported that their husbands take no responsibility as compared to 16 percent who reported that their husbands are supportive of their use of contraceptives.

In 1999, the National Family Health Survey reported that only 21.7 percent of Indian women discussed family planning and contraceptive issues with their husbands. Almost 75.3 percent women did not discuss this issue with their husbands. The results of the study suggest that Meo husbands are generally not supportive of contraceptives as compared to national statistics on the same issue.

Of the women whose husbands are supportive of the use of contraceptives, only 58 percent found themselves confident to discuss the issue with their husbands. It implies that 42 percent of the sample women, who believe their husbands support for the use of contraceptive, were unable to openly discuss these issues with their husbands. About 28 percent of the women reported that they do not have the courage to negotiate fertility regulation with their husbands and 16 percent are scared of rejection from their husbands. Almost 32 percent of the women do not want to regulate fertility at all.

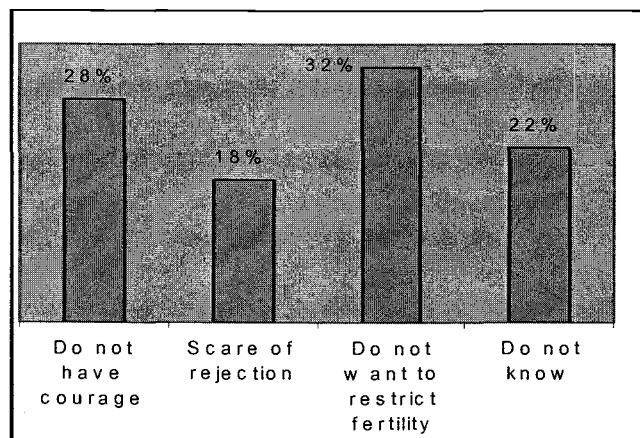


Figure 4.9 Reasons of women not being confident on contraceptive with their husbands

Spiritual healers also play in fertility regulation among the Meo. A large majority of informants reported that spiritual healers are the people in the Meo culture who have greater influence on the norms of large family size, and only rarely recommend herbal medicines to regulate fertility.

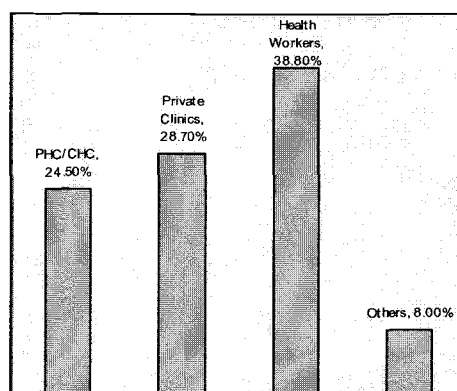


Figure 4.10 Places where newly married couple access contraceptives

Willingness to Delay First Child:

Only ten percent of the respondents reported attempting to delay their first pregnancy by using condoms, IUDs, or oral pills. Despite strong cultural beliefs associated with conception as a natural event, there is an emergent trend of contraceptive use, especially among young Meo informants.

About 39 percent of women respondents reported accessing contraceptives from the village health workers (*aganwardi* worker), while 25 percent reported accessing from government-sponsored primary health care center. About 29 percent of the respondents relied on local shops for buying contraceptives.

The Meo informants used contraceptives primarily for the purpose of delaying or avoiding conception. Only 4 percent of the sample women used contraceptives on a regular basis and about 44 percent used contraceptives occasionally. Nearly half of the sample women had never used contraceptives. Meo women did not report using contraceptives to avoid STI/HIV/AIDS.

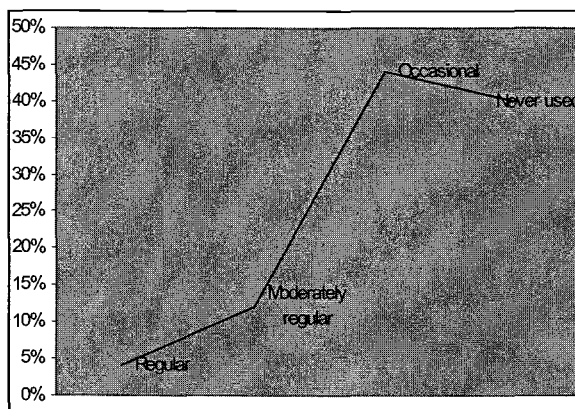


Figure 4.11 Utility patterns of contraceptive by the Meo couples

Sexually Transmitted Diseases and HIV/AIDS

Beliefs and Perceptions on STIs/HIV/AIDS:

Meo informants possess insufficient knowledge suffused with misconceptions about sexually transmitted infections (STIs). Most informants reported itching, appearance of rashes and genital ulcers as sexually transmitted diseases and strongly denied the presence of HIV/AIDS in the community. Some informants reported that Meo women are not vulnerable to HIV/AIDS because they live a protected life. A few male informants believe that nocturnal emissions among men constitute a sexually transmitted disease.

Meo men reported that one can get HIV only through sexual contacts with commercial sex workers. Male informants did not report other activities or means of getting infected with HIV. In terms of protection from sexually transmitted infections, the majority of the respondents (53 percent) reported that maintaining sexual relation with a single partner is the best way to protect oneself from sexually

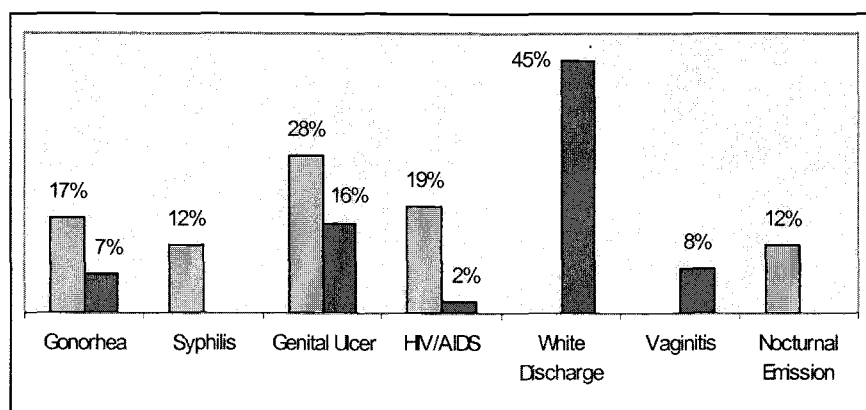


Figure 4.12 Knowledge of Meos on sexually transmitted diseases (STDs)

transmitted infections. Thirty-one percent of the respondents stated that condom use during sex is the best means of protection, while 16 percent believed that avoiding sex with commercial sex workers (CSWs) is the best protection against sexually transmitted infections. It must be noted that the Meo men consider condoms as the primary means of avoiding conception and not as protection against STIs.

Treatment Seeking Behavior against STIs:

Almost half of the Meo respondents (46 percent) reported that people seek cures for STIs from private clinics. Eighteen percent of respondents stated that people go to government hospitals for this purpose and 38 percent believed that the Meo people do not seek professional cure for STIs, instead they go to traditional healers and herbalists in the community.

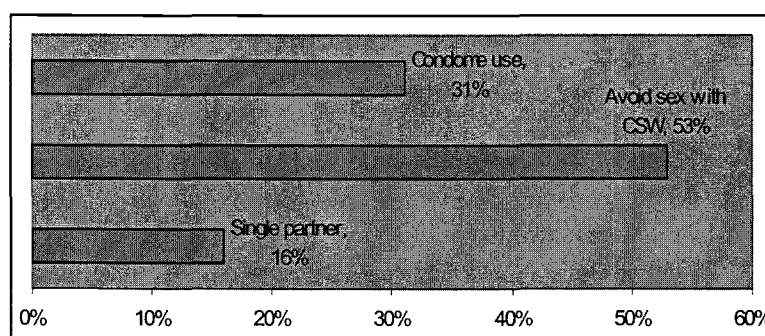


Figure 4.13 Knowledge about protection from STI/HIV/AIDS

Spiritual healers and herbalists in the Meo community also provide advice and treatment for STIs. In general, respondents reported that spiritual healers play an important role in controlling the spread of STIs by providing religious advice and guidance that discourage pre-marital or extra-marital sexual relations and

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having sex with prostitutes. Twenty eight percent of the respondents reported that
spiritual healers treat STIs by providing herbal medicine. Only eight percent stated
that spiritual healers make referrals to professional doctors for treatment.

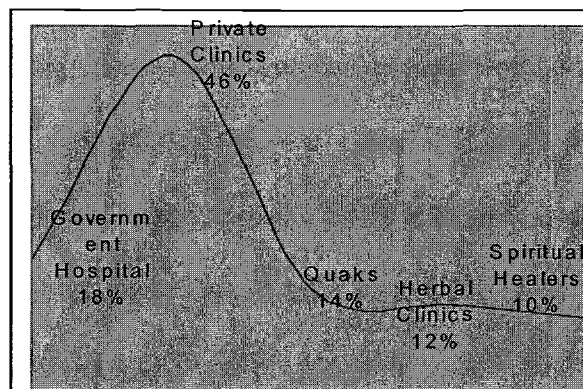


Figure 4.14 Treatment seeking behavior for STDs in Meo culture

Chapter 5: Conclusion and Recommendations

This study was conducted in five Meo villages in the region of Mewat, a region adjacent to the major industrial and commercial centers of Haryana, Rajasthan and New Delhi in India .During the last two decades, this region has experienced considerable development of roads, health care centers, schools, and a gradual replacement of agricultural activities with small-scale and large-scale industries. The Meo families, the subjects in the present study, have embraced these changes amidst attempts to continue their traditional lifestyle.

Meos have traditionally been agriculturists and their present cultural ethos reflects their agrarian traditions. Consequently, high fertility rates among the Meos of Mewat may reflect the community's need to carryout a labor-intensive agricultural subsistence system. This study shows that, as a result of a strong patriarchal ideology characteristic of the north Indian agrarian culture, Meo women face considerable restrictions on their mobility and decision-making power. Meo women's access to health care is strongly influenced by restrictions of their mobility and decision making power within the household. Meo women's poor health status can, in part, be attributed to their inability to seek timely and professional health care due to restrictions on their mobility.

The study suggests that the practice of early marriage among the Meo often leads to early pregnancy, sometimes during late adolescence. This in turn leads to poor health status of both the mother and the infant due to what has been described in the health literature as "maternal depletion syndrome." One could argue that the Meo might be experiencing a cycle of negative biological outcomes often

influenced by cultural practices. Although state sponsored prenatal health care services are available and can easily be accessed by Meo women, gender norms and expected roles of women act as barriers to access and utilization of services.

Meo women deliver babies at home with the help of traditional birth attendants. This trend is, however, less observed among younger women who are more likely to access the available services. Village health centers (*Aganwadis*) provide an easily accessible and sensitive means of health services and counseling. These centers are equipped with basic prenatal, antenatal and postnatal care facilities.

The study results suggest that the Meo community's perceptions of "contraceptives" are strongly influenced by the bitter history of the policy of forced sterilization enforced by the Indian government during the mid to late 1970s. Recent changes brought about by urbanization and education have caused the Meo to think positively about "contraceptives," although it continues to be a slow process of adoption. Consequently, despite the availability of temporary contraceptives, such as condoms, oral pills and intra-uterine devices as well as permanent methods of sterilization, the acceptability of contraceptives among the Meos remains low.

The study also suggests that the low acceptance of contraceptives among the Meo exposes them to contracting STI/HIV/AIDS. The level of awareness regarding STI/HIV/AIDS is alarmingly low in the Meo population targeted in this study. In particular, the majority of my informants do not believe that they are under any risk of contracting HIV. In other words, the perceived risk of HIV

among the Meo is dangerously low. This would prove to be a challenge for risk communication and health promotion programs among the Meo. Meo women believe that personal hygiene practices such as cleaning and regular washing of their genitals, reduces the risk of contracting STI/HIV/AIDS. Clearly, a lack of disease etiology places the individual at risk of contracting STI/HIV/AIDS.

The study also suggests that spiritual healers, such as *maulvi* , *hakeems*, *mirasis* and *fakir* are widely accepted among the Meos and are regularly consulted on matters related to conception and fertility regulation. Irrespective of the scientific basis for healing, these spiritual healers are an integral part of the the Meo community's healing tradition. These healers use their healing abilities for their capacity of fertility, or with the conception, conception of a son or a daughter, or for treatment of nocturnal emission and masturbation, which are believed to be illnesses. In particular *hakeems* treat infertility, premature ejaculation, problems with erection, genital ulcers, rashes and white discharge. *mirasis* and *fakirs* use their praying powers to cause conception of a desired child.

The results of this study provide a strong basis for developing health promotional programs aimed at promoting condom use and prevention against sexually transmitted diseases. The study suggests that health promotion programs must take into account Meo cultural beliefs and the roles of community healers. The study shows that the prevalent ethno-medical beliefs and practices in the Meo culture play a vital role in the determination of their cultural notions of conception and contraception. Beliefs and practices associated with fertility, conception and

contraception are strongly influenced by the prevalent gender norms, educational status and economic status. ⁶⁷

Recommendations

The outcomes of this study suggest that health promotion program in the Meo community should be culturally competent and should consider the beliefs of the Meo people regarding fertility, conception, contraception and sexually transmitted diseases.

The following recommendations are meant for the governmental and non-governmental development agencies, who engaged in health promotion programs among the Meo. These recommendations are aimed at helping agencies to formulate programs. The recommendations have been made both at the macro level- dealing with the policy and planning related activities such as need assessment, and at the micro level- dealing with designing projects, building strategies for implementation, and assesment.

Macro-level Recommendations:

1. Programs on culturally sensitive issues, such as conception, contraception, sexuality and reproductive health must be developed on the basis of a comprehensive needs assessment through extensive ethnography among the Meos. Involvement of Meo community leaders and other stakeholders should be ensured at the time of the needs assessment and at the time of program planning.
2. Since holistic development in the Meo culture depends on activities of various sectors, such as education departments, welfare departments, health

departments and youth affairs departments, it is essential that these sectors must be involved in the implementation program. By doing this, the objective of the programs would be shared by all of the above mentioned sectors and would have a high possibility of success.

3. Intervention programs on reproductive and sexual health should be made in such a way that other relevant concerns of the Meo community, such as poverty, illiteracy, gender identity and roles, girls' education and unemployment, are addressed.
4. The government/non-government organizations, those who are planning to work for reproductive and sexual health promotion among the Meo should work with local media, opinion leaders, religious leaders, important community stakeholders and health service providers.

Micro-level Recommendations:

The specific micro level recommendations are as follows:

1. Since sexuality is a hidden subject in the Meo community thus awareness generation should be done through peer education approach, which is a well tested and effective strategy in such conditions. Trained peer-group educators can be created at the village level for the different age groups by orienting them on the issues such as conception, contraception, gender, STI/HIV/AIDS can be openly discussed.
2. Spiritual healers and members of local self government institutions should be involved at the time of intervention because they are the main stakeholder groups in the Meo community.

3. Spiritual healers should be oriented on the relevant issues related to fertility, conception, gender, sexually transmitted disease and HIV/AIDS as grassroots level health care agent. They can also be used as linkages for referrals from grassroots to the quality health care services at district level.
4. Meo Youths (15 to 25 years) should be specifically targeted because this group has shown the emerging trend of acceptance of condoms for contraception and as protection from STI/HIV/AIDS. They are relatively more literate and more sensitive towards reproductive health issues.
5. To increase involvement of men in the promotion of women's health, awareness and sensitization programs should be initiated in collaboration with Meo male leaders. Prevalent patriarchal ideologies have made women's health a secondary issue in the household, which makes women vulnerable to unwanted pregnancies and increases their chances for infection from sexually transmitted diseases.

APPENDICES

Appendix-1

INFORMED CONSENT DOCUMENT

Project Title: Conception to Contraception: An Ethnographic Study Among the Meo Community

Principal Investigator: Dr. Sunil Khanna

Research Staff: Faiyaz Akhtar, Graduate Student, Department of Applied Anthropology

PURPOSE

The purpose of this study is to understand perception, attitude, and practices related to conception and contraception among the members of the Meo community living in Haryana and Rajasthan, India. This study will also examine the relationship of existing beliefs and practices with gender and role of spiritual healers in the Meo community in order to treat problems related to fertility, conception and sexually transmitted diseases and HIV/AIDS. The findings of this research will help academia, professionals and social development agencies to design culturally informed development programs.

The purpose of this consent form is to give you the information that will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask any questions about the research, what you will be asked to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When all of your questions have been answered, you can decide if you want to be in this study or not. This process is called "informed consent". You will be given a copy of this form for your records.

PROCEDURES

If you agree to participate, your involvement will last for 1-2 hours.

The following procedures are involved in this study. You may likely to participate any of these:

1. Household Survey/Reproductive History Questionnaire

The household survey will collect information on age and sex composition, economic status, and educational status of household members. The purpose of adopting household survey/ reproductive questionnaires and individual interviews

as methods is to collect firsthand demographic information about your community. The filling up of this questionnaire should take 45-60 minutes.

2. In-depth Interview

The interview questions will be primarily open-ended and each interview session will last for approximately one to two hours. Both men and women of 18 to 45 years age group will be interviewed.

3. Focus Group Discussion

Each focus group will last for one hour to two hours and 8-10 participants are expected to participate in it. The session will focus on beliefs and practices related to fertility, contraceptive use particularly condom use, myths and misconception related to sexuality, condom use and sex linked disease, gender roles and reproductive health access behaviors, sexually transmitted diseases and HIV/AIDS and role of local spiritual healers in fertility regulation and treatment of sexually transmitted diseases and HIV/AIDS.

4. Participant Observation

Beside aforesaid methods, I will directly observe believe and practices prevailing in the community. The purpose of this is to witness and validating the information collected from you

5. Secondary Data Collection

I will also collect data related to conception and contraception from various governmental and non-governmental organizations working in your area.

RISKS

There are no foreseeable risks. Pseudonyms will be used to maintain anonymity and confidentiality. In addition we will request the participants not to discuss the question, topics and issues with the other members of the community. To reduce the chances of leakage of information; papers and audiotapes used will be destroyed after the completion of the research.

BENEFITS

There are no direct benefits to you as a participant, however in long term; the research findings will help to develop culturally informed reproductive and sexual health development program for the Meo community. By this reduction in suffering and expenses on health related problems will substantially reduced. This is the expected benefit to the community.

CONFIDENTIALITY

Records of participation in this research project will be kept confidential to the extent permitted by law. "The information you share with the researcher will be reported in a way that will protect your identity."

VOLUNTARY PARTICIPATION

Taking part in this research study is voluntary. You may choose not to take part at all. If you agree to participate in this study, you may stop participating at any time. If you decide not to take part your information will not included in the research

work. No penalty will be imposed on you if you withdraw or decline to participate⁷³
in research.

QUESTIONS

Questions are encouraged. If you have any questions about this research project, please contact:

1. **Dr. Sunil K. Khanna**, Department of Anthropology, Oregon State University, OR-97330, USA. Phone: 541-737-3859 email: skhanna@oregonstate.edu
2. **Md.Faiyaz Akhtar**, email: akhtarm@onid.orst.edu
Mobile: 09896032793

If you have questions about your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator, at (541) 737-3437 or by e-mail at IRB@oregonstate.edu.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Participant's Name (printed): _____
(Signature of Participant) _____ (Date)

(Signature of Parent/Guardian or Legally Authorized Representative) _____ (Date)

RESEARCHER STATEMENT

I have discussed the above points with the participant or, where appropriate, with the participant's legally authorized representative. It is my opinion that the participant understands the risks, benefits, and procedures involved with participation in this research study.

Signature of Researcher)
(Date)

Appendix-2

Introductory Script

Hello, my name is Faiyaz Akhtar, a student researcher from Oregon State University, USA. I am here to study ethno-medical beliefs and practices related to conception and contraception in your community. I would like to learn about your viewpoints and opinions on the various issues related to conception and contraception and sexually transmitted diseases. I will use several methods to collect the data; the recording of these data would be done on the papers. In addition to it, I will also observe prevalent beliefs and practices in your community. I will explain findings of this study to you before drawing conclusion.

The finding of this research is important in two ways. Firstly; it will lead us to know your community in relation to contraceptives and related issues. Secondly, this will help academia and public health agencies to formulate a culturally informed health promotion plans for your community.

For the Household Survey/Reproductive History Questionnaire:

I have to take information regarding your family and household, for example about your family size, income, education etc. Here is the survey form; if you can fill this form by yourself. If you don't want to fill it by your own then I will help you in filling this form. The whole process should last for forty five minutes to one hour.

In-depth Interview participants:

I have to take information regarding your community and about your personal life on fertility, conception and contraception, sexually transmitted disease and HIV/AIDS. Here is the interview form; if you can fill this form by yourself. If you don't want to fill it by your own then I will help you in filling this form. The whole process should last for one to two hours.

For the Focus Group Participants:

If you are interested in participating in this study, I would like you to participate in a group of about eight people. I will raise the issues and topics for the discussion. You can offer your opinion on these topics. Please do not tell the matters discussed within the group during our focus group discussions after this session. If you don't want to involve in any of topics/issues raised during the discussion, it will be welcomed. But I will appreciate if you take part in whole discussion. The discussion should last about one hour to two hours.

Appendix-3

Household survey/Reproductive History Form

Conception to Contraception: An Ethnographic Study in Meo Community

Participant Code.....

Area Code.....

1. Age.....
2. Education.....
3. Family income.....
4. Family size.....
5. Age at onset of Menarche.....
6. Age at marriage.....
7. Age at first pregnancy.....
8. Total number of children.....
9. Whether first delivery was institutional or home delivery
- 9.1 If delivery was at home then was it carried out by a trained birth attendant or with the help of non trained traditional attendants? Yes/No
10. Did you receive ante-natal care during first pregnancy? Yes/No
 - 10.1 If yes then elaborate
 - a. Anti-Tetanus Shots
 - b. Iron supplements
 - c. Regular gynae check ups
 - d. Counseling
 - 10.2 From where you received services mentioned in question 9.1
 - a. At government primary health care center
 - b. At Private health clinic
 - c. From government health workers
 - d. Other, Specify.....
 - e.
 - 10.3 Was the ante-natal care center within the limit of approachable distance?
 - a. Yes
 - b. No
 - 10.3.1 If no then who accompanied you for the ante-natal care?
 - a. Husband
 - b. Mother in law
 - c. Sister in law
 - d. No one
 - e. Other, specify.....

10.4 Place of first child birth

- a. Place of in-laws
- b. Maternal Place
- c. Other, specify the place.....

10.5 Did you receive any nutritional supplement during first pregnancy?

- a. Yes
- b. No

10.5.1 Mark what kind of nutritional supplement you did receive during first pregnancy?

- a. Wheat
- b. Rice
- c. Meat
- d. Fish
- e. Egg
- f. Butter
- g. Fruit
- h. Green leafy vegetables

10.6 Did you use any contraception to delay first pregnancy?

- a. Yes
- b. No

10.6.1 If YES then specify the method?

- a. Condoms
- b. Pills
- c. Cu-T
- d. Other, specify.....

11 How did you observed husbands attitude towards use of contraceptive?

- a. Very supportive
- b. Not so supportive
- c. Has very less concern about it
- d. Don't bother at all

12 Do you feel confident when you talk about contraceptive with your husband?

- a. Yes
- b. No

12.1 If NO then specify the reason?

- a. Culture don't encourage
- b. Scare for bothering him
- c. Don't want to restrict own fertility
- d. Due to shame

13 Your regularity for the use of contraceptives?

- a. Regular
- b. Moderately Regular
- c. Irregular

d. Occasional

14 Do you maintain hygiene to protect yourself and your partner from contacting infection?

- a. Yes
- b. No

14.1 If YES then specify?

- a. By keeping genital area clean
- b. By using Condoms
- c. Other, Specify

15. What kind of concerns do you have for the menopause?

- a. It is disastrous for the female since she loose fertility
- b. It is alright one can leave with it happily
- c. Serious psycho-social change takes place that id depressive for the women
- d. Don't know

Conception to Contraception: An Ethnographic Study in the Meo Community

Area code.....

- | | | | | | |
|-----|---|---------------------|---------|----|-----------------------|
| I | General | | | | |
| 1.1 | Age..... | | | | |
| 1.2 | Sex | a. | Male | b. | Female |
| 1.3 | Marital status | a. | Married | b. | Unmarried |
| 1.4 | Religion | | | | |
| | a. | Hindu | | c. | Christian |
| | b. | Muslim | | d. | Other |
| 1.5 | Caste | | | | |
| | a. | Backward | | c. | Scheduled Tribe |
| | b. | Scheduled Caste | | d. | General |
| 1.6 | Education | | | | |
| | a. | Illiterate | | b. | Secondary School |
| | c. | Primary School | | d. | High school and above |
| II | Family Details | | | | |
| 2.1 | Head of the family | | | | |
| | a. | Father | | c. | Brother |
| | | | | d. | Other |
| | b. | Mother | | | |
| 2.2 | Age..... | | | | |
| 2.3 | Occupation | | | | |
| | a. | Agriculture | | c. | Service |
| | b. | Business | | d. | Other |
| 2.4 | Annual Income of the Family | | | | |
| | a. | Below Rs.10,000 | | c. | Rs.20,000-Rs.50,000 |
| | b. | Rs.10,000-Rs.20,000 | | d. | Above Rs.50,000 |
| 2.5 | Family Size excluding self, please specify the number | | | | |
| | a. | Mother | | e. | Sister in law..... |
| | b. | Father..... | | f. | Brother in law.... |
| | c. | Mother in law..... | | g. | Father in law..... |
| | d. | Other | | | |
| | h. | Children..... | | | |

h.i Sons.....
h.ii Daughters.....

2.6 Do your members of the family have access to the following household items?

- | | |
|-------------------------|---------------------|
| a. Electricity | e. Magazines |
| b. Clean drinking water | f. Refrigerator |
| c. Television | g. Cooking gas |
| d. News paper | h. Sanitary latrine |

III. Gender

3.1 Who is the decision maker in the house?

- | | |
|--------------------------------|------------------|
| a. Father | c. Elder brother |
| b. Mother | d. Elder Sister |
| e. Other (Specify if any)..... | |

3.2 What kind of work female members in you family do?

- | | |
|---------------------|-------------|
| a. Cooking | f. Business |
| b. Nurturing child | g. Grocer |
| c. Domestic work | |
| d. Agriculture work | |
| e. Service | |

3.3 Details of education of the members of the family including self

I SNo	II Mark 1 if Male 2 if Female	III Mark 1 if education is continue 2 if education finished 3 if drop out	IV Standard (Class)	V Reason for the dropout (See the guideline below)	VI Distance from the house
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Guide lines for the column V

1. Not good in studies
2. Got employment
3. Educational Center is far
4. Financial Crisis
5. insecure school environment
6. Because of cultural norm
7. Got married
8. Domestic work

3.4. Do people in your prefer son over daughter?

- a. yes
- b. No

3.4.1 if YES, then why?

- a. Dowry
- b. Don't carry family lineage
- c. Can't extend financial support to the family
- d. Difficulty in searching appropriate bride groom
- e. Brings addition responsibility on family to protect herself
- f. Other, specify.....

IV. Conception, Contraception and Beliefs

4.1 Should people go for the contraception?

- a. yes
- b. No

4.1.1 If YES then why?

- a. It helps to plan family size
- b. It helps to maintain mothers health
- c. Family resources go for less people so prosperity exists in the family
- d. Other, specify.....

4.1.2 If NO then why?

- a. Bad for the health
- b. Banned by religion
- c. Small family size implies less family strength
- d. Cultural Norm to have large family size
- e. Other, specify.....

4.2 What kind of contraception people use in your community?

- a. Condom
- b. Vasectomy
- c. Tubectomy
- d. Denial/absenteeism
- e. Other, specify.....

4.3 Which contraception method is more accepted?

- a. Condom
- b. Vasectomy
- c. Tubectomy
- d. Denial/absenteeism

PLEASE give the reason

.....

4.4 Who decide use of any contraception method?

- a. Husband
- b. Wife
- c. Both wife and husband
- d. Mother in law

Give your comment if you want to tell more

.....

.....

.....

.....

4.5 Can you access contraception in your vicinity?

- a. Yes
- b. No

4.5.1 If YES then from where?

- a. Medicine Shops
- b. Provision Stores
- c. Government community Health Centers
- d. From health workers
- e. Other, specify.....

4.5.2 If No then why?

- a. Not available
- b. Difficult to ask in shops and hospital
- c. Use is taboo in the culture
- d. Religion Prohibits
- e. Other, specify.....

4.6 Why people support large family norm?

- a. lack of awareness about right contraceptive
- b. by default
- c. provide socio-political strength in the community
- d. influenced by tradition
- e. Don't know

4.7 Who influence most for the more numbers of children in the family?

- a. Couple themselves
- b. Mother in law
- c. Father in law
- d. Friends
- e. Other, specify.....

4.8 Did you have heard about female feticide?

- a. Yes
- b. No

4.8.1 If YES, then what is your opinion about this practice?

- a. This practice is harmful to the community
- b. It protect family from huge financial expense to arrange marriage and dowry
- c. Girl are less preferred child
- d. Don't Know

- 4.9 Where do people go to for the selective abortion?
- Government health centers
 - Private health clinics
 - Local quakes
 - Shamans
- 4.10 Who influence for the selective abortion most in the family?
- Couple themselves
 - Father in law
 - Mother in law
 - Sisters in law
 - Friends
- 4.11 Is abortion safe for the pregnant women?
- Yes
 - No
 - Yes, but with proper health care
 - Don't know
- 4.12 Other than medical service providers any of the spiritual healers help to regulate fertility in your community?
- Mirasis
 - Faqirs
 - Jogies
 - Gorakhnaths
 - Aughars
 - Other, specify.....
- 4.13 What kind of treatments these spiritual healers offer?
- Suggest religious practices
 - Provide herbal medicines
 - Perform magic
 - Pray to God for healing
 - Other, specify.....
- 4.14 Do these spiritual healers extend their service for contraception?
- Yes
 - No
- 4.14.1 If Yes, then give your comment on that
-
-
-
-

V. STD/HIV/AIDS

- 4.15 Does any sexually transmitted disease prevail in your community?
- Yes
 - No
- 4.15.1 If YES, then specify for the men?

- a. Syphilis
- b. Gonorrhea
- c. Genital Ulcer
- d. HIV/AIDS
- e. Other, specify.....

4.15.2 If YES, then specify for the women?

- a. Gonorrhea
- c. Genital Ulcer
- d. White Discharge
- e. Vaginitis
- f. HIV/AIDS
- g. Other, specify.....

4.16 Where do people go for the treatments of sexually transmitted diseases?

- a. Government health care centers
- b. Private clinics
- c. Quakes
- d. Herbal clinics
- e. Spiritual healers

4.17 Are the healers available in your vicinity?

- a. Yes
- b. No

4.18 What is the most effective method of prevention for sexually transmitted disease?

- a. Use of condom during sex
- b. Have single and faithful sex partner
- c. Avoid sex with the commercial sex workers
- d. Other, specify.....

4.19 How local spiritual healers useful for the treatment of sexually transmitted disease?

- a. Give expert guidance
- b. Forbid wrong practice
- c. Give local herbal medicine
- d. Refer to the right place for the quality health care

FGD Questions (guidelines)Conception to Contraception: An Ethnographic Study in Meo Community**Group Code.....****Area Code.....**

1. What important fertility and conceptions in your culture?
2. Where Meo people go for accessing prenatal, antenatal and postnatal care.
3. What kinds of care women take during pregnancy?
4. Where do you prefer your infants to be delivered?
5. Is women's health is important for better quality of life?
6. How many children should be in a single household?
7. What are the population control measures available in the vicinity?
8. Do Meo men and women like to access contraceptives? If yes, then why? If not, then why?
9. Is there any sex linked disease exist in the Meo community?
10. What people do if they suspect STD?
11. Do you know about HIV/AIDS?
12. Are sons preferred in the Meo society? If yes then Why?
13. How can female health status be improved in the Meo community?
14. Is there any traditional method exist in the community to deal with the fertility problems, pregnancy and STDs? If yes who are they?
15. How spiritual healer work for fertility? Conception, contraception and sexually transmitted diseases
16. Are spiritual healers effective in healing with above said health problems?

Glossary of words

<i>Aganwadi worker</i>	Village level health worker
<i>Agni parikarma</i>	Solemnization of marriage by circling of fire in the Hindu marriage
<i>Ahsubh</i>	Unholy
<i>Baligh</i>	Adult
<i>Banjh</i>	Fruitless, a women without children
<i>Churi</i>	Traditional birth attendant in the Meo culture
<i>Brahmin(s)</i>	Priest caste in Hinduism religion
<i>Chamars</i>	Backward cast in Hindu caste system
<i>Deeni taleem</i>	Religious education
<i>Gaunna</i>	Marriage agreement between parents of bride and bride groom when they are minors
<i>Gogi</i>	Spiritual healer in the Meo culture
<i>Gotra(s)</i>	Sub-caste in Hinduism used for the purpose of marriage
<i>Gujar(s)</i>	Agrarian caste in Hinduism
<i>Hakeem</i>	Herbal medical practitioner, Spiritual healers in the Meo community
<i>Jat(s)</i>	Agrarian caste in Hinduism
<i>Jahiliya</i>	Ignorant
<i>Launi</i>	Harvesting Season
<i>Maika</i>	Maternal place of women
<i>Maulvi</i>	Muslim Priests, Spiritual healers in the Meo culture
<i>Mewat</i>	Name of area where Meo people are concentrated
<i>Mewati(s)</i>	Residence of Mewat, Meo
<i>Mirasis</i>	Spiritual healers in Meo culture
<i>Nikah</i>	Vow taking rituals in Islam
<i>Ojhas</i>	Spiritual healers
<i>Randies</i>	Commercial sex workers, Prostitutes
<i>Sasural</i>	Place of in-laws
<i>Tablighi Jamayat</i>	Group of Muslims priests who preach Islam
<i>Kshatrya</i>	Marshal caste in Hinduism religion, Rajputs
<i>Pal(s)</i>	Sub-caste in Hinduism used for marriage
<i>Rajputs</i>	Kshatrya, Marshal caste in Hindu religion

Appendix-7**Acronyms Used**

AIDS	Acquire Immune deficiency Syndrome
CHC	Community Health Center
HIV	Human Immunodeficiency Virus
MDA	Mewat Development Agency
PHC	Primary Health Center
STD	Sexually Transmitted Disease
STI	Sexually Transmitted infection
UNDP	United Nations Development Program
UNESCO	United Nations Educational, scientific, and Cultural Organization
UNICEF	United Nations Children Fund
WHO	World Health Organization

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