Chapter 6

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This study is an attempt to assess the overall position of women in the state of Meghalaya, characterised by its tribal and matrilineal social structure. This has been done through an assessment of female autonomy in various spheres of life. This has entailed a study of the demographic, socio-cultural, educational and economic variables and the interlinkages between these.

As is well-known, the tribal population of India have a distinctive socio-cultural structure and it is particularly reflected in the relative high status and autonomy that is enjoyed by their women.

Both in pre and post-Independent India, the FMR among the tribal population has been more balanced than that for the country as a whole. The mean age at marriage for the tribal females has always been higher than that of Indian women with the practice of child marriage being absent among the tribes. The higher age at marriage endows tribal females with more freedom in this respect, defers child-bearing, lowers fertility rate by shortening the reproductive span and reduces the risk of mortality and morbidity for both the mother and the child. The tribal fertility rate in the late-nineteenth and early twentieth centuries has been distinctively lower than that for the mainstream population. The IMR and CMR have also been relatively lower among tribal infants and children. FWPR among ST women has been the highest when compared to that among other groups of Indian women. On the other hand, the literacy rate among the tribal females has been significantly lower than that among the Indian women in general (Maharatna, 2005).

However, for the ST population of India, FMR, female literacy rate and FWPR have declined during the period from 1961 to 1991 and the mean age at marriage has declined between 1991 and 1998-9 (Maharatna, 2005). This has been attributed to the process of assimilation and interactions with the mainstream and non-tribal population and to 'sanskritisation' (Maharatna, 2005).
In case of Meghalaya, the mean age at marriage of the females has been much higher than that of both the Indian women in general and Indian ST population and it has even registered a marginal rise during the period from 1981 to 2001. However, side by side with rising mean age at marriage for females, the female literacy rate has also been rising and has been found to be much higher than the corresponding national figure. TFR has also registered a marginal rise and continues to be almost double of the corresponding national figure over the period from 1981 to 2001. During the entire period of time, there has been a sharp reduction in the proportion of births to adolescent mothers in both the rural and urban areas while the proportion of births in the high-risk category has been one of the highest in the region during 1992-3.

The FMR of the state after being favourable to females till 1921 has been registering a deficit of females in the population. Though the deficit still continues, yet, in the last two decades from 1981 to 2001, further decline in this deficit has been halted (in the first decade) and in the later decade, proportion of females in the population has recorded a significant increase. The improvement in the FMR has resulted partly from a decline in the single male in-migration and female out-migration combined with an increase in female in-migration. But the impact of migration on the FMR has been rendered more and more insignificant over the period. It is actually the population share of urban females of age 7 years and above that has registered a sharp rise in both the rural and urban areas (more so in the urban areas). The deficit of females in the population appears to have been caused by a deficit of females at birth (during the period from 1981 to 2001) coupled with a rise in the percentages of induced and spontaneous abortions as well as of stillbirth during 1993-4.

As per data, in 2002, IMR in Meghalaya is not very different from that of the country. However, while in case of the country as a whole and in the states, during the period from 1998 to 2002, IMR for the infants of both the sexes has declined consistently in both the rural and urban areas, in Meghalaya, it has infact risen among infants of both the sexes in both the rural and urban areas. The point worth noting in this regard is, after being substantially lower than the national figure during 1998-9, the IMR in Meghalaya for the infants of both the sexes has surpassed the national figure marginally in both the rural and
urban areas during 2002. Moreover, in 1998, Meghalaya's IMR figure for rural-based male infants has happened to be the highest and that for female infants has happened to be the second highest among the states of the northeastern region and during 2002, the IMR figures for infants (irrespective of their sex and residence pattern) have been the highest in the region. Thus, the survival chances of infants have worsened over time irrespective of their sex and residence pattern.

During 1998-9, there has been a rise in both the components of IMR, that is, NNMR and PNMR and they have been higher than the corresponding national figures. Of the two, NNMR has been higher than the PNMR for infants of both the sexes, implying that both the sexes have higher mortality risk in the first month of life than that in the subsequent months leading to one year. Thus, both the endogenous and exogenous causes of IMR seem to be at play and more so the endogenous ones, which are more difficult to control. The NNMR and PNMR have been higher for the male infants.

The mortality rate has also risen for children of both the sexes marginally in the age group of 0-4 years (more so for the male children). The under-5 years mortality rate as per both NFHS-2 (1998-9) and the census (1991) data has been much higher than that of the country. In the age group of 5-9 years, the mortality rate for the males has halved with the said rate having doubled for the female children. This is in keeping with the universal trend that female children have lower survival chances in the 5-9 years age group. Insufficiency with regard to both exclusive and any breastfeeding, early supplementation of it (which may also be inadequate and improper) and the existing socio-economic infrastructure have been at the root of the higher mortality rate among the minors.

During the period from 1981 to 2001, with respect to the adult age groups, there appears to be some EFM in the early, peak and late years of reproductive span. In addition to this, over the period from 1991 to 2001, the death rate has been higher for males in general and especially for those who have been over 50 years of age. This excess male mortality seem to have been caused by lifestyle factor an appears to be the main reason behind the rise in FMR for the 50 years + age group.
During the period from 1983 to 2000, virtually there has not been any perceptible reduction in the proportion of population below the poverty line. There has been a slight reduction in inequality in income distribution in both the rural and urban sectors of the state, though the rural-urban disparity in this regard seems to have remained the same. Moreover, during the period from 1993 to 2000, the proportion of people living on nutritionally inadequate diet (in terms of the poverty line) has risen in both the rural and urban areas of the state. This seems to have been caused by the sharp rise in expenditure to procure nutritionally adequate food basket, reduction in people's control over the CPRs and the forest products and reduced cereal consumption (which is a rich source of nutrient) of people. During 1987-8, on the basis of MPCE incurred by the households to meet it's minimum and nutritional needs, in the rural areas, no occupational group seems to be deprived, though in 1999-2000, households who have been 'self-employed in non-agriculture' appear to be so to a little extent. In the urban areas, the casual labour households seem to be deprived in this respect over the entire period from 1987 to 2000.

Both the rural and the urban economies seem to have undergone some transformation, as a result of which, the endowment of both the rural and urban household have also changed. During the period from 1987 to 2000, there has not been any major change in the size of landholdings (which has been less than 1 hectare in size) possessed and cultivated by the rural households. At the same time, the percentage of households, possessing and cultivating land holdings of size 4 hectares and above has declined much.

But in the rural economy, there has been a shift of the occupational groups towards agriculture. During the period from 1987 to 2000, in the rural areas, there has been a reduction in the proportion of households who have been 'self-employed in non-agriculture' and 'other labour households' and a simultaneous increase in the proportion of households who have been 'self-employed in agriculture' and 'agricultural labour'. In 1987-8, relatively higher MPCE has been incurred by households who have been 'self-employed in non-agriculture' and 'other households', while in 1999-2000, relatively higher MPCE has been incurred by households who have been 'self-employed in agriculture' and 'other households'. We have found that, during the period from 1987 to 2000, many diverse
sources of income have emerged, such as earning of pension, rent, remittances, interest and dividends. As a consequence, for households who have been ‘self-employed in non-agriculture’, running of non-agricultural enterprises has ceased to be the main source of income and the said sources have diversified. For ‘self-employed in agriculture’ households, cultivation has no longer remained the main source of income, rather their incomes have diversified. For ‘other households’ as well, the sources of income have diversified a lot as compared to wage and salaries, earned by them earlier. Only the sources of income of ‘agricultural labour’ households appear to have remained the same (being wage and salary, cultivation and fishing).

In the urban areas, during the period from 1987 to 2000, there has been a reduction in the proportion of ‘self-employed’ and ‘other’ households and a simultaneous increase in the proportion of ‘regular wage and salary households’ and ‘casual labour households’. Thus, casualisation of jobs has increased. In 1987-8, relatively higher MPCE has been incurred by households who have been ‘regular wage and salary’ earners and ‘self-employed’, while in 1999-2000, relatively higher MPCE has been incurred by households who have been ‘regular wage and salary households’ and ‘other households’. The households having regular wage and salary as incomes have begun to earn from diverse sources, while the ‘self-employed households’ have started to earn incomes from above-mentioned diversified sources along with the running of non-agricultural enterprises. For ‘other households’ the source of income has begun to include incomes from diversified sources along with the earlier sources of earning from remittance and wage and salaries.

Both the NSSO and census data point towards a sharp decline in the WPR among workers of both the sexes in the rural areas, with the WPR having risen marginally among female urban workers. The WPR among the main workers has declined sharply for both the sexes in the rural areas, though in the urban areas it has remained almost the same for the female workers. Marginalisation has increased among workers of both the sexes in both rural and urban areas. Among the workers, in general, the proportion of cultivators has fallen sharply, though among the females the proportions of agricultural labourers and other workers have
risen mainly in the rural areas and has remained the same in the urban areas. The proportion of workers engaged in the household industries has been insignificant.

Over the last two decades, the provision of basic amenities in terms of housing, electricity, safe drinking water to the masses appears to be inadequate. Inspite of the fact that, the per capita public expenditures on health and family welfare and education have been much higher in Meghalaya than that incurred on an average Indian, the requisite infrastructural facilities do not seem to have been created in the health sector to the desirable extent as per latest data of 2000-1.

Breastfeeding is universal in Meghalaya. The practice of not feeding the first milk (a practice common to most of the states of the region) to the child seems to have been losing ground. During the period from 1992-9, the average durations of both 'exclusive' and 'any' breastfeeding have been very low in the region as a whole (much below the national figure) and the corresponding figures for Meghalaya have been one of the lowest and have declined further marginally. Exclusive breastfeeding is virtually discontinued by mothers in general at the completion of 6 months of age by the child (this has also been true of the entire northeastern region). Moreover, while in the region, 50% to 75% of the children of age 2 years and above are breastfed, in Meghalaya it is only 25%. The supplementation of breastfeeding with solid and semi-solid food starts earlier in Meghalaya than that in the region as a whole.

The proportion of households consuming non-iodized salt in Meghalaya has been one of the highest in the region and the proportion of the households consuming salt with requisite and higher degrees of iodine content has been one of the lowest in the region, though the said figure has been higher than the national figure. We have found that, the current market price per kilogram of the iodized salt is double of that of the non-iodized salt and this factor seems to encourage the sale and consumption of the latter.

With respect to vaccination for all the five diseases, the coverage of children population has increased from about 6% during NFHS-1 to over 14% during NFHS-2. The inadequacy in
the coverage of children for vaccination has also been corroborated by the data generated by
the District Level Rapid Household Survey, which has reported that, the percentage of
children who have been fully vaccinated has declined sharply from 32.7% in 1998-99 to
14.1% during 2003-04. The proportion of children in Meghalaya, who have not been
vaccinated at all, as per NFHS-1 and NFHS-2 data, have been the highest and moderate
respectively. Along with this, there has been an increase in the number of children
vaccinated for each of the five diseases separately. But the proportion such children has been
the lowest in the region during 1992-3 and the highest during 1998-9. However, there has
been a sizable decline in the number of children covered in the administering of the
subsequent doses of the vaccines. This shows the lackadaisical approach and complacency
on the part of both the guardian of the children and of the government machinery (which is
the largest source of paediatrics health care services in the state) in creating awareness about
these ailments that cause life-long deformities in children. In overall terms, the sex-
differential in vaccination has not been significant, yet in case of vaccination for each of the
five diseases separately, significantly larger proportion of female children have been
vaccinated. Thus, in case of this important healthcare intervention, male children appear to
be deprived. Even with respect to the administering of the Vitamin A, the proportion of
children population covered has been very low compared to the corresponding figure for the
region.

The nutritional status of children in general has improved. The incidences of undernutrition
have been significantly higher among the male children. All types of undernutrition-related
deformities have been prevalent in double measure in the rural areas as compared to the
urban areas. In general, more than two-thirds of the children are anaemic. Though Anaemia
is equally prevalent among children of both the sexes, the severe forms of Anaemia have
been higher among the males. Moreover, between the two NFHSs, there has also been
manifold rises in the prevalence of ARI, Fever and Diarrhoea among children in general. In
terms of accessing the existing healthcare facilities for children, the proportion of children
has been either at par with or higher than the respective national averages.
private medical sector. In terms of motivating the women towards the use of contraceptives, the roles played by health workers belonging to both government and private sector have been grossly inadequate. As a result, during the period from 1981 to 1999, the proportion of couples effectively protected by all family planning methods has been very low in the state. The Couple protection rate has declined from 6% in 1981 to less than 5% in 2000 (and is significantly behind the national figure). Between the NFHS-1 and NFHS-2, the percentage of currently married women who have ever used any contraceptive method has remained stable at around 27%, marking a decline in the use of any traditional method by about 4% and a simultaneous shift to the use of any modern method. The use of contraceptive methods (both modern and traditional) apart from being prevalent among only one-fifth of the currently married women has remained virtually at the same level. The modern methods of contraception have been more popular. The low prevalence of contraceptive methods in Meghalaya has also been corroborated by the data generated by District Rapid Household Survey, which reported that the Contraceptive Prevalence Rate has risen marginally from 13.2% during 1998-9 to 14.7% in 2003-4.

Unfortunately, this has happened even when the total demand for family planning services has registered a rise from 45.8% to 55.7%. Moreover, while during NFHS-1, less than half of that demand has been satisfied, during NFHS-2, little more than one-third of that demand has been met. Thus, there has been substantial unmet demand to the extent of 25% during NFHS-1, that has risen further to 35% during NFHS-2. Moreover, the percentage of women who mention of lack of knowledge being the reason for non-use, has increased three-fold, between 1992-3 and 1998-9.

The failure of primarily the government machinery in meeting the family planning needs of it's womenfolk for proper spacing and limiting of births, combined with nutritional and iodine deficiencies (as reflected in the prevalences of Anaemia and reproductive health complications), appears to be the factor behind repeated child-bearing. This has taken a toll on the health of women, which has got reflected in the health status of their offsprings. it has been observed that, during 1992-93, only 23.1% of babies have exceeded the requisite weight of 2.5 kilograms. But by 1998-99, the proportion of such newborns has decreased to
15%. The proportion of newborn babies being small in size at birth has also risen substantially from 19% to over 27% over the same period of time. We have already noted that, more than two-thirds of the children (of both the sexes) are anaemic (in equal proportions) and between the two NFHSs, there has been manifold rises in the prevalence of ARI, Fever and Diarrhoea among children in general. The prevalence of Anaemia among children has seemed to be positively related to the mother’s anaemia status.

The picture that has emerged from the above discussion points towards some interesting facts. The survival chances of female infants and children have been uniform in the rural and urban areas, though with respect to the adult population, those based in the urban areas no doubt seems to be more advantageously placed. The provision of basic facilities has been inferior in the rural areas and the employment situation has also worsened therein. The food consumption of women has been found to be positively related to their standard of living and educational level attained by them. The vaccination of both children an women appears to be positively related to the educational level attained by the mothers and their standard of living. The nutritional and anaemic statuses of both children and women have been found to be positively related to the educational level attained by the mothers and their standard of living. The prevalences of cases of morbidities among both children and women have been inversely related to the educational level and the standard of living of women. Similarly, the existing healthcare facilities (both general and reproductive) have been accessed in a larger measure and in terms of better quality by the urban dwellers, those with higher educational levels and with a higher standard of living.

Moreover, women based in rural areas with lower level of education and hailing from lower standard of living have failed to a significant extent (in relation to their urban, more educated and rich counterparts) with respect to the satisfaction of their family planning needs.

In the Indian context, generally the literacy rate among the tribals has been the least among the general, SC and ST population. The gap between the tribal and non-tribal literacy rates has also widened. There has also been a gap between tribal male and female literacy rates.
During the period from 1981 to 2001, the literacy rate has registered a significant rise in both the rural and urban areas. It has been much lower for the females in both the rural and urban areas, yet it has been spreading faster. In India, during the period from 1978 to 1999, the enrolment ratio of girls has remained virtually at the same level in class I-V and risen marginally in classes VI-VIII, IX-X and XI-XII and stands approximately at a uniform 45% in classes I-XII, which has been much higher than the corresponding national figures. The age-specific enrolment ratio in the age-group of 6-11 years has almost remained unaltered among the girls (it has risen much among the girls in the country) and in the age-group of 11-14 years the said ratio has registered sharp rise. Compared to 1981, substantially larger proportion of the school-going children (mainly males) in the age group of 10-14 years have reported participation in economic activities in 1991, more so as marginal workers. Economic participation of non-school-going children has declined in both the rural and urban areas. Thus, 60% of children are neither attending school nor participating in economic activities. However, it has been observed that, about 80% of the rural households have been engaged in crop production and about 71 (that fell to about 61) percent of the households carry out production without any hired labour. Only about 9 (that rose to 19) percent of the households hire labour either during agricultural peak season or on a casual basis. Thus, children might have been pressed into service to supplement hired labour and as this type of service is domestic and informal in nature, it has escaped the official records. Moreover, that since these children were already out of school, their time has been utilised for family purposes or that they have been withdrawn from schools to assist in domestic production. The drop-out rates among children in classes I-V, VI-VIII and IX-X, very high. But in the past two decades, the drop-out rate has declined sharply and uniformly among children of both the sexes in the classes I-X. Both poverty and inadequate facilities have been responsible. A good proportion of students have cited 'not interested in studies' as a cause for never attending school or dropping out. For girls, additional factors have been household work, early marriage and repeated failure.

As the inheritance of property is through the female line, women in general seem to be better placed. The inheritress daughter (be the youngest or the chosen one) is the custodian of ancestral property and a limited heir. The actual management of it is in the hands of her
brothers and maternal uncles, and her father is to be consulted. She cannot sell family property without the knowledge and consent of her matrilineal kins. But the amount of responsibilities that she has to discharge in the form of rituals, towards her aging parents and clan and family members who may be sick, disable and non-earning, sometimes may surpass her capacity. In addition to this, there are social restrictions imposed on her conduct, which when violated, may invite strict punishment. Moreover, passing of the Meghalaya Succession Act in 1986, has the potential to weaken the women’s position because this act does not allow the wife to have any claim over her husband’s self-acquired property and she may be rendered economically insecure if her husband chooses to neglect her or divorce her, as has happened as a consequence of the patrilineal coding of the matrilineal customary (inheritance) laws in Kerala during the British rule that has drastically altered the traditional rights and powers of the Nayar women within the extended family.

The marital residence pattern being matrilocal in nature no doubt ensures for all daughters a sense of security. All the sisters have a right to occupy a portion of the family land as co-parceners. If they do not remain in the parental home after marriage, they may build or establish separate households close to that house and either within their mother’s village or in the same vicinity. Thus they retain rights over material resources including the CPRs, links with the household (or the domestic group) and locality (or vicinage) and their bargaining power and relative autonomy.

In household decision-making process, majority of women have been involved, though the decisions have been primarily joint decisions of the couples. The extent of involvement of women in the decision-making process seems to be positively related to their educational achievement. Urban women have been more consulted in this regard. Yet, the smaller proportion of women belonging to high-income households are involved in such decision-making than those belonging to the low and medium-income households.

Significantly larger numbers of urban women (than their rural counterparts), those with higher level of education and higher standard of living discuss family planning matters with their husbands or with any other person. But for the majority of women, there is no such
discussion either with husband or with any person. So, there is little scope for negotiation in this regard.

While the proportion of the males who are either divorced or separated has declined from 8.69% to 2.2%, that of the females has risen from 1.56% to 4%. The rates of divorced/separated men and women (as per data of 1991) in Meghalaya have been much higher as compared to the corresponding figures for India (which is less than 1% for each of the sexes). It may point to the fact that more males remarry than the females. Higher divorce and separation may be due also to, what can be called ‘women-initiated divorce’ as is often an indicator of relatively strong breakdown position or fallback option, such as in Zimbabwe (Jackson, 1996).

To study the interlinkages among the relevant variables, we have constructed correlation matrix\(^1\) with the variables such as TFR, educational level attained by women, educational level attained of the husband (or partner), female age at marriage, current use of contraceptive by type of method, number of ANC visits availed of by women, current employment status of women, husband’s (partner’s) occupation and standard of living of women (refer to the matrix in the appendix). The value of the correlation coefficient between educational attainment of women and age at marriage is .26 significant at 1% and 5% levels of significance; that between educational attainment of women and TFR is -.16 significant at 1% and 5% levels of significance; that between educational attainment of women and contraception is .20 significant at 1% and 5% levels of significance; that between educational attainment of women and ANC visits is .34 significant at 1% and 5% levels of significance; that between educational attainment of women and household standard of living of women is .46 significant at 1% and 5% levels of significance. In addition to this, the values of the correlation coefficient between educational attainment of the husband and TFR has been -.18, that between educational attainment of the husband and contraception has been \(r = .25\), between educational attainment of the husband and ANC has been \(r = .30\), all the correlation coefficients being significant at 1% and 5% levels of significance. The values of the correlation coefficients between educational attainment of

\(^1\) Refer to appendix.
women and age at marriage (.34 in the urban areas as against .16 in the rural areas), between educational attainment of women and TFR (-.31 and -.13 respectively), between educational attainment of women and ANC visits (.32 and .20 respectively), between educational attainment of women and standard of living of women (.41 and .11 respectively) have been found to be higher than the corresponding correlation coefficients for the rural areas.

Matriliny does not appear to be a major factor in the quality of life lived by women in Meghlaya. It no doubt grants them relatively higher freedom with respect to age of marriage, divorce, movement, economic participation and control over self-earned money. Women also appear to be better placed with regard to inheritance of property, living space in the form of matrilocal residence, retention of links with the matrilineal kins even after marriage and the support of the community than their counterparts in patrilineal set-up. The female offsprings are not subjected to any socio-cultural discrimination in the spheres of food, nutrition, healthcare and education.

We have found that, be it female children or adult women, their entitlements and capabilities in every sphere of life are determined by their socio-economic status as reflected in their residence pattern, educational attainment and standard of living as is the case of an average Indian woman.

The women of the state fail to translate the advantages that they get in terms of higher age at marriage and higher literacy into a lower fertility and better living standard. Because the existing socio-economic and health infrastructures do not provide them with the necessary support system in this regard (for example, high fertility may be due to higher mortality rates among infants and children). Moreover, they remain mainly titular owners of property and are often burdened with enormous familial, ritual and communal responsibilities that are much more than they can bear.

Thus, the effects of the women's agency has been neutralised in the absence of adequate socio-economic and health infrastructures.