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Trends in Family Planning Methods: An Intergenerational Study of the Lived Experiences of Tribal Women in Attappady, India
By Asha Sankar V. and Moly Kuruvilla

Abstract
Family planning methods have the potential to improve maternal and child health outcomes; thus, ensuring the right to family planning methods is critical in safeguarding the sexual and reproductive health rights of women. Despite the high standards of maternal and child healthcare in Kerala, a southern state in India, tribal pockets within the state such as Attappady have a high prevalence of maternal health issues and infant death rates. The present study conducted in Attappady, which focuses on an intergenerational comparison from an intersectional approach, is intended to explore the trends, practices, and experiences of tribal women regarding their awareness of, access to, and use of family planning methods. Qualitative fieldwork was carried out based on 45 in-depth, dyadic (two-subject) interviews with Attappady women (specifically mothers and grandmothers), and case studies were also used to substantiate the data. The intergenerational comparison revealed the following: a higher acceptance of sterilization among the older women; an increasing awareness and assertiveness in demanding their rights among the younger generation of mothers, who were nevertheless denied their demand for female sterilization by healthcare workers; and fear, stigma, and misconception among women due to lack of reliable information and awareness about temporary modern methods. Thus, the majority of women are opting for natural methods like abstinence to avoid unplanned/unwanted pregnancies. Other major factors determining the family planning experiences of tribal women are lack of men’s engagement, lack of timely and quality family planning services, and patriarchal norms and gendered roles in families. The study proposes the need for men to be engaged in the process along with realigned efforts from the state, both of which are crucial to the fulfilment of the right to family planning among tribal women.

Keywords: Family planning methods, Contraception, Sterilization, Indian tribal women, Intergenerational study, Dyadic interviews, Attappady

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Introduction: Family Planning in India

Of the United Nations’ Sustainable Development Goals (SDGs), number 3 (Health) and number 5 (Gender equality and empowering women) are intended to safeguard universal access to sexual and reproductive health (SRH) care services (United Nations Development Program, 2024). Similarly, the International Conference on Population and Development has identified and defined SRH as a human right. Women’s access to contraceptive choices and their ability to make decisions concerning the number, timing, and spacing of pregnancies are crucial determinants of women’s empowerment and gender equality, thereby leading to the achievement of the SDGs (Starbird & Norton, 2020). The declining fertility rates in low-to-middle-income countries between 1990 and 2005 helped avert over one million maternal deaths. In addition, an increase in the use of modern contraceptives also reduced maternal mortality by decreasing the rate of high-risk pregnancies and controlling the number of births (Stover & Ross, 2010). Though the use of modern contraceptive methods slightly increased from 74% in 2000 to 76% in 2019, the United Nations (2019) report of the same year revealed that around 190 million women of reproductive age face the unmet need of family planning, which account to about 10% of women of reproductive age; this number has remained constant since 2000.

Furthermore, contraceptive use varies by age and marital status globally. In India, the use of modern contraceptives among adolescent women has remained low since 1985 as indicated by an increased rate of conception shortly after marriage (United Nations, 2019). In 1952, the Indian government was the first among lower-middle income countries to launch the largest government-sponsored family planning program in the world with the purpose of reducing the rate of population growth. But the coercive and target-driven family planning program faced public backlash and thus failed to control population growth. Eventually, the government merged the family planning program into a more comprehensive Health and Welfare Program (Ledbetter, 1984). Later on, the introduction of the Panchayati Raj system in India, which facilitated the decentralization of power, along with global efforts by the International Conference on Population and Development, focused attention on gender concerns and positively affected family and health policies. Since then, there has been a fundamental shift from the target-driven, vertically run approach to family planning to a target-free and client-based one (Visaria et al., 1999), which was designed to promote reproductive health and reduce maternal, infant, and child mortality and morbidity. As a result of these initiatives, the current total fertility rate has declined from 2.2% to 2.0%, and the use of modern contraceptives by currently married women has increased from 48% to 56% at the national level (International Institute for Population Sciences, 2015-16, 2019-21). Interestingly, only 38% of married women have undergone female sterilization even though it has been considered the most popular choice of permanent contraception in the country (Bansal & Dwivedi, 2020; Sivaram et al., 2022). Meanwhile, male sterilization (vasectomy) has been declining drastically from 74% in 1970 (Tripathy et al., 1994) to 0.3% in 2019 (International Institute for Population Sciences, 2019-21), which indicates that birth control is largely a women’s burden in India today.

Interestingly, contraceptive use among Indigenous women (otherwise known as tribal women) in India is 64.4% which is close to the non-tribal population (International Institute for Population Sciences, 2019-21). This could be attributed to two possible reasons: tribal people’s access to contraceptive services and the targeted and incentive-driven sterilization programs (Ministry of Health and Family Welfare GOI & Ministry of Tribal Affairs, 2018). Forced sterilization and denial of family planning services are two different forms of coercive family planning programs. In 2014, in the Bilaspur district of Chhattisgarh state in India 13 women died
following laparoscopic sterilization which is a method of target-oriented family planning implemented by the government, which threatened health workers with disincentives or loss of jobs if they did not promote sterilization (Sarojini et al., 2015). In contrast, the Chhattisgarh government has been restricting particularly vulnerable tribal groups from accessing permanent contraceptive services for decades. These coercive policies were once thought of as the “preservation” method. These policies have denied the autonomy and bodily integrity of tribal women and have only served to further impoverish their SRH status (Nandi et al., 2018).

The present study was conducted in Attappady, a tribal block in southern Kerala, which has been known for its maternal and child health complications. Although studies show a higher rate of female sterilization among Attappady women than the state average (Thomas et al., 2021), the State Integrated Tribal Development Program reported 137 infant deaths, 300 abortions, 90 intrauterine deaths, and 21 stillbirths in the last ten years (Nazir, 2022). In this context, an intergenerational assessment of the practices and effectiveness of family planning methods among tribal women would contribute to the understanding of the continuing high rates of maternal and child health complications.

This paper focuses on an intergenerational comparison of the awareness, access, and use of family planning methods along with the trends, practices, and reproductive health experiences of tribal women in Attappady. This is the first study to attempt a comparative analysis of the intergenerational experiences of doubly marginalized Indigenous women using in-depth, face-to-face dyadic interviews from an intersectional perspective.

Methods

The study was conducted among women belonging to the three Indigenous communities in Attappady: Irula, Muduga, and Kurumba. Dyadic interviews consist of interviewing pairs of people who share a pre-existing relationship. It enables the research participants to co-construct knowledge by interacting with each other while sharing their lived experiences regarding the research topic (Morgan et al., 2013). The researcher interviewed mother-grandmother dyads together and explored their lived experiences to understand intergenerational changes over the last few decades. Both separate and joint interviews with the same participants were used due to the sensitive nature of the research topic and to balance the advantages and the disadvantages of each type of interview (Eisikovits & Koren, 2010). The topics concerning sexuality and contraception were discussed separately to ensure privacy as well as to encourage personal narrative without the participants feeling that they were being judged for their experiences. Other topics were addressed in the joint interviews, wherein participants shared their experiences, shared stories, collective memories, perspectives, agreements, and disagreements. This process helped the respondents to understand the intergenerational changes that happened over the decades, proving that dyadic interviews were a more appropriate choice for the research.

Forty-five dyadic interviews with an intersectional lens were conducted to collect subjective experiences of tribal mothers belonging to the younger and elder generations. A dyad consists of a young mother along with her mother or mother-in-law, who were purposely selected for the in-depth, face-to-face interviews (90 individuals in total). Tribal women of reproductive age, having at least one child under five years old, and belonging to any of the three tribal communities of the valley were included in the study. Excluded from the study were tribal mothers without a child under five or who did not have a mother/mother-in-law, and non-tribal women who

3 Dyadic interviews are conducted with two subjects simultaneously.
were married to tribal men. Ten case studies were included to further substantiate the findings from the interview dataset.

The researcher had to get permission from various government institutions such as the Health and Tribal Departments, since the participants belong to the “vulnerable population” category. Special permission was also necessary from the Forest Department as the work involved the participation of Indigenous women living in the remote forest area. The permission mandated the assistance of field level workers throughout the field work, and the researcher acknowledges the involvement and guidance of the gatekeepers (Bell, 2014) in the present study and how they helped to facilitate access and enhance field knowledge. The multilevel monitoring was intended to ensure the safety of the researcher and the interviewees, but it must be acknowledged that their discretion might have affected the access to potential participants as well as the outcomes. However, the researcher appreciates their field experiences and commitment to their work.

The fieldwork process was complicated and time-consuming because of the COVID-19 pandemic. The hamlets were closely populated, and the community people were not wearing masks, which escalated the challenges. However, necessary protective measures were taken by the researcher during the fieldwork. The researcher obtained ethical clearance from the Calicut University Ethics Committee for Human Research and strictly followed their ethical regulations during the field work. Informed consent was obtained from the study participants prior to the interview process.

The interviews were conducted at the convenience of the participants either at their residences, workplaces, or at the community centers in their hamlets. The interviews were audio recorded with permission, and the anonymity of all the participants was guaranteed by using pseudonyms. The interviews were conducted in the regional language, and they were transcribed and translated into English afterwards. The data was subjected to thorough descriptive analysis. An intra-categorical approach to intersectional analysis which focuses on one social category at the intersection of multiple social identities (McCall, 2005) was used to compare the intergenerational lived experiences of tribal women. The major observations of the study are given below.

**Results and Discussion**

**Background Characteristics**

The mean age of participants is 52 for the older women and 28 for the younger women. Among the participants, 2% of the elder generation and 40% of the younger generation have education levels of higher secondary education or above. The main sources of livelihood are daily wage labor and MGNREGA, the Indian government’s social security program that ensures right to work by providing at least 100 days of wage employment per year; 89% of the older women and 80% of the younger women work under MGNREGA. Among the elder generation, the mean age of marriage was 18, and the mean age of first pregnancy was 20. For the younger women, the mean age of marriage was 20 and first pregnancy was 21. Among the elder generation, 159 total pregnancies were reported and the average number of children was 4, while among the younger generation, 103 total pregnancies were reported with an average of 2 children.

Around 90% of the young women were categorized as high-risk mothers as per the Mother Child Protection Card, which includes details of reproductive and child health information such as antenatal and postnatal care, immunization, breastfeeding, child growth and development, and birth control. Moreover, 87% of the young women were anemic during their pregnancy (Hb<11) and 4% had sickle cell anemia. In addition, 13% of the young women and 9% of the older women
experienced one or more infant deaths. Furthermore, 9% of the young women experienced miscarriage which surprisingly was not reported among the elder participants, but the miscarriages may be related to the increased incidence of anemia and sickle cell among the young mothers. 82% of the older women had heard of modern methods for family planning and of those, 81% used at least one method. In the case of the younger women, 100% of them have heard of the same, but only 44% used at least one modern method for family planning. The major modern method among older women was female sterilization as 64% of them had undergone sterilization, and only 7% have ever used a temporary modern method. In the case of younger women, 18% had undergone sterilization, and 31% have used at least one temporary modern method for family planning. These findings are represented in Table 1.
### Table 1: Use of Contraceptive Services among Tribal Women

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Older Women</th>
<th>Younger Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use and Knowledge of Family Planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(number and percentage out of 45 women)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heard of modern methods for family planning</td>
<td>37 (82%)</td>
<td>45 (100%)</td>
</tr>
<tr>
<td>Used at least one modern method for family planning</td>
<td>30 (81%)</td>
<td>20 (44%)</td>
</tr>
<tr>
<td>Undergone sterilization</td>
<td>29 (64%)</td>
<td>8 (18%)</td>
</tr>
<tr>
<td>Used at least one temporary modern method</td>
<td>3 (6%)</td>
<td>14 (31%)</td>
</tr>
</tbody>
</table>

| **Type of Temporary Modern Methods**           |             |               |
| (number and percentage out of 45 women)       |             |               |
| Copper T                                       | 2 (4%)      | 9 (20%)       |
| Condom                                         | 1 (2%)      | 4 (9%)        |
| Injectables                                    | Not available | 1 (2%)      |

**Use of Temporary Modern Methods**
(number and percentage refers to those who had ever used temporary modern methods in each group)

<table>
<thead>
<tr>
<th>Current using temporary modern methods (N=45 total women)</th>
<th>Older Women</th>
<th>Younger Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td>8 (57%) (N=14 younger women)</td>
</tr>
<tr>
<td>Discontinued temporary modern methods (N=3 older women)</td>
<td>1 (33%)</td>
<td>6 (43%) (N=14 younger women)</td>
</tr>
</tbody>
</table>

*Source: Primary Data*

An intergenerational comparison reveals an increase in higher level educational attainment, age of marriage, and age of first pregnancy among younger women compared to the elder generation of women. Additionally, in comparison to the elder generation, there is a decrease in the total number of pregnancies and average number of children among younger women. However, more maternal and child health complications are reported among younger tribal women than the older women. Education, income, and occupation do not seem to affect the contraceptive choices among the younger generation of women in Kerala (Thadathil & Sujina, 2016). This study reveals that
increase in education and occupation outside the home among young tribal women in Attappady have created more awareness of modern methods of family planning. Although younger women are using temporary modern methods more than the older women, 43% had to discontinue using them due to various reasons such as physical discomfort, inaccessibility, and unavailability of quality services. In agreement with previous studies (Thomas et al., 2021) on older tribal women, this study reveals the higher rate of female sterilization (64%) and average number of children (4) when compared to the state average. Among younger women, the rate of female sterilization (18%) and average number of children (2) is declining due to various reasons which are discussed later with the in-depth interviews and case studies.

**Experiences of Elder Tribal Women with Permanent Contraception**

The majority of the older women were sterilized at various camps organized by governmental and non-governmental institutions within and outside Kerala. The respondents shared their memories of health workers entering their hamlets to talk about the availability of sterilization facilities. Groups of tribal women from neighboring hamlets would walk or travel by private vehicles to obtain these services. The private vehicles were arranged by voluntary organizations for the few hamlets by the main roadside as the roads were mostly unpaved. Many elder women openly shared the concerns they had, difficulties they faced, and the lack of family support they had experienced while deciding whether to utilize the contraceptive services. 93% of the older women found it a scary task while 7% described it as an adventure. Bharathi (49 years old) was enthusiastic while describing her experience with the sterilization procedure. At first, she found it odd and scary on account of her lack of awareness regarding the procedure and related apprehensions. Bharathi said:

> They covered my face with some clothes as I was talking with the woman on my nearest bed. I merely remember some needles performing something on my lower abdomen. And after the procedure they told me to leave. I remember that I was laughing and felt happy running away from the bed. (personal interview)

Moreover, in a rare case, Lakshmi (56 years old) underwent a sterilization procedure unknowingly. She shared: “A few women from my hamlet were going to that camp, and I too went with them. They did some procedure, and we came back home. It was only after a few days that I realized I could not bear children anymore” (personal interview). The experiences shared by Bharathi and Lakshmi clearly indicate their lack of awareness regarding the purpose or procedure of female sterilization. They followed the authorities’ recommendations unquestioningly and ended up having permanent contraception.

Ruku (a 49-year-old grandmother) had decided to undergo sterilization despite the lack of support from her husband and his family. She shared her traumatic experience:

> After two children, I decided to stop my pregnancy. In those times, there were sterilization camps, and I told my husband and in-laws about my wish to perform it. They denied it because they wanted more children. But I did not listen to them, I went ahead with my decision, and I had my sterilization done. But they tortured me after the surgery, they did not allow me to take rest. I was too weak, but they forced me to do household work and take care of the cattle. On the same day of my procedure, I had to go to the forest to collect firewood and grass for the cattle. While in the forest, I fell unconscious, and no one was
around to help me. When I regained consciousness, I returned home with firewood and grass for the cattle. (personal interview)

Ruku was emotionally overwhelmed by re-experiencing those moments while sharing it. She finished sharing her experiences with a deep sigh, after which she looked relaxed. Ruku also shared about her children’s health concerns as both of them are sickle cell anemia patients. She feels that it was the right choice to have stopped her pregnancy as she believes that if she had more children they would also be born with the same medical condition. Her statement exuded confidence in her decision-making despite the lack of familial support.

A few of the older women reported failure of the sterilization procedure which resulted in unwanted pregnancies later on. Nanchi (a 48-year-old Irula grandmother) recollected, “After my fifth delivery, I decided to undergo sterilization and went with two other women from my hamlet to the camp. But it was not done properly and all the three of us got pregnant several times afterwards. I had three more deliveries and then stopped pregnancy only after my eighth delivery” (personal interview). While the elder generation of mothers narrated such stories of ignorance and helplessness, lack of family support, and failure of the sterilization process itself, the younger generation did not face similar experiences. The most significant issue related to permanent contraception faced by the younger generations is the denial of permanent contraceptive services by the health care providers.

**Young Tribal Women’s Experiences with Permanent Contraception**

The lack of proper information regarding female sterilization is evident among a few of the research participants, and this has created barriers in accessing family planning services. The age criteria, health of the mother, and health of the child were found to be reasons attributed to the denial of sterilization services among the research participants. According to the standards for female and male sterilization services published by the Ministry of Health and Family Welfare in 2006, married women clients should be above the age of 22 and the couple should have at least one child above the age of one year in order to access sterilization services (Ministry of Health and Family Welfare, 2006). However, many of the younger mothers are denied sterilization by health workers despite meeting these standards. Sutha, a 23-year-old Muduga woman, shared the following:

I wanted to stop the pregnancy after the first delivery because of my health complications. But unfortunately, I conceived my second child within 6 months after the first delivery and I went ahead with it. When I had asked the hospital staff about sterilization post-delivery, they told me that I could only do sterilization once I am 27. I am 23 now. Four more years? I don’t know what to do now. Do I want one more child or not? (personal interview)

Sutha had two successive pregnancies and had health issues so she wanted to undergo sterilization. The hospital staff denied her demand by insisting on an incorrect age criteria. Her husband and his family decided that they needed one more child, but she is determined to avoid pregnancy for at least a few years. She used Copper T as a spacing contraceptive following her second delivery, but then developed an infection and had it removed. After that, she opted for an injectable contraceptive which is taken once in three months (Antara scheme) from the Mannarkkad hospital, which is around 30 km from her hamlet. Though she experienced difficulties with this process, she is determined and has not skipped any of the course of treatment.
Mathu, a 32-year-old Kurumba mother, was also denied access to permanent contraception. She had been trying to stop pregnancy for the last few years and finally delivered her seventh child, which died in infancy. Her third child had also died in infancy. The demand for more children from family, lack of access to quality contraceptive services in the remote forest, and restricted mobility were the major reasons that she mentioned that thwarted her hopes for contraception. Mathu narrated:

I have heard of Copper T, but I have also heard stories from fellow women that it is not comfortable to use it. Three months back, I had my seventh delivery. I wanted to stop my pregnancy immediately after that, but doctors told me to wait because of my lung related morbidities. It just keeps getting postponed. Currently I am abstaining and waiting to become healthy, so I could stop further pregnancy. (personal interview)

Denial of sterilization rights in the case of Mathu could be attributed to her bad health conditions, but it left her in a vulnerable situation. The vicious cycle continues as she struggles to avoid yet another pregnancy that might endanger her own life and the future child’s life.

An intergenerational comparison shows changes in the nature of preference for permanent contraception among the Attappady women. The medical outreach camps and health care facilities serve to increase the rate of sterilization among Attappady women. The older generation of women faced difficulties due to various reasons such as preference for more children, lack of support from the husband and family members, and lack of access to and availability of quality health care services. However, in the case of younger women, there has been a decrease in preference for more children and increased support from the husband and family members for sterilization.

In Kerala, women with low levels of education prefer female sterilization more so than highly educated women. Thulaseedharan (2018) reports a lack of proper information on vasectomy, lack of motivation to use reversible methods, and economic implications as the major reasons why sterilization is used as the main means of contraception by women in Kerala. The case studies in this research show that, along with the above reasons, the prevalence of maternal and child health complications persist in the valley, which is also a major reason for young tribal women to seek female sterilization.

Though health interventions have played a critical role here, the accessibility and availability of quality healthcare services remain a challenge in the valley. 22% of young women reported that they were denied their right to permanent sterilization due to various reasons such as the health of their children or of themselves and their age. Of these women, the majority are opting for natural methods like abstinence to avoid unwanted pregnancies. Despite the government provisions for permanent contraception (Ministry of Health and Family Welfare, 2006), the non-written, verbal directions are the age criteria and the health conditions of the mother and child which pose a barrier for aspiring women to access sterilization procedures. The healthcare workers’ adoption of these tacit guidelines might be intended to control the demographic indicators in the valley; however, the case studies show that these measures deny self-determination, increase women’s vulnerabilities, and inadvertently contribute to deteriorating maternal and child health conditions.

**Impediments to Temporary Contraception Methods**

Many of the tribal women expressed their dissatisfaction with the use of temporary and artificial contraception methods by sharing the misinformed community narratives they had heard
from other women in the hamlet. According to them, women had physical discomfort such as irritation, weakness, and back pain after resorting to such methods. A few women expressed their concerns over implants, and they also seemed confused about how such devices might impact their sexual life. They had heard narratives of implants getting hooked in the male partner’s penis; thus, they feared using it. Rangi (a 49-year-old woman) said:

When I was visiting the health center for my check-up, a woman was admitted there for removing Copper T. She had been lying there for hours. First, the doctor said that the Copper T was missing and then after a few check-ups, they found that it was still in the uterus. As per the woman’s request, the doctor was trying to take it out. She was screaming in pain; I could not bear it. After seeing that, I decided not to use any such methods. And I shared this incident with other women in my hamlet. I purposefully did that. (personal interview)

They also shared stories of the IUD getting lost inside the body and pointed out the fears raised by men about Copper T damaging the penis during intercourse. These sensationalized stories lead to an aversion to temporary, artificial contraception methods and a preference for permanent ones.

Inaccessibility to quality contraceptive health care services is another major reason behind the non-use of temporary artificial methods among tribal women. Of those women who had used Copper T, 50% reported serious health issues and discomfort and later had it removed. Deepthi (a 22-year-old mother) described her dissatisfaction with Copper T as a spacing contraceptive: “It was comfortable in the beginning, but I got infected after two years and then had it removed. Though I have heard about the condom, we were not comfortable with it. We had heard lots of stories and now we had the experience also. So, we decided to stick to natural methods like omnichirikilla [abstinence]” (personal interview).

Proper use of contraceptives is critical in ensuring women’s reproductive health. If women discontinue one particular method and do not switch to another one in a timely manner, they will be at risk for unwanted pregnancies. The major reasons for discontinuation are the side effects and the health concerns related to the reversible methods and, most importantly, the lack of access to the health facility. Women prefer nearby, quality services to continue their preferred contraceptive methods, so, with the lack of these, they therefore change to methods which do not need a health care visit or medical assistance.

Women must be well informed about the options they have, and timely intervention is also critical. As reported by Sato and associates (2020), the timing when women acquire information, the source of the information, and availability and accessibility to the service are critical in contraceptive usage. Knowledge and acceptance of modern reversible contraceptive methods have increased among tribal populations (Mog et al., 2020). The younger generation is more aware about the need for child spacing and the causes and consequences of maternal and child health issues, which in turn has helped to improve the acceptance of temporary methods. Along with that, the presence of field level workers and the availability of more options such as injectables have led to an increase in demand. However, the present study found that 33% of the young women have had children less than 3 years apart, and of those women, 47% had a child spacing of less than 2 years. Low education among couples, high fertility demands, and gender issues are the major determinants hindering the use of spacing contraceptives among tribal women (Battala et al., 2016). The apprehensions about physical discomfort and the misinformed community narratives are still prevalent in the present study area. These are seen to restrict the choices and
decisions of the research participants, limiting the younger generation’s usage of temporary methods of contraception.

*Use of Herbal Contraceptives*

A few of the older women shared their experiences regarding the use of traditional medicine for fertility control. Kali, a 50-year-old Irula woman, shared her views on family planning methods and her experience using traditional medicine to manage pregnancies:

I could not conceive for 8 years… We [she and her husband] consulted different doctors and had medicines, but it did not help us. We lost faith in it. My husband is a certified *vaidhyan* [a person who practices indigenous medicine], and he is still practicing. He prepared some traditional medicine for me. I took it continuously for 8 days as per the rituals and conceived within a few days. I had three normal deliveries and we stopped pregnancy by using his medicines. (personal interview)

Herbal contraceptives are eco-friendly, easily available, and affordable family planning methods in rural areas, and they allow a couple to practice fertility control without the help of the modern health care system (Bala et al., 2016). In addition, herbal contraceptives are available from local sources, and they offer protection of privacy (Lampiao, 2011). Though the reliability of the herbal contraceptives remains uncertain, it provides alternative options for women who have health issues or lack access to proper contraceptive services (Anand et al., 2015). In the study area, the use of herbal medicines was widely practiced among the tribal women as a method of family planning. But over the years, these remedies have lost popularity due to the introduction of modern medicine and the loss of biodiversity in the valley.

*Role of Gender Norms and Engagement of Men in Ensuring SRH*

Though women possess awareness of modern family planning methods, distrust in artificial methods is quite prevalent in the valley. The high dependence on the withdrawal method often leads to unplanned conception, and in most cases, the women have to continue with the pregnancies (Ravindran, 2021). As per the findings, 2% of older women and 27% of younger women reported that they had unplanned pregnancies due to circumstances which restricted their choices, such as the lack of adequate and acceptable family planning services, negligence or violence from their husbands, and the patriarchal norms embedded in family systems.

Rangi, a 53-year-old Irula woman, expressed her disappointment on the lack of access to contraceptive services to avoid unintended pregnancies. Rangi had suffered the deaths of four of her first five children, which left her with emotional scars. If she was able to access the contraceptive services, she could have avoided the physical and mental trauma associated with her last (9th) pregnancy and the related postpartum issues. The lack of family support and access to support systems made it worse for her. In her own words:

It was my 9th delivery, and my family found my last child as a shame as it was a late pregnancy; I did not want that pregnancy. But what could I do? I suffered a lot. Nobody was there to help me or look after the child. I thought of giving away the child to somebody else. I was fine with that, or she would have died like my elder children. I had not heard of contraceptives then, otherwise I would have preferred avoiding it and its trauma. (personal interview)
The majority of the participants talked about the alcoholic nature of their spouses and the resultant violence they had gone through. The refusal of alcoholic partners to use spacing contraceptive methods has resulted in several unplanned pregnancies. Chelli, a 49-year-old Irula woman currently working as an Anganwadi helper, shared her experience with her alcoholic husband and the violence she endured. She got pregnant soon after the birth of her first child, and the continued physical harassment from her husband and financial issues forced her to take drastic steps. Chelli decided to abort the second child and travelled to the nearest state to an unauthorized clinic. She became weak following a poorly performed procedure. Heavy bleeding continued for weeks, and she had to travel back to the clinic to procure medicines to stop the bleeding. The lack of access to proper family planning services along with the harassment from an alcoholic partner made Chelli’s life miserable. After that, she delivered three more children and then chose sterilization. Her family was also not supportive. She added that she had no other choice but to live with her husband.

The role of women in deciding the number of children is important in ensuring the rights of women. Mallika, a 29-year-old Irula woman, shared:

My second pregnancy was unplanned. We decided on abstinence for child spacing. But it is difficult to sustain, especially when your husband is an alcoholic. He would not understand. If I had access, I could have used contraceptives to avoid unplanned pregnancy. I consulted a doctor for kalakkal [an abortion], but he advised me to keep the child. I kept it and delivered a boy. (personal interview)

Following the unplanned pregnancy and denial of abortion services, she had to go through one more pregnancy to fulfill others’ desires (her husband and father-in-law wanted a girl child) despite her disinterest.

Therefore, men’s support for using contraception would positively affect the reproductive health of women. However, the lack of participation of men in family planning methods remains a challenge (Thadathil & Sujina, 2016). Among the research participants, a few women reported husbands’ support using the reversible methods. Mani, a 49-year-old Muduga woman who has four children, narrated her experience on the use of condoms. She is among the few women who used condoms in prior decades. Mani said:

I was in my late teenage years while getting married and conceived soon after marriage. As I was very young, the pregnancy got complicated and after delivery the health workers told us to use temporary methods of family planning to help with child spacing. My husband was a wise and kind man. He decided to use nirodh [condoms] and brought it from the medical store. We were using it to maintain spacing between children. It was for our health, my children’s and mine. (personal interview)

In another incident, Deepa, a 31-year-old Irula mother, shared her experience about the use of condoms, a temporary artificial method. The incident is a clear example of the lack of proper information among the tribal communities about the use of spacing contraceptives. She narrated:

I got nirodh packets from the field health workers and I showed it to my husband. There is some oil on it, right? He found it uncomfortable. He blew it up like a balloon and popped
it with his hands. I was sitting next to him; it was crazy to watch. I did not say a word and I just laughed with him. What else could I do? (personal interview)

The above case studies show the different approaches of men regarding family planning methods and how they influence the SRH of tribal women. In Mani’s case, when her husband decided to use the reversible method on the advice of health workers, it ensured the safety of his wife and children. On the contrary, Deepa’s situation is a clear example of the dismissive attitude of men towards artificial methods.

According to Tripathy and associates (1994), Indian couples in the 1990s usually completed their family during their mid-twenties and then sought permanent contraceptive methods. In addition, the chances of divorces and remarriages were low, which led to the frequent adoption of vasectomy, a safe, low cost, and effective permanent method. However, the situation has changed a lot now, with a marked decrease in the use of vasectomy. According to the International Institute for Population Sciences (2019-20), female sterilization is preferred by 37.9% of currently married women in India and is the most popular method of contraception today; thus the burden of family planning falls largely on women’s shoulders. Informing women and men about the available contraceptive methods and encouraging men to perform vasectomy would help to share the burden of fertility control (Ravindran, 2021).

Conclusion

In the present study, the intergenerational experiences of Attappady women regarding family planning were explored using dyadic interviews, and an intersectionality approach informed the data. The increase in tribal women’s education, occupation, and health interventions have positively impacted the utilization of family planning services. The knowledge and attitude towards artificial methods for family planning are slowly improving; more options are added to the basket of choices, and more access points have been created. However, the findings reveal that in several instances, the younger generation of women are denied permanent contraception by health-care workers despite maternal and child health complications. They often must discontinue temporary modern methods because of persisting apprehensions and the inaccessibility of quality services. The aforementioned factors force tribal women to rely heavily on natural methods, which often fail, resulting in unplanned or unwanted pregnancies. The intersectional analysis shows that structural inequalities persist and that gendered power relations underlie the denial of SRH rights of Attappady women. Patriarchal norms within families continue to make women vulnerable to a loss of control over their bodies and reproductive choices. In addition, the lack of family support and engagement of men in family planning greatly limits women’s decision-making capacity as well as their negotiating power. Nonetheless, the persistent maternal health issues and infant deaths in the valley emphasize the need for more focused interventions to facilitate the utilization of family planning methods, which would allow women to achieve their right to SRH.

References


concern?. *Contraception and Reproductive Medicine*, 5(13), 1–12.


