

Abstract - Group n°41

## **Santal women and birth control: knowledge, perceptions and attitudes**

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### *Introduction*

The study explored the birth control of Santal women in three villages near Santiniketan, West Bengal, India.

The Santal are one of the largest tribes in India. Like the rest of the population of India, they are the recipients of national policies that aim at reducing fertility rates. To slow its population growth - population that reached 1.210 billion in 2011, India implemented a National Family Welfare Program in 1952, reducing the total fertility rate to 2.68 in 2010<sup>1</sup>, and launched the National Rural Health Mission in 2005, which introduced Accredited Social Health Activists (ASHA) in the villages. ASHAs play a vital role in the delivery of reproductive and child health services<sup>2</sup>.

The control of fertility rate is done in large part through policies regarding birth control: access to methods and services is crucial, as the "increased availability of contraceptives" and the "extension of services offered through family planning" are key factors in fertility decline<sup>3</sup>. But access to methods is not sufficient, as "knowledge regarding fertility and family planning measures" are also necessary<sup>4</sup>. In this regard, the Santal are in a good position, as knowledge of modern contraceptive methods is almost universal among them, with 80% knowing about sterilization, while oral pills, IUDs and traditional methods are less known (1 %, 1,7 %, 3,7 %) <sup>5</sup>.

After considering the level of awareness regarding birth control methods, it is also necessary to look at the perceptions surrounding birth control, as these perceptions affect how various methods are used or not by the population. Negative perceptions, for example, regarding health concerns, fear of side effects, lack of access, inconvenience, or fear of becoming sterilized, affect use of modern birth control methods<sup>6</sup>. It is therefore important to look not simply at government policies regarding birth control, but to also investigate the knowledge and perceptions of the concerned population.

While, as discussed above, it exists literature on the use and access of various birth control methods and on elements affecting fertility rate, there is very little written about the knowledge, perception, and attitudes of the women who actually use, or don't use, these methods. One exception is a study that talks about fertility perception<sup>7</sup>, but it looks at the general population of West Bengal, and does not differentiate the Santal as a particular group within the studied population. A study, which speaks specifically about knowledge and attitude of Santal and Lhoda tribes<sup>8</sup> is helpful, but it is a quantitative study that does not delve in depth into the perceptions and attitudes of the women, as it offers only a cursory look at the various levels of awareness regarding different birth control methods. Most of the literature, in fact, is quantitative in nature. It does not offer many elements, such as the structure of marriage or the relationship between Santal women and ASHAs, that might help us contextualize Santal's birth control uses and knowledges. Our research question, therefore, is of a more qualitative nature. Specifically, it asks: What are the knowledges, perceptions and attitudes towards birth control among Santal women in West Bengal and the health network that surrounds them?

### *Methodology*

Our objective was to explore birth control perceptions, knowledge and attitudes of Santal women and the health network that surrounds them.

Unlike most studies regarding birth control, our research was carried out by an inter-professional student team of nurse, doctor, anthropologist and social worker, which enabled us to open up the biomedical perspective and offer more elements of context (political, economic, social, cultural), a more patient centered approach, and helped us in our attempt to apprehend the complexity of the primary health care system.

The studies on birth control also tend to be quantitative. Ours, in contrast, is an exploratory qualitative research that considers the perspectives of both the health sector and the concerned population. Our interviews with 11 health professionals enabled us to obtain a more general perspective on the question of birth control in the rural health care system of India. The two ASHAs and the ANM (auxiliary nurse midwife) allowed us to better understand the work and position of the ASHA, who are central to Indian birth control policies. We also interviewed 3 traditional healers, the founder and a health worker of a local health and education NGO, a medical doctor turned public health administrator, an OB/GYN, and a pharmacist.

Our interviews and focus groups with Santal women were organized in a casual and spontaneous manner. The 4 individual interviews, conducted in the home of the women, with sometimes the presence of their husband, mother in law or children, allowed us to pay attention to the unspoken relationships between family members, and to go in depth into their life stories, thereby broadening our focus to gather contextual data. The 5 focus groups permitted women to discuss among themselves, and for us to see how group dynamics could function between these women. We carried out one focus group with teenage girls, 3 with Santal women, and one with Santal women who had received a ligation operation. All interviews and focus group discussions were translated by the Indian social worker with whom we worked. Her knowledge of the field, of Santal women and of questions of sexual and reproductive health was invaluable for this research.

Finally, we used a flexible and reflexive methodology, as we adapted our protocol to what we found in the field, had nightly debrief sessions with the professors who accompanied us, analyzed our data each day to reorient our questions so as to have a dynamic analysis-fieldwork relationship, and presented our preliminary results and received feedback from our local partners in India.

## Results

In our data we noted the following trend: Santal women's lives seem to be divided in three parts, life prior to marriage, marriage and child making, and sterilization. These different life periods have different relations to birth control methods and information, which appear to be highly influenced by the role of the ASHA in their differential dissemination of information and materials.

Prior to marriage, it looks like rural women in India have little access to government sponsored forms of birth control, as the government seems to consider that these women are not supposed to be having sex before marriage, and therefore should not need methods of birth control. ASHAs give advice to young unmarried women only about periods and intimate hygiene. The teenagers we had in our focus group knew about condoms and abortion for example, which they learned through a workshop given by an international NGO, but didn't know about the copper IUD or the pill. Unmarried women can have access to the 72h pill, legally sold in pharmacies, and chemical abortion pills, sold illegally when without prescription. Our study suggests that it is usually the male partner who will go and buy these pills.

Of those we interviewed, some told us that once Santal women get married, they become targets of the Indian government's policies regarding birth control and population control, through the work of ASHAs, who carry out government policies into the villages. It appeared that marriage was automatically linked with having children and having children automatically linked to marriage. ASHAs seem to participate in this connection of marriage and child bearing, as they go door to door to offer newly married women and couples easy access to birth control methods (such as condoms, the pill and the copper IUD), to birth control information, and encourage child spacing (to wait a year before conceiving the first child, and three years spacing between first and second child).

Once married Santal women have given birth to the number of children they desire (usually two), most seem to get a sterilization, which is the method advocated by the healthcare system and disseminated through the information given by the ASHAs. ASHAs, we were told, are trained by the government and play a key role in implementing the government of India's Policy and "small family norm" of two children. The two ASHAs we talked to indeed told us that they encourage women to have a ligation after the birth of their second child. The government appears to use financial incentive, which it distributes to the woman getting a ligation, the ASHA who informed her and the surgeon performing the operation, to encourage ASHAs to promote ligation, and to encourage women to get a ligation. This might participate in the popularity we noted regarding this definitive method. We noted that even in villages without an ASHA, women were still proactive in getting their ligation done, indicating that the "small family norm" seems to have been well integrated by the Santal community we talked with.

## Discussion

Through the work of ASHAs and government policies on birth control, married Santal women have access and tend to use temporary methods of contraception to space children and usually get a sterilization when they have given birth to the number of children they desire. Our results seem to confirm that services for reproductive health are "largely restricted to married women, with unmarried young women and men relying mainly on the informal private sector, and seriously underserved."<sup>9</sup> One major limit of our study is that we spoke almost exclusively to women, and this might be an issue as some studies have pointed out that for young couples, the decision-making control for use of family planning methods belongs exclusively to the husband<sup>10</sup>.

## References

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## Keywords

India ; West Bengal ; Birth Control ; Santal ; Sterilization ; Family Planning.

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# Birth control in Santal population, West Bengal, India

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## STRENGTHS

- interview strategies regarding timing and phrasing created during fieldwork
- casual organization of focus groups and interviews → could do more than planned
- integration of feedback into fieldwork and analysis
- cooperation with social workers who know the field well

## LIMITS

- could not always take notes in field
- presence of husband or mother-in-law impacted quality of responses
- Santal women probably edited their responses compared to who we are
- brought our own presuppositions that can be difficult to deconstruct

## DISCUSSION

Within our research data, we noted a trend that Santal women's lives are divided in three parts: prior to marriage, marriage and child making, and sterilization.

Before they get married, the government and health system gives women very little access to birth control, as they are not supposed to be having sex before marriage, and therefore should not need methods of birth control. Once they get married, Santal women become targets of the Indian government's policies regarding birth and population control, through the dispersion of ASHAs within the villages, who give married women easy access to birth control methods and information. Once married women have given birth to the number of children they desire, they get a sterilization, which is the method advocated by the healthcare system through the door to door work of information dissemination of the ASHAs.

Finally, while it appears that Santal married women are pro-active in the process of getting a ligation, we wonder how we might think of this sense of 'choice'. When we consider the weight of the policies of the state regarding birth control, and that these women are not isolated individuals but are integrated into a couple, family and community, assessing their ability to 'choose' becomes more complicated.

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## RESEARCH CONTEXT

Our research in North East India looked at the birth control in Santal population in three villages in rural areas near Santiniketan, West Bengal.

The research focused on birth control because this issue often has tremendous impact on women's control over their own bodies, yet also concerns the whole population. In addition, the context of India brings up issues of family planning and population control, as India has the second largest population in the world.

The Santal population, one of the largest tribes in India, was studied because scheduled tribes usually have a higher fertility rate than average in India, and because tribes usually live in rural areas, they have a lower access to the healthcare system.

## METHODOLOGY

• **Research question:** What are the knowledges, perceptions and attitudes towards birth control among Santal women in West Bengal and the health network that surrounds them ?

• **Exploratory qualitative research:** 11 interviews with professionals, 5 focus groups with Santal women, 4 individual interviews with Santal women

• **Flexible and reflexive methodology:** adapt protocol to field, debriefs and feedback in India, continuous analysis and reorientation

• **Interprofessional:** social work, medicine, nursing, anthropology

• **International:** Swiss, French, Indian

ASHA – Accredited Social Health Activist  
Health educators and promoters, women from the community, go door to door to inform about health and collect information on community, depend on government, key actors in family planning system



Santal women during a wedding ceremony



BEFORE MARRIAGE	MARRIAGE + CHILDREN	STERILIZATION
<p><b>Women</b></p> <ul style="list-style-type: none"> <li>- know about some methods (condoms, abortion)</li> <li>- mostly boyfriends who know about pharmacy</li> <li>- shy to talk about birth control in front of married women</li> </ul> <p><b>ASHA</b></p> <ul style="list-style-type: none"> <li>- talk about period and hygiene</li> <li>- do not talk about birth control methods</li> </ul> <p><b>Medical shop</b></p> <ul style="list-style-type: none"> <li>- 72h pill – legal without prescription</li> <li>- chemical abortion – illegal without prescription, but sold without prescription</li> </ul> <p><b>Government policy</b></p> <ul style="list-style-type: none"> <li>- neglect regarding birth control for unmarried couples</li> <li>- sex before marriage is not supposed to exist, so treated as inexistent</li> </ul> <p><b>Culture</b></p> <ul style="list-style-type: none"> <li>- India: no sex before marriage, especially no children before marriage</li> <li>- Santal specific: no child is “illegitimate” (Santal headman)</li> <li>- if unmarried, a woman cannot attend her child's wedding rituals</li> <li>- if pregnant but unmarried, village council encourages child's parents to get married</li> </ul>	<p><b>Women</b></p> <ul style="list-style-type: none"> <li>- marriage = family, family = marriage</li> <li>- ideal family = husband + wife and 2 children</li> <li>- small number of children for economic reasons (can't afford more children)</li> </ul> <p><b>ASHA</b></p> <ul style="list-style-type: none"> <li>- meet every newly married couple</li> <li>- encourage to wait between marriage and first child</li> <li>- encourage to space children</li> <li>- encourage to have only two children</li> <li>- give contraceptives (contraceptive pills, condoms)</li> </ul> <p><b>Health center</b></p> <ul style="list-style-type: none"> <li>- provide copper IUD, pill, condoms</li> </ul> <p><b>Government policy</b></p> <ul style="list-style-type: none"> <li>- contraceptives free of charge or symbolic price</li> <li>- financial incentives for getting copper IUD</li> </ul> <p><b>Population control</b></p> <ul style="list-style-type: none"> <li>- encourages birth spacing because it reduces population on the long term</li> </ul>	<p><b>Women</b></p> <ul style="list-style-type: none"> <li>- sterilization is well perceived and accepted by women</li> <li>- no woman showed any regrets getting the procedure done</li> <li>- women with 2 or 3 children were already sterilized or waiting to be</li> <li>- women without children yet also showed intentions of getting the procedure done</li> </ul> <p><b>ASHA</b></p> <ul style="list-style-type: none"> <li>- encourage women to get their ligation after 2 children, going door to door</li> <li>- have target numbers of sterilization per year</li> <li>- even if there's no ASHA in the village, women still get ligation</li> </ul> <p><b>Government hospital</b></p> <ul style="list-style-type: none"> <li>- chosen by most of Santal women for operation</li> </ul> <p><b>Government Policy</b></p> <ul style="list-style-type: none"> <li>- financial incentives given to ASHAs</li> <li>- financial incentives given to women</li> <li>- small financial incentives given to surgeons</li> </ul> <p><b>Population control</b></p> <ul style="list-style-type: none"> <li>- National Rural Health Mission of the « small family norm »</li> <li>- small family norm = 2 children, defined by the government of India</li> <li>- stabilizing the total population of India by 2070</li> </ul>