Tribal eligible couple and care providers' perspective on family planning: A qualitative study in Keonjhar district, Odisha, India

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ABSTRACT

Introduction: Cultural belief and individual's perception play an important role in acceptance of modern family planning method, more so among tribal communities. It is important to understand the prevailing beliefs and practices among tribal as well as their felt and unmet needs to address existing gaps and improve family planning services for them.

Methods: Total 32 in-depth interviews and eight focus group discussions were conducted among service providers and the tribal eligible couples respectively from April to June 2017 in six villages of Anandpur block in Keonjhar district, Odisha to explore about tribals' beliefs and cultural practice on marriage and childbirth, barriers and challenges in adopting family planning methods and their practices to address unwanted pregnancies. Data were analysed thematically using content analysis method.

Results: The most prevalent barriers for accepting permanent family planning method were their cultural practice to ban woman acceptor from worshipping God, fear of unable to provide sexual satisfaction to their partner that may cause remarriage of their spouse. Non availability of contraceptives with front line health workers was an important factor for its non adherence. Low affordability and lack of easy access to public health facilities during any reproductive health related complications make tribal consult local traditional healers.

Conclusions: Round the clock availability of contraceptives with front-line health providers along with continuous behavioural change communication involving male partners and local influential persons will improve family planning service among tribal.

1. Introduction

According to census 2011, India is having a tribal population of 8.6% with majority concentrated in the states like Madhyapradesh, Jharkhand, Chattishgarh and Odisha. Odisha is one of the states in India, situated in the eastern part of country and having 22.8% of its population as tribal.^{1,2} The socio-economic indicators (low literacy, poor economic and living conditions) among tribal population reflect their socioeconomic deprivation compared to nontribal counterpart in India.³ Also there exist a large-scale intra and interstate variations in terms of socio-economical, demographic and cultural diversities among tribal.³ Limited policy/strategy and gap in implementation of family planning (FP) program causes barrier to access quality reproductive health services for tribal eligible couples (EC), especially the young married couples.⁴ Low education, limited social protection, power imbalance and inadequate negotiation skills in their marital relationships,

trap them in a vicious cycle of poverty with early and repeat child-bearing. In addition, a large number of tribal societies follow their traditional customs of sexual behavior and child rearing practices, thereby making them further vulnerable for unhygienic and risky reproductive practices.⁵

According to the National Family Health Survey (NFHS)-4 (2015–2016) report, though Odisha has achieved the total fertility rate (TFR) target of 2.1, the same among tribal (also called as scheduled tribe) is 2.5 compared to others with TFR 1.8.⁶ Moreover, evidence from many studies suggest majority of the tribal undergo early marriage and have a very low contraceptive usage in spite of their high unmet need for family planning.^{7,8} All these attribute to child bearing at an early age, no healthy timing and spacing between pregnancies thereby causing more morbidity and mortality among mothers and infants.⁹ In spite of many initiatives undertaken through national family planning program, still there are barriers and challenges existing which prevent

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in addressing high unmet need and achieving target TFR of 2.1 among tribal. With this backdrop, it is crucial to explore and understand the prevailing local and context specific barriers among tribal for developing appropriate and effective strategies under family planning program. This study was an effort to provide insight for better understanding about the prevailing cultural beliefs and practices with regard to marriage, child birth, family planning and management of unwanted pregnancies among tribal people in Keonjhar district of Odisha, India.

2. Methods

2.1. Study design, setting and sample size

Keonjhar is one of the 30 districts in Odisha, situated in North-West part of the state with majority of its land area surrounded by hilly terrains and forest landscapes. About 45.5% people of this district are tribal, distributed in 16 different principal tribes such as Bathudi, Bhuyan, Bhumij, Gond, Ho, Juang, Kharwar, Kisan, Kolha, Kora, Munda, Oraon, Santal, Saora, Shabar and Sounti.¹⁰ This qualitative explorative study among the eligible couples (EC) and health care providers was carried out during April to June 2017 in Anandpur block of Keonjhar district, Odisha. Anandpur block (block is a sub-district level administrative division) having 49% tribal population¹¹ was purposively identified and six villages from four of its tribal dense grampanchayats were selected for study considering tribal predominance. Grampanchayat, otherwise called as village council is a formalised local self-governance system in India at village or small town level. Eight focus group discussions (FGDs) separately for male and female participants were undertaken involving a total of 81 participants with 8–12 participants in each FGD group and 32 in-depth interviews with local health care providers were performed during data collection.

2.2. Inclusion and exclusion criteria

The participants included under this study were tribal married eligible couples living together; where the female participants were between 15 and 49 years of age and male participants were 21–54 years. The health care providers interviewed were Accredited Social Health Activist (ASHA), Health Worker Female and Male (HWF/HWM), Lady Health Volunteer (LHV), Staff Nurse (SN), pharmacist or druggist and doctors. The local informal health care providers were not considered and excluded from our study.

2.3. Data collection method

The study participants for FGD were selected according to their age, education and occupation. They were identified from the register maintained by HWF/HWM and ASHA. Considering FP a sensitive issue, FGDs were conducted separately for male and female participants. During the FGD, trained female and male moderators facilitated the female and male groups respectively using a predesigned interview guide with probes. In-depth interviews (IDI) were conducted among the health care providers using a predesigned flexible interview guide for an average duration of 20 min per interview, with a range of 15–45 min.

2.4. Analysis

IDIs and FGDs were performed in local vernacular (Odia) language. All the IDIs and FGDs were audio recorded, transcribed in verbatim and translated into English. The data analysis was done using the qualitative data analysis software (ATLAS.ti 7)¹² with content analysis method.

2.5. Ethical consideration

The ethical approval was obtained from institutional ethics

committee at Indian institute of public health, Bhubaneswar vide number IIPHB/2017/14 and written informed consent was obtained from all participants after appraising them the purpose, confidentiality, benefit and risk of the research. Participants unable to make their signature were asked to give their thumb impression in the presence and signature of a literate witness and assent was obtained from the participants below 18 years, after getting consent from their husband.

3. Results

3.1. Participants' demographic characteristics

Among 81 FGD participants, about two-third were females (61.1% females and 38.9% males). While 55% of the male participants were in the age of 26–35 yrs, 55% of female participants were in the range of 15–25 years of age. A major proportion of participants were laborers (48%) followed by farmers (29%) and housewife/no occupation (22%). All study participants belonged to four different tribal categories, Santalis (30.2%), Ho (25.5%), Kolha (23.2%) and Bathudi (20.8%). More than half of the participants (59%) were illiterate and 32% had qualified primary education. Among the study participants, 52.3% had monthly family income of less than 5000 Indian rupees (69.85 USD as on 6th February 2019). Majority of EC practice traditional methods (39.6% withdrawal) followed by Intra Uterine Contraceptive Device (IUCD) (30.2%) and Oral Contraceptive Pill (OCP) (13.4%). Acceptance for permanent method was almost negligible (2.68%) in both the genders.

Qualitative analysis was done under four main categories viz. 1) Existing beliefs and practices on marriage and child birth, 2) Awareness and practice of family planning methods, 3) Socio-behavioural factors influencing contraceptive use, and 4) Barriers to contraceptive use and practices during complication. Findings under each category/sub-category are given along with quotes from the participants.

3.1.1. Category 1: Existing beliefs and practices on marriage and child birth

3.1.1.1. Sub-category: Traditional belief on marriage and child birth. None of the participant could correctly tell about the 'ideal age gap between two children'. The reproductive practice among study population was to go for child birth after marriage without thinking for any gap and to give birth as many. Majority of the women had the fear that if they won't do that, their husband may leave them and remarry to another girl. Some participants mentioned that-

"The people here want to have child early after marriage. If the bride will fail to conceive early, second marriage of their son (means the husband) is a common practice".

The health care providers also opined similarly and added that tribal couples do early child birth, so that their children would assist in their work. A strong preference for girl child among the tribal couples in expectation to get dowry by doing their daughter's marriage was observed.

3.1.1.2. Sub-category: Existing practices on marriage and child birth.

Majority of the female and male participants were not sure about the ideal age for marriage, though few expressed 15–24 years as the appropriate time for males and 12–18 years for females. According to both health care providers and participants, usually the tribal boys and girls marry according to their own choice. Key findings about their views on contraceptive usage are depicted in Table-1.

3.1.2. Category 2: Awareness and practice of family planning methods

3.1.2.1. Sub-category: Perception of EC on contraceptive use. Both male and female participants were aware about the use of contraceptives like IUCD, OCP, condom and withdrawal. Natural method like withdrawal "locally they call *Baharkarideba*" was found to be the most common practiced method.

Table 1
Key findings on beneficiary and providers views on contraceptive use among tribal eligible couple in Keonjhar, Odisha.

Category	Existing beliefs and practices on marriage and child birth	Awareness and practice of family planning methods	Socio-behavioural factors influencing contraceptive use	Barriers to contraceptive use and practices during complication
Sub-category	Existing practices on marriage and child birth	Perception on contraceptive use	Sources of information regarding family planning	Views on health system accountability
Codes	Traditional belief on marriage and child birth Gap between marriage and 1st child, space between two children	Knowledge and awareness, types of contraceptive methods	Front line workers, nurses and doctors of hospital, other health care providers	Consequences of improper management
	Age at marriage, choice of marriage type		Traditional birth spacing methods and acceptance of modern methods	Availability and accessibility of family planning service
			Repeated child birth, gap between two children, use of different contraceptives	Availability of free contraceptives, available at medicine stores, economic inaccessibility of contraceptives
			Cultural belief, burst inside, lodge inside, dissolve with muscle, gives birth to more girls	Irregular use of OCP, unwanted pregnancy, complication related to abortion, Sexually transmitted diseases
			Stigma and taboo related to contraceptive uses	Unavailability at stock, IEC and BCC, training and counselling

3.1.2.2. Sub-category: Sources of information regarding family planning. Frontline health workers like ASHA and Anganwadi workers were found to be the prime source of information about FP. They were also the major source for availing contraceptives.

3.1.3. Category 3: Socio-behavioural factors influencing contraceptive use
3.1.3.1. Sub-category: Traditional birth spacing methods and acceptance of modern methods. Majority of participants were unaware about the complications due to frequent child birth, though we found a felt need of ‘child spacing’ among them. The reason why they need for child spacing was to feed their children better by earning more. They said “... so that we can work and earn more, so as to feed our children sufficiently and better”. Though modern contraceptives were not widely accepted methods among them, still some use condom, OCP, emergency pill and IUCD. One participant told:

“After birth of the baby, the sister of hospital had given something inside (Mostly she means IUCD)”

3.1.3.2. Sub-category: Stigma and myths related to contraceptive uses. Regarding IUCD (Cu-T) and condom, the common myth was its permanent lodgment in the abdominal wall, while some also added that with IUCD, their husbands were not sexually satisfied.

“The condoms will go inside and will permanently retain in the abdominal wall by mixing with muscles.”

Women participants had the belief that regular use of OCP will lead to weakness, heaviness, irritation and head reeling. Some participants also added that ‘use of OCP leads to birth of more female child’. One woman participant told-

“Use of pills will lead to weakness. We are very poor. We can't do hard work.”

The females of study area had strong reluctance for permanent sterilization, reason being if they do so, they will not be allowed to worship their God. This was an important barrier for accepting permanent family planning (FP) method among tribal women. Also some had the fear that after permanent sterilization, they could not give sexual satisfaction to their partner resulting in their separation. Among the males, fear of ‘becoming weak’ and ‘unable to work efficiently’ were the reasons for not undergoing male sterilization. These socio-behavioural aspects were verified from local health care providers who also had the similar opinion.

3.1.4. Category 4: Barriers to contraceptive use and practices during complication

3.1.4.1. Sub-category: Availability and accessibility to family planning service in the study area. The availability and accessibility of contraceptives from health system was found to play a critical role in determining its adherence. Poor economic condition prevents purchasing contraceptives among tribal. Some female participants expressed that

“For last 6–7 months, OCP is not available with ASHA, for which we are unable to use them”.

“We think twice to spend one rupee. Even in disease condition, we are unable to buy medicine, how can we spend money on contraceptives!!”

3.1.4.2. Sub-category: Consequences of contraceptive nonuse and its management. A few participants cited unwanted pregnancy as a consequence to not using FP methods. In case of unwanted pregnancy, females usually visit to local informal health practitioners (quacks), medicine stores and traditional healers (guniea baidya) to avail abortion care. In case of post abortion complications (according to

participants-heavy bleeding, abdominal pain, incomplete removal, bad smell and white discharge after abortion), they visit to Govt. hospital or private clinic along with ASHA for treatment. One female participant responded-

“We take roots and tubers from the traditional healers also we call the dhai (local old lady who conducts home delivery in village) from village. If more problems arise, then we try to go Thakurmunda (Government hospital). Otherwise we don't do anything. We don't have money to eat well, how we can buy medicines!!”

The health care providers opined that as tribal earn their livelihood by daily work; they don't want to waste time by seeking care from hospitals or even visiting to ASHA. According to a medicine store vendor-

“Our duty is to sell; we give them the medicine without doing any test. If there will be more bleeding, then we give them methergin tablet. If bleeding does not stop, then we advise for hospital visit.”

3.1.4.3. Sub-category: Views on health system accountability. Unavailability of contraceptives with the frontline workers was found to be a barrier to its adherence. Lack of awareness among male partners was found to be an important deciding factor for contraceptive acceptance. According to the study participants, more focussed counselling programmes separately for male and female along with round the clock availability of OCP will improve the FP acceptance.

We observed a reduced level of motivation among ASHAs, when one of the ASHAs told-

“Government has not given us incentive for last (7–8) months, for which we don't wish to do work with interest. If all medicines will be available in time and we will get incentive in time, then there will be some improvement”.

A model demonstrating barriers and facilitators for use of FP methods and coping strategies adopted by participants is given in [Figure-1](#).

4. Discussion

Family planning is an important domain for achieving population stabilization, improving maternal and child health outcomes as well as improving social and economic indicators, especially in tribal dominated states like Odisha. Natural contraceptive method like withdrawal method was found to be practiced by majority (39.6%), while use of modern method was low (IUCD 30.2% and OCP 13.4%). Similar low usage of modern contraceptives among tribal has been observed by other studies.^{13,14} One study has found use of IUCD and OCP to be 0.2% and 20% respectively among ECs,¹³ which is in contrast to our study finding. Recent priority on IUCD use (both post partum and interval) by health department could be the reason for increased IUCD acceptance. Non acceptance to permanent method in this study is purely attributed to the locally prevailing myths such as ‘not allowed to worship’, ‘unable to sexually satisfy the partner’, in contrast to our findings majority of tribal in Karnataka state of India were found to accept permanent methods.¹⁵

Present study reveals that tribal of our study area prefer for girl child to get dowry for their daughter's marriage, which is not the case in other parts of the state. A study from Maharastra state has found tribal couples to have preference for male child,¹⁶ which was opposite to ours. Both boys and girls in our study area undergo early marriage, which is in accordance with other studies that tribal girls are getting married at lesser age.^{17,18} Eligible couples were dependent on ASHAs for contraceptives and other medicines, similar to the findings of a study done in six states of India,¹⁹ while another study has showed tribal won't accept modern medicine and they mainly rely on magico-religious practices.²⁰

This implies there has been a change in health seeking behavior among tribal as a result of better reach out by health system through ASHAs; similar to observation made from Madhyapradesh and Tamilnadu states.²¹ Whereas we found frontline health care providers as prime source of information for family planning, others have also found mass media,²² inter-spousal communication²³ and second hand use²⁴ to influence for contraceptive use. Low awareness among tribal people about the health consequences due to repeated child birth as observed in this study supports the evidence from a study that found the gap between two children among tribal to be low with more than 53% having birth interval less than 24 months.¹⁶ Limited awareness on how to prevent unwanted pregnancy and where to seek quality abortion care services were the reasons for their visit to informal health practitioners for abortion care service. This makes them vulnerable to post abortion complications. In spite of the fact that health department has implemented comprehensive abortion care program these services are yet to reach many. A study among primitive tribes of India has shown the unhygienic practices by local healers causing complications like sexually transmitted infection.²⁰

Socio-cultural practices and myths for different FP methods pose a major barrier to accept modern contraceptive use especially among tribal population. There exist geographic and population specific variation in socio-cultural practices and myths with respect to reproductive health. The unique socio-cultural barriers such as ‘not allowing woman to worship if she undergoes sterilization’, ‘husband will leave his spouse if she doesn't give birth early’; myths like ‘sterilization will make them inactive’, ‘sexual inactiveness will make their spouse separate’, ‘IUCD and condom may travel and retain in abdomen’, ‘IUCD will reduce sexual satisfaction’ and ‘OCP will cause birth of more female children’ were observed from this study. Other researchers have found social factors like social limitations,¹⁶ preference of child birth,¹⁵ preference for girl child²⁵; and myths like “people who use contraceptives end up with health problems”, “contraceptives are dangerous to women's health”, “contraceptives can harm your womb”^{26,27}; and personal problems like ‘shyness to ask for FP’,²⁸ ‘expulsion of IUCD’ and ‘complain of side effects’²⁹ as important barriers to modern contraceptive use.

This study demonstrates the urgent need to develop context specific and culturally acceptable appropriate (IEC/BCC) strategy and implement the same involving male partners to improve the FP acceptance among tribal. Other studies have also similarly recommended to improve the awareness and wipe out the myths.^{8,17,23,30} The importance of male involvement for better contraceptive acceptance have been highlighted by many other studies.^{23,24,31}

Availability and accessibility of contraceptives through public health system play an important role in determining its usage and adherence. We found unavailability of contraceptives with ASHA leading to its non adherence by the beneficiaries, which was also observed in an assessment study done in six states of India.¹⁹

5. Conclusion

Despite many initiatives undertaken through current family planning program, usage and adherence to modern contraceptive methods especially among tribal eligible couple is prevailing as a challenge. Socio-cultural practices and existing myths are the major barriers to use modern contraceptive methods. It's high time to develop locally appropriate and culturally acceptable behavior change communication strategy and implement the same involving male partners for better community awareness. This will increase the acceptance, usage and adherence to modern methods, thereby improving health related outcomes.

Limitations

As this study is done among tribal community of Keonjhar district,

Fig. 1. Model demonstrating Barriers and Facilitators for use of FP methods and Coping strategies adopted by Participants.

Odisha, the study findings require context specific interpretation. Though affordability was found as a barrier, further economic exploration could not be done, which needs a further study. Exploring qualitative information from the traditional healers would have added value to the current findings.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.cegh.2019.04.008>.

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