Knowledge, perceptions and attitudes

Santal women and birth control

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Our research in North East India looked at birth control in the Santal population in three villages in rural areas near Santiniketan, West Bengal [1].

Introduction

Our 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 [2]. 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 [3]. The Santal population, one of the largest tribes in India, was studied because Scheduled Tribes, which are officially designated groups of historically disadvantaged people in India, usually have a higher fertility rate than average in India [3]. Also, as tribes usually live in rural areas, they tend to have a lower access to the healthcare system [4].

Method

Our research focused on the following question: What are the knowledge, perceptions and attitudes towards birth control among Santal women in West Bengal and among the health network that surrounds them?

Our team was interprofessional, comprising a social worker, a nursing student, two medical students and a social science student. It was also international, with Swiss, French and Indian team members.

We used an exploratory qualitative research approach. We conducted 11 interviews with health professionals, five focus groups with Santal women, and four individual interviews with Santal women.

Our methodology was flexible and reflexive: we had to adapt the protocol to the field, we participated in debriefs and received feedback in India, allowing a continuing analysis and reorientation.

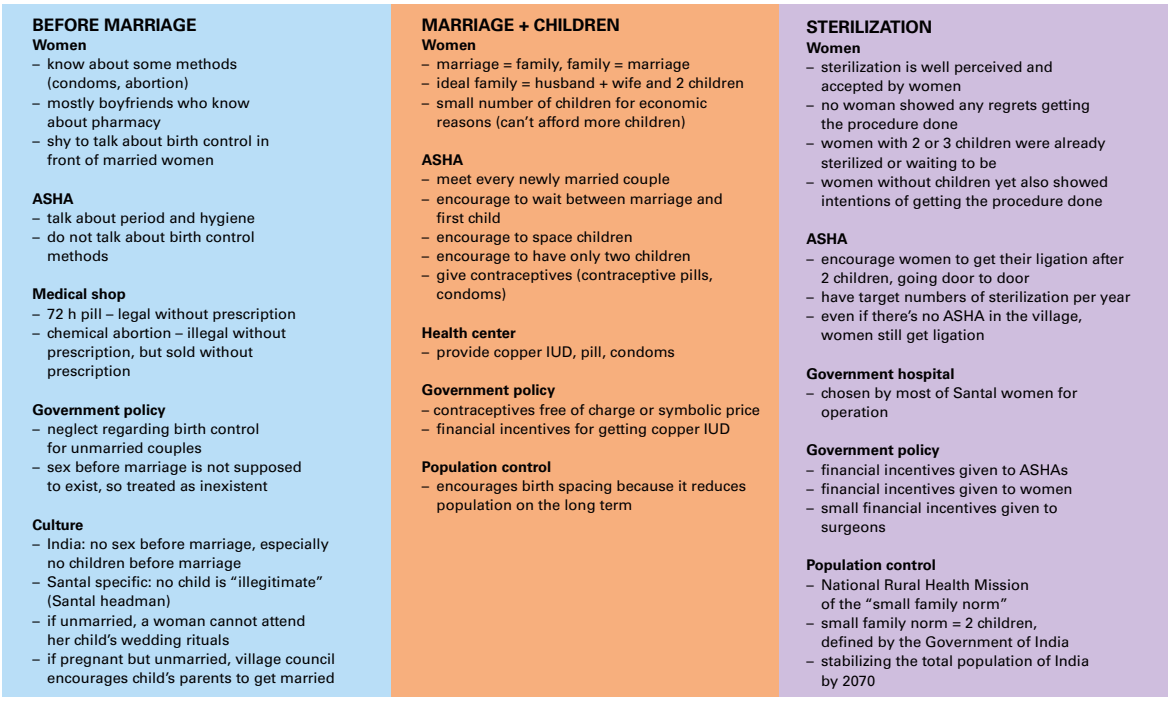

Figure 1: What are the knowledge, perceptions and attitudes towards birth control among Santal women in West Bengal and among the health network that surrounds them? Main results. ASHA = accredited social health activist

Figure 2: Context of a focus group discussion (photo by Muriel Bruttin).

Results

Our main results are presented in figure 1.

First, we came to understand that accredited social health activists (ASHAs) were key actors in the family planning system. ASHAs are women from the community who work as health educators and promoters, go from door to door to inform about health, and collect information on community. They depend on the government.

Within our research, we noted that Santal women's lives tend to be divided in three parts: (1) prior to marriage, (2) marriage and child-bearing, and (3) sterilisation. Before they get married, the government and health system gives women very little access to birth control, as they are not supposed to have sexual intercourse 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 dispersal of ASHAs within the villages. ASHAs give married women easy access to birth control methods and information.

Once married, when they have given birth to the number of children they desire, women seek sterilisation, in the form of tubal ligation, which is the method advocated by the healthcare system through the door-to-door work of information dissemination of the ASHAs.

Discussion

Santal women's reproductive lives are divided into three parts, and at each stage the government intervenes differently regarding birth control. Although it appears that Santal married women are proactive in the process of obtaining a ligation, we wonder how we should understand "choice" in this context. If we consider the weight of the policies of the state regarding birth control, and the fact that these women are not isolated individuals but are integrated into a couple, a family and a community, assessing their ability to "choose" becomes more complicated. This opens up further questions regarding the power of state government to control women's birth control choices.

Overall, we also noted that the field was surprisingly more accessible than we had anticipated, which made it easier to gather data. Its casual nature made it easier to organise focus groups and interviews, but also required us to be ready to improvise and adapt. We could not always take field notes, and this affected the quality of some of our data, especially individual interviews. We also cannot account for the ways in which Santal women might have edited their responses according to their perceptions of who we were.

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