REPRODUCTIVE HEALTH STATUS OF TRIBAL WOMEN: AN INTERGENERATIONAL STUDY

Thesis submitted to
University of Calicut in partial fulfilment for
the award of the Degree of

DOCTOR OF PHILOSOPHY IN WOMEN'S STUDIES

By

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Under the Guidance of

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DEPARTMENT OF WOMEN'S STUDIES
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2023

DECLARATION

I, Asha Sankar V., hereby declare that the thesis entitled **"Reproductive Health Status of Tribal Women: An Intergenerational Study"** submitted to the University of Calicut for the award of the Degree of Doctor of Philosophy in Women's Studies is an original work done by me under the supervision of Dr. Moly Kuruvilla, Professor, Department of Women's Studies, University of Calicut. The thesis has not been previously submitted by me or any other person elsewhere for the award of any Degree/Diploma/ Certificate. In all cases, where it is relevant, material from the work of others has been acknowledged, given credit to and referred.

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CERTIFICATE

This is to certify that the thesis entitled **"Reproductive Health Status of Tribal Women: An Intergenerational Study"** submitted to University of Calicut for the award of Degree of Doctor of Philosophy in Women's Studies is a record of independent research work done by **Ms. Asha Sankar V.** during the period of her research under my guidance and supervision. The thesis has reached the standard of fulfilling the requirements of the regulations relating to the Ph.D. Degree of the University of Calicut. The contents of the thesis, in full or in parts, have not been submitted to any other Institute or University for the award of any Degree/Diploma/Associateship/Fellowship.

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DECLARATION

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ABSTRACT

This thesis explores the intergenerational changes in reproductive health status of tribal women from an intersectional perspective. This feminist qualitative study is based on the tribal communities residing in Attappady tribal block, which has a high rate of maternal and child health complications, a contradictory tale with regards to Kerala's development indicators. The study aims to analyse the demographic and socio-economic conditions affecting the reproductive health of tribal women and exploring the myths and misconceptions prevalent among them in this regard. It also assesses the extent of access to reproductive health services by examining the challenges faced by them. This is the first study to attempt a comparative analysis of the reproductive health of tribal women from two generations in the study area and it provides a novel way of understanding how these intergenerational changes influence the intersectional positionalities of tribal women and thus contributes to their reproductive health experiences.

The study focuses exclusively on dyads consisting of mothers of children under five along with their grandmothers. Forty-five dyads (a total of 90 participants) were selected using purposive sampling and in-depth, face to face interviews were used to collect data. Case studies were also used to substantiate the data. Ethical considerations and pandemic protocols were strictly followed during the fieldwork. The interviews were conducted in regional language after which they were transcribed and translated into English. The collected data was subjected to qualitative analysis. The research found that the intergenerational changes have positively and negatively impacted the reproductive health status of tribal women in Attappady. Despite the progress in demographic, socio-economic and reproductive health services, maternal and child health complications are still prevalent in the study area. The lack of secure livelihood opportunities, food and nutritional insecurity, myths and misconceptions about sexual and reproductive health, lack of engagement of men, gaps in health system delivery are the major reasons behind this trend. Young women are more assertive in demanding their rights compared to their elder generations. Nevertheless, the intersections such as gender, caste, age, education, employment, access to resources and culture interact with each other resulting in multiple inequalities and consequently limiting the potential of reproductive health rights of tribal women.

Keywords: Reproductive health, tribal women, intergenerational, dyadic interviews, intersectionality

സാരാംശം

ആദിവാസി സ്ത്രീകളുടെ പ്രത്യുല്പാദന ആരോഗ്യനിലയിലെ അന്തർ- തലമുറ മാറ്റങ്ങളെ ഒരു ഇന്റർസെക്ഷണൽ വീക്ഷണകോണിൽ നിന്നും പര്യവേഷണം ചെയ്യുകയാണ് ഈ പ്രബന്ധത്തിൽ ചെയ്യുന്നത്. കേരളത്തിന്റെ വികസന സൂചകങ്ങളുമായി ബന്ധപ്പെട്ട് പരസ്പര വിരുദ്ധമായ അവസ്ഥയാണ് ആദിവാസി മേഖലയിൽ കാണാൻ സാധിക്കുന്നത്. അതിനാൽ മാതൃ-ശിശു ആരോഗ്യപ്രശ്നങ്ങൾ കൂടുതലുള്ള അട്ടപ്പാടിയിലെ ഗോത്രവർഗ വിഭാഗങ്ങളെ അടിസ്ഥാനമാക്കിയുള്ളതാണ് ഈ ഫെമിനിസ്റ്റ് പഠനം. ആദിവാസി സ്ത്രീകളുടെ പ്രത്യുത്പാദന ആരോഗ്യത്തെ ബാധിക്കുന്ന ജനസംഖ്യാശാസ്ത്രപരവും സാമൂഹിക-സാമ്പത്തികവുമായ അവസ്ഥകൾ വിശകലനം ചെയ്യുന്നതിനൊപ്പം ഇതുമായി ബന്ധപ്പെട്ട് അവർക്കിടയിൽ നിലനിൽക്കുന്ന മിഥ്യാധാരണകളും തെറ്റിദ്ധാരണകളും പരിശോധിക്കാനും ഈ പഠനം ലക്ഷ്യമിടുന്നു. തുടർന്ന്, അവർ നേരിടുന്ന വെല്ലുവിളികൾ പരിശോധിച്ച് പ്രത്യുൽപാദന ആരോഗ്യ സേവനങ്ങൾ ലഭ്യമാക്കുന്നതിന്റെ വ്യാപ്തിയും വിലയിരുത്തുന്നു. പഠന മേഖലയിലെ രണ്ട് തലമുറകളിൽ നിന്നുള്ള ആദിവാസി സ്ത്രീകളുടെ പ്രത്യുത്പാദന ആരോഗ്യത്തിന്റെ താരതമ്യ വിശകലനത്തിന് ശ്രമിക്കുന്ന ആദ്യ പഠനമാണിത്. കൂടാതെ ഈ അന്തർ തലമുറ മാറ്റങ്ങൾ ആദിവാസി സ്ത്രീകളുടെ ഇന്റർസെക്ഷണൽ സ്ഥാനങ്ങളെ എങ്ങനെ സ്വാധീനിക്കുന്നുവെന്നും അതുവഴി അവരുടെ പ്രത്യുത്പാദന ആരോഗ്യ അനുഭവങ്ങൾക്ക് എങ്ങനെ സംഭാവന നൽകുന്നുവെന്നും മനസ്സിലാക്കുന്നതിനുള്ള ഒരു പുതിയ മാർഗമാണിത്.

അഞ്ച് വയസ്സിന് താഴെയുള്ള കുട്ടികളുടെ അമ്മമാരും മുത്തശ്ശിമാരും അടങ്ങുന്ന ഡയഡുകളിൽ മാത്രമാണ് പഠനം ശ്രദ്ധ കേന്ദ്രീകരിക്കുന്നത്. നാൽപ്പത്തിയഞ്ച് ഡയഡുകളെ (ആകെ 90 പങ്കാളികൾ) പർപസീവ് സാമ്പിലിങ് ഉപയോഗിച്ച് തിരഞ്ഞെടുക്കുകയും ഡാറ്റ ശേഖരിക്കുന്നതിനായി ഇൻ-ഡെപ്ത്, ഡയാഡിക് അഭിമുഖങ്ങൾ സംഘടിപ്പിക്കുകയും ചെയ്തു. ഡാറ്റയെ സാധൂകരിക്കാൻ കേസ് പഠനങ്ങളും ഉപയോഗിച്ചു. ഫീൽഡ് വർക്കിൽ നൈതിക പരിഗണനകളും പാൻഡെമിക് പ്രോട്ടോക്കോളുകളും കർശനമായി പാലിച്ചു. ഇന്റർവ്യൂ പ്രാദേശിക ഭാഷയിൽ നടത്തിയ ശേഷം അവ പകർത്തുകയും ഇംഗ്ലീഷിലേക്ക് വിവർത്തനം ചെയ്യുകയും ചെയ്തു. ശേഖരിച്ച ഡാറ്റ ക്വാലിറ്റേറ്റിവ് വിശകലനത്തിന് വിധേയമാക്കി. തലമുറകൾക്കിടയിലുള്ള മാറ്റങ്ങൾ അട്ടപ്പാടിയിലെ ആദിവാസി സ്ത്രീകളുടെ പ്രത്യുത്പാദന ആരോഗ്യനിലയെ ഗുണപരമായും പ്രതികൂലമായും ബാധിച്ചതായി ഗവേഷണം കണ്ടെത്തി. ജനസംഖ്യാശാസ്ത്ര, സാമൂഹിക-സാമ്പത്തിക, പ്രത്യുൽപാദന ആരോഗ്യ സേവനങ്ങളിൽ പുരോഗതിയുണ്ടായിട്ടും, മാതൃ-ശിശു ആരോഗ്യ പ്രശ്നങ്ങൾ ഇപ്പോഴും വ്യാപകമാണ്. സുരക്ഷിതമായ ഉപജീവന മാർഗങ്ങളുടെ അഭാവം, ഭക്ഷണ, പോഷകാഹാര അരക്ഷിതാവസ്ഥ, ലൈംഗിക, പ്രത്യുൽപാദന ആരോഗ്യത്തെക്കുറിച്ചുള്ള മിഥ്യാധാരണകളും തെറ്റിദ്ധാരണകളും, പുരുഷന്മാരുടെ പങ്കാളിത്തത്തിന്റെ അഭാവം, ആരോഗ്യ സംവിധാനത്തിലെ പോരായ്മകൾ എന്നിവയാണ് ഈ പ്രവണതയ്ക്ക് പിന്നിലെ പ്രധാന കാരണങ്ങളായി കണ്ടെത്താൻ സാധിച്ചത്. തങ്ങളുടെ മുതിർന്ന തലമുറകളെ അപേക്ഷിച്ച് തങ്ങളുടെ

അവകാശങ്ങൾ ആവശ്യപ്പെടുന്നതിൽ യുവതികൾ കൂടുതൽ ഉറച്ചുനിൽക്കുന്നു. എന്നിരുന്നാലും, ലിംഗഭേദം, ജാതി, പ്രായം, വിദ്യാഭ്യാസം, തൊഴിൽ, വിഭവങ്ങളിലേക്കുള്ള പ്രവേശനം, സംസ്കാരം തുടങ്ങിയ ഘടകങ്ങൾ പരസ്പരം ഇടപഴകുകയും അത് ഒന്നിലധികം അസമത്വങ്ങൾക്ക് കാരണമാവുകയും അതുവഴി ആദിവാസി സ്ത്രീകളുടെ പ്രത്യുത്പാദന ആരോഗ്യ അവകാശങ്ങളുടെ സാധ്യതകളെ പരിമിതപ്പെടുത്തുകയും ചെയ്യുന്നു.

കീവേഡുകൾ: പ്രത്യുൽപാദന ആരോഗ്യം, ആദിവാസി സ്ത്രീകൾ, അന്തർ-തലമുറ, ഡയാഡിക് അഭിമുഖങ്ങൾ, ഇന്റർസെക്ഷണാലിറ്റി

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Asha Sankar V.

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ABBREVIATIONS AND GLOSSARY

AHADS	Attappady Hill Area Development Society
ASHA	Accredited Social Health Activist
AW	Anganwadies
AWCs	Anganwadi Centres
AWW	Anganwadi Worker
AWH	Anganwadi Helper
Bindi	Ornamental dot on her forehead
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
Chadichi	A green plant
CHC	Community Health Centre
Cheeru	Ceremony that celebrates first menstruation
Current operation	Laparoscopy
Dai	Elderly women who assist deliveries
Daivaveedu	Prayer room
DLHS	District Level Household Survey
DLHS-RCH	District Level Household Survey -Reproductive and Child Health
FWSC	Family Welfare Sub Centre
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
ICPD	International Conference on Population and Development
ICU	Intensive Care Unit

IIPF	International Planned Parenthood Federation
IIPS	International Institute of Population Science
ITDP	Integrated Tribal Development Programme
IUD	Intra Uterine Device
IMR	Infant Mortality Rate
JJR	Janani Janma Raksha
KA	Kudumbasree Animator
Kai idal	Vaginal examinations before delivery using hands
Kai operation	Mini-laparotomy
Kalakkal	Abortion
Kudusu	Small hut
Kuttikittuka	Getting Pregnant
LBW	Low Birth Weight
Malleswaran	Lord Shiva
MAM	Moderate Acute Malnourishment
Masakulivaral	Getting first period
MCH	Maternal and Child Health
MCP	Mother and Child Protection
MDGs	Millenium Development Goals
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MH	Maternal Health
Michabhoomi Patta	Land assigned by the government
MMR	Maternal Mortality Rate
NFHS	National Family Health Survey
NFSA	National Food Security Act
NGOs	Non-Governmental Organisations
NHP	National Health Policy

NIN	National Institute of Nutrition
NRLM	National Rural Livelihood Mission
Onnichirikila	Abstinence
Onnichirikkukka	Involving in sexual act
Ooru	Hamlet
PoA	Programme of Action
Panchakkad krishi	Swidden agriculture or Shifting cultivation
PDS	Public Distribution System
Pela	Post-delivery ritual
Periya panam	Money given by groom to bride's family at the time of wedding
PHC	Primary Health Centre
Prasadam	Blessing
Pulirasam	Post-delivery food item
PVTGs	Particularly Vulnerable Tribal Groups
RCH	Reproductive and Child Health
RH	Reproductive Health
RTIs	Reproductive Tract Infections
RTPCR	Reverse Transcription-Polymerase Chain Reaction
SAM	Severe Acue Malnourishment
SDGs	Sustainable Development Goals
SHGs	Self Help Groups
SRB	Sex Ratio at Birth
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STPs	Scheduled Tribe Promoters
STD	Sexually Transmitted Diseases

Tadisi	A green plant
Theetu	Impurity
TSP	Tribal Sub Plan
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIGME	United Nations Inter-Agency Group for Child Mortality Estimation
U5MR	Under-five Mortality Rate
Vayasariyikkukka	Getting first period
Vettaykkupokka	Getting first period
WHO	World Health Organisation

Chapter 1
INTRODUCTION

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1.1 Introduction

Human reproduction encompasses events that span the human life cycle, like fertility, childbirth, maternal care and child nurturing which are closely related to social norms and cultural practices. Family is a historical development and the position of women in the family is determined by the social relations of reproduction (O'Brien, 1981). When families became the basic unit of civilisation during the agricultural revolution, women's sexuality and reproductive role also got controlled. Consequently, the control of women's fertility was considered essential for social as well as economic reasons. And it can also be seen that institutions such as state, religion, law and education have been controlling women's sexuality and reproductive role in the history of every society (Sarkar, 1993).

Sexual and Reproductive Health Rights (SRHR) are human rights because they are universal, indivisible and undeniable. Even though the Universal Declaration of Human Rights proclaims equal rights for all human beings without regard to their sex, women all around the world continue to experience inequality which is largely justified on cultural or religious grounds. Women's SRHR violations are entrenched in societal relations and values. Women are often evaluated based on their reproductive capacity and infertility is considered to be their fault, constituting gross human rights violations. Early marriages, forced sexual relationships, miscarriages, repeated pregnancies and lack of nutrition lead to deterioration of health in mothers as well as children. These violations have continued for generations and the patriarchal notions embedded in structural mechanisms reinforce the adverse intergenerational impact on women's sexuality and reproductive health (RH) (Walker et al., 2007).

1.2 Evolution of Sexual and Reproductive Health Rights

The traditional maternal and child health (MCH) care programmes by governments were mainly concentrated on the health of the child without addressing the specific needs of the mother other than supplementary nutrition and family planning (Rosenfield & Maine, 1985). In the beginning of 18th century, women's organisations and advocates of women's rights in the developed and developing countries were looking for alternatives to the narrowly focused government and private family planning programmes. The international and national efforts emphasised the significance of women's health and wellbeing rather than the effectiveness of family planning programmes. The women's rights organisations stressed on a multisectoral approach to sexual and reproductive health (SRH) and claimed the role of women as active agents rather than passive beneficiaries. Feminist health advocates and women's organisations from developed and developing countries played an active role, resulting in this paradigm shift in the history of SRHR (Qadeer, 1988).

The Nairobi Conference on Global Safe Motherhood in 1987 has focussed on the problems of maternal morbidity and mortality. In 1990, the International Women and Health Meeting at Manila, studied the characteristics of population policies throughout the world. The International Network of Women's Health advocates produced the Women's Declaration on Population Policies, describing the feminist population policies, which included the minimum requirements and a set of basic principles. It underlined the importance of respect for women as decision makers in the family and the society, and laid down the principles of equity, non-coercion and inclusion of women at all levels of policy making. In 1992, the major international family planning organisations such as the International Planned Parenthood Federation (IPPF) and the Population Council put forth a broad approach to RH that includes gender relations and sexuality, giving more attention to those issues throughout a woman's life. In January 1994, 200 women's health advocates from over 80 countries met in Brazil at the International Women's Health Conference. The report highlighted the need for human development efforts aimed

at the empowerment of women, which underlined the significance of ensuring high-quality health care more than the distribution of contraceptives and recognised the importance of safe abortion as an intrinsic part of health and human rights. They emphasised the need for counselling and interpersonal dynamics instead of coercive and target driven family planning methods with those models conceptualising the interplay of wider set of socio-economic and familial situations in which women live (Hempel, 1996).

Till the 1990s, the focus of global policy discussions regarding reproduction was on controlling women's fertility. SRHR were conceived as and equated with maternal and child mortality rates and population control measures. Population control policies have had a history of negative effects on women's health and rights. Responsibility for reproduction continues to be placed largely on women. From forced sterilization of women to the scarce promotion of male contraception, population control has traditionally been a female affair. The research and activism from the part of the global women's movement and global RH allies have concluded that the terms 'population control' and 'family planning' have become old fashioned and unusable in most settings. Instead, SRHR have been adopted into the discourse of nearly every organizational body and program documentation.

It was the International Conference on Population and Development (ICPD), Cairo, in 1994 which institutionalized the right to SRH as a global norm, and solidified the movement away from the demographic targets and population control programs of the 1960s. It was at the ICPD that the macro and micro strands of the population movement started to comprise, marking a significant step for SRHR. It also focused on the individual's SRH needs from a human rights perspective, by linking the struggle for social justice and respect for human dignity (Shalev, 1998).

The ICPD defines "reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes". Reproductive rights include:

> the right to be informed of and have access to safe, affordable, effective and acceptable methods of fertility regulation of their choice, the right of access to suitable healthcare services that will empower women to go securely through pregnancy and childbirth and to provide couples with the best circumstances to have a healthy infant. (United Nations Population Fund, 2014, p. 59)

Reproductive rights also include sexual rights, which are relied on

> the basic right of all couples and individuals to decide responsibly, the number and spacing of their children, to have the information to do so, and the right to achieve the highest standard of SRH. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights. (United Nations Population Fund, 2014, p. 60)

Okin (1998) emphasised the inevitability of rethinking human rights because she believes, the early conception of "the rights of man" in the 17th century and the original conception of international "human rights" in the mid-20th century were formulated on the basis of a male as the head of the household. A growing body of feminist knowledge has questioned the male bias on the construction of human rights.

1.3 The Need of Sexual and Reproductive Health Rights

SRHR have been treated distinctly from people's overall health and wellbeing for years. The ICPD convention in 1994 helped to provide a solid platform by linking the SRHR to human rights. It also underlined the significance of political and cultural sensitivities relating to sexuality, reproductive choices and gender equality and recognised that promoting individual choices can lead to women empowerment. Even though it has been 25 years since the landmark agreement, full realization of SRHR has still been insubstantial for many sections of the population across globally. People's health and socio-economic development are greatly dependent on the accomplishment of SRHR. Denial of SRHR have specific

consequences like poverty and gender inequality. It creates gaps in opportunities and capabilities of women can lead to vulnerability in terms of unplanned pregnancy, gender-based violence, gender- related health issues, complications of maternal and childbirth, unsafe abortion practices, sexually transmitted diseases (STDs) (Starrs et al., 2018).

Realization of SRHR, which lies at the core of human rights, is critical in safeguarding gender equality and women empowerment: to lead healthy lives by participating in socio-economic and political life. It is also critical for women in order to understand power relations and also to recognize violence in their lives. (International Planned Parenthood Federation [IIPF], n.d.). Globally, gender norms is defined by culture, varying significantly across and within cultures, disproportionately limiting women's access to and control over their SRHR, and the lack of these rights thereof can amplify and aggravate existing gender inequalities (Namasivayam et al., 2012). Furthermore, gender norms restrict the constructs of female sexuality and womanhood in existing global public health scenario and disrupted the inclusion of SRHR in 2030 agenda by denying the rights of one-third of women globally (Crockett & Cooper, 2016).

In communities, where men are privileged, they might act as gatekeepers, controlling information and services related to SRHR. Unequal power relations limits healthy communication between partners about SRH needs such as contraception. Even if women acting independently to avoid unplanned pregnancies could incite backlash from their partners in the process, which might also lead to either change or avoid contraceptive use. Additionally, unmarried women are vulnerable to social stigma and it affecting the SRH seeking behaviour regarding contraception and abortion services (Starrs et al., 2018). On the contrary, in societies with more equitable gender norms, men's support can facilitate women's autonomy and thus access to SRH awareness and services (Ouahid et al., 2023).

1.4 Global Trends in Sexual and Reproductive Health Rights

SRHR are critical in achieving Sustainable Development Goals (SDGs) because of their links to women's wellbeing, gender equality, and also their impact

on MCH. Even though, SDGs offer a common set of targets and indicators for governments to evaluate their improvement, they fall short of addressing the full potential of SRHR needs of people globally. SDG 3.1 intends to "reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births", and SDG 3.2 proposes to "end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least 25 per 1,000 live births", SDG 3.7 proposes to "ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes" and SDG 5.6 advocates to "ensure universal access to sexual and reproductive health and reproductive rights", are directly linked with the realisation of SRHR. All these goals strive to move beyond survival by guaranteeing that women and children reach their full potential for health and well-being (United Nations, 2015). Although the SDGs are important and applicable in general to all countries, the steadiness and nature of the hurdles will be different in different contexts (Haseena, 2020).

At present, the SRHR information and services are concentrated among women and men of reproductive age and limiting the need of people outside the reproductive age. All People need SRHR services despite of their age group and the relative size of the same varies and impacts the extent of the demand for SRHR. As the population in low-income countries and middle- income countries continue to grow, countries like India, must meet prevailing SRHR needs and also plan for the needs of the growing populations. Furthermore, these countries also experience a surge in chronic non-communicable diseases such as malnutrition, obesity hypertension and diabetes add complexity to SRH care (Graham et al., 2016).

Worldwide, 4.3 billion people aged between 15-49 have insufficient access to SRH services, 30 million have no access to institutional delivery, 45 million have not received antenatal care, 200 million women have unmet need for family planning, and 25 million abortions happen each year (Starrs et al., 2018). Report on trends in maternal mortality from 2000 to 2017 assessed by WHO, UNICEF,

UNFPA, World Bank Group and United Nations Population Division shows that, the Global MMR declined 38 percent in this period, with 2.9 percent average rate of reduction. Appreciatively, with 59 percent reduction, South Asia has achieved the greatest overall percentage of reduction. It also states that, although maternal deaths have declined at the global level, they remain high in low and lower middle-income countries (94 percent) including India. Sub-Saharan Africa accounts for 86% of global maternal death with South Asia at 20% and which is unacceptably high (World Health Organization [WHO], 2019). In addition, only 55 percent of married or in-union women of reproductive age globally, possess the decision-making capacity regarding their SRHR. It is essential to remove unnecessary legal, medical, clinical and regulatory barriers to ensure gender equity in the access to SRH services. Furthermore, enhancing women's autonomy will not only facilitate access to SRH, but also contributes to the attainment of broader SDGs (United Nations Population Fund [UNFPA], n.d.).

Although SRHR are centred on individual autonomy and choices, accomplishment of these rights takes place in a broader socio-economic, and cultural context. SRH information and services should be affordable and reachable to all individuals, irrespective of their multiple identities: age, race or ethnicity, sexual orientation, gender identity, marital or socioeconomic status. The interplay of factors has shifted substantially over the past two decades and remains to do so and it has created broad implications within and across countries in worldwide. Globally, indigenous people are disadvantaged, especially indigenous women, who are doubly marginalised and experience multiple forms of discrimination, such as, inaccessibility to land and natural resources, poverty, displacement, lack of access to education and quality health care. These structural factors further deteriorate women's position, limiting the complete accomplishment of RH rights (United Nations, 2010).

1.5 Reproductive Health of Women in India

India, with a population of more than one billion people, has many hurdles to overcome, such as cultural diversities and social inequalities in improving health and

nutrition, and particularly the SRH needs of its citizens. India is characterised by an unfavourable female sex ratio, large number of rural populations, heavy reliance on agriculture and widespread poverty with more than half of the population living below poverty line. A land with varied geography and gender disparities, along with a patriarchal setting in the society, has a huge influence on the SRHR of Indian women.

When we look at the RH history of India, according to Hodges (2006), there are three overlapping events that exist: medicalization of childbirth, social history of reproduction and national efficiency. The medicalization of childbirth in colonial India comprised of, firstly, providing a new setting for childbirth i.e. the shift from houses to hospitals, and secondly, replacing the assistance of childbirth from traditional midwives to trained ones or qualified physicians. Social history of reproduction explains how reproduction was constituted and reconstituted in political and social reform agendas. Some of the nationalists and medical professionals embraced Science and wished to replace the traditional practices with modern medicine. Social reformers argued about the need for the abolition of child marriage and early pregnancies which result in high maternal and child mortality rates. Official publication of census reports and campaigns for marriage reforms provided a fertile ground for the nationalists to articulate the need to look critically at reproduction. But some groups worried about this trend and saw it as a threat to the cultural and traditional practices of the country. During this time, popular literature got momentum in India and women's journals and medical professionals published articles on domestic hygiene, child health care, pregnancy and infertility (Hodges, 2006).

Montagu-Chelmsford reforms in 1919 transferred Health to local self-governments and formalised a set of relationships that emerged between national planning and reproduction. It shows that the domestic sphere was open to public sensibility and the personal and household regime identified with the national interests. The National Planning Committee in the 1930's worked along the line of these ideas. By the time of Independence in 1947, birth control and eugenics

converged under family planning, and the first five-year plan in 1951 addressed women's health as a stepping stone to national progress. In the same year the National Family Planning Programme was launched with an objective to reduce the birth rate with a macro-objective of population stabilisation (Hodges, 2006).

The target-driven, narrow-minded and aggressive population control policies gained a lot of criticism from the civil society organisations and women's organisations. After the 1990s, India witnessed a shift in the family welfare policies and programmes. The 72nd and 73rd amendments in 1992, along with the ICPD in 1994, brought dramatic changes and focused attention on gender concerns. The National Population Policy of 2000 focused not only on population stabilisation but also strived to promote RH in the wider context of sustainable development. Later, the National Health Mission was launched in 2015 with the objective of reducing maternal and child mortality.

1.5.1 Current Scenario of Sexual and Reproductive Health of Women in India

The United Nations Inter-Agency Group for Child Mortality Estimation (UNIGME) assessed that, five million children died globally before five years of age in 2021. India's share in these child mortalities was estimated at 7,09,366 under-five deaths; 5,86,787 infant deaths; and 4,41,801 neonatal deaths (United Nations Children Fund [UNICEF], 2023). As per the Sample Registration System Statistical Report 2020, India achieved a significant decline in MMR, which is 97/lakh live births. By realizing this, India has realized National Health Policy target of an MMR less than 100/lakh live births and is on the right track to accomplish the SDG target of less than 70/lakh live births by 2030.

Moreover, India has been witnessing a progressive reduction in Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR) towards achieving the SDGs (Office of the Registrar General, 2022). In addition, the NITI Aayog health index (2021) shows that, there are large inter-state and intra-state disparities in IMR, U5MR, MMR and SRB; for example, Kerala, the best performing state, with health index score of 85.97, which is about three and half times better than Uttar Pradesh with a score of 25.64, the worst performing state. (World Bank, NITI Aayog, and

Ministry of Health and Family Welfare, 2021). The RH characteristics of tribal women in India based on National Family Health Survey (NFHS) is detailed in Table 1.1.

Table 1.1

Reproductive Health Characteristics of Tribal Women in India

ITEM	NFHS 5	NFHS 4	NFHS 3	NFHS 2	NFHS 1
Women age 20-24 years married before age 18 years (%)	23.3	26.8	47.4	50	54.2
Total fertility rate (%)	2.0	2.2	2.7	2.9	3.4
FP Methods any (%)	66.7	53.5	56.3	48.2	40.7
IMR (per 1000 live births)	35.2	41	57	68	79
U5MR (per 1000 live births)	41.9	50	74	95	109
Institutional Birth (%)	88.6	78.9	38.7	33.6	26.1
C5 Severely wasted (%)	7.7	7.5	6.4		
C5 Anaemic (%)	67.1	58.6	69.4	74.2	
Women age 15-49 years Anaemic (%)	57.0	53.1	55.3		
Men age 15-49 years Anaemic (%)	25.0	22.7	24.2		

Source- NFHS data

The NFHS statistics has shown significant development in the RH of women in India. Still, certain social groups continue to be marginalised, with their reproductive health rights remaining compromised for decades.

1.6 Reproductive Health Rights of Tribal women in India

According to the Census of India 2011, the Scheduled Tribe population constitutes 8.6 percent of the total population of the country. There exists a vast diversity in their culture and lifestyle, and huge disparities in their socio-economic and health conditions. Yet, poor MCH condition, and very limited access to health care facilities are common across the communities. Even in a progressive state like

Kerala, tribal communities face similar issues. Most importantly, a near complete absence of data on health conditions of different tribal communities remains a challenge.

1.6.1 Demographic and Household Characteristics of Tribal Population

Tribal populations live in unique geographical, cultural and socio-political conditions in India. They can be divided into 5 major regions i.e., Himalayan, middle, western, southern and island regions. They are also differentiated based on their socio-economic, ecological, administrative and ethical factors. The tribes of the central and east region constitute 52.51% of the tribal population. The western region contains 27.63 percent and the north east region contains 12.41 percent. 2.03 percent of the total tribal population inhabit the Himalayan region, while the southern region includes 5.31 percent. Only 0.11 percent belong to the island region (Ministry of Tribal Affairs, 2014).

Almost 60 percent of the forest land in the country is situated in tribal areas, covering 188 tribal districts. But the provisions in the Forest Rights Act, serve to alienate these tribals from the forest in the name of conservation. The central Indian states like Odisha, Chhattisgarh and Jharkhand contain 70 percent of India's mineral resources and much of the forest land in these states has been diverted for mining purposes. The resulting environmental degradation, loss of traditional livelihoods, unemployment among common people and Maoist issues aggravate poor health standards and poverty among tribal communities. India is known for the construction of the largest number of dams and 40 percent of the resultant displaced (20-50 million) population are tribals. When we look at the tribal population (8.6 percent of the total) it is disproportionately high and leads to the loss of traditional livelihoods. Tribal women had earlier enjoyed higher employment rates as compared to the rest of the population, even though their engagement is restricted to the primary sector. However, the unemployment rate among tribal women has been increasing, while the unemployment rate among other populations is seen to be decreasing (Ministry of Tribal Affairs, 2014). This disproportionate distribution is also visible in the average employment rates in the government sector which is only

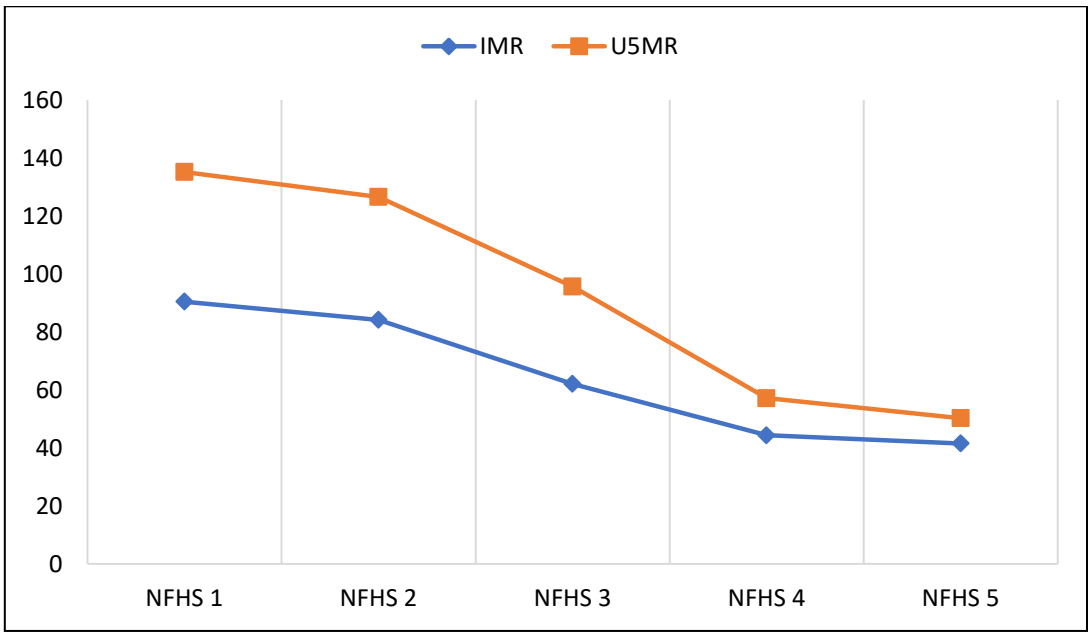
6.24 percent with respect to the 8.6 percent of the total tribal population. Among these, only 2.4 percent are working in Group A and Group B services (Thorat & Senapati, 2007). More than 40 percent of the tribal population belongs to the BPL category against the 20 percent of other population with almost 70 percent of the tribal households lacking sanitation and practicing open defecation (Panagariya & More, 2014).

1.6.2 Reproductive and Child Health among Tribal Communities

Tribal communities in India, continue to remain in a lower status in the society due to cultural and geographic isolation, illiteracy, primitive livelihoods and poverty (Haseena, 2020). Early marriage and pregnancy, early childbirth, high prevalence of anaemia etc are the main reasons for maternal mortality rates. According to the Rapid Survey on Children, 10.5 percent of the tribal women of age 15-19 have begun childrearing (Ministry of Women and Child Development, n.d.). The *Lancet* study on global comparison of IMR among tribal populations in 2016 shows the IMR amid the tribal population in India as the second highest in the world (Alkema et al., 2016). Remarkably, as per the report of the expert committee on tribal health in 2018, the IMR and U5MR among the tribal population reduced significantly over a quarter of the century. In fact, the IMR amongst the tribal population in India has nearly halved, however, the gap with the other social groups has widened from 10 percent to 38 percent. The U5MR also showed a 58 percent decline but the gap has increased from 21 percent to 48 percent (Ministry of Health and Family Welfare and Ministry of Tribal Affairs, 2018).

Figure 1.1

Time Trend of IMR and U5MR among Scheduled Tribe Population



Source – NFHS 5

As per NFHS-5 (2020), IMR among the tribal population stands at 42 deaths per 1000 live births, while the U5MR stands at 50 deaths per 1000 live births (see figure 1.1). It also shows that stunting, wasting and the underweight among the tribal children are 36 percent, 23 percent and 40 percent respectively. According to the NFHS-5 findings, 72 percent of tribal children, 65 percent of tribal women and 33 percent of tribal men are anaemic, which is highest among the social groups. As per the same report, 82 percent of the tribal women have received antenatal care and 17 percent of the deliveries still happen at home (International Institute for Population Sciences [IIPS], 2022).

Ethnicity and inequitable gender norms have greater impact on fertility decisions and reproductive behaviour of tribal women than non-tribal women (Khanna et al., 2018). Poverty and lack of access to transportation (Kumar et al., 2016) widespread malnutrition, high prevalence of anaemia, instances of domestic violence (Nagda, 2004)) are all harmfully affecting the RH behaviour and practices of tribal women.

1.6.3 Contradictions in Policies and Darkness of Information in the Implementation of Programmes

The unmet need of family planning is a major concern among tribal communities in India. Although 80 percent had information regarding family planning methods, only 53 percent of tribal married women used contraceptive services and female sterilisation was the most preferred method. It also revealed that the contraceptive prevalence was high in eastern and north-eastern states than the southern and central states in India (Panda et al., 2023). However, deaths due to sterilisation has not been a new problem in India. According to the Health Ministry data, more than four million sterilisation surgeries were performed every year in India. Between 2003 to 2012, a total of 1434 people died and the government had paid compensation for 568 deaths as part of sterilisation (The Guardian). In 2014, 83 disadvantaged women from tribal, dalit and other backward communities were subjected to sterilisation and 13 of them died. The sterilisation procedures were performed within a couple of hours by one health care provider. The incident indicates that over the past several decades, nothing has really changed in the implementation of family planning programme India. The standard operating procedures and ethical norms were violated during the execution of sterilisations, that subsequently lead to a severe violation of basic rights, especially the SRHR of the affected women. Furthermore, it shows the persistence of target-based approach and insensitive attitudes of health-care service providers and policy-makers towards the disadvantaged women (Sarojini et al., 2015).

At the other end, the undivided Madhya Pradesh government (then including Chhattisgarh) had passed a policy in 1979, which denied permanent family birth control methods among Particularly Vulnerable Tribal Groups (PVTGs) such as Paharias, Baigas, Kamars and Pahari Korvas of central India, in order to protect them from the mass sterilisation waves in north India and ensure population growth because of their “endangered” status. Social backwardness and low population levels are the result of the historical injustice faced by them and instead of addressing these structural factors, the state government implemented an aggressive

and disastrous policy by denying their human rights, especially the RH rights (Nandi et al., 2018). After a long legal battle by the tribal women, Chhattisgarh high court revoked the order (The Wire, 2018).

The fact that India has never witnessed a special policy on tribal health or RH programme, needs a in-depth review. The public health system in India must guarantee access to safe and quality family planning services to marginalised women. Tribal Sub Plan, National Health Policy and other social security programmes including National Food Security Act and Integrated Child Development Service Scheme are implemented and documented separately, resulting in discrepancies in data which generate confusing statistics. There is a complete absence of data on RH of women from different tribal communities and it prevents the exact gauging of the extent of the problem. As earlier mentioned, India's population is highly diverse and the existing national surveys are extremely limited and very difficult to access. The compilation and periodical updating of available data can solve the issue to a certain level (Ministry of Health and Family Welfare & Ministry of Tribal Affairs, 2018).

1.7 Reproductive Health of Tribal Women in Kerala

Kerala, a southern Indian state, has achieved high development indicators which is considered at par with developed nations. NFHS-5 data shows that IMR in Kerala has decreased to 4 deaths per 1000 live births and U5MR has come down to 5 deaths per 1000 live births. However, of those children under the age of five, 39 percent were anaemic, which is three percent higher than the NFHS-4 data. Moreover, 16 percent of the under-five children were wasted (too thin for their height), 23 percent stunted (too short for their age) and 20 percent underweight. Maternal health (MH) indicators show that, 79 percent women in the reproductive age group obtained antenatal care and 94 percent received postnatal care. As per the data, nearly two-fifth (39%) of births were c-section deliveries (IIPS, 2020).

The tribal population in Kerala constitutes 1.5 percent of the total population. Even though Kerala has been the front runner in IMR and MMR, and has already accomplished the SDG targets, the tribal pockets in Kerala tell some contradictory

stories. According to the Census report of 2011, the highest decline in IMR was reported i.e., 16.3 percent between 1988-2000 and 2008-2010 (Office of the Registrar General & Census commissioner, India, 2011). During 2013-14, in Wayanad (the district with a high tribal population), 55 percent of the total infant mortalities were reported among tribal communities. In Attappady, the IMR was 6600 per 100,000 against the state figure of 14.1 percent and the MMR was 700 per 100,000 against the state figure of 1.3 percent (Commonwealth, 2013).

Despite significant reductions in Kerala's poverty, the dalit and tribal communities face hunger, poor consumption and low nutrient levels with limited landholdings. The caste, class, ethnicity and gender inequalities play a critical role in it and the lack of disaggregated data worsens the situation (Thresia, 2018). The tribal communities in Kerala have long been disproportionately prone to different morbidities from malnutrition, anaemia, respiratory infections, skin infections, diarrhoea and lifestyle diseases such as hypertension, diabetes and cardiac disorders, and these morbidity issues have been on the rise among the tribal communities (Nalinam, 2016).

The utilisation of MH care services among tribal population is lower as compared to the non-tribal population in Kerala. Lack of education and lack of awareness on the need of health care services are the main reasons behind this. Along with that, the bad-mannered and hostile behaviour of health workers adversely affects the health care behaviour of tribal people (Jose et al., 2014). Studies have reported that, along with a low socio-economic status, lack of access to effective antenatal care, prevalence of MH complications such as hypertension, anaemia, premature birth and intra-uterine growth restrictions were high among them (Jayasree & Suneela, 2020; Rashid, 2019; Shamna & Krishnankutty, 2022). Girls' education, sanitation, improvement of food security, creation of health awareness, improvement of access to quality health care, and most importantly, disintegrated data to address the gaps in health delivery are all critical in improving MCH among tribal communities in Kerala (Thomas et al., 2021).

1.8 Rationale for and Significance of the Study

Maternal health studies from the human rights perspective highlighted how lower maternal health contributes to the cycles of intergenerational marginalisation and oppression (Batist, 2019). Maternal nutritional status is significant in this context as it has an intergenerational linkage with the survival and health of the child (Khatun et al., 2018). Access to RH care is a key determinant of human development and also affects the health of the next generation (Ramana & Rani, 2014). The connection between maternal malnutrition and child malnutrition is a key issue which has neither been seriously addressed nor prioritised in public policy making. This is evident from the fact that the prevalence of anaemia in women of reproductive age (15-49) has remained stagnant for three decades (Sappani et al., 2023), despite the existence of various welfare programmes.

Kerala's record development indices and a high prevalence of malnutrition in tribal pockets paint an appallingly contradictory picture. Tribal women are vulnerable due to impoverishment, exposure to discrimination and lack of voice to express their priorities and views. Young tribal girls enter the reproductive age as victims of undernourishment and anaemia, facing greater health risks. In this context, the continuing intergenerational cycle of malnutrition and deterioration in the RH status of tribal women should be broken and the various unfavourable circumstances that come into play, redressed. The socio-economic and cultural factors like caste, class, location and gender are crucial in accentuating tribal women's vulnerable position in the society. An intersectional perspective can give a detailed and in-depth analysis regarding the interdependence of the factors affecting RH status of the tribal women. This would be helpful in framing a convergence platform for the implementation of SRHR.

The study makes contribution to the feminist empirical literature on RH status of tribal women by examining the intergenerational changes. It provides a novel way of knowing how these intergenerational changes influence the intersectional positionalities of tribal women and thus contributes to their RH status. This study expects to be helpful in formulating specific and local interventions, and

also anticipates policy changes in this regard. Moreover, this is the first study to attempt a comparative analysis of the RH of tribal women from two generations by using dyadic interviews.

1.9 Statement of the Problem

Kerala, a south Indian state, has seen remarkable achievements in improved condition of MCH indicators as reflected in the social development indices, which are considered at par with many developed countries. Still, the tribal pockets in the state have high rates of maternal malnutrition and infant mortality. An intergenerational study on the RH status of tribal women from an intersectional perspective, using dyadic interviews would help to explore the lived experiences of the tribal women in this regard. It would aid in understanding the factors that influence MCH and its complications. This is the first study to attempt a comparative analysis of the RH of tribal women from two generations in the study area.

1.10 Research Questions

The main question, what are the intergenerational changes related to the reproductive health status of tribal women, is operationalised through questions 1 -3 while question 4 addresses the influence of the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

1. What are the demographic and socio-economic conditions influencing the reproductive health of tribal women?

2. How does the myths and misconceptions affect the reproductive health of tribal women?

3. How far do women exercise their reproductive health rights and what are the challenges faced by them in the process?

4. How does the intergenerational changes influence the positionality of tribal women and contribute to their reproductive health experiences?

1.11 Research Objectives

The major objective of the study is to explore the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective. The specific objectives are arranged in a logical way in which, they all contribute to achieve the major objective of the study.

Major Objective

- To explore the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

Minor Objectives

- To analyse the demographic and socio-economic conditions affecting reproductive health of tribal women
- To explore the myths and misconceptions prevalent among tribal women in terms of reproductive health
- To assess the extent of access to reproductive health services by examining the challenges faced by tribal women
- To suggest measures for promoting reproductive health among tribal women

1.12 Structure of the Thesis

This thesis consists of eight chapters. This *first chapter* provides the background to the research, including the general overview of the RH status of tribal women and the rationale for and significance of the research topic. It also lists the research questions and objectives of the study.

Chapter Two presents a theoretical framework of the study and it also reviews the literature related to the study and addresses the research gaps and proposes a conceptual framework for the study.

Chapter Three outlines the feminist research design and methods used in the study. It provides an introduction to the study context and elaborates on the methods used

for data collection. It also describes the experiences and challenges faced throughout the data collection procedure due to Covid 19 pandemic. The ethical considerations encountered and data analysis process are also detailed in this chapter.

Chapter Four, Five, Six and *Seven* are empirical chapters which answers the specific research objectives and provides an overall answer to the major objective of the study. *Chapter Four* informs about the demographic and socio-economic conditions of tribal women in the study area. It also elaborates about the influence of these factors on their RH choices and decisions. *Chapter Five* provides an exploration of deep-rooted myths and misconceptions and its effect on the RH status of tribal women. These two chapters provide an understanding of the context in which the tribal women negotiate their RH rights. *Chapter Six* and *Seven* discusses about the extent of access to RH rights by examining the challenges faced by them. These chapters are organised based on the domains of RH: menstruation, marriage, sexuality, contraception *(Chapter Six)* and pregnancy and childbirth *(Chapter Seven)*.

Chapter Eight concludes the study, presents the key findings based on research questions. It also recommends policy interventions, discusses the limitations of the study and proposes potential areas for future research.

Chapter 2
THEORETICAL FRAMEWORK AND RELATED REVIEW OF LITERATURE

CHAPTER 2

THEORETICAL FRAMEWORK AND RELATED REVIEW OF LITERATURE

Introduction

This chapter discusses about the theoretical framework and reviewed literature related to RH of tribal women. Furthermore, it identifies the research gap and proposes a conceptual framework for the study.

2.1 Theoretical Framework

This part includes two segments. The first segment discusses about the feminist stands on reproduction and the second segment details about the intersectional perspective and its need in RH studies.

2.1.1 The Feminist Stances on Reproduction

Reproduction and motherhood have been present as significant aspects that constituted the core of women's movements. Reproduction was seen as a "women's topic" and scholarship till the1960's dealt with the values, norms and beliefs related to RH behaviour (Ginsburg & Rapp, 1991). From the 1970's, the realm of reproduction and its analysis was enriched with the growth and expansion of feminist movements, in which women's reproductive experiences were studied as sources of power as well as subordination (Ginsburg & Rapp, 1991).

First, second and third wave feminist movements addressed the status of reproduction and motherhood which brought about certain splits in feminist movements. Many feminists found reproduction and motherhood as a common, positive element but some saw it as an obstacle leading to women's suppression. First wave feminism looked at political agenda, while the second wave put forth discussions of reproduction based on sexuality, cultural and gender normative, and the third wave addressed the issues of medicalization in reproduction. Harriet Taylor Mill's *Enfranchisement of Women* (1851), did not specifically address reproduction

but opened the options for women and encouraged political discussions on their equal property rights, importance of access to education and career opportunities. Her arguments also concern the unquestioned, suppressed position of women (Rossie, 1970).

During the second wave of feminism, reproductive rights issues were at the centre of the movement (Barlow & Smith, 2019). Betty Friedan's *The Feminine Mystique* (1963), critically discussed the role of child bearing, nursing and early child care. But women's reproductive labour still remained under-acknowledged and undervalued. In Simon de Beauvoir's *The Second Sex* (1949), the main task is to distinguish women's biology - especially the reproductive capacity - with social identity. According to her, the only way to women's freedom lies beyond maternity.

Feminists insisted on the distinction between biological reproduction and social reproduction. Such distinctions helped to explore the construction of social perceptions of reproduction and the resultant exploitation of women as child rearers. According to Shulamith Firestone in *The Dialectic of Sex* (1970), women's oppression stems from their reproductive role and she asks women to take control over the power of decision making regarding the reproductive function and to develop their knowledge of birth science and technology. Kate Millet's *Sexual Politics* (1971), discusses at length on women's bodies and sexuality, orienting the issues towards the biological basis of male dominance, thus failing in part to address the issue of reproduction and its role in women's suppression.

During this period, the fight for RH had two fronts. One directly challenged the ban to access contraception and abortion, and the second was targeted on medical paternalism. *Our Bodies, Ourselves* is a compendium published by the Boston Women's Health Book Collective in 1970, providing basic health information, including RH information, to women. It was considered as a basic information guide to help them make their own decisions relating to RH choices.

The Radical, Marxist and Socialist feminist discourses linked reproduction to socio-cultural and economic constraints such as patriarchy and capitalism (von Werlhof, Bennholdt-Thomsen and Mies (1983) in Neyer & Bernardi, 2011).

According to radical feminists, patriarchy, which defines the power position of women in social hierarchy, is the root cause of women's oppression. They claimed that reproductive choices are situated within the structural constraints of women's lives, and tried to explain the relationship between socio-economic freedom and RH choices (Denny, 1994).

From a Marxist feminist perspective, gender and class are seen as categories responsible for women's oppression. Identifying gender relations as a category that operates along with class, helps to understand the history of women's oppression. Gender inequality especially reinforces class inequality and class divisions are heightened by gender discrimination. These two categories mutually reinforce and result in the oppression of women. According to Socialist feminists, neither patriarchy nor capitalism can provide a complete picture of women's reproductive health experience and oppression. They tried to comprehend the reasons with the synthesis of both concepts. Patriarchy and capitalism are also mutually reinforcing and are inextricably linked to the subordinate position of women in society. They do believe that the subordination of women cannot be separated from other forms of oppression such as class exploitation and racism. Liberal feminists conceive freedom as individual autonomy and self-fulfilment. They emphasise the need to conceive reproduction as a matter of individual autonomy because it implicates the body, personal identity and the ability to participate in economic and political life (Neyer & Bernardi, 2011).

The third wave of feminism witnessed the development of Critical Race Theory by Dorothy Roberts which expands the scope of reproductive rights. Critical Race Theory is concerned with the role racism plays in reproductive control especially on women of colour. It uses post-modernist tools including deconstruction, storytelling and contextualisation, and questions the idea of objectivity. Critical race feminists focussed on the intersection of colour, patriarchy, class structures and other forms of subordination. They used intersectionality as a tool to reveal the interlocking matrices and distribution of power. It helps to

understand the gaps between reproductive rights and gender equality (Crenshaw, 1991).

2.1.2 Rights-based Approach to Sexual and Reproductive Health: Using Intersectionality as a Tool

The rights-based approach to SRHR is influenced by several international and regional agreements, which have affirmed the significance of endorsing gender equality and human rights in order to ensure the same for all. However, majority of the interventions have addressed gender equality and a few have addressed human rights interventions (Hartmann et al., 2016).Several studies have emphasised the need for focusing on human rights for the fulfilment of SRHR of all and it is imperative for the realization of the 2030 Agenda (Cottingham et al., 2010; Gruskin et al., 2021). Creation of knowledge based on the human rights approach can enable all, especially marginalised communities by the provision of opportunities for capacity building and access to resources. Thus, intersectionality can be used as a tool to understand the hierarchies of power and examine how multiple axes of inequalities operate together and exacerbate the situation (Sri, 2022).

Intersectionality is a feminist theory and methodology for research which addresses these "different experiences" and how the interrelation of different forms of oppression creates systems of discrimination. Emerging in the late 1980's, and coined by Kimberlé Crenshaw, intersectionality was introduced as a theory that could highlight the complexity and interplay of multiple identities (Crenshaw, 1991) and has since grown to be the newest and most widely respected framework within feminist development circles.

"Intersectional analysis has become a predominant way of conceptualizing the relation between systems of oppression which construct our multiple identities and our social locations in hierarchies of power and privilege" (Carastathis, 2014, p. 304). The basis of intersectional approach is to fulfil in-depth analysis of differing markers of identity and discrimination in order to obtain a clear and accurate contextual understanding. An intersectional analysis exposes compounding discrimination and points of intersection which would otherwise be missed. The

paradigm exposes structural and systemic inequalities which are otherwise reduced to individual level or country-level problems based on bias, discrimination and stereotyping. These stereotypes and forms of discrimination are often institutionalized yet unspoken (Carastathis, 2014).

Intersection is a distinct and layered experience of discrimination which may not be fully understood when viewed through one form of discrimination. Intersectionality recognizes that issues such as race, class, religion, sexuality and gender intersect to form separate and unique points of discrimination and oppression (Hulko, 2009). This suggests that race, class, and gender are dominant forces that shape people's lives (Zinn & Thornton, 1996) and the intersections are hierarchical, mutually reinforcing, and simultaneous (Collins, 2000). It is widely understood that identity categories are fluid and contingent upon time and place, and that the systems and processes which place value on intersecting identities shift temporally and spatially, culturally and historically (Hulko, 2009).

Reproductive justice was defined as "reproductive health integrated into social justice." Reproductive justice is grounded in intersectional theory, which focused on the experiences of women of colour whose communities experienced reproductive oppression (St. John, 2019). Reproductive justice activists have dynamically used the concept of intersectionality as a source of empowerment to propel one of the most important shifts in reproductive politics in recent history. Besides that, the foundation of reproductive justice relies on the basic human rights framework and applying intersectionality based on the individual's identity as well as collective identities would help to cater to every person's needs. It also provides insights regarding the intersecting RH experiences of individuals and groups by analysing the matrix of structures (Ross, 2017).

The SRHR agenda has not been fulfilled as a result of not taking intersectionality seriously. The new researches emphasise that intersectional analysis must be taken seriously within the UN system and promoted as the paradigm for SRHR research and action. The current framework, based on a human rights and women's empowerment approach, inhibits the extraction of class and race from the

complex matrix of power relations that shape inequality. Intersections of race, class, and gender, are power hierarchies that operate both at individual as well as systemic levels. Intersectional analysis must clarify the associations between broad societal structures, events and trends and the ways in which people in diverse social locations experience their lives (Weber, 1998). This would lead to the advancement in addressing health service disparities at individual, interpersonal, community and structural levels (Hankivsky et al., 2009).

According to Hankivsky et al. (2009), power is central to intersectional analysis, which has a critical role in creating and perpetuating the personal and social structures of discrimination and oppression, in addition to the linked systems of power and inequality. Intersectional analysis helps to understand the interconnectedness of different social identities and also explicitly examines the multifaceted lived experiences of individuals, which are collectively formed by the interplay of these social identities (Hankivsky et al., 2009).

The institutional forces such as racism, sexism and poverty affect people's individual freedom and influence the decision-making capacity regarding parenting and child bearing, especially of indigenous women and other marginalized communities globally. Issues of SRHR do not merely concern better health conditions or access to funding, but are determined by intersecting forms of discrimination. In this sense, intersectionality was found to reflect the socially constructed nature of reality and to open up a point from which to redefine and challenge existing oppression. Collective narratives in a particular socio-cultural context can influence the health behaviour of people and its outcomes. Their beliefs are part of exclusion and powerlessness they face, which intertwine and create lived experiences. While exploring the unique barriers in accessing SRH services, location is a critical aspect of intersectional approach, as power and inequality are conferred by social, historical, geographical and political contexts (Bowleg, 2017; Jaiswal et al., 2019).

Although there are various intersectional approaches that exist in intersectional analysis, an intra-categorical approach helps to examine the

complexity of lived experiences of a particular social group at the intersection of multiple categories. Moreover, it helps to understand diversity and differences within a social group created by multiple oppressions (Angelucci, 2017; Caiola et al., 2014; Giritli-Nygren & Olofsson, 2014; McCall, 2005).

2.2 Related Studies on the Reproductive Health of Tribal Women

Caceres et al. (2023) assessed the "perceptions, health seeking behaviour and utilization of maternal and newborn health services among an indigenous tribal community in Northeast India – a community based mixed methods study". The study used mixed methods, conducted 109 interviews with tribal mothers, 17 in-depth interviews and seven focus group discussions were used for data collection. It was found that 40 percent of the deliveries were at home and only 4 percent received antenatal care. Maternal education, low self-esteem, traditional beliefs are the major factors affecting the health seeking behaviour among the participants. It also found that inaccessibility to and unavailability of quality health services persist in the study area.

Pandit and Patel (2023) conducted a mixed method study on "child birth practices and use of antenatal care services among migrant tribal women in urban areas of Gujrat". 592 participants were selected using simple random method and in-depth interviews were also conducted with 20 participants. The findings revealed that 60 percent of them were illiterate, 18 percent of them had home deliveries and 51 percent of the participants received four antenatal care services. Additionally, traditional beliefs and cultural practices influenced the health care access among the participants. It was also reported that even though the participants have trust in field-level workers, the lack of trust in modern health services worsened the modern health care access among the participants.

Adhikari and Paria (2022) studied the "utilisation of health services and its perceived barriers regarding infant care among tribal mothers in selected areas of West Bengal". Purposive sampling was used to select 100 participants and structured interviews were conducted for data collection. It was found that 96 percent and 60 percent of the participants received health education and postnatal care respectively.

Additionally, 74 percent of tribal mothers and 51 percent of their children were fully immunized. It was also found that the lack of transportation, lack of caregiver and economic insecurity are the major barriers in accessing RH services among the tribal women in the study area.

Majumder (2022) assessed the nutritional status of married women from Bhumji, Birhor, Ho, Sabar and Santal tribal communities by using mixed method design. 200 participants were selected using purposive sampling and field observation, interviews, focus group discussions and case studies were used for data collection. It found that 54 percent of the participants were illiterate, 66 percent engaged in agricultural activities, 85 percent had no proper housing, 73 percent lacked access to clean water, and 72 percent had no sanitation facilities. Furthermore, 71 percent of participants reported food insufficiency and majority of children are depending on supplementary nutrition from social security programmes.

Choudhary (2021) assessed health care patterns among tribal communities in Jharkhand. In the descriptive study, 100 tribal women from Mahli, Oraon, Munda, Lohra Baraik and Chik communities using purposive sampling. Observation and interview schedule was used for data collection. The study found that the around half of the participants were illiterate only 2 percent are graduated. Although 85 percent of the tribal women are accessing modern health care facilities, both communicable and non-communicable diseases are prevalent among them. Additionally, majority of them also access other social security measures such as Anganwadi centres and it helped them to improve their health education.

Chandana and Kumar (2020) studied the health status and assessed the factors affecting health care access of tribal women from Koya, Banjara and Kondareddi tribal communities in Telengana. 120 participants were selected using stratified random sampling and structured questionnaire was used for data collection. In the study, 80 percent of the participants lacked transportation facilities. Additionally, 70 percent of them lacked awareness regarding vector-borne diseases and 76 percent of the them diagnosed with chronic illness. Furthermore, the decline in traditional medicines and increase in modern health care seeking were noticed.

George et al. (2020) assessed the factors affecting the poor health care access among tribal communities in Attappady, Kerala by conducting 47 in-depth interviews and 6 focus group discussions with the community members and health care providers. The findings revealed that the culturally insensitive health care services and discrimination from the service providers are the major reasons behind poor health access among the tribal communities.

Panda and Subudhi (2020) studied MCH patterns among tribal communities in Odisha by using National Family Health Surveys for the study. The study found that the MCH indicators are lagged behind among tribal areas compared to other areas. Educational attainment and age at marriage of tribal women are the major determinants in ensuring MCH. The study suggested the need to invest in maternal education and awareness creation regarding MCH care.

Mavelil and Srivastava (2019) studied the RH of tribal women from matrilineal communities in Meghalaya. In the particular quantitative study, 900 tribal women from 142 villages were selected randomly and semi-structured questionnaire was used to collect the data. It revealed that various RH risks such as severe anaemia and abnormal blood pressure are prevalent among the tribal women. Low education, lack of economic security, early marriage and pregnancy were also found among the participants. The researchers reported that one-third of the population is not accessing health services and all these contributed to their low RH.

Babu (2019) studied the RH beliefs, customs and practices among paniya tribal women in the reproductive age group (15-45) in Wayanad District, Kerala. A total of 288 respondents were selected from all grama panchayats of the district by using multi stage sampling. Interview schedule, focus group discussion and ethnography were used to collect data. They found that the habit of substance abuse and using of pills for postponing menstruation are prevalent among the tribal communities. The study also found a high level of adherence to the customs. They are practising religious and cultural belief systems in their life and especially in the RH matters. Around 50 % of the respondents are still depending on traditional medicine.

Rohisha et al. (2019) studied on the prevalence of anaemia among tribal women in Kasaragod district in Kerala. Descriptive study design was administered and survey was conducted among 445 tribal women in reproductive age group (15-49). The study found that 89 percent of the tribal women had anaemia in which 62 percent had moderate and 11percent had severe anaemic conditions. It was also found that, 87 % participants become pregnant at the age of 18-25 years and 39 percent had education till high school and 45 percent of them have chewing habit. The study suggests the need of promotive and therapeutic activities for the better health status of tribal women.

Contractor et al. (2018) explored the needs and experiences of the tribal women with their pregnancy, childbirth and the relationship with the formal health system in Rayagada District of Odisha. In order to collect the data, they conducted 36 in-depth interviews and also organised 3 focused group discussions with tribal women, traditional healers and public health professionals. The results show that the community is practising traditional medicine and they are treating pregnancy and childbirth as part of the natural processes. The community has a well-established practice and they also recognise the need of the interventions when there is an occurrence of complication. The authors argue that the formal health system is still focusing on the incentives and there is no conscious effort for the integration of traditional medical practitioners in to the formal health system. They concluded by emphasising the need to cater the cultural needs and building the trust by ensuring effective communication with the tribal women.

Ghosh-Jerath et al. (2018) assessed the awareness and availability of indigenous foods and their intakes and also the nutritional status of tribal women in the reproductive age group in Jharkhand. 143 household dietary surveys were conducted and the study found that 40 percent of women had various degrees of chronic energy malnutrition. The comprehensive knowledge about the indigenous food resources was present, however the consumption of indigenous food was low and thus the household food security. And the study highlighted the important role of indigenous food in improving the dietary diversity among underprivileged tribal

communities and especially the nutritional status of tribal women in the reproductive age.

Khanna et al. (2018) studied the effect of ethnicity and gender on fertility intention among the married rural young women from Madhya Pradesh and Rajasthan by using a mixed method approach. The study intended to explore the fertility intention among the non-tribal and tribal young married couple in rural areas and also the effect of gender and ethnicity on their reproductive choices. A three-stage sampling design was used for participant selection and data was collected from 273 young married couple which included 108 tribals and 165 non-tribals using structured questionnaire and in-depth interviews. The study found that the ethnicity and inequitable gender norms play a critical role in RH choices of young married rural tribal women. It also found that early marriages and low contraceptive use are playing a crucial role in early child bearing choices among participants. It concludes with an emphasis on the need for education and gender equity to reduce early childbirths.

Kumari and Kshatriya (2017) studied the factors related with the utilisation of MH care services among currently married women (15-31 years) belonging to Santal, Mahli, Oraon and Ho tribe of Purbi Singhbhum district of rural Jharkhand. Interview schedule was used to collect data from 919 participants. Selected demographic factors like women's education, autonomy, son preference, and waiting time to conception were considered as predictor variables. Overall, 64.9 percentage of women received an adequate pregnancy care, 59.5 percentage had institutional delivery and 25.6 percentage of women had their child fully immunized. The results from both bivariate and multivariate analyses confirmed the importance of women's age, education, and autonomy for the usage of MCH care services.

Corrêa et al. (2017) studied the high burden of malaria and anaemia among tribal pregnant women in a chronic conflict corridor in India. The tribal communities such as Koya and Gotikoya from forest areas of Andhra Pradesh, Telangana and Chhattisgarh were selected as the burden of malaria and anaemia on tribal pregnant women are highly unknown in the study area. The data was collected using the

antenatal care records and it found that, among the 575 pregnant tribal women, 92.4 percent were anaemic and 6.9 percent severely anaemic. 29.3 percent of them had prevalence of malaria. It was also found that the malaria was related with the severe anaemic condition in tribal women in the study area. The study also emphasises the need for the systematic screening of prevalence of malaria and anaemia should be integrated with the RCH services for the tribal women in the conflict affected tribal areas across India.

Sethi et al. (2017) conducted a study on partnering with women collectives for delivering women's nutritional intervention in tribal areas of eastern India. It used an exploratory mixed methods research design. It includes review of the government reports and available data, focussed group discussions and interviews with the community members and different stakeholders. 18 different types of community collectives were identified, their reach and capacity were assessed by administering a capacity assessment tool. The study found the gap in the delivery of services including delay in registering pregnancies and low micronutrient supplement supply. It was also found that by using the capacity of grass root level collectives, it is possible to redress the gaps in the service delivery to the women in RH in tribal areas.

Hamid et.al. (2017) evaluated the RH status of Gujjar and Bakkerwal (Scheduled tribe) women in Kashmir. 410 tribal women in the reproductive age group of 18-45 were selected and interviewed. The particular study explored the menstrual practices, utilization of antenatal and intra natal care practices, usage of contraceptive methods and the prevalence of RTIs and STDs using the Standard RH Status schedule framed by the National Family Health Survey with selective modifications. It revealed the existence of poor RH status among the tribal women including poor educational background and unhygienic menstrual practices, non-acceptance for the utilization of contraceptive methods and prevalence of STDs among the respondents.

Kumar et al. (2016) studied the "MCH practices among Baiga tribe in Central India." In the study, the have conducted twelve focus group discussions

among ever married women aged 15-49 years, by the help of trained village investigators. They also used content and thematic analysis in addition to focus group discussions. Cultural patterns, lifestyle and health seeking behaviour were found to be the different factors influencing the tribal women's RH, delivery system and maternal and child care practices among the participants. It was also found that few women were disclosing their pregnancy status to their family members after three months and women were having many wrong perceptions about safe delivery and abortions. It was found that the tribal women have low awareness followed by underutilisation of MCH services and lack of transport facilities and poverty are also create barriers in the accessibility of health care services.

Dehury (2016) studied MH care service challenges and implications among the tribal community of Balasore district in Odisha, where 23 percent of the total population is constituted by tribals and have significantly high maternal mortality rates. The study was conducted among tribal women in Jaleswar block. It intended to appraise MH services available to tribal population and tried to capture the perceptions of the tribal community regarding MCH. It also assessed the infrastructure capacity and the competence of the ASHA workers in the MH service promotion. Infrastructure capacity was measured by "Parijata tool" developed by United Nations Child Fund by making regional modifications. It included the manpower strength, availability of drugs and quality of clinical procedures. They designed a checklist to assess the competency of the field level workers. The findings revealed the inefficiency of public health care systems and gaps in implementation of services to the tribal communities due to lack of cultural sensitivity. It also found the Low competence ASHA workers in promoting safe health care practices among the study participants. The study emphasises the need of including regional and cultural inputs in to the implementation of government programmes.

Nayak and Sreegiri (2016) studied the nutritional status of tribal women in Vishakhapatanam district in Andhra Pradesh. A multistage sampling method was used to identify the sample and around 225 tribal women from reproductive age

were randomly selected and interviewed using a semi-structured interview schedule. The study found the prevalence of anaemia among more than 60 percent of the participants as well as low BMI status among tribal women in reproductive age. It was also found that the young women in the age group of 15-30 were having better nutritional status as compared to the older women in the age group of 31-49 years. It also found the significant association between the economic security and BMI of the study participants. The study concluded with a concern that one fifth of the study population were at a risk of further nutritional deficiency.

Battala et al. (2016) examined the association between tribal status and space contraceptive usage of tribal women in rural Maharashtra. A baseline survey was conducted among 867 non-sterilised couple from the study area. Around 70 percent of the participants were tribals and it was found that use contraceptive methods for family planning is less among the tribal communities. And the findings also shows that the lower space contraceptive usage among tribals is associated with lower education, higher fertility preferences and social vulnerabilities.

Jayaprakash and Saravanan (2016) studied the tribal women's health status in Tamilnadu. It intended to study the knowledge, practices and access to health care among the tribal women. it also studied the relationship of socio- demographic indicators with their health seeking behaviour. Purposive sampling was used to select 60 tribal women and an interview schedule was used to collect the data. The study population lack adequate socio-economic facilities and they lack proper access to health care. The gap in health care service delivery including reproductive and MH care delivery is also prevalent in the study area.

Lenka (2016) studied the nutritional status and traditional health culture of tribal women of reproductive age in seven villages of Odisha. Purposive sampling method was used to collect data from 100 literate participants. It used a questionnaire cum interview method to collect data from the respondents about their nutrition intake, health culture and practices and food habits during illness and reproductive stage. All of the respondents belong to the low-income group and having agriculture as primary occupation. Dietary diversity and traditional healing

systems are prevalent among them. Even though they have a normal BMI, they are suffering from malaria and joint pain. The study was concluded by emphasising the necessity for educational access to tribal women in order to maintain their health status.

Chanu and Arunkumar (2015) studied the knowledge and practices regarding the traditional RH care among Thadou tribal community in Manipur. The study participants still believe in traditional methods and depends on it during pregnancy and post-partum. They also avoid certain food items during pregnancy as part of their traditional believes. However, the study shows that the younger generation is not interested in traditional methods and the and practices are slowly disappearing. The unavailability of medicinal plants and the increasing use of modern medicines are the major reasons behind this trend.

Ramana and Rani (2014) studied the tribal women's RH status in three regions of Andra Pradesh by using stratified random sampling. A total of 1200 tribal women interviewed in the study. It helped to analyse the extent of human rights violations faced by these women. It was found that around 60 percent of the respondents received ante-natal care services and a majority of respondents faced complications during the pregnancy time due to nutritional deficiency. Around 70 percent of them chosen permanent contraceptives because of economic constraints while supporting large families.

Jose et al. (2014) studied the factors effecting utilisation of maternal care services among the tribal women in Wayanad, Kerala. In the qualitative study, semi structured in-depth interviews were used for data collection, from randomly selected 70 participants, which included equal number of tribal and non-tribal women. the study found that the educational and income status are lower among the tribal women compared to the non-tribal women. it was also found that the utilisation of MH care services is also lower among tribal women (85%) than the non-tribal women (100%). Lack of awareness and transportation facilities also effect the underutilisation of MH care services among the tribal women in Wayanad.

Verma and Verma (2014) studied the history of RH of tribal women from Bhatra tribal community in Chhattisgarh. Structured interview schedule was used to collect data from 359 households of Bhatra tribe in the study area. The study found that majority of the participants are less educated and socio-economically backward and the fertility among the study participants increases with the increase of age at menarche. Age at menarche and age at first pregnancy are lower among the tribal women compared to women in other tribal communities. however, abortion rates and still births are high among them than the other tribal communities.

Borah et al. (2014) studied the reproductive behaviour of tribal women working in the agricultural sector. 390 participants from Deori and Mishing tribal communities were selected randomly for the interview. The study found that the farm size has no significant correlation with the reproductive behaviour of tribal communities. however, malnutrition, abortion and inaccessibility of health services are the major issues among the tribal communities and affecting the reproductive behaviour of study participants.

Sharma et al. (2013) studied the choices made by the tribal women in Gujarat regarding the childbirth practices by using a grounded theory approach. They administered eight focus group discussions with the tribal women and five in-depth interviews with the traditional birth attenders and the service providers in order to collect data. The study showed a transition from home-based deliveries to the hospital-based deliveries and transition was shaped by multiple factors like impact of economic growth and access to modern health care facilities, international MH care discourses and socialisation into medical childbirth practices. Even though women are interested to make hospital birth choices, the resource poor settings leave them with limited choices which causes the higher number of maternal and child mortality rates. It envisages the need of region-specific strategies based on the socio-cultural context.

Saha et al. (2013) explored the experiences of Baiga tribe of central India about reaching tribal men to improve awareness to sexual morbidities. The study was conducted among 400 tribal men in reproductive age group, who are currently

married, from 18 villages in Madhya Pradesh. Quasi experimental and control design with the help of IEC materials were used to conduct the study. The study revealed that only 18 percent and 22 percent of the participants were aware about the reproductive tract infections and sexually transmitted infections respectively. It was also found that different misconceptions and myths are present among them regarding sexual and RH.

Srinivasan and Ilango (2002) studied the delivery related and antenatal care practices of Kolli tribal women in Nammakal. They also studied the misbeliefs regarding food and working status of women during pregnancy. The particular study found the poor nutritional status, low socio-economic status and high health issues among the study participants. The agricultural activities are reducing and the participants lost interest in traditional medicine. It also revealed the great knowledge gap between the existing health care system and the availability of the RH care to the tribal women in the study area.

Hazarika and Chutia (2013) in their study they intended to map the RH risks of tribal women in north east India. They specifically looked at abortions, still birth and other reproductive issues among tribal women. the explorative research used comparative analysis method to understand the major factors of weakening of RH of tribal women in the region. The study was conducted in four districts of Assam, tribal women from Deori and Mishing communities, who had at least either abortion or still birth were selected using purposive sampling. Structured questionnaire was used data collection from 240 respondents. The study found that abortions and still births have been common among tribal women. 33 per 1000 Deori married women and 25 per 1000 married women of Mishing women were having RH issues. Poverty and lack of knowledge about health care services are the major influential factors affecting the RH of tribal women. Authors suggest investments in health and population education sectors as the prime factors for promotion of general health and RH of women.

Gogoi and Prusty (2013) examined the treatment seeking behaviour and RH complications among tribal women in north-east India. The study used DLHS-3 data

for the analysis and it was found that awareness regarding RTIs/STDs is lower among tribal women and only few of them are accessing public health facilities. It also found that more RH complications are reported among tribal women than the non-tribal women. The study revealed that irrespective of the caste, lowest class women have highest RH complications in the study area. The findings rise the necessities for advancement of RH care services and access to resources.

Kamath et al. (2013) studied the prevalence of anaemia among tribal women of reproductive age. 170 participants were selected from Marathi Naik and Koraga tribal communities and interviews schedule was used for data collection. The findings shows that the around 56 percent of the respondents were found to be anaemic and its prevalence is high among the tribal women in reproductive age. The study concluded by emphasising the need of appropriate interventions in order to the betterment of RH status of tribal women.

Susuman (2012) studied the "Correlates of Antenatal and Postnatal Care among Tribal Women in India". The study is conducted among the 1569 tribal women, who are currently married, from eight districts in Chhattisgarh. They have used data from DLHS- RCH and the study found that the 73 percent of the participants are illiterate and 84 percent of them have low standard of living. It was also found that the women who had institutional delivery received 2.5 times higher antenatal care than the other women. It concluded with the need for necessity for ensuring economic necessity in order to improve their postnatal care.

Sri et. al. (2012) investigated the maternal deaths in a tribal district of Madhya Pradesh. The team contained of authors, an obstetrician, health activists and health system analyst were visited the fields of Barwani district in MP, to investigate the maternal deaths (27) of tribal women. It found the high level of anaemia and low access to antenatal care among them. lack of accountability and discrimination in service delivery was also found and these could the major reasons behind the death of tribal women. The lack of skilled birth attenders and emergency facilities worsened the situation. The study demanded the need for minimum quality care for the tribal women by enhancing the RH services delivery.

Vlassoff et al. (2012) studied the "HIV related stigma in rural and tribal communities of Maharashtra." It used a mixed methods approach and 494 married women and 186 adolescents from 49 tribal villages were responded in the study. The study found that the respondents have high awareness related to HIV. It also found that, HIV-related stigma was predominant in all communities however, older generations possess more stigma. Additionally, high-risk behaviour was found among the participants and raised concerns regarding the slow increase of cases among them. Study helped to understand the characteristics and persistence of stigma among the participants.

Jat et al. (2011) conducted a multilevel analysis on the aspects influencing MH services in Madhya Pradesh. They conducted a cross sectional study and interviewed 15,782 ever married women aged 15-49, who participated in the DLHS. The household socio-economic status and the mother's education were the most influential factors according to the findings and they found a sufficient variation from one district or community to the other. The study emphasises the need for specific interventions at district and community levels.

Shah and Bélanger (2011) aimed to analyze and compare the MH care utilization patterns of tribal women in north east and central regions. They also aimed to explore the tribal women's perceptions and opinions on the MH care utilization. The study was based on the data collected for the NFHS II and III and it was found out that the tribal women in north eastern parts are utilizing the services more than the tribal women in central regions.

Bhardwaj and Tungdim (2010) studied the RH profile of scheduled caste (SC) women and scheduled tribe (ST) women from Rajasthan. The comparative study found that the age at menstruation, age at marriage and age at first conception are higher among SC women than the ST women. It was also found that the education level is also high among SC women than the ST women. The utilisation of family planning methods was also high among SC women, with 83 percent compared to 25 percent of tribal women. Along with that, only 17 percent SC

women did not use any family planning methods whereas 75 percent of the tribal women did not use any methods.

Deb (2010) studied the knowledge, attitude and practices of Khasi tribal women in Meghalaya related to their use of contraceptive methods. 1560 Khasi tribal women in reproductive age, ever-married participated in the study. It found that the tribal women possess high knowledge regarding the family planning methods and more than half of the study participants adopted modern methods for family planning. The study also found the gap in the knowledge and practice of family planning methods among tribal women.

Negi et al. (2010) assessed the effect of demographic and socio-economic variables on the use of antenatal care services among the tribal communities in Jharkhand and Chhattisgarh. It also assessed the accessibility of health services among the participants. The data from 8860 and 10,569 tribal women who are currently married from Chhattisgarh and Jharkhand respectively by using DLHS-RCH data. The study found the low socio-economic and demographic conditions among the participants. Additionally, even though the participants have access to the public health services nearby, they are preferring quality services at far away distances.

Sharma and Rani (2009) studied the contraceptive services among tribal women in central India. The information from DLHS-RCH used in this study. The study found that the majority of tribal women are aware of at least one method of family planning however, only 42 percent are ever used at least one method. Of those, 33 percent preferred female sterilisation while only 2 percent opted for male sterilisation. The study found that the use of sterilisation increased with the age of women, female literacy, marital duration and number of surviving children.

Narahari et al. (2009) studied the pediatric practices among Porja tribal communities of Visakhapatnam District, Andhra Pradesh. The interviews were conducted with 260 ever married women from 18 villages from the study area. The findings revealed that the majority of the respondents started breast feeding immediately after the birth however, 71 percent of them avoided colostrum.

Illiteracy and unawareness might be the reasons behind this. It was also found that the 42 percent of the respondents reported that the average period of lactation was around 2 years and 38 percent reported around 3 years. Furthermore, the supplementary feeding started from 6 months and majority of them gave traditional food from their cultures.

Chandraker et al. (2009) studied the "Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chhattisgarh, India". 174 ever married tribal women and 68 under-five children were participated in the study. The structured interviews were used for data collection. The study found that the around half of the tribal women were anaemic and children are malnourished. Additionally, 95 percent of them had deliveries at their home and only 52 percent of the tribal women had no antenatal checkup. It was found that the lack of socio-economic facilities, lack of education, and lack of proper awareness are the major reasons behind the malnutrition and poor health of tribal women and their children in the study area.

Rao et al. (2009) conducted a study among the tribal population of central India, regarding the prevalence of sexually transmitted diseases. They have conducted house visits and interviews among the total 2568 tribal people which included both married tribal men and women from selected villages. The study found that the 13 percent of the participants had at least one sexually transmitted disease. Of those, 67 percent are tribal women and 33 percent are tribal women: tribal women reported vaginal discharge as a major symptom. Age group wise, age group range from 30-34 have highest prevalence of STDs. Overall, low level of STD symptoms was found among the study participants and thus it created possibilities for prevention of increase in the rate from very early stage.

Kumar and Joshi (2008) explored the issues related to family planning methods, knowledge and practices of tribal women in south Gujarat. The study focussed on the accessibility and usage of various contraceptive methods among the tribals and also about the availability of modern methods. They used personal interviews as data collection method and interviewed 720 respondents from two

districts, Surat and Valsad and nine taluks of south Gujarat. Female sterilisation is the widely known method and around 89 percent of the respondents recognise at least one method and 24 percent of the married women are using contraception. 83 percent of respondents use either female or male sterilisation as a contraceptive method and other methods account only less than one percent each. The respondents are approaching public hospitals for the services. The study emphasises the need of employing and empowering local women as field level health workers, encouraging co-operation among men and women, need of focused and wide spread methods of communications and campaigns, creating private organisations as partners in provision and ensuring of services and the need of quality improvement in public health services.

Saha et al. (2007) explored the importance of tribal men's participation in and the barriers for their involvement in matters related to RH of women. The study carried out in Khairwar tribal men in age group 15-49 years in central India found that even though the majority of the participants have heard of RH problems, they lack proper knowledge regarding the same. 59 percent of the tribal men have heard of different family planning methods but only 13 percent are using any method; in which female sterilisation is the major method. Only 29 percent had the proper information regarding the antenatal care and they possessed faulty knowledge and myths towards sexual health. It also found that the higher fertility decisions are influenced by high infant and child mortality among the tribal community.

Susuman (2006) studied the contraceptive practices and son preference among selected tribal communities in Tamil Nadu. A household survey was conducted among 398 currently married women from the age group of 15-49. The study found that the demographic and socio-economic variables are strongly linked with the contraceptive practices among the tribal women in the study area. Results also revealed the son preference among tribal women based on the expectations around the financial care in old age. In addition to that, study found that the tribal women who have more son preference are likely to use spacing methods compared to other tribal women. It also found that the high educational and occupational status of husband had a positive impact on the contraceptive use and negative influence on high fertility among tribal women.

Nagda (2004) examined the RCH among tribal population in Rajasthan. Researchers used both primary and secondary sources for data collection such as ethno-demographic literature, Census, NFHS-2 data, surveys, in-depth interviews and focus group discussions. It was found that the Rajasthan has 12 percent tribal population and the growth rate was higher than the State average. 58 percent of the tribal women and 80 percent of tribal children are anaemic. Additionally, the number of deaths related to pregnancy is also higher among them and majority of the participants were illiterate. The incidents of domestic violence are also reported high among them: 62 percent suffered physical abuse and 83 percent had verbal abuse. It was found that the alcoholism, smoking and unemployment of husband are the major factors behind the high rate of domestic violence. It was also found that only 29 percent were using contraceptive methods and female sterilisation is the major method preferred by them. Furthermore, 86 percent of home deliveries reported and they are depending more on the traditional health care system. It was also revealed that 74 percent of them avoided colostrum.

Maharatna (2000) reviewed the prevailing literature accessible on fertility, mortality and gender bias among the tribal communities in India. It was revealed that the demographic and RH status of tribal communities is lower compared to non-tribal communities in majority of regions. A shift from egalitarian gender relations is noticed and more gender bias are reported among them. The review concludes that the strong steps have to taken in order to balance the lag in the development of tribal communities in comparison with the non-tribal communities.

2.3 Summary and Research Gap

The review of literature revealed that the earlier studies related to the RH of tribal women shows an interplay of various factors, which are mutually reinforcing each other, creating a vicious cycle and it has an impact on the SRH of tribal communities. However, most of the previous studies relating to RH of tribal women have focused on the topic from the individual rights point of view, which has often led to the exclusion of the social context from which the rights should be defined and realised (Price & Hawkins, 2007). In the context of SDGs, exploration of lived experiences of tribal women from an intersectional perspective is necessary in safeguarding their sexual and RH rights. Furthermore, there is not much research in

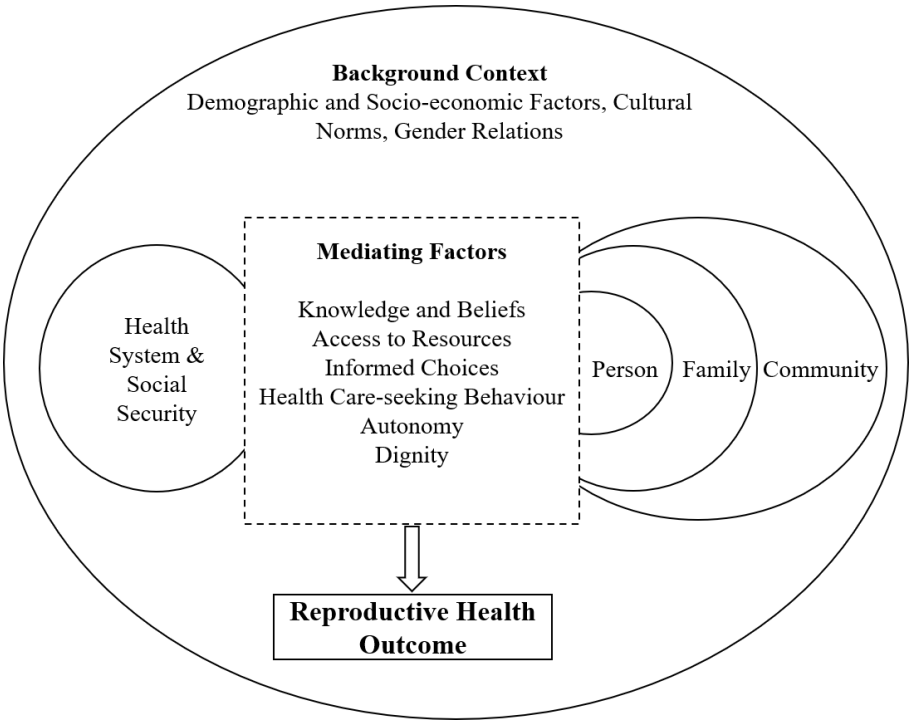
the literature about the intergenerational changes related to the RH status of tribal women in India as well as in Kerala. Thus, conducting an intergenerational study using feminist methodologies in the particular study area would enrich the feminist scholarship in this area.

2.4 Conceptual Framework of the Study

Based on the review of the available literature, the variables were identified and classified. The conceptual framework includes contextual factors, mediating factors and RH outcomes (see figure 2.1). The contextual factors include demographic and socio-economic factors, cultural norms and gender relations and these factors has influence on the mediating factors, which include knowledge and beliefs, access to resources, informed choices, health care-seeking behaviour, autonomy and dignity. These factors are also determined by the influence of institutions such as family, community, health system and social security networks. At last, the interplay of contextual and mediating factors determines the RH outcomes.

Figure 2.1

Conceptual Framework of the Study



Conclusion

This chapter discussed about the theoretical framework adopted in the study and reviewed the literature related to the RH of tribal women. The first part detailed the feminist stands on reproduction and described the use of intersectionality as a tool in right based framework. In the second part, various studies were reviewed to identify the research gap and formulate a conceptual framework for the study.

Chapter 3

RESEARCH METHODOLOGY

CHAPTER 3
RESEARCH METHODOLOGY

Introduction

The chapter presents the feminist methodological approach used during the research process in order to answer the research questions. It begins with an introduction in to the study context and discusses about the research questions, objectives and participant recruitment. Then it discusses about the data collection procedures and reflects on the experiences and challenges faced throughout the data collection process in detail. It further discusses about the ethical considerations in the study. Lastly, it discusses the data analysis process and structuring of findings.

3.1 Understanding the Study Context

'Holding his child's body, Attappadi man walks 4 km through forest in rain'

Mathrubhumi.com, 13 July 2022

'One more infant dies in Attappadi, sixth this year'

The New Indian Express, 9 August 2022

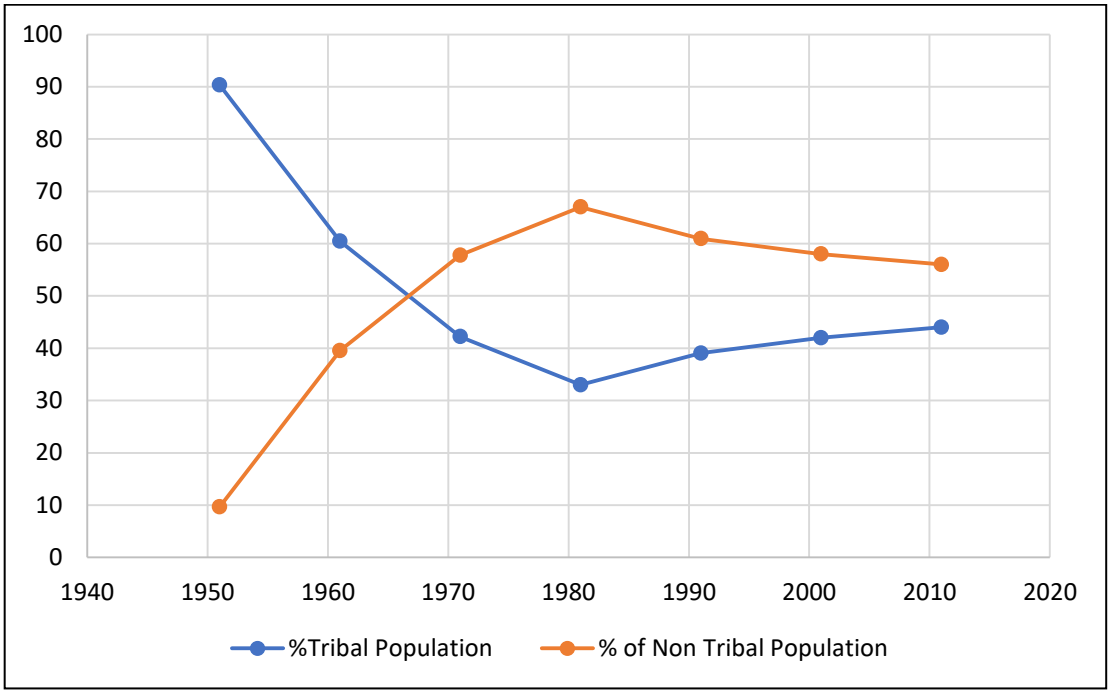
'Kerala: Pregnant Tribal Woman Carried on Makeshift Stretcher for 3.5 km Due to Lack of Proper Roads'

The Logical Indian, 12 December 2022

Kerala, a southern Indian state has witnessed rapid and unparalleled development in the health profile of its population. Nevertheless, disparities in health outcomes persist across social boundaries**.** Attappady, the only tribal block in Kerala situated in Palakkad district. It has a total population of 70,000 and only 44 percent of them constitute tribals. Attappady has faced major demographic changes since post-independence due to the uncontrolled migration of people from central regions of Kerala and settlers from Tamil Nadu (Haseena, 2020). The growth rates of population in Attappady is given in figure 3.1.

Figure 3.1

Growth Rates of Population in Attappady



Source: ITDP

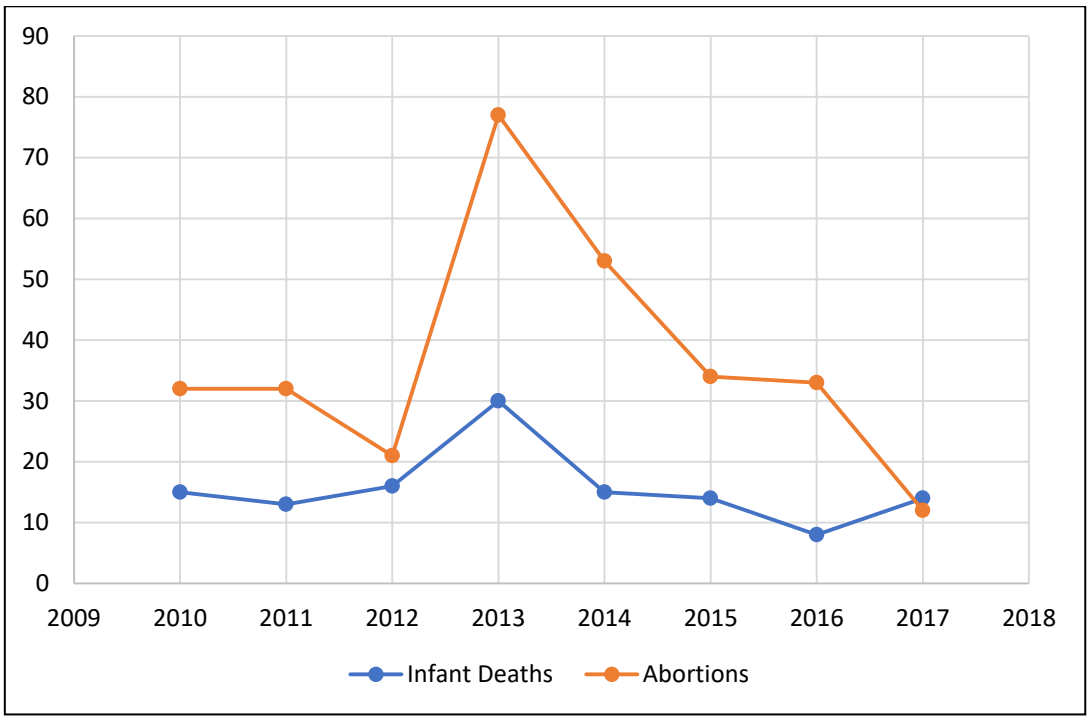
The Attappady block is divided into three Grama Panchayaths, Agali, Pudur, Sholayur. 192 tribal hamlets are situated the valley including three tribal communities, Irula, Muduga and Kurumba. Development efforts in the valley have resulted in slightly positive improvements in education, health and livelihood attainments of tribal people. According to Athira and Nalini (2022), the health system and the healthcare seeking behaviour of tribal communities in Attappady have improved. It consists of one Tribal Speciality Hospital, one Community Health Centre, three Primary Health Centres and 29 Family Welfare Sub Centres in that valley. Besides that, eighty-five ASHA workers, 175 Anganwadies and 182 community kitchens are also functioning there. Despite these efforts from government and NGOs, maternal and child health complications are still being reported from the valley (Kareem, 2019).

Although, Attappady has witnessed various development programmes since 1970s, it remains as one of the most backward blocks in Kerala. Tribal communities are facing poverty and malnourishment for more than 50 years now. The studies critically evaluated the impact of development programmes in Attappady. They pointed out that the development efforts such as Attappady Hill Area Development Society (AHADS) and PDS were a failure and inefficiency and delay in implementation lead to the poor performance of various programmes (Haseena, 2020; Nair & Saisree, 2021).

The Iqbal Committee report found that the majority of the mothers were anaemic and lacked nutrition to deliver a healthy child. Thus, the average infant weighed around 600-800 gram and most of the children were affected with intra uterine growth retardation (Pariyaram Medical College, 2016). High incidence of maternal anaemia including sickle cell anaemia, pregnancy induced hypertension and obstetric complications are prevalent among the Irula, Muduga and Kurumba communities in Attappady (George & Beegom, 2019; Kareem, 2019; Murshid & Krishnaprabha, 2018). Besides that, overweight and obesity issues are also increasing among the tribal women in Attappady (Indian Council of Medical Research ICMR] & National Institute of Nutrition [NIN], 2023). The details regarding the infant deaths and abortions in Attappady from 2009 to 2018 made by the authors based on various news reports given in figure 3.2.

Figure 3.2

Infant Deaths and Abortions in Attappady from 2009 to 2018



Source: Authors made based on various News Reports

In 2013, the IMR in Attappady was 32 per 1000 live births (Kozhisseri, 2019), the upsurge in infant deaths, represents the historic inequity in the state compared to 6 per 1000 live births in Kerala as per NFHS 5. The IMR in Attappady is still higher among tribal communities than that of the general population in Kerala (Edison & Devi, 2019). As per *The Logical Indian* news report of May 2022, the State Integrated Tribal Development Programme reported at least 300 abortions, 90 intra uterine deaths and 21 still births since 2012 (The Logical Indian, 2022). According to the National Institute of Nutrition, between 2012 to 2021, 136 neonatal/infant deaths were recorded and mean age (in days) at death was 49 days of birth. Acute respiratory syndrome, preterm birth, congenital heart disease, extremely low birth weight, milk aspiration, intrauterine growth retardation and congenital anomalies are reported to be the major causes of these deaths. At the time of death, 27 percent of children were at home without any medical attention. It also found that, malnutrition rates among Attappady children are much higher than in

comparison to other children in Kerala. They have 2.3 times higher chances of having anaemia and 1.7 times higher risk of being stunted. There is a decrease in the rate of stunting, underweight remained stagnant, however rate of wasting has increased (ICMR & NIN, 2023).

All the above news reports show the current status of social exclusion and marginalisation faced by the tribal communities in Kerala. The lack of transportation facilities, delay in accessing healthcare services and persisting maternal and child health complications are prevalent in the Attappadi valley.

3.2 Research Questions

The main question, what are the intergenerational changes related to the reproductive health status of tribal women, is operationalised through questions 1 -3 while question 4 addresses the influence of the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

1. What are the demographic and socio-economic conditions influencing the reproductive health of tribal women?
2. How does the myths and misconceptions affect the reproductive health of tribal women?
3. How far do women exercise their reproductive health rights and what are the challenges faced by them in the process?
4. How do intergenerational changes influence the positionality of tribal women and contribute to their reproductive health experiences?

3.3 Research Objectives

The fundamental objective of the research is to explore the intergenerational changes in the reproductive health status of tribal women. The process of adapting the research objectives happened inductively in this study. The in-depth, dyadic interviews explored the prevalence of deep rooted myths and misconceptions related to reproductive health among the tribal women and it was incorporated as a second

specific objective in order to maintain the logical flow of inquiry in the study. So, the first two specific objectives provide a contextual understanding and the third objective analyse the extent of access to reproductive health rights by examining the reproductive health challenges.

Major Objective

- To explore the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

Minor Objectives

- To analyse the demographic and socio-economic conditions affecting the reproductive health of tribal women
- To explore the myths and misconceptions prevalent among tribal women in terms of reproductive health
- To assess the extent of access to reproductive health services by examining the challenges faced by tribal women
- To suggest measures for promoting reproductive health among tribal women

3.4 Methodological Approach and Design

Feminist qualitative research originates with the understanding that all knowledge is positioned in the bodies and subjectivities of people, predominantly women and marginalised groups; truth and knowledge are inseparable from the lived experiences of the researched (Haraway, 1988). Feminists have criticised traditional quantitative research in which the participants are transformed into "object-like subjects" (Unger, 1983) where "their voices are silenced and their experiences are invalidated, occluded or erased" (Woolgar, 1983). In addition, they have constantly insisted on the importance of social context, which is essential in the quest for valid knowledge creation based on women's voices and experiences.

Qualitative research offers prospects for establishing trust and rapport building with the research participants. It is essential to deliberate sensitive topics

such as sexuality, sexual health, contraception, maternal and child health, and infant deaths. (Lee, 1993; Liamputtong, 2013). Thus, descriptive design from a qualitative approach was chosen for this study to provide a holistic understanding of the RH status of tribal women.

3.5 Study Location and Preparations for Data Collection

Attappady block is situated in the Western Ghats and consists of Agali, Sholayur and Pudur grama panchayaths. According to Integrated Tribal Development Programme (ITDP, is a tribal development programme under Kerala Government) statistics, it is estimated that 44 percent of the population consists of tribal people with an average literacy rate of 62percent. Irula (82%) Muduga (10%) and Kurumba (8%), a PVTG group are the major tribal communities in the study area and they are distributed in 192 hamlets. Of those, 149 are Irula hamlets, 26 Muduga hamlets and 19 are Kurumba hamlets and majority of the Muduga and Kurumba hamlets are situated in the interior forest (ITDP, n.d.).

As the study participants included in the vulnerable population group, the researcher had to acquire permission from several governmental institutions, in order to carry out the study. Due to COVID-19 pandemic, the procedure got more complex and time consuming. For field access, a request letter and documentation including the research proposal, biodata of the research scholar and the supervisor, interview schedule and a plan for fieldwork were submitted at the Sub-collector office. Covid vaccination certificate had to be given for request initiation and the verification process took almost two months. Five months permission was granted to the researcher by the Sub-Collector’s office and a bond was signed with the ITDP project officer, which also mandated assistance of field level workers (STPs) during the course of the fieldwork. The researcher was given strict guidelines such as the follow up of pandemic protocols and timings in the field during the entire course of the work. For accessing research participants from the Muduga and Kurumba tribal communities, a separate permission from the Forest Department was taken, as the participants lived in the remote parts of the forest. Arranging transportation, confirming the availability of the accompanying staff from ITDP and the forest

department along with ensuring the convenience of the research participants was both challenging and exciting. However, the researcher encountered certain problems and limitations in the process of gaining access to the participants.

3.6 Participant Recruitment

Qualitative research is primarily concerned with the in-depth engagement of participants rather than being representative in nature (Bryman, 2015). In feminist research, in order to obtain an in-depth understanding of an issue it is preferable to work with small samples. Here, priority is given to the process or meanings of the shared experiences (Hesse-Biber, 2014). This qualitative research was aimed to explore the RH experiences of the tribal women from a feminist perspective, giving prime consideration to the women's voices and experiences from an individual perspective. O'Reilly and Parker (2012) argue that purposive sampling aims to recruit a wide range of research participants to ensure diversity of experiences by collecting rich data. Therefore, the study adopted purposive sampling, a non-probability approach, as the main strategy for participant selection by contacting the ST promoters, the field level workers working under the ITDP, who are assigned to assist the researcher in the field as per the sub-collector's instructions for conducting field work.

It was difficult to select the research participants, as the research focuses on interviewing dyads, which consist of mothers of under-five children (at least one under-five child, so they could share recent experiences) along with their grandmothers, as most of them stayed apart, either in their maternal hamlets or their husband's hamlets which were not easy to access. Besides that, the pandemic restrictions made it more difficult to access them. Thus, the researcher included mothers in-law instead of their mothers as study participants. The ST promoters were the primary contact points to the hamlets and the participants were identified with their help. Moreover, the participants were selected proportionally from the three tribal communities.

Table 3.1

Profile of the Study Participants

Tribal community	Proportion in the total population (%)	No. of dyads taken
Irula	82	36
Muduga	10	5
Kurumba	8	4

Source ITDP

Irula, Muduga and Kurumba tribal communities constitute 82, 10 and 8 percent respectively of the tribal population in Attappadi. Thus, the sample was taken proportionally to the population of tribal communities. Out of 45 dyads, 36 belong to Irula, 5 belong to Muduga and 4 belong to Kurumba tribal communities.

3.7 Operational Definitions

The key terms and concepts used throughout the thesis are defined below for clarity.

- **Reproductive Health Status:** In the present study, reproductive health status denotes the status of women concerning their RH events during their reproductive age. It includes menstruation, marriage, sexuality, family planning methods, and pregnancy and childbirth.

- **Intergenerational:** In the particular study, it is operationally defined as a dyad consisting of young tribal mother along with her mother or mother in-law, from two consecutive generations of tribal women residing in the study area.

- **Tribal women:** Is operationally defined as the women belonging to Irula, Muduga and Kurumba tribal communities in the study area.

- **Young woman/young mother:** Tribal woman in the reproductive age, who has at least once child below the age of five, residing in the study area. And both terms are interchangeably used throughout the thesis.

- **Elder woman/grandmother:** Tribal woman, who is a mother or mother in-law of young woman residing in the study area. And both terms are interchangeably used throughout the thesis.

3.8 Inclusion Criteria

The study attempts an intergenerational comparison of RH status of tribal women in Attappady. Hence dyads which consist of mothers of under-five children and their grandmothers who belong to the three tribal communities of the valley were included in the study.

3.9 Exclusion Criteria

The tribal young mothers who did not have at least one under-five child or who did not have mother/ mother-in-law were not included in the study. Non-tribal women who are married to tribal men were also excluded from the study.

3.10 Doing Feminist Research in Field: Data Collection Methods

Dyadic interviews consist of interviewing pairs of people, who share a pre-existing relationship. It enables the research participants to co-construct the knowledge by interacting with each other while sharing their lived experiences regarding the research topic (Morgan et al., 2013). The particular feminist research focuses on the intergenerational changes in the sexual and RH experiences of tribal women by taking the mother-grandmother dyads as a unit of study. In the context, the researcher administered dyadic interviews which brought mother- grandmother dyads together and explored their lived experiences in order to understand the intergenerational changes that might have happened over the last few decades.

Both separate and joint interviews with the same participants were used to balance the advantages and the disadvantages (Eisikovits & Koren, 2010) by considering the sensitive nature of the research topic. The in-depth semi- structured interview guideline was developed based on the literature review of the previous studies. Some parts of the interview guideline needed careful consideration; especially the sexuality and contraceptive related topics, thus those parts were

interviewed separately to ensure privacy as well as to encourage personal narrative without being judged for their experiences. But the other topics were interviewed jointly, where participants shared their experiences, shared stories, collective memories, perspectives, agreements and disagreements. This helped the respondents to understand the intergenerational changes happened over the decades. Thus, the dyadic interviews were a more appropriate choice for the particular research.

In-depth interviewing allows feminist researchers to explore the lived experiences of the study participants. It is a popular method in feminist research and helps to uncover the subjugated knowledge of the oppressed groups such as tribal women. According to Reinharz (1992),

> Interviewing offers researchers access to people's ideas, thoughts and memories in their own words rather than in words of the researcher. This asset is particularly important for the study of women because in this way, learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women. (p. 19)

As the in-depth interviews are issue oriented, they help in procuring rich data from the perspectives of the researched. An interview guide was constructed based on the conceptual framework for the interview process. Special attention was given to maintain the fluidity of the participants' communication. Active listening and the effective use of probes facilitated effortless communication.

As suggested by Patton (1990), method of triangulation offers the multiple use of methods to understand complex issues and the researcher conducted 10 case studies to substantiate the data collected through in-depth interviews. Case study is a common qualitative method to closely examine complex issues. According to Yin (1994), case study is "an empirical inquiry that investigates a contemporary phenomenon in its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p.13). Thus, incorporating case studies facilitated a comprehensive understanding of the specific issue.

3.11 Data Gathering: Opportunities and Challenges

The gatekeepers -field level workers or ones who hold managerial positions with access to the field and to potential participants – have to be incorporated into the study by the feminist researchers (Bell, 2014). The researcher had immense help from the field level workers who served as the main access points into the field and helped to enhance the researcher's knowledge of the field. The researcher acknowledges their vast experience in the field and their work integrity. The strict monitoring of the research work at various levels was intended to ensure the safety of the researcher and the researched. Accessing the field, building communication with the community members and gaining their trust was a gradual process. Decisions regarding the choice of the participants was left to the discretion of the field level officers which would have affected the choice of potential subjects and thus reflected in the research outcomes. The subtle play of gender relations was visible in the process of gatekeeping. The gatekeepers being mostly males, the young female participants showed signs of hesitancy in opening up during the interviews. Compared to the elderly population, it was easier for the researcher to communicate with the younger women because of several factors like age, language and relatable health experiences. Moreover, the researcher's identity of being a married woman helped to build the rapport effortlessly. The researcher also made a conscious effort in dressing: churidars or kurtas were mostly the dress code adhered to which was familiar to the participants.

The place and time of the interviews was decided in mutual understanding with the participants. Priority was given to the convenience of the participants as they would feel less comfortable to talk in public about emotional and sensitive personal experiences; homes, worksites of MGNREGA and community halls were preferred by them. Participants who satisfied the inclusion criteria were contacted first and the researcher explained to them about the purpose of the visit and procured informed consent from them. During the course of the interviews, the researcher allowed the natural process of narration to unfold with least interference. The talks were sometimes interrupted by household chores or the demands of child care

during which the researcher waited or arranged later sessions. The researcher faced certain language constraints in the field being an outsider, as the participants used specialised local phrases in their talks. For example, '*vayasariyikkukka*' means getting the first periods, '*kuttikittuka*' means getting pregnant, '*onnichirikkuka'* means involving in sexual act, '*kallakal'* for abortion, etc. It was difficult to understand their usages initially, but later on, the researcher was able to identity and utilise those words during the interviews, which helped to communicate effortlessly with the participants.

Majority of the responses were positive, but a few raised their concerns about the purpose and the impact of the study outcomes. The researcher acknowledged their concerns and clarified it. The research participants used the opportunity for clearing doubts on related topics and it facilitated the raising of awareness, which is a fundamental goal of feminist research. They said that there had been so many visits and interventions happening for various purposes, but despite all efforts, they still have infant deaths and MH issues. "What would we know… the government knows everything, right," an elderly woman expressed her disappointment in a sarcastic way.

Fieldwork during the pandemic was not without its challenges. Alternatives to physical presence in the field was thought out in the form of telephonic or online interviews; but considering the nature of the study site and the infrastructural constraints, data collection methods were not changed. The field work was delayed for several months due to potential health concerns, practical and technical challenges of reaching the field such as approvals from government institutions, vaccination requirements and transportation facilities during the pandemic induced lockdown. Government guidelines required the researcher to incorporate slight changes in the research plan which were included also in backdrop of further challenges. Necessary precautionary measures like the use of face masks and sanitiser, isolation in case of any symptoms of illness and occasional RTPCR tests were taken by the researcher. Lack of availability of vehicles and the rugged nature of the terrain posed obstacles in terms of accessibility to the field. Only a few

hamlets were connected by means of public transport; people generally prefer to walk, travel by jeep, autos or two-wheelers as the terrain allows.

The researcher walked long distances through bad roads which aggravated her post-Covid health condition. Precautionary measures were mostly one-sided with the participants not wearing masks and the villages thickly populated, which increased the chances of further infection. At times, private vehicles had to be arranged by the researcher. Mobile connectivity was poorer in the valley which affected communication with the field level workers/ gatekeepers. A few hamlets like the Murugala and Kinnatukara had neither sufficient transportation nor communication facilities. The participants and the field level workers walked long distances in order to make calls or send messages. Despite infrastructural limitations their participation in the field work was exceptional which needs to be appreciated. Staying in the field for months on end was exciting as well as challenging for the researcher, being a woman hailing from a middle-class background; the researcher also faced uncertainties, insecurity and safety concerns at times during the stay.

Mobile connectivity was also limited in the valley and it created hurdles in communicating with the field level workers/gatekeepers. Particularly, a few hamlets in the interior forest like Murugala and Kinnatukara, lacked both transportation and communication facilities. The participants from these hamlets and the field level workers had to walk long distances to send a message or to make calls. The researcher would like to appreciate their remarkable efforts during the fieldwork despite these infrastructural limitations. As a middle-class young woman researcher, it was both challenging as well as an exciting task to conduct the fieldwork by staying in the field for months. The researcher had to face uncertainties, insecurities and safety concerns during the fieldwork.

3.12 Ethical Considerations

According to Bell (2014), feminist researchers have to focus on the eight key aspects of ethical practice: beneficence; privacy, anonymity and confidentiality; informed consent; disclosure and potential for deception; power relations between the researcher and the researched; ownership of research findings; ensuring the

rights of vulnerable populations, dignity, self-determination and justice and finally has to obtain formal ethics approval. Therefore, the researcher obtained ethical approval from the Calicut University Ethics Committee for Human Research and abided by all the ethical considerations and also adhered to the pandemic protocols during the fieldwork tenure.

3.12.1 Informed Consent

Informed consent aims to guarantee the human subject's right to know about the study and empower the participants to approve, reject or even withdraw from their participation at any point of research work (Homan, 1991). The researcher explained in detail the nature and purpose of the study to the participants through a participatory information sheet. Moreover, they were informed about their choice to not answer any particular questions which they feel uncomfortable with. It was communicated with the participants in an understandable language and written consent was taken from all the participants prior to the face-to-face, in-depth interview sessions. The participants were provided with an opportunity to seek further clarification if needed until they were satisfied and only voluntarily decided to participate in the study.

3.12.2 Privacy, Anonymity and Confidentiality

The privacy of the research participants during the interviews were protected by arranging the meeting place as per their convenience. As the study deals with women's RH experiences, a few participants hesitated to open up in the presence of their family members and gate keepers. For example, the researcher when enquired to Geetha about the use of family planning methods, she responded, "Please talk softly, my mother-in-law does not know about it (*contraception*). She wants more children, but I do not." In some other instances, a few young women expressed concerns about sharing their experiences in the presence of male gatekeepers. So, the field level workers were requested to provide space for the participants in order to ensure their privacy.

The anonymity of all the participants was guaranteed by using pseudonyms and ensured that the reported quotes and incidents are not traceable to the participants. Though the interview sessions were audio recorded, the entire data was protected in order to maintain anonymity and confidentiality. The researcher also acknowledges that, as part of the academic process, research findings would be available to the public at the end of the research work and a copy of the work will be submitted to the government as per the permission guidelines. The details were communicated with the respondents while explaining the participatory information sheet and that precautionary measures were taken into consideration throughout the research work.

3.13 Data Analysis and Structure

The in-depth interviews were audio recorded using mobile phones, once informed consent was received. The researcher shifted from the use of voice recorders to mobile phones for the recording of interviews as the participants were more comfortable around the latter, perhaps due to familiarity with the device. The voice recordings in the regional language were promptly transcribed, including verbatim transcripts along with non-verbal responses like emotional cues, and then translated into English; the transcription and translation was promptly done with the reflections and observations recorded in a field diary. The field notes were referred to regularly and this habit helped the researcher to remember the experiences and responses of the participants during the interview process. This enabled the researcher to understand, reflect on and interpret the data which is sensitive in nature. The codes generated in the second stage were based on the characteristics of this data. All the coded data with similar experiences or ideas were linked together under themes which would help to "capture and unify the nature or basis of the experience into a meaningful whole" (DeSantis& Ugarriza, 2000).

Codes and themes were inductively arrived at from the data collected with the subsequent methodical presentation of research findings at two levels: descriptive and interpretive. At the descriptive level, extracts from interviews were included to provide an insight into the immediate life experience of the participants.

A framework based on the rights of participants, with intersectionality as a tool to analyse the data, was utilised at the interpretive level. The complexities of multiaxial oppression faced by the tribal women in terms of their sexual and RH experience was understood through the application of intersectionality.

The analysed data, backed by the research objective is presented in the research work in four chapters. The *first chapter* gives a brief understanding of the socio-economic characteristics of the participants and the demography of the area of study. The *second chapter* provides an exploration of the "Myths and Misconceptions" prevail among the tribal women regarding their RH behaviours and practices. The *first two chapters* are foundational, in that they attempt to place the RH experiences and challenges faced by the tribal women in the context of their lives which are influenced by several factors. The *third chapter* dwells on domains of marriage, sexuality, sexual health and family planning experiences, while the *final chapter* deals with pregnancy and childbirth experiences of the tribal women.

Conclusion

This chapter has discussed the feminist methodological approach and data collection procedures in the study. It started with an introduction into the context of the study area. After that, research questions, objectives, participant selection, data collection procedures and challenges were also described in detail. It also discussed about the ethical issues that were considered in the study. Lastly, it discussed about the data analysis process and the structuring of analysis chapters.

Chapter 4

DEMOGRAPHIC AND SOCIO-ECONOMIC CONDITIONS OF TRIBAL WOMEN

CHAPTER 4
DEMOGRAPHIC AND SOCIO-ECONOMIC CONDITIONS OF TRIBAL WOMEN

Introduction

This chapter deals with the first specific objective, which identifies the demographic and socio-economic factors influencing the RH experiences of tribal women. It includes age, educational attainment, access to basic infrastructure facilities such as water, housing, sanitation, transport and communication. It also deals with the land, livelihood, and food and nutritional security issues among the participants. Furthermore, it looks into the substance use, alcoholism and related incidents of violence among them. The chapter provides a comprehensive understanding about the importance of demographic and socio-economic context, and its influence on the RH outcomes of tribal women in the study area.

4.1 Age of the Participants

The mean age are 28 years and 52 years respectively for young mothers and grandmothers. As mean age at marriage is 20 among younger generations, it is higher than that of the older generations. Similarly, there is an increase in the young mothers' mean age at first pregnancy. It is 21 and 18 respectively for the mothers and grandmothers. If we are looking into the mean spouse age-gap, it has decreased among young mothers. The details are presented in Table 4.1.

Table 4.1

Age of the Participants

Indicators	Total (N)	Mean age of participants Years (±SD)	Mean age at marriage Years (±SD)	Mean spouse age-gap Years (±SD)	Mean age at first pregnancy Years (±SD)
Mothers	45	28.4 (±4.84)	20.11 (±3.05)	3.51 (±3.22)	21.33 (±3.18)
Grandmothers	45	52.17 (±7.28)	18.31 (±2.16)	5.83 (±5.87)	19.84 (±3.29)

Source: Primary Data

4.2 Educational Attainment

Education plays a significant role in safeguarding the RH rights of women. Numerous studies have found the positive correlation between the education of women and their utilisation of maternal and child health care services. Increase in education of mothers improves their capabilities thus would promotes child survival and reduces maternal mortality (Jat et al., 2011; Jose et al., 2014; Kumari & Kshatriya, 2017; Susuman, 2012). The education level of study participants along with that of their husbands is presented in Table 4.2.

Table 4.2

Educational Attainment of the Participants and their Husbands

Qualification	Mothers %	Fathers %	Grandmothers %	Grandfathers %
Up to 10	29	49	96	98
SSLC	31	24	2	2
Plus Two	22	27	2	0
TTC	9	0	0	0
Graduation	7	0	0	0
Post-graduation	2	0	0	0
Total (%)	100	100	100	100

Source: Primary Data

The results found that 40 percent of the mothers have plus two or above education compared to the two percent of grandmothers which clearly indicates the increase in education among younger generation. However, many women reported that, although they have education, they lack employment opportunities and have ended up working in agriculture or enrolled for MGNREGA work, which is flexible as it provides immediate access to income. “Manju,” a 26-year-old young mother, who is graduated in science shared,

> I have completed my graduation in first attempt with high score. After that I tried to write few exams for government jobs. However, my parents wanted me to be married. So, I married my lover, who is a daily wage worker from

the nearest hamlet. After marriage, I got pregnant immediately and could not try for more employment opportunities. After my pregnancy, I enrolled in MGNREGA work, which is very flexible for me.

Few other young women also shared similar experiences and very few of them expressed their regret in not getting enough employment opportunities at par with their educational qualifications.

4.3 Possession of Identity cards

All the participants possess Aadhar and Health insurance cards. But 11 percent of the younger women do not have Voter ID card. Of those, few have submitted applications and the procedure is progressing. But the other few are not much concerned about it as they possess Aadhar card. The data in this regard is summarised in Table 4.3.

Table 4.3

Possession of Identity Cards

	Voter ID %	Aadhar %	Health Insurance %
Young Women	89	100	100
Elder Women	100	100	100

Source: Primary Data

4.4 Access to Water, Housing and Sanitation

Access to clean water, proper housing and household and community sanitation facilities are crucial for better maternal and child health. Poor water and sanitation practices increases the risk of maternal and child morbidities and mortalities (Campbell et al., 2015; Saleem et al., 2019; Schuster-wallace et al., 2019) and put burden on women's physical and mental health, time and privacy (Mahon & Fernandes, 2010). Studies have found housing instability to adversely affect the maternal and child health outcomes. It leads to anaemia, maternal hypertension and haemorrhage during pregnancy, pre-term birth and low-birth weight among children (Muchomba et al., 2022; Pantell et al., 2019).

Majority of the participants have access to clean water and they are depending on multiple sources to meet their needs. Yet they face difficulties at various times in a year depending on the availability of water. Mostly people are aware about the safe drinking water practices. Majority of the people drink boiled water and the sources of drinking water vary from Jalanidhi, rivers and streams. Jalanidhi is one of the major government initiatives in the valley to ensure water security. But in a few hamlets, the pipe connection and the motor facilities remain damaged for years and people spend their own money for buying new pipes and motors. In some hamlets, people have arranged pipe connections from the rivers and streams for water availability. In a very few hamlets, people have no direct access to rivers or streams, so they dig well/pond in private land by giving money and lay pipe connections to houses. The black color pipe lines through trees and across roads is a common scene in hamlets. People in those hamlets situated near Siruvani or Bhavani rivers and other small streams, prefer to wash, bath and do cattle rearing in the flowing water.

“Mari,” a 59-year-old elder woman shared,

> earlier, we used to live near our fields, which was mostly near the river or streams. We also depended rain for our needs. In my childhood, we used harvest rain water: even collected running water from trees using vessels made out of areca nut leaf sheaths. But nowadays rivers and streams got contaminated.

They also shared that, now people are used to living together in hamlets which may or may not situate near water resources which in turn affect the access to water. Meeting the needs of entire people and livestock may lead to water stress and pollution. Studies have pointed out that sanitation facilities and access to clean water are low in Attappady compared to the State data and it is increasing the risk of communicable diseases, consequently deteriorating the maternal and child health (Thomas et al., 2021).

The results of the present study reveal that, 38 percent of young women and 98 percent elderly women possess own house under various government schemes. It

is also found that, 62 percent of the young and 98 percent of the elder study participants have proper sanitation facilities and they are using it. Others have no proper sanitation facilities and some of them are using their natal home and neighbouring home facilities for sanitation purposes. Murugala, an interior Kurumba tribal hamlet, situated near the banks of Bhavani, have no toilet facility at all. The hamlet people are going to the bushes/ forest for their toilet purposes. They have also given applications for government grants and are still awaiting their turn.

31 percent of them, who do not have own house, got house permission through various government schemes, such as LIFE Mission. Karuna is a 38-year-old Irula woman, who is currently living in her natal hamlet near her family. She also has made a shed in her father's land and is using her parental home facilities for sanitation purposes. She has secured house construction permission under LIFE mission and her own house is under construction in her husband's hamlet.

69 percent of those who do not own house, are still waiting for their chances and few reported that as they lack own land, they are being denied of their right to have a safe shelter. Vanni, is a 33-year-old Irula woman, who has been trying for house permission for years now. Every time, she got denied because she and her husband have no land in their name. Currently she is living in an old, unused house in the hamlet and it has no sanitation facilities. She has two young daughters and she is worried of their safety also.

Those study participants who do not own house (majority are young mothers) either are living in rental (not giving money, they will choose old, unused houses in the hamlet) or build a shed for housing in their land. Pavitra, a 33-year-old Irula woman, live in a shed, built in the backyard of community hall in the hamlet. It is a small hut (less than 200 sq. ft), with thatched roof and sheet in between, the wall is made of wood and kitchen is also included in that space. They have no toilet facility and water connection in the current living space and they are using her natal home facilities for sanitary purposes.

Similarly, Deepthi is a 22-year-old Irula woman, who used to live with her in-laws. Since the in-laws are alcoholic, she is not happy to live there with the one-

year-old child. So, they returned to her hamlet. Her father has some land and they have built a shed (less than 200 sq. ft) in a corner of it. They cleaned the land, built half wall with mud and used wood to build the structure of wall and roof and covered it with sheet. The house has one room and one kitchen with a door. The surrounding courtyard is besmeared with cow dung. They have no toilet facility and are openly defecating. They have built a small shed, covered with cloth for bathing.

Even though few young women have access to proper housing, they lack sanitation facilities. Laya, a younger mother, though have toilet facility in their house, is not currently using it. Its door got damaged and currently they are defecating in the open. Her sister-in-law also has no toilet facility in her home and her family also used to depend on Laya's family facilities. But now both the families are waiting for government grants to fix the issue with the damaged door. In another incident, Shari a younger mother, lives with her husband in his hamlet. They have no toilet facility in their house. She depends on her neighbour's toilet and her husband go outside in the bushes. Her in-laws are living in a hut in their forest land, doing farming there. That hut also has no toilet facility and they prefer to go outside in the bushes. They are also waiting for the government schemes for aid.

Over the years, the valley has witnessed better access to secured homes, clean water and sanitation. However, the results of the present study reveal that the tribal young women still face issues in these aspects which cause physical and mental health issues in them, specifically because of their gender identity. However, the concerns raised regarding their over dependence on government for meeting their basic needs, emphasise the need for improving their capabilities by providing sustainable options.

4.5 Communication and Transportation Facilities

Communication and Transportation facilities are critical in maternal and child health care, serving as a link between home and health care facilities. The effective use of mobile technologies enabled with internet facilities would positively impact the maternal and child health outcomes. It would help in advancement of knowledge and practices among mothers as well as improve the efficiency of health

care professionals. Several studies have exposed the effectiveness of mobile network with internet connectivity in improving maternal and child health (Balogun et al., 2020; Dahdah & Kumar, 2018; Musiimenta et al., 2020). Along with the communication facilities, access to transportation is critical in ensuring risk appropriate maternal care of women especially from rural areas (Burch & Spinnato, 2021). Lack of vehicle support forcing pregnant women to use risky methods of travel consequently put mothers and children at risk (Atuoye et al., 2015).

Although newspaper reading is not prominent among hamlets, majority of the houses have access to television and cable connection and women are used to see films, serials and songs. 44 percent of younger women ever had access to smart phones and others are using keypad phones. Few elder women are also using the keypad phones. Though the internet availability is very limited in hamlets, they mainly use the internet in order to explore YouTube and Google search. They search cooking channels, nutrition diet for children and mothers during pregnancy and first year of child growth, post caesarean care for mothers, breast feeding and solid food options. They also search about weight loss exercises after pregnancy, self-employment opportunities like tailoring and PSC coaching classes.

"Preetha," a 32-year-old Muduga woman, used to have smartphone until few months back. It got damaged and currently she is using the keypad phone. When the researcher was reaching her home, she kept her phone in front window, towards right, a particular place where the connectivity is available. That is the only place in her home with good connectivity. In her words,

> I am preparing for PSC exams, I do not have connectivity in my home. So, I study either in the community hall, which is 50 meters from my home, or in front of my house where there is an electric post on the road.
>
> She pointed towards the electric post while saying this.

During the pandemic, few of the participants got help from governments and NGOs, with electric gadgets like, television, laptop and mobile phone. Even though few of them possess electronic gadgets, lack of network connectivity is creating

hurdles in effective communication. Murugala and Kinnatukara are Kurumba hamlets, situated in interior forest. They do not have network connectivity in their hamlets. They walk one to two kilometres to make a phone call. During the field work, researcher witnessed their struggle (several incidents, where men, women and adolescents walked kilometres for making phone calls and sending messages and researcher also faced difficulties in contacting field level workers during field work). During the pandemic, they have got one television with victor's channel connection in their hamlet for children's education. It is very difficult for the service providers to reach out to the beneficiaries and they often complaint about the network connectivity issues.

Along with lack of communication facilities, few hamlets still lack transportation facilities. As part of the study, 24 hamlets have been visited, of those 16 hamlets have no bus route. Other than bus, the hamlet people prefer for jeep and auto.

"Rani," a 23-year-old Muduga woman is married to Thudukki, a hamlet situated in interior forest with no transportation facility. She has to walk 5 km steep mud roads and then travel 12 km in antilock road (where jeep can travel) to reach bus route. She has two young girls aged 4 and 3 years. Though they have house in her husband's hamlet, she wants to have a house in her hamlet, so they could have more access to transportation. She states that,

> I am living in an interior hamlet, with my husband and two young daughters, where we have no transportation facilities. If we need to go to the hospital, we will come to my natal hamlet a day before, which is closer to main road. So, we could reach there on time. After that, we will stay in my house on that night and will return on the day after.

As mentioned earlier, in Murugala and Kinnatukara Kurumba hamlets, people face more challenges to cross Bhavani River. In summer, if the water level is low, they walk across stones, as the river is filled with different sizes of stones. Also in summer time, jeep ride is possible in the mud road through the forest. If rains get intensified, the jeep drivers will not take the risk of travelling through it. They have

made hanging bridges during the monsoon while it would be impossible to cross the river by walking. In this case, people have to walk 3 to 5 km to Tadikkundu, the nearest vehicle point. Currently the government is building a bridge to connect the hamlets with the nearest vehicle point, but it is very challenging though slowly happening.

Several women from interior hamlets shared their struggle during pregnancy (the case studies, are detailed in analysis chapter 4) and reported that, because of the transportation and communication issues, hospital workers often advise them to admit in hospital few days earlier for delivery.

4.6 Land Possession, Livelihood Options, and Food and Nutritional Security

The results found that, nine percent of young women and seven percent of elder women possess land in their own names. But the land is not inherited from the parents, they got it from the government as '*michabhoomi patta*' which means land assigned by the government. Though majority of the participants have claim to land inheritance, partition is not happening in recent generations and thus they have no clarity regarding the extent of land they could have owned. The details of the land possession by the participants are given in Table 4.4.

Table 4.4

Land Possession by the Participants

	Own land %	Do not have Own land %
Mothers	9	91
Grandmothers	7	93

Source: Primary Data

The tribal communities residing in Attappady, (Irula, Muduga, and Kurumba) are patrilineal and patrilocal in their practices (Poyil, 2021; Tharakan, 2007). Although they used to have collective ownership of their land, nowadays they are preferring individual possession of land. However, the absence of legal documents of land ownership creates hurdles in partition of inherited land and they are fighting

legal battles for their land rights. The lack of ownership documents also creates issues for availing governmental schemes for land cultivation.

"Malli," a 60-year-old grandmother, shared her experiences,

> My father had some land and after his death, my brother is looking after it. He started farming and I didn't ask for any benefits from it. Few years later, I asked for partition and he is not interested in it. My husband also had some land and used to give it for lease to non-tribals for farming. He was an alcoholic, eventually he got cheated and lost the land. Currently we have no land in our name. But now my daughter got 80 cent land from government as '*michabhoomi patta*'. But the land is far from the hamlet and we cannot do farming because of the animal encroachment issues and lack of irrigation facilities.

The women reported that, their parental land is being handled by their brothers after the death of their father. Similarly, their husbands are working in parental lands which eventually will get transferred to sons, whoever is staying in the same hamlet. They also reported that, few of them are constantly trying to figure out the land scenario, but they find it as a hideous task as they possess the 'tribal women' identity.

Land degradation and marginalisation are interconnected and both are threatening the support system of tribal communities in Attappady. Attappady has faced major change in its demographic structure since 1951 due to the uncontrolled migration of Tamil-speaking Gowdas and people from south and central regions of Kerala. The proportion of non-tribal population continued to increase till the 1980s, and during that period they lost 10,234 acres of land. Tribal people used to mortgage or sell their land in order to repay the debt to moneylenders. The loss of land eventually resulted in the failure of livelihood strategies (Haseena, 2020). Moreover, the large-scale deforestation and introduction of cash crop cultivation by settlers disturbed the shifting cultivation practiced by tribal communities in their communally owned land. Eventually tribal communities leased out their land for non-tribals and became their underemployed wage labourers (Kozhisseri, 2019).

Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA is a Government of India's social security program that ensures "right to work" by providing at least 100 days of wage employment per year) and Daily wage labor are the major livelihood options available in the valley. 84% of women are registered for MGNREGA work. In that, 47 percent are young women and 53 percent are elder women. Many reported the delay in payment though they depend on it as a constant source of income. Men are also registered for MGNREGA, other than that, they are going for daily wage labours for meeting the household expenditure. "Vijayashanti," an Irula tribal young mother shared, "we have three children and we both are registered for MGNREGA work. But this money (from MGNREGA) is not enough for us. So, my husband is going for coolie work, when he has no work in MGNREGA". Even though they face issues related to irregular wage credit, many shared similar stories of survival.

Farming was the major source of food for them. The consumption of indigenous food contributes to the better nutritional intake among tribal women of reproductive age (Ghosh-Jerath et al., 2016). "Radha," a 61-year-old elder woman, who is wife of '*ooru mooppan'* shared her farming and dietary experiences,

> We used to farm millet varieties, such as little millet, foxtail millet, finger millet, and corn and pulses. Along with that, we used to have vegetables available from the forest like the variety of leafy vegetables, root vegetables etc. Other than that, we used to have fish from the river, wild meat items from goat, deer, pig etc collected by hunting in their farming land only. We also used to have field rats picked from our farms.

Many elderly women, recalled similar experiences. Even during their monthly periods, they used to work in the fields. "Maruthi," 48-year-old elder woman also shared her past experiences,

> in the morning, we used to prepare and make millet food. After having that, all the family members including children used to go to our land. We used to have food and water from field only, with no formal food. In the evening, we

> will again prepare and cook the food freshly collected from the field and go to sleep.

Tribal communities in Attappady used to do shifting cultivation and swidden agriculture. Currently, Kurumba tribal community stay in the interior forest and are involved in swidden cultivation or '*panchakkad krishi'*. Among the Irula and Muduga communities, farming is decreasing and they are preferring for daily wage work. Theparticipants also shared their experiences with farming. At present only 16 percent of the younger mothers and 33 percent of grandmothers are involved in some kind of farming activities along with their husbands. The younger generations find farming as a difficult procedure, as they lack skills, profits and will. Many of them shared that after the death of parents, they will quit farming and opt for coolie work. "Mari," a 59-year-old Muduga grandmother shared,

> We have land in Thudukki and Kadukumanna, which are situated in interior forest. After the death of my father, we bought some land in Chinkdakki and settled there (it is almost 10 years now), where we have access to transportation. Even though we have land there, we (me and my husband) prefer MGNREGA work, which is more convenient for us now. So, we are not going back to Thudukki and currently my relatives are taking care of it.

Along with the household work, women also have to work in the field with their husbands. Dhanya, a 25-year-old Irula young woman, whose husband and father-in-law are involved in farming have land in their own hamlet, which is one km from their home. They have a hut in the forest and she used to live there with her husband. She is also involved in the agricultural activities such as weeding and collecting seeds. she is currently living in the hamlet as her second child is 7 months old only. However, the family has goats and she will go to the farm with them in the mornings and return by evening. She is planning to return to her husband within a few months.

Farming is decreasing and even if few are doing it, they are converting it from millets to cash crops. Now initiatives for millet farming are happening with the help of government, but the processing of millets is a challenge. Earlier, they had

instruments in home for doing all these. Now they are looking for mills, especially, for the grinding of millets, and its availability is rare in Attappady.

Earlier the tribal communities used to cultivate 60 varieties of vegetables, 50 varieties of fruits and so many varieties of millets. Thay used to collect edible roots, leafy vegetables and honey from their land and also included meat, fish and milk in their diet. Later on, lack of education, along with the negligence of state policies and the exploitation by powerful settlers denied the tribal communities their access to land, livelihood, food and nutrition. The encroachment of their ancestral land by the settlers caused the destruction of cultural heritage and freedom of living and forced the marginalised tribal communities to adapt to the newer lifestyle. Even though there were efforts made by the government for the restoration of land, the absence of cultivable land and the loss of livelihood have aggravated the problems of tribal communities in Attappady (Haseena, 2020).

"Ramani," a 31-year-old Kurumba woman shared her experiences of current food pattern; on the day of the visit, she made dhal curry and rice. It was finished before noon and she had to make something else for children at noon.

> On the day before yesterday, there was nothing to make and I told my husband about it. While we were talking, few chickens were roaming around in our courtyard and he told me to make curry of that. I killed one of them and made curry and served it to children.
>
> She shared with a laugh.

The day before the visit, she had no vegetables in her home and she went to her field and collected some mushroom and made a curry out of it. She lives in her husband's hamlet in interior forest, and only four houses of relatives are situated in their land. So, they have access to the yard produce.

Women used to feed their families with produce from their fields and gardens. But now, the increase in land degradation, loss of agricultural diversity and lack of purchasing power leads to the unmet need of food and nutritional

requirement of households. This argument is supported by similar findings from other studies (Kozhisseri & Rajan, 2020).

"Rangi," 59-year-old elder woman expressed her concerns,

> Our younger generation is eating medicines… not food, that's why our children are unhealthy. In our times, nobody died of malnutrition and poverty. We used to cultivate enough food for ourselves, we also got food from our forest. It was nutritious……now everything is changing drastically.

Similarly, 61-year-old "Devu" also shared her concerns,

> we (older generation) have seen both sides: deficit and surplus food. It was not like every day we used to have enough food, it varied with seasons. But we used to consume fulsome food at least two times a day from our fields or backyards. Nowadays, we have surplus food (from various programmes like PDS) but we lack diversity in diet.

Many of the elderly women expressed their concern over the changes in the food pattern: from millets to rice. They have experienced the shift from traditional food to the current food pattern. They remembered the introduction of Public Distribution System (PDS). They used to get 1 kg rice per head in family by paying a certain amount. And now they are getting enough rice and younger generations are losing interest in traditional food. Now chicken, grams, vegetables such as tomato, potato, cauliflower etc. have come into their basket of food items along with fast food. They believe that the drastic changes in food patterns may have unhealthy repercussions on the health of younger generations.

The tribal communities in Attappady experienced multiple alienation from non-tribal settlers as well as from the state, which affected their lifestyles, agrarian practices and dietary choices. (Edison & Devi, 2019). Nowadays, they have become more dependent on the rice supplements from the Public Distribution System and also depending on sources such as community kitchen, Integrated Child Development Services (ICDS) and Integrated Tribal Development Programme (ITDP) for supplementary kits for their nutritional requirements (Kozhisseri, 2019).

Public Distribution System (PDS) is a food security system established by Indian government, to distribute food and non-food items to poor at affordable prices. 100 percent of the elder women and 69 percent of young women possess ration card and they are availing services and they reported that the food from PDS is the major source of their diet. Though older generation found it difficult to consume rice, younger generation is more comfortable with it.

Though they are eligible to have their own ration card with their husbands and children, 31 percent of younger women do not own their own ration cards (see table 4.5). Of those, majority of them are included in their parental ration cards. Few of them have submitted applications and others are considering to apply for it. Few of the participants reported that, as they lack residential proof, (do not have a rental agreement, electricity bill etc) they are not eligible to apply for the ration card.

Table 4.5

Possession of Ration Card

	Ration card (PDS) %
Young Women	69
Elder Women	100

Source: Primary Data

"Deepthi," 22-year Irula women, shared her experience,

> After our marriage, we used to live in my husband's hamlet, with his father and mother. His father and mother were alcoholic, and it became difficult for us to stay there. We returned to my hamlet, still my husband is included in the same ration card with my in-laws. So now, we have an arrangement, one month my in-laws will have the ration and on the next month, we will collect it.

Community Kitchen is a programme proposed by Social Justice Department, Government of Kerala, aimed to ensure the enhancement of nutritional food among the Attappady tribal people. The initiative started in 2013, in the backdrop of

malnutrition and infant deaths among the tribals and later handed over to Kudumbasree mission (self-managed units by the neighbourhood groups in each hamlet). It revived the community practice of eating together to improve the nutritional status of community people. Pregnant and lactating women, children up to 6 years, adolescent boys and girls, senior citizens, mentally and physically challenged people and people with chronic illness are the beneficiaries of the particular programme and they are to be provided with two meals per day- morning and evening. As of 2022 Kudumbasree report, 182 community kitchens were registered with 11080 beneficiaries in Attappady (Kudumbasree, n.d.).

At the time of field visit, 21 out of the 24 hamlets had community kitchen services. Majority of the participants reported the intake of food from community kitchen. "Malli," 53-year-old elder woman, who is living with her husband shared,

> My husband is getting food from community kitchen, two times a day- morning and evening and we are sharing the food, which is enough for us. After breakfast, we will go to forest with our goats and will return only in evening. So, I don't need to cook. If the community kitchen is not working on a particular day, we will have food from our daughter's house, which is situated near our house.
>
> She also added that "Though it lacks our traditional food items, we found it convenient."

Many of the shared similar stories. "Saritha," a 26-year-old young pregnant woman with a 2-year-old child shared,

> Myself and my two-year-old son are getting two meals per day from community kitchen. As we are a three-member family, we are sharing the food. If the food is not enough, we buy food from the nearest hotel. So, I only have to prepare one meal per day.

Majority of the tribal people are dependent on community kitchen for their nutritional requirement (Kozhisseri, 2019) and it has helped to increase the weight of children and to reduce the anaemic rates among children and women of

reproductive age (Sachana & Bonny, 2020). However, studies questioned the nutritional quality of meals provided under community kitchens as they cater different target groups and also criticised the efficiency of programme in tackling the nutritional security as it is limited towards reducing hunger like other projects such as PDS (Menon, 2019). The present study found the lack of traditional food items in the menu of community kitchen, sharing of meal among the household members, increased share of fast food and bakery items in the intake from outside, and the dependency on cooked food rather than cooking own meal, all of which rise the difficulties in guaranteeing the nutritional intake of beneficiaries.

Along with those concerns, the inconveniences of people who are running the community kitchen due to fund issues and lack of quality and timely supply of ingredients are the major reasons behind the irregular functioning of community kitchens. In other hamlets, though the community kitchen is working, most of them lack proper infrastructure. For example, the community kitchen in Nanjan Colony is run in a shed behind the Anganwadi centre. The shed is built of wood and sheet. Though they have locking facilities in the shed, theft happens once a while. On an occasion somebody stole rice, vegetables, curry masalas and while leaving the intruder had left a coconut plant in the shed which was stolen from another place. Fortunately, some Bengal gram and rice powder was left aside because of which the community kitchen could function on that day.

Integrated Child Development Service (ICDS) scheme is a major national programme to address the growth and development needs of children in the age group of 0-6. It also includes pregnant and lactating women as target groups. The programme provides supplementary nutrition, immunization, nutritional and health education, growth monitoring and preschool education. At the time of visit, 4 among the 24 hamlets had no Anganwadi centre while the others had this facility. Majority of the participants have utilised the various services, however, few of the participants reported delay and irregularity in services.

Dhundoor and Seenkara have no Anganwadi centre (AWC) in their hamlet and hamlet people are depending on nearest Anganwadies for the services, which are

almost one km from the respective hamlets. So, the hamlet children are not sent to preschool and it is difficult to reach there. The family members will go and collect the entitlements once in a month. Murugala and Kinnatukara, are two Kurumba hamlets situated across the Bhavani River and the nearest AWC is Tadikkundu. The children usually do not go to preschool. They directly go to the hostel education facilities from first standard onwards. Sometimes the Anganwadi Worker and Helper will come to the bank of Bhavani with entitlements and the hamlet people go and collect it from there.

Integrated Tribal Development Programme (ITDP) was established in 1976 and intended to reduce poverty, improve educational status and eliminatee exploitation of tribal families. Scheduled Tribe Promoters (STPs) are the field level workers under ITDP and they are reaching out to the tribal women during their antenatal and postnatal care. The enrolment of tribal women in various MH benefit programmes and household delivery of food kits for pregnant and lactating women are done by the STPs.

All the 24 hamlets have Scheduled Tribe Promoters. Majority of the respondents were reached out by the promoters during their antenatal and postnatal care and received benefits form the scheme. In Murugala and Kinnatukara hamlets, even though they have promoters from their own hamlets, it is difficult to reach out to them because of the transportation and connectivity issues. Thus, the ITDP kit distribution during pregnancy and lactation period is irregular.

The study has found that the lack of awareness about services, lack of accessible and quality services are the major reasons behind the gap in implementation of services. The argument is supported by similar findings in other studies (Niloufer & Gnanadev, 2023). The irregularity in the supplementary kits weaken the aims of the programme and thus compromising the nutritional requirement of targets. The immediate and temporary solutions fail to address the food and nutritional requirements and make the tribal community dependent rather than self-reliant (Athira & Nalini, 2022).

Social safety nets have the potential to improve the balanced diet, nutritional status of beneficiaries as well as women's economic empowerment (Habtu et al., 2023). It helps to increase income resilience, subsequently improves food choices especially among vulnerable population such as pregnant and lactating mothers and children (Bwalya & Zulu, 2021; Karlan et al., 2014).

4.7 Access to other Social Security Networks

Kudumbasree Mission is a women-centered poverty alleviation programme through community participation implemented by Kerala government in 1998. Besides micro finance, the programme facilitated women empowerment by improving livelihood skills, micro enterprise and wage employment. Beyond all those, women get opportunities for participation in a wide range of activities, thus helping to augment their capabilities (Christabell, 2017).

87 percent of the elderly women and 84 percent of younger women are enrolled in Kudumbasree Mission and it provides a network platform as well as economic source for the women. 24-year-old "Ramya" shared,

> I have been part of Kudumbasree programme for the last few years. We both enrolled in MGNREGA work and my husband is also going for daily wage work. Still, we often face economic crisis. In those times, I take loan from Kudumbasree. Last time, I rented money for my child's hospital needs.

Many women shared their experiences regarding the benefits of Kudumbasree programme. Besides the economic benefits, few of them are actively participating in it and the networking has helped them to be more independent. However, few of them shared their experiences of malpractices in the neighborhood units and how they had to withdraw their membership.

Other than the Kudumbasree programme, tribal people are getting various social security benefits from the government. Results found that, 18 percent of elderly women are getting one or the other form of social security pension (1600 rupees per month), 50 percent are getting widow pension and the other 50 percent are getting old age pension. Some of their husbands are also availing old age

pension. In their opinion, even though the credit is irregular, it is helping them to meet their basic expenditure. As per field level workers, age discrepancy among older generation exists in Attappady. The age records of older generations are improperly done as proper recording of date of births started only in 1990s. So, the current percentage of older generations in Attappady could be different from the estimated percentage which also affect their eligibility for applying old age pension.

Other than that, 31-year-old Malli got diagnosed with sickle cell anaemia and is getting a monthly pension of Rupees 2000 as part of Kerala government scheme for sickle cell patients. (From among the study participants, Devi's husband is also getting the same pension).

4.8 Substance Use, Alcoholism, and Incidents of Violence

Indigenous communities are at higher risk of alcoholism (26%), betel quid chewing (36%) and smoking (25%) compared to 9%, 19% and 18% respectively among non-tribal populations in India and consequently they face higher health inequalities (Subramanian et al., 2006). High rate of alcoholic consumption and substance use among the tribal communities in Kerala are associated with their socio-cultural rituals, parental influence, peer pressure, occupational factors and exploitation of landlords. It has resulted in a substantial burden on women and children such as economic insecurity, domestic violence and school dropouts (Sadath et al., 2019). Poverty, alcohol and tobacco consumption are reported to be major factors responsible for the high rates of maternal and child death among tribal communities (Babu, 2019; Nalinam, 2016). The details regarding the substance use and alcoholism are given in table 4.6.

Table 4.6

Substance Use and Alcoholism among Participants and their Husbands

	Young Women %	Husbands-Young Women %	Elder Women %	Husbands-Elder Women %
Chewing	60	78	96	87
Smoking	0	40	0	32
Alcohol	0	82	0	76

Source: Primary Data

The results found that 60 percent of young women and 96 percent of elder women have chewing habits. Elderly women are highly addicted with chewing and it is visible on their teeth. They carry a plastic kit in their lap with all chewing ingredients and it is a common scene there. Earlier, women used to work in their fields and reared livestock and they started chewing as part of it. They found it as a part of their daily life practices and not convinced about the health hazards associated with it. "Rangi," a 56-year-old, an elderly woman shared that,

> Chewing is part of our daily life. In my younger age, I used to have food around 8 am and went to the forest with our animals. I used to chew while shepherding the cows and goats and I used to drink water from the streams. After that, the habit continued and I did the same while working in the farm also.

According to Cheeru, another elderly woman, "I used to chew during my pregnancy, I had no health issues then and I am still healthy…. I have three children and three of them are healthy", she said undoubtedly.

Intergenerationally, results show slight decrease in chewing practices among younger generation compared to older generation. The lifestyle changes along with the health interventions are the major reasons behind this change. The younger mothers are taking more precautions during pregnancy. Younger women, who had chewing habit during pregnancy reported that, health workers were constantly talking to them about the effects of chewing and they had to stop it during pregnancy

and lactation. But afterwards they have restarted it. "Veena," a 21-year-old Irula lactating mother, shared,

> I was addicted to chewing before my pregnancy. As I was continuing the habit while pregnancy, my husband scolded me for it (he has no habit of chewing and drinking) and I had to stop it. He told me that it will affect the health of our child, so at present I am not using it. I will restart chewing once I stop lactating.

Tribal communities in Attappady are addicted to illicit alcohol. High rates of alcoholism is prevalent among tribal communities in Attappady (Manikandan, 2014), which is contributing to poor nutrition and associated morbidities among them (Kozhisseri & Rajan, 2020). Although, '*Thaykula Sanghom'*, tribal women collective in Attappady started anti-liquor movement and made efforts to tackle the issue of high rates of alcoholism among tribal people (The Hindu, 2019), illicit alcohol making and consumption is still prevalent in hamlets. Consequently, it has increased the burden of families on women. The hard work, lack of proper food and rest, repeated pregnancies and domestic violence lead to mental health and physical health issues among tribal women in Attappady (Haseena, 2020).

The results found that, none of the participants are alcoholic and they do not possess smoking habits. However, alcoholism and smoking habits has increased among the husbands of young women compared to the older generations. As per "Ramani,"

> My husband is an alcoholic and he used to buy one litre for 1200 rupees. In our hamlet, few houses have this business, each house will do illicit making of alcohol ('*vaattu'*). They dig large holes in the courtyard and keep the processed illicit alcohol there and would cover using mud so as to look natural. After few days, they would take it back and sell it. and they keep doing it rotationally.

Many of the participants complained about their husband's alcoholism and shared the associated violences they have faced such as economic burdens,

unwanted pregnancies, unsafe abortions and domestic violence. "Rajamma" an elderly Muduga woman shared experiences of physical and emotional abuse along with the economic insecurity.

> "My husband is severely alcoholic and will not give any money to household expenditure. Moreover, I had to tolerate his violent behaviour too. I had to struggle a lot to look after our three children." When asked about old age pension, she replied, "We did not apply for that, why should I? He will drink for that money too and create more issues. So please do not tell him about it.

In another incident, "Shanti," a 32-year mother shared her experiences of violence from her alcoholic husband. After their first pregnancy, they decided to be in abstinence for few years. Her husband also agreed for that, but once he had alcohol, he forgot all the promises and it resulted in her second pregnancy.

Conclusion

The intergenerational analysis of demographic and socio-economic characteristics among tribal women shows a drastic change happening in the valley. The increase in education, age at marriage, age at first pregnancy and decrease in spouse age-gap are reported among young tribal women in Attappady. It clearly indicates that the increase in education have positive impact on the age at marriage and age at first pregnancy among the young women. The housing, water and sanitation facilities have improved over the years but that in turn seems to have caused a higher dependency of tribal people on government schemes. Along with that, transportation and connectivity have also increased over the years but in a few interior hamlets, it still remains as a major challenge in the access to resources.

However, the loss of land, livelihood and traditional food patterns pose serious threats to the sustainability of tribal population. The majority of study participants, including the educated women are depending on MGNREGA as a major source of income. The decrease in land ownership and lack of interest in farming among younger generation have led to a decrease in agricultural activities and subsequently loss of traditional food patterns. Currently majority of them

depend on various government schemes for their food and nutrition; older generation does not find it comfortable, but the younger generation seemed more comfortable in this arrangement and little interested in reviving their traditional food patterns. Furthermore, alcoholism and chewing habit is more prevalent among the younger generation compared to the older generation. It might have led to more incidents of violence among young women when compared to their elder counterparts. These demographic and socio-economic factors are found to be major contributors in deteriorating maternal and child health in Attappady.

Chapter 5
MYTHS AND MISCONCEPTIONS RELATED TO REPRODUCTIVE HEALTH

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Introduction

This chapter deals with the second specific objective, which explores the prevalence of myths and misconceptions related to RH among tribal women. During the in-depth, dyadic interviews with the respondents, the prevalence of deep rooted myths and misconceptions and its influence on the RH choices and behaviour of tribal women was noticed. Thus, the particular objective was identified and incorporated inductively throughout the study.

The chapter provides an in-depth understanding about the cultural context, which is critical in defining and realising the RH rights, especially among marginalised communities. The data related to myths and misconceptions was analysed and discussed under various domains of RH such as menstruation, sexuality, contraception, pregnancy and childbirth, abortion and infertility.

5.1 Myths and Misconceptions related to Menstruation

Even when menstruation is a biological process, the cultural importance of the *cheeru* ceremony that celebrates a girl's first menstruation, is deeply embedded in their cultural and social system. They are willing to spend more on this particular event than a marriage ceremony. Usually, the *cheeru* is performed on the 7^{th} day of menstruation or it has to be conducted within one year of a girl's menarche. It is believed that *cheeru* alone would redeem them from impurity brought in by menstruation. For the first seven days of her periods, a girl has to stay confined in the '*kudusu'*, a small hut made of palm leaves, fig leaves and bamboo sticks; palm

leaves being a symbol of purification. Usually, it is built outside the home but nowadays as the people are living in hamlets and the houses are situated close to one another which limits courtyard space, the families have to create a space for the '*kudusu'* inside the houses**.** They have different terms for menstruation like '*vettaykkupoka'*, '*vayassariyikkal'*, '*masakkulivaral'* etc. After building the menstrual hut, the girl's maternal cousins push the girl into it and for seven days, the girl has to stay inside. According to "Valli," a grandmother from Nalashinga hamlet, '*vayasinuvanthal kudusu kettanam*,' which means "if a girl has started menstruating the menstrual hut should be built".

Mostly, the girl stays alone in the hut, but sometimes, her maternal cousins or sisters in law would accompany her. The girl shall not see anyone especially boys or men. She is not allowed to go to school for the seven days. She is given food and water in separate utensils and the girl should not wear '*bindhi'*, which means an ornamental dot on her forehead, bangles or flowers nor oil her hair. The girl is allowed to take a bath either early in the morning or late at night without being seen by anyone, especially boys and men. They have to go to the nearest stream or river. If the water body is faraway, they are allowed to take bath in the courtyard. Earlier, cloth was used during menstruation, mostly torn pieces of a *saree* or *lungi*. Sanitary pads are increasingly being used nowadays. A few women were happy about the event as they used to get treats like '*pori'*, '*kadala'* and '*muttayi'*; now the girls get to have bakery goods, gingelly oil, egg, milk etc.

If the family has no money to conduct the *cheeru*, they could perform a ritual to let her enter home, but the function has to be conducted within a year for purification. Otherwise, the family members are ostracised and are forbidden from entering other houses, temples or dining with others. As per their belief the gods can take the form of any random thing like a snake or a mud pot which prevents them from venturing outside or to any other houses. Every house has a '*daivaveedu',* a prayer room, which has to be kept pure and hence people from a menstruating girl's house do not enter other people's houses. And if they enter, they believe that they will be cursed and something bad would come about, which prevents them from visiting others during the time. It is mandatory to confiscate the '*theetu*', the

impurity. On the seventh day, the girl is taken to a nearest stream or river by female relatives or friends for the ritual bath. She is then allowed to use oil, turmeric etc for bath. After the bath, a green leaf called '*tadisi'* or '*chadichi'* is used to drive out any evil spirit from the girl's body. The '*chadichi'* leaves are collected from the river bank, the veins are separated from the leaves and the veins are waved around the girl's body from head to toe. The girl digs a shallow pit in the soil where she stands and buries the leaf veins in it. It is a part of removing impurity and driving out evil spirits. If the buried leaf veins come out, the evil spirit is still considered to be with her and she has to do it again.

After the ritual bath, they have to burn all the dresses and '*kudusu*' and will flow the ashes in the river. They will smear the house courtyard with a paste of cow dung and hang the '*chadichi'* leaves to purify the place. As a part of the rituals at home, the girl carries several items like fruits, grains, leaves, flowers, beauty products etc in her saree pallu or in a shallow basket made of bamboo. She also carries a child in one hand and pounds on the mortar with the pestle. The child is chosen from her immediate family members; there is a preference for male children aged two to three years and if a boy is not found, a girl child is taken. If the girl carries a male child, they believe she would give birth to a baby boy and if a girl child is carried the first progeny would be a girl. The ritual has to be carried out carefully without dropping any of the things from the saree pallu; if the girl drops anything, it is supposed to bring bad luck which would lead to her first child's death. According to "Kavya," "if anything spills, she will lose her first child. It could be an abortion, miscarriage, still birth or even child death. It has happened in our hamlet." She was serious and certain about her statements and also gave proofs for her arguments.

After the ritual, the girl enters the house and a feast is given to the people of the hamlet called '*oru nazhi arivaykkal'*, as a token of sharing the family's happiness. In early days, rice and *sambar* were the preferred feast offerings, which has switched to chicken biriyani these days. It is the responsibility of the maternal uncles and aunts to conduct the function; they buy clothes, ornaments and sweets for the girl and she is decked up like a bride. If money is short, they keep the arrangements simple. "Chelli" says, "These days girls don't wait for the family to arrange marriages, they choose their own partners and elope with them. So, we

think, let us celebrate this function as we don't know if we can get to see their wedding.". Even after the first menstruation, women have to practice separation for the first seven days. They are not supposed to go to the kitchen or the '*daivaveedu'* during that time; neither can they cook or be with their husbands. They must not be seeing other men and must not call anyone with the name of the gods. Nowadays, since there are more nuclear families, men cook during the wife's periods and women do other household chores like cleaning, washing clothes etc.

Even when developmental efforts regarding educational, infrastructural, livelihood, health have claimed to have made improvements among the tribal communities (Nair & Saisree 2021), the people continue with their superstitious beliefs in evil spirits. All the rituals surrounding women and reproductive events bring about the alienation of women's bodies. A majority of the women see the rituals as cultural and spiritual events and they are unaware of the human right violations and exclusions happening around them. Moreover, a largely unhealthy diet and unhygienic practices during menstruation, pregnancy and childbirth adversely affect the physical and mental health of women and children. Similar findings had also been reported in previous studies (Bandyopadhyay, 2009; Begum, Sebastain, Kulkarni, Singh & Donta, 2017; Hansdah & Rath, 2021). The only concern expressed by the young mothers is the declining age of menstruation and the lack of the girl child's ability to understand the importance of cultural practices related to it. Otherwise, the community strongly advocates for the preservation of such rituals. The local and cultural beliefs around SRHR determine the behaviour and choices of indigenous women. (Srivastava & Sahu, 2022). However, addressing and giving up the harmful practices in culture without losing the aspects of meaning and harmony is what is required (Kaur, 2019).

5.2 Myths and Misconceptions about Sexuality

Talking about sexuality was not easy among the respondents. They see it as shameful for women to talk about these things publicly. Most of the women responded "it is the men's matter and we do not like to talk about those things". They believe that sexuality is a private affair and women should learn and clear doubts about sexuality from their husbands. "Malika," a 26-year-old Muduga woman says:

> If we have any doubts about sex, my husband would ask his close friends or seek information on Google or YouTube. Network coverage is low in our hamlet, so my husband goes to the nearby hill to get better connectivity and later shares the information with me. Now anyone can learn anything using a phone and internet.

Only a few people reported discussing SRHR related doubts with their friends during leisure time without being noticed by the elders. "Nachi," an elder woman aged 48 shared,

> In those times, we had no mobile phone, we were afraid of discussing anything with our husbands and we believed that we should not ask them, we have to understand it on our own. I used to work in the corn fields. We had lunch time and we could talk only during that time, otherwise they will cut the wage. So, I used to talk with my close friend, who was married and came to understand all these things.

Some women conveyed that expressing sexual needs to their husbands was sometimes problematic. According to "Bina," a 26-year-old Muduga tribal woman,

> We usually do not ask for it; we let them decide. If they express a wish, we are happy to go along. But if we express our wish, they might not listen to us. They would start doubting that we have an affair with someone if we do not consent when they wish to have it.

There is a widespread misconception among the indigenous women that girls and women must remain ignorant about sexuality. Only a few women opened up about sexuality related experiences. Most of them were shy and needed time to articulate their thoughts. They also think that talking or expressing about their sexual needs to husbands will lead to misunderstandings in their marital relationship. These misconceptions about sexuality deny the fulfilment of women's sexual needs and undermine women's right to sexual knowledge.

5.3 Myths and Misconceptions about Contraception

Myths and misconceptions related to contraception are widely prevalent among indigenous women. Many women are concerned that the contraceptives,

especially artificial ones, would cause health problems for women and children. Many of them reported their negative experiences about Copper T usage and reported health issues such as weight loss, heavy and irregular bleeding, back pain, vomiting, urinary infection, inability to lift heavy objects etc. The misconceptions created by stories of Copper T gone missing inside the uterus and other dangers of contraceptives including its degrading effect on the health of future children are still prevalent. Contradictory to the younger women's misapprehensions, a few elderly women shared that, they would have used contraceptives to avoid unneeded pregnancies, if they had known of those methods in the past.

Some of the tribal women believe that children are God's blessing, so there is no need of contraception, particularly the artificial methods. According to them, natural methods of contraception are appropriate to achieve spacing between children and they are the safer methods as there is no harm on the body. They added that men are mostly uncomfortable and reluctant to use condoms, denying them the protection of contraception completely. "Mani," a 49-year-old Muduga woman who has four children narrated her experiences. She had delivered her first child within one year of marriage. She said,

> I was eating good food and conceived quickly after marriage. So, the health workers advised us to keep child spacing. My husband is a good man. He knew about Nirodh from the newspaper, bought it from a medical store and we decided to use it for birth spacing. It was for our children's health and mine. During the fourth pregnancy, a cyst was found in my uterus. I think, maybe my uterus condition was triggered by the use of Nirodh. There is an oil in it, right? No one told me this could be the reason for the cysts, but I believe so.
>
> She finally went to a medical college and underwent hysterectomy.

"Sudha," a 36-year-old Muduga woman, had worked as ST promoter for four years. She was part of the Kudumbasree (the largest women's network in the world, started as an anti-poverty programme in Kerala) and MGNREGA programmes (the Government of India's social security program that ensures "right to work" by providing at least 100 days of wage employment per year). She had five children of

which only four are alive now. She had heard of contraceptives, but did not know about any of these methods. She said, "it will cause health problems to children, right? So, we decided not to use it. For child spacing, we follow abstinence". In situations where abstinence is not possible, they consciously avoided vaginal penetration. Her last and fifth child was four months old during the interview and they were planning to stop pregnancy by sterilisation. They had talked to the doctor, who asked them to wait for six more months. Even though she had worked as an ST promoter for years and was an influencer, she had several misconceptions about contraception. She had heard about negative impacts on health such as weight loss, back pain, infections etc caused due to the use of contraceptives like Copper T and she also feared that the artificial methods which are inserted in the body could negatively affect child health. She was actively participating in the social networking platforms which have the potential for behavioural change and transformation. When misconceptions and positive social exposure were counted, misconceptions got leverage over the exposure and she ended up with a lack of access to SRHR.

On the contrary, Rani a 23-year Muduga woman, who had an unplanned second pregnancy, wanted to stop her pregnancy by sterilisation. But she was denied the services as the hospital staff told her that she was still young and she has to wait till she reaches the age of 27. She was determined to use contraceptives to avoid unwanted pregnancy. Earlier, she had used Copper T, but due to infections she had it removed. Though she had heard of condom, her husband was not comfortable with it. Later, she took contraceptive injection which is given once in three months from the government hospital, 30 km away from her home. It was difficult for her to reach the hospital every three months for the dosage but her determination was exemplary. In this case, this tribal woman could somehow overcome the prevalent myths and misconceptions surrounding contraception. But the lack of access to quality contraceptive services has turned out to be major challenge.

Many indigenous women expressed their concerns over female sterilisation procedure. Within the community, they have heard about two types of sterilisation

procedures: first one is '*current operation*', a term the women use to refer to laparoscopy and the other is '*kai operation*', the term for mini-laparotomy (done through a small cut in the abdomen). They have heard stories about women dying during '*current operation*' (laparoscopy) and are scared to go for that. So, they prefer '*kai operation*' (mini-laparotomy). They fear, that if there's a power failure during the laparoscopy procedure, it would be harmful or can even be fatal for them. They also have doubts about the success of the procedure; they think it might fail and lead to undesired pregnancy in the future. A lot of misconceptions are widespread so much so that women prefer doctors to do mini-laparotomy even following a normal delivery. "Bhagya," a 49-year-old Irula woman, who had undergone laparoscopy described her experiences with a smile, excitement, and relief. She went alone to get the surgery done. She said,

> I was watching it keenly and we (another woman from a neighbouring hamlet) were praying to God for continuous power supply. We were afraid if electricity goes, we would die. There was a woman on the bed next to me, covered in white cloth. I think she might have died because of power failure.

She continued describing her experiences in the operation theatre for a long time.

"Chinnamma," a 39-year-old Irula woman, who was working as an MGNREGA mate, had four deliveries; one was a still birth and the other three children were born healthy. All of them were normal deliveries. She had not used any contraceptives for birth control or for child spacing. She went for sterilisation and opted for mini-laparotomy. She says,

> I stopped pregnancy by undergoing 'kai operation' as I was scared of 'current operation'. We had enquired to people around about the procedure and they told me that there are several risks involved in current operation. What if there is electricity failure? What if we get pregnant again? It was like c-section, I have to take minimum three-months rest, and still, I have pain in those parts while doing heavy work, but it is better than dying and I also do not want to get pregnant again.

Palo et al. (2020) report that the indigenous women are reluctant to adopt permanent family planning methods because of the fear of a cultural ban to worship and they also worry that such methods would lead to sexual dissatisfaction. Contrary to that, several participants of the present study were willing to adopt permanent family planning methods. Yet the prevailing misconception that contraceptives cause health issues for them and their children hold some women back from contraceptive use. Similar findings were reported from another study (Adongo et al., 2014) where the respondents shared their health concerns over the use of contraceptives. The study underlined the role of cultural beliefs in formulating their perceptions and determining the usage of family planning methods. The irrational choices, decisions and practices such as preference for '*kai operation'* over '*current operation'* in sterilisation due to fear, at times leads to physical and mental health complications.

5.4 Myths and Misconceptions about Pregnancy and Childbirth

Majority of the women said that they have three months of '*pela*', a post-delivery ritual. They have to stay separate for a period of three to six months. Earlier, the mother and child used to stay separately in a hut for six months but now, due to shortage of space, it is a part of the house, and mostly it is a room, or a hall, as per the availability. "Priya," a 26-year-old Irula tribal mother shared that,

> We sit in the hall and the family members give us food and clothes. We use separate utensils; visitors are allowed to stand at the door and watch the mother and child. We should not enter the kitchen or the prayer room, nor should we touch anybody else. In some cases, the father stays with them for their immediate needs; he sleeps on the floor and the mother and child sleep on the cot.

This ritualistic separation is believed to be beneficial for the mother and child as it offers protection from unwanted infections. pregnant women avoid certain food items like gram, meat and certain vegetables believing that "it will be harmful for the children resulting in swelling or burns on their bodies." "Bhagya," a 49-year-old Irula woman talked about the time when they used to avoid colostrum, the first milk for breastfeeding. But nowadays people get awareness classes about it from health workers leading to a favourable outcome. So, it is a positive behaviour

change among the young mothers in relation to the myths and misconceptions on post-delivery care.

Women lack the decision-making power to determine the number of children. They are under the misconception that the decision-making capacity always lies with the husband. "Mala," a 33-year-old Irula woman with two children had wanted to stop her pregnancy but she was not sure about it. She says, "my husband says not to stop pregnancy, though I want to. I only wanted two children but what to do? We have to obey our husbands, right? So, I cannot say no to him." "Thumba," a 33-year-old Irula woman, with three children also shared her experience. The elder child is with her first husband. After their separation, she married again and had two daughters from the union. When asked about family planning, she had no idea about it and her husband's decision would be the final word. "I do not know. Whatever he demands, I will follow that."

Many women revealed their helplessness saying that they were trying for one more child just because their husbands wished to. "Madhu," a 30-year-old Muduga woman had two children; she had lost two others, one in a miscarriage and the other in premature death. She did not want another child but her husband wanted more children. "I do not have the courage to talk to him, he will scold me, so I am keeping quiet." When asked about contraceptives, she said that she was not comfortable with contraceptives and had not used anything at all. She had four deliveries and only two of the children were alive. She was concerned about her health as well as her children's, and did not wish to go through the trauma again. She had wanted to stop her pregnancy by surgery. In this case also, the woman was sure of what she wanted, but as she believed that the final decision would be her husband's, she was in a dilemma with lot of uncertainties about her reproductive life.

5.5 Myths and Misconceptions related to Infertility

"Suja," a 31-year-old Irula woman, had studied till class 10^{th} and her husband aged 38, is a coolie who had no formal schooling. They had two children, a boy and a girl. The elder son was 4 years old and the daughter was one and half years of age. They had their first child after 8 years of marriage. At the time of

marriage, she had been going for daily wage work. "I used to go for construction work, I had to carry heavy load on my head and it is a hard job. I think, because of that I could not conceive easily," she said. So, they took advice from a doctor and she was asked to avoid lifting heavy loads. She left the job when she was the sole bread winner of the family as her husband had not been working then. She later became pregnant.

"Mala," a 33-year-old Irula woman, whose husband is a 37-year-old coolie worker, had not conceived for 6 years after marriage. "I used to feel sad when people asked about children. But I did not do any poojas for that, I just prayed to God." They had a 5-year-old son and she was 6 months pregnant at the time. In both these cases, the women were also victims of stigma and violence from their mothers-in-law as well as the society. The pressure to conceive is immense and if women fail to do that, it often creates chaos in their lives. Conception is seen as a woman's sole responsibility and infertility in women causes the society to view them as a liability. Such women reported trauma following the efforts of the family to disown them and to get their husbands to remarry.

5.6 Myths and Misconceptions related to Abortion

Many women believe that the children in the valley are the gift of '*Malleswaran'* or Lord Shiva and they have no right to decline his blessing, the '*prasadam'* (through abortion). But a few women had undergone abortions due to the unfavourable situations like their husbands' alcoholism and related violence, poverty etc. "Raji," a 28-year-old Irula tribal woman, who was a B.Ed. drop out, had married a man who had quit his B. Tech course. Their marriage was planned at first and later the families decided not to proceed with it. But the couple went on with their relationship and the girl got pregnant. The families got them married and as the pregnancy progressed, scans and check-ups at the government hospital revealed that the foetus had acute heart issues. They were advised to abort the pregnancy, but the couple decided to proceed with it.

> We did not want to abort the child. It is a sin. After all, he was our first child. He was God given, right? So, we decided to keep him. We continued to stay

at the hospital after the delivery. The baby died after 10 days. It was traumatic for us. We tried for another child only after 2 years.

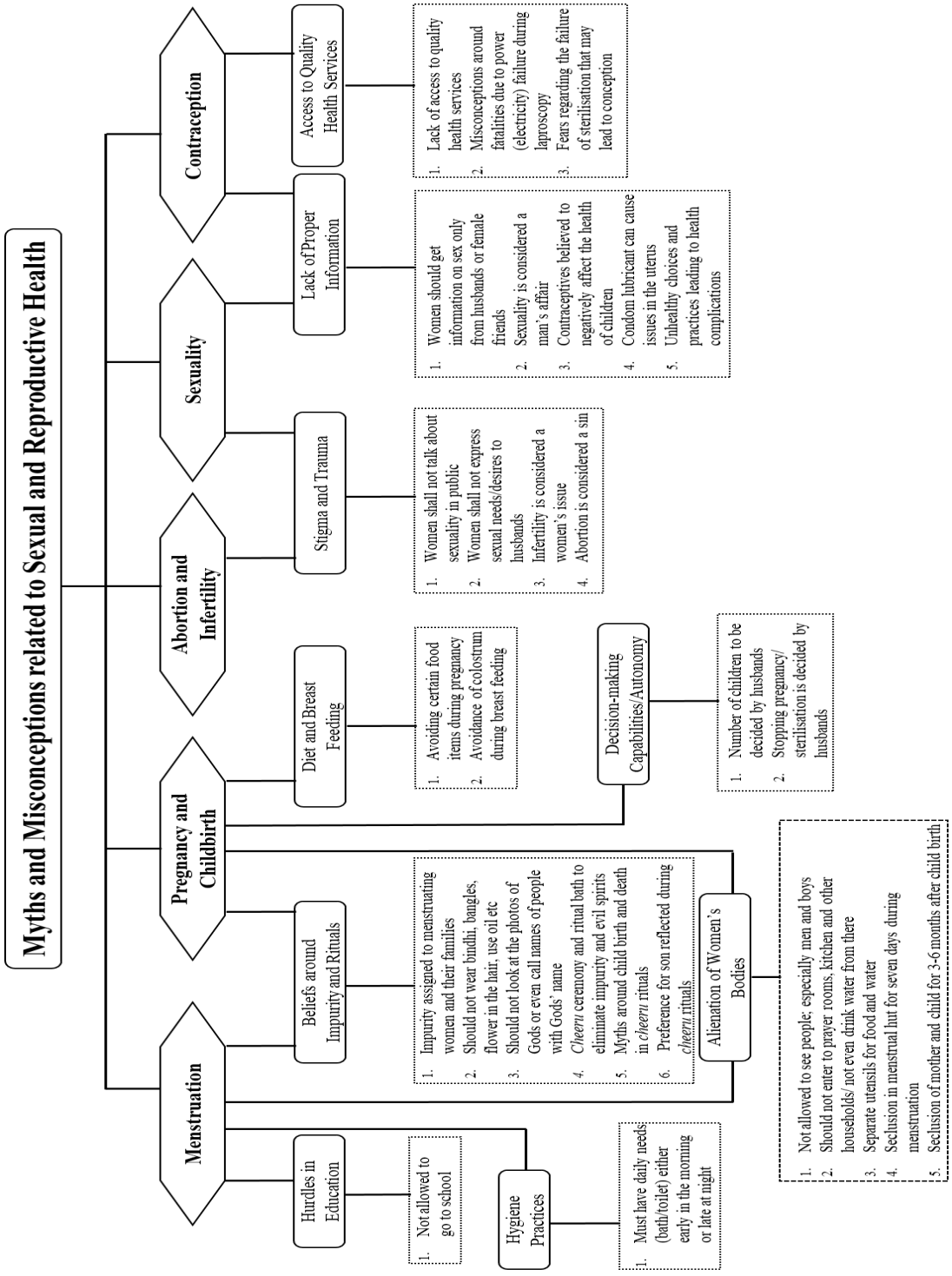
This decision was their personal choice which was based on their myths and misconceptions about the process of pregnancy and abortion. In India, medical termination of pregnancy is legally permitted when the foetus has chronic diseases. But the couple decided to go through tough times. They reported that they still carried the trauma of the loss but were relieved that their conscience is clear. Moreover, they believe birth and death are all decided by God.

Indigenous women's role in reproductive decisions related to the number of children, spacing and sterilisation are also influenced by the myths and misconceptions prevalent among them. They are not aware about their rights and believe that the decisions should be taken by their husbands. The study also found that infertility is still considered a woman's problem and she has to face the stigma and violence associated with it. The indigenous women also believe that abortion is a sin and they should not resort to it even when there is a medical emergency. Navya, who ignored the doctor's advice for abortion, was going through the physical and mental trauma of pregnancy followed by child death. However, she believed that she had made the right decision. The prevalence of myths and misconceptions immensely affect the choices and decisions related to their sexual and reproductive behaviour like sexuality, contraception, infertility and abortion. Furthermore, inadequate SRHR information, decision-making capacity and access to quality SRH services complicates the RH status of indigenous women and leading to higher maternal and infant mortality rates.

The different forms of myths and misconceptions related to sexual and reproductive health prevalent among tribal women are summarised in Figure 5.1.

Figure 5.1

Myths and Misconceptions related to Sexual and Reproductive Health of Tribal Women



Source: Primary Data

Conclusion

Gender bias and discrimination are embedded in the cultural beliefs and traditional practices of tribal women. The case studies reveal that patriarchal notions and power relations are controlling the willingness and the ability of women, depriving women from realizing their SRHR. The experiences of indigenous women indicate the unequal knowledge, opportunities, and access to sexuality and contraceptive information compared to their husbands. Consequently, women lack autonomy to decide matters such as choice of contraception and decisions regarding the number of children. Furthermore, culturally insensitive health care services are intensifying the vulnerability of indigenous women. These tendencies sustain the inferior position of women and hamper the attainment of practical and strategic gender needs of women and girls. As opined by Lundius (2019), "access to education, including comprehensive sexuality education, and to SRH services is essential in supporting the autonomy and agency of women and girls".

The intergenerational comparison has found only slight positive changes among younger generations as compared to the older generations. The social networking platforms and the health interventions of field level workers might have led to such changes. However, the the unequal relations with the partner, prevalence of gender norms embedded in cultural practices and traditional beliefs and inaccessibility to resources are intersecting with each other, creating barriers in fulfilment of SRHR of indigenous women.

Thus the SRH experiences of indigenous women in Attappady are shaped by certain myths and misconceptions about impurities and the alienation of women's bodies, irrespective of their age and education. The fear of social exclusion, unhealthy diet, uninformed choices, and the stigma and trauma related to SRH events negatively impact indigenous women's physical and mental health. Furthermore, lack of access to quality healthcare services, lack of male engagement, and lack of decision-making capacity result in the denial of women's rights.

Intergenerational changes with regard to myths and misconceptions are minimal among indigenous women. The existence of gender-power relations has been identified, which is critical in determining the perpetuation of myths and misconceptions regarding SRH experiences. The findings of this study emphasize the need for culturally sensitive community interventions from an intersectional perspective aimed at eliminating myths and misconceptions and generating awareness of SRHR among indigenous population.

Chapter 6
Menstrual Health, Marriage, Sexual Health and Family Planning Methods

CHAPTER 6
MENSTRUAL HEALTH, MARRIAGE, SEXUAL HEALTH AND FAMILY PLANNING METHODS

Introduction

The third specific objective examines the extent of access of tribal women to the RH rights by addressing the challenges faced by them. The findings are classified into various domains of RH which includes: menstruation, marriage, sexuality, contraception, pregnancy and childbirth, and presented in chapter 3 and chapter 4.

This chapter discusses the intergenerational changes in the RH behaviour of tribal women regarding menstrual health, marriage, and sexual relations. ***This chapter also includes the experiences of tribal women regarding the utilisation of family planning methods. This part is in communication with the Journal of International Women's Studies for the publication process.***

6.1 Menstrual Health and Status

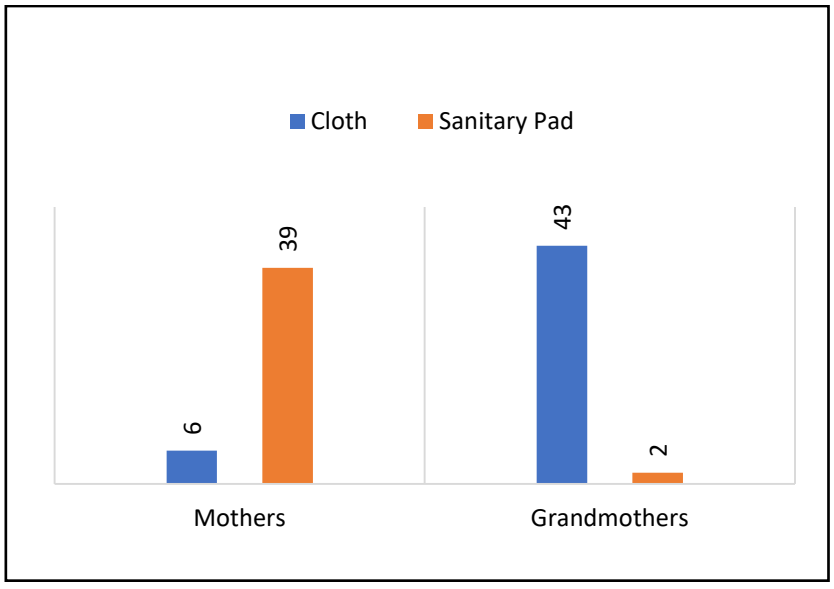
Age at menarche is a critical element of women's SRH (Sommer et al., 2015). Uninformed and unprepared menarche at early age have potential health effects on women's physical and mental health (Giles et al., 2010). As per data, forty percent of younger mothers have reported that they got their first periods in their 14^{th} age and 33 percent in their 13^{th} age. Most of the grandmothers reported that they got their first periods in their 15^{th} or 16^{th} age. Many young mothers were concerned that the starting of menstruation in their daughters happens even earlier these days. This indicates the decreasing age of menstruation in their girl children over the years. Similar findings were observed in other studies also (Yaliwal et al., 2020). Several studies report that the age at menarche is declining across globally with environmental factors such as nutritional status and psychosocial variables associated with it (Lee, 2021; Leone & Brown, 2020).

Ninety six percent of grandmothers had used cloth during their periods. Only four percent has ever used pads during their period. They said that, they came to know about pads from their daughters and they are comfortable using it. Rangi, an elderly woman remembered that, during the earlier stage of her periods, she had not used any cloth. Her family was poor and it was difficult to get cloth at that time as it was expensive, so she had free periods. They used to wash the clothes while bathing. And she also added that she used to work in the fields while bleeding.

Lakshmi, another elderly woman shared her experiences with a laugh. Once she had to travel to someplace during periods and she used cloth as absorbent. During the travel, her cloth came out and she got scared. Somehow, she got off from the bus and went behind some bushes and discarded the cloth

Figure 6.1

Type of Absorbent Used by Tribal Women During Menstruation



Source: Primary Data

Among the younger mothers, 87 percent use sanitary pads. But a few of them prefer using cloth at home and use pads when they go outside. Majority of them had changed to pads after their first delivery when they were given instructions by the hospital staff. It shows that, in the last decade, the use of sanitary pads has rapidly

increased among tribal women. However, 13 percent of the younger mothers still prefer to use cloth during periods. The reasons they pointed out are lack of proper disposal facilities, skin irritation, infection and discomfort while using it, and also cost issues.

"Veena," a 21-year-old younger mother said,

> When I was at my home, I had used pads and we had enough place to burn it. But here, houses are situated very close to each other and disposal by burning is not possible. So, I have changed to cloth.

Similarly, "Seetha", a 24-year-old mother shared,

> I use cloth during my periods. I have used pads before and I didn't like it. If I use pads, I have to go to the riverside for washing and burning it. By using cloth, I can handle it at home and also save money, right? One small packet cost almost 40 Rupees and why should I spend it?

As per "Meera," a 28-year-old another young mother shared,

> I have heavy bleeding during my periods. If I use pads, I have to change it more than 4 times a day. So, I prefer to use cloth, as it can soak in more blood and I do not need to change it so often.

Unhygienic use of absorbents is high among rural tribal women and result in adverse health outcomes (Mahapatra, 2023). Contrary to that, the present study found that the awareness regarding the menstrual hygiene and the use of hygienic absorbents is high among young women than elder women.

The findings raise concerns regarding the increasing incidents of irregular periods among young women. While 73 percent of younger women have ever experienced irregular periods, only 7 percent of grandmothers have reported the same. Irregular period is a common and a critical health condition in the valley. Majority of the women have experienced irregular periods before and after marriage. Some of them have reported they have heavy bleeding after two months of missing periods. This creates a confused situation when assessing pregnancy and

miscarriages. Usually, they get iron and folic acid tablets from the field level health workers or collect ayurvedic medicines from the dispensaries without a doctor's prescription in order to regain their periods.

6.2 Marital Status, Rituals and Incidents of Domestic Violence

Age at marriage has decisive effects on the RH of women. Studies found that, early marriage is associated with frequent and unplanned pregnancies, abortions and early childbearing, consequently resulting to maternal and child health complications (Prakash et al., 2011; Santhya et al., 2010).

Table 6.1

Preference for Type of Marriage and Certification among Tribal women

	Type of marriage		Marriage certificate	
	Arranged %	Love %	Yes %	No %
Mothers	31	69	11	89
Grandmothers	96	4	0	100

Source: Primary Data

In this study, the mean age at marriage is 20 among younger generations and 18 among the older generations. The results also found that 69 percent of younger women had a love marriage and 89 percent of them have no marriage certificate (see table 6.1). In love marriages, normally, they used to have a yellow thread with '*mangal sutra'* (called '*thali'*) or there may not be a '*mangal sutra'* and they tie a yellow thread only. Sometimes, they live together without doing any of these rituals. Marriage certificate is not considered necessary by the tribal people. The numbers show that love marriages are rapidly increasing in their community. The elderly women also raised concerns over the increasing number of love marriages. "We do not get a chance to conduct our children's wedding, so we are conducting grand functions for the menstrual ceremony."

The wedding function extends for three to four days. First day, the groom's family will come to the bride's hamlet and receive permission from the hamlet god and respectable people of the hamlet. The next day, the ritual will be performed along with '*thali kettal'*, after which they will travel to the groom's hamlet and finish the rituals. The marriage rituals are interesting: all the tribals, belonging to the subcategories should be invited for the wedding. If the groom's parents are not married as per the tribal rituals, first, they have to marry accordingly. Only then can the young couple marry following the rituals.

In the tribal culture there is no dowry system according to their tradition. But the change is visible as the tribal people try to replicate mainstream "*Malayali*" culture. Usually, in their culture, the groom and his relatives give 1000 Rupees called '*periya panam'* to the bride and her family. It is viewed as a symbol of thanks to the hamlet people and the bride's family for giving their daughter to them. The women used to wear, only a few gold ornaments like a single gold chain, a pair of earrings, one or two bangles etc. Nowadays, gold is getting more importance among the tribals. Usually, they live at the husband's place - patrilocality. But nowadays, the couple could choose their living place as per their convenience. A few years after marriage, the couple usually try to find their own place. It may depend on the availability of land and housing programmes from the government.

Separations, extramarital affairs and related domestic violence are common in the hamlet. Most of the incidents of violence reported are marriage related. Husband and in-law families are the perpetrators in most of such cases. Studies have found that tribal women face high rate of domestic violence across India (Jyotirmay et al., 2022; Premi, 2016). 20 percent of the study participants reported that they had violent experiences from their partners or in-laws. Of those, 55 percent are young women and 45 percent are elder women. Major issues include the extramarital affairs and suspicious nature of partners, violence from in-laws, infertility, alcoholism etc. Both generations have faced violence but the younger generation are prone to more issues such as extramarital affairs and doubting nature of partners and infertility.

Lakshmi is 37-year-old and had tried for suicide in her first marriage. it was an arranged marriage and happened just after her tenth-class education. As she got pregnant within six months of pregnancy, she could not finish her higher studies. After few months of delivery, she got ASHA worker job in her hamlet. Her husband and his family members were not supportive. Still, she managed to do her job for three years. The physical and emotional violence increased and she decided to end her life. She had paracetamol overdose and admitted in government hospital. Her parents got shocked after this and took her with them. Her husband and family kept the first child. After seven years, she entered second marriage, it was a love marriage and they have two children now.

Malathi, a 21-year-old Irula woman, had love marriage. They were happy in the beginning of their marriage. After few months, he started to have doubts on her character and accused her for having extramarital affairs. They used to fight and she will return to her house. After few weeks, he will come and take her with him. Quarrels happen again and the wheel kept rotating. Due to these traumatic issues, she did not even know about her pregnancy. In her sixth month, health workers felt doubtful about her condition. They brought the pregnancy kit for testing and found her to be pregnant. They are living separately now. She had her delivery and the child is six months old now. He also doubts the parentage of his child and has not even come to visit the child. However, his home is in her neighbourhood and he is used to come drunken and create issues for her.

In another incident, 25-year-old Maya is married to a non-tribe through self - choice. She was happy during the early days and marriage got worsened as years went by. She got pregnant soon after marriage. Though she wanted to study, she went on with the pregnancy and delivered the child. After that, she started demanding for education and employment. He disagreed and kept on doubting her for extramarital affairs. She wanted to use copper T after her first delivery for spacing. He did not like that and blamed her that she wanted it to have relations with more men. She had to experience physical, verbal and emotional abuse. She tolerated all these and got pregnant with the second child. When her husband

accused that the child is not his, she had to leave his home. Currently she is living with her second child in her hamlet and he is living in his home with the first child. She completed her graduation through distance education with her natal family support. She met a new person through Facebook, she shared her experiences and demands with him. He agreed to all and now she is planning to live with him after completing the divorce procedures.

In case of Neeraja, a 28-year-old Irula mother, also had love marriage. He was caring and loving then. She believed him blindly. They had two children, but the elder child died of heart issues and the other child is two years old. She got to know about her husband's extramarital affairs during her third pregnancy, (currently 8 months pregnant). She returned to her own hamlet and is planning to get separated. They used to have lot of fight and for the last few months, he is not even vising the child.

31-year-old Laya has also experienced physical and emotional violence from her in-laws for delayed pregnancy. She did not conceive for eight years of marriage and she had to leave her in-law house. Meanwhile, her mother in-law created issues and also tried to remarry his son. Her husband also left his home and both were staying in her house while conceiving. After delivery, she had to return to her in- law house. Few other women also shared similar stories of experiences of violence.

6.3 Sexual Health and Exercise of Sexual Choice

The major reaction from women when asked about sexual practices were mostly a shy smile or an expression of disapproval to talk on the topic. Many of them did not know how to respond to the questions in this regard. Majority of the women said that they received information regarding sex from their husbands, while a few others, from their friends. A lot of the women also traced back their first exposure to sex education to the high school Biology texts. Majority of the women think of sex only as an instrument for childbirth; they lack the awareness that knowledge about sex is part of SRHR. Many of them have heard about HIV/AIDS, but only a few of them were able to explain what it is.

Stigma related to female sexuality, perceptions regarding the male sexual entitlements and fear of relational sanctions are the major factors or social expectations that influence and motivate the women to have sex with or without consent (Moreau et al., 2020). Kavitha, a 26-year-old Muduga mother, who had worked as a field level worker for a few months, opened up about her sexual life. She used to freely express her sexual feelings and demand sex with her husband. She also added that, he was very supportive and respected her feelings, which made it easier for her to express her thoughts.

Bindu, another Muduga mother, who is now into her second marriage, expressed her husband's lack of interest in sex. Sometimes, she thought of talking to her husband, but she was afraid to bring that to his attention. She was constantly intimidated by the social norms that women must be ignorant about sex and sexuality, and also because the sexual role of women in marriage was largely considered as passive. The women were reluctant to express their thoughts, assuming that their husbands may perhaps misunderstand them. There is no space for them to even talk about their sexual feelings and pleasure. So, these women end up compromising their needs and prioritising their husbands' interests and choices.

Majority of the respondents did not feel confident enough to open up about their sexual needs with their husband. They were afraid to indicate to their partners if they felt like having sex or when was their preferred time. They were also not ready to dissuade their husbands when they were not comfortable with sex, and were incapable of avoiding it.

6.4 Use of Family Planning Methods

Eighty-two percent of the elderly women had heard of modern methods for family planning and of those, eighty-one percent have ever used at least one method. In case of young women, hundred percent of them have heard of the same, of those forty-four percent have ever used at least one method for family planning. The major modern method among elderly women was female sterilisation; sixty-four percent of them had undergone sterilisation and only seven percent ever used at least one temporary modern method. In the case of young women, eighteen percent had

undergone sterilisation and thirty-one percent ever used at least one temporary modern method for family planning. The utilisation of contraceptive services among tribal women are given in Table 6.2.

Table 6.2

Utilisation of Contraceptive Services among Tribal Women

Indicators	Elderly Women %	Young Women %
Women who ever heard of modern methods of family planning	82	100
Women who ever used at least one modern method for family planning	81	44
Women who have undergone sterilisation	64	18
Women who ever used at least one temporary modern method	6	31
Use of temporary modern methods		
Copper T	4	20
Condom	2	9
Injectables		2
Women who are currently using temporary modern methods		18
Women who discontinued temporary modern methods	2	13

Source: Primary Data

An intergenerational comparison in the analysis of demographic variables reveals an increase in education, age at marriage and age at first pregnancy among young women than the elderly women. Additionally, there is a decrease in the total of number of pregnancies and average number of children among young women compared to the elderly women. Education, income and occupation of women do not seem to affect the contraceptive choices among the younger generation in Kerala (Thadathil & Sujina 2016). Herein, this study found that increase in education and employment among young tribal women in Attappady have created more awareness on modern methods for family planning. Although more young women are using

temporary modern methods than the elderly women, forty-three percent of them had to discontinue due to various reasons such as physical discomforts, inaccessibility and unavailability of quality services. In agreement with a previous study (Thomas et.al., 2021), this study also reveals high rate of female sterilisation (sixty-four) and higher average number of children (four) among elderly tribal women compared to the state average. However, among younger women the rate of female sterilisation (eighteen percent) and average number of children (two) is declining due to various reasons, which are discussed later based on in-depth interviews and case studies.

6.4.1 Experiences of Elderly Tribal Women on Permanent Contraception

Majority of the elderly women had their sterilisation from various camps organised by governmental and non-governmental institutions from within and outside Kerala. The respondents shared their memories of health workers walking to their hamlets and talking about the availability of sterilisation facilities. Groups of tribal women from neighbouring hamlets would walk together or travel by private vehicles for availing these services. The private vehicles were arranged by different voluntary organisations for transportation purpose from a few hamlets by the main road side; the roads being mostly unpaved. Many elderly women shared openly about the concerns they had, difficulties they faced and lack of family support they had experienced while deciding to utilise the contraceptive services. As per "Mari" (59),

> In our times, people (health workers) used to visit us (for spreading awareness). They told me about Copper T, but I was indifferent to it. We (couple) used to practise abstinence ('*onnichirikilla*') for child spacing. After a few deliveries we (women) would go for sterilisation, walking long distances and we got saree, money, bucket, mat etc. as incentives.

The study participants were willing to share their experiences during the sterilisation procedure. Many of them found it a scary task while a few others described it as an adventurous experience they had taken up in their lifetime. "Bharathi" (49) was enthusiastic while describing her experiences about the sterilisation procedure. She found it odd and scary. In her words,

> 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.

In a rare case, a woman underwent sterilisation procedure unknowingly. "Lakshmi," a 56-year-old Irula grandmother was one among them.

> 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 realised I couldn't bear children anymore.

Lack of Family Support

Several women shared how they were forced by husband and in laws to have more children and denied help and support to take contraception including sterilisation. "Ruku," a 49-year-old grandmother, had decided to undergo sterilisation despite the lack of support from her husband and his family. She shares her experience,

> After two children, I decided to stop my pregnancy. In those times, there were sterilisation 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 sterilisation 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 for collecting 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.

She was emotionally overwhelmed and was re-experiencing those moments while sharing it. She finished sharing her experiences with a deep sigh, after which she looked relaxed. She also shared about her children's health concerns as both of them have sickle cell anaemia. 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.

Failure of Contraception

A few of the elderly women reported failure of the sterilisation procedure which resulted in unwanted pregnancies later on. "Nanchi," a 48-year-old Irula grandmother conveyed,

> After my fifth delivery, I decided to undergo sterilisation and went with two other women from my hamlet to the camp. But it was not done properly and the three of us got pregnant several times afterwards. I had three more deliveries and then stopped pregnancy only after my eighth delivery.

6.4.2 Denial of Female Sterilisation: Young Tribal Women's Experiences with Permanent Contraception

According to the standards for female and male sterilisation services published by the Ministry of Health and Family Welfare in 2006, the female married 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 sterilisation services. The lack of proper information regarding female sterilisation is evident among the research participants and this has created barriers in accessing family planning services. The age criteria, health of the mother and child were found to be reasons attributed to the denial of sterilisation services among the research participants.

"Keerthi" is a 22-year-old Irula mother who was married at the age of 17. Soon after marriage, she conceived and had two children. Both pregnancies were complicated, she had multiple blood transfusions and she wanted to stop pregnancy desperately. She says,

> I hate it and I am done with it. I wanted to stop my pregnancy after my second delivery. The hospital staff told me that I could only do sterilisation once I reach the age of 25. My sister also had a similar experience, but she just crossed 25 and had her sterilisation done last month. So, presently, I am

> waiting to be 25 and meanwhile I have decided to use Copper T to avoid pregnancy.

"Sutha" a 23-year-old Muduga mother also shared similar story.

> I wanted to stop pregnancy after first delivery because of my health complications. But unfortunately, I conceived the second child within six months of my first delivery and I went ahead with it. When I had asked the hospital staff about sterilisation post-delivery, they told me that, I could only do sterilisation 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?

Sutha, had two successive pregnancies and was having health issues because of which she wanted to undergo sterilisation. The hospital staff denied her demand by pointing out the wrong age criteria and presently her husband and his family say they need one more child. But she is determined to avoid pregnancy for at least a few years so she would get some time to decide. She is using Copper T as a spacing contraceptive after her second delivery. But then she developed infection and so had it removed. After that she opted for 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 was sticking on and has not skipped any course.

"Charu," a 30-year-old Kurumba mother also shared a similar experience about the denial of permanent contraceptives.

> I had twins in my second delivery. Both were low birth weight children and one child died within 15 days of delivery. So, they did not perform the procedure. But I do not want more children. Since then, I am using Copper T. When I had discomforts while using it, I visited the health centre to fix it. It has been three years now and I am planning to remove it in the coming months after which I will approach the health workers for sterilisation.

Mathu, a 32-year-old Kurumba mother was denied access to permanent contraception. She had been trying to stop pregnancy for the last few years but she

could not do it. Different reasons came up and finally she delivered her seventh child. The demand for more children from family, lack of access to quality contraceptive services in the remote forest, and restricted mobility are some reasons that she mentioned. The pregnancy outcomes of Mathu detailed in Table 6.3.

Table 6.3

Pregnancy Outcomes of Mathu

Indicator	Pregnancy outcomes						
	1st	2nd	3rd	4th	5th	6th	7th
Sex of Child	Male	Male	Female	Female	Male	Female	Female
Current status	Aged 16 yrs	Aged 14 yrs	Died (10 days)	Aged 6 yrs	Aged 4 yrs	Aged 3 yrs	Died (3 months)

Source: Primary Data

Though she had heard of spacing contraceptives like Copper T, rumours within the community has sowed distrust among the members and many decided against its use. Instead, they opted to stick on to natural methods. “Mathu” shares,

> I have heard of Copper T, but I 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 issues. It is just getting on postponed. Currently I am abstaining and waiting to become healthy, so I could stop my pregnancy for ever.

Denial of sterilisation rights in the case of Mathu could be attributed to her bad health condition but it had left her in a vulnerable situation. The vicious cycle continues as she struggles to avoid one more pregnancy.

The medical outreach camps and health care facilities have served to increase the rate of sterilisation among the tribal women in Attappady. However, elderly women had to face difficulties due to various reasons such as preference for

more children, lack of support from the husband and family members, and the lack of access to and availability of quality health care services. According to the young women, there has been a decrease in preference for more children along with an increased support from the husband and family members for sterilisation.

In Kerala, women with low levels of education prefer female sterilisation than the highly educated women and lack of proper information on vasectomy, lack of motivation to use reversible methods and economic implications are the major reasons behind it (Thulaseedharan, 2018). The case studies show that along with the above reasons, the maternal and child health complications persisting in the valley is also a major reason behind the tribal young women's decision for female sterilisation.

Though health interventions have played a critical role here, the accessibility and availability of quality healthcare services remain a challenge in the valley. Twenty two percent of young women reported that they were denied their right to permanent sterilisation due to various reasons such as lack of healthy children, health issues of the young mothers and age criteria. Of these women, majority are opting natural methods like abstinence to avoid unwanted pregnancies.

6.4.3 Role of Community Narratives and its Effect on the Use of Family Planning Methods

Many of the tribal women expressed their disagreement on the use of temporary artificial methods by sharing the misinterpreted community narratives they had heard from the other women in the hamlet. According to them, women had physical discomforts such as irritation, weakness, back pain etc after resorting to such methods. Only a few women expressed their concerns over the working of implants and they also seemed confused about their sexual life. They have heard narratives of implants getting hooked in the male partner's penis, so, they are not sure about using it.

"Ragini," a 49-year-old woman said.

> When I was visiting the health centre for my check-up, a woman was admitted there for removing her 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.

They also shared apprehensions regarding Copper T as there were stories of the IUD getting lost inside the body and also pointed out the health concerns raised by men having intercourse with women who used Copper T.

6.4.4 Lack of Proper Information and Inaccessibility to Quality Services

Inaccessibility to quality contraceptive health care services is the major reason behind the denial of temporary artificial methods. Of those women who had ever used Copper T, 50 percent reported serious health issues/ discomforts and later had it removed. "Deepthi," a 22-year-old, shared her experiences about the use of 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 condom, we (she and her husband) were not comfortable with it. We have heard lots of stories and now we had the experience also. So, we decided to stick to natural methods like '*onnichirikilla*' (abstinence).

"Veena," a 21-year-old Irula mother, shared her apprehensions based on the misinterpreted community narratives. In her words,

> I talked to my mother about the health staff's advice to implant Copper T, but she did not allow it and shared stories of women who had health issues and discomforts after using it. Currently we are trying to use natural methods, if

it does not seem to work, we will use condoms. My husband gets it from the medical store.

An uptake of contraceptives is critical in ensuring women's RH and if women who discontinue do not switch to another method in a timely manner, it will put them at high risk. The major reasons for discontinuation are the side effects and the health concerns related with the reversible methods and most significantly the lack of access to the healthcare facility. Women prefer easily accessible quality services in order to continue certain methods and with the lack of these they prefer to change to methods which do not need a health care visit or assistance. Women have to be well informed about the choices they have and the timely intervention is also critical. The timing when women acquire information, the source of the information and availability and accessibility to the service are also critical in contraceptive usage (Sato et al., 2020).

The knowledge and acceptance towards modern reversible contraceptive methods have increased among tribal population (Mog et al., 2020). The younger generation is more aware about the need of child spacing and the common maternal and child health issues have helped to improve the acceptance of temporary methods. Along with that, the presence of field level workers and the accessibility and availability of more options such as injectables have led to an increase in demand. However, the present study found that, 33 percent of the young women have ever had a child spacing of less than three years, and of those women, only 47 percent 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 discomforts and the misinterpreted community narratives are still prevalent in the present study area and they seem to restrict the choices and decisions of the research participants, at the same time, limiting the coverage and usage of temporary methods among the young people.

6.4.5 Use of Herbal Contraceptives

A few elderly 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 of using traditional medicine as a means 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" 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.

Herbal contraceptives are eco-friendly, easily available and affordable family planning methods in rural areas and allow a couple to practice fertility control without the help of the modern health care system. The anti-fertility effects such as anti-ovulation and anti-implantation benefits of herbal contraceptives have proven to be effective. It has been found that the side effects are minimal in comparison with the chemical methods (Bala et al., 2016). In addition, herbal contraceptives are available from the local sources and it offers 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 practised among the tribal women as a method of family planning. But over the years, it has lost popularity due to various reasons such as introduction of modern medicine and the loss of biodiversity in the valley.

6.4.6 Role of Gender Norms and Engagement of Men in Ensuring SRHR: Restricted Choices and related Unplanned Pregnancies

Though women possess awareness on modern family planning methods, distrust in artificial methods is quite prevalent. The higher 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, two percent of elderly women and twenty seven percent of young women reported that they had unplanned pregnancies due to various reasons. Along with the lack of adequate and acceptable family planning services, the negligence from the alcoholic husband and patriarchal norms embedded in family systems force women to have unplanned/ unwanted pregnancies and childbirth. "Rangi, a 53-year-old Irula woman said.

> It was my 9th delivery and my family found it as shameful 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 the child and its trauma.

Rangi expressed her disappointment on the unavailability and lack of access to contraceptive services to avoid unintended pregnancies. If she was able to access the contraceptive services, she could have avoided the physical and mental trauma associated with her last and very late pregnancy and the related postpartum issues. The lack of family support and access to support systems made it worse for her. The pregnancy outcomes of Rangi is detailed in Table 6.4.

Table 6.4.

Pregnancy Outcomes of Rangi

Indicator	Pregnancy outcomes								
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Sex of Child	Male	Male	Male	Female	Male	Female	Male	Male	Female
Current status	Died	Died	Aged 31 yrs	Died	Died	Aged 26 yrs	Aged 22 yrs	Aged 20 yrs	Aged 14 yrs

Source: Primary Data

Majority of the participants talked about the alcoholic nature of their spouses and the resultant violence they had gone through. Alcoholic partners and their

refusal to use spacing contraceptive methods resulted in unplanned pregnancies. Chelli, a 49-year-old Irula woman, currently working as an Anganwadi helper, shared about her experiences with alcoholic husband and the violence she endured as part of it. She got pregnant soon following the birth of her first child. Continued physical harassment (on her and the elder child) and financial issues forced her to take drastic steps. She decided to abort the second child and travelled to the nearest state for availing the service from an unauthorised clinic. She turned 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. In "Chelli's" own words,

> My husband had severe alcoholic issues and he used to beat me and my elder child. So, I decided to abort my second child. I had bleeding after that and it did not stop for weeks. In those days I used to take bath in the river. While I sit in the water, I could see blood leaving my body tinging the water red. After that, I decided not to do abortion again.

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 stopped her pregnancy through sterilisation. Her family was also not supportive. She added that she had no other choice but to live with her husband. "I could not think of it(separation) then; I had no courage. But now I have a job. So now I am brave and feel confident. If I had this courage then, I would have thought of leaving him."

"Mallika," a 29-year-old Irula woman also shared her experiences with her alcoholic partner and the subsequent unplanned pregnancy:

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

Following the unplanned pregnancy and denial of abortion services, she had to go through one more pregnancy to fulfil others' wishers despite her disinterest.

> Though I wanted to stop my pregnancy, my husband and father-in law wanted a girl child and I could not do it. Then I waited for a third child and luckily it was a girl so I could do sterilisation.

The role of women in deciding the number and spacing of children are both important in ensuring the rights of women. "Revathi," a 30-year-old Muduga mother talked about her dilemma. She had four pregnancies, of which one ended in miscarriage and one child died within hours of birth. She carried that trauma and was not interested to go through one more pregnancy. But her husband wanted one more child. When asked about the use of contraceptives, she said,

> Though I have heard of Copper T and condom, I am not comfortable to use either. I want to do sterilisation. I have had enough of pregnancies; I am done with it now, but my husband wants one more child. I cannot talk to him about it and now I am in a dilemma.

She had no healthy communication with her husband to talk about her feelings. She was anxious and never tried talking. She thinks it is not right to talk about such things to her husband. Her husband's insensitivity in understanding her feelings along with her lack of decision-making capacity in determining reproductive choices made the situation worse.

In another incident, "Rama," a 22-year-old small and thin built Irula woman, has two girl children aged 3 and, 2 years. Both her children had low birth weight (1.500 kg and1.900 kg respectively) and both suffer from severe acute malnourishment. She says,

> After my second delivery, health workers advised me to use Copper T for child spacing. As my husband wants more children, I do not want to stop my pregnancy now. So, I have decided to use it. After a few months, I had pain and discomfort and had it removed. Then I thought of using condoms but my

husband is not comfortable with it. Currently I am not following any such methods.

Her choices on spacing contraceptives are highly compromised because of the lack of proper information and the inaccessibility to quality services. Along with the infrastructural constraints, her husband's lack of knowledge and negligence from his part had limited his involvement in ensuring her SRH rights, which consequently made her more vulnerable.

6.4.7 Attitude of Men on Modern Methods for Family Planning Matters

Men's engagement in family planning would positively affect the RH of women. However, the lack of participation of men in family planning methods still remains a challenge (Thadathil & Sujina, 2016). Among the study participants, a few women reported husbands' support in 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 one among the few women who used condoms in those times. She said.

> I was in my late teenage while getting married and conceived soon after my marriage. As I was very young, the pregnancy got complicated and 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" 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.

In another incident, Deepa, a 31-year-old Irula mother, shared her experience about the use of Nirodh, 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' (condom) 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?

The above case studies show the different approaches of men regarding family planning methods and how it influences the SRH of tribal women. In the earlier case study, her husband decided to use the reversible methods with the advice of health workers and ensured the safety of his wife and children. On the contrary, the second instance is a clear example of the improper attitude of men towards the artificial methods. According to Tripathy et.al (1994), in India, the families are mostly stable and couples usually complete their family during their mid-twenties and seek out permanent contraceptive methods. The chances of divorces and remarriages are low, thus promoting safe, low cost and effective permanent methods such as vasectomy is critical. Informing women and men about the available contraceptive methods and encouraging men to perform vasectomy would help in sharing the burden of fertility control with women (Ravindran, 2021).

Conclusion

The increase in tribal women's education, occupation and health interventions have positively impacted the menstrual health, sexual health and utilisation of family planning services. The knowledge and attitude towards artificial methods for family planning is slowly getting better; more options were added in the basket of choices and more access points were created. However, the findings reveal that the young women are denied of their demand for permanent contraception despite the increase in maternal and child health complications. They have to discontinue the temporary modern methods because of the persisting apprehensions and the inaccessibility of quality services. The aforementioned factors force tribal women to rely on natural methods, which often fails, resulting in unplanned or unwanted pregnancies.

The intersectional analysis shows that the structural inequalities still persist, which intersect with each other and the resulting gender-power relations underlie denial of SRHR of Attappady tribal women. Patriarchal norms and the gendered nature of family planning continue to aggravate the vulnerability of women through

the control of her body and her choices. In addition, the lack of engagement of men and lack of family support greatly limit women's decision-making capacity as well as their negotiating power. Furthermore, the prevailing gaps in timely and quality services create fear and stigma among the tribal women towards the utilization of modern family planning methods. Consequently, the existing gender and power relations across the individual, family and societal levels are seen to negatively impact the tribal women and thus denying them the SRHR rights. The persistent MH issues and infant deaths in the valley emphasise the need for more focused interventions in order to redress the hurdles in the utilisation of family planning methods.

Chapter 7
PREGNANCY AND CHILDBIRTH EXPERIENCES OF TRIBAL WOMEN

CHAPTER 7

PREGNANCY AND CHILDBIRTH EXPERIENCES OF TRIBAL WOMEN

Introduction

This chapter contributes to answer the third specific objective, which discusses the intergenerational comparison of pregnancy and childbirth experiences of tribal women. It includes RH characteristics, pregnancy care and routine, delivery experiences, maternal and child health complications and postnatal care among the two generations in Attappady.

7.1 Reproductive Health Characteristics of the Participants

Among the mothers, the mean age at marriage was 20.11(±3.05) and the mean age at first pregnancy was 21.33(±3.18) and in grandmothers, it was 18.31(±2.16) and 19.84(±3.29) respectively. Out of the 103 pregnancies in mothers, 87 percent of the children are alive with an average of 2 children per woman. Thirteen percent of the mothers had four or more than four pregnancies and along with that, 9 percent had a miscarriage, 2 percent had an abortion and 2 percent had a stillbirth. Among the grandmothers, out of 159 pregnancies, 92 percent of the children are alive with an average of 4 children per woman. Thirty one percent of the grandmothers had four or more than four children, 2 percent had an abortion and 4 percent had a stillbirth (see table 7.1).

Table 7.1

Reproductive Health Characteristics of the Participants

Indicators	Mothers	Grandmothers
Total (N)	45	45
Mean age of participants (Years (±SD))	28.4 (±4.84)	52.17 (±7.28)
Mean age at marriage (Years (±SD))	20.11 (±3.05)	18.31 (±2.16)
Mean age at first pregnancy (Years (±SD))	21.33 (±3.18)	19.84 (±3.29)
Total no. of pregnancies	103	159
No. of living children (%)	87	92
Average number of children per woman	2.28	3.53
Number of women with four or more than four pregnancies (%)	13	31
Number of women who ever had a miscarriage (%)	9	0
Number of women who ever had an abortion (%)	2	2
Number of women who ever had a stillbirth (%)	2	4

Source: Primary Data

Over the years, the mean age at first pregnancy, number of women with four or more than four pregnancies and the average number of children per woman have decreased. The major reasons behind this might be the increase in the rate of education, access to more quality health interventions and better use of family planning methods. According to the younger mothers in the study, 40 percent of them have plus two or above plus two education, 44 percent of them have used at least one contraceptive and majority of the participants have received health care services. However, the number related to child health seems problematic and especially the number of live children is proportionally less compared to the grandmothers.

7.2 Pregnancy Care and Routine

As per the elderly women, pregnancy routine was nothing much different than their daily life routine. Though they were excited, they did not feel any need of "to be taken care of" like the practices today. They used to do all household work and took part in farming. They would walk long distances to reach the farming sites which were situated in the forest and also go to fetch water and firewood. As farming is a seasonal activity, most of the participants also work in the estates. Work in the estates is highly strenuous as they have to work without any breaks.

Nachi, an elderly Irula woman, used to work on a coffee estate during her pregnancy. Usually, they had two meals per day. While she was working on the estate, she had to carry her lunch. She would wake up early in the morning to prepare food for the entire family before she leaves for work. She worked on the coffee estate until her 7th month of pregnancy.

Similar stories were shared by other elderly tribal women and they expressed their concerns over the changing concept of "being healthy". In their opinion, in the past, the tribal women used to be healthy and they considered pregnancy as a natural phase of life. As per "Mari," a 49-year-old Irula grandmother,

> Everything has changed now. In our times, we used to have healthy pregnancies and childbirths; the children were healthy. Nowadays, majority of the pregnancies are complicated, every month check-ups, MH issues and regular medicines, after all these, the children are born with low birth-weight and other health complications.

When the researcher asked about their thought on increasing maternal and child health complications, "Nachi," a 52-year-old tribal grandmother sounded sarcastic and disappointed when she replied, "the government knows everything right? We are uneducated people, what would we know?"

Young mothers conveyed that, the field level workers distribute iron and folic acid tablets to newlywed tribal women as a proactive step. It would help them have regular periods as well as enough nutrients during conception. Once a woman

conceives, the field level workers like Anganwadi Workers (AWW) from Integrated Child Development Service scheme, ASHA workers from Health department, Scheduled Tribal promoters (STP) from Integrated Tribal Development Programme and Kudumbasree Animators (KA) from National Rural Livelihood Mission register her name in their respective offices for ensuring the entitled services from various government schemes and programmes.

The field level workers are supposed to attend to the needs of the women during pregnancy and childbirth. They work as an intermediary between the beneficiary and the government by conducting weekly visits to their houses and by imparting information related to healthy pregnancy and childbirth. The STPs will register her for receiving supplementary nutrition and Janani Janma Raksha (JJR) programme, a financial assistance given to pregnant women for 18 months devised by the Ministry for Welfare of Scheduled Tribes in Kerala and the STPs in association with KA run the community kitchen which is also a supplementary nutrition programme and pregnant and lactating women are entitled to such support.

Accredited Social Health Activist (ASHA) worker is a trained female community health activist under the National Health Mission Programme. They involve in reproductive and child health services by promoting universal immunization, referral and escort services. At the time of visit, all 24 hamlets have the ASHA worker access. The ASHA worker does health check-ups for the woman and the AWW will register her in the Anganwadi centre for benefits such as supplementary nutrition, weight monitoring etc. Almost every participant received services from the ASHA worker, however, very few reported the delay in services due to transportation issues.

Hundred percent of the young mothers have reported to have availed antenatal and postnatal health care services. Majority of them are satisfied with it. However, few of the young mothers who are living in the interior forest, have experienced difficulties in accessing the services. Tribal women from a few Kurumba hamlets, especially from Murugala and Kinnatukara hamlets have to travel long distances to avail services due to transportation and connectivity issues. And it

has also created difficulties for the field level workers such as the AWWs and other health department staff, like the health inspectors to reach them. But both hamlets have ASHA workers and STPs from their own hamlets and they are the communication points to access the pregnant and lactating women, and under five children. Lack of transportation facilities has caused denial or delay in accessing services such as weekly house visits, weight monitoring and supplementary nutrition provision.

Hundred percent of the young women have received Mother and Child Protection (MCP) Card, which will include the details of reproductive and child health information such as antenatal and postnatal care, immunization, breastfeeding, child growth and development, and birth control. It also includes health check-up details of the mother and child during pregnancy and childbirth including child immunization and weight monitoring of children under the age of five. Of those, only less than 10 percent have ever read the information in the MCP card. Others did not find it as a source for gathering useful information.

Though most of the young mothers have received all health services, twenty percent of the MCP cards were incomplete as they failed to record the entire details which indicates that there are lapses in the data recording system. As per the MCP card details, most of the mothers were categorised as high-risk mothers as they have different health conditions such as blood pressure variations, low weight and low height, anaemia and thyroid issues.

Janani Janma Raksha (JJR) is a monthly financial assistance (2000 per month) programme for tribal women from their third month of pregnancy till the child attains one year. Seventy eight percent of the under-five children have received the benefits of the programme. Of these 99 percent have reported about irregularity in the crediting of funds. They should be getting 2000 rupees per month, but the amount is credited only occasionally, so they are not able to rely on it. And even if they know the purpose of the financial aid, they use it for other purposes like purchase of gold, mobile phones, clothes etc. Some, use it to buy food, medicine etc and for transportation and hospital needs in private hospitals for delivery. Some put

the money into fixed deposit schemes and use it for conducting cultural ceremonies of children.

Twenty two percent of the under five children have not received JJR benefits of which seventy one percent have applied for it, but do not know the status and the other twenty nine percent have failed to submit the application. Lack of information and delay in timely submission of the application are the major reasons behind this. Krishna, an Irula tribal young mother, married to a non-tribe and living in his house, had no information about the scheme during her two pregnancies, and could not apply for it. In the other instance of Geethu, a Muduga young mother, living in her hut in the forest with her husband - as they do farming there - could not apply for the benefit so far.

"Nithya," a 21-year-old Irula mother said.

> Usually, the STP will register the pregnant women during the third month. Maybe they wait to confirm the pregnancy as there may be chances of miscarriage. In my case, I could not recognize my pregnancy till the 5th month because of my personal issues. My husband (now separated) was alcoholic and he also had doubts on my character. He used to fight with me all the time and so I went away from his home. Moreover, I have irregular periods, so I did not understand the reason for my missing periods. On the fifth month of my pregnancy, a field level worker in my hamlet had doubts about my health condition and she brought a pregnancy kit. I did the test with her help and confirmed the pregnancy. So, I lost my chance to avail the scheme. But the field level workers helped me to register in PMMVY (6000 Rupees support) instead and I received the benefit.

7.3 Delivery Experiences of Elderly Women: Transportation, Delivery Methods and Childbirth

According to the elderly women, there were no special care schemes for pregnancy or delivery from the government during their younger days. There were only a very few health workers, and they used to visit hamlets once in a while to

advise them on the need and benefits of hospital care. Most of the tribal women never availed those services and only a few went to the hospitals to have institutional delivery. Among the 159 total pregnancies in elderly women, 92 percent were home deliveries and only 7 percent were institutional deliveries, with a 1 percent rate of abortion.

In those times, the health system in the valley was only getting established. All the more, there was a lack of trust on the health systems and modern medical services which affected their choices and decisions with a decreased interest to try out the same. Thus, only a few women ever tried institutional delivery. Other than that, lack of transportation facilities also affected the choices. Very few hamlets had access to proper road and transportation. Others had to walk long distances to reach the hospital. Thus, most of them preferred to have home deliveries and traditional medicine and care, centred around their home and hamlets.

Lack of transportation

"Radhamani," a 50-year-old Irula grandmother, has three children. She started going to the hospital for consultation during her second pregnancy. She decided to have delivery at the hospital and sought the help of her mother and sister-in-law and decided to walk all the way to the hospital. When midway, her delivery pain started and she could not reach the hospital. In her words:

> I could not walk more as my delivery pain started. We had to stop walking and we found a clean place in the forest beside the road. The people from a nearby hamlet gave us some cloth, so we could make a mara, a cover. I delivered the child there; it was a girl child. The women helped us cut the umbilical cord and buried the placenta. They gave us some food and water. We rested a while and headed back home.

Traditional methods of delivery

The traditional delivery methods among tribal women were found to be very interesting. Most of the deliveries happened at home and different strategies were used to enable the delivery process. In almost all the cases, the fellow women helped

the pregnant woman through the delivery process. In one of the usual traditional delivery methods, the pregnant woman would sit facing the wall and push against it. While two fellow women hold her hands, the third woman press her lower back. And in another method, they hang cloth from the roof for the woman to hold onto and made small pits on the floor. The pregnant woman would squat on the floor, by holding the hanging cloth and push, keeping her ankles in the small pit. After the delivery, they cut the umbilical cord using a knife, blade or thread. And they bury the placenta on their land. After the delivery, they are given a hot water bath. They start breastfeeding immediately after childbirth and a few women reported that, they used to avoid colostrum in those times, but now it is not practised. Mothers used to have locally prepared nutritious food called '*pulirasam'* or '*mulakurasam'* which is part of the post-delivery care. A few elderly women reported that they have given birth to their children without anyone's help. There would not be anyone other than husband to call for help, so they did it alone. In some instances, husbands assisted the women by holding them while pushing and also helped them to cut the umbilical cord.

If the delivery has complications, the '*dai'*, an elderly woman, who is an expert in assisting deliveries, will help the woman during labour. In those times, the health system was not that much established. But in the case of Bharathi, the '*dai'* could not help and she had to suffer pain for three days. "Bharathi," a 49-year-old grandmother, remembered her first home delivery experience. She had pain for days but the delivery did not happen and she got tired every day. She could not handle the delivery by herself or with the help of other women from the hamlet. So, the hamlet people brought a health nurse, stationed 20 km from her hamlet and she helped her to deliver the child. In her words "she was a god to me. I carefully noted what all she did and based on that I prepared for the next deliveries by myself," she sounded animated while sharing this.

If the placenta does not come out, they have different methods to aid the process. In one method, the woman sits near the fire with the groin area facing it and they believe this would help the movement of the placenta. In another method, they

have traditional herbal medicine made out of '*tadisi'* or '*chadichi'* a green plant found in the locality. They collect the leaves and make a paste out of it, the jelly-like and fibre-rich nature of which, they believe, would aid afterbirth

Studies found that the son preference is high among the tribal communities and the RH decisions are largely affected by that (Battala et al., 2016; Susuman, 2006) and it is also prevalent among the tribal communities in Kerala (Rajitha & Kuruvilla, 2021). The results found that the more son preference was found among the older generations than the younger generations. "Malathi," a 47-year-old Irula grandmother had eight deliveries, the first four were at home and the last four were institutional deliveries. The couple kept trying for more children as they wanted a boy. She delivered girls in her first five deliveries and had sons in her sixth and seventh deliveries. The health workers and her own children advised the couple to stop pregnancy but they would not listen. Though the couple were getting aged, they had a girl child in her eighth pregnancy after which she stopped her pregnancy and her husband died soon after that.

Table 7.2

Pregnancy Outcomes of Malathi

Indicator	Pregnancy outcomes							
	1st	2nd	3rd	4th	5th	6th	7th	8th
Sex of Child	Female	Female	Female	Female	Female	Male	Male	Female
Current status	28 yrs and married	26 yrs and married	23 yrs and studying	22 yrs and studying	16 yrs and studying	12 yrs and studying	8 yrs and studying	3 yrs

Source: Primary Data

7.4 Young Women's Delivery Experiences: Lack of Transportation and Access to Quality Services

Of those 103 total pregnancies among the young mothers, 89 percent of the deliveries were institutionalised and six percent happened at home. And importantly, five percent of the total pregnancies ended in abortions or miscarriages.

Thara, a 24-year-old Irula mother, conceived within six months of her marriage. Though she had missed her periods for two months, she did not notice it because of her usual irregular periods. After two months, she had heavy bleeding and she perceived it as periods. But the bleeding became heavier and they consulted doctors. As per the scanning report, it was a miscarriage and the doctors removed the remaining pregnancy tissue.

Among the 45 participants, only one woman reported of contracting COVID -19 during her late pregnancy term followed by childbirth. Gopika, a 21-year-old Irula woman was diagnosed with COVID-19 during her pregnancy. She had normal delivery, and both the mother as well as the child are healthy.

Around 90 percent of the women were categorised as high-risk mothers as per the MCP card. When the researcher asked the respondents about it, most of them did not know what it meant. A few women reported that, it might be because of blood pressure variations, anaemia, low weight and height etc, but they were not fully aware of the situation. Lack of proper nutrition lowers the capability of immune system, which leads to the chronic health conditions. Malnutrition, lack of social security measures and lack of quality health care services are major factors in neonatal deaths in Attappady (Haseena, 2020).

- *87% of women have Hb levels less than 11*
- *4% have sickle cell anaemia*
- *Many reported to have blood pressure variations, thyroid issues and other related complications during pregnancy*
- *9% of younger mothers reported having multiple blood transfusions during pregnancy*

The four percent of young mothers who have sickle cell anaemia, were diagnosed with it after marriage. Two of such women have children who are continuously monitored for their health conditions. As financial assistance they get pension from the Kerala government.

Manjusha, a 33-year-old Irula mother, conceived her second child after she was diagnosed with sickle cell anaemia. She conducted regular check-ups in the government hospital till the last trimester. When the delivery was nearing, she was referred to the nearest private hospital, as she belongs to the high-risk category. She had normal delivery at the private hospital and the mother and child were healthy.

Lack of transportation facilities to hospitals

As transportation is a major issue in the valley, majority of the participants depend on jeep/auto facilities to travel to the hospital. Nandhini, a 26-year-old Kurumba mother, who happened to deliver her second child in a moving vehicle, shared her experiences. She was staying at her maternal home. Her birthing pain started on a rainy evening. Her hamlet was situated in the interior forest, which was connected to the main road by a mud road. The heavy rain continued overnight and they could not find any vehicle. They had to wait till next morning to arrange a vehicle. She had to walk around 1 km from her home to the vehicle point. From there, they travelled for almost 3 km and she delivered the child in the vehicle. Her mother helped her during the delivery and they cut the umbilical cord. They directly went to the hospital, got admitted, did all the check-ups and were discharged within three days.

Lack of quality health care services

Many women reported to have different uncomfortable incidents regarding health care services during their pregnancy and childbirth.

1. **Scared of referral services and preference for private hospitals (need for more infrastructure and human resource facilities)**

Of the 63 deliveries that happened in the last five years, 14 percent were referred from government speciality hospital to medical colleges, taluk hospitals and other private hospitals. Lower weight of children, less fluid in the uterus, maternal blood pressure variations, heavy bleeding after delivery and anaemic conditions of the mothers are the major reasons reported by young mothers for the referral. Lack

of awareness or clarity regarding their medical conditions during pregnancy and delivery are other common issues.

Many women are scared of the referral services. According to "Devika,"

> if we consult the government hospital, they would refer us to other hospitals at any point of pregnancy or delivery. We are afraid of that. We do not know how things will turn out. We have heard from other people that the medical colleges are big places and they had to wait in the halls for hours or even days to get admitted there. If that is the case, why would we consult doctors at the government hospital. We would directly go to other hospitals, right? So, we do not prefer government hospital here. Though we have to give money, the private hospitals are better. So now we prefer that.

Mathu added that other than fear, money is also a major factor. Sometimes they may not have enough money to go to medical colleges in the neighbouring districts. So, nowadays people opt to go to nearby private hospitals where they feel comfortable with the doctors and the facilities.

2. Changes of doctors

Many women reported that, during the monthly check-ups and even during the delivery, the attending doctors keep on changing which was inconvenient for them.

> It would be comfortable for us, if we could see the same doctor over the period of pregnancy and childbirth. It will help us communicate more easily with them. Many of the things they say, we do not understand, especially the medical terms, but the familiarity could help us to have trust in what they are saying.

Durga, a 28-year-old Irula mother, had two children, both were normal deliveries at private hospitals. They do not prefer to go to the government hospital as she feels that they do not get good treatment there because of their tribal identities.

> If we can pay money, private hospitals provide us good care. We used to source money from JJR and we arranged it by borrowing a loan. And there is no shifting of doctors like in the government hospitals and we can consult a single doctor. So, we chose that.

Other young mothers also reflected similar choices and experiences.

3. Discomforts during vaginal examinations: '*Kai idal'*

'Kai idal' is a local usage among tribal women, which means using hands for vaginal examinations during or before delivery by medical staff to check the dilation and position of the foetus. "Keerthi" (22), expressed her disapproval of the same when she was admitted to a hospital for delivery:

> After I was admitted for delivery, doctors and nurses used to perform the examination twice a day, but said nothing to me. Apart from that, the doctor students also did the same. It was truly uncomfortable as everyone on duty used to repeat it. If one doctor was doing it, then I could understand the medical necessity of it. But it is so rude and I felt it as needless. I confronted them on this practice, but I know many women could not do it and they were suffering. I strongly think of it as a violation of my body rights.

4. Unnecessary C-sections

Among the total deliveries that happened in the last five years, 27 percent were c-sections due to various reasons such as low heartbeat and low movement of foetus, umbilical cord wrapped around the neck of the foetus, baby passes stool in the uterus, water breaks, foetus is not in head down position, less fluid in the uterus and an underdeveloped uterus or lesser capacity of the uterus.

As per Bindu, her delivery happened at the government hospital. Initially everything was normal and she was supposed to have a normal delivery. Suddenly, they told her that the child is not moving, and they have to do a c-section. She felt doubtful about the decision as she had heard that the hospital staff were manipulating people for their hidden benefits. "Bindu" says, "we are not educated,

we do not know what is happening in our uterus. We have no other option other than trusting the medical staff and nobody is there to question them on behalf of us."

As opined by Srivastava and Sahu (2022), cultural competence is a major factor in ensuring quality health care services and lack of it creates distrust among the care seekers towards the institutional care. Equally, discrimination of community people at the healthcare facilities, centralisation of delivery services and the lack of negotiating power are the determinants in ensuring health care access to indigenous communities (George et al., 2020).

7.5 Child Health Complications During Pregnancy and Neonatal Care

The children born premature and with low birth weight get care at the neonatal care unit. Once the organ functions of the infant stabilises and it reaches a minimal weight, the mother and child get discharged and the follow ups would be done with the help of field level workers. A few women recounted their experiences about the low birth weight of children and the immediate transfer of children to the Intensive Care Unit (ICU).

Sarojini, a 26-year-old Irula mother, had c-section as her child pooped in the uterus and also the child had low birth weight. So, the hospital staff transferred the child to the new-born ICU. After a few weeks, the child gained weight above 2.5 kg and they were discharged.

Deepthi, a 22-year-old Irula mother, was admitted to the hospital for her delivery. The child's movement was low during scanning and her condition also worsened; her hands and legs were swollen and she was shaking. So, the hospital staff immediately prepared her for c-section. After the delivery, the child had difficulties (she was unable to explain them), and the hospital staff shifted the child to the incubator for two weeks after which they got discharged. Currently, the child is healthy but the doctors have advised them to do yearly check-ups and also referred to do an Echocardiogram when the child is three years old.

7.6 Child Health Characteristics: Birth Weight of Children Under-five

During the time of data collection, 65 children were under the age of five. Of those, 63 of them are children of young mothers and 2 are children of grandmothers. The birth weight data was limited to these under five children and the graph depicts the distribution of the same. Thirteen percent of children had a birth weight below 2 kg while, 24 percent of the children's birth weight belongs to a range of 2 to 2.49 kg and 51 percent of the children's birth weight belongs to 2.5 to 3 kg (see table 7.3).

Table 7.3

Child Health Characteristics of Children Under-five at the Time of Fieldwork

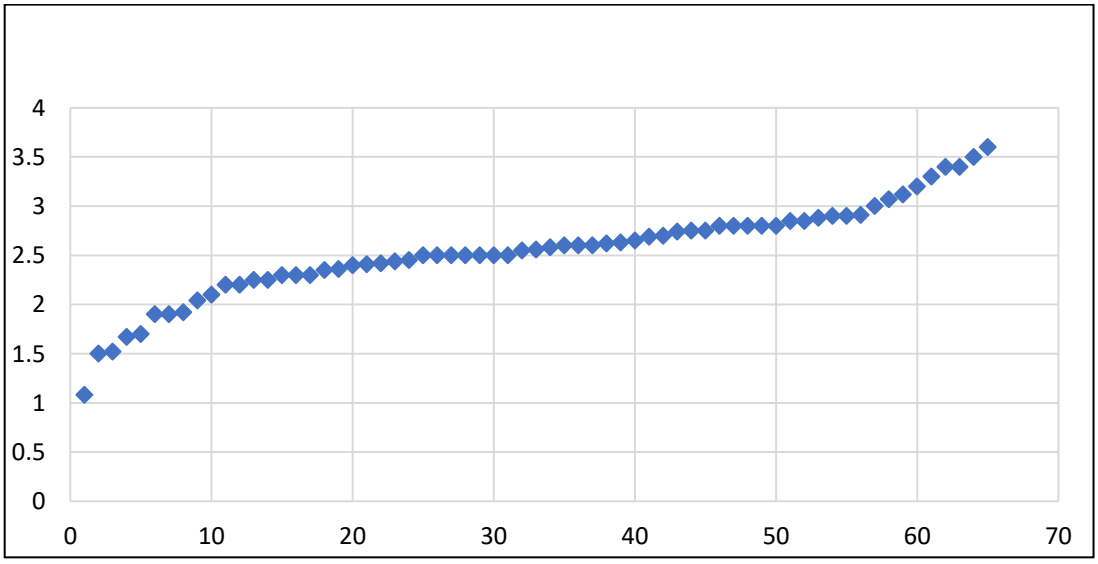
Indicators	Mother	Grandmother
Total number of under-five children	63	2*
Number of under-five children with normal weight	40	1
Number of under-five children with low birth-weight	23	1

Source: Primary Data

**Two grandmothers have children under five at the time of data collection*

Figure 7.1

Birth Weight of the Children Currently Under-five



Source: Primary Data

As per Growth chart, which is an Anganwadi register, records monthly weights of children under five. As per the time of the visit, 13 percent of the children had Moderate Acute Malnourishment (MAM) and 11 percent of the children had Severe Acute Malnourishment (SAM). In addition to that, twenty four percent of young women did not know the current status of their children's weight.

7.7 Case Studies of Infant Death

Thirteen percent of the younger mothers have ever experienced one or more than one infant death. Most of the reasons are low weight of children, milk aspiration, pneumonia and organ dysfunctions. Despite the access to health care services, they could not save the children

Devi is a 32-year-old Kurumba mother has two daughters now. She had twins in her second delivery. They used to consult at tribal speciality hospital and were referred to EMS Hospital, Perinthalmanna during her 8th month. As per her understanding, she was referred because of her high blood pressure. They went to the referred hospital and got admitted there. After one week, the hospital staff advised her to go for a c-section, as her uterus did not have enough fluid for the babies to survive. She delivered two girl children by c-section who weighed 1.520 and 1.120 kgs. Both were under observation for almost two weeks. The one with 1.120 kg weight, had critical health issues as the child's organs were not fully developed, Moreover, the child had infection in the small intestine, and this was recorded as the cause of its death. They were discharged once the child with 1.520 kg weight was better. After the death of the child, many government officials visited her house and they continue to visit her, she added. In this regard she received 1 lakh compensation for her child's death and she spent it for household expenditures like children's health and education.

Priya, a 32-year-old Kurumba mother, had seven deliveries and five of the children are alive now. Two of her children died due to various health issues (Manikandan, July 13, 2022). Her seventh child, a girl, died in her 5th month. As per the autopsy, milk aspiration is recognised as the cause of death. This is her second

child loss, as her third child, which was also a girl, died within 10 days of delivery, due to poor health conditions.

Padmini, a 36-year-old Kurumba mother, had six children, five of them are alive now. Her third delivery was normal, but the child's health was unstable. It was difficult to breast feed the child as he was less responsive. Due to heavy rains, they could not make it to the hospital. After two days of delivery, the rain subsided, and they decided to go to the hospital. The hamlet people, made a makeshift carrier for the mother and child to cross the Bhavani River, and from there, they took a vehicle to the hospital. The hospital staff scolded her and her husband for making delay in accessing the health services. They had to spent seven days in the hospital. But on the seventh day, the child had nose bleeding and died on the same day.

Neethu, a 28-year-old Irula mother, had two deliveries and lost her first child. During the first pregnancy, the doctors informed the couple about the child's heart issues and recommended an abortion. But the couple decided to go on with the pregnancy, because it was their first child and they were also against abortion. The government hospital in Attappady referred them to the medical college where she delivered the child. But the hospital staff could not save the child and he died within 10 days of birth.

Kavya, a 30-year-old Muduga mother, lost her first child. During the 9th month, her water broke when she was at home. She was rushed to the hospital, where she delivered the child and his weight was good. But the child developed breathing issues and died within hours. In case of Sindhya, a 36-year-old Muduga mother, had five children; four are alive now. Her third child died due to pneumonia in the 4th month after birth.

7.8 Postnatal Care and Trauma among Grandmothers

According to the elderly women, hot water bath and serving of '*pulirasam'* are significant factors in postnatal care. Hot water bath for the mother follows the delivery and it will be done twice a day, early morning and late evening, which continues for a few weeks. During the bath, hot water would be poured directly to

the lower back from a one to two metres distance. They believe that hot water would help the muscles and bones to relax and also help heal the vagina after birth.

The other major element is food and they make special food like '*pulirasam'* or '*mulakurasam'* during postnatal care. They take these daily for three months with millets dishes such as '*ragi kali'* and '*chama choru';* Ragi means finger millet and chama is little millet. The '*pulirasam*' contains different types of fennel seeds, coriander seeds, pepper and bird's eye chilli. They believe it helps to heal the body and also increases breast milk secretion. In earlier times, they were not allowed to eat dal or meat preparations. Many of the participants talked about the richness of their traditional food culture, which is diminishing rapidly in these times. They also incorporated traditional herbal medicines along with this for postnatal health care if needed. During home delivery, many women shared experiences of heavy bleeding for days and how most of them got cured by using traditional medicines. But Shiva, reported that, her bleeding continued for a long time after delivery and she had to visit a nearby hospital. Her uterus was not big enough to hold another child, so she underwent sterilisation as the doctors had advised.

Elderly women also shared their traumatic experiences with after pregnancy. Rangi, a 49-year-old Irula grandmother, experienced many difficulties during her pregnancy and delivery. She shared her memories with a heavy heart but looked relieved after the talk. Before her first delivery they prepared everything needed like hanging rope/cloth from the roof, making small pits in the room, arranging cloth, knife, needle, thread etc. But one morning, she could not feel the movement of the child in the womb. They waited and by evening her pain started and it went on till next day noon until she delivered a boy child, but it was a still birth. Her parents came home after hearing the news, and her father buried the child. But the placenta did not come out for another three days, as it had hardened. She also had difficulty with urination. Then, some people referred an elderly woman from another hamlet, she came to her house and gave some herbal medicine. Within a few hours, the placenta came out and they buried it in their land.

Her last pregnancy was also complicated and she had to go through post-partum issues. She did not know about her pregnancy during the early months. Later she was doubtful and decided to consult a doctor, who confirmed her pregnancy after an examination. She was also informed about her child's low growth rate. She said,

> There were issues around my late pregnancy, my husband or my children were not supportive and I too had not wanted this, but I got pregnant. What can I do? It was late to have an abortion so I had to keep the child.

As the pregnancy was complicated because of the lesser growth of the child, the hospital staff asked her to get admitted to the hospital for delivery. She did not get any vehicle to reach the hospital and had to deliver the child at home. It was a girl child and both the mother and child were healthy. She did not receive any help from her husband or children as it was a late and unintended pregnancy. She had to take care of the new born herself. She said,

> Sometimes I wished for the child's death, like what happened to my elder children. And I also had thoughts of giving away my child to childless mothers. I had to go through a lot of physical and mental trauma during that time. I could not differentiate right from wrong.

She talked in a confessional mode.

7.9 Postnatal Care and Trauma among Young Mothers

The postnatal care among the young study participants is mostly based around modern medicine. Though there is a massive change in the food pattern of younger mothers compared to the grandmothers, the one main thing they continue to incorporate in their diet is '*pulirasam'* which they still have for three months following childbirth.

Many women had to go through several physical and mental health issues after pregnancy. Lack of access to proper contraceptives complicates their struggles. Post-delivery maternal and child health complications such as bleeding, blood pressure variations in mothers and low weight issues in children are common among

the younger generations which needs special mention. Constant hospital visits and health check-ups are putting a lot of pressure on the physical and mental health of the mother as well as the child. The family members also suffer, especially the grandmothers, who are in charge of caring for the new born child and the lactating mother.

"Riya," a 23-year-old Muduga woman shared that,

> After two days of my delivery, I was referred and admitted in the medical college for almost a month. Many of those days, I was in the ICU and I barely remember those events. They put some tubes through my nose and some yellow fluid came out.

She thinks that she had gastritis during that time, but she could not recollect the medical terms and have no reports with her. The only thing she could recollect was that, she was ill. Most tribal women lack knowledge of their medical conditions. The women have the right to know it but they are completely unaware of it probably because of lack of education.

For Ramani, a 36-year-old Kurumba woman, her first two deliveries were normal, happened at home and she had healthy children. She had her third delivery at home, and the child had weakness. But they could not cross the Bhavani River as it was flooded with heavy rain. After two days of delivery, the hamlet people helped her and her child to cross the river by carrying them to the nearest vehicle point. From there, the hospital staff picked them and took them to the hospital. But the child got weaker and they could not save it and it died within one week. "The hospital staff scolded me and my husband, but what could we do?" she expressed her helplessness.

The fourth delivery was to be at the government hospital, but she had high blood pressure and they referred her to the medical college in the seventh month of pregnancy. She had to stay there for one and a half months, but she could not recollect the medical conditions she had. The only thing she remembers is that they did not allow her to feed the baby for many days. Her next delivery was also

complicated; the child had a small swelling near the lower abdomen. Once again, they were referred to the medical college. They had to spent a few days there. Gladly all the tests were negative and they could return peacefully. She shared,

> For the last few years, I have been constantly travelling to the hospital for my children's needs and my own ailments. I felt scared, helpless and clueless during that time. I can still remember the trauma that I had undergone at that time. It will stay with me forever.

Laya, a 31-year-old Irula woman, had a low-birth-weight baby in her first delivery. After a few months, the child had epilepsy and he is unable to walk since then. They consulted the government hospital doctors and they referred the child to the medical college. The family spent two to three months there, and the hospital staff advised them to continue physiotherapy. They took loan from Kudumbasree and borrowed money from various people to continue the physiotherapy treatment. But they could not further go on with the treatment as she conceived her second child at that time. They had to stop the physiotherapy as there was nobody to take the child to the centre (which is almost 10 km away from their home) regularly and also because of the economic issues. Now it has been stopped for more than two years.

Karuna, an Irula mother says,

> After my second delivery, the child used to cry all day for almost three months, I could not have any rest or sleep. I had thoughts of killing my own child. I was exhausted, nobody was there to help, not even my husband or family members. The only thing I did was comforting the child. One day, I was sitting in a chair with the child, I fell asleep and child fell onto the floor from my lap. I woke up hearing the noise. I was scared and regretful, but what could I have done? I was tired and unhappy then, but now when I remember all those times, I feel relaxed. My child is healthy now, nothing happened during that incident.

7.10 Lack of Engagement of Men

Around half of the participants think that men have a critical role in ensuring the RH of women and they have reported the lack of support and understanding from their husbands during their pregnancy and childbirth. They added that men do not know about the physical, mental and emotional difficulties related to pregnancy and childbirth.

"Kavya," a 28-year-old Irula young mother, shared about her post-partum struggles and lack of support from her husband through her three deliveries.

> I was admitted to the hospital for my first delivery. I went alone, my husband or parents were not with me. It was my first delivery, I had so many confusions, doubts etc. I was scared, clueless and I could not talk to anybody as there was no one accompanying me. I used to walk around and when the pain came, I ran back to my bed and sat there. I spent the whole day like that. By night, my delivery was over. Then only my husband reached the hospital.

Only very few women shared about the experiences of support from their husbands. Sarojini, a 26-year-old Irula mother says, "my husband was highly supportive as he collected information from the internet regarding caesarean delivery and related care." They were living in a rented house near her maternal home and they did not have enough furniture. After her delivery, he brought a cot for her which would be comfortable than lying on the floor. He did not know how to take care of the child but he would listen to her and did accordingly.

Several of the elderly women also shared about their experiences related to delivery and the role of men in it. In those times, men knew about delivery procedures, like cutting of the umbilical cord and postnatal care. In those times, couples used to stay in the forest for farming activities and they would not be able to inform the '*dai'* or the elderly woman to help the pregnant women during delivery. Thus, husbands were the ones who helped the women.

Power is a central concept in intersectional analysis, which has an important role in creating and perpetuating the individual and social structures of discrimination and oppression (Hankivsky et al., 2009). For example, Rama, a tribal woman, shared her RH experience. The discussion included a case study of tribal young mother, where her lived experiences analysed from an intersectional perspective. Which would help to restate the findings and give more detailed and clarified picture from the field.

Rama, a 22-year-old emaciated, Irula tribal woman, lives with her husband and her two girl children. She had attended school till class 10, but her husband had not studied in school. Both have enrolled for MGNREGA work and her husband also does work for daily wages. Though she has Aadhar card, she has neither the voter id card nor a ration card, while her husband has ration card but his wife's or children's names are not included in it. She was married off not long after she finished secondary school. Her menstruation had been irregular and did not conceive in the first two years. The Anganwadi provided her with iron and folic acid tablets after which her periods became regular and she was pregnant with her first child. During her first pregnancy, her weight ranged from 29 kg to 36 kg and the Hb level was low, between the range of 9 to 10. She had a premature vaginal delivery and the child had low birth-weight (1.500 kg) after which both mother and newborn stayed in the hospital for two months. Her first child is presently three years old and she has always been in the SAM (Severe Acute Malnutrition) category.

She was pregnant again not long after her first delivery, during which her weight ranged between 36 to 39 kg but her Hb level was still low in the range of 9 to 10. It was a normal delivery and the child had a low birth-weight (1.900). The second child is two and a half years old now who is also under the SAM category. Both her children are going to Anganwadi in the hamlet and get supplementary nutrition from Anganwadi and community kitchen. (But on the day of the researcher's visit, the community kitchen was not functioning for reasons not known to her.)

After her second delivery, health workers had advised Rama and her husband to use family planning methods and she had opted for contraception using Copper-T; but she had it removed soon as it had caused her physical discomfort. With the help of health workers, she procured condoms which her husband declined to use. Afterwards, she gave up the use of any modern methods to avoid confrontation with her husband and has practised sexual abstinence ever since. They have not resorted to sterilisation methods as they want one more child.

Contextual factors have a profound effect on RH outcomes based on which an individual identifies and prioritises needs and makes decisions. In the above-mentioned case, a low educational status had resulted in an early marriage. Likewise, lack of livelihood opportunities created economic constraints and nutritional insecurity in the family. These aforementioned factors lead to low MH during conception and pregnancy. Although, she received MH benefits of 2000 Rupees per month for a period of 18 months during both pregnancies, the credits received were irregular. Consequently, low MH affected her children's health and both had low birth weight. At the time of the visit, even after the availability of supplementary nutrition from various governmental schemes, her children were under the SAM category. Thus, it raised concerns regarding food and nutritional security in the household. Lack of awareness on contraceptives and quality health services, and her husband's lack of involvement in family planning has limited her choices as well as influenced her decisions. It has resulted in closer pregnancies and deterioration of her health. As she currently relies solely on natural methods of family planning, it has further increased her vulnerability. The above case study clearly depicts that a tribal woman's RH experience is influenced by multiple axes of inequalities and they operate together and often exacerbate each other. The study explores other similar incidents of RH experience among tribal women in Attappady.

Conclusion

An intergenerational comparison of tribal women's pregnancy and childbirth experiences have found a significant change over the years. Earlier, tribal women were healthy and very few complications were reported during delivery. Traditional

food patterns and postnatal care might have helped them to be healthy during pregnancy and childbirth. However, the findings reveal that the MH deteriorated among young women and child health complications have increased over time. The elderly women mostly were eating millet-based food, freshly prepared and cooked after cultivation from their own fields. The loss of land and livelihood in valley over the years caused the changes in their food patterns and this might have a negative impact on the health status of young tribal women. Meanwhile, the traditional post-natal care is also declining among them. Thus, the young women's lived experiences regarding pregnancy and childbirth are complicated and layered than the elderly women's experiences.

Though elderly women were introduced to the health services, lack of transportation services, prevalence of traditional methods and the lack of trust in modern medicines hindered the utilisation of services. Over the years, the valley witnessed a lot of positive changes such as increase in health interventions and transportation facilities, which positively contributed to the increase in accessibility of health care services among young tribal women. However, few tribal hamlets still lack proper transportation and communication facilities, which hinders the access to quality and timely health care services among tribal women. Though young women are utilising modern health services, they still have fear, misconceptions and concerns over the health delivery systems. Redressing the identified gaps would help to increase the utilisation of health care services among tribal women.

Chapter 8
SUMMARY, FINDINGS AND SUGGESTIONS

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Introduction

The final chapter concludes the thesis and includes **four segments:** first section provides an **overview of the research and research findings** in relation to the research objectives. **Policy recommendations** are detailed in the second section for the perusal of policy makers, community development workers and academics. Section three enumerates certain **limitations** of the research and the last section includes suggestions on **areas for further research**.

8.1 Overview of the Research and Research Findings

The present feminist research explores the intergenerational changes in RH status of tribal women from an intersectional perceptive using dyadic interviews. This qualitative study is based on the tribal communities residing in Attappady, which has a high rate of maternal and child health complications. The study focuses exclusively on dyads consisting of the mothers of children in the community aged five years and below along with grandmothers from three tribal communities. Purposive sampling was used for participant selection and data was collected using in-depth interviews. Ethical considerations and pandemic protocols were strictly followed during the field work, which was conducted from December 2021 to May 2022. Forty-five dyads (a dyad consist of a younger mother along with her mother or mother in-law) were purposively selected for the in-depth, face to face interviews (ninety in total) and ten case studies were used to substantiate the data. The interviews were conducted as per the convenience of the participants, at their places of residence, at their work place or at community centres in their hamlets. Informed consent was taken from the participants and permissions were obtained prior to audio recordings. The interviews were conducted in the regional language after which they were transcribed and translated into English. The data was subjected to qualitative analysis. The major findings of the study are given below.

Research Questions

The main question, what are the intergenerational changes related to the reproductive health status of tribal women, is operationalised through questions 1 -3 while question 4 addresses the influence of the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

1. What are the demographic and socio-economic conditions influencing the reproductive health of tribal women?

2. How does the myths and misconceptions affect the reproductive health of tribal women?

3. How far do women exercise their reproductive health rights and what are the challenges faced by them in the process?

4. How does the intergenerational changes influence the positionality of tribal women and then contributes to their reproductive health experiences?

Objectives

Major Objective

- To explore the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective.

Minor Objectives

- To analyse the demographic and socio-economic conditions affecting the reproductive health of tribal women
- To explore the myths and misconceptions prevalent among tribal women in terms of reproductive health
- To assess the extent of access to reproductive health services by examining the challenges faced by tribal women
- To suggest measures for promoting reproductive health among tribal women

Question-wise Key-Findings

The main question, what are the intergenerational changes related to the reproductive health status of tribal women, is operationalised through questions 1 -3 while question 4 addresses the influence of the intergenerational changes relating to the reproductive health status of tribal women from an intersectional perspective. The question-wise findings are discussed in the following section.

Intergenerational Changes in Tribal Women's Reproductive Health Status

1. What are the demographic and socio-economic conditions influencing the RH of tribal women?

The present study among the tribal women indicates a positive outcome in terms of an increase in education, a higher age at marriage and first pregnancy among younger generations in comparison to the older generations. However, despite the improvement in education, livelihood opportunities have become limited to daily wage labour and MGNREGA work. Almost half of the participants from the younger generation use smartphones, with more opportunities open for them via social networking through Kudumbasree more social networking opportunities through Kudumbasree. Chewing has decreased among young women, but higher incidence of domestic violence has been reported in the hamlets. Housing, water, sanitation, transportation and communication facilities have improved over the years. However, hamlets in the remotest parts still lack most of the facilities, thus putting the tribal women of reproductive age at higher health risk. Lack of access to land and decline in agricultural activities have led to changes in their traditional food patterns, adversely affecting the food and nutritional security of the tribal households. Thus, there is an over-dependence of the communities on supplementary nutrition provided through various governmental schemes. This trend emphasises the need for a concerted action towards sustainable options for food security. Hence, education, livelihood opportunities, food, water and sanitation, transportation and communication etc are found to be the major demographic and socio-economic factors affecting the RH of tribal women in Attappady.

2. How does the myths and misconceptions affect the RH of tribal women?

The intergenerational changes in terms of the myths and misconceptions about RH experience among the tribal women have been minimal. Beliefs and rituals around impurity still exist and women's bodies are subject to alienation as seen in the cultural practices surrounding menstruation, pregnancy and childbirth. Misconceptions around sex, contraception, abortion and infertility are also prevalent. Sex is considered a man's affair and women are generally less expressive about sexual needs/desires to their husbands. Women are hesitant to talk about sex in public and they consider it their husband's duty to enlighten and initiate them into sex.

Most men and women are negligent in the use of contraceptives for family planning and they feel that the contraceptives would negatively affect the health of women and children. Infertility is believed to be a woman's problem and abortion is considered a sin. The tribal women thus become victims of stigma and trauma which can be attributed to the continuing presence of myths and misconceptions surrounding the female body and its bodily processes. Lack of knowledge about sex and unequal marital relationships still persist, resulting in unmet sexual needs. Women do not have proper information on many facilities or access to quality health services; they also lack autonomy in society. Persistence of these myths and misconceptions among the tribal women gives rise to the denial of SRHR.

3. How far do women exercise their RH rights and what are the challenges faced by them in the process?

Young tribal women have mostly shifted to using hygienic absorbents and thus menstrual hygiene has seen an improvement. It also found that the age at menarche decreases among the female tribal population, however, irregularity in periods and such health issues increases. Moreover, increase in age at marriage and preference for love marriages also has increased among them. Furthermore, extramarital affairs and separations due to doubting nature of partners and infertility are high among younger generations. Majority of them were hesitant to share about

their sexual choices and needs with their husband. They think it as an instrument for childbirth and they also lacked proper awareness regarding the STDs and RTIs.

Young women are more informed about contraception and their attitude towards it has been changing for the better. More options have been added to the basket of family planning methods and various access points made available which increases the chances of usage. However, community narratives that spread apprehensions and misconceptions around the modern family planning methods are prevalent. This in turn restricts the choices and decisions of tribal women resulting in unmet needs of family planning. More young women demand sterilisation at hospitals as they prefer to have smaller number of children due to maternal and child health complications as well as economic issues. However, the health system is not efficient enough in these parts as 22% of women reported that they were denied permanent sterilisation by the hospital workers citing various reasons such as age, health of the mother and child etc. Of these women, thirty percent mostly rely on temporary methods to avoid pregnancy, while the rest of the seventy percent follow natural methods of contraception. This trend points to the faulty and insensitive approach of health care workers and the inefficiency of the system, worsening the vulnerable situation of the tribal women and leading to the denial of their SRHR.

Institutional deliveries have increased among young women; better transportation facilities and quality health care access being the major reasons behind this change. Among the 159 total pregnancies in elderly women, 92 percent were home deliveries with 7 percent institutional deliveries and 1 percent ending in abortion. Low level of trust on modern health care system, lack of interest and absence of reliable transportation facilities etc were identified as the important reasons behind this. Among the 103 total pregnancies among the young mothers, 89 percent of the pregnancies ended up in institutional delivery and 6 percent happened at home. And importantly, 5 percent of the total pregnancies got aborted or miscarried.

Over the years, the number of women with four or more pregnancies and the average number of children per woman have decreased. Increase in education rates,

access to more quality health interventions and better use of family planning methods could be considered the major reasons. Though transportation facilities have also improved over the years, some hamlets in the remote forests still lack proper transportation facilities, hindering timely access of health services during pregnancy and childbirth.

However, MH has seen a decline over the years. Irregular periods and anaemia are on the higher side among younger women. Around 90 percent of the women have been categorised as high-risk mothers as per the MCP card. 87 percent of young women have less than 11 Hb level and 4 percent young women have sickle cell anaemia, with many women reporting blood pressure variations, thyroid issues and related complications during pregnancy. Nine percent of younger mothers have undergone multiple blood transfusions during their pregnancy. High incidents of infertility were also reported among the younger generation as compared to the older generation.

More of maternal and child health complications during pregnancy and childbirth are reported among the younger women. Thirty three percent of younger women had a child spacing of less than 3 years, and 27 percent reported that they had unplanned/unintended pregnancy. The percentage of live children is lower among younger generations than the older generations. Though the number of child deaths has decreased, the number of miscarriages has increased among the young mothers. Child health complications were also reported more among the young mothers; 13 percent of the younger mothers had experienced one or more than one infant death. Low bodyweight of children, milk aspiration, pneumonia and organ dysfunction are some of the main reasons behind this. Besides, high incidence of infertility has been reported among the younger generations.

Young women are concerned about the quality of referral health services. They also complain about repeated vaginal examinations during delivery and the increasing number of C-sections. Twenty seven percent of the deliveries performed were C-sections, citing various reasons such as low heartbeat of foetus, low movement of the baby, umbilical cord wrapped around neck, baby faeces in the

womb, water breaking, less fluid in the uterus and low development of uterus. The tribal women demand more accountability and transparency in the system but they lack the knowledge and agency to raise their concerns. Preference for male child could be seen among the older generation, but it has declined over the years. Young women only hope that they have healthy children due to the high incidence of health complications in newborns. Meanwhile, traditional methods of post-natal care has decreased among the younger generation.

MH benefit schemes have provided a certain level of security to the young mothers. But only 78 percent of the applicants have reportedly received benefits of programmes such as Janani Janma Raksha. Sixteen percent of the applicants are yet to receive the benefits, whereas, 6 percent had not submitted applications. The implementation of such schemes have been ineffective as irregular credits and other such procedural delays denies the intended benefits to the mother and child.

Maternal and child health complications, lack of family support and denial of quality health services were reportedly high among the younger generation, having a negative impact also on the grandmothers, as they are the next immediate care givers in the traditionally gendered structure of tribal families. The intersectional analysis of the intergenerational RH experiences of tribal women shows the existence of gender power relations between the various structural factors and the subsequent impact on the lived experiences of women.

4. How does the intergenerational changes influence the positionality of tribal women and then contributes to their RH experiences?

The present intergenerational study on RH status of tribal women in Attappady was conducted from an intersectional perspective with the help of dyadic interviews. It reveals that intergenerational changes have positively as well as negatively impacted the RH status of tribal women in Attappady. Despite the progress in demographic, socio-economic and RH services, maternal and child health complications are still prevalent in Attappady. The lack of secure livelihood options, food and nutritional insecurity, myths and misconceptions about the female body, sex, and reproduction, the lack of cooperation of men in family planning, gaps

in the delivery of the health system and other social security networks etc might be the major reasons behind this continuing negative trend.

The present study shows an increase in education, age at marriage and age at first pregnancy among the younger generation compared to the older generation. But despite the improvement in education, livelihood opportunities are limited to daily wage and MGNREGA work. Decline in agricultural activities and lack of secure livelihood opportunities results in poverty and marginalisation, thus excluding the tribal women from accessing resources, assets, goods and services. The study found that the economic constraints among households affect the tribal women's purchasing capacity of meeting basic needs such as food items, sanitary pads, condoms etc and transportation expenses to access RH services. Tribal women also conveyed that, if they had money, they would have chosen private hospitals, which provide better atmosphere and quality care than the public hospitals.

Moreover, the study found that the welfare and social security programmes have helped to increase the RH standards of the younger generation by improving their access to housing, water and sanitation, livelihood options, transportation facilities, supplementary nutrition, and maternal and child health care. But they lack sustainability and the younger generation are forced more and more to rely on these state sponsored programmes.

Along with demographic and socio-economic conditions, the cultural and gender constraints are also critical in shaping the RH realities of tribal women. The prevalence of myths and misconceptions among young people restricts women's access to information on sex, sexual needs and quality health services. Cultural norms and expectations influence the RH behaviour of tribal women by stripping away their autonomy in decision making. Besides, the study found that, power dynamics play a part in negotiating sexual relationships, the use of contraceptives, the decisions on when to have children and how many etc, where husbands and in-laws are seen to exercise more control over these RH decisions. The study also found that the high rate of alcoholism and domestic violence among the young people results in unintended pregnancies and low physical and mental health of

tribal women. Therefore, cultural and gender power relations within marriage exacerbate the vulnerability of tribal women.

Along with the aforementioned factors, the gender-based inequalities in the health system adversely impact the RH experience of tribal women. A range of factors determines the access to quality health services, which includes availability, affordability, acceptability, convenience, knowledge and trust (Price and Hawkins, 2007). Healthcare system in Attappady has improved over the years and the younger generation has more access to health services. But still, remote tribal hamlets lack transportation and communication facilities and thereby, tribal women are denied quality and timely services.

Most participants shared ambivalent attitudes about the services from public hospitals because of their bitter experiences mostly due to unequal power relations between the health system and their social identity. Even though a majority of them access public health services, a few had lost their trust in it. They raised concerns over the denial of sterilisation, increasing number of C-sections, frequent referrals to other hospitals and the uncooperative attitude of health workers towards them. A few women reported that they felt neglected at public hospitals because of their social identity and poverty. And these were the major reasons cited by them for preferring private hospitals over public hospitals.

In addition to culture and gender power relation in marriage, gender-based inequalities in the health system put women in a more vulnerable position. For instance, a few women reported about the denial of sterilisation services at hospitals. Their husbands could have utilised contraceptive methods to reduce the risk of unwanted pregnancies. Despite low MH among tribal women, neither their partners nor the health system acted in a way which could have reduced their vulnerability by ensuring the involvement of men in family planning. Herein, intersections such as gender, caste, age, education, culture and poverty interact with each other resulting in multiple inequalities and consequently limiting the potential of RH rights of tribal women.

8.2 Policy Recommendations

The findings point out that the valley has witnessed various intergenerational changes over the years and has influenced the SRH experience of tribal women in both generations. However, the study suggests that more interventions are needed to advance the SRHR of women as stated below:

1. Improve the Basic Infrastructure Facilities in the Hamlets

Tribal hamlets in Attappady, especially in the remote regions, lack basic necessities such as access to housing, water, sanitation, transportation and communication. Improving the access to these basic needs would facilitate in bettering the RH status of tribal women.

2. Enhance Livelihood Opportunities and Nutritional Security in the Tribal Households

Decline in land and livelihood opportunities are predominant reasons for poverty and marginalisation in the valley. Despite education, majority of women depend on MGNREGA work, where the wage credit is irregular. These factors eventually lead to economic constraints and nutritional insecurity in households. As a short-term measure, support through micro-credit schemes and creation of self-employment opportunities through capacity building of Self Help Groups (SHGs) would help to reduce economic insecurity. Along with that, strengthening the implementation of government programmes for food security would also help to control the nutritional insecurities in the valley. As a long-term measure, land conflicts in Attappady need to be redressed with the provision of legal support if necessary, and agricultural activities should be promoted for ensuring the sustenance of their traditional food patterns.

3. Create Environments to Support Behaviour Change among Tribal Communities

Proper information would facilitate informed choices among tribal women regarding their RH. Introduction of awareness generation programmes and

integration of men's participation in RH events is also necessary: for example, men should be encouraged to utilise family planning methods. Moreover, community narratives, peer networks, and attitude of husbands and family members influence the reproductive behaviour of tribal women as they receive and exchange information based on their trust in social relationships. Creating continuous, community-based and culturally-sensitive interventions would help to address the prevalent myths and misconceptions about SRH, eventually supporting behaviour change.

4. Ensure Transparency, Accountability, and Gender Equity in Health Care Access

Health system in Attappady needs to ensure transparency and accountability as many women raise concerns regarding the availability of quality services and attitude of service providers. The gender-power relation limits women's autonomy over RH decisions. Besides that, alcoholic nature of husbands makes them more vulnerable. In this context, gender-based inequalities exaggerate their vulnerability. Thus, lack of engagement of men in RH affairs should be addressed in order to reduce the gaps in health system delivery.

5. Need for Convergence of Sectoral Interventions and Periodic Assessment

The intersectional analysis emphasises the need for the convergence of sectoral interventions in order to address maternal and child health complications in Attappady. Health sector interventions are increasingly relevant. However, it overlaps with the other sectors of agriculture and food security, water and sanitation, education, employment, transport and communication, family planning and maternal and child health. They are interconnected and changes in one sector has a ripple effect on other sectors, for example, increase in livelihood strategies increases food security and eventually MH. Thus, the convergence of sectoral interventions in a local context facilitates the enhancement of rights of the marginalised communities. For example, developing a family care plan centred on the tribal woman's lived experience by mapping the vulnerabilities, challenges, needs, capacities, privileges etc would help to provide assistance tailored to their specific context. As the

intersections are fluid and shifting, periodic assessment of sectoral interventions is also necessary to ensure its effectiveness.

6. Social Audit of Health System and Social Security Programmes

The health system and social security programmes have improved the basic needs of tribal women and thus facilitated positive RH outcomes. However, gaps still exist in the form of irregularities in services, inequalities in implementation, lack of transparency and accountability. Social audit is an ongoing process by which potential beneficiaries and other stakeholders of a programme or a project would be able to participate from planning to monitoring and evaluation. It helps to improve the participation of beneficiaries in the process as well as increases the transparency and accountability of the services among them (Puri & Lahariya, 2011). Thus, the aforementioned challenges can be addressed by conducting a social audit of the health system and social security programmes.

7. Need for Sustainable Options

The study found there was an over-dependence of the tribal communities on the government schemes for basic needs such as housing, water and sanitation, livelihood, food and nutritional security, etc. Even though, those interventions facilitated the enhancement of tribal communities in various ways, findings indicate the need for long-term, bottom-up, and right-based sustainable options for the development of the communities rather than short-term welfare services.

8.3 Limitations of the Study

One of the major limitations of the study was the exclusion of healthcare professionals in the study. This specific feminist research intends to explore the intergenerational changes in the RH status of the tribal women from an intersectional perspective through interviews. The focus of the research was to provide a platform for them to get their voices heard by the sharing of lived experiences, as they are marginalised and are at the receiving end of the services. Given the focus of the study, the participants are limited to the tribal women of two generations in Attappady. Although including the opinions of healthcare

professionals could have helped to provide a holistic picture of the RH status of tribal women in the valley, focusing on the marginalised voices has helped to balance the power relations between the tribal women and the healthcare professionals.

Another major limitation was related to the restrictions and challenges posed by the pandemic. The pandemic protocols created hurdles in the data collection procedure and the researcher had to avoid participatory methods in the research work such as focused group discussions. As the present feminist research focuses on the SRH experience of tribal women from two generations, the researcher strongly believes that the group activities could have facilitated more exploration into the area of research as well as the co-creation of experiences and helped in raising consciousness among the tribal women. Moreover, the pandemic also limited revisits to the participants, as was planned during research.

Another limitation of the study is regarding the selection of the respondents. As the focus was on the dyadic interviews of mothers and grandmothers, it had been planned earlier to stick to the young mothers of under-five children (at least one under-five child, so they could share recent experiences) and her mother. After approaching the field, it was difficult to locate many young mothers along with their mothers, as most of them stayed apart, either in their maternal hamlets or at their husband's place which were not easy to access. All the more, pandemic restrictions made it difficult to find the samples. Thus, the researcher also had to include the mothers in- law of young mothers in the study.

8.4 Suggestions for Future Research

The present study reveals that the intergenerational changes impact the RH status of tribal women in Attappady. It has also been found that the dynamic interaction between the individual and institutional factors (such as age, education, poverty, gender, caste and culture) create multiple inequalities which consequently hinder the RH outcomes among the tribal women. Based on the evidence discussed in the thesis, four areas of future research are identified.

The first suggestion is the possibility of a community based participatory action research, which would be more useful in exploring the lived experiences of tribal women regarding their SRH. Secondly, this research is fully focused on the lived experiences of tribal women regarding RH. The insights from the intersectional analysis show the existence of gender power relations. Thus, exploring the involvement of stakeholders including partners of tribal women, family members and healthcare professionals in formulating the SRH experiences can be utilised in further understanding the particular topic.

Thirdly, the research participants include tribal women from three major tribal communities residing in Attappady and the study could be extended to other communities in Kerala as well. The intersectional comparison of lived experiences of tribal women from other communities in various parts of Kerala would give a comprehensive picture of RH status of tribal women in Kerala.

Lastly, it is also possible to conduct similar studies among the general public. In addition, comparative studies on the RH status of women in various communities can also be conducted to enrich the feminist understanding of the RH of women in Kerala.

Conclusion

The chapter discusses the findings of this research which revealed the lived experiences of tribal women from two generations regarding their RH status. It has led to a broader discussion about these intergenerational changes and its impact on women's RH from an intersectional perspective. The study has suggested various recommendations for policy makers, academicians and social workers. In addition, study has identified the limitations and continued with the suggestions for future research.

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APPENDICES

APPENDIX I

UNIVERSITY OF CALICUT
MALAPPURAM, KERALA, 673635
INFORMED CONSENT FORM

Project Title: REPRODUCTIVE HEALTH STATUS OF TRIBAL WOMEN: AN INTERGENERATIONAL STUDY

I…… have read (had it read and explained to me) the participant information sheet for the above-mentioned project. The information contained in the participant information sheet regarding the nature and purpose of the study, safety, and its potential risks / benefits and expected duration of the study and other relevant details of the study including my role as a study participant have been explained to me in the language that I understand.

I understand that my participation is voluntary and that I have the right to withdraw from the study at any stage without giving any reasons for the same and without any adverse consequences or penalty. I have had the opportunity to ask queries, which have been clarified to my satisfaction. I understand that the information collected during the research study will be kept confidential.

I hereby give my consent willingly to participate in this research study.

Name of the consenting person/guardian

Name of the person administering the consent

Note: All parties signing the consent section must date their own signature.

PI of the project **Co-PI of the project**

Contact details **Contact details**

APPENDIX II
INTERVIEW GUIDE

Areas	**Factors, Challenges, and Experiences:** What are the factors affecting sexual and reproductive health? What are the major challenges they have faced, and what are their lived experiences regarding the same?
Demographic and Socio-economic Information	Name: Location: Age: • Age of the participant and their family members Tribe: Details of family members? Education of participants and their husbands? • Have you been to school? • If yes, what grade did you complete? Identity card: • Do you possess identity cards? If not, why and what is the current status of those? Housing: • Is your house own or rented? • Have you applied under any scheme? what is the current status of it? Access to Water: • What are the major sources of water? • Is there water scarcity in hamlet? • Are you depending on any other sources? Sanitation: • Do you have proper sanitation facilities? If not, what are the major reasons? Communication: • What are the available communication methods? How far they are accessible and what are the major challenges they face? Transportation: • What are the major transportation methods available? How far they are accessible and what are the major challenges did you face to access them? Land, Livelihood and Food Security: • Do you possess any land in your name? • Are you involved in any kind of agricultural activities? • Does your family involve in any agricultural activities?

	• What are the major things you cultivate? • Are there any changes in the agricultural practices and food patterns? • If yes, what are they and what might be the reasons? • What do you do for a living? • How long have you been working? • Has there been times when you wanted to work but there is no work available? • Do you think your household has enough money to meet the basic needs of all members? • If not, how do you manage those situations? • Do you have access to any social security schemes? What are they and how frequent are they? • Did you face any challenges in accessing those services? • Do the social protection benefits impact you and your family? Elaborate. • Do you think that the social security programmes have benefited your standard of living? Elaborate? Substance Abuse: • Do you or your husband use any kind of substance? Have you both ever used any? What are they? How long have you been using that?
Sexuality, Fertility and Reproduction	Menstrual health: • Age at menarche? • Do you have regular or irregular periods? If you have irregular periods, are you taking any medications? • Which type of absorbent using? Why did you prefer that? • Did you practice any cultural practices related to this event? If yes elaborate?
	Marriage: • What is your marital Status? (single, married, widowed, separated, divorced) • Age at marriage? • Could you share information about the marriage ceremonies and cultural practices related to it? Sexuality and family planning: • How do you perceive sexuality? • How often do you prefer it? • Have you heard about family planning methods? • Where did you get the information from? • Are you using any methods now?

	• Did you ever use any methods? • Were you or are you comfortable with it? Was it accessible, affordable, or culturally appropriate? • If not, which method are you practicing for child spacing? • Did you experience any difficulties from your husband, family, or health care providers? • Did you hear of STDs or RTIs? Explain? • Did you experience any form of violence from your husband or other family members, especially related to reproductive health? Pregnancy and childbirth: • Age at first pregnancy? • Have you experienced any infertility issues? • Total number of pregnancies? Where did the deliveries happen? • Total number of live children? • How old are they? • Did you experience any miscarriages, abortions, infant deaths or child deaths? Could you elaborate? • Could explain the experiences during pregnancy: access to food and nutrition, health care services, support of family members etc • Could you explain the delivery experience? • How was your post-delivery experience? • How do you see your husband's involvement during your pregnancy time? • Do you have any local reproductive health practices? Explain? • Was there any cultural practices related to pregnancy and childbirth? • Do you have any health issues related to reproductive health? • Did you receive any maternal health benefits? If yes, which scheme? What are the provisions? Was it regular? How did it help you? • If no, why? Could you explain more about the health status of children: • What was their birth weight? • Were they healthy? • What is their current weight? • Did they experience illness? • If yes, how frequent?

	• Can you explain in detail the steps you took to address the illness?
Health Care Access	• Where did you learn about sexual and reproductive health? (school/ education, culture, family members or relatives, friends, community members, media) • Where did you seek treatment? Are there any local health beliefs that exists? • For what kind of illness do you visit the hospital? • Do government hospitals provide quality health care and is it accessible to you? • Do you prefer public facilities or private hospitals and why? • What things influenced your decisions? • What kind of health care facility is nearest to your house? • How do you normally get to this health care facility? • How long does it take to get to this health care facility? • What mode of transportation do you use to get there? • Are there any factors that prevented you from going to a health center or hospital? • Do you think caste is important when accessing health care? • Do you ever feel treated differently? • If yes, what might be the reasons behind those? Were you able to confront? And how did you do it?

അഭിമുഖ ചോദ്യാവലി

വിഭാഗങ്ങൾ	ഘടകങ്ങൾ, വെല്ലുവിളികൾ, അനുഭവങ്ങൾ: ലൈംഗികവും പ്രത്യുൽപാദനപരവുമായ ആരോഗ്യവുമായി ബന്ധപ്പെട്ട പ്രധാന ഘടകങ്ങൾ ഏതൊക്കെയാണ്? ഇതുമായി ബന്ധപ്പെട്ട് അവർ അഭിമുഖീകരിച്ച പ്രധാന വെല്ലുവിളികൾ എന്തൊക്കെയാണ്, അവരുടെ ജീവിതാനുഭവങ്ങൾ എങ്ങനെയൊക്കെയായിരുന്നു?
ജനസംഖ്യാശാസ്ത്ര, സാമൂഹിക-സാമ്പത്തിക വിവരങ്ങൾ	പേര്: ഗോത്രം: സ്ഥാനം: പ്രായം: • പങ്കെടുക്കുന്നവരുടെയും അവരുടെ കുടുംബാംഗങ്ങളുടെയും പ്രായവിവരങ്ങൾ. • കുടുംബാംഗങ്ങളുടെ വിശദാംശങ്ങൾ? പങ്കെടുക്കുന്നവരുടെയും അവരുടെ ഭർത്താക്കന്മാരുടെയും വിദ്യാഭ്യാസം? • നിങ്ങൾ സ്കൂളിൽ പോയിട്ടുണ്ടോ? • അതെ എങ്കിൽ, നിങ്ങൾ ഏത് ഗ്രേഡാണ് പൂർത്തിയാക്കിയത്? തിരിച്ചറിയല് രേഖ: • നിങ്ങൾക്ക് തിരിച്ചറിയൽ കാർഡുകൾ ഉണ്ടോ? ഇല്ലെങ്കിൽ, എന്തുകൊണ്ട്, ഇവയുടെ ഇപ്പോഴത്തെ അവസ്ഥ എന്താണ്? പാർപ്പിട സൗകര്യങ്ങൾ : • നിങ്ങളുടെ വീട് സ്വന്തമാണോ അതോ വാടകയ്ക്കാണോ? • സ്വന്തമായി വീടിലെങ്കിൽ, ഏതെങ്കിലും സ്കീമിന് കീഴിൽ നിങ്ങൾ അപേക്ഷിച്ചിട്ടുണ്ടോ? ഇപ്പോഴത്തെ അവസ്ഥ എന്താണ്? ജലത്തിന്റെ ലഭ്യത: • ജലത്തിന്റെ പ്രധാന സ്രോതസ്സുകൾ ഏതൊക്കെയാണ്?

	• നിങ്ങളുടെ ഊരിൽ ജലത്തിന് ക്ഷാമമുണ്ടോ? • നിങ്ങൾ മറ്റേതെങ്കിലും ഉറവിടങ്ങളെ ആശ്രയിക്കുന്നുണ്ടോ? വിശദമാക്കു. ശുചീകരണം: • നിങ്ങൾക്ക് ശരിയായ ശുചിത്വ സൗകര്യങ്ങൾ ഉണ്ടോ? ഇല്ലെങ്കിൽ, പ്രധാന കാരണങ്ങൾ എന്തൊക്കെയാണ്? ആശയവിനിമയം: • ലഭ്യമായ ആശയവിനിമയ രീതികൾ എന്തൊക്കെയാണ്? അവ എത്രത്തോളം പ്രാപ്യമാണ്, നേരിടുന്ന പ്രധാന വെല്ലുവിളികൾ എന്തൊക്കെയാണ്? ഗതാഗതം: • ലഭ്യമായ പ്രധാന ഗതാഗത മാർഗ്ഗങ്ങൾ ഏതൊക്കെയാണ്? അവ എത്രത്തോളം പ്രാപ്യമാണ്? അവ ഉപയോഗിക്കുന്നതിൽ നിങ്ങൾ നേരിട്ട പ്രധാന വെല്ലുവിളികൾ എന്തൊക്കെയാണ്? ഭൂമി, ഉപജീവനമാർഗം, ഭക്ഷ്യസുരക്ഷ: • നിങ്ങളുടെ പേരിൽ എന്തെങ്കിലും ഭൂമി കൈവശമുണ്ടോ? • നിങ്ങൾ ഏതെങ്കിലും തരത്തിലുള്ള കാർഷിക പ്രവർത്തനങ്ങളിൽ ഏർപ്പെട്ടിട്ടുണ്ടോ? • നിങ്ങളുടെ കുടുംബം ഏതെങ്കിലും കാർഷിക പ്രവർത്തനങ്ങളിൽ ഏർപ്പെട്ടിട്ടുണ്ടോ? • അവർ പ്രധാനമായി കൃഷി ചെയ്യുന്ന വിളകൾ എന്തൊക്കെയാണ്? • കാർഷിക രീതികളിലും ഭക്ഷണ രീതികളിലും എന്തെങ്കിലും മാറ്റമുണ്ടോ? • അതെ എങ്കിൽ, അവ എന്തൊക്കെയാണ്, എന്തായിരിക്കാം കാരണങ്ങൾ? • ജീവിക്കാനായി നിങ്ങൾ എന്തുചെയ്യുന്നു? • നിങ്ങൾ എത്ര കാലമായി ജോലി ചെയ്യുന്നു? • നിങ്ങൾക്ക് ജോലി ചെയ്യാൻ ആഗ്രഹമുണ്ടെങ്കിലും

	ജോലി ലഭ്യമല്ലാത്ത സമയങ്ങൾ ഉണ്ടായിട്ടുണ്ടോ? • എല്ലാ അംഗങ്ങളുടെയും അടിസ്ഥാന ആവശ്യങ്ങൾ നിറവേറ്റാൻ ആവശ്യമായ പണം നിങ്ങളുടെ വീട്ടിൽ ഉണ്ടെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ? • ഇല്ലെങ്കിൽ, ആ സാഹചര്യങ്ങൾ എങ്ങനെ കൈകാര്യം ചെയ്യുന്നു ? • നിങ്ങൾക്ക് ഏതെങ്കിലും സാമൂഹിക സുരക്ഷാ പദ്ധതികളുടെ ഉപഭോക്താവാണോ? അവ എന്തൊക്കെയാണ്, അവ തുടർച്ചയായി ലഭ്യമായിരുന്നോ? • ആ സേവനങ്ങൾ പ്രാപ്യമാക്കുന്നതിൽ നിങ്ങൾക്ക് എന്തെങ്കിലും വെല്ലുവിളികൾ നേരിട്ടിട്ടുണ്ടോ? • സാമൂഹിക സംരക്ഷണ ആനുകൂല്യങ്ങൾ നിങ്ങളെയും നിങ്ങളുടെ കുടുംബത്തെയും സ്വാധീനിച്ചോ? അവ നിങ്ങളുടെ ജീവിത നിലവാരത്തിന് ഗുണം ചെയ്തുവെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ? വിശദമാക്കുക? ലഹരിവസ്തുക്കളുടെ ദുരുപയോഗം • നിങ്ങളോ നിങ്ങളുടെ ഭർത്താവോ ഏതെങ്കിലും തരത്തിലുള്ള ലഹരി പദാർത്ഥങ്ങൾ ഉപയോഗിക്കുന്നുണ്ടോ? • നിങ്ങൾ രണ്ടുപേരും എപ്പോഴെങ്കിലും എന്തെങ്കിലും ഉപയോഗിച്ചിട്ടുണ്ടോ? • ഉപയോഗിച്ചിട്ടുണ്ടെങ്കിൽ അവ എന്താണ്? • നിങ്ങൾ എത്ര കാലമായി അത് ഉപയോഗിക്കുന്നു?
ലൈംഗികത, ഫെർട്ടിലിറ്റി, പ്രത്യുൽപാദനം	ആർത്തവ ആരോഗ്യം: • ആദ്യമായി ആർത്തവം വന്ന പ്രായം? • നിങ്ങൾളുടെ ആർത്തവം ക്രമമാണോ ക്രമരഹിതമാണോ ? • നിങ്ങൾക്ക് ക്രമരഹിതമായ ആർത്തവമുണ്ടെങ്കിൽ, എന്തെങ്കിലും മരുന്നുകൾ കഴിക്കുന്നുണ്ടോ? • ഏത് തരം അബ്സോർബൻറ് ആണ് ഉപയോഗിക്കുന്നത്? എന്തുകൊണ്ടാണ് നിങ്ങൾ അത് ഇഷ്ടപ്പെട്ടത്?

	• ആർത്തവവുമായി ബന്ധപ്പെട്ട ഏതെങ്കിലും സാംസ്കാരിക ആചാരങ്ങൾ നിങ്ങൾ തുടർന്നുപോരുന്നുണ്ടോ? • ഉണ്ടെങ്കിൽ വിശദമാക്കുമോ? വിവാഹം: • താങ്കളുടെ വൈവാഹിക നില എന്താണ്? (അവിവാഹിതൻ, വിവാഹിതൻ, വിധവ, വേർപിരിഞ്ഞ, വിവാഹമോചിത) • വിവാഹപ്രായം എത്രയായിരുന്നു? • വിവാഹ ചടങ്ങുകളെക്കുറിച്ചും അതുമായി ബന്ധപ്പെട്ട സാംസ്കാരിക ആചാരങ്ങളെക്കുറിച്ചും പങ്കുവെക്കാമോ? ലൈംഗികതയും കുടുംബാസൂത്രണവും: • നിങ്ങൾ ലൈംഗികതയെ എങ്ങനെ കാണുന്നു? • നിങ്ങളുടെ ലൈംഗിക ആവശ്യങ്ങൾ പൂർണമാണോ? • കുടുംബാസൂത്രണ രീതികളെക്കുറിച്ച് നിങ്ങൾ കേട്ടിട്ടുണ്ടോ? • നിങ്ങൾക്ക് എവിടെ നിന്ന് വിവരങ്ങൾ ലഭിച്ചു? • നിങ്ങൾ ഇപ്പോൾ എന്തെങ്കിലും കുടുംബാസൂത്രണ രീതികൾ ഉപയോഗിക്കുന്നുണ്ടോ? • നിങ്ങൾക്ക് അതിൽ തൃപ്തിയുണ്ടോ? • അത് നിങ്ങൾക്ക് പ്രാപിക്കാവുന്നതോ,താങ്ങാവുന്നതോ സാംസ്കാരികമായി ഉചിതമോ ആണോ? • ഉപയോഗിക്കുന്നില്ലെങ്കിൽ, കുട്ടികളുടെ അകലം പാലിക്കുന്നതിനായി എന്താണ് പരിശീലിക്കുന്നത്? • നിങ്ങളുടെ ഭർത്താവിൽ നിന്നോ കുടുംബത്തിൽ നിന്നോ ആരോഗ്യ പരിപാലന ദാതാക്കളിൽ നിന്നോ എന്തെങ്കിലും ബുദ്ധിമുട്ടുകൾ അനുഭവപ്പെട്ടിട്ടുണ്ടോ? • എസ്ടിഡി/ആർടിഐകളെക്കുറിച്ച് നിങ്ങൾ കേട്ടിട്ടുണ്ടോ? വിശദീകരിക്കാൻ? • നിങ്ങൾ ഭർത്താവിൽ നിന്നോ മറ്റ്

	കുടുംബാംഗങ്ങളിൽ നിന്നോ ഏതെങ്കിലും തരത്തിലുള്ള അക്രമം അനുഭവിച്ചിട്ടുണ്ടോ, പ്രത്യേകിച്ച് പ്രത്യുൽപാദന ആരോഗ്യവുമായി ബന്ധപ്പെട്ട്? ഗർഭധാരണവും പ്രസവവും: • ആദ്യ ഗർഭകാലത്തെ പ്രായം? • എന്തെങ്കിലും വന്ധ്യതാ പ്രശ്നങ്ങൾ നിങ്ങൾ അനുഭവിച്ചിട്ടുണ്ടോ? • എത്ര തവണ നിങ്ങൾ ഗർഭിണിയായി? • എവിടെയാണ് പ്രസവങ്ങൾ നടന്നത്? • ജീവിച്ചിരിക്കുന്ന കുട്ടികളുടെ ആകെ എണ്ണം? • അവർക്ക് എത്ര വയസ്സുണ്ട്? • നിങ്ങൾക്ക് ഗർഭം അലസലോ ഗർഭച്ഛിദ്രമോ ശിശുമരണമോ ശിശുമരണമോ ഉണ്ടായിട്ടുണ്ടോ? വിശദമാക്കാമോ? • ഗർഭകാലത്തെ അനുഭവങ്ങൾ വിശദീകരിക്കാമോ? ഭക്ഷണവും പോഷകാഹാരവും, ആരോഗ്യ പരിപാലന സേവനങ്ങൾ, കുടുംബാംഗങ്ങളുടെ പിന്തുണ തുടങ്ങിയവ • പ്രസവ അനുഭവങ്ങൾ വിശദീകരിക്കാമോ? • നിങ്ങളുടെ പ്രസവത്തിനു ശേഷമുള്ള അനുഭവങ്ങൾ എങ്ങനെയുണ്ടായിരുന്നു? • നിങ്ങളുടെ ഗർഭകാലത്ത് നിങ്ങളുടെ ഭർത്താവിന്റെ പങ്കാളിത്തം നിങ്ങൾ എങ്ങനെ കാണുന്നു? • നിങ്ങൾക്ക് പ്രാദേശിക പ്രത്യുത്പാദന ആരോഗ്യപരിപാലന രീതികൾ ഉണ്ടോ? വിശദീകരിക്കാമോ? • ഗർഭധാരണവും പ്രസവവുമായി ബന്ധപ്പെട്ട് എന്തെങ്കിലും സാംസ്കാരിക ആചാരങ്ങൾ ഉണ്ടായിരുന്നോ? • പ്രത്യുൽപാദന ആരോഗ്യവുമായി ബന്ധപ്പെട്ട് നിങ്ങൾക്ക് എന്തെങ്കിലും ആരോഗ്യപ്രശ്നങ്ങൾ ഉണ്ടോ? • നിങ്ങൾക്ക് എന്തെങ്കിലും മാതൃ ആരോഗ്യ

	ആനുകൂല്യങ്ങൾ ലഭിച്ചിട്ടുണ്ടോ? • ഉണ്ടെങ്കിൽ, ഏത് പദ്ധതി പ്രകാരമാണ് അനുക്കൂല്യങ്ങൾ ലഭിച്ചത്? • എന്തൊക്കെയാണ് വ്യവസ്ഥകൾ? • അത് പതിവായിരുന്നോ? • അത് നിങ്ങളെ എങ്ങനെയെല്ലാം സഹായിച്ചു? • ഇല്ലെങ്കിൽ, എന്തുകൊണ്ട്? കുട്ടികളുടെ ആരോഗ്യസ്ഥിതിയെക്കുറിച്ച് കൂടുതൽ വിശദീകരിക്കാമോ: • അവരുടെ ജനന ഭാരം എന്തായിരുന്നു? • അവരുടെ ആരോഗ്യ അവസ്ഥ എപ്രകാരമായിരുന്നു? • അവരുടെ ഇപ്പോഴത്തെ ഭാരം എന്താണ്? • അവർ അസുഖം അനുഭവിച്ചിട്ടുണ്ടോ • ഉണ്ടെങ്കിൽ, എത്ര തവണ? • അസുഖത്തെ നേരിടാൻ നിങ്ങൾ സ്വീകരിച്ച നടപടികൾ വിശദീകരിക്കാമോ?
ആരോഗ്യ സേവനങ്ങളുടെ ലഭ്യത	• ലൈംഗിക, പ്രത്യുൽപാദന ആരോഗ്യത്തെക്കുറിച്ച് നിങ്ങൾ എവിടെ നിന്നാണ് പഠിച്ചത്? (സ്കൂൾ/ വിദ്യാഭ്യാസം, സംസ്കാരം, കുടുംബാംഗങ്ങൾ അല്ലെങ്കിൽ ബന്ധുക്കൾ, സുഹൃത്തുക്കൾ, കമ്മ്യൂണിറ്റി അംഗങ്ങൾ, മാധ്യമങ്ങൾ) • നിങ്ങൾ എവിടെയാണ് ചികിത്സ തേടുന്നത് ? • ഏതെങ്കിലും പ്രാദേശിക ആരോഗ്യവിശ്വാസങ്ങൾ നില നിൽക്കുന്നുണ്ടോ? • ഏതുതരം അസുഖങ്ങൾക്കാണ് നിങ്ങൾ ആശുപത്രിയിൽ പോകുന്നത്? • സർക്കാർ ആശുപത്രികൾ ഗുണനിലവാരമുള്ള ആരോഗ്യ പരിരക്ഷ നൽകുന്നുണ്ടോ? അത് നിങ്ങൾക്ക് പ്രാപ്യമാണോ? • പൊതു ആശുപത്രികളാണോ സ്വകാര്യ ആശുപത്രികളാണോ നിങ്ങൾ പ്രാധാന്യം നൽകുന്നത്?

	• അവിടുത്തെ • ആരോഗ്യ കേന്ദ്രത്തിലോ ആശുപത്രിയിലോ പോകുന്നതിൽ നിന്ന് നിങ്ങളെ തടയുന്ന എന്തെങ്കിലും ഘടകങ്ങളുണ്ടോ? • നിങ്ങളുടെ വീടിന് ഏറ്റവും അടുത്തുള്ളത് ഏത് തരത്തിലുള്ള ആരോഗ്യ സംരക്ഷണ സൗകര്യമാണ് ഉള്ളത്? • അവിടെയെത്താൻ നിങ്ങൾ ഏത് ഗതാഗത മാർഗ്ഗമാണ് ഉപയോഗിക്കുന്നത്? • അവിടെ എത്താൻ എത്ര സമയമെടുക്കും? • ചികിത്സയെക്കുറിച്ചുള്ള നിങ്ങളുടെ തീരുമാനത്തെ സ്വാധീനിച്ച ഘടകങ്ങൾ എന്തൊക്കെയാണ്? • ആരോഗ്യ പരിപാലനത്തിൽ ജാതി പ്രധാനമായ ഘടകമാണോ ? • നിങ്ങൾക്ക് ഇത്തരത്തിൽ എന്തെങ്കിലും അനുഭവമുണ്ടായോ? • അതെ എങ്കിൽ, അവയ്ക്ക് പിന്നിലെ കാരണങ്ങൾ എന്തായിരിക്കാം? • നിങ്ങൾക്ക് അതിനെ നേരിടാൻ സാധിച്ചോ? എങ്ങനെയാണ് നേരിട്ടത്?