

Original Research Article

Knowledge, attitudes and practices of contraception among women in an urban slum of Coimbatore, Tamil Nadu: a community-based cross-sectional study of a Gondi tribal settlement

Balaji Prasad*, Raja Ramasamy, Sangeetha Priya

Department of Community Medicine, Karpagam Faculty of Medical Sciences and Research, Coimbatore, Tamil Nadu, India

Received: 06 May 2026

Revised: 30 September 2026

Accepted: 01 October 2026

*Correspondence:

Dr. Balaji Prasad,

E-mail: balajiprasadwork@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Urban slum communities in India bear a disproportionate burden of unmet reproductive health needs, driven less by unawareness than by barriers to access and use, compounded by gendered norms that assign reproductive responsibility to women. This study assessed contraceptive knowledge, attitudes, and practices (KAP) among women of Gondi tribal descent in an urban slum of Coimbatore, Tamil Nadu.

Methods: A community-based cross-sectional survey of 190 married women aged 18-45 years was conducted using a structured interviewer-administered questionnaire covering sociodemographics, reproductive history, and KAP, supplemented by field observations. Socioeconomic status was classified using the updated BG Prasad scale (2025). Descriptive statistics and chi-square tests were used.

Results: Mean age was 32.9 years; 50.5% were illiterate and 51.6% belonged to the lower socioeconomic class. Awareness was highest for female sterilization (79.5%) and injectables (68.4%) and lowest for oral contraceptive pills (8.9%); 20.0% had never heard of any method. Although 95.8% wanted no more children, only 51.1% had ever used contraception. Female sterilization accounted for 46.4% of ever-users; the remainder had used reversible or traditional methods, but fewer than 5% of all women were currently using a reversible method. No husband had undergone vasectomy. Higher parity and any formal education were significantly associated with ever-use ($p < 0.001$ for both).

Conclusions: The knowledge-practice gap in this Gondi community is shaped by social isolation, gendered norms excluding men from reproductive responsibility, undifferentiated fear of side effects, and reactive healthcare use. Doorstep outreach, male partner engagement, and community-based education on all methods are needed.

Keywords: Contraception, Family planning, Health knowledge attitudes practice, India, Tribal population, Urban slum

INTRODUCTION

India's rapid urbanization has generated expansive informal settlements in which women of reproductive age frequently face a convergence of poverty, low literacy, social marginalization, and limited access to healthcare. While national surveys document improving aggregate contraceptive prevalence, these figures obscure marked intra-urban disparities between formally housed residents

and slum communities, where unmet need for family planning remains persistently high.¹

The gap between awareness and use in such communities is not primarily a failure of broad awareness. Studies from urban slums of South India show that most women have heard of at least one contraceptive method, yet a substantial proportion have never used any, and many remain hesitant about spacing methods, preferring

sterilization once the desired family size is reached.^{2,3} The gap lies instead in not knowing how to access a method, in misconceptions about its safety, in the absence of social norms that permit discussion of reproductive health within households, and, critically, in the near-total exclusion of male partners from shared reproductive responsibility. Concerns about side effects and health risks are among the most common reasons for contraceptive non-use among women with unmet need in low- and middle-income countries.⁴ In India, male sterilization accounts for less than 1% of current contraceptive use, and contraception has largely been constructed as a female concern, with male partners occupying a role that ranges from indifferent to actively obstructive.⁵

These dynamics are further complicated when the community belongs to a tribal group with strong cultural cohesion and limited integration with surrounding populations. In central India, knowledge and use of temporary contraceptive methods are considerably lower among tribal than non-tribal women, with fear of adverse health consequences, poor access, and limited knowledge cited as leading reasons for non-use.⁶ Nationally, female sterilization dominates modern contraceptive use among tribal women while spacing methods are rarely used, and studies of individual tribes in southern India have documented similarly low awareness and use of temporary methods.⁷⁻⁹

The present study was conducted in an urban slum of Coimbatore, Tamil Nadu. During fieldwork, it became evident that the entire study population comprised descendants of the Gondi tribe- a Marathi-speaking tribal community originating from central India- who have maintained strong social cohesion and cultural insularity within the urban setting. This finding substantially reframes the study: it is not merely a KAP survey in an urban slum, but an examination of the reproductive health realities of a migrant tribal community navigating the intersection of traditional norms and urban healthcare infrastructure.

The study aimed to characterize contraceptive KAP among Gondi women in Coimbatore, with particular attention to the gendered dimensions of non-use, the role of community knowledge networks, and the structural barriers that prevent available services from reaching those who need them.

METHODS

Study design and setting

A community-based cross-sectional study was conducted in a defined urban slum locality of Coimbatore City, Tamil Nadu, from 4 July 2025 to 9 July 2025. The area was selected purposely based on its official slum classification. During fieldwork, all participating households self-identified as Gondi community

descendants- a Marathi-speaking tribal group from the Vidarbha region of Maharashtra who had settled in Coimbatore across generations while maintaining endogamous social ties and cultural cohesion. Data were collected through door-to-door household visits.

Participants

Married women aged 18-45 years who were permanent residents of the study area were eligible. Both currently married and previously married (widowed or separated) women were included; women temporarily visiting the area were excluded. Eligible women were approached during door-to-door visits, and 190 women who provided informed consent were enrolled.

Data collection

A structured, pretested questionnaire was administered in the local language by trained female interviewers. The questionnaire covered sociodemographic characteristics, reproductive history, and KAP of contraception, including sources of contraceptive information (multiple responses permitted), method-specific awareness, ever-use and current use, reasons for non-use, attitudes toward family planning, and perceptions of male partner involvement. Interviewers also documented field observations on community context and participant responses. These observations, together with the questionnaire responses, were reviewed by the authors and grouped into barrier domains (Table 3).

Socioeconomic classification

Socioeconomic status was classified using the updated BG Prasad scale (2010), which assigns households to five classes based on per capita monthly income adjusted for the current consumer price index.¹⁰

Statistical analysis

Data were entered and analysed using standard statistical software. Categorical variables were summarized as frequencies and percentages, and continuous variables as means (with median and range for age). Percentages were calculated against all 190 participants unless stated otherwise; because more than one source of information could be reported, those percentages do not sum to 100%. Chi-square tests were used to examine the association of contraceptive ever-use with educational attainment and parity. A two-tailed p value <0.05 was considered statistically significant. The study is reported in accordance with the STROBE guidelines for observational studies.¹¹

Ethical approval

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from the institutional ethics committee, Karpagam

Faculty of Medical Sciences and Research, Coimbatore, before commencement. Informed consent was obtained from all participants in the local language before enrolment.

RESULTS

Sociodemographic and reproductive characteristics

A total of 190 women were enrolled. All participants were descendants of the Gondi community who had resided in this settlement across generations while maintaining endogamous social ties and limited intermarriage with surrounding communities. This shared tribal identity is a foundational contextual characteristic that informs interpretation of all KAP findings.

The mean age was 32.9 years (median 28; range 18-45). Educational attainment was strikingly low: 50.5% were

illiterate, 43.2% had completed some primary or secondary schooling, and only one woman (0.5%) had graduated from college; for the remaining 11 women (5.8%), educational level was not recorded in these categories. Nearly all participants (97.4%) identified as Christian. By BG Prasad classification, 51.6% were in the lower class and 36.3% in the lower-middle class. Most women (65.3%) lived in nuclear households; 74.7% were currently married and 25.3% were widowed or separated. In 45.3% of households the woman was the sole earner, in 46.3% only the husband earned, and in 8.4% both partners or other family members contributed. At the time of the survey, 10.0% were pregnant, and the mean number of living children was 2.8; several households, predominantly older families, reported four, five, or six children. Induced surgical abortion was reported by 17.4%, and 6.3% had experienced at least one infant or child death. The overwhelming majority (95.8%) did not want any more children (Table 1).

Table 1: Sociodemographic and reproductive characteristics of participants (n=190).

Characteristic	Category	N (%)
Age (years)	Mean (median; range)	32.9 (28; 18-45)
Religion	Christian	185 (97.4)
	Other	5 (2.6)
Education	Illiterate	96 (50.5)
	Primary to secondary schooling	82 (43.2)
	College graduate	1 (0.5)
	Not recorded in these categories	11 (5.8)
Socioeconomic class (BG Prasad 2025)	Lower	98 (51.6)
	Lower-middle	69 (36.3)
	Other classes	23 (12.1)
Family type	Nuclear	124 (65.3)
	Non-nuclear	66 (34.7)
Marital status	Currently married	142 (74.7)
	Widowed or separated	48 (25.3)
Household earner	Woman only	86 (45.3)
	Husband only	88 (46.3)
	Both partners or other members	16 (8.4)
Reproductive history	Currently pregnant	19 (10.0)
	Living children, mean	2.8
	Induced (surgical) abortion, ever	33 (17.4)
	Infant or child death, ever	12 (6.3)
	No desire for more children	182 (95.8)

Values are N (%) unless otherwise stated. Socioeconomic class by the updated BG Prasad scale (2025). All participants self-identified as descendants of the Gondi tribal community.

Contraceptive knowledge and sources of information

Contraceptive knowledge was narrow in scope and heavily shaped by informal intra-community channels. The most frequently reported source of contraceptive information was family members or friends (39.5%), followed by doctors or hospitals (36.8%), nurses or community health workers (6.3%), and school (4.7%);

one in five women (20.0%) had never heard of any contraceptive method (Table 2, Figure 1A).

Awareness mapped closely onto what the community's own networks had circulated, predominantly methods promoted and distributed free of cost by government programmes. Awareness was highest for female sterilization (79.5%), followed by injectable contraceptives (68.4%). Knowledge dropped sharply for

methods requiring procurement or male involvement: 26.8% were aware of condoms and only 8.9% knew of oral contraceptive pills (Figure 1B). No woman reported knowing where to obtain female condoms or natural family planning services from a health facility. Awareness of vasectomy was not recorded as a separate item; however, during interviews many women were unaware that a permanent method existed for men.

Table 2: Contraceptive knowledge and practice among participants (n=190).

Variables	N (%)
Source of contraceptive information^a	
Family or friends	75 (39.5)
Doctor or hospital	70 (36.8)
Nurse or community health worker	12 (6.3)
School	9 (4.7)
Never heard of any method	38 (20.0)
Awareness of specific methods	
Female sterilization (tubectomy)	151 (79.5)
Injectable contraceptives	130 (68.4)
Male condoms	51 (26.8)
Oral contraceptive pills	17 (8.9)
Vasectomy (male sterilization)	Not quantified ^b
Knew where to obtain female condoms or natural family planning services	0 (0.0)
Contraceptive practice	
Ever used any method	97 (51.1)
Female sterilization	45 (23.7) ^c
Reversible or traditional methods other than sterilization	52 (27.4) ^d
Never used any method	93 (48.9)
Currently using any reversible method	<5% ^e
Husband had undergone vasectomy	0 (0.0)

^aMultiple responses permitted; percentages are of all 190 participants and therefore do not sum to 100. ^bAwareness of vasectomy was not recorded as a separate item; during interviews, many women were unaware that a permanent method existed for men. ^c46.4% of the 97 ever-users. ^d53.6% of the 97 ever-users; method-specific counts were not reliably recorded. ^eFewer than five current users each of oral pills, condoms, and injectables.

Contraceptive practice

Just over half of all participants (51.1%; n=97) had ever used a contraceptive method. Female sterilization had been undergone by 45 women, accounting for 46.4% of ever-users and 23.7% of all participants. In most cases, sterilization was performed as a government-initiated procedure at delivery, typically after the second or a subsequent birth, and was rarely the result of a deliberate prior decision. The remaining 52 ever-users (53.6% of ever-users; 27.4% of all participants) reported past use of

reversible or traditional methods other than sterilization; method-specific counts for this group were not reliably recorded. Use of these methods was seldom sustained: fewer than 5% of all participants were currently using any reversible method, with fewer than five current users each of oral pills, condoms, and injectables, and traditional methods such as rhythm or withdrawal were each reported by fewer than 5% of respondents. No woman reported that her husband had undergone vasectomy (Table 2, Figure 1C).

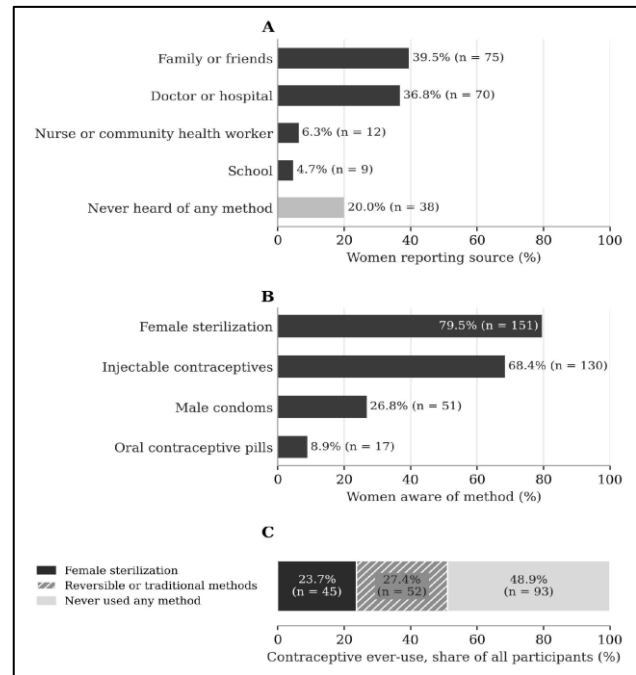


Figure 1: Contraceptive knowledge and practice among participants (n=190): (A) sources of contraceptive information (multiple responses permitted); (B) awareness of specific contraceptive methods; (C) contraceptive ever-use by method type. Percentages are of all 190 participants.

Attitudes toward family planning

Most women agreed with family planning in principle, and over 90% considered it acceptable once their families were complete. This acceptance was framed around limiting rather than spacing births. The belief that contraception could cause infertility was commonly expressed, although its prevalence was not quantified.

Barriers to contraceptive use

Field observations, combined with the questionnaire findings, enabled structured characterization of barriers across five domains (Table 3).

Table 3: Barriers to contraceptive uptake identified in the study population.

Barrier domains	Specific barrier identified	Group most affected
Gender dynamics	Contraception perceived as exclusively women's responsibility; male partner absent from decision-making	All
	Husbands refused condom use; women did not negotiate, anticipating refusal	All
	Vasectomy largely unknown; male sterilization not considered an option	All
Knowledge gap	Awareness limited to methods circulating through intra-community word-of-mouth	All
	Contraception understood as permanent family cessation rather than birth spacing	Younger women
	Full range of reversible methods unknown; newer methods unfamiliar	All
Fear of side effects	Undifferentiated fear of infertility attributed to all methods	All
	IUD and injectable use discouraged by community-circulated adverse reports	All
Healthcare access	Nearby PHC avoided owing to perceived social exclusion; preference for distant district hospital	All
	Contraception taken up mainly when offered by hospital staff at delivery	All
Generational and cultural norms	High parity linked to marital strength and vitality	Older women
	Marriage from age 18 and school dropout after puberty limit ASHA outreach	Adolescents and young women
	Preference for children of both sexes prolonged childbearing	All
	Endogamy and social closure restricted exposure to wider health information	All

Barriers derived from structured questionnaire responses and interviewer field observations. ASHA- accredited social health activist; IUD: intrauterine device; PHC: primary health centre.

Gender dynamics

The most structurally significant barrier was the complete exclusion of male partners from contraceptive decision-making. Family planning was initiated either independently by women or by hospital personnel at the time of delivery; it was seldom discussed at home. Condom use was refused by husbands in virtually all instances raised; women anticipated refusal and did not attempt negotiation. The community norm, articulated openly, was that contraception is not a man's concern.

Knowledge gap

Contraceptive knowledge was limited to what had entered the community's own informational ecosystem: female sterilization, copper-T, and government-distributed injectables. The concept of using contraception to space births, rather than as a permanent measure after family completion, was essentially absent. Younger women were receptive to family planning in principle but perceived it as relevant only after their families were complete. Newer methods available in public facilities and private pharmacies were unknown.

Fear of side effects

A community-wide, undifferentiated fear of side effects deterred use of all methods. Participants did not

differentiate risk profiles across methods; pills, injectables, intrauterine devices, and sterilization were perceived through a single lens of potential harm, with infertility as the most feared outcome. Isolated adverse experiences with intrauterine devices and injectables spread rapidly through community networks, while uneventful use went unshared, creating an informational asymmetry that reinforced negative perceptions.

Healthcare access

Despite a primary health centre (PHC) in close proximity, women consistently preferred to travel to the main district government hospital, reporting a sense of not belonging at the nearby PHC. This perceived social exclusion from proximate services represented a structural access failure that facility proximity alone could not address. Women expressed a clear preference for contraceptive services to be brought to their doorstep.

Generational and cultural norms

Older women associated high parity with marital strength and vitality; several households had four to six children without contraceptive use. Marriage from age 18, accompanied by school dropout after puberty, limited effective outreach by accredited social health activists (ASHAs) to this community. A preference for children of both sexes drove continued childbearing in a proportion

of families. Underpinning all barriers was the community's strong endogamy and social closure, which restricted the penetration of health information from the broader urban environment.

Factors associated with contraceptive use

On chi-square analysis, higher parity ($p < 0.001$) and any formal educational attainment ($p < 0.001$) were significantly associated with ever-use of contraception. Women with three or more children were more likely to have ever used a method than those with one child, consistent with the community's framing of contraception as a response to completed rather than planned fertility. Women with any schooling were more likely to have used contraception than illiterate women, underscoring the role of even modest educational exposure in expanding health knowledge and agency.

DISCUSSION

This study documents the contraceptive knowledge-practice gap in a community that is simultaneously urban in geography and tribal in social organization. The Gondi community of Coimbatore represents a population for whom the conventional assumption that urban residence confers access to health information and services does not hold. Physical proximity to urban health infrastructure has not translated into meaningful engagement with the full range of modern contraceptive options.

The finding that contraceptive knowledge was largely limited to methods delivered through government programmes and intra-community word of mouth aligns with a broader pattern documented in tribal communities across India. Muralidhar et al, studying pregnant women of the Jenu Kuruba tribe in rural Mysore, found that only 39.3% had heard of any temporary contraceptive method and only 2.7% had ever used one, and that women who had delivered in a government facility had greater odds of knowing of a temporary method.⁸ They also described the Jenu Kuruba as a socially closed network, a characteristic shared with the present community. Sreedevi et al similarly found that only 26.4% of tribal women in Wayanad, Kerala, were currently using contraception, with permanent methods accounting for 63.8% of use.⁹ The present findings align with this pattern, with the additional dimension that the community's urban location may create a false presumption of access, causing it to be overlooked by tribal health programming.

The gendered structure of non-use is among the most striking findings. Contraception has been constructed in this community as an exclusively female responsibility, to be borne, managed, and suffered by women, while male partners remain absent from reproductive decision-making. Thompson et al, in a study across 38 urban slum areas of Karachi, found that despite satisfactory knowledge of contraceptives, uptake remained limited by

cultural and religious norms, concerns about side effects (reported by 78%), and spousal disapproval.¹²

The near-invisibility of vasectomy is a particularly striking asymmetry. Female sterilization was known to nearly 80% of participants, yet male sterilization was largely absent from women's awareness and no husband had undergone it. This mirrors national data, in which male sterilization accounts for less than 1% of contraceptive use, a consequence of decades of female-focused family planning outreach.⁵ Notably, among Gond and Madia men in Maharashtra, the state from which this community originates, male sterilization accounted for about two-thirds of current modern method use, suggesting that the absence of vasectomy in this migrant community may reflect its local service environment rather than an intrinsic cultural rejection of male methods.¹³ This strengthens the case for engaging men through trusted community leaders.

The framing of contraception as a permanent measure after family completion, rather than a spacing tool, is traceable to the community's exposure history. Government programmes have historically prioritized fertility limitation over birth spacing, and community networks transmit what services have delivered. Nationally, female sterilization accounts for the large majority of modern contraceptive use among tribal women, with child spacing largely overlooked, and more than 80% of tribal women obtain family planning information from public health facilities and health workers.⁷ In the present community, by contrast, family and friends were the most frequently reported source of information. The result is limited and uneven knowledge of reversible contraception: pills and condoms were little known, and injectables, although widely known, were rarely used on a sustained basis. Among ever-users who had tried reversible methods, continued use was uncommon, consistent with the community-wide fear of side effects. Worry about side effects and partner opposition were likewise the main reasons for non-use among tribal women in Kerala, and phobia of adverse health consequences was a leading reason for non-use among tribal women in central India.^{6,9}

The community's preference for the distant district hospital over the nearby PHC, driven by perceived social exclusion rather than cost or distance, echoes an ethnographic study of the indigenous community of Attapadi, Kerala, in which hesitancy to use free and accessible services was attributed to a failure to provide culturally respectful care and to discrimination at health facilities.¹⁴ The participants' expressed preference for doorstep delivery of contraceptive services is a clear, actionable programme demand.

The generational divide observed is important programmatically. Older women's association of high parity with vitality is unlikely to shift rapidly through information campaigns alone. Younger women's greater

receptivity, tempered by limited knowledge, represents a window of opportunity that must be engaged before the same gaps are inherited by the next reproductive cohort. The community's strong internal networks, while a barrier to incoming information, also have the potential to transmit accurate information rapidly once it enters trusted channels.

This study has several limitations. First, the sample was drawn from a single, purposively selected slum settlement and was modest in size (n=190), which limits generalizability beyond this Gondi community and setting. Second, the cross-sectional design permits only associations, not causal inference, and the associations of ever-use with parity and education were tested by chi-square without adjustment for confounders such as age and socioeconomic status. Third, knowledge, attitudes, and practices were self-reported and may be affected by recall and social desirability bias, particularly for sensitive topics such as abortion and male partner involvement. Fourth, the barrier domains were derived from structured questionnaire responses and interviewer field observations rather than a formal qualitative method such as in-depth interviews or focus group discussions, and should be regarded as exploratory. Fifth, only women were interviewed, so the perspectives of male partners were not captured directly, although their exclusion emerged as a central finding. Finally, method-specific counts of past reversible method use, awareness of vasectomy, and the prevalence of specific beliefs such as fear of infertility were not quantified, precluding method-specific analysis. Despite these limitations, the study provides community-level evidence from an understudied tribal population living in an urban setting.

CONCLUSION

Women in this Gondi tribal community of Coimbatore know of contraception almost exclusively through what has been delivered to their community, predominantly female sterilization and government-distributed methods. Reversible spacing methods remain little known and, where tried, are rarely sustained. Male partners are absent from every dimension of reproductive responsibility. Younger women are willing to use contraception but do not know what is available or how to obtain it, and understand it as relevant only after family completion rather than during the reproductive years.

Addressing the unmet need in this community requires doorstep delivery of a full contraceptive method mix, active male partner engagement through community leaders, explicit education differentiating reversible from permanent methods, and a healthcare environment in which this community feels welcome. The community's social cohesion, so often the mechanism through which misinformation spreads, is equally the mechanism through which accurate information, once seeded, can travel rapidly and lastingly.

ACKNOWLEDGEMENTS

The authors thank the women of the Gondi community who participated in this study for their time and candour, and the trained female field investigators whose diligence and community rapport were essential to data quality. An AI-based writing tool was used for language editing and formatting of the manuscript; the authors reviewed all content and take full responsibility for it.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee Karpagam Faculty of Medical Sciences and Research, Coimbatore

REFERENCES

1. Bhattathiry MM, Ethirajan N. Unmet need for family planning among married women of reproductive age group in urban Tamil Nadu. *J Family Community Med.* 2014;21(1):53-7.
2. Sekhar MA, Edward S, Grace A, Sushmitha G, Priscilla SE. Contraceptive behaviors and awareness in an urban slum community of south India. *Asian Pac J Reprod.* 2024;13(4):160-8.
3. Kalva J, Rao AP, Narayanan P. Unmet need for contraception among eligible women of urban slums in Chennai. *Int J Community Med Public Health.* 2021;8(11):5352-8.
4. Sedgh G, Hussain R. Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries. *Stud Fam Plann.* 2014;45(2):151-69.
5. Salve PS, Shekhar C. Disappearing male sterilization in India: do we care? *Contracept Reprod Med.* 2023;8:31.
6. Prusty RK. Use of contraceptives and unmet need for family planning among tribal women in India and selected hilly states. *J Health Popul Nutr.* 2014;32(2):342-55.
7. Panda SN, Barik M, Acharya AS, Kanungo S, Pati S. Spatial distribution and factors influencing modern contraceptive practice among tribal married women in India: evidence from National Family Health Survey 5 (2019-2021). *BMC Womens Health.* 2023;23(1):318.
8. Muralidhar K, Nishimura H, Coursey K, Krupp K, Jaykrishna P, Srinivas V, et al. Knowledge and practice of family planning among pregnant tribal women in Southern India: an observational study. *Contracept Reprod Med.* 2024;9(1):2.
9. Sreedevi A, Vijayakumar K, Najeeb SS, Menon V, Mathew MM, Aravindan L, et al. Pattern of contraceptive use, determinants and fertility intentions among tribal women in Kerala, India: a cross-sectional study. *BMJ Open.* 2022;12(4):e055325.
10. Shah PP, Bhaskar S, Singh MM. Updated BG Prasad's socio-economic status classification for the

- year 2025. *Int J Community Med Public Health*. 2025;12(5):2345-7.
11. von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP. The strengthening the reporting of observational studies in epidemiology (STROBE) statement: guidelines for reporting observational studies. *Lancet*. 2007;370(9596):1453-7.
 12. Thompson AM, Thompson JM, Sharif H, Seemi T, Sharif S. Unveiling barriers to the modern contraceptive uptake in the urban slums of Karachi: perceptions, attitude, and accessibility. *Cureus*. 2024;16(3):e56164.
 13. Jungari S, Paswan B. Male perception and participation in family planning among tribal communities of Maharashtra, India: a mixed-method study. *Int J Community Health Educ*. 2020;40(3):163-9.
 14. George MS, Davey R, Mohanty I, Upton P. “Everything is provided free, but they are still hesitant to access healthcare services”: why does the indigenous community in Attapadi, Kerala continue to experience poor access to healthcare? *Int J Equity Health*. 2020;19(1):105.

Cite this article as: Prasad B, Ramasamy R, Priya S. Knowledge, attitudes and practices of contraception among women in an urban slum of Coimbatore, Tamil Nadu: a community-based cross-sectional study of a Gondi tribal settlement. *Int J Community Med Public Health* 2026;13:6430-7.