

The Social Context of Family Planning In a South Indian Village

By A. Dharmalingam

A quasi-anthropological study, relying on structured and unstructured interviews and observation of participants, reveals several factors that have a strong bearing on birth control in a South Indian village, where the level of contraceptive use is lower than the statewide level. These factors are the lack of follow-up services, gender inequality and the unsuitability of sterilization to all working situations and living conditions. To improve program performance and quality of life, the government family planning program needs to address the side effects associated with the adoption of sterilization and facilitate individual choice, taking into account the village's social and economic context.

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Various population projections have estimated that India will have one billion inhabitants by the end of this century.¹ The implications of this population size seem ominous in view of the thinking of some academics that “a small India is a happy India.”² For a country already burdened with many social and economic problems, an expanding population seriously jeopardizes the prospects for eradicating poverty and improving the living standards of the masses.

Reflecting the seriousness of the problem, the late prime minister Rajiv Gandhi stated in 1989 that “a solution to India’s population problem would, in large measure, amount to a solution of the world’s population problem.”³ Some demographers warn that unless the social and institutional obstacles that impede fertility decline are soon removed, “more draconian population policies will eventually be contemplated.”⁴

The Indian government’s concern about rapid population growth, however, is not recent; India prides itself on being the first country to have adopted an official family planning program—in 1951. In fact, the foundation for the program was laid in the 1891 census report, which asserted that overpopulation was responsible for India’s misery.⁵ The first development plan after independence, launched in 1951, recognized that the population was so

large that further increases would hamper efforts to improve the standard of living. Successive plans placed increasing emphasis on improving the family planning program, in order to achieve targets that would help reduce the birthrate.

The family planning program started with a clinic approach in the 1950s and 1960s, and subsequently added a network of fieldworkers. In the mid-1960s, the IUD was introduced on a massive scale. This was followed by an extensive communication drive to motivate acceptance of the small-family norm. The failure of these approaches to bring about substantial changes in the birthrate led to the adoption of target-oriented programs.

Also as a result of the ineffectiveness of these initiatives, during the 1975–1977 political emergency, the government established mass vasectomy camps and undertook a forcible sterilization drive. To fill government quotas, sterilizations frequently were performed on individuals who were more than 45 years old and in poor health; many of them died within a few years. In some public health clinics in North India, men and women beyond a certain age were forced to undergo sterilization before receiving routine medical attention.⁶

What the family planning program was all about, particularly during the political emergency, was succinctly described in an editorial of a leading Indian journal: “Thousands upon thousands of people, mostly poor and illiterate, were herded like cattle to face the butcher’s knife and then to become statistics of targets achieved two and three times over.... Whether the person on whom the knife was wielded was 18 years old or 60, whether he was married or unmarried, whether he had six children

or none, became matters of irrelevance since the objective was to tote up awesome figures as proof of loyalty to the powers-that-were in New Delhi.”⁷

Once the emergency ended, it took almost five years for the government to restore family planning acceptance to its previous level. Although the government had changed, the policy of persuasion remained intact, and the program’s approach of setting targets at the central level also remained essentially unchanged. After the emergency, however, the strategies adopted seemed to be more passive and women became the targets.⁸

Despite the family planning program’s shortcomings, its coverage has expanded since the early 1980s, and its performance appears impressive. Overall contraceptive prevalence has risen, and reversible methods account for a larger share of use. Fertility declines, however, have been smaller than expected.⁹

With these complexities of the Indian family planning program as a background, this article examines family planning attitudes and practice in a South Indian village, with emphasis on the social context and implications for the national program.

Study Design

A “quasi-anthropological” approach was employed to collect quantitative and qualitative information. Quantitative information was collected between June and October 1987 through structured and unstructured questions, participant observation and in-depth probing. The importance and contribution of this approach to understanding a community’s demographic, cultural and political characteristics have been well demonstrated.¹⁰

The study village is located in the southern district of Tirunelveli in Tamil Nadu State, about 50 kilometers west of the district headquarters. In 1987, the population of the village was 1,451, including 318 households and 196 currently married women. The majority of the population (85%) belonged to the peasant caste (Nadar), and about 10% were untouchables. The selection of the study village, where I was born and grew up, was based largely on my familiarity with its population and history.

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Seven households were excluded from the analysis because attitudinal and family planning information was not collected from them, and two declined to participate. The structured questionnaire was administered to all married women under 50 years of age, but only about 10% of currently married men and women were selected for in-depth interviews.

My familiarity with the village facilitated informal discussions about family planning and gender relations, a technique particularly helpful to in-depth case studies. However, some respondents were hesitant to give information on property and wealth. And on certain attitudinal variables, some asked me to record my own assessment, assuming I was familiar with their day-to-day life. I had to explain the objectives and importance of the project before I could get their responses.

Village Economy and Society

Until recently, the majority of the population in the study village worked in agriculture. As a result, social relations were shaped largely by individuals' and families' function in agricultural production and distribution. Despite the emergence of alternative employment opportunities in the last 15–20 years, the possession of land suitable for paddy cultivation remains an important determinant of social status.*

As in the rest of India, the distribution of land is highly skewed. More than one-half of the households do not have access to fertile land. Further, the occupational characteristics of the cultivators have changed significantly over the last two decades. More than two-fifths of the paddy cultivators are engaged in non-agricultural secondary occupations.

The transformation from a solely agrarian to a mixed economy began in the mid-1970s, with the massive expansion of the *beedi*[†] and brick industries, which draw large numbers of women and men, respectively, into their work forces. Owing to the growth of these industries, only about one-fifth of all women and men now do some agricultural work. Moreover, the last five years have seen an increasing number of adults migrating out in search of remunerative employment.

Effects of Emerging Industries

The *beedi* and brick industries have had a strong effect on the lives of the local population. Almost all *beedi* workers in the village are females, although this is not the case elsewhere in India. At the time of the survey, there were 346 female *beedi* workers (representing more than 90% of village women

of reproductive age), five male workers and 39 female *beedi* assistants (roughly half of them young girls). About one-half of the *beedi* workers were introduced into this work at 5–10 years of age, and the rest at ages 11–15. Typically, by the age of 15, a *beedi* assistant becomes a main *beedi* worker.

About one-third of *beedi* workers work six days a week, and about one-half work five days a week; the average work day is 10–14 hours. *Beedi* work is done in the home, although the women must bring their work to an agent in the town at an appointed time each day. Workers are paid a piece rate, and annual earnings average Rs 1,700–2,200 (US \$85–\$110 in 1987).

Likewise, the brick industry has provided new employment opportunities for males. As making raw bricks demands great strength, it is reserved for males aged 15–40, but boys younger than 15 are employed in brick carrying. On average, a brick worker works 11–12 hours a day, five days a week, eight months a year. As in the *beedi* industry, the wage is paid at piece rate. Most workers net about Rs 2,400 (\$120) annually and are indebted to their employers.‡

This economic transition—especially women's ability to earn income—has engendered a number of social changes. Women's earnings facilitate short-term planning and budgeting for families; in better-off families, daughters' wages are saved for special purposes, such as marriage or land acquisition. Furthermore, being wage earners gives women personal power; they can translate earned wages into relative freedom of movement and some degree of autonomy in decision-making.

Another major social change has been in the dynamics of intergenerational relationships. When agriculture was the main field of economic activity for men and women, children handed over their earnings to their parents, and newly married couples usually lived with the husband's parents at least until they had their first baby (but an only son rarely moved his own family out of his parents' home). Today, however, with material necessities available in the market, a young person does not have to be subservient to an authoritarian family head, and most couples live on their own and start their own families within six months after marriage. This weakens the control a young man's parents have over his wife, and most parents feel that an increasing proportion of the younger generation have become disobedient. Parents commonly complain about the uncaring attitudes of their son and daughter-in-law; in some cases, parents are physically abused by their sons.¹¹

The implications of these changes for the small-family norm and for adopting family planning methods are manifold. For instance, uncertainty about future return from the younger generation could translate into a preference for a small family; women's demand for equal participation in decision-making could give them a greater voice in matters related to fertility and contraceptive use. Similar observations have been made elsewhere in South India.¹²

Family Planning Awareness

In this article, knowledge about family planning methods refers to knowledge of modern contraceptives. This usage precludes the wrong notion that in the past, people had no knowledge of how to avoid conception and terminate pregnancies—actions that invited social sanctions. Demographers evaluate the knowledge of family planning methods to get a rough idea about the potential for fertility reduction. Knowledge, however, does not always translate into behavior.

Over the last half century, the Indian government has worked relentlessly to encourage couples to have small families. The slogans and symbols seen on billboards, in movies, on television and in the newspapers conveyed the prospect of a prosperous life if the number of children was restricted to two. In addition, a major instrument of the program has been the payment of financial incentives to contraceptive acceptors. The payment, intended as compensation for incidental expenses and lost earnings, was Rs 150 (\$750) in 1987. The program also offers incentive payments to official providers and private motivators. These strategies were ineffective in motivating people to adopt a small family size, particularly before 1980.¹³

*Caste has always been a dominant social parameter in the village. Land traditionally has been owned or operated only by the peasant caste; a few washermen and barbers have recently acquired some land, and the untouchables are still landless.

†*Beedi* is a crude cigarette: Tobacco is rolled in a small *beedi* leaf and tied with a cotton thread. A *beedi* is smaller and less expensive than a cigarette; it is considered the poor man's cigarette and is smoked only by men in the study village and in rural Tamil Nadu generally.

‡The majority of workers who were indebted to their employers reported that they had to borrow in order to pay essential household expenses. Also, most brick workers receive their wages before the work is completed; if rain destroys the bricks already laid, the wage becomes debt to the employer.

§A group of young boys I spoke with related how the recent showing of a family planning movie in the village had been canceled because of some boys' disruptive behavior. In the early 1970s, elsewhere in Tamil Nadu, even adult men disturbed family planning propaganda events, and in Maharashtra, where researchers collecting baseline demographic data were mistaken for government family planning workers, "great pains" had to be taken to correct the misunderstanding (see reference 13).

Table 1. Percentage distribution of husbands of women younger than 50, by approval of family planning, according to selected characteristics, South Indian village, 1987

Characteristic	N	Approve	Disapprove	No opinion	Total
Total	192	57	35	8	100
Landholding*					
Landless	105	61	32	7	100
Landed	87	53	37	10	100
Years of schooling					
<3	98	48	42	10	100
3-5	58	62	31	7	100
>5	36	75	19	6	100
Occupation					
Wage laborer	96	58	33	9	100
Cultivator†	58	48	41	11	100
Self-employed/salary earner/businessman	38	68	26	6	100

*In this table and in Table 2, "landless" refers to those with less than one-quarter of an acre of land; "landed" refers to those with one-quarter of an acre or more. †In this table and in Table 2, cultivators are those whose reported main occupation was farming.

probably because they overlooked the fact that material and social conditions were unfavorable to a small-family norm.¹⁴

While the program's motivational effects are dubious, it has at least increased awareness of family planning. More than 90% of couples in the study village were aware of at least one contraceptive method. This increased knowledge of family planning methods has occurred throughout India. The All-India Surveys on family planning conducted in 1970 and 1980 showed that the program's major achievement in the 1970s was the substantial increase in the level of awareness of at least one method among the rural population.¹⁵

"Family planning," however, has become a euphemism for sterilization. Among survey respondents who knew of any method, all knew about sterilization; only 6% knew of the condom and IUD, and 2% the pill. To most, acceptance of family planning meant the end of reproduction. This perception may be partly the result of the role of the 1975-1977 political emergency in making the family planning program known. While ostensibly promoting sterilization for fam-

*The information about traditional methods was not collected through the survey; rather, it was obtained over years of informal exchange with a few young and old people in the village.

†A man in the study village now 30 years old was breast-fed until he was about 10.

‡Condoms are available in some grocery shops in the village, and small numbers of them are sold. This suggests a certain level of use, although none was reported. The local health worker confirmed that no women were using other modern reversible methods, and added that women do not resort to abortion as a birth control method. The health worker is a reliable source of information because it would be unusual for a married woman in the village to obtain an IUD, pills or an abortion without her knowledge. Women who become pregnant premaritally, however, may resort to abortion for social reasons, and may obtain the procedure without the health worker's knowledge.

ily limitation, the emergency deterred people from accepting it in the future.¹⁶

As Table 1 shows, 57% of husbands in the village approve of family planning, but that leaves a substantial proportion who do not. The differences by characteristics are not significant, and no consistent pattern emerges in the level of approval. For instance, while increasing education seems to raise approval, landholding appears to have little influence on ap-

proval levels. Likewise, there is no difference by occupation; in particular, the approval rate among the wage laborers (58%), who are poor and account for 46% of the population, is not significantly different from that among the self-employed, salary earners and businessmen (68%).

Traditional Methods

Even before modern contraceptives were made available, the villagers prevented unwanted pregnancies and births, not to limit family size, but to fulfill social and cultural expectations and to improve the health of the baby and mother. Abortion, withdrawal and abstinence were the most commonly used methods.*

In the past, rather than disclosing premarital pregnancies and jeopardizing their chances of eventually marrying, unmarried women often resorted to folk remedies to induce abortions. Unripened papaya was commonly consumed as an abortifacient, as were certain local herbs that were believed to act both as abortifacients and as contraceptives. There is, however, no evidence of the effectiveness of these methods. (Today, women can obtain abortions in nearby towns without the knowledge of anyone in the village. This option is made possible by the independent cash income women earn through beedi work; improved bus transportation to the towns; and increased access to information about abortion through health workers, networks of friends and the mass media.)

Withdrawal is used relatively widely in the case of extramarital relations and to space births, but the overall prevalence of this method is probably low.

Among the oldest couples, strict abstinence is followed, both because of the lessened urge for sexual intercourse with in-

creasing age and because of the strong social sanctions against pregnancy in late middle age. A study in North India made the same observation.¹⁷

Breastfeeding, although not covered in the village survey, is another factor that can lengthen the birth interval. Indian women typically breastfeed until their infant becomes entirely dependent on other foods, breast milk supply fails or they become pregnant again. Research in another Tamil village documented that people knew that prolonged lactation reduced the likelihood of another pregnancy.¹⁸ In the study village, women breastfeed their children as long as they can,† although not with the intention of postponing the next pregnancy; however, they likely are aware of such effects.

Use of Sterilization

The adoption of a particular contraceptive method is influenced by the perceived benefits of its use, as well as the perceived social, economic, psychological and physical costs.¹⁹ It may also be influenced by the inequalities in the relationship between a husband and wife.

The majority of the study population are not against the use of family planning methods; thus, there is no significant social sanction preventing an individual from practicing contraception. The government program offers free contraceptives and services (although of poor quality); therefore, economic cost cannot be a major deterrent to use, either. Even psychic costs, in terms of lack of sexual pleasure, violation of sexual modesty and conflict with religious belief, do not seem to be an obstacle. And because most young couples live apart from their parents, intergenerational conflict cannot account for nonuse. As will be seen, however, in the village context, strains in spousal relationships and physical and material costs (health effects and costs of medical treatment) after sterilization appear to discourage the practice of family planning.

Overall Acceptance

Despite the high level of awareness about family planning methods, particularly sterilization, the level of use is low. Of all women with at least two living children, only 26% were practicing contraception at the time of the survey. More important, all of these were protected by sterilization; 36 had undergone the surgery themselves, and one had a husband who had undergone vasectomy. No one reported using any of the available spacing methods—the IUD, pill and condom.‡

Sterilization dominates contraceptive

use partly because many women are not even aware of the range of methods available. In addition, the official motivators do not encourage using other methods because they have to keep track of acceptors of reversible methods, but not of those who become sterilized. Furthermore, most women themselves prefer sterilization because they would like to end childbearing.

Most sterilizations in the village took place after the emergency; the few village residents who underwent vasectomy during the emergency were so old that their wives were beyond reproductive age. The level of acceptance in the study village is lower than the national level of 35% of currently married women and the state level of 41% in 1985–1986. This contrast is significant because the village women's earnings from the beedi industry make this village economy relatively sound compared with the country's average rural standard.

The demographic characteristics of the acceptors indicates that the impact on the fertility level of the village would be modest. About one-half of sterilization acceptors in the village were 30–39 years old when they underwent the surgery, and about one-half were aged 20–29. About two-fifths of eligible women aged 30–39 are protected by sterilization, compared with fewer than one-fifth in the younger and older cohorts. This pattern indicates that increasing acceptance of family planning is a recent occurrence and that the acceptance level rises as couples enter their 30s.

Achieved parity appears to be the main demographic determinant of sterilization. Just 10% of acceptors had two living children; 43% had three, and 46% had at least four. Among couples younger than 30, the proportion sterilized increased from 9% overall to 18% when only those with at least two surviving children were considered.

The levels of acceptance of sterilization by landholding, education and occupation are shown in Table 2. The acceptance rate appears to be higher among women whose husbands are landless (35%) than among those whose husbands own land (19%). However, this difference needs to be interpreted with caution because the landless group includes some well-to-do self-employed persons and businessmen. Thus, it is very likely that there is no relationship between landholding and sterilization.

Sterilization prevalence among wives of cultivators (21%) is slightly lower than that among wives of wage laborers (27%), which in turn is slightly lower than the prevalence among the self-employed, salary earners and businessmen (36%); these differences, however, are not significant. Moreover,

given the small sample size, socioeconomic differences are difficult to determine.

Available evidence for India shows a linear relationship between education and demand for children, and between education and contraceptive use.²⁰ Nevertheless, the study data show no significant difference in acceptance by level of education.

Acceptance Among Wage Laborers

Whereas cultivators are underrepresented among sterilization acceptors, and the self-employed, salary earners and businessmen are overrepresented, wage laborers account for the same proportion of sterilization acceptors as they do of eligible couples (46%). Two factors seem to account for acceptance among wage laborers: the government's encouragement of the small-family norm and families' economic circumstances.

The effect of the small-family ideology has to be seen in the context of the changing village economy and society. When most of the village population depended on agricultural work to earn their livelihood, the family planning workers had little chance to meet people and persuade them to adopt family planning because the work schedule of the motivators was incompatible with that of a largely agrarian population. Furthermore, in agricultural work, young and old people work together, and discussions about sex and family planning would therefore be considered inappropriate. Additionally, the effect of persuasion through radio and cinema was limited because only a small proportion of the population had access to these media.

Today, the environment is much more conducive to the spreading of information about contraception and the exchange of views among women about the adoption and side effects of particular methods. In beedi work, younger and older people usually work separately; this provides opportunities for discussions about family planning and other issues. Around 40% of households have transistor radios, and some even have tape recorders. Furthermore, an increasing number of young people, both married and unmarried, go to the movies (where family planning advertisements are usually shown) at least once every two weeks, and

some young people go once a week.

Another change stems from the working environment itself. When women worked in agriculture, their older children looked after the younger ones and kept them away from the mother so that she was not disturbed while working in the fields. But women in the beedi industry work at home, where children may distract them and affect their productivity. Given the need to produce a certain amount of beedi each day, the importance of practicing family planning and having small families takes on new meaning.

Financial constraints are particularly acute for beedi workers whose only source of income is their earnings. A woman with four children whose husband was an alcoholic and did not contribute his earnings to the family reported: "I cannot even feed the children I have. The better alternative for me was to get sterilized. I did that and got about 150 rupees; the money provided us with good food for a week."

Similarly, brick workers' income may not be enough to cover essential costs for their families. For instance, a brick worker in his 30s with three sons said that the oldest, a teenager, wanted to go to school: "But the economic problem of my family did not permit that. I want to educate at least the two younger ones, who are in the primary school. If we keep having children one after another, we cannot educate anyone, so my wife underwent the sterilization operation. But now it seems to me that even educating at least one son would be out of my reach."

Evidence from other parts of South India also shows that poverty-driven family planning acceptance is a widespread phenomenon. One study in the mid-1980s revealed that the high level of family planning adoption among the agricultural laborers in Kerala State was due to their poverty and re-

Table 2. Percentage distribution of currently married women with at least two living children, by sterilization acceptance, according to selected characteristics of their husbands

Characteristic	N	Acceptor	Non-acceptor	Total
Total	139	27	73	100
Landholding*				
Landless	66	35	65	100
Landed	73	19	81	100
Years of schooling				
<3	72	25	75	100
4–5	44	29	71	100
>5	23	26	74	100
Occupation				
Wage laborer	63	27	73	100
Cultivator	48	21	79	100
Self-employed/salary earner/businessman	28	36	64	100

*Differences within this category are significant at $p < .10$.

duced employment opportunities.²¹ In an earlier study, using micro-level data from a few villages in Kerala, the investigator argued that because of the extreme pressures on employment in a situation of a steadily decreasing amount of work available, "the decline in fertility among agricultural laborers need not be seen as an indication of an improvement in their quality of life. In the Kerala context, it can equally well be seen as a sign of greater poverty."²²

Thus, it seems that family planning acceptance among wage laborers, most of whom are poor, is influenced by their economic conditions and the spread of the ideology of the small family; acceptance is facilitated by easy access to sterilization. It may be that among the relatively well-off self-employed, salary earners and businessmen, acceptance is due to their aspiration to make use of modern facilities (e.g., education, urban jobs) and thereby improve their social status.²³ This does not mean that the poor do not also aspire to improve materially and socially; they do, but their objective conditions do not seem favorable.

Family Planning Intentions

When the eligible couples were asked about their intentions to use any family planning method, the responses given were not encouraging: Two-thirds of women did not intend to use any method in the future. The reasons for this lack of interest are not hard to trace.

Health Concerns

Although it is generally argued that sterilization should not affect health, and therefore fears about the procedure are misplaced, the poor living conditions, poor health (e.g., malnutrition) and lack of good-quality family planning and follow-up services in the study village increase the risks for some people undergoing sterilization.

Living conditions for women in the village are especially poor, leaving them susceptible to ill health. Before a man leaves for work each day, his wife has to get up, clean the house, go to the well to fetch water, and make his breakfast and lunch. After he has left for work, she has to feed the children, send them to school if they go and start making beedi. She must submit her day's beedi to the agent in the village (her failure to do so may create tension with her husband) and should have her husband's dinner ready when he returns home in the evening.

In village families, women have no time

to look after themselves; they bear most of the hardships. If there is not enough food left for breakfast or for lunch, the wife goes without. She bathes the children, and the husband can bathe at his place of work; the wife does not have time to wash. Other considerations also constrain the working mother's chances of taking a bath. For instance, most houses in the village do not have a bathroom; if there is one, it offers no privacy. Also, since it is the women who fetch water from the well, they will sometimes forgo bathing to reduce their workload.

If a woman accepts sterilization in such an environment, the follow-up services need to be exceptionally good to avoid any health problem. In addition, she should have someone to do her housework for at least a week after the operation; but in most cases, that does not happen. Her husband may be willing to help her, but he has to go to work.

For example, Uma was a beedi worker with three children at the time of the survey. Her husband was a bricklayer with no other source of income. They live in a small room in a cattle shed of a rich man in the village, who does not ask for rent. Their home has no washing facilities, so it is hard for her to take a bath very often. Having considered the incentive offer and hoping for a better future for her children, Uma decided to undergo sterilization when her last child was less than one year old.

It appears that Uma did not receive proper follow-up care, and the surgical wound did not heal well. Eventually, she was taken to the public hospital, where she was given medication. After a few days, her condition had deteriorated; she was, according to her brother, "almost dead." Uma was moved to a private hospital, and her husband had to borrow about Rs 1,000 (\$50) to pay for it. Uma is fine now, but it will take years for her and husband to repay the Rs 1,000.

Similar conditions prevail in Punjab, where the family's social and economic conditions may affect the risks associated with sterilization acceptance, and where sterilization may lead to unintended repercussions for the family.²⁴

A further obstacle to acceptance is that if even one case goes wrong, the news is likely to spread rapidly throughout the village. For example, a brick worker in his 30s related that after having three sons, he and his wife, a beedi worker, had decided to stop having children; his wife underwent sterilization.

He said: "My wife cannot perform any hard work after her sterilization. She finds it very difficult to fetch even a pot of water

from the village well. I am blaming myself for what we did." He reportedly told some women who were interested in undergoing sterilization: "Your husbands are not like me, to fetch water from the well; so don't do it." That was enough to put those women off. He added: "It is good for rich people because they do not have to do hard work. For poor people like us, who have to work every day without any break, it is not good. I would not recommend to anyone to undergo this after my experience."

Similarly, a landless brick worker aged 35 and married with one child said: "I will not accept it, even if am offered 1,000 rupees. After sterilization, we cannot do hard work." In support of this claim, he cited a movie in which the hero was beaten up after undergoing sterilization; under normal circumstances, the villain is beaten up by the hero.

It is not, therefore, surprising to find that about three-quarters of eligible couples who were not intending to use family planning, and more than four-fifths of those who disapproved of sterilization, cited health effects as their reason. Some couples use withdrawal instead, because it does not involve any health risk.*

Gender Inequality

Another factor that discourages the practice of contraception is the unequal relationship between husbands and wives.²⁵ Although women initiate the discussion about adopting family planning, men make the final decision. Men usually do not consent to use condoms or undergo vasectomies. Even when couples rely on withdrawal, some women said it was they who must draw away from their husband before he ejaculates.

Men's opposition to female sterilization arises both from their concern for their wives' health and from fear that they are losing control over their wives. Men may be suspicious that sterilization will make it easy for their wives to indulge in extramarital sexual relations because there is less risk of pregnancy and, hence, discovery.

Disagreements between husband and wife on this issue sometimes create significant tensions in the family. For instance, a woman in her early 30s with three children said: "My husband does not want me to undergo sterilization, presumably because he is suspicious of me. But I want to have it. Whether he likes it or not, I am going to go after a month to the nearby town and get sterilized without his knowledge. Even if he does not support me later in my life, I can support myself and my children from my beedi work."

*The observation about withdrawal comes from the in-depth interviews, not from the structured interviews, which did not collect systematic information on reversible methods or abortion.

For some men, their wives' health does not matter in their pursuit of the desired number, and combination, of children they want to have. When the expected subordinate role of a wife is not sustained, the family is in turmoil, as in the following case.

A young couple have only an eight-year-old daughter. The delivery had been so complicated that the woman had had to be hospitalized; but wanting to have at least one son, she became pregnant again. This pregnancy was more complicated than the first, and surgery was necessary; the baby was born dead. The doctors who operated warned this woman that another pregnancy might cost her her life.

Knowing that her husband would not let her undergo sterilization, the woman made her own decision to obtain the procedure. Once her husband learned that she had been sterilized, he began drinking away his earnings, coming home drunk a few times a week and fighting with his wife. Villagers take this case as a lesson to all women that if they disregard their husbands, the consequence is lifelong quarreling and unhappiness.

Conclusion

The family planning program in India has not been successful in making people aware of a variety of birth control methods. For villagers such as those interviewed for this study, family planning means sterilization. Neither does the program address the problems associated with adopting birth control methods.

The organized family planning program in India was originally designed to improve the quality of life of ordinary people by enabling them to choose a small family size. Although a considerable proportion of sterilization is poverty-induced, the program's ultimate success depends partly on how it contributes to achieving a better standard of living.

Program performance and quality of life cannot be improved if the side effects experienced by poor acceptors of sterilization are left unattended, and a variety of contraceptive methods that are appropriate for Indian men and women's living and working conditions are not offered. By ignoring issues faced by a large majority of people, the program not only fails in its objective, but also delays achieving replacement-level fertility.

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Resumen

Un estudio cuasi antropológico, basado en entrevistas estructuradas y no estructuradas y en la observación de los participantes, revela varios factores que influyen significativamente sobre el control de la natalidad en un pueblo ubicado en el sur de la India, donde el uso de anticonceptivos es más bajo que a nivel estatal. Estos factores son la falta de servicios de seguimiento, la desigualdad por razón de sexo y el hecho de que la esterilización no es apropiada en todas las situaciones de trabajo y condiciones de vida. Para mejorar el programa y la calidad de vida, es necesario que el programa de planificación familiar del gobierno resuelva los problemas secundarios relacionados con el uso de la esterilización y facilite la elección individual, tomando en cuenta el contexto socioeconómico de la población.

Résumé

Une étude quasi-anthropologique, basée sur des entrevues structurées et non structurées ainsi que sur l'observation de participants, met à jour plusieurs facteurs qui exercent une forte influence sur le contrôle des naissances dans un village du sud de l'Inde, où le niveau d'utilisation des contraceptifs est inférieur à celui à l'échelon de l'état. Ces facteurs sont le manque de services de suivi, l'inégalité entre les sexes et le fait que la stérilisation n'est pas adaptée à toutes les situations de travail et conditions de vie. Pour améliorer les prestations des programmes et la qualité de vie, le programme gouvernemental de planification familiale doit aborder les effets secondaires liés à l'adoption de la stérilisation et faciliter le choix individuel, compte tenu du contexte social et économique du village.