Family Planning and the Scheduled Tribes of Rajasthan: Taking Stock and Moving Forward*

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In this paper an attempt has been made to document the reasons for low acceptance of family planning methods among the scheduled tribes of Rajasthan, India. Three tribal groups—the Bhils, Garassias and Meenas—were selected for detailed investigations. The study was conducted using in-depth interviews and focus group discussions. The respondents included, among others, community members, community leaders, eligible couples and the service providers of the area. The results of the study show that resistance *to family planning is due to sociocultural and socioeconomic factors, the user's knowledge of and access to contraceptive methods and the attitude of the service providers towards the beneficiaries. The sociocultural factors include, among others, polygamy, the felt need for a large number of sons to defend and preserve family honour, prevalence of* nata *system and the excessive use of alcohol among men. One socioeconomic factor is the huge amount of compensation to be paid to one's wife's parents in case of her sterilisation. One of the salient findings of the study is an almost non-existent client-provider relationship. Based on the findings of the study a plan has been suggested to address this weakness. This plan advocates basic changes in the state policy in order to make family planning acceptable to tribal groups.*

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* This paper is dedicated to the memory of late Professor Rushikesh M. Maru, who took tremendous interest in the study.

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Introduction

The issue of population management has been a focus of extensive research for nearly a quarter of a century in India. Centralised target-driven approaches to decentralised target-free ones have been tried during this period to address the issue. The focus of the population programme in the country has changed during the last three decades from *family planning* to *family welfare* to *reproductive and child health*—the last being a much wider and a better integrated package of services that has gained wider acceptance following the International Conference on Population and Development (ICPD) 1994.

The states of Rajasthan, Bihar, Madhya Pradesh and Uttar Pradesh fall under the high-fertility regime, where the fertility rate is above the national average. During the decade 1981–91 these four states contributed 42 per cent of the net increase to India's population (Census of India 1991). A study by Satia and Jejeebhoy (1991) analysed the demographic scenario in these four large north Indian states. The analysis presented in their book clearly shows that the differences between these four states and the rest of India are very sharp. When compared with the rest of India these four states lag by about a quarter of a century in terms of literacy, per capita income, child survival, contraceptive use, decrease in fertility and fall in the number of children desired.

A large number of empirical studies conducted in India show that the contraceptive prevalence rate (CPR) of the scheduled tribes is significantly lower than that of the other caste groups. For example, the National Family Health Survey 1992–93 shows that the contraceptive use (all-India) among the scheduled tribes was 33 per cent compared to 42.4 per cent among the general caste groups (PRC et al. 1995). The survey of eligible couples in the rural areas of Tonk district of Rajasthan shows that CPR among the scheduled tribes during 1995 was 26.6 per cent compared to 36.1 per cent among the other castes (Kothari and Krishnaswamy 1998).

The possible reasons for the lower acceptance include cultural backgrounds, attitudes towards family planning, meagre knowledge of family planning methods, the attitude of the service providers towards these communities, the lack of accessibility and availability of services, and the prevalence of traditional methods of birth control. For Rajasthan state NFHS (Govindswamy and Ramesh 1997) found that the differences between SC/ST and non-SC/ST populations were significant even after controlling for education and residence.

Why has the family planning programme, despite the availability of large amounts of money, manpower and resources, failed to achieve the desired level of success? This issue of national importance calls for immediate attention.

Most of the studies conducted in Rajasthan, such as knowledge, attitude and practice (KAP) service, impact of training on community leaders (Sharma and Sharma 1993), popularisation of sterilisation (Sharma and Sharma 1996, Westley 1995), provision of incentives to the acceptors (Sharma and Sharma 1994), and preference for a male child (Muthurayappa et al. 1994) report on the quantitative aspect of family planning. A few studies also deal with natural contraception among the scheduled tribes of Rajasthan (Rensberger 1994).

In Rajasthan very few in-depth investigations have been conducted to study the reasons for the low acceptance of family planning in tribal communities. An effort has been made in the present study to take stock of the situation by undertaking an in-depth anthropological investigation of tribal communities and study in detail the reasons for their low acceptance of FP methods. Based on it certain suggestions to change the situation have also been provided.

Objectives

The study was undertaken with the following objectives:

1. To examine the cultural practices, norms, traditions, taboos, etc. influencing childbirth and child numbers, including the attitude of the communities towards family planning.
2. To study the knowledge of FP practices, apprehensions about various FP methods among the members of the resistant communities, and the benefits and limitations of various methods of family planning.
3. To study the accessibility to and the community's perception of the quality of the services provided, service providers, level of client satisfaction, etc.
4. To suggest ways to make family planning more acceptable among resistant communities.

Methodology

The three communities selected—in consultation with government officials and research organisations working in the area—for study were

the Bhils, Garassias and Meenas. It was decided to select one research site for each community for detailed investigation through qualitative methods of research, namely, focus group discussions and in-depth interviews. The study subjects included women of reproductive age as well as their spouses, community leaders and health providers.

Focus group discussions were held separately with groups of six to ten persons in the selected groups of females of reproductive age, male members of the society and community leaders, including members of village panchayat and others who were in a position to influence the decision making vis-à-vis family planning matters. In all, 21 focus groups were held during the study.

In-depth interviews were held with health providers at the grassroots level, such as auxilliary nurse midwives (ANMs), traditional birth attendents (TBAs) and *aanganwadi* workers (AWWs). The case studies focused on individual decision making regarding family planning, and were undertaken in order to highlight the problems faced by the people in having an access to and availing of family planning services. The total number of in-depth interviews conducted during the project was 24.

Area

District Udaipur

Udaipur, formerly a part of Mewar state, is situated in the south-west of Rajasthan. Its population profile is presented in Table 1. According to the Census of India, 1999, the district has a population of over 2.8 million and the sex ratio is 965 women per 1,000 men, which is higher than the state average of 910. The literacy rate of the district is 34.38 per cent, which is slightly below the state average of 38.55. As given in Table 1, female literacy in the district is exceptionally low. The district is largely rural (82.90 per cent people live in the area) and a large proportion of the population (36.79 per cent) is tribal. The major tribes are Bhils, Garassias and Meenas. A majority of the district's population (around 70 per cent) is engaged in agriculture and agriculture-related activities.

Table 1 shows that the two panchayat *samiti* areas of the district under study, namely, Dhariawad and Kotra, have registered a higher population growth rate than the district as a whole. These two areas are among the least literate in the district and female literacy in these

Table 1
Profile of the Study Area

Indicator	*Udaipur District*	*Kotra Panchayat* Samiti	*Dhariawad Panchayat* Samiti
Population			
Total	2,889,301	130,449	164,836
Male	1,470,028	66,743	84,182
Female	1,419,273	63,706	80,652
Literacy			
Total	808,527 (34.38%)	8,876 (6.8%)	20,952 (12.7%)
Male	588,776 (49.27%)	7,600 (11.4%)	16,133 (19.2%)
Female	219,751 (17.10%)	1,276 (2.0%)	4,819 (6.0%)
Population			
Decadal variation (1981–91)	22.59	27.91	28.81
Population			
Total	2,889,301	130,449	164,836
Rural	2,395,282 (82.90%)	130,449 (100.00%)	156,024 (94.65)
Urban	494,019 (17.10%)	0	8,812 (5.35)
Sex ratio	965	954	958

Source: Census of India (1991).

two blocks is practically negligible. Kotra *tehsil* is totally rural (100 per cent), whereas Dhariawad *tehsil* is largely rural (about 95 per cent) (Table 1).

Brief Profiles of Study Villages

The three villages selected for the study are dominated by tribal population and are located in Kotra and Dhariawad *tehsil*s. All the villages are located in the hills and the terrain is difficult. The brief profile of these villages is given in Table 2.

Mamer The village Mamer is a part of Kotra panchayat *samiti*. It is located about 145 km from Udaipur. The village is very close to the Gujarat border. Due to its location it is not linked properly by road and there is no provision of electricity. The transportation facilities to and from the village are very poor. The people are engaged mainly in agriculture. The twenty-odd *phala*s (hamlets) that comprise the village are scattered all over the hills. The village is dominated mainly by the

Table 2
Profile of the Study Villages

Indicator	*Mamer*	*Malwa Ka Chora*	*Dholiya*
Area (in hectares)	2,220	1,070	2,496
Number of households	333	190	417
Population			
Total	1,868	1,066	2,149
Male	917 (49.1%)	605 (56.8%)	1,079 (50.2%)
Female	951 (50.9%)	416 (43.3%)	1,070 (49.8%)
Scheduled tribes			
Total	1,763 (94.4)*	923 (86.6)*	1,972 (91.8%)*
Sex ratio (at the village level)	1,072	799	995
Literacy			
Total literates	83 (4.4%)*	144 (13.5%)*	143 (6.7%)*
Male	70 (7.6%)	138 (22.8%)	126 (11.6%)*
Female	13 (1.4%)	6 (1.3%)	17 (1.6%)

Note: * These figures are per cent of the total village population
Source: Census of India (1991).

Bhils, who constitute about 95 per cent of the total population. The village has a primary health centre (PHC) and a government school up to standard VIII with a hostel facility. Though the village boasts of a primary health centre, the only person posted there at the time of study was an ANM. In addition, the village has a bank and a veterinary hospital.

Malwa Ka Chora The village Malwa Ka Chora is located right on the Udaipur–Pindwara road. It is 70 km from Udaipur, the district headquarters. It is well connected by a *pukka* road, making mobility relatively easy. Malwa Ka Chora is located in the Garassia belt and is dominated by the Garassia community. The village is divided into 12 *phala*s. It has a subcentre recently upgraded to a (PHC), a high school, a hostel for students, an ayurvedic dispensary and an adult education centre. There are a few government residential quarters, which are occupied by government employees such as school teachers, the ANM, the multi-purpose worker (MPW) and the ayurvedic doctor.

Dholiya Dholiya is located in the south-eastern part of Udaipur district, about 110 km from the district headquarters. The village has around

14 *phalas* spread over a wide geographical area. A majority of the population (over 90 per cent) belong to the Meena community. In addition, there are a few households of other castes such as Rajputs, Jats, Kalals and Meghwals. Dholiya has a subcentre, a school upto standard VIII and a panchayat *bhawan*, which is also being used as an *anganwadi* centre. The village is connected by a *pukka* road and has the provision of electricity.

Results

There are four factors that determine a community's accextance oz zmjection of any programme offered to them. These are sociocultural, socioeconomic, knowledge and access, and factors related to provider–beneficiary interaction. An effort has been made to assess these factors in the present study.

Sociocultural Issues

Polygamy The three tribes under study are not polygamous per se, but polygamy is not looked down upon. It has more or less been institutionalised and people often adopt it. In a polygamous relationship a man maintains relations with more than one woman concurrently. This increases the overall fertility compared to a monogamous marriage where only one woman maintains relations with a man.

Nata *System* The tradition of *nata* is followed in all the three communities under study. In case of *nata*, a woman is accepted as long as she is not sterilised. Nobody likes to marry a widowed woman who cannot bear him children. This is so because in tribal parlance a barren woman is not regarded useful any more. Women want to keep the option of *nata* open. Therefore, either through *nata* or marriage, most Garassia women remain sexually active for a longer period, increasing the chances of pregnancy and the number of children they bear during their reproductive span.

Need for a Large Number of Sons Tribes feel a need to have more men in the clan as they come in handy in times of conflicts and disputes. The life of a son may be sacrificed in saving the honour of the family/clan. Conflicts are very common among the Bhils and having a

large contingent of sons is always seen as an advantage by the community. Though such clashes are not as common in the other two communities, the desire for having a large contingent of sons is equally strong. Like in any traditional society a family having a large number of sons always commands more respect in the community. This is more so in the case of Bhils as they are more orthodox and still believe in traditional ways of life, in which intra-group and inter-group clashes are a frequent occurrence.

Liberal Attitude towards Premarital Sex Among the Garassias and the Bhils there is no restriction on establishing sexual relationships. Premarital sex is institutionalised and young people are permitted to marry afterwards. Among Garassias sometimes marriages are solemnised many years after starting to live together and even after having children. The only restriction is clan exogamy, that is, people are not allowed to have relationships within the same *got* or *gotra*. In such a case, if the woman conceives, the common practice is to have an abortion, which is induced mostly by using indigenous methods. Since premarital sex is not taboo, premarital pregnancies are also a part of their cultural and not looked down upon as in other communities.

Role of Faith Healers As in any other traditional society, among the three tribal societies under study the institutions of witchcraft and superstition play a major role. The *bhopa* (the faith healer) is considered a liaisoning agent between God and human beings. It was observed during discussions that the three tribal groups had tremendous faith in the institution of faith healers. They play a very vital role as providers of the first phase of treatment outside the home for illnesses ranging from indigestion to infertility. It was evident from discussions with the members of the community that *bhopa*s still command respect and their opinion is valued by the tribes. It was also observed during discussions that the *bhopa*s are not interested in family planning practices and therefore do not encourage people to adopt them. Their accepting, owning and promoting family planning can enhance acceptance of family planning methods manifold.

Gender Although sons are preferred in tribal society as elsewhere in this part of the world, a daughter's birth is not looked down upon since her arrival signals another advantage. Daughters are trained from birth to accept a subordinate role in the family and their equality is not

an issue among the three tribes under study. Girls are not sent to school, and even if they are their drop-out rate is much higher than that of the boys. They are trained to perform household chores such as helping their mothers in the kitchen, rearing younger siblings, especially younger brothers and collecting firewood from the forest.

Another factor that motivates people to produce more girls is the bride price that the girl commands. This also encourages early marriage of girls as the parents see their daughters as an asset which can be encashed in case of any family emergency. In fact, as and when the family needs money, they get their girls engaged and receive the bride price in advance (in full or part) in addition to silver jewellery and other gifts that are part of the wedding (*lagan*) gifts.

Early marriage is also responsible for starting early procreation among young couples. The moment a girl is wedded her in-laws start exerting pressure tactfully as well as indirectly on her parents to send their daughter to them. However, parents want to postpone the departure of their daughters as long as possible because a working girl is a source of income that parents want to hang on to as long as possible. In addition, the girl's help in domestic chores and rearing young siblings is invaluable. Thus, her in-laws want to avail themselves of these services in their own households.

Preference for Sons In the tribal context although it does not make much difference whether the the child is male or female, preference for male offspring exists. An interesting conversation between a member of the research team and a female leader of the Meena community was as follows:

'How is the birth of a child celebrated in your village?'
'In our village, the birth of a son is a joyous occasion, people beat *thali* [bronze platter substituting a gong]. And the birth of a daughter is celebrated by beating *baans* [a hollow bamboo substituting a small kettle-drum].'
'Whose birth is considered auspicious, boy's or girl's?'
'Boy's.'
'Are the girls also sent to school?'
'Both are sent to school.'
'Who drops out first?'
'The girl.'
'If you go shopping, for whom do you buy clothes first?'

'The girl goes to her in-laws after marriage.'
'But for whom do you buy clothes first?'
'I buy clothes for the boy, and have to buy for the girl also.'
'Okay. In case of sickness, is the boy taken for treatment first and not the girl?'
'Both are taken, the girl also has to be taken to hospital.'
'Fine, when a boy is born, do the relatives, friends and villagers get together to celebrate by eating sweetmeats and distributing *batashas*?'
'Yes, sweetmeats are distributed and parties are thrown and the brahmin is called to make the *janam patri* [horoscope].'
'And, how about the girl?'
'The girl's *janam patri* is also made, the rich do everything.'
'Please do not bring the money in. Just tell me how people celebrate.'
'Even then, sweetmeats are distributed.'
'Do people think about the sex of the baby in the womb?'
'They only think about it after the delivery.'
'Whose birth is a more joyous occasion?'
'Boy's.'

To sum up, she was asked: 'Okay. When people bless you, do they wish you to be the mother of a son, or of a daughter?'

Her reply bears the trademark of the Indian psyche: 'They say that I may be blessed with a son. A boy's birth is auspicious and a must. What is there without a son? Nothing!'

It is evident from the above extended quote that there is a hidden preference for sons among the tribes under study, even though it is not as marked as in case of other caste groups of the region.

Addiction of Alcohol A factor which adversely affects the use of FP methods in any community is alcoholism. In an intoxicated state one's mind is only partly conscious or not under control. In tribal villages, alcoholism is very common and is an accepted cultural practice. As a result, condoms are not regularly used by men as they are not under control or not in a position to listen to their wives' pleas. Since in an intoxicated state the only thing on the mind of the male partner is sexual gratification, he is not really concerned about its consequences in terms of conception, etc. This consequently leads to higher number of conceptions.

A Sterile Woman Has No Value in Bhil Society Another crucial factor that puts people off family planning is the fact that in the tribal context a woman is seen as an instrument for producing children. She is valued in society so long as she is able to procreate. In case she opts for sterilisation after completing her family and her husband dies afterwards, no one will be willing to accept her as a wife in the *nata* system. This is because she has become 'useless' in tribal parlance.

As one of the villagers put it: 'Both sons and daughters are a must; if a woman cannot bear children, especially sons, she is not valued [in our society].'

Another community leader of Kotra block put it in simple words:

> The birth of a boy is a must. If a woman is unable to bear a son, she is thrown out of her in-laws' home. Even otherwise, her husband acquires another woman who could bear him sons. If the second woman also is not able to provide sons, he acquires another woman, and so on.

Ideal Size of Family and Role of High Infant Mortality For a tribal family the ideal number of children is four—two boys and two girls. This is done in order to compensate for the possible deaths of infants and children. Often in tribal communities families choose to have even more than the ideal number of children in order to compensate for the possible death of infants and children. The tribals are mentally prepared for some children dying owing to poor nutrition and other environmental factors. It was reported during discussions that due to poor nutrition there was very high infant and child mortality. Therefore, additional children are bred as insurance against deaths.

Husband-Wife Interaction It was observed during discussions with the community that though the people are liberal in their attitude towards sex, there is little, if any, communication between spouses on matters related to sexual behaviour. Sex is considered more of a physical pleasure and pregnancy is not what people think about when they indulge in intercourse. So the physical part of sex is looked upon as a means to sexual gratification and not procreation, especially by male partners in a state of drunkenness. Even in the traditional Indian context discussion of sexual matters is considered perverse and obscene, and is generally looked down upon in the community.

In general, there is not much verbal interaction between partners as the social system, more so in a joint family, does not encourage it. This is especially so during the active fertile period.

Decision Making vis-à-vis FP It was observed during discussions with community members that decision making is a ticklish issue. During the initial discussions with the community one gathered the impression that women are allowed to regulate their fertility, the number of children, and their sex composition. But on in-depth probing one found that the decision making power rested with the male members. First and foremost, it is the husband and then the father-in-law who decides about the timing and number of children a couple should have.

Discussing Condoms It was felt during the discussions with the community that people did feel comfortable when condoms are mentioned as a method of contraception. So much so that one of the AWWs said that condoms should not be discussed since she felt embarrassed: '*Aap iske bare baat nahin karen*'/'*Chorho, uski kya baat karna hai*' (Let us not talk about it).

Frequent Abortions Abortion among tribes does not seem to carry any social stigma attached to it as in the case of other castes in India. Abortion is a relatively common practice among the tribal groups under study. Generally, they are performed by traditional health practitioners. In the Garassia village a majority of abortions are induced and are performed to avoid unwanted pregnancies. In quite a few cases, where abortions are unsuccessful, they also contribute towards higher fertility, besides posing a major health hazard.

Another interesting fact to be highlighted here is that women in general, due to health hazards involved, want to avoid pregnancy, but the men are not interested in it. As a result, females resort to the extremely hazardous practice of induced abortion.

Little Appreciation of Education It was observed that the community has little or no appreciation for education. Educated children, especially girls, face lots of problems both before and after marriage. Education is actually looked down upon by the community as is evident from the following quote by a community leader:

> In case of an educated girl, the *dhapa* [bride price] is higher, and nobody likes to have an educated girl as wife. As a result, in order to

marry educated girls, people end up paying more *dhapa*. Therefore, by and large, people don't prefer to send their girls to school.

Herbal Contraception: Its Use and Efficacy There are some indications that Bhils and Garassias living in the study villages and surroundings use a herbal contraceptive. This consists of a herb whose identity is a closely guarded secret of the community. Nobody was willing to disclose this information to any non-tribal person. The efficacy of the herb, according to the villagers, is quite good.

Some people who used this herbal medicine said it was effective for postponing pregnancy as long as one year. These herbs are kept covered in a utensil for a fortnight and are given to the women after fasting overnight for a period of 10 to 15 days. According to community members this herb is quite effective and its use is advocated by women over other methods.

Socioeconomic Factors

There are some traditional issues related to family planning which have a strong bearing on the economic status of a family. These traditional issues, which have a strong influence on tribals' decision making vis-à-vis family planning matters, are discussed below:

Heavy Compensation to be Paid to Bride's Parents in Case of Death as a Result of FP Operation In Bhil society, unlike others, the bride continues to be under the tutelage of her parents even after marriage. They have a right to decide her course of action in her in-law's house. Even though a man pays for his bride in the form of *dhapa* (bride price), the life of the woman continues to be controlled by her parents.

The fear among Bhils is that in case a woman dies during a sterilisation operation, her in-laws would have to pay an enormous amount of compensation to her parents. This factor dissuades many people from opting for family planning measures such as sterilisation.

There are instances where daughters-in-law are given basic care due to the fear that they may die following sickness and it may lead to conflicts between their parents and in-laws.

Practical Difficulties in Using Condoms Most of the tribals belong to the poor class (officially referred to as 'below the poverty line'). Their houses are very small and normally have two rooms. One is used for

the cattle, fodder, etc., whereas the other is used as the living quarters for the entire family. The family includes elderly people, the eligible couple and the children. The presence of children and elderly people in the same bedroom makes it difficult for the couple to have any privacy, thereby rendering the use of contraceptive methods like condoms difficult within the household. A considerable number of consummations take place outside the house—in the fields, forest, etc., around the village where people go to work. So it is not possible for people to carry condoms every time they go out. Therefore, condoms cannot be used effectively.

Migration and Family Planning Another important factor that affects adoption of family planning methods is the seasonal outward migration of males, especially in the case of Bhils and Garassias. This in a way hampers the effective adoption of any FP methods. Visits by migrant males to their homes are often not planned and when engaging in sexual intercourse during these visits family planning is the last thing on their minds.

Issues Related to Knowledge and Access

Negative Attitude and Apprehensions of the Community towards FP Methods It was observed that the community looks down upon persons opting for family planning. During the emergency period (1975–77) family planning methods were forced on people. In addition to the sociological factors given in the previous section, another reason for lower acceptance was the negative attitude towards FP, especially in the post-emergency period.

One community leader remarked:

> Before emergency [before 1975], when I referred a few cases to the health functionaries, people came forward and underwent sterilisation without hesitation. During the emergency period, they were coerced by the government and people lost faith in the system.

It was also noted that people have strong apprehensions about tubectomy. It can be best put in the words of a Garassia woman:

> Yes, we do talk about family planning, but people refuse to undergo sterilisation since we have to undertake hard physical labour, break stones and walk long distances. We don't have time for rest. Therefore, people here refuse to undergo operations.

On being asked what difference sterilisation would make, she replied, '*It does harm to our body. One women has died following sterilisation.*' Then, she summed up the whole issue thus:

> We can't rest following the operation. Our lifestyle demands going to forests to collect firewood and undertaking heavy agricultural work. In case something untoward should happen, it has grave repercussions in the form of misinformation that sterilisation leads to death, and people are put off.

Fears and Apprehensions about the Methods of FP Post-operation Care

Tribal people have various apprehensions about family planning methods. They think that FP operations lead to death or render the persons undergoing the operations incapable of undertaking any heavy physical work in future. Heavy physical activities are so essential in tribal life that they stay away from these family planning measures.

People expressed apprehensions about 'operations'. They fear that sterilisation leads to weakness, thus inhibiting a person from undertaking heavy physical work. In one of the discussions, the conversation between the researcher and a male member of the panchayat went like this:

> 'Agreed that operation does not lead to death, it definitely induces weakness.'
> 'Does it? Who says?'
> 'Everybody says so.'

Another villager summed up his fear thus:

> If there is a small cut on the hand or any of the exposed body parts, one feels weak for weeks. How come that they cut deep inside here [pointing towards stomach] and you do not feel weak? No, it definitely leads to *kamzori* [weakness].

Tribal people are still very apprehensive about the availability of post-operative care through the state system. One of the community leaders in the Garassia village put the problem squarely:

> No post-operative care is available. The body gets weak, and hence unfit to undertake heavy work. Seeing that, people do not go for operations. Some 10 to 12 years ago, a person got operated and died following the operation.

A community leader highlighted the problem as follows:

> People here are scared of operations [sterilisation]. They [the doctors] just perform the operation and leave the place. No one comes for follow-up. Whether we live or not nobody bothers. When a person goes to get his stitches removed, he has to make his/her own arrangement for doing so. Nobody feels it as his/her responsibility to take care of it. Whether the stitches have been removed properly or not and whether the requisite medicine has been given or not seems to be nobody's business. No one bothers whether one is sick or well.

The community leaders proposed their own solution to the problem:

> A camp should be held for at least a fortnight. A doctor and a nurse should stay there throughout to make arrangements and to look after the cases. Only then will people understand. Only then will women go on their own to these camps.

A new way out was also pointed out by one of the local leaders: 'Look at the laproscopic operation. No trouble whatsoever! After two days, one is free to do anything. One can even carry a load.'

No Follow-up after FP Due to lack of interaction between health functionaries and beneficiaries, there is very little provision for follow-ups. Household visits by the ANM, according to the community, are almost non-existent, and there is no follow-up of curative cases by service providers. It may sound strange to talk about follow-up of curative cases when FP behaviour is being discussed, but it is significant in the sense that even in case of FP behaviour one needs to establish a rapport as a prerequisite. Casual unplanned visits by the ANM and her staff and little surprises can go a long way in establishing the credibility of functionaries and institutions.

Perceptive Issues

Poor Knowledge of FP Methods among Community Members According to the panchayat members only 5 per cent of the tribals know about

spacing methods of family planning, whereas most of them know about sterilisation, popularly called 'operation'. When asked about it, their responses were typical. A conversation with one of the female ward *panch*s in the Meena village went like this:

'Since you are the female ward *panch*, suppose the sister [ANM] comes to you and asks about *phooka* [a local term for condom], would you know what it is?'
'No, I do not know. The sister does not come to our place.'
'Do you know, condom is used to prevent conceptions and is used by men? Have you ever seen it or heard about it?'
No. I have not seen it or heard about it.'
'Do you know about oral pills, which, if taken regularly by women, stop pregnancies?'
'No. I do not know about them.'
'Do you know about Cu-T [*Choodi Chadana* is the local term], which stops pregnancies?'
'No, I do not know.'

Some of the community members who knew about Cu-T expressed the apprehension that it induced bleeding, leading to weakness. Therefore, they did not want to use it as a method of contraception. Since most of the community did not know about Oral Pills (OP), we asked them the reasons for their ignorance. Again one of the Meena panchayat members reacted arrogantly:

You are talking useless things. Since the lady [ANM] does not come to the village, who do you think will tell us all this? Why talk of that lady only? The other government officials like *gram sevak, patwari*, etc., hardly come to the village. All are work-shirkers. 'Look, even our village school is under-staffed. It is a middle school, but has only one teacher who has to teach eight classes and 150 students. How do you expect him to teach well?

Protected (!) Couples There is very low use of the various spacing methods. As per official records there are a few couples in the Meena village who are effectively protected. The research team tried to cross-check this with the help of AWWs during the meeting of OP users who are on the rolls, asking them questions such as when to start taking

OPs. However, almost all of them admitted that they were not taking the pills, but only obliging the AWW by accepting them from her. When asked what they were doing with the OPs, they replied in unison: '*Pheink die*' (threw away).

When the research team tried to cross-check this with the ANM she said that she used to give the pills to the AWWs, but had not tried to individually follow-up the women who were supposedly consuming them individually. On being asked why, she replied, '*Wahan meri zindagi ko khatra hai*' (my life over there is under threat). That is the end of the story of OPs in a tribal village.

The other AWW was able to produce all the stock given to her by the ANM during the previous few months. Though she had in-depth knowledge of OPs and Condoms and was able to explain effective use of these two spacing methods, she said that she had to take the OPs from the ANM, but there was little she could do if nobody was willing to use them.

Client–Provider Relationship Motivating couples to adopt FP and, before that, creating awareness about FP and other issues related with health in general and in the tribal context in particular is a team effort. Effective coordination between panchayat members, informal community leaders, AWWs, school teachers, *gram sevak*s, public distribution depot holders and other government functionaries is a must. In the case of the Meena village under study there is no joint networking of these functionaries. Since the panchayat in general and the *sarpanch* in particular are at loggerheads with the local health provider, things have come to a standstill. The *sarpanch* of the village feels that the ANM is not fit for working in the village and the ANM feels that her life to be under threat in certain *phala*s of the village. There is no effective contact and communication between service providers and beneficiaries even regarding basic health services. Talking about FP in this context appears inappropriate.

High Infant Mortality Another reason for desiring a large number of children among the Bhils is the very high 'perceived' rates of infant and child mortality. The quality of the environment—nutritional and otherwise—being poor, the rate of deaths among the children is very high. A family produces, on an average, six to eight children so that even in case some of the children should die the parents are still left with the desirable family size.

One village women said, '*Mata* [chicken pox] has killed many children. We are not sure about the survival of children.'

Absenteeism among Health Workers and Poor Monitoring and Supervision A frequent complaint of the villagers is that health functionaries do not stay in the village and that they remain away from the village for a very long time on some pretext or the other even during working days.

According to the villagers there is very little or no effective monitoring of activities of the village level health functionaries by their superiors. The higher officials hardly come to the village for surprise checks. If at all they do, the health functionaries of the village get prior information and make themselves available in full strength on those days. Otherwise they are hardly seen in the village.

Another observation made by the research team was that the service providers have failed to establish a rapport with the community and win their confidence as their well-wishers. This is very important as we are discussing modification in the behaviour of the communities vis-à-vis family planning. Health functionaries need to win the confidence of the community and then try to bring in family planning for discussion. Instead, the present approach of the health functionaries is very casual and they try to sell FP services to ignorant villagers without bothering about their immediate medical requirements. So the community takes a very negative view and over a period of time has become allergic and immune to their sermons on family planning.

Incentives The state policy of providing incentives in both cash and kind has helped cement the tribal belief that family planning is a state-owned programme rather than based on community needs. The grassroots and middle level health workers have given them the impression, while distributing money incentives in the past, that the money is for taking a rich diet, namely *ghee* (clarified butter). Since *ghee* is given to a person who is weak following an accident, delivery, long illness, etc., it leads to their concluding that sterilisation leads to weakness, disabling them from undertaking heavy physical work in future. Now, with the incentives withdrawn, the motivation for acceptance of sterilisation has dropped all of a sudden. Their impression is that since FP is a government programme, sooner or later it is going to provide cash incentives. They are not willing to accept sterilisation without the incentives. As one of the villagers remarked: 'Money, you will have to pay.'

The community leaders are of the view that if cash incentives are re-introduced at least 25 per cent of the eligible couples will opt for sterilisation. An extract from one of the discussions follows:

'Since the government has stopped giving money, people have stopped getting operations done.'
'If the government re-introduces cash incentives, will more people start undergoing operations?'
'Even earlier, people used to get it done for money.'
'If money is given, will people opt more often for . . .?'
'Oh yes, definitely'

On being asked whether they would like to have incentives in cash or in the form of bonds, which mature after a certain number of years, they preferred to have cash then and there. As one of the community leaders said: 'It should be instant benefit.'

Client–Provider Relationship vis-à-vis Behaviour Change It seems that the relationship between the community and the providers is poor. The ANM does not meet the community regularly. When there is need, services are not provided. Therefore, client satisfaction vis-à-vis curative services is pretty low. Client satisfaction is a prerequisite for establishing a rapport with the community. Only this, if done effectively, can lead to health workers persuading/motivating people to adopt FP. A quote from a discussion with the community leaders illustrates the point:

No, she [the ANM] does not come to attend the deliveries. If you call her today, she will come only after three months. By then, the baby would have been delivered, might have been dead or be suffering from some serious illness.
I tell you, I went to the nurse saying that my child was sick and very weak. She said that he wouldn't die. She just examined the child and gave him some tablets, but didn't inject any medicine. When I told her that he [the child] was far too serious, she said that he would recover gradually. And, what happened? The same night, at 9'o clock, my child passed away.

Such incidents are not rare in the community, and these, if not addressed, will not take the programme any further.

Taking Stock

The three research sites selected for the present study are located far away from each other and have different cultural set-ups as the tribal communities living there are different. Yet when we look at the issues that affect their family planning behaviour—be they cultural, social or linked to availability and accessibility of services—they are very much alike. In some cases a specific issue may not be marked particularly strongly but all the issues identified are strikingly similar.

The Present Ground Level Situation

The area, Udaipur district in general and the two blocks under study in particular, is difficult and not easily approachable. The settlement pattern of the tribes is scattered, and most of their hamlets are located on tops of hillocks.

The community members, who are tribal and extremely poor and ignorant, have lost faith in the system. Most tribal men are addicted to alcohol and the service providers (especially the ANMs) are reluctant to go to their households even during their routine visits.

These providers, for various reasons, are demotivated, non-committal and not dedicated enough to provide effective services. One of the senior medical officers of the district described the problems of the workers in the area very tellingly:

> All those posted in Dhariawad and Kotra *tehsil* come under one of these three categories: they are either freshers, promotees or those on punishment. So, being posted in these two blocks is already a demotivation for them. So they consider that this is the worst thing that could happen to them.

Moving Forward: Recommendations with Programmatic Implications

The family planning movement is seen by the tribes as a government intervention in their natural way of life. So, first and foremost, there is a need to involve the community in the programme so that they are in a position to own the programme. In creating a conducive environment, the foremost requisite is involving all those who are capable of influencing decision making in the community and also the service providers.

The issue of popularising family planning in a society known for its traditional way of life for centuries, orthodox thinking and living away from the influence of development is no doubt a difficult one. However, an attempt has been made to propose certain measures which will be helpful in improving the present state of affairs vis-à-vis family planning.

Though the present-day strategies of the state government are decentralised, the effect of the same is not felt at the grassroots level. The workers at the lower level are pursuing their activities as they were doing before. The paradigm shift from a targeted to a target-free approach, from family planning to family welfare and, of late, to reproductive health has not gone down to the workers at the village level.

Keeping the above situation in view, the following recommendations are made in order to make family planning more effective in tribal areas.

1. *Recruiting and training local staff:* Identifying, recruiting and training local women for providing services is necessitated by the sensitive nature of tribal culture, language problems and other issues faced by outsiders. This also takes care of the problems of cultural insensitivity, housing, security, etc. to a large extent.
2. *Strengthening AWWs:* Since most of the AWWs are local and stay within the community, they can be more helpful in the behaviour modification of the beneficiaries. They need to be strongly oriented towards the FP programme.
3. *Providing MPWs in the villages:* Providing multi-purpose workers (MPWs) to assist ANMs would be useful. The MPWs could effectively talk to the male members and persuade them to adopt family planning methods more effectively than the ANM. They could also take care of providing effective services in the areas which are inaccessible to ANMs due to various reasons.
4. *Involving local leaders in programmes:* Involving faith healers and TBAs in promotional activities would be a vital measure. Since the community in general has tremendous faith in these service providers, they can be effectively integrated for spreading the message of family planning and motivating people to adopt the small family norm.
5. Strengthening innovative community-based programmes like *jan mangal, swasth karmi* and *mahila swasthya sanghs* (MSSs).
6. *Integrated approach:* From the community's side there is a need to involve traditional leaders and panchayat members in the FP

programme. Involving the *gametis*, faith healers and local health providers like the *bhopa* and the *jharewala* along with TBAs, other influential leaders such as teachers, public distribution system (PDS) staff and *patwaris* is essential. From the health provider's side, it is important to involve ANMs and others providing services at the grassroots level. There is a need for effective coordination of all these people. A common programme has to be drawn up, agreed upon and executed in order to work effectively. The role of government employees like teachers, *patwaris* and staff of the PDS is also crucial. The other people who could be involved are workers of various NGOs who have gained community acceptance by doing development work for the villagers.

The issue of family planning is being taken up by many state government departments and it seems that every department thinks that the onus is on the health and family welfare department. Workers of other departments at the grassroots level seem to be taking up the issue half-heartedly. What is needed is an integrated approach. All the state departments need to work out a comprehensive plan and work in a coordinated manner.

7. *IEC Strategies:* Successful IEC activities play a very significant role in the acceptance of any programme. The same should be designed keeping in mind the prospective audience. Since tribals are largely illiterate and have no access to/interest in electronic media like radio, television, etc., innovative IEC strategies like folk media—puppet shows and folk songs—incorporating messages about the small family norm should be used more extensively to raise people's level of awareness about the advantages of having a small family, its importance and various FP methods.

It has been seen that even in tribal areas innovative schemes have succeeded when promoted in an effective way. An example of effective information, communication and orientation is clearly seen in the form of solar lights in one of the study village, Malwa Ka Chora where, incidentally, there is high *resistance* to family planning.

The ways to improve IEC also include improving interpersonal communication, which will result in improved client–provider relationship and thus acceptance by the beneficiaries of the providers and the state schemes. This can also be done through improved social marketing. Once a market for

contraceptives has been created, community-based distribution can be introduced in a phased manner.

The current IEC district plan as regards tribal populations needs to be reviewed keeping the following factors in view:

- The prevailing tribal culture does not favour small families:
- Preference for a son is strong but the girl child is not considered a burden.
- Early marriage is encouraged due to various reasons.
- Male monopoly prevails on decisions regarding nuptiality, marriage, fertility and parity.
- The social prestige of a family is related to the size of the family.

8. *Strengthening the existing infrastructure:* It was observed that in two of the three villages selected for the present study, though the village health facility was 'designated' as a primary health centre, there was only one ANM providing services, while one village had an MPW to support the ANM in her activities. There were no indoor or any other facilities which should be available at a PHC. The building and the equipment used for providing curative services were in poor shape. Therefore, there is an urgent need to fill the vacant positions and ensure regular supplies of stocks to health institutions.

   Another important step promoting education among the tribals and raising their levels of awareness and modifying their behaviour pattern also includes educating young tribals on issues of population and family planning in the broader context of reproductive health.
9. *Incentives:* The issue of incentives for the acceptors of family planning was raised by the community time and again. As has been said earlier, the community strongly feels a need for individual incentives. Since the individual incentives have been withdrawn by the government in order to increase acceptance of FP methods, it is recommended that community-based incentives be introduced. This could include schemes like *Rajlakshmi*, Well Baby Clinics and Mobile Reproductive Health/Curative Care Services at villages where no services are available locally.
10. *Need for change in behaviour and training in counselling:* It was strongly felt during the study that service providers at the grassroots level need to be trained in counselling and behaviour modi-

fication. This training should be made compulsory since, if undertaken properly, it will go a long way in achieving the mission of providing effective services and achieving the desired population size.

Conclusions

Though states like Tamil Nadu are referred to as success stories vis-à-vis family planning services, issues like client–provider interaction, informed choice and constellation of services are as appropriate there as they are in a poor performing state like Rajasthan (Sundari Ravindaran 1999). Another study by Barge and Ramachandar (1999) in the central Indian state of Madhya Pradesh also highlights that the situation there is very similar to that in Rajasthan.

As seen from studies elsewhere in India, the issue of motivating rural and tribal people has certain commonalities. They include a host of factors—social, cultural and economic, including low level of education among women (Koenig 1999). These issues have also been found to be present among the tribal communities of Rajasthan. Some of these factors, including polygamy and the *nata* system, are only far more pronounced among the study populations.

The issues that come under quality improvement as brought out by Koenig and Khan (1999) are also all the more relevant in a state like Rajasthan where most of the tribal beneficiaries have become immune to the sermons of family planning. What is unique about these population groups is that they have lost their faith in the state health system and the functionaries of the system. It is hoped that if the above recommendations are implemented seriously, it will begin to restore the faith of these people in the system. The impact of the proposed intervention, if implemented, will pave the way for the acceptance of family planning among the tribes. But there is a long way to go before we see light at the end of the tunnel!

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