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RESEARCH PAPER - IV

FAMILY PLANNING IN TRIBAL AREAS —

A Case Study In Rajavommangi Tribal Development Block

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D. R. PRATAP, M.A.,
DIRECTOR-IN-CHARGE

TRIBAL CULTURAL RESEARCH AND TRAINING INSTITUTE
TRIBAL WELFARE DEPARTMENT
GOVERNMENT OF ANDHRA PRADESH
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The teaming billions of the world are increasing by leaps and bounds. If it is allowed to continue at the present rate there will be population explosion of grave consequences threatening the very existence of human race as aptly warned by Prof. L.C.White that "The race of man is more surely threatened with extinction from the explosion of a 'Population bomb' than by "Hydrogen bomb". This view is amply supported by the UNESCO which says that "The worlds Population has taken about 2 lakh years to reach the level of 2,500 millions. It is continues at the present rate, this figure will be doubled in less than 30 years and by the end of this century it will have risen to 7 or 8 hundred millions".

The situation in India is no less grave. It is amply evident from the classification of the U.N. Report on pattern of Population growth, according to which the economically less developed areas like India come under areas of high fertility. The U.N.O. report enumerates the following disadvantages which are the products of rapid population growth:

1. It can and does increase the pressure of population that is already densely settled and so retard increase in productivity of agricultural labour.

2. Accelerating population growth can aggravate the problem of capital shortage which is one of the most important obstacles to economic development of nearly all under-developed countries.

3. The high birth rates of underdeveloped countries create a heavy load of dependent children for the working population.

Other undesirable effects may be noted as follows:-

1. Already two-thirds of the world's population are under nourished, and as the absolute number of human mouths increases the absolute total of under-nourished human beings is bound to increase for a time and also the acuteness of under-nourishment in underprivileged countries. By promoting under-nourishment of protiens, calories and vitamins, population increase keeps both the physical and mental energy of the people at a low level and so reduces their possibilities of initiative and achievement in all departments of life, impeding higher production.

2. Over two-third of the population are still illiterate. Increasing population makes the situation worse. This holds up the progress of industrialisation and agricultural production.

3. Over population has great reparcussions on food production.

a) Increased population has led to hypertrophied cities and conurbations, which are inturn producing discomfort, inefficiency and nervous strain as well as cutting off millions of people from any real contact.

b) When population of a country increases faster than the growth of economic resources there is bound to be discontentment and a desire to expand beyond one's boundaries.

The alarming rate at which India's population is growing especially during the forty years between 1921 and 1961 is a clear warning of the impending population explosion. From 27.44 millions increase in the decede ending 1931 to 81.5 millions increase in the decede ending 1961 amply corroborate this view. The situation is no less grave in Andhra Pradesh as is evident from the decinnial increase recorded between 1921 and 1961 which is as follows:

* VARIATION IN POPULATION, 1901 to 1961

Year	Population (in lakhs)	Decennial variation in population increse (+) or decrese (-)	
		(Persons in lakhs)	(Percentage)
1.	2.	3.	4.
1901	190.66	..	..
1911	214.47	+23.81	+ 12.49
1921	214.20	- 0.27	- 0.13
1931	242.03	+27.83	+ 12.99
1941	272.89	+30.86	+ 12.75
1951	311.15	+38.26	+ 14.02
1961	359.83	+48.68	+ 15.56

Source: Census of India 1961, Paper No.1
* Hand Book of Statistics, Andhra Pradesh. 1968-69

While decennial increase between 1921-31 was 27.83 lakhs, 48.68 lakhs was the decennial increase between 1951-61 recorded in the population of Andhra Pradesh. Similarly, if not at the same rate as that of India, the Scheduled Tribe population in Andhra Pradesh is also showing an upward trend between 1951-61. The total Scheduled Tribe population according to 1951 census was 7,66,677 whereas according to the 1961 census returns the total scheduled tribe population was 13,24,368 showing an increase of 72.74% between 1951-61. But this phenomenal increase in population cannot solely be attributed to the increase in the birth rate as a major portion of this increase was due to the inclusion of certain tribal groups like Yerukula, Yenadi and Sugalis in the list of Scheduled Tribes in 1956. Excluding these three newly included tribal groups, the percentage increase between 1951-61 is only 16.7.

This increase is about 5% less and 1% more than the decennial percentage increase recorded for the whole of India and Andhra Pradesh respectively.

India's population of 439 millions enumerated during 1961 census is expected to increase to 560 millions by 1971. Assuming that the general fertility rate will tend to decline by 5% the total population figure will reach 625 millions by 1976. But if the expected decline in general

fertility rate does not occur, the total population would be roughly 632 millions by 1976.

According to the Transition theory or the theory of Demographic cycles, in under developed countries like India whose characteristic features are low productivity, low standard of living, heavy agricultural dependence, primitive means of production and underdeveloped means of transport, birth and death rates will be high. This is evident from the fact that in India birth rate was of the order of 45 per thousand and death rate 40 per thousand. But due to the introduction of development programmes and the consequent improvement in general medical facilities, drinking water facilities etc., the death rate came down to about 19 per thousand while the birth rate remained as high as ever.

India apprears to be in the second stage of the Demographic cycle viz., the 'Transition phase' as the birth rate is still high around 42 whereas death rate has come down to 19 resulting in a growth rate of 2.3 per cent per annum. As the economy of our state in general and the economy of the tribal areas in particular are also characterised by low productivity, subsistence standard of living and primitive agricultural practices, what holds good for India, also equally holds good for Andhra Pradesh

and more so for tribal areas. Such an alarming situation generally calls for serious efforts to narrow down the vast divergence between birth and death rates in order to shorten the duration of the transition phase.

As has been discussed already the birth rate in tribal areas is also high. Due to the effective eradication of Malaria, Yaws, and other endemic diseases and the provision of Maternity, Child Welfare and other medical facilities in the tribal areas there is sizeable fall in the death rate. Further, in the tribal areas the low fertility of land and the limited area available for cultivation, can not sustain ever growing population on agriculture. The high birth rate coupled with low productivity further aggravate the situation. The Family Planning Programme has been extended even to tribal areas even though the density of population in these areas is less than that of the plains areas. This is yet another example of stereotyped mass programme implemented in tribal areas without visualising its far reaching consequences. It is a simple implementation of a national programme evolved on the basis of trends of population growth in the densely populated plains areas without taking cognizance of the sparse distribution of tribal population and the distinct socio-cultural systems of tribals.

More than two scores of tribal groups are found living in the mountainous and forest regions of the State practising occupations ranging from settled plough cultivation to food gathering and ekeing out not more than a subsistance living. It is common for a Chenchu man and women of Nallamalai forest to dig roots and tubers and collect honey from even steep cliffs in leading a precarious life. The Gond,Koya, Bagatha, Valmiki, Mukha Dora and the beautiful Mathuras are settled cultivators attempting crude plough cultivation on patches of soil found dispersed in the rockey terrain and struggling to secure a few bags of grain after watching the crops day and night to protect them from the ever threatening wild birds and animals. The colourful Banjaras and the simple Goudus are the surviving examples of a fast vanishing pastoral economy, breeding bulls and rearing cattle in the green pastures and lush forest growth of Amrabad plateau in Mahaboobnagar district and Araku valley of Visakhapatnam district. The most backward tribes like Hill Reddies, Samantha and Savaras mainly thrive on shifting cultivation or 'Podu' in the hill slopes of Papi, Anantagiri, Araku, Kakili, Chilekam, Mahendragiri and Vangara hill ranges of West Godavari and East Godavari, Visakhapatnam, and Srikakulam districts respecitvely.

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The Social systems of the various tribal groups also vary from region to region. The typical fourfold phratry organization of the Gonds, Pradhans, Kolams and Thoties is absent among other tribal groups. In contrast, at the other extreme, near the north-eastern borders of the State, the Savaras of Seethampet Tribal Development Block of Srikakulam District are even devoid of clan organization. Sandwiched in between the complex phratry organization of Gonds and simple family organization of Savaras live some of the important tribal groups like Bagatas, Valmikis, Konda Doras, Muka Doras etc., who have common clan organization and Gadabas and Samanthas whose social structures are characterised by loose phratry organization which a product of the prescribed and prohibited marital relations and the traditional bond friendship institutions. But this varied social pattern has certain common features like the practices levirate* and sororate** and marrying plural wives. While polyandry is strictly prohibited, widow remarriage is socially approved by all the tribal groups. Divorce is freely allowed among all the tribal groups.

Marriage by elopement, service, capture and negotiation are the most prevalent permitted methods of acquiring mates. If a married women elopes with another man, the latter husband should pay 'Manganali' or

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* Younger brother inherits the widow of deceased elder brother.
** Plural wives of a man are sisters.

compensation to former husband. If the woman is pregnant at the time of elopement the neonate is returned to the former husband along with other children born to her former husband. Polygynous marriages are generally restricted to well to do tribal families as the cost of acquiring viz., payment of bride-price, presenting new clothes and ornaments and arranging marriage feast is too costly to be born by an average tribal man. Barrenness of first wife, need for additional hands in agricultural work and prestige in society are the major criteria contributing for acquiring more than one wife.

Both men and women love their children and lavish affection is bestowed upon them. As every member is an economic unit even children of 10 years age are found engaged in lending a helping hand in some economic pursuit or the other of the family, thus each member is expected to contribute for the family income however small it may be. Since her childhood, a girl is trained in performing sundry household duties like helping her mother in cleaning utensils, clothes, house, looking after younger siblings etc., and ultimately grows up into a responsible maiden fully trained to shoulder the responsibilities of domestic and economic pursuits of her parents home and future husband's home as well. Unlike the girls of some upper caste non-tribals, a grown up tribal girl is an economic asset as the parents

secure bride-price and incur no expenditure on the marriage celebrations since marriages are performed in the bride-groom's house. On the other hand a tribal boy is almost left care free indulging in the favourate sport of hunting small game and roaming about in the forests. But as a grownup youth, he starts helping his parents in the family pursuits and becomes a responsible head of the family and succeeds to the authoritarian status of his father in discharging social obligations to the community. Thus while a girl grows up into a hard working woman, a boy is groomed for the authoritarian status of his father both within and without house besides discharging his economic responsibilities as head of the family. Sex has a very limited role to play in the division of labour in the tribal groups. It is only physical capability that generally forces a man to undertake heavy and hazardous works like ploughing, hunting, felling trees, etc. None of the tribal groups of the state show any visible inclination or attachment towards either male or female children as both of them almost equally contribute for the maintenance of the family in their own way.

It was during III Five Year Plan period that family planning programme was for the first time introduced in the tribal areas of Andhra Pradesh. Since then much headway has been made and the physical targets attained, speak very

high of the success achieved in the Tribal Development Blocks.

It is even interesting to note that two Tribal Development Blocks, namely, Bhadragiri in Srikakulam District, and Rajavommangi in East Godavari District stood first in family Planning achievements among all the Blocks of the State in two successive years. But the tremendous success is not without a discordant note as is evident from the fact that Rajavommangi Tribal Panchayat Samithi's members had considered to pass a resolution to the effect that the Family Planning Programme should be suspended in the Block areas as it endangered the very existence of future generation of tribals because of the indiscriminate conducting of vasectomy operations on a mass scale among the gullible tribals of the Block.

This paradoxical situation of success under the rumblings of the tribal people necessitated a quick appraisal of the situation so as to bring the emerging performance situation of family planning programme amongst the tribals with the following objectives.

1. To study the various methods of family planning introduced in the block area.
2. To judge the performance levels of each method on the basis of their respective physical achievements.
3. To analyse and isolate the social economic and religious factors that contributed for the emergence of a conflicting situation.

4. To assess the tribal motivations and attitudes towards family planning programme.
5. To bring out the operational maladjustments, if any in the programme implementation process and suggest ways and means for the smooth introduction of Family Planning Programme.

As it is a quick assessment of the nature of receptivity and impact of the Family Planning Programmes, case study method was adopted for gauging the situation. Further, the case histories of thirty acceptors of Family Planning method of one type or other have been collected from three different villages which are selected on the basis of their proximity to family planning centre. For this purpose, Rajavommangi, the block headquarters in which one I.F.Dispensary and Head quarters of mobile medical unit are located , Konda palli-a roadside village and Labbarthi, an interior village were selected. 10 persons from the three selected villages are selected on purposive sampling basis according to the method adopted in the following ratio:

6 Vasectomy: 2 Tubectomy: 1 loop: 1 condom.
Besides, 20 tribal and 8 non-tribal acceptors were interviewed to guage their motivations and attitudes towards Family Planning Programme in the three selected villages.

THE BLOCK:

Rajavommangi Tribal Development Block is situated in Yellavaram Taluk of East Godavari District and it is one of the four Tribal Development Blocks of the District bounded by Koyyuru Tribal Development Block of Visakhapatnam on the North-East and by Addateegala Tribal Development Block on the West and Prathipadu Community Development Block on the South-East. The Block Head quarters is Rajavommangi situated at a distance of 65 and 40 miles from the District and Taluk Headquarters respectively. The total geographical area of the block is 56,329 hectares with its jurisdiction extending over 75 villages.

POPULATION:

The total population of the blockis 23,066 constituting 0.88 percent to the total population of the District, the tribal component being 11,996 of which 5906 are males and the rest females. The percentage of the tribal population of this block to the total tribal population of the district is 11.9%.

There are as many as 13,348 workers constituting 57.86% to the total population. Agriculture and allied occupations are the major occupations of the people of the block and their occupational distribution is as follows:

A)	Cultivators.	..	7,141
B)	Agricultural labour	..	4,846
C)	Mining, Quarrying and live Stock.	..	246
D)	Household Industries	..	212
E)	Manufacturing other than household industry.	..	71
F)	Constuction.	..	18
G)	Trade and Commerce	..	217
H)	Transport and Communication		21
I)	Other Services.	..	576
		Total:	13,348

From the statement it is evident that about 90% of the workers of this block are either cultivators or agricultural labourers. But the net area sown is only 7,321 hectar s out of the total geographical area of 56,329 hectares and it works out to 13% of the total geographical area. Hence the ratio between man and the actual land under production is 1:0.32 Hectares in the Block. The total area that can be utilised for productive purposes is 15,549 hectares which includes current and old fallows, cultivable waste and land under Miscellaneous tree crops, besides net area sown and the man-land ratio thereon works out to 1:0.67 hectares. The estimated population in the Tribal Development Block for 1969 is 25,2[illegible]3*. If the

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*Source: Block Family Planning Extension Educator.

man-land ratio is worked out on the estimated population, it will further be reduced to 1:0.62. In any case the man-land ratio is less than one hectare which dwindles at a faster rate if the population of the block is allowed to multiply at the present birth rate in future. This uneconomic fragment of land of low-productivity can barely sustain a man for quarter of a year. So the available productive land of the Block can not accomodate and sustain any additional population.

The study of birth and death rates indicates the rate at which the population of the Block is multiplying. The following are the birth, death and infant mortality rates* for a period of four years.

	1965	1966	1967	1968
Birth rate (per 1000 popula-tion)	15	15	23	18
Death rate (-do-)	6	7.7	12	7
Infant Mortality(- do-)	50	52	63	49

Eventhough both death rate and birth are very low when compared to the figures at the national level, the very low death rate which is roughly about half of the birth rate for the period points out the increasing tendency of the population of the Block. But there may be an error in the calculation of birth and death rates in the Block as birth and death registers are never properly maintained in the Scheduled areas of the State due to the

*Source: Block Family Planning Extension Educator.

tribals' ignorance of the procedure of registering births and deaths on the one hand and the negligence of the village officials in maintaining these registers on the other land. But it can be definitely said that with the successful implementation of Malaria, Yaws and other endemic diseases' eradication programmes together with vastly improved Medical and Public Health facilities during the three Plan Periods, there is steep fall in the death rate.

FAMILY PLANNING IN RAJAVOMMANGI:

It was in October, 1965 that the Family Planning programme was first introduced in this block with special staff consisting of one Block Extension Educator and two Health Inspectors. One Health Inspector is stationed at Rajavommangi and the other at Zaddangi. Besides, three A.N.Ms are also appointed with headquarters at Zeddangi, Guntuvaripalem and Kondapalli villages. As the block is not equipped with a Mobile Surgical Unit, the Moble Surgical Unit stationed at Kakinada camps every Saturday and Sunday at Rajavommangi and Sarabhavaram respectively. In addition to these medical facilities for family planning, one L.F.Dispensary, one Mobile Medical Unit, one Maternity and child Welfare Centre, one N.M.E.P. Sub-unit have been established as part of general Medical and Public Health Programmes of the Tribal Development Block. The L.F.Dispensary is headed by one M.B.B.S. Doctor with one compounder, one Nurse and one ward boy. The building of L.F.Dispensary

is in a dilapidated condition affording no protection against sun and rain. Two Health Inspectors and eight Malaria workers are working in the N.M.E.P. sub-unit. Maternity and child welfare centre is functioning with one Aya and one A.N.M. only. Primary Health Centre is not established in this Block. In general the Medical and Health facilities of the Block are not adequate to meet the growing needs of the tribals.

According to Survey conducted by the Family Planning Unit of the Block there are 3,704 'Target couples' of which 2,466 couples are having more than three children. A 'Target couple' may be difined as wife and husband having two or more children and still capable of further reproduction and whose reproductive capacity can either be arrested for the time being or completely sterilised by using family planning methods of one type or other. Assuming that the average size of a tribal family is 5, the total number of families in the Block works out to 5,038 as the total estimated population of the Block in 1969 is 25,203. As most of the couples live in nuclear families in Tribal areas, the number of 'Target couples' constitutes about 73% of the total estimated families or couples. In other words, if all the 73% of the 'Target couples' are brought under family planning programme, only 27% of the total estimated families remain reproductive. 1,277 couples are already sterilised by conducting vasectomy operations alone

by March 1970 constituing 34.45% of the total targeted couples. Besides the vesectomy operations, five tubectomy operations were conducted bringing the total number of sterilised couples to 1,282 constituting 34.61% to the total targeted couples. Further 61 loops have been inserted during the last five years temporarily arresting the procreation process of 61 couples. In total 1,343 couples have been brought under family planning programme. Further 1,920 condoms have been distributed among 265 users. Thus about 1,608 couples have been brought into the fold of family planning programme, which works out to 43.47% to the total 'Target couples'. Thus during its first five years the Family Planning Programme in this block has achieved remarkable results.

The campaign gained momentum by 1968-'69 and the maximum number of vasectomy operations - 1769 were conducted during the year but many of the people who underwent operations, numbering 1254 were from outside the block area. Even within the block area, of the 1277 vasectomy operations performed 1033 operations have been conducted during 1967-'68 (518) and 1968-69 (515) even exceeding target during 1968-'69. This shows that the programme was at its peak during 1967-68 and 1968-69 but this achievement could not be sustained in the next year as only 50 vasectomy operations could be conducted during 1969-'70. This

anti-climax is a consequence of the indiscriminate conducting of vasectomy operations in their eagerness to achieve the targets, if not exceed them, that generated the public antipathy as reflected in the ~~[illegible]~~ tion of resolution against further implementation of Family Planning Programme in the Block.

The parity-wise, age group-wise and income range-wise analysis of the vasectomy operations and I.U.C.D. insertions for the year 1968-69 which was the year of peak performance of Family Planning Programme gives certain interesting facts about the performance of the programme as given below:-

	Parity-wise				Age group-wise							Income Range			
	0	1	2	3 and above	15-20	21-25	26-30	31-35	36-40	41-45	46 and above	Below Rs. 100	101-200	201-300	301 and above
Vasectomy (1769)	-	12	319	1438	--	36	615	570	403	117	28	1768	1	--	--
I.U.C.D. Insertions (43)	-	12	8	23	5	12	18	8	-	-	-	43	-	--	-

Of the 1769 Vasectomy operations referred 515 operations are performed on people living within the Block and the rest are outsiders drawn from the neighbouring areas.

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*Source: Block Extension Educator.

Almost all the I.U.C.D. insertions are on local women except one. Majority of Vasectomy operations are on men having three or more than three children. But it is interesting to note Vesectomy is conducted even on men having only one child and evidence is not lacking to show that vasectomy operations are conducted even on men having only one child and evidence is not lacking to show that vasectomy operations are conducted even on unmarried people as is evident from the case of Kunjam Surya Rao, Koya Dora of Kondapalli village.

The vasectomy operations were performed on widowers also as is evident from thecase of Chodi Venkanna, a Koya of Kondapalli village, who lost his wife. Even married men without children have also been operated upon as exemplified in the case of Challapalli Malleswara Rao, a Non-tribal, Mangali (barber) by caste belonging to Iabbarti village. 28 persons in the age group of 46 years and above also underwent vasectomy operations. Some of them are too old like Shri Lokaram Somulu who is 56 years old and whose wife is 50 years old, to procreat children. But none of the women who are above 35 years old came forward to have loops inserted, inspite of their proved fertility.

Further, I.U.C.D. insertions are not serving the purpose as 17 out of 19 and 32 out of 43 loops inserted have been expelled in the years 1967-68 and 1968-69 respectively

indicating the unsuitability of loops for tribal women and thereby necessitating a thorough study of the anatomy of uterus among tribal women in order to ascertain whether loop is anatomically suitable to tribal women. For temporary stopping of conception condoms were distributed during the three years so as to space the birth of children suitably. But the use of condom does not seem to be popular among the people as only 265 people adopted condoms numbering 1920 during the years 1967-68, 1968-69 and 1969-70, the peak year being 1968-69 during which 151 users were given 1202 condoms. On an average about 7 condoms were used by each acceptor during the period of 3 years showing its poor impact.

While at Block level, Loop, Condom and Tubectomy failed to make any perceptible impact, at village level also the situation is not different as is evident from the study of the three sample villages, Rajavommangi, the Block Headquarters tops the list with 99 Vasectomy operations, 3 Tubectomy operations and 35 loop insertions. In total 137 familes accepted family planning methods of one type or other out of total estimated families of 453. In Kondapalli village 68 Vasectomy operations were conducted and five loops were inserted, covering 73 families of the estimated 94 families. In Iabbarthi village 74 Vasectomy operations were conducted and there

were no tubectomy operations and loop insertions, the total estimated families being 156 according to 1961 Census. It is seen from the statement (Annexure I) showing the Vasectomy and Tubectomy operations and I.U.C.D. insertions performed between 1965-'66 and 1969-70 that the response towards family planning programme was encouraging upto 1968-69 in Rajavommangi village, the peak year being 1968-69. But during the first five months of 1969-70 only 7 Vasectomy and 3 Tubectomy operations could be conducted without any Loop insertions. Maximum Vasectomy operations were conducted during 1966-'67 in Kondapalli village with 38 operations but the number of operations decreased to 22 operations during 1967-'68 and further there was a steep fall during 1968-'69 and 1969-70 with three and one operations respectively. In Labbarthi village the performance was erratic. While no Vasectomy operations were conducted during 1966-67, 38 and 32 operations were conducted during 1967-68 and 1968-69 respectively. No operations were conducted during 1969-70. In general the response towards family planning which was at its best during 1967-68 and 1968-69 showed a perceptible fall during 1969-70. Thus the programme could not sustain its progress and it has almost suddenly came to a halt during the first half of 1969-70.

The commendable performance between 1967 and 1969 and the utter failure during 1969-70 is to be viewed in the context of three important factors, viz., the prevailing

natural conditions, the vigorous efforts of the family planning staff and the monetary inducement, 1967 and 1968 were very lean years for the people of the Block as near famine conditions prevailed due to continuous failure of monsoon. The people of the Block, who were mostly tribals, are not in the habit of saving for the 'rainy day' as most of them lead a hand to mouth life characteristic of their subsistence economy. Both tribal agriculture and the forests, their main sources of livelihood, failed to yield due to lack of rains and the tribals in desperate mood were driven to tap any source for keeping the wolf away from the door even for a few days. It is at this juncture that the family planning programme started gaining momentum with the added attraction of cash payment to the acceptor and promoter. The famine conditions made them realise that their meagre sources of livelihood are not conducive for the maintenance of large families even though every member of the family is an economic unit. The near conditions of starvation almost forced the semi-starving tribal to undergo Vasectomy operations for earning a few rupees and in the process secure some money for himself, however small it may be, as each operation provides him a few days' food for his family. The role of promoters is amply illustrated in the fact that even unmarried, widowed and old men are also induced to undergo the operation by giving false declarations and without fully understanding the implications of

their action. Further, on the spot payment increased the number of acceptors. Moreover, the fact that the operations can be conducted at a moment's notice with shortest convalescence and without any side effects gave further impetus for undergoing vasectomy. The orverwhelming preferance for Vasectomy to loop inspite of latter's advantage of removal at will can be attributed to the monetary inducement and minimum after effects.

With a view to assess the impact of various family planning methods and the conditions under which each acceptor agreed to adopt family planning, case histories of 10 acceptors were collected from the three selected villages, as detailed below:

C A S E S T U D I E S:

Type of Family Planning Method		No.of case studies
1. Tubectomy.	..	2
2. Vasectomy	..	6
3. Loop.	..	1
4. Condom.	..	1

The two tubectomy acceptors belong to Konda Kapu and Konda Kammari tribes. The Konda Kapu woman has two children while the Konda Kammari woman has three children with the size of their family ranging from 4 to 5. In both the cases the family expenditure is more than the income. Both the families are thriving on agricultural sector with one family

exclusively depending upon agriculture and the other agricultural labour and construction work. Both the families are in debt as their source of income is inadequate to maintain the families. The Konda Kapu women underwent tubectomy operation as she could not retain the loops for more than 8 months. She underwent the operation with the consent of her husband and under the guidance of Health visitor. She said that she would not have preferred operation, had the loop not been dropped out. She opted for Family Planning for economic reasons. She complained of no after effects. The Konda Kammari woman did not use any contraceptives before opting for tubectomy. She has three living children and lost two children. As the last two children died she came to the conclusion that in future her children might meet the same fate. Further, her health also deteriorated due to frequent deliveries. She preferred to undergo tubectomy instead of her husband undergoing Vasectomy as their family is solely dependent upon the earnings of her husband. Hence, if her husband were to undergo Vasectomy, family maintenance will be very difficult during the 7 day rest period. The two cases indicate that while the first woman underwent operation due to poverty, health of the mother and loss of children apart from poverty motivated the latter woman to undergo tubectomy.

Six Vasectomy case studies were conducted, two in each of the selected villages. The two cases recorded in

Rajavommangi have deficit budget with the size of the family ranging from 6 to 8 members. One head of the family underwent Vasectomy after 4 children and the other after 6 children. But both of them complained weakness and pain in the body and the weakness is hampering their work. Both of them depend for their livelihood on agricultural and forest labour, which require manual work. In view of the post-surgical weakness they are not favourably inclined to Vasectomy.

Two interesting case studies have been recorded in Konda Palli village. Both of them are Koya Doras. One man is the father of 7 living children while the other is a widower past 50 and has no inclination for second marriage. The most interesting feature is thatthe first man's wife conceived even after the operation and he was blessed with a male child, which ultimately resulted in mis-understanding between wife and husband. However, it did not result in family disorganisation as he was convinced that it was due to the failure of the operation as his wife is too old to have any paramour. He too complained that he is feeling nervous weakness after the operation. As his operation was not successful both husband and wife are very critical about the utility of the Vasectomy and disuading others from undergoing operations lest it results in family dis-organisation and break down of health. The other man who is having one married son and one married daughter lost his wife about 6 years back

along with two children and remained widower. The promoter prompted the ignorant man to undergo the operation without knowing its full implications by baiting him with the monetary incentive of Rs.16/- just to secure the promoter's fees of Rs.2/- The acceptor who is on the wrong side of 50 years is also feeling pain after the Vasectomy operation. He has become antagonistic to the Vasectomy and consequently became hostile to family planning.

A Koya Dora man and a Konda Kapu man of Labbarthi were interviewed. The Konda Kapu is the head of the family of 8 members which has a deficit budget. On the advice of Health Inspector and with the consent of his wife, he volunteered himself for Vasectomy operation. He complains of weakness in his waist while attending to heavy work. Nevertheless, he is convinced of the advantages of and the necessity for family planning. If the doctors guarantee the success of the Family Planning Operation, he says that he can advocate family planning operations for others as the failures in operations may very often break the wed=lock.

The other acceptor of Family Planning is surprisingly an unmarried Koya Dora whose income has even slight edge over his expenditure. He underwent Vasectomy by giving a false declaration that he has one male and two female children. He alleges that the promoter instigated him to undergo family planning operation for money. The promoter prevailed upon the acceptor mainly for the promoter's remuneration of Rs.2/- per case. The ignorant and gullible Koya Dora ultimately

submitted himself for Vasectomy by giving a false declaration without knowing the consequences of his fateful decision.

Besides the tribals, 8 non-tribal cases of Vasectomy are also recorded to gain a comparative picture of the performance of family planning programme. It is interesting to note that similar to tribals the non-tribals also complain of post operational weakness which is hampering their routine work. All of them have deficit budgets with the family size varying from 2 to 9. Except in one case all others have undergone operations voluntarily. Four of them underwent operations without the consent of their wives. Of the remaining four who underwent operation with the consent of their wives, the wife of one informant is repenting for having given her consent as she now feels it a sin to adopt unnatural family planning methods.

Even among non-tribals one case of Vasectomy failed as the man's wife conceived after the operation. The man underwent the operation after having five children. But it did not result in family disorganisation as the conception is attributed to failure of operation. It is also interesting to note that while 7 informants have undergone operation after having 2 to 7 children, one informant underwent operation even without having any children at the instance of the promoter who baited him with the monetary incentive. He did not inform his wife about the operation for the fear of incurring her displeasure.

One Kammari woman who had a loop inserted since March, 1968 has been studied. The family depends upon forest and agricultural labour and the size of the family is four which includes mother-in-law, the woman and a son. She opted for loop to fetch a gap as she is having only one son and their income is less than expenditure. The family is very small. But since the insertion of the loop she has developed pain in the abdomen during mensus and she is undergoing treatment by way of taking tablets and injections under the guidance of Health visitor. Inspite of this inconvenience and incurring expenditure of Rs.1/- towards cost of injection, she did not get the loop removed. As she has no other complaint against loop she is favourably inclined towards insertion of loop as family planning method. However, nearly 80% of the loops inserted have dropped out.

One Koya Dora who had used condoms was interviewed. He had used condom after having 2 children (one male and one female) in order to fetch the gap. But he was not satisfied with the performance of condom as it is causing inconvenience. So he thought of opting for Vasectomy. But he reversed his decision on hearing the experiences of those who underwent Vasectomy. He feared that he too may suffer weakness or the operation may even fail. As an alternative he is now contemplating to use advertised Ayurvedic medicine for birth control.

The case studies reveal that about 87% of the cases studies are in favour of family planning and among these 69% favour family planning for the reason that larger families are

not economically viable units. The four informants who have adopted Vasectomy and condoms are repenters who were either not satisfied with the condoms they used or met with failure in Vasectomy or realised their fault in meekly submitting to the viles of the promoters and turned hostile when it was too late to rectify the mistake.

It is also interesting to note that 61% of the favourable respondents opined that it is advisable to undergo vasectomy after four or more than four children indicating their ingrained love for more children. Among these, 50% opined that they favour the adoption of family planning after four children, while 44% desired to adopt family planning after the birth of fifth child and the rest after the sixth child. Among 30% of the acceptors who wanted to adopt family planning after the third or second or even first child, 50% of them wished to adopt family planning after the second child, while 40% liked to adopt family planning after the third child and the rest after one child only.

CONCLUSIONS

The phenomenal success of Family Planning Programme can be guaged from the physical targets which sometimes exceeded the expected results. Of all the methods of Family Planning, Vasectomy is the most favoured one because of the following inherent advantages (1) The operation is very simple and can be performed at a moment's notice requiring no operation theatre and minimal pre-surgical testing and preparations. Further, it involves minimum use of complicated instruments.

2. This simple and short duration operation has minimum after effects. The period of convalescence is very short and even during this period the acceptor need not be confined to bed at all.

3. Unlike tubectomy the performance of operation does not involved biological cycles. As it is performed on men only, the inborn feminine conservatism characteristic of tribal women folk is not the major hurdle unlike in the case of tubectomy.

4. Absence of procedural delays and cumbersome rules in performing the operation and on the spot payment of remuneration promoted even the hesitant acceptor to undergo the operation.

5. The promoter's remuneration sometimes played havoc in enticing the innocent and gullible tribals by baiting them

with acceptor's remuneration to undergo the operation as is evident from the case studies of the unmarried, widower and senile people who underwent Vasectomy.

6. Last but not the least, the prevailing famine conditions at the time of large scale introduction of family planning programme showed the famine sticken tribals a ready source of income, however small it may be as it sustains the starving family for a week days. It is also reported that some of the petty money lenders have doned the mantle of promoters not only to get his outstanding debt recovered though in part from the acceptor's remuneration but also to pocket his share of promoter's remuneration. As is evident from case studies and records of the Family Planning Unit of the Block most of the acceptors belonged to low income groups and have deficit budgets.

As clearly mirrored in the attitude survey, the overwhelming majority of acceptors are not favourably inclined to restrict the size of the family to two or three children. The ingrained love for more children, fear of infantile mortality and the economic gain from each family members are the main reasons for preferring more than the number of children advocated by the family planning programme. The thumping success achieved during 1967-68 and 1968-69 could not be sustained during 1969-70 and there has been a steep fall in the number of acceptors of various family planning methods due to the following reasons:

1. Loop proved to be unsuitable for vast majority of the tribal women as is evident from the large number of I.U.C.D.Expulsions.

2. The ingrained shyness of tribal women, complex nature of the operation and consequent longer period of convelscence, lack of properly equipped operation theatres in the vicinity and necessity to observe biological cycles are mainly responsible for very poor receptivity to tubectomy.

3. The codom is not appealing to the tribal as it is not giving the natural sexual satisfaction.

4. Eventhough the Vasectomy was the most acceptable method, it soon fell into disrepute after the initial popularity due to following reasons:-

(i) Post-Operational weakness and lack of after-care and follow-up medical attention. Cases of pain in waist and pus-formation and similar minor complaints have been reported. No medical attention, it is alleged, was paid to such complaints, as the staff were more eager to achieve the targets than waste their time on such minor matters which infact mattered very much in making ultimately the Family Planning Programme unpopular.

(ii) The reported cases of unsuccessful operations were not thoroughly investigated into and the facts brought to public notice, resulting in tarnishing the efficacy of Vasectomy operations among the people.

(iii) The permanent sterilisation of an individual sometimes resulted in a sort of remorse and development of guilty conscience for adopting the unnatural methods. Further, even the slightest sickness to the living children and the consequent sense of insequrity and anxiety have become more prominent in the context of his incapacity to replace the lost children.

(iv) The indiscriminate conducting of Vasectomy without adhering to the 'Target couples' register aroused public indignation and a sort of mass antipathy has developed about the bona fides of the intentions of Family Planning Programme for fear of group extermination when people became aware of large scale operations.

The preceeding discussion brings into lime light certain loop holes in the implementation of family planning programme which are to be plugged for the smooth implementation of the programme without disturbing normal life of the people. Firstly, it is of paramount importance to see that the material inducement does not take the upper hand in attracting tribals to avoid post-operation hostility towards the Programme. Secondly, comprehensive, authentic and upto date lists of 'Target couples' should be prepared before conducting mass vasectomy or tubectomy camps. Thirdly, instead of depending upon the declaration and witness of the acceptor and promoter their statements should be varified with

'Target couples' register so as to avoid false declarations; Fourthly, the 'Target couples' register should be periodically checked by random sampling method by a responsible officer to ensure its authenticity and keep it uptodate. Fifthly, all cases of failure should be thoroughly investigated and the results should be made public to dispel false notions and rumours. Even if it is an established case of failure it should not be hidden from the people in order to avoid casting of aspersions on the professional ethics of the doctor and sincerity of purpose of the programme. Sixthly, instead of trying to achieve large scale sterilisation it is advisable to stagger the programme on a moderate scale as the present mass sterilisation programme is giving scope for attributing ulterior motives like extermination of tribes as a whole to the programme. With a view to counteract the malpropaganda, wide publicity should be given in tribal areas to the achievements of Family Planning among plains people. Follow up medical aid should be made available for all the acceptors by way of introducing systematic periodical post-surgical checkup. The present family Planning slogan 'Two or Three enough' may have to be modified for the time being as 'Three or four enough' in view of high incidence of infant mortality due to inhospitable environment, rampant malnutrition and lack of sufficient medical facilities in tribal areas. Seventhly, there should be provision for meeting out severe punishment to dubious promoters in order to curb their coercive and deceitful tactics in convincing innocent and

gullible tribals to undergo Vasectomy, though they do not require any Family Planning. Lastly, there is need for doing spade work before launching mass Family Planning camp through audio-visual methods in order to keep the tribals fully informed of the aims and advantages of family planning programme and in the process eliminate post-camp mass-hysteria.

It is also essential to keep in mind the peculiar social practices and norms of the tribal societies while performing either tubectomy or vasectomy. In a polygynous family the wife with children may allow her husband to under go Vasectomy where as the other wives may resist the same as their natural desire for children remaining unfulfilled. In such cases it is the wife with children that is to be sterilised to avoid disappointment of other wives and the consequent family disorganization. Easy divorce is another factor to be reckoned with while assessing the impact of vasectomy as undergoing vasectomy may be one of the potent factors in disrupting the family. A tribal woman may prefer to elope with a man who has not undergone vasectomy and continue to procreate children without any additional burden to her latter husband since the children born to her former husband are restored to him by the law of the land. Age is not always a factor in fixing marital alliances among tribals especially in the context of prevailing child marriages and the custom of inheriting the widow of the deceased elder brother. In such case if the

young man is operated upon, the widow may refuse to be the wife of her younger brother-in-law leading to social tension as it is against the norm of the society.

If the family Planning Programme is implemented on sound lines, this can herald a new era of hope and prosperity for the tribals.

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ANNEXURE - I

Statement showing achievements made under family planning programme in Panchayathi Samithi:

Rajavommangi from the year 1965-66 to 1969-70(upto August'69)

Sl. No.	Name of the village.	Population as per 1961	1965-66			1966-67			1967-68			1968-69			1969-70			Total		
			V	T	L	V	T	L	V	T	L	V	T	L	V	T	L	V	T	L
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.
1.	Rajavommangi	2267	6	..	..	6	..	..	20	..	7	60	..	28	7	3	..	99	3	35
2.	Iusaripamu	946	14	..	..	3	..	..	9	..	..	11	..	3	..	..	..	37	..	3
3.	Amirakula	321	..	..	..	..	..	..	4	..	..	12	..	..	1	..	..	17	..	..
4.	Kimmiligadu	162	..	..	..	..	..	..	2	..	..	18	..	..	..	..	..	20	..	..
5.	Badadevampalli	383	..	..	..	7	..	..	21	..	..	13	..	..	1	..	..	42	..	..
6.	Chinarellangipadu	181	..	..	..	14	..	..	6	..	..	2	..	..	2	..	..	24	..	..
7.	Doyyada	42	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	3	..	..
8.	Mullavanipalem	86	..	..	..	1	..	..	..	..	..	1	..	..	..	..	..	2	..	..
9.	Subbampadu	30	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
10.	Yerrampadu	160	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	2	..	..
11.	Surampalem	323	..	..	..	21	..	..	11	..	..	1	..	..	..	..	..	33	..	..
12.	Zaddangi	1326	1	..	..	5	..	..	45	..	3	39	..	1	6	..	..	96	..	4
13.	Borragudem	49	..	..	..	..	..	..	1	..	..	..	..	..	1	..	..	2	..	..
14.	Cherukumpalem	123	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	3	..	..
15.	Revatipalem	205	..	..	..	..	..	..	6	..	..	2	..	..	1	..	..	9	..	..
16.	Valagolopalem	272	..	..	..	..	..	..	7	..	..	11	..	..	1	..	..	19	..	..
17.	Marripalem	108	..	..	..	..	..	..	17	..	..	..	..	..	..	..	..	17	..	..
18.	Donelapalem	224	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	1	..	..
19.	Bonangipalem	293	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	1	..	..
20.	Gobbilamadugu	95	..	..	..	..	..	..	1	..	..	1	..	..	1	..	..	3	..	..

....2/

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	19.	20.	21.	21.
21.	Gadvakurthi	224	..	..	..	..	..	..	..	..	..	4	..	..	..	..		4	..	..
22.	Janikonda	1003	..	..	..	..	..	..	7	..	..	26	..	..	2	..	..	35	..	..
23.	D.Mallavaram	74	..	..	..	..	..	..	1	..	..	1	..	..	3	..	..	5	..	..
24.	Singamapalli	193	..	..	..	..	..	..	6	..	..	1	..	..	..	..	..	7	..	..
25.	Gingerte	105	..	..	..	2	..	..	..	..	..	22	..	..	2	..	..	26	..	..
26.	Aminabada	679	..	..	..	..	..	..	9	..	..	5	..	..	2	..	..	16	..	..
27.	Vanchangi	373	..	..	..	..	..	..	13	..	..	..	..	..	..	..	..	13	..	..
28.	Balijipadu	242	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
29.	Maredubaka	272	..	..	..	..	..	..	19	..	..	..	..	..	..	..	..	19	..	..
30.	Kondalingam-parthi	195	..	..	..	..	..	..	1	..	..	6	..	..	..	..	..	7	..	..
31.	Karudwupalem	379	..	..	..	..	..	..	1	..	..	2	..	..	..	..	..	3	..	..
32.	Chikilintha	336	..	..	..	..	..	..	3	..	..	8	..	..	..	..	..	11	..	..
33.	Pedagarrangi	66	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	2	..	..
34.	Kothapalli	98	..	..	..	..	..	..	2	..	..	1	..	..	..	..	..	3	..	..
35.	Vrlakulapadu	265	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	3	..	..
36.	G.Sarabhavaram	24	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
37.	Sarabhavaram	778	..	..	..	14	..	..	21	..	..	41	..	7	3	1	..	79	1	7
38.	Kondapalli	471	3	..	..	39	..	..	22	..	3	3	..	2	1	..	..	68	..	5
39.	Dakarai	194	..	..	..	..	..	..	10	..	..	11	..	..	1	..	..	22	..	..
40.	Vanakarai	62	..	..	..	..	..	..	3	..	..	11	..	..	1	..	..	15	..	..
41.	Appanapalem	26	..	..	..	..	..	..	..	..	..	5	..	..	..	..	..	5	..	..
42.	Boyapadu	69	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	2	..	..
43.	Tallapalem	106	..	..	..	..	..	..	3	..	..	15	..	..	1	..	..	19	..	..

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.
44.	Bodlagondi	39	..	..	..	..	..	..			..	3		..	1	..	..	3	..	..
45.	Kirrabi	230	..	..	..	..	..	..	..	..	..	10	..	..	..	..	..	10	..	..
46.	Konalova	544	8	..	..	..	..	..	16	..	..	..	..	..	..	..	..	24	..	..
47.	Kinaparthi	142	1	..	..	..	..	..	5	..	..	9	..	..	1	..	..	16	..	..
48.	Doramamidi	113	..	..	..	..	..	..	6	..	..	..	..	..	..	..	..	6	..	..
49.	Gavarayyapeta	84	..	..	..	1	..	..	3	..	..	1	..	..	1	..	..	6	..	..
50.	Veerabhadrapura	393	..	..	..	..	..	..	10	..	..	..	..	..	..	..	..	10	..	..
51.	Kottampalem	103	..	..	..	..	.	..	1	..	..	..	7	..	..	..	..	7	..	..
52.	Languparthi	130	..	..	..	3	.	..	1	..	..	4	..	..	..	..	..	8	..	..
53.	Lagarai	1371	..	..	..	21	.	..	65	..	..	30	..	..	1	..	..	117	..	..
54.	Labbarthi	778	4	..	..	..	..	..	38	..	..	32	..	..	..	..	..	74	..	..
55.	Nellimetla	237	..	..	..	..	..	..	18	..	..	13	..	..	..	..	..	31	..	..
56.	Munjavarappadu	250	..	..	..	1	..	..	2	..	..	1	..	..	1	..	..	4	..	..
57.	Ananthagiri	330	1	..	..	..	..	..	10	..	...	15	..	1	3	..	..	29	..	1
58.	Kindra	237	..	..	..	4	..	..	13	..	..	10	..	..	2	..	..	29	..	..
59.	Damanampalem	43	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
60.	Guntivampalem	1366	10	..	..	..	..	..	13	..	6	..	..	..	..	1	..	23	1	6
61.	Kottampadu	105	..	..	..	..	..	..	4	..	..	..	..	..	..	..	..	4	..	..
62.	Kottampadu	169	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
63.	Puliogulopadu	367	..	..	..	..	..	..	3	..	..	..	..	..	1	..	..	4	..	..
64.	Kimmuru	600	4	..	..	..	..	..	8	..	..	..	..	..	..	..	..	12	..	..
65.	Doddivaka	64	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	2	..	..
66.	Serrampetapadu	139	..	..	..	..	..	..	6	..	..	..	..	..	..	..	..	6	..	..

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.
67.	Vathangi	363	..	..	..	..	..	..	16	..	..	10	..	..	1	..	..	27	..	..
68.	Okurthi	121	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	3	..	..
69.	Ogipalem	168	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	1	..	..
70.	Pedarelangipadu (UN-I)	5	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
71.	Komarapalem	192	..	..	..	..	..	..	..	..	..	3	..	..	1	..	..	4	..	..
72.	Lododdi	303	..	..	..	..	..	..	..	..	..	15	..	..	..	..	..	15	..	..
73.	Pudedu	113	..	..	..	..	..	..	..	..	..	1	..	..	2	..	..	3	..	..
74.	Pakavelthi	89	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	3	..	..
75.	Kesavaram	60	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	2	..	..
	Other than Block area	..	..	..	..	..	..	21	..	..	1254	..	1	56	..	..	..	..	..			
	Grand Total:	23066	52	..	..	142	..	..	539	..	19	1769	..	[illegible]	16	5	..	1277	5	61

Source: Block Family Planning Extension Eductor.

V = Vasectomy.
T = Tubectomy.
L = Loop

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Tribal Cultural Research and Training Institute
Tribal Welfare Department
Basheer Bagh, Hyderabad-29
Phone: 32591