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Modern Fertility Control: People's Experiences

Tulsi Patel

Modem means of fertility control have made inroads into Mogra in recent times. Since these means were introduced mainly under the national Family Planning Programme (FPP), this chapter focuses on people's response to it. How did FPP find its way into the village? What do people think about it? Do they evaluate its philosophy and techniques and then accept/reject the total package, or do they judiciously select certain components? Does FPP reinforce prevailing fertility practices or interfere with them? How is it seen in relation to indigenous practices of fertility control discussed in Chapter 6? How do these varying frameworks co-exist in the village? What is the process of acceptance of FPP in the context of prevailing norms, values and cosmology of fertility and its control? Although India is the first country in the world to have officially introduced FPP in 1952 along with the five-year plans, the people of Mogra became familiar with it during the national emergency of 1975-7. A state of national emergency was declared in June 1975 family planning then entered the forefront of Indian politics. The family planning compaign during this period was more intense than at any other time in India, using sometimes coercive methods for its acceptance. During the 22-month period 11 million people (many of them unmarried, many average, and many with less than two children) were sterilized compared with 1.3 million in the preceding year (see Bose 1988: 50-55 for a detailed account).

Despite its official introduction in 1952, FPP took an unusually long time to reach Mogra like many other villages in the country. FPP evaluation studies and KAP surveys reveal the poor penetration of FPP in the country, especially in rural areas. Although the people of Mogra had heard about the birth control programme and techniques propagated by the government before 1975-7, they had little clarity about it. The spread of FPP in rural India began with an emphasis on sterilization through the 'camp approach' in the early seventies, especially in Kerala and Gujarat.

FPP embodies a set of assumptions ubiquitous in most family planning packages in developing countries. Three of them need special mention. First, there is a general Neo-Malthusian and western view that increasing population means a constant drain of the limited resources of the nation and that fertility control is a necessary step without which economic development would be retarded. The

second assumption, also borrowed from western experience, is that fertility behaviour is based on the decision and planning of the individual couple. The third assumption is that the couple do not feel the need to plan the family due to their ignorance of the effective use of contraceptives, and the importance of spacing children for the health of both mother and child. Effective fertility control is, therefore, possible only by adequately motivating and enlightening the couple to practice family planning.

As we have seen, people in Mogra subscribe to a complex set of practices and beliefs about fertility, spacing of births, mother and child health, and optimum family size. But FPP reflects little knowledge of people's reproductive beliefs and practices and is actually at variance with them. Therefore, people's response to FPP has been neither passive nor ignorant. In other words, they have been assessing the package and comparing it with their own practices of fertility behaviour.

The norms, values, social practices and related cosmology discussed in Chapter 6 are too complex to permit an uncritical acceptance of FPP in its totality. As discussed in Chapter 4, there exists in Mogra a complex institutional arrangement to take overall care of the mother's and child's physical and emotional health. The prevailing beliefs, rituals and folk medicines play a vital role in this regard. The prevailing practices take care of the parturient mother's recovery. A person who does not suffer from a serious ailment is considered to be healthy. [1]

The data in this chapter pertains to people's knowledge of FPP, their experiences of its practice, and evaluation of some of its popular components the information was obtained from ever married men as well as women in Mogra during prolonged interviews. Owing to people's secretive attitude towards most contraceptive measures, data collection regarding FPP relied largely on unstructured interviews and group discussions. Clues about people using modem contraceptives came from their close friends and relatives. However, it was not easy to extract information about use of modern contraceptives. Hanging on with people who were said to have some experience of modem contraceptives did yield data occasionally. But information on sterilization was rarely a secret. Questions about sterilization, the technique, place where sterilized, etc. were included in the interview schedule itself. Unstructured interviews were used for obtaining additional information about men and women who had opted for sterilization.

Some Experiences with FPP

To most people in Mogra, FPP is synonymous with termination of fertility, i.e., sterilization. Such a perception is typical of the trend prevalent in most developing societies, particularly in the Asian region (U. N. 1981). Even when some persons have a vague knowledge about certain contraceptives, they seldom use them regularly. Both contraceptives and sterilization are seen by the people as governmental means to curtail or stop childbirth (locally called, *baccha band karno;* literally, stop the children) contraceptives that cause inconvenience or embarrassment are discarded. The inconvenience and/or embarrassment is not entirely without justification.

> *Kamala, aged 35, mother of six children, said about her experience of the condoms: 'They (condoms) are a menace. It is always difficult to keep them from the reach of children. No corner or niche in the house remains hidden from them. They are always on the look out for something to eat or play with. A condom is like a balloon for them. What an embarrassing sight it is when the condom is blown and people laugh meaningfully!'*

> *Mangli Sargara, mother of three children, disclosed her experience of the condom: 'Disposing of it is always a problem. There scarcely is a moment when you can bury it without being seen.' Paani, a young Patel mother with four children, had her own experience of the condom: 'One can't carry it all the time. What if one needs it in the field?'*

> *Sugan reported about Mohni's agonizing experience of IUD: 'Ever since the insertion, her menstrual cycle was disrupted. She bled incessantly for three months and turned pale. She ultimately had to get it removed, or she would have died leaving behind her children to ruin.'*

> *Alpu had once experimented with contraceptive oral pills. She reported: 'I would always forgot its schedule. For me it never worked.'*

In people's experience contraceptives threaten whatever little privacy they have (insufficient in any case by urban middle class standards). To handle contraceptives is to risk public disapproval or ridicule. The contraceptives also intrude into people's definition of item and freedom. In the case of pills it is extremely difficult for a woman to maintain a specific time schedule. Condoms are a perpetual source of embarrassment for both husband and wife. They restrict freedom of sex outside the house-in the fields or any other hideout. Disposing of them is not easy either. They are not easily perishable, and consequently have to be buried carefully to avoid children playing with them.

The nature of housing in Mogra is unlike urban apartments or bungalows. The notion of a room in Mogra is different from its dictionary meaning. It ranges from a proper enclosed structure with a ceiling, a floor and a door, to a straw shed with walls on three, and sometimes only two, sides. Each house has at least one proper room to store valuables, clothes, etc, locally called *ori.* Although houses in Mogra are quite spacious, construction is sparse. Many houses do not have a separate kitchen. An average house has about three rooms (including sheds). In addition, there are cattle sheds.

All household members have an almost equal claim and access to rooms in the house. The storeroom *(ori)* is accessible to all household members. It is mostly locked. But when opened children are curious to know why. It is not easy to escape children's vigil and take the contraceptives away. It is not easy to clench the shelved. The sense of individual privacy is discouraged. It is rare for persons to have a room exclusively to oneself. No couple in Mogra has a bedroom to itself all day and night. The newly married couples have a separate room exclusively to themselves only at nigh. In about two years of marriage, the couple begins to use a shed or such other site away from the courtyard where most of the household members sleep at night. Sleeping arrangements have been discussed in the pervious chapter. A near lack of privacy during daytime and the sleeping arrangement at night are hardly conductive to regular use of contraceptives. The problem is more acute in larger and complex household, where the early years of one's marriage are spent. Later one's own children share the rooms and other space, allowing little privacy to a couple.

The experience of using modern contraceptives is seldom bereft of inconvenience or other problems. Whereas couples try contraception with a desire to stop fertility, their actual use confronts them with a series of pain and discomfort, besides failing frequently in curtailing fertility. People disapprove and discontinue the use of modern contraceptives and prefer an alternative devoid of problems and perils. They believe that there exists a more simple and convenient contraceptive in the form of an injection, which is not available to them partly due to its exorbitant cost and partly due to the ignorance of most doctors and medical personnel about its very existence. Three women past their childbearing age claimed to have administered such injections on themselves. One of them related her experience regarding what she considered was an injectable contraceptive.

> *Jamni, an old Patel woman who had two sons and five daughters, confided in me: `I, along with two of my friends, had taken a contraceptive injection as all of us had enough children. The injection was effective as none of us had any child after that. And in five years time we reached menopause. Unfortunately the chemist*

> *who administered the injection is dead. He would have been so helpful if he were alive today. He could have rescued several women desiring that injection.'*

Other women also believed strongly in the existence of an injectable conveptive. For instance:

> *Haski Suthar, mother of five, always complained against me for not arranging her the most sought after injection that prevents conception for a duration of five years. She said: 'All these (available contraceptives) are useless. We can't handle them. But an injection would be so good. It would only pain little when pricked. And then one need not bother about anything (typical problems associated with the use of prevailing contraceptives)'.*

Several similar comments were made by many other women desiring such an injection, although local doctors seldom confirmed their views. Despite popular belief regarding the existence of a contraceptive injection, I was unable to gather more data. Therefore, I cannot say much about it.

Sterilization is another method tried in Mogra. It was introduced during the national emergency by schoolteachers, doctors, nurses and other officials visiting the village occasionally. Official propaganda and urban contact also exposed people to this new idea. A few of these officials persuaded people to sterilize themselves. They exerted pressure on people in order to fulfill their target of sterilizations. All sterilizations except one were performed on men in camps in a neighbouring village during the emergency. Nevertheless, sterilization was strongly disapproved. People were critical of it. To them it was a matter of shame and thus unwelcomes. At the level of cosmology, it was a sinful act. On the other hand, tubectomy was believed to interfere with a woman's physical capability for hard agricultural work, be it backbreaking tasks or the transporting of heavy loads on head.

Most of these notions continue to hold good in Mogra (see Caldwell *et al* 1984: 201 for an account of such skepticism in Karnataka). The post-operative complications are feared to incapacitate people and bring a couple's sexual life to a virtual end. These apprehensions were strengthened by the initial sterilization experiences of people during the emergency. These experiences are still alive in the collective memory of the people. They construct their images, meanings and opinions from the details of these cases. Often the experiences of the sterilized reinforce people's fears and strengthen their views against it. It becomes a common body of knowledge for people, especially when it results in some complication. The news spreads like wild fire through word of mouth, recurs in gossip, and becomes common know-ledge in the village.

Meeri, mother of two sons and a daughter, the first and the only woman in Mogra, to be sterilized during the emergency suffered from numerous complications soon after the operation. Her physical ailment, depression and inability to work hard led to terrible disapproval and criticism in the household. She had continuous body ache and severe backache. To top it all, the household elders criticized her because she could not work as hard as her sisters-in-law (husband's brothers wives). Rather than being sympathized for remaining unwell she was rebuked and blamed for being a work shirker. The whole experience was agonizing till she separated from the complex household and her growing children actively assisted her in the household work. Meeri's experience became a sailing deterrent for other women against sterilization.

Saori, a Harijan woman had a son a few years after her husband was sterilized during the emergency. Although technically the operation had failed, the ridicule continued to be hurled at the household and the couple for several months. Even till a few years later a reference to her made people exchange meaningful gestures or some derogatorey comment. Only when laparoscopy [2] failed in two female cases did people accept the possibility of the failure of sterilization.

Such discouraging encounters are part of the meaning assigned to sterilization. These meanings, as part of collective memory, contribute in dissuading other people from accepting it. The fear of prolonged post-surgical weakness and pain encourage few people to opt for it even when social norms expect them to stop procreation. As modern means of fertility control are not uncommon use, any post-surgical complication is given scarce attention. It is also clear to these women that they cannot seek any concessions in household or other work on this ground. The seven cases of sterilization during 1975-7 acted as negative references for others in Mogra. The post-operative complications and the consequent miserable condition of Meeri deterred women from sterilizing themselves.

As the new technique of laparoscopy has fewer complications, several younger mothers have opted for it. Each time a few women get sterilized by this technique in a camp, others are curious to know if there are any adverse after-effects. When a woman does not suffer from any, one or two of her friends and relatives (who have achieved the socially optimum number of children) begin to contemplate sterilizing themselves. For about seven years after the emergency no one in Mogra opted for sterilization.

But things have not remained the same. By 1982-3 there emerged a new trend among women to volunteer for sterilization. Birth control (laparoscopy) camps in Mogra and its vicinity had become active during the early eighties. The more convenient alternative of laparoscopy with few complications was an added

attraction. It was during this period that female sterilization's outnumbered male ones.

> *Sangari, a widow in her early fifties, confided in me that female sterilization is safer these days: 'The problem of security is mounting, and it is not safe for a solitary woman to go to the fields. Men's morals are fast degenerating. In such a condition it is safer for a woman to get sterilized so that if an accident (rape) happens she is safe. If her husband is vasectomized she would be ruined.'*

Laparoscopy is becoming popular among a small minority of women. They find it convenient as well as less demanding on their schedule. It is perceived to be different from the usual notion of surgery. 'It involves only a prick,' is the usual comment. Thus, the numerous fears associated with a surgical operation (particularly tubectomy and vasectomy) are substantially contained. Laparoscopy is gaining popularity over tubectomy also because it does not require abstaining from heavy work and sexual life for long. There is little fear of serious incapacitation as compared to other methods of sterilization. It does not upset the daily round of women's activities. Little forethought is required. A casual slip out of the house, akin to a brief gossip session or a siesta, is all that is required. In real terms, women have to abstain from home for only an hour or two. It is possible for them to walk back home on their own within half an hour of the laparoscopy 'prick'. None of the women in Mogra experienced any difficulty in resuming or supervising work after they returned home. All this is in sharp contrast to tubectomy which requires considerable planning, including leaving the domestic scene for a few days.

Acceptance of Sterilization: Modern Techniques in a Traditional Context

Although I have clarified in Chapter 1 how tense has been used, it is necessary to reiterate it. While the discussion of sterilizations till they were done is in the past tense, the discussion of modern means of fertility control in the post-sterilization period is in the present tense. Of course, other general observations are also made in the present tense.

As already mentioned my probe into fertility experiences of 713 ever married women and some of their husbands included questions on fertility control, especially through sterilization. In all, 64 persons (45 women and 19 men) were sterilized between 1975 and 1985 (when the present fieldwork was done). To gather additional data relating to sterilization, I had especially long probing sessions with most of the sterilized women and a few men.

As discussed in Chapter 6, fertility behaviour in Mogra is far from being unrestrained and unregulated. Fertility follows a certain trajectory, a certain span of reproductive career in a couple's life. The fertility career is marked by a

socially prescribed beginning and an end. It is controlled through the prevailing institutions, norms, the associated statuses and roles. It may appear that acceptance of sterilization by a couple points to a radical change in their attitude to family size. But my inquiry reveals that they have all followed the basic norm of fertility. Their notions of the optimum number of children in the family have altered little. There exists a contradiction between the expectations that planners and people have of sterilization. This contradiction may be explained through an analysis of fertility behaviour of persons who accepted sterilization.

The 64 persons constitute nearly 9% of the total number of 713 ever-married women or their husbands in Mogra. Their sex distribution (45 women and 19 men) follows the larger Indian pattern, namely, more women than men have undergone sterilization (Mahadevan and Sumangala 1987: 130 report this for India in general and for Andhra pradesh and Kerala in particular). Of the 45 sterilized women, 17 accepted tubectomy and 28 laparoscopy.

Of the 64 sterilized persons, 60 were sterilized before the age of 40, and only four after. Most of them belonged to the age range of 26 to 40. Even within this range the majority were between 26 and 35 years. These figures show that the need for sterilization after 40 is not felt so acutely. The main reason is that indigenous methods (primarily abstinence) are adopted to put an end to one's fertility career after this age. This is also the stage when the fecundity of older women is coming to an end.

Proportionately more men engaged in the relatively modern occupations of business and government service have got themselves sterilized than those in the traditional occupations of animal husbandry, agriculture, artisanship, and wage labour. Also, more men in business and service have vasectomized themselves as compared to their wives. This may be explained by the fact that sterilization is considered to be debilitating and therefore inhibitive of hard physical labour. Because these men perform less strenous tasks than their wives they preferred to get themselves sterilized. Their wives do more strenuous jobs because they continue to engage in agriculture. If they were to get sterilized, the entire household economy based on agriculture would suffer. Of the 19 vasectomies, seven were performed during the emergency period of 1975-7, under severe pressure and threat. Most of the rest were accepted by men who either live in urban areas and/or employed in urban centres. The influence of urban ethos has some role to play in their case.

The place of sterilization is important to show the extent of motivation, courage, and social approval that the concerned individual has. Those more determined to sterilize are less fearful of surgery, have greater approval of their act from other members of the household, and usually get themselves sterilized in hospitals in

the nearby city. Of the 64 cases, 20 got themselves sterilized in hospitals, a few of them primarily because they were predominantly urban-based. The remaining 44 were sterilized in various camps organized in the village or its vicinity. Eight of them were sterilized by coercion during the emergency.

The feeling of security is stronger in a sterilization camp by virtue of its proximity to one's home. The fear of surgery in a hospital has resulted in a larger number of sterilizations in camps. In some cases of laparoscopy, women have dared to take the step without a dear consensus or approval of their household members. One of the reasons for their courage is the understanding that laparoscopy in Mogra and its vicinity is more convenient than tubectomy in many ways.

Survival of a few children, including sons, is a crucial factor behind the decision to sterilize. All the sterilized persons have as many children as the non-sterilized. Their average number of childbirth's, child mortality and child survival are not very different from those of the others. The average fertility of the sterilized is 5.68 children per couple (husband and wife), while the average child mortality is one child per couple at the time of sterilization. Each of the sterilized persons had on an average about five surviving children, with nearly three surviving sons, out of six children born to them. Only six couples had one surviving son each, while 25 had two; 16 had three; and 12 had four sons each at the time of the wife's/husband's sterilization. As already noted, to have only one son is to put the parents in a dangerously precarious condition.

Most of the sterilized husbands/wives having only one son had sterilized themselves after having several daughter, and after having reconciled with their fate (of having only one son). More than one half of the sterilized (36 out of 64) have experienced no child loss in their fertility careers. Table 7.1 depicts fathers/mothers by number of children born, dead, and surviving to them at the time of sterilization. Of the 64 persons, 28 have experienced the agony of the death of one or more children. Eight of them lost one child, 11 lost two, three lost as many, four persons lost four and two lost five or more children each. But none got sterilized before assuring themselves of the survival of the required number of children. Forty two of the 64 have 4-6 children surviving, 15 have 1-3, 6 have 7-9, and one has more than nine surviving children. The sex break-up worked out from Table 7. 1 shows that more sons (178) than daughters (137) were surviving in the case of a majority of parents when they sterilized themselves. Thirty eight of them had proportionately more sons and 10 more daughters surviving. Only 12 had an equal number of sons and daughters. The value of sons is indicated by the fact that three persons got themselves sterilized without any daughter being born to them, while none got sterilized without the birth of a son or soon after the birth of daughters.

Table 7.1: Distribution of fathers/mothers by children born, dead and surviving at the time of sterilization

No. of Chld	Number of fathers/mother with								
	Children born			Children dead			Children surviving		
	S	D	T	S	D	T	S	D	T
0	0	3	0	49	40	36	0	3	0
1	5	16	0	8	14	8	6	21	0
2	23	15	2	3	7	11	25	21	3
3	11	9	11	3	2	3	16	10	12
4	12	12	10	1	0	4	12	3	14
5+	13	9	41	0	1	2	5	6	35

Note: Chld = children; S = Sons; D = Daughters; T = Total

The sex proportion of a couple's children dead before the time of sterilization is important to place it in perspective. While only 15 sterilized persons had experienced a son's death, as many as 24 had lost their daughters, and 36 had lost none. It is well known that sex distribution of children at birth is in favour of boys all over the world. So also, of 315 children born to 64 persons, 178 (56.5%) were boys and 137 (43.5%) girls. The data on child mortality for all 713 couples in Mogra discussed in Chapter 5 reveals higher female mortality. In the case of 64 couples, the survival rate among boys is almost 85% compared to 72% among girls. Male child mortality (15.16%) is lower than that of females (28.46%).

But these averages should not convey that every couple had experienced child mortality. Although 36 persons did not suffer directly the tribulations of child mortality, they had indirectly experienced it occurring around them. Thus, they did not want to take any risk, and got themselves sterilized only after having at least two surviving sons and a daughter, normatively held to be the minimum. No one decided on sterilization before a few of their children's survival could be hoped for. This criterion also applies to the youngest age group (up to 25 years) of the sterilized persons. All the children born to them were surviving at the time of sterilization. On an average, the younger couples had nearly four children each before one of the spouses got sterilized, because they did not find it worthwhile to continue to bear more children. Child death after one's sterilization cannot be ruled out. Of the 64 sterilized persons, four lost one son, and three lost one daughter each after their sterilization. The fear of the possibility of child mortality after sterilization rarely encourages couples to get themselves sterilized as soon as they have two or three children, including one or two sons. There is only one couple with two sons, three couples with two sons and one daughter each, and two couples with one son and two daughters each

who put a stop to their reproduction by means of sterilization. None of these six couples lost any child.

The data shows a marked decrease in child mortality in recent times, especially during the past decade as mentioned in Chapters 3 and 5. Persons belonging to different ages have different experiences of child mortality. The younger persons have lost fewer children than did the older ones. Mothers above the age of 30 have lost 22-25% of the children born to them, those in the age group of 26 to 30 have lost 11% of the children born, and those below 25 have lost none. The general experience of child survival in the community assured these young persons of the survival of their children after they had over two sons and a daughter on an average.

A comparison of the average number of child births and child deaths per person (see Table 7.2) shows that people get themselves sterilized only after assuring the survival of the socially expected number of children. Persons who did not lose any child were the only ones to have sterilized themselves at a very early age. Those persons who suffered higher mortality of children sterilized at a sulater age. Child mortality dissuades couples from accepting sterilization. Couples as well as their relatives wish to see that at least a few children survive. To ensure about five surviving children, including at least two sons, it is thought rational to have one or two extra children. This logic is used even by those parents who have not lost any children. The termination of reproductivity is thus pushed somewhat further and the time range of active fertility is stretched. The total number of children born thus increases as parents keep a margin for losses. Table 7.2 shows how fertility and child loss are concomitant with delayed birth control among the sterilized. Older mothers have higher average fertility as well as child mortality, compared to younger mothers. But the average child survival figures show lesser variation across age groups (3. 5 for mothers aged between 21 and 25, and four for those above 46).

Table 7.2: Distribution of average fertility, child mortality and child survival per couple by mother's age

Mother's age (in years)	Fertility	Child mortality			Child survival
		Before sterilizing	After sterilizing	Total	
21-25	3.6		0.07	0.07	3.5
26-30	5.0	0.7	--	0.7	4.3
31-35	6.2	1.3	0.2	1.5	4.7
36-40	8.0	1.3	0.5	1.8	6.2
41-45	8.0	1.8	0.2	2.0	6.0
46+	7.0	3.0		3.0	4.0

The distribution of fertility and mortality by mother's age is an important indication that a person does not decide to get sterilized exclusively on the basis of his/her own fertility experiences. The couples do not view their fertility experiences in isolation from those of others ' around them before deciding to stop procreation. Of the 64 persons who terminated their fertility career, senior mothers aged 36 and above had higher fertility as well as child mortality, in contrast to mothers in the 21 to 35 age groups. This can be explained by the collective experience of mortality being an important aspect of a couple's behavior as discussed in Chapter 5. Even if an individual could escape the trauma of child mortality, the, couple continue to be influenced by the wider experience of child mortality in the community. As a corollary, it is rare to find a person sterilizing him/herself after one son and one daughter, or two sons and one daughter, are born. He/she waits for a few years to be assured of child survival before putting a stop to procreation.

However, with the recent decline in child deaths in the community, younger couples have had relatively lesser exposure as well as self-experience of child mortality. They have lesser fear of losing their children than their seniors. They feel little need to produce more children to compensate for an eventual loss, while older parents with greater exposure to child mortality sterilize only after sufficiently providing for the loss of a few children. But this does not mean that they go on producing children as long as they can. The distribution in Table 7.2, especially of child survival, supports this observation.

Another important factor for sterilization is attainment of the status of mother-in-law. Of the sterilized women, 16 are aged 36 and above-an age when most women are likely to become mothers-in-law. Of the 16 women, as many as 14 had become so before sterilization. One mother-in-law got herself sterilized even though she was below 35. Several young women aged between 31 and 35 also got themselves sterilized as they were to become mothers-in-law in the coming one or two years.

The mothers-in-law prefer to end their fertility to avoid conception and consequent ridicule. In addition, they have the advantage of grown up daughters or daughters-in-law living with them whose presence is helpful in overcoming any ill-effects of sterilization. They take up major household responsibilities and enable the sterilized woman to have the required rest.

Thus, sterilization remains within the traditional value-frame for older as well younger couples. It helps stop childbirth's after one's grown-tip children enter their reproductive life. On the other hand, sterilization enables the couple to avoid the birth of an unwanted child. This is particularly so when the couple has secured the socially optimum fertility and child survival. Sterilization is adopted

by one of the spouses as a means to an end, once they fulfill the conventional fertility norm.

The limited scope and relevance of FPP in Mogra may be compared with Kara and Sinha's (1987) study of the impact of FPP in India in general and Orissa in particular. Their study points out that FPP made little dent, as the number of living children in all cases of tubectomy and vasectomy exceeded three. There is sufficient empirical evidence that people observe strictly the social norms of fertility behavior. The Khanna villagers (Wyon and Gordon 1971) accepted contraceptives only as far as they dovetailed with the norms. Contraception did not alter the community norm as to when to have children, how many to have, and when to stop having them. Only women who were over 30 and approaching the traditional terminal stage of child bearing used contraceptive tablets. Instead of cutting down the birth rate, the tablets enabled them to live up to traditional norms with more modem techniques. Similarly, Dandekar (1959) observes that the attitude towards family planning was more favourable among couples with three to five children in the six rural communities she studied in India. FPP could only narrow the gap between the socially expected and the actual family size. It reinforces traditional ideas of family size and fertility by shortening the active fertility duration.

Our material suggests that the people who adopted sterilization have in no way digressed from existing norms about the socially optimum family size. The family planning package is accepted only to the extent that it is instrumental in supporting expected fertility behaviour. Although the technique of sterilization to control fertility is unconventional and its adoption a sort of deviation, it hardly upsets prevailing meanings and practices associated with the traditional reproductive career. Similarly, sterilization, especially by laparoscopy, does not interfere with a woman's routine activities. Although people do not deviate from their cosmologies in accepting sterilization as a technique to terminate fertility, they are rather indifferent to the meanings associated with FPP by planners. This is the context in which FPP is locally unpackaged.

A few of the 68 educated and naukri-(salaried job) holding fathers in Mogra are not identical with their illiterate counterparts in fertility behaviour. The former do adopt some modem birth control techniques but only after achieving the socially expected minimum, i.e. at least two sons and a daughter.

> *Kana Patel is a college dropout and clerk in a government department. He has three children with over four years of interval between each of them. His eldest child, a daughter, is married. His wife got herself sterilized a year before their daughter's muklawo. Anil Charan, with a Ph.D. degree, has nearly five years' gap between his two sons.*

Shera Patel, employed in defence services, has three years' interval between each of his six children.

Inda, a young childless Raika, employed as a police constable, feels awkward that his mother is pregnant, although he has been married for two years.

Binja Patel, a school teacher in his late twenties, has stopped bearing further children after having three of them (two sons and a daughter).

Gokal Bhambi, a schoolteacher, put an end to procreation after having four children (three sons and a daughter).

The above examples enable us to discern that education and *naukri* together make a mark at least on some couples' fertility behaviour but only insofar as they adopt modern measures of control after they achieve the socially minimum fertility. However, in the case of several other couples, this combination has little influence on their fertility.

Shera Patel sent his wife for tubectomy when his three sons and two daughters, of the six children born, were surviving with good health. He allowed tubectomy primarily because of the compulsions of urban ethos, to avoid being ridiculed for having a large number of children, or feeling awkward in social gatherings where his counterparts have fewer children. Even his illiterate counterparts in the village do not consider it proper to have more children after these many.

Inda felt awkward to see his mother pregnant more because of the traditional norm that enjoins termination of fertility when the offspring are married.
Other educated *naukri*-holders tend to follow traditional fertility norms more closely.

Despite education and urban jobs, Ajay, a Charan clerk and father of three, Hetu, a Charan peon and father of six daughters, and Kewal, a Patel factory worker with two children, have two years' spacing each between their children, which is in conformity with what others follow in the village. The only Charan girl Ansu, is married to a lawyer in another town and holds an M. Sc. degree. She has had five daughters in 10 years of marriage. She will not stop conceiving till she has a son.

Irrespective of urban jobs or the level of education, social expectations and values regarding sex and number of surviving children continue to dominate a couple's decision to stop or continue child bearing. The individual couple rarely decides their fertility career independent of social norms and compulsions from kin, neighbours and the community. This is clear from the number of children born to educated and *naukri*-holding parent(s).

Decision to get Sterilized

Despite the non-interference of FPP with prevailing fertility norms, sterilization is not unanimously approved. As its practice is unconventional, it evokes disparaging remarks, ranging from opprobrium to ridicule from people. Nevertheless, sterilization occupies a place within the permissible range of deviance.

Almost every woman in Mogra is in a dilemma while deciding about sterilization. A number of countervailing factors impedes her decision. First of all it interferes with hard labour and what is worse she can secure no exemption from household chores on this count. Secondly, dependence on senior members of the household makes it mandatory for her to take their permission. In this respect, men are more independent and can take their own decision without seeking the concurrence of their wives or senior household members.

Women consider many factors before they opt for sterilization. We have already discussed the desire of mothers with growing children to terminate their fertility career. Also, a couple's fertility is terminated only when they have attained the eligibility to do it. This does not mean that the eligibility to stop procreation leads automatically to a decision to get sterilized. Sterilization is not accepted as though it were a normative precept or an undisputed maxim. Quite the contrary. Both men and women encounter moments of wavering before making up their mind. Women are of course free to ventilate their agony, but they do not enjoy the same freedom as men do to get sterilized.

Even if a woman is keen, she has to consider the reactions of her husband and other close relatives, especially those in the conjugal household. At the same time she has her own fears about surgery and its adverse after-effects, which in popular opinion renders people incapacitated. As regards vasectomy, people believe that, 'male operation is like castrating a calf. A sterilized male cannot be a bull.' Similarly, there are apprehensions that sterilized women will suffer pain in the limbs, including backache and other ailments that reduce stamina.

A person is initially confronted with all popular fears, in the process of deciding to sterilize. During this phase, the fears are sorted out individually. Not all women manage to overcome the apprehensions and remain indecisive. A few men and women confessed to me that they were scared of surgery, and dropped the idea of getting sterilized.

Almost all sterilized persons had shared their fears with close friends and relatives. In such informal discussions, the decision is discussed threadbare with a mixture of humour and seriousness. The pros and cons are weighed. While

some fears are dispelled, others are reinforced. However, a favourable disposition resulting from prolonged discussions does not always lead to a positive decision. The discussions that took place in a circle of close friends now shift to the spouses. The spouse with higher motivation to get sterilized takes the initiative. The themes related to sterilization are repeated. In a sense, the state of indecision is prolonged. From the pool of collective memory, the couple recalls and discusses other couples' varied experiences. For instance, they recall cases of those who had no post-surgical problems. Those with many children and very little land, those, who sterilized soon after having the socially minimum number of children etc., are recalled. During such discussions the spouses waver between the two positions: one, in favouring and the other against. It is rare for husbands to give unqualified permission to their wives for sterilization, especially if they are living in a joint household. In the latter case, parents have greater authority over the couple in such a matter. However, there are also instances where parents are overruled. While the majority of women seek their household elders' permission, most men do not wait for it.

For a woman the permission of the parents-in-law, particularly the mother-in-law, is crucial, if she is residing with them. As a manager of household affairs, the mother-in-law's opinion and judgement matters considerably. As knowledge about post-surgery complications is common, the mother-in-law is apprehensive. She feels concerned primarily about the adverse impact of sterilization on the daughter-in-law's health and hence on the household routine. Her main anxiety is that if the daughter-in-law's health were impaired the household routine would be seriously disrupted. The breakdown would not only burden household resources but also strain its relationships. The common reaction of most mothers-in-law is one of disapproval, reflected in loss of temper. They vent their premonition that the household would be ruined if the daughter-in-law gets sterilized.

These initial reactions are usually followed by more definite responses. They are of three types. First, the mother-in-law might leave the entire Matter to the son and his wife. While keeping her fingers crossed, she restrains herself to merely explaining the undesirable consequences. In a sense, there is in this posture a conscious attempt to relinquish responsibility in the matter and to shift it on to the couple. This response is indicative of helplessness, an apprehension of the possibility that her words might be dishonoured. This kind of response is uncommon, as we shall soon see.

A second typical reaction is outright displeasure. It is justified on the ground that the daughter-in-law's decision is an expression of both ignorance and irresponsibility. It is ignorance insofar as she displays little awareness of the adverse consequences of sterilization on her health and strength to perform hard

manual labour. The desire to get sterilized lacks maturity in that it fails to appreciate the problems it is likely to engender. The daughter-in-law is considered irresponsible insofar as her desire ignores the possible breakdown of the household in case of post-surgical complications. The mother-in-law usually resorts to a personal threat by declaring that she would be least responsible in case of any problem. It implies that the daughter-in-law shall have no claim to any concession in work for rest, recuperation and treatment in case sterilization indisposes her.

Bhoori had pointed out categorically to both of her daughters-in-law who had made up their mind to get sterilized: 'You will have to suffer for your deeds. Don't expect that you will he relieved from household work after the operation. You are doing this while knowing fully well how it disables a woman for hard work. You will have to bear the consequences if the household suffers.'

Mothers-in-law thus make it dear that there is little reason to allow the household to suffer by relieving its active members. In such a situation, the husband either chooses to remain silent or wavers between the stands taken by his mother and wife.

Vena, father of two sons and two daughters, initially agreed to his wife getting sterilized but revoked his concurrence immediately after his mother stressed her disapproval. He had almost agreed with his wife after she convinced him but chose to remain silent when his mother spoke against the decision.

Both the husband and the mother-in-law share a premonition regarding the woman's well-being and its consequent impact on the household. Of course, if they are party to the decision, they would be obliged to allow concessions and bear the added burden.

There is an additive dimension that prevents the mother-in-law from granting direct permission for sterilization. This relates to her managerial shrewdness, which tells her that even if there is no post-surgical complication the daughter-in-law might demand exemption on this count. Therefore, even if the mother-in-law is convinced about the merits of sterilization, it is seldom expressed in her readiness to allow her daughter-in-law to get sterilized. In such a condition the daughter-in-law's decision to get sterilized always appears contrary to the household elders' wishes'

A third typical reaction of the mother-in-law is outright rejection of the very idea of sterilization. They maintain an aggressive posture, which unequivocally dismisses the artificial termination of fertility. Most of such mothers-in-law have experienced mortality either of their own children or of their siblings.

Vaddi, aged 60, experienced the agony of mortality right from her childhood. As a child, she witnessed the loss of a few siblings and as a mother she lost all four children. Such a trail of misfortune continued even in the case of her near relatives, particularly her husband's brother's family (all except one boy and a girl died). Given this background of personal tragedy, Vaddi turned hysterical whenever sterilization was discussed.

Vaddi's adopted son's (her husband's brother's orphaned son's) wife, a mother of four daughters and two sons, recalled vividly: 'I wished to get sterilized after I had four children. Upon hearing this Maaji (mother-in-law) got so wild that I dared not mention it again. She called insulting names to those who had sterilized. To her they were blind and crazy. How can I tell her that even I want to get sterilized?'

Only a minority of mothers-in-law are disposed favourably. Such a mother-in-law will readily allow her daugher-in-law to go for sterilization. The permission however, derives its rationale not from FPP but from the compulsions of household routine and traditional fertility norms. The household may not depend entirely on the daughter-in-law's labour, because there are grown up children and other household members who can shoulder extra responsibility in an eventuality. Another reason for ready permission may be that the daughter-in-law would have transgressed social norms of fertility by producing more children. Some of her children may have reached marriageable age while others may have embarked upon their fertility careers. Sterilization is thus readily accepted to avoid the ridicule of producing children while one's grandchildren are due.

Devi, an elderly mother-in-law, is one of the rare examples. She accompanied her daughter-in-law all the way to the city for sterilization. After Devi's eldest granddaughter had been married off to her conjugal home, Devi had a strong desire that her daughter-in-law should end her reproductive career.'

A woman living in a simple household faces an entirely different set of problems compared to one living jointly with her parents-in-law. It is important to recall that a woman usually secedes from the joint household after a few years of marriage, by which time she attains motherhood and may have two or more children. By the time she establishes and manages her nuclear household efficiently, she bears one or two more children. It is at this time that she begins to contemplate termination of fertility. By this time she reaches the age of about 30. Many a time she thinks of getting herself sterilized. In Chapter 5 we have discussed a senior woman's responsibilities, multiple roles and greater interest in managing the household. Her primary interest lies in continuous hard work. Sterilization is not an easy decision when a woman is so preoccupied with the

household. The overall responsibility of the household makes her think about all those issues, which a mother-in-law raises before allowing her daughter-in-law to get sterilized. But once a senior woman decides to get herself sterilized, she somehow manages to seek her husband's support, which makes the decision less difficult for her than for a daughter-in-law living jointly in a complex household.

Phooli, aged 35, initially discussed her desire to get sterilized with a friend who had prior experience. She then discussed the matter with her husband who agreed without much hesitation. Eventually, she got herself sterilized through laparoscopy in a family planning camp organized at Mogra. She chose an appropriate time-just a few months before she was to send her daugher away to her conjugal household for muklawo.

Disapproval by the husband or the mother-in-law is not always an effective deterrent to a woman's final decision to get sterilized.

Sugan, a young Charan woman in her late twenties and mother of three sons, always felt disgusted with her husband's indifference to her desire to get sterilized. He always diverted the issue and gave her false promises that her sterilization would be arranged. As time passed, she feared another conception. During one of her occasional stays at her parental home, she got herself sterilized, much to the displeasure of her husband and mother-in-law.

Bhanwari, a middle-aged Harijan woman, mother of four sons and a daughter, felt exhausted by the continuous bearing and rearing of children alongside regular wage work. Her husband, who lacked sympathy with her situation, always disapproved of her desire to get sterilized. One day she could not resist and went to the village camp for laparoscopy. On her return, she found her husband fuming in anger. He ordered her to leave his house and even hinted at divorcing her. It was only with the intervention of neighbours and friends that she could save herself from his wrath.

The women who acted in open defiance of their husbands' and in-laws' wishes were sure of their strength in the household. It derived partly from a few healthy surviving sons. This provided ample assurance to the mothers that their position in the household could not be easily destabilized.

Sugan offered a vivid narrative of how she finally convinced her husband inspite of his strong reactions against her act: 'If we get a fourth son, how little land will each of the sons get! And if we had any daughter, how can we afford to marry her? The dowry expenses are rising day by day. Your salary is just sufficient to support the three boys and to educate them. Your opium addiction is no less expensive.' Sugan recalled that it took time before such an explanation finally pacified her husband's anger. She maintained that although the reaction of her husband and mother-in-law was hostile and painful (in the sense that she was not allowed to take proper rest after

the operation), it did not last long. She summed up her gain, 'Whatever it may be, I am not reproducing like a goat.'

The foregoing description depicts the social resistance encountered by a woman in the process of deciding about sterilization. The tension between the woman's decision to get sterilized and the social resistance reveal significant principles of social organization within which fertility behaviour takes place. The process also highlights how the status of women ranges between moments of subordination and assertion in their attempts to control fertility. In other words, women have to submit to pressures from household elders on certain occasions, and are able to overthrow the pressures on other occasions.

It is significant to note that none of the sterilized women dared do so without making an effort to seek permission of the husband and household elders (cf Caldwell *et al*. 1984 for this practice in South India). The few women who picked up courage to get themselves sterilized in open defiance of the husband and household elders may convey an impression that they were bold enough to take radical steps. But these women had overruled disapproval only after an overall assessment of their socially optimum fertility performance and their consequent status in the household. Only upon securing their expected fertility achievement did these women take to sterilization. It was accepted as an effective means of putting an end to their fertility career, which had reached an optimum point within the traditional norms. What appears to be a violation of fertility norms is in fact its reinforcement.

Responses to Sterilization

The villagers' response to sterilization ranges from outright disapproval on the one hand to willing approval on the other. In between there are responses of ridicule, gossip, sacrasm, halfhearted acceptance, prudent indifference, etc. These responses are seldom arbitrary. They contain pointed references to people's experiences of fertility and child mortality. In most cases the responses come from the older people who have had greater exposure to high mortality during their younger days. Both over and under-conformity fertility norms evoke negative responses. Those who have got themselves sterilized after having just three or four children are believed to have ignored the child mortality of others in the village. To opt for sterilization in the face of imminent child mortality is to be blind.

Some reactions hardly assign a substantial reason against sterilization. Often the act of sterilization is criticized as unconventional. Such criticism, however, should not he taken merely at its face value. The disapproval is based on the elder's practical consciousness, which is rarely expressed elaborately. A serious

examination unfolds the imperatives of a subsistence- and labour intensive economy and high child mortality circumscribing the fives of people in Mogra. Getting sterilized after having three or four children is seen as refusal to recognize the real conditions. However, many young, and a few old, people are favourably disposed to sterilization, especially after a couple have had a few healthy grown up children.

Bijoji, an old man owning a small patch of land, was perturbed when his only daughter gave birth to eight children in quick succession with two years' gap between each of them. He confided in me: 'It is no point having so many children without a stop. Three or four are enough. There are several means to put a stop these days. See how the whole house is littered.'

Those couples, all of whose children are surviving, give an impression of being more prolific than others. Having eight children with the eldest one about 16 years is exceeding the traditionally optimum fertility. With the eldest child reaching marriageable age, the household and other elders begin to get worried. They are anxious that such a couple cease to procreate any further.

Kera, a 36-year-old Patel, had one son and a daughter. His first child came after a long wait of 12 years. Despite such an experience, he did not like the idea of having many children. He emphasized: 'I will wait for two more years. May be, In get one more son. If 1 don't get a son in two years, I win put an end to this business (of procreation)'.

Devi, an elderly woman with five daughters, two sons and 15 grandchildren was convinced of the utility of sterilization, so much so that in her enthusiasm she willingly accompanied five women all the way to the hospital in Jodhpur city for operation. She looked after the five women and their infants for two days during their stay in the hospital. All these women were Devi's relatives. One of them was her daughter, while another her daughter-in-law.

Madi, a 62-yeu-old woman, was all in favour of getting her daughters-in-law sterilized. She arrived at this decision after her eldest daughter-in-law had three children and the next one, five.'

Kera, Devi and Madi have a few relatives in Jodhpur city. In addition, they have easy access to medical facilities as the doctor and nurse living in the village are their neighbours. Devi and Madi have several children and many more grandchildren. Neither of them has lost any grandchildren. The company of the doctor and the nurse has helped them favour sterilization. Such an approval of sterilization is not always forthcoming.

Several young persons make fun of those persons who get themselves sterilized.

> *Hadi, a young man, ridiculed Bhera for his inability to control his wife from getting sterilized. 'Can't you even control your wife, or are you henpecked?' Choonoji, on the other hand, was rather indifferent and unconcerned about Bhera's wife's sterilization: 'It is their (Bhera's and his wife's) business. We can't stop it.' Vanji reacted in his peculiar way: 'This is in fashion these days.'*

Even younger women drew caricatures of other women upon their sterilization.

> *Veeri Darjee, a mother of four children, mimicked Ansi's awkward gait soon after her tubectomy in the city hospital. She also mimicked the gait through a play of her two fingers. She commented: 'It is so embarrassing to walk like that through the streets before so many elders. I would rather not get sterilized than walk awkwardly.'*

As already discussed, sterilization is not a traditionally accepted practice, nor has it become very popular. Those getting sterilized have to face various ludicrous reactions. A pregnant woman's gait is seldom considered awkward, or ridiculed. Mimicking the changed gait after tubectomy is an expression of the cultural distinction of what is held as normal and abnormal.

A large number of people do not appreciate the new 'craze' for sterilization, and disapprove the technique disparagingly.

> *Kesar, an old Charan woman with five sons and one daughter, did not approve of sterilization. She wanted her sons to have more than two sons each. Her desire got further strengthened as one of her sons could not produce a child despite more than a decade of marriage, and her only daughter lost her husband within two months of her marriage.' These experiences raised her doubts about sterilization and further strengthened her desire for high fertility.*

Elderly parents become sensitive about fertility control, especially after the experience of prolonged childlessness of their married children. A large family is a matter of prestige for them.

> *Bhoori, an old woman and mother of three sons and a daughter, had her own justifications against sterilization: 'I don't know what these younger women are up to. We never got ourselves mutilated like this. Mutilation for what? They are not better off than we. They can't sit back in a luxurious 'swing' (hindo) with a foot resting on its edge and relax in a queenly way. Their life is no better than ours. What they derive out of such a step, only they know.' However, all her three daughters-in4aw got sterilized after two of them had four surviving children each and the third*

had three with two surviving sons. Even her daughter underwent tubectomy after having three healthy sons. She fails to understand why her daughters-in-law and daughter should get sterilized.

As already mentioned, most elderly persons continue to fear high child mortality. Some of them took a tough position in not permitting younger women in their households to get sterilized.

An old lady, addressed as Vaddi by most of her clan members, was so averse to sterilization that she would immediately become abusive whenever a reference was made to it. She would not only lose her temper and burst out emotionally while abusing people but also offer reasons for her negative reaction. During an interview she remarked: 'All those who are getting themselves sterilized are simply stupid. They do not understand any thing about life. They are going against God's will and life's wisdom. If the government claims to be powerful enough to stop more children through those white-attired doctors, then why can't it provide children to those who are sterile and barren? It is only when it does so, can I believe in its superiority and power. Otherwise anyone can cut a 'cord' (nad) and commit the crime. Only the provider has the right to stop, those who can't provide have no such right. And what about bringing back to life those who die? What if your children die after your operation? Of what avail is the operation in such an eventuality? Of the three sons I had, two died in childhood and the last one died when he was old enough for muklawo. He was my only hope. The doctors couldn't save him. I was left with no one in the world. Man is helpless before death. Then, where is the wisdom of getting sterilized? It is nothing but madness.'

Vaddi spoke in an intensely emotional way under the burden of her life experiences full of successive tragedies. She constantly carried the agony of losing all her family members and being left with none. To further substantiate her point she said: 'My husband's brother's daughter also had no children despite 20 years of marriage. The latter had a daughter who died within a few hours of birth and no child was born at her after that.' To her, children are hope; the more of them the greater the hope. Naturally, sterilization is termination of life and willing invitation for hopelessness. Vaddi's biography is replete with the wrath of child mortality which has left her 'With no strength even to tolerate others putting an end to their fertility.

Chidi, an old Harijan woman, strongly disapproved of the emerging trend towards fertility control. She was provoked when she overheard her daughter-in-law, a mother of four sons, being interviewed on the issue. She said: 'No one should get sterilized. There is no guarantee of life these days. Times are very adverse. There is a lot of sin spread all over the world. What can a woman do if all her children were to die after sterilization? In Tanavara (a neighbouring village) a Sargari (woman of Sargara caste) underwent tubectomy last year. She thought the three sons she had were enough for her. But as unfortunate as she is, two of her sons died of fever within two

days of each other, and another died a month later. All the three healthy boys simply slipped out of her hands in less than a year of sterilizing. She couldn't help at all. She would only weep and wail. All this has driven her to mental illness and she talks incoherently. Her life is ruined. I will not permit my daughter-in-law to do such a thing. We will all share what we have. We will eat half instead of one (Poori khjta adi khaon) and be satisfied rather than ruin ourselves by trying all kinds of nonsense. It is a sin to sterilize and the sinner is punished sooner or later. Sterilization leads to suffering.'

The adverse effects of sterilization are vividly recalled which deter several others from mustering courage to opt for it. Most of the elderly people disapprove of it partly from fear of post-surgical complications. The prevailing cosmology supports people's doubts about fertility terminating measures, especially sterilization.

Jhammu, a young woman in her twenties, was apprehensive about her future incarnation because of sterilization. 'So many people have told me that sterilization amounts to torturing all those beings who were destined to be born to a woman. Denying them entry in this world does not absolve the woman. She will have to bear all the remaining children in het next incarnation. There is no respite from this. One has to finish one's task before attaining gati.'

The apprehensions and premonitions pertain not only to some of the actual fertility experiences of people and of those who got -themselves sterilized, but also to the religious and moral notions of procreation and of karma that a couple is destined to fulfill. Some of the elderly take the cosmology more seriously than others in not permitting their young daughters and daughters-in-law to get sterilized. As sterilization is a relatively recent, unconventional technique, the elderly rarely welcome it. Factors such as fear of child mortality, post-operative debility, and interference in religious and moral precepts, constitute the mixed reactions to sterilization.

Conclusion

As none of the modern contraceptive and sterilization techniques has indigenous cultural moorings, the village people experience a variety of tensions, uncertainties and indecision in adopting them. The family planning techniques are definite indices of change but have not radically altered the continuities in the norms of fertility behaviour.

People's acceptance of FPP is partial, and is mediated by prevailing norms and values, resulting in selection of its various components. The selective acceptance is only a fraction of the total package, and is conditioned by people's real

experiences in the handling of family planning techniques and consequent accumulated memory. A technique is accepted insofar as it facilitates the norms of fertility regulation. The acceptance of sterilization in no way contravenes traditional norms regarding the onset and termination of fertility, the socially expected number of children, and the status of the woman as bearer of children. The compulsion of strenuous physical work has a crucial role in deciding the choice of the method of sterilisation. Since laparoscopy does not require prolonged absence from work in and outside the household, and is accessible in the vicinity of the village, and sometimes even within it, it is preferred to tubectomy. People's indifference to some of the components of the package is not an indication of their ignorance or non-response as is observed by numerous KAP surveys. On the contrary, people's indifference to many FPP measures is a result of their rejection of them. What KAP surveys call indifference is the other name for irrelevance to people.

Even in the case of villagers having vital links with the city, acceptance of sterilization has not contravened prescribed norms of fertility. In earlier chapters, we discussed the fertility behaviour of those holding urban jobs and/or living in urban areas or of those commuting to the city regularly. They have accepted fertility control only after achieving the socially optimum number of children. Even if a technique reinforces prevailing fertility practices, it is not always accepted unquestioningly by one and all. The responses of the people vary from outright opprobrium to quiet acceptance. This is the way FPP is locally unpackaged. Only those convenient components gain gradual acceptance among some people. Also, only the constituents which conform to the pressures and prescriptions of traditional society find a place in the village society, and of course invite mixed responses.

1. People's notion of health is indicated commonly through two words, fat (mato) and thin (thakodo), meaning good and poor health respectively. A bodily disorder impeding normal course of life is categorized as illness. If an ailment does not hamper one's daily routine, the person is rarely considered as being seriously ill.

2. Laparoscopy is considered to be an operation conducted with the help of *beejli and doorveen*, literally, electricity and telescope.