THE RADICAL POSSIBILITIES OF CONSERVATIVE INSTITUTIONS

AN ANALYSIS OF DEMOGRAPHIC CHANGE

in

MALUR TALUKA
KOLAR DIST
KARNATAKA STATE

Devaki Jain, Bhanumathi Vasudevan, Kathleen Maloney

and

Leela Chandrasekhar

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Sutradar or Story teller

Institute of Social Studies Trust
Delhi and Bangalore
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DEVAKI JAIN
DIRECTOR

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CHAPTER I

INTRODUCTION

The low and uneven impact (over time and by regions) of the national family planning programme throughout the 1960's induced the Government of India to consider measures to improve the efficiency (measured in terms of the achievement of pre-set targets) and effectiveness (referring to the ratio of programme costs to input utilization) of the family planning programme. Priority was given to the formulation and enactment of appropriate methodologies suitable at the regional level.

As part of this initiative, the GOI borrowed a loan of $ 21.2 million fron the IDA of the World Bank and received a grant of $10.6 million from SIDA to launch the India Population Project (IPP-I) for a period of five years from 1973 to 1978. Two states, Uttar Pradesh in the North and Karnataka in the South, were chosen for experimentation with strategies designed to improve Family Welfare (FW) coverage, including MCH, with regard to both the quality and quantity of family planning acceptors.

In Karnataka, the India Population Centre (IPC) was established in Bangalore to evaluate the entire IPP-I and generate innovative ideas to increase demand for family planing services. An "Expert Group" Meeting of about 50 demographers, social scientists, family planning administrators and public health

officials from five districts of Bangalore Division in Karnataka state, was convened in April 1975 at the IPC.

One of the alternative strategies that emerged from this consultation was to entrust the responsibility for family planning implementation and MCH in a rural area covered by a single PHC to a Non-Governmental organisation. (NGO). The assumption was that NGOs enjoy greater flexibility in choice of personnel etc, staff's commitment to a cause, as well as better contact and rapport with potential family planning acceptors than Government bodies. Although in the IPP-I experiment the administering NGO was to be bound by Government rules, the hypothesis underlying this strategy was that the exclusive implementation of the family planning and MCH programmes in rural areas by an NGO would lead to better performance in both realms than if the programmes were run exclusively by Government.

The non-governmental Family Planning Association of India (FPAI) was invited to undertake administrative and technical control of the family planning and MCH programmes through a PHC. FPAI chose to work in Malur taluka, one of the eleven blocks of Kolar District, Karnataka State. Malur Rural Project (MRP) was thus launched as a two-year experiment in 1976 through a PHC that had exhibited a particularly poor performance in the twin realms of FP and MCH.

From April 1976 to March 1977, the spadework for the development of FPAI's first-ever rural project was completed from Malur town,

the taluka's headquarters. One of the most striking features of this spadework was gradual and self-conscious evolution within the FPAI organization and staff - from their initial focus on the narrow objectives of meeting assigned Government targets and improving FP and MCH performance in the taluka (a time-bound, method-centered and goal-oriented approach) - to the broad objective of promoting a holistic, integrated kind of community development amongst the rural population (a client-oriented and community-specific approach). Over the decade, villagers and local institutions thus came to be treated as "partners" by FPAI rather than as "targets" for MCH or FP quotas set by the State or Central Governments.

The Malur Rural Project, conducted by the Family Planning Association of India (FPAI) in South India and spanning the years from 1976-1986, was identified by the Institute of Social Studies Trust (ISST) as an ideal example for documentation and generalisation. ISST's study, commissioned by ILO under the title of "Linking Fertility and Economic Activity of Rural Women" was undertaken in November 1986.

Prior to ISST's review of the changes in the absorption of family planning and development schemes/benefits in Malur taluka over the past decade, the criteria adopted by outside agencies to evaluate the "success" of FPAI's experimental interventions in the area had been almost exclusively quantitative. Macro - statistics had been gathered to measure the positive shifts in Sterilisation Equivalent Rates (SER's), Vital Rates, the percentage of

Government family planning (FP) targets achieved and the percentage of eligible couples effectively protected by contraceptive methods in the project area, yet no study had been undertaken to identify the strategies and methodologies responsible for FPAI's unprecedented and phenomenal success in Malur taluka from 1976-86 in boosting family planning adoption and mobilizing the community for socio-economic advancement, especially with respect to women.

By as early as 1977, the declared objectives of FPAI had been enlarged to encompass the support of community welfare work, especially through the formation and revitalization of Local Voluntary Groups (LVG's) such as Mahila Mandals (MM-Women's Clubs), Yuvathi Mandals (YM - Young Women's Clubs) and Yuvak Mandals (YC - Youth Clubs). FPAI identified these LVG's as suitable agencies for the itegration of MCH and FP with community initiatives and needs. The following two years ushered in the "experimental phase" of MRP, consisting of multi-pronged attempts by FPAI to involve the Malur community in socio-economic activities and local institution-building. A variety of new services were delivered by FPAI in the taluks with the following stated goals in mind:

1. to activate and educate community organizations on a self-help basis to initiate, plan and implement need-based developmental activities including those of family welfare and MCH services on a continuous basis;

2. to assist and guide the community in making use of available facilities, including health and family welfare services, offered by Governmental and Non-Governmental agencies and progammes;

3. to increase the level of family planning acceptance in the project area by bringing about the integration of family planning with other rural development activities.

Between 1980-83, FPAI displayed an intense determination to increae local participation in FP and MCH activities in order to promote the acceptance of the small family norm as an integral component of individual and collective progress in Malur taluka. Since then, the MRP's accent has been increasingly placed on the stimulation of local self-determination through the support of LVG's and the recruitment of both men and women into income generation schemes. In 1985, FPAI's number one goal, as outlined in their Annual Report, was "to assist atleast one-third of the project villages to become self-reliant in terms of the planning and implementation of more than half of the Project's developmental activities in their own village".

The purpose of ISST's comprehensive case study was therefore to highlight (1) the linkages exhibited between fertility and female economic activity and (2) the qualitative processes and factors associated with the dramatic improvement in the area's overall family planning performance profile over the previous decade.

MALUR: The Backdrop

Malur, one of the eleven talukas of Kolar District, includes 334 villages and a population of 144, 535 (1981 Census) spread

over an area of 647.5 square kilometer, with 11,431 people living in Malur Town, located 48 kilometers east of Bangalore, the state capital of Karnataka.

Approximately 25% of Malur taluka's residents are landless. According to the 1981 Censu, 25% of the population belongs to the Schedule Castes (SC's) and 8% comes from Scheduled Tribe (ST) Communities. The State Minimum Wage Act has fixed the minimum wage for both men and women at Rs.12.00 per day for work (8 hours) on dry-lands and Rs.10.00 per day for work on wet-lands (7 hours). Women working in local tile factories are paid an average of Rs. 5.00 per day while men in these same units receive wages of Rs.8.00 per day.

Agriculture is the mainstay of the Malur's rural economy. Ragi (one type of finger millet) crops cover approximately 50% of the total cultivable land area and rice is the other dominant staple grown. Mulberry bushes are also planted on 28% of the available land since silk-worm and cocoon-rearing (for sericulture) provide a major source of livelihood for a significant portion of Malur's inhabitants, especially for women in related home industries. Dairy production and fruit and vegetable-raising farms also engage a substantial percentage of the population throughout the taluka. Eucalyptus plantations now occupy upto 30-40% of the taluka's land.

Only 7.9% of the total geographical area of Malur is used for non-agricultural purposes, including the manufacturing of tiles in about 30 factory units that are primarily fueled by eucalyptus

timber grown and harvested locally. Rainfall only averages 758.9 mm per annum. 22 % of the total crops grown are rainfed and 60% of the area is classified as "dry-land". Only 28,810 hectares out of a total of 63,166 in the taluka were categorized as "cultivable" as of 1983-84 and only 27% of these (out of the gross sown area) are irrigated. Irrigation is supplied predominantly fron tanks (artificial lakes) and lift (well) sources, but for the past six years, Malur has been delared as "drought-prone" and has been facing famine conditions since 1983.

Sixty percent of the villages in Malur were electrified as of 1979-80. There were 120 Adult Education Centres throughout Malur in 1984-85. (The district average per taluka was only 82 in the same year). As of 1983-84, 97 general co-operative societies had been registered. Although 289 out of 334 villages had no medical facilities whatsoever in 1979 (according to the 1981 District Amenities Abstract) and no hospitals existed in the taluka as of 1984-85, there is one Government Primary Health Centre (PHC) serving a population of the block. Six Primary Health Units (PHU's) provide curative, preventive and promotive health services in the taluka. Each PHU covers 15,000 population and is staffed by one Medical Officer, one Pharmacist, three Female Health Assistants, two Male Health Assistant and one Attender. These PHU's are supported by three Auxilary Nurse Midwives (ANM) subcentres, each responsible for serving 5000 people in the area. Maternal and Child Health (MCH) and Family Planning (FP) services are thus dispensed in the villages by these ANM's on a regular basis. ANM's are also responsible for the collection of vital

health statistics and the registration of births and deaths. The village Accountant is the registrr of births and deaths. PHC and PHO staff collect births and deaths during their visits to village and when ANMs conduct deliveries or register post-natal cases.

CHAPTER II

METHODOLOGY

The Survey drawn on secondary and primary quantitative data, as well as interviews through questionnaires and group discussions for qualitative information.

1. Secondary Sources:

Extensive review and exhaustive study of secondary reference materials and sources was made which covered,

- global demographic studies related to women including World Bank Publications ;
- ILO working papers and other studies on female productive and reproductive roles ;
- recent demographic/population studies since the 1981 Census at all-India and state (Karnataka) levels ;
- FPAI's Annual Reports for the period 1976 to 1986 ;
- IPP-I and IPC's evaluation and studies related to MRP and Karnataka.

2. Primary Data:

Two preliminary visits were made to the area for survey and sample village selection.

3. Four different questionnaires were designed for use in gathering quantitative and qualitative data from IPC and FPAI staff, villagers, dais (traditional midwives) and community leaders. The questions were mostly open-ended to facilitate voluntary and spontaneous sharing of views and information although they also concentrated on issues pertaining to FP attitudes/behaviour and women's reproductive roles and status.

4. In-depth interviews with the volunteers and officials from the Family Planning Association f India who worked with FPAI for the last eight to ten years in order to gain their perception ; understanding and insights into dynamics of social change catalyzed by MRP's strategies and methodologies in the taluka. A total of 13 such interviews were conducted.

5. In-depth interviews with representatives of funding organizations for MRP and IPC such as the World Bank and the Government of Karnataka to assess the nature of the relationship between these bodies and MRP and to solicit their perceptions about MRP.

6. Key officials from the State Government's Block Development Office (BDO) and Health and Family Welfare Department as well as from voluntary agencies associated with MRP such as the KSCCW and KSWAB were also interrogated about their impressions and critical assessments of MRP. Auxiliary Nurse Midwives, (ANM's) and Lady Health Visitors from Government Primary Health Centres were also consulted along these same lines.

SELECTION OF A STRATIFIED VILLAGE SAMPLE

As the study was to be small but in-depth, it was decided to select 15 to 20 sample-villages out of the 364 (as per census list including un-inhabited villages) in Malur taluka. Malur taluka is divided geographically into four hoblis and one village from each of these administrative units was chosen so as to capture a wide measure of (and to control for) variation by region.

All the villages were categorized into "high-level" (above 65%) "medium-level" (40% to 64%) and "low-level" (39% and below) groups derived on the basis of the percentage of eligible couples protected by some method of family planning in their respective communities. These categories were derived from the FPAI statistics upto October 1986 which were based on Government Primary Health Centre data for Malur taluka.

A 65% FP coverage rate of EC's in a village was designed as "high" since the GOI's goal is to achieve a nation-wide EC protection rate of 60% by the year 2000 (currently the national average is only around 35% while the State average hovers between 30-40% and the districts at around 40%).

It was decided to include a cross-section of villages stratified by population groupings (the average population of Malur's villages numbers 400-500) as well as the two major towns housing over 2000 people, Masthi and Lakkur.

Since the primary purpose of the study was to explore the linkage between female participation in socio-economic activities and the adoption of family planning in these villages, family planning adoption (FPA) was selected as the baseline dependent variable for our enquiry. Independent variables were drawn up into four major categories:

1. The institutional/infrastructural base existing in a given village, including the presence of:

a) Mahila Mandals (passive, active and non-existent)

b) Youth Clubs (passive, active and non-existent)

c) Income-generation projects and social forestry schemes sponsored by both Government and NGOs;

d) Health services (taking into account the village's proximity to PHC, PHU and ANM subcentres)

e) Other institutions such as balwadis/anganwadis, adult education/literacy centres for women/men, cooperatives, primary/middle/high schools/Junior Colleges;

2. Economic indices:

a) Relative proportion of landless/marginal farmers and manual labourers in the village population (landownership and land-use patterns);

b) Occupation/employment pattern at the village level (engagement in cultivation, agricultural and manual labour, sericulture, dairy, sculpting, mat-weaving, agarbathi-making and other cottage industries);

c) Level of "development" in terms of roads, irrigation facilities, drinking water, banks, provision and type of housing, electricity, communication facilities and distance from major town/city (degree of urbanization/industrialization);

d) Class composition (high/middle/low income groups);

3. Sociological Variables:

a) Caste composition of the village, including scheduled caste/schedule Tribe gradations ;

b) Religious community profile - e.g., Hindus, Muslim ;

c) Level of social and political awareness/activity/ leadership;

d) Level of education/literacy ;

4. Demographic indices:

a) Population as per 1981 Census of each village;

b) Geographical area and size of village.

By taking all of these factors into account with a view to later disaggregating the impact each was found to exert on the over all level of family planning adoption (FPA) in a community, it was hoped to isolate the independent variables most highly-associated with the adoption of family planning norms and practices at both the inter- and intra-village levels. The principal objective was to test our hypothesis that female participation in income-

generation and other socio-economic schemes, especially through Mahila Mandals, has been pivotal in increasing FPA at both the personal and corporate levels in Malur taluka over the last decade. In order to establish whether a direct correlation exists between this factor and higher levels of FPA, it was necessary to select a representative cross-section of villages and consider a wide variety of intervening and intermediate variables besides high rates of female participation in such projects. These included the variables a indicated in the enclosed chart.

Although there were quite a large number of independent variables and sub-variables to consider within the methodological frame-work, their inter-relatedness and overlap made the choice of a representative set of villages less complex. Unfortunately, however, it was not possible to arrive at an even distribution of sample villages by Hobli (geographically). Guidance was taken from the Malur Rural Project's Director, Community Development Workers, Project Coordinators and other FPAI personnel in order to choose an appropriate sample of villages. The list of the 19 sample villages finally selected after lengthy consultations is as follows:

Kasaba Hobli

1. Bopannahalli
2. Chickapura
3. Yeshavantapura
4. Bellavi
5. Sivarapatna
6. Bhoovanahalli
7. Kodur
8. Bingipura

Tekal Hobli

9. Nidiramangala
10. Nutave
11. Huladenahalli

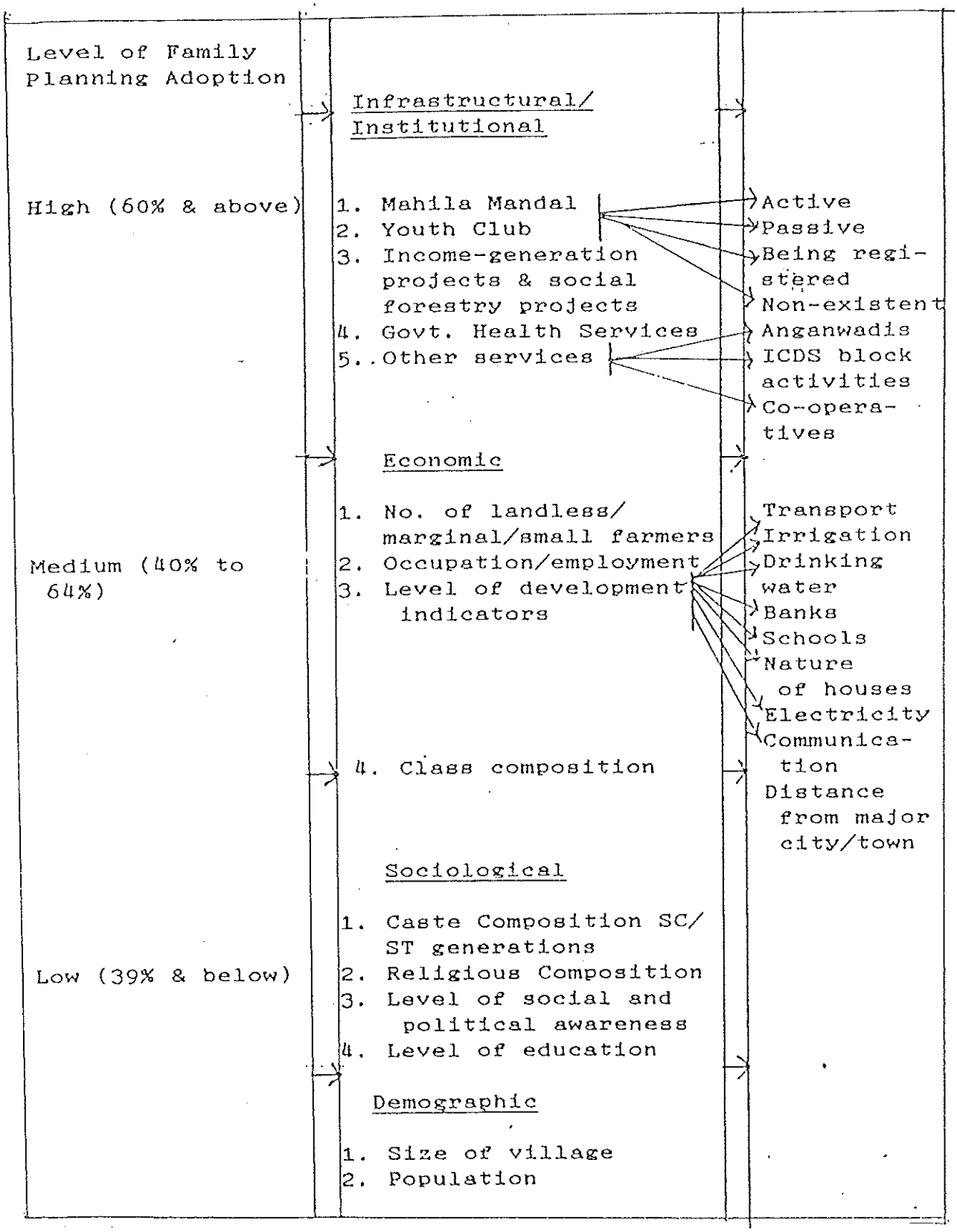
Masthi Hobli

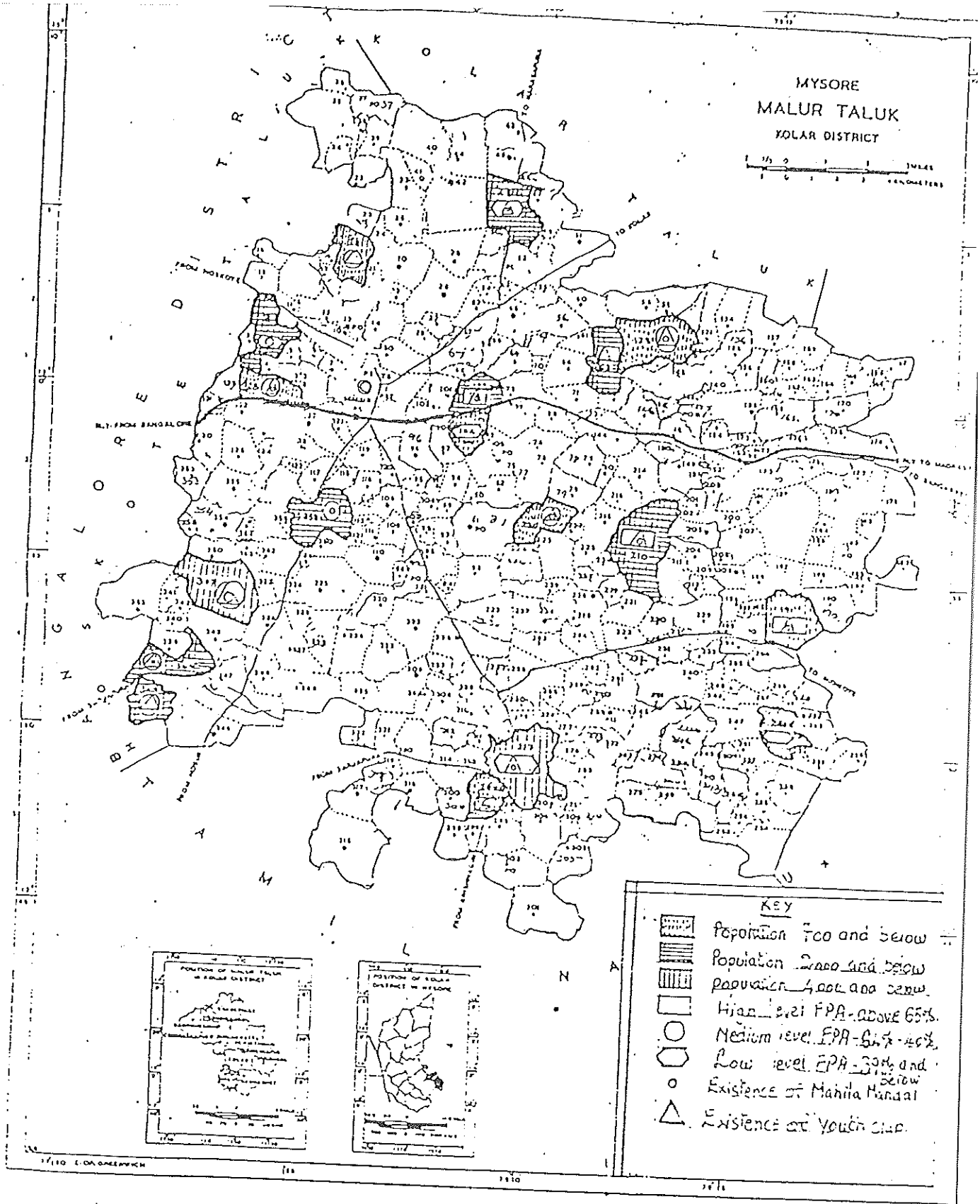
12. Masthi
13. Digoor (a hamlet clubbed with village Gundlapalaya in the Census)
14. Kesagare
15. Thirumalahatti

Lakkur Hobli

16. Lakkur
17. Kalkare
18. Chikkathirupathy
19. Seethanayakanahalli.

(PPlease refer map of Malur Taluka denoting key variables in all ninetee sample villages)


Dependent Variable
Independent Variable
Sub Variable
Level of Family Planning Adoption
High (60% & above)
Medium (40% to 64%)
Low (39% & below)
Infrastructural/ Institutional
1. Mahila Mandal
2. Youth Club
3. Income-generation projects & social forestry projects
4. Govt. Health Services
5. Other services
Active
Passive
Being registered
Non-existent
Anganwadis
ICDS block activities
Co-operatives
Economic
1. No. of landless/ marginal/small farmers
2. Occupation/employment
3. Level of development indicators
4. Class composition
Transport
Irrigation
Drinking water
Banks
Schools
Nature of houses
Electricity
Communication
Distance from major city/town
Sociological
1. Caste Composition SC/ ST generations
2. Religious Composition
3. Level of social and political awareness
4. Level of education
Demographic
1. Size of village
2. Population



KEY VARIABLES AND NINETEEN SAMPLE VILLAGES IN MALUR TALUKA

CHART A

VILLAGE PROFILE CHART

Name of Village	Census Location Code +	Level of FP adoption- (%of Eligible couples protected as per Oct 1986 FPAI statistics)	Population	% of population landless	Literacy Rate Male (calculated from 1981 census) %	Female %	Caste composition ++/ Religion %	Presence of +++ Mahila Mandal	Youth club	Income generation schemes for women
1	2	3	4	5	6	7	8	9	10	11
KESARGARE	297	High 90.78	529	15	44.3	15.4	55 Gowdas 25 SC/ST 8 Achars 2 Brahmin	Yes 1980 SA	Yes 1961/ 1976 SA	Sericulture (Oxfam-Indirect) Pisciculture(YK) Dairy (KSWB)
KODUR	100	High 76.23	720	25	37.6	17.2	80 Thigala 20 SC/ST	Yes 1976/ 1983 P	Yes 1972/ 1977 SA	Tailoring (FPAI+TRYSEM) Dairy (KSWB+IRDP)
CHIKKAHAPPALLI	63	High 73.8	745	20	38.9	.09	50 Vokkaligas 45 SC/ST 5 Nayakas (BT)	No N-E	Yes 1977 A	Sericulture (FPAI)Muthuga-dale (eating-leaf plates) (FPAI)
MUTAVE	191	High 72.05	691	10	27.5	1	65 Lingayats 25 SC/ST 10Devanga, Kusbara Nesaaru	Yes 1981 A	Yes 1976 A	Dairy (IRDP, KSWB) Tailoring (TRYSEM)
HALAGONA-HALLI	210	High 70.96	1216	20	33.4	15.8	55 Vokkaligas 30 SC/ST 15.7 Muslim	Yes 1978 P	Yes 1973/ 1976 SA	Tailoring(FPAI) Coffee powder-making (FPAI) Chamarakes rental Dairy (KSWB)
BELLAVI	13	Medium 60.56	445	15	44	0	80 Lingayat 20 SC/ST/BC	BR	Yes 1980 P	X

BOPPANNA-HALLI	128	Medium 60	450	20	53.6	25	50 Vokka-ligas 30 Lingayat 20 SC/ST	Yes P	Yes 1976 A	X	
CHICKAPURA	126	Medium 57.4	330	50	32.3	14.3	70 SC/ST 20 Vokka-ligas/ Lingayats 10 Mudda-layars	ER	Yes P	X	
LAKKUR	307	Medium 52.38	2696	22	54	27.8	40 Vokka-ligas 31 SC/ST 29 Muslim	Yes 1971/ 1976 YM 1984-A	Yes 1974/ 1980 A	Credit scheme(FPAI) Dairy (KSWMS) Food/condiment-preparation(FPAI)	
THISUVULA-HATTI	226	Medium 49.29	467	20	14.5	17.3	60 Vokka-ligas 40 SC/ST	Yes P	Yes 1966/ 1976 SA	X	
NIDIGA-KANGALA	138	Medium 47.6	654	25	26.5	.07	60 Vokka-ligas 40 SC/ST (Barbara)	Yes 1985 A	Yes 1978 A	Social forestry (Oxfam-America Tailoring(FPAI) Mushroom-rearing (Local)	
KALYANE	345	Medium 46.61	843	15	33.7	15.5	55 Vokka-ligas 40 SC/ST 5 Achars, Banglgas	No N-E	Yes 1976 A	X	
CHIKKA-THIRUPATHI	344	Medium 46	1107	30	57	29.4	40 Vokka-ligas 30 Gangars 30 SC/ST	Yes 1977/ 1983 A	Yes 1974/ 1982 A	Tailoring (TRYSEM) Papad and petty trades	
SEETHANAYA-KANAHALLI	358	Medium 41.65	740	30	59	33	31.6 ST/ST 58.4 Muslim	Yes 1982	No N-E	Food Preparation scheme nippattus, papad (Local) scheme (FPAI)	
SIVAGAPATNA	48	LOW 38.6	1575	40	59	33.8	40 Acharyas (Silpi) 35.5 SC/ST 44.5 Muslim	Yes 1960/ 1985 A	Yes 1946/ 1984 A	Tailoring(TRYSEM) Chandrankes Menta. (Local, FPAI) Muthugadde(FPAI)	

MASTHI	217	Low 34.85	3673	10		41.8	26.6	50 Paleyagar 20 SC/ST 30 Muslim	Yes 1976 P	Yes 1973/ 1977 P	Tailoring (TRYSEM Food Prep./Veg.V ding(FPAI)Paper wire bag making (Local)
YESHAVANTAPURA	8	Low 27.4	1380	25		33	14.6	40 Vokka-ligas 29 SC/ST 11 Paleyagar 33 Muslims	Yes 1965 A	ER	Tailoring (FPAI)
BINGIPURA	104	Low 27.2	347	60		.03	0.00	89 BT (Nayakas) 11 ST	No N-E	No N-E	X
DIGGA Clubbed with GANGAPALYA	260	Low 0	150	25		14	0.02	90 ST(Dasaru) 10 BT(Nayaka)	No N-E	No N-E	X

(Key: + Census Location Code = Placement of village on Taluka map.

++ Caste Groups: Vokkaligas/Gowdas = Cultivating Castes/farmers; SC = Scheduled Caste(Harijans); ST = Scheduled Tribes; BT = Backward Tribe; Lingayat = Shivacharas, cultivators, trade services; Devanga = Weavers and traders; Kumbara = Potters; Nesabru = Weavers; Nayaka = ST = Hunting nomads; Thigala = Horticulture, agriculture, Gardeners; Muddalayars = Gowdas; Achars = Goldsmi Acharyas = Sculptors (Silpis); Bangigas = Bangle-makers and sellers; AK = Adi-Karnatakas= Agri culture labourers; Paleyagars = BC = Hunting, Agriculture, Watch guards.

+++ Date in numerator = when founded
date in denominator = when revitalized
SA = Super-Active, A = Active N-E = Non-Existent, P = Passive, ER = Being Registered
( ) = Sponsoring Funding Organization/group.

Sericulture = Silkworm-rearing, Pisciculture = Fish-rearing, KSWAB = Karnataka State Social Welfare Advisory Board
IRDP = Integrated Rural Development Program (Govt), TRYSEM = Training for Rural Youth and Self-Employment (Govt)
KSWD = Karnataka State Social Welfare Dept (Govt), FPAI = Family Planning Association of India (Non-Govt), Local = Through local Mahila Mandal (Woman's Clubs), Chandrankes = Trays for rearing silk worms, Kuthugade = eating-leaf stitched plates).

(Source for Caste groups: Mysore State Gazeteer, Kolar District, Directorate of Printing at Govt. Press, Bangalore, pp119-29.)

In each of the 19 villages, a purposive sample of respondents was chosen in order to explore the selected variables and their inter-relationship rather than undertaking a random sample household survey. Key informants from the population of each village were identified and consulted. The ensuing in-depth interviews usually lasted an hour and a half and were conducted in the local language - either Kannada or Tamil - and transcribed later the same evening into English. An average of five persons were interviewed per village and were in many cases limited to potential respondents' availability and willingness to answer our long list of questions (see Appendix III for questionnaire).

Upon entering a village, either the Community Development Welfare workers or other FPAI staff on familiar and friendly terms with the local residents would introduce the investigators to the leaders of the village, help explain the purpose of our visist, circumvent any possible misunderstandings or fears and win local cooperation for our enquiry. Wherever Mahila Mandals or Youth Clubs existed, the President and/or Secretary (past or present) were contacted first for the administration of the "leaders questionnaire" (see Appendix III). In order to build rapport with these representatives, they were encouraged to share their enthusiasm about their goals, activities and achievements in the community since the inception of their organization. The evolution and objectives of these local institutions thus became clear through reports of the leaders on one hand, while the impct such organizations have had on the community surfaced through

interviews with the organization's members and socio-economic scheme beneficiaries on the other.

As a rule any available political leaders such as chairpersons of the old village panchayat system were also interviewed along with other elders and contestants for the upcoming mandal panchayat and zilla parishad (village and district councils) elections. In addition, a minimum of one Dai and two other women - one belonging to either Scheduled Caste or Scheduled Tribe groups - were approcahed for interviews in each village. Female respondentswere chosen irrespective of whether or not they are beneficiaries of an income generation or development projects or members of a Mahila Mandal, although an attempt was made to interview an even number of participants and non-participants in such community programme. Women from all ages, castes, religions, occupations, income and land/asset-owning groups were interviewed in the villages but special priority was given to married women of reproductive age (since these constituted eligible persons for FP) if hard and fast decisions had to be made on whom to interview within a constrained period of time. Repeat visits to several villages were required in a few cases in order to make contact with a representative mix of members from all strata of the community.

The interviews were usually conducted in the entryways or on the threeholds of village huts which allowed the investigators to observe behaviour related to gender roles and status, interpersonal and community relations and to perceive attitudes

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dominating in the household and in the village, especially since most sessions were well-attended. Rarely was it possible to talk to women privately for any extended period of time as family, neighbours and friends were curious and eager to contribute their comments, some times even responding on behalf of the interviewee. This was especially true with regard to the male relatives and spouses of these women. As a result, the data from the interviews (a total of 80 plus numerous group sessions were conducted in the villages) was frequently gathered through informal discussions and group affirmations rather than through answers consistently given to a logical sequence of questions answered by a single respondent.

The research findings could be distorted by the fact that women may have been inhibited to give their frank opinions or disclose/espouse a deviant behaviour or attitude in the presence of so many others as well as by the fact that villagers possibly underplayed the positive changes in their lives over the decade because they frequently perceived us as representing access to Government or NGO socio-economic schemes. In the hope of benefitting from loans or development package possibly forthcoming through the survey. Some respondents accentuated their present plight and "felt needs" with respect to the future over whatever past progress/benefits that they or their community may have made/enjoyed. Some respondents therefore totally denied any positive strides that in their family or community in the last decade in spite of their adoption of birth control methods or

procurement of proceeds from Government or VoluntaryAgency schenes. For example,. sometimes beneficiaries of IRDP loan or other schemes would stress how absolutely nothing had changed in their lives since the MRP began inspite of otheir obvious ownership of a cow or buffalo or other assets recently accrued by them, usually through liason efforts of FPAI or a local institutions to bring such government programme benefits to their village. On the other hand, others interviewd in the presence of FPAI's official or Community Development Workers would exaggerate the positive transformations catalyzed by FPAI and local volunteers in their village, proclaiming for example "now there are no more caste divisions here"(when obvious demarcations of status and clear residential segrations by caste still existed) or, "men cannot do anything these days without the permission of women who have all the power now".

An attempt has been made to balance extreme assertions on both ends of the spectrum by confirming responses through consultations with other members of the family community and/or FPAI field workers. Of course, the findings can only be considered (ultimately) to be as reliable as the ability of people to acknowledge and articulate real changes that have taken place in and affected their lives. An analysis of the perceptions people hold of the manifestations of and possibilities for a transformation of their situation may serve as an even more powerful and accurate indicator of their "objective" conditions/envirnment.

Therefore, in analyzing the strategies, results and the relative "success" of FPAI's Malur Rural Project, equal attention has been paid to subjective factors as to the concrete and perceptible indices of social-economic and demographic changes unearthed and highlighted by the study.

CHAPTER III

THE STRATEGY

The core ingredients of FPAI's strategy can be consolidated under three separate prongs:

1) The establishment of Local Voluntary Groups (LVG's) such asMahila Mandals (MM's) and Youth Clubs (YC's) and the training of local leaders through these;

2) Involving other Voluntary Agencies in efforts towards the betterment of the community; and

3) Linking Government programmes to local needs and initiatives.

However, as LVG's sprouted up over time, these branches gradually became intertwined and ultimately overlapped through the formation of income-generation projects, especially for women, sponsored and supported by FPAI, Voluntary and Governmental agencies in Malur taluka.

A) Establishment of LVG's:

Wherever FPAI ventured in Malur, its fieldworkers' energies were oriented towards mobilizing the community to establish YC's, MM's and Yuvathi Mandals in villages where they didn't exist and towards organizing and revitalizing such associations if they were defunct. FPAI's implicit aim was to activate the local populace to undertake social and economic projects for the positive transformation of their own communities. FPAI assumed that as

local leaders underwent training and became more aware, FP and MCH motivational compaigns would become part and parcel of LVG activities. Never was the idea of FP presented as an end unto itself, but always as a kind of health insurance or development measure when FPAI first began guiding and counselling these local groups. Only gradually, as LVG's became awakened to the real possibilities for progress in their villages in both productive and reproductive arenas, did FPAI officially highlight the linkages between the two. Over the decade, FP motivational and MCH outreach efforts came to constitute some of the regular and central activities of these LVG's as their numbers increased and their respective membership's swelled.

In villages where MM's did not exist or were passive, FPAI would usually appeal to the wife or sister of a local leader such as the YC President or Secretary to form a women's club, presuming that such a personality would command a greater following amongst women in the community and would most likely be more highly educated and/or politically active/aware. FPAI made it a point to give funds to MM's and LVG.s (not to individuals) in order to encourage the building of local institutions and a kind of collective empowerment that would include all members of the community. FPAI therefore thus urged LVG's to recruit espcially lower income groups into their ranks and to allocate grants on a priority basis to their SC and ST members.

The expansion of LVG's and intensification of their role as change agents was stimulated by FPAI not only through the

extension of financial grants but also through in-kind and infrastructural assistance to LVG's and training of their members. For example, FPAI provided funding and sericulture plates for silk-worm rearing and other income generation projects for a variety of MM's, cash loans for the launching of home-based industries and group projects such as papad, nipattu, pickle, sambar and rasam - powder - preparation, mat-weaving, bead - and wire-bag making, vegetable vending, dairy schemes and other income-generation projects for women in a select number of villages in malur. FPAI also donated sewing machines for the training of, and income-generation for women in Kodur, initiated a tailoring scheme in Huladenahalli, Nidiramangala and Yeshavantapura and introduced a credit scheme for women in Seethanayakanahalli. Food-and condiment-preparation projects to increase female earnings were launched in Lakkur and Masthi. Chandrankes (sericulture trays) were also distributed to women's clubs for rental in Bavanahalli, Sivarapatna and Hungenahalli and Muthugade leaves (stitched by women into eating plates) were introduced in Sivarapatna - all as a part of FPAI's extension efforts to organize women for self help and to stimulate their greater economic independence.

In a similar vein, FPAI contributed seed-money for the formation of Small-Scale Industries and Co-operative Socieities, the acquisition and rental of agricultural tools as well as improved seeds, fertilizers, improved technologies and infrastructural facilities in a large number of villages by YC's.

These inputs to LVG's gave rise to a new orientation amongst community members, triggering the integration of socio-economic projects with FP and health services. Incentives for LVG's to link these various activities were inculcated by FPAI through its selective donation of grants, loans, awards and gifts on a priority basis to adopters of FP and/or LVG's that had been the most active and effective on the MCH and FP fronts in their communities. YC's and MM's hence became increasingly involved in organizing, and providing funds towards, sterilization and IUD-insertion camps, immunization and other health camps, MCH clinic sessions and other sanitation - and nutrition-related events taluka-wide. In addition, they began offering FP counselling, follow up care of acceptors, identifying dais for FPAI training, taking on the responsibility for the distribution of condoms in YC's (through Community Based Depots-CBD"s) and oral pills (through MM's) and sponsoring programmes to engender a favourable community disposition towards the small family norm and FP methods. As a result, between 1976-85, an average of 31% of the total FP acceptors had been motivated by LVG's and community members (9).

B) Involvement of Other Voluntary Agencies in Community Development Activities

The second methodological limb of FPAI's strategy effectively placed the FPAI staff and fieldworkers in a "liason role" between NGO's and the Malur Community. This approach increasingly entailed the recruitment and coordination of Voluntary Agencies (at state, national and international levels) to collaborate with

FPAI in the Malur Rural Project over the years. FPAI succeeded in bringing projects and grants to Malur through such Voluntary Agencies - some of whom had never before extended their activities or schemes to the rural areas at all. Malur thus became the "laboratory" for experiments in rural work by a wide cross-section of NGO's.

Coordinating NGO funding and inputs has also been one of FPAI's major activities over the decade in Malur. In fact, FPAI volunteers never visited Malur alone, for they always brought other NGO representatives along. From stimulating the interest of local Rotary, Lions and Jaycees clubs to involving the Department of Youth Services, the State Youth Centre and Taluk Youth Federation in MRP, FPAI has been quite effective in building the resources and skills of local institutions to work towards socio-economic development and FP advocacy. Two international Voluntary Agencies, Oxfam-America and SIDA, agreed to finance the launching of three relatively extensive projects in Malur in the early 1980's.

Oxfam-America therefore released Rs.215,400 for the establishment of a silk-reeling unit in 1984 through a Mahila Mandal in Kesagare and initiated social forestry scheme (Rs.3,000) through the MM in Nidiramngala in 1985. Both of these projects aimed at increasing income generation prospects and employment for rural women. SIDA also financed (Rs.143,000) the construction of an Integrated Community Facilities Complex (ICFC) at Huladenahalli

in 1985. This ICFC houses bathing fcilities, latrines and a biogas plant and is being managed jointly by the local YC and MM, also maintains a community garden at the site.

All three of these externally-funded projects have greatly enhanced village pride and reportedly contributed to a sense of social identity enhanced by the fact that visitors from all over India and abroad come to their villages to see these projects and their progress.

C) Linking Government Programme to Local Needs.

To name a just few of FPAI's collaborative endeavours at the State Government level in Malur: (1) the National Adult Education Programme (NAEP) funded adult education and literacy classes in the taluka; (2) the National Institute of Mental Health and Neurosciences (NIMHANS) adopted Malur and sent some of its staff from the Bangalore Office to conduct workshops for local health personnel, psychiatric programmes and mental health camps in the taluka; and (3) at the suggestion of FPAI, the Karnataka State Council of Child Welfare (KSCCW) undertook programmes - for the first time in a rural area - to run creches (child-care centres), balwadis and female adult education classes through its trained balasevikas sent to work in twelve to thirteen villages of Malur. Since 1977, these balasevikas have been trained in cultural and folk media skills to attract the community to participate in health, FP, and nutritional programmes.

In addition, the Community Canning and Preservation Center of the Government of India in Bangalore conducted nutrition and cooking demonstrations and training workshops in Malur. One of the most popular and widespread schemes to reach and benefit the population throughout the taluka has been sponsored by the Karnataka State Social Welfare Advisory Board (KSWAB) which has supported at least ten MM's in Malur in purchasing milch animals (cows and buffalos) through their dairy development scheme in recent years. The Training for Rural Youth and Self Employment (TRYSEM), a Government programme, has been well-utilised in Malur, especially by MM's, who have been the recipients of sewing machines, training and funding for tailoring and income-generation projects. The Integrated Child Development Services (ICDS) has also been extremely active in starting and running anganwadis in Malur, thus providing pre-primary school centers and services throughout the taluka. FPAI also urged the Indian Medical Association (IMA) to send its personnel from Bangalore out to Malur to conduct general health camps on dental, TB detection, ENT and other disorders, which IMA did from 1977 onwards.

The National Diary Research Institute, (NDRI), the Bangalore branch responsible for a variety of programmes under the Indian Council of Agricultural Research (ICAR), also agreed to collaborate with FPAI in Malur by transferring a wide range of their improved agricultural technologies and inputs (tools, sericulture plates, new brands of seeds, fodder and fertilizers, sheeps, goats and cows) to landless labourers and marginal and

small farmers, especially through its "Lab to Land" program. NDRI and ICAR have also sponsored a number of agricultural training camps in different villages in Malur taluka, leading to improvements in farming knowledge and practices locally.

As a consequence of this third methodological thrust of FPAI's strategy involving the infusion of Governmental programmes and personnel into Malur, the villagers became increasingly aware of the existence of government services and of how to obtain programme benefits, especially where LVG's and FPAI have played mediating/facilitating roles. The Block Development Officer in Malur boasted that as a result of this spreading consciousness and enhanced local capabilities to procure loans and take advantage of existing programmes, women currently constitute 30% of all beneficiaries of Government schemes. He also claimed that Malur taluka has one of the highest absorption rates of Government services and programmes, women currently constitute 30% of all beneficiaries of Government schems. He also claimed that Malur Taluka has one of the highest absorption rates of Government services and programmes in the entire district. The Social Education Officer for the taluka also expressed a great degree of enthusiasm about the fact that Malur has introduced the highest number of both smokeless "chulas" (stoves) - 750 or so as of December 1986 - and biogas plants - 47 as of December 1986 - in the entire district.

CHAPTER IV

THE SUPPLEMENTARY STRATEGIES

The Qualitative Profile

When FPAI commenced its work in Malur, in the words of the Statistical Assistant associated with the Project for the last decade, "The people's attitude to family planning was lethargic, family planning was equated with sterilization and the whole program was considered as a Government exercise." (10). In fact, under IPP-1 FPAI chose Malur - precisely because it was the most "backward" - economically and socially - taluka in the entire district at that time. Malur was known to be a drought-prone region, largely inaccessible by road and disadvantaged by a dearth of local leadership and infrastructure. Moreover, the health and FP status of the local population were abysmally low.

In 1976, FPAI's task, delegated by IPP-I as the achievement of official State-wide targets for FP adoption and MCH indicators, seemed herculean in light of existing widespread local antagonism towards both the concepts and programmes related to FP. This near-universal resistance stemmed from the fear and anger provoked during the Emergency Period (1976-77) wherein mass vasectomy camps were conducted and sterilization quotas were fulfilled mostly through coercive tactics and abuse of the local population, particularly near the Tamil Nadu border. In fact, throughout the taluka the Government FP Department was referred to as the

"cutting department", according to interviews with villagers and FPAI field workers. These hostile conditions compelled FPAI to consider innovative strategies to improve and alter the socio-psychological disposition of the community towards FP.

Staff improvement was an essential component of this strategy. In April 197 , FPAI assumed administrative and technical control of the Malur Primary Health Centre (PHC) and thus took charge of one Lady Medical Officer, ten Female Health Assistants, 29 ANM's and a statistician - all employed by the Government at the time. Although FPAI was bound by Government rules and procedures, it was authorized by the IPP-I to appoint its own staff and re-organize and coordinate all health and family planning (and related) activities in the taluka in pursuing MRP objectives - as long as they did not spend more than the Government budget would have allocated for the same purposes.

A former Senior Deputy Director of Health and Family Welfare Services for the State of Karnataka, was hired as Project Director. Five Community Welfare Workers (CWW) were enlisted from Kolar and other districts and each CWW took responsibility for the initiation and coordination of health, FP and integrated development activities over a specific portion of the taluka encompassing approximately 30,000 inhabitants, respectively.

The staff was oriented and trained for better management, delivery of services, sharing of their experiences with LVG's and greater dedication to the programme cause. A Liason Committee was

established, including three Volunteers, Project Director as ex-officio member and regional director representing Bombay headquarters to formulate the MRP strategy, review its progress and amend its methodologies along the way.

FPAI seems to have resorted to a systems-engineering approach in Malur. This entailed the ponderous evaluation of the objective totality of the social system and a thorough study of the fundamental dynamics, needs and attitudes of the rural communities at hand. FPAI considered and tried to anticipate how a change in one element or sector of a village might relate to and influence other aspects of community life. Hence, rather than plunging blindly into the direct propogation of FP methods through population education and/or media campaigns, the FPAI staff concentrated their skills and energies on mingling with the villagers, mostly informally at first, and on building a solid rapport with a cross-section of members of a limited set of villages - ten to begin with. CDW's educated themselves about the existing conditions and concerns of the community in this manner.

According to these FPAI fieldworkers and villagers, before FPAI entered the taluka, hardly any development work had been pursued by either NGO's or Government agencies in the area. At the time, no Block Development Officer (BDO) had even been posted in Malur, inspite of Government regulations (as specified under the Community Development Program started in India in 1952.) Similarly, the LVG's initiated under Government schemes since the

1960's were virtually defunct, attracting only nominal community involvement.

In addition, village elders indicated that just a decade ago, caste, gender and religious segregation and tensions were high, male dominance was the norm and took the form of the widespread imposition of restrictions on female mobility and activities. Infant mortality was high at the time due to poor maternal health and the lack of ante-or post-natal care as well as the unhygienic practices-- such as using dirty razors/knives to cut the umbilical cord and then dressing it with cowdung-- of traditional midwives (dais) that produced tetanus in many instances. Local taboos on feeding newborns coloestrum (the mother's first milk, rich in antibodies and nutritive value), the indigenous practice of branding babies to ward off the 'evil eye' and illnesses as well as the general lack of medical supplies or services in the taluka also contributed to the low MCH and overall health status of Malur's population. Confronted with such environmental conditions on top of extremely low levels of literacy and high degrees of popular ignorance about modern FP methods (indigenous methods included the insertion of fruits, seeds and sticks into the vagina or the ingestion of local herbs or even ground glass to induce abortions), FPAI was prompted to develop an approach that would be most appropriate to Malur. One of the first experiences of the FPAI staff in Malur indicated the magnitude of the challenge posed by the locality, for when the staff attempted to supply child immunizations in the villages, parents rejeted the service fearing that such a measure would

render their children sterile.

Nevertheless, throughout 1977, FPAI chose health and other check-up camps to serve as their "entry point" into their "target" communities. Only gradually did FPAI succeed in building solid rapport with village institutions and residents.

FPAI's initial contacts in the villages were usually made by approaching influential local leaders and elders so as not to threaten or defy existing power structures and/or entrench local resistance. FPAI selected a cluster of ten villages for intensive work with the hope that the cooperation of these initial "client" communities would spread from this nucleus to a wider area through a kind of "ripple effect". In these villages, panchayat meetings and social functions were convened by FPAI in order to cultivate local relationships and allow the ventilation and analysis of existing problems and the articulation of aspirations. In some villages where the Government health personnel had good relationships with the local people, FPAI was introduced to the leaders through them. Significant leaders in local religious, medical, social and political circles, especially those known to be resistant to FP, were initially consulted by FPAI on one-to-one asis. Teachers, dais, youth and female leaders were also personally approached by FPAI fieldworkers and encouraged to organise community meetings. Despite the requests and repeated visits to the villages by FPAI staff and the fact that they never presented themselves as FP workers in the beginning stages, it

took FPAI a long time to make any inroads at all in Malur.

As one villager admitted in Nutava, "We used to shut our doors and remain inside until the FPAI officials left the village. But they kept coming back and instead of talking about FP adoption, they took interest in the development of our village, helping us to get Integrated Rural Development Programme (IRDP) schemes from the Government and establishing balwadis for our children. Slowly we started trusting them. It tookus six months to talk to them pesonally without fear".

Village women were especially shy in the face of, and non-responsive to, FPAI.s initial overtures. As the MRP Project Director recounted. "When we first started visiting the villages, the women would never come out of their houses. We used to sit for two hours - or sometimes even two years - in some villages waiting for the women to be willing to talk to us".

Apparently, this kind of inhibition and resistance was especially strong in villages containing a high percentage of Muslims. FPAI therefore tried bringing educated Muslim women from Bangalore to talk to these village women, conduct training workshops to promote skills such as tailoring amongst them. FPAI also initiated income generation projects to mobilize them. Rural Muslim women were specifically recruited to be the beneficiaries of health, gynacological and other special check-up camps.

In most cases, FPAI secured a foothold in the villages by entering a community through the already-established local hierarchy, wooing those most dominant in the existing social order. FPAI officials describe this tactic as the only way to ensure that their interventions would be accepted at all and continue on a long-term basis. They explain that their purpose behind such an approach was not to maintain the status quo but rather to erode these same entrenched hierarchies. Their goal was to eventually reform and ultimately break the structures inhibiting just and healthy social relations.

As FPAI Chairperson Leelavathi Chandrashekar put it, "we even made sure not to undermine the existing Government machinery. For instance, before even going to Malur, we solicited the counsel and expertise of the Kolar District Commissioner". In a similar tectical vein, FPAI always tried to maintain the balance and goodwill in family relatios by approaching eligible couples and youth through their elders, in-laws, spouses and parents first. Later, FPAI encouraged family discussions on the topic of family planning and the number of children they desired.

FPAI's approach in the villages was explained by one of its liason Committee member who pointed out. "We joined hands with the 'Powerful' at first and operated through these leaders. For example. we co-opted the men before we talked about women's development in the villages". On the other hand, FPAI avoided making any distinctions on the basis of caste, consciously and consistently emphasizing inter-caste unity and equality. FPAI

tried to promote communal integration and harmony by appealing to an recruiting members of all castes and classes to join in projects and local activities. Extra efforts were also made to bring Hindus and Muslims together for FPAI functions and LVG's were urged to evoke the participation of peripheral caste and religious groups in local institutions and programmes.

Before supplying any services in Malur, FPAI as an organization focussed on meeting community demands. From the beginning, FPAI field workers imparted the concept of FP as a health measure and as the most important one of all elements crucial to integrated development initiatives. A conscious decision was made by the FPAI staff to prooomote FP adoption through community participation in rural development activities. In the initial phases of the MRP, strong emphasis was lent to indentifying local youths and female leaders for training and the formation of LVG's - thus "motivating the motivators. By 1979 a body to sustain the burgeoning voluntary network was founded by FPAI, the Taluk Youth Federation, effectively widening the vision of LVG participants from village-level to block-level development.

A) Cultural Involvement and Mobilization

Aside from their all-out effort to build and strenthen local institutions. FPAI attempted to circumvent local resistance and transcend community lethargy by sponsoring and participating in village cultural programmes and religious occasions. Rapport was

thus created mainly by virtue of FPAI's highly personalized approach. The Project staff won the affection and trust of the villagers through their attendance and assistance at life-cycle events such as births, naming rituals, weddings. deaths, local festivals and other ceremonies in Malur.

Cultural mobilization was stimulated by FPAI's use of folk media such as "lavanis", "harikathas", "burrakathas" (local forms of epic story-telling) and dramas to share MCH knowledge and convey FP-related messages/information. LVG's also sponsored "rangolis" (rice-flour drawings), song and essay contests and community debates - eventually incorporating the themes of FP and the benefits of embracing the small family norm into all of these. "Bhajan Mandals" (devotional song groups) and "Satyanarayan Poojas" (the workship of Hindu Gods practicing or representing the ideal of a small family) were also included in FPAI's repetoire to cultivate a receptivity in the community towards FP methods and developmental ethics. After 1977, FPAI brought films, slide shows, exhibitions and other educational and cultural programmes to the villages.

As the MRP grew and FPAI became more familiar with Malur and its people, such activities were supplemented by FPAI's formation of "Pariwar Pragati Mandals" (Women Acceptors Clubs), "Salaha Sanghas" (Elder's Clubs) and "Anubhava Mateyara Sanghas" (Experienced WOmen's Associations). FPAI also reinforced the FP message through events like "Felicitation Processions" and "Kalyanamathas" (both honoring sterilization acceptors through the

presentation of "Jyothi/neelanjanas" - small oil lamps - to "welfare minded mothers" and others). Competitions were also organised by FPAI in Malur villages and towns amongst male and female acceptors of sterilization with an aim to dispell fears and misconceptions about these operations and their short-and long-term effects. Vasectomy acceptors thus joined in FPAI - sponsored cycle-racing, running and shotput contests while women who had undergone either tubectomy or laparoscopy operations participated in ragi-pounding, water-carrying, head-loading and weight-lifting competitions.

Prizes were also awarded by FPAI over the years for healthy babies ("Well-Baby Shows") and to "Model Couples" (those having only a limited number of children and practising good nutrition, sanitation, housekeeping and some form of family planning). Training workshops for newlyweds were also held in the villages to educate young EC's on responsible parenting, birth control methods, health, nutrition and the advantages of postponing their first child and spacing subsequent children. Programmes including the staging of dramas and teaching of songs at all levels of schooling which incorporated some FP theme were effective not only in planting FP concepts in the minds of future generations but in motivating parents inevitably exposed to their children's recitals and queries to consider the messages therein. School health programmes and door-to-door immunization compaigns run by FPAI also helped to win parental confidence in, and enthusiasm for, FPAI's projects and intentions.

B) Education and Training

A variety of other educational and training programmes launched by FPAI likewise succeeded in convincing Malur villagers of the staff's dedication and constructive motivations. One such scheme included the establishment of pre-primary schools (Balwadis/anganwadis) through the KSCCW in 1977. Mahila Mandals were frequently either started or re-energized by KSCCW's balsasevikas. MM's usually "adopted" these trainees and aided them in providing mid-day meals for their pre-primary pupils. YC's built many balwadi buildings through "shramadan" (voluntary labor donation), a testimony of widespread local support for FPAI's educational and outreach efforts.

A central feature for MRP was FPAI's continual identification of existing and potential local leaders through village meetings and discussions in order to recruit such personalities for running population education, health, nutrition and other classes and to offer them leadership and other types of trainingf. Local teachers and medical practitioners were also attracted by FPAI to participate in such sessions/workshops.

Another particularly important aspect of FPAI's methodology in Malur involved the training of traditional birth attendants (dais) on a continous basis. The hardest-working and most popular (and willing) dais were chosen by FPAI staff with the assistance of the community to attend workshops held in various sub-centres of Malur. These midwives were thereby instructed by Lady Doctors

in basic hygiene and sage birthing techniques. The PHC policy was to pay trainees Rs. 10/day for the duration of such sessions. FPAI paid newcomers a stipend of Rs. 5/day and old-comers (for re-orientation) Rs 10/day. Incentives were transformed created for the dais to participate in the re-orientation workshops held every six months by FPAI. The dais were equipped with kit-boxes including scissors, towels, thread,soap,sterilization utensils, a water bowl, forceps, a fingernail brush and boric acid. These supplies were replenished on a regular basis by ANMs, Lady Health Visitors and FPAI's CDWs - all of whom checked up on the deliveries performed in the villages.

These workshops and kits greatly enhanced the dais's skills, self-esteem, confidence and standing in the villages and increased demand for their services. FPAI - trained dais became a link in their communities, thereby improving immunization services as well as the efficiency of the local health care system. In many settings, dais become some of FPAI's staunchest allies, health workers and FP motivators. ALthough "conventional wisdom" had popularised the notion that dais were "anti-FP" (since their earnings depend on the number of deliveries they perform), FPAI found that these dais were generally sympathetic to the suffering they had been women experience as a result of repeated childbirths in weakened conditions, and that they frequently counselled women to space and limit their offspring. The few dais who were antagonistic to FPAI's aims were in several cases co-opted by the fieldworkers' procurement of old age ad widow pensions for them through Government schemes.

Adult Education Centers and classes were also gradually added to FPAI's mushrooming list of activities in Malur. Requests for reading rooms and libraries increased as the ranks of the newly-literate gre and as LVG's expanded the scope of their operations with FPAI's help. Population and development education seminars were introduced in the villages by FPAI and partner Voluntary Agencies. Workshops and lectures on issues pertaining to health and nutrition as well as cooking demonstrations were held. Meetings were organised in the villages around discussions of local and national problems. These gatherings served to impart additional knowledge and frequently sparked processes of community brainstorming and solution-building. Coalitions were hence formed around self-help programmes and efforts to eradicte "social evils" like dowry, alcoholicm, child marriage and discrimination on the basis of gender and caste. A number of villages sponsored events to increase social and political awareness of these problems, including YouthClub processions wherein marchers took oaths not to accept dowry, pledged to delay their marriages and declared "No Birth Year" or "No Pregnancy Year" to bring down the village birth rates.

A Village Health Guides Scheme was also launched by FPAI in 1981 which entailed the training and assignment of local volunteers to monitor health status and provide basic first aid and primary health care in their communities. The programme was tailored along lines and concepts similar to China's "Barefoot

Doctors'' network. Upon witnessing the programme's effectiveness inMalur , the Government of Karnataka decided to implement the scheme on a larger scale in Kolar District as a whole in 1982, along with few other districts where this scheme was initiated.

FPAI health education sessions held throughtout Malur taluka also inspired a local movement to form Village Health and FP Committees. These locally-constituted bodies expanded from a membership of 56 in 1983 to 453 in 1986 (with FPAI's encouragement) and greatly improved the initiatives in at least 55 villages.

C) Local Contribution to Planning and Implementation

Wheras in the seminal stages of MRP, FPAI played the role of a "catalyst agent", approaching its "clients" and extending its services wherever they found receptivity to, or a demand for what they could deliver, within six months of the inception of MRP, villagers themselves began to seek FPAI's advice and assistance. Their interest in fostering personel and community socio-economic development grew as they became increasingly aware of local and external opportunities available to them to improve their own condition. FPAI's approach had somehow ignited a desire in villagers to gain greater control over their lives and promoted an enlargement of their horizon of vision and field of action.

Eventually, the spark of FPAI-initiated activities caught fire and spread to other villages and sectors of the community.

Programmes and events gradually became locally-planned, funded - and - executed, especially through LVG's. Project villages started submitting an annual agenda of community development activities which was posted by FPAI. The resultant calendar encouraged long-term planning at the village as well as the inter-village levels and communication and cooperation at the taluka level. This agenda-setting practice also instilled a sense of pride in villagers and local leaders and promoted a sense of identity by village ("hali") rather than according to narrow caste, religious. class or political affilations. This sense of belonging to the "hali" first and foremost was expresses by many Malur residents we interviewed, especially in villages where the FPAI and LVG's had been particularly active over the years. Moreover, this realignment of individuals and previously-segregated groups into larger collectives manifest itself in terms of high levels of local participation in "shramadan" - activites lead to LVG's that were undertaken for the welfare and improvement of whole villages throughout the taluka. In our survey of Malur, we came across countless monuments to this kind of community dedication and pride, including irrigation, drainage, housing, school, transport, sanitation and health units and facilities constructed by YC or M volunteers in their respective villages. TC's usually shouldered the responsibility of organising weekly or monthly village cleanings, reparations or maintenance "shramadans".

Local recognition of the need for the possibility of positive change hence evolved and took the form of self-help action and

self-determining programmes in Malur villages. The FPAI as "catalysts"- Malur as "client" relationship was consequently transformed into a partnership ushering in a qualitatively new and exciting phase of the project.

CHAPTER V

THE IMPACT AND ACCOMPLISHMENTS OF MRF:

The "success" of FPAI's project was outlined by its own staff members as consisting of a variety of components - from the very ethernal to the very tangible. Some of the qualitative accomplishments referred to included:

1) the fact that in Malur the women are less inhibited and more mobile now;

2) They speak up about FP, are more open and relate to their spouses and other men better;

3) children are exposed to FP and population education at an early age;

4) people's disposition towards self-help is much more prevalent now than before MRP; and

5) community participation is much higher, with LVG's having taken over FPAI's catalyst role and now approaching Government officials on their own to procure schemes.

Other improvements mentioned by officials connected to MRP, such as Dr. P.H.Reddy of the India Population Center, concerned the purportedly "increased economic status of Malur villages, better caste unity, greater integration of men and women and various religious groups in the area, an enhanced political consciousness (especially amongst women) and the committment of local youth to the small family norm and the eradication of 'social evils' like dowry".

Increased political activism has also produced an informal cadre of youth and female leaders through the LVG's in Malur. In fact, 60% of all candidates in Malur who contested for seats in the local Zilla Parishad and Mandal Panchayat elections belonged to YC's and 15% belonged to MM's. Moreover, women are reportedly attending village meetings more frequently and in greater numbers and supposedly now seek FP services voluntarily after bearing two or three children.

FPAI's "success" in Malur has been attributed by Project personnel to a wide range of unique factors, such as the freedom and flexibility MRP enjoyed in terms of personnel selection and transfers as well as FPAI's total technical and administrative control of Government machinery already in place. In addition, no policy constraints or restrictive guidelines were issued by the funding agencies of the IPP-I MRP experiment (the World Bank, SIDA and the GOI), with the only donor-specified stipulation being that FPAI's expenditures for MCH and FP not exceed the Government's budget of Rs. 1,20,000 per annum in the taluka.

Other aspects contributing to MRP's success that were emphasized by officials interviewed were the education and training components for all levels of health personnel, the care taken by FPAI to follow up on all such programmes and interventions and the "parallel approach" adopted, whereby in increase in demand for FP services was met with an adequate supply of services on the spot. FPAI described their motto for their project work in Malur as being: "PROVIDE SERVICES and DELIVER on-

promises made to provide Government schemes. Never engender false hopes in the people". Their initial efforts revolved around MCH and family welfare programmes and concerns, only later motivating villagers for family planning in a gradual and indirect fashion.

Most importantly, the quality and style of leadership embodied by FPAI's Malur Project Director was invariably mentioned by all personnel and officials interviewed as one of the central reasons for the success of MREP. His prior experience as the Deputy Director of Health and Family Welfare Department in Karnataka proved to be invaluable in securing the necessary rapport and linkages with Government health personnel and programmes in malur. The leadership and effectiveness he demonstrated as Project Director over the decade inspired the selfless service, committed teamwork and extraordinary dedication of the Projects CDW's and associated Government staff, according to interviewees familiar with the operation of MRP across the board. One of the FPAI staff in Malur underscored this dynamic when he summarized:

" We have not had the technical competence, management or health skills that other IPP-I strategies exhibited through, and provided to, their personnel, but we have had the human touch necessary to implement the programme effectively and therefore we have been well-received by the Malur community".

QUALITATIVE PROFILE

A).Health and Family Planning Indicators:

With respect to vital rates, when the FPAI launched the MRP in 1977, the Crude Birth Rate (CBR) was 23.79 whereas by 1984 it had been reduced to 22.23. Likewise the Crude Death Rate (CDR) decreased over the same period from 4.77 to 3.65. The Infant Mortality Rate (IMR) was registered at 52.86 (per 1000 live births) in 1977 and 37.4 in 1984 (see table 1). Maternal mortality fluctuated over the project years from .63 in 1977 to 2.3 in 1980 and 0.92 in 1984, according to FPAI Project Office Statistics and measured per 1000 live births. The all-India average for Maternal Mortality Rate has been estimated to fall somewhere between 460-800 maternal deaths per 100,000 live births(12).

(Note: MMRs do not include maternal deaths during pregnancy, stillbirths or abortions and thus are gross underestimates).

In terms of the FP performance, Malur's achievements also compare favourably to state and national averages. While in 1976 FP acceptance (FPA) was recorded by the PHC to be a mere 11.75% of all eligible couples (ECs) in the taluka in 1975-76 before FPAI entered the area, it had risen to 61.5% by 1985-86 (see table 2). The average proportion of ECs protected in Kolar District between 1979-86 was 41.5%, still lower than the taluka's average for the same period (13).

Of even more significance in terms of the project's potential impact on the configurations of fertility in Malur are the trends manifest over the decade and highlighted by table 3. The increasing acceptance of sterilization and IUD's even amongst younger eligible couples with only three or less children as well as the charted decline in the average age and number of children of FP acceptors indicate dramatic shifts to come in Malur's demographic profile. The fertility trend in Malur represents a distinct departure from those exhibited at both state and national levels in recent years. Table 4 on general fertility and total fertility rates of all-India and Karnataka from 1976 to 1983 reveals marginal declines in both until 1979-80. However, since 1981, a substantial increase in general fertility rates are registered both in India and Karnataka. In sharp contrast to this trend, Malur's Crude Birth Rate (see table 1)- a rough measure of fertility - has decreased considerably from 1980-1983 and then again between 1980-85.

We must mention here that fertility rates for Malur have not been computed by either the FPAI Project Ofice or the Government of Karnataka or the Census Directorate's Sample Registration System. Hence, we have only been able to estimate the trend in fertility rates of Malur on the basis of existing statistics that measure only (CBR). Malur's decline in CBR from 1980-83 stands as an exception to the

overall national and state increases in General Fertility Rates (GFR) and relatively stable Total Fertility Rates (TFR).

Table 1

Vital Rates from 1977 to 1986

	CBR			CDR			IMR		
	Malur	Karnataka	India	Malur	Karnataka	India	Malur	Karnataka	India
1977	23.79	28.3	33.6	4.77	11.6	14.6	52.86	83	129
1978	24.98	28.3	33.3	4.07	10.6	13.1	34.31	82	127
1979	26.98	28.3	33.3	4.77	10.6	13.1	43.79	83	120
1980	25.15	27.6	33.7	4.13	9.6	12.6	31.24	71	114
1981	23.07	28.3	33.9	4.13	9.1	12.5	39.67	69	110
1982	22.41	27.9	34	3.78	9.2	11.9	24.50	65	94
1983	21.85	29.1	33.6	3.77	9.3	11.9	38.07	?	?
1984	22.23	30.1	33.8	3.65	9.6	12.5	37.4	74	142
1985	24.94	NA	NA	4.80	NA	NA	35.68	NA	NA
1986	21.43	NA	33.3	4.64	NA	12.5	39.75	NA	127

(Note: NA denotes Not Available

(Sources: Census; Family Welfare Programme of India Year Books 1972-80; Sample Registration Bulletin Dec. 1985; FPAI Statistics, 1986; SRS Report, 1979; Registrar General's Newsletter: Vol.XVII No.3, July 1986, Ministry of Home Affairs, GOI, New Delhi; Family Welfare Programme at a Glance in Karnataka, Diary 1986, State Family Welfare Bureau Directorate of Health Services, Government of Karnataka, December 1986.)

Table 2

Coverage of Eligible Couples for Family Planning Acceptance

Year	MALUR % FPA	Karnataka % FPA	India % FPA
1975-76	11.75	13.72	17.1
1976-77	20.21	20.58	23.7
1977-78	25.87	20.70	22.6
1978-79	31.13	20.96	22.3
1979-80	34.98	22.06	22.2
1980-81	40.62	22.82	22.7
1981-82	43.62	24.22	23.7
1982-83	51.78	27.1	25.9
1983-84	54.35	29.5	29.6
1984-85	55.54	32.2	32.3
1985-86	61.50	36.3	36.2

[Note: The percentage of eligible couples protected by Family Welfare Methods as of March 31, 1985 in Kolar District was only 37.8% according to the Family Welfare Programme at a Glance in Karnataka: Diary 1986, State Family Welfare Bureau, Directorate of Health and Family Welfaare Services, Government of Karnataka, Bangalore 1986, P.21].

Sources:
(i) FPAI Statistics based on PHC's Statistics for for Malur; (ii)Govt. of Karnataka, Dept. of Health and Family Welfare, Status Report 1985-86 for Karnataka. (iii) Govt. of Karnataka, An Evaluation of the F.P. programme in Karnataka, India, Population Centre, Bangalore, 1984.(iv) Govt. of India, Dept. of Health & Family Welfare Year Book, 1984.(v) Govt. of Karanataka, State FW Bureau, Directorate of Health and Family Welfare Services, Bangalore.)

Table 3

FPAI MALUR RURAL PROJECT - MALUR

Salient Features	Sterilisation		IUD	
	1976	1986	1976	1986
I. Increasing trend in FP acceptance among younger age groups (below 30 years)	42%	75%	70%	80%
II. Increasing trend in FP acceptance with small family norm (3 or fewer children)	41%	75%	74%	88%
III. Decreasing trend in the average age of FP acceptors	31yrs	27yrs	27yrs	25yrs
IV. Decreasing trend in the number of living children among FP acceptors	3.78	2.86	3.46	1.94

[Note: The figures pertaining to India for 1980-81 were:

	Ster.	IUD
FP acceptors with below 30 yrs	49%	67%
FP acceptors having 3 or less children	51%	77%
Average age of FP acceptors(yrs)	30	28
Average no.of living children	3.7	2.61

(Source: Mr.K.N.Ghalgi, FPAI Statistical Assistant, MALUR, Karnataka, March, 1987.)

Table 4

Fertility trends in India and Karnataka

	India		Karanatka	
	GFR*	TFR**	GFR*	TFR**
1976	148.5	4.7	117.3	3.8
1977	137.8	4.5	110.9	3.6
1978	139.5	4.5	119.1	3.8
1979-80	137.8	4.4	113.2	3.6
1981	140.9	4.5	113.9	3.6
1982	142.2	4.5	114.3	3.6
1983	143.5	4.5	120.1	3.7

(Note: * GFR = General Fertility Rate = No. of live births per 1000 women in the age group 15-49 years in a given year.

** TFR = Total Fertility Rate = Average No. of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive (15-49 years) lifespan.

(Source: Sample Registration System: 1970-75 to 1983, Government of India, Ministry of Home Affairs Vital Statistics Division, Office of the Registrar General, New Delhi.)

Community promotion of family planning through Local Voluntary Groups (LVG's) and trained village dais successfully attracted an average of 31% of all new FP acceptors per year in Malur over the decade. An all-time high was reached in 1979, and then again in 1983, when 42% of all new FP adoption cases were motivated through LVG's. The Youth Clubs (YC's) proved to be particularly effective along these lines since they served as the distributors of "Nirodh" (condoms) through Community Based Depots (CBD's). These CBD's originated as an FPAI experiment in Malur, to be maintained by the YC's at the village level. In the first year of MRP, 49 CBD's thus provided contraceptives to 178 users. By the end of 1985, there were 69 depots supplying condoms to 369 users. In 1984 there were 77 CBD's. YC's thus motivated men to accept greater responsibility for birth control in Malur, surpassing the Government target set for the use of condoms every year from 1977 to 1984. During this period, Malur achieved at least 120% over and above the Karnataka target specified for condom coverage, attaining the phenomenal level of 257% of the quota set for 1978. Other spacing methods also enjoyed above-average popularity throughout FPAI'S MRP, with oral pill adoption 390% over target levels in 1980-81 and above 95% for all other years (see table 5).

Table 5

MALUR'S ACHIEVEMENT OF F.P.TARGETS SET BY THE GOVERNMENT

CALENDAR,1977-1983

YEAR TARGET % ACHIE-VEMENT	STERILI-SATION	I.U.D.	ORAL	CONDOM	% OF COMMUNITY PARTICIPATION TO TOTAL PERFORMANCE STER	IUD	ORAL (NA)	CONDOM
1977								
	1,406	327	-	1,479	16	-	21	39
	16.50	47.38	100	129.60				
1978								
	1,015	189	-	604	49	17	40	28
	27.09	101.59	82	257.62				
1979								
	1,189	224	100	594	42	27	15	59
	24.64	188.84	344.00	164.98				
1980								
	864	222	95	601	26	27	19	23
	33.91	200.81	390.99	163.89				
1981								
	720	210	95	470	32	49	8	49
	95.00	181.42	398.95	130.64				
1982								
	1,042	341	95	500	26	35	11	33
	121.02	90.62	204	168.60				
1983								
	1,465	584	204	604	36	11	16	77
	69.01	88.36	108.33	141.72				
1984								
	1,686	699	255	676	38	17	6	37
	51.72	87.41	208.88	174.85				

[Note: * N.A. = New Adopters]

(Source: FPAI and IPC Statistics)

The Sterilization Equivalent Ratio (SER) per 1000 population achieved over the decade was higher every year from 1977 to 1985 in Malur than in the control area of Kamasumadram and higher than in Kolar district every year during this same period except in 1978, 1981 and 1984. This accomplishment seems particularly significant considering that Malur's MCH and FP rates had been lower than both comparable taluka and district averages for the 6 years prior to the launching of MRP (see table 6).

Table 6

Family Planning Performance in terms of SER per 1000 population

YEAR	PROJECT AREA Malur	CONTROL AREA Kamasumadram	DISTRICT Kolar
1977	2.36	1.75	2.13
1978	2.74	1.68	2.95
1979	4.42	2.88	3.82
1980	5.90	3.26	4.46
1981	6.25	4.63	6.30
1982	9.93	6.17	9.33
1983	9.69	8.55	8.20
1984	8.35	6.68	8.77
1985	10.15	8.44	9.37
1986	11.22	9.20	10.70

* SE = Sterilization Equivalent = Sterilizations + IUD/3 + Oral Users/9 + CC users/18.

* SER = $\frac{SE \times 1000}{Population}$

(Source: Compiled from FPAI and IPC statistics.)

Malur outperformed both the Control area and Kolar as a whole with regard to the percentage of the Government-established FP targets achieved on a consistent basis in terms of spacing (non-terminal) methods (see table 7).

Table 7

FPAI MALUR RURAL PROJECT - MALUR

Percentage Achievement of Family Planning Target

Year	Sterilization			IUD			Oral Pills			Condoms		
	Proj. area	Con. area	Dist.	Proj. area	Con. area	Dist.	Proj. area	Con. area	Dist.	Proj. area	Con. area	Dist.
77-78	16	11	24	47	6	30	No target			127	109	21
78-79	33	26	30	179	144	57	was assigned			336	275	28
79-80	21	23	35	179	113	101	123	9	81	161	76	56
80-81	51	49	72	213	127	146	157	2	10	255	82	84
81-82	100	68	85	160	86	103	159	11	12	239	133	82
82-83	129	100	110	103	105	92	246	46	64	162	25	66
83-84	54	49	68	83	79	83	113	11	25	148	33	60
84-85	51	69	65	92	113	90	239	100	60	150	161	126
85-86	94	82	100	158	130	120	138	92	100	226	120	143

(Source: Mr.K.N.Ghalgi, FPAI, Malur, 1986 Dec.)

An independent evaluation of FPAI's Malur Rural Project conducted by the India Population Center (IPC) and the end of the experimental period in 1979 found both the SER and MCH rates (ante-natal care and post natal care plus two times the number of deliveries by trained persons over a population times 1000) as well as the respective Staff Efficiency Indices to have exhibited statistically significant and

impressive gains in Malur since 1976, especially when compared to Control area and Kolar averages. These above-average health and FP accomplishments in Malur substantiated the hypothesis which the MRP had been designed to test - i.e., that Non-Governmental Organizations (NGO's), when charged with the exclusive implementation of MCH and family welfare programmes in the rural areas, are more effective than Government bodies entrusted with sole responsibility for such programmes.

By 1981, Malur had already gained the distinction of exhibiting the second lowest population growth rate in the entire District throughout the 1970's, according to 1981 Census figures which indicate a cumulative growth rate of 23.20 for the decade (an average of 2.32 per year) in Malur taluka compared to the District's average of 2.53 per annum(14). The State-wide and All India average population growth rates for the same decade were recorded to be 2.37(15) and 2.28(16) per annum, respectively.

[Note: The Karnataka State Status Report 1985-86, places the decennial growth rate at 26.75 for Karnataka 1971-81 and the corresponding all-India growth rate at 25.00(17).]

During the first year (1977) of FPAI's involvement in Malur, 34% of all birth deliveries were conducted by PHC

staff (ANM'S), 18% by trained dais and 48% by untrained dais. By 1985, however, 41% of the total number of deliveries in the taluka were assisted by ANM's, 31% by trained dais and only 28% by untrained dais. So far, FPAI has trained 380 dais in Malur to sensitize villagers with regard to hygiene, health precautions, nutrition, pre- and post-natal care and the need for immunization. Immunization coverage for pregnant mothers and children had also skyrocketed to almost 100% for Malur taluka by 1985.

The FPAI-initiated establishment of Village Health and FP Committes that brought elders, youth and women together to monitor MCH and FP performance in the villages contributed greatly to an overall rise in health status from 1983 to 1986 in Malur. During this time, the number of such committees existing in the villages shot up from 7 to 55 to encompass a membership of 453 persons by the end of 1986.

B.Education:

According to FPAI's Project Coordinator for MRP in a December 1986 interview, female literacy increased from an estimated 18% in 1976 to 23% in 1986. A glance at 1971 and 1981 Census figures reveals a rise in the overall literacy rate in Malur from 21.6% to 26.7% and a jump in female literacy from 12.3% to 16% over the decade, respectively (see table 8 for a comparison with District State and all-India stastistics).

Table 8

TOTAL AND FEMALE LITERACY RATES

(% literates to total population)

	MALUR		KOLAR		KARNATAKA		ALL INDIA	
1971	Total %	Fem. %	Total %	Fem. %	Total %	Fem. %	Total %	Fem. %
Combined	21.60	12.30	27.06	17.15	31.52	20.97	29.48	18.70
Rural	19.50	10.30	20.53	10.60	25.13	14.54	23.69	13.08
Urban	43.00	33.00	52.10	42.80	51.43	41.61	52.37	42.05
1981								
Combined	26.75	16.00	35.58	22.79	38.46	27.71	36.23	24.82
Rural	24.26	13.20	26.50	14.90	31.05	19.71	29.65	17.96
Urban	48.15	40.00	57.80	49.70	56.70	47.00	57.40	47.82

(Sources: FPAI 1986; Census statistics 1971 and 1981; Table 3 of 1981 Census (provisional);and 1984 Ministry of Health and Family Welfare Year book; Census of India 1971 series-14; District Primary Census Abstract Handbook Kolar District, PP.302-303; and Census of India Final Population Figures, Bangalore 1983.)

The rise in female and general literacy rates in Malur can in part be attributed to the fact that between 1977-85, FPAI sponsored the formation of 25 Female Adult Education Centers and 38 Male Adult Education Centres were created by the community, with many of both kinds of centres being run by LVG's. During the same period, FPAI organized and established ten schools, five reading rooms and 137 training programmes for skills development in vocations like tailoring throughout the taluka. A total of 103 Adult Education classes had been conducted by March 1979, thus enabling an additional 1100 men and 250 women to attain literate status in Malur between 1977 and 1979.

Whereas in 1976, no pre-primary schools (balwadis or anganwadis) existed in Malur, by 1986, a total of 143 had been formed and were attended by over 6000 children under five years old. Funding assistance was provided by the Government ICDS program and the Indian Council for Child Welfare as a result of FPAI's liason efforts. The Karnataka State Council for Child Welfare trained a number of these balwadi teachers and members of local YCs and MMs began monitoring the enrolment and encouraging the attendance of children in primary schools. As a consequence, by 1983, enrolment in Malur primary schools encompassed 97% of all children and 96% for girls taluka-wide(18). Average attendance had in fact already reached 86% of all school-

going children by 1980. Youth volunteers provided books, clothing and helped teachers serve the "Mid-day" meals that were in many cases supplied by the MMs, that ran 21 pre-primary schools as early as of 1978.

C.General Development Activities:

Other community development initiatives were undertaken by the villagers and LVG's with the assistance of FPAI over the decade, including the organization and provision of 85 general health camps, Eye/ENT/Skin camps, 436 immunization camps, 78 "Well-Baby" shows, 524 nutrition demonstrations and 215 new drinking water facilities (plus the repair of the 411 existing ones). LVG's disinfected 257 water sources, cleaned and repaired 438 roads, prepared 293 soak pits, provided and maintained 442 drainage systems and conducted a variety of general cleanliness programmes such as oral rehydration demonstrations and the chlorination of drinking water. MCH sessions, sterilization camps and other events were also initiated and carried out by the voluntary network in Malur over the decade.

Voluntary labor ("shramadan") activities sponsored through Youth Clubs and Mahila Mandals were responsible for: the repairing and/or construction of 506 roads and bridges; the extension of nine and the erection of six bus facilities; the construction and/or repair of 436 schools,

hospitals and other public buildings in the villages; the provision of 101 "Janata"(Government-funded) houses and of 73 electrical facilities (through the "Bagya Jyoti" Government scheme); and the establishment of three post and telegraph offices - all between 1977-85. In addition, 561 pensions were procured through these LVG's for elderly and disabled men and women and 117 loans and 264 bank accounts were obtained.

A burst of community activity related to agricultural and animal husbandry improvements also spread throughout the villages as a consequence of the FPAI's liason efforts to secure and coordinate Governmental and NGO schemes and LVG-sponsored projects. Through these collaborative endeavours, 318 families were provided with improved seeds, fertilizers and pesticides, 140 families enjoyed new irrigation facilities, 156 people were exposed to training in agricultural methods, 45 households planted kitchen and fruit gardens, land was distributed to 79 landless families, 16 veterinary service camps were held and improved breeding techniques were popularized. Also between 1977-1985, 87 compost pits were prepared, 67 demonstrations were performed on how to do so and 1164 cattle were immunized in Malur taluka. All of these undertakings involved a high degree of community motivation, funding, execution and participation. In addition, 202 tree planting ceremonies were conducted and a total of 56,312 saplings were introduced in the taluka upon

the sole initiative of the villagers themselves.

Grassroots support of FPAI's attempts to stimulate development took the form of community funding for village activities in addition to the kind of volunteerism exemplified above. The generation and donation of local finances was strengthened in Malur by the fact that the villagers were planning up to 85% of the total annual activities undertaken in the taluka by the end of MRP and were almost uniquely responsible for their execution. LVG's mobilized Rs.220,000 to finance village local activities between 1977 and 1983, thus contributing 80% of the total available expenditures used during that period(19).

Without a doubt, the most significant accomplishments of FPAI have hinged on and resulted from the formation of LVG's which have mobilized community resolve and resources over the years. The fruit of FPAI's work is not only demonstrated by the number and membership of such LVG's (as represented in table 9 below) but by the degree of activism such groups have displayed.

Table 9

FPAI MALUR RURAL PROJECT - MALUR

Local Voluntary Groups and their membership

Year		Youth clubs	Women's Clubs	Village FP Committees	Total
1976	No.	77	12	-	89
	Membership	2438	284	-	2722
1977	No.	114	22	-	136
	Membership	3548	534	-	4082
1978	No.	132	23	-	155
	Membership	4088	559	-	4647
1979	No.	138	29	-	167
	Membership	4268	709	-	4977
980	No.	146	30	-	176
	Membership	4620	760	-	5380
1981	No.	150	35	-	185
	Membership	4628	859	-	5487
1982	No.	152	36	-	188
	Membership	4688	884	-	5572
1983	No.	152	38	7	197
	Membership	5543	1115	56	6714
1984	No.	156	40	34	230
	Membership	5661	1221	281	7163
1985	No.	148	40	55	243
	Membership	4862	1263	453	6578
1986	No.	150	42	55	247
	Membership	4939	1305	453	6697

[Note: Four Yuvathi Mandals (Young Women's Clubs) have also been commenced in Malur in the last couple of years].

(Source: FPAI-MRP statistics provided by K.N.Ghalgi, 1987.)

In 1976, nine of the 77 existing YC's (with 829 registered members) and nine out of the twelve existing MMs (with a total membership of 168) were virtually defunct. Today, 60% of all 150 YC's are active, with 102 of these being super-active, 21 moderately active and the rest relatively passive. As of 1986, of the 42 Mahila Mandals in Malur, 22 were very active, 10 moderately so and 10 were fairly passive. Many YCs and MMs are still being registered and the number of Yuvathi Mandals (YMs) is on the rise. A total of 55 Village Health and FP Committees are also active in Malur at present. In contrast to this dynamic scenario, in the Control area of Kamasumadram taluka, there are only 32 YC's and no MMs or YMs to date.

One of the most striking aspects of Malur's LVG's (besides their developmental activities over the years) resides in the high level of FP adoption by their members. Out of the 37% EC's that belonged to LVG's in 1985, 85% of the male members and 48% of the female members had accepted some form FP. A similar pattern can be discerned in the Village Health and FP Committees, as 43% of their members were practicing some form of FP in 1985. These facts reflect the enthusiasm of nearly one-third of the taluka's total population between the ages of 18-25 towards village betterment programs. Through their participation in LVG's, especially younger ECs have been exposed to development

concerns and how these in turn are linked to population issues. The result has been a marked increase in the postponement of the first child by newlyweds, a rise in the use of FP spacing methods and a trend towards limiting the number of children per family to around two or three in the younger generation of Malur.

D.Socio-economic schemes:

LVG's have also responded to the tremendous demand for Milk Producers' Cooperative Societies in Malur by establishing collection centers for milk in a cluster of villages. Now there are 17 milk producer cooperatives and collection centers in Malur as opposed to none when MRP started in 1976. Some of the YCs and MMs have even started fair price shops in their villages to serve their community and generate income.

As of December 1986, ten Diary Development projects, twenty-four tailoring, four pisciculture, nine sericulture, four petty business and twenty seven other socio-economic projects were thriving throughout Malur. Of these, income-generation projects for women have been (and are) particularly effective and widespread.

E.Income-Generation Activities:

The broad-based approach towards integrated development

by LVG's in Malur has also included the initiation of income-generation activities for villagers. Various Government, Non-Governmental and international agency's programmes have been linked through FPAI to the Local Voluntary Groups such as Yuvak Mandals and Mahila Mandals and thus to village women. Mahila Mandals have mainly focussed on income-generation activities for their members, especially the poorer women, in their villages while Youth Clubs have concentrated on generating income-yielding activities and distributing resultant benefits on an individual and collective basis for both men and women.

In 1978, FPAI inspired and funded Malur Mahila Mandals and Youth Clubs to start a few projects in their villages and assisted them in securing grants from the Taluk Development Board. For example, Rs.500 or Rs.1000 were given to a few Mahila Mandals and these sums were in turn loaned to five or ten of their members (50 to 100 rupees each) for petty trades like leaf-making, idli-preparation, vegetable- and flower vending, etc. The members who had received such loans repaid the Mahila Mandals Rs.10/- per month. This common fund thus constituted the seedmoney for the extension of loans worth of Rs.100 to another member. Sewing machines were also donated to some of the Mahila Mandals to enable village women to learn to sew and engage in an income generating activity. In 1977 itself, ten tailoring classes had already been by

FPAI in Malur taluk. The Youth Clubs were likewise funded to purchase sericultural and agricultural implements and accessories for rental to other villagers at nominal rates. Youth Clubs thus accrued income to start new development projects in their respective localities.

This spurt of income-generating activities by YCs and MMs gained momentum in 1980. Awareness about various State- and Centrally-sponsored Government schemes, began to percolate throughout Malur. Demand for these schemes mounted. Since these projects like "Lab to Land" and others sponsored by ICAR, the Ministry of Agriculture, TRYSEM and the Karnataka State Social Welfare Advisory Board were particularly successful, other special development schemes were introduced in Malur. These included dairy schemes for MM's, pisciculture projects funded by the Department of Fisheries, Government of Karnataka, a sericulture project at Kesaragere through Oxfam-America and a social forestry scheme at Nidiramangala funded by SIDA. State Government schemes like the Special Component Scheme (for SC's/ST's) and other agriculture-related schemes as well as Integrated Rural Development Programme (IRDP) have been increasingly sought after and absorbed by Mahila Mandals and Youth Clubs. These LVG's act as agents and co-ordinators in procuring sanction for such schemes, fulfilling the required formalities for applications and follow-through and render guidance to

individuals who wish to become beneficiaries. At the end of 1985, the following schemes were operative in Malur Taluka:

MALUR RURAL PROJECT
INCOME GENERATION PROJECTS

	Recipients Individuals	MM/YC
Lab to land (Banahalli and Bhuvanahalli)	200	—
Dairy schemes	119	7
Goat rearing	87	1
Sericulture	160	8
Tailoring	210	22
Petty businesss	61	8
Renting equipment	80	4
Fisheries (Pisciculture)		4
Sericulture project(Kesaregare)		1
Social forestry project (Nidiramangala)		1
Total	917 +	56 = 973

In order to place these most recent figures in a historical and fiscal perspective, the number of LVG's involved and the income generated through these projects from 1978 to 1984 are presented in Table 10. Clearly, remunerative schemes have become increasingly popular and lucrative over the years in Malur a trend highlighted by the fact that between 1980-86, 84% of the total resources mobilized for MRP-related activities towards village betterment were raised

and disbursed by the community and LVG's alone.

F. Female Age at Marriage

Another striking aspect ofthe growing number of income-generation projects for women as well as FPAI's and LVG's educational campaigns and other activities lies in the way they have all helped to produce a noticeable rise in the mean age at marriage throughout Malur over the years (see tables 11 and 12).

TABLE 10
FFAI MALUR RURAL PROJECT - INCOME GENERATING ACTIVITIES

Year	No. of YC's and WC's assisted				Funding By		Income generated from Projects during the year		
	Youth Clubs		Women's Clubs		FFAI	Community	By YCs	By WCs	Total
	Newly started	Total Functioning	Newly started	Total Functioning					
1978	22	22	8	8	13,830.24	-	335.00	100.00	435.00
1979	9	31	2	10	10,720.00	-	10,734.00	3,989.00	14,723.00
1980	-	31	2	12	1,460.00	-	7,015.00	2,940.00	9,955.14
1981	-	30	1	11	804.00	-	3,213.00	1,203.00	4,416.00
1982	-	26	6	14	4,808.00	300.00	1,090.00	984.00	2,074.00
1983	7	14	8	15	11,240.00	150.00	141.00	1,200.00	1,341.00 *
1984	2	9	5	14	7,000.00	250.00	1,047.15	1,240.00	2,287.25
Total	40	165	32	84	55,862.24	700.00	23,635.29	11,656.10	35,231.00

(Note: * During 1983, income-generation projects were started in the month of December;
YC = Youth Club; WC = Women's Club)

(Source: 1983 FFAI Annual Report and K N Ghalgi)

Table 11

Taluka, State and All India: Comparison of Average Female Age at marriage

Year	Malur	Karnataka	India
1961	NA	16.5	16.1
1971	NA	17.9	17.2
1977	18.70	NA	NA
1978	18.90	NA	NA
1979	19.50	NA	NA
1980	19.00	NA	NA
1981	20.21	19.2	18.3
1982	19.02	NA	NA
1983	19.82	NA	NA
1984	20.30	NA	NA

[Note: NA = Not Available

(Source: (i) Census reports of 1961, 1971, 1981.

(ii) FPAI Statstics based on data from Malur PHC.

(iii) Summary Population Statistics of 1983-84 yearbook of Health and Family Welfare, Ministry of Health and Family Welfare, New Delhi, Government of India, P.1.)

Table 12

MALUR TALUKA Mean Age at Marriage

Year	For Boys	For Girls
1977	24.30	18.70
1978	28.00	19.90
1979	24.80	19.50
1980	25.50	19.00
1981	26.43	20.21
1982	24.69	19.02
1983	25.91	19.82
1984	25.17	20.30
1985	25.87	20.63
1986	26.13	21.11

(Source: K.N.Ghalgi, FPAI Statistical Assistant to MRP, March 1987 figures.)

As these tables illustrate, the average female age at marriage in Malur has risen by 2.41 years between 1977 and 1986. In 1981, the usual age for women to wed in Malur was at 20.21 years, whereas the comparable averages for Karnataka and All-India in the same year were 19.2 and 18.66 respectively. This trend and the magnitude of change in Malur is not only exceptional when placed in the context of rural India as a whole where the average female mean age at marriage was 16.6 in 191, but in the sense that they undoubtedly contain the seeds of a substantial decline in fertility in the years to come in Malur taluka.

CHAPTER VI

FINDINGS OF SAMPLE SURVEY OF HIGH* MEDIUM** AND LOW ***LEVELS OF COVERAGE IN VILLAGES IN TERMS OF FAMILY PLANNING ADOPTION (FPA) RATES.

FAMILY PLANNING ADOPTION (FPA) RATES.

(A) DEMOGRAPHIC VARIABLES-SUBJECTIVE DATA:

1) PERCEPTIONS REGARDING AGE AT MARRIAGE:

Respondents from villages in the high-level FPA category noted a marked change in the age at marriage in their communities - from 13-15 years a decade ago to 18-20 years today. Boys were said to now marry at 25 or above versus at ages 18-20 years in the recent past. In the medium-level villages, the average age at marriage for girls was stated to have risen from 8-15 years to 15-20 years in the past decade. Likewise, men who married at age 16-20 before currently marry after the age of 25, according to the majority of those interrogated. In communities falling in the low-level of FPA cluster respondents observed a shift in female age at marriage from 12-15 years to 12-20 years over the last ten years. Regarding male age at marriage, villagers identified it to have been 15-20 years before but around 27 years nowadays.

[Note: * = over 65% FP coverage of EC's

** = between 40-64% FP coverage of ECs

*** = below 39% FP coverage of ECs]

One of the reasons clarified by villagers as contributing to these increases in the female age at marriage is the rising cost and prevalence of dowry. The FPAI staff, Community Development Workers (CDW's) and Health Guides all corroborated these villagers perceptions, asserting in their respective interviews that women now marry at around age 20-21 and men at about 25 years on the average in Malur. According to them, the common practice in the past was for women to wed at age 12-15 and men at the age of 18-20.

2) AVERAGE NUMBER OF CHILDREN PER FAMILY:

Nearly all of those interviewed noted a visible reduction over the past ten years in the average number of children per family. In villages exhibiting high levels of FPA, people stated that while family size averaged six to ten children a decade ago, today the average is only one to three per family. In communities characterized by medium levels of FPA, respondents remarked that whereas married couples usually bore between four to ten children in 1975, nowadays only two to four children are found in the average family. In one such village, Seetanayakanahalli, where Muslims constitute over 50% of the population, a distinction was made between the average size of Mulsim families (with an average of six to seven children) and the average size of Hindu families

Nidiramangala, a low-level FPA village, who had borne nine children confessed, "In the olden days we did not know about or have all these methods. Otherwise, I would have preferred to have only two children".

4) ATTITUDES TOWARDS FP IN GENERAL:

For the most part, villagers viewed family planning as a positive economic and/or health measure to take, with resultant benefits accruing mainly to women. Reasons identified by villagers as responsible for the higher motivation to limit the number of children per family were related to:

(i) the fragmentation of scarce land holdings due to the implementation of land reform ceilings and inheritance laws over the past decade;

(ii) declining standards of living and real wages in face of the rising cost of living;

(iii) the fact that children are generally no longer perceived as economic assets but rather as liabilities given the trend of greater child enrolment in formal schooling and a general reduction in child labour;

(iv) the deterioration in female health status associatead with repeated childbearing along with the strains of child rearing; and

(v) the weakening of strong joint-family ties and co-

habitation which formerly provided alternative child care and domestic assistance to rural women, especially those working outside the home.

As a rule, low-income women (especially agricultural and landless labourers belonging mostly to SC and ST groups) remarked that they feel caught in a double bind. Although they expressed a desire to control the number of children they bear because they cannot afford to feed and clothe additional ones, they also feel that they cannot afford to adopt family planning (equated mostly with terminal methods such as tubectomy and laparoscopy) measures since they believe that these operations would require them to take anywhere from one day to two months rest from their hard manual labour.

A prevalent misconception still exists in Malur villages that sterilization invariably undermines both male and female labour on a long-term basis. For instance, a SC female coolie with two daughters and one son in Bhingipura (a village exhibiting 27-29% FPA and dominated by SC/ST groups) complained, "If I get sterilized, my health will diminish. Even if I have another child, at least I can leave it with someone and go to work. Besides, I want to have another son". In Digoor, a village where absolutely no one has adopted FP in the population - composed entirely of ST (Nayaks - landless labourers) - complete ignorance about both

the existence of non-traditional spacing methods and the fact that Government supplies some contraceptives free of charge was pervasive. Here, "family planning" was equated in the minds of the people with sterilization "operations" in spite of FPAI's educational outreach efforts.

The potential loss of potency of female labour and health that sterilization symbolizes in the working, and especially assetless, classes/castes is generally considered to be less threatening to family welfare and economic survival than the negative effects vasectomy is perceived to exert on male fitness, mobility and income-earning capacity. Misconceptions also still prevail amongst both sexes of all social groups that vasectomy leads to irreversible sterility and the long-term impairment of male health and virility, sometimes even resulting in death. Such fears seem to be founded on the damaging effects the local population experienced during the Emergency period where mass sterilization camps characterized by unhygenic conditions, medical incompetence, lack of follow-up care and infection- did actually result in deletorious and even fatal consequences for some men. For instance, a community leader from Digoor remarked, "People are afraid of FP and no one will accept it. I cannot force the men to adopt sterilization. Two men out of five died from vasectomies

during the Emergency".

Widespread and deep fear of vasectomy has led to intense male resistance towards shouldering responsibility for terminal methods. This attitude was vividly enunciated by a youth club leader in Lakkur who contended, "Unless women are convinced to get sterilized, we cannot adopt family planning. Women volunteer for operations so men do not have to go". Male resistance to vasectomy and FP in general is particularly pronounced especially amongst Muslims, as one woman from this faith complained in Yeshavantapaura. A number of respondents told us that Muslim women adopt FP methods and often go for sterilizations "on the sly" because of widespread religious opposition to FP in their community. Muslim female FP acceptors reportedly fear ostracism and rejection by their community and religious leaders. On the other hand, it is difficult to assess just how strong or widespread such censure actually is, for as a Mulsim male youth leader in Masthi confided, "It is a myth that Muslims do not accept FP. They too know that having more children means more problems. Muslims also control family size but don't propogate the fact because of religious reasons. Most Muslim women get operated on secretly in Bangalore".

However, most Muslim women we spoke to expressed extreme frustration with their professed lack of ability to regulate

their own fertility. For example, one Muslim mother of five daughters admitted, "I would have had only two kids if I'd had the choice and freedom. But my husband did not agree! He says children are 'God-given'. I have no right to advise my daughters on how many children they should have". As a result of this kind of male antagonism to limiting their family size, many Muslim women tend to adopt spacing methods without the knowledge or consent of their husbands. In fact, in one village, the existing Mahila Mandal has found it effective to motivate Muslim women to adopt contraception by way of distributing oral pills and counselling for IUD's (after recipients have satisfactorily met the necessary health requirements, of course). This service has allowed these women to take independent action since such FP methods are less temporary and visible. A Muslim woman from Seetanayakanahalli observed, "Muslim women hide their adoption of FP out of shame, fear of religious oppositon and significant persons' reactions". Such negative repercussions can be devastating, especially for the poorest village women who rely on community support and the sanction of religious leaders to arrange and conduct the marriage of their daughters.

As a rule, we found the most prevalent male attitude towards FP to be ambivalent. They usually stated that even

though limiting the number of children per family was a desirable and even beneficial thing for the family and community, women were and should be the ones ultimately responsible for taking contraceptive measures - even in those cases where a decision had been made (most commonly, unilaterally by the men) to regulate fertility and control family size. As a result, it is still the women in the villages, to a great extent, who take it upon themselves to adopt both spacing and terminal FP methods. Yet very few women felt their decision to adopt FP was self-determined or even mutually-arrived at in consultation with their respective spouses.

DOMINANCE OF FEMALE TARGETTED FP METHODS:

Reports from the village leaders and FPAI officials all indicate the most popular FP method to be female-sterilization by either tubectomy or laparoscopy operations. Quantitative data gathered from PHC and FPAI sources confirm these impressions of the villagers (refer to chart X). Although "nirodh" (condoms) are perceived by those interviewed as being very popular and the next most commonly used contraceptive method in Malur, in no village does condom use exceed recourse to female sterilization as an FP measure. In medium- and high-level FPA villages, especially where Community-Based Depots are run by Youth Clubs and/or ANM subcentres are located, the number of condom users totals

TABLE 13

FAMILY PLANNING PRACTICE BY METHOD
(as of October 1986 and according to Malur Taluka's Primary Health Center)

	PGFN	TC	PS	SS	EM	EC	TO	VO	IUD	ORAL	CC	FP TOTAL	REC	% EC'S COVERED	PRESENCE OF CBD ‡‡	PRESENCE OF ANM SUBCENTER ‡‡‡
Kesagare	529	84	2	6	-	76	51	9	3	-	6	69	7	90.78	Yes	-
Kodur	720	109	1	5	2	101	42	24	4	2	5	77	24	76.23	Yes	Close to PHC
Bhoovanahalli	745	118	4	23	1	84	35	15	4	3	5	62	22	73.80	Yes	-
Nutave	691	74	3	2	1	68	26	-	15	2	6	49	19	72.05	Yes	Yes
Huladena-halli	1216	186	5	20	6	155	60	-	15	9	26	110	45	70.36	Yes	Yes
Bellavi	445	86	1	13	1	71	34	-	4	2	3	43	28	60.56	-	Yes
Boppanahalli	450	75	2	5	3	65	25	-	2	2	10	39	26	60.00	Yes	-
Chickapura	330	51	2	1	1	47	16	-	2	1	8	20	5	57.40	-	Yes
Lakkur	2696	425	8	27	5	333	146	8	20	10	20	204	181	52.90	Yes	Yes
Thirasula-hatti	1467	77	4	-	2	71	23	-	3	-	9	35	36	49.23	Yes	-
Nidira-aangala		654	92	3	1	2	86	30	-	-	2	9	41	45	47.60	Yes	-
Kaikare	843	125	3	4	-	118	40	-	2	8	5	55	63	46.61	Yes	-
Chikkathiru-pathi	1107	172	10	22	2	138	48	1	1	3	6	54	79	46.00	-	Yes
Seethanaya-kanahalli	740	93	4	4	1	84	22	-	6	4	3	35	49	60.56	-	Yes
Sivarapatna	1575	260	7	10	3	234	66	-	10	8	6	90	15	38.60	Yes	Yes
Masthi	3673	400	6	32	9	353	92	1	8	9	13	123	230	34.84	-	PHU ‡‡‡‡‡
Yesha-vantapura	1360	160	5	25	15	140	30	-	1	-	7	38	102	27.40	-	Close to PHC
Bingipura	347	52	1	5	2	44	8	-	-	-	4	12	51	27.20	-	-
Digoor	150	17	0	9	0	8	-	-	-	-	-	-	8	0.00	-	-

(Key to chart:

TC - Total couples
PS - Primary Sterility
SS - Secondary Sterility
EM - Early Menopause
EC - Eligible Couples
TO - Tubectomy
VO - Vasectomy
FP -:FP Coverage by no. adoptors
Total:
REC - Remaining Eligible Couples
% Covered - % of EC's effectively protected by FP method

‡‡ CBD - Community Based Depots for distribution of nirodhs (condoms) by YC members (all male) established in the area by FPAI and (free) given by govt. (ANM Subcentres).
‡‡‡ ANM - Auxilliary Nurse Midwife, responsible for servicing 5,000 population in the rural area attached to 1 Primary Health Subcentre; especially, in charge of Maternal Child Health (MCH), including Family Planning
‡‡‡‡ - Primary Health Center (serves over 50,000 pop.)
‡‡‡‡‡ - Primary Health Unit (serves 15,000 pop.)]

(Source: Calculated and derived from fieldworkers' chart on Family Practice by Method, FPAI, KRP as of October 1986.)

TABLE 14
TALUKA, STATE + NATIONAL PATTERNS OF FP USE BY METHOD

	% ECs Effectively Protected			% Protected by Sterilization			% To to all Sterlizations			% covered IUD			% Others (Orals + CC's)		
	Malur	Karnataka	All-India	Malur	Karnataka	All-India	Malur	Karna-taka	All-India	Malur	Karna-taka	All-India	Malur	Karna-taka	All-India
1975-76	11.75	13.72	17.10	91.85	12.12	39.20	NA	82.69	46.10	5.34	0.69	8.90	2.81	1.50	1.50
1976-77	20.21	20.58	23.70	90.00	18.83	65.90	47.00	47.50	25.00	2.69	0.98	4.60	7.31	1.63	1.63
1982-83	51.78	29.50	25.70	73.51	68.15	22.00	100.00	99.00	85.30	20.47	7.72	1.40	5.96	4.12	2.50
1983-84	54.35	32.20	29.60	83.12	86.57	30.10	100.00	97.90	85.41	11.92	8.70	4.12	5.96	4.73	16.49
1984-85	NA	36.30	32.30	NA	84.30	41.60	99.00	97.40	86.55	NA	10.62	5.02	NA	5.87	13.26

[Note: NA = Not Available; Orals = Oral Pills; CC's = Condoms; To = Tubectomies and IUD = Intra Uterine Device]

(Sources: Ministry of HFW Year Books 1982, 83 & 84, Karnataka Status Report HFW Year Book 1985-86, IFC pp. 80-83 Evaluation of FP Programme in Karnataka and Government of Karnataka, A Study the Working of the Family Welfare and MCH Services in Karnataka 1980-85, Dept. of Institutional Finance and Statistics, Karnataka Govt., Secretariat Bangalore, Jan. 1986, pp 73 and 86).

between 30-50% of female sterilization acceptors on the average. In villages with low FPA rates, the use of condoms is only 7-15% as common as female sterilization amongst eligible couples (see table 13). Compared to national and state-level FP coverage of EC's by condoms, Malur's performance along these lines is indisputably superior (see table 14).

ANALYSIS OF PATTERN OF TYPE OF FP METHOD ADOPTED PER SAMPLE VILLAGE:

Wherever the YC was "superactive" in a particular village, such as in Kesagare, Kodur, Huldenahalli and Thiramulahatti, the proportion of male spacing methods adopted in relation to the total percentage of spacing methods used in that village is almost 50% or higher. In fact, in Thirumalahatti, male use of condoms is over three times greater than the exhibited female use of spacing methods (IUD's and oral pills). Similarly, the ratio of total male methods to total female methods is around 25:75 in all of these four villages, which is higher than the corresponding average ratio for the entire sample. The only village out of these four where YC activities are supplemented by those of a MM is in Kesagare, where the MM is superactive. These two general patterns also hold true in

CHART X

SPACING vs TERMINAL FP and PATTERN OF MALE vs FEMALE METHODS

Village	% of EC coverage	% Sterilizations (VO&TO) to total FP Methods	% To/Steri-lizations	% Female Methods (oral IUD's Ster'n) to all Methods	% Male Methods (VO/Condoms) to all Methods	Total % spacing(CC, IUD/Orals) to Total FP	% Spacing methods to all spacing used	
							% Female	% Male
1	2	3	4	5	6	7	8	9
Kesagare	90.78	86.36	73.91	78.26	21.74	13.04	4.35	8.70
Kodur	76.23	85.71	63.64	62.31	37.66	14.29	7.79	6.49
Bhoovanahalli	73.60	80.65	70.00	67.74	32.26	19.35	11.29	8.06
Nulave	72.05	53.06	100.00	87.76	12.24	46.94	34.69	12.24
Huladenahalli	70.96	54.55	100.00	76.36	23.64	45.45	21.82	23.64
Ballavi	60.56	79.00	100.00	93.00	7.00	20.00	14.00	6.00
Boppanahalli	60.00	64.00	100.00	75.00	25.00	36.00	10.00	26.00
Chickapura	57.40	80.00	100.00	95.00	05.00	55.00	15.00	40.00
Lakkur	52.56	76.00	71.00	86.00	14.00	25.00	15.00	10.00
Thirumulahatti	44.29	66.00	100.00	74.00	26.00	34.00	08.00	26.00
Nidiramangala	47.60	73.00	100.00	79.00	21.00	26.00	04.00	22.00
Kalkere	46.60	72.00	100.00	90.00	10.00	27.00	18.00	9.00
Chikkathirupathi	46.00	90.74	88.09	96.30	03.70	16.52	07.41	11.11
Seethanayakanahalli	41.66	62.86	100.00	91.43	08.57	37.14	28.57	08.57
Sivarapatna	38.60	73.33	100.00	93.33	06.67	26.67	20.00	06.67
Masthi	34.84	75.61	74.80	88.61	11.39	24.39	13.82	10.57
Yeshavantapura	27.40	78.95	100.00	81.58	18.42	21.05	02.63	18.42
Bingipura	27.20	66.67	100.00	66.67	33.33	33.33	00.00	33.33
Digoor	00.00	00.00	00.00	00.00	00.00	00.00	00.00	00.00
Total sample Average %		69.43	86.43	70.02	16.71	27.53	12.41	15.09

(Source: Calculated and derived from fieldworkers' chart on family practice By Method. FPAI, MAP as of October 1986.)

medium- level FPA villages in a couple of settings where the ... is classified as "active", namely in Boppanahalli and Nidiramangala. In only one of these villages is there an active MM.

Conversely, wherever the YC's are categorized as either "passive" or "non-existent" the ratio of male to female spacing methods as well as the overall ratio of male to female FP methods is relatively low- except in the case of Bingipura where the use of spacing methods is exclusively male and the adoption of male methods is one-third of the total FP methods used in the village.

In villages where both MM's and YC's are "active" and working together, the percentage of spacing methods used is always above 19% of the total FP methods adopted by eligible couples in that village. Indeed, for the entire sample, the proportion of spacing methods to the total FP methods used is consistently above 18% in all but two of the villages surveyed. In approximately two-third of these villages, use of spacing methods constitute over 25% of the total use of all FP methods. Additionally, in eight out of the 19 villages, the percentage of male methods to total FP methods adopted is above 20%. Out of these eight villages, four of them are clustered in the high-FPA category.

The proportion of sterilizations to all FP methods

accepted in these 19 villages is universally above 50%. The percentage of female sterilizations performed was invariably found to be at least 70% of the total number of sterilizations, except in Kodur village where around 36% of the sterilizations to date have been vasectomy operations. From our interviews in this village, we discovered that the majority of these vasectomies were done during the Emergency period but since YC leaders in this locale have themselves volunteered to undergo the operation, an above - average number of men have followed their example. Still, we found that in twelve out of the 19 villages surveyed, 100% of all sterilizations have been performed on women only. Wherever MMs are active (in six villages) we found the percentage of female sterilizations to comprise 100% of all sterilizations done except in Chikkathirupathi, where it was only 89%.

Taking all 19 sample villages as a single analytical batch, we found the average ratio of sterilizations to all methods to be 69.43%. The average proportion of female sterilizations to total operations (Vasectomy and Tubectomy) constituted 86.43%. The mean percentage of female methods adopted out of all FP methods was 78.22% while the mean percentage of FP coverage by male methods added up to only 16.71% of all FP methods. The average proportion of spacing methods to all contraception used was found to be 27.53%,

with female vs male spacing methods comprising 12.44% and 15.09% of this figure respectively.

In order to place our sample averages within the framework of Malur's overall FP performance, it is useful to take a look at the relevant taluka-wide figures over time. In 1983-84 in Malur as a whole, permanent methods constituted 82.12% of all FP methods adopted while 17.88% of the EC's effectively covered had chosen spacing measures. Out of this total 12.54% were adopted by women and 5.34% by men at the time. Table 14 locates place this breakdown within a wider geographical and historical perspective.

While the proportion of tubectomies to all sterilizations averaged 86.43% for our sample as a whole in 1986, the corresponding percentage for the state of Karnataka was much higher even in 1982-83 - when it was 99%. In all-India during 1984, tubectomies constituted 85.3% of all sterilizations, with the comparable statistics for 1985 being 86.55%.

Between 1975-76 and 1983-84, the percentage of spacing methods to all FP methods adopted in Malur increased from 8.15% to 17.88%, a notable rise of 9.73%. The percentage of sterilizations to total methods exhibited a commensurate decline in Malur over the same period whereas the coverage of ECs by sterilizatison as a percent of FP totals actually

increased in the state of Karnataka from 12.12% in 1975-76 to 88.15% in 1983-84.

In summary, the adoption of spacing methods has not only substantially increased (and risen to levels surpassing both state and national averages) over the decade of MRP but the percentage of ECs adopting male-oriented FP methods in Malur is also much higher on the average than in both Karnataka and all-India. This trend and the 1986 FP coverage rate of 61.50% coverage rate for Malur (in contrast to the state-level coverage of 36.39% and national rate of 36.2%) may be attributed to the exceptionally high degree of local activism through YCs and MMs that has exerted a dramatic impact on Malur's FP profile and performance over the decade.

In spite of the fact that vasectomy is a relatively simple, inexpensive and reversible method requiring no hospitalization (unlike tubectomy) and the fact that condoms are free of side-effects, reliable, easily obtainable and protect against disease, programme emphasis on and popular adoption of these male-centered methods has been dismally low at district, state and national levels. Malur taluka has shown at least some improvement in condom coverage amongst ECs over the last decade, which represents a promising departure from the otherwise poor male record with regard to responsibility for, and adoption of, contraception.

Yet even in Malur, a situation still reigns wherein female sterilizations capture almost 80% of the total FP methods adopted. In order to identify the factors contributing to the overwhelmingly high rate of tubectomy/laparoscopy relative to other readily - available birth control methods, we probed female attitudes and behaviour with respect to decision-making about, and responsibility for, adoption of family planning.

It became obvious to us in the course of interviewing a cross-section of women from the 19 sample villages that a certain maternal, protective disposition that these women share across caste, religion, class and residence groups prompts them to volunteer or agree to undergo sterilization rather than exposing or subjecting their husbands to the procedure. Even though their own present well-being and/or future earning ability may be perceived to be endangered by such an operation, women apparently would rather incur the health and economic risks sterilization poses (or is believed to pose) than request their husbands to submit to analogous ones. Both men and women we interviewed usually underplayed the adversities associated with female FP operations while they exaggerated those connected with vasectomies. It seemed to us that in most instances, female acceptance of sterilization stems from the implicit trade-off women see

between the long-term suffering that additional child-bearing and rearing represent and the short-term inconvenience and pain that sterilization may bring. They frequently opt for the latter (if given a choice and the facility), especially once the desired number of children have been borne into the family. In Malur, women's manifest willingness to undergo the "operation" in such a non-coericive context suggests that their desire to determine their own fertility is more powerful than their fear of possible negative repercussions of either tubectomy or laparoscopy.

Female socialization patterns in Indian society also produce a certain disposition amongst rural women towards an unquestioning submission to the pressures prevailing upon them to undergo sterilization. Rural Indian women seem to succumb to this procedure more readily or frequently than they seek or insist upon their partner's cooperation or initiative in taking action/responsibility for FP. Such resignation is vividly exemplified by the following comment, stereotypical of most women that we interviewed regardless of caste, class, religion or age: "We tell our husbands not to get sterilized because their earning ability or health might get impaired so we offer to get operated on ourselves".

Malur women's willingness to martyr themselves in this manner reflects a tendency that forms part of the general

psycho-social make-up of women, especially in rural areas of India. This self-effacing propensity has made Indian rural women particularly fertile recipients of the official thrust of Government FP policy which to date, has been predominantly female-targetted

CHAPTER VII

FIELD NOTES RELATED ON WOMEN FOCUSSED BIRTH CONTROL STRATEGIES

The Indian rural women's pre-disposition towards the adoption of terminal methods must be placed in the overall context of national and state-level official FP programmes which have by and large focussed on female targets for FP quota fulfillment. High female receptivity to birth control has been well-capitalized upon by past and present Government health infrastructure and policies. The symbiosis between rural women's vested interest in regulating their fertility and health on the one hand, and the Government's long standing objectives in achieving population control on the other have thus given rise to and resulted in disproportionately high rates of female sterilizations vs other FP methods.

Despite the decade long efforts made by FPAI to promote other FP methods, ten years time is hardly sufficient to reverse the historical tide favouring female-oriented terminal methods over all other contraceptive measures. This

state of affairs persists due to a variety of factors related to:

(A) the Indian Government's policies in terms of motivating FP adoption;

(B) the process of FP programme implementation;

(C) socio-cultural conditions, and

(D) past and present power configurations prevalent in rural Indian communities.

(A) GOVERNMENT POLICY/FP MOTIVATION:

Government incentives to health personnel responsible for meeting FP targets favor and depend heavily on women-oriented FP methods, especially sterilization. Governmental monetary rewards for both male and female sterilization cases are equivalent. However, Government targets have been formulated in such a way that the motivation of one sterilization case is weighted as equal to motivating either nine cases of oral pill users, three cases of IUD acceptors or twelve cases of condom acceptors. Official health personnel thus find it more remunerative, convenient and efficient to focus their outreach efforts on potential female sterilization cases and thus end up giving greater priority to these easily-motivated, one-time interventions.

The competition for meeting FP targets and quotas at the district, state and national levels has created a situation where health departments encourage the motivation of terminal over spacing methods. Currently, the State Health

and Family Welfare Department receives from the Central Government of India Rs.80 per vasectomy operation done as opposed to Rs.100 per tubectomy performed These fees include drugs, dressings, diet transport and motivational rewards (see table 15).

B.PROCESS OF FP PROGRAM IMPLEMENTATION:

In a parallel vein, the Government's approach to the MCH system in rural areas in effect encourages more frequent contacts and rapport with potential female sterilization cases (mothers who need pre-natal and post-natal care) than with eligible male candidates. In addition, because of socio-cultural practices favouring the ante- and post-natal confinement of mothers, these women are available during the official working hours of the ANM. The ANM's daily schedule effectively limits her house calls to the period of time when men are at work in the fields or in respective occupations. This set-up thus places women in a more strategic and susceptible position to absorb FP outreach and messages. In addition, the Health and Family Welfare Department of Karnataka State have actively encouraged Mahila Mandals to launch FP campaigns by earmarking funds exclusively for this purpose further increasing the likelihood that women will continue to be more ready recipients of contraception in their communities than men.

TABLE 15
MONETARY INCENTIVES FOR ACCEPTOR/MOTIVATOR OF STERILIZATIONS

	GOVERNMENT OF KARNATAKA				GOVERNMENT OF INDIA	
	Acceptor	Motivator			Acceptor	Motivator
		Employee of Health & Family Welfare Dept	Employee of Other Dept	General Public		State Govt. Health/FW Dept
Vasectomy(VO)	Rs. 50.00				Rs. 100.00	
Tubectomy(TO)	Rs. 100.00				Rs. 160.00	
Special rules for VO/TO cases:						
First 20 cases		20 Rs x 15 = 300				
Next 10 cases		10 Rs x 30 = 300				
Next 10 cases		45 Rs x 10 = 450				
		60 Rs x 10 = 600				
		cases 65 = 1650 Rs.				
First 5 cases			Rs 15 x 5 = 75			
Next 5 cases			Rs 30 x 5 = 150			
Next 10 cases			Rs 45 x 10 = 450			
Next 10 cases			Rs 60 x 10 = 600			
			cases 30 = 1275 Rs.			
First 5 cases				Rs 15x 5 = 75		
Next 5 cases				Rs 30x 5 = 150		
Next 20 cases				Rs 45x20 = 900		
Next 20 cases				Rs 60x10 = 600		
				cases 40 = 1125 Rs.		
Per VO case (drugs, diet, transport, miscellaneous)						80 Rs
Per TO case (drugs, diet, transport, miscellaneous)						100 Rs

(Sources: Government of India Ministry Health and Family Welfare Dept. Year Book 1983-84; Interview with State Demographer of Karnataka Health and Family Welfare Dept. 2-3-1987, Bangalore; and Government of India Health and Family Welfare Dept. No. 105 FPs 84/16-4-1985).

(C).SOCIO CULTURAL CONDITIONS:

Given the socio-cultural milieu in Malur, the additional deterrents of vasectomy (apart from the most visible and already mentioned ill effects of mass vascetomy camps conducted during Emergency) include the strong social stigmas and embarassment related to cases of pregnancy where the husband has undergone vasectomy. Doubts invariably arise as to whether such a pregnancy is the result of infidelity or operation failure.. Such a situation leads to family break-ups and community scandals. Women thus are prone to accept a terminal FP method themselves rather than risking such vasectomy-associated humilitations after completing the desired family size. This reality has produced a situation in Malur where the word "sterilization" or "operation" is virtually synonymous with laproscopy and/or tubectomy.

One middle-class woman interviewed in Masthi town questioned this bias in policy and practice. She asked us, "Why should females be the only ones to get sterilized. Why not men?" We should strike against the men, who need to know about family planning more than we do".

COMMUNITY DECISION MAKING REGARDING RESPONSIBILITY FOR FP AS A REFLECTION OF COMMUNITY POWER CONFIGURATIONS:

While the majority of women we interviewed in Malur indicated that they have little leverage in decisions pertaining to reproduction one educated/literate "high" caste and land-owning woman claimed, "Middle-class women now want to stand on their own two feet, earn money to help themselves and decide on the number of children they will have." Another woman from the small town of Masthi substantiated that progress has been made in this realm, remarking, "Now our girls can decide for themselves and tell their husbands, 'we will only have two children'".

We must qualify, however, at this point, that decision-making perogatives and privileges are still overwhelmingly vested not only with the male members of these rural families but with the elders and in-laws of both spouses even with respect to family planning. This reality posed many problems for FPAI in organizing rural women, both to form/participate in Mahila Mandals and to adopt health and family planning measures. As the former Chairperson of FPAI's Bangalore Branch commented, "Even to get to the kitchen to talk to the 'target' women was quite a difficult task. We would have failed if we had initially approached young women and men directly. The best way to reach this

group was through the right royal road - the elders - because the youth were scared and said they could not make decisions without the permission of their elders".

Some rural women seem to feel so utterly disenfranchised from decision-making even within their own household that often they were not even able to express how many children they would like to have. If they could or did articulate the number of offspring they desired, these women rarely felt they had the means, choice or power to act on such preferences. One sixteen year old newlywed with a six month-old baby from the remote village of Digoor could not even articulate her preference when asked what she thought of ideal family size would be. She merely sighed, "My husband wants ten children, but we do not discuss family planning. I do not know anything about it."

On the other hand, some exceptional women have made and implemented on family planning decisions without the approval of their husbands or in-laws. One SC marginal farmer from Bellavi, a candidate for Mandal Panchayat elections and a mother of three children, shared with us her traumatic experience of being locked in her house by her husband and mother because they did not want her to get sterilized. Somehow she escaped and got operated on. She justified this unilateral move, asserting to us "I was the one who would

suffer from bearing another child so it was my right to take action". This courageous and rebellious woman now motivates many women in the same region to adopt different family planning measures. The Director of an NGO who has been closely associated with FPAI's and MRP aptly observed, "Once the FP concept catches on in an area through women it spreads like fire".

PERCEIVED CHANGES IN FEMALE STATUS/ROLES/ACTIVITIES

In all of the nineteen villages visted,. both men and women of all socio-economic, religious and age groups consistently voiced the opinion that women in their communities have generally become more educated, aware of the need for better education and proper health care, hygiene and nutrition, politically conscious and active in society. Many have generally benefitted from FP and health services.

These trends were particularly visible in the high-level FPA villages where women, as a rule, were involved to a greater degree in both MM's and income-generation projects. In general, the five MMs in these high FPA settings were inclusive of all castes and classes and were characterised by a high degree of determination and activism to improve the economic status of women and the community.

The female participants in MM's and beneficiaries of

income-generation schemes that we interviewed in these five villages expressed unqualified enthusiasm about the changes they had observed over the past decade to the benefit of most women in their communities.

They perceived these changes as being sparked by MM activities along a variety of lines, including the organization of nutrition demonstrations and health care programmes such as the immunization of pregnant women and children, counselling of mothers about ante and post-natal care and motivational events for FP adoption. MM's also were reported to be responsible for the monitoring and encouragement of female school-going children, the establishment of Balwadis, Adult Education Centres for women and income-generation schemes. These ranged from the allocation of seed money for petty trading activities to the construction of a major sericulture employment centre for women.

Another positive contribution to the enhancement of female status in these villages involved the close collaboration of MM's with the local YC's and Village Health and FW committees. In Kodur, for example, the YC organised a "No Birth Year" in 1978 while in Huldenahalli, the local youth mobilized processions around themes such as anti-dowry and the importance of delaying age at marriage. In Nootave,

the MM and YC have conducted campaigns such as the declaration of a "No Pregnancy Year" (1982) and "No Birth Year" (1985), and around anti-dowry issues. They have also successfully eradicated alcohol (1981) as did the LVG's in Kesagare. Women perceive this achievement as greatly easing family tensions, violence against them and the misallocation of household income in particular.

Women in these villages have also joined hands with the YC's in "Shramadan" (voluntary labour donation) over the years thus improving community infrastructural facilities, anitation and a sense of strong village identity/pride.

A wide cross section of women themselves within this FPA category were well aware of the tide of positive changes in their communities as well as self-conscious of transformations in their own roles and identities. One middle class woman, Govindamma, the MM secretary of Kesagare and the first and only woman ever to buy silk cocoons at the Kolar Cocoon Market and sell silk in Bangalore Silk xchange and bid in an all-male market, acknowledged, "Ten years ago, I was so frightened to come before people. Now I can not only meet and talk to them on the same platform, but I can do so without fear; even with a Member of the Legislative Assembly (MLA) or a Minister..... We all have fewer children now so we have more leisure and can engage in income-

generation schemes. Now we women know what the world is outside the four walls of the home".

The men interviewed in this high-level grouping also corroborated these perceptions. In fact, some men in these villages appeared to feel threatened by the positive changes the women have experienced. For instance an influential male leader from Kesagare commented, "In this village most of the decision making is done by women now. Give these women one step and they will take a mile. Now men are in danger because women have progressed so much and they don't need us economically any more."

In terms of decision-making, there seems to be a direct relationship between female participation in MM's and income-generation projects and their improved status both in the household and the community. The mechanism through which such transformations seem to take place is through the formation of new female roles and identities engendered by their involvement with an organized, social collective of women which centres around work activities (income-generation) as well as community causes. One of FPAI's CDW's observed, "MMs and income-generation schemes catalyze women to think about themselves for the first time and ideas begin to flow amongst them on how to change their lives and raise their status". The newly-found work roles and identities of

these women triggers the development of an awareness of their own potentials and the possibilities for utilising them fully. Apparently, participation in the collective leads to a strengthened confidence in these women to assert themselves and express their opinions within their own families, which exerts a ripple or domino effect on decision-making with respect to fertility regulation and reproductive behaviour within the household. This dynamic is reinforced by the example set by influential female leaders who have already adopted FP methods and who motivate other women in these groups to limit their family size.

In one of these villages a young newly-married man confirmed the observations of such changes articulated by female respondents by stating, "Women have a great position and are more knowledgeable now. For any decision made in the house, women have to agree before action is taken." Another youth leader in Huldenahalli proudly remarked, "Decision-making in the families used to be totally male dominated. Now there is greater equality between men and women. Women have progressed so much that now men can not decide on their own. Men have no more freedom".

As a consequence of greater female leverage in the family decision-making process (due either to the increased earnings and/or to the greater social awareness and status

enjoyed by women involved in MM's and income- generation projects in these villages), the eligible couples concerned more frequently tend to make a mutual decision to adopt a family planning method. This effectively frees the female partner from the burden of repeated child-births and provides her with greater opportunities to engage in alternative activities. The women we interviewed who described this increased independence and their resultant higher degrees of productivity (rather than of reproductivity) experienced these transformations as empowering to themselves and beneficial to the overall community.

The most striking pattern we observed in these high-level FPA villages was that although middle and upper class and caste women were usually the founders and first members of the MMs (since they could afford to pay the registration fees), the lower-class and SC/ST women were absorbed gradually into these associations. Cultural programmes (i.e. films, dramas, discussions) sponsored by FPAI and MMs in the villages as well as the lure of prospects for income generation through schemes initiated by these groups served to attract the involvement of these more disadvantaged groups. We found that the primary reason that these poorer women joined MM's was the opportunity they saw these clubs as offering in terms of a more reliable source of livelihood.

The consequences of female participation in such organisations/projects have primarly been the attainment of greater economic security and status for women of all classes, religions and caste groups. Other consequences (perhaps unintended and rather surprising) of their association with such collectives include: the visible and professed improvement in women's position within the household (especially reflected in better communication with their spouses) ; less segregated and more equal gender relations in the community and across generations; a substantially higher level of female participation in public meetings and developmental activities; the breaking down of caste prejudices and barriers; greater harmony between Hindu-Muslim religious groups; and a higher overall level of family planning adoption in these five villages. Other manifest and unanticipated spillover effects of higher levels of female activism in these arenas include pronounced reductions in infant and child mortality rates due to enhanced maternal health and child-care facilities as well as a greater emphasis on the equality of boys and girls both within the family and in the local schools.

Although these positive consequences were most visible and more frequently articulated in the high FPA villages, especially in terms of women's development, they have by no means been restricted to the top-ranking five villages in our

sample. In the medium range FPA category, most notably in those villages where MMs and income-generation projects existed, women exhibited a relatively high degree of awareness about the realistic possibilities for the socio-economic transformation of their condition and communities but a lesser degree of participation and effectiveness in translating these ideals into action. The struggle of women in this category of villages, to organize themselves for self-help has taken a variety of forms. These include attempts to mobilize women through the funding of MMs (in Chikapura and Bellavi, these are now being registered with the help of Government balwadi teachers) and Yuvathi Mandals as well as entreprenurial schemes for women (such as in Lakkur) to experiment with new types of income-generation activities. Such projects have involved the planting of Muthugade and eucalyptus saplings and mushroom-rearing (in Neederamangala) and the provision of MM members with rolling loans, sewing machines and skills (through Trysem in Chikkathirupathi) inspiring women in nearby villages (Kalkare and Seethanayakanahalli) to commence similar schemes. In Seethanayakanahalli, the MM is determined against all odds to start a dairy project for women even though they have been waiting for over a year for a KSWAB loan and have no seed money for the formation of a much desired Consumer Cooperative Society.

The MMs in this middle FPA category, even though they have only partially succeeded in sponsoring lucrative income-generation schemes and absorbing Governmental socio-economic development schemes, have made substantial strides in instilling a high degree of awareness and activitism in their members. In four out of nine of these villages, MMs have elicited the participation of women in village developmental and FP motivational activities. For instance, the Lakkur Yuvathi Mandal motivated 15 women (of which two were Muslims)to get sterilized through a door-to-door campaign undertaken in collaboration with the Malur Block Development Officer (BDO). The MM in this village has also gained a reputation for motivating 15 new FP new cases per year over the past decade as well as for providing many women with income-generation opportunities. In Seethanayakanahalli, the MM has likewise encouraged ten Muslim women to undergo sterilization in the last three years.

In Bellavi, where a MM is being registered, and 90% of the village women want to join as soon as possible, an elderly male leader remarked, "Women attend meetings now, unlike before. They are not so much afraid these days of leaving their homes". The increased degree of female participation in public life is for the most part viewed

favourably by both men and women in this category of villages but especially where MM and income-generation projects are operative. For example, one male youth leader in Lakkur commented, ". Women are outspoken in the family now. Economically they are earning a small amount and depending on themselves for minor expenses. They are eager to know about and utilize Government schemes. Awareness is the reason women are advancing now." As a powerful male leader in Bopanahalli put it, "Women are much stronger now. They come forward to ask for things boldly. Ten years ago they didn't ask for anything. Still, there is lots to be done".

Women themselves are very conscious of, and repeatedly expressed their impatience about, this fact. As a poor woman from a SC community admitted, "There has been little improvement in our lives but at least now the way to progress is clear to us."

Compared to the highdegree of inclusion of women across castes and classes that we found to exist in the MMs in this top FPA category (except in Kodur where no SC woman belonged), the MMs in the medium-level villages suffered from their relative failure to incorporate members from all socio-economic groups in the community. Only in four of these nine villages did we notice a dissolution of caste and class barriers in women's organizatisons, and in only one of these

did the MM include a membership of 50% Muslim women in Seethanayakanahalli.

The intensity of YC activity in six of these medium-level FPA villages has compensated to some degree for the relative inactivity of the MM's in that YC's have been particularly effective in inspiring all members of the community, including women, to work for the greater social good. Community welfare programs sponsored by these LVG's have included "shramadan", the eradication of alcoholism, the adoption of FP methods and a considerable reduction in maternal mortality. In Thiramulahatti, for example, there were absolutaely no pregnancies or childbirth related deaths throughout 1978.

In the lower-level FPA villages, we encountered a much greater number of negative assessments and attitudes voiced with respect to women's status. The reaction we got when we approached an SC male leader in Digoor epitomizes the state of affairs in these low FPA villages, for he warned us, "Don't ask the women. They don't know anything. The women have a great position here [sarcastic]. They sit at home and go for coolie work - what is the big deal about them?"

Negative views pertaining to changes in women's status were mainly expressed by very poor, landless agricultural

labourers - both male and female. Poorer women saw little or no positive or tangible changes in their lives in contrast to the reports we received from those belonging to the middle and elite classes and castes. For example, one elderly SC woman in a cash-crop-dominated area from a village with a low FPA rate (27.3%), Bhingipura, grumbled, "Before agriculture was good. Now there are no rains and everyone is poor. Things have gotten worse especially since eucalyptus is now planted for 50 kms. all around. Now we have to go far away for agricultural coolie work and wwe have so many difficulties". Another older woman recounted. "In those days at least we had enough food and strength. But these girls have a bad diet, crooked backs and no rains". Due to these adverse ecological and health conditions, particularly in the drought-prone and poorer areas of Malur, FPAI volunteers have observed that elderly women in these villages, contrary to conventional wisdom and traidition, encourage their daughters-in-law to adopt FP methods nowadays.

In this lowest FPA category of five villages, only two MMs were functioning, both recently founded in 1985. Each included only around thirty members and thus have not had adequate time or the enrolment necessary to substantially transform their communities or women's lives. In Yeshavantapura, there has been a great resistance amongst women themselves to come together and join the MM. One

Muslim woman confided, "I am afraid of joining the MM, as people will talk behind my back and it will be difficult to get my daughters married". On the other hand, the Muslim President of the MM in the same village who comes from a very poor family felt that distinct and positive changes in gender relations had taken root recently, although these had been rather sporadic and confined to the public arena.

Only four small-scale income-generation projects have been launched in these villages, two by the active MM in Sivarapatna and two by the more passive MM in Masthi. The MM in Yeshavantapura has acquired a sewing machine from FPAI and is currently running a tailoring class but no income for women has been generated yet. This relative lack of female activism and the absence of schemes to enhance women's earnings can be seen as one of the limiting factors in this category to stimulating the kind of greater awareness and independence that we found women had attained in the other two categories of villages where MMs and income-generation projects were particularly effective.

Only in interviewing middle-class women of Masthi did we encounter women who held positive views about the transformations that have taken place in their lives and about family planning. One such woman recounted, "Now women are freer and don't feel so shy anymore. They have the

courage to work, go out and study. As women, before we didn't realize that we have to do what we want. No one else can do it for us. For example, I myself wouldn't have talked to you ten years ago. Now I do so boldly". However we found negative attitudes towards FP and pessimistsic outlooks on women's status prevailing amongst poorer women and most men in this set of villages. For instance, a low-income Muslim mother of five children in Sivarapatna complained, "Girls are waiting to get married until later these days so I can't even marry my sons off. If we had two more boys, we would have enough to eat now and be better off." Similarly, an old man in the same village told an FPAI's CDW, "A pumpkin can never be a weight to a creeper," insinuating that childbearing never poses any problems for women and children and ought not to represent a burden to them.

In the lowest FPA villages, especially where no MMs or income-generation projects existed, we generally found a relatively low degree of awareness amongst women . They seem to feel little control over their lives and experience high levels of frustration and apathy. Muslim and SC/ST women, as members of most deprived sector of society, had a great deal of difficulty - exhibiting feelings of shyness and a sense of frustration/desperation - in trying to articulate changes that had taken place in their community and in their

personal lives. Most of these women spoke of transformations in their villages in fairly narrow terms, such as identifying changes in the number of borewells and types of housing available, the provision of electricity, roads and other infrastructure. Rarely did they mention shifts in attitudes and or qualitative aspects of village life or even exhibit an awareness of, or concern about, greater community issues. In fact, one ST woman in Digoor revealed, "Only men go to village meetings. We women have nothing to do there. I don't know what they talk about. The men don't tell us anything". She added, "Our needs are no different nowadays. We wanted houses ten years ago also". Muslim women, who are most commonly engaged in agricultural coolie work and/or home-based production (such as agarbathi-rolling), conveyed a sense of resentment and exasperation about the fact that development programmes benefits have accrued primarily to "others" who are "well-dressed" and "well-off" in their village. The only qualitative changes stated to have affected Muslim women included the adoption of family planning and membership in MMs in a few contexts as well as the expressed "freedom" of not having to wear their burqua (veil) in their village anymore, but rather only when they leave the village. Muslim women on the whole appear to enjoy greater social and spatial mobility in villages such as Yeshavantapura and Sivarapatna where relatively higher

degrees of local female activism through MMs are found.

FELT NEEDS AS EXPRESSED BY WOMEN AND MEN IN HIGH, MEDIUM, AND LOW LEVEL FPA VILLAGES

Most of the women interviewed in the low-level FPA villages (as well as SC/ST and Muslim women across all categories of FPA villages) expressed a sense of frustration and demonstrated a lack of long-term vision or planning relative to other women surveyed in our sample. These poorer and landless women enumerated their most pressing "felt needs" as consisting of loans, land and houses. The few who demonstrated a longer-term perspective identified their most-needed amenities as including balwadis, IRDP schemes and "a factory where 50 women could work." One dai belonging to an SC group grumbled, "We want so many things, but what will ever come of it?" Another woman from an ST (Nayaka) group, when asked to express her "felt needs" replied, "After I finish the loan I have now, I'll take another". While some of these women could only conceptualize "felt needs" of the community in terms of their own individual needs, the majority of those interviewed could not even articulate what they would benefit from personally.

In contrast, women from other economic and social strata identified income-generation projects as the most needed item in their community. Some women specified the nature of the

income-generation project they would prefer, mentioning either dairy or consumer cooperative societies, livestock, cottage and small-scale industries like brick-making or home-based craftmaking and tailoring. Skills development such as typing was also frequently referred to as a "felt need". Training for poor, illiterate women that would enable them to engage in income-generation projects constituted another top priority. Sericulture facilities like silk-reeling units and other infrastructral and educational amenities were also in high demand. Miscellaneous "felt needs" referred to by the women ranged from "rain" to "Hindi language classes". The members of MMs and beneficiaries of existing income-generation projects were on the whole more articulate and visionary than isolated women.

Men, on the other hand, as a rule perceived income-generation prospects and entertainment facilities to be the most pressing "felt needs" of their communities. While the majority of male interviewees across caste and class groupings identified dairy and sericulture schemes as offering the greatest potential for the acquisition of material benefits in their communities, many others named sports, cultural and cinema facilities, films, microphone sets and harmoniums as constituting the most-desired items. Village industries, drinking water supplies and irrigation

facilities were also frequently-cited "felt needs". It was interesting to note how many men across all socio-economic sectors mentioned the need for developing infrastructure (including schools, adult education and literacy classes) and income-generation projects for women and girls as first priorities. In comparison to the majority of women we interviewed, men on the whole demonstrated a much greater ability to spontaneously enumerate their "felt needs" and suggest ways these could be fulfilled. Their vision extended beyond their immediate, individual or village-level needs to encompass inter-village concerns, issues and programs. For example, Youth Club leaders reported a "need" to exchange their experiences with other LVG's amd recommended the formulation of more flexible rules to be incorporated into Government schemes.

CHAPTER VIII

ANALYSIS OF VARIABLES USED IN FIELD STUDY

As mentioned in Chapter-II (METHODOLOGY) 19 villages which were selected for this survey were classified in terms of levels of family planning adoption. It can be recalled that this classification was into 3 levels, high, medium and low.

It is also to be remembered that several items of information were gathered such as:

(i) Proximity to Health Facilities and Level of Village Development.

(ii) Female Literacy

(iii) General Occupation and Degree of Landlessness

(iv) Caste Composition and Religious Factors

(v) Existence and Participation Rates of LVGS and Income-Generation Projects.

(vi) Existing Linkages Between Female Participation in MMs and Income generation projects.

While the method and data do not allow for strict affirmation of causal relationships, cross-tabulation of the data were done against these 3 categories to see how far explanations can be asserted with some degree of certainity or validity.

Many interesting inferences emerge, some of which challenge existing views as well as research findings in the field of demography.

For example - taking item (1), throwing the data against these 3 categories,it is found that proximity to health facility and the level of village development do not necessarily account for high family planning acceptance. The same is true in terms of relationships between literacy and FPA and so on. What, however emerges as a striking relationship, where a positive association is made between one of these items and family planning adoption is the degree of participation of women in Mahila Mandals and the income generation of the FPA. The strongest link is noticed between these 2 phenomena.

It must be remembered however that whole villages were compared in groups with these independent variables and not just households. Yet it is a revealing experience as it further supports the view of this study, namely, that empowerement of women through institutional participation and secure participation in economic activities is one of the key factors that influences voluntary adoption of small family norms. It is important to observe that this factor is more significant than "economic development", "level of development", literacy, class, occupation, etc. In an article on female autonomy and fertility , presented in 1989,

Gita Sen makes a similar point using secondary data (Ref. International Economic Association ; Round Table on Economies and Gender ; Athens).

Macro-Analysis of Variables Affecting the Degree of FP Adoption at the Village Level

(i) Proximity to Health Facilities and Level of Village Development

While one might be tempted to attribute the low FPA rate in Digoor to its remote location and inaccessibility, the fact that Bingipura with a 29% FPA rate is situated only 5 to 6 Kms from the Malur PHC and taluka headquarters cancels out such an inference. No association is manifest across all sample categories between "level of development" (in terms of existing infrastructure such as paved roads, transport and communication facilities, the provision of housing, electricity, irrigation and water supply) of a particular village and its FP performance. For example, out of five "low level FPA" villages, both Sivarapatna and Masthi are accessible by paved roads in good repair, relatively urban in character, electrified and otherwise "highly developed" infrastructurally, yet demonstrate only 38.6% and 34.85% FPA. Villages Nutave and Bhoovanahalli are both fairly remote, approachable only by poor unpaved roads, suffer from inadequate water supplies and a general lack of infrastructure, yet they have achieved 72.5% and 73.8% FPA

The only significant positive association observed between FPA levels and infrastructural amenities is the presence (or absence) of CBD's and ANM sub-centres in the villages. In all of the five highest-ranking FPAI sample villages, a CBD is being run effectively by the local Youth Club and in two of these villages ANM sub-centres (responsible for dispensing MCH and FP services directly to a population of 5000) are operating. In the nine medium-level FPA villages there are five active CBD's and five functioning ANM subcentres. In the lowest sample set, only the village exhibiting the highest FPA rate out of five contains both an ANM subcentre and a CBD. This may be due to the fact that CBD holders and ANM's share the common characteristic of having intimate contact with, and knowledge of, the local populace. Their regular interaction with the community probably cultivates a certain rapport which most likely creates a more conducive climate for the adoption on FP norms and methods by Eligible Couples (EC's). This relationship also allows a more consistent and reliable dissemination of FP and health services and related information.

Mere proximity of a village to a PHC or PHU, or even the existence of one of these facilities within a village itself, does not necessarily give rise to a higher rate of FPA. The presence of a PHU in the town of Masthi (one among the lowest FPA levels in our sample - 34.8%) as well

as the proximity of Yeshavantpura (with an FPA rate of only 27.4%) to a PHC clearly illustrates this point.

(ii) FEMALE LITERACY

A comparison of the female literacy rates (as recorded in the 1981 census) with the FPA level per sample village reveals no consistent association. In Bhoovanahalli, where a high FPA rate of 73.8% is found, female literacy is registered as only 0.9% whereas in Bingipura, which has a similar female literacy rate of 0.8%, FP has been adopted by only 27.2% of the population. In Sivarapatna, where 33.8% of the women have attained literate status, the FPA rate continues to be as low as 38.6% . It was thus found that some of the highest female literacy rates were registered in the low and medium-level FPA villages and some of the lowest female literacy rates in the highest FPA category. In fact, within the group of five highest level FPA villages, female literacy never exceeds 17.29%.

For the taluka as a whole in 1986, female literacy was estimated to average 23% while the taluka-wide adoption rate of FP by EC's was recorded to be 60% for the same year. This phenomenon seems to refute the conventional wisdom and hypotheses that low female literacy rates are generally associated with low adoption rates of FPA (and hence higher fertility rates) in a given setting.

However, on the basis of field survey and experiences, there is enough reason to suspect that the Census reported female literacy rates as well as the rates of female enrolment in schools have been either greatly under estimated or are entirely erroneous. For example, in the village of Bellavi (where 60.56% of the EC's have adopted some form of FP) the female literacy rate given by 1981 Census statistics was 0%, whereas a large number of literate women and girls who had completed a full eight years of formal education were personally interviewed. It is also discovered that Adult Education Classes for women had been conducted over the years in Bellavi with the assistance of the Governmental ICDS scheme and that primary and secondary schools have been well-attended by many girls in the village over the decade.

(iii) GENERAL OCCUPATION AND DEGREE OF LANDLESSNESS:

In the 19 villages surveyed, it was found that the pattern of employment/occupation roughly corresponds to that prevailing in Malur taluka as a whole. The majority of residents - both male and female - are landless, marginal and small farmers and work as agricultural labourers (coolies) on neighbouring farms that usually raise three crops a year. As intensive agricultural techniques and new high-yield varieties have been introduced in the area over the last decade these small/marginal cultivators are also frequently engaged in raising mulberry crops and silk worms of their own

for the sericulture industry. The landless are also increasingly being hired to work in the local tile factories as eucalyptus plantations have been proliferating throughout the taluka and subsistence crops that rely on labour-intensive methods of agriculture have been displaced.

In the high-level FPA category, the degree of landlessness ranges from 10% to 25% whereas in the medium-level FPA villages, this figure fluctuates between 15% and 50% by village. In the lowest FPA group, the percent landless ranges from 10% to 60%. It was thus discerned that no positive correlation between degree of landlessness expeirenced by a given village's population and its level of FPA. Indeed, as visits and studies were undertaken in all 19 villages, two distinct and conflicting patterns arose with respect to this association between the level of landlessness and FP adoption.

The first of these striking attitudinal and behavioural patterns were identified amongst the landless women in villages characterized by the highest FPA rates in the sample. Interviews with these women revealed their rationale for adopting some method of FP (usually terminal) and preference for the Small Family Norm (SFN) to be related to the economic hardships and heavy manual labour they endure. They explained that it is difficult for them to take care of additional children and still keep fit for work under these arduous conditions. Thus they generally choose to get

sterilized and limit the number of children they bear, so as not to unduly impair their income-earning capacity.

This tendency was particularly salient in those five villages with the highest levels of FPA and may be attributed to the existence of strong Mahila Mandals and female leadership in at least four of these villages. Moreover, these same MMs have effectively recruited poorer women in the community as members and encouraged them to also space or limit their off-spring. The presence of alternative child-care facilities (anganwadis, balwadis and pre-primary schools) as well as greater economic and employment opportunities especially through income-generation projects (existing in all the five of these villages) may also be a decisive contributing factor in promoting higher levels of FPA amongst even the poorest women in these communities.

The second pattern discovered,was, regarding the degree of landlessness as it relates to FPA rates and was mostly noticeable amongst landless women in the lowest FPA category. In these villages, landless women expressed a reluctance or refusal to adopt any form of FP, especially sterilization, because they are afraid that doing so would undermine their present or future ability to work. This attitude towards bith control is highlighted by the statement made by the landless SC female coolie in Digoor (where not a single EC has adopted FP) who stated,"if i get operated on, there will

be no one to look after the children and I can't go to work for three months afterwards". At first glance, it may seem curious that such women explain that they do not accept FP for precisely the same reason that landless women in the highlevel FPA villages say they do adopt some measure. Yet perhaps this reality is due to the fact that such women in the lowest FPA category regard the adoption of FP as requiring them to go for tubectomies or laparoscopies (since a high degree of ignorance about spacing methods prevails in these communities) whereas in the higher level FPA villages, greater awareness about a variety of FP options exists among women by virtue of the higher degree of MM activitism in this category.

Even more recently, in the two villages exhibiting the lowst degrees of FPA - Digoor and Bingipura - absolutely no alternative child-care facilities existed. In all the other villages that the team visited, at least one balawadi or anganwadi was present, providing a place where landless female workers could leave their children during the day. It was also noticed, that in Digoor, respondents viewed the nuclear family system prevailing in the village as preventing women from going for sterilizations. They claimed no one would be able to look after their children while they recovered from such operations. In most other villages, landless women at least had access to alternative child-care assistance, either in the form of pre-primary facilities or through extended/joint family relations.

The interesting point lies in the perception of alternative child-care facilities - i.e., whether they were seen as posing an obstacle to, or incentive for a women to adopt FP (sterilization) and limit their family size. Some women viewed the provision of alternative child-care as allowing them to take time off for FP operations, whereas others saw these facilities as removing the incentive for them to get sterilized since they could continue to work unhindered regardless of the number of children they bore.

In any case, the opportunities for landless women to derive some additional earnings through participation in income generation schemes was conspicuously scarce or non-existent in the low and medium-level FPA villages when compared to those existing across the board for women residing in high FPA classified villages.

(iv) CASTE COMPOSITION AND RELIGIOUS FACTORS

The analysis here has been restricted to Hindu-Muslim differentials regarding FPA since in these 19 villages the entire population constituted either of Hindus or Muslims and no other religious category. The Muslim population is dispersed throughout the sample set in varying concentrations, with the highest density found in Seethanayakanahalli (58.4% of the population is Muslim) - a medium level FPA - and the lowest being in Huladenahalli

(15.7%) which falls in the highest FPA category.

It was found that there is a relatively consistent positive relationship between a vilage's degree of FPA and the proportion of Muslims residing in that particular village across all categories of the sample.(Out of the 19 villages, the six demonstrating the lowest FPA rates are composed of atleast 33%-50% muslim population.

This could be due to the negative attitude towards FP that seem to be existing in Muslim communities which deterred Muslim women even if they expressed eagerness to curtail their fertility. In some cases, the unfavourable view of Muslim men and leaders with regard to FP not only manifests itself in their unwillingness to accept or share responsibility for birth control, but also through their active prohibition of the muslim women from taking any initiative to limit their family size. This stricture is made effective in some instances by the threat of (or real) withdrawal of community, economic and social support from families (who rely on this social network for survival) who do choose to adopt some FP method. Women are especially ostracized for practicing contraception according to female Muslim informers in Malur.

The dominance of SC/ST groups in a given village (see "caste composition" profile "village profile" on chart) does not appear to exert any distinct influence on its level of FPA. In Bhoovanahalli, for instance 45% of the population is comprised of SC/ST groups but 73.8% of the eligible couples living there have chosen to adopt FP. Another village consisting of 40% SC/STs, Thiramulahatti has achieved the fairly high rate of 49.29% FPA. On the other hand, Sivarapatna, 35.5% of whose population belongs to SCs/STs, exhibits the rather low FPA level of 38.6%.

There does seem to be some connection, however, between the fact that Bingipura and Digoor, the two villages with the lowest FPA rate in the sample both consist of virtually 100% Backward and Scheduled Tribe population. Bingipura has 89% backward tribes, and 11% STs while Digoor contains 90% ST's and 10% backward tribes. The extremely low levels of FPA in these two villages may be due to the combination of a variety of factors other than caste/tribal composition already referred to, including the near or complete absence of political awareness or leadership in both locales.

The population in all the top-ranking ten villages in terms of FP performance are constituted by atleast 40% of the majority caste, Vokkaligas. Only one village surveyed, Yeshavanthapura - with 40 Vokkaligas - is found in the lowest FPA category, ranking 17 out of the entire sample. Vokkaligas (also called Gowdas locally) are basically

agriculturalists, ranging from large land-owning farmers, and/or marginal/small cultivators and landless agricultural labourers. Wherever the Lingayat caste, primarily an agriculturalist group, is found in concentrations above 65% of the population, the FPA rate of the village also exceeds 60%. Another case where this linkage between the prominance of cultivator castes in a village and a higher than average FPA rate can be identified, is in Kodur, where 80% of the population belongs to the Thigala ("gardener") caste and 76.23% of all EC's have adopted some form of FP.

All three of the "cultivator" castes are notably absent in those six villages ranking lowest in FPA in the sample except in Yeshavanthapura, where Vokkaligas form 40% of the population. The relationship that seems to exist between the dominance of these "cultivator" castes and a higher level of FPA in particular villages could be attributed to the fact that Vokkaligas, Lingayats, or Thigalas have consistently assumed visible leadership roles in these settings, especially within LVG's functioning. The connection in these cases seems to stem from the fact that LVG's led by these castes have been particularly active in promoting FP and linking it to socio-economic programmes/benefits and income-generation projects. In fact, wherever such LVG's have been active along these lines, those villages have exhibited a relatively higher FPA level than has been the norm over the decade in Malur. Conversely, in the two villages with the lowest FP

coverage in the sample there is absolutely no local leadership or any form of LVG. Where the leadership was found to be complacent, self-appointed and/or to hold a negative view of women and FP, the level of FPA in that particular village was also exceptionally low.

Therefore, the impact that caste composition apparently exercises on the level of FPA in a village can be assumed to be indirect since the magnitude and mechanism of this linkage seems to operate through leadership variables and depend on the nature of the local institutions. Of course, these intermediary variables both reflect and determine to some extent the degree of political awareness and participation manifest in a given village, which also affects the level of the concerned population's knowledge, attitude and practice of FP. THe nature and configuration of leadership in a village also appears to exert a powerful influence on the degree of local activism and FP acceptance. For example, FPA levels were significantly higher in those villages where local leadership was visibly oriented towards the overall development of inhabitants and infrastructure within the community, thus fostering: (1) popular participation in, and sharing of the benefits from, community activities and Government programmes, (2) a feeling of unity between different castes, religions, classes and men and women within and across generations, (3) and a sense amongst residents of belonging to the village as a holistic unit.

Only in the highest level FPA category was found this particular brand of benevolent, dynamic and populist leadership to exist and/or promote the above conditions or processes of social change. In all five of these villages, LVG leadership had succeeded in stimulating an unusually high degree of enthusiasm and boldness in the younger generation, giving rise to large numbers of contestants seeking seats in the first-time ever Zilla Parishad (block council) and Mandal Panchayat (village council) elections. (These bodies have been designed to decentralize political power in rural Karnataka). Such exceptional leadership and political awakening may also be attributed to of the relatively longer-standing existence of LVGs in all five of these high FPA villages, where the YC's and MM's have been extremely active, thus giving rise to a cadre of newly-trained and confident leaders oriented towards greater community welfare.

As a rule, in the nine villages clustered in the medium-level FPA category, the past and present leadership has been engaged over the years in a variety of struggles to rally, involve and bind members of the community to undertake the formation and sustenance of local institutions geared towards development activities. The leaders in these villages have experienced different degrees of success in running LVGs in their own settings. A fair number of LVGs have been founded over the decade in this medium-level FPA category and are in varying stages of evolution, but on the whole they have not

consistently produced the kind of strong leadership and outstanding FP performance that has been found in the highest FPA villages.

The formation and effective activity of LVGs in the lowest FPA category of villages has been thwarted by either the unsupportive nature of, or the veritable absence of leadership in these communities. FP performance is hence correspondingly low in all five of these villages, with the exception of Sivarapatna - where 38.8% of the population has accepted FP and both MM's and YC's have been active during recent years.

(v) EXISTENCE AND PARTICIPATION RATES OF LVGS AND INCOME-GENERATION PROJECTS

In the high-level FPA category, it was found that four functioning MMs (one super active, one active, and two relatively passive) were all currently sponsoring and executing income-generation projects for women in their respective villages. In the one village (Bhoovanahalli) where no MM exists, two income-generation projects for women (sericulture and stitching of 'Muthugadele' eating-leaf plates) are neverthless being sponsored by FPAI. A great number of women are also benefitting from a "Lab to Land" Scheme initiated by the Indian Council for Agricultural Research and brought to the village by FPAI in appreciation of its high FP performance. Livestock, poultry and sericulture assets have been distributed to 100 families in

Bhoovanahalli since 1982 through this scheme. In the two villages, Huladenahalli and Kodur, where MMs are classified as "passive" because of current leadership conflicts, intensive income-generation projects are still being pursued due to the previous level of activity of the MMs (founded in 1978 and 1976, respectively) in these villages.

All the four MMs in these five villages were established between 1976 and 1978 and have been collaborating with the Youth Clubs in the same localities. This cooperation has greatly strengthened their organisation and enhanced the quality of LVG operations. For the most part then, it can be said that in the high level FPA villages there is an above-average degree (samplewise) of participation in both MMs and YCs, in income-generation projects and in community socio-economic development programmes sponsored by FPAI, Government and/or local institutions.

With respect to income-generation projects for women, in the high FPA villages, these have all been undertaken by MMs, with the exception of one. All MMs in this group have received dairy loans/assets through the KSWAB, which stipulates as a precondition to their schemes that such grants be distributed to women exclusively through MMs. In most cases, KSWAB funding disbursement has been recommended on a priority basis to MMs in villages that had attained a

fairly high level of FPA.

The nature of the female-centered projects in this category in general appears to be more comprehensive than those found in medium or low-level FPA villages, in terms of building skills through training and longer-term employment. These schemes in the high-level FPA settings are characterized as offering greater posibilities for the multiplication, extension and renewal of assets and better guarantees of procuring a sustained regular income throughout the year (such as sericulture and dairy projects) than those existing for women in villages with lower FPA rates. Additionally, in Kesaragere, in the village with the highest level of FPA for our sample (90%), a large-scale income-generation project for women was started in 1984 and funded by Oxfam. This scheme involves the reeling of silk from cocoons and employs 25 women of all castes and classes, providing regular wages and bringing female participants together in a central work-place. The Mahila Mandal in Kasaragere is the only one classified as 'superactive' out of our entire sample. As has been the case with all MMs in contact with FPAI over the decade, it has been promoting MCH and FP amongst the women in the village and linking Government services to FPAI and community programmes.

Of the nine villages clustered in the medium level FPA category, only three contain active MMs. In addition, the

town of Lakkur has recently commenced a Yuvathi Mandal (Young Women's Club). The rest of the MMs in this group are either passive (two), being registered (two), or non-existent (one). Nonetheless, the level of awareness displayed by most women in all of these villages was relatively high. The majority of those interviewed were either already active in, or eager to join, in community activities sponsored by LVGs and FPAI. There were income-generating projects for women in only four of these villages but the women in those villages where MMs were being registered were clearly anxious to start their own income-generation projects and bring Government socio-economic development schemes to other women in the community. Their plans and motivation seemed to have been inspired in many cases by similar activities already sponsored through the YCs (five of which were active and one that was superactive) in this category. Only one village in this subset, Seethanayakanahalli was devoid of a YC but its MM has been active since 1982, involving women in income-generation projects.

In no village in this medium-level category was there found to be a total lack of, or passivity of, both MM's and YC's. The fact that either a MM or YC exists in all of these communities has most likely contributed to a higher degree of local activism, awareness and FP adoption than was found in those villages falling in the lowest FPA cluster.

Out of nine villages found in the medium FPA range, five are characterised by an absolute lack of income-generating schemes for women coupled with either the sheer nonexistence of a MM (as in three of othese villages) or the presence of a passive one (in two of the villages). The remaining four villages in the medium-level set have enjoyed only sporadic and short-term income generation projects with minimal participation and marginal benefits, mostly accruing to middle class women. In fact, such income-generation projects seem to attract the participation of mostly middle-class women belonging predominantly to marginal and small farmer households since the earnings derived from such schemes are usually supplementary and rarely the sole source of livelihood. Consequently, it was found that the poorest of women - landless, agricultural labourers and SC/STs hardly ever choose to spend their time engaged in such income generation activities unless they offer the opportunity for stable, long-term and substantial economic proceeds (which is not the case for the schemes reviewed except in the highest FPA villages). These poorest women, although they do not participate in income-generation schemes through MMs in large numbers, frequently have benefitted from increased income and improvements in their material conditions derived from socio-economic schemes allocated by Government and obtained for them and their families through the local YCs.

In the medium-level category, the efforts of one 'superactive', five 'active' two 'passive' and one 'non

existent' YCs along these lines have succeeded in procuring assets through Government schemes designated for the poorest of the poor and/or exclusively for SC/ST groups. Such programmes have included the Special Component Scheme, 100 wells scheme and others provided by the State Government of Karnataka.

By and large, both MMs and YCs in all of these mid-FPA-range villages were formed and constituted mainly by members of the 'cultivator castes' (Vokkaligas, Lingayats and Thigalas) of the upper and middle-classes. These LVG's grew and have been sustained primarily by the leadership and involvement of these three caste groups who made a conscious attempt to recruit SC/STs into the LVG's by serving as liasons between the most destitute members of the community and Government socio-economic schemes as well as FPAI programmes. As a consequence, the typical pattern we found making the evolution of LVG's, was the gradual absorption of the most disadvantaged caste and religious groups in the villages (a trend that FPAI actively encouraged all along) as these groups became convinced that they had an economic state in joining the LVG's.

In the bottom-most category of villages, the general dearth of income-generation projects was striking. Those that did exist failed to provide earning opportunities or proceeds for women on a more than intermittent, part-time or

ad hoc basis. Strong Mahila Mandals were also conspicuously lacking in this category. The two MMs that are active were founded as recently as 1985 and have not yet absorbed a large number of women or socio-economic development programme benefits. Tailoring skills and marginal income for women have been extended by FPAI and TRYSEM through these MMs but the few beneficiaries of othese schemes cannot yet be said to have gained or secured a reliable regular income sufficient to greatly enhance their livelihood. Of course, as already indicated in the village Profile Chart, it was observed that there was a complete absence of both MMs and income-generating schemes for women in the two villages at the very bottom (by virtue of their poor or non-existent FPA rates) of our sample list. Neither in Bingipura nor in Digoor have YC's been started. Indeed, in only two out of the five lowest-ranking FPA villages have YC's been initiated. One of these is active and the other has been fairly passive.

In villages with an FPA rate below 40%, there seemed to be a direct relationship between the low levels FP performance and the relatively low level of LVG activity and absence of visible leadership. An exception to this pattern can be identified in the case of Sivarapatna - (the top most ranking village in this category - where both MMs and YC's have been started. The only other village in this group where an active LVG is found is Yeshavanthapura, where the local MM was initiated in 1985 by a strong pair of young women. One of these is a Muslim who has succeeded in

mobilising women in her religious community (which constitutes 39% of the village population)to participate in both a tailoring income generation scheme and FP motivational programmes.

The salient linkage between the presence of LVGs and income-generation projects and a higher level of FPA unearthed by this survey is perhaps even more striking when framed in the negative sense - i.e., in those villages where there are neither LVGs nor any income-generation projects for women (nor any articulated desire to establish either), the level of FPA is invariably low. This case is substantiated by the two villages ranking lowest in the sample, Bingipura and Digoor with FPA rates of 27% and 0% respectively.

The fact that frequently Government and FPAI schemes were distributed on a priority basis in recognition of higher rates, FP acceptance achieved by individual villages stimulated competing LVG's to promote the adoption of FP methods by its members and nurture a positive climate towards FP in the community as a whole. Other tactics increasingly embraced by LVG's involved awarding the economic benefits from programmes sponsored by FPAI to those members who had already adopted some form of FP. This selective channelling of credit, income and assets by LVG's served to motivate villagers to accept coontraceptive methods at an accelerated pace in Malur.

At the same time, adoption of FP by EC's frequently occurred in tandem with, or as a result of, enhanced earnings derived from such income-generating programme packages. In some cases recipients of an FPAI-, Government-, or LVG - sponsored income-generation or development schemes adopted birth control only after benefitting economically from such projects. In others, according to village interviewees, the motivation that emerged in such beneficiaries (especially women) to space or limit their number of children appears to have been a direct consequence of their increased capacity to earn a decent living without unduly relying on the labour of even-more children. Apparently, such modifications in fertility behaviour have also flowed from the enhancement of their health status stemming from an improved diet, better standards of living and higher incomes permitting greater access to and use of existing health services enjoyed in many Malur—communities. All of these factors seem to engender a stronger parental sense of security that their children will survive as they are better able to provide quality care for them and as overall maternal health improves. This increased tendency of individuals and couples to adopt FP when they attain a higher degree of economic and social security than they were previously accustomed to, was particularly obvious in the case of women who belonged to very active MMs or have greatly benefitted from some income generating scheme.

It was found that one of the most powerful ingredients trigerring such changes in attitude and reproductive behaviour among women is their attainment of a higher degree of economic independence and security, relative not only to their previous situation but also to their intra-familial status and to their menfolk associated in most instances with greater female decision-making powers in all these realms.

In other cases, the adoption of FP was reported to have stemmed more from the individual's increased contact with other members of the community than from purely material advances or considerations. The sponsorship by FPAI of a wide variety of events and programmes that propogated the concept and demonstrated the advantages of the Small Family Norm -- usually with the help of LVGs where they existed and the collaboration of local leaders wherever they were favourable to FP - in connection with ongoing efforts to meet community concerns and needs also cultivated an overall climate conducive to the adoption of FP methods by individuals in certain villages.

The demonstration effect - whereby people voluntarily follow the lead of influential and high-status men and women in the community who opted for FP - acted in a domino-fashion in some villages such as Kesagare, where 90% of all residents are effectively covered by some method of FP. Likewise, in other settings, as the respect of villagers for FPAI field workers grew, so did their trust in the organisation's

motivations. Community confidence in the staff's skills and ability to bring development schemes to their villages rendered more and more people willing to respond to FPAI's advice about and deliverance of health and FP services.

Another important factor in the adoption of FP hinges on a community's level of awareness about wherein lie the roots of their problems, how these relate to larger society and what they can do about them. In the case of women, greater consciousness about, and an ability to resolve, common dilemmas seems to be strengthened by and born of contact with a female collective endeavouring to transform members' lives either through MMs or income-generation projects. Such institutions seem to infuse women with new vision and foster a greater sense of possibility in both productive and reproductive arenas as their participants are exposed to educational events and new ideas.

(vi) EXISTING LINKAGES BETWEEN FEMALE PARTICIPATION IN MMs AND IN INCOME GENERATION PROJECTS

Wherever MMs were found to exist, to incorporate relatively large number of women across caste, class and religious identities and to be characterized by a high degree of activism (including MCH and FP promotional campaigns, the sponsorship of income generation projects for women and the inculcation of an awareness amongst its members about new and alternative jobs and avenues they could pursue) a markedly

higher level of female leverage in decision-making pertaining to the adoption of FP norms and methods could be observed. It must be qualified, however, that this positive association was more distinct and powerful in villages where the MM had been functioning effectively for longer periods of time and had successfully enrolled younger women who thus became sensitized to the multiple social and economic options available to them through their participation in income-generation schemes and educational activities. These unmarried and younger wedded members of female collectives were exposed to the relative advantages of FP norms and methods as well as opportunities and means by which to increase their economic independence. They therefore more frequently than not decided to either postpone their marriage or their first child. Members of MMs from the sample of Malur villages were also more commonly found to be using some spacing contraceptive technique (or had adopted a terminal method of FP) than non-members.

This pattern was also much more entrenched in those villages where the local MM had launched income-generation projects that provided skills, training, a central productive workplace in which women could come together and/or a cooperative through which they could market their products without having to resort to the services of a middle-man. The existence of supportive facilities such as child-care and pre-primary centres, adult education classes and health and

FP services for women also appears to play a decisive role in determining both the degree of female participation in MMs and income-generation schemes and the level of FP adoption in a village. These kinds of amenities, collective and projects (especially when they are all present and mutually supprotive in a given village) offer women a more reliable source of earnings as well as a forum that provides them with greater social and economic security, particularly when the MM is adept at soliciting Government schemes and services in the village on behalf of their members. MMs serve an extremely useful function for women in Malur - especially the illiterate, poor, landless and disenfranchised among them - who would otherwise never know about the existence of, or attempt to gain access, to such programmes and schemes. What would be considered an impossibility for one such woman to achieve on her own thus becomes a real option for her through her participation in collective and the mobilization of existing resources, as we observed in Malur, occurs through MMs.

Even when the benefits of NGO and Government schemes distributed to and obtained by these women are derived from home-based production and involve only as interimittent, short-term and/or one-time interventions (such as the granting of credit schemes to purchase and/or reacquire assets for income generation projects), the simple fact that such women usually experience new-found or greater economic self-reliance significantly enhances their self-esteem, skills, respect in the family and visibility/power in the community. Women recounted that this in turn triggers a realisation within them that they are indeed capable of determining the contours of their own environment which ignites an internal will to act on their desire to improve their social and economic status rather than succumb to circumstance. A greater degree of confidence and sense of control over their lives was apparent in those women who had accrued even a minimal amount of benefits accrued through their participation in MMs and socio-economic projects. The members of such collectives, in contrast to others interviewed, conveyed a sense of vision and a focus on a broader, more distant horizon in terms of creating new openings for themselves and their communities.

In many instances, it could be noted that a woman's increased capacity to earn and greater returns to her productive activities enables and/or leads her to exercise a higher degree of autonomy over her reproductive behaviour as well. Of course, the mere augmentation of a woman's income

is not always sufficient to (nor does it necessarily) enhance her position within the household or in relation to her husband. However, the near-unanimous impression painted by FPAI personnel and villagers on this topic was communicated by a former FPAI Chairperson, who has been intimate with many women in Malur over the decade:

"Money talks. These women emerge from their involvement in income generation projects better able to stand on their own and make decisions about their own lives and FP. They have become more confident and independent as a consequence".

The field findings indicate that only when and if a woman's improved economic status co-exists with (or translates into) a greater degree of authority and assertiveness on her part as well as the cooperation of her spouse, is her decision-making power within the family enhanced, especially with respect to FP adoption. In other words, the mere preference of a woman to regulate or limit her fertility even when she provides a larger or major share of family income through her productive activities, is not always sufficient to convince her spouse to adopt a FP method. Since the married women who were interviewed would very rarely (or never) act unilaterally on their desire to adopt birth control, the conscientization of male, elderly and other members of the community geared to create a favourable social disposition towards and knowledge of FP

norms and practices is extremely important in fortifying women's ability to take action along these lines. Therefore, wherever LVGs were found to be active and effective in generating such a climate (across generations and gender) conducive to greater female autonomy over their own bodies and fertility, women were better able to adopt FP methods and limit their family size.

The mechanisms through which this correlation between the enhanced reproductive and productive independence of women originate and operate are complex and multidimensional. As the MRP Project Director observed, "The linkage between greater economic activity of rural women and their adoption of FP works in both directions and sometimes simultaneously". In some cases, women in Malur accepted FP in order to secure the economic benefits being allocated by FPAI and through MMs on the basis od members' acceptance of some method. Additionally, the beneficiaries of income-generation projects were more easily approached and motivated for the adoption of FP by local health workers and FPAI volunteers. In most instances however, it was found that women had opted to adopt some form of birth control primarily as a result of their growing income and awareness about the advantages of and access to contraception. Their increased tendency to adopt FP was stimulated by population and health education, adult literacy courses and the consolidation of a cadre of female leaders who themselves were usually the first members in a given community to choose to curb their own fertility. The

public example that the middle class and elite castes set in adopting FP, especially in deciding to undergo sterilization imbued poorer women with the confidence necessary to overcome their anxieties and follow suit, usually after they had heard these leaders speak of (or witnessed their satisfaction with) having limited their parity. The advantages associated with a chosen reduction in family size for the middle and higher class women included, " a greater amount of leisure time" and for the lower class women, " a better ability to survive" (as they put it).

While all sectors of female adopters of FP perceived their choice as having enhanced their health status and capacity to provide more and greater quality care to their existing children, the more "well-to-do" women who were interviewed, emphasized the socially emancipating aspects of FP adoption whereas the lower-income and assetless women stressed the economic benefits that accrued to them as a spinoff of their (perceived) liberation from the repetitive cycle of unwanted pregnancies and multiple, closely-spaced childbirths, especially given their state of poor health and poverty. One villager asserted that "even the upper class has benefitted from the adoption of FP because both men and women are now able to earn in the fields with fewer children to look after".

All the women who were interviewed and who had

voluntarily and successfully reduced their fertility (regardless of whether their decision to avail of FP services was a consequence of their participation in a MM or income-generation project) voiced no regrets about their adoption of contraception. Indeed as a rule, women who had adopted any method of FP found that it ultimately extended the amount of time available to them for tasks other than child care, regular employment or household work and thus they usually chose to engage in income-generation ventures or to enhance their productive potentials and skills. Many women also expressed their new-found reproductive and/or productive status by shouldering additional responsibilities and taking on amplified roles in the larger community. Frequently this inclination took the form of their adoption of new work-related identitites/activities as well as their intensified participation in MMs.

In any case, there seems to be a direct relationship between the expanded sense of possibility that women who were interviewed had experienced (as a result of their enjoyment of greater degrees of reproductive control and a wider range of productive options introduced through and catalyzed by MRP) and their engagement in further economic avtivities, including better utilization of existing NGO and Government schemes in the community. In many settings, it could be seen that women who were pleased with their decision and ability to regulate the spacing and number of their offspring were eager to share this transformation in their lives with other

women and thus took on motivating and leadership roles in the village. This phenomenon frequently also inspired younger women to explore similar possibilities and to gravitate towards new roles and activities. As one village youth leader noticed, "women accepted FP only after the MM was formed. Then the message caught on". Likewise, the adoption of FP by a critical mass of women in a village appeared to produce a "ripple effect" on other aspects, personalities and spheres of community life.

Although the mere adoption of FP does not necessarily enhances a woman's economic or social status in many cases, it was notable that many women viewed FP adoption as the first (or at least a critical) step towards their gaining greater self-determination and influencing to a greater degree the course of family and community events. Those women who had chosen to join a MM, income-generation project and/or adopt FP conveyed a self-consciousness and enthusiasm about their movement and evolution from a previous state of relatively passive dependency (and a resignation to circumstance/fate) to one of an active interdependency with other members of the village.

Observations and conclusions indicate that the correlation between the adoption of FP and female participation in inocome-generation projects and MMs is by no means linear, unidirectional or sequential. Rather, the

linkage is usually multidimensional, mutually reinforcing (two-way), simulataneous and influenced by a variety of intermediate factors that operate in a synergistic fashion. The findings unearthed by fieldwork have been substantiated by the views articulated by the CDW's and FPAI personnel who have been closely involved in MRP and familiar with the changes that have taken place in Malur since 1976.

One such official, Dr. Rama Rao, FPAI Project Director for MRP for the last ten years, confirmed, "Women in general have more time when they have smaller families, to take up income generation activities and other projects". He also has observed over the years in Malur that "the existence of MMs in a village makes a dramatic difference with regard to FP the level of adoption there. Much higher levels of FP acceptance are found in those villages with MMs". FPAI's Malur Project Coordinator added, "Women who have adopted FP have in countless cases motivated others to accept birth control and participate in socio-economic schemes". Another FPAI fieldworker, in his decade long experience as CDW, has witnessed a common pattern of social change in the villages he has worked with, in Malur: Income-generation projects and MMs catalyze women to think critically about themselves and their situation and ideas inevitably start flowing amongst them on how they can improve their lives and raise their status. One of the results of women's association in such contexts is their eventual adoption of FP. Likewise, FP adoption triggers women to discuss and solve their problems".

Whenever and wherever MMs and income-generation projects have efficiently brought women together with these objectives in mind, the villagers themselves say they have noticed a dynamic transformation of women's lives from a previously isolated (individual) existence to integrated (collective) efforts to translate their needs/desires into purposeful action. The Block Development Officer responsible for allocating Government funds and disbursing programme benefits in Malur perceives the linkage between rural women's increased productivity and reduced fertility as operating in reciprocal directions. He pointed out in a December 1986 interview, "Women with fewer children have more time and energy to take up income-generation schemes and women who participate in such schemes discover new incentives to limit the number of children they bear". Many other officials of villages also held the opinion that fertility regulations and female participation in remunerative activities sponsored by a collective at the village level were mutually enhancing processes, often times inextricably interwined.

To summarize, villagers in Malur have experienced and witnessed a definite symbiosis and compatibility between rural women's increased income through socio-economic projects and their adoption of FP - the combination of which exerts a kind of multiplier effect on women's status in the family and community. In some cases, female adoption of FP

norms and methods has not only assured women across all caste, class and religious groups of greater control over their reproductive functions but has gradually enhanced their productive options and roles as well. In other instances, this linkage manifests itself in the reverse sense or casual order. In both scenarios of social change, this process has taken place at an accelerated pace and in a more synergistic manner wherever a MM plays an active, supportive role in the rural community. Women's organisations thus apparently can and do mediate between, and intensify the mechanisms contributing to, the reciprocity of this two-way linkage between female reproductive and productive roles, behaviour and status. As the President of the KSCCW, who has been supervising the training of "balasevikas" (pre-primary childcare centre teachers) dispatched to Malur stated, "Once women get organised into MMs and start moving on an income generation project, they really take off. In the same way, once the FP concept catches on in an area through women, it spreads like fire".

The conclusions, therefore, arrived at concerning the inter-relationship between enhanced female economic activities and greater contraceptive control can best be symbolised by the following diagram instead of through the linear equations commonly relied upon and presented to illustrate these linkages.

Figure-1

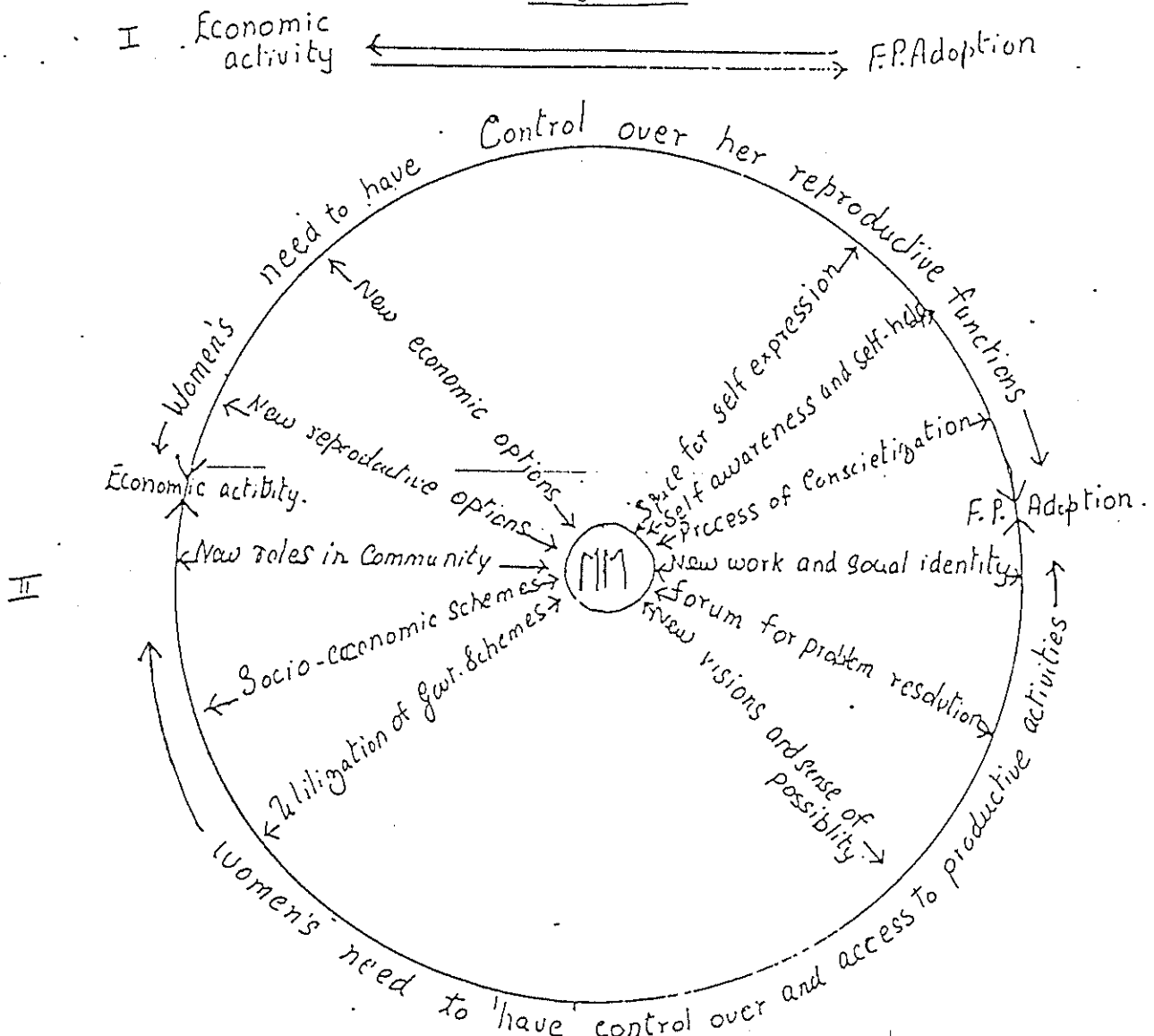

Figure-1

CHAPTER IX

COMPARISON OF RELATED CASE STUDIES

In order to place the Malur Experiment and the strategy and methodology that FPAI developed in awakening natural functional and interest groups at the local level with a view to increasing their access to social and action resources, we decided to study operative aims and processes other organizations in different parts of India have pursued in stimulating similar type of transformations in the socio-economic and health staus of women. In the interest of constructing a kind of paradigm most appropriate for the mobilization and empowerment of the most disadvantaged sectors and women in a cross-section of Indian localities, the ideologies, inputs, objectives, methodologies, substantive issues/problems and outputs of three different associations oriented towards the promotion and creation of alternative development options for the poorest women and communities were investigated. This prong of the research project involved an in-depth analysis of secondary sources pertining to the approaches taken by, and impact of, the Working Women's Forum (WWF) based in Madras, the Self-Employed Women's Association (SEWA) in Ahmedabad and the Athoor Health and Family Planning Project under the auspices of the Gandhigram Institute for Rural Health and Family Welfare (GIRHFW) in Tamil Nadu. Our evaluation of these

three experiments was also based on fieldtrips to the WWF project in Dindigul, Anna District, Tamil Nadu, the SEWA's headquarters and projects in and around Ahmedabad and the GIRHFW in Athoor Block, Tamil Nadu - all of which inculded extensive interviews with the staff and fieldworkers connected to these institutions. The following three sections deal with the impressions of and conclusions about the distinctive features and effectiveness of each organisation, and are thus meant to serve as mini case studies relevant to the lessons already presented by the Malur Rural Project vis-a-vis the stimulation of community participation and integration of development efforts.

A. The Athoor Experience:

Since the Athoor initiative most closely resembles and corresponds to the Malur Rural Project in terms of both its aims and impact we will outline its major features and accomplishments first. As early as 1959, a Pilot Health Project sponsored by the Government of India and Tamil Nadu, the Indian Council of Medical Research and Ford Foundation was designed for implementation in this rural area of Madurai District and was extended in 1962 to encompass an action - research family planning programme to develop a methodology to improve local disposition towards, and delivery of, FP services. This experiment in social change was to be

conducted in Athoor Block, where a population of 100,605 (1961 census) was clustered in 22 village panchayats, 106 hamlets and three towns covering 91.2 sq.miles. These rural agriculturists and weavers (the main occupations of Athoor) suffered a population density of twice the national and 75% greater than the State average (with 40% of the residents under 15 years of age), a crude birth rate (CBR) of 43.1 per 1000 in 1959 (despite positive local attitudes towards FP in a survey done during that same year), extreme poverty (80% of all families earned less than Rs.600/- per year) and a female literacy rate of under 24% The Family Planning-cum-Action-Research (FPCAR) was launched in 1962 in the area.

Through the baseline surveys conducted in three villages for six months each where no resistance to FP was found, a methodology was designed by the Pilot Health Project fieldworkers. Local leaders were selected to receive information on MCH and training at the GIRHFW to promote the programme objectives which included: 1) The creation of a social climate congenial to FP acceptance (with a goal of reducing the CBR from 40 to 25 and increasing the Knowledge, Attitude and Practice (KAP) of FP to cover 80-90% of all ECs over a span of ten years); 2) the formation of a methodology geared towards the participation of local leaders and groups in meeting these goals; 3) the coordination of Governmental

and Voluntary Agencies in intensifying MCH and FP coverage and follow-up; and 4) the combination of individual interpersonal, group, mass media and training techniques in educating and motivating villagers with respect fo FP and the Small Family Norm. One of the primary aims was to stabilize the health and FP personnel's continuous evaluation of the methodology used in order to generate a prototype for duplication in other rural areas.

Phase I of the programme entailed the building of an informal and appropriate approach towards meeting the most pressing needs of their communities and suggest ways that the GIRHFW (which assumed technical and administrative control over the FP staff of the concerned Government PHCs under its technical control for the duration of the experiment) could assist them in fulfilling these. Such discussions and exchanges took place at first during GIRHFW training camps and then later in a gradual manner in responsive villages where social workers each covering 2000 population were sent by Phase II of the project to stay and make contact with younger ECs. Since the idea was to coordinate the job functions and interventions of Government Health and Community Development bodies, during Phase II, a Block Level Action Committee (BLAC) was formed. This BLAC consisted of a mix of PHC, staff, Block Development Officers (like BDO, Mukhya-sevikas and gramsevikas) village teachers, panchayat

members, priests, patels, dais and other local representatives and GIRHFW's Director. Its purpose was to facilitate direct communication, data collection, planning and implementation of the project at all levels. This multi sectoral approach ushered in a continuum of monthly meetings, orientation sessions, health education camps and leadership training.

After the initial six months of the project fieldworkers presence in several receptive villages, invitations started pouring in for GIRHFW to send similar staff to other villages - even those with communities highly resistant to FP - to help them address their felt needs and deliver the audio-visual and educational programmes that by then had gained a reputation for being quite imaginative. Such intensive involvement of GIRHFW and frequent vists by its fieldstaff to a limited number of villages proved effective in reaching the "hardcore" groups antagonistic to FP (i.e. Christians and Muslims as a rule) in a small area. Through the sharing of positive experiences by community leaders and satisfied "clients" with people from other villages, GIRHFW's involvement soon spread to other area in the block.

The Block Education Extension (BEE) Officers (in charge of 20,000 population each) and Lady Health Visitors (LHVs serve 10,000 population each) - both Government servants -

supervised the FP workers and supportive staff (all trained for 3-6 months), including the ANM's attached to the Government- administered PHC's. The BEE acted as a Health Extension Officer of sorts, purchasing and distributing condoms (1962-67) through depots, keeping vital statistics records and maintaining FP and medical supplies. This innovative delivery of contraceptive services was taken over by youth clubs and other local volunteers in later years, leading to the present-day 400 condom depots in Athoor run by both male and female holders, 50% of which are very active. GIRHFW also introduced a novel organizational structure for the BEE-based coordination of the activities of four Health Inspectors, who in turn supervised the outreach services of the four ANM's under them (each responsible for 5000 persons). This system worked so effectively that the Government of India adopted it in the 1970's modifying its previous policy of assigning one ANM per 10,000 population and leading to the current norm found in states like Karnataka of one ANM per 5000 covered through official PHCs. In addition, the Multi-Purpose Health Scheme pioneering by GIRHFW in the block was so successful (by 1964 near universal immunization was achieved) that the Government of Tamil Nadu and India have since modelled many of their child survival and material health programmes after Athoor interventions. Just as the GIRHFW gave recognition (prizes) to motivators of

20-30 FP cases, the Government adopted the introduction of material incentives for both its block development and health personnel to meet FP targets as of 1968-69.

In Athoor FP methods were slowly presented in a step-wise fashion only after the social and other rural workers connected to the project gained a given community's trust by assisting them in coping with immediate socio-economic and health problems. Condoms were presented to villagers first, vasectomy (VO) operations offered next, IUD's distributed after 1965 and tubectomies (TO) were being performed by 1967. Local leaders and medical practitioners received training and encouragment to facilitate the filling out of TO/VO forms, escort EC's to and from such procedures, provide drugs, follow-up services and contact/publicize "satisfied customers" cases in their communities - all in conjunction with GIRHFW's personnel and District Education Officer (a faculty member). Consequently, FP coverage spiralled from a mere 5% of all ECs in 1961 (mostly from the middle-income group earning Rs.600-1200/year) to 34.35% by 1971 in Athoor Block(22). By the time the project was terminated in 1974, dramatic declines had also been achieved in resident Crude Birth Rates (from 43.1 in 1959 to 27.4 in 1974) total fertility rates (from 4.8 to 3.5), general fertility rates (182.3 to 125.5) and total marital fertility rates (6.0 to 5.1) during the same period (23).

Moreover, male acceptance of sterilization was relatively higher than female adoption of tubectomy (16% vs 7% of all family methods practised by block residents as of 1971, respectively) and 90% of all men plus 65% of all women in Athoor were well-informed about contraceptive measures. Female literacy likewise increased between 1971-81 from around 27% to 34% and the birth interval after ECs first child (especially amongst younger women) had increased by ten months between 1964-74. By 1984-85, the mean female age at marriage had risen to 18.5, the infant mortality rate was as low 79.2 and the crude death rate registered as 10.4 (24) (see table 16 and compare with tables I and II of Malur Rural Project Report, Section XIV for state-wise and national figures).

Table 16

Study of Determinants of Fertility in Athoor Block at a Glance

Aspects		Rates Athoor (Experimental)	Betlagundu (Control)
Population (as per census)	1981	130,516	82,720
Population surveyed	1986	17,969	18,485
Crude birth rate	1984	27.4	25.2
	1985	23.9	26.4
	1984-85	25.6	25.8
Crude death rate	1984	11.4	10.4
	1985	9.4	11.9
	1984-85	10.4	11.1
Infant mortality rate	1984	80.6	94.1
	1985	77.6	132.2
	1984-85	79.2	113.7
Couple Protection rate (15-44)	1986	34.1	30.8
(15-49)		33.5	30.5
Marriage age	1984-85	6.48	7.41
Female mean age at marriage	Singulate	19.8	20.3
	(84-85) marriages	18.5	18.5

(Source: T.Rajaretnam's provisional finding from a 1986 household survey as reported in interview with him on Feb.26, 1987 at GIRHFW).

Interviews with Gandhigram University Staff and GIRHFW fieldworkers as well as a review of independent evaluations of the "Athoor Experience" indicate that the relative "success" of the project can be attributed primarily to the following factors: 1) the engagement of rural, social and health workers who functioned on an experimental schedule (not 9 am to 5 pm) in harmony with village rhythms and life; 2) a multi-pronged, flexible strategy (not uniform or rigid according to Government rules) adjusted and specific to local needs and sensitivities; 3) a problem-solving and self-correcting methodology constantly altered in response to community participants and Liason Committee Members' feedback; 4) the formation of Mathar Sangams (MS - Mother Clubs) which currently number over 30 in Athoor Block alone; 5) the focus on field-based health education and insertion of IUDs in the villages by female doctors on fixed days; 6) the informal and supportive services of the Kasturba Rural Hosptial (of Gandhigram); 7) the involvement of other voluntary agencies in the provision of educational sessions, socio-economic services and schemes for child care, loans, dairy projects and skills training; and 8) the expansion of socio-economic activities, especially through income-generation projects for women, sponsored by Gandhigram University.

Gandhigram was founded by female activist Dr.Soundram as a training centre for workers concerned with different aspects of rural development assistance in neighbouring areas or the stipulation that income-generation and skills training programmes be createad especially with the interests of village women and the poorest in the mind. As a result, village industry projects sponsored by Gandhigram now employ over 258 women in 36 units in Athoor and wages to people in 268 villages spread over nine blocks and four districts.

An independent survey of 400 women in different spinning villages surrounding Gandhigram revealed that the majority of the 300-400 women who have benefitted from income-generating activities through the university had delayed their marriage by upto three or four years, had accepted some form of FP and 85% stopped having children at the age of 28-30 (25). In Athoor in particular, the number of women gainfully engaged in income-generating activities has gone way up in the last decade, with dramatic implications for an increase in female average age at marriage and hence fertility reaductions. Average family size has reportedly declined from 4-5 children a decade ago to 2-3 today. In fact, it was discovered last year at a FP seminar held at Gandhigram and attended by 200 women employed in one or the other of the University's

economic schemes that the young female participants indicated that when given a job and skills training they became more secure and independent financially, less of a burden to their parents and were less hurried or pressed to marry as a result(26).

Apparently, it was usually only after socio-economic options were introduced on a significant scale in Athoor villages and neighbouring rural areas affiliated to Gandhigram that women accepted FP as a realistic alternative, opted to space or limit their offspring and/or delay their marriage.

According to Dr.Kausalya, who has been working at Kasturba Rural Hospital for the last four decades, the mean female age at marriage in Athoor Block has increased from 14.5 just ten years ago to 17.5 today, and is 22-23 for girls who are earning income in the villages through a variety of schemes. She also noted that the number of women who come to the 200 bed (190 beds are reserved for women only and 100 of these for sterilizations) Kasturba Rural Hospital has skyrocketed to the current average 30 women a day who check (no forms or protocol are required) for tubectomy or laparoscopy operations and enjoy a week of rest (with free follow-up care and board and lodging also provided for their families who enjoy the open air latrine, sleeping quarters

and traditional village diet and atmosphere) plus free health care for one to two years afterwards and recanalisation if desired in the case of infant or child deaths. Kasturba does not require the written consent of a woman's husband to perform female sterilizations, which gives women a greater say over their own fertility and leverage in related decisions.

Although GIRHFW has had no direct involvement in Athoor since 1974, the launching of the District Development Demonstration (DDD) project by the Tamil Nadu Ministry of Health on a pilot basis from 1978-82 to try out the methodology and work pattern of the Athoor Experiment in a wider area (10 blocks, including Athoor and a total population of 900,000) has en hanced both health and socio-economic conditions and the status of women in the Block over the years. The DDD was designed to test the efficiency and effectiveness of Government machinery - through the PHC and BDO systems in implementing the Multipurpose Health Workers scheme and meeting FW targets, improving the managerial skills of medical and supportive staff officers as well as the Recording system. Another objective of the Pilot project was to energize local "Mother Sanghams" (100 per block were given Rs.200/year by the Government) to integrate health and FW programmes with socio-economic activities in the villages,

a strategy that the Athoor Experiment had demonstrated to be particularly successful. As a consequence, through the DDD, Athoor's MS' became primarily responsible for identifying what kind of income-generation projects were most desired in the community and by their members procuring schemes and recovering loans. They also undertook the responsibility of providing FP immunization and MCH services, motivating FP acceptors (the children of whom were admitted to the creches and nursery schools run by these MS on a priority basis) and organizing "Shramadan" and household latrine construction over the years.

Problems encountered throughout the project included the facts the Government staff turnover was high, FP workers were not from the villages and/or unmarried themselves, clinic hours were inconvenient and drug/vaccine supplies inadequate, no unitary control over or communication between PHC, BLAC and District level staff existed, most MS suffered from a lack of harijan members as well as caste barriers and strong female leadership and anti-poverty programmes have yet to be effectively linked through the BDO with MS economic activities. Nonetheless, the declines in fertility, morbidity and mortality rates witnessed in Athoor over the past three decades can be partly attributed to the experimental use and strengthening of Mathar Sangams. As a result, the Population Council has recently initiated a case

study to investigate just how great an impact socio-economic advances and MS efforts in the area have exerted on Athoor's fertility performance.

One puzzle that the Athoor experience poses, however, relates to the fact that although the FP coverage rate of ECs in 1980 was 28% and the CBR stood at 24, in 1986 EC coverage had increased to 34% while the CBR had also risen by 1.5% to the rate of 25.4 in 1986. Not only does this phenomenon suggest that an EC coverage rate of 60% is not necessary to reach the target CBR set by the Government of India in the Seventh Five-Year Plan, but that implies even in contexts characterized by low literacy, economic development and female status, fertility levels can be reduced by active FP promotion and that yet increases in EC coverage are not always commensurate with decreases in crude birth rates in the same setting.

Clearly, the Malur Rural Project represents a more comprehensive and promising approach to the promotion of long-range improvements in FP and MCH conditions in rural areas precisely because it went further in concentrating on and meeting subsistence needs first and stimulating self-management and -sufficiency as the ultimate goals. While both the Athoor and Malur experiments initially embraced the goals of precipitating fertility reductions through higher FP and MCH acceptance and performance, the Malur Rural Project

matured to encompass the broader objective of improving rural women's status through clubs and income-generating activities for them. Local Voluntary Groups in Malur played a more prominent role in emphasizing the importance of direct community involvement and female participation in linking productive socio-economic schemes with reproductive and health concerns. Athoor's strategies and methodologies have been more limited in the sense that the enhancement of rural women's economic activities and Mothers Clubs were treated merely as vehicles or means to promote overall community development mainly through contraceptive advances. In Malur, the energization of MMs and their members' status were seen by sponsoring agencies (as the project evolved) as goals worthy in and of themselves.

We will now turn to a look at two organizations that actually originated from, and revolve around a concern for, the economic advancement and empowerment of women per se. The interesting development in both their approaches is that MCH and FP- related schemes have been linked to the socio-economic agendas of these groups for their members, thus linking reproductive and productive aspects of women's lives and incorporating new thrusts/priorities in their respective programmes in a reverse order and through different strategies and methodologies than those pursued and

highlighted in both Athoor and Malur.

B) The Working Women's Forum (WWF)

WWF, founded in April 1978, began as a self-help credit association for poor women working as petty traders, hawkers, retailers, service specialists, vendors and micro-entreprenaurs in the urban setting of Madras, South India. Jaya Arunachalam and associates launched WWF as a response to what they perceived to be the most severe problem self-employed women in the informal sector (where 89% of all Indian women work) face - i.e., a lack of direct access to working capital requirements for their occupations, ranging from flower-selling or cartloading to junk recycling or rice trading. The original idea was to meet the credit needs of poor women and thus enable them to bypass moneylenders and their usurious rates of interest. Eight hundred women were thus organized in the initial year to receive loans of Rs.300 each for "productive purposes", with one local leader responsible for disbursing and repaying loans procured by WWF from Nationalized Banks under the "Small Borrower Scheme" which offers Differential Interest Rates of 4% per year on a ten-month repayment schedule for the "weaker sections" of society.

WWF's strategy evolved around the formation of Neighborhood Loan Groups, consisting of 10-25 members who pay

fees of Rs.12/year each and serve as mutual guarantors. Each loan applicant must bring nine other women in need of credit and act as group leader. This approach was devised to strengthen grassroots leadership and encourage self-mobilization and monitoring on the basis of economic problem-solving and solidarity. The backbone of WWF's strategy therefore consists of the provision of income-generation alternatives (including credit) to self-employed women.

An operational methodology centered around decentralized, participatory management of small neighborhood groups thus grew out of WWF's intent to support existing female enterprises through the utilization of existing Government (financial) services. Each Neighborhood leader automatically joins WWF's Governing Body, which meets monthly to coordinate and process loan applications and repayments, resolve individual and collective problems that arise and reassess goals according to feedback given by the field and Area Supervisors.

Although by 1980 WWF included 13,000 members, had created 2800 jobs, increased female earnings by 50% in existing enterprises and achieved a 95% repayment rate on loans granted, the Forum continued to suffer from the rigid system and delays related to credit disbursement (27). The Women's Cooperative Credit and Social Service Society was thus

created by WWF in 1981 as an independent bank offering enhanced credit, technical and marketing asistance to shareholders. WWF further diversified its activities after 1980 to include day care centers, night classes, skills training and health and family programme schemes, expanding into rural areas as well. In May 1982, the National Union of Women Workers (NUWW) was also formed with a view to organize marginalized women not only around neighbourhood ties but along occupational lines.

Despite the success WWF enjoyed in meeting the critical economic and immediate subsistence needs of poor women through the various branches of its organization, the Forum's leaders in 1980 recognized a lacunae in WWF's efforts to improve the quality of life earnings and working conditions for their members. The missing link was identified as the provision of health and FP services since organizers felt that female income-generation activities and large families in the city were incompatible (a 1981 survey found that 25% of NUWW female members living in Madras slums were heads of households and 60% contributed at least half of the household monthly income averaging Rs.180/month for 4-8 family members) (28). WWF Organizers discovered that their original aims of increasing women's accesss to productive resources and their labour power value were being undermined by lack of female access to and under utilization of, available health and FP

services and information. In order to facilitate female transcendence of the draining cycle of repetitive pregnancies, lactation and high parity as well as to expand opportunities for women to take full advantage of their potential and socio-economic development options a decision, was made to introduce health and FP programmes into all WWF branches.

The Family Planning Foundation (FPF) thus agreed to fund WWF to develop female leadership to promote health and family welfare movements and integrate these with their credit schemes and other services. In order to train a cadre of such grassroots women leaders, Rs.300,000 were earmarked by FPF for the creation of low-cost educational materials which the 60 female FP workers could use to communicate with the 100 families they would cover for three years under the project. The GIRHFW provided training for these leaders who were selected from both urban and rural settings more on the basis of economic need (Rs.75/month was paid as a stipend as well as Rs.10/day during training to these FP workers) than either their acceptance of contraception themselves and/or their greater than average knowledge of health.

A non-formal educational and organizational methodology was followed by GIRHFW and WWF in training these female workers to give environmental and hygiene-related talks,

nutrition demonstrations, collect vital statistics data, provide MCH and FP supplies and information, escort and refer patients to clinics and build rapport through and one-to-one contacts and care. The first phase of the project covered 6000 families in 85 slums in Madras (1981-84) while the second extended the coverage to urban dwellers and 34 rural areas (as of August 1984). Each trainee visited 20 households/day six days a week, avoiding those hostile to FP altogether. These fieldworkers overcame the inertia and social obstacles they initially encountered in the slums and villages through the provision of child and maternal immunization, the distribution of vitamin A drops, oral rehydration solution and medicines to combat scabies and other diseases. Efforts were also made to link health and FP issues to welfare and socio-economic schemes. Monthly meetings of area-wide staff also aided them in applying tactics that had been effective in other settings and in building group support. This approach worked primarily because the WWF staff were all married, from the community they were responsible for and practising some form of birth control themselves.

An FP coverage of 30,000 (or 94.5% of targetted EC's) was thus achieved in three years, triggering positive shifts (i.e. declines) in maternal, infant and child mortality rates. Near-universal immunization reached in a mere one and

half years. An independent evaluation of the Experiment in Madras slums found EC coverage to have increased from 24% in November 1980 to 87% as of October 1983, use of temporary FP methods to have risen from 1% to 15% and adoption of permanent methods to have swelled from 27% to 70.23% in the same period(29). Likewise, dramatic increases were found to have occurred in both ante-natal care and the incidence of abortions, with resultant declines in the crude birth rate from 33 before to 21 after the Experiment. Dr.Reddy also recorded decreases in crude death (12 to 5) and infant mortality (160-90) during the project period and noted that whereas women regarded FP as an unsavory "health sapper" before 1980, their views towards contraception were mostly favourable following WWFs interventions. New targets have therefore been set by WWF to extend its FP coverage to 100,000 people through 200 female health workers.

Just as the Forum has rejected male or elite leadership in its social action and economic programmes, it has pursued a female-intensive strategy and methodology in promoting FP as compatible with women's productive roles and interests, especially among the poor. This approach has proven to be particularly successful in rural areas like Dindigul in Anna District of Tamil Nadu, where WWF maintains one of its three health projects.

In Dindigul a drought-prone area of Anna District where WWF branched out from Madras four years ago to provide landless female agricultural coolies (who were making only Rs.3 per day at the time) with ICAR-sponsored "Lab to Land" programme benefits, 1000 women have been assisted by WWF's establishment of a livestock dairy project, milk-producer cooperative and extension of bank loans to traders and "shandy" workers (seed, flower, fruit, vegetable, rope and scrap metal sellers in the local market, 3000 of whom have received petty loans in the last two and half years of Rs.200 at 8.5% interest per year) through a credit society. Area-wide results have included increases (by 200%), in beneficiaries' income-earning capacity in female wages (now Rs.5 per day as landlords have to compete with existing non-farm employment options made available by WWF) and in female mobilization (both spatial and contextual). Moreover, the Dindigul women now have more time to take up alternative income-generating activities since by September 1985, WWF's Health and FP outreach programme had succeeded in effectively covering 72% of EC couples in the project area(30). According to WWF's FP Supervisor, Coordinator and fieldworkers in Dindigul, after only three years of intervention, an 85% coverage rate of 9300 households in 21 villages has been achieved (31).

Each of the 30 FP workers under WWF's Dindigul scheme (funded by the Family Planning Foundation in the 1st phase and by the Government of India in the second - current - one) has been trained at the near-by GIRHFW in Athoor Block, gets retrained every three years. Review sessions are held every three months. They actually live in the 21 (plus ten new) villages targetted by the project and motivate ECs to accept FP methods by offering Rs.50 to acceptors of sterilizations, Rs.9 for IUD acceptance. No money is given for adoption of either oral pills or condoms. Fieldworkers (paid Rs.150-200 per month plus Government motivation fees) specify that FP resistance in their areas is greatest among the Harijan and Christian (especially) communities but that spacing methods are becoming more popular.

These WWF rural health workers are selected from village applicants and must have the qualifications of being educated up to the 7th or 8th standard, FP adoptors with only one to two children and middle-aged. Rapport between motivators (each in char ge of contacting 300 families) and community residents is created primarily through one-to-one interactions, thus by passing the intervention of dais and/or local leaders. WWF does not connect FP-related efforts in the rural areas to socio-economic programmes or income-generation opportunities for women -. linking these only with some small-scale loan procurements.

In contrast to both Malur and Athoor experiments, WWF has consciously decided to avoid the collective approach of co-opting local elites and male leaders in their attempt to deliver and promote FP services and/or economic support. WWF has concentrated on reaching rural women on an individual basis rather than through collective associations. In the same way, beneficiaries of WWF's MCH and FP programmes in the Dindigul area may have experienced personal gains in terms of autonomy and access to certain resources (productive and/or reproductive) but have not yet been brought together for social or group empowerment to struggle or bargain for land-rights, minimum wages, fair prices, social security, child-care and other needs or supportive services.

While WWF-Madras has pursued a strategy of improving the living and working conditions of low-income, slum women through confrontations of female pressure groups with oppressive relations and institutions, through social action (mass, inter-caste marriages, no dowry or sexual harassment campaigns) and group lobbying (for market space, latrines, shelter or legal aid) on a participatory or decentralized basis, its rural branches have yet to stimulate this kind of solidarity, counter-culture and/or a sense of belonging to a movement. The ideology incorporated by and promoting WWF's diverse actions is fuelled a pro-secular and feminist slant

as well as an anti-elite party poitics and caste-orientation. Yet WWF's methodology of raising the consciousness of and mobilizing women through grassroots leadership and economic emancipation from middlemen and exploitative credit/loan terms has proved to be more effective in close-knit urban neighbourhoods than in rural areas. The Forum has yet to integrate their health and FP interventions with socio-economic programmes and the formation of collective action or occupational units in the variety of settings they have extended their operations to.

C. THE SELF-EMPLOYED WOMENS' ASSOCIATION:(SEWA)

Just as WWF began as an advocacy group for self-employed women in Madras to strengthen their economic rights and status, challenge the myth of the "supplementary" role of women in the household and public arenas and build grassroots leadership among the poor, SEWA started as an organization of poor and self employed female workers in the "informal sector" of Ahmedabad City in Gujarat State. While WWF has absorbed over 36,000 women from six different centres into its ranks since 1978, SEWA has expanded to encompass over 25,000 members in both rural and urban India today.

SEWA, formally affiliated to the Womens' Wing of the Textile Labor Association from which it was born 1972, was

founded to enhance the visibility, security, income, cooperation and self-respect of self-employed women in the informal sector, clustered predominantly in three categories of occupations: (1) Vending, petty trading and hawking; (2) home-based production; and (3) labour and service provision. Since such women, working in trades as diverse as construction and agricultural casual labour, vegetable and used-clothes selling or paper-picking, cart-pulling and beedi-rolling, have no regular or identifiable employer in most cases, the registration of SEWA as a trade union posed decisive challenges not only to its organizers but to those with whom they negotiated on behalf of the poor - such as moneylenders, legislators, contractors, bureaucrats, middle-men and the police.

In contrast to WWFs operational refusal to collaborate with different strata of society in its provision of supportive services, facilitation of political and civic action and procurement of loans and credit, SEWA's "cadre" of female leaders pursues a conciliatory strategy in striving to increase their clients' earnings and welfare. Although the Forum purportedly follows a philosophy inspired by Gandhi and Martin Luther King, its tactial rejection of the domination of upper-class, -caste, male or political interests/interventions and systems differs greatly from SEWA's concessionary, integrative and processual approach to

bargaining with and co-opting the "powers-that-be". This divergence most likely stems from SEWA's strong commitment of Gandhian ideology and methods for historical reasons.

Both, however, have embraced women-intensive, managed and -directed strategies and methodologies oriented towards fostering non-formal and non-hierarchical female leadership and an ethic of self-help and esteem at the grassroots level among the poor. Both organizations are also bent on using available resources offered through Government and Voluntary institutions, acting as liasons to demands for and the delivery of existing schemes and interacting with established agencies in the national economy with a view to bring "marginalized" women into the mainstream of the labour movement. Consciousness-raising, the promotion of personnel rapport, leadership, and analytical and organizational skills amongst the most disadvantaged women and their familites (through training, child-labour centres, night-schools, literacy classes and creches) also constitute features and aims shared by WWF and SEWA. Participatory, field-based and applied research/survey methods serve both associations well in identifying felt needs, solving problems and delivering appropriate technology and supportive services desired by their respective constituencies. The formation of WWF's Credit Cooprative and Social Service Society Union over the

years has served functions parallel to SEWA's provision of alternative channels for the procurement of minimum/fair wages, protective benefits, loans, credit, cheap raw materials, collectivized production units, sales outlets and marketing assistance through its Union, Bank, Rural and Economic Wings and Supportive Services.

One aspect of SEWA that differs from the Forum, however consist of the way SEWA organizes women in the city primarily around trade interests or occupations rather than through neighbourhood groups (just as its non-confrontational or Sarvodaya methodologies and strategies founded on a belief in non-violence for the good of all as the most effective pathways to social change and self-reliance contrast with WWFs principles to some extent.) Another feature that distinguishes SEWA from WWF and the Malur and Athoor Projects is its approach to health and family planning issues and programmmes.

In 1975, SEWA decided to strengthen its multi-tiered interventions on behalf of women workers on the direct, lobbying and implementing action as well as on the legal anc policy fronts by introducing supplementary protection of maternity benefits for its members - both urban and rural (after 1976). This broadening of SEWA's twin objectives of advancing the economic security and social position of self-

employed women in both occupational and familial spheres stemmed from the following rationale and observations:

"For many poor women, pregnancy is one of the major stresses they face in life. Their often poor health, anemia and nutritional state is exacerbated by the burden of child-bearing, and a lack of ante-natal care and facilites for safe delivery leads to high morbidity and mortality, as shown by the maternal mortality rate of 4.8/1000. For the 75% of women who live in rural areas, their isolation increases the risk they face.... For working women, pregnancy adds a burden to their lives. They need extra money for food, clothes and medical care but their earning capacity may be reduced both due to ill health and at the time of delivery. Thus they are forced to take loans, pushing them deeper into debt. Financial pressures also result in them working right up until their labour pains start, and then returning to work soon after delivery with inevitable consequehces on their health and on that of their new-born child" (32).

Since only women working in the organized sector (and thus only 0.1% of all Indian working women) receive maternity benefits under the 1961 Act and the ESIA (1948), SEWA decided to help the self-employed women to transcend the cycle of poverty, ill-health and indebtedness (aggravated by repeated pregnancies which make them even more vulnerable) by

providing them with an alternative to Government maternity, life and death insurance schemes. A Pilot Project of health care and financial support was thus launched by SEWA, whereby any member (upon payment of an annual fee of Rs.15/year) could solicit SEWA's assistance after her fifth or sixth month of pregnancy in procuring the Governmentally-supplied ante-natal health care, iron tablets, immunizations (tetanus) she was also thus entitled to a stipend of Rs.51 upon delivery, plus a kilo tin of ghee - a traditional pregnancy and post-natal dietary item for mothers-provided by SEWA.

In the initial phase of the scheme, SEWA limited the distribution of such benefits to women experiencing their first and second pregnancies. However, this policy was amended within a short time due to SEWA's perception that it was based on misplaced middle-class views on family planning and the Small Family Norms that were irrelevant and unrealistic for poor self-employed women. Consequently, SEWA extended the scheme to cover any and all pregnancies as well as rural women.

A programme involving the training of village dais (dayans) on safe delivery practices and hygiene ensured that women from twelve different villages enjoyed supplementary pre-natal care, post-natal follow-up, cash qnd ghee through SEWA. The success of these experiments led to rural health

education radio programmes and training courses created by SEWA and funded by the Gujarat Labour Ministry until the end of 1982. Creches were also established for the children of maternal beneficiaries in an attempt to free women to pursue other avenues of self-development and income-generation.

A full-fledged rural MCH programme was started in 1984 in addition to SEWA's continuing health work throughout Ahmedabad City and District.

Two villages, Chhabasser and Dumali, were selected for the expansion of SEWA's interventions by way of dayan training, maternal and child ante- and post-natal care and immunizations and the provision of a delivery kit (to pregnant women themselves) containing a razor blade, soap, gauze and cotton. This comprehensive package was designed to cover 200 women per annum in conjunction with Government ANM services and visits. Special priority has been given to landless families, small and marginal families, rural artisans, women in the (familial) income bracket of less than Rs.3500 per month, working as casual and migrant labourers and residing in remote rural areas. The Gujarat Labour Ministry has recently agreed to provide maternity benefits in the form of guaranteed minimium wages (up to three child births) as a result of SEWA's lobbying on behalf of these

most disadvantaged female labourers.

Just as fees are collected from SEWA's members (Rs.5 per annum) to finance the services offered by SEWAs Cooperative (Rs.25 for participants), Bank (Rs.10) and Life insurance scheme (Rs.11), those wishing to enjoy benefits under SEWA's maternity scheme must pay Rs.15 per year (an exception is made in the case of the most deprived, who are obliged to pay only Rs.5). The idea behind such requirements is to generate attitudes of self-help and promote SEWAs ideal of self-sufficiency and autonomy in terms of funding - a distant goal given current conditions and exigencies in meeting expenses related to training and health schemes.

Although the medical care, innoculations and finances organized by SEWA for pregnant women and mothers have helped reduce maternal mortality in project areas, infant mortality is still quite high (a survey found that 356 children died out of 2600 born in a SEWA-served rural area in 1982), women are still going back to work only two weeks after delivery, Government finances are frequently delayed and day care facilities continue to be sparse. SEWA is striving to address some of these problems through its rural health programmes (started in 1975 with a random medical check of 350 SEWA members and the provision of eye examinations and free spectacles to a select group and then expanded in 1984 to

encompass collaboration with ANMs for the distribution of iron and folic tablets, child immunizations, home visits, MCH and training of rural women health workers in the villages) and occupational health studies/campaigns/services.

The preventive and promotive thrusts of SEWA's health schemes have been strengthened by its establish ment of child-care facilities through the "Sangini Wing", a child survival programme (through CHETANA), the workshops and training of balawadi teachers in nutrition and first-aid, and the opening of a primary health clinic in Vicchya village, serviced by several female health workers trained by CHETANA/SEWA covering three villages (4500 people) in Sanand taluka. SEWA has also sponsored a community health programme in Shankarbhuvan, a slum area of Ahmedabad city where 10,000 people live without proper housing, water-supply, sanitation or nutrition. Since April 1985, SEWA has trained six health workers from this community in preventive and curative skills and has recently set up a clinic where two weekly sessions are held by a doctor and medicines are available at nominal prices provided by LOCOST - a Baroda based centre that supplies generic drugs at rational cost. Health awareness classes for young mothers and adolescent girls have also formed a part of SEWA's vocational training programmes in this Shankarbhuvan and other communities. Sessions include discussions on nutrition, sexually transmitted diseases,

vaccine-preventable illnesses, breast-feeding, gynecological and other health problems. "Know Your Own Body" lectures are also given. Other issues such as employment, wife-beating and alcoholism that women face are also dealt with as ways to organize women around common problems.

The objectives of SEWAs multi-faceted health schemes revolve around empowering women to control their own sexuality, health and fertility through a variety of measures that complement and enhance their income-earning capacities. However, SEWA does not espouse the Government's orientation towards meeting FP targets nor its policy of limiting benefits/eligibility to women with only a limited number of children. SEWA recognizes the need to raise women out of the poverty in which they live that renders child-bearing imperative (rather than a choice) first instead of coercing them to have fewer children through policy pressures and quotas. SEWA has yet to integrate its health programmes with wide variety of income-generation and cooperative schemes it is sponsoring in rural and urban areas, but it is definitely moving in that direction in ways quite different from those strategies and methodologies pursued by the Malur, Athoor and WWF experiments.

CHAPTER X

CONCLUSIONS

Even stereo type development services, offered in a stereo type way can become more efficient if the receptacles, the so called "beneficiaries" are altered.

The Malur Rural Project shows that wihout necessarily developing special cadres, social formations of persons in rural India can strengthen themselves if provided with a certain kind of "software" that is the light touch or facilitation using culturally acceptable modes of communication, using the indirect method of theatre, song and dance rather than slogans, classes/lectures and the extension agent, who tries to hardsell an idea. The medium of the performing arts, the context of culture is being increasingly recognised as an appropriate instrument of development. There is a growing body of literature illustrating the efficacy of these mediums from all over the world.

The analysis and the debate contained in this documentation is that National Policy can afford to be reverential to the capability of people, and especially women amongst them. Women,

especially those living close to the ground and those close to poverty - expressed in the form of shortage of resources, inadequacy of access, "seclusion" from information - are capable of generating methods and developing forms of association, with the soft touch from the outside, which can grow to revolutionary dimensions. Most organisations working at the grass root, dealing with not only complexity but with inter-related phenomena find that monitoring and evaluation modules and techniques are not only inappropriate and insensitive but even destructive. They neither have methods of assessing qualitative change nor good enough time frames for change to happen but they still have uniform measures of success and failure derived from orthodox theories of progress and backwardness. Much more needs to be understood and written which encourages the pre-project appraisal as well as monitoring and evaluation systems to respect locally evolved and locally manageable changes.

The Malur Case Study has special significance in the context of current Indian development strategies. One of the major thrusts in terms of intruments and development enshrined in the strategy for the 8th Five Year Plan 1990-1995 is the devolution of financial and "designing" powers onto local bodies whether they are in the rural areas (village panchayats) or in urban areas (municipal bodies). This decentralised system of management of development has become the lynch pin of the new strategy.

It has been derived after painful and critical appraisal of the previous 40 years of planned development and a recognition not only that the presence of poverty persists but more positively that people who populate the poverty households have minds, creativity and the wisdom of exprience which if harnessed provides a more efficient and sustainable design of development projects.

The above recognition is being translated into legislative and financial policies which will require fairly serious dismantling of centralised or national level structures including nationally sponsored schemes. It will be based on the principle of offering more space not merely geographically but also politically and financially for decision making and choice at the local level. The ideas and potential revealed by the documentation and analysis of the experience in Malur Taluka and response to development would encourage this new approach.

The Malur Rural Project Experience may suggest that radicalisation of conservative institutions is easy passage ; however, confronted by the diverse political and cultural contexts in which "Mother's clubs" find themselves, it would be foolhardy to overstate the possibility. It may appear wise to extract a list of conditions that existed in the environment or external conditions in Malur Taluka and offer them as indicators of necessary conditions. The Malur experience in a sense, supports one aspect of a feminist perspective, namly to allow space and to trust the less articulate sections of the society.

QUESTIONNAIRES

A. QUESTIONNAIRE FOR FPAI AND OTHER OFFICIALS:

1. What do you think are the necessary conditions (social, infrastructural, psychological, political, economic) for respectivity to and adoption of family planning norms and methods in a rural community?

2. Did these conditions exist in Malur before MRP? If not, how were they brought about (in terms of strategy and process)?

3. Could you describe what has been "unique" about the approach and tactics of MRP over the years?

4.a) How do you define/measure the "success" (both qualitative and quantitative indicators) of MRP?

b) What are the reasons behind its success?

5.a) What was your "entry point" into the Malur Community in 1976 and why?

b) What was the nature of the local resistance, if any?

c) What obstacles did you face in achieving your objectives?

6. What methodologies/strategies did you apply to generate community participation and involvement in MRP?

7.a) Do you see any linkage between female participation in income-generating or other development activities

and adoption of family planning norms and methods (and/or reduced fertility)?

b) Could you specify the nature and casual sequence of this linkage?

8. How did you stimulate the awareness and empowerment of women in the reproductive and productive arenas?

9. What other factors besides family planning programmes have contributed to the adoption of contraception and a reduction of fertility in Malur taluka to date? (i.e. male migration, socio-economic, ecological, average female age at marriage, demographic variables, female education, change in the value of children, female employment outside home, etc.)

10. a) What kind or group of women first joined income-generating projects and Mahila Mandals in Malur?

b) Which group was most resistant?

c) In general, what factors have influenced women's participation in MRP? (particular caste, marital status, age, religion, class, occupation, etc.)

d) What have been the most salient consequences for these women (power/community/family relations, division of labour?)

11.a) How did the financial limitations of your organization

affect the nature of MRP and its activities?

b) What effect did the assistance/intervention of outside agencies and funding have on MRP?

c) What was the response of the community? (including generation of local resources).

12.a) What strategy/methods did you employ to bring the community together to discuss their "felt needs"? What were the dominant "interest groups" and most pressing concerns?

13.a) Do you think the MRP experience/model is generalizable to other regions?

b) If so, what policy recommendations or changes need to be enacted in Karnataka? All-India?

14. Do you foresee any serious problems that MRP will face after FPAI withdraws this year?

15. What impact will the new system of Zilla Parishad and Mandal Panchayats have on the Project and area?

16.a) Who would be the most valuable contacts for interview?

b) Which villages should we study?

B. QUESTIONNAIRE FOR COMMUNITY LEADERS:

(Find out name, village, age, education, occupation, assets, caste, income, religion).

1.a) What are the most significant changes that you have seen taking place in the community over the last decade? (Attitudes, behaviour, material, conditions etc.)

b. What are the reasons for these changes? What has been your role/involvement in enacting such changes?

c) What consequences have these transformations had on:

- community power configurations;
- relations between men and women;
- intra-familial relations?

2.a) How did you become a leader?

b) What motivated you? What were your objectives and underlying philosophy?

c) How did you promote these?

d) How did you organize the group?

- (methods and incentives used)

e) What were the obstacles/resistance you faced and how did you overcome these?

3.a) What role do Mahila Mandals and Youth Clubs play in your community?

b) How were they formed or reactivated? On what basis?

4.a) What section of the community first participated in these associations and as time went on?

b) What attracted them to do so?

5.a) How did the family planning message first reach your community? What was the content of this messsage?

b) How did you gain the acceptance of this by women/men?

c) Which FP methods have been most popular in your village?

6. What has been the most successful way of promoting adoption of F.P. methods in your community?

7.a) Which sector of the community was most receptive to family planning?

b) Which members were least receptive and why?

8.a) How did the introduction/adoption of family planning benefit your community if at all? Women in particular?

b) Who makes the decisions and takes responsibility regarding FPA generally in the household?

9.a) To what extent and how have local community resources been mobilized?

b) How were the villagers involved in planning, decision-making and resource management?

10.a) What were/are the indigenous methods of birth control in your community?

b) Did FPAI incorporate these into their programmes and have local medical practitioners cooperated with them?

11. What are the felt needs of the community now?

12.a) What do you think about Government and NGO's working together?

b) How can their interventions be made more effective?

13. In view of your personal experience and knowledge, what policy recommendations you would make with respect to improving community health and socio-economic status, especially that of women?

14.a) Please enumerate the infrastructure in your village, such as irrigation facilities, number of borewells functioning, no. of dais, pre-primary centres (Balawadi, Anganwadi), adult education centres for men and women, primary/secondary/highschools and number of socio-economic schemes in operation.

b) What if any, improvements need to be made in these?

C. VILLAGERS' QUESTIONNAIRE:

(Fill in their age, sex, marital status, occupation, level of education, age at marriagae, income, land/asset holding, caste, religion and size of family/type of family).

1.a) How was the community's and your life different ten years back?

b) What were the felt needs of your village community ten years ago?

c) How and why are these needs different today?

2.a) Who is responsible for the positive changes in your village?

b) What were their motives in bringing about these changes?

3.a) Did you participate in any of these projects or local institutions that have developed din the last ten years?

b) Are you a member of a Mahila Mandal, Youth Club?

c) Did you participate in any income-generation or any other community project activities?

4.a) If yes, how have you benefited?

b) Was there any resistance to your participation and if so, how did you overcome it?

c) Has anyone else benefited from these activities?

5.a) Do you attend village meetings?

b) If yes, what are they usually about and who organized them?

c) What was your role/contribution?

(Voicing opinion, decision making, planning)?)

d) How were decisions made in these meetings and who implemented the decisions taken.

6. What do you think inspires local leadership?

Participation in community activities?

7.a) What are the traditional methods of birth control in your community?

b) What method did your mother and your grand mother use?

8.a) When did the message of family planning first reach you and through which media? What was its content?

b) Did you/your husband accept family planning? Why, when and which method?

c) Was there any resistance to your adoption (family, elders, religious etc) and how did you over come it?

d) Are you still using a FP method? If yes, what is it? How many children do you have now and before you adopted FP?

9.a) What do you think about family planning and how many children did/do you want to have?

b) What advice about family size and FP method do/would

you give to your children?

c) How have male/female attitudes/behaviour changed over the last decade with respect to responsibility for FP adoption/contraception? why?

d) Which is the most popular method of FP and what is the - average number of children per household in your community?

10.a) What role has FPAI/MRP played in your community? What effect has it on your life and - your village?

11. What do you think have been FPAI's aims and how successful have they been in meeting these objectives?

12.a) Has there been any local resistance to FPAI's programmes and why? How could their efforts/interventions/ programmes be improved and made more appropriate?

13. What role have Government and NGO agencies played in your village and how do you think their efforts could be made more relevant to your needs?

14. What do you feel about the Zilla Parishad system and its impact?

D.QUESTIONNAIRE FOR IPP AND IPC OFFICIALS:

1.a) Briefly describe the basic objectives and the outcome of the Malur Rural Project.

b) Any variation in the projects goals/expectations and emerged outcome?

c) Did any alternative strategy/linkage evolve/emerge?

2. In your methodology of Evaluation, what factors were measured and what measurement criteria was adopted to measure/define success?

3.a) What was the influence of funding body on IPC?

b) Did they give any broad/specific guidelines and/or action plan for Malur Rural Project?

4. Did you issue/recommend any directive guidelines to FPAI?

5. When and why was the population education program started and how has it been refined over the years?

6. Which contraceptive methods are most popular in Malur and control talukas and why?

7. How is Malur Rural Project (as NGO) "unique" or different from Government-sponsored FP programmes?

ADMINISTRATIVE QUERIES:

8.a) Was any other Evaluation conducted at MRP by any other party? If yes-how did it influence the MRP and were any course corrections undertaken?

9. Who would you recommend us to talk to?

XXIX. BIBLIOGRAPHY

Anker, Richard. "Deomographic Change and the Role of women: A Research Programme in Developing Countries". Population and Employment Working Paper No.69. Geneva: ILO, Nov. 1978.

Arunachalam, Jaya. "A Case Study of NUWW: An Experiment" Paper presented at World Bank Workshop on Community Participation. Washington, D.C. Economic Development Institute, Sept. 25-26, 1986.

Azad, Nandini. "Reaching Out to Women Workers Through Grassroots Delivery Systems" in Indian and Foreign Review. Vol.21, No.22, 15 Sept., 1984, PP.11-28.

Balasubramanyam, Vimal. Contraception as if Women Mattered. Bombay: Centre for Education and Documentation, May 1986.

Bhatt, ILA, Chatterjee, Mirai and Price, Janet. "Towards Material Protection", Paper presented at National Conference on Women's Struggles and Movements. Chandigarh: Punjab University, October, 1986.

Bhende, Asha. and Kanitkar Tara. Principles of Population Studies. Bombay: Himalaya Publishing House, 1978.

Bongaarts, John. "A Frame Work for Analyzing the Proximate Determinants of Fertility". Population and Development Review: Vol.4, No.1, 1978, PP.105-132.

Bose, Ashish, Mitra, Ashok, Desai P.B., and Sharma, J.N.(eds.). Population in India's Development 1947-2000. Delhi: Vikas Publishing House, 1974.

Brown, Lester R. and Jacobsen, Jodil. "Our Demographically Divided World", in Science Age. Vol.5, No,4, Bombay: Nehru Centre, April 87, PP.26-32.

Caldwell, John C. Theory of Fertility Decline.

London: Academic Press, 1982.

Caldwell, John C, Reddy, P.H. and Caldwell, Pat. "The Causes of Demographic Change in Rural South India: A Micro Approach". Reprinted from Population and Development Review. Vol8, No.4, Dec. 1982.

Chen, Marty. "Organizing for Credit and Change", in SEEDS. No.6, 1983, PP.1-20.

Chowdry, Mahinder, "Population Policy Target of Net Reproduction Rate of Unity by 2000 - How Realistic?" in Economic and Political Weekly. Vol.XXI, No.48, November 29, 1986.

Coale, Ansley J. and Hoover, H.Edgar. Population Growth and Economic Development in Law Income Countries - A Case Study of India's Prospects. Princeton. Princeton University Press, 1958.

Cochrane, Susan H. "Fertility and Education: What Do We Really Know?": World Bank Paper No.26. Baltimore: John Hopkins University Press, 1979.

Davis, Kingsley and Blake, Judith. "Social Structure and Fertility in an Analytical Framework. "Economic Development and Cultural Changes. Vol.4, No.2. April 1956, PP.211-235.

Dharmarajan, S. "The Mother is the Message", Times of India. June 4, 1986.

Dhopakia, Anila. Rural Women and Food Production. Ahmedabad: SEWA Reception Centre, 1983.

Director of Census Operations. Final Population Figures. Bangalore: Office of the Director of Census Operations, 1983.

Director of Census Operations. Census of India 1971 Series 14 District Primary Census Abstract Hand Book: Kolar District. Mysore: Office of the Director of Census Operations, 1983.

Director of Census Operations. Census of India 1981: Amenities and Infrastructural Facilities - Taluk Abstracts, Kolar District, Series 9.

Bangalore: Office of the Director of Census Operations, 1984.

Dixon, Ruth B. Rural Women at Work: Strategies for Development in South Asia. London: Johns Hopkins University Press, 1978.

Dyson, Tim and Crook, Nigel (eds.). India's Demography: Essays on Contemporary Population. New Delhi: South Asian Publishers Pvt. Ltd., 1984.

Family Planning Association of India. Malur Rural Project: Annual Reports 1976-1985. Bangalore FPAI Bangalore Branch.

Family Planning Foundation. People Show the Way ... . New Delhi: the Statesmen Press, 1984.

Ghalgi, K.N. "Developmental Activities and Family Planning: The Experience of Malur Project". Paper presented at the Workshop on Research Projects. Organized by Family Planning Association of India: Pune: 15-18 December 1986.

Government of India. Ministry of Health and Family Welfare Report Working Group on Health for all by Year 2000. New Delhi:Ministry of Health and Family Welfare, 1981.

Government of India. Family Welfare Programme in India 1984. New Delhi: Ministry of Health and Family Welfare, 1985.

Government of India. Family Welfare Programme in India, Year Book 1984-85. New Delhi: Ministry of Health and Family Welfare, 1986.

Government of India. Women in India: A Country Paper. New Delhi: Ministry of Social and Women's Welfare, 1985.

Government of India. Family Welfare Year Book 1983-84. New Delhi: Ministry of Health and Family Welfare, 1985.

Government of India. Central Bureau of Health Intelligence Statistics. New Delhi: Ministry of Health and Family Welfare, 1983.

Government of Karnataka. A Note on Kolar District Facts and Figures 1984-85. Kolar: District Statistics Officer, 1985.

Government of Karnataka. The Karnataka State Status Report 1985-86. Bangalore: Department of Health and Family Welfare, 1986.

Government of Karnataka. Government of Karnataka Family Welfare and MCH Programme Monthly Bulletin. Bangalore: State Family Welfare Bureau, Directorate of Health and Family Welfare Service, June 1986.

India Population Centre. India Population Project: Project Completion Report. Bangalore. Population Centre, 1980.

ISIS. Women in Development Handbook: A Resource Guide for Organization and Action. Geneva: ISIS Women's International and Communication Service, 1983.

Jain, Anrudh. "Fertility Effects of Female Education:A Simple Explanation". Working Paper No.130 of the Population Council. New York:Population Council, April, 1981.

Jain, Devaki. Women's Quest for Power: Five Case Studies. Ghaziabad: Vikas Publishing House, 1980. Papers Presented to Workshop on Women, Health and Reproduction. Bombay: Shakti, December, 1986.

Jain S.P. and Reddy, Krishnamurthy V. Role of Women in Rural Development: A Study of Mahila Mandals. Hyderabad. National Institute of Rural Development, 1979.

Jain, S.P. "Leadership Among Rural Women". Social Change. Vol.13, No.3, September, 1983, PP.8-12.

Jeffers, Hilde. Organizing Women Petty Traders and Producers: A Case Study of Working Women's Forum, Madras. Berkeley: Department of City and Regional Planning, UC Berkeley, November 1981.

Jha, Saroj, "The Hazards of Being a Woman", in

Science Age. Bombay:Nehru Centre, April, 1984, PP.45.

Jhabvala, Renana. "Women's Struggles in the Informal Sector". Paper Presented at National Conference on Women's Struggles and Movements. Chadigarh: Punjab University, October, 1986.

Kachirayan, M. "Estimates of Fertility, FP use and Growth Rates in Athoor Block: - 1974", in Bulletin of GIRHEE. Vol.XIII, No.2, November 1978, PP.1-21.

Kalpagam, U. "Solidarity, Strength and Success: WWF Points the Way". Madras: WWSF/NUWW, 1986.

Karkal, Malini "Indian Family Planning Programme: A Historical Perspective". Background for workshop on Feminist Perspective on Women, Health and Reproduction. Bombay: Dec. 4-7, 1986.

Karnath, Suryanath U. (ed.) Karnataka State Gazeteer, Part II. Bangalore: Government of Karnataka, 1983.

Khan, M.E. and Prasad, C.V.S. Family Planning Practices in India: Second All-India Survey. Baroda: Operations Research Group, 1983.

Kirk, D. "A New Demographic Transition", in Rapid Population Growth: Consequences and Policy Implications. Baltimore: John Hopkins Press, 1971.

Kocher, James E. Rural Development, Income Distribution and Fertility Decline. New York: Population Council, 1973.

Krishnakumar, "Revised Strategy for National Family Welfare Programme - A Summary". New Delhi: Government of India, Ministry of Health and Family Welfare, 1986.

Maine, Deborah. Family Planning, Its Impact on the Health of Women and Children. New York Centre for Population and Family Health, Columbia University, 1981.

Mamdani, Mahmood. The Myth of Population Control. London: Monthly Review Press, 1982.

Marguiles, Newton and Raia, Anthony, P. (eds.), Organisation Development, Values, Process and Technology. New Delhi:Tata McGraw Hill Publishing Company, Ltd., 1975.

Mascarenhas, M.M. The Dynamics of Health in Indian Women and Strategies to Facilitate Optimum Health. Bangalore: Centre for Research, Education, Service and Training for Family Life Promotion, 1985.

Mysore Government Press. Mysore State Gazeteer: Kolar District. Mysore: Director of Printing at Government Press, 1968.

Nag, Moni, Anker, Richard and Khan, M.E. "A Guide to Anthropological Study of Women's Roles and Demographic Change in India". Working Paper No.115 of Population ad Labour Policies Programme. ILO: Geneva, March, 1982.

Office of the Registrar General India, Vital Statistics Division, Registrar General's Newsletter. Vol.XVII, No.3, July 1986, Ministry of Home Affairs, Government of India, New Delhi.

Oppong, Christine. "A Synopsis of Seven Roles and Status of Women: An Outline of a Conceptual and Methodological Approach". Population and Labour Policies Programme, Working Paper No.94 Geneva:ILO, September 1980.

Oppong, Christine. "Family Structure and Women's Reproductive and Producitve Roles: Some Conceptual and Methodological Issues. Population and Labour Policies Programme, Working Paper No.79. Geneva:ILO, September, 1979.

Pisharoti, K.A. et al. "The Athoor Experience: Implications for a Statewide FP Programme". Action Research Monograph. No.4. Gandhigram: GIRHFP, 1971.

Premi, Mahendra K. The Demographic Situation in India. Hawaii: East West Centre, 1982.

Qadeer, Imrana. "Population Problem - Myth and Reality". in In Search of Diagnosis. ed. by Patel, Ashvin, J. New Delhi: Medico Friends Circle, 1983.

Rajaretnam. "The Relationship Between Female Age At Marriage and Fertility", in Bulletin of GIRHEP. Vol.21, No.3. December 1986, PP.31-55.

Rao, Bhaskara, Kukkarni, P.M. and Royappa, Hanumantha, P. Determinants of Fertility Decline: A Study of Rural Karnataka. New Delhi: South Asian Publishers, 1986.

Rao, K.S. "Alternative Strategies in Implementation of Family Planning Programmes - An Experimental Project: Progress and Problems". in Population Centre Newsletter. Vol.II, No.4. July/August, 1976 India Population Centre, Bangalore.

Rao, K. Seshagiri et al. Experimentation of Alternative Strategies in Family Planning: An Evaluation. Bangalore, India Population Centre, 1979.

Ravindra, R.P. The Scarcer Half. Counterfact No.9 CED Health Feature. Bombay: Centre for Education and Documentation, January, 1986.

Reddy, P.H. "Primary Health Care and FP: An Experiment in CBD Approach in Madras Slums". Paper Presented for WWF, Madras, 1986.

Rich, William. Smaller Families Through Social And Economic Progress. Washington, D.C.: Overseas Development Council, 1973.

Ridker, Ronald (ed.). Population and Development: The Search for Selective Interventions. Baltimore: Johns Hopkins University Press, 1976.

Sebstad, Jennefer. Struggle and Development Among Self-employed Women: A Report on SEWA. Washington DC: USAID, 1982.

SEWA. Annual Reports 1985 and 1986. Ahmedabad: Sewa Reception Centre, 1985.

Sharma, K.K. "Integrated Family Welfare Plan Soon". Deccan Herald. February 19, 1987.

Sharma, Sudhirendra. "If Leftovers had Leaves" in Times of India. October 28, 1984.

Sholapurkar, M.V. and Gopal, Y.S. An Evaluation of the Family Planning Programme in Karnataka. Bangalore:India Population Centre, 1984.

SNDT Women's University. Women in India:A Handbook. Bombay Research Unit in Women's Studies, 1981.

Srinivasan, K. Ahmed, Syed, Riyaz and Rao, K.S. "Experimental Strategies: An Interim Evaluation", Population Centre Newssletter. Vol.IV, No.1, January/February, 1978, India Population Centre, Bangalore.

Srinivasan, Viji. Working Women's forum: A Case Study. New Delhi: Ford Foundation, 1982.

Srivastava, V.C. Figures at a Glance - India. Bombay: Family Planning Association of India, October, 1984.

Srikantan, K.S. The Family Planning Programme in Socio-economic Context. New York: The Population Council, 1977.

Subramaniam, Parvathi. Organising Women for Self-Help. Bangalore: Family Planning Association of India, 1979.

Suryanath, U.Kamath (ed.) Karnataka State Gazeteer Part II. Bangalore: Government of Karnataka, 1983.

UNICEF. Women, Health and Development: A Kit Geneva: United Nations, 1983.

United Nations. The Population Debate: Papers of World Population Plan of Action at Bucharest, 1974, Vol.II. New York: United Nations, 1975.

World Bank Development Report, 1984. New York:Oxford University Press, 1984.