CHAPTER I

INTRODUCTION
Indian society consists of numerous social, ethnic, linguistic, religious and territorial groups, which by and large reside in villages where poverty, illiteracy, ignorance and superstitions prevail. Indian rural economy is based predominantly on agriculture. Land is the basic means of production in rural economy. Land is a part of nature, though made arable by human labour. From land, the rural people produce, by means of technique and their labour power, such a variety of agrarian products as food, cotton, jute, tea, coffee, tobacco and others. But the main economic source, the land is generally owned by several middle and higher class and caste groups. The scheduled castes, scheduled tribes and other backward castes form the economically weaker sections in the society. Most of them live in the villages. In West Bengal, in general, and North Twenty Four Parganas District in particular the scheduled castes group lead a precarious economic life and their health status too is generally very poor.

It is difficult to ascertain why people want more children as it is associated with economic, social and psychological considerations, which cannot be easily disentangled. The situation also varies from society to society and among individuals within a society. In many societies it is found that parents' reproductive goals, where they exist, are based on the number of children expected to survive them and care for them in their old age, they must have-in high- mortality country (ESCAP, 1988). Such a level of fertility is close to a biological ceiling for all practical purposes.

To-day the most urgent and important problem, which is standing before us and affects the well being of mankind, is the rapid growth of population.

India holds a special position in the world in terms of population. It is one of the oldest civilisations in the world. People have inhabited it for thousands of years. No wonders, at present it constitutes one of the most crowded parts in the world. According to 1991 census, India's population was 844 million, which had increased to 950 million by 1997. It is estimated that by 2025 India's population would be 1400 million, which is likely to increase further to 1800 million by 2075 (Chandna, 1999).

Growing population numbers have equally serious socio-economic implications at global, national and household levels. While at individual household level, social
awakening through education may hold the key to the change in the perspective, at national and global levels thoughtful population planning policies, capable of producing both immediate and long term gains are needed (Chandna, 1999).

India's current demographic phase is characterised by rather high fertility and moderate mortality rates. As a result, the country's population is growing rapidly with about 18 million people being added to it annually, to give a 2.1 per cent increase per annum (Rao, 1996). In order to check the growth of population it is essential to understand the process through which the fertility behaviour is regulated in different cultural groups. The norms, values, customs and taboos prevalent in a society regulate reproductive behaviour. To understand the fertility behaviour of any group, these norms and values must be pinpointed.

Reproductive behaviour in animals includes all the events and actions that are directly involved in the process by which an organism generates at least one replacement of itself. In the evolutionary sense, the goal of an individual in reproduction is not to perpetuate the population or the species, rather, relative to the other members of its population, it is to maximise the representation of its own genetic characteristics in the next generation. The dominant form of reproductive behaviour for achieving this purpose is sexual (Encyclopaedia Britannica, 1983).

Reproductive behaviour of man was channelised by marriage, which is a vital, social as well as cultural institution in human society. In the Hindu society marriage is regarded as a necessity for the procreation of children. There is a Sanskrit saying "Putrarthe Kriate Varya" means one selects a wife only to have a son.

Reproductive patterns and behaviour- age at marriage, timing and spacing of birth, and family size- directly impinge upon the viability of young children and the probability of their survival (Ruzicka and Kane, 1987).

While adopting the constitution on January 26, 1950, we, the people of India, dedicated us to the creation of a new social order based on equality, freedom, justice and the dignity of the individual and, to that end, decided to eliminate poverty, ignorance and ill-health.
As defined in the constitution of the World Health Organisation (WHO) "health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity".

The health of a society is intimately related to its value system, its philosophical and cultural traditions and its social, economic and political organisation. Since each of these aspects has a deep influence on health and since health in its turn, also influences all these aspects, it is not possible to raise the health status of a people unless such efforts are integrated with the wider effort to bring about the overall cultural, social, economic and political transformation of the society as a whole. Such coordinated and simultaneous efforts to improve health status and change the entire social order generally yield better results because they are interdependent and mutually supportive. This is the entire more so if one is planning for the health of the people and not merely for health services. In fact, good health and good societies go together.

Health seeking is an important factor in health management, but in a country like India, where most of the health schemes are centralised, this is often ignored while considering for providing health facilities to people. As a result, new schemes for providing health do not get the desired acceptance of the community and are therefore, rendered unsuccessful. The decision makers in the health sector are recognising the need for understanding the health seeking behaviour and perception of the communities and their acceptance and use of traditional and modern methods, as also the perception of the community regarding the service delivery. This is especially relevant to the communities of weaker section, where due to their under-exposure and strong beliefs in traditional culture, there is strong influence of age - old traditions and values (Singh, 1999).

The health status of population is determined not only by the availability and the level of health facilities but also by the ability to take advantage of these by various groups of the people. It is observed that public health centers are essentially curative, capital intensive and are oriented towards the rich and the urban areas. The fact remains that the urban areas generally get the lion's share of medical resources. While assessing their impact in rural areas it is necessary to throughly examine if the public health centers are well equipped in terms of professional expertise and staff members. However, the
fact remains that though the public facilities are to play dominant role in the lives of the patients belonging to the rural areas, but their performances have not be perfect and adequate in many areas (Gupta, 1998).

World Bank in his February 1980's report in the titled "Health - sector policy paper" states that the health problems of developing countries can be controlled or treated with presently known technologies. Infectious diseases could be reduced through good hygiene, early diagnosis and treatment and immunisation. Improvements in water supply and waste disposal would greatly facilitate control of fecal related diseases, but good personal hygiene, careful preparation of food, and use of safe drinking water are also essential. Immunisation against the most common and serious childhood diseases, such as measles, polio, tetanus, diphtheria and pertusis are available at moderate cost. Use of better weaning foods and continuation of breast-feeding would reduce early childhood malnutrition and diminish the seriousness of infectious diseases. Parental care, screening for difficulties in delivery, safe delivery and neonatal care would drastically reduce maternal and neonatal mortality and greatly improve the health prospects of children.

Health care is a high priority in all developing countries and is a constitutional right in a number of them. The term primary health care is defined by a conference convened by WHO and UNICEF at Alma-Ata, USSR, in September 1978. It means, "essential health care based on practical, scientifically sound and socially acceptable methods, and technology made universally accessible to individuals and families in the community and country can afford. ......(It) addresses the main health problems in the community providing promotive, preventive, curative and rehabilitative services accordingly,...... (and) includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally epidemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs." The term basic health care refers to maternal and child health care, family planning, immunisation,
prevention and control of epidemic diseases and treatment of common diseases and injuries, but excludes such health-related activities as education, nutrition, water supply and sanitation".

There is urgent need to update our present knowledge about health status and health care practices among the weaker section especially scheduled caste population.

In view of the above backdrop it is proposed to undertake an intensive study on reproductive behaviour and health care practices among the Namasudra, a scheduled caste of West Bengal with special reference to Bongaon Block in North Twenty Four Parganas.

**Review of literature:**

The fertility behaviour is affected by biological factors and personal preference and indirectly by social customs and collective preferences. All these biosocial factors are therefore should be taken into account while formulating an effective population policy of a country (Sadhu, 1957).

Studies on menarcheal age and menopause with relation to fertility pattern have been conducted by several scholars (Seetha, 1957; Rakshit, 1962; Memoria, 1965; Bardhan, 1966; Biswas, 1967; Buck and Stavarky, 1967; Khan, 1973; Goyal, 1974; Rami Reddy, 1977 and Thomas, 1987). In another study Pandey and Tiwary (2000) estimated the vital rates of the primitive tribes of Madhya Pradesh.

Different scholars studied effects of age at first marriage, number of wives and types of marital union on fertility. Age at first marriage is one of the most important variables affecting fertility (Hajnal, 1963). Within marriage there is contradictory evidence on whether wives in polygynous union have lower completed fertility than those in monogamous unions (Smith and Kunz, 1976). It has also been suggested (Van de Walle, 1968; Page, 1975) that women in defacto unions tend to have lower fertility than women in formal marriages.

Different scholars have studied family type with relation to fertility pattern. During the past 25 years many demographic studies have examined the relationships between family composition and fertility but their findings have been largely inconclusive. Lorimer (1954), Davis (1955) and Davis and Blake (1956) held that extended family systems support early marriage, which encourages high fertility and the nuclear families and later marriages are characterised by lower fertility. But several more recent Indian studies (Driver, 1963; Nag, 1967; Prakasi and Malaker, 1967; Bebarta, 1977; Mahadevan, 1979) have contradicted these theoretical expectations by reporting that joint families have lower fertility. This negative association has been explained by lack of privacy in joint households (Driver, 1963; Nag, 1967), taboos upon intercourse leading to lower coital frequency (Nag, 1967; Mahadevan, 1979). Still other studies have found little or no significant variation in fertility according to family type (Stykos, 1958; Freedman et al., 1964; Palmore, 1972). Karim (1974) found that Pakistan women in joint families had a smaller average family size than those in nuclear families.

The increase in average age at marriage plays a positive role in reducing fertility as shown by various studies (Mukherjee, 1962; Barrai et al., 1968; Bumpass, 1969; Matsunga and Tonomura, 1972; Selvin and Garfinkel, 1976; Mastunga, 1973; Goyal, 1975; Luella, 1974; Mo-Im et al., 1974; Chouhan, 1974 and Dandekar, 1974). Pandey et al. (2001) conducted a study on the correlates of infant mortality in a primitive tribe of Madhya Pradesh.

Poor environmental and sanitary conditions are associated with high infant and child mortality (Da Vanzo et al., 1983; Trussell and Hammerslough, 1983; Jain, 1985; Merrick, 1985; Rahman, 1985; Victoria et al., 1988; Gubhaju et al., 1991).
Diarrhoea is a major problem in developing countries and caused an estimated 2.9 million deaths in 1992 (Grant, 1994). At least a further three million children die annually in developing world from consequence of respiratory infections (Pio et al., 1984; Leowski, 1986).

Control of food and water born diseases (diseases of dirty hands) is possible through promotion of personal hygiene (Stanton et al., 1988; Henry and Rahim, 1990) in conjunction with improved water supply sanitation (Briscoe, 1987; Briscoe et al., 1988; Manun‘ebo et al., 1994) and sanitary disposal of faeces (Baltazar and Solon, 1989; Han and Moe, 1990). Lower socio-economic status, an unclean domestic environment, use of non-purified water, absence of soap and feeding methods other than exclusive breast feeding in early infancy are also risk factors for diarrhoea (Huttly et al., 1987).

Benefits of breast-feeding in protecting young infants against common childhood diseases such as diarrhoea and respiratory diseases are well known (Mata and Wyatt, 1971; Chandra, 1978; Jelliffe and Jelliffe, 1978; Janowitz et al., 1981). Breast-fed children experience considerably lower risk of morbidity and mortality than non-breast-fed children (Robinson, 1951; Plank and Milanesi, 1973; Cunningham, 1983; Goldberg et al., 1984; Adlakha and Suchindran, 1985).

Research based on data from diverse sources provides convincing evidence of positive effects of breast feeding and long birth intervals on infant survival (Cleland and Sathar, 1984; De-Sweemer, 1984; Forste, 1994; Hobcraft et. al., 1985; Koenig et al., 1990; Kuate Defo and Palloni, 1995; Lantz et al., 1992; Muhuri and Menken, 1997).

Increasing concern over infant and maternal health in developing countries has focussed new attention and its impact on health, nutrition and fertility (Buchanan, 1975). In addition, breast-feeding makes a major contribution to fertility control by lengthening the period of post-partum amenorrhoea (Perez et al., 1972).

The level of educations of husband and wife and their economic status also play important role in child bearing age of mother (Nayer, 1974; Gupta et al., 1975; Frisancho et al., 1974; Chouhan, 1974). Education is a direct and powerful indicator of the status of women. However, the relationships between education and fertility are complex. It is intricately associated with many social, economic and psychological factors and
attitudes. Education depresses fertility by raising the age at marriage, fostering a favourable attitudes towards small family size norm and improving awareness and use of family planning methods. A number of studies (Singh, 1989; Patnaik, 1985; Gomti Arora, 1990 and Vashisht et al., 1991) have brought out clearly the impact of female education on reduction of fertility.

Population growth is the result of desire for more children and preference to male sex (Novitsky and Kimball, 1958; Pareek and Kothandapani, 1969; Raina, 1969; Gustavus and Nam, 1970; Culright et al., 1974; Stinner and Madar, 1975; Talwar, 1965 and Coombs, 1979).

Fertility in relation to parity has been studied by Yerushalmyo (1945), Freedman and Coombs (1966), Grabill and Davidson (1968), James (1969), Bhanot and Gandotra (1970) and Khan (1973).

Nutrition, socio-economic condition and state of health effect the menarcheal age and menopause and in turn determine the reproductive span of women. This has been studied by various scholars (Clegg and Harrison, 1971; Baker and Dutta, 1972; and Dutta, 1980).


Health and disease are a continuous process and are linked to the health seeking behaviour of a community. A number of factors have been reported to influence the health seeking behaviour of individuals among which the socio - cultural pattern of the community is the most important (Rosenstock, 1960; Pandey and Tiwary, 1993).

Caldwell et al. (1983) points out that a child's mother is the person most likely to notice problem with a child's health because of her role as the primary carer, and she is therefore likely to be in the best position to make health care choices, but where women
are likely to live in extended families with their mother-in-law, health care decision may often be made by the husband's mother or woman's mother-in-law, rather than the woman herself.

As well as household decision-making processes, household resources are likely to influence the health and mortality of infant and children. Household production determines the capability of household to purchase health goods and services (Chatterjee, 1989; Doan and Bisharat, 1990; Berman et al., 1994; Berhrman, 1998). Basu (1987) found that a mother's ability to make her decision-making count was limited by the resources available to the household. It has also been argued that while the nuclear household may create more initiative to access health services, the joint household offers a better social security system for dependants and is therefore more likely to provide the necessary resources for seeking health treatment (Chakki, 1974; Caldwell et al., 1996; Murthy et al., 1985).

The effects of social, economic, occupational, educational and other cultural factors on fertility are generally known (Pearl, 1939; Lorimer et al., 1954; UN, 1973; Nag, 1962; Bogue, 1969; Pandey, 2000) but while some studies reveal an inverse relationship between fertility and economic status (Whelpton and Kiser, 1950; US Bureau of the census, 1950; Chang, et al., 1979) others do not (US Bureau of the Census, 1953; Grabil et. al., 1958: Bean and Wood, 1974). An inverse relationship between mortality and economic status is also recognized and infant mortality is regarded by many as a measure of community health status (Yanakura, 1959). In the Indian context, such relationships of fertility and mortality with economic condition have been analysed recently by Mitra (1978), whereas Frisancho et al.(1976), show that low economic status is inversely related to fertility and childhood mortality.

The importance of cultural factors for fertility control in under developed countries has often been stressed (Chandrasekharan, 1959; Lorimer, 1954; Freedman, 1963; Opler, 1964; Schnaiberg, 1970; Khalifa, 1973; 1976). Yet few studies have actually attempted to measure their impact (cf, George, 1973). The measurement of traditionalism as such moreover, has generally been restricted to male subjects in developing countries (Lerne, 1958; Smith and Inkeles, 1966; Kahl, 1968; Williamson, 1970; Poston and Singlemann, 1975). The exclusion of women, however, may be a
serious shortcoming; indeed "a modern mother may be the central figure in bringing about societal modernisation" (Fawcett and Bornstein, 1973).

An important factor contributing to high fertility and low acceptance of family planning in less developed countries like India is high infant mortality (Chandrasekhar, 1972). It is particularly in these countries that control of fertility through promotion of family planning is an urgent issue, to prevent population growth.

Evidences from recent studies on the interrelation between mass media and family planning in developing countries support the claim that mass media do influence behaviour (Bertrand et al., 1987; Piotrow et al., 1990). Westoff and Rodriguez (1993) examine the relationship between exposure to media messages on family planning and a number of indicators of reproductive behaviour (including ever and current use of contraceptive, intention to use among non-users, desire for more children and ideal family size). The results indicate that women who are exposed to such messages in the media are more likely to use contraceptives and to desire fewer children. Evidence from a focus group study (Bankole, 1994) shows that this is indeed possible. Responses to the question on media exposure may be affected by selective recall. For instance, women have used or are currently using family planning methods may be more sensitive to media messages about family planning and may be more likely to report having heard or seen such messages than those who have not used any method (Westoff and Rodriguez, 1993).

Universal and prolonged breast-feeding in developing countries has the twin effects of lengthening birth intervals and reducing infant mortality (Jain and Bongaarts, 1981). The health benefits of breastfeeding have been discussed in detail (Mc Cann et al., 1981; Van Landingham, et al., 1991). Breast milk is a vital source of nutritious uncontaminated food for infants.

In the last decade, there has been a tremendous increase in the literature on fertility and family planning. Attempts have been made both in India (Dandekar, 1959; Mysore population study, 1961; Driver, 1963; Mamdani, 1972) and abroad (Hill et al., 1959 ; Meier, 1959 ; Freedman, 1967) to develop theories or models on fertility and family planning behaviours. They have succeeded in pointing out some of the
determinants of fertility behaviour, but still the picture of the whole mechanism which regulates fertility behaviour is not clear (Marshal, 1972; Sinding, 1974). Realising the scarcity of 'grand' or even "middle range" theories on fertility and family planning, several scholars such as Bogue (1966), Fawcett (1970), Pohlman (1969), Youkey (1969) have emphasised the need for developing a model and conceptual frame-work for the analysis of fertility behaviour.

The health of mothers and their young children are closely related, especially during gestation and in the neonatal period (Mubarak, 1989; Tinker and Koblinksy, 1993). It has been estimated that 99 percent of the world's maternal deaths and 50-60 percent of infant deaths in developing countries occur within one month of birth, mainly because of lack of maternal health care (Bolam et al., 1998; World Health Organisation, 1996). The International Conference on Population and Development (ICPD) of 1994 focussed on reproductive health, with the objective of enabling women to go safely through pregnancy and childbirth and providing couples with the best chance of having a healthy infant. The ICDP policy document says that both mother and child have the right to appropriate health care services (United Nations, 1994).

Most studies of maternal and child health have focused on social, economic, environmental and demographic patterns in infant and child mortality (Gubhaju, Streitfield and Mazumder, 1991; Gubhaju, 1985; Pant, 1996). Lack of antenatal care is also a major cause of neonatal mortality (Miller et al., 1996; Clarke and Coward, 1991; Bhatia and Cleland, 1995; Foege, 1983). Several risk factors are closely associated with insufficient antenatal care, age of mother, education, birth order, poverty and geographical location (Wallace, 1992). If the mother is in good health and free of complications, she may be able to deliver at home safely (Poovan et al., 1990; Drejer, 1991). On the other hand, some women who do not receive medical supervision during the pregnancy period may be at risk, but not recognized as being in high-risk category. So have delivery could pose dangers for both baby and mother.

It is hypothesized that the availability of health care infrastructure, personnel and services has a positive impact on children's health outcomes, that access to health care has a greater effect among the poor than the non-poor, and that mothers with formal schooling use the health care system more efficiently to improve the health of their
children than mothers with no formal schooling. An improved understanding of the causal relationship between the health services supply environment and health status, and the identification of which groups benefit most from the availability of government services, should be useful to government policy makers responsible for expanding health care and nutrition programmes in rural communities (Hotchkiss et al., 2002).

The caste system is a unique feature of the Indian social structure and has a considerable influence on the individual's personality and life-style. In the study of any kind of social behaviour, it is desirable that caste should be taken as an independent variable and its influence is understood properly. It has been observed in several studies (Wyon and Gordon, 1971; Rele, 1963; Saksena, 1973) that higher caste couples had relatively lower fertility than those of low caste couples.

In national health policy scheduled caste groups become priority groups. A critical review of the literature clearly shows that there are only few valuable investigations have been made so far on fertility, mortality differentials among these groups in India and hardly any anthropological study conducted ever in this on Namasudra scheduled caste population of West Bengal (Mukhopadhyay, 1981; Ghatak, 1990; Basu et al., 1992 and Sarkar, 2000) which is an urgent need for meaningful policy to provide better health care services.

Keeping the above in view the present study has been carried out among the Namasudra scheduled caste population of North 24 Parganas of West Bengal.

The objectives of the Study:

1. To study reproductive variables (i.e. menarcheal age, age at marriage, menopause) and their relationships with reproductive profiles;

2. To ascertain their fertility and mortality profiles and associated socio-cultural factors;

3. To study their concept of health, perception and treatment of diseases and performances of availed health care services and

4. To understand the extent of awareness and use of family planning methods and its impact on fertility behaviour.