Fertility Behavior: Examples from the Santhal Community of Bankura District, West Bengal, India

Buddhadev Hembram[1], Jayanti Hembram[2]

[1]*M.Phil. Research Scholar, The University of Burdwan, West Bengal*
[2]*B.A Student, Bankura Sammilani College, West Bengal*
buddhadevhembram95@gmail.com and 95buddhadev@gmail.com

Abstract.

Majority of the Santhal Community had adopted early marriage, premature pregnancy, higher fertility and child loss experiences. Nearly one fourth Santhal community had an appropriate concept of family planning. The present study entitled "Fertility Behavior: Examples from the Santhal Community of Bankura District, West Bengal, India" was carried out specially village Dhobargram, Jugunthol, Salukdanga, Bindabonpur of Bankura Districts with aim of finding the demographic and socio-economic and knowledge and practice of fertility in Santhal community. The study area and santal community were chosen purposively and respondents (i.e. 15-49 years santhal women having at least on child) were taken by census method and interviewed through structured and semi- structured interview schedule.
It is observed that Illiteracy has been one of the vital causes for their high fertility level because of their early marriage and less awareness about family planning.

Keywords: *Fertility, Behavior, Santhal Community, Awareness.*

2

1   Background of the Study

Health is the most important factor for the fulfillment of human needs and quality of life. It should be an easy access for them regardless of any caste, religion and economy boundaries. Today with the trend of rapid industrialization and modernization, the entire world is changing very fast, consequently increasing the gap between the haves and haves not. The direct impacts of this gap between the rich and the poor ones have severely affected the health of the people, like in our developing countries. The historic " Alma-Ata conference" organized by the WHO in 1978 with main agenda how to provide minimum health services to the maximum people" and participated countries of the world made an amenities commitment to a global strategy of "Health for all" by 2001 A.D. and to the principles of primary health care through the Alma- Ata declaration. All the member's country were requested and also committed that not to foe form the responsibility to provide health services toothier citizens. Now it is about 42 years right after the Alma – Ata declaration but the expected outcomes of the conferences could not be reflected in actual sense. Furthermore, new health problems exist in addition to the precious ones throughout the world more especially in the developing countries, Malnutrition cycled with poverty, population exposing, environment degradation, life style related health problems, antibiotic resistance prevalence of communicable disease, etc. have threatened the health care system of the recent world. The right of the people to be healthy citizen and the responsibility of the government of provide health services toothier people both under questions.

Among these problems that the country has for face fertility behavior a problems has become the major health problem in our society. Human fertility is responsible for biological replacement and for the maintenance of human society. The growth of the population the world depends entirely a human fertility. Fertility behavior is the process of giving birth which is interacted with environment and the environment is different societies. Within the biological limits of human fertility, several social cultural psychological as well as economic and political factors are found to operate and these are responsible for determining the levels and differentials of fertility (Bhende and Kanitkar, 2008)

Human fertility is a very complex process relation not only to biological components but also to social and economic components of society. The subject of human fertility covers a wide range of areas reflecting the complexity of this aspect of human behavior. It is influenced by a host of biological, sociological and economic factors (CBS, 2002). Only the reduced level of infant and child mortality may be strongly governing factors for fertility reduction in a largely uneducated agrarian society. Socio- economic and cultural mechanisms play active roles to persist their high fertility in India. In this context education has a strong positive impact on both fertility and mortality. Caldwell's propositions that children usually have a greater chances of survive when they are born to highly educated mother (Tuladhar, 1999)

Fertility is generally determined by the psychological factors and their interplay with social cultural, economic and modernizing factors, societies and population sub- groups within society's categories by their socio- economic characteristics have different level of fertility. Much more fertility is determined by various socio- economic and demographic variables. Also caste, ethnicity, region , culture women's Education, occupations preference use of contraceptive devices, age at marriage etc. affect the fertility behavior of any groups community. The socio-cultural theories have focused on the attitude and motivational factors at community level for explaining the reproductive behavior (Davis, 1956).Santhal community is economically backward group and characterized by high fertility. In Santhal community early marriage is persistent mortality (infant and child) rate is also higher in this community compared to other communities.

Santhal is one of the lower castes in Indian society. Santhal are living in different state of India like West Bengal, Bihar, Jharkhand, Orissa, and Assam. Among them Santal of Bankura in West Bengal were

the subject of the study. In this study the researcher has tried to analyze the fertility behavior affected by demographic and socio- economic factors of this community. The Santhal is one of the disadvantageous groups in terms of socially, culturally, politically and economically. There might have the demographic pattern different from other caste/ ethnic minorities of India. So this study tried to examine the fertility behavior and its socio- economic and demographic determinates in this community their present study is conducted in Bankura district.

2   Statement of the Problem

India is a country having a rapid growth of population as a result various socio-economic and demographic features are affected by various factors. Low literacy rate high infant and child mortality rate, low socio-economic status of women in the society, high economic value of children, traditional son favoring attitudes and practices are some of the significant factors contributing high level of fertility in India, besides, house of contraceptive and limited access to contraceptive devices. Lack of community participation and low motivation in people are also the causes of high fertility in India. Fertility behavior is the complex phenomenon, which may be affected by the social economic, religious, biological behavioral and cultural factors. Therefore, all these factors must be taken into account to explain fertility behavior.

It is obvious that the persistence of high level of fertility is the main cause of the present rapid population growth. Therefore, for the control of population explosion the existing fertility rate must be reduced. The reduction of fertility is possible through development of socio-economic statues of people and effective implementation of family planning programs. At the early year of marriage is also one of the major factors determinate of fertility. The increasing age at marriage would have decreasing effect on the number of children ever born which ultimately result in decrease fertility level by declining the number of younger women exposed to pregnancy.

The social structure of each society is interrelated with specific population levels. It is also closely related to environmental, technological and other material factors which intervened reproductive behavior. Moreover, there are significant caste differentials (Niruala and Shrestha,1997) Low socio-economic status of women in the society, high economic value of children, high infant mortality rate, socio- economic traditional favoring son, low literacy rate of women etc. are the some main factors that contribute to high level of fertility in India. Beside the persistence of high fertility is also attributed to the lack of knowledge attitude and practice to contraceptive methods. In India as a whole and special community and also every stage of life, irrespective of caste and ethnic groups has strong cultural stress to cause high fertility (Dahal, 1999). In Santhal community generally the prevalence of fertility may be high because of their early marriage and their socio- economic, cultural and religious reason.

Contraceptive prevalence may below among Santhal because lack of knowledge about contraceptive use, which is also the factors for prevailing high fertility. The majority of the women of this community are engaged in household work. The main occupation of Santhal community is laboring like farming wages labour etc.

There are several studies related to fertility behaviour in different ethnic groups but there is no study carried out in this Santhal community. So this study focuses on fertility behavior of Santhal community.

3   Objectives of the Study

1. To identify the knowledge and proactive of family planning methods.
2. To assess the knowledge and proactive of fertility in Santhal community.

4

4 Methodology

4.1 Research Design

This is a descriptive and quantitative type of study where data divided form respondents santhal women 15-49 years having at least one child were described with the help of frequency and percentage.

4.2 Population of the Study

This study was conducted in Bankura district. It lies between N 22°46' and N 23°38' and between E 86°36' and E 87°46'.Total area of the districts is 6881.24sq.km. According to the Census 2011, total population of Bankura district is 3596674. Out of them 1838095 are male and 1758579 are female. There is altogether 6638 habitation. Sample village, There are 150 santhal household in four villages amount them the total population of santhal is 850. Out of them, there are 460 are male and 390 are female. Out of 390 there're 120 female in reproductive age which is the sample size of this study.

4.3 Sample Design and Sampling Procedures

The sample size of this study depict in table 1. The Santhal community and Bankura were taken purposively whereas the samples were taken by using census method.

Table 1. Distribution of Sample Size

Village Name	Household	Total Population	Female	Sample Size (reproductive age women having at least one child) 30.7%
Dhobargram	19	138	50	14
Jugunthol	32	167	70	20
Salukdanga	52	248	120	38
Bindabonpur	47	297	150	48
Total	150	850	390	120

4.4 Tools use for Data Collection

For the purpose of data collection, the researcher used mainly the interviews schedule which was developed on the basis of stated of started objectives. The tools were pre-pared according to the nature and objective of the study. The interview schedule was semi- structured in nature.

4.5 Method of Data Analysis and Interpretation

After collecting the necessary data form the respondent's possible errors and inconsistencies were removed. The data were processed with the help of computer software program and carefully editor so as to ensure its quality. The required frequency and table were generated on the basis of collected data and ob-

jectives of the study. Furthermore, the information was classified, categorized and sub categorized according to the nature of obtained data the data were analyzed through tables and percentages and they were used for processing, analyzing and interpreting the result. Since this is a descriptive study the quantitative information were interpreted and explained in details. Possible discussion was added to clarify the collected information form the respondents. Statistically, mean and percentage were used to describe and explain the collected information after they were organized in table and figures.

5   Analysis and interpretation of data

5.1   Knowledge and Practice of Family Planning Methods

Knowledge on Family Planning Methods

Contraceptive use is the proximate determinate that has the greatest impact on fertility leaves in modern societies (Bombasts and potter, 1983) Better educated women many have more status in the household and therefore have greater authority to speak openly with their husbands about their contractive preference (Martin 1995; Akmam 2002; Kravdal 2002). Interviewing and analyzing responding response from both parents is an important step toward determining the extent of male involvement in contraceptive method choice and use. In the present study all the respondents (N= 200) were asked about the family planning methods with the assumption that they might have known. The responses are presented in table 2. The table 2 Shows that the knowledge of the family planning method, the majority (62.5%) of the respondents were unknown to any kind of family planning methods only 37.5 percent respondents had some kind of knowledge on family planning methods.

Table 2. Distribution of the Respondents by Knowledge of Family Planning Method

Knowledge of family planning method	No. of respondents	Percent
Yes	75	37.5
NO	125	62.5
Total	200	100
If yes		
Pills	5	6.66
IUD	3	4
Depoprovera	17	22.66
Female sterilization	20	22.66
Male Sterilization	9	12
Condom	15	20
Norplant	6	8
Total	75	100

Out of 200, only 75 respondents had knowledge on family planning methods. The highest percent of respondents (22.66%) had some knowledge of female sterilization and Depoprovera and 20 percent has knowledge on condom. Similarly, the respondent's knowledge on male sterilization (12%) Norplant and Pills (8%) and Intra Uterine device (IUD) (4. %) respectively.

6

It reveals that almost all of the respondents had knowledge on different contraceptive devices specially; most of the respondents had knowledge on female sterilization and Depoprovera. This finding corroborates with the studies of Martin (1995) .He noted that women education can also play an important role in the use of contraceptive effectively. That may have some influence to reduce the fertility rate of the community.

Source of Knowledge about family Planning

The knowledge about the family planning methods reduces the birth control. When they were asked the questions about how they get the knowledge of family planning methods. They gave the answer as such which are presented in table 3.

The table 3 shows the information about the family planning methods. Most of the respondents received information form Mobile/T.V (48%) similarly, Hospital (23%) relatives (18.5%) and others (10.5%) respectively.

It reveals that the most popular source of getting information regarding family planning methods was Mobile/T.V.

Table 3. Distribution of the respondents by source of Knowledge about Family Planning

Source of Information	Number	Percent
Mobile/T.V	96	48
Hospital	46	23
Relatives	37	18.5
Others	21	10.5
Total	200	100

Current Use of Family Planning Methods

Family planning methods are important for shaping size, prevention of HIV/ AIDS and STIs and birth spacing. An availability of Family Planning service/ devices to the accuses of users have positive effect. An availability of Family Planning service encourages the users and gradually admonishes the hesitation and shyness. The data on current use of Family planning methods in study are given in table 4.

Table 4. Distribution of the respondents by current use of Family Planning Methods.

Knowledge of family planning method	No. of respondents	Percent
Yes	42	37.5
NO	158	62.5
Total	200	100
If yes		
Pills	17	40.45
IUD	2	4.76
Female sterilization	5	11.90
Condom	15	35.71
Norplant	3	7.14

Total	42	100

The table 4 shows the status of current use of Family Planning methods by the respondent. Out of 200, 42 (37.5%) of the respondents were found current used of Family Planning methods. The most commonly used method was oral pills (40.45%) and Condom (35.71%) Followed by female sterilization (11.90%) Intra Uterine device (IUD) (4.76%) and (7.14%) respectively.

The previously mentioned information reveals that the most popular family planning method was pills and Condom.

6   Knowledge and Practice of Fertility

6.1   Age at First Menstruation

The initial appearance of the menstruation occurs about two years after the first appearance of the pubescent changes. The normal age change of menarche is usually 10-15 years. The responses of the respondents are given in table 5.

Table 5. Distribution of Respondents by Age of Their First Menstruation

Age of First Menstruation	No. of Respondents	Percent
Age<13	63	31.5
Age(14-16)	115	57.5
Age>17	22	11
Total	200	100

Table 5 shows that out of 200 respondents, majority (115) of the respondents' first menstruation was 57.5 percent at the age (14-16) year. Those whose first menstruation was below 13 years were 31.5 percent. Only 11% women had their first menstruation 17 and above.

6.2   Age at Marriage

Ages at marriage of the respondents are the important socio-cultural variables. Early marriage has a longer fertile time and is expected to end up with high fertility, while late marriage is expected to have a lower fertility (Wall 1973). In our society, marriage is taken as a universal phenomenon that take place in human life. Marriage is also adopted for the continuation of generation. The table 6 shows the age at marriage of the respondents.

Table 6. Distribution of the Respondents by Age at Marriage

Age Group	Number	Percent
<14	17	8.5
14-16	42	21
17-19	117	58.5
20>	24	12

8

Total	200	100

Table 6 show that 8.5 percent women are currently married who are less than 14 years. Out of the married, only 21 percent are fund to be at the age of 14-16 years and, 58.5 percent belong to 17-19 years and 12 percent belong to greater than 20 years of age. The majority of married women were found in the age group 17-19 years i.e. 58.5 percent.

It is clear that early marriage is prevailing in this community. However, the causes behind it may be the low level of awareness and cultural values. The researcher could not find any one gets marry at the age of 24 and above.

6.3 Type of Marriage and Current Marital Status

Type of marriage and current marital status of wives is the important socio-cultural variables. In our society, marriage is taken as a universal phenomenon that takes place in human life. Marriage is also adapted for the continuation of generation. The table 7 shows the type of marriage and current marital status of the respondents

Table 7. Distribution of the Respondents by Type of Marriage and Current Martial Status

Type of Marriage	Number	Percent
Love marriage	22	11
Arrange marriage	170	85
Court marriage	7	3.5
Widow marriage	1	0.5
Total	200	100
Current Marital Status		
Together	163	81.5
Separated	3	1.5
Divorced	5	2.5
Husband not at home	27	13.5
Widowed	2	1
Total	200	100

Table 7 shows that 85 per cent performed arrange marriage i.e. traditional marriage, followed by love marriage (11%), court marriage (3.5%) and widow marriage (.5%). Similarly, highest proportion of couples (81.5%) loved together. Furthermore, 13.5 per cent of the respondents' husbands were not at home, 2.5 percent had divorced, 1.5 per cent had separated and 1 per cent of the respondents were widowed.

The above mentioned information reveals that there was trend of love and widow marriage except arrange. This can be the result of early sexual maturity, lack of entertainment materials, influence of modernity etc. The love marriage fosters the early marriage and has higher fertility and risks on reproductive health of women. The widow marriage also increases the fertility rate. These kinds of married couples have low social status in the family and community.

6.4   Mean Age at Marriage and Children Ever Born (CEB)

Marriage broadly defamed here to include consensual unions. This was formally recognized as civil or religious unions. In most societies, marriage is considered as the bedimming of socially sanctioned sexual relations and exposure to the risk of child bearing. The mean age at marriage of women in developing countries range from younger than 16 to older than 22 (Singh and Samara, 1996). Among the many social and economic factors that potentially explain these differences in the timing of marriage. Empirical is considered as one of the most important factor to decide marriage time. Empirical studies have found a strong association between education and age at first marriage at both the individual and societal level (Singh and Samara, 1996). The mean age at marriage and Children Ever Born (CEB) are shown in table 8.

Table 8. Distribution of the Respondents by Mean Age at Marriage and Children Ever Born

Age at Marriage	Number	Percentage	Mean AM (%)	Mean CEB (%)
Less than 15 years	38	19	13.96	2.53
15-17 years	57	28.5	16.39	2.68
18.20 years	90	45	19.39	2.57
21 and above years	15	7.5	23.44	2.5
Total	200	100		

6.5   Ideal Number of Children

Ideal family size is correlated with number living children. Veleti (2001) mentioned that traditional norms and behavior within the joint family may restrict the fertility of women. In santhal societies, parents believe that birth of children entirely depends upon god and fate. The ideal number of sons and daughters in the past days seen very high, but the study shows that future plan to have ideal number of children for the respondents seen to be in around this replacement level. The available information is presented in table 9.

Table 9. Distribution of Respondents by Ideal Number of Children

Ideal No. of children	Number	Percentage
0	10	5
1	15	7.5
2	100	50
3	33	16.5
4	17	8.5
5	17	8.5
5 and above	8	4
Total	200	100

The table 9 shows that highest (50%) of the respondents their ideal number of children is 2 followed by 3 child (16.5%), 4 children (8.5%), 6 respondents did not want to have any child. so, the above table 9

10
shows the respondents were too conscious about the total number of children, which determine the fertility behavior of the respondents.

6.6   Age at First Child Birth

In Santhal community most of the boys and girls marriage at early age. The early marriage has become the supportive factor for the growth of population. There is low literacy rate in low income community. Therefore, they cannot understand the causes of population growth. If not more computation could be faced, lastly it can lead to death. The collected information about age at first child bearing from the study area has been presented in the following table 10.

Table 10. Distribution of the Respondents by Age at First Child Birth

Age Group	Number	Percent
13 to 16	108	54
17 to 19	67	33.5
20 to 24	25	12.5
Total 200	200	100

The table 10 shows that large number of women bearing their first child at the age group of above 13 to 16 is 54 percent. Followed 33.5 percent at age 17-19 and 12.50 percent at age 20.24
It reveals that most of the respondents had got their first child at the age of 13 to 16 years of age which is considered as early child bearing. Such type of practice increases the fertility age and behavior which eventually increases the fertility.

6.7   Child Lose Experiences

The proportion of girls who bear a child before age of 20 varies widely among developing countries. The respondents of this area were no exception for this. Early child bearing of the respondents can shape and alter her entire future life. Adolescence pregnancy and child bearing have a strong and unwelcome association with low levels of educational achievement for young women, which have negative impact on their position and reproductive health status (UN, 1995).

Table 11. Distribution of the Respondents by Child Loss Experiences

Description	Number	Percent
Yes	117	58.5
No	83	41.5
Total	200	100

The table 11 shows that, Santhal community of Bankura districts, 58.5 per cent of the respondents had experienced child loss during their reproductive age. There was also higher child ever born (CEB) (2.89) in child loss experienced respondents comparing with the no child loss experienced respondents (2.5). Similarly, the mean child ever born (CEB) of entire population was 2.61.
It seems that there is strong association between child loss experience and CEB. The higher the mortality of children the higher the fertility. This can the result or early marriage, low educational achievement,

11

high IMR, preference to son, lack of proper health facilities, health education and increase women's status in family by education them.

7   Major Findings

The main findings obtained by the analysis of data collected from sample survey were as follows:

7.1   Knowledge and Practice on Family Planning Methods

1. The highest percent of respondents (22.66%) had some knowledge of female sterilization.
2. Most of the respondents received information from Mobile/T.V (48 %) Similarly, Hospital (23%) relatives (18.5%) and others (10.5) respectively.
3. Out of 200, 42 (37.5%) of the respondents were found current used of FP methods. The most commonly used method was oral pills (40.45) and Condom (35.71%) Followed by female sterilization (11.90) Norplant (7.14%) and (4.76%) respectively.

7.2   Knowledge and Practice on Fertility Behavior

1. Majority (115) of the respondents first menstruation was 57.5 percent at the age (14-16) years.
2. Eighty five percent performed arrange marriage, followed by love marriage (11%) court marriage (3.05%) and widow marriage (0.5%)
3. Highest proportion of couples (81.5%) lived together.
4. Majority (58.5%) of the respondent's age at marriage was between 17 to 19 years and by 21 percent of respondents was in the age between 14 to 16years.
5. Highest (50%) of the respondents reported their ideal number of children is 2, followed by 3 child (16.5%), 4 and 5 children (8.34%) 6 respondents did not want to have any child.
6. First child at the age group of above 13 to 16 is 54 percent
7. About 58.5 percent of the respondents have experienced child loss during their reproductive age.

8   Conclusion

Education plays a vital role for determining fertility behavior. It resulted in high fertility because of the santhal traditional and religious thinking about family planning but fertility level among the educated is relatively low in comparison to uneducated.
The study in relation to fertility and marriage concludes that early marriage is the major cause of high fertility. The relationship between age at marriage and fertility were significantly related. So, the early marriage should be discouraged for the reduction of fertility in the study area. It is also necessary to encourage them to use contraceptive methods to reduce fertility.
Higher level of occupation plays an important role to reduce fertility. Those women in unorganized sectors had relatively high level of fertility as compared the women of working in organized formal sector. The study shows when women loss her child, she will be motivated to replace her dead child. In this way higher child loss promotes women to reproduce more children. This study comes to the conclusion that the mortality rate of the children and infants should be controlled to reduce fertility rate.

12
Acknowledgments

References

1. *Bhende A. and Kantikar, T. (1996). Principles of Population studies. Bombay: Himalayan Publishing House.*
2. *CBS (2002) Statistical pocket book, Ramshah path: Central Bureau of statistics.*
3. *Caldwell, John C. (1997) persistence of high fertility. Canberra: The Australian University.*
4. *Tuladhar, J.M. (1999) the persistence of high fertility in Nepal, New Delhi: Inter India Publications.*
5. *Niruala, B.B and Shrestha, D.P (1997) Does cat/ ethnicity matter in futility transition? An Analysis of Nepale data Nepal Population Journal, 6(18-37).*
6. *Dahal D.R. (1992). Determinatts of fertility in Nepal. In Bal Kumar K.C. (ed.) Population and Development in Nepal. Vol. 5 Pp. 1-15*
7. *Census of India. (2011). District Census Handbook, Bankura District, West Bengal.*
8. *United Nations (1997). World population trend and policies. New hour: department of International and Social Affairs.*
9. *Singh, S. and Renee, S. (1996) Early marriage among women in developing countries international Family Planning Perspectives. Pp. 388-399.*
10. *Martin TC. 1995. Women's education and fertility: results from 26 demographic and health surveys. Stud Fam Plann 26:187–02.*
11. *Akmam W. 2002. Women's education and fertility rates in developing countries with special reference to Bangladesh. Eubios J Asian Int Bioeth 12:138–43.*
12. *Kravdal O. 2002. Education and fertility in sub-Saharan Africa: individual and community effects. Demogr 39:233–50.*
13. *Wall VD. 1973. Age at marriage and fertility (Implications for family planning): IPPF Med Bull 7:1–2.*
14. *Martin TC. 1995. Women's education and fertility: results from 26 demographic and health surveys. Stud Fam Plann 26:187–02.*
15. *Davis, Kingsley and Judith Blake: Social Structure and Fertility: An analytical Framework. Economic Development and Social Change, 4(3): 211-235(1956).*
16. *Veleti K. 2001. Family structure and its effective influence on fertility. J Hum Ecol 12:387–90.*