Sharma, Vinit; Sharma, Anuragini : The status of women, fertility and family planning among tribals of South Rajasthan. The Journal of Family Welfare. December 1993. 39(4). P. 20-25.

The Status of Women, Fertility and Family Planning among Tribals of South Rajasthan

Dr. Vinit Sharma and Ms. Anuragini Sharma

Introduction

The status of women in many parts of rural India is low. The situation is even worse among tribal communities or primitive societies, which constitute approximately 7.5 percent of the total population of the country [1]. In such societies, which still lead an isolated existence, far removed from the modem way of life, a wife is primarfly regarded as an investment for production of labour and a chfidbearing housekeeper. In such societies, male dominance is a rule, and preference for a male child, a traditional compulsion. Women are considered too inferior in status to voice their views and concerns even in matters which have a direct bearing on their own health and well-being. Family elders and caste leaders reign supreme in the decision-making processes and prehistoric practices and primitive rituals and customs are still very prevalent [2-5]. Consequently, such societies are typically characterised by uncontrolled fertility and very high maternal and infant mortality rates [6-7].

The concept of the interrelationship between the social status of women and fertflity, though well-established by deductive reasoning, has aroused considerable scientific debate and controversy in the past, for the mere reason that research workers had not attempted to quantify the status of women in numerical terms [8-13]. Moreover, a number of vital medical parameters with social causes and consequences had been omitted in such computations. In the present study, an attempt has been made to develop a comprehensive socio-medical scale to measure the social status of women and to study fertility behaviour and family planning practices among tribal communities.

The scale was developed by taking into consideration a number of social and medical parameters such as the height and weight of adult women, their educational status, age at marriage, number of children possessed and desired, preference for male children, nutritional deficiencies (especially prevalence of anaemia and night blindness), the utilisation of health care services such as antenatal care, family planning pracice, and so on.

Samle and Methodology

The study was conducted in the Udaipur district of Southern Rajasthan, which has a high concentration of tribals. Out of the 18 Community Development Blocks in the district, nine are Tribal Development Blocks, which are included under the tribal sub-plan. By the process of simple random sampling, four of the Tribal Development Blocks were selected for the study. A list of the villages in the selected tribal blocks was obtained and six villages from each of the selected Tribal Development Blocks were chosen to form the sampling frame of the study. We thus had a list of 24 villages with a high concentration of tribal population. However, we were compelled to include one more village in the study during the time of survey because of a request from the local leaders of that village to whom the inclsion of their village in the study was a matter of prestige.

Based on the objectives of the study, all the female opinion leaders and wives of male opinion leaders from the 25 sample villages were included. For the purpose of the present study, the definition of opinion leaders proposed by Rogers [14] was adhered to, wherein opinion leaders have been defined as, "those individuals ftom whom others seek information, guidance and advice", and the sociometric method of identification of opinion leaders was followed [15-16].

The rationale for selecting the female opinion leaders and or the spouses of male opinion leaders for this study was that opinion leaders represent the local elite whose advice is often sought by the community. They are a mirror of the socio-cultural practices of the community, since the general population of the area tends to follow and copy their lifestyles and patteim of social behaviour. Furthermore, a study of opinion leaders obviates the necessity of stratification of the population sample according to religious, socio-economic or cultural characteristics.

Based on the above inclusion criteria, a total of 182 female opinion leaders/spouses of opinion leaders could be enlisted for our study. Out of these, 83 (45.6 percent) had received a short-term orientation training in family planning organised by the Government of India through the local primary health care set up. These respondents were assigned to Group A of the study, while the remaining 99 had not received a formal training in family planning and were included in Group B.

Data regarding the age, socioeconomic status, educational background and other relevant general characteristics of the respondents were collected by means of a pretested, structured interview schedules. Additionally, the social status of these women was determined by scoring on a five-point equidistant scale (Appendix I). We also calculated the bias in favour of the male child in the study groups.

Results and Discussion

The present study was carried out in 25 remote villages with a high percentage of tribal population. Most of the villages do not have proper transport facilities and the majority of them are cut off from the rest of the world during the rainy season. In these villages while even the bare necessities of life like food and adequate clothing are scarce, water and electricity are unaffordable luxuries. A large majority of the population is illiterate and poverty is rampant.

Table 1 presents the socio-demographic profile of the respondents.

Table 1 : Socio-demographic profile of respondents

Parameter studies	**Group A**	**Group B**
Number	83	99
Mean age (in years)	46.7	52.3
Number of members per family 1 2-5 > 5	6 (7.3) 8 (21.6) 58 (71.1)	11 (11.1) 26 (26.3) 62 (62.6)
Average family size	5.7	5.9
Desired number of children 2 3 > 3	20 (24.1) 58 (69.9) 5 (6.0)	31 (31.3) 59 (59.6) 9 (9.1)
Age at marriage < 14 years 15-19 years > 20 years	29 (34.9) 47 (56.7) 7 (8.4)	34 (34.3) 59 (59.6) 6 (6.1)
Age at birth of first child 14-16 years 17-19 years > 20 years	17 (20.5) 46 (55.4) 20 (24.1)	22 (22.2) 58 (58.6) 19 (19.2)
Age of youngest child 5 years 6-10 years > 21 years	15 (18.1) 56 (67.5) 12 (14.4)	21 (21.2) 47 (47.5) 29 (29.3)
Mean social status score	15.2	14.1

* 2 couples had no children.

Weight mean of both groups = 14.60 (social status of women). Figure in brackets denote percentages.

It was observed that almost all (95.4 percent) the respondents were illiterate as against 31.3 percent of their husbands who were also illiterate. A large majority

of them were less than 45 cms. in height (90.3 percent) and less than 38 kg. weight (70.0 percent), thus pointing to chronic under-nutrition and inadequate care received during their childhood and adolescent years. Moreover, more than 92 percent of them were found to be suffering from moderate to severe anaemia and almost 33 percent of them showed evidence of varying degrees of vitamin A deficiency.

These clinical manifestations reflect the current nutritional status of the women in the study, and are in accordance with the findings of earlier studies carried out among tribal populaitions [5], [17]. Malnutrition among tribal women has a multifactorial aetiology with its roots embedded deep in the tribal psyche. To the tribals, who are faced with object poverty, a young woman is more importantly an earning member of the family and hence a vital asset. Pregnant tribal women are compulsorily underfed under the notion that overfeeding or even proper feeding of the pregnant mother will result in a healthy, large baby, and thereby to prolonged and difficult labour. Such a myth has forced the tribals to underfeed pregnant mothers in the hope that the baby will be small and hence easily delivered [5], [17]. Earlier studies [18] in this population, have also reported that a larger percentage of the girl children were suffering from moderate to serve degrees of malnutrition (62 percent) as compared to male children (38 percent).

Another important factor which has been documented as having a direct and significant bearing on the fertility of a couple is the age at marriage [13]. In our study we found that quite a large number of the respondents (35.0 percent) had been married even before attaining the age of 4 years, and not surprisingly, almost 21 percent of them had given birth to their first child when they were between 14-16 years of age.

In rural India, a large number of girls are married off before their 15th birthday inspite of legislation prohibiting the marriage of girls before 18 years of age. In tribal communities, it is customary to marry children at any time during their childhood and some parents even indulge in anticipatory marriages, even before the birth of their children [5], [19].

Fertility and family planning

Table 1 also indicates that irrespective of their family planning training, the average family size was over 5 children, bemg slightly higher (5.9) among respondents who had not received such training as compared to 5.7 among those who had. Similarly, on the basis of the number of children desired and actually possessed by the respondents, were able to calculate a clear-cut bias of the magnitude of 13 times (461: 36.14) in favour of the male child (Table 2).

Table 2 : Preference for male child expressed by the respondents

Parameter studies	Group A	Group B
No. of living male children	(200)	(230)
1	10	8
2	42	49
> 2	31	40
No. of male children desired	(209)	(241)
1	8	3
2	57	61
> 2	18	33
No. of living female children	(187)	(213)
1	31	38
2	29	33
> 2	23	26
No. of female children desired	(80) 80	(86) 86
1	-	-
2		

Bias in favour of the male child = 461 : 036.40 (Approx. 12 times). Figures in brackets indicate the cumulative total for the group.

None of the respondents interviewed by us desired more than one female child in their families, whereas over 61 percent expressed a preference for at least two male children and 21 percent desired more than two male children. The centuries old concept of a male child being the cause and medium of salvation still appears to dominate tribal thoughts and consequently, female children are mostly neglected and underfed. In such societies the birth of a son is a matter of great jubilation and a family is considered incomplete, and the mother a downtrodden, worthless creature without the birth of a son.

Additionally, we also tried to inquire about the age of the youngest child of the respondents. Surprisingly, the youngest child of about one-fifth of the respondents was less than five years of age, thereby indicating that most of them had themselves been actively reproductive up to the very time of menopause. Such a trend was evident in both the groups, their training in family planning notwithstanding. Further more, barring a few exceptional cases, none of the interviewed women had ever availed of antenatal care and most of the deliveries had been conducted by untrained traditional birth attendants at home.

Most of the respondent's felt that they had no say, whatsoever, in decision making within the family. Similarly, almost all of them said that they had not inherited anything (and were not likely to get anything) from the ancestral

property of their parents. Both these factors point to a degradingly low status of women in this society and it was surprising to note that even in matters like family planning, the method of contraception to be adopted by the couple, utilisation of antenatal care services, etc. which are all known to have a direct effect on the health and wellbeing of women, the women had to depend on the decisions of their husbands or even their mothers-in-law.

The practice of family planning and the use of modern contraceptives have been known to be non-existent among tribal people [3], [5], [18]. In our study as well, we observed that irrespective of the training in family planning received by about 46 percent of the respondents, they themselves or their spouses were not using any method of contraception. This significant credibility Gap or KAP-Gap [20], [21] can only be explained by the low status of women in these societies. Tribals have been reported to depend on certain indigenous methods for family size limitation and our respondents also described a number of primitive and/or herbal-based methods of family planning with yet unproved efficacy or safety [3], [5].

The study is thus an attempt to highlight the low status of women based on computations of a number of medico-social factors in a primitive tribal community in India and reaffirms that the status of women is a very important factor which governs fertility and family planning attitudes and practices in a community. In order to make any family planning programme a success it is imperative that the status of women is improved so as to give them the power to decide their own destiny and the destinies of their families [22].

References

1. Census of India, 1981: Primary census abstract. Scheduled Tribes; Series 1, Part II,B, Government of India Press, Shimla (1983).

2. Sharma, D.: Education and Socialisation among the Tribes, Commonwealth Publishers, New Delhi, 1988.

3. Sharma, V.: "India's poor tribes stick to their traditions", Entre Nous (WHO/UNFPA), V. 19, 18 December 1991.

4. Singh, J.P., Vyas, N.N. and Mean, R.S.: Tribal Women and Development, M.L.V. Tribal Research and Training Institute, Udaipur, 1985.

5. Sharma, V. and Sharma, A.: "Health profile of pregnant adolescents among selected tribal populations in Rajasthan, India", Journal of Adolescent Health, 13:696-703 (1992).

6. Ramalingaswami, P.: "Tribal women and their health problems", Swasth Hind, 31:148-50 (1987).

7. Behura, N.K.: "Environmental changes affecting tribal women-Problems and solutions", In Pati, R.N. and Jena B. (eds.), Tribal Development in India, Ashish Publishing House, New Delhi, 1989.

8. Jejeebhoy, Shireen J.: "Women's status and fertility-Successive cross-sectional evidence from Tamil Nadu, India 1970-80", Studies in Family Planning, 22:27-33 (1991).

9. Kritz, M.M. and Gurak, D.T.: "Women's status and family formation in sub-saharan Africa", International Family Planning Perspectives, 15:100-105 (1989).

10. Weeks, J.R.: "The demography of Islamic nations", Population Bulletin, (Population Reference Bureau, Inc. U.S.A.), 43:25 (1988).

11. Population Crisis Committee: "Poor, powerless and pregnant-Country rankings of the status of women", Population Briefing Paper No.20, 1988.

12. United Nations: "Status of women and family planning", Policy Paper (C/CN-6/575/Ref. No. E/75/VS), New York, 1975.

13. Jejeebhoy, Shireen J.: Women's roles-health and reproductive behaviour". In UNFPA South Asia Study and Population Policy and Programmes: India (Report), New Delhi, 1990.

14. Rogers, E.M. and Shoemaker, F.F.: Communication of Innovations, Free Press, New York, 1971.

15. Sinha, K.S.: "Identification of leaders in health education" Swasth Hind, 24:324-26 (1986).

16. Mann, C.K.: "Identification and utilisation of local leadership in family planning programmes in an urban set up", Journal of Family Welfare, 19:15-20 (1973).

17. Singh, A.K., Sinha, S.K., Singh, S.N. and Jayswal, M.: "The mythy of the healthy tribal", Social Change, 17:3-17 (1987).

18. Sharma, V., Sharma, A.: "Family planning practices among tribals of South Rajasthan, India", Journal of Research and Education in Indian Medicine, 10:5 (1991).

19. Bhandari, B.: "Tribal marriages and sex relations, Himanshu, Publications, Udaipur (1989).

20. Westoff, C.F.: "Is the KAP--gap real?", Population and Development Review, 14:225-243 (1989).

21. Bongaarts, J.: "The KAP-gap and the unmet need for contraception", Population and Development Review, 17:293-313 (1991).

22. Boserup, E.: "Population, the status of women and rural development" In Mc Nicoll, G. and Cain, M. (eds.), Rural development and populaton-imtrtutions and policy, Population and Development Review, Supplement, 15:45-69 (1989).