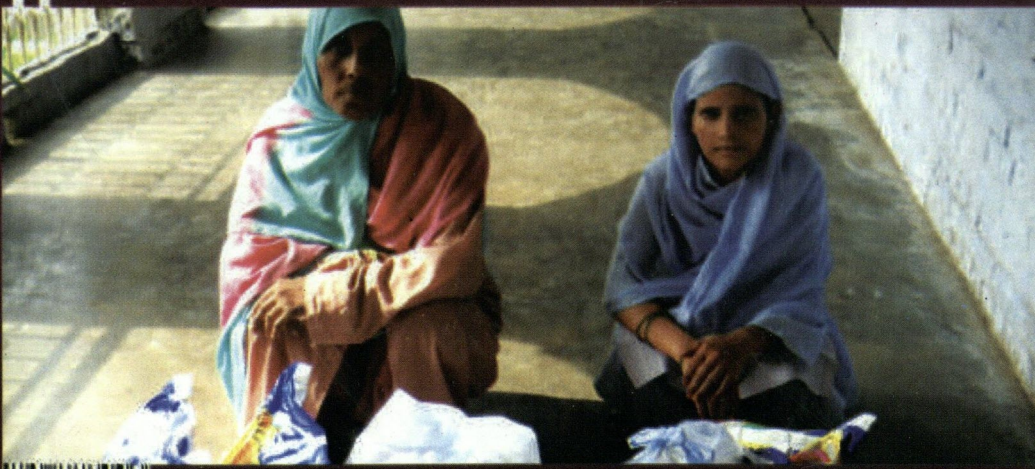
Fertility and Health Behaviour Among Hindu and Muslim Women in Assam



Kishor Singh Rajput

The International Conference on Population and Development, held in Cairo in 1994, maintained that population policies would fail to deliver the desired results if the reproductive health needs of different groups of population, particularly that of married women, are not properly attended to. Since then, reproductive health has become a key component in India's family welfare programme.

This book makes a holistic attempt to explain the reproductive health behaviour of the Hindu and Muslim women of Assam in their socio-cultural context so as to understand the true dynamics of their behaviour. Based on primary data, this book revolves around key areas of reproductive health behaviour, such as contraceptive use, son preference, fertility, breastfeeding practices, antenatal care, institutional delivery, natal care and post-natal care.

This book deserves the attention of students, research scholars, and teachers of different social science subjects, in general and population studies, in particular. The policy makers and administrators involved in the population and social welfare programmes would also immensely benefit from this book.

Dr. Kishor Singh Rajput, presently a Lecturer in the Department of Economics of St. Anthony's College, Shillong is a triple Master Degree holder in Economics, Population Studies and Ecology and Environment. As a result, his research priorities revolve around themes that allow him to analyse the inter-linkages between population, economic development and environment, mainly at the micro level, so as to have findings that can promote sustainable livelihood in the society.

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Introduction

Statement of the Problem

Continuous rapid population growth has remained a major problem in the path of economic development of Assam. For example, Assam's total population increased from 8.02 million in 1951 to 14.62 million in 1971 and further to 26.64 million in 2001—a more than 3 times increase. This magnitude of increase in the population definitely acts as a drag on limited economic resources of the state.

High fertility is an important cause of rapid population growth of Assam. The fertility rates and fertility behaviour vary among the different communities of Assam. Perhaps this is because the various socio-economic variables that determine fertility behaviour of different groups of population affect them differently.

However, the past attempts of the Government to lower the fertility rates of different groups of population failed to a great extent. Most importantly, the fertility reduction policies of the Government in the past failed to take into account the reproductive health needs of the people, particularly that of the married women. High maternal mortality and infant mortality rates, high level of anaemia, etc. are few indicators of the poor situation that exists in the health sector of Assam. However, Government's focus has been reoriented after the International Conference on Population and Development (1994), held in Cairo, as it now puts heavy emphasis on meeting the reproductive health needs of the population in the framework of fertility control programme.

Comprehensive reproductive health programme adopted by consensus at the ICPD, Cairo, in 1994 signifies a paradigm shift in the conventional family planning and population control related approaches. Revolving around women's health as a matter of reproductive right the reoriented health approach aims to address a large number of distinct yet closely interrelated issues which go much beyond conventional family planning and MCH issues. Broadly speaking, client oriented reproductive health programmes try and address issues relating to safe motherhood, abortion, sexually transmitted diseases including HIV/AIDS, family planning, etc.

The Governments all over the World are now trying to incorporate the component of reproductive health in the overall framework of the population policy. The Indian Government as well as the Government of Assam is also now trying its best to meet the reproductive health needs of the people, particularly that of the mother. Keeping in view the paradigm shift in the population policy framework, this book looks into various aspects of fertility and reproductive health behaviour of two major religious communities of Assam, viz., Hindus and Muslims.

Need for the Study

James and Nair (2005) observed that there is ample evidence available in India to suggest a significant variation in fertility across different regions of the country. Even within a state itself, the fertility rate varies across districts. So this present study is the result of the felt need to undertake a detailed study of a district to find out the differences in the fertility and fertility related behaviour of the Hindu and Muslim women.

Furthermore, the past attempts of the Government to lower the fertility levels of different groups of population have, by and large, failed. The past policies were too much targets driven and obsessed with numbers. Consequently, the policies failed to recognize the health aspirations of the people, especially of the married women. But in recent years the focus has shifted towards this aspect of fertility control programme.

As a result, the number of researches undertaken in this area has also increased significantly.

The NFHS-I and NFHS-II surveys have thrown some light on the basic reproductive behaviour of women in Assam, including Hindu and Muslim women. But in the NFHS study, Hindu and Muslim women or religious affiliation has been taken as one of the various socio-economic variables. So a detailed study on the reproductive health behaviour of the Hindu and Muslim women has not been done in Assam, in general and Sonitpur district of Assam, in particular.

Furthermore, as the proposed study will try to explore how the various socio-economic variables like education, occupation, age at marriage, the type of family, family planning practices, etc. affect them (differently or the same way), a greater understanding of the problem in hand is likely to be obtained. The findings, therefore, are likely to throw more light on various aspects of fertility and reproductive health related behaviour of the Hindu and Muslim women. The findings are furthermore likely to be of some help in the future formulation and implementation of a reproductive health delivery system to some extent. We know that if the reproductive health behaviour varies among different groups of population, then the corresponding health delivery system has to approach these groups differently. The present study may help the policy makers to get better insights on the reproductive health behaviour of the Hindu and Muslim women.

Overview of Literature

The fertility rate is very high in Assam as in some other parts of the country (NFHS, Assam, 1992-93). This situation persists basically due to the lower age of marriage, low level of literacy, poor economic status of the couple, large family size, sex consideration/value of children, ignorance, taboos, myths, customs and superstitions and often non-availability of means of reproductive choices (Jain, 1994). In fact, fertility is a very complicated phenomenon and it is affected by social development and cultural change. Fertility is, thus, a multi-

dimensional outcome of all the socio-economic norms and network of couple which are translated through biological reproduction (Mahadevan and Sumangalam, 1987). Furthermore, there are large spatial variations in the religious composition and fertility in India (Alagarajan and Kulkarni, 1998). The striking inter-regional diversity is an important confounding factor in India (Govindasamy and Ramesh, 1997).

Also there exists inter-religion fertility differentials in India. For instance, the mean number of children ever born to Muslims of 3.5 children is significantly higher than Hindus of 2.9 children (Moulasha, 2000). According to the NFHS, 1992-93, the average number of living children for Hindu was 3.0 against the figure of 3.4 for the Muslim. Though the second survey, NFHS-II, 1998-99, showed lower fertility for all the religions, but still the gap between the Hindu and Muslim fertility continued to exist.

Caldwell *et al.* (1988) in his report on "Causes of Fertility Decline in South Asia" maintained that Muslims exhibit significantly higher fertility and are less likely than Hindus to practice family planning. Kulkarni (1996) in his analysis on Hindu and Muslim population growth indicated that the higher growth among Muslims as compared to Hindus was primarily attributable to the higher fertility of Muslims.

On the basis of the analysis of NFHS-II data, Dharmalingam *et al.* (2005) in their article 'Muslim-Hindu Fertility Differences' commented that Muslim-Hindu differences in fertility and contraceptive use are substantial and pervasive across India. A Muslim woman is about 50 per cent more likely to want to have an additional child, and is about half as likely to use contraceptives as a Hindu woman. This result is net of observable socio-economic characteristics at individual, household and district levels, and after taking into account the multi-level structure of data and reality.

Likewise, by analyzing the 2001 Census data on Total Fertility Rate (TFR), Rajan (2005) showed that there was a net difference of TFR of 2.3 between the Muslims and Hindus of Assam as the Muslim TFR was 5.1 and Hindu TFR was 2.8. As far as the Sonitpur district is concerned, the TFR for the Hindus

stands at 2.9 as against the TFR of 5.4 for the Muslims. Likewise, other studies (Visaria, 1974; Cassen, 1978; Sharma and Mishra, 1978; Balsubramanian, 1984; Srivastava *et al.*, 1998; Kulkarni, 1996 and Bhat and Zavier, 2005) by using primary as well as secondary data have shown that the Muslims in India exhibit higher level of fertility than the Hindus.

Religion is one of the oldest socio-cultural characteristics associated with the mankind and civilizations created by them over thousands of years of known history. In fact, religion has become a worldwide institution. Its influence is found in all societies and it really acts as a powerful system of social control (Moulasha, 2000). Hence, religion can be considered as an important social attribute. It is of particular importance in our country because we have many faiths and our civilisation is closely linked to religion (Hussain, 1994). India is a country of many religions. Hindus and Muslims are the two major religious communities of India. According to the Census of India, 2001, Hindus constitute 80.46 per cent of the total population of the country, Muslim population's share is 13.43 per cent and the rest is accounted by other religions. However, the religious composition of the population has undergone change over the years. In 1951, for example, the share of the Hindu and Muslim population in the total population stood at 84.9 per cent and 9.9 per cent respectively.

Religion prescribes a code of life, refers to a system of beliefs, attitudes and practices which individuals share in groups, and through this orientation towards life and death, is supposed to affect one's fertility behaviour (Chaudhury, 1982; Ram and Mehta, 1983). This is due to the fact that different communities and people perceive religion in their own unique way (Census of India, 2001).

According to Westoff (1959), religious affiliation of the couple affect the family, directly by imposing sanctions on the practice of the birth control or legitimizing on the practice of less effective methods and indirectly by guiding its members with a moral and social philosophy of marriage and family which emphasize the virtues of reproduction. Clifford (1971) and Jain (1975) observed that belief system and value

orientation were important determinants of fertility behaviour and birth control. Religiosity of an individual is a cultural variable and is expected to influence the individual's fertility behaviour (Lorimer, 1954). Borooah and Iyer (2005) in their article 'Religion, Literacy and the Female to Male Ratio' observed that the faster growth rate of the Muslim part of the Indian population is blamed on Indian Muslims' obeying the tenets of Islam in rejecting family planning and embracing polygyny.

Lorimer (1954) considers religiosity of an individual as a cultural variable and, hence, he expects it to influence the individual's fertility behaviour. Kulkarni and Alagarajan (2005) in their article "Population Growth, Fertility and Religion in India" opined that higher than average fertility among Muslims is on account of the religion factor, be it theological or of minority position. Furthermore, they have found strong effect of religion on the contraceptive use of the Muslims. However, Borooah and Iyer (2005) suggested that there is no consensus in India as to how much influence Islam has on contraception and marriage and ultimately on fertility.

However, the seed of the debate on the differential population growth rates of the Hindus and Muslims was planted in the undivided India itself. Kingsley Davis, an eminent demographer, was one of the first to raise a debate on the Hindu-Muslim population growth rates in the sub-continent. In his famous book "The Population of India and Pakistan" (1951), he presented before the world the fact that Muslim fertility was higher than the Hindu fertility. For instance, the decline in the proportion of the Hindus from 75.1 per cent to 72.9 per cent in between the censuses of 1881 and 1901 (Davis, 1951) created strong reaction and fear among the Hindus that the Muslims would become the majority population in India in the future.

Numerous research and review studies have been done on this area since then. But there seems to be no end to this highly debated topic and it still remains a very popular area for research studies among the research scholars and population scientists.

Basu (1997) refers to this whole debate as nothing but the politicization of fertility whereby criticisms are levelled against the Muslims on demographic front for non-demographic interventions in Muslim lives. But Ashish Bose (1969) in his article "Differential Fertility by Religion in India" terms this problem as a technical problem rather than a political problem in demographic analysis. It is always easy to quote stray figures and mislead the people and arouse passions. He, therefore, urges the demographers and statisticians to analyse this problem in a scientific manner and place before the country the findings of their studies. In other words, it is important to go beyond the population growth rate figures of Hindus and Muslims and give a thought to other demographic, economic and social variables (Bose, 2005).

Many other scholars, however, object using religion as an explanatory variable in understanding demographic change (Ludden, 1996; Jeffrey and Jeffrey, 1997; Jeffrey and Jeffrey, 2002). According to them, in addition to directly influencing fertility through the proximate determinants, religion can also impact fertility indirectly through socio-economic factors. Religion can differentially affect or be related to the distribution of individual and group characteristics which then influence reproductive behaviour.

They also conclude that Muslims are less educated and are in weaker economic positions than Hindus. Schooling and some other socio-economic aspects have very strong bearing on fertility—much stronger than the relationship with religion. The socio-economic factors, therefore, have important bearing on fertility (Rajendran, 1997; Manna, 1998). Since socio-economic variables are known to be associated with fertility, the religious differentials in these can plausibly cause differentials in fertility (Shariff, 1994, 1995 and Jeffrey and Jeffrey, 1997). For Moulasha (2000) also, the determinants of Hindu fertility were different from that of Muslim fertility. He has found out that the variables that were influencing the fertility of Hindus and Muslims were not the same.

Jeffrey and Jeffrey (2000 and 2002) observed that Muslims are not a homogeneous group in respect of their socio-economic

and demographic behaviour in different regions of the country. For instance, the Muslims are found closer to Hindus in respect of their socio-economic and demographic behaviour in a particular region of the country than they do with the Muslims living elsewhere in the country. Thus, Bhagat and Praharaj (2005) observed that the fertility levels and differentials among Muslims within India, as well as across Muslim countries, indicate that reproductive behaviour among Muslims is essentially not uniform; there are factors other than religion, which are even more important. Therefore, they commented that the relatively higher fertility among the Muslims cannot be understood independent of its socio-economic and political contexts.

Consequently one of the important hypotheses for the religious differentials of fertility suggested by many research scholars (Jones and Nortman, 1968; Kirk, 1968, Goldscheider and Uhlenberg, 1969 and Chamie, 1977) is that of characteristics, i.e. the socio-economic characteristics could vary by religion causing fertility differentials. However, it is also true that considerable disagreement exists among the population scientists as to how far socio-economic disparities can explain the fertility differential (Bhat and Zavier, 2005). As such it can be said that population of different religions that vary in factors such as education, income, occupation, etc. could actually lead to differential fertility. The religious differential in fertility can, therefore, be considered as the product of the differences in the socio-economic characteristics and the influence of these characteristics on fertility.

The results of the MCA analyses of the NFHS-II data for the major states of India by Kulkarni and Alagarajan (2005) countered the characteristic hypothesis. Moulasha (2000) also arrived at the same conclusion. In other words, socio-economic factors do not seem to explain the religious differentials in fertility. However, literatures also exist to show that Hindu-Muslim differences in observed fertility might not be real (Dharmalingam and Morgan, 2004). As a result, Hindu-Muslim fertility differentials disappear once the background socio-economic variables are controlled.

For Kulkarni and Alagarajan (2005), religious as well as other differences in fertility are inevitable during fertility transition—the process of decline from high fertility in the past to voluntarily regulated low fertility. This happens because sections, whether regions or religions, do not transit from a high fertility regime to a low fertility regime at the same time or pace. Therefore, at a given point of time, those ahead in this process would have lower fertility than those lagging—thus opening a wide gap. India is currently undergoing the process of fertility transition and there is irrefutable evidence that fertility has declined substantially in all the major religious communities in India over the period of time.

Contrary to fertility studies, research on women's reproductive health and reproductive rights is considered as a neglected area (Lane, 1994; McDaniel, 1996, 2000; and Freedman 1999). A distinctive gender-related and health-related aspect of much demographic research today is on the assumption that women are the keepers of a nation's health (Basu, 2000). The role of women as primary custodians of family health should be recognised and supported (United Nations, 1995).

Therefore, it is very necessary that studies and research activities are undertaken on issues like men and women's perceptions and current health seeking behaviour in different settings of population, viz., urban, rural, slum, etc. and on various health aspects like antenatal care, pregnancy complications, child survival, immunisation of the mother and child and so on (GoI, 1997). However, the knowledge that exists in this field can be considered as the tip of iceberg only.

Maternal health requires urgent attention, as there is an extraordinary difference in maternal death rates between the developed and developing countries (ICMR, 1990). According to the World Bank (1993), about one-third of the total disease burden of women of 15 to 44 years of age in developing countries is linked to health problems related to pregnancy. Every minute of everyday a woman dies as a result of pregnancy or childbirth. Every time a woman in the Third World becomes pregnant, her risk of dying is 200 times higher

than the risk run by a woman in the developed World (Motashaw, 1997). In many developing countries about 50 per cent of pregnancy terminations occur among the high-risk mothers (Rinchart and Kols, 1984).

In developing countries older women usually have many children and women who marry young may have several closely spaced births before they reach the age of 20. Among these pregnancies, there are greater risks of miscarriage, stillbirths and deaths during infancy (Swenson and Harpner, 1979; Chen *et al.*, 1974; Koenig *et al.*, 1988). Pregnancies of younger mothers (below 18 years) and older mothers (over 35 years), too many pregnancies (5 or more) and closer birth interval of less than 24 months are likely to produce high risks to mothers and child life (Perkin, 1968).

Chatterjee (1996) stresses that women in India bear their health problems in a 'culture of silence' and do not seek timely health care; they often cannot travel beyond the area of their normal activities to obtain services; they cannot usually approach male health providers; in general, families, including women themselves, spend less time, effort and money seeking health care for women and girls than men. There are substantial data to show that Indian women also bear a heavy burden of reproductive morbidity (Bang and Bang, 1991 and Pachauri, 1994). The fact that 1,00,000 women in India are estimated to die every year from pregnancy and child-birth related causes reinforces the importance of ensuring that all pregnant women receive adequate antenatal care during pregnancy and the deliveries take place under the supervision of trained medical personnel in a hygienic environment (IIPS, 1995).

Traditionally, women in India have been associated with home while the men with the world of work. This compartmentalization has led to gender differentiation of an order that distinguishes men and women. As a result, the females in the society are being led by the cultural traditions and religious beliefs rather than legal rights (Ashraf, 1994). Therefore, the need to emphasize reproductive health as a matter of human right issue cannot be exaggerated (Rajput, 2002).

Only in 1995, the Ministry of Health and Family Welfare introduced the Reproductive and Child Health Programme (RCH) as a part of 'Paradigm Shift' in its ongoing family welfare programme (Kumar, 2002). All these changes have followed the International Conference on Population and Development (ICPD), held in Cairo, in 1994. The Programme of Action formulated at the end of the Cairo Conference postulated that population policies should be viewed as an integral part of programmes for women's development, women's rights, women's reproductive health, poverty alleviation and sustainable development. In recent years, particularly after the Cairo Conference (1994), researchers from all over the World have started putting more and more emphasis on various reproductive health issues, specially that of married women.

Like fertility, reproductive health behaviour of different religious groups may vary considerably. Recently, interest has grown in examining community influences on individual health outcomes, so as to place health-care seeking behaviour in its socio-economic context (Manda, 1998; Magadi *et al.*, 2000; and Chacko, 2001). Studies have shown that the use of reproductive health care services is influenced by individual and household characteristics. Studies of health service use highlight a range of modifying factors in a woman's propensity to seek health care that include demographic, socio-economic and health experience characteristics (Becker *et al.*, 1977 and Stephenson and Tsui, 2002). Khan (1990) also maintains that knowledge and utilisation of reproductive health care services in different communities in India is intimately associated with traditional beliefs, customs and the individual's background characteristics. The different socio-economic and cultural practices ultimately have a bearing on maternal and child health and family welfare services.

Various socio-economic and demographic factors that have been considered as having important bearing on health problems and the likelihood of health service use are urban residence (Addai, 1998), household living conditions (Bloom *et al.*, 1999; Magadi *et al.*, 2000), household income (Kavitha and Audinarayana, 1997), occupational status (Nwakoby, 1994; Miles-Doan and Brewster, 1998; Nuwaha and Amooti-kaguna,

1999), the type of family in which they live and their status (Ashraf, 1994), woman's employment in skilled work outside the home (Addai, 1998; Miles-Doan and Brewster, 1998; Estrin, 1999), husband's high level of education (Nwakoby, 1994; Nuwaha and Amooti-kaguna, 1999), low parity (Bhatia and Cleland, 1995a; Kavitha and Audinarayana, 1997; Magadi *et al.*, 2000) and young maternal age (Bhatia and Cleland, 1995a). Hobcraft (1993) and Desai (1994) have also established the linkage between mother's schooling and her reproductive health behaviour. Educated women are better able to break away from tradition to utilize modern health care services for safeguarding their own health and that of their children (Caldwell and Caldwell, 1988; Cleland, 1990). Educated women are better able to utilize what is available in the community to their advantage (Barrera, 1990; Caldwell, 1990; Goodburn *et al.*, 1990) and may be able to make independent decisions regarding their own and their children's health leading to greater utilization of modern health facilities (Caldwell, 1979; Caldwell, 1986).

Kapadia (1999) also believes that high levels of mortality and morbidity of the women are affected by a complex interplay of biological, economic, socio-cultural and psychological factors throughout their lives. So, there is the need to consider women's health problems in the context of their empowerment.

However, the various socio-economic and demographic factors are quite often mediated by cultural influences that shape the way an individual perceives his or her own health and the health services available (Basu, 1990; Obermeyer, 1993; Bhatia and Cleland, 1995b; Goodburn *et al.*, 1995).

Community beliefs and norms relating to health care seeking behaviours are reflected in individuals' decisions, which are based, to some degree, on how they think the community views their actions (Rutenberg and Watkins, 1997). Community beliefs concerning childbearing preferences and sexual and reproductive health behaviour exert a strong influence on individual attitudes towards family planning and fertility preferences (Greenwell, 1996). Similarly, traditional

beliefs surrounding childbirth coupled with misconceptions about and fear of medical institutions act to maintain women's reliance on home delivery in India (Basu, 2000; Griffiths and Stephenson, 2001). Therefore, it can be said that though socio-economic factors are key determinants of health behaviour and the service use, the individual's cultural environment influences the extent to which these factors can lead to service use.

Recently, that is why, interest has grown among research scholars in examining community influences on individual health outcomes, so as to place health care seeking behaviour in its socio-economic context (Entwisle and Mason 1985; Entwisle *et al.*, 1989; Von Korff *et al.*,1992; Pebley *et al.*, 1996; DeGraff *et al.*, 1997; Manda, 1998; Magadi *et al.* 2000; and Chacko, 2001). These studies relate individual health outcomes and health care seeking behaviour to the socio-economic characteristics of the community.

Objectives of the Study

The proposed project mainly aims to explore certain important areas of fertility and basic reproductive health behaviour of Hindu and Muslim women. The specific objectives of the proposed study are:

1. to find out the existing level of fertility and fertility behaviour among Hindus and Muslims.
2. to find out the effect of important socio-economic variables of fertility and fertility behaviour among Hindus and Muslims.
3. to find out the maternal health care experience of these communities of Assam, viz., the maternal health problems, treatment behaviour and avenues of treatment seeking, in case of health problems.
4. to find out the effect of important socio-economic variables on the basic reproductive health behaviour of Hindus and Muslims.

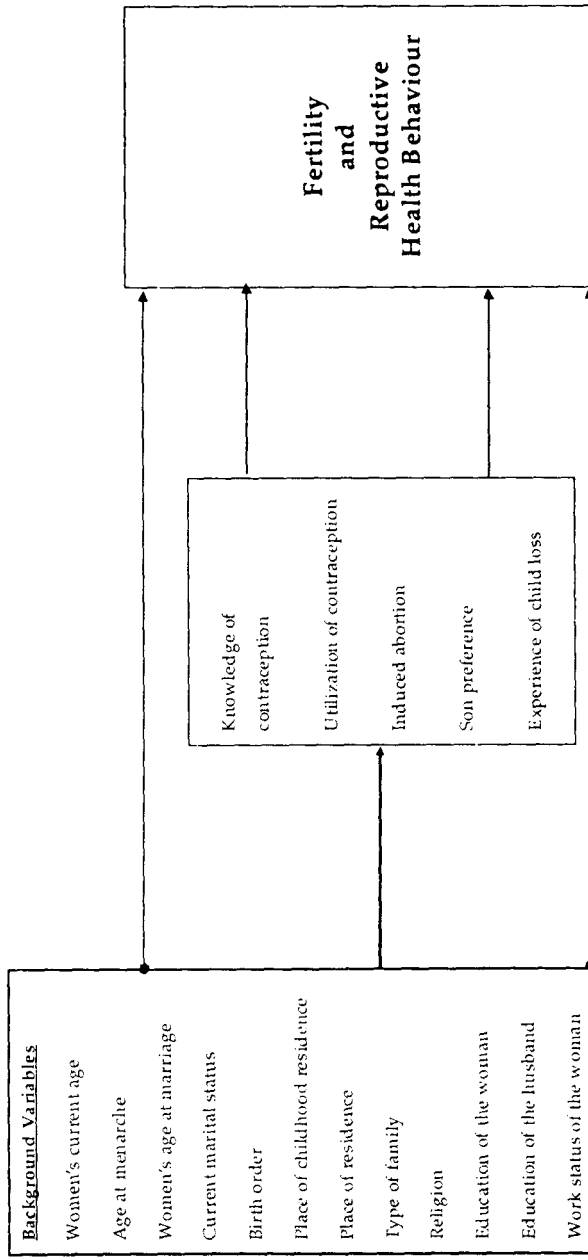

Fig. 1.1 : Conceptual framework used for the study