CHAPTER I

INTRODUCTION

1.1 Population in Tamil Nadu
1.2 Population theories
1.3 The Demographic transition theory
1.4 Fertility theories
   Biological theories
   Social theories
   Economic theories
1.5 Wealth flow theory
1.6 Determinants of fertility
   Social and cultural determinants
1.7 Need for the study
1.8 Title of the study
1.9 Objectives
1.10 Organisation of the thesis
1.11 Scope and limitations of the study
India’s Population reached one billion on 11 May 2000 and is next only to China’s. While the global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million to 1 billion in the same period. If the current trend continues, India may overtake China in 2045, to become the most populous country in the world. One-sixth of the world’s people reside in India and its demographic trends will have a strong global impact. What is baffling about India’s population growth is that India was almost the first country to officially recognize the problems arising from high fertility and it launched the family planning programme in the early fifties. However, despite the commitment to population control and substantial expenditure over the last four decades, the results have not been commensurate with the inputs. Indeed, countries which launched family planning programmes later have achieved better results. Vijayanunni (2000) states that, considering the present precarious position of the country on
the population front child-births occurring to mothers having two or more children is on the same level as prevailing fifty years ago. One of the objectives of National Population Policy (2000) is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection. Stabilising population is an essential requirement, for promoting sustainable development with more equitable distribution. The NPP (2000) provides a policy framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India and to achieve net replacement levels by 2010. The anticipated growth of population in India is given in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>If current trend continues</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total Population (in million)</td>
<td>Increase in Population</td>
<td>Crude Birth Rate</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>2002</td>
<td>1027.6</td>
<td>15.4</td>
<td>23.0</td>
<td>50</td>
</tr>
<tr>
<td>2010</td>
<td>1162.3</td>
<td>16.8</td>
<td>21.0</td>
<td>30</td>
</tr>
</tbody>
</table>

The population growth in India continues to be high on account of several factors:

i) The large size of the population in the age-group (estimated contribution 58 percent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reduction in family size in several States, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the reproductive age group adopts without further delay or exception the “small family norm”, for the reason that about 45 percent of population increase is contributed by births above two children per family.

ii) Higher fertility due to unmet need for contraception is another predominant factor (estimated contribution 20 percent). India has 168 million eligible couples, of which just 44 percent are currently effectively
protected. Urgent steps are currently required to make contraception more widely available, accessible and affordable. Around 74 percent of the people live in rural areas, in about 5.5 lakh villages, many with poor communication and transport. Reproductive health and basic health infrastructure and services often do not reach the villages, and accordingly, vast numbers of people are unable to avail of these services,

iii) High wanted fertility due to the high infant mortality rate (IMR) (estimated contribution about; 20 percent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.

iv) Over 50 percent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of “too early, too frequent, too many”. Around 33 percent births occur at intervals of less than 24 months, which also results in high IMR.
1.1 Population in Tamil Nadu

Tamil Nadu, is located on the eastern coast of the south Indian peninsula. According to the 2001 census, Tamil Nadu had a population of 62.11 million. The population trend is given in Table 1.1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (millions)</th>
</tr>
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<tbody>
<tr>
<td>1981</td>
<td>48.4</td>
</tr>
<tr>
<td>1991</td>
<td>55.9</td>
</tr>
<tr>
<td>2001</td>
<td>62.11</td>
</tr>
</tbody>
</table>

Source: India, Registrar General

Although the Total Fertility Rate in Tamil Nadu has reached the replacement level, 23% of the children were of birth order 3 and above for the period 1996-1998 (Ramanujam et al., 2001). There is a need for further studies in order to design the ways and means to bring down the fertility rate, especially among the vulnerable population and to sustain the existing fertility rate in the population where the replacement level has already been achieved.
1.2 Population Theories

The phenomenon of population growth is explained by theories of population. The rise and fall, the growth and decrease trends in population and the causative factors in the curve of population are ascertained. The history of population theories has been classified after the celebrated demographer Malthus, and the periods are classified as Pre-Malthusian, Malthusian and Post-Malthusian periods. The Pre-Malthusian period is calculated from the beginning of the 16 to the end of 18th century. It was a rapid thinking in all aspects of human life. According to Malthus, population, when unchecked, increases in a geometrical ratio, subsistence increases only in an arithmetical ratio. This theory was subjected to harsh criticisms. Malthus was the first thinker who established that uncontrolled increase of population will lead to poverty and therefore birth control must be popularised. According to Neo-Malthusianism, Malthus did not distinguish between sex desire and desire for children. Both these are fulfilled by the same physical organs. The sex desire also involves desire for reproduction. Neo-Malthusians, however, do not accept this
view. They reject the Malthusian theory that sex desire is identical with the desire for children. According to them sex desire is a natural and biological desire. It is the most physical and psychological desire among the adults. Its repression leads to so many mental and physical evils. Desire for children, on the other hand, particularly depends upon social, moral and cultural values. It is not inherent but a product of socio-economic conditions. Fulfillment of sex desire is a must for normal and healthy life. The desire for children, however, should be adjusted according to favourable or unfavourable circumstances. Only that woman should reproduce who is physically and mentally fit for the purpose. Males and females should be allowed to satisfy their sex desire without procreation. There is no moral evil in using chemical or mechanical means of birth control to satisfy sex desire. The classical theory of population was based upon the idea that the production, consumption and distribution of wealth are determined by economic laws.
The Neo-classical school of thought placed more emphasis on mathematical economics and the analysis of the psychological background and consumer demands, decisions and actions. Both the classical and neo-classical schools were concerned with an examination of the inter-relationships between population and production. The optimum population theory states that at any given time, the population which can exist on a given extent of land, consistent with the greatest productiveness of industry at that time, is definite. This theory implied that the growth of population was beneficial up to a certain point, after which it becomes harmful.

1.3 The demographic transition theory

The demographic transition theory - a propos the transition from high morality and high fertility levels to low mortality and low fertility levels is an excellent contribution in the field of Population science. The development of this theory was based on European experience where fertility decline in most cases was accompanied by or preceded by decline in mortality. Notestein (1952) indicated that changes in mortality took place
in conjunction with economic development in the west. The growing importance of the individual rather than family and particularly the decline of the extended family group; the development of a rational and secular point of view; the growing awareness of the world and modern techniques through popular education; improved health; and the appearance of alternatives to early marriage and child bearing as a means of fulfillment and prestige of women were considered the determinants of low fertility. Notestein particularly emphasized the role of education which might stimulate an innovative and rational view of life, enhance the importance of the individual as opposed to the extended family group, improve the status of women, and substitute the ideal of a healthy and prosperous family life. Davis (1957) explored factors that kept underdeveloped areas at high fertility levels even though many countries experienced a sharp decline in mortality. Institutional factors were held responsible for high fertility in the developing world. Coale (1975) identified the weakness of the demographic transition concept after examining the process of demographic change in European countries. Historical demographic concept
failed to define the specific levels of a set of variables that are required for fertility decline. Coale considered three general prerequisites for decline in marital fertility viz Fertility must be within the calculus of conscious choice, reduced fertility must be advantageous and effective techniques of fertility reduction must be available.

1.4 Fertility Theories

Ever since the science of demography has been developed, fertility occupied the central position in it. The growth of population depends on fertility. It is the positive force behind the expansion as well as the dynamism of a population. Population growth in particular circumstances has been explained by theories of fertility. They analyse cause effect relationships and point out the factors determining fertility. These theories have been classified as follows.

1.4.1 Biological Theories

These theories, as is clear by the terms used, lay emphasis upon biological factors influencing fertility. The most important theories in this category are: The Density principle propounded

1.4.2 Social Theories

Sociologists have advanced social theories of fertility. Different social theories emphasized different factors determining fertility. One of the most important, social theories of fertility is known as the theory of social capillarity. According to Arsena Dumont, a French philosopher, the urge to rise in social status influences fertility. Kingsley Davis advanced a fertility theory of change and response based on the theme of social capillarity, i.e., the desire to rise in the social scale. The theory of Diffusion or Cultural Lag is another significant social theory. It explains the spread of the concept of birth control all over the world.
1.4.3 Economic theories

Among the economic theories of fertility, laying emphasis upon economic factors, the following two theories have been important contributions to the economic interpretation of fertility during 1960-1970. i) Liebenstein’s Theory.- Harvey Liebenstein formulated a theory which explained the factors determining the number of children desired by each couple. It was based upon the assumption that people calculate the number of children they should have on the basis of satisfaction or utilities and cost both monetary and psychological. The type of utilities derived are: (a) the utility of the child as a consumption good or a source of pleasure, (b) the utility as a productive unit, and, (c) the utility as a source of security in old age. The two types of cost involved are direct costs and indirect costs. ii) Theory of Backer - In 1960 Backer presented the economic analysis of fertility based on micro-consumption theory of fertility. He argued that fertility behaviour is the result of household choice. Treating children as household commodities, Backer argued that a couple’s decision in this respect depends on the balance of preferences,
The constraints of income and the costs of the child. If knowledge of birth control were widespread, fertility would be directly related to the income. (iii) Socio-economic theories - An example of socio-economic theory of fertility is what is known as the Threshold Hypothesis. It uses the following 12 indicators: per capita income, energy consumption, degree of urbanization, proportion of economically active male employed in non-agricultural activities, hospital beds per thousands population, life expectancy, infant mortality rate, proportion of married women in the 15-19 age group, female literacy rate, newspaper circulation, number of radio sets, and the cinema attendance. The value of each of these indicators differs in countries showing high and low fertility. The different measures of fertility are crude birth rate, the general fertility rate, age specific fertility rate, total fertility rate, gross reproduction rate, sex-age adjusted birth rate, measures based on census age and measures based on number of children ever born.
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1.5 Wealth Flow Theory

Caldwell’s wealth flow theory (1976) assumes that fertility behavior in both pre-transitional and post-transitional societies is economically rational. In a society where there is no economic gain to the family from lower fertility levels, the intergenerational net wealth flow is from the younger to the older generations. In a society where there is economic gain to the family from lower fertility, the intergenerational net wealth flow is from older to younger generation; thereby, since parents have no benefit from higher fertility levels, fertility will decline. Caldwell pointed out that there are at least six different economic advantages of children to one or both parents, which might have kept a stable but high fertility levels in pre-transitional rural societies.

As the number of children beyond infancy grows and ultimately the number of children increases, it is inevitable that the person on top of the pyramid controls more resources and has access to more services (as well as enjoying more objectives power) even if per capita income remains static;
Children work in the household and on the farm not only producing goods but providing a range of services that adults regard as wholly or partly children’s work;

 Adult children usually assist their parents, especially with labor inputs into farm;

 Adult children provide particular assistance in making up the family contributions to community festivities and to such family ceremonies as marriage, funerals, and celebrations connected with births;

 The care of aged parents, who may insist on having their farm, business and households propped up as if they were still running them, can be a major undertaking; and

 Parent’s can invest in training or education of children so as to increase their ability to make return

1.6 Determinants of Fertility

The determinants of fertility include physiological factors such as adolescent sterility, post-partum sterility, primary and secondary sterility and reproductive wastages. Apart from physiological factors Kingsley Davis and Judith Blake have
developed a model classifying the intermediate variables through which social factors affect the stages of child bearing which compromise social and cultural determinants of fertility. They are as follows.

1.6.1 Social and Cultural Determinants of Fertility.

I. Factors affecting exposure to intercourse

A) Those governing the formation and dissolution of unions in the reproductive period

1. Age of entry into sexual unions.

2. Permanent celibacy: proportion of women never having sexual union.

3. Part of the reproductive period spent after or between unions.

B) Factors governing exposure to intercourse within unions.

1. Voluntary abstinence

2. Involuntary abstinence

3. Coital frequency

II. Factors affecting exposure to conception

1. Fecundity or infecundity, as affected by involuntary causes
2. Use or non-use of contraception

3. Fecundity or infecundity as affected by voluntary causes

III. Factors affecting gestation and successful parturition

1. Foetal mortality from involuntary causes

2. Foetal mortality from voluntary causes.

The above intermediate variables governed the influence of social and cultural factors on fertility.

1.7 Need for the study

Researches on fertility incorporating socio-psychological variables are very limited in India. The socio-psychological research on fertility is based on the assumption that behaviour is the product of interaction between the individual and socio-psychological environment. Two noteworthy developments have emerged as there is a shift from the broad Knowledge Attitude and Practice (KAP) type of studies to in depth and detailed analysis on the dynamics of fertility behaviour. The decision making process involved in reproduction and contraceptive use need to be examined from social and psychological decisions. A comprehensive frame work involving the behaviour pattern,
economic considerations as well as biological factors can be taken as determinants of fertility. The fertility behaviour is also determined by the availability of contraceptive devices, medical services, family planning polices, knowledge, intelligence, personality traits, attitudes, beliefs, values and value orientation, individual life history in a particular socio cultural context, including various institutions, mores and traditions (Chung et al., 1973). The impact of these variables will also vary across geographical regions, cultural practices and time periods.

In the early seventies there were some breakthroughs in the analysis of fertility with the identification of an important determinant, namely value of children (VOC). The contributions by Hofman (1972), Hoffman and Hoffman (1973), Fawcett (1972), Arnold and others (1975) are worth mentioning in this context. The shift from high to low levels of fertility is usually accompanied by a corresponding shift in the demand for children in terms of the values attached to them. In other words, the transition in the values attached to children acts as
a mediating mechanism through which modernization affects
the demand for children (Bulato, 1980). In many countries the
importance of children for old age support comes first, whereas
in other countries this type of value has disappeared and has
been replaced by predominantly emotional expectations (Hohn,
1980). The couples who frequently discuss different family
matters were found to have more favourable attitude toward
birth control than those who seldom interact. They are likely to
practice birth control and attain a lower pregnancy level.
A country’s commitment to its demographic goals and the
family planning program, and the way in which the program is
implemented, determine significantly the rates of acceptance
and the use of family planning methods in the population.
Programs which have a strong national political commitment,
an efficient bureaucracy, and a service delivery system that
makes modern contraceptive methods easily accessible and
readily available to couples; sound information, education, and
communication strategies; and good record-keeping and
monitoring systems have higher acceptance and use rates.
Statistically, significant effects have been observed by good
programs even in rural, economically backward, and largely illiterate populations. Key family planning program components are also believed to contribute substantially to increased contraceptive practice and therefore to reduce fertility. Many studies have focused on social, economic, demographic and biological variables to analyse the fertility behaviour. The socio-psychological variables are found to be better determinants of fertility than economic and demographic variables (Sud, 1991). As such there is a need to examine the role of psycho-social variables on fertility behaviour. Hence the present study is designed with a view to find out the psycho-social determinants of fertility. The study has been under taken in Athoor block of Dindigul District.

1.8 Title of the study

PSYCHO-SOCIAL DETERMINANTS OF FERTILITY IN ATHOOR BLOCK OF DINDIGUL DISTRICT.
1.9 Objectives

The major objective of the study is to find out the psycho-social determinants of fertility in Athoor block of Dindigul District.

The specific objectives are:

i) To examine the influence of socio-economic and demographic factors on fertility.

ii) To find out the influence of economic and social values of children on fertility behaviour.

iii) To study inter-spouse communication as a factor associated with fertility.

iv) To study the relationship between exposure to Information Education Communication activities and fertility.

v) To study the knowledge and perception on contraception in relation to fertility.

1.10 Organisation of the thesis

The thesis has been reported in five chapters

Chapter 1: Introduction emphasizing the Population problem, fertility and need and significance of psycho-social study on fertility, objectives and scope and limitations of the study.

Chapter 2: Description and findings of related literature and studies.
Chapter 3: Methodology and Procedure adopted for the study such as Study area, Study sample, Sampling Design, Tools used, Variables, Field work and data collection, Method of analysis, Data entry and coding, Index used for independent variables and data analysis.

Chapter 4: Results and Discussions

- Characteristics of Study population
- Psycho-social characteristics
- Bi-variate analysis
- Regression analysis
- Logistic Regression analysis

Chapter V : Summary and Conclusion

Bibliography

1.11 Scope and Limitations

The study was carried out in one of the community development block of Dindigul district and the results of the study can be applicable to similar blocks in Tamil Nadu. The sample consisted of 500 eligible married women in the age group of 15-49 years and the fertility was measured in terms of number of children ever born to the women. The data were
obtained by recall method and only one eligible woman in one household is interviewed.

In this study, the psycho-social variables of economic value and social value of children; inter-spouse communication; information education and communication; and perception on contraception have been analysed as determinants of fertility. This does not assume that the study has tested all the proximate determinants of fertility. On the other hand the field data have been analysed by applying a number of statistical tests. Certain policy implications have been suggested to reduce the fertility in rural India based upon the results of the present study.