INDIA

Gender Inequalities and Demographic Behavior

Sonalde Desai

GENDER INEQUALITIES AND DEMOGRAPHIC BEHAVIOR

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Preface

This is one of three reports on the relationship between gender equity, family structure and dynamics, and the achievement of reproductive choice prepared by the Population Council for the 1994 International Year of the Family and the 1994 International Conference on Population and Development. These reports provide critical reviews of the relationship between gender inequality and demographic behavior in three demographically significant, culturally distinct parts of the developing world: (1) Egypt, (2) India, and (3) Ghana and Kenya. Their purpose is to help governments and international agencies design and implement policies that are affirmative of women, sensitive to the family's central role in resource allocation and distribution, and effective in achieving broad-based population and development goals.

As a companion to these reports, the Population Council will issue a pamphlet in its series of Issues Papers on gender inequality and demographic change. This will provide a population policy agenda focusing on policies that support women's status and access to resources and that are likely to have desirable demographic impacts.

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Cynthia B. Lloyd
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INDIAN POPULATION POLICY AT A CROSSROADS

As India prepares for the 1994 International Conference on Population and Development, it is clear that the country's population policy is faced with a number of serious challenges. Although India was the first country to announce an official family planning program in 1952, its population has grown from 361 million in 1951 to 844 million in 1991. Over this period, the crude birth rate has declined from 44 births per 1000 population in 1951 to 30 in 1991. Although India's total fertility rate of 3.8 births per woman can be considered moderate by world standards, the sheer magnitude of population increase has resulted in such a feeling of urgency that containment of population growth is listed as one of the six most important objectives in the Eighth Five-Year Plan (Government of India, 1992a, p. 9).

Until recently Indian population policy has largely been synonymous with the family planning program and contraceptive service delivery (Ghosh, 1991). Increasingly, however, considerable frustration has emerged with this approach and two divergent alternatives have been advanced. The first argues that governments must move beyond the provision of contraceptive services to active promotion of small-family norms through community incentives and individual disincentives[1] (Government of India, 1992b, p. 336). Some of the incentives and disincentives considered include elimination of maternity leave for third and higher order pregnancies, restricting eligibility to stand for election to individuals with small families, providing government jobs only to individuals who did not enter into adolescent marriages, and assigning priority for development assistance to parts of

[1] A focus on individual incentives in the form of monetary compensation for undergoing sterilization or for motivating others to undergo sterilization has long been part of the Indian program. Discussion of individual-level disincentives is relatively new. The Indian program had begun to move toward open discussion of more coercive measures during the period of emergency (Government of India, 1976), but this discussion withered away in the political fallout of the emergency and there has been relatively little new discussion of individual disincentives until recently.

the country with high levels of contraceptive prevalence. The second alternative argues for a decentralized planning process in which population policy is incorporated within a broader framework of development policy.

Links between population and development have long been recognized in India; in fact, the slogan "Development is the best contraceptive" was coined by the then Indian minister for health and family planning, Dr. Karan Singh, at the 1974 World Population Conference in Bucharest. Ironically, two years after Bucharest, Dr. Singh issued the ill-fated national population policy statement which advocated increasing priority for the family planning program and suggested that the country might be ready for compulsory sterilization programs (Government of India, 1976). This lack of integration between population and development sectors can be attributed to a highly centralized and compartmentalized administrative structure (Bose, 1988).

However, these administrative and political barriers may possibly be overcome following passage of the 73rd and 74th amendments to the constitution, through which a variety of powers are devolved to the local governments—village *panchyat* and urban *nagarpalika*—including control of health and family welfare activities. At present, therefore, the potential for integrating population and development efforts is unparalleled in Indian history.

The organization of local governance structures and their prospective roles are still being hotly debated but, constitutionally, they are expected to reserve one-third of their seats for women. Given the close link between the family welfare policy and women's health, it is hoped that women will spearhead a movement for integration of social sector services for women and children and engage actively in formulating and implementing these programs (Ghosh, 199 1).

Although the need to transform the implementation of population policy is well recognized, the need to change the fundamental goals of that policy is less clear

cut. However, if the energies of local leaders are to be mobilized, it is necessary to change the focus from national goals to the enhancement of individual welfare within a local context. Similarly, if women are expected to spearhead this movement for change, the population policy must respond to women's experiences and needs.

Although Indian population policy has routinely adopted the view that improvement in women's status is a precondition for fertility decline, a women-centered population policy has yet to be articulated. This report brings together various strands of the literature on women's issues in India and in the international arena[2] to develop a gendered perspective on population policy. Increasingly, activists as well as researchers call for a population policy built on two planks:

(1) Changes in social structure that would allow women to make marital and fertility choices free of social or economic constraints. These changes include elimination of marriage as the only means of survival for women, reduction in women's economic dependence on children, and elimination of unequal economic opportunity structures and kinship patterns that result in a strong preference for sons and discrimination against girls.

(2) Improvement in women's and girls' health by promoting social conditions that enable women to obtain better health and wellbeing for themselves and their children. These conditions include improved nutrition, increased sensitivity to cultural barriers influencing women's health-seeking behavior, improved health services, greater attention to reproductive health concerns of women, and better access to appropriate contraceptive technology in a family planning program free of implicit or explicit coercion.

[2] For an extended discussion of some of these concerns in an international context, see Dixon-Mueller (1993).

This approach seeks to redefine the goals of population policy from the perspective of the individual by focusing on reproductive choice and women's health. In many instances, these goals are commensurate with the stated societal goals of lowering population growth, since they seek to reduce the pronatalist pressures on women, reduce their desire for large families, and reduce their reliance on marriage as the only means of survival[3] (Dixon-Mueller, 1993; Sen, Germain, and Chen, 1994). Nevertheless, public policies flowing from these broader goals are likely to have different priorities than public policies flowing from the narrower goal of population control. Most obviously, a focus on reproductive choice and women's health would have little scope for individual or community incentives and disincentives—often a euphemism for coercive population policies.

A shift in goals would also result in a shift in the means of achieving such goals. In particular, population policies would need to move beyond simple provision of contraceptive services to creating a climate within which these goals can be achieved. In this report I synthesize ideas and concepts from several strands of research and public policy debates to argue that constraints on women's reproductive choice and health are caused by a variety of forces. These include: cultural beliefs about appropriate roles of men and women; marriage and kinship systems; household-based inequalities in resources available to men and women; gender inequality in the legal and educational systems and in labor markets; poorly designed public health systems and family planning programs; persistent poverty; and class and gender bias in development strategies.

Within a broadly defined population policy framework, this report seeks to relate gender inequality in Indian society to the constraints on women's reproductive

[3] It is important to note that policies enhancing individual welfare may also have pronatalists effects. For example, treatment of reproductive tract infections will reduce infertility and result in some fertility increase.

choice and health. I recognize that such factors as poverty, poorly organized health services, and lack of public investments in water and sanitation affect both men's and women's health and reproductive choice. Nonetheless, women face a variety of added risks due to pervasive gender inequality. I focus on these added constraints faced by women, while recognizing that gender inequality is simply one of the factors constraining women's reproductive choices and health. Uneven development, widespread poverty, and class, caste, and religious inequalities are equally, if not more, important.

SOURCES OF GENDER INEQUALITY

In recent years, exhortations for improving the "status of women" have become part of the vocabulary of Indian population policy documents (for example, see the language of the Eighth Five-Year Plan, Government of India, 1992b). Unfortunately, little attention has been paid to the content of this well-meaning phrase. A similar confusion abounds in the demographic literature, both within India and internationally. As Mason (1984) points out, demographers have used a variety of terms more or less synonymously, including "status of women," "female autonomy," "patriarchy," "sex stratification system," "women's rights," and "men's situational advantage." All of these definitions implicitly refer to gender inequality or status of women vis-à-vis men, holding all other factors constant.

Increasingly it has become apparent that this focus on gender inequality per se overlooks some important aspects of how gender actually affects women's life chances. In order to understand the social construction of gender, we must:

View gender inequality as a part of class, caste, and religious inequality and recognize that a woman's location in these other stratification systems structures the meaning of gender for her.

Direct our attention to macro political and social processes, which, while not gender-differentiated in origin, frequently affect men and women differently.

Examine those elements of political and scientific culture that have been ignored precisely because they are defined as female.

A detailed examination of these issues falls beyond the scope of this report, but three macro processes deserve special consideration. Introduction of structural adjustment policies and associated changes in the role of the state; environmental degradation and unequal distribution of common property resources; and pervasive inequalities based on caste, class, and religion all play important roles in diminishing women's wellbeing.

(1) The introduction of structural adjustment policies in 1991 has generated an intense debate regarding the consequences of adjustment on women (see articles in Shaw, Burra, and Kelles-Viitanen, 1993). The ultimate effects of liberalization policies introduced in the 1980s and subsequent initiation of the adjustment program in 1991 remain far from clear. However, some features of the new economic policies can be expected to affect women adversely. These include reductions in subsidies for health, education, water and electricity, and food grains, and removal of protective labor legislation (Ghosh, 1994). In contrast, greater employment opportunities in export-oriented jobs may increase women's chances of finding employment (Pathak, 1993), although these jobs are likely to be in the poorly paid informal sector (Kalpagam, 1994).

(2) In recent years, significant declines in the availability of forest products, wood, and water have been documented (Shiva, 1991). Although some of these shortfalls may be attributable to increased population pressure, inappropriate development strategies and unequal distribution of political power play a significant

role. For example, some rural parts of Maharashtra have suffered from such severe domestic water shortages that water has to be brought in by tankers. The depletion of groundwater in Maharashtra is associated with increased use of energized pumps, which drain groundwater at deeper and deeper levels. These borewells have been used to irrigate sugarcane and are actively supported by sugar cooperatives.[4] As a result, public wells and shallow wells belonging to small farmers have become dry. Similarly, the government has continually increased its control over forests, granting selective access to a favored few (Guha, 1983, 1985). This has been done through a variety of policies that restrict the access of the local population to forest products, while doing little to combat illegal felling of trees and encroachment by large farmers (Jodha, 1986). Both of these trends, although gender neutral in origin, tend to affect women more than men. Since fetching water and collecting firewood are primarily women's responsibility, declines in access to water and firewood result in an increased burden on women as they travel farther to obtain them.

(3) It is difficult to examine gender inequality in India without considering other forms of inequality defined by class, caste, and religion. Women's social class location has a strong impact on their economic activities, access to agricultural land, employment opportunities, gender relations within the household, and intrahousehold resource distribution. Similarly, religious conflicts and a desire to establish separate religious identities have increasingly colored gender politics among Hindus and Muslims. Consequently, concerns about religious identity and legitimacy have taken precedence over gender-related concerns among many Muslim women's organizations (Agnes, 1994).

[4] Sugarcane is a very lucrative cash crop but demands considerably more water than other crops. For example, one hectare of land planted with sugarcane demands 30 times as much water as a hectare planted with millet (Shiva, 1991).

This report does not examine these macro processes per se, but whenever relevant, gender inequality is addressed within the context of these broader inequalities. I also note that the social construction of gender varies widely across parts of India. Although the differences between northern and southern India are well recognized, within each region there is also considerable variation. I focus mainly on general patterns while acknowledging that many of these generalizations are honored in the breach.

GENDER INEQUALITY IN THE FAMILY

Research has increasingly documented the association between gender inequality within the family and such unfavorable demographic outcomes as early marriage, discrimination against daughters in access to food and health care, poor nutritional status of women, and their inability to seek health care for themselves. Research on the sources of this inequality points to three distinct and qualitatively different sets of antecedents: difference in men's and women's economic roles and power; cultural traditions restricting women's autonomy and physical movement; and marriage and kinship patterns. I discuss each of these in turn.

Economic Power and the Division of Labor

It has been argued that women's economic dependence on men reduces their bargaining power within the family. As a result, women's increased participation in income-earning activities is seen as a key to reducing gender inequality (World Bank, 1991). This issue is particularly salient in the Indian context since India, along with other South Asian countries, shows strikingly low female labor force participation rates. Only about 23 percent of Indian women report that they were employed in the year preceding the 1991 census. Table 1 shows the gap between male and female labor force participation rates in selected Asian countries. This

Table 1

Ratio of Female-to-Male Labor Force Participation Rates in Selected Asian Countries

Country	Ratio
Bangladesh	7
China	76
Hong Kong	57
India	34
Indonesia	66
Korea, Dem. Republic of	85
Malaysia	45
Nepal	51
Pakistan	13
Philippines	59
Singapore	64
Sri Lanka	59
Thailand	88
Vietnam	88

Source: United Nations Development Programme (1992).

table indicates that for every 100 men employed, only about 34 women are employed in India as compared to 88 in Thailand and 59 in Sri Lanka.

As Table 2 indicates, within India considerable diversity exists across different regions.[5] On the whole, women in north India are less likely to be emp-

[5] Note that Tables 1 and 2 rely on different sources. Table 1 relies on census data in order to facilitate comparison with other countries. Table 2 is based on National Sample Survey data, which are generally considered more reliable estimates of labor force participation in India.

Table 2

Number of Persons Usually Employed per 1000 Population by Sex and Residence. All India and Major States

State/Union Territory	Rural		Urban	
	Males	Females	Males	Females
Andhra Pradesh	595	470	503	215
Bihar	500	193	448	79
Gujarat	559	381	510	112
Haryana	475	297	553	123
Kamataka	568	377	494	196
Kerala	506	286	530	198
Madhya Pradesh	546	410	480	144
Maharashtra	546	462	496	159
Orissa	566	276	493	125
Punjab	560	317	540	123
Rajasthan	512	450	471	191
Tamil Nadu	587	461	558	227
Uttar Pradesh	518	219	489	94
West Bengal	550	196	539	125
All India	539	323	506	152

Source: National Sample Survey Organisation, 1990, statement 23. Based on National Sample Survey 1987-88.

loyed than those in the south. However, several northern states also show fairly high female labor force participation rates; for example, 45 percent of women in rural Rajasthan are employed. For India as a whole, only about 15 percent of urban women are employed, compared with 32 percent of rural women. This urban-rural

difference mainly reflects the agricultural labor opportunities available to rural women.

Considerable speculation has surrounded the causes of relatively low female labor force participation rates in India, and a variety of plausible explanations have been suggested. Of particular interest is a concern expressed by Bose (1979) that data on *women workers* do not give a correct picture of *women's work* in rural areas. Underenumeration of women's economic activities has been documented in a variety of settings, both within and outside India (Beneria, 1982; Anker, Khan, and Gupta, 1988; Jain, 1985). It has been argued that the conventional international standards for measurement of the labor force, as followed by the data-collection agencies of developing countries, reflect a pronounced gender bias in failing to fully recognize women's presence in the labor force and to record their contribution to economic activity (Beneria, 1982). In India, this underenumeration should be attributed to two causes: cultural norms against women's labor force participation, and the frequently held view that the activities women engage in are not economically productive. For example, the report of the National Commission on Self-Employed Women and Women in the Informal Sector quotes the Director of Social Welfare in one state as saying, "There are no women in any unorganized sector in our state." Then the Commission had to probe, "Are there any women who go to the forest for collecting firewood? Do any of the women in rural areas have cattle?" The director said, "Of course, there are many women doing that type of work." This government official was just one of many to confirm to the Commission members that working women are invisible to the public at large (National Commission on Self-Employed Women, 1988).

In order to account for some of these hidden activities, the National Sample Survey (NSS) asked women who considered themselves housewives a series of

Table 3

Number of Women Participating in Specified Activity Per 1000 Females Usually Engaged in Household Tasks

Activity	Rural	Urban
Maintenance of kitchen garden	163	49
Work in household poultry	330	67
Collecting fish	212	19
Collecting firewood	405	72
Husking paddy (own produce)	178	12
Grinding foodgrains	175	27
Preparing gur	9	—
Preserving meat	7	4
Making baskets	25	4
Preparing cow dung cakes	519	94
Sewing, tailoring	195	251
Tutoring own children	36	108
Fetching water from outside premises	608	320
Fetching water from outside village	30	—
Participation in any economic activity	877	661
Number of women engaged in household tasks per 1000 women	348	440

Source: National Sample Survey Organisation, 1990, statement 55. Based National Sample Survey, 1987-88.

probing questions. Answers to these probes are presented in Table 3. These suggest that nearly 60 percent of rural and 16 percent of urban housewives make substantial economic contributions to their families through maintenance of kitchen gardens and poultry, and collection of fish. Additionally, they engage in a variety

of expenditure-saving activities such as sewing, grinding foodgrains, bringing water from outside the household, collecting firewood, and husking paddy. If all such activities are taken into account, 88 percent of rural housewives and 66 percent of urban housewives can be seen as economically productive.

The preceding discussion documents the economic content of women's work and argues that instead of being labeled as housewives, a majority of Indian women should be called farmers or self-employed laborers. This observation presents an interesting paradox, however. Although most women engage in economically productive activities, their work is rarely seen as being economically productive. Hence, if power within the family is tied to economic contribution, participation in this hidden sector is unlikely to increase women's power. This issue is particularly salient for the vast majority of women who work on the family farm as unpaid workers. Results from the 1987-88 NSS show that women account for over 50 percent of unpaid family workers (World Bank, 1991). However, most of the land that they farm is owned or rented by male members of the family. Thus, their lack of land ownership tends to mitigate the importance of their economic contribution. As I later document, inheritance laws and customary practices combine to perpetuate this inequality.

Women's employment in family enterprises—farms or family business—and their work in domestic production, such as dehusking rice or preparation of gur, contribute to the total household income. Nevertheless, this work is rarely recognized as economically productive, either by men or by women. Additionally, any cash income generated from such activities is usually controlled by men. Hence, participation in such activities is unlikely to increase women's control over family resources[6] (World Bank, 1991). A similar tendency is documented by Baud

[6] It has been argued that wage employment improves women's bargaining position within the household (Acharya and Bennett, 1983 on Nepal; Parthasarathy, 1988; Kumar, 1978; but

(1992) in a study of family-based workers in the textile industry. Male children who help out in a home-based handloom mill receive pocket money, but adult females or girls do not.

Furthermore, when women do earn income, they contribute most of their earnings to household maintenance, whereas men reserve some of their income for personal consumption such as the purchase of tobacco or alcohol. For example, a study of 20 villages in Kerala and Tamil Nadu reports that, on average, women contributed 98 percent of their earnings toward family maintenance while men contributed only 78 percent, keeping substantial amounts for personal use (Mencher, 1988). Studies from other parts of India confirm this finding (Sharma, 1980; Gulati, 1981; Meis, 1986).

Although a large proportion of women participate in economically productive work, male participation in such domestic tasks as cooking, cleaning house, fetching water, and cleaning and grinding grain is extremely limited. Additionally, relatively few men participate in child care. Table 4, drawn from a detailed time-allocation study in Rajasthan, shows that most of the domestic work and work involved in caring for young children is undertaken by women. Men concentrate mainly on income-earning activities.

Moreover, women's work is usually considered "light." For example, a field study in Uttar Pradesh (Jeffery, Jeffery, and Lyon, 1989) reports that men only reluctantly conceded that their womenfolk really work. The researchers in this area were repeatedly told that women—like children—simply eat food and do nothing

see Standing, 1985). However, research in this area has relied on small sample studies of households in selected localities, and it is usually difficult to generalize from these data.

Table 4

Daily Number of Hours Allocated to Work by Age and Sex in Rajasthan Villages

	Agri-cultural Activities	Activities Related to Agri-culture	Nonagri-cultural Work	Fetching Water and Fuel	Domestic and Child Care	Total Work
Age 5-9						
Male	0.51	1.15	—	—	0.17	1.83
Female	1.63	1.28		0.17	2.42	5.50
Age 6-14						
Male	1.38	0.94	0.16	0.03	0.47	2.98
Female	3.06	1.60	0.04	0.43	2.53	7.66
Age 14-19						
Male	2.00	1.28	1.76	0.00	0.20	5.24
Female	2.98	1.09	0.04	0.56	3.24	7.91
Age 19-34						
Male	2.75	0.68	2.70	0.00	0.11	6.24
Female	2.44	1.13	0.10	0.60	4.56	8.83
Age 34-44						
Male	6.31	1.38	1.00	0.01	0.29	8.99
Female	3.62	1.38	0.04	0.50	4.47	10.01
Age 44-70						
Male	4.04	1.21	0.37	0.02	0.35	5.99
Female	3.05	1.43	0.09	0.32	3.04	7.93

Source: Jain (1985).

economically important. This vision of women's work conceals their huge energy expenditures, and is used to legitimize discrimination against women in food allocation[7] (Batliwala, 1985).

Cultural Restraints on Women's Autonomy and Physical Mobility

The power structure in Indian families is dominated by gender, age, and generation. The origin of the Indian ideal of appropriate female behavior can be traced to the rules laid down by Manu around 200 B.C. Some of the rules prescribing the duties of women include: "by a young girl, by a young woman, or even by an aged one, nothing must be done independently, even in her own house"; "in childhood a female must be subject to her father, in youth to her husband, when her lord is dead to her sons; a woman must never be independent"; and "though destitute of virtue or devoid of good qualities, yet a husband must be constantly worshipped as a god by a faithful wife" (Wadley, 1988).

In this context, young women are at a serious disadvantage and behavioral norms reinforce this powerlessness. The most prominent of these are seclusion, subservience, and self-denial, which have important implications for women's control over their fate, including their reproductive choice (Jejeebhoy, 1994). Although these norms are rooted in broader social institutions, their impact on the behavior of individual men and women occurs within the domain of the family and immediate kinship network.

While it is often assumed that the introduction of purdah is a response to Islamic culture, in fact there is evidence of its existence among royal and noble households long before the advent of the Muslims (Altekar, 1959; Ganesh, 1989). In spite of considerable religious diversity in India, many ideals regarding appropriate female behavior can be traced to the Laws of Manu and the Hindu culture in existence before the introduction of Islam in India. Following the introduction of Islam in the eighth century, Islamic prescriptions regarding the rights

[7] Interestingly, this bias that women's work is less energy-intensive than men's is occasionally also reflected in the social science literature; see Pitt, Rosenzweig, and Hassan (1990) on Bangladesh.

of women to education, property, and approval of marital partner were ignored; others, such as the prescription regarding purdah, were avidly accepted and incorporated because they were consistent with the existing belief systems (Shah, 1986).

Seclusion is used to ensure the virtue of a woman, and thereby the honor of her family. A variety of restrictions are imposed on women: their spatial movement outside the home is restricted; total or partial veiling of the head and face (purdah or ghunghat) is enforced; a strict code of behavior governs any interaction with men. The extent of seclusion varies according to the social norms prevailing in the region and community and according to the economic status of the household. The strictest form of purdah is observed by relatively wealthy households and higher-caste families, predominantly in the north. The practice of village exogamy among northern Hindus makes young brides strangers in their husbands' homes and hence places them under as strict surveillance inside the home and village as outside it (Mandelbaum, 1986; Jeffery, Jeffery, and Lyon, 1989). Even within the home, women's heads are covered and they rarely socialize with male family members and have little opportunity to build a social network. In contrast, Muslim women, as a result of frequent endogamy, tend to be less secluded within the home and village; still, they rarely leave their villages unescorted (Jejeebhoy, 1994). Notwithstanding these subtle differences, in practice neither Hindu nor Muslim women in the north have freedom of movement and rarely perform even everyday tasks, such as shopping for food (Basu, 1992).

Although strict purdah is infrequently practiced in the south (Ganesh, 1989), a semblance of seclusion is enforced through limits on direct interaction with men and on women's social mobility and wage labor outside the home, even during periods of considerable need (Lessinger, 1990). Finally, while poverty limits the extent to which seclusion can be practiced, higher family income provides the opportunity to withdraw women from the labor force, limiting their freedom of movement and making them increasingly dependent on men.

Over time, increasing Westernization, urbanization, and school enrollment of girls can be expected to reduce parental ability to enforce women's seclusion, but

there is relatively little data to document the magnitude of this change. Research does indicate that even among slum dwellers in Delhi, women from the northern province of Uttar Pradesh continue to remain segregated from contact with the outside world (Basu, 1992).

Marriage and Kinship Patterns

Given the religious, regional, and cultural diversity in India, it would be impossible to generalize about Indian marriage patterns,[8] but three marriage regimes are of relevance here: (1) the north Indian custom of village exogamy whereby girls must marry outside their own village and extended family; (2) the south Indian custom of within-family marriage (cross-cousin marriages are also prevalent in many Muslim communities); and (3) matrilineal kinship systems characterized by a variety of marriage types and residence patterns.

Among Hindus in north India, a girl generally must marry outside her own village and outside the circle of a carefully chosen list of relatives. Moreover, given a system of arranged marriages, the bride and bridegroom have very little contact with each other before marriage. Thus, a new bride has almost no support system in her husband's village. This type of marriage system is also frequently related to wealth flows from the bride's family to the groom's. Madan (1993), describing marriage relations among the high-caste Pandits of Kashmir, argues that the difference between wife-givers and wife-takers leads to a system of hierarchical and nonreciprocal relationships, with wife-takers gaining precedence over wife-givers. This system has also been connected with a high incidence of dowry payments in which the monetary and nonmonetary gifts given at the wedding become primarily the property of the groom and his parents (Sharma, 1993).

In contrast to the almost complete separation of daughters from their parents in north Indian village exogamy, Dravidian marriage patterns prevalent in large parts of south India result in continuing close contact between the bride and her

[8] For descriptions of a variety of kinship and marriage patterns in India, see the studies reported in Uberoi (1993).

natal family. Marriage arrangements vary across communities, but the preferred marriage partner for a man is his father's sister's daughter, mother's brother's daughter, or niece (Karve, 1965). Although this type of marriage relationship sometimes leads to gross mismatches in which a much older uncle marries a young niece, on balance these arrangements appear to encourage women's contact with their natal families and increase their personal autonomy in their husbands' homes (Dyson and Moore, 1983; Miller, 1981). Women frequently marry within their own villages and have their own social networks. Thus, village endogamy may help increase women's power within the household.

Matrilineal kinship systems provide an important contrast to the two family systems mentioned above. Matriliny is practiced by a relatively small segment of the population in the northeast and southwest. Residential and marriage patterns across matrilineal groups vary considerably. For example, among the Nayars of Kerala, women were traditionally married to a man of higher caste; subsequently. she could enter into sexual unions with one or more men. However, the management of property was in the hands of a senior male, usually the brother of the senior female. Marriage relations were complicated by the underlying caste dimension: among the higher-caste Nambudiri males, the oldest brother alone could marry within his caste; the younger brothers established sexual unions with women of matrilineal castes, thus limiting the number of Nambudiri males. Some researchers have commented on the role of matriliny in facilitating the demographic transition in Kerala, but considerable debate exists on the importance of this factor (Bhat and Rajan, 1992). Among the Garos, the largest matrilineal tribe in northeast India. traditional society was characterized by considerable class and gender equality. All daughters had use rights in the communal land shared with their husbands. Women's labor input in agriculture was equal to or greater than men's, and women enjoyed considerable independence. In the last century, however, the matrilineal system has eroded substantially, frequently under direct or indirect pressure from state policies (Agarwal, 1988).

Hindu marriage systems provide interesting examples of how gender and caste stratification systems are closely intertwined and how the marriage of a

daughter can be used either to maintain the stratification system or to negotiate upward mobility for one's family and caste (Berreman, 1993). On the one hand, marriage—that is, caste-endogamous marriage—affirms and maintains caste status. On the other hand, marriage may also be the instrument whereby individual families and larger groups negotiate a higher status for themselves by marrying their daughters upwards in the caste hierarchy (Uberoi, 1993). This practice, termed hypergamy in the literature, is consistent with the Hindu ideology of *kunyadana* (gift of a girl) and is often facilitated by a large dowry—in effect, an exchange of wealth for status. However, increase in prestige can be attained only when a bride from a lower caste is given in marriage to a groom from a higher caste; marriages of brides from a higher caste with grooms from a lower caste actually reduce the prestige of the family. Similarly, widow remarriage is also seen as a sign of low caste status (Srinivas, 1969).

A major factor related to women's disadvantage in the marriage market is the recent escalation of dowry. Traditionally, dowry consisted mainly of goods prepared by the bride and her family, including rugs, clothing, and bedding (Sharma, 1993). But recent years have seen a tremendous expansion of money and consumer goods given in dowry, and unmet dowry demands have been associated with extremes of domestic violence (Uberoi, 1993). Although dowry has been traditionally more prevalent in the north, this practice has gained popularity in the south in recent decades. A study in rural south India shows that dowry frequently amounts to over 50 percent of a household's assets (Rao, 1993a).

The preceding discussion suggests that gender inequality in the family has both cultural and economic roots. This dual focus has occasionally led to the advocacy of divergent public policy prescriptions. Concern with women's lack of access to economic resources has resulted in initiatives for increasing women's economic opportunities and thereby increasing their power within the household. In contrast, a concern with gender role ideology has led to initiatives for creating institutions that empower women to deal with a discriminatory household and social setting. Women's development corporations provide an example of the former;

organizations like Mahila Samakya, initiated by the government to empower women, provide an example of the latter.

Nevertheless, cultural and economic sources of gender inequality are inextricably linked. For example, the ideology of female seclusion is sustained by women's meager employment opportunities. If presented with opportunities for earning high income, many families may find it hard to forgo this income by insisting on women's seclusion (Desai and Jain, 1994; Sharma, 1980). Similarly, village exogamy remains a principal barrier to women claiming their share of parental property (Agarwal, 1988).

GENDER INEQUALITY IN SOCIAL INSTITUTIONS

Although some of the pioneering work on gender inequality in India documented inequality within the household (see studies included in Jain and Banerjee, 1985), increasingly the focus has shifted to the role of social institutions, particularly the role of the political system, in creating and perpetuating gender inequality (Agarwal, 1988b). In the following sections I focus on gender-based inequalities in the inheritance and legal systems, in the economic and educational systems, and in family planning services.

The Legal System and Inheritance

Although the Indian constitution grants women equal rights and opportunities, and a number of progressive laws such as the Equal Remuneration Act assert this principle, India's legal system continues to discriminate against women. This is most evident in two areas: the inheritance laws, and divorce and maintenance laws. Public discourse on eliminating legal discrimination against women has focused on the demand for a uniform civil code. This demand has by and large been supported by Hindu religious leaders and strongly opposed by Muslim and Christian religious leaders. In reality, however, almost all personal laws, whether Hindu, Muslim, or Parsi, discriminate against women.

In theory women are constitutionally guaranteed the basic right to property. In practice, the progressive nature of the constitution is offset by a parallel regime

of personal law that limits women's inheritance, custody, and maintenance rights. Inheritance laws are a striking example of gender inequity in the control and distribution of resources (Sarkar, 1977).

The Hindu Succession Act of 1956 was intended to improve the rights of Hindu women. Although the Act has reduced some gender inequalities, many still persist (Agarwal, 1988; Singh, 1989). Under Hindu law, sons have an independent share in the ancestral property. However, daughters' shares are based on the share received by their father. Hence, a father can effectively disinherit a daughter by renouncing his share of the ancestral property, but the son will continue to have a share in his own right. Additionally, married daughters, even those facing marital harassment, have no residential rights in the ancestral home.

Under Muslim law (Muslim Personal Law Shariat Application Act, 1937), daughters can inherit half the share of sons. Similarly, the Indian Succession Act of 1925, which governs Christians and Parsis (in two separate schemes), was enacted to consolidate the many laws existing at the time. Among Christians, the law provides that one-third of a man's estate goes to his widow, while the other two-thirds are equally divided among his children irrespective of sex (excepting Goan Christians, who are governed by the Portuguese Civil Code). Among Parsis, on the death of a man, his wife and sons inherit equal shares of his property, while daughters inherit half the amount that sons receive. On the death of a woman, however, sons and daughters inherit equal shares (Sarkar, 1977).

Under the pretext of preventing fragmentation of agricultural (joint family) holdings, several states have successfully excluded widows and daughters from inheriting agricultural land. The Hindu Succession Act of 1956 leaves unaffected any state law designed to prevent fragmentation of agricultural land and preserve tenancy rights. Since the meaning of "tenancy rights" is unclear, states frequently define these to include all interests arising in and out of agricultural lands. In most cases, these regional laws place direct female heirs at a disadvantage. Muslim laws of succession among both Shias and Sunnis are also superseded by these discriminatory state laws in many states.

Although laws themselves have not been gender-equitable, even the weak laws protecting women have not been adequately enforced. As a result, in practice women continue to have little access to land and property, a major source of income and long-term economic security. Even when the state confers rights on the disadvantaged through land reform, the title to the land is invariably in the name of the male head and is rarely held jointly with his wife. And powerful peasant lobbies in north India have recently sought to deprive women of nominal property rights (e.g. in Haryana and Punjab) (Kishwar, 1991b). Large proportions of women continue to be ignorant about their rights of inheritance; and, where knowledgeable, societal forces inhibit women from demanding these rights. Women themselves often resist changes in inheritance patterns (Kishwar, 1991a), with two of three women being reportedly against girls receiving an equal share with boys in parental property (Singh, 1989).

Table 5 shows results from a study of 145 diverse agricultural communities in India by Agarwal (1988). Inheritance of land is largely patrilineal in 90 percent of the communities examined, but pockets of matrilineal and bilateral inheritance continue to exist, located in the northeast and southwest. Occasionally daughters do inherit land, but mainly when their families have no sons and the daughters continue to live with their parents after marriage. In rare cases, as among the Gaddis of Himachal Pradesh, female inheritance is explicitly forbidden and women cannot hold any land, not even self-acquired land (Agarwal, 1988). Even when inheritance is allowed, the custom cannot be seen as affirming female rights, since usually the daughter merely acts as a custodian on behalf of her son. Inheritance by a widow, again, is usually conditional on her not remarrying outside the family and forfeiting her rights if she is unchaste. The claims of widows are more likely to be recognized if they have sons (Agarwal, 1988).

A variety of customary practices restrict women's ability to exercise their legal rights. Wherever women have customary rights to parental immovable property, mainly agricultural land, they are associated with village endogamy and, often, with marriage to close kin. In the north, girls are usually married out of the village and have almost no ability to claim their legal rights. Thus, under north

Table 5

Percent of Women with Access to Land under Various Conditions by Geographic Region

Condition/Region	Northern	Central	Eastern	Northeastern	Southern	Total
Norms of Land Inheritance						
Communal ownership	—	—	—	10	2	2
Patrilineal	100	100	100	74	79	90
Matrilineal		—	—	16	16	7
Bilateral	—	—	—	—	2	1
Access via Specific Customs Under Patriliny						
As daughters in son-less families	30	44	43	—	12	23
As widows	8	12	14	—	—	6
Usufructory rights only	6	12	14	10	7	8
As dowry	—	—	—	—	14	4
Mention of Actual Possession Under Patriliny						
As daughters in son-less families	2	12	—	—	5	3
As widows	8	12	—	—	5	6
Usufructory rights only	—	—	7	—	—	1
Total no. of communities studied	53	16	14	19	43	145

Source: Agarwal (1988).

dian marriage patterns, women lose contact with their natal family at the same time as they lose any possibility of inheritance of ancestral property.

Sexual control over women forms another constraint on women exercising their legal rights. Widows frequently forfeit rights to their deceased husband's property if they remarry (Chen and Dreze, 1992). Additionally, in many communities levirate marriage (remarriage with the deceased husband's brother) is

promoted in order to keep the property in the family. Moreover, women often voluntarily give up their rights to ancestral property in favor of their brothers in order to maintain brothers' good will. A brother is seen as a woman's main link with her natal home and virtually her only protector in the event of marital discord. Unfortunately, this anticipated support from brothers often does not materialize (Chen and Dreze, 1992).

Maintenance rights of women in the case of divorce are equally weak. Both Hindu and Muslim law recognizes the rights of women and children to maintenance. In practice, maintenance is rarely set at a sufficient amount and is frequently violated, with dire consequences for women. For example, under Muslim law, maintenance is provided for only three months following divorce (Iddat period). As a result, men not only have virtually unlimited right to repudiate marriage at will, they also have the power to regulate maintenance.

Both Hindu and Muslim personal laws fail to recognize matrimonial property. Hence, at the time of divorce, women have no rights to their house or to other property accumulated during marriage; in effect, their contributions to the maintenance of the family and accumulation of family assets go unrecognized and unrewarded.

The Economic System

Although the need to improve women's employment opportunities has received considerable attention in research and public policy documents, the role of the economic system and governmental economic policies in influencing the nature of women's work and their incomes continues to be poorly understood. In this context, certain dimensions of the economic system and governmental policies deserve special attention, in particular the nature of the informal sector, labor market discrimination, and domestic drudgery.

The informal sector as a whole and women's participation within it are frequently seen as necessary evils in the process of economic development. It is assumed that, as the country develops, this sector will diminish in importance. It is also argued that women, due to their lower skill levels, are less likely to find jobs

in the formal sector and, hence, improvement in their human capital will reduce women's concentration in the informal sector (World Bank, 1991).

Self-employment in rural and urban informal sectors forms an important source of employment for Indian women. A variety of activities such as making bidis and pickles, making handicrafts such as lace, vending vegetables, domestic work, and factory piece-rate work fall in this category (National Commission on Self-Employed Women, 1988). In this large and heterogenous sector, very few government regulations protect workers and whatever regulations do exist are rarely enforced.

The government's regulatory policy toward small-scale enterprise is based on the assumption that these micro-enterprises are run by self-employed workers and that any concessions given to these enterprises will benefit only informal-sector workers. Meanwhile, many large industries resort to contracting practices that in effect employ casual workers who remain in the informal sector. Many large industries benefit from the labor of casual workers, while denying them the benefits accorded regular employees in these industries (Meis, 1982; Banerjee, 1985; Baud, 1992). Women workers in the informal sector seem to be particularly vulnerable to this type of inherently exploitative situation. With the government's declared intention of simplifying labor legislation, this situation is likely to worsen in the near future (Saxena, 1993). When paid by piece rate, many women work long hours in their homes producing garments, lace, or bidis and frequently rely on the labor of their children. In spite of long hours of work, their wages are even below those of agricultural laborers.

Research on workers in home-based and piece-work enterprises shows an interesting overlap between the nature of the market economy and women's work. A pathbreaking study of lace makers in Narsapur by Meis (1982) shows that whereas workers are paid barely Rs. 0.60 per piece of lace (about US $0.08 in 1978 prices), the profit of the exporters and traders is about three times that amount. This exploitation of women workers was made possible by an ideology of female seclusion and the belief that lace work allows women to earn money while not

having to venture out of their homes. The benefit from this patriarchal ideology was reaped by exporters and traders, who were mostly male.

Furthermore, women continue to be discriminated against in the formal labor markets, mainly through (1) labor market segmentation resulting in limited and low-paying employment opportunities for women; and (2) lower wages compared to men in the same occupation despite the equal remuneration act.

Employer discrimination against hiring women for certain jobs, particularly high-paying jobs, is blatant (Banerjee, 1985; Nayyar, 1989). A study of the textile industry by Baud (1992) shows that women's share of employment in textile mills, with their relatively higher wages, secure jobs, and a variety of benefits, is declining. In these mills, even though older women continue to operate machines and fulfill the demands of their work in spite of their low levels of education, the newer workers are almost all males because employers now demand higher levels of education. This appears to be one way of screening out women, who are protected by labor laws which mandate that women should not work night shifts and must be given maternity leave. But at the same time, textile mills subcontract work to small powerloom operators, about half of whom employ family labor. In such cases, women as home-based workers receive very low wages and no benefits, and frequently their wages are appropriated by the male household head who nominally heads the family enterprise.

Even within the same occupation, women do not have equality with men. Although the ratio of the female to male rate for agricultural wages has improved between 1970 and 1985 (Jose, 1988, cited in World Bank, 1991), women continue to earn less than men. Interestingly, one of the most successful programs for meeting women's employment needs, Maharashtra's Employment Guarantee Scheme (EGS), was gender neutral in its conception. This scheme was devised to provide work to all of the rural unemployed who demand work. It involves government initiating some kind of project, usually in construction, in areas where 50 or more people demand work. Initially, the wage level was set below the local wage to prevent labor diversion, but this requirement has been dropped and pay is set at the Maharashtra minimum wage. A study by Acharya and Panwalkar (1986) of

matched EGS and non-EGS households reveals that women contributed more than half the income in EGS households, while in non-EGS households women rarely participated in wage labor since there were few opportunities to do so.

In order to fully assess women's contribution to the domestic economy as well as to the national product, it necessary to include the full gamut of women's activities. All Indian women, whether or not they are defined as being employed by the conventional labor force standards, are also engaged in domestic production. Their activities take a variety of forms: cooking, cleaning grain, collecting firewood or making cow dung cakes, fetching water, foraging, standing in lines to obtain subsidized grains or kerosene through the public distribution system, and so on.

Given pervasive poverty and lack of modern conveniences, these activities consume a substantial portion of women's time, although the actual time spent varies considerably across different parts of the country. For example, studies of women's time use in the hills of Uttar Pradesh where forest reserves are depleted show that women spend nearly five hours per day collecting wood for household fuel (Swaminathan, 1984; Agarwal, 1986), whereas women in the plains of Uttar Pradesh have easier access to cow dung and agricultural wastes and spend only about 50 minutes per day (Dasgupta and Maiti, 1986, cited in World Bank, 1991). Similarly, studies have documented the enormous time burden of fetching water (Desai and Jain, 1994; Shiva, 1991). Since women retain the major responsibility for domestic chores regardless of their labor force participation, when domestic work, home-based economic work, and labor outside the home are combined, women work far longer hours than men, particularly within poor households (Jain, 1985; Batliwala, 1985). Thus, any strategy for improving women's access to paid employment must simultaneously reduce the burden of domestic work.

The burden of domestic work is particularly problematic because families frequently rely on children to fetch water, bring firewood, and look after livestock. This type of child labor releases adults, particularly women, to participate in more remunerative activities. This reduces the educational attainment of children and also acts as a rationale for higher family size desires.

The Educational System

The constitution of India, framed in 1950, guaranteed equality of opportunity irrespective of sex and directed the states to endeavor to provide, within ten years, free and compulsory primary school education (up to age 14). Although this goal has been repeatedly reconfirmed by the national government, the Planning Commission, state governments, and others, primary education in India is neither compulsory nor universal, nor is child labor illegal.

Although literacy rates among women continue to be lower than those for men, 39 percent versus 64 percent respectively, they have risen steadily in the past 20 years. Overall, the female literacy rate has improved from 47 percent of the male rate in 1971 to 62 percent in 1991 (Table 6). At the same time, school enrollment ratios for girls have also increased: to 86 percent at the primary school level (and over 100 percent for boys) and 46 percent at the middle school level (73 percent for boys). Girls' enrollment now constitutes over 40 percent of all enrollment at the primary level and 39 percent at the middle school level (figures for 1985-86, World Bank, 1991).

In spite of these improvements, as Table 6 indicates, female literacy and enrollment remain low in the northern part of the country. The female literacy rate in the four large northern states, Bihar, Uttar Pradesh, Rajasthan, and Madhya Pradesh, was around 25 percent in 1991 compared to an average of 48 percent in the remaining ten major states; and gender inequities in the north were much wider (the female literacy rate averages 46 percent of the male rate in these four states and 69 percent in the remaining ten). Enrollment ratios suggest inequities of similar magnitudes. Primary school enrollment ratios for girls range from 63 percent in the four large northern states to 105 percent in the rest of the country (compared to 106 and 126 percent respectively for boys); middle school enrollment ratios for girls range from 27 percent in the four large northern states to 61 percent in the rest (65 and 82 percent respectively for boys) (Jejeebhoy, 1994).

Table 6

Literacy Rates for Males and Females Aged 7+ and Female Literacy Rates as a Percent of Male Rates: 1971, 1981, and 1991

	Literacy Rates						Female Literacy Rate as a Percent of Male Rate	
	1971		1981		1991			
	Male	Female	Male	Female	Male	Female	1981	1991
Andhra Pradesh	40.5	19.2	46.8	24.2	56.2	33.7	51.6	59.9
Bihar	37.7	10.7	46.6	16.5	52.6	23.1	35.4	43.9
Gujarat	56.7	30.3	65.1	38.5	72.5	48.5	59.0	66.9
Haryana	46.4	18.6	58.5	26.9	67.9	40.9	46.0	60.3
Karnataka	51.2	25.7	58.7	33.2	67.3	44.3	56.5	65.9
Kerala	81.3	65.4	87.7	75.7	94.5	83.9	86.2	88.9
Madhya Pradesh	40.9	13.7	48.4	19.0	57.4	28.4	39.2	49.4
Maharashtra	62.7	32.4	69.7	41.0	74.8	50.5	58.9	67.5
Orissa	46.9	17.0	56.5	25.1	62.4	34.4	44.5	55.2
Punjab	48.9	31.3	55.5	39.6	63.7	49.7	71.4	78.1
Rajasthan	35.7	10.5	44.7	14.0	55.1	20.8	31.3	37.8
Tamil Nadu	62.8	32.3	68.1	40.4	74.9	52.3	59.4	69.8
Uttar Pradesh	38.7	13.0	47.4	17.2	55.4	26.0	36.2	47.0
West Bengal	52.3	27.8	59.9	36.1	67.2	47.2	60.2	70.1
India	48.5	22.9	56.4	29.8	63.9	39.4	52.8	61.7

Source: Census of India, 1991 - Series I, Paper #l of 1991, Provincial Population Totals, Registrar General and Census Commissioner, India.

Even these poor enrollment ratios give an optimistic view of the level of female education in India. Attendance rates obtained from the 1981 census suggest that no more than a third of all girls (and a lower proportion of rural girls) aged 5-14, compared to over half of all boys, were actually attending school.

Why, given the longstanding concern for women's education among policymakers, have rates of female literacy, enrollment, and attendance remained so low? Possible answers lie in both demand and supply factors (Jejeebhoy, 1994). Parents' reluctance to educate daughters has its roots in the situation of women. While the education of sons is viewed as an investment in future economic returns, especially as a source of support to parents in old age, educating girls is seen to have no particular advantage. On the other hand, parents have several incentives for *not* educating their daughters. Foremost is the view that education of girls brings no returns to parents and that their future roles, being mainly reproductive and perhaps including agricultural labor, require no formal education. As a result of strong patriarchal norms and exogamy, girls in northern settings tend to be married off in distant districts and are likely to spend their reproductive years under strict seclusion; if they work, they rarely control their wages so that even working women are unlikely to be able to provide support to their parents. Additionally, work opportunities for women are limited and female wages remain low. Indeed, school enrollment of girls is higher in areas that have high female wages (Rosenzweig and Evanson, 1977). Interestingly, a growing demand among better-educated men for better-educated brides seems to provide an incentive for some parents to educate their daughters.

As more and more boys are engaged in education, there is a growing reliance on the labor of girls. Girls are increasingly replacing their brothers on the farm while carrying on their usual responsibilities in housework. In 1981, 24 percent of 11-13-year-old girls in rural areas and 9 percent in urban areas participated in the labor force, most of them in agriculture. School enrollment seems to be incompatible with market work; fewer than 2 percent of girls who engaged in such work attended school. In this context, it is disturbing to note that over the 1971-81 decade, there has been a sharp increase in the number of girls below 14 in the labor

force in rural areas (+ 30 percent) compared to a decline among boys (-8 percent) (Jejeebhoy, 1994). Aside from wage work, a large proportion of the roughly 40 million "nonworking" girls who are not in school are kept at home because of responsibilities in housework. Both boys and girls take part in these domestic activities but girls work longer hours than boys at such chores as fetching water and fuel, cooking and cleaning, minding younger siblings, and seasonal work on the family farm. Even though fewer girls than boys are regular wage earners, they play an important role in the maintenance of the household, hence the opportunity costs of their schooling are high (Jejeebhoy, 1993).

Further, given the perceived irrelevance of education for most girls, parents are unwilling to assume the direct costs of educating their daughters. Although education in government schools does not require tuition, parents may still be required to contribute toward the purchase of books and other materials, uniforms, transport, and so on—a heavy burden to many poor families and one more likely to be borne on behalf of sons than daughters. In addition, the future costs of educated daughters are often perceived to be higher than for uneducated ones: educated girls have to be married to better-educated boys, who in turn can demand a higher dowry.

Yet another disincentive for sending daughters to school is a concern for the protection of their virginity. Hence, when schools are located at a distance, when teachers are male, and when girls are expected to study along with boys, parents are often unwilling to expose their daughters to the potential assault on their virginity. This plays a particularly important role in removing young girls from school.

While poor demand for the education of girls is a major constraint, supply side factors have failed to counter these obstacles. Schools hours remain inflexible to the labor demands on young girls. Schools continue to be located inconveniently: almost 10 percent of all villages do not have access to a primary school and over 15 percent to a middle school. There is a dearth of female teachers: fewer than one-third of India's primary and middle school teachers are women. While programs exist under which the government covers the costs of textbooks, materials, and uniforms for poor girls, these supply side schemes have succeeded in offsetting

only some of the costs to some poor families. And ironically, these conditions are worst precisely in those areas where overall literacy is low and where the situation of women calls for especially sensitive strategies to promote female education.

Family Planning Services

I argued earlier that one of the major contributions of feminist scholarship in India has been to direct our attention to those elements of society and public policy that have been ignored largely because they relate to female experiences. One of the most significant in this arena is the ongoing evaluation of the country's population policy and its reproductive health services.

The Indian family planning program, renamed the family welfare program, relies mainly on women as clients. As Table 7 shows, the practice of family planning is heavily dominated by sterilization, with 70 percent of current contraceptors being sterilized. However, male sterilization accounted for only 8 percent of all sterilizations in 1989-90 (Ravindran, 1993b), and a 1988 survey by the Operations Research Group (1990) showed that only 5 percent of couples use condoms. Thus, the family welfare program is almost exclusively thought of in terms of increasing contraceptive use by women, mainly through female sterilization.

Sterilization received a strong push in the early 1970s with the introduction of mass vasectomy camps. Following the emergency, however, rates of male sterilization fell sharply in the late 1970s. In the early 1980s, sterilization was again being vigorously promoted, but this period coincided with the introduction of a new technology, laparoscopic female sterilization. With its typical attraction to new technology, the administrators of family planning programs endorsed this new technique with enthusiasm (Narayana and Kantner, 1992). After an initially high rate of acceptance in 1983-84, the proportion of tubal ligations done by laparoscopy fell from nearly 50 percent to about 40 percent. Laparoscopic procedures were mainly conducted in mass sterilization camps under unsanitary conditions. Although few large-scale studies have assessed the complications associated with laparoscopic

Table 7

Percent of Couples Using Terminal and Reversible Methods of Contraception, 1989

State	Total Users	Terminal Methods	Reversible Methods			
			IUD	Conventional Contraceptives	Oral Pill	Total
Andhra Pradesh	42.0	35.2	2.8	2.8	1.2	6.8
Bihar	25.8	21.9	3.1	0.7	0.1	3.9
Gujarat	55.1	39.2	9.2	5.0	1.7	15.9
Haryana	59.3	31.3	13.6	12.8	1.6	28.0
Karnataka	44.1	36.4	5.1	1.5	1.1	7.7
Kerala	49.7	41.9	4.1	2.8	0.9	7.8
Madhya Pradesh	38.8	28.1	4.4	4.5	1.8	10.7
Maharashtra	54.8	43.0	6.6	3.2	2.0	11.8
Orissa	39.5	31.2	4.6	2.6	1.1	8.3
Punjab	69.6	37.2	21.3	9.2	1.9	32.4
Rajasthan	28.9	21.8	3.6	2.9	0.6	7.1
Tamil Nadu	55.0	43.1	8.3	1.8	1.8	11.9
Uttar Pradesh	32.3	19.2	9.7	2.6	0.8	13.1
West Bengal	32.3	28.8	1.8	1.0	0.7	3.5
India	41.7	29.7	5.9	4.5	1.6	12.0

Source: Ministry of Health and Family Welfare (1990).

sterilizations, small-scale studies paint a bleak picture. In Madhya Pradesh, a camp held in a town hospital had 17 failures out of 19 laparoscopic sterilizations (Narayana and Kantner, 1992, p. 109). Based on a village-level study in south India, Caldwell and Caldwell report, "The majority of those who have been sterilized report that they have in fact suffered debilitating effects. In their private capacity, all members of the family planning program know this but it is never reported partly because it would be regarded as non-constructive and partly because the doctors do not believe there can be a physical basis for it" (Caldwell and Caldwell, 1982, cited in Hartmann, 1987). This disproportionate emphasis on female sterilization, in conjunction with a lack of concern about health outcomes for women, is a manifestation of gender inequality built into the government bureaucracy as well as into Indian society.

Fascination with high-technology contraceptives has continued to govern the Indian medical profession as well as government officials. As a result, relatively simple methods such as the diaphragm have received very little attention, and the potential side effects of various contraceptive methods have been ignored. For example, the leaflet for the contraceptive pill *Mala* does not mention any contraindications or possible adverse effects (Ravindran, 1993b); and in their enthusiasm to introduce injectable contraception, providers ignore the constraints on women's physical mobility, which may make it difficult for them to return for another injection within the time required.

The poor quality of contraceptive services is a direct consequence of the family welfare program's reliance on a system of targets and incentives (The Population Council, 1987; Jain, 1989). Centrally determined targets regarding the number of IUDs to be inserted and the number of sterilizations to be performed are passed down to district and local levels, and local authorities are expected to implement them. However, this pressure on service providers has encouraged a number of unethical medical practices. According to a recent report (Ravindran, 1993a), health facilities have pressured women seeking abortion into accepting sterilization following the first procedure. IUDs have been inserted and women sterilized after delivery without their knowledge. Sometimes providers are so

concerned about meeting targets that they deliberately withhold information from women about possible adverse effects and the need for checkups. A disproportionate focus on provider-dependent methods, whether sterilization, implants, or injectables, in the current structure dominated by method-specific targets ignores the potential for abuse due to the unequal relationship between providers and women clients.

Notwithstanding the poor quality of family planning services, considerable money is spent on providing incentives for family planning acceptance and for information, education, and communication (IEC); the latter consists largely of propaganda about why families should have fewer children, and why a daughter is as good as a son. The success of IEC programs remains doubtful, and the Eighth Five-Year Plan observes: "Adoption of the small family norm and use of appropriate measures for birth control are matters of personal choice and decision. The IEC activities have to take this into account. However, until recently, IEC activities have been directed to national issues rather than personal issues. Undoubtedly, this incongruity of perception between the people and the providers of services has cost the program dearly" (Government of India, 1992b, p. 334).

Monetary constraints have frequently been cited as a reason for not focusing on the quality of services, but elimination of payments to motivators and acceptors (by one rough estimate, a minimum of 12 percent of total family planning expenditures—Ravindran, 1993b) may free a large part of the budget for improvements in the quality of services.

In contrast, considerable ambivalence exists regarding the role of the government in providing safe abortion. It is difficult to obtain good estimates of the total number of abortions in India. However, some estimates suggest that roughly 5 million abortions are performed annually in India, the large majority (about 4.5 million) illegally (Khan et al., 1993; UNICEF, 1990, cited in Jejeebhoy, 1994). As a result, abortion-related mortality and morbidity continues to be high and at least 10 percent of all maternal deaths result from abortion. Since abortion has been legal in India since 1972 and India has one of the least restrictive abortion laws, the existence of widespread illegal abortion is highly disconcerting. Studies suggest that

although official policy seeks to make pregnancy-termination services widely available, in practice guidelines on abortion limit access to services, particularly in rural areas. In 1981, of the 6,200 physicians trained to perform abortion, only 1,600 were working in rural areas, and only 10 percent of rural health facilities were equipped for pregnancy termination (Conly and Camp, 1992). This neglect of abortion services seems to reflect the ambivalence of policymakers. The government emphasizes that abortion should not be viewed as a method of family planning. Consequently abortion, euphemistically called medical termination of pregnancy, is the responsibility of the health delivery system rather than the family welfare program. Abortion is often available only if the woman agrees to a subsequent IUD insertion or sterilization (Ravindran, 1993a; Conly and Camp, 1992).

GENDER INEQUALITY AND REPRODUCTIVE CHOICE

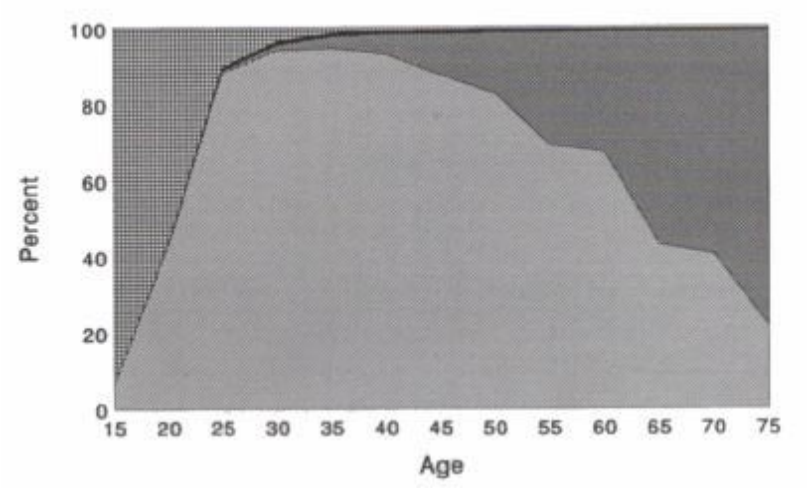
At the beginning of this report I argued that gender inequality in Indian society constrains women's reproductive choice and health. Although such factors as poverty, poorly organized health services, and lack of public investments in water and sanitation affect both men's and women's wellbeing, Indian women's reproductive and marital choices are particularly circumscribed by their social and economic circumstances. In particular, women's choices are severely curtailed by the absence of socially acceptable alternatives to marriage and a high degree of reliance on sons for old-age support.

Early and Universal Marriage

In spite of the well-known Gujarati saying "[We] have seen a never-married elderly man, have you ever seen a never-married elderly woman?," marriage is almost universal for both men and women in India. As Figures 1 and 2 indicate, over 90 percent of Indian men are married by age 35, while nearly 95 percent of Indian women are married by the same age.

Although between 1951 and 1981 singulate mean age at marriage rose from 20 years to 23.3 for men and from 15.6 to 18.3 for women (Government of India,

Figure 1
Percent Distribution of Female Population, by Age and Marital Status, India 1981



Source: Government of India, 1988.

1988), marriage continues to be early and almost universal. As Karkal and Rajan (1989) show, even these figures overestimate actual mean age at marriage since the census does not collect marital-status information for children below age 10; a survey in Maharashtra shows that between 5 and 10 percent of the women said that they were married before that age.

Age at first marriage varies considerably across the country. As Table 8 shows, the average of 18.3 years for women and 23.3 for men includes very low mean ages at marriage—under 17 years for women-in Bihar, Madhya Pradesh, and Rajasthan and relatively high ages at marriage—20 years and over for women—in Kerala, Punjab, and Tamil Nadu. Corresponding figures for men average some 5 to 6 years higher. Following marriage, there is pressure on women to prove their fertility by conceiving as rapidly as possible. Hence adolescent marriage is

Figure 2
Percent Distribution of Male Population, by Age and Marital Status, India 1981

Source: Government of India, 1988.

synonymous with adolescent childbearing: an estimated 10-15 percent of all births take place to women in their teens (Mathai, 1989; Kapil, 1990).

Arranging marriage for a daughter is considered one of the primary duties of parents. In fact, Hindu scriptures charge parents with this task before their daughters reach puberty. In addition to the cultural predispositions toward marriage, women's absence of independent means of subsistence makes spinsterhood a nonviable option for most Indian women. While marriage is almost universal for both men and women, men retain much greater power while searching for a spouse. Studies have suggested that if marriage did not form the only survival strategy for

Table 8

Mean Age at Marriage by Sex in Major States in 1981

State	Males	Females
Andhra Pradesh	23.0	17.3
Bihar	21.5	16.5
Gujarat	23.1	19.5
Haryana	21.7	17.9
Kamataka	25.9	19.2
Kerala	27.2	21.9
Madhya Pradesh	20.6	16.5
Maharashtra	24.6	18.8
Orissa	24.2	19.0
Punjab	24.4	21.0
Rajastban	20.4	16.1
Tamil Nadu	26.0	20.2
Uttar Pradesh	20.9	17.8
West Bengal	25.7	19.3
India*	23.3	18.3

Note: Figures refer to singulate mean age at marriage using Hajnal's method.
* Excludes Assam.

Source: Census of India, 1981-Series #I, India, Paper 2 of 1983, Key Population Statistics Based on 5 Per Cent Sample Data, Registrar General & Census Commissioner, India, New Delhi, 1983, p. 13.

women, the inequality in the search process would be reduced, thereby moderating the amount of dowry to be paid as well as women's subordinate position in the household following marriage[9] (Rao, 1993b).

[9] High fertility and the resultant age distribution ensure that for each man, there are many potential brides among the cohort five years younger than himself. This also increases men's value in the marriage market relative to that of women (Rao, 1993a).

A recognition of women's lack of power in marriage decisions is important from another perspective. Public policies excluding adolescent brides (and their husbands) from government employment would ultimately result in discrimination against women who had very little power in choosing when to marry and consequently would punish the victim.

Son Preference and High Fertility

Although fertility in India has declined in the last 30 years, this is mostly attributable to decline in some parts of the country, particularly in states like Kerala and Tamil Nadu. Fertility remains high in northcentral India (Table 9). In particular, the four large states of Uttar Pradesh, Madhya Pradesh, Rajasthan, and Bihar show substantially higher fertility, with an average TFR of 5.3 as compared to 3.5 for the rest of India (Satia and Jejeebhoy, 1991).

Although some portion of this high fertility is due to unplanned pregnancies, the desire for large families continues to play an important part. Recent data presented in Table 10 suggest that while preferred family size is moderate (about 3 children), the preference for at least two sons is very strong. As a result couples often pursue childbearing until the ideal composition, rather than a certain number, is achieved. The preference for sons is evident in both north and south and there appears to be a negligible decline in desired family size over time. Women appear to be readier than men to have many daughters in order to have a second son; and northern women seem to be firmer in this resolve than southern women (Operations Research Group, 1990).

Strong preference for sons is related to high fertility. Table 11 indicates that, among couples with three living children, 66 percent of those with three daughters want a fourth child, as opposed to 28 percent of couples with one son and 11 per-

Table 9

Total Fertility Rate and Total Marital Fertility Rate, 1985

State	TFR			TMFR	
	Rural	Urban	Total	Rural	Urban
Andhra Pradesh	3.8	3.3	3.7	4.8	5.0
Bihar	5.6	4.4	5.4	6.3	5.9
Gujarat	4.2	3.4	3.9	5.4	5.1
Haryana	4.8	3.8	4.6	5.8	5.4
Karnataka	3.9	2.9	3.6	5.7	4.9
Kerala	2.4	2.3	2.4	4.8	4.6
Madhya Pradesh	5.6	4.0	4.6	6.4	5.6
Maharashtra	3.8	3.1	3.5	4.7	4.9
Orissa	3.9	3.3	3.8	5.2	5.1
Punjab	3.6	3.1	3.5	5.2	4.5
Rajasthan	5.8	4.3	5.5	6.4	5.3
Tamil Nadu	3.0	2.5	2.8	4.9	4.5
Uttar Pradesh	5.9	4.2	5.6	6.6	6.0
West Bengal	4.2	2.5	3.1	5.8	5.0
India*	4.6	3.3	4.3	5.8	5.2

* Excludes Assam.

Sources: Family Welfare Programme in India, Year Book 1987-88, Government of India, Ministry of Health & Family Welfare, Department of Family Welfare, New Delhi.

Table 10

Mean Ideal Family Size and Ideal Number of Sons, 1990

State	Ideal Family Size			Ideal Number of Sons		
	Total	Rural	Urban	Total	Rural	Urban
Andhra Pradesh	2.9	3.0	2.8	1.7	1.7	1.6
Bihar	3.5	3.5	3.2	2.2	2.2	1.9
Gujarat	2.7	2.8	2.5	1.7	1.8	1.5
Haryana	2.8	2.9	2.5	1.6	1.6	1.4
Karnataka	2.7	2.7	2.7	1.6	1.6	1.6
Kerala	2.4	2.4	2.4	1.3	1.4	1.3
Madhya Pradesh	3.1	3.1	3.0	1.9	1.9	1.8
Maharashtra	3.0	3.1	2.7	1.8	1.9	1.6
Orissa	2.9	2.9	2.6	1.8	1.8	1.6
Punjab	2.7	2.8	2.6	1.6	1.7	1.5
Rajasthan	3.2	3.3	2.7	2.0	2.2	1.6
Tamil Nadu	2.4	2.4	2.4	1.3	1.6	1.3
Uttar Pradesh	3.3	3.3	2.9	2.1	2.2	1.6
West Bengal	2.8	2.9	2.4	1.6	1.7	1.3
India	3.0	3.1	2.7	1.8	1.9	1.6

Source: Operations Research Group (1990).

cent of couples with two sons. Similarly, a survey in Uttar Pradesh, Andhra Pradesh, and Kerala suggests that the mean number of children is 3.9 among families that indicate a preference for sons, compared with 2.7 in families that do not indicate such a preference (Mahadevan and Jayasree, 1989).

Table 11

Percent of Couples Desiring an Additional Child by Sex Composition of Existing Children, 1988

Number of Children	Sex Combination		Percent Desiring Additional Child
1	1 Son	0 Daughter	78
	0 Son	1 Daughter	87
2	0 Son	2 Daughters	66
	1 Son	1 Daughter	37
	2 sons	0 Daughter	31
3	0 Son	3 Daughters	66
	1 Son	2 Daughters	28
	2 sons	1 Daughter	11
	3 Sons	0 Daughter	13
4 +	0 Son	4 + Daughters	61
	1 Son	3 + Daughters	22
	2 Sons	2 + Daughters	7
	3 sons	1 + Daughter	10
	4+ Sons	1 + Daughter	8
	4+ Sons	0 Daughter	12

Source: Operations Research Group (1990), Table 3-9 (All India).

Son preference forms only part of the explanation for persistent high fertility, particularly in north India. In an interesting simulation Bhat and Rajan (1992) show that even if sex preference was totally eliminated, and the contraceptive prevalence rate for all two-child couples was the same, regardless of sex composition, this would close only 15 percent of the gap in contraceptive prevalence between Kerala and the four large northern states. Thus, it seems reasonable to conclude that son preference plays an important, but not dominant, role in maintaining high fertility. On the other hand, it plays an important role in discrimination against daughters

through sex-selective abortion, neglect of and high mortality among young girls, and lack of parental motivation to educate girls.

The profound preference for sons in India is rooted in the perception of sons as the major source of economic security in old age. Daughters are regarded as belonging to their husband's family, and usually little economic support can be expected from them.[10] This attitude is so strong in the north that many parents, while visiting their married daughters, do not accept food or other hospitality from them. However, given women's low independent incomes and lack of control over their earnings, few can provide economic support to their parents even if the parents were willing to accept it.

Yet another aspect of gender inequality bolsters the desire for sons. While both men and women rely on sons to provide support in their old age, women's reliance on sons is more extensive (Cain, 1986; Chen and Dreze, 1992). Given the age difference between spouses, it is likely that women will spend a number of years as widows. As Figures 1 and 2 indicate, after age 40 women's risk of widowhood begins to increase considerably, while that for men remains low, increasing only after age 60. But even at age 70 and above, 70 percent of men are currently married, compared with only 22 percent of women. Similarly, calculations for the period 1979-80 show that the mean duration of widowhood is 10.7 years for women compared to 6.4 years for men, and the differential in the length of widowhood appears to be increasing (Narain and Narain, 1989).

This difference is caused by three factors: (1) because men are older than their wives, they are more likely to predecease their wives; (2) widowed men are

[10] There are some important exceptions. Sometimes married daughters in a son-less family may reside with their parents, but usually this occurs when parents have property that needs to be cared for. Matriliny forms another important exception. Parents in south India whose daughters have married within the family can expect more help from their daughters than parents in north India.

more likely to remarry than widowed women; and, (3) from their late 30s onward, women have a survival advantage over men (Dreze, 1990; Bhat and Kanbargi, 1984).

Men have access to land and other property, including dowries, income, and savings. Additionally, they can count on physical, emotional, and economic help from their wives. Sons are additional security assets. For women, however, sons are the primary and frequently the only source of social, economic, and residential support. Reproduction—particularly the birth of a son—is the only means available to women to gain prestige and to legitimize their position in their husband's family (Jejeebhoy and Kulkarni, 1989; Karkar, 1978). While childless women are particularly at risk, women who have borne only daughters can also be subjected to harassment. In old age, women are exposed to the risk of widowhood, divorce, or husband's debilitating illness, that is, to the risk of losing their chief or sole source of economic support. Without access to independent economic opportunities, sons are critical to survival, especially for widows (Cain, 1984; Dreze, 1990; Chen and Dreze, 1992; Datta and Nugent, 1984; but see Vlassoff, 1990).

GENDER INEQUALITY AND WOMEN'S AND GIRLS' HEALTH

The most important health problems facing Indian women arise from general conditions that affect both sexes, such as respiratory diseases (tuberculosis, pneumonia, and bronchitis); fevers related to malaria and typhoid; and gastroenteric and other infectious diseases. Women are less likely to be promptly treated for such problems, however, and their poorer general condition makes them more susceptible in terms of the severity of the disease (Jejeebhoy, 1994). Women face added risks during two critical periods in their lives: early childhood and the reproductive years. Discrimination against girls results in higher mortality rates for females below age

5, and poor reproductive health services and high rates of reproductive tract infections pose added risks to women in adulthood.

Women's health risks are affected both by poverty and by gender inequality in the household. Women in rural areas face greater health risks than those in urban areas. Women in richer households are better fed than women in poorer households. But although poverty is an important cause of women's inadequate nutrition and access to primary health care, gender inequality in the household places the burden of poverty disproportionately on the shoulders of women. Hence, within any social class, men usually receive better food and health care than women.

Four critical areas of women's health and physical wellbeing deserve special attention: discrimination against girls resulting in higher female mortality; poor nutrition; poor reproductive health; and lower use of medical services when sick.

Higher Mortality Among Girls

India, along with some of her South Asian neighbors, is one of the few countries in which men outnumber women. Data on the sex ratio of the population between 1901 and 1991, presented in Table 12, indicate that this imbalance has increased over time.[11]

Despite a lively debate on the causes of change in this imbalance[12] (Premi, 1991). there seems to be a consensus that higher female mortality between ages 1 and 5 and high maternal mortality rates result in a deficit of females in the pop-

[11] Some researchers have suggested that the sex ratio in 1991 does not reflect a real decline between 1981 and 1991, but is an artifact of the quality of the 1981 census data.

[12] Presently life expectancy for both men and women is about 60 years. This figure is the result of higher female mortality rates during childhood and in the reproductive ages and higher male mortality rates in older ages. Due to a growing population, a deficit of women at younger ages carries more weight in determining the overall sex ratio.

Table 12

Sex Ratio (Females per 1000 Males), India 1901-91

Year	Sex Ratio
1901	972
1911	964
1921	955
1931	950
1941	945
1951	946
1961	941
1971	930
1981	934
1991	929

Source, Bose (1991), Table 3.

ulation Chatterjee (1990) estimates that deaths of young girls in India exceed those of young boys by over 300,000 each year, and every sixth infant death is specifically due to gender discrimination. As Table 13 indicates, as recently as 1988, mortality levels for females exceeded male mortality levels by 10 percent, 13 percent, and 21-56 percent at ages 0-4, 5-9, and 15-29 respectively. Of greater concern is the fact that in the 1980s when the economy was growing at a rapid pace, the gap in mortality rates between males and females remained unchanged and the practice of amniocentesis for sex determination and subsequent induced abortion emerged (Ravindran, 1993b).

The primary way in which parents discriminate against girls is through neglect during illness. A study in Punjab villages shows that medical expenditures

for boys are 2.3 times higher than for girls (Das Gupta, 1987). Additionally, several studies have argued that throughout South Asia, discrimination against girls in food intake leads to higher female mortality (Miller, 1981; Chen, Huq, and D'Souza, 1981; but see Basu, 1989).

Another noteworthy trend is the recent practice of abortion of female fetuses following sex-determination tests in urban areas. In spite of the sensational newspaper reports on the high prevalence of this practice, exact numbers of such procedures are difficult to determine. One estimate places the number at 78,000 between 1978 and 1983 (Kelkar, 1992). The posters advertising this test in Bombay, "It is better to pay 500 Rs. now than 50,000 Rs. [in dowry] later," seem to prey upon parents' fear of costs associated with the birth of a girl and may be an indicator of a dangerous trend. Ironically, changing norms regarding appropriate family size are likely to aggravate this situation. If fertility continues to decline while couples continue to desire two sons, the temptation to engage in sex-selective abortion or female infanticide through neglect of girls is likely to increase[13] (Das Gupta, 1987).

High mortality for girls and sex-selective abortion are indicative of the low value placed on girls. In areas where girls have higher economic value—as indicated by the demand for female labor at the household level, by high rates of female employment in the district, or by high female wages—the sex ratio tends to be more favorable to women (Kishor, 1993; Bardhan, 1974; Miller, 1981; Rosenzweig and Schultz, 1980). This is also true in areas where women tend to marry within their own villages and thus may provide economic or physical help to their parents (Kishor, 1993; Dyson and Moore, 1983).

[13] On similar lines, Jejeebhoy (1993), using data from rural Maharashtra, found that fertility decline had a perverse effect on girls' school enrollment, with lower enrollment rates for girls from smaller families than from larger families due to an increased burden of domestic work on girls in small families.

Table 13

Estimated Age-Specific Mortality Rates by Age Group and Sex, India 1988

	Rural			Urban			Combined			Sex ratio (F/M) of Mortality		
Age group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Rural	Urban	Total
0-4	35.1	39.1	35.7	18.8	18.7	18.7	31.8	34.9	33.3	111	99	110
5-9	3.6	3.9	3.6	1.6	1.8	1.7	3.0	3.4	3.2	108	113	113
10-14	1.6	1.8	1.7	0.7	1.2	0.9	1.4	1.7	1.5	113	171	121
15-19	2.0	3.1	2.5	1.1	1.6	1.3	1.8	2.8	2.2	155	145	156
20-24	2.5	3.4	3.0	1.8	2.7	2.2	2.3	3.2	2.8	136	150	139
25-29	2.5	3.3	2.9	1.9	1.7	1.8	2.4	2.9	2.6	132	89	121
30-34	3.0	3.5	3.2	2.6	2.1	2.4	2.9	3.2	3.0	117	81	110
35-39	4.6	3.8	4.2	4.1	2.5	3.4	4.5	3.5	4.0	83	61	78
40-44	6.8	4.7	5.8	5.0	3.4	4.2	6.4	4.4	5.4	69	68	69
45-49	9.4	6.7	8.1	7.8	5.5	6.7	9.0	6.4	7.8	71	71	71
50-54	14.0	10.6	12.3	14.3	9.2	11.9	14.0	10.3	12.2	76	64	74
55-59	20.4	15.8	18.2	21.9	16.6	19.4	20.7	16.0	18.4	77	76	77
60-64	33.9	27.1	30.4	30.8	22.4	26.6	33.2	26.1	29.7	80	73	79
65-69	51.1	40.6	45.7	48.1	36.0	41.9	50.5	39.7	45.0	79	75	79
70 +	100.8	88.1	94.3	100.9	84.0	91.7	100.9	87.3	93.8	87	83	87
All ages	11.9	12.0	12.0	7.9	7.4	7.7	11.0	11.0	11.0	101	94	100

Source: SRS 1988, Office of the Registrar General, India, Vital Statistics Division, Ministry of Home Affairs, New Delhi. Cited in Jejeebhoy, 1994.

Malnutrition

Gender disparities in nutrition are evident from infancy to adulthood. In fact, gender has been the most statistically significant determinant of malnutrition among young children (Chatterjee, 1989, quoting Levinson, 1974), and malnutrition is a frequent direct or underlying cause of death among girls below age 5. Girls are breastfed less frequently and for shorter durations in infancy; in childhood and adulthood, males are fed first and better (Das Gupta, 1987; Khan et al., 1988). Adult women consume approximately 1000 fewer calories per day than men according to one estimate from Punjab (Horowitz and Kishwar, 1991). Additionally, comparison of household dietary intake studies in different parts of the country shows that nutritional equity between males and females is lower in northern than in southern states (World Bank, 1991; Agarwal and Agarwal, 1987; Basu, 1992).

Two major consequences for women of nutritional deprivation are failure to achieve their full growth potential and widespread anemia. First, anthropometric data suggest that from an early age, girls have poorer growth levels than boys, especially in the region north of the Vindhyas (Miller, 1981; Srikantia, 1989; Sen and Sengupta, 1985). At later ages, an estimated 47 percent of 15-year-old girls and 12-23 percent of 20-24-year-olds in India have body weights less than 38 kg while 39 percent and 15-29 percent respectively have heights less than 145 cm (Jejeebhoy, 1994). These are identified as risk factors in pregnancy (Gopalan, 1989; Mathai, 1989). Second, it is estimated that anemia ranges from 40-50 percent in urban areas to 50-70 percent in rural areas (UNICEF, 1990, cited in Jejeebhoy, 1994). Anemia is more prevalent in the north (World Bank, 1991; Agarwal and Agarwal, 1987) and is especially acute among pregnant and lactating women. These conditions not only complicate childbearing and result in maternal

and infant deaths, maternal depletion, and low birthweight infants, but also severely affect women's productivity and quality of life.

Poor Reproductive Health

Indian women suffer from a variety of conditions resulting in poor reproductive health. Important among these are high maternal mortality, high rates of reproductive tract infections and related infertility, poor health during pregnancy, unsafe abortion, and poor access to healthful contraceptive services.

Maternal mortality, exceptionally high in India, is exacerbated by frequent pregnancies starting from adolescence. As Table 14 indicates, roughly 555 maternal deaths occur for every 100,000 births, suggesting that at least 120,000 to 150,000 women die each year of maternity-related causes (Bhat, Navaneetham, and Rajan, 1992). Given incomplete vital registration, even these disturbing figures are likely to underestimate the true magnitude of the problem. From the global perspective, India accounts for 19 percent of all live births and 27 percent of all maternal deaths (Acsadi and Johnson-Acsadi, 1990). Maternal deaths account for about 2.5 percent of all female deaths in India and 12.5 percent of deaths among rural women of reproductive age. Three in four maternal deaths result from sepsis, abortion, hemorrhage, toxemia, and anemia, and well over two-thirds are considered preventable (Jejeebhoy and Rama Rao, 1992).

For every maternal death in India, an estimated 20 or more mothers suffer from impaired health (Kapil, 1990), suggesting an additional 2.4 million women with poor health and productivity. Incontinence, uterine prolapse, and infertility, for example, are common pregnancy-related complications. Pelvic inflammatory disease is commonly associated with unclean conditions at delivery and can cause infertility. And infectious diseases such as hepatitis and gastroenteritis can be particularly serious during pregnancy. In addition, gynecological infections appear

Table 14

Indirect Estimates of Maternal Mortality, India 1982-86

State	Maternal Mortality Ratio [a]	Maternal Death Rate [b]	Percent of Maternal Deaths [c]
Andhra Pradesh	402	51	13.7
Bihar	813	139	26.6
Gujarat	355	49	14.5
Haryana	435	69	22.3
Karnataka	415	50	15.7
Kerala	234	20	14.2
Madhya Pradesh	535	89	22.1
Maharashtra	393	48	16.8
Orissa	778	105	21.9
Rajasthan	938	164	44.1
Tamil Nadu	319	32	8.6
Uttar Pradesh	931	162	32.3
West Bengal	551	71	19.9
India	555	78	20.2

[a] Maternal deaths per 100,000 live births.
[b] Maternal deaths per 100,000 women aged 15-49.
[c] Maternal deaths among all female deaths at ages 15-49.

Source: Bhat et al., 1992. Cited in Jejeebhoy, 1994.

to be common, though there have been few systematic attempts at classifying them. One village-level study (Bang et al., 1989) of rural women in Maharashtra determined on the basis of physical examinations that some 92 percent suffered from

one or more gynecological disorders: infections of the genital tract, including pelvic inflammatory disease, vaginitis, and cervicitis, contributed half of these conditions.

Although relatively little data are available on the prevalence of infertility, evidence from the 1981 census and from a village-level study in Maharashtra suggest that 6-7 percent of all couples are infertile (Ministry of Health and Family Welfare, 1989; Bang et al., 1989). Infertility poses a serious social and emotional threat to female wellbeing in a culture that prizes reproduction, and, in extreme cases, childless women face abandonment by husbands. Infertility has received scant attention in the family welfare program.

Sexually transmitted diseases, especially HIV, have serious implications for women. Though not statistically representative of the Indian population at large, a village-level study in Maharashtra suggests that high proportions of women were suffering from gonorrhea (0.3 percent) and syphilis (10.5 percent) (Bang et al., 1989). Further, an estimated 300,000-500,000 men and women were HIV positive at the start of 1992 (Thant, 1993). Women are especially vulnerable since male-to-female transmission of HIV is more efficient than the reverse. Nevertheless, neither of the two major categories of women at risk, sex workers and wives of infected men, are in a position to refuse the sexual advances of their clients and husbands.

Mention was made earlier of the poor quality of services and neglect of women's health in the target-driven structure of family planning programs. Ironically, in spite of the emphasis on such programs, frequently at the expense of other health services, the estimated unmet need for contraception is widespread (Table 15). About 24.6 million couples, representing roughly 18 percent of all married women, want no more children but are not using contraception (Operations Research Group, 1990). The causes of this unmet need remain poorly understood, but a qualitative study in Tamil Nadu suggests that women's lack of decisionmaking power in the family, opportunity costs involved in seeking contraception, fear of

child death, and poor quality of contraceptive services all play an important role (Ravindran, 1993).

Barriers to Health-Seeking Behavior

Despite the higher levels of female morbidity and mortality discussed above, women receive less health care than men. They tend to be less likely to admit to an illness, to seek timely or appropriate health care, and to continue treatment for the prescribed course.

Gender inequity in seeking health care is documented from an early age. Even among children, boys are more likely to receive health care early in their illnesses and to receive better quality care, from qualified doctors instead of local quacks; and expenditure on medicine is also greater in the case of boys than girls (Das Gupta, 1987). Similarly, studies on attendance at rural primary health centers reveal that more males than females are treated (Khan and Prasad, 1983). Studies of hospital admissions show that more men are admitted than women in almost all parts of the country. The differences are greater in northern hospitals (2.1 male admissions to every female admission) compared to the southern ones (1.3 to 1), pointing once again to regional differences in the value placed on women by society and family (see Miller, 1981).

As a result, women tend to seek medical help only if an illness is advanced, thereby reducing their chances of surviving it. Women's socialization to tolerate suffering and their reluctance to be examined by male personnel are further constraints on their access to health care. Evidence from Uttar Pradesh suggests that treatment was sought from nearby primary health centers in no more than 9 percent of female illnesses; the vast majority simply used traditional remedies (Khan and Prasad, 1983). Few women even know the location of the available health services or their business hours.

Table 15

Percent of Couples with an Unmet Need' for Contraception, 1990

State	Total	Rural	Urban
Andhra Pradesh	15.2	14.1	18.1
Bihar	21.7	21.6	22.1
Gujarat	11.6	11.6	11.6
Haryana	11.1	11.7	9.1
Karnataka	20.1	19.2	22.1
Kerala	7.6	7.6	7.6
Madhya Pradesh	18.7	18.5	19.4
Maharashtra	10.6	9.7	11.9
Orissa	12.0	12.5	8.9
Punjab	10.4	11.4	8.2
Rajasthan	22.3	23.9	16.1
Tamil Nadu	16.2	17.7	13.5
Uttar Pradesh	25.9	26.4	23.4
West Bengal	18.2	21.5	9.3
India	18.3	18.9	16.6

* Defined as the percent of couples not wanting additional children but not using contraception. Approximately one-third of this group is estimated to be naturally sterile.

Source: Operations Research Group (1990), Family Planning Practices in India - Third All India Survey, vol. II, Operations Research Group, Baroda.

Although use of health services for antenatal care and delivery is increasing, it is estimated that only 40-50 percent of pregnant women receive any antenatal care and only 21 percent and 47 percent of rural and urban women are actually registered for care (UNICEF, 1990, cited in Jejeebhoy, 1994). While these figures are disturbing, local evidence suggests that they overestimate the actual use of maternal and child health (MCH) services (Table 16); studies in such states as

Bihar, Rajasthan, Orissa, Uttar Pradesh, Maharashtra, and Gujarat find registration for services to be as low as 5-22 percent in rural areas and 21-51 percent in urban areas (Kanitkar and Sinha, 1989; Khan et al., 1988). As far as service content is concerned, few checkups are performed and even immunization and referral of high-risk cases are afforded to few women. There is a general reluctance to seek medical care for pregnancy, a condition that will disappear after birth (Kanitkar and Sinha, 1989). As a result, trained institutional and professional attendants at birth, though their number is increasing, are available for only about 40 percent of births (Table 17). While official statistics suggest that three-quarters of all rural births take place within homes with untrained assistance, microlevel surveys suggest proportions closer to 90-95 percent. Again, trained attendants at birth are more prevalent in the south than in the north. That this is rooted in the cultural devaluation of women is seen from the fact that even among women residing in a Delhi slum with virtually identical socioeconomic conditions, those who migrated from Uttar Pradesh were much less likely to have trained attendants at birth than those from Tamil Nadu (Basu, 1990).

The same constraints apply to contraceptive services. Although women need not have the consent of their husbands to obtain such services, including sterilization, barriers of a different nature can prevent women who want to curtail childbearing from seeking services. First, awareness of contraception is limited and often restricted to terminal methods: no more than a third of all women have correct knowledge of such temporary methods as the IUD and oral contraceptives. Second, few women know the location of available services or their hours. Third, as a result of their subordinate role in decisionmaking and their limited spatial mobility, few women have the freedom to seek contraception (Visaria, 1993); nor can women initiate discussion or action on family planning, since sexual matters are “shameful”

Table 16

Women's Use of Antenatal Services, Sample Surveys, Five States

	Percent of Women with Births in the Four Years Preceding the Survey Who Were				Percent Naming Reasons for Not Using Services		
	Registered with MCH Center for Antenatal Checkup	Visited by MCH Staff	Receiving Antenatal Care	Immunized for TT	Lack of Knowledge	Not Necessary	Economic or Transport Difficulty
Rural areas							
Bihar	4.9	3.7	6.8	9.9	15.9	55.7	24.5
Gujarat	11.0	27.6	—	10.7	2.5	82.8	5.4
Maharashtra	22.2	17.0	—	28.4	1.5	60.5	24.0
Orissa	17.0	10.9	24.7	15.7	7.2	78.4	11.4
Rajasthan	5.7	3.3	—	—	18.0	41.2	11.5
Urban areas							
Bihar	21.2	1.4	21.1	24.8	8.4	69.3	18.4
Orissa	51.4	10.0	55.1	49.0	8.9	83.5	5.4
Rajasthan	31.0	2.3	—	—	23.0	54.6	8.8

Source: Kanitkar and Sinha, 1989, pp. 201-211.

Table 17

Percent of Births Delivered by Type of Attention Received by Mother, 1979-80 and 1988

	Institutional		Trained professionals		Others	
State	**1979-80**	**1988**	**1979-80**	**1988**	**1979-80**	**1988**
Andhra Pradesh	14.7	32.4	17.1	18.4	68.3	49.2
Bihar	—	11.0	—	12.8	—	76.2
Gujarat	14.0	22.0	9.7	31.5	76.3	46.5
Haryana	6.1	17.0	38.5	63.3	55.4	19.7
Karnataka	15.9	29.7	14.2	26.0	70.0	44.3
Kerala	49.0	84.9	16.5	6.2	34.5	8.9
Madhya Pradesh	9.9	10.4	7.9	13.0	82.3	76.6
Maharashtra	27.9	33.6	6.7	12.7	65.4	53.7
Orissa	6.2	7.5	14.9	15.0	78.9	77.5
Punjab	3.0	6.2	48.0	74.4	49.0	19.4
Rajasthan	4.1	4.2	10.5	16.7	85.4	79.1
Tamil Nadu	31.8	47.2	16.2	19.7	52.0	33.1
Uttar Pradesh	4.3	4.1	18.8	23.1	76.9	72.8
West Bengal	—	28.0	—	8.2	—	63.8
India	17.4	21.5	16.6	19.7	66.0	58.8

Source: SRS 1979-80, Vital Statistics Division. Office of the Registrar General, India, Ministry of Home Affairs, New Delhi. Cited in Jejeebhoy, 1994.

and in the male domain. Finally, interspousal discussion on contraception and reproduction is limited.

Women's ability to obtain health care for themselves and their children is particularly limited by their lack of geographic mobility. Hence, the importance of good domiciliary health and family planning services cannot be overstressed. Home visits by credible health personnel can, in the short run, compensate for the many restrictions on women's access to and use of family planning services discussed above. These visits provide an opportunity to disseminate information on a host of issues related to health, family planning, hygiene, and sanitation; to investigate the morbidity status of women and children, especially pregnant and lactating women; and to deliver primary health care and nonterminal contraceptives and follow-up services.

GENDER INEQUALITY AND POPULATION POLICY

In focusing on gender inequality in the context of population policy, it is important to locate discussion of policy in the context of broader political changes in India. Three trends are of great importance:

(1) Structural adjustment policies initiated in 1991 severely restrict the resources available for such social services as health, education, and water and sanitation programs. Future initiatives must either accept these limitations and focus on a limited set of goals, or modify these policies in order to develop effective subsidies for such vulnerable groups as women and girls from lower and lower-middle classes. This report advocates the latter approach.

Research cited above suggests that gender inequality in the family and in society distorts the effects of gender-neutral public policies. Thus, policies must be devised so as to overcome family-based inequalities in order to reach the intended beneficiaries. For example, Sen and Sengupta (1985) argue that direct nutritional intervention through supplementary feeding may be more beneficial to girls than indirect supplementation

achieved by increasing household incomes through land reforms. Similarly, reduction in government subsidies to the health sector may have a greater negative impact on women's health than on men's.

(2) At present Indian population policy is synonymous with contraceptive service delivery. The location of population policy within the family welfare program, and its high degree of compartmentalization, effectively guarantees that population policy is seen as distinct from development policy. With the introduction of the 73rd and 74th amendments to the constitution, mandating devolution of various of powers to local governments, it will be possible to overcome this compartmentalization by integrating population policy into development policy.

(3) The magnitude of India's population growth, from 361 million in 1951 to 844 million in 1991, has created a sense of urgency, prompting legislators and policymakers to identify coercive population policies as demonstrations of political will. Experience increasingly suggests, however, that target-driven family planning programs are not only ineffective, but also have serious negative consequences for women's health and quality of services. Additionally, given the links between such socioeconomic factors as caste, status, and education on the one hand and age at marriage, fertility, and child mortality on the other, punitive policies directed at individuals with large families or with low age at marriage may further discriminate against the weaker sections of the society.

Given these political conditions, what should be the goal of Indian population policy? In this report, I have argued for a woman-centered policy with two primary goals: reducing socioeconomic constraints on women's marital and fertility choices; and improving women's and girls' reproductive health and wellbeing. Indian women's reproductive choices are severely constrained by their socioeconomic condition, and early marriage and high fertility form an integral part of their survival strategies. A variety of factors limit women's choices: lack of socially acceptable means of survival other than marriage, poverty and discrimination in the labor market, inequality in inheritance

patterns, high rates of widowhood, and lack of power within the family are important among these. Indian women continue to suffer from neglect and poor health, in childhood and throughout the reproductive ages. Devaluation of girls, women's lack of autonomy and the ideology of self-denial, poorly structured and often oppressive service delivery systems, and poverty combine to limit women's ability to care for their own health and that of their children.

Recent discourse between feminist activists and researchers in India suggests that recognition of the added constraints facing women requires moving beyond traditional concepts of women's status to incorporate a broader view of the social context within which gender inequalities are embedded. Thus, efforts to address these gender inequalities must recognize that they operate at three levels and must approach each of these individually:

(1) Gender role ideologies, kinship and marriage patterns, and familial distribution of power create a family context in which women's opportunities and choices are severely limited, daughters are devalued, and male household members receive a disproportionate share of family resources.

(2) Gender inequalities in such broader social institutions as labor markets, the legal and educational systems, and family planning services constrain women's opportunities and exacerbate gender inequalities at the familial level.

(3) A variety of social policies, although gender-neutral in origin, affect men and women differently. Given the underrepresentation of women's perspectives in the political arena, situations that adversely affect women are frequently overlooked. Examples of these policies include a contraceptive service delivery system warped by the imposition of centrally driven targets, inappropriate development strategies resulting in excessive deforestation and reduction in groundwater supply, withdrawal of government subsidies to the health system during structural adjustment, and submergence of concerns regarding gender inequality within a broader concern with religious inequality.

In the context of public policy formulation and provision of public services, it is important to note that gender inequality not only directly affects women's reproductive choice and health, but also mediates the effects of other public policies. Changing deeply embedded cultural norms is a gradual process at best. In the short term, efforts to improve women's access to health, employment, education, and family planning will have occur within the framework of these constraints. Simply setting up the infrastructure for credit opportunities, health care, education, or skill development does not automatically result in their utilization. Efforts such as the Integrated Rural Development Programme, for example, in which 30 percent of the beneficiaries are expected to be women, have registered only 15 percent half that proportion of female participants.

This issue is particularly crucial in the present climate of privatization associated with structural adjustment policies. The intellectual tradition behind these policies assumes that the withdrawal of state subsidies to health, education, and nutrition can be compensated by individual expenditures if incomes continue to rise. However, if rising incomes are controlled by male household heads, benefits may not reach women and girls.

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