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**Poverty, Gender and Reproductive Choice**

SWAPNA MUKHOPADHYAY  
R. SAVITHRI



# Poverty, Gender and Reproductive Choice

An Analysis of Linkages



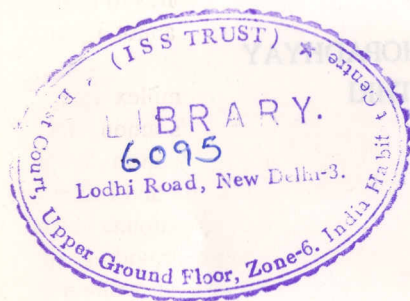
SWAPNA MUKHOPADHYAY  
R. SAVITHRI



Reproductive choice and Reproductive rights are two of the current buzzwords in discussions on population policy, which in India has until recently been dominated by compulsions of fertility control. Choice in any area presupposes the existence of a set of feasible options, and the rights issue may be looked upon as a factor that shapes out the contours of that set. What relevance, if any, do these concepts have for the majority of Indian women shackled down by the dual burden of poverty and gender bias?

This book is an attempt to explore the complex interlinkages of gender with poverty on the one hand and the interface of both with women's fertility behaviour and reproductive choice on the other. Within the parameters of a focussed literature review, the book analyses the data generated from a very detailed household survey carried out in two thousand households in rural areas of Uttar Pradesh and Karnataka in 1994 in order to explore the connections between a whole range of potentially interlinked variables. The results bring out some interesting patterns and throw up some fresh hypotheses which one hopes will influence the future research agenda in this important and emergent area of research.





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## Preface

Choice in any area presupposes the existence of a feasible set of options. The boundaries of such a set are defined by the nature of constraints, social, cultural and economic. Any policy measure that aspires to bring about change in a non-coercive and participatory manner cannot afford to lose sight of these ground realities.

The present study provides new insights into the complex interlinkages between factors that determine fertility decisions among the rural poor. It contains an analysis of the data generated by an in-depth household survey of 2,000 households in rural Uttar Pradesh and Karnataka which was carried out during 1994. The survey questionnaire is very detailed—covering some 1,600 variables—thereby providing an opportunity to investigate the complex interlinkages between women's disempowerment in rural society, both as individuals as well as members of the household and the community. The genderized inequalities in terms of access to education and skills training, nutrition and health care, income-earning opportunities and control over resources, get compounded in situations of generic poverty and inadequate infrastructural facilities.

This study is based on the work carried out by the Institute of Social Studies Trust in a recently completed project titled 'Poverty, Gender Inequality and Reproductive Choice'. ISST is indebted to the John D. and Catherine T. MacArthur Foundation for sponsoring the study. We are particularly indebted to Carmen Borroso, Director of the Population Program and Anu Kumar, Program Officer of the Foundation. We are also very grateful to the Population Council, New York, especially to Judith Bruce, and to Sonalde Desai who worked in close collaboration with ISST in the early stages of the project. The National Council of Applied Economic Research (NCAER), New Delhi fielded the questionnaires in Uttar Pradesh and Karnataka and provided us with the data on which this study is based. We are grateful to all these organizations for the support extended to ISST.



A number of ISST researchers have been involved with the project at various stages. We would like to thank in particular Praachi Tewari Gandhi, Pallavi Ghosh and Surekha Garimella for the work they have put in. Krishna Soman, Vandana Sinha and Claire Noronha have worked as consultants at different times under the project. Pratap Sharma, Arpana Bhowmik, Ritu Batra, Sudhir Miglani, Harinder Kaur and Sanjay Kumar Pattanaik have helped with the computer work at different stages. Sandhya Kandhari has spent endless hours going over several revisions of the draft manuscript. We are very grateful to all of them.

NEW DELHI SWAPNA MUKHOPADHYAY  
23 March 1997 R. SAVITHRI

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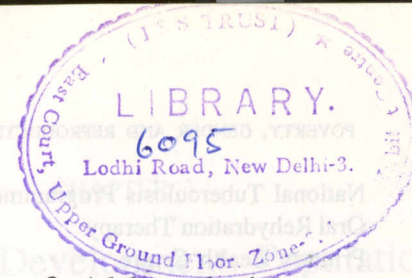
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### List of Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
CEHAT	Centre for Enquiry Into Health and Allied Themes
CHC	Community Health Centre
CHV	Community Health Volunteer
CINI	Child In Need Institute
CSSM	Child Survival and Safe Motherhood
FRCH	The Foundation for Research in Community Health
GDP	Gross Domestic Product
GOBI	Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization
GOI	Government of India
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICPD	International Conference on Population and Development
ICSSR	Indian Council of Social Science Research
IIPS	International Institute for Population Sciences
IUCD	Intra Uterine Contraceptive Device
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MNP	Minimum Needs Programme
MPW	Multi-Purpose Worker
NACO	National AIDS Control Organization
NAEP	National Adult Education Programme
NCAER	National Council of Applied Economic Research
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NIHFW	National Institute of Health and Family Welfare
NIPFP	National Institute of Public Finance and Policy
NRC	Nutrition Rehabilitation Centre
NSSO	National Sample Survey Organization



NTP	National Tuberculosis Programme
ORT	Oral Rehydration Therapy
PHC	Primary Health Centre
PHN	Public Health Nurse
PNC	Post Natal Care
RTI	Reproductive Tract Infection
RUWSEC	Rural Women's Social Education Centre
SIDA	Swedish International Development Cooperative Agency
SRS	Sample Registration System
STD	Sexually Transmitted Diseases
UIP	Universal Immunization Programme
UNICEF	United Nations Children's Educational Fund
WHO	World Health Organization

## Economic Development, Population Policy and Reproductive Choice

### THE BACKGROUND

Both as a concept and as a rallying point for gender-based concerns, the emergence of reproductive choice is a relatively new phenomenon in the area of population policy. For decades on end, population policy had been primarily, if not solely, concerned with the regulation and control of human fertility. The prime mover has always been the perceived need to control the rate of growth of population in the aggregate. The Malthusian spectre of a population explosion in the developing world, perceived as a growing strain on world resources, prompted several governments in the North and many international organizations as well to press for demographically-driven population control policies in the developing countries—a position that found widespread support among bureaucrats and policy makers in a majority of Third World countries.<sup>1</sup>

In a manner of speaking, India paved the way for target-driven population control policies by being the first nation to launch an official family planning programme in the early fifties. The pressure for controlling a fast growing population built up over the years as population growth rates picked up in the aftermath of planned development. The lament that economic growth in the aggregate is being siphoned off by a growing population and that in spite of the rise in foodgrain production as a result of the green revolution, the impact is negligible since there is an increasingly large number of mouths to feed, became all too common in public debates.

Yet there was little conclusive evidence on the complex nature of interlinkage between GDP growth or development on the one hand, and population growth on the other. One of the earliest demographic studies that sought to establish a link between population growth and economic development was the Coale-Hoover study of the late fifties. The prognosis of the simulation exercise carried out by these two Western demographers was that high fertility in a country like India is likely to be associated with low rates of economic development and vice versa.



This particular exercise played a significant role in shaping the entrenched belief in the population lobby in subsequent years on the necessity of bringing down aggregate fertility rates. Although the sixties and the seventies threw up several cases in the developing world which negated the inverse relationship between the two and questioned the simplistic formulation of the Coale-Hoover model, the fear of a population explosion in the Third World had come to stay. While official policy stayed geared to centrally administered and demographically driven targets of fertility control, doubts about the efficacy of such measures, even for the limited purpose of reduction in fertility, increasingly came under scrutiny. The apparent lack of correlation between fertility rates and contraceptive supply, as measured by such indicators as couple protection rates in the aggregate, was one angle of the issue. The socio-economic context of pushing contraceptives on a population that may not be prepared for it, was another. In a society marked by early marriage for girls, strong social sanctions against women who fail to bear children, and entrenched son preference, the desire for contraception stands seriously tempered by social constraints. Under such conditions supply driven fertility control measures that discount such constraints can easily turn out to be coercive. There had been little scope in the official FP programme for differentiation between wanted and unwanted conceptions and to cater only to the latter. By the early seventies, critiques of the official programme focused on the need for long-term, non-coercive measures to reduce the desired family size through reduction in infant mortality rates, improvement in the quality of life and sensitization in matters of benefits of a small family. 'Development is the best Contraceptive' became the slogan of Third World experts confronting international forces urging for reduction in aggregate population growth. The 1974 Bucharest Conference was privy to this stand.

However, despite the rhetoric of development being the best contraceptive being flaunted in official documents and pronouncements, there was little reflection of the adage in the area of formulation and implementation of official policy in India at that juncture. Maternal and Child Health (MCH) continued to be the central concern of the Ministry of Health and Family Welfare, and family planning programme with its top-down, target-driven approach continued to rule the roost. Over the years, family planning used up an increasing share of the combined allocation for health and family welfare, which together constituted a substantive fraction of the total allocation of public resources on health.<sup>2</sup> The latter in its turn, continued to be an abysmally small percentage of

total budget allocations. In the sphere of hierarchically designed official government programmes with little, horizontal interlinkages either in desire or in implementation strategies, there was little scope for testing the hypothesis as to whether development, of whatever kind, is indeed the best contraceptive. Family planning programme of the Government of India continued with unabated force, irrespective of the misgivings being sounded from various quarters regarding its faulty design and inefficient functioning. *Gender as an issue continued to be virtually absent in the central core of concerns.*

An interesting development in the scenario occurred during the Emergency years of 1975-7, in Indian political history when for the first time official FP programme targeted men as receptacles of contraceptive policy. Targets were set for vasectomies to be carried out by health officials in PHCs and sub-centres across the country. The share of male sterilizations in total contraceptive use shot up significantly during these years. The backlash came in the form of widespread disaffection which is believed to have been the main factor that threw the ruling Congress Party at the Centre out of power in the 1977 general election. Subsequent governments learnt their lesson well. While family planning programme continued unabated through the late seventies and all of the eighties, and sterilizations continued to be the preferred official measure, it was women, who were clearly more docile, more manipulable, and much less likely to revolt, who re-emerged as targets of official attention. In spite of being a complicated and hazardous operation as compared to vasectomies, female sterilizations accounted for over 90 per cent of all sterilizations in the late eighties and the early nineties. Feminists and activists had by now started voicing their concerns on the gender-insensitivity of official family planning programme. But gender concerns continued to be peripheral in the design and implementation of official policy.

#### ICPD 1994: THE POLITICS OF CONVERGENCE

The International Conference on Population and Development (ICPD) held in Cairo in September 1994 remarked a watershed in the design, conceptualization and perhaps more so, in the rhetoric of population policy. The Conference and the pre-Conference deliberations witnessed a complex process of interaction between different ideological and political positions and provided a convergence of sorts that took shape in the Plan of Action that emerged at the conclusion of the conference. The major achievement, and what is believed by a wide range of critical



actors to be the lasting legacy of the Cairo ICPD, is a paradigm shift in population policy debates: from the macro to the micro, from aggregate, target-driven, hierarchically designed fertility control programmes to the issue of the individual woman—her concerns, her choice and her rights over her body. Although some have expressed concern over the durability of the seeming alliance of diverse ideological positions and the content of the common minimum programme, the fact that the conference did manage to achieve a convergence of sorts among such diverse players has been hailed as something positive and unprecedented.

Among the various political and ideological actors that played a crucial role in shaping the outcome of the Cairo ICPD, has been the Northern Feminist Movement which had forged an alliance with the nascent Women's Movement in the third world countries over the years. Together, they put full support behind the process of conceptualizing a pro-woman, gender-sensitive population policy. Within the feminist movement, the Women's Health Movement that had been gathering momentum since the 1985 Nairobi Conference on Women and had coalesced into a force to reckon with by the time of the 1994 ICPD, had a significant role to play. The strong involvement of NGOs and feminist groups both from the third world countries as well as from the North, something that marked the 1992 UN Conference on Environment and Development (UNCED) at Rio was carried over to the Cairo ICPD. To this was added the considerable power of the US State Department which reflected the pro-abortionist stand taken by the Clinton administration within USA in favour of safe abortion rights for women. This was poised against the pro-natalist, anti-abortionist lobby in US which had on its side a strange alliance of powers forged between the Holy See on the one hand and Islamic fundamentalist forces on the other, pressing for traditional family values and the rights of the unborn. In the complex interaction of such a motley of political and ideological forces, when the resultant, if somewhat unexpected, paradigm shift from fertility control in the aggregate to the issue of women's reproductive rights and choice did emerge, the euphoria it generated in feminist circles is understandable.

It would be useful to dwell a little more on the major actors that brought it about. The Women's Health Movement worldwide had gathered momentum during the decade of the eighties. The first International Women and Health meeting was convened in the late seventies by European and North American women. Subsequent meetings saw

increasing participation of Southern women and articulation of their concerns. In Asia, the strongest streams emerged in the Philippines and in India. While the Philippino movement was organized as a reaction to Roman Catholic pro-natalist pressures, in India the rallying point for concerned NGOs and activists in the movement had been the hierarchical, target-driven and gender-insensitive approach of the official family planning programme.

The confrontation of the pro and anti-abortionist lobbies in the US was another strong influence that fed into the final shape of the Cairo document. The conflict was resolved in favour of the former by dint of the strong stand taken by the Clinton administration in favour of safe abortion rights for women. Apart from the ideological differences that marked the two sets of protagonists, the resolution of the conflict needs to be seen in the context of contemporary political scenario at the US. The weight of the Clinton administration behind pro-choice, feminist groups may be seen as a political antidote to the anti-abortionist, Catholic stance of the preceding Republican administration. Thus the change in political power in US stood in good stead in pushing forward the objectives of the feminist movement. The fact that the US State Department through various statements categorically put the weight of its support behind a plan of action encompassing comprehensive reproductive health care for women including safe abortion services, to a great extent eased the passage to a reproductive choice-oriented policy document from the ICPD (McIntosh and Finkle, 1995).

The other force that acted as a catalyst in the scenario is the strong NGO presence that sought to reflect the voices of women from the ground. Beginning the 1992 UNCED at Rio, the NGO-movement has increasingly sought to consolidate its place in UN Conference, and the Cairo ICPD was no exception.

In conjunction with all these critical actors was the complex process of mutation that came about in the professed position taken by the conventional population lobby on the one hand and religious forces represented by the Holy See and the Islamic fundamentalists on the other. By the time of the convening of the conference, the traditional population lobby was almost ready to accept the reproductive health approach, in form at least if not in substance, what with the negative evidence against the advisability of pushing target-driven fertility control programmes. It is a different matter if in essence it may have simply meant expanding the scope of the traditional family planning programmes to include reproductive health issues: at least the language was acceptable (Qadeer, 1996).



A major set of factors that eased the process of convergence was however being played out between the official US position and the Vatican, both of which made compromises of varying nature to reach a consensus. The political compulsions of a dwindling support base for the anti-abortionist position of the Catholic Church even in some predominantly Catholic countries like the Philippines, the waning strength of the unlikely partnership that was sought to be built by the Holy See in the pre-ICPD days with some Islamic fundamentalist countries also professing anti-abortionist policies in the name of traditional family values, as also the spate of problems that President Clinton was facing at that time in domestic politics, all combined to make for some conciliatory moves by all parties concerned. But given the strength of the strategic alliances that did build up in favour of pro-women, anti-coercive positions, the Cairo document emerged in a form that gladdened the hearts of feminists, activists and NGOs who had been demanding the rights of women to be placed centre stage in the formulation of population policies.

#### THE NEW PARADIGM

This statement from the ICPD document synthesizes the new development paradigm that puts women's empowerment at the centre of concerns: 'The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself . . . (and) is essential for the achievement of sustainable development.' (ICPD, 1994: Ch. 4).

Women's movement, in India and elsewhere, has been questioning the genderized nature of social and personal power equations within as well as outside the family.<sup>3</sup> Over the decades, the fundamental and ethical implications of contemporary population policy have been questioned and debated over by human rights activists, environmentalists and the women's movement. There is a general agreement that population policies in most countries have failed to address the actual needs of the people. They have been more concerned with meeting demographic targets and ignoring the fundamental needs of women such as reproductive and sexual health and their right to reproductive choices.

It was felt that population policies reflect and reinforce the secondary status of women in the family and society, where their voices remain unheard all too often. There is a need to redefine these policies in a manner such that they are women-friendly and truly address the multiple needs of women. Only when such needs are prioritized and women as

the primary users of population programmes are involved in the making of policies and in the implementation process, can universal health and rights for women become a reality.

In other words, what is needed is a programme that does not use coercion but consensus; that respects human rights and gives women control over their lives and bodies through their empowerment. These needs become a reality when governments recognize the importance of such a new agenda, create imaginative strategies and reallocate resources to the new agenda.

Those who struggle to make gender equality possible and recognize women's rights believe that the solution lies in the 'Empowerment' of women. To give women the power to make informed decisions and to redistribute resources to help enact these decisions, would be the first step in the right direction. Such an approach would not only respect the integrity of women and their basic rights but simultaneously would condemn social and cultural conditions that curtail the freedom to choose, and in doing so violate basic human rights due to gender bias and ideological conservatism. Empowerment is seen as a prerequisite, for the attainment of social, cultural, and political emancipation; it is a necessary condition for the attainment of rights over reproduction and resources; it is the primary necessity for a change in the existing imbalances in power relations and for gaining greater control over sources of power.

Stated simply, this challenges the patriarchal ideology, traditional social structures and institutions that reinforce gender discrimination. Only when women begin to question the violence perpetrated against them by the system will an alerted consciousness arise and female identities, roles and status be more clearly articulated. Change can be initiated through a supportive social system, through the educational process, through activism and through energizing the collective potential of women the world over.

#### REPRODUCTIVE RIGHTS AND CHOICE

Within this broad framework, reproductive rights are seen to consist of:

- The right of the individual woman to regulate her own sexuality: by conceiving when she wants, and as often as she wants, by terminating unwanted pregnancies and carrying the desired pregnancies safely to term.



- The right to freedom from pain, fear, disability or death arising from matters relating to reproduction and sexuality.
- The right to bear and raise healthy children.
- The right to her own sexual and reproductive health (Pachauri, 1995; Ravindran, 1996).

Reproductive health is perceived as an essential ingredient of reproductive rights. Reproductive choice in its turn is perceived as something that requires as a precondition the existence of a feasible set of acceptable options on matters relating to reproduction and sexuality that is available to the individual woman. It also assumes as a prerequisite, a certain capability and access over resources and information, as well as decision-making power of the individual for making informed choices.

#### THE STRUCTURAL CONTEXT OF REPRODUCTIVE CHOICE

The common set of concerns that has held the international women's health movement together and successfully pushed forward the paradigmatic change in population policy debates is the realization that the world over, irrespective of the context and their life situations, women have little control over their bodies, their sexual lives as well as their reproductive health. Yet it is only too obvious that the nature and modalities of control over women and their sexuality vary widely across socio-economic and cultural contexts. Given the varied history and context of the feminist movement in the North and in developing countries like India, reproductive rights and reproductive choice for women are concepts that are arguably much more clearly defined for Northern women than for the majority of women from Southern countries, where choice and rights are constructs that are deeply embedded in the socio-cultural context and put on the hold for the majority by the compulsion of grinding poverty and deeply entrenched patriarchal values and norms (Qadeer, 1996).

For the majority of women in India for instance, the concept of reproductive choice is devoid of content, for oftener than not, the set of feasible options is inordinately small if not null. Patriarchy operates through numerous social practices and norms that limit such options. Gender discrimination manifests itself through unequal access to nutrition, health care and education from early childhood, early marriage and child bearing. Female sexuality is strictly controlled by a myriad of

social constraints and professed norms for womanly behaviour, while marital rape is something unheard of in the Indian Penal Code. Choice in matters of sexuality is something that the average Indian woman can barely exercise. To this scenario is added the grim reality of poverty and lack of access to resources, constraining the limits of the choice set even further.

#### DEVELOPMENT POLICY

Development policy and economic planning in India have not helped much either. The capital intensive, core-sector based industrial policy of earlier plan periods has been supplemented by ad hoc palliatives of various kinds from time to time ranging from concessions to the informal and small scale sectors to a bevy of 'poverty alleviation programmes' designed at direct targeting of the poor. Agricultural growth has taken place largely in the context of near absence of any systematic land reforms programme. The growing power of the agricultural lobby in state politics which has been shaped by the concerns of large and medium framers, ensued a range of concessions and subsidies to the farm sector, which, however, has failed to substantially reduce the incidence of poverty in the country, leave alone eliminating it. The history of centralized economic planning for decades on end has left a lasting legacy of centralized bureaucratic control in the conceptualization and implementation of programmes in just about everything, including in social sectors like health and education.

In recent years under the structural adjustment programme of the Government of India, there is an attempt towards greater liberalization, deregulation and privatization of the economy. There is an apprehension that this may bring about a trend towards lowering of the responsibility of the state for the social sectors and for vulnerable sections of the population. The reduction in relative terms in certain components of the public health budget in recent years is believed to be a signal of such a possibility. In such scenario strongly entrenched patriarchal traditions can set in forces that increase the work load of women, enhance their economic vulnerability and generally reduce their welfare.<sup>4</sup>

The average Indian woman works hard at home and outside at feeding, clothing and maintaining the family. Poverty shapes the boundaries of her options in virtually all spheres including reproduction. It defines the parameters of the risks she has to bear in managing the survival of her family and her own life situation. Reproduction is only one aspect



of that problem. Reproductive choice for her has to be placed in the context of the deprivation she faces in the guise of lack of access to resources both in the context of the generic poverty affecting the household and the community, as well as in the context of gender disparities within the household as a consequence of entrenched patriarchal values. Poverty and gender discrimination together shape the contours of reproductive behaviour of the majority of Indian women. Any emphasis of the latter has to be based on an understanding of the complex interlinkages of these major forces that constrain women's reproductive behaviour.

This particular study attempts to do precisely this. It contextualizes the notion of reproductive choice under conditions of poverty and gender discrimination.

#### STRUCTURE OF THE STUDY

The book is structured as follows: This introductory chapter is followed in Chapter 2 by a literature review of the linkages between poverty, gender and reproductive choice. Chapter 3 looks at the policy scenario on women's health in India since independence. Chapters 4, 5 and 6 contain a statistical description and analysis of the data generated by a household sample survey of 1,078 rural households in the state of Uttar Pradesh and 800 households in rural Karnataka designed to delineate such linkages. Chapter 7 is conclusion.

#### NOTES

1. There is a large literature on the dangers of rapid population growth for the healthy survival of planet earth. The debates ushered in by the alarmist vision of growing population in the developing world have been supplemented over time by deliberations on the interlinkages between poverty, economic development, and environmental concerns. For an analysis of the growing synergy between the environmentalist and the feminist views on this whole range of issues, see Gita Sen, 1994.
2. For details, see Chapter 3 of this volume.
3. For details, see Chapter 1, Vol. I of ISST, 1995.
4. For an analysis of the set of concerns voiced by critics of the SAP especially in the context of women, see Mary John and K. Lalitha, 1995, especially, Chapters 4 and 5.

## CHAPTER 2

### Poverty, Gender Inequality and Reproductive Choice: A Review of Evidence

Reproductive decision-making and behaviour are in the 'private' domain of social life. At the same time, they are also fundamental for the formation of institutions such as marriage, and to that extent are encompassed by the particular socio-economic reality of the individual.

A range of complex variables shapes reproductive decision-making and behaviour. Poverty and aspects of gender inequality are the more important among these. Gender inequality stemming from an entire range of values and practices that privilege men, have a significant constraining effect on the choices available to women in reproductive decision-making or behaviour. On issues such as whether to have children, how many, when, and so on, women's choice is curtailed by gender inequality.

Various hypotheses have been postulated on poverty and gender inequality *vis-à-vis* fertility behaviour by demographers, sociologists and feminist scholars. While many of these factors characterize whole groups such as the community or a socio-economic class, most significant for reproductive behaviour is their impact at the level of the household. Gender differences are played out, and individuals are differentially empowered with respect to gender, age or generation, more forcefully within the household and in interpersonal relations therein. Under conditions of poverty, even a well-organized system of contraceptive supply may fail to induce potential users, because of domestic constraints.

More than anything else, it is the values imbibed by the process of socialization that most emphatically influence reproductive behaviour. Establishing the various ramifications of this linkage would be of considerable benefit for a prognostic study of reproductive behaviour.

#### POVERTY AND REPRODUCTIVE BEHAVIOUR

Poverty is characterized by limited access to resources. It limits the household's ability to fulfil basic needs, such as food, shelter and education. Studies point out that government policies and macro-level



processes have a strong bearing on the poverty situation of individual households. It is, however, difficult to pinpoint the exact nature and extent of this influence.

Poverty adversely affects health, and indirectly, fertility behaviour. Poverty limits the household's capacity to spend on food and medical services in times of pregnancy and otherwise. The resulting poor health, especially of women and children, affects reproductive choice. Because of poverty-induced infant morbidity and mortality, couples may tend to have more conceptions in order to ensure that at least some will survive.

Reproductive behaviour is also strongly influenced by maternal health. Sundari Ravindran's study (1993b) of two communities in Tamil Nadu in south India reveals that secondary infertility results from reproductive tract infections (RTI). Also, pregnancy wastage may be very high in the presence of RTIs, with 10 per cent of the later pregnancies being aborted or stillborn. The result of this social experience is that women prefer to undergo a greater number of pregnancies in their early reproductive span itself. The use of contraceptives for child spacing is consequently limited.

On the basis of data from different parts of India, it has been argued that many factors such as household expenditure on food, the nutritional status of the women and children, and timely receipt of vaccines help in decreasing mortality and morbidity levels (Jain and Visaria, 1988). These factors are themselves closely related to the socio-economic status of the family.

Gunasekaran's data on infant mortality from Madurai in Tamil Nadu are given in Table 2.1. It may be observed from the table that infant mortality rate goes up in the presence of some unfavourable conditions. These include deliveries taking place at home, by untrained *dais* and lack of supplementary feeding. Poor access to proper health services contributes greatly to these conditions. Further, utilizing the available health services and fulfilling nutritional needs depends on the economic well-being of the family.

The impact of government policies and macro level processes on poverty and reproductive behaviour may be seen in terms of the fall-out of increased life expectancy. As life expectancy goes up, it is found that insecurity with regard to survival of children decreases, with a positive impact in reproductive decision-making (Table 2.2). Education also provides exposure to information and develops the capacity to make informed decisions. But life expectancy and literacy are only partly dependent on per capita incomes. Thus, China, Sri Lanka and Kerala in India with per capita incomes lower than that of developed

TABLE 2.1: INFANT MORTALITY RATES (IMR) PER 1,000 LIVE BIRTHS: SOME DETERMINANTS

Characteristics	Number of Live Births	IMR
All	1190	100
Antenatal Care (TT)		
Never	737	118
1st Dose	145	96
2nd Dose	308	58
Place of Birth		
Hospital/PHC	357	84
MCH Centre	59	68
Home	774	110
Attendant at Delivery		
Qualified Doctor/Nurse	162	80
Maternity Asst./ANM	465	84
Trained <i>Dai</i>	195	123
Untrained <i>Dai</i>	368	117
Immunization (DPT)		
Yes	417	10
No	773	149
Initiation of Supplementary Feeding		
1st Month	72	306
2nd - 4th Month	311	39
5th - 7th Month	445	9
8th - 10th Month	228	18
11th - 12th Month	43	46
No Supplementary Feeding	91	824
Average Monthly Expenditure on Food (Rs)		
<200	497	76
201-400	541	133
>400	152	60
Availability of Health Personnel in the Village		
Yes	652	90
No	538	112

Source: Gunasekaran (1988: Table 8.3).

countries have life expectancy and literacy levels that are on par with developed country figures. Anand (1994) argues that government policies and the resultant public spending on food subsidies, health facilities and education make for this difference. Similarly, Desai (1994) argues that a lack of preventive health measures by government, such as availability of clean drinking water, leads to poor health and in turn affects fertility behaviour.



TABLE 2.2: MALE AND FEMALE LIFE EXPECTANCY AT BIRTH, AND GNP PER CAPITA, 1990

State/Country	GNP Per Capita (in \$)	Male Life Expectancy	Female Life Expectancy
Bangladesh	210	52	51
Sierra Leone	240	40	44
Kerala, India	275	68	73
India	350	60	58
China	370	69	71
Pakistan	380	50	55
Sri Lanka	470	69	73
Senegal	710	46	49
Costa Rica	1,900	73	78
Chile	1,940	69	76
South Africa	2,530	59	65
Brazil	2,680	63	69
Saudi Arabia	7,050	63	66
United States	21,790	73	80
Japan	25,430	76	82

Source: Anand (1994: Figure 1) as taken from World Bank (1992: Tables 1 and 32).

Increased work burden on all members of the family, and especially the women and children, is another result of poverty impinging on their health. Daughters contribute to child care, food preparation and other household tasks (Adam and Castle, 1994). Sons work for wages from a young age. Thus, poverty may also provide the motivation to have more children in the belief that every mouth to feed also means twice the number of hands to work.

Macro level processes such as environmental degradation or the widening resource gap between the rich and the poor may also worsen poverty conditions. Many studies have shown how environmental degradation, by rendering resources inaccessible, also makes some tasks like wood gathering, livestock pasturing and water fetching difficult. This factor may increase the value of children who would assist in the performance of these tasks (World Bank, 1992).

Ravindran (1993a) argues that population growth is lower in India than in some other parts of the world (Table 2.3). Further, she points out that agricultural growth is in pace with population growth but a skewed distribution rather than the increase in population *per se* ensures that the poverty situation of some worsens even as the number of poor increases.

TABLE 2.3: POPULATION GROWTH IN DIFFERENT REGIONS OF THE WORLD

Region	1951-61	1961-71	1971-81
India (census figures)	1.98	2.24	2.26
Africa	2.27	2.56	2.82
Latin America	2.75	2.70	2.38
W. Asia	2.75	2.70	2.88
S.E. Asia	2.10	2.45	2.28
E. Asia	1.64	2.20	1.76

Source: Ravindran (1993a: Note 5) as taken from United Nations (1989).

Lack of resources or their inequitable distribution may worsen the pressure on individual households. Thus, one reason for having more children could be to supplement one's own labour. Further, strenuous childhood labour impinges on health that in turn may feed the demand for more children. Where fulfilling basic needs is difficult, education or proper health care are at a discount.

Poverty thus limits access to resources, affecting health and fertility. Limited access to food, education or any other resource impinges on fertility decisions and behaviour down generations, on account of poor health and inadequate exposure to information on health, contraceptive use and low decision-making capacity.

For the impoverished woman, there is little autonomy in fertility behaviour. Forced to work, she may have little control over her income, given the dire needs of the household, for control on fertility. The same holds for greater exposure to information. Also, in spite of knowledge of contraceptives, its use may be limited, on account of the high opportunity costs in terms of time, income, and pressures of household and other work (Ravindran, 1993b).

## GENDER AND REPRODUCTIVE BEHAVIOUR

Reproductive behaviour is also influenced by a number of gender-related factors such as gender roles and relationships which are shaped by societal values. These in turn influence gender gaps in education, work, household responsibilities and property rights. Research has established the influence of some of these values such as early marriage and son preference on reproductive behaviour. Education and work, forming part of the gender 'complex' also have an impact on reproductive behaviour. Many studies have taken woman's access to education and her



independent earning as primary explanatory variables for analysing reproductive behaviour.

### CULTURAL DEFINITIONS OF GENDER ROLES AND REPRODUCTIVE BEHAVIOUR

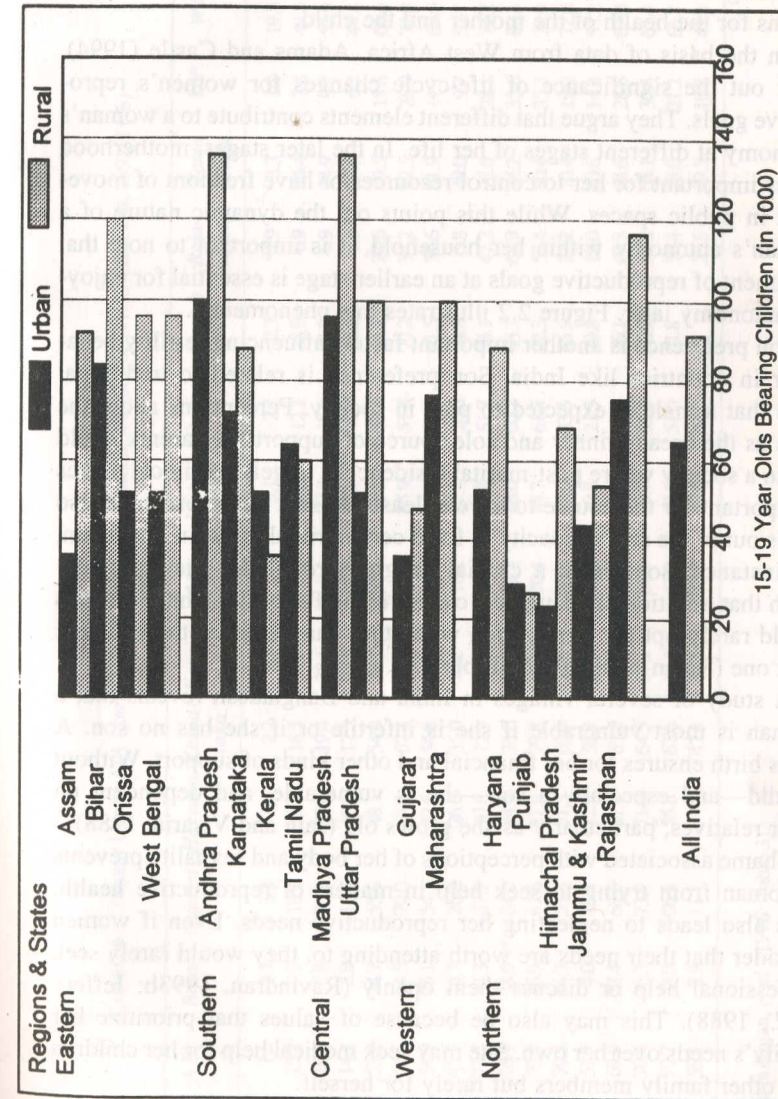
A number of socio-cultural variables, values and practices are crucial in reproductive decision-making and behaviour<sup>1</sup>. Some of these are: the importance of marriage and child bearing, the differentiation of private and public spheres and son preference.

Values related to a woman's role as wife and mother greatly influence reproductive decision-making by the couple. In India, marriage is a near universal phenomenon, especially in rural areas, and age at marriage is also very low. A number of studies, such as by Jeffery *et al.* (1988) in Punjab in north India, point out the importance attached to early marriage of the girl child, as guarding the family *izzat* (honour): it ensures that the girl does not stray sexually. Early marriage leads to early childbirths, impinging on her health and fertility. In tradition-bound societies, where modern values have not yet made an impact, early marriage for the girl is still the norm. It may be seen from Figure 2.1 that the fertility rates among 15-19-year old women are high particularly in rural areas. There is reason to believe that the reported mean age at marriage is higher than the actual age.

Societal pressure is particularly strong since the institution of marriage is considered sacrosanct by the prevailing religious values. Choice is limited as childbearing is considered a natural consequence of a conjugal union. Children are considered as God's gifts and infertility or childlessness seen as a curse. Social stigma is attached to terminating a pregnancy. Thus, while women report that others undergo abortions, few accept having undergone one themselves (ISST, 1995). Thus, a pregnant woman has no option but to carry the pregnancy to term. It may be far more acceptable for her to use contraceptives to limit fertility.

Even the woman who decides to terminate her pregnancy resorts to unsafe methods, because of the poor government facilities available and the need to be secretive (Ravindran, 1993b). The considerable health risk to which women thus expose themselves has an impact on their reproductive behaviour subsequently.

Within the household the woman has no status and no say in household decision-making until she becomes a mother (Dwyer and Bruce, 1988; Ravindran, 1993b). As housewife and mother, much of the responsibility at home and of child care falls on her.<sup>2</sup> For instance, in



Source: GOI (1988; Fig. 9.3).

FIGURE 2.1: AGE-SPECIFIC FERTILITY RATES, 15-19 YEAR OLDS, URBAN AND RURAL (1984)



rural south India, women, whether or not they are engaged in outside economic activities, spend about 7½ hours per day in domestic activities excluding child care (Desai and Jain, 1992). This has serious implications for the health of the mother and the child.

On the basis of data from West Africa, Adams and Castle (1994), point out the significance of life-cycle changes for women's reproductive goals. They argue that different elements contribute to a woman's autonomy at different stages of her life. In the later stages, motherhood is less important for her to control resources or have freedom of movement in public spaces. While this points out the dynamic nature of a woman's autonomy within her household, it is important to note that fulfilment of reproductive goals at an earlier stage is essential for enjoying autonomy later. Figure 2.2 illustrates this phenomenon.

Son preference is another important factor influencing fertility behaviour in countries like India. Son preference is related to traditional roles that a male is expected to play in society. Perceptions about the male as the bread-winner and sole source of support for parents in old age in a society where post-marital residence is largely patrilocal makes it important for the couple to have at least one son. Son preference also arises out of the son's capacity to fulfil certain ritual roles. In Hinduism, for instance, sons have a crucial religious role after their parents' death that traditionally daughters cannot fulfil. People who have no sons would rarely opt for sterilization while they may do so if they have at least one (Rajan *et al.*, 1996; Table 2.4).

A study of several villages in India and Bangladesh reveals that a woman is most vulnerable if she is infertile or if she has no son. A son's birth ensures for her financial and other kinds of support. Without a child—and especially a son—she is vulnerable, and dependent on other relatives, particularly as she grows old (Jain and Visaria, 1988).

Shame associated with perceptions of her body and sexuality prevents a woman from trying to seek help in matters of reproductive health. This also leads to neglecting her reproductive needs. Even if women consider that their needs are worth attending to, they would rarely seek professional help or discuss them openly (Ravindran, 1993b; Jeffery *et al.*, 1988). This may also be because of values that prioritize her family's needs over her own. She may seek medical help for her children and other family members but rarely for herself.

Shame also affects a woman's communication on matters of reproduction with her husband and in-laws. She is expected to keep such matters to herself. Also, her physical mobility is curtailed by social

TABLE 2.4: CURRENT USE OF ANY CONTRACEPTIVE METHOD BY NUMBER AND SEX OF LIVING CHILDREN, 1992-3 (%)

No. of Children	A.P.	Bihar	Gujarat	Haryana	Karna- taka	Kerala	M.P.	Maha- rashtra	Orissa	Punjab	Raja- sthan	Tamil Nadu	U.P.	W.B.	All India
None	1.6	1.7	3.3	3.4	2.2	8.5	2.2	3.1	2.7	2.3	1.9	3.3	1.8	19.8	4.2
One	15.2	7.9	18.2	19.8	18.5	37.1	9.3	22.8	12.1	28.9	6.9	24.4	7.8	49.5	19.3
1 Son	16.2	7.8	23.3	20.6	19.4	38.1	9.1	27.3	14.0	31.2	6.9	24.9	9.2	53.9	20.9
0 Son	14.2	8.0	11.7	18.8	17.5	36.0	9.6	17.8	9.9	26.3	7.0	23.9	6.3	44.8	17.4
Two	53.2	24.7	55.6	48.1	54.9	78.1	35.2	50.3	39.9	61.1	27.6	59.5	18.6	66.4	46.1
2 Sons	55.5	34.5	70.0	65.3	67.3	78.2	52.6	65.9	51.8	70.2	34.2	62.5	26.9	74.8	55.0
1 Son	54.9	23.1	54.7	42.6	54.6	80.1	32.2	48.1	40.0	61.5	30.6	61.9	17.1	67.0	46.4
0 Son	45.7	14.7	26.2	26.0	35.0	73.1	16.2	27.9	20.0	34.8	5.8	49.0	9.7	52.7	31.5
Three	73.5	34.3	67.7	70.6	72.3	83.1	54.9	74.8	51.7	74.1	47.2	72.6	28.1	74.2	58.9
3 Sons	76.9	38.0	84.0	84.9	76.0	85.3	57.3	86.0	60.2	85.7	63.9	74.2	35.6	82.3	64.9
2 Sons	79.9	46.9	81.6	81.9	79.8	86.5	70.4	84.7	61.5	82.3	57.4	80.4	35.3	78.0	68.0
1 Son	70.8	24.7	53.3	51.3	69.9	81.8	39.3	63.9	43.3	65.9	27.2	70.4	19.0	72.0	51.2
0 Son	51.7	4.0	18.3	12.8	38.9	74.3	16.4	30.8	21.5	29.8	12.0	50.6	14.8	53.2	31.7
Four-plus	69.9	33.4	68.6	67.1	63.5	68.9	57.6	76.0	54.3	76.1	49.3	64.6	28.5	62.0	52.4
2+ Sons	70.4	36.3	73.9	71.0	64.5	67.1	60.9	79.7	55.8	80.9	52.2	64.1	30.4	61.4	53.8
1 Son	70.7	53.9	56.5	55.8	62.6	77.4	48.2	69.5	51.0	61.8	36.4	68.0	21.2	66.7	49.5
0 Son	59.1	8.9	11.1	-	47.4	65.5	33.3	48.6	42.7	-	26.5	59.5	10.8	47.3	34.8

Source: Irudaya Rajan, *et al.* (1996: Table 3).



values. She may not be allowed to move alone in public places, which limits her ability to seek help from the local public health centre (PHC) or hospital about contraceptive methods or means for safe abortion. Thus a genderized socialization process determines the health-seeking and reproductive behaviour of women in clear, definable ways.

### WOMEN'S EDUCATION AND FERTILITY

Studies from different parts of the world indicate that a woman's education is positively correlated with lower fertility rates. It has been argued that educating women would lead to lower fertility rates in varying socio-cultural settings.

The World Fertility Survey data for 30 countries show an average total fertility rate of 6.9 children per woman among those with no education. On an average, they have three children more than women with seven or more years of schooling (UN, 1987). Martin (1995), on the basis of data from the Demographic and Health Surveys, also finds that there is a decline in fertility rates with an increase in the educational levels of women. However, the pattern of decline in fertility rates as a result of women's education is dissimilar around the world. In some regions there is a rise and then a fall in fertility rates. Martin argues that where birth control methods are not adopted education may initially increase fertility as a result of reduced breast feeding and *post partum* abstinence till an educational level is attained where fertility comes down (Table 2.5).

Women's education has a definite and positive effect on age at marriage, delaying the onset of childbearing and thus reducing their reproductive span (Tables 2.6 and 2.7).

The beneficial effects of education include the ability to read and comprehend, awareness of one's own health needs and those of one's family, and knowledge about ways to promote good health and utilize available health services. Caldwell (1979) points out that women of western Nigeria who have had schooling take actions and make others take actions that are beneficial for their child's health. This helps to reduce morbidity and mortality that, as pointed out earlier, could negatively influence fertility. Women's education may be particularly important for the health of the family members as a major share of care-taking responsibilities falls on the mother.

Education could also shape reproductive behaviour by exposing a woman to different attitudes. This could feed into a woman's autonomy

TABLE 2.5: TOTAL FERTILITY BY WOMEN'S EDUCATION IN DEVELOPING COUNTRIES

Region/Country	TFR	Years of Schooling					Difference 0-4-6	Difference 0-10+
		0	1-3	4-6	7-9	10+		
Sub-Saharan Africa								
Botswana	5.0	5.9	5.6	5.1	4.5	3.1	-0.8	-2.8
Burundi	7.0	7.0	7.4	6.7	(6.6)	(4.2)	-0.3	-2.8
Ghana	6.4	7.1	6.6	6.4	6.8	4.9	-0.7	-2.2
Kenya	6.7	7.2	7.5	7.5	6.2	4.6	0.3	-2.6
Liberia	6.6	6.8	7.1	7.5	5.7	4.2	0.7	-2.6
Mali	6.9	7.0	6.9	6.6	5.7	(4.7)	-0.4	-2.3
Senegal	6.6	7.0	6.4	5.5	4.3	3.6	-1.5	-3.4
Togo	6.6	7.2	7.1	6.0	3.9	4.8	-1.2	-2.4
Uganda	7.3	7.7	7.4	7.0	7.2	5.3	-0.7	-2.4
Zimbabwe	5.7	7.3	7.2	6.3	5.0	3.3	-1.0	-4.0
North Africa								
Egypt <sup>a</sup>	4.7	5.7	5.3	4.2	3.4	3.4	-1.5	-2.3
Morocco <sup>a</sup>	4.9	5.5	3.9	2.9	2.4	2.2	-2.6	-3.3
Tunisia <sup>a</sup>	4.4	5.1	4.7	3.7	2.8	2.6	-1.4	-2.5
Asia								
Indonesia <sup>a</sup>	3.4	3.8	4.0	3.6	2.8	2.6	-0.2	-1.2
Sri Lanka <sup>a</sup>	2.8	2.8	3.0	2.9	2.7	2.7	0.1	-0.1
Thailand <sup>a</sup>	2.4	3.5	2.8	2.5	2.1	1.5	-1.0	-2.0
Latin America/Caribbean								
Bolivia	5.1	6.2	6.4	5.3	4.2	2.8	-0.9	-3.4
Brazil <sup>b</sup>	3.7	6.7	5.2	3.4	2.8	2.2	-3.3	-4.5
Colombia	3.3	5.6	4.5	3.6	2.5	1.8	-2.0	-3.8
Dominican Rep.	3.8	5.8	5.0	4.4	3.5	2.6	-1.4	-3.2
Ecuador	4.3	6.4	6.3	4.7	3.5	2.6	-1.7	-3.8
El Salvador	4.4	6.0	5.2	3.9	3.5	2.5	-2.1	-3.5
Guatemala <sup>b</sup>	5.6	6.9	5.6	4.2	2.8	2.7	-2.7	4.2
Mexico	4.1	6.4	6.3	4.0	2.7	2.4	-2.4	-4.0
Peru	4.5	7.4	6.1	4.6	3.7	2.5	-2.8	-4.9
Trinidad & Tobago	3.1	(2.3)	4.3	3.6	3.8	2.9	1.3	0.6

( ) = Based on fewer than 100 cases.

Note: Total fertility rates based on the five-year period prior to the survey.

<sup>a</sup> Ever-married sample. Estimates for all women are derived by applying a multiplication factor based on the information from the household questionnaire.

<sup>b</sup> Based on data for women aged 15-44.

Source: Martin (1995: Table 2).



TABLE 2.6: MEDIAN AGE OF WOMEN AT FIRST MARRIAGE, BY COUNTRY,  
ACCORDING TO EDUCATION, IN SOME DEVELOPING COUNTRIES

Region/Country	Total	Years of Schooling					Difference 0-10+
		0	1-3	4-6	7-9	10+	
<b>Sub-Saharan Africa</b>							
Botswana	25.3	23.7	22.8	23.6	27.2	26.6	2.9
Burundi	20.0	19.8	20.2	20.3	(21.7)	(22.7)	2.9
Ghana	18.4	17.8	18.0	17.9	18.4	20.0	2.2
Kenya	18.8	17.0	17.3	18.1	19.6	22.2	5.2
Liberia	17.8	16.9	17.6	18.7	19.6	21.7	4.8
Mali	15.7	15.7	15.6	16.0	17.0	(19.3)	3.6
Senegal	16.8	16.2	18.7	20.3	21.3	23.9	7.7
Togo	18.6	17.8	17.7	19.5	21.5	23.4	5.6
Uganda	17.4	16.6	16.9	17.7	18.7	22.6	6.0
Zimbabwe	19.1	17.2	17.7	18.3	19.4	22.4	5.2
<b>North Africa</b>							
Egypt <sup>a</sup>	19.5	17.4	17.8	19.8	22.4	24.2	6.8
Morocco <sup>a</sup>	19.8	18.7	21.9	23.3	26.4	26.1	7.4
Tunisia <sup>a</sup>	22.1	20.6	22.4	22.9	24.7	24.5	3.9
<b>Asia</b>							
Indonesia <sup>a</sup>	18.4	16.2	16.4	18.0	21.7	23.2	7.0
Sri Lanka <sup>a</sup>	22.9	21.0	20.9	21.3	23.1	25.2	4.2
Thailand <sup>a</sup>	20.8	18.8	19.4	20.2	21.6	25.8	7.0
<b>Latin America/Caribbean</b>							
Bolivia	20.6	20.0	19.6	20.0	20.1	23.0	3.0
Brazil	21.3	19.4	19.6	20.5	21.6	25.0	5.5
Colombia	21.2	18.4	19.6	20.6	21.7	26.3	7.9
Dominican Rep.	19.2	16.4	17.1	17.8	19.7	23.3	6.9
Ecuador	20.4	18.6	18.7	19.4	20.2	23.5	5.0
El Salvador	19.1	17.8	18.2	18.9	19.8	22.7	4.9
Guatemala	18.8	17.7	18.4	19.8	20.7	23.8	6.1
Mexico	20.3	17.2	18.2	19.7	22.1	24.1	6.9
Peru	21.0	18.7	18.7	19.9	20.6	24.9	6.2
Trinidad & Tobago	19.7	(17.9)	17.7	18.7	19.0	20.8	2.9

( ) = Based on fewer than 100 cases.

Note: Life-table estimates. Marriage includes consensual unions.

<sup>a</sup> Ever-married sample. Estimates for all women are derived by applying a multiplication factor based on the information from the household questionnaire.

Source: Martin (1995: Table 3).

TABLE 2.7: MEAN AGE AT MARRIAGE OF FEMALES BY  
EDUCATION LEVEL, RURAL AND URBAN, 1981

Education	Age in Years	
	Rural	Urban
All	16.5	17.6
Illiterate	16.3	16.8
Literate		
Primary	17.1	17.4
Middle	17.8	18.1
Matric	19.3	19.8
Graduate	21.5	21.9

Source: Census of India, 1981, Series 1, India, Part II: Special Reports and Tables Based on Five Per cent Sample Data.

within the household and influence her reproductive goals and contraceptive use patterns. With increase in education, motherhood may become relatively less important to women's status within the family and society: women may begin to have other commitments and consequently prefer a smaller family.

Various studies substantiate the view that a shift in perceptions about ideal family size among women need not directly lead to changes in actual family size. This depends upon, first, her capability to make other members of the family, and particularly her husband, accept these goals; and secondly, implement her plans by using contraceptive methods for spacing or limiting births. Caldwell finds that education helps the woman to take and carry out decisions opposing age and gender hierarchies within the household. Also, education would enhance her capacity to utilize available reproductive technologies.

The nature of education imparted also determines the attitudinal changes. As may be seen from Table 2.8, Kane *et al.* (1993) find that among tribal groups in Banjul in Gambia, exposure to 'family life education' makes a substantial difference in knowledge and use of contraceptive methods. 'Family life education' lectures include information on human reproduction, puberty, menstruation, pregnancy, labour, delivery, breast-feeding, family planning, and sexually transmitted diseases. 'Family life education' is accessible not only in secondary schools but also in youth centres, hospitals, vocational centres, community meeting centres and so on.



TABLE 2.8: PERCENTAGE OF EVER SEXUALLY ACTIVE RESPONDENTS AGED 14-24 WHO USED CONTRACEPTIVES, BY GENDER, MARITAL STATUS AND ATTENDANCE AT A FAMILY LIFE EDUCATION LECTURE, GREATER BANIUL, GAMBIA, 1986-7

Contraceptive Use	Women						Total	Men		
	Ever-Married			Never-Married				Never-Married		
	FLE	No FLE	Total	FLE	No FLE	Total		FLE	No FLE	Total
At First Intercourse	12	5	6	30	16	21	11	9	6	7
Never Used	34	65	62	26	52	44	56	47	60	56
Ever-Used	66	35	38	74	48	56	44	53	40	44
Pill <sup>a</sup>	36	16	18	30	25	27	21	23	17	19
Condom	31	10	13	57	28	37	21	46	34	38
Injection	6	1	2	0	0	0	1	n.a.	n.a.	n.a.
IUD	18	5	6	9	5	7	6	n.a.	n.a.	n.a.
Foam, Spermicide	18	2	4	20	8	12	7	n.a.	n.a.	n.a.
Rhythm, Safe Period	6	2	3	26	8	14	6	n.a.	n.a.	n.a.
Withdrawal	10	1	2	9	3	5	3	n.a.	n.a.	n.a.
Abstinence	10	6	7	9	1	4	6	n.a.	n.a.	n.a.
Other Traditional	10	9	9	3	8	7	8	n.a.	n.a.	n.a.
Last Method Used										
Modern Temporary	55	23	27	66	38	47	35	n.a.	n.a.	n.a.

(Contd.)

TABLE 2.8 (Contd.)

Contraceptive Use	Women						Total	Men		
	Ever-Married			Never-Married				Never-Married		
	FLE	No FLE	Total	FLE	No FLE	Total		FLE	No FLE	Total
Pill <sup>a</sup>	30	13	15	24	20	21	17	6	5	5
Condom	6	5	6	30	12	18	10	42	31	34
Injection	4	1	1	0	0	0	1	0	0 <sup>c</sup>	0 <sup>c</sup>
IUD	13	3	4	6	4	5	5	0	1	1
Foam, Spermicide	2	1	1	6	2	3	2	3	1	2
Traditional, Total	11	12	12	8	9	10	10	2	2	2
Total <sup>b</sup>	100	100	100	100	100	100	100	100	100	100
(N)	(67)	(549)	(616)	(98)	(204)	(302)	(918)	(187)	(425)	(612)

Note: n.a. = not applicable. FLE: Family Life Education.

<sup>a</sup> Percentage of ever-use of pills by partners reported by never-married men exclude 105 sexually active males who stated they did not know whether their partner was using oral contraceptives.

<sup>b</sup> Percentages for ever-use and never-use of individual methods may add upto more than 100 because more than one method may have been ever used by some respondents.

<sup>c</sup> Percentage for these categories = 0.2.

Source: Kane et al. (1993: Table 4).



Mahmud and Johnston (1994) therefore argue that it would be limiting to see only formal education as providing a positive outcome on fertility control. For various other sources such as adult education programmes, informal education and extension services and even peer and support networks can provide such exposure. This may be especially important for countries like India where these may be more common than formal schooling, particularly in rural areas. Exposure to information under the family planning programmes could also substitute formal schooling in developing countries. While studies have uncovered the positive effect of educating women for greater reproductive choice and family planning, they are not agreed on the reasons for this influence. Thus, formal schooling or adult education and other non-formal programmes of education may be equally effective in bringing about these changes.

#### WOMEN'S WORK AND FERTILITY

Woman's work primarily refers to her economically remunerative activities and excludes the entire gamut of her activities within the household that are unpaid. Studies point out that paid work may be significant for woman's autonomy, promoting her decision-making authority that in turn positively influences reproductive choice. Demographic surveys in different parts of the world such as South America, the Middle East and South East Asia indicate that fertility is lower among working women.

The relationship between women's work and fertility is neither direct nor simple (Youssef, 1982). Studies reveal that through various intermediary factors, work may have a positive or negative effect on fertility. Some studies suggest that the negative correlation may be in terms of greater child spacing.

A number of hypotheses have attempted to capture the relationship between women's work and fertility in cause-and-effect terms. One explanation is on the basis of the economic or 'rational' aspect. When children are weighted in terms of cost and benefit, the opportunity costs for every childbirth may be too high for the couple where the woman is working. However, others have argued that there may be considerations involved in reproductive decision-making that a cost-benefit model does not take into account.

Mahmud and Johnston (1994) argue that independent earning positively contributes to women's decision-making authority in the

household. As many studies in South Asia reveal, women involved in credit programmes supported by governmental or non-governmental organizations have greater authority within the household than women who depend solely on their husband's income. Greater access to resources may be one reason, greater self-esteem another. Safilios-Rothschild (1982) on the basis of data from different parts of the world argues that independent earning through the factors of greater access to economic resources, extra-familial, social and psychological support networks, and access to public spaces may enhance women's say in reproductive matters.

Much also depends on the nature of woman's work—whether it is full-time or part-time, it requires her to stay away from home, it is agricultural or non-agricultural work. To some extent this relationship may be a result of a greater demand on the woman's time and other resources if her work is full-time, requires staying away from home and is non-agricultural. As Youssef (1982) derives from these findings, the negative impact on fertility may be highest where the role conflict between home and work is greatest for the woman.

However, reproductive decisions result from the interplay of a number of factors and so we find that non-working urban women may have fewer children than working rural ones. Youssef (1982) mentions that in Thailand, rural agricultural women workers had on an average 6 births as against 3.8 among urban housewives. Even the demand on their time because of their engagement in productive work may positively influence fertility in contrast to the argument made earlier. Data for Thailand show a fertility rate of 4.5 for rural agricultural workers as against 4.3 for rural non-agricultural workers. The household size might create a demand for more household income or, as pointed out earlier, children may prove useful in the household as the demand on women's time increases. The children in such houses contribute to the household work.

Thus, a number of factors related to women's work have a negative influence on fertility. Yet, independent earning may have little significance if she cannot use even a small part of it for her own health needs and those of her family and to buy contraceptives if she wishes to use them. As Mencher's study (1988) of a number of districts in Tamil Nadu and Kerala in southern India reveals, the woman's income may primarily be used to serve basic household needs, accounting for a major part of her income unlike her husband's (Table 2.9). Further, the woman's earning may rarely be in her control except what is allocated for household expenditure.



Mencher also argues on the basis of her qualitative data that the situation is worse where the husband does not earn or earns very little. In such cases, all the household burden, her husband's personal expenses and debts fall on the woman. Independent earning may not, therefore, necessarily enhance her autonomy and give her control over her fertility behaviour: it is the control over income that enhances her reproductive choice. Thus, the context in which a woman decides to work outside the house influences her control over her fertility.

A number of studies have taken woman's education or employment as an indicator of her autonomy that in turn enhances her decision-making authority. These factors are presumed to be definitely linked with greater reproductive choice. Nevertheless, the existence of any of these factors may not really make a difference. For one needs to take into account her values and attitudes, which are as socially influenced as those of her husband's or of any older female in the household. Circumstances may also be against her exercising an option even if she is aware of it. It may be useful here to recall Correa and Petchesky's (1994) argument about the multiplicity of influences on any reproductive decision-making process. Any factor that is in general positively related to reproductive choice may influence it negatively in a particular circumstance.

The debate concerning sterilization prevalence rates in Brazil provides a striking illustration. In a context of rapid fertility decline, female sterilization has become a 'preferred' method in Brazil, used by 44 per cent of current contraceptors. In some regions, the sterilization rate is greater than 64 per cent, as in the case of the north-east. The average age of sterilization has also rapidly declined since the early 1980s (15 per cent of sterilized women in the north-east are under 25 years of age). They argue that a complex mix of factors explains this trend: concerns about the side-effects or effectiveness of reversible contraception, failure of the public health system to provide adequate information about and access to other methods, severe economic conditions, women's employment patterns, and cultural and religious norms making sterilization less 'sinful' than abortion. Thus opting for sterilization is not a free choice as societal and religious pressures, constraints on the woman's time and other household resources may together make her opt for it.

Ravindran (1993a) also points to the drastic rise in female sterilization in the late 1970s in India. Coercive mass vasectomies during the political emergency in 1975-7 were followed by large-scale protests,

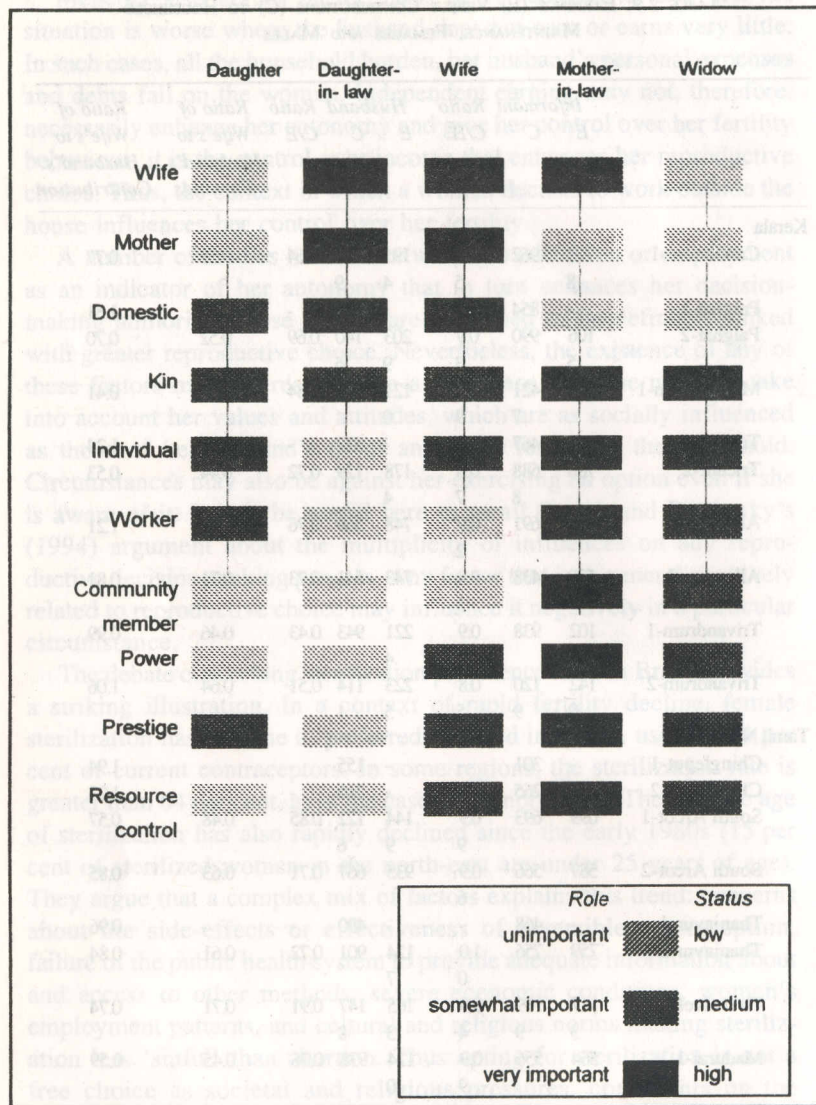
TABLE 2.9: EARNINGS (E) VERSUS CONTRIBUTIONS (C) TO HOUSEHOLD MAINTENANCE, FEMALES AND MALES

	Informant Ratio			Husband Ratio			Ratio of Wife's to Husband's Earnings	Ratio of Wife's to Husband's Contribution
	E	C	C/E	E	C	C/E		
<b>Kerala</b>								
Cannanore-1	113	962	0.8	195	124	0.64	0.58	0.77
	8		5	4	9			
Palghat-1	-	854	-	-	645	-	-	1.31
Palghat-2	106	990	0.9	203	140	0.69	0.52	0.70
	5		3	9	6			
Malappuram-1	435	421	0.9	121	102	0.84	0.36	0.41
		7	9	0				
Trichur-1	-	467	-	-	377	-	-	1.24
Trichur-2	786	688	0.8	178	129	0.72	0.44	0.53
		8	7	4				
Alleppey-1	752	691	0.9	748	569	0.76	1.01	1.21
			2					
Alleppey-2	530	438	0.8	743	541	0.73	0.71	0.81
			3					
Trivandrum-1	102	938	0.9	221	943	0.43	0.46	0.99
	7		1	4				
Trivandrum-2	142	120	0.8	223	114	0.51	0.64	1.06
	0	9	5	5	1			
<b>Tamil Nadu</b>								
Chingleput-1	-	301	-	-	155	-	-	1.94
Chingleput-2	-	265	-	-	216	-	-	1.23
South Arcot-1	699	693	0.9	144	122	0.85	0.48	0.57
			9	9	6			
South Arcot-2	587	566	0.9	935	667	0.71	0.63	0.85
			6					
Thanjavur-1	-	468	-	-	490	-	-	0.96
Thanjavur-2	759	756	1.0	124	901	0.72	0.61	0.84
			0	7				
Tirunelveli-1	117	109	0.9	165	147	0.91	0.71	0.74
	3	9	4	3	8			
Madurai-1	564	556	0.9	124	938	0.76	0.45	0.59
			9	0				
Kanya Kumari-1	-	369	-	-	365	-	-	1.01
Kanya Kumari-2	599	570	0.9	129	808	0.62	0.46	0.71
			5	7				

Note: Districts in each state are listed from north to south. In six villages data on earnings were not collected.

Source: Mencher (1988: Table 4).





Source: Adams and Castle (1994: Figure 2).

FIGURE 2.2. WOMEN'S ROLE THROUGHOUT THE LIFE CYCLE IN WEST AFRICA

leading to a shift in the gender focus of the government's family planning programme. A lack of alternatives and men's involvement put the onus on women. Consequently, female sterilization doubled in incidence, accounting for 80 per cent of all sterilizations in 1977-8, 85 per cent during the 1980s and 91.8 per cent in 1989-90.

Clearly, the data from round the world suggest that a plurality of influences determines reproductive choice, with poverty and gender inequality being among the predominating factors. As pointed out earlier, poverty of individual households is conditioned by macro-level structures and processes. Gender also shapes reproductive behaviour in different ways. The importance of the roles of wife and mother for a woman, son preference, gender relations within the household are some of the factors. It is considered that a woman who has autonomy within the household would also have say in reproductive matters. Important elements of such autonomy are education and independent earning.

A review of literature reveals that the influence of these factors on reproductive choice is significant but not definitive. A number of intermediary factors such as control over income and the kind of education available can alter the nature of influence. Thus, a whole range of factors operating at different levels influence reproductive choice. The process of reproductive decision-making and behaviour is complex because the significance of these factors varies with the context.

NOTES

1. Some attempts have been made to construct indices of female autonomy to examine the effect of gender discriminatory variables on reproductive decision-making and behaviour (Visaria, 1993; Sen *et al.*, 1994). Women's education and independent earning form an important part of these indices along with age at marriage, freedom of physical mobility and others.
2. Debates on reproductive choice, however, emphasize the need to shift the sole burden of care taking from women for a more equitable distribution between men and women.



CHAPTER 3

## Policy Scenario on Women's Health in India

Women's health and nutritional status is inextricably linked with social, economic and cultural factors and has a direct bearing on a nation's development. India has 15 per cent of the world's population and accounts for 25 per cent of the world's maternal deaths (World Bank, 1996). The maternal mortality rate, at 437 per 100,000 live births, is among the world's highest and results primarily from infections, eclampsia and anaemia (Table 3.1). Iron-deficiency anaemia affects 50-90 per cent of pregnant women in India. About 30 per cent of Indian women are married between 15 and 19 years of age followed by closely spaced pregnancies which not only pose a health risk for the women but endanger the survival of infants and older siblings. This partly explains the high differential between male and female mortality rate for women aged 15-24 years. Communicable diseases, malnutrition, maternal and perinatal causes account for 60 per cent of the disease burden among girls and women. Over 30 per cent of the deaths occur among children under 5 years of age and despite girls' innate biological advantages over boys, more girls die.

The primary cause of deaths in pregnancy and childbirth in a developing country like India is maltreatment of women (UNICEF, 1996). And for every woman who dies, an additional 30 infections and disabilities go untreated. This is because women are conditioned to cope and not complain.

Statistics also indicate a high rate of mortality (22-8 per cent) among girls under 5 as compared to those in the 5-14 year age group (4.7-5.4 per cent) during 1982-93 (Qadeer, 1996). This is attributed to the discriminatory practices that female infants suffer from. The risk of death for a woman in the reproductive age group (15-45 years) was also high (16-19 per cent) over the same period of time. While the major cause of death is diseases such as tuberculosis, pneumonia, whooping-cough, gastro-enteritis and senility, deaths due to childbirth account for 2.1-2.9 per cent of total female deaths (Table 3.2). Shiva (1996) notes that 65 per cent of female deaths occur due to infection-related causes.

TABLE 3.1: TOTAL FEMALE DEATHS IN INDIA, 1982-93

Age Group	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
0-4	2000 (28.05)	2065 (26.62)	2113 (26.74)	2080 (27.01)	2155 (26.32)	2546 (24.76)	2309 (24.32)	2055 (22.39)	2274 (22.68)	2680 (23.56)	3258 (24.51)
5-14	368 (5.16)	392 (5.05)	412 (5.21)	391 (5.08)	426 (5.20)	510 (4.96)	452 (4.76)	472 (5.14)	544 (5.43)	551 (4.84)	654 (4.92)
15-44	1168 (16.38)	1340 (17.27)	1300 (16.45)	1319 (17.12)	1414 (17.27)	1603 (15.59)	1724 (18.16)	1661 (18.09)	1770 (17.66)	2144 (18.85)	2543 (19.13)
>=45	3593 (50.40)	3961 (51.06)	4077 (51.59)	3912 (50.79)	4192 (51.20)	5624 (54.69)	5009 (52.76)	4992 (54.38)	5437 (54.23)	5998 (52.74)	6836 (51.43)
Total	7129	7758	7902	7702	8187	10283	9494	9180	10025	11373	13291
Total Deaths in Age >= 15 yr. % of Total Deaths	4761 66.78	5301 68.33	5377 68.04	5231 67.91	5606 68.47	7223 70.28	6733 70.92	6653 72.47	7207 71.89	8142 71.59	9379 70.56

Note: Figures in parentheses represent percentages.  
Source: Survey of Cause of Death, RGI, Vital Statistics Division. Cf. Qadeer (1996).



TABLE 3.2: CAUSES OF DEATHS IN INDIA, 1982-93

Major Causes	1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
Accidents and Injuries	4.4	4.6	4.9	5.1	6.0	5.5	6.4	7.5	7.7	7.1	6.82
Childbirth and Pregnancy	2.4	2.6	2.2	2.7	2.1	1.8	2.1	2.3	2.5	2.4	2.93
Fever	10.4	10.8	10.7	9.9	11.0	8.8	8.2	8.2	7.9	8.5	7.35
Digestive Disorders	7.4	7.8	7.8	7.6	7.7	6.8	6.9	6.8	6.7	6.9	7.22
Cough (Disorders of the Respiratory System)	17.2	18.0	18.2	18.8	17.6	18.6	18.3	16.3	16.3	17.2	16.15
Disorders of the Central Nervous System	3.5	4.5	3.9	3.9	3.9	4.6	4.6	4.3	4.4	4.3	4.25
Disease of the Circulatory System	7.4	8.5	9.1	9.1	8.3	8.4	9.8	9.7	9.8	9.3	9.67
Other Clear Symptoms	8.2	7.4	7.6	8.8	8.8	8.7	8.0	8.0	7.9	7.9	8.26
Causes Peculiar to Infancy	12.4	11.2	10.8	10.7	10.2	10.1	9.8	9.9	10.7	10.2	11.74
Senility	24.8	24.2	24.2	23.4	24.4	26.1	26.0	27.1	26.1	26.2	25.61

Source: Survey of Cause of Death, RGI, Vital Statistics Division. Cf. Qadeer (1996).

General anaemia, which 84 per cent of pregnant women suffer from, is also a major cause of death among women.

Malnutrition affects 53 per cent of the population, most of them women, which is why a girl child is often stunted. All this indicates that considerable apathy exists towards women in India although health planning with some consideration for women's health has figured prominently in the planning documents.

#### FIVE YEAR PLANS

The two documents which influenced independent India's health policy in later years were the Bhole Committee Report (1946) and the Sokhey Committee Report (1948). These two reports, which were in the form of recommendations, singled out health as a potent factor in determining the level and character of national development. The two committees took special note of the high rates of mortality and morbidity prevailing among women and children and emphasized the need for improving their health (Soman, 1995). The Bhole Committee suggested a three-tier organizational set-up at the district level to include a primary health care centre (PHC) serving a population of 20,000 and also village-level health committees of 5-7 volunteers to help in PHC activities. The Sokhey Committee's recommendations were directed towards reducing the high mortality rates through preventive, promotive and curative care in health planning, especially for pregnant and lactating mothers. Thus the concept of maternal and child health services took shape but in doing so, women's health was perceived mainly in the context of motherhood.

While accepting the recommendations of the two committees, the Government of India in the first five-year plan (1951-56) integrated maternal and child health (MCH) care services with general health service as an important component. At independence, maternal mortality rate in some provinces was as high as 12.9/1,000 live births and 50 per cent of the maternal deaths were due to communicable diseases and anaemia. MCH received a high priority along with the control of other communicable diseases. In the Second Plan, too, maternal health service was stressed, but its evolution was influenced by the shift in policies for the control of communicable diseases and the need for containing the rapidly growing population. India became the first country in the world to embark on a family planning programme on a large scale. This influenced the trend in fund allocation and within MCH, planning was



tilted more in favour of child health rather than mother's. As Rao (1995) points out, this trend is evident from the fact that during the First and Second Plan periods 55-60 per cent of the funds were allocated for improving the curative health services, and promoting medical training and education. Primary health care centres received a setback during this period.

Alarmed by the results of the 1961 census which indicated a higher rate of growth of population than had been anticipated, the Third Plan (1961-6) was marked with a high priority to family planning programme although the plan to control communicable diseases also received attention. At the behest of the Health Survey and Planning Committee Report (1961), the existing primary health centres were proposed to be upgraded and strengthened in order to meet the demand for health, family planning and maternal health services. The report recommended that further opening of PHCs be disbanded. At this point in time, auxiliary nurse midwives (ANMs) were responsible for MCH as well as family planning work among rural women. However, in 1963, the Chaddha Committee Report proposed that the health and family planning services be integrated and served through male and female multipurpose workers. In short, the Third Plan witnessed an integration of family planning, MCH services and control of communicable diseases at the PHC level but in reality, this kind of integration did not work. In 1966, the UN Advisory Mission proposed delinking of family planning from MCH. This propelled the government to divert the ANMs, who were promoting MCH services at the village level, towards meeting the targets set for population control. In doing so, MCH was largely ignored because of the target-oriented approach to the population problem adopted by the planners.

In 1966, five-year planning was suspended, to be replaced with annual plans in the following three years. During this period an Advisory Committee was set up to review the progress of the MCH programmes. The Advisory Committee's report suggested augmentation of MCH services and thus targets were set by it which included immunization of pregnant mothers against infectious diseases and treatment for nutritional anaemia. Preventive and curative health services through PHCs and augmentation of medical personnel also continued to occupy the attention of the planners during this period.

In 1973, the Committee on Multipurpose Workers, also known as the Kartar Singh Committee, reviewed the functioning of the PHCs and criticized the segregation of duties of various health workers and lack

of coordination among them. The committee recommended the integration of health services for better effectiveness and feasibility of health packages. In doing so, MCH became one of the many activities a primary health worker was required to carry out.

The Fifth Plan (1974-9) witnessed the launching of the Minimum Needs Programme as a package to provide services related to health, nutrition, family planning, housing, environmental improvement and sanitation in rural areas. There was also an increase in the number of PHCs and sub-centres and the doctors serving them. This Plan period marked a change in government policy and formulation of people-oriented strategies as a result of the WHO-UNICEF declaration of 'Health for All Through Primary Health Care' (to which India was a signatory) at Alma Ata in 1978. This gave an impetus to the MCH programme. In order to make it more effective, training inputs to *dais* or traditional birth attendants were initiated.

'Health for All by AD 2000' caught on in the Sixth Plan (1980-5), where it was proposed that the horizontal and vertical programmes be integrated at the PHC level. The Plan also emphasized improved health services to women and children through extension programmes. The Seventh Plan (1985-90) did not propose anything different and the focus continued to be on inter-sectoral coordination and consolidation of primary health centres to meet the goals of 'Health for All'.

According to Rai (1996), 'Health for All' has become a receding mirage. She points to the first Regional Health Report (1996) which states that diseases such as tuberculosis, cholera, and malaria still dominate the disease pattern (tuberculosis being the major killer disease) and 80 per cent of the female deaths occur in the reproductive age group of 15-45 years.

It has been observed that although MCH has figured quite prominently in the five-year plans, its implementation has not been smooth and without ambiguity and this has failed to improve women's health the way it should have.

#### POPULATION POLICIES

Commencing with the Third Plan, the swelling number of people living below the poverty line prompted the planners to link population explosion with poverty and as a major hurdle to development. Although the National Policy formulated in 1976 asserted the importance of removing socio-economic imbalances in health services, it accepted 'birth



control' as a vital means for achieving 'Health for All through Primary Health Care'. Reducing the birth rate has had serious implications for women's health as high fertility is seen mainly as women's problem. In order to hasten the process of fertility reduction, the family planning programme was transformed into a population reduction programme, with specific demographic targets to achieve. This often translated into number of family planning 'acceptors', the ANMs being given specific targets to achieve. Very often these targets are accompanied by attractive incentives, mainly cash. Even within the purview of family planning programme, women have become easy targets for adopting temporary as well as permanent methods of family planning. The figures on sterilization reflect a gender bias (Ravindran, 1993a). Female sterilization or tubectomy, which accounted for 46 per cent of the total number of sterilizations during 1975-6, accounted for over 90 per cent in the early 1990s. Increased financial assistance from international agencies such as the UNFPA (United Nations Population Fund) and USAID (United States Agency for International Development) has aimed at women in most parts of the country. The population policies do not seem to have contributed positively to improving women's health conditions but continue to exert pulls and pressures on them to lower fertility. There has been a change-over to a target-free reproductive and child health (RCH) programme in April 1996, but it is too early to assess its working.

#### TREND IN FINANCIAL ALLOCATIONS

Data generated by the Planning Commission indicate that investments in the health and family welfare sector over the Plan periods have remained below the recommended level of 10 per cent of the total allocation on development. During the First and Second Plan periods, health obtained 3.3 per cent and 3.0 per cent of total investment outlays respectively; out of this 55-60 per cent of the funds were allocated for curative health services and promoting medical training and education (Rao, 1995). In the Third Plan, due to emphasis on family planning, the allocation to health was reduced to 2.6 per cent of the total outlay. Though investments in 'health' have been higher than that in 'family welfare', the gap has been reducing (Table 3.3). Thus, while Rs 5 crore (0.1 per cent) were allocated to family planning in the Second Plan, the figure rose to Rs 24.9 crore (0.3 per cent) during the Third Plan.

TABLE 3.3: PATTERN OF INVESTMENT IN HEALTH AND FAMILY WELFARE (ACTUALS)

Plan Period	Total Plan Investment Outlay (Rs crore)	Health	Family Welfare	Sub Total
First-Plan: 1951-6	1,960.0 (100)	65.2 (3.3)	0.1 (-1)	65.3 (3.3)
Second Plan: 1956-61	4,672 (100)	140.8 (3.0)	5.0 (0.1)	145.8 (3.1)
Third Plan: 1961-6	8,576 (100)	225.9 (2.6)	24.9 (0.3)	250.8 (2.9)
Annual Plans: 1966-9	6,625.4 (100)	140.2 (2.1)	70.4 (1.1)	210.6 (3.2)
Fourth Plan: 1969-74	15,778.8 (100)	335.5 (2.1)	278.0 (1.8)	613.5 (3.9)
Fifth Plan: 1974-9	39,426.2 (100)	760.8 (1.9)	491.8 (1.2)	1,252.6 (3.1)
Annual Plan: 1979-80	12,176.5 (100)	223.1 (1.8)	118.5 (1.0)	341.6 (2.8)
Sixth Plan: 1980-5	10,9291.7 (100)	2,025.2 (1.8)	1,387.0 (1.3)	3,412.2 (3.1)
Seventh Plan: 1985-90	2,18,729.6 (100)	3,688.6 (1.7)	3,120.8 (1.4)	6,809.4 (3.1)

Note: 1. Figures in parentheses indicate percentage of total.

2. Health includes Minimum Needs Programme/Rural Programme, Control of Communicable Diseases, Hospitals and Dispensaries, Medical Education and Training, Indian Council of Medical Research, Indian System of Medicine and Homoeopathic Medicines, Employees Insurance and other programmes.

Source: Economic Survey 1991-2 and Planning Commission. Cf. Soman (1995).

In the subsequent Plan periods (1966-90) the health sector, of which MCH is a component, continued to receive reduced funds, while the funds for family planning kept mounting phenomenally. Statistically, the fund allocation on health decreased from 2.1 to 1.7 per cent of the total Plan investment, and that on family planning programmes increased from 1.1 to 1.4 per cent. The gap in investments has been reducing over the years, and in the Eighth Plan (1991-7) while allocation to health amounted to Rs 7,572 crore, that to family planning was Rs 6,500 crore. These figures are indicative of withdrawal of India's commitment to the health sector. Specifically for women's health care, there is only the MCH programme which gets a meagre 2 per cent of the national health



TABLE 3.4: EXPENDITURE ON MCH SERVICES—ALL INDIA

Expenditure	1975-6	1980-1	1985-6	1991-2	1992-3	1993-4 (R.E.)
Rs Crores	2.36	6.03	13.61	105.62	111.72	139.75
% to Total Health Expenditure	0.39	0.51	0.50	2.03	1.80	1.95

R.E.: Revised Estimate.

Source: Duggal (1995), *Economic and Political Weekly* 30 (15/16), April 1995.

budget (Duggal, 1995; Table 3.4). The trend of fund allocation reflects the reality that the basic health needs of people in general and women in particular remain largely ignored.

### CONCLUSION

The five-year plans have certainly made some contribution to health planning but have left large areas neglected. The country has not only developed a wide network of health services and community level volunteers but also a large network of institutions for research, training and education needed to provide support to the development of health services system and for curative care. The minimum needs programme was a comprehensive package to improve the people's social, economic and health conditions but it did not quite take off. The MCH programme, which was conceived exclusively for women and children, gained momentum in the First and Second Plan periods but got side-tracked subsequently because of its integration with other health programmes at the PHC level. In the following years, MCH got linked with the family planning programme and due to the target-oriented approach of the latter, MCH services stood neglected. At the PHC level, the shuttling between unipurpose and multipurpose workers transformed MCH service into one of many activities of a multi-purpose worker and in doing so the basic aim of MCH services paled.

## CHAPTER 4

# The Survey: Broad Parameters

### BACKGROUND OF THE STUDY

Feminist scholars have defined gender as the social organization of sexual difference, or a system of relationships between sexes. Gender is understood as a relational concept, like 'class'. Hence, gender is not just about women but it refers to a structural relationship between the sexes which is linked to the state, the economy and to other macro and micro processes and institutions (Moghadam, 1990). Perpetuation of gender inequality is an issue widely studied. Gender distinctions are not a fact of nature or accident but are produced and reproduced institutionally, the most important institution being the family. Some have linked gender inequality to the psychodynamics of mothering (Chodorow, 1978). Some others say that women's relative lack of economic power is the clinching determinant of inequalities, including those of marriage, parenthood and sexuality (Blumberg, 1978; Chafetz, 1984, 1990). Inequalities are also learnt and taught and 'the non-perception of disadvantages of deprived groups helps to perpetuate those disadvantages' (Kynch and Sen, 1983, as quoted in Papanek, 1989). Thus, inequalities are internalized in addition to being imposed. The result, and a reflection of gender inequality, is summed up in the now-famous formulation of the UN Decade for Women. While women account for half the world's population and perform two-thirds of the hours worked, they receive only one-tenth of the world's income, and have one-hundredth of the world's assets. However, gender inequalities are often either ignored in development planning and policy formulation, or reinforced through the design of specific development projects.

The present study seeks to understand and explore the relationship of gender inequality in households with poverty and the interface of that relationship with reproductive behaviour of rural households in general, and of rural women in particular. Do poverty conditions directly impinge on fertility decisions and fertility behaviour of rural households? Or do they operate primarily through other intermediary mechanisms such as gender discrimination and patriarchy? To the extent such linkages



do exist, how tenuous are they, and how responsive to policy initiatives? And if so, of what kind? These are some of the questions that need to be explored in depth in the context of rural India.

In the study an attempt to delineate the overlap between poverty, gender inequality and reproductive choice as manifested through observed fertility behaviour has been made using household survey data from five districts each in the states of Uttar Pradesh (north India) and Karnataka (south India). Recent demographic literature has sought to explain fertility behaviour through changes in women's status. To the existing knowledge base we have attempted to add an understanding of the complex linkages between gender inequality, poverty and reproductive behaviour.

The study has focused also on exploring the differences in men's reproductive roles and motivations in contrast to women's. Most of the related literature implicitly assumes that fertility decisions are made by the couple as a unit, assuming similarity in male and female attitudes. But recent understanding points out that a key barrier to realizing a woman's choice is her inability to overcome covert and overt disagreements within her own household. Because this has its base in the wider social and historical context of gender bias, a discussion on reproductive choices needs to confront the differences in roles and motivation between the sexes.

It is difficult to get intra-household gender differences in poverty since much of the economic data pertain to the household as a whole. But considering that intra-household gender discrimination does exist, had such data been available, the estimated incidence of poverty among women would have been higher than among men. Such discrimination manifests itself through a variety of mechanisms in the economic sphere. Women's labour force involvement is much more restricted than men's and their access to resources and property rights significantly more limited, resulting in persistent inequalities within the household. Decision-making, especially in the economic domain, is essentially a male prerogative, wherever an adult male is present. We need to consider whether such inequalities vary significantly across income (or expenditure) groups and to what extent such divergences colour reproductive choice.

Estimating poverty is a tricky business. Relative poverty brings up problems of comparability across space, time and categories. Even absolute poverty in a given context is not easy to conceptualize or estimate. Yet demands of public policy necessitate poverty estimation. The major source of data for poverty estimation in the country are the

annual consumption surveys carried out by the National Sample Survey Organization (NSSO) under the Ministry of Planning, Government of India. The data pertain to household consumption expenditure. Poverty lines for rural and urban areas are arrived at through a combination of observed consumption behaviour of various expenditure groups and average specified calorie norms for different population groups. The data relate to total household level consumption, and not to individuals. According to the report of the Expert Group on Estimation of the Proportion and Number of the Poor (1993), incidence of poverty in rural India in 1987-8—the latest year for which full sample estimates are available—was 39.06 per cent. The corresponding figures for rural Karnataka and rural Uttar Pradesh, where surveys were conducted under the present study, were 32.82 per cent and 41.10 per cent respectively.

To measure poverty ratios, poverty studies in India rely also on nutritional adequacy. But these do not take into account the 'non-random structured pattern' of intra-individual variations in nutritional norms (cf. Sukhatme's Supplementary Note to the Report of the Expert Group, 1993). Thus, although poverty is likely to be positively linked with levels of malnutrition, large systematic variations are likely both among households and among individuals. In particular, malnutrition among lactating and pregnant mothers might be much higher than suggested by the per capita expenditure estimate. Also, such variations might be considerable between different states and different cultural milieus. These in turn would have an impact on an entire gamut of reproductive indicators like child-spacing, child mortality and fertility behaviour. It is imperative, therefore, to explore the links between poverty incidence and reproductive behaviour beyond household level poverty estimates.

#### GENERAL FEATURES OF THE SAMPLE POPULATION

*Area and Sample Population.* The study was conducted in five districts each of Uttar Pradesh and Karnataka. Districts were chosen to represent the agro-climatic diversities of each state. In Uttar Pradesh, the districts selected were Almorah, Faizabad, Ghazipur, Mathura and Muzaffarnagar, and in Karnataka, Bidar, Dakshina Kannada, Kodagu, Kolar and Mysore. Thirty-five villages in each state were covered, averaging 7-9 villages per district. The sample households were selected by systematic random sampling, which provided equal probability to each household within a village. The total households covered were 1,078 in Uttar Pradesh and 800 in Karnataka. The focus of the study being women in the repro-



ductive age group of 15-49 years and men with wives in the same age group, the number of women covered were 914 and 687 for Uttar Pradesh and Karnataka respectively. Of these, the women who responded along with their husbands to the questionnaire of this study were 529 in Uttar Pradesh and 658 in Karnataka. This is the sample used for statistical analysis of reproductive behaviour.

*The Survey.* An extensive household survey was conducted by using a questionnaire, which had in-built mechanisms for cross-checking information on gender differences in perception of certain aspects of life. The survey questionnaire was prepared in the respective regional languages and had separate sets for women and men. The questionnaires were pretested and methods of collecting information were standardized before launching the main survey.

*The Questionnaire.* The questionnaire was formulated for both women and men, covering certain common dimensions of the household. These included:

- (i) The socio-economic background of the household, which included information on economic, religious and caste profile of the sample household, living conditions, access to information and educational facilities.
- (ii) Place of women in the family was assessed on the basis of women's control over the family resources and existing norms around women.
- (iii) Certain basic information relating to marriage, conception and family planning.

*Limitations of the Study.* The field work for this study was carried out by the National Council of Applied Economic Research (NCAER), New Delhi during July to September 1995. According to NCAER, heavy monsoon, an outbreak of cholera in two districts of Uttar Pradesh and the Uttarakhand agitation in Almora district of Uttar Pradesh were major constraints faced by them during the field work.

The high level of non-response to parts of the questionnaire is another constraint in interpretation of the data. Partially, this may be due to inadequate rapport between the investigators and the respondents, especially when the private domain of life is being probed, such as reproductive behaviour. This problem has been taken care of by focusing only on those who had responded.

## SOCIO-ECONOMIC PROFILE OF THE HOUSEHOLDS

The socio-economic profile of the households provides information on various indicators which include religion, caste, income, occupation, living standards and exposure to information of the sample households and individuals in them.

*Religion and Caste.* The households covered were predominantly Hindu (87 per cent in each state). 12 per cent households in Uttar Pradesh, and 11 per cent in Karnataka were Muslims. The rest represented other religious groups, namely Christians, Sikhs and Tribals. The proportion of scheduled castes (21 per cent and 14 per cent), and other backward castes (21 per cent and 17 per cent) were higher in Uttar Pradesh while upper caste Hindus were more in Karnataka (55 per cent as against 33 per cent respectively). The proportion of tribals was higher in Karnataka (5 per cent as against 1 per cent in Uttar Pradesh).

*Income Distribution.* The distribution of households across the various income categories is fairly even. The majority of the households fall in the range of Rs 500-2,000 per capita annual household income. But there is a sizeable percentage, about 18.8 per cent in Karnataka and 12.0 per cent in Uttar Pradesh, who earn more than Rs 5,000 (Table 4.1).

The size distribution of income is relatively evenly spread across the two major religious groups, i.e. Hindus and Muslims, in both states, with Karnataka having a larger share of Muslims in the lower income groups. In terms of caste categories, the distribution of per capita household income is reasonably evenly spread. However, in both states a higher percentage of scheduled caste households belong to poorer households.

*Ownership of Assets.* Household assets include cultivable land, agricultural implements, livestock and consumer durables. About 30 per cent of households in both states are landless. Among the landowners, 45.3 per cent in Uttar Pradesh and 43.6 per cent in Karnataka own one acre or less of cultivable land. Karnataka has about 5 per cent more households owning more than one acre than Uttar Pradesh (Table 4.2).

Among Muslim households, 45.6 per cent in Uttar Pradesh and 51.5 per cent in Karnataka are landless. For the Hindus, the respective figures are 27.0 per cent and 31.6 per cent. A large number of the Hindus, however, own less than one acre. Landlessness is higher among



TABLE 4.1: PER CAPITA ANNUAL HOUSEHOLD INCOME OF THE SAMPLE HOUSEHOLDS

Per Capita Household Income (Rs)	Uttar Pradesh	Karnataka
1- 500	100 (9.3)	2 (0.3)
501- 1000	186 (17.3)	92 (11.5)
1001- 1500	199 (18.5)	139 (17.4)
1501- 2000	158 (14.7)	136 (17.0)
2001- 2500	108 (10.0)	88 (11.0)
2501- 3000	73 (6.8)	69 (8.6)
3001- 4000	73 (6.8)	77 (9.6)
4001- 5000	52 (4.8)	47 (5.9)
> 5000	129 (12.0)	150 (18.8)
Total	1078 (100.0)	800 (100.0)

Note: Figures in parentheses are percentages.

TABLE 4.2: LANDHOLDINGS

Landholding (acres)	Uttar Pradesh (%)	Karnataka (%)
Landless	29.6	33.6
.01- 1	31.9	23.0
1.01- 2	13.4	12.6
2.01- 5	15.7	18.4
> 5	9.5	12.4

the scheduled castes (about 40 per cent) than among the tribals, other backward classes and other castes in Uttar Pradesh. Even among the landowning scheduled caste households, most own less than one acre. In Karnataka, a large proportion of both scheduled caste and other backward class households own less than one acre; 82.9 per cent of tribals are landless. In both states, a large percentage of castes that are generally of higher social status own more than 2 acres (Tables 4.3a and 4.3b).

About 86 per cent of the households in Uttar Pradesh and 70 per cent in Karnataka owned cattle or buffaloes. Ownership of advanced agricultural implements (tractors and threshers), cycles and tube wells was more common in (Table 4.4). More households owned scooters/motor-cycles and transistors in the Karnataka sample.

*Occupational Profile.* The major occupations of both men and women in both states were agricultural/non-agricultural labour, farming and

TABLE 4.3a: SIZE OF CULTIVABLE LANDHOLDINGS BY CASTE (UTTAR PRADESH)

Landholdings (in acres)	Caste						Total
	Scheduled Tribe	Scheduled Caste	Other Backward Classes	Others Non-Hindu/ No Caste	No Response/ Do not Know		
Landless	2 (0.6) (25.0)	90 (28.2) (39.5)	68 (21.3) (29.8)	40 (12.5) (11.1)	3 (0.9) (60.0)	116 (36.4) (46.6)	319 (100) (29.6)
0.01-1	1 (0.3) (12.5)	102 (29.7) (44.7)	81 (23.5) (35.5)	88 (25.6) (24.4)	- (-) (-)	72 (20.9) (28.9)	344 (100.0) (31.9)
1.01-2	- (-) (-)	25 (17.4) (11.0)	38 (26.4) (16.7)	47 (32.6) (13.1)	2 (1.4) (40.0)	32 (22.2) (12.9)	144 (100.0) (13.4)
2.01-5	3 (1.8) (37.5)	6 (3.6) (2.6)	32 (18.9) (14.0)	110 (65.1) (30.6)	- (-) (-)	18 (10.7) (7.2)	169 (100.0) (15.7)
> 5	2 (2.0) (25.0)	5 (4.9) (2.2)	9 (8.8) (3.9)	75 (73.5) (20.8)	- (-) (-)	11 (10.8) (4.4)	102 (100) (9.5)
Total	8 (0.7) (100.0)	228 (21.2) (100.0)	228 (21.2) (100.0)	360 (33.4) (100.0)	5 (0.5) (100.0)	249 (23.1) (100.0)	1078 (100.0) (100.0)

Note: The first entry in a cell stands for the absolute number of households belonging to a particular caste group and landholding category, the second entry gives the percentage distribution across the caste group for a given landholding category and the third is the percentage distribution of land ownership for a given caste group.

home-based work. Fewer women were working than men. Relatively more men and women reported to be in the labour force in Karnataka. In both states, the majority of the women came under the housewife/home-based work category. Unfortunately, these two categories have been clubbed together in the questionnaire, although the latter should be categorized under economically productive activity. Some insights into this problem emerges when we look at the responses of women and men to the question of earning. They responded by a majority that the women did not 'earn' anything (Uttar Pradesh: 81 per cent women and 83 per cent men; Karnataka: 67 per cent women and 65 per cent men; Table 4.5).



TABLE 4.3B: SIZE OF CULTIVABLE LANDHOLDINGS BY CASTE (KARNATAKA)

Landholdings (in acres)	Caste						Total
	Scheduled Tribe	Scheduled Caste	Other Backward Classes	Others Non-Hindu/ No Caste	Non-Hindu/ No Caste Response/ Do not Know	No Response/ Do not Know	
Landless	34 (12.6) (82.9)	45 (16.7) (40.2)	57 (21.2) (43.2)	112 (41.6) (25.6)	-	21 (7.8) (27.3)	269 (100.0) (33.6)
0.01-1	4 (2.2) (9.8)	27 (14.7) (24.1)	40 (21.7) (30.3)	97 (52.7) (22.2)	1 (0.5) (100.0)	15 (8.2) (19.5)	184 (100.0) (23.0)
1.01-2	1 (1.0) (2.4)	19 (18.8) (17.0)	15 (14.9) (11.4)	56 (55.4) (12.8)	-	10 (9.9) (13.0)	101 (100.0) (12.6)
2.01-5	1 (0.7) (2.4)	16 (10.9) (14.3)	12 (8.2) (9.1)	98 (66.7) (22.4)	-	20 (13.6) (26.0)	147 (100.0) (18.4)
>5	1 (1.0) (2.4)	5 (5.1) (4.5)	8 (8.1) (6.1)	74 (74.7) (16.9)	-	11 (11.1) (14.3)	99 (100.0) (12.4)
Total	41 (5.1) (100.0)	112 (14.0) (100.0)	132 (16.5) (100.0)	437 (54.6) (100.0)	1 (0.1) (100.0)	77 (9.6) (100.0)	800 (100.0) (100.0)

Note: See Note to Table 4.3a for explanation.

**Living Conditions.** Accessibility to electricity, drinking water, sanitary facilities, and the type of dwelling give us some idea about the living conditions of the surveyed households. In Uttar Pradesh 42 per cent lived in *kutchha* houses while about 28 per cent lived in semi-*pucca* houses. For Karnataka, the trend was just the reverse: 60 per cent of the households lived in semi-*pucca* houses, and about 14 per cent *kutchha* ones. In Uttar Pradesh 30 per cent and in Karnataka 26 per cent lived in *pucca* houses.

Access to electricity was better in Karnataka, where 55 per cent of the households availed of electricity and paid for it while 9 per cent enjoyed it free. In Uttar Pradesh only 26 per cent availed of electricity while only 4 per cent paid for it.

The nature of the source of drinking water and availability of toilets are indicative of the public health facilities available to a community.

TABLE 4.4: AGRICULTURAL AND NON-AGRICULTURAL IMPLEMENTS OWNED

Item	Uttar Pradesh (n=1078) (%)	Karnataka (n=800) (%)
Motor Car	1	2
Cycle	59	32
Scooter/Motor Cycle	4	8
Transistor	31	48
Television	11	11
Video Cassette Player	1	1
Buffalo Cart	8	9
Tractor	6	1
Thresher	9	0
Mixer-grinder	1	4
Pressure Cooker	12	9
Tube Well	17	1

TABLE 4.5: OCCUPATIONAL DISTRIBUTION

Occupational Category	Uttar Pradesh (n=1078)		Karnataka (n=800)	
	F (%)	M (%)	F (%)	M (%)
Agricultural Labour	3	8	20	28
Non-Agricultural Labour	1	14	1	3
Farmer	9	43	9	51
Service	0	7	1	7
Housewife/Home based Work	83	6	65	0

Note: F = Female; M = Male.

In Uttar Pradesh, the prime source of drinking water was piped supply (57 per cent) followed by canals (24 per cent), protected wells (7 per cent) and hand pumps (8 per cent). For Karnataka, the major source was hand pump (39 per cent) followed by piped supply (30 per cent), protected wells (22 per cent) and canal (3 per cent). Canals not being a healthy source of drinking water, the 24 per cent households in Uttar Pradesh and 3 per cent in Karnataka who were drinking canal water were exposed to water-borne health hazards (Table 4.6).

Regarding toilet facilities at home, the sample households of both states were equally deprived. Only 10 per cent households in Uttar Pradesh and 11 per cent in Karnataka had toilets at home. It is not clear what proportion of the rest of the households had access to a community toilet.



TABLE 4.6: SOURCE OF DRINKING WATER

Source	Uttar Pradesh (%)		Karnataka (%)	
	(n = 1078)		(n = 800)	
	Normal Source	During Dry Season	Normal Source	During Dry Season
Pond	0.2	0.3	0.3	-
Unprotected Well	0.5	1.1	0.5	0.8
Canal	23.7	23.7	5.5	4.5
Protected Well	7.3	6.0	22.0	21.4
Pipe Water	57.1	57.3	29.8	32.1
Hand Pump	8.3	7.4	38.8	37.9
Tanker Truck	-	-	2.8	2.9
Others	2.2	3.4	0.5	0.5
No Response	0.7	0.7	-	-

## EXPOSURE AND INFORMATION

Levels of formal education and exposure to the mass media can to some extent give us an idea regarding the exposure of the population to information.

*Formal Education.* The proportion of illiterate women was much higher than men in both states (Table 4.7). In other words, less women than men participate in formal education. The overall scenario looks better in Karnataka.

*Accessibility to Mass Media.* In general, the Karnataka sample had better access to radio, television or cinema. In Uttar Pradesh, disproportionately few women had access (Table 4.8).

## DEMOGRAPHIC PROFILE

*Household Size.* The average household size was lower in Karnataka (Uttar Pradesh—7.63, Karnataka—5.77). In both states, the average size generally decreased with an increase in income (Table 4.9).

*Age Distribution.* In both states in almost all age groups the sex ratio is below 1,000, the overall ratio being 915 for Uttar Pradesh and 914 for Karnataka. The only exceptions are the age group 46-55 (Uttar Pradesh, 1,310; Karnataka, 1,092) and the age group 26-35 in Uttar Pradesh (1,049).

TABLE 4.7: LEVELS OF FORMAL EDUCATION AMONG WOMEN AND MEN

Educational Level	Uttar Pradesh		Karnataka	
	(n=1078)		(n=800)	
	F (%)	M (%)	F (%)	M (%)
Illiterate	75	40	58	41
Less than Primary	7	9	13	16
Formal Education				
Upto Matric	16	39	26	38
Higher Secondary and Graduate	2	12	3	5

Note: F = Female; M = Male.

TABLE 4.8: ACCESS TO MASS MEDIA

Access to Media	Uttar Pradesh		Karnataka	
	F (%)	M (%)	F (%)	M (%)
Hear Radio	35	68	50	59
Watch TV	23	47	99	95
Watch Cinema	14	37	42	57

Note: F = Female; M = Male.

TABLE 4.9: AVERAGE HOUSEHOLD SIZE BY PER CAPITA INCOME

Annual Per Capita Household Income (Rs)	Uttar Pradesh		Karnataka	
	Average Household Size	Total No. of Households	Average Household Size	Total No. of Households
	(< 500)	8.40	42	6.00
(501 - 1000)	8.59	113	7.03	85
(1001 - 1500)	7.40	110	6.36	125
(1501 - 2000)	7.60	78	5.81	116
(2001 - 2500)	6.92	56	5.68	75
(2501 - 3000)	7.52	36	5.33	54
(3001 - 4000)	7.05	35	5.38	62
(4001 - 5000)	6.17	23	5.42	35
(> 5000)	7.27	36	4.64	104
Total	7.63	529*	5.77	658*

Note: \*The number of households where both husband and wife are respondents.



In both the lowest as well as the highest age brackets the sex ratio is extraordinarily low. For children below one year, the sex ratio stands abnormally low at 793 in Uttar Pradesh and at the slightly more respectable figure of 895 in Karnataka. For children below five years, the ratio is 852 for Uttar Pradesh and 858 for Karnataka. The low sex ratio for infants and children below five suggests the presence of significant gender discrimination against female babies within the family in the provision of nutritional and health care facilities. The very low sex ratio among the elderly is also quite unusual, being as low as 788 among the 66-plus age group in Uttar Pradesh and even lower at 643 in Karnataka. This could reflect the effect of high mortality that may have prevailed among women in reproductive age groups two to three decades earlier. The relative parity in sex ratio in the 26-35 year age group in both states may be the result of male out-migration from the study locations (Table 4.10).

Nearly all respondents got married at or below the age of 30 years. In Uttar Pradesh, 69.7 per cent of the women and 58 per cent of the men were married before they were 16. In Karnataka, around half the women got married between 16 and 20 years. Marriage of women below 16 was also less common in Karnataka. Also, the majority of the men in Karnataka seem to marry at higher ages than in Uttar Pradesh.

The 'age at *gauna*' (i.e., starting to live with husband) followed a trend similar to that of age at marriage. From this perspective, respondents from Karnataka seem to be in a better health situation than those from Uttar Pradesh (Table 4.11).

*Average Number of Pregnancies.* In the 15-24 years age group the average number of pregnancies was slightly higher in Karnataka (1.93; Uttar Pradesh 1.73); in the 25-34 years age group the overall average increased in Uttar Pradesh (3.83), much more than in Karnataka (3.38). This trend continued in the 35-49 years age group (Uttar Pradesh 5.19, Karnataka 4.22). As regards the relationship between income level and the number of pregnancies, only in the 15-24 years age group is a rise in income level associated with a decline in the average number of pregnancies in both states, while the same cannot be said about the other two age groups. Any generalization about the effect of income therefore needs to be done with caution (Table 4.12).

*Pregnancy Experiences.* Women from Karnataka experienced greater number of still-births whereas a much higher percentage of women

TABLE 4.10: AGE DISTRIBUTION OF THE SAMPLE POPULATION

Age Group	Uttar Pradesh			Karnataka		
	Male	Female	Total	Male	Female	Total
0 - 1	213 (55.8) (5.5)	169 (44.2) (4.8)	382 (100) (5.2)	76 (52.8) (3.4)	68 (47.2) (3.3)	144 (100) (3.4)
2 - 5	503 (53.3) (13)	441 (46.7) (12.5)	944 (100) (12.8)	171 (54.3) (7.6)	144 (45.7) (7)	315 (100) (7.3)
6 - 15	1047 (54.2) (27.1)	884 (45.8) (25)	1931 (100) (26.1)	535 (52.8) (23.9)	479 (47.2) (23.4)	1014 (100) (23)
16 - 25	675 (53) (17.5)	599 (47) (16.9)	1274 (100) (17.2)	483 (51) (21.5)	464 (49) (22.6)	947 (100) (22.1)
26 - 35	466 (48.8) (12.1)	489 (51.2) (13.8)	955 (100) (12.9)	343 (50.9) (15.3)	331 (49.1) (16.1)	674 (100) (15.7)
36 - 45	312 (51.7) (8.1)	292 (48.3) (8.3)	604 (100) (8.2)	261 (54.4) (11.6)	219 (45.6) (10.7)	480 (100) (11.2)
46 - 55	264 (43.3) (6.8)	346 (56.7) (9.8)	610 (100) (8.2)	162 (47.8) (7.2)	177 (52.2) (8.6)	339 (100) (7.9)
56 - 65	236 (54.3) (6.1)	199 (45.7) (5.6)	435 (100) (5.9)	128 (52.9) (5.7)	114 (47.1) (5.6)	242 (100) (5.6)
66+	146 (55.9) (3.8)	115 (44.1) (3.3)	261 (100) (3.5)	84 (60.9) (3.7)	54 (39.1) (2.6)	138 (100) (3.2)
Total	3862 (52.2) (100.0)	3534 (47.8) (100.0)	7396 (100.0) (100.0)	2243 (52.2) (100.0)	2050 (47.8) (100.0)	4293 (100.0) (100.0)

Note: The first entry in each cell stands for the number of individuals, male or female, in a particular age-group in either state; the second entry gives the percentage distribution of the population by sex in a given age-group and state and the third gives the percentage distribution of the population of a given sex and in a state across age-groups.



TABLE 4.11: AGE AT MARRIAGE AND GAUNA

	Uttar Pradesh (n=1078)		Karnataka (n=800)	
	F (%)	M (%)	F (%)	M (%)
<i>Age at Marriage</i>				
30 yrs or below	99	98	99	96
15 yrs or below	69	58	39	21
Between 16 yrs & 20 yrs	28	26	51	10
Between 21 yrs & 30 yrs	2	14	9	65
<i>Age at Gauna</i>				
30 yrs or below	99	99	100	96
15 yrs or below	55	50	39	20
Between 16 yrs & 20 yrs	40	28	52	10
Between 21 yrs & 30 yrs	4	21	9	66

Note: F = Female; M = Male.

from Uttar Pradesh stated that they had experienced abortions. Overall mortality rates for both male and female children were higher in Uttar Pradesh. Mortality is greater among female children in both states, the differential against the girl child being more biased in Uttar Pradesh. In both samples, quite a high percentage of women (42.8 per cent Uttar Pradesh; 44.1 per cent in Karnataka) had experienced between 3 and 5 live births (Table 4.13).

#### FAMILY PLANNING DETAILS

*Awareness and Use of Family Planning Methods.* This section discusses the households where both husband and wife were respondents. Large proportions of the respondents stated that they were aware of both modern and traditional methods of family planning. Stated awareness was higher among the male respondents than the women (Table 4.14). Fewer proportions of the respondents, however, reported using any of the methods.

In Uttar Pradesh, traditional methods were more commonly used. The women's second preference was tubectomy, and for men, the condom. In Karnataka, tubectomy was the most commonly used method of contraception, as reported by both women and men. In the context of choice, women's status and women's health, the higher prevalence of the use of tubectomy over vasectomy reflects the social pressure that women bear in the realities of family planning (Table 4.15).

TABLE 4.12: AVERAGE NUMBER OF PREGNANCIES BY AGE AND PER CAPITA INCOME

Annual Per Capita Household Income (Rs)	15-24 Years		25-34 Years		35-49 Years	
	U.P.	Karnataka	U.P.	Karnataka	U.P.	Karnataka
<=500	3.62	-	4.38	8.50	5.15	-
501 - 1000	1.60	2.16	4.39	4.10	4.82	4.26
1001 - 1500	1.68	2.73	4.06	4.01	4.77	6.59
1501 - 2000	1.61	1.90	3.70	3.29	6.03	4.00
2001 - 2500	1.45	1.78	3.37	2.95	5.52	4.10
2501 - 3000	1.87	2.00	3.66	2.86	5.09	3.76
3001 - 4000	1.11	1.16	2.92	2.78	5.76	3.52
4001 - 5000	1.16	2.20	2.87	2.80	5.25	4.75
>5000	2.80	1.36	2.61	2.29	4.66	3.18
Total	1.73	1.93	3.83	3.38	5.19	4.22
No. of Women	(128)	(153)	(209)	(239)	(181)	(124)

TABLE 4.13: PREGNANCY EXPERIENCES OF WOMEN (PERCENTAGE)

Pregnancy Experience	Uttar Pradesh (N=914)*	Karnataka (N=687)*
Still Birth	8.2	9.4
Abortions	11.4	6.8
Son Died after Birth	23.0	10.0
Daughter Died after Birth	28.0	11.0
Currently Pregnant	8.5	5.1
Unsure whether Pregnant Currently	0.2	2.5
Live Births (%)		
0	8.5	7.0
1-2	24.8	36.7
3-5	42.8	44.1
6-9	21.7	9.7
> 9	2.0	4.2

Note: Abortion includes both miscarriages and induced abortions.

\* The number of women in the reproductive age group.

*Factors Affecting the Use of Family Planning Methods.* The respondents who had used family planning methods saw family planning as a necessity. Only a small proportion of the respondents considered that there was no problem in resorting to family planning. The majority, who expressed problems with the different methods of family planning,



TABLE 4.14: KNOWLEDGE OF FAMILY PLANNING METHODS: MALE AND FEMALE RESPONSES (PERCENTAGE)

Family Planning Methods	Uttar Pradesh		Karnataka	
	Female	Male	Female	Male
Oral Pill	62	64	57	54
Copper-T/Loop	49	49	52	64
Nirodh	63	87	52	71
Tubectomy	85	94	88	96
Vasectomy	82	91	66	99
Abortion	58	62	58	62
Withdrawal	14	27	30	31
Abstinence	72	56	36	43
No. of Observations	529		658	

TABLE 4.15: USE OF BIRTH CONTROL METHODS: MALE AND FEMALE RESPONSES (PERCENTAGE)

Family Planning Methods	Uttar Pradesh		Karnataka	
	Female	Male	Female	Male
Oral Pill	7	15	2	1
Copper-T/Loop	7	12	3	2
Nirodh	11	24	6	8
Tubectomy	18	14	63	53
Vasectomy	6	5	5	2
Abortion	10	3	1	1
Withdrawal	28	19	7	4
Abstinence	51	45	9	9
No. of Observations	529		658	

Note: The question asked to both the husband and the wife was: 'Have you or your spouse ever used any one or more of the following contraceptive devices?' The differences between the responses of husbands and wives to the same question are worth noting.

saw less problems with the traditional methods. The women stated that the traditional as well as permanent methods, such as tubectomy and vasectomy, were less problematic than the temporary methods. The men did not hold similar views.

As regards temporary methods both women and men complained that their spouse was not ready. This can only be interpreted to signify

that temporary methods such as the pill or the condom were not liked by the couples. For women, disapproval by the elders and non-availability acted as deterrents in the use of these methods. Non-availability may be due to the restriction on women's mobility to the health centre; the elders' disapproval does not seem to be a binding constraint, considering that, as reported in this study, interference of other members in the use of family planning methods by the couple was less than 2 per cent—mostly it was a joint decision, as reported by 91 per cent of the men and 87 per cent of the women.

'Spouse not ready' or 'is not willing' was the stated problem for not seeking vasectomy and abortion. Prevailing norms and values associated with abortion, which is often perceived as a sin, offer some explanation for the stated cause. Irreversibility of the permanent methods was also a reason for concern for both women and men (Table 4.16).

#### INDICATORS OF WOMEN'S POSITION IN THE FAMILY

Women's say and share in the family economy, their mobility outside the household and certain social norms and beliefs prevailing in the communities studied have formed the basis on which women's position in the family has been assessed. In this section, percentages in tables have been calculated on the basis of those that have responded, thus netting out cases of non-response.

*Say and Share in the Family Economy.* Although women had a say in family expenditure, they had less control over resources. A larger proportion of both women and men in Uttar Pradesh claimed that the wives in their households had a say in family expenditure, received a share of it, and could spend on their personal items without causing dissatisfaction to other members in the family (Table 4.17). In Karnataka, fewer women and men make such claims. There are, however, apparent differences in the reporting bias of women and men. Similarly, when reporting that their wives had a say and share in family expenditure, fewer men agreed with women's claim that there was no disagreement in the family on their expenditure on personal items. In any case, the proportion of women making this claim was in the minority, more so in Karnataka.

Women's control over their income did not mean much as a large majority of them did not earn. This was more true of Uttar Pradesh. The



TABLE 4.16: PROBLEMS IN THE USE OF FAMILY PLANNING METHODS (PERCENTAGE)

	Pill		Copper-T		Nirodh		Tubectomy		Vasectomy		Abortion		Abstinence		Withdrawal	
	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk
<b>FEMALES</b>																
No Problem	-	25.5	-	22.3	-	26.0	-	36.1	-	31.4	-	20.7	-	38.3	-	40.3
Not Successful	-	0.3	8.1	8.1	8.1	-	-	0.3	4.2	0.2	-	0	3.5	0.4	4.8	0
Spouse Disapproves	-	28.6	-	28.1	-	34.7	1.2	4.0	-	23.3	-	20.4	-	6.7	-	4.5
Elders Disapprove	-	7.7	-	11.9	-	5.8	-	2.9	-	3.4	-	9.5	0.7	1.3	-	0.5
Health Problem	26.0	6.6	5.4	5.5	5.4	1.7	33.3	2.6	25	3.9	15.6	5.0	-	2.1	-	2.0
Problem in Supply	-	13.0	2.7	11.9	2.7	7.5	-	5.0	-	6.4	-	17.2	-	14.6	-	15.4
Difficult to Use	-	1.1	-	0.9	-	0.6	-	0.9	-	0.5	-	1.2	-	1.3	4.8	0.5
Menstrual Problem	74.0	2.1	65.0	5.2	64.9	8.1	54.3	6.9	66.7	8.9	18.8	6.5	55.6	10.4	71.4	14.4
Irreversible	-	8.2	-	8.7	-	8.4	-	33.6	-	3.5	-	8.6	-	11.3	-	10.0
Others	-	1.3	-	1.2	-	1.7	1.2	1.5	-	2.3	-	2.7	-	3.3	4.8	3.0
Do not Know/No Response	-	5.6	19.7	4.3	18.9	5.5	8.6	6.2	4.2	6.2	81.3	8.3	39.6	10.4	14.3	9.5
No. of Observations	23	377	37	345	37	346	81	581	24	437	32	338	144	240	21	201

(Continued)

TABLE 4.16 (Continued)

	Pill		Copper-T		Nirodh		Tubectomy		Vasectomy		Abortion		Abstinence		Withdrawal	
	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk	UP	Krk
<b>MALES</b>																
No Problem	-	19.9	-	20.3	-	24.4	-	25.7	-	22.4	-	17.5	-	38.8	-	39.6
Not Successful	2.0	0.3	10.0	-	-	-	1.4	0.3	-	0.3	-	0.9	3.0	-	21.4	-
Spouse Disapproves	-	31.5	3.3	34.9	-	33.5	-	8.3	-	24.7	-	31.5	-	13.4	-	13.5
Elders Disapprove	-	1.7	-	0.9	-	1.1	-	1.1	4.2	1.1	-	1.1	-	1.1	-	1.4
Health Problem	10.0	5.6	10.0	3.8	0.9	0.6	8.5	1.4	4.2	2.6	22.2	2.6	-	1.1	-	0.5
Problem in Supply	-	12.9	-	8.3	-	5.1	-	4.1	-	5.6	-	19.5	-	9.8	-	12.6
Difficult to Use	-	0.3	6.7	0.5	1.8	0.2	-	0.2	-	0.2	-	0.3	3.0	-	7.1	10.5
Menstrual Problem	80	3.1	63.3	5.2	89	6.6	60.6	6.0	79.2	4.6	66.7	5.7	85.7	10.1	64.3	12.6
Irreversible	-	10.1	3.3	11.6	-	11.3	7.4	31.5	4.2	11.8	-	7.2	-	10.5	-	7.7
Others	4	3.9	3.3	3.5	2.8	3.4	12.7	3.5	-	3.4	-	2.9	0.8	5.4	3.6	4.3
Do not Know/No Response	4	10.7	-	11.1	5.5	13.7	15.5	18.0	8.3	23.4	11.1	10.9	7.5	9.8	3.6	7.2
No. of Observations	50	356	30	424	109	468	71	635	24	612	9	349	133	276	28	207



trend of husbands having part share in the wife's income was more common in Uttar Pradesh while in Karnataka the husbands were in full control of the wife's income. When the men were asked to comment on this, those in Uttar Pradesh did not agree with their wives' reporting but the men in Karnataka were in complete concurrence with their wives (Table 4.18).

Only 3 per cent women in both states reported that they had land in their own name. As regards having any savings account at the post office or at a bank, the majority of the women (Uttar Pradesh 76 per cent, Karnataka 83 per cent) reported in the negative. Those who reported having one, mostly reported that it was in the husband's name alone. A joint account with the wife or account only in the wife's name was rare (Table 4.19).

*Mobility.* Women in both states overwhelmingly claimed (Uttar Pradesh 65 per cent, Karnataka 89 per cent) that they could go out alone. At the same time, many (57 per cent in Uttar Pradesh and 32 per cent in Karnataka) admitted that they had to seek permission of the senior members in the family. Also, when it came to visiting specific places such as the health centre or another village, the women (30 per cent and 15 per cent respectively in Uttar Pradesh; 43 per cent and 9 per cent respectively in Karnataka) answered in the negative. Interestingly, when further probed about the necessity of asking permission from senior members in the family for visiting the health centre or another village alone, a much larger proportion of women (77 per cent and 86 per cent in Uttar Pradesh, 63 per cent and 94 per cent in Karnataka) reported in the affirmative. The seemingly conflicting answers point to the fluid nature of constraints on female autonomy.

*Purdah.* Women in both states had to practise *purdah* to a certain extent, the rigidity of such a norm being more for the women in Uttar Pradesh (61 per cent) than in Karnataka (26 per cent).

*Dowry.* There was a range of items given as dowry by the bride's family. Four major dowry items were common. These are cloth, gold, silver and cash (Table 4.20). The pressure of demand for dowry was much less in Karnataka. Land and house were equally rare as dowry items in both states. The custom of taking dowry from the bridegroom's family was nearly absent.

TABLE 4.17: WOMEN'S SAY AND SHARE IN FAMILY RESOURCES (PERCENTAGE)

Response	Uttar Pradesh (As reported by)		Karnataka (As reported by)	
	Female	Male	Female	Male
Wife Has Say in Household Expenditure	66	80	42	62
Wife Receives Money for Household Expenditure	61	72	41	58
Other's Approval Required for Wife's Expenditure on Personal Items	37	30	19	16

TABLE 4.18: HUSBAND'S SHARE IN WIFE'S INCOME (PERCENTAGE)

Husband's Share in Wife's Income	Uttar Pradesh (As reported by)		Karnataka (As reported by)	
	Female	Male	Female	Male
Wife Does not Earn	81	83	67	65
Full Share	5	7	22	27
Part Share	10	5	8	6
No Share	4	4	3	1
Land in her Name	3	n.a.	3	n.a.

TABLE 4.19: WOMAN'S CONTROL OVER FAMILY SAVINGS (PERCENTAGE)

Response	Uttar Pradesh	Karnataka
No Account	76	83
In Husband's Name	13	11
In Wife's Name	2	3
A Joint Account	2	2

### OLD AGE SUPPORT

Not less than 80 per cent women and men preferred to receive economic support and physical care from their sons over the daughters. Further analysis reveals that it was due to the prevalent strong belief (81 per cent men and 85 per cent women in Uttar Pradesh; 80 per cent men and women in Karnataka) that it was the son and his family who would provide the necessary support during old age. A small minority, however, thought otherwise. For them a daughter was more supportive than a son. Whether the latter is an indicator of the transition in the traditional norms, one cannot tell.



TABLE 4.20: CUSTOM OF DOWRY (PERCENTAGE)

Dowry Custom	Uttar Pradesh (As reported by)		Karnataka (As reported by)	
	Female	Male	Female	Male
	From Bridegroom			
Yes	11	10	7	9
No	89	90	93	91
From Bride (Selected Items)				
Cloth	99	-	52	-
Gold	87	-	81	-
Silver	92	-	40	-
Cash	79	-	46	-
Land	2	-	3	-
House	3	-	3	-
Motor Cycle/Scooter	40	-	4	-
TV/VCR/Refrigerator	49	-	1	-

*Inheritance.* Like other indicators, inheritance was also very much in tune with the traditional norms biased against the women. The respondents in both states almost wholly (96 per cent women and 99 per cent men in Uttar Pradesh, 97 per cent women and 99 per cent men in Karnataka) reported that it is the son who has the first right to inherit the parents' property. This is a pointer to the fact that women have a secondary status in the family when it comes to controlling their own income or access to family resources.

#### OLD AGE

A part of the study specifically addressed the elderly in the population. The fielding of the questionnaire was done in a sub-sample of the total households. The issues addressed in the questionnaire primarily relate to ties with and support from children, under the assumption that reproductive behaviour may be affected by the presence of the elderly in the family.

The issues covered in the questionnaire include the capacity of the old to undertake different chores within and outside the house, major source of financial support, links with children in terms of co-residence, mutual financial assistance and visits. The sample of old people is 366 in Uttar Pradesh and 203 in Karnataka. The proportions of the males and females within the sample is approximately 65 per cent and 35 per

TABLE 4.21: MOBILITY AND ABILITY TO WORK (PERCENTAGE)

Different Tasks	Uttar Pradesh		Karnataka	
	Have the Ability to	Have Done So in the Past Month	Have the Ability to	Have Done So in the Past Month
	Visit Neighbours	86.3	82.2	90.1
Go out of Village	68.3	61.5	82.8	76.4
Do Work at Home	73.0	68.9	75.9	70.4
Take Care of Children	76.8	70.8	80.8	71.4
Tend Animals	55.5	53.0	61.1	56.2
Work in the Field	39.9	37.7	47.8	43.3
Earn by Other Means	13.4	10.9	20.7	15.3

cent respectively in both states. In Uttar Pradesh there are 237 males and 129 females and in Karnataka 135 males and 68 females in the sample chosen. On the basis of data regarding capacity to do different kinds of work, it is seen that fewer old people in the Uttar Pradesh sample than in Karnataka are able to undertake different tasks such as work in the fields, tend animals, earn by other means and undertake visits to neighbours or go outside the village. The capacity to do work at home is similar in both samples. A possible reason for the difference in capacities could be the difference in age of the group under consideration. While large numbers in both states claim that they can do most of the work, fewer are capable of undertaking physically strenuous work that fetches remuneration such as working in the fields and even fewer say they are capable of earning through other means (Table 4.21).

Support available from other sources can be significant for the survival of the old. In Uttar Pradesh, 81 per cent and in Karnataka 66 per cent said that they were getting financial assistance from at least one source. The source was primarily the government in the form of old age or widow's pension (85-90 per cent) and in a rare case the source was the village community.

The elderly were asked about the nature and extent of their children's support (Table 4.22). Data are available on all the children. Cultural practices such as the near universality of marriage, patrilocal residence, etc. create differences in the extent and nature of support that sons *vis-à-vis* daughters may give to their parents. For this reason, children have been classified into four groups based on sex and marital status, as married sons, single sons, married daughters and single daughters. Since



TABLE 4.22: TIES WITH CHILDREN (PERCENTAGE)

Ties with Children	Uttar Pradesh				Karnataka			
	Single* Sons	Married Sons	Single Daughters	Married Daughters	Single Sons	Married Sons	Single Daughters	Married Daughters
Staying with Parents	80 (115) **	52.6 (684)	62.3 (61)	2.4 (613)	74.1 (116)	49.3 (357)	66.7 (63)	11.3 (337)
Monetary Help to Parents	18.3 (115)	35.5 (684)	3.3 (61)	1.8 (618)	23.3 (116)	26.1 (357)	14.3 (63)	9.5 (337)
Monetary Help from Parents	16.5 (115)	10.2 (684)	19.7 (61)	24.3 (613)	12.1 (116)	2.8 (357)	11.1 (63)	5.3 (337)
Frequent (at least monthly) Visit by Children	18.9 (16) ***	19.0 (158)	0 (15)	10.1 (584)	33.3 (15)	24.2 (66)	62.5 (8)	24.1 (337)
Frequent (at least monthly) Visit by Parents	18.9 (16) ***	8.9 (158)	0 (15)	5.4 (584)	33.3 (15)	9.1 (66)	37.5 (8)	9.8 (244)

Note: \* Single includes the unmarried, divorced, separated, widowed sons and daughters.

\*\* Figures in parentheses are the sample sizes.

\*\*\* Sample sizes in the last 2 rows are smaller as the questions have been asked to children living outside the village.

the classification reduces the size of each group as compared to the initial sample size and the rate of 'no response' is high to some questions, the observations made below suggest some patterns and are not definitive statements on the issue.

Single children, male or female, stay with their parents. Most married sons live with their parents or closeby. In most cases, the shift may be an outcome of a partition of the original residence. Most married daughters live in a nearby village or town. As the incidence of co-residence is low among married daughters in both states and most daughters are married off by a certain age, certain kind of support from the daughter is ruled out, such as assistance in work, help in fulfilling basic needs of parents, etc. Sons, whether single or married, visit their parents more frequently if they are not staying in the same village. Further, as fewer daughters are involved in economically remunerative activities they are unable to economically support their parents.

This argument finds support in the data as more sons than daughters give money to their parents even if mainly in times of need rather than regularly. In Karnataka, 10-15 per cent more women, both single and married, give their parents money in times of need. Further, in both states more parents give money in times of need to daughters than to sons. This has to be interpreted keeping in mind the fact that most parents live with their sons and thereby contribute to their households in other ways. Dowry demands from in-laws which may continue for several years after the marriage, may well be the other explanation.



## A Selective Bivariate Analysis of Survey Results

Reproductive choice in India has largely been synonymous with fertility regulation. In operational terms, it has been centred around issues such as the number of children a woman would want to have when she wants them, and her need for and access to contraceptive devices in order to operationalize that want.

Among factors identified as being likely to affect reproductive choice are infant and child mortality, desire for children, in particular desire for male children, women's participation in the labour market, educational status, their availability of health and family welfare services and other relevant indicators of women's socio-economic status. Since we are mainly interested in women's situation and its effect on reproductive behaviour, the focus here is on the notion of gender inequality. Inequality has been mainly expressed in terms of the extent to which women have autonomy within a marital relationship and within the family (Dyson and Moore, 1983) and in terms of prestige, power and control over social and economic resources (Mason, 1984). Seclusion and marriage patterns, nature of the household, dowry and inheritance patterns, are intra-household factors, while women's educational status, their participation in economic production, control over wages, etc., are some of the factors outside the household that have been used to capture the position of women (Jeejeebhoy, 1991). Factors influencing fertility are also thought to be strongly influenced by gender relations within and beyond the household. Women and men often have conflicting interests and men tend to reap the benefits of large families while women bear the costs (Kabeer, 1994). Generally, women's improved educational status is thought to be associated with better bargaining power, with a resultant increase in control over resources. Within the home it is thought to improve their knowledge and skills required for traditional norms and help in harbouring more equal relationships with the spouse (Jeejeebhoy, 1991). Women's participation in economic activities by itself may not necessarily be an adequate indicator of their autonomy. There is not much evidence to support the hypothesis that relative

autonomy of working or earning women necessarily exceeds that of non-earning women, independent of other intervening variables such as the economic status of the household and the extent of gender discrimination within the household. Women's control over their income and not merely work status may have a greater bearing on autonomy (ibid.).

Family and kinship structures believed to affect women's status are the practice of exogamy, and the extent of severance of links with their natal home after marriage. Of interest are various other indicators of women's status and their effect on fertility. This to some extent can be captured by looking at the number of children a couple will have in the absence of fertility regulation, women's status as it affects the demand for children, mainly male children, and finally women's status as it affects knowledge, attitudes and practice of fertility regulation.

'Age at marriage' can also be an important determinant of low degree of reproductive control resulting in higher fertility. Early age at marriage results in poorer control, greater lack of power and hence inability to take control of one's fertility. Another good reflector of women's low status and gender inequality is the number of desired children, particularly male children. Perceived value of children, male or female, greatly influences the demand for total number of children. There is evidence that son preference and family size are negatively related to women's status (Cain, 1988). Woman's lack of power itself forms the basis of demand for children, and sons in particular, to legitimize her own status and ensure economic survival (Jeejeebhoy, 1991).

Hence, the understanding of power relations between men and women is essential if women's capability to participate in decisions affecting reproduction is to be enhanced. Further, reproductive decision-making while very much a personal concern of the couple in question, is also significantly affected by the social location of the woman, her access to independent information, support structures, and the degree of physical mobility that she can enjoy or claim. There is a need to go beyond an instrumental treatment of women's education and employment to really substantiate the concepts of women's autonomy and empowerment and how these impact on reproduction (Swaminathan, 1996).

In the following sections we have summarized some findings of the survey on the basis of statistical tables presented in Volume II of the report on Poverty, Gender Inequality and Reproductive Choice (ISST, 1996). In particular, we have looked into (a) the pattern of contraceptive use; (b) women's autonomy as given by different indicators; (c) couple



comparisons; and (d) contradictions in the responses of husband and wife. The following chapter reports the results of some multiple regressions that reveal interesting causal linkages.

### CONTRACEPTIVE USE

This section focuses on the possible influence of some chosen factors on the use of contraception. Information related to the awareness of and responses to use of family planning methods has already been discussed in Chapter 4. The variables chosen are mainly female and male occupation, total number of live births, male and female years of schooling, per capita annual household income, religion, caste, the woman's current age and size of cultivable landholding. These variables have been cross-tabulated with contraception currently practised. The sample used for statistical analysis comprises couple-based information from 529 households in Uttar Pradesh and 658 households in Karnataka.

Some interesting features of the two samples that have emerged on cross-tabulation may be summarized as follows:

- The rate of non-use of contraception is higher in Uttar Pradesh (68.8 per cent) than in Karnataka (42.6 per cent). Female sterilization is the most commonly practised method in both states.
- In the Karnataka sample, among the women who had got themselves sterilized, a very large proportion had experienced 1-4 live births. In Uttar Pradesh, although the proportion of women sterilized was not large, the spread is concentrated among those who had experienced 2-6 live births.
- The effect, if any, of religion and caste on contraceptive use is not discernible, on account of the two factors that dominate across all categories: (a) female sterilization, which is the predominant method; and (b) the predominance of Hindus (87.8 per cent in Karnataka; 88.7 per cent in Uttar Pradesh). As regards caste, the 'others' category dominates in both states, and hence we cannot draw any inferences.
- There was no discernible effect of years of schooling of husband on variations in use of contraception, with tubectomy predominating in both states. The same can be said for schooling of the wife too in both states. In Karnataka, however, use decreases with increase in years of wife's schooling (Table 5.1).

TABLE 5.1: CURRENT CONTRACEPTIVE USE BY WIFE'S SCHOOLING (KARNATAKA)

Current Contraceptive Use	Years of Schooling			Total
	No Schooling	1-3 Years	4-6 Years	
Not Using Any	131 (46.8)	111 (39.6)	38 (13.6)	280 (100.0)
Female Sterilization	235 (67.3)	86 (24.6)	28 (8.0)	349 (100.0)
Oral Pill	1 (100.0)	-	-	1 (100.0)
Copper-T/Loop	1 (20.0)	3 (60.0)	1 (20.0)	5 (100.0)
Others	15 (65.2)	6 (26.1)	2 (8.7)	23 (100)
Total	383 (58.2)	206 (31.3)	69 (10.5)	658 (100.0)

Note: 1. Others includes withdrawal, abstinence, abortion, vasectomy, condom.

2. In every cell, the first figure refers to the absolute number of females in the category, the second figure is the row percentage and the third is the column percentage.

- Factors like per capita annual household income and size of cultivable landholding had no linear effect on contraceptive use. This was true of both samples under study.
- The effect of female age on the kind of contraception practised is somewhat curious, as seen from the kind of spread of women who were sterilized across the different age groups. This is more so for Karnataka. In Uttar Pradesh, the concentration of female sterilization is spread from 26 years and above. While this is true of Karnataka too, there is still quite a high percentage of women below 26 years who have got themselves sterilized. Further exploration is needed before any conclusions can be drawn from the above results (Tables 5.2a and 5.2b).
- Female occupation does not seem to have any striking effect on contraceptive use. There does not seem to be much difference in kind of contraception used *vis-à-vis* working and non-working



TABLE 5.2A: CURRENT CONTRACEPTIVE USE BY AGE OF WIFE (UTTAR PRADESH)

Current Contraceptive Use	Age of Female (Years)						Total
	<20	20-5	25-30	30-5	35-40	40+	
Not Using Any	52 (14.3) (83.9)	92 (25.3) (88.5)	86 (23.6) (68.3)	57 (15.7) (63.3)	40 (11.0) (45.5)	37 (10.2) (62.7)	364 (100) (68.8)
Female Sterilization	1 (1.4) (1.6)	1 (1.4) (1.0)	15 (21.4) (11.9)	13 (18.6) (14.4)	28 (14.0) (31.8)	12 (17.1) (20.3)	70 (100) (13.2)
Oral Pill	-	1 (12.5)	-	3 (37.5)	3 (37.5)	1 (12.5)	8 (100) (1.5)
Copper-T/Loop	-	2 (22.2)	5 (55.6)	1 (11.1)	-	1 (11.1)	9 (100) (1.7)
Others	9 (11.5) (14.5)	8 (10.3) (7.7)	20 (25.6) (15.9)	16 (20.5) (17.8)	17 (21.8) (19.3)	8 (10.3) (13.6)	78 (100) (14.7)
Total	62 (11.7) (100.0)	104 (19.7) (100.0)	126 (23.8) (100.0)	90 (17.0) (100.0)	88 (16.6) (100.0)	59 (11.2) (100.0)	529 (100.0) (100.0)

Note: 1. Others includes withdrawal, abstinence, abortion, vasectomy, condom, etc.  
2. For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

women. Also within the working category, which includes very few women (<35 per cent in Karnataka and <15 per cent in Uttar Pradesh), not much real difference is seen, with female sterilization predominating in the various work categories. The various occupations of males do not seem to have an influence of any type on the methods as well as use/non-use of contraception. This is true of both states.

— Women who had not experienced even a single live birth understandably did not use any contraception. Among the women who had experienced 1-2 live births, 21 per cent in Uttar Pradesh and 43.6 per cent in Karnataka used some form of contraception. To be noted is the fact that in this category while in Uttar Pradesh sterilization as an exercised option was negligible (7.4 per cent), in Karnataka among the users 87 per cent had opted for sterilization. A similar pattern is seen among women who have experienced more than two live births in both samples.

— Questions related to 'contraceptives ever used', problems related

TABLE 5.2B: CURRENT CONTRACEPTIVE USE BY AGE OF WIFE (KARNATAKA)

Current Contraceptive Use	Age of Female (Years)						Total
	<20	20-5	25-30	30-5	35-40	40+	
Not Using Any	67 (23.9) (77.9)	76 (27.1) (59.8)	46 (16.4) (32.9)	27 (9.6) (24.5)	25 (8.9) (22.5)	39 (13.9) (46.4)	280 (100) (42.6)
Female Sterilization	15 (4.3) (17.4)	46 (13.2) (36.2)	89 (25.5) (63.6)	79 (22.6) (71.8)	79 (22.6) (71.2)	41 (11.7) (48.8)	349 (100) (53.0)
Oral Pill	-	-	-	-	1 (100.0)	-	1 (100) (0.2)
Copper-T/Loop	-	2 (40.0)	2 (40.0)	-	1 (20.0)	-	5 (100) (0.8)
Others	4 (17.4) (4.7)	3 (13.0) (2.4)	3 (13.0) (2.1)	4 (17.4) (3.6)	6 (26.1) (5.4)	3 (13.0) (3.6)	23 (100) (3.5)
Total	86 (13.1) (100.0)	127 (19.3) (100.0)	140 (21.3) (100.0)	110 (16.7) (100.0)	111 (16.9) (100.0)	84 (12.8) (100.0)	658 (100.0) (100.0)

Note: 1. Others includes withdrawal, abstinence, abortion, vasectomy, condom, etc.  
2. For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

to use, or reasons for non-use were also addressed by the survey. Although there were mainly female users, these questions were posed to both females and males. We have chosen only female sterilization, oral pill and copper-T/loop for analysis. For each of the above methods problems related to use and non-use were cross-tabulated. The major findings are presented in Tables 5.3a and 5.3b.

- 'Menstrual problems' was the most cited problem of users of oral pill and copper-T in the Karnataka sample. In the sample from Uttar Pradesh women and men in a majority stated menstrual and health problems as the main problems for women using copper-T or oral pill.
- 'Disagreements over use' and 'menstrual problems' were the most commonly cited reasons for not using either copper-T or oral pill in Karnataka. While some of them cited 'lack of reversibility', and 'problems with supply' as reasons for non-use, interestingly only women cited disagreement with elders as a reason for non-use. Menstrual and health problems were the two most commonly stated



TABLE 5.3A: PROBLEMS WITH FEMALE STERILIZATION (UTTAR PRADESH)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
<b>FEMALE RESPONSE</b>											
Users	1 (1.2) (50.0)	1 (1.2) (9.1)	-	27 (33.3) (22.7)	-	-	44 (54.3) (28.4)	-	1 (1.2) (33.3)	7 (8.6) (3.1)	81 (100.0) (15.3)
Non-users	-	10 (2.7) (90.9)	2 (0.5) (100.0)	92 (24.9) (77.3)	2 (0.5) (100.0)	1 (0.3) (100.0)	67 (18.2) (43.2)	8 (2.2) (100.0)	2 (0.5) (66.7)	185 (50.1) (81.9)	369 (100.0) (69.8)
No Response/ Do not Know	1 (1.3) (50.0)	-	-	-	-	-	44 (55.7) (28.4)	-	-	34 (43.0) (15.0)	79 (100.0) (14.9)
<b>Total</b>	<b>2</b> (0.4) (100.0)	<b>11</b> (2.1) (100.0)	<b>2</b> (0.4) (100.0)	<b>119</b> (22.5) (100.0)	<b>2</b> (0.4) (100.0)	<b>1</b> (0.2) (100.0)	<b>155</b> (29.3) (100.0)	<b>8</b> (1.5) (100.0)	<b>3</b> (0.6) (100.0)	<b>226</b> (42.7) (100.0)	<b>529</b> (100.0)
<b>MALE RESPONSE</b>											
Users	-	-	-	7 (8.6) (10.1)	-	-	40 (49.4) (48.2)	1 (1.2) (4.5)	9 (11.1) (47.4)	24 (29.6) (7.4)	81 (100.0) (15.3)

(Continued)

TABLE 5.3A (Continued)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
Non-users	2 (0.5) (100.0)	5 (1.4) (83.3)	2 (0.5) (66.7)	55 (14.9) (79.7)	1 (0.3) (100.0)	-	37 (10.0) (44.6)	15 (4.1) (68.2)	8 (2.2) (42.1)	244 (66.1) (75.3)	369 (100.0) (69.8)
No Response/ Do not Know	-	1 (1.3) (16.7)	1 (1.3) (33.3)	7 (8.9) (10.1)	-	-	6 (7.6) (7.2)	6 (7.6) (27.3)	2 (2.5) (10.5)	56 (70.9) (17.3)	79 (100.0) (14.9)
<b>Total</b>	<b>2</b> (0.4) (100.0)	<b>6</b> (1.1) (100.0)	<b>3</b> (0.6) (100.0)	<b>69</b> (13.0) (100.0)	<b>1</b> (0.2) (100.0)	<b>-</b>	<b>83</b> (15.7) (100.0)	<b>22</b> (4.2) (100.0)	<b>19</b> (3.6) (100.0)	<b>324</b> (61.2) (100.0)	<b>529</b> (100.0)

Column headings for Tables 5.3a and 5.3b:

Problems with the method

- |                       |                             |
|-----------------------|-----------------------------|
| 1. Not Successful     | 6. Difficult to Use         |
| 2. Spouse Disapproves | 7. Menstrual Problem        |
| 3. Elders Disapprove  | 8. Irreversible             |
| 4. Health Problem     | 9. Others                   |
| 5. Problems of Supply | 10. Do Not Know/No Response |

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.



TABLE 5.3A: PROBLEMS WITH FEMALE STERILIZATION (UTTAR PRADESH)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
<b>FEMALE RESPONSE</b>											
Users	1 (1.2) (50.0)	1 (1.2) (9.1)	-	27 (33.3) (22.7)	-	-	44 (54.3) (28.4)	-	1 (1.2) (33.3)	7 (8.6) (3.1)	81 (100.0) (15.3)
Non-users	-	10 (2.7) (90.9)	2 (0.5) (100.0)	92 (24.9) (77.3)	2 (0.5) (100.0)	1 (0.3) (100.0)	67 (18.2) (43.2)	8 (2.2) (100.0)	2 (0.5) (66.7)	185 (50.1) (81.9)	369 (100.0) (69.8)
No Response/ Do not Know	1 (1.3) (50.0)	-	-	-	-	-	44 (55.7) (28.4)	-	-	34 (43.0) (15.0)	79 (100.0) (14.9)
<b>Total</b>	<b>2</b> (0.4) (100.0)	<b>11</b> (2.1) (100.0)	<b>2</b> (0.4) (100.0)	<b>119</b> (22.5) (100.0)	<b>2</b> (0.4) (100.0)	<b>1</b> (0.2) (100.0)	<b>155</b> (29.3) (100.0)	<b>8</b> (1.5) (100.0)	<b>3</b> (0.6) (100.0)	<b>226</b> (42.7) (100.0)	<b>529</b> (100.0)
<b>MAL-RESPONSE</b>											
Users	-	-	-	7 (8.6) (10.1)	-	-	40 (49.4) (48.2)	1 (1.2) (4.5)	9 (11.1) (47.4)	24 (29.6) (7.4)	81 (100.0) (15.3)

(Continued)

TABLE 5.3A (Continued)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
Non-users	2 (0.5) (100.0)	5 (1.4) (83.3)	2 (0.5) (66.7)	55 (14.9) (79.7)	1 (0.3) (100.0)	-	37 (10.0) (44.6)	15 (4.1) (68.2)	8 (2.2) (42.1)	244 (66.1) (75.3)	369 (100.0) (69.8)
No Response/ Do not Know	-	1 (1.3) (16.7)	1 (1.3) (33.3)	7 (8.9) (10.1)	-	-	6 (7.6) (7.2)	6 (7.6) (27.3)	2 (2.5) (10.5)	56 (70.9) (17.3)	79 (100.0) (14.9)
<b>Total</b>	<b>2</b> (0.4) (100.0)	<b>6</b> (1.1) (100.0)	<b>3</b> (0.6) (100.0)	<b>69</b> (13.0) (100.0)	<b>1</b> (0.2) (100.0)	<b>-</b>	<b>83</b> (15.7) (100.0)	<b>22</b> (4.2) (100.0)	<b>19</b> (3.6) (100.0)	<b>324</b> (61.2) (100.0)	<b>529</b> (100.0)

Column headings for Tables 5.3a and 5.3b:

Problems with the method

- |                       |                             |
|-----------------------|-----------------------------|
| 1. Not Successful     | 6. Difficult to Use         |
| 2. Spouse Disapproves | 7. Menstrual Problem        |
| 3. Elders Disapprove  | 8. Irreversible             |
| 4. Health Problem     | 9. Others                   |
| 5. Problems of Supply | 10. Do Not Know/No Response |

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.



TABLE 5.3B: PROBLEMS WITH FEMALE STERILIZATION (KARNATAKA)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
FEMALE RESPONSE											
Users	1 (0.3) (50.0)	2 (0.5) (8.7)	1 (0.3) (5.9)	2 (0.5) (13.3)	9 (2.5) (31.0)	3 (0.8) (60.0)	160 (44.0) (51.4)	181 (49.7) (92.8)	- - -	5 (1.4) (9.6)	364 (100.0) (55.3)
Non-users	1 (0.5) (50.0)	21 (9.7) (91.3)	16 (7.4) (94.1)	13 (6.0) (86.7)	20 (9.2) (69.0)	2 (0.9) (40.0)	90 (41.5) (28.9)	14 (6.5) (7.2)	9 (4.1) (100.0)	31 (14.3) (59.6)	217 (100.0) (33.0)
No Response/ Do not Know	- - -	- - -	- - -	- - -	- - -	- - -	61 (79.2) (19.6)	- - -	- - -	16 (20.8) (30.8)	77 (100.0) (11.7)
Total	2 (0.3) (100.0)	23 (3.5) (100.0)	17 (2.6) (100.0)	15 (2.3) (100.0)	29 (4.4) (100.0)	5 (0.8) (100.0)	311 (47.3) (100.0)	195 (29.6) (100.0)	9 (1.4) (100.0)	52 (7.9) (100.0)	658 (100.0) (100.0)

(Continued)

TABLE 5.3B (Continued)

Use of Sterilization	Problems										Total
	1	2	3	4	5	6	7	8	9	10	
MALE RESPONSE											
Users	1 (0.3) (50.0)	4 (1.1) (7.5)	- - -	- - -	8 (2.2) (30.8)	- - -	112 (30.8) (53.6)	194 (53.3) (97.0)	5 (1.4) (22.7)	40 (11.0) (31.0)	364 (100.0) (55.3)
Non-users	1 (0.5) (50.0)	39 (18.0) (73.6)	6 (2.8) (85.7)	9 (4.1) (100.0)	17 (7.8) (65.4)	- - -	75 (34.6) (35.9)	2 (0.9) (1.0)	12 (5.5) (54.5)	56 (25.8) (43.4)	217 (100.0) (33.0)
No Response/ Do not Know	- - -	10 (13.0) (18.9)	1 (1.3) (14.3)	- - -	1 (1.3) (3.8)	1 (1.3) (100.0)	22 (28.6) (10.5)	4 (5.2) (2)	5 (6.5) (22.7)	33 (42.9) (25.6)	77 (100.0) (11.7)
Total	2 (0.3) (100.0)	53 (8.1) (100.0)	7 (1.1) (100.0)	9 (1.4) (100.0)	26 (4.0) (100.0)	1 (0.2) (100.0)	209 (31.8) (100.0)	200 (30.4) (100.0)	22 (3.3) (100.0)	129 (19.6) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.



problems by both males and females in Uttar Pradesh for non-use of copper-T and oral pill.

- Among the couples in the Karnataka sample who had opted for 'female sterilization', 'lack of reversibility' featured as the most cited problem with the method. The second most commonly cited problem was 'menstrual problems'. Both females and males were in agreement regarding the problems as well as their order. In the Uttar Pradesh sample, 'menstrual problems' was cited by the majority as the main problem.

### AUTONOMY

Specific questions which could be possible indicators of some facets of autonomy have been addressed in detail in this section. Woman-related questions that have been analysed are:

- whether the woman has a say in household expenditure;
- whether she can move outside the house without permission;
- who decides on how many children to have; and lastly
- what is the husband's share in the wife's income.

These questions were cross-tabulated with current age of the women, annual per capita household income, size of landholding, female years of schooling, current contraceptive use and total number of live births. The salient features that emerged are presented below:

#### (A) WOMEN'S SAY IN HOUSEHOLD EXPENDITURE

- The majority of the women from Uttar Pradesh stated that they had a say in household expenditure, but not so for women in the Karnataka sample. Older women had a greater say in household expenditure in both samples.
- In the Karnataka sample women from the higher income groups had a greater say, while income did not have any effect in the Uttar Pradesh sample. Size of landholding did not have any effect in either sample.
- Education of women, measured by years of schooling, seems to have a positive effect on autonomy in the Karnataka sample; not so in Uttar Pradesh (Table 5.4).

TABLE 5.4: WIFE'S SAY IN HOUSEHOLD EXPENDITURE BY YEARS OF HER SCHOOLING (KARNATAKA)

Wife's Say	Years of Schooling			Total
	No Schooling	1-3 Years	4-6 Years	
Has Some Say	145 (53.1) (37.9)	95 (34.8) (46.1)	33 (12.1) (47.8)	273 (100.0) (41.5)
Has No Say	237 (61.9) (61.9)	111 (29.0) (53.9)	35 (9.1) (50.7)	383 (100.0) (58.2)
No Response/Do not Know	1 (50.0) (0.3)	- (0.0) (0.3)	1 (50.0) (1.4)	2 (100.0) (0.3)
Total	383 (58.2) (100.0)	206 (31.3) (100.0)	69 (10.5) (100.0)	658 (100.00) (100.00)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

- Use of contraception does not seem to be related to women's autonomy in either sample.
- Greater autonomy is indicated among women who had more number of live births in both samples (Tables 5.5a and 5.5b).

#### (B) WHETHER THE WOMEN MOVE OUTSIDE THE HOUSE WITHOUT PERMISSION

- The majority of the women from Uttar Pradesh said that they could move outside the house without permission; not so for the women from Karnataka.
- Neither the woman's age nor use of contraception seems to have any effect on whether or not she can move outside without permission.
- Women from the poorer classes in Karnataka seem to be more mobile. There is no impact of income in the sample from Uttar Pradesh as more women could move outside the house across various income classes than those who could not.
- In Karnataka, mobility was greater for women from higher landholding households. In Uttar Pradesh, the size of landholding did not have any effect on mobility.



TABLE 5.5A: WIFE'S SAY IN HOUSEHOLD EXPENDITURE  
BY LIVE BIRTHS (UTTAR PRADESH)

Wife's Say	Live Births					Total
	0	1-2	3-4	5-6	7+	
Has Some Say	17 (5.1) (37.0)	70 (20.8) (56.5)	116 (34.5) (71.2)	84 (25.0) (67.7)	49 (14.6) (68.1)	336 (100.0) (63.5)
Has No Say	29 (15.2) (63.0)	54 (28.3) (43.5)	47 (24.6) (28.8)	39 (20.4) (31.5)	22 (11.5) (30.6)	191 (100.0) (36.1)
No Response/Do not Know	-	-	-	1 (50.0) (0.8)	1 (50.0) (1.4)	2 (100.0) (0.4)
Total	46 (8.7) (100.0)	124 (23.4) (100.0)	163 (30.8) (100.0)	124 (23.4) (100.0)	72 (13.6) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

TABLE 5.5B: WIFE'S SAY IN HOUSEHOLD EXPENDITURE  
BY LIVE BIRTHS (KARNATAKA)

Wife's Say	Live Births					Total
	0	1-2	3-4	5-6	7+	
Has Some Say	19 (7.0) (33.9)	79 (28.9) (35.1)	115 (42.1) (47.9)	46 (16.8) (44.7)	14 (5.1) (41.2)	273 (100.0) (41.5)
Has No Say	37 (9.7) (66.1)	144 (37.6) (6.40)	125 (32.6) (52.1)	57 (14.9) (55.3)	20 (5.2) (58.8)	383 (100.0) (58.2)
No Response/Do not Know	-	2 (100.0) (0.9)	-	-	-	2 (100.0) (0.3)
Total	56 (8.5) (100.0)	225 (34.2) (100.0)	240 (36.5) (100.0)	103 (15.7) (100.0)	34 (5.2) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

TABLE 5.6: WIFE'S MOBILITY BY YEARS OF  
HER SCHOOLING (KARNATAKA)

Can Move Out Without Permission	Years of Schooling			Total
	No Schooling	1-3 Years	4-6 Years	
Yes	141 (63.8) (36.8)	61 (27.6) (29.6)	19 (8.6) (27.5)	221 (100.0) (33.6)
No	241 (55.3) (62.9)	145 (33.3) (70.4)	50 (11.5) (72.5)	436 (100.0) (66.3)
No Response/Do not Know	1 (100.0) (0.3)	-	-	1 (100.0) (0.2)
Total	383 (58.2) (100.0)	206 (31.3) (100.0)	69 (10.5) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

- Here too, woman's education seems to have a positive impact on her autonomy in Karnataka; it did not have any impact in the Uttar Pradesh sample (Table 5.6).
- In both samples there was greater autonomy for women with greater number of live births (see Tables 5.7a and 5.7b).

### (C) WHO DECIDES ON HOW MANY CHILDREN TO HAVE?

- The main feature that stands out in both samples is that it is mainly the males who decide on the number of children that a couple should have. In the Uttar Pradesh sample 81 per cent of the decision-makers were males; in Karnataka 53 per cent were males and 40.7 per cent were females.
- The woman's age does not seem to have a significant impact on who decides, with males being the majority decision-makers. An aspect that needs to be noted and studied in greater depth is that in the Karnataka sample in the 21-30 years range there were comparatively greater number of women stating that they are the ones who decide on the number of children to be had. Almost equal proportions of males and females in this age group were the stated decision-makers.



TABLE 5.7A: WIFE'S MOBILITY BY LIVE BIRTHS  
(UTTAR PRADESH)

Can Move Out Without Permission	Live Births					Total
	0	1-2	3-4	5-6	7+	
Yes	37 (11.8) (80.4)	81 (25.8) (65.3)	91 (29.0) (55.8)	65 (20.7) (52.4)	40 (12.7) (55.6)	31 (100.0) (59.4)
No	8 (3.8) (17.4)	43 (20.2) (34.7)	71 (33.3) (43.6)	59 (27.7) (47.6)	32 (15.0) (44.4)	213 (100.0) (40.3)
Depends	-	-	1 (100.0) (0.6)	-	-	1 (100.0) (0.2)
No Response/Do not Know	1 (100.0) (2.2)	-	-	-	-	1 (100.0) (0.2)
Total	46 (8.7) (100.0)	124 (23.4) (100.0)	163 (30.8) (100.0)	124 (23.4) (100.0)	72 (13.6) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

TABLE 5.7B: WIFE'S MOBILITY BY LIVE BIRTHS  
(KARNATAKA)

Can Move Out Without Permission	Live Births					Total
	0	1-2	3-4	5-6	7+	
Yes	27 (12.2) (48.2)	72 (32.6) (32.0)	64 (29.0) (26.7)	43 (19.5) (41.7)	15 (6.8) (44.1)	221 (100.0) (33.6)
No	29 (6.7) (51.8)	153 (35.1) (68.0)	176 (40.4) (73.3)	59 (13.5) (57.3)	19 (4.4) (55.9)	436 (100.0) (66.3)
No Response/Do not Know	-	-	-	1 (100.0) (1.0)	-	1 (100.0) (0.2)
Total	56 (8.5) (100.0)	225 (34.2) (100.0)	240 (36.5) (100.0)	103 (15.7) (100.0)	34 (5.2) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

- In the Karnataka sample higher incomes coincided with greater autonomy for women, while it did not have any particular impact in the Uttar Pradesh sample. There was no impact of size of landholding on decision-making in either sample.
- In Karnataka among those who owned between 2 and 5 acres of cultivable land, 52.3 per cent women said that they were the ones who made the decisions as against 40.2 per cent men. Among those who had up to 1 acre of land the picture reverses drastically, with only 24.3 per cent women stating that they had a say as against 72.4 per cent men.
- The wife's education measured by years of schooling had strong positive influence on her decision-making powers in the Karnataka sample, while it has no impact whatsoever in the Uttar Pradesh sample (Tables 5.8a and 5.8b).
- Contraceptive use did not have any correlation with decision-making in either sample, with males being the major decision-makers, whether or not contraception was used. In the Uttar Pradesh sample irrespective of the number of live births, males have the major say, with the data showing quite emphatically that the males are the decision-makers. In Karnataka while it was the males who were the major decision-makers, greater number of women who had experienced between 1 and 4 live births stated that they made the decisions, but not the women who did not have any children or had more than 5 children.

#### (D) DOES THE HUSBAND HAVE A SHARE IN THE WIFE'S EARNINGS?

- The proportion of husbands who had 'full' share of the wife's income was higher in the Karnataka sample; in the sample from Uttar Pradesh, husbands who had some share in the wife's income were the major category.
- Age of the female, contraceptive use, total live births and annual per capita household income did not seem to have any effect on the husband's share in either sample.
- The wife's education seems to have some impact, with more literate women having greater control of their earnings, both in Karnataka and Uttar Pradesh. The percentage of working women is too small in Uttar Pradesh to allow generalizations (Tables 5.9a and 5.9b).
- Size of landholding seems to have an impact in terms of women retaining their income, with the women from the higher landholding households appearing to have greater control over their incomes in both samples.



TABLE 5.8A: DECISION-MAKING ABOUT NUMBER OF CHILDREN BY WIFE'S YEARS OF SCHOOLING (UTTAR PRADESH)

Decision-making	Years of Schooling			Total
	No Schooling	1-3	4-6	
Wife	30 (71.4) (7.5)	7 (16.7) (7.8)	5 (11.9) (13.5)	42 (100.0) (7.9)
Husband	332 (76.7) (82.6)	75 (17.3) (83.3)	26 (6.0) (70.3)	433 (100.0) (81.9)
Elder Male	6 (100.0) (1.5)	-	-	6 (100.0) (1.1)
Elder Female	11 (57.9) (2.7)	4 (21.1) (4.4)	4 (21.1) (10.8)	19 (100.0) (3.6)
Others	2 (66.7) (0.5)	1 (33.3) (1.1)	-	3 (100.0) (0.6)
No one/Do not Know	21 (80.8) (5.2)	3 (11.5) (3.3)	2 (7.7) (5.4)	26 (100.0) (4.9)
Total	402 (76.0) (100.0)	90 (17.0) (100.0)	37 (7.0) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

### COUPLE COMPARISONS

Choice in reproductive matters is not entirely in a woman's control. Such choice as exists can be exercised only within the context of her social, or at least her conjugal situation, in consultation with her husband. Where conjugal communication is feeble in other matters, such communication about reproductive matters is likely to be even more feeble. The greater the distance between the couple, mentally, intellectually or otherwise, i.e. the lower the husband-wife parity, the higher is the probability of a significant communication gap.

Many questions in the survey were addressed to both husband and wife in reproductive age groups. The wide divergences that emerge in most indicators suggest that there may be significant absence of conjugal

TABLE 5.8B: DECISION-MAKING ABOUT NUMBER OF CHILDREN BY WIFE'S YEARS OF SCHOOLING (KARNATAKA)

Decision-making	Years of Schooling			Total
	No Schooling	1-3	4-6	
Wife	135 (50.4) (35.2)	92 (34.3) (44.7)	41 (15.3) (59.4)	268 (100.0) (40.7)
Husband	229 (65.6) (59.8)	99 (28.4) (48.1)	21 (6.0) (30.4)	349 (100.0) (53.0)
Elder Male	7 (63.6) (1.8)	3 (27.3) (1.5)	1 (9.1) (1.4)	11 (100.0) (1.7)
Elder Female	7 (50.0) (1.8)	4 (28.6) (1.9)	3 (21.4) (4.3)	14 (100.0) (2.1)
Others	-	1 (100.0) (0.5)	-	1 (100.0) (0.2)
No one/Do not Know	5 (33.3) (1.3)	7 (46.7) (3.4)	3 (20.0) (4.3)	15 (100.0) (2.3)
Total	383 (58.2) (100.0)	206 (31.3) (100.0)	69 (10.5) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

parity in the sample. The variables we have chosen to provide a comparative picture of the partners in marriage are: age at marriage, age at *gauna*, educational attainment as given by years spent in school and ability to read, and finally media exposure as given by the frequency of exposure to radio, television and cinema. This has been done for 529 couples in the reproductive age group in Uttar Pradesh and 658 such couples in Karnataka. Given the pattern of grouping for any one of these variables in the tables, parity ratios are computed as the number of observations along the diagonals divided by the total number of observations. Similarly, dominance ratios, defined as the number of observations below or above the diagonal depending on the order of the variable concerned divided by the total number of observations, can provide a measure by which the husband dominates over the wife within the marriage with respect to that particular variable.



TABLE 5.9A: HUSBAND'S SHARE IN WIFE'S INCOME BY WIFE'S YEARS OF SCHOOLING (UTTAR PRADESH)

Husband's Share	Years of Schooling			Total
	No Schooling	1-3	4-6	
Full Share	15 (65.2) (3.7)	4 (17.4) (4.4)	4 (17.4) (10.8)	23 (100.0) (4.3)
Some Share	46 (86.8) (11.4)	4 (7.5) (4.4)	3 (5.7) (8.1)	53 (100.0) (10.0)
No Share	12 (63.2) (3.0)	1 (5.3) (1.1)	6 (31.6) (16.2)	19 (100.0) (3.6)
Wife Does not Earn	328 (75.9) (81.6)	80 (18.5) (88.9)	24 (5.6) (64.9)	432 (100.0) (81.7)
No Response/Do not Know	1 (50.0) (0.2)	1 (50.0) (1.1)	- - -	2 (100.0) (0.4)
Total	402 (76.0) (100.0)	90 (17.0) (100.0)	37 (7.0) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

Thus if for any particular variable, the parity ratio is  $x$  per cent, this would suggest that in case of  $x$  per cent of the couples, husbands and wives belong to the same grouping, while a dominance ratio of  $y$  per cent suggests that for  $y$  per cent of the sampled couples in the reproductive age group, the wife ranks lower than the husband. The parity ratios for age at marriage and the age at *gauna* in Uttar Pradesh are 53.3 per cent and 34.9 per cent respectively, corresponding ratios in Karnataka being 6.8 per cent and 7.1 per cent respectively. The dominance ratios in the two states are correspondingly very diverse. The ratios in Uttar Pradesh are close to 60 per cent as compared to the corresponding ratios in Karnataka which are as high as 88 per cent. However, the picture changes when we compare the parity ratios in the two states with respect to educational achievements or media exposure. Table 5.10 provides a summary statement of the ratios in the two states with respect to the concerned variables.

While on an average there appears to be greater disparity between

TABLE 5.9B: HUSBAND'S SHARE IN WIFE'S INCOME BY WIFE'S YEARS OF SCHOOLING (KARNATAKA)

Husband's Share	Years of Schooling			Total
	No Schooling	1-3	4-6	
Full Share	106 (72.6) (27.7)	34 (23.3) (16.5)	6 (4.1) (8.7)	146 (100.0) (22.2)
Some Share	29 (55.8) (7.6)	19 (36.5) (9.2)	4 (7.7) (5.8)	52 (100.0) (7.9)
No Share	8 (57.1) (2.1)	5 (35.7) (2.4)	1 (7.1) (1.4)	14 (100.0) (2.1)
Wife Does not Earn	240 (53.8) (62.7)	148 (33.2) (71.8)	58 (13.0) (84.1)	446 (100.0) (67.8)
Total	383 (58.2) (100.0)	206 (31.3) (100.0)	69 (10.5) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

husband and wife in age at marriage and at *gauna* in Karnataka, in terms of other variables the husband-wife distance seems greater in Uttar Pradesh. For instance, the dominance ratio in Uttar Pradesh for years spent in school is 58.7 per cent as compared to only 30.2 per cent in Karnataka. Similarly, the dominance ratio with respect to exposure to radio in Uttar Pradesh is 48.5 per cent whereas in Karnataka it is only 14.2 per cent. This is significant, considering that among as high as 34.8 per cent of the couples in Karnataka both husband and wife listen to radio broadcasts everyday whereas in Uttar Pradesh this number is a meagre 6.6 per cent. Similarly, the high parity with respect to the ability to read variable in Karnataka is explained by the fact that in 18.5 per cent of all couples, both husband and wife reported that reading comes easily to both, whereas in Uttar Pradesh the corresponding figure is only 11.1 per cent (Tables 5.11a and 5.11b).

A mapping of parity and dominance along the dimensions given above provides a backdrop against which choices are made within marriage in all matters, including matters concerning reproduction. The differing scenario in these respects in the two states points to the likely differences in the ground conditions against which such choices are worked out.



TABLE 5.10: COUPLE COMPARISONS

Variable	Uttar Pradesh		Karnataka	
	P.R.	D.R.	P.R.	D.R.
Age at Marriage	35.35	58.22	6.84	87.39
Age at <i>Gauna</i>	34.97	59.17	7.14	87.99
Years Spent in School	37.05	56.71	59.72	30.24
Ability to Read	44.42	52.71	44.22	17.32
Exposure to Radio	37.43	48.58	78.42	14.29
Exposure to TV	56.14	34.03	52.22	6.69
Exposure to Cinema	62.00	29.30	50.00	39.06

Note: P.R. = Parity ratio; D.R. = Dominance ratio.

TABLE 5.11A: COUPLE COMPARISON: ABILITY TO READ (UTTAR PRADESH)

Husband	Wife	Easily	With Difficulty	Not at All	No Response/ Do not Know	Total
With Difficulty	3 (6.8) (4.5)	2 (4.5) (3.8)	39 (88.6) (9.5)	- - -	44 (100.0) (8.3)	
Not at All	5 (2.7) (7.5)	8 (4.3) (15.4)	174 (93.0) (42.5)	- - -	187 (100.0) (35.3)	
Total	67 (12.7) (100.0)	52 (9.8) (100.0)	409 (77.3) (100.0)	1 (0.2) (100.0)	529 (100.0) (100.0)	

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

### CONTRADICTIONS

The questionnaire consists of a number of sections related to relative decision-making authority of husband and wife, desired number and sex of children, contraceptive use patterns, etc., that are significant in examining the reproductive behaviour of the population. These are analysed in other sections of this chapter. This section pertains only to the differences in responses given by the couple to identical questions. The questions relate to the above mentioned areas. The attempt is to map out the gaps in perceptions and attitudes of husband and wife by looking

TABLE 5.11B: COUPLE COMPARISON: ABILITY TO READ (KARNATAKA)

Husband	Wife	Easily	With Difficulty	Not at All	No Response/ Do not Know	Total
With Difficulty	16 (14.2) (10.8)	30 (26.5) (41.7)	33 (29.2) (11.5)	34 (30.1) (22.4)	113 (100.0) (17.2)	
Not at All	2 (1.3) (1.4)	4 (2.5) (5.6)	139 (86.9) (48.6)	15 (9.4) (9.9)	160 (100.0) (24.3)	
No Response/ Do not Know	8 (5.6) (5.4)	6 (4.2) (8.3)	65 (45.5) (22.7)	64 (44.8) (42.1)	143 (100.0) (21.7)	
Total	148 (22.5) (100.0)	72 (10.9) (100.0)	286 (43.5) (100.0)	152 (23.1) (100.0)	658 (100.0) (100.0)	

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

at similarities and differences in responses. The differences are significant both for the areas where they occur and their very nature. The outcome of the decision-making process can be an agreement. But the husband-wife relationship is located in a wider context of intra-household power differentials based on gender, age and institutional mechanisms that discriminate against women. The context, therefore, influences communication between husband and wife. Thus, differences in attitudes could influence the husband's decision to outweigh the wife's so that it may appear the couple is deciding or acting as a homogeneous 'unit'.

Research on reproductive behaviour reveals that a woman's economic autonomy exerts a positive influence on decision-making about reproduction. The literature primarily refers to woman's independent earning and its contribution to her economic autonomy. The data available from this study, however, includes her access to money earned by others particularly her husband, both for household expenditure and personal expenditure. Remarkably, in both Uttar Pradesh and Karnataka, the responses of the husband and wife are similar in 70-80 per cent of the households. But in the 20-30 per cent cases where the responses differ, a large proportion consist of husbands who say that the wife has access and wives deny it.



Among the 20 per cent or so of the women who claimed to have independent earning in Uttar Pradesh, 90 per cent couples differed on the share the husband got. More men claimed to get the full share of their wives' earnings than their wives did. In both states, 15-17 per cent of the women who earned said that part of the income was given to other family members while few men said so. While the responses may imply, on the one hand, woman's limited control over her income, it may, on the other hand reflect the husband's perception regarding his wife's control over her income as being minimal (Tables 5.12a and 5.12b).

The nature of husband-wife responses to questions on control over income indicates that it would be too simplistic to consider that fertility will be limited where the woman is earning or where she undertakes expenditure for the household. For independent control over her income may be limited even in the presence of her own income or her access to household income. This lack of control may feed into other dimensions of intra-household gender discrimination, further constraining the space for the exercise of 'reproductive choice'. Intra-household gender relationships might also be reflected in households where men say they have no bank accounts but their wives believe there is one in the husband's name. About land, an important economic and income-generating resource in rural areas, couples agree on women's lack of access through inheritance. In Uttar Pradesh, unlike in Karnataka, in about 12 per cent households even where no sons exist, men consider that the norm should be to pass on property to brothers or other male members of the family rather than wives or daughters, while their wives consider that wives and daughters are the rightful inheritors.

Questions related to the participation of different individuals in the household in decision-making could be a reflection of lack of parity in the husband-wife relationship and the role other members play in crucial matters, so that the authority of both husband and wife is circumscribed. These aspects may have an impact on decision-making related to reproduction and its outcome. Some interesting facts on whether the wife can go out to work, how many children to have or education of children are thrown up on examining the responses of husband and wife. In most important matters both seem to have a say. However, differences in responses change with respect to elder males and females. While 5-7 per cent couples in Karnataka and 15-17 per cent in Uttar Pradesh agree that the elders have a say, fewer females in Karnataka and fewer males in Uttar Pradesh than their spouses do so. The difference is about 4 per cent in Karnataka and more than 10 per cent (up to 20 per

TABLE 5.12A: HUSBAND'S SHARE IN WIFE'S INCOME (UTTAR PRADESH)

Wife Husband	Full Share	Some Share	No Share	Wife Does not Earn	No Response/Do not Know	Inconclusive*	Total
	Full Share	5 (12.8) (21.7)	13 (33.3) (24.5)	2 (5.1) (10.5)	19 (48.67) (4.4)	- - -	- - -
No Share	1 (4.8) (4.3)	4 (19.0) (7.5)	2 (9.5) (10.5)	14 (66.7) (3.2)	- - -	- - -	21 (100.0) (4.0)
Wife Does not Earn	17 (3.8) (73.9)	27 (6.1) (50.9)	12 (2.7) (63.2)	386 (86.9) (89.4)	1 (0.2) (100.0)	1 (0.2) (100.0)	444 (100.0) (83.9)
No Response/Do not Know	- - -	- - -	- - -	1 (100.0) (0.2)	- - -	- - -	1 (100.0) (0.2)
Inconclusive*	- - -	9 (37.5) (17.0)	3 (12.5) (15.8)	12 (50.0) (2.8)	- - -	- - -	24 (100.0) (4.5)
Total	23 (4.3) (100.0)	53 (10.0) (100.0)	19 (3.6) (100.0)	432 (81.7) (100.0)	1 (0.2) (100.0)	1 (0.2) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

\* Denotes Inconclusive Coding.

cent) in Uttar Pradesh. There is little difference in husband-wife responses about who has the maximum say: both agree that mostly the male has the maximum say and rarely the female. Interestingly, in both states more males consider that elder males have the maximum say; and more females consider that elder females have a greater say. The almost total absence of cases where women have the maximum say according to either male or female respondents must be noted. Nevertheless, in about 50 per cent cases there are variations in the spouses' perceptions, which indicates that decision-making is a complex process, with a number of influences acting upon it, contingent on circumstances that point to the ability of the woman to create spaces for manoeuvring within the constraints. The influence of elder males in decision-making as perceived by husbands and of elder females by wives suggests some differences by gender in intra-household interaction and communication which have implications for household dynamics.



TABLE 5.12B: HUSBAND'S SHARE IN WIFE'S INCOME (KARNATAKA)

Husband \ Wife	Wife			Wife Does not Earn	Total
	Full Share	Some Share	No Share		
Full Share	130 (74.3) (89.0)	10 (5.7) (19.2)	2 (1.1) (14.3)	33 (18.9) (7.4)	175 (100.0) (26.6)
No Share	2 (28.6) (1.4)	- (0.0) (0.0)	3 (42.9) (21.4)	2 (28.6) (0.4)	7 (100.0) (1.1)
Wife Does not Earn	8 (1.9) (5.5)	7 (1.7) (13.5)	7 (1.7) (50.0)	395 (94.7) (88.6)	417 (100.0) (63.4)
No Response/Do not Know	1 (50.0) (0.7)	- (0.0) (0.0)	- (0.0) (0.0)	1 (50.0) (0.2)	2 (100.0) (0.3)
Inconclusive*	5 (8.8) (3.4)	35 (61.4) (67.3)	2 (3.5) (14.3)	15 (26.3) (3.4)	57 (100.0) (8.7)
Total	146 (22.2) (100.0)	52 (7.9) (100.0)	14 (2.1) (100.0)	446 (67.8) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

\*Denotes Inconclusive Coding.

Statistics reveal that education is a major dimension of gender inequality and discrimination. Perceptions about education are related to prevailing norms about gender roles and the supposed benefits of investing in the son's rather than the daughter's future. This is reflected in the responses of men and women on their plans for their children and their expectations of them. Making allowance for the gaps that may exist between stated plans and actions in the future, women in both states seem to hold more conservative views than their husbands. A much larger number of women prioritize boys' education over girls' and plan to educate boys longer. The husbands on the other hand state that they would give equal preference to educating boys and girls and also consider that the levels to which they are educated would depend on the children. Perception also varies with regard to sons and daughters as sources of support. The 15-20 per cent households where husband-wife responses differ, however, reveal no pattern. There are no significant

differences in the husband-wife opinions on the relative importance of sons and daughters as sources of support. In both states about 5 per cent more men than women admit to being unsure of their children's support.

Responses relating to number and sex of children desired are directly relevant for reproductive behaviour. In Uttar Pradesh 65 per cent of the couples and 75 per cent in Karnataka give similar responses. Among the rest in about half the cases either the husband or the wife said that they were 'unsure' or left it to 'God', which does not signify a contradiction of the spouse's view. Thus, there is a high level of similarity in husband-wife desires about number and sex of children. In Karnataka 80 per cent of the couples agree on the number of daughters they want. The differences emerge in other cases primarily because of one partner's doubt about his/her ability to influence outcomes. While dissimilarity in desires or plans may reflect lack of husband-wife communication, similarity does not necessarily imply the opposite. This is substantiated when responses to questions on contraceptive use are examined: these reflect a number of differences, in comparison with the number and sex of children desired.

Responses to questions on contraceptive use reveal a variation in husband-wife responses for a remarkably large number of couples. The differences are higher with regard to perception of problems in the method and plans for future use in contrast to questions on current or past use (Tables 5.13a and 5.13b).

TABLE 5.13A: HAS WIFE BEEN STERILIZED? (UTTAR PRADESH)

Husband \ Wife	Wife			Total
	Yes (Spontaneous)	No	No Response/Do not Know	
Yes (Spontaneous)	60 (84.5) (74.1)	10 (14.1) (2.7)	1 (1.4) (1.3)	71 (100.0) (13.4)
No	18 (4.2) (22.2)	336 (79.1) (91.1)	71 (16.7) (89.9)	425 (100.0) (80.3)
No Response/Do not Know	3 (9.1) (3.7)	23 (69.7) (6.2)	7 (21.2) (8.9)	33 (100.0) (6.2)
Total	81 (15.3) (100.0)	369 (69.8) (100.0)	79 (14.9) (100.0)	529 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.



TABLE V.13B: HAS WIFE BEEN STERILIZED? (KARNATAKA)

Husband \ Wife	Yes (Spontaneous)	No	No Response/ Do not Know	Total
Yes (Spontaneous)	331 (97.6) (90.9)	5 (1.5) (2.3)	3 (0.9) (3.9)	339 (100.0) (51.5)
No	27 (9.1) (7.4)	203 (68.6) (93.5)	66 (22.3) (85.7)	296 (100.0) (45.0)
No Response/Do not Know	6 (26.1) (1.6)	9 (39.1) (4.1)	8 (34.8) (10.4)	23 (100.0) (3.5)
Total	364 (55.3) (100.0)	217 (33.0) (100.0)	77 (11.7) (100.0)	658 (100.0) (100.0)

Note: For explanation of the three numbers in every cell, refer to Note 2 of Table 5.1.

Similarity in responses is more than 70 per cent in Karnataka, much higher than in Uttar Pradesh, where the questions pertain to the time when the couple started using the method, the method being used and so on. But regarding the problems the couples face with the method, the similarity in responses is lower in Karnataka than in Uttar Pradesh. Primarily, the men say there are no problems and women state they have menstrual/health problems. Besides indicating the gaps in communication between the couple, this also suggests that women are largely isolated in their painful experiences that result from contraceptive use. This lack of communication and the extent to which responsibility for contraception is placed on women is to be noted. In the 20 per cent cases in Karnataka where women intend to undergo tubectomy within the next one year, their husbands were not even aware of it. In Uttar Pradesh, men rarely respond to the question on contraceptive use in the next one year while their wives consider that they will either undergo tubectomy or abstain.

Some interesting patterns have emerged from the bivariate analysis. But since many factors are involved, it is important to look at the effect of all the factors simultaneously. This has been attempted in the next chapter with the help of multivariate analysis.

## CHAPTER 6

## Multivariate Analysis: Some Results

In the last two chapters, we have looked into the links between different variables, taking them two at a time. Although this does unravel interesting characteristics of the sample, it does not suffice in analysing complex interlinkages. An attempt has been made in this chapter to look into such linkages through the use of multiple regression.

Our primary concern has been to explore the complex linkages between reproductive choice on the one hand, and poverty and gender inequality on the other. Such linkages can operate directly or through the mediation of a number of related variables. Ideally, fertility behaviour and reproductive choice, or any indicator of such choice, should be analysed in the context of other dependent variables such as child mortality and reproductive health. In other words, ideally, such investigation should be done within a simultaneous equations format. No such attempt has been made here, partly because the data set generated is not conducive to such analysis. In the first place, information on reproductive health of the interviewed women is too scanty for exploring the linkages between reproductive health and child mortality or fertility behaviour. Secondly, although a large number of questions have been asked on the pregnancy history of women, this is not linked in any systematic manner to the pattern of contraceptive use, if any, in the sample. Therefore, instead of formulating a full-blown simultaneous system, two sets of multivariate exercises have been carried out in single equation formats in order to explore the interlinkages. One of these seeks to look into the determinants of fertility behaviour and the second deals with the determinants of current contraceptive use and of female sterilization in particular. Since no attempt has been made to write out the entire system of equations, the estimated equations should be looked upon as structural equations where parameter estimates may involve an element of simultaneity bias.

The question of current contraceptive use in our sample becomes



almost redundant, considering that an overwhelmingly large percentage of women in the sample who have reported contraceptive use, either currently or at any time in the past, are cases of female sterilization. In other words, reproductive choice for these women, if indeed they exercised it under conditions of free choice, is tantamount to terminating the ability to bear children. Nearly one-sixth of the Uttar Pradesh sample of women in reproductive age groups and over 58 per cent of such women in the Karnataka sample have had tubectomy. In both states they constitute an overwhelmingly large fraction of contraceptive users. Such choice as is manifest by their action of going in for sterilization may not have been a matter of free choice: it could have been the best option they may have had among a set of bad ones, if any. Indicative of this is the fact that most women who have had tubectomy also say that they are unhappy with its terminal nature, and also complain of the various post-operative health problems they have had.

Intriguingly, especially in Karnataka, a large number of women who have gone in for tubectomy are also rather young—many among them less than 25 years old. In contrast, in Uttar Pradesh, most women who have reported tubectomy are older—above 30-5 years old, i.e. women who have, presumably, already gone through their desired reproductive life span. Thus, while only 1 per cent of the Uttar Pradesh women in the age group 20-5 years have had tubectomy, the corresponding figure in the Karnataka sample is 36.2 per cent. The question arises: why are the women in Karnataka sample going in for tubectomy at such a young age? Is it of their own volition? If so, what makes them put such an early end to the process of child-bearing, which in most parts of rural India is looked upon as the unquestioned natural duty of married women? The fact that Karnataka women are generally much more literate and have a much higher labour force participation rate than women in Uttar Pradesh could be taken as an indicator of what might seem like higher female autonomy in Karnataka. But there is need to exercise caution in interpreting these data since, as seen earlier, a much larger percentage of Karnataka women than those from Uttar Pradesh claim to have no control over the earnings from their own labour. This only underscores the involved nature of the underlying forces that shape observed action and the limitations of a structured questionnaire to elicit the nature of complex phenomena such as female autonomy and choice. Multivariate analysis can only supplement qualitative analysis. It cannot substitute it. This caveat applies to the results reported in this chapter.

### FERTILITY BEHAVIOUR

A selected sample of regressions on fertility behaviour is reported in Table 6.1 for the two states. For comparison, we have reported the results of same or almost similar models for both states, although different indicators for the same variables may have shown better performance in either state. A brief description and analysis of the reported results is given below. The sample consists of all married women in reproductive age groups (15-49 years) with husbands on site. This boils down to 529 couples in Uttar Pradesh, and 658 couples in Karnataka.

The dependent variable, fertility behaviour, is measured by two alternative indicators: total number of pregnancies and total number of live births. Explanatory variables are clubbed into a number of socio-demographic and household characteristics. These are as follows:

*Age.* Since fertility is not normalized by age of the respondent (FA13), it is included as an explanatory variable. Normalization is possible in principle, but would have been an *ad hoc* procedure (see paper by Mukhopadhyay, Tewari and Savithri in Volume III of ISST (1996) report). Understandably, the t-values are consistently positive and significant.

Two other age variables are age at marriage (FF3A1) and age at *gauna* (FF3B1). These have been used alternately in the equations along with FA13 in order to capture the reproductive life span to date. Generally, these occur with negative coefficients, which is as it should be, but are not very significant, especially in Uttar Pradesh.

*Literacy.* Female literacy has been heralded as a highly significant variable determining women's status and autonomy. We have experimented with three indicators of female literacy and awareness in these equations, i.e. years of schooling (FD3), ability to read (FD4) and exposure to radio (FD5A). The corresponding male variables are D3, D4, and D5A. Literacy appears to have very little influence on fertility behaviour in the Uttar Pradesh sample, except for radio exposure for women (FD5A), which is negative and significant. In Karnataka, where the level of female literacy is much higher, these indicators, especially FD4, has a strong negative influence on fertility, whereas the radio exposure variable performs weakly.

*Child Mortality.* One explanation advanced for high fertility among the poor has been the low survival rate of children. The two indicators of



TABLE 6.1: FERTILITY BEHAVIOUR IN UTTAR PRADESH AND KARNATAKA—SINGLE EQUATION OLS ESTIMATES

Exp. Var.	Uttar Pradesh		Karnataka	
	Total	Total	Total	Total
	Pregnancies (Equation 1)	Live Births (Equation 2)	Pregnancies (Equation 3)	Live Births (Equation 4)
Constant	0.693 (1.10)	1.730 (1.74)	2.436 (0.80)	3.427 (3.91)
FA 13	0.158 (13.13)	0.149 (11.5)	0.191 (3.34)	0.073 (6.39)
FF3A1	-0.100 (-0.90)	-	-0.658 (-0.87)	-
FF3B1	-	-0.52 (-3.19)	-	-0.432
FD3	-	-0.247 (-0.94)	-	-0.106 (-0.44)
D3	-	-0.068 (-0.83)	-	-0.234 (-2.33)
FD4	-	-	-3.562 (-2.72)	-
D4	-	-	0.709 (5.1)	-
FD5a	-0.369 (-1.69)	-	-	-
D5a	0.035 (0.16)	-	-	-
FHFYC	-	-0.804 (-1.30)	-	-0.197 (-0.32)
FHFY	0.774 (3.18)	-	1.492 (-1.24)	-
E9a2	0.433 (1.35)	0.120 (0.35)	1.865 (1.13)	0.099 (-0.31)
MIDDLEEA	0.181 (0.35)	-	1.130 (0.43)	-
HIGHEA	0.217 (0.25)	-	-0.906 (-0.15)	-
FK4	-	0.259 (0.97)	-	0.091 (-0.40)
FJ2	-0.122 (-1.07)	-0.135 (-1.23)	-5.414E-03 (-0.01)	-0.101 (-0.94)
J5D	-0.158 (-0.43)	-	-0.660 (-0.26)	-

(Continued)

TABLE 6.1 (Continued)

Exp. Var.	Uttar Pradesh		Karnataka	
	Total	Total	Total	Total
	Pregnancies (Equation 1)	Live Births (Equation 2)	Pregnancies (Equation 3)	Live Births (Equation 4)
PC	-3.326e-d <sup>4</sup> (-3.33)	-2.861e.04 (-2.80)	-	-
PC <sup>2</sup>	1.239e-08 (1.79)	9.728e-09 (1.49)	-	-
BIO	-	-	-0.273 (-1.44)	-0.112 (-2.78)
BIO <sup>2</sup>	-	-	0.22 (5.18)	8.620e-03 (8.70)
R <sup>2</sup>	0.306	0.373	0.122	0.289
ADJUSTED R <sup>2</sup>	0.290	0.353	0.106	0.277
F	18.956	18.797	7.499	23.646
SAMPLE SIZE	529	529	658	658

Note: Figures within brackets are t-values.

Dep. Var. = Dependent Variable; Exp. Var. = Explanatory Variable.

## VARIABLE LIST FOR TABLE 6.1

FA13	Age of wife
FF3A1	Age at marriage (wife)
FF3B1	Age at <i>gauna</i> (wife)
FD3	Years of schooling (wife)
D3	Years of schooling (husband)
FD4	Ability to read (wife)
D4	Ability to read (husband)
FD5a	Exposure to radio (wife)
D5a	Exposure to radio (Husband)
FHFYC	Incidence of under-five child mortality
FHFY	Frequency of under-five child mortality
E9a2	Presence of elderly family member for support in child care
MIDDLEEA	Middle level economic autonomy (wife)
HIGHEA	High level economic autonomy (wife)
FK4	Husband's control on wife's earnings
FJ2	Current use of any contraceptive device
J5D	Couple contradictions in reporting of current contraceptive use
PC	Per capita household income
PC <sup>2</sup>	Square of per capita household income
BIO	Size of landholding
BIO <sup>2</sup>	Square of landholding size



child mortality we have experimented with are the number of children who have died before reaching 5 years (FHFY) and the incidence of any under-5 child mortality that the couple has experienced in the past (FHFYC). Both indicators are positive and significant in the Uttar Pradesh sample, especially when fertility is measured by total number of pregnancies, signifying perhaps the high incidence of lost pregnancies in the sample. None of these indicators is significant in the Karnataka sample.

*Presence of the Elderly for Child Care Support (E9a2).* Once again, the impact on fertility is positive, especially when fertility is measured by the number of pregnancies and not the number of live births, both in Uttar Pradesh and Karnataka.

*Female Autonomy.* Autonomy, as noted earlier, is a rather difficult phenomenon to capture. We experimented with a number of autonomy variables, both singly and in the form of a number of indices we had constructed using the multi-faceted information collected through lengthy questions on the extent and nature of independence and control women enjoy in different matters. Indices of local autonomy were constructed in economic and personal matters (see paper by Mukhopadhyay, Tewari and Savithri in Volume III of ISST (1996) for more details). Two indicators used in the equations reported in Table 6.1 are levels of economic autonomy (a categorical variable with low economic autonomy LOWEA=0, middle economic autonomy MIDDLEEA=1 and high economic autonomy HIGHEA=2; and whether or not husband takes control of wife's earnings (FK4). None of these indicators has strong explanatory power in the reported regressions.

*Contraceptive Use.* This factor has been incorporated in the reported equation in two ways. One is through a dummy variable, FJ2, on whether or not the couple is using any contraceptive device currently. This comes out with a predictable negative sign, not significant in Karnataka, and with better explanatory power in Uttar Pradesh.

Another variable linked with contraceptive use is derived out of couple comparisons in reported use. The variable J5D is a dummy variable which assumes value 1 where there is a contradiction in reported use of contraceptives between husband and wife and 0 otherwise. J5D is constructed to capture the presumed lack of communication between the partners in matters of contraception. The variable as constructed does not appear to have significant explanatory power in the reported regression equations.

*Poverty Indicator.* A number of variables were explored to capture the economic status of the households. Two of the more important indicators are per capita household income (PC) and size of landholding (BIO).

Each has its pros and cons. Per capita household income (PC) is better in terms of range and variability, especially if there is a sizeable number of households in landless and marginal landholding categories. On the flip side, PC has been computed from a range of component variables, some of which are imputed values. The extent of ad-hocism and error is likely to be correspondingly higher. Incorrectness of reporting of incomes by respondents is another persistent problem which has been reported for collection of income data from rural India: the reason why the National Sample Survey uses expenditure data as income surrogates. The Karnataka data on per capita incomes appear particularly suspect. We have reported results using PC for Uttar Pradesh, where it performs well, and have used landholding size for Karnataka. The significance for fertility of these economic status variables in both states is rather interesting.

In both states, fertility behaviour appears to be significantly dependent on the economic status of the household. But in both, the relationship appears parabolic. Fertility appears to decline with rising economic status of the household and then start rising beyond a point. Thus t-values of the quadratic term of the relevant variable— $PC^2$  in UP and  $BIO^2$  in Karnataka—are positive and significant, while t-values of the corresponding linear components are negative and significant. This pattern comes up consistently in a whole range of equations we have tried out with various permutations and combinations of other explanatory variables, which suggests robustness of the result.

## REPRODUCTIVE CHOICE

Results of a second set of equations exploring the determinants of reproductive choice using multinomial logit format are reported in Tables 6.2a and 6.2b for Uttar Pradesh and Karnataka respectively. The dependent variable is a binary choice variable. Two versions of the dummy are used: whether the couple is currently using any contraceptive device or not (FJ5), and whether the wife has undergone tubectomy or not (FJ5A).

A number of explanatory variables used for the logit exercise are common with those used for equations in Table 6.1 while some others



are new. All variables except dummy variables have been used in natural logs. The new variables used are as follows:

*WPREG: Wasted Pregnancies.* This includes still-births, miscarriages and abortions. The variable has been found to have significant negative impact on the probability of contraceptive use in both Uttar Pradesh and Karnataka, except for women in Uttar Pradesh who had gone in for tubectomy, perhaps because for these women the number of pregnancies is so high that wasted pregnancies are not a deterrent.

*TCH: Number of Living Children.* This variable is uniformly highly significant and positive in both states, which is as it should be.

*SMORT: Number of Male Children who Died.* This variable has significant and negative impact on the probability of contraceptive use in Uttar Pradesh and is not very significant in the Karnataka sample. We take this as an indication of higher degree of son preference in Uttar Pradesh than in Karnataka. It may be noted here that other indices of child mortality constructed from our sample, such as total number of children (male and female) who died within five years, or incidence of child death of both sexes, or death of girl children in the family, did not have any explanatory power.

*AD, FAD: Awareness Dummy for Males and Females Respectively.* These are defined as follows:

AD=0, if D3=0 and D5A=0

AD=1, otherwise.

Where D3=0 stands for no schooling and D5A=0 stands for zero exposure to radio.

Variable names preceded by F refer to corresponding female variables. Thus FAD=0 for women who have had no schooling at all and never listen to the radio. For all other women, FAD=1.

All the three literacy and awareness variables used for explaining fertility, i.e. years of schooling of males and females (D3, FD3), ability to read (D4, FD4) and exposure to radio (D5A, FD5A) appear to have little explanatory power in determining contraceptive use. The new awareness dummy AD also performs badly for males. For females, however, FAD is significant and negative in Karnataka. This raises a whole range of questions on the nature of information dissemination

TABLE 6.2A: MULTINOMIAL LOGIT REGRESSION OF DETERMINANTS OF CONTRACEPTIVE USE (UTTAR PRADESH)

Dep. Var.	Current Contraceptive Use (FJ5)		Female Sterilization (FJ5a)	
	(Equation 1)	(Equation 2)	(Equation 3)	(Equation 4)
Constant	-8.20 (-5.37)	-7.79 (-5.09)	-12.46 (-4.92)	-12.05 (-4.71)
Log FA13	1.60 (3.95)	1.59 (3.90)	2.54 (3.50)	2.42 (3.28)
E9A2	0.44 (1.26)	0.30 (0.85)	-0.96E-01 (-0.20)	0.14 (-0.28)
BIO	-	-	0.10 (1.18)	-
BIO <sup>2</sup>	-	-	0.57E-02 (-1.03)	-
PC	0.28E-03 (2.89)	0.26E-03 (2.71)	-	0.01E-03 (0.88)
PC <sup>2</sup>	-0.12E-07 (-1.85)	-0.11E-07 (-1.76)	-	-0.42E-08 (0.55)
Log WPREG	-0.42E-03 (-1.50)	-0.50E-03 (-1.80)	0.32E-06 (0.00)	0.22E-04 (0.06)
Log TCH	0.18E-02 (3.09)	0.18E-02 (3.14)	0.55 (1.64)	0.60 (1.77)
Log SMORT	-0.61E-03 (-2.00)	-0.51E-03 (-1.70)	-0.11E-02 (-2.39)	-0.11E-02 (-2.26)
AD	0.31 (1.05)	0.16 (0.54)	-0.84E-01 (-0.22)	-0.13 (-0.32)
FAD	0.52 (2.44)	0.49 (2.33)	0.44 (1.57)	0.41 (1.47)
FOCC1	0.94 (3.26)	-	-0.66E-01 (-0.16)	-
FOCC2	-	-1.60 (-1.50)	-	-0.60 (-0.56)
No. of Observations	529	529	529	529
Log Likelihood	-286.13	-289.68	-177.76	-177.80
Restricted Log	-325.89	-325.89	-206.72	-206.72
Likelihood Chi-square	79.52	72.42	57.93	57.84
Significance Level	-	-	-	-
Percentage Correctly Predicted	72.2	73.7	87.15	86.6

Note: Figures in parentheses are t-values.



TABLE 6.2B: MULTINOMIAL LOGIT REGRESSION OF DETERMINANTS OF CONTRACEPTIVE USE (KARNATAKA)

Exp. Var.	Current Contraceptive Use (FJ5)		Female Sterilization (FJ5a)	
	(Equation 1)	(Equation 2)	(Equation 3)	(Equation 4)
Constant	-2.61 (-2.66)	-2.60 (-2.64)	-2.63 (-2.68)	-2.69 (-2.72)
Log FA13	0.93 (3.65)	0.93 (3.65)	0.87 (3.40)	0.87 (3.45)
E9A2	0.43 (1.52)	0.42 (1.51)	0.43 (1.58)	0.44 (1.62)
BIO	-0.035E-01 (-1.11)	-0.33E-01 (-1.05)	-	-0.38E (-1.21)
BIO <sup>2</sup>	0.11E-02 (1.35)	0.11E-02 (1.31)	-	0.5E-03 (0.65)
PC	-	-	0.33E-05 (-0.19)	-
PC <sup>2</sup>	-	-	-0.38E-10 (-0.36)	-
Log WPREG	-0.33E-03 (-1.38)	-0.34E-03 (-1.41)	0.31E-03 (-1.28)	0.32E-03 (-1.32)
Log TCH	0.30E-02 (5.59)	0.30E-02 (5.58)	0.43E-02 (4.06)	0.43E-02 (4.16)
Log SMORT	-0.54E-04 (-0.16)	-0.46E-04 (-1.13)	-0.44E-04 (0.13)	-0.58E-04 (0.17)
AD	0.10 (0.38)	0.11 (0.41)	0.16 (0.64)	0.26 (0.97)
FAD	-0.74 (-3.29)	-0.75 (-3.39)	-0.69 (-3.15)	-0.70 (-3.24)
FOCC1	0.11 (0.55)	-	0.18 (0.90)	-
FOCC2	-	0.10 (0.47)	-	0.27 (1.24)
No. of Observations	658	658	658	658
Log Likelihood	-390.53	-390.57	-394.74	-393.06
Restricted Log	-448.77	-448.77	-454.87	-454.87
Likelihood Chi-square	116.48	116.40	120.26	123.62
Significance Level	-	-	-	-
Percentage Correctly Predicted	68.5	69.0	68.4	67.3

Note: Figures in parentheses are t-values.

## VARAIBLE LIST FOR TABLES 6.2A AND 6.2B

FJ5	Dummy variable for current contraceptive use by the couple: Yes = 1, No = 0
FJ5A	Dummy variable for female sterilization: Yes = 1, No = 0
FA13	Age of wife
E9a2	Presence of elderly family member for support in child care
BIO	Size of landholding
BIO <sup>2</sup>	Square of landholding size
PC	Per capita household income
PC <sup>2</sup>	Square of per capita household income
WPREG	Wasted pregnancies, includes still births, abortions and miscarriages
TCH	Total number of living children
SMORT	Frequency of under-five son mortality
AD	Dummy variable of awareness among men
FAD	Dummy variable of awareness among women
FOCC	Dummy variable for work participation
FOCC2	Dummy variable for work participation in paid employment

on contraceptive use, the process of internalization of such information by women in rural settings and the differential nature of constraints that women may be facing in different socio-economic and cultural set-ups.

*FOCC1: Work Participation Dummy for Females*, where FOCC=1, if the woman is in the labour force; 0 otherwise.

*FOCC2: Participation Dummy for Paid Employment for Females*, where FOCC2=1, if the woman is in paid employment; 0 otherwise.

FOCC1 differs from FOCC2 in that while FOCC1=1 also for women working on own farms or are involved in other forms of unpaid work, FOCC2=0 for these group of women. This has been done to capture the differential influence, if any, of working for pay from working as unpaid labour.

The impact of work on contraceptive use, if any, is not clear cut. In Uttar Pradesh, where the incidence of any kind of 'productive' work among women has been reported to be very low, the work participation dummies are significant but with different signs when the dependent variable is FJ5 and insignificant when it is FJ5A. In Karnataka where the incidence is much higher the coefficients are uniformly positive but generally insignificant. However, the explanatory power of the dummy increases if the dependent variable is FJ5A. For this group of equations, the result improves considerably if one switches from FOCC1 to



FOCC2, suggesting that for the Karnataka women, the decision to go in for tubectomy, to a certain extent at least, depends on whether or not one is in paid employment, in contrast to the situation of unpaid work or being outside the labour force.

Our results seem to suggest that in Uttar Pradesh women who have had no schooling and have little exposure to the radio have a lower probability for going in for contraceptive use in any form, including tubectomy, whereas the picture in Karnataka is different. The patterns thrown up by the samples in Uttar Pradesh and Karnataka are quite interesting. Among the 364 women in Uttar Pradesh who have reported no contraceptive use, 282, or 77.5 per cent have had no schooling and 51 of the 70 women, or 72.9 per cent, who have reported having tubectomy are also illiterate. In Karnataka, however, of the 349 women who report sterilization, 67.3 per cent have had zero schooling, while among the 280 women who use no contraception, the percentage of illiterates is only 46.8 per cent [see Tables 3.6a and 3.6b, Vol. II of ISST (1996)]. Similarly, while only 11.3 per cent of women who have had no exposure to the radio in Uttar Pradesh have gone in for tubectomy, in Karnataka the corresponding percentage is set at a high of 56.1 per cent. It is informative to note that while among women who listen to the radio everyday, the percentage of those going in for tubectomy is only 18.2 in Uttar Pradesh, the corresponding percentage is 53.1 in Karnataka. It appears that if female literacy and exposure to the radio does positively influence the probability of contraceptive use, as it comes out clearly from the Uttar Pradesh sample, some intervening variable may have altered the picture in Karnataka. One factor that may have had a significant influence in this scenario is the much higher incidence of paid work among women in Karnataka.

Thus, while fertility seems to be significantly determined by the economic status of the household and index of women's awareness in a predictable manner, neither of these variables appears to have a significant and predictable impact on contraceptive use, at least not in our sample. Linkages exist, but are not proximate. Poverty may drive women to higher paid work in one cultural context as compared to another and this may act as the crucial intervening variable constraining the choice in one setting as against another. Unless these interlinkages are clearly defined, augmenting contraceptive supplies alone cannot automatically lead to increased use.

## CHAPTER 7

### Concluding Observations

The present study has focused on investigating whether three major areas of concern affecting poor women and their families, i.e. poverty alleviation, reduction in gender inequality, and achieving demographic goals, are separate and non-overlapping concerns—as may appear from the pattern of advocacy pursued by various lobby groups—or whether they are indeed factors intricately interlinked in fairly substantive ways. A major purpose of this study has been to delineate the nature and extent of overlaps, if any, among these objectives. If, for instance, reduction in poverty is positively and significantly correlated with reduction in gender inequality, and or with enhancement in the power of the woman to take decisions in reproductive matters, then there is a case for a common platform of complementary concerns—an opening up of the possibility of meaningful dialogue between, say, the 'feminist agenda' on the one hand and the paradigm of fertility regulation for controlling population growth on the other.

The picture that emerges from our survey of available literature and from the results of the household survey reported in this volume is that while the linkages are very much in place, the pattern of linkages is far from simple or unilinear. Nor is the nature of complementarity in any sense complete or absolute. The design of the household survey conducted in two states in culturally dissimilar north and south of India, provides interesting insights into the complexities of the linkages.

Our results clearly suggest a fall in fertility as one moves up the income scale both in Uttar Pradesh and in Karnataka, except that the pattern changes beyond a certain range. Women from more affluent families tend to have a larger number of children, keeping age constant. Thus, while reduction in abject poverty is likely to be associated with a fall in the number of pregnancies, beyond the point of absolute destitution households may indeed want more children as a conscious decision, as economic status goes up.

Our findings on the nature of linkages between reduction in gender inequality and poverty alleviation on the one hand, and reproductive choice matters on the other, are much more complex to interpret. This



is partly explained by the complexities involved in defining female autonomy and delimiting the parameters of choice. But mainly it is derived from the fact that autonomy and choice are categories that are meaningless unless they are contextualized. Reproductive choice, like choice in any other context, is difficult to gauge by mapping observed behaviour alone. One needs to also map the parameters of feasible sets of options from which choice is made and the extent to which these are circumscribed by structural, behavioural and informational constraints. Responses to structured questionnaires can at best provide limited insights into the complex phenomenon of choosing between options. The fact that over 58 per cent of the sampled women in reproductive age groups in Karnataka have had tubectomy, some at astonishingly low ages, is intriguing, especially when one compares the situation with Uttar Pradesh, where barely 15 per cent have had tubectomy, almost all of them being older women opting for sterilization after completing their desired reproductive life span. When alongside one considers the fact that Karnataka women are much better educated and have a higher labour force participation rate, one wonders whether overall it indicates higher autonomy or lower gender inequality in Karnataka. If indeed it is so, then what explains the endemic unhappiness of sterilized women in Karnataka about the terminal nature of the operation or the reported lack of control over their own earnings?

The fact remains that gender bias is an elusive category that resides in the collective mind of the community. The so-called 'indicators' of gender development popularized by the UNDP in its Human Development Reports in recent years are only some of the commoner and more easily measurable observed manifestations of such bias. Such indicators certainly have their uses, but one must not lose sight of their limitations either. The adequacy of any one or group of these manifestations in capturing the nature and intensity of such bias is heavily conditioned by the socio-cultural context within which they are embedded. It would be wrong to presume, for instance, that gender discrimination does not exist in situations where the sex ratio is not adverse, and where there are no gender gaps in the measured literacy levels and wage rates—the three dimensions that constitute the components of UNDP's Gender Development Index. Like a genie suppressed, it may show up in a new guise—in reduced mobility for women, higher dowry demands or in increased gender-based stress and violence. It is ironic that Kerala, which has been widely cited as the front-runner in gender development among Indian states, far surpasses almost all other states in the reported

rates of crimes against women. Even allowing for reporting bias, this is hardly the heaven one would like to put up as an ideal.

A related facet of the problem that is often lost sight of is that external interventions in the realm of gender tend to have rather strong and intricate repercussions, most of which are played out in the private domain, in altered mutations of gender equations within the family and the community. External interventions in areas such as female literacy, or women's involvement in the labour market may significantly change material conditions. Concurrently, they can, and indeed often do, unleash a process of changing mindsets. However, the rates and patterns of internalization of new sets of norms and values need not necessarily be the same for everybody. Given the unequal power balance in gender relations to start with, it is only too likely that such a process of internalization of new norms will vary across sex, age and other characteristics of the individual. Thus while targeted affirmative action can reduce measured gender disparities in these areas, such interventions can themselves be instrumental in creating new areas of tension and stress. The Karnataka women in our sample may indeed be paying the price of higher 'gender development' in terms of greater familial discord and tension, while the U.P. women, presumably sharing the same values with their menfolk, appear to be more at peace with life.

It will be wrong to interpret this as a plea against affirmative action for women. What it does highlight, however, is the dire necessity in all advocacy and policy initiatives, of dealing with women, especially poor women, as individuals who operate within a whole range of constraints. They must be treated as such within the context of their real life situations, and not as receptacles of artificially compartmentalized policy initiatives or as targets of the latest fads in international advocacy. In order to design realistic policies or to carry out effective advocacy, it is absolutely imperative that one is in tune with ground realities. Perhaps in the ideal world that all policy and advocacy initiatives are trying to reach, there is no poverty, no gender bias and choice is truly free. What we have captured in our sample is a cross-section of the complex of linkages along one of the many paths that may be leading to it. The challenge for advocacy is to design strategies that will build on the positive linkages to reach that ideal state.



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