CHAPTER 2

A Glimpse into Earlier Studies

2.1 Introduction: The wellbeing or the status of any person depends broadly on three aspects; education, health and economic independence. All these three factors impart capability\(^1\) to a person to lead a fulfilled human life. Unfortunately, access to these basic needs observe high inequality across regions, groups and individuals. Most of these inequalities are highly interlinked and form an inequality trap which is hard to break away from. For a long time, it was believed that poverty is the main reason behind all inequality and that it affects both the sexes equally. But later researches found gender as a limiting factor for accessing the above mentioned primary goods. The denial of basic goods like education and health to women could, in many cases, be attributed to the fallacious assumption regarding their economic role in the household and in the society. Traditionally, male are considered as breadwinner while women’s work is often taken as supplementary (if she is working outside) or unproductive (if she is not employed outside)\(^2\). However, there are enough evidences that in the rural community in India, women’s labour is extensively used in primary sector, particularly, agriculture and household industry (Krishnaraj and Shah, 2004) and their share is increasing over the decades (NSS various rounds). Notwithstandingly, the traditional division between breadwinning male and subordinate female in accessing primary goods still persists in India. Scholars revealed that the accesses to education, health and employment opportunities to women are broadly determined by two types of variables: i) predetermined variables which are

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\(^1\)“Capabilities” is defined as peoples’ potential functioning like reading, working or being healthy or politically active. All capabilities together correspond to the overall freedom to lead the life a person has reason to value (Sen, 1985).

\(^2\)Gender inequality is the archetypical “inequality trap”......gender inequality is the result of an overlapping set of economic, social, cultural and political inequalities that reinforce each other (World Development Report, 2006).

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mainly demographic in character and ii) policy variables. The predetermined variables are generally regressive in character whereas the policy variables try to mediate those regressive factors to give a better outcome. In this chapter we will briefly elaborate the available literature on this topic.

2.2 Determinants of Schooling of Girls:

In economic theory, education is regarded as both production and consumption good. As a capital good, education can be used to develop the human resources necessary for economic and social transformation and as a consumer good it offers increased utility to a consumer in terms of increased income, better job opportunities, etc. On the other hand, the cost of education consists of the direct cost (cost of inputs such as school fees, books, school stationeries etc.) and the indirect cost (foregone income of the child if he/she does attend school, opportunity cost of time). However, the decision to invest depends on the parents who often run a cost benefit analysis before the investment. The investment will continue so long as the marginal rate of return to additional schooling exceeds the prevailing cost of schooling. To the parents, the benefits of education mainly include monetary benefits, while the non-monetary gains of education are mostly overlooked. These non-monetary gains include improvement in nutrition and health of the family members, decrease in child mortality, decrease in fertility that are more pertinent for the female. Education of parents, particularly the mother, was found to be the most important determinant of infant survival in a study in Pakistan (Agha, 2000). Similar type of study in the context of rural Jamaica found that better educational status of the mother can reduce the probability of incidence chronic diseases (Handa, 1998). The fact is supported by Schultz (1995) who found that in less developed countries, female gains are more in terms of non-market benefits and due to stringent gender relations in labour market, men gains more in term of market benefit. This may produce gender specific schooling demand functions and in this respect
household income plays a critical role, particularly for the girls (Taubman, 1981 and Ghosh, 1991). In India, for example, the gap between boys and girls from the richest households is 2.5 percent, but the difference for children from the poorest households is 24 percent (Filmer, 1999). It may so happen that parents of a low income household wish to invest a given amount on children’s education; they may lack the personal resources to do so. Therefore, the children have to compete with their siblings for the resources currently available to their parents. Boys have an additional advantage in this competition if the parents believe that the monetary return on girl’s education is far less than that of the boy’s for that household (Tansel, 2002; Garg and Murdoch 1997). Also, according to general perception, girl’s education is taken as “watering someone else plant”\(^3\). The above attitude is very much present in the rural areas. Drèze and Kingdon (1999) stated “Parents are not generally opposed to female education but they are reluctant to pay for it”.

Apart from income status of the household, parental education has an extremely strong influence on girl’s school (Behrman and Wolfe: 1983, 1984; Psacharopoulos and Arriagada, 1989; Pandey, 1990). Parents’ education may represent their taste for schooling. It is expected that the educated parents can easily understand the importance of education in children’s life. Qualitative data from four educationally backward states– Bihar, Uttar Pradesh, Rajasthan and Madhya Pradesh suggest that irrespective of educational differences among parents, 90% of them believe that a boy should attend school but in case of girl students, education level of parents does matter in deciding the fate of her schooling (Ramachandran, 2004). The probability of girl’s schooling goes up to 30% if their parents believe that a girl should go to school. King et al. (1986), using

\[^3\]This means that daughters would join their husband’s household at marriage and therefore the expected benefit of educating daughters may be small relative to the expected benefit of educating sons who provide help for parents in old age.
the 1979-80 Asian Marriage surveys, found a clear positive effect of father’s education on both sexes, but no significant effect of mother’s education on boy’s schooling and a significant effect for girls only in the middle class, urban sub-sample. Holmes (2003), shows that this impact differs by gender- the education of the father increases the expected level of school retention of boys and that of the mother’s enhances the educational attainment of girls.

Child labour employed both in-house (sibling care provider, helper in family business etc.) and out-house (wage employment) in developing countries is an extremely important factor determining their educational outcome. Children are expected to undertake a range of low-skilled tasks such as taking care of siblings and household duties. It has been shown in many studies that these types of chores tend to reduce the educational attainment (King and Hill, 1993; Ghosh, 1991, Rosensweig and Evenson, 1997). However, Cigno and Rosatti (2002), in reference to rural India found that for children aged 6-16 years, there is a positive impact of the time used to work and a negative effect on the time used to attend school.

Parent’s perception about ideal age of marriage of daughter affects girl’s education inversely (Odaga and Heneveld, 1995; Bhan, 2001). They note that parents worry about wasting money on the education of girls because there are most likely to get married before completing their schooling and that once married, girls become part of another family and the parental investment in them is lost. Moreover, in the communities where the custom of ‘bride price’ rather than the ‘groom price’ is prevalent poor people prefer to marry off their girls as early as possible because it would benefit her family in terms of attaining bride price (Kasente, 2004; Kakuru, 2003). In the context of rural India, Bhan observed that education goes against the interest of marriage because of the fallacious perceptions of rural people. They hold that, educated girls lack domestic skills and thus fail to be good wives. They also feel that it is harder to find a groom for an
educated girl (it may be that an educated groom demands more dowry than an uneducated one).

Adult female workforce participation turns out to have a positive and highly significant effect on school attendance, both male and female in India (Wolfe and Behrman, 1984; Psacharopoulos and Arriagada, 1989; Tansel, 1997; Jayachandran, 2002). She explained that higher rates of work force participation by women give them greater bargaining power in household decisions; since women can be expected to be more concerned about the education of their children which in turn enhance school participation by the children. In other words, women’s labour force participation could enhance their influence on schooling decisions making them less male centred. On the contrary, there are also instances (Chernichovsky, 1985) where mother’s labour force participation decreases educational attainment of the daughters. They explained that in absence of the mother, the burden of household chores and sibling’s care left on the elder daughter reducing her chances of schooling.

The study of NSSO\textsuperscript{4} (52th round, 1996) investigated the impact of these variables on girl’s schooling status. The study revealed that financial constraint is the topmost reason for non-enrolment for both boys and girls followed by parents’ apathy towards children’s schooling, particularly for girls. As expected girls non-schooling status is mainly due to their domestic burden and sibling care; while for boys, it is participation in economic activities that result in non-enrolment. The trend is common all over the India irrespective of rich (Maharashtra) and poor (Uttar Pradesh) states. This observation reveals that the schooling status of children is strongly determined by their gender stereotyped roles in the

\textsuperscript{4}The National Sample Survey Organization (NSSO), now known as National Sample Survey Office, is an organization under the Ministry of Statistics of the Government of India. It is the largest organization in India conducting regular socio-economic surveys. It was established in 1950.
community. NFHS-3 (2005-06)\textsuperscript{5} carried out a similar type of investigation about the dropout of the students. Their observation reveals poverty as a major hindrance of schooling for both the sexes; 17.4\% of girls as against 18.4\% of boys leave school as their parents can’t afford schooling. The second most important reason for boy’s dropout is engagement in income generating activities inside and outside home. Similarly, it is household work that encourages dropout among the girls. Surprisingly, household work also proves to be a significant hurdle for boys schooling. Getting married causes dropout for 5.8\% of girls whereas it is only 0.2\% for boys. Lack of awareness about the importance of education is a significant factor for dropout: 3.8\% girl’s dropout because education is not considered necessary for them. The corresponding figure is 2.5\% for the boys. Sibling care accounts least for both the sexes.

The caste stratification of education is one of the major concerns in India and it is more profound when women are considered. SC and ST girls are the worst off in terms of most educational outcome indicators (Sarkar, 1996; Jamison and Lockheed, 1987; Pandey, 1990; Raju, 1991). According to MORD report (2007): 73\% of SC women, 79\% of ST women are illiterate. The drop out rate for the above mentioned social groups are 34.2\% and 43.3\% respectively. Cultural factors such as the lower classes not considering education as something required for upliftment could be possible reasons for their low levels of enrolment and attendance. Discrimination could also exist within the schooling system e.g. in the form of hostile teacher’s attitudes towards children belonging to disadvantageous community (Jaychandran, 2002). However, the effect of caste bias on education,

\textsuperscript{5}The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India. Three rounds of the survey have been conducted in 1992-93, 1998-99, and in 2005-06. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anemia, utilization and quality of health and family planning services.
according to PROBE\(^6\) study, required further exploration. The PROBE study put forward that there is a doubt about the perceived presence of caste bias in education sector if household income, parental literacy status and related characteristics are controlled. Secondly, it is expected that after introducing incentives and caste based reservations, the caste bias is eliminated in recent years. Like caste, religion is another factor affecting girl’s education. It is well known that school participation and educational levels in India are particularly low among the Muslim girls in rural area. Various researches (Sharma, 1997; Kareem, 1989; Engineer, 1994; Shariff, 1995) have shown that a Muslim girl has lesser chances of schooling than their Hindu counterpart\(^7\).

Access to and quality of schools prove to be very crucial for girl’s schooling. Access to and infrastructure of schools (inadequate number of teachers, school is far away, timing of educational institute is not suitable, unfriendly atmosphere in school, non-availability of lady teachers and non-availability of separate toilet for girls constitute the supply side barrier for the girls. Although, poor supply side conditions affect students of both the sexes; it is the girls who suffer most. Mensch

\(^6\)The PROBE survey (1999) formed the cornerstone of the Public Report on Basic Education in India, widely acclaimed as a landmark study on primary education in India. The states covered by the PROBE survey were Rajasthan, undivided Bihar, Madhya Pradesh and Uttar Pradesh. These states were referred in the report as the ‘PROBE states’. Himachal Pradesh was also surveyed, as the state of primary education there provided a contrast to the situation in the other states.

\(^7\)The most exhaustive analysis of the situation of Muslims in India is—“Social, Economic and Educational Status of Muslim Committee in India” – A Report. Cabinet Secretariat, GOI, New Delhi November 2006. The 2002 household survey by Jha and Jhingran also illustrated that Muslim children are much worse off than even those from SC/ST categories. The comparison becomes yet more skewed and unfavourable in case of Muslim girls, particularly those from lower castes. Whereas the aggregate figure for enrolment of Muslim children is 50.7 per cent as compared to 67.3 per cent for SC and 59.8 per cent for ST, the enrolment for lower caste Muslim children falls to as low as 36 per cent. The lower caste Muslim children also record the highest percentage (32.6 per cent) in the “never enrolled category” (Jha and Jhingran, 2005).
and Cynthia (1998), in the context of educational attainment in Kenya, observed that boy’s dropout rates are more often affected by the family’s socioeconomic status, while girl’s dropout rates are more often affected by the school environment. For instance, distance to school is a more serious handicap for girls than the boys. Similar type of observations has been found in the context of India (Drèze and Kingdon, 1999; Duraisamy and Duraisamy, 1991; Duraisamy, 1992). The results of PROBE study (1999) also shows how this infrastructure related variables affect girl’s education in an inverse way in India. The study of Ramchandran (1998) in the context of rural Rajasthan observed that even in a very gender stereotyped society like Rajasthan, families no longer need to be convinced for the importance of sending their girls to school. Wherever accessible and good quality educational facilities are provided, girls come in large numbers. The tragedy, she said, is not that people are not convinced about the importance of education for their daughters; the tragedy is that they want to send their daughters to school, but cannot do so because of lack of access to school and poor quality of schooling. Therefore, the supply-side interventions must be improved to enhance the chances of girl’s schooling.

In terms of government policies on women's education, it was observed that in both developed and developing countries there are no explicit discrimination by gender in education sector (Report of the Task Force on Educational Development, UNDP, 2010) but it may be implicit in the system. King and Hill (1993) observed that one of the main factors behind the gender disparity in education is the institutional structure where there are biases against girl’s school choice, and another one is the cultural impediments and different standards applied to genders. For example, teachers may be prejudiced against girls for their low skills in mathematics and science.

The cross-country data shows that many middle income countries like China, Sri Lanka and Cuba have managed to build education systems with stress
on universalization of elementary education. Even amongst the poorest countries today\(^8\), an encouraging number have begun to register strong and sustained increase in primary completion rates.

Some of the particular measures adopted in those countries are: i) eliminating school fees, ii) improving access and infrastructure, iii) focusing on low performing regions, iv) instituting conditional cash transfers, v) introducing school feeding programmes etc. Several interventions have been proved particularly successful where girl’s participation is low (ibid). In India, most of these measures have been adopted through the SSA programme.

<table>
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<tr>
<th>Age groups</th>
<th>Sector</th>
<th>Currently Not Enrolled</th>
<th>Enrolled and currently attending</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Never Attended</td>
<td>Ever Attended But Currently Not Enrolled</td>
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<tr>
<td>Elementary school age (5-14) years</td>
<td>Rural+ Urban</td>
<td>11.07</td>
<td>9.77</td>
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<tr>
<td></td>
<td>Rural</td>
<td>12.77</td>
<td>11.13</td>
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<tr>
<td></td>
<td>Urban</td>
<td>7.27</td>
<td>6.76</td>
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<tr>
<td>Secondary school age (15-18) years</td>
<td>Rural+ Urban</td>
<td>12.42</td>
<td>7.89</td>
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<tr>
<td></td>
<td>Rural</td>
<td>12.48</td>
<td>9.05</td>
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<tr>
<td></td>
<td>Urban</td>
<td>6.19</td>
<td>5.72</td>
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Despite the effort, however, the gender gap is still significant in the advanced age group and particularly in rural areas (table 2.1); although, in the primary level, the gap has noticeably been narrowed down.

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\(^8\)These include many countries in Sub-Saharan Africa- Benin, Burkina Faso, Eritrea, Ethiopia, Gambia, Guinea, Malawi, Mali, Mozambique and Togo. Our neighbouring countries Bhutan and Nepal are also making similar strong progress.
2.3 Investment in Health and Human Development:

Like education, health is fundamental to the social and economic development and thus, it is the core of human development. The household provides the environment in which individuals produce and consume health along with other goods and services. The household also provides the mechanism for intra-household allocation of essential commodities such as health care, food, clothing and reproductive health services. This allocation mechanism is important because it determines the well-being of all household members. This allocation often goes against the women and elderly persons who are considered “unproductive”. A study by Sen (1984) has shown that females received lower nutrition than the required quantity in all the age groups starting from 10 to 12 years onwards. The intake shortfall varies from 11% in the younger age groups to 40% in the older category. Kocher (as quoted in Ray, 1996), in reference to rural Pakistan, pointed out that medical expenditure varies systematically (and inversely) against women and elderly person because the household allocation is often decided according to the earning ability of the members of the household which is supposed to be less for these groups. The bias is reflected not only in smaller allocation of expenditures to members perceived to be earning little or none but sometimes in absolute terms as well. In this backdrop, the women of the developing countries are exposed to greater risk of mortality in general and specifically during pregnancy. The most important aspect of maternal death is that they are preventable if the pregnant women have availed adequate antenatal and post natal care and if the delivery is assisted by health personnel. Unfortunately, there are very few women who have availed all of the above three components of safe delivery practices particularly institutional delivery in less developed regions of the world including India (NFHS 3, 2004-05).

Now, the familiar microeconomic consumer theory tells us that a rational consumer, while making purchase decision always tries to maximize his/her
utility subject to the available resources. If we consider institutional delivery as ‘health care consumption’, then necessarily the purchase decision will be depended on the associated price of it and available resources and perhaps most importantly, the perceptions of the consumer regarding the utility associated with it. If we write the intuitional delivery demand function in the line of Grossman’s Human Capital Approach to health (Grossman 1972, 2000) then it becomes -

\[ Qd \ (ID) = D \ (Pm, QL, PS, Y, T, E, K) \] ………. ….(i)

Where -

\( Pm \) is the price to the consumer of obtaining medical care. Price is a complex variable that includes various qualitative and quantitative aspects such as official user fee, opportunity cost of time spent on waiting and getting the treatment. \( QL \) is quality of care, \( PS \) is a vector of prices of substitute care at other facilities, \( Y \) is summary variable for income of the individual or household, \( T \) represents social, household, cultural and individual preferences, \( E \) is education and \( K \) is knowledge about the characteristics of and need for medical treatment.

The direct price for receiving ante-natal care or institutional delivery in public institution in India is minimal but the opportunity cost of time for rural women is very high. In rural India as well as in rural West Bengal, household is also a workplace for many poor women. If the household belongs to a family dependent on agriculture, the women of the household spend considerable time as unpaid family labour. She generally takes part in field preparation, transplantation, harvesting and threshing. She has a significant share in total labour use in production of crops. A study in tribal Orissa shows that women have spent 185 days in cultivation as family labour whereas her male counterpart spent 85 days as family labour (Krishnaraj and Shah, 2004). Similarly, if she belongs to a rural artisan family having own family business then she is a committed labourer in the production process. Thus, rural poor women carried out both the market and non-market related activities and therefore the opportunity cost of time is
very high for the rural females. Sen (2011) pointed out household responsibilities and increasing workload on women as a major hindrance to their health use. Quality of care is a significant factor in a women's decision to seek care, to give birth at a clinic instead of at home, or to continue using contraception. Health programmes achieve better outcomes when recipients believe that their needs are being met and when they are treated with respect and technical competence. Unfortunately, in rural India, supply side distortions like unavailability of doctors, corrupt health personnel, uncompassionate nurses, etc are very familiar problems in public health institutions that greatly reduce the credibility of the system (Menon, Sen and Shivkumar, 2001). On the other hand, substitute care like birth assisted by traditional birth attendant (Dai) is both cost effective and culturally permitted. The study of Verma, Khan and Hazra, 2010), in the context of rural Uttar Pradesh, found the choice between home and institutional delivery is not determined by the direct cost associated with each option rather is affected by other factors such as family’s trust in the ability of “dai”, their desire to follow family customs and rituals regarding birthing and the easy accessibility within the community. Total income of the household is another important concern that affects women's exposure to disease and injury, their diet, their access to and use of health services and the manifestations and consequences of disease. Mathiyazhagan (2003) corroborates that health expenditure of household members of rural India is sensitive to changes in household income levels and the elasticity of health expenditure with respect to income is the largest for high-income groups. Health status is a direct product of economic power. Chakraborty (2003), found that higher the capacity of persons to purchase health and medical services, greater the likelihood of better health status. Alternatively, the poorer section of the population suffers badly in the maintenance of health and treatment of ailment due to poor financial status. Although, in general, women in higher socioeconomic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socioeconomic groups, factors such as
education appear to be important mediators (Addai, 2000; Leslie and Gupta, 1989). Apart from family income, personal income of the mother or mother’s work status does play a major role in deciding about delivery location and attitude towards safe delivery practices. It is expected that the employed women are better informed and better aware about personal care and thereby tend to have institutional delivery and associated pre-natal and post natal care. But in most cases, the opportunity cost of time invested for such practices is very high for employed poor women. Since in rural area, the relationship between work participation of women and the economic status of the household is inversely related (Srivastava, 2009), there is little scope for leisure or respite from work due to the pressure for securing the daily meals and for other requirements (school fees, cloths, purchasing books and stationeries) for her existing children. Maternal education along with the income status is perhaps the strongest predictor of utilization of maternity care services (Stewart and Sommerfelt, 1991). The most direct effect of schooling is dissemination of knowledge that increases the accessibility of women towards employment, mass media, modern ideas and values which in turn affect the reproductive behaviour. In the high fertility countries such as Egypt, Taiwan and Chile, a distinct negative relationship is found between educational attainment and the number of children born to her (Bhende and Kanitkar, 1978). However, some researchers (Alauddin, 1980; Martin and Juarez, 1995) found that this negative relationship is not universal one. They observed that universal primary education, would not, by itself, have much immediate effect of fertility decline but it is the single most important determinant of the knowledge of clinical methods of contraception. Father’s education, in this context is also relevant. The study of Ajakaiye, Mwabu (2007), showed that the correlation of health demand with education is not a universal one. Using Kenyan data they showed that in rural areas, a mother’s education is positively correlated with utilization of tetanus immunization services but in urban areas, a woman’s own education is weakly correlated with demand for such services. Rather the
main determinant of a woman’s demand for vaccination is her spouse’s education than her own. Religion and caste are also important concern that affects reproductive health behaviour. Muslim and Schedule Caste and Tribe women are considered to be more vulnerable than other sections of the community. The lesser health use by these three sections of the community may be attributed to their lesser access to education and widespread poverty amongst these groups. However, there are other reasons too. Muslim families are more conservative and therefore are less reluctant to institutional delivery particularly in absence of all women health centre (Khan 1989, pp: 76 and Mondal 1992, as quoted in Singh, 2008). The tribal are reluctant to use public facility regarding delivery because they believe in their own medicine and medical practices (Verma & Roy 1993; Roy & Sahu 2006). Acharya (2011) in a study of Dalit Children in selected villages of Gujarat and Rajasthan observed that about 7 out of 10 times, children were discriminated by doctors, lab technicians and even by Rural medical practitioner and this sort of discrimination was more vigorously practiced by pharmacists, ANMs and Anganwadi Workers also. They did not touch the dalit children for almost every time they interacted with them. In some cases no information or incomplete/incorrect information is provided about health and immunization camps. Jumani (1991) also identified that sometimes the poor, rural, dalit women actively disallowed development assistance by the higher caste ‘Sarpanch’. Realizing the need for medical assistance is another factor that determines the use of reproductive health care. The ‘need’ is generally felt by other members of the family. In case of reproductive matters, the decision is generally taken by others rather than the incumbent herself. The report of Centre for Operations Research & Training (CORT), 2007 found that the decision regarding delivery location, in 65% cases, is decided by the husband. As pointed out earlier, women are at the end of the chain of recipients of intra-household resources; the need for any type of personal care is felt much later than required. There is also a ‘lay health’ culture among the rural women. According to Bhende and Kanitkar (1978), this lay health
culture is also attributed to lower social status of women. From supply side perspective, accessibility of health services has been shown to be an important determinant of utilization of health services in developing countries. In most rural areas in India, one in three women lives more than five kilometers from the nearest health facility (World Bank, 1994). The scarcity of vehicles, especially in remote areas and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. Some studies stress the accessibility factor more than the demand side factors. The study of Sawhney (1993) and Elo (1992) has shown that the effects of inadequate access to services on utilization of services are greater than the effects of socioeconomic factors. Rosenzweig and Schultz (1982); Govindasamy and Ramesh (1997) also acknowledged that the effects of socioeconomic factors on utilization of services become less important in the presence of adequate health care supply. The study of Sugathan, Mishra, and Rutherford (2001) shows that availability of a hospital within 5 km of the village does not have a statistically significant effect on the odds of giving birth in a medical institution in most cases, after other potentially confounding variables are controlled. The effect of availability of an all-weather road on institutional delivery is usually positive, but again not statistically significant in most cases. Muller et al. (1998) found that the willingness of patients in the rural tropics to seek medical care at primary health care facilities is decreased with the increase in distance; however, the relationship is not a linear one and varies regarding age and sex.

The study of Thind et al. (2008) combines all the above factors. In the context of Maharashtra, maternal health care utilization includes three distinct types of variables namely-i) predisposing variables, ii) enabling variables and iii) need variables. Predisposing factors include demographic characteristics that reflect the propensity of the individual to use the currently available resources. The predisposing variables include age, education status, caste, religion etc. Enabling factors (both organizational and personal) represent the actual ability of
the individual to seek health care. **The enabling variables** are household’s major source of income, average monthly income of the family, occupation of the incumbent, distance of health centre and ultimate place of delivery, exposure to information, number of antenatal visits, timing of first visit to centre during pregnancy etc. The most immediate factor of health service utilization is **need** that can be addressed by the individual or the family caregivers. In the context of reproductive health status of poor rural women, neither the predisposing factor nor the personal enabling factor worked well because of the widespread poverty, illiteracy and overall lower social status of women. According to Thind et al. (2008), JSY may emerge as an enabling factor in respect of health care utilization.

The programme JSY tries to reduce maternal mortality by improving the rate of ante natal check-ups and institutional delivery. The JSY is one of a number of different types of financial incentive programmes that have become popular in developing countries during the 2000s. However, the effect of JSY on safe delivery practices is quite controversial even though there is an improvement of safe delivery practices (institutional delivery perhaps is the most important of them) after the initiation of the programme. Maternal mortality has fallen by 47 percent from 398 deaths per 100,000 live births in 1997-98 to 212 deaths per 100,000 live births in 2007-09 (Registrar General of India, 2006; Registrar General of India, 2011). In the interim period, under-five mortality has also improved, from 109 deaths per 1,000 live births in 1992-93 to 74 deaths per 1,000 live births in 2005-06 (International Institute for Population Sciences and Macro International, 2007) and neonatal mortality currently stands at 35 deaths per 1,000 live births (Registrar General of India, 2009). Nonetheless, these trends are not sufficient for India to meet its international health targets in 2015.\(^9\)

\(^9\) India’s MDG 4 target is to reduce IMR by two-thirds between 1990 and 2015, i.e., from 80 infant deaths per 1000 live births in 1990 to ‘28’ by 2015. India’s main MDG 5 target is to reduce MMR by three quarters between 1990 and 2015, i.e., from 437 maternal deaths per 100 000 live births to ‘109’,
In addition, the national picture masks enormous differences across states. For example, Kerala’s maternal mortality rate is almost five times lower than some of the worst performing northern Indian states (Registrar General of India, 2011). India’s maternal and child health programmes have not aggressively promoted institutional deliveries, except in high-risk cases till the introduction of JSY. Several studies (Verma, Khan and Hazra, 2010) detected JSY as the most important factor that has increased the rate of institutional delivery. In the context of rural Uttar Pradesh, they found that, subsidization of out of pocket payment under JSY scheme helps 74 percent of women to opt for public facility for delivery. The formative study of Population Council (2010) also found that after the initiation of JSY, 44 percent of women had delivered in an institution. Corresponding figures reported in NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3 (2005-06) and DLHS-3 (2007-08) were 7, 11, 17 and 23, respectively. The study also shows that after the introduction of the JSY, the share of institutional deliveries in private hospitals declined from 63 percent in 1998-99 to 37 percent in 2009. Reciprocally, the share of institutional deliveries at public facilities increased from 37 percent to 63 percent due to the JSY incentive. On the contrary, the study of Mazumdar, Mills and Jackson (2011), has shown that there is no evidence that JSY had a substantial effect on utilization of antenatal care services. The point estimate on the outcome indicating whether a woman received three or more antenatal care visits is small and statistically insignificant in the specification without demographic controls. Similarly, JSY increased access to maternity services at health facilities below the district hospital, which are less able to manage emergency complications at childbirth. Jeffrey and Jeffrey (2010), in the context of Uttar Pradesh, found that that neither the NRHM nor the JSY were intended to address the health care challenges in rural area. They argued that decades of mistrust of government

while it has also committed to improve the ‘proportion of births attended by skilled health personnel’.
health services and controversial family planning programmes\textsuperscript{10} have left a credibility gap not easily filled by offering financial incentives and investing in new infrastructure. Dongre (2010) indicates that in the initial one and a half years of its operation, the scheme did not have any effect on the disparity between the targeted and non-targeted states. In fact, the gap between the two was widened in this period, albeit marginally. But beginning from 2007, the targeted states have shown much larger improvements in the institutional deliveries, leading to a dramatic decline in the gap between the targeted and the non-targeted states.

2.4 Economic Independence and Empowerment:

The third selected programme- Swarnjayanti Gram Swarozgar Yojana (SGSY) is a credit-based scheme sponsored by the Government of India aiming both for poverty alleviation and women empowerment. Self-Help Groups created under the programme help the poor, particularly women; obtain credit that would empower them economically (NABARD, 1995). So in respect of SGSY programme, the outcome of impact of the programme could be twofold: the economic impact and the non-economic impact. Several studies (Das, 2013; Garg \textit{et al.}, 2012) showed that there was significant increase in income generation activity, expansion and diversification of activity, increase in personal savings and income level, man-days generation, economic independence and assets creation among

\textsuperscript{10}On June 26, 1975, state of political Emergency was declared by Prime Minister Indira Gandhi. In 1976, with India’s population growing rapidly and the Emergency extended for another year, the Minister of Health and Family Planning, Karan Singh (with the patronization of Sanjoy Gandhi-the son of Indira Gandhi), announced a National Population Policy aimed to deter population growth and events that contributed to it. Even if the policy proposal did not proposed compulsory male sterilization, but indirectly it advocated for it. A large number of vasectomy camps were opened in each state. The incentive of vasectomy was either Rs. 500 or a radio. Intense bureaucratic pressure led these camps to falsely believe that they were more prepared for the increase in the only the number. Hence, a number of deaths occurred as a result of infection from unhygienic procedures (Gwatkin, 1979; Cassen, 1978).
the SHG members after they were linked to credit. Dasgupta (2000) observed that micro-financing through informal group approach has several benefits viz.: (i) savings mobilized by the poor; (ii) access to the required amount of appropriate credit by the poor; (iii) matching the demand for and supply of credit structure; (iv) reduction in transaction cost for both lenders and borrowers; v) tremendous improvement in recovery; (vi) heralding a new realization of subsidy-less and corruption-less credit and (vii) remarkable empowerment of poor women. He stressed that SHGs should be considered as one of the best means to counter social and financial citizenship not as an end in itself. On the other hand, Purushotham (2008) found that even in the better performing State of Andhra Pradesh, the income gain to a swarojgari from enterprise activities under SGSY was a mere Rs. 1,228 per month. Pathak and Pant (2008) in the context of rural Uttar Pradesh also observed that SGSY has not contributed significantly in change in the level of income of the beneficiaries; but women have shown greater enthusiasm in the making of SHGs and these SHGs were vibrant too. The small income gain to swarojgaris from enterprise activities may be attributed to (among other factors) the low productive traditional activities in which the swarojgaris were engaged in and also due to low absorption of technology; unless at least one member of the family acquires skills and engages in high value addition activities, a BPL family may not move out of poverty. The diversification of productive activities is, perhaps, minimal under the programme (diagram 2.1). The diagram shows that SGSY programme could not come out from the dependence on low skilled primary sector activities.

Integrated Rural Development Programme (IRDP) from which SGSY was generated experienced similar type of shortfalls. The Evolution Report on IRDP (1985) has shown that even though additional incomes were accrued in case of 55 to 90 percent beneficiary, not more than 40 percent crossed the poverty line. The assets created by IRDP were mainly in low productive traditional items like dairy
and other animal husbandry, cottage industry and handicrafts (Mishra and Puri, 2001). So, there is no basic difference of economic aspects between SGSY and IRDP.

Diagram 2.1: Funds utilization on different productive activities- SGSY

![Diagram showing funds utilization on different productive activities- SGSY](image)


The difference is mainly in non-economic perspective like inclusion of women in mainstream economic activities. This induces some changes in the expenditure pattern of the household\(^\text{11}\). One such study provided by Manimekalai (2010) is cited in table 2.2. It may be seen that after food, the second most important item on which the additional income is spent is education. A Similar type of study on IRDP found only 6.7% increase in expenditure after any member of the household joins IRDP (Singh, 1996). There have been recent suggestions that participation in micro-credit may be beneficial to the health of the poor,

\(^{11}\)It has been well documented that an increase in women’s resources results in increased well-being of the family, especially children. Transfers to women rather than men appear to have an impact on nutrition, child goods, education expenditure and school enrolment. Similarly, old-age pensions for women appear to have a positive impact on the outcomes of children and younger adults in the same household, including school enrolment, nutrition and expenditures. This is not the case with pensions for men (Young \textit{et al.}, 2012). For example, health of Brazilian children improved when additional non-labour income was given in the hands of mother through Bolsa Familia Programme (Thomas, 1990). In the United Kingdom, when legislature ensured that child support payments were given directly to the mothers, expenditures on children’s clothing tend to rise (Lundberg, Pollack and Wales, 1997).
particularly for women, because the participatory status under SHG increases both assets and female autonomy (Feurestein, 1997; Fisher, Holland and James, 2001; Patel, 2000).

Table 2.2: Item wise Distribution of Consumption Expenditure before and after Joining in SHG (in Rs.)

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean expenditure Before</th>
<th>Mean expenditure After</th>
<th>Difference in Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>1257.01</td>
<td>1615.41</td>
<td>358.40</td>
</tr>
<tr>
<td>Clothing</td>
<td>98.99</td>
<td>141.52</td>
<td>42.53</td>
</tr>
<tr>
<td>Education</td>
<td>59.23</td>
<td>123.95</td>
<td>64.72</td>
</tr>
<tr>
<td>Health</td>
<td>41.94</td>
<td>61.38</td>
<td>19.44</td>
</tr>
</tbody>
</table>

Source: Manimekalai (2010).

Chakraborty (2003) also observed that most of the women members of SGSY were found conscious of the need for literacy and keen to educate their children. They were more aware of family planning too. On the contrary, Kundu and Mukherjee (2011) found that from 2004 to 2008, the programme has significant impact on female agency across all socio-religious groups except Muslims; but the role of the programme in forming human capital is insignificant irrespective of socio-religious groups. Ahmad (1999) through a case study on Thrift Groups in Assam highlighted that women are coming to the administration directly for their just rights and to address their grievances boldly. It proved that Self Help Groups are successful in North East India even in the midst of insurgency. Similarly, Gurumoorthy (2000) mentioned that SHG is a viable alternative to achieve the objectives of rural development and to get community participation in all rural development programmes. SHGs enhance the equality of status of women as participants, decision-makers and beneficiaries in the democratic, economic, social and cultural spheres of life.

In reference to the socio economic profile of SGSY participants, a report of planning commission (Credit Report, 2008) observed that most of the beneficiaries
were belonging to the age group of 26-45 years. They were found either illiterate or educationally backward. They are mostly married and belong to nuclear families. Their housing conditions are not so good where they face problems of electricity, safe drinking water and sanitation. The land holding size of respondent’s families has been reported to be small and one third of them were landless. The beneficiaries were mainly self-employed and housewives. The respondent’s husbands were mostly either unemployed or self-employed. The household income of majority of respondent’s families has been reported to be low; however, the contribution of beneficiaries to the family income has been recorded to be significant.

The SGSY programme has been found to serve another very important function—that of the lender of short term loans. People in the rural areas even those who benefit from different other government programmes are often in need for short term small amounts of loans to tide over immediate requirements. For example, that the JSY monetary assistance for institutional delivery which is reimbursed later the expenditure has to be made earlier and there are no formal banking institutions to offer such type of small ready loans. Similar examples can be set for the education sector also. For example, the children of tobacco rollers, schedule caste or schedule tribe children, Muslim students are entitled to get different types of monetary assistance so that they can continue education. But most of the time the grants came once in a year but the expenditure for schooling continues throughout the year. In such cases, repayment of the borrowing for education or health is not a tough task but the access to the borrowing is very limited in rural area especially for women. The programme of SGSY which is basically a poverty eradication programme through self help groups may challenge this situation. A study in rural Uttar Pradesh reveals that SHG is now functioning in the place of moneylenders because loans could be taken from it at any time as and when needed for any purpose. There are no formalities involved
and the transaction cost is low (Singh, 2002). So, microfinance may act as an escape route to avert poverty trap and allow greater investments in human capital.

2.5 Conclusion:

The foregoing discussion attempts to briefly enumerate the main findings of the impact on the three selected programmes directed towards human development and empowerment of rural women. Against this background, the present study seeks to throw some light on the implementation status of these selected programmes in backward vis-à-vis advanced state of India with a special focus on the state of West Bengal. This will be followed by an attempt to identify the determinants as well as the magnitude and direction of their influence on the impacts of these programmes and on the quality of life of the beneficiaries. The next chapter will provide a brief description of the selected programmes and investigate the implementation status of them in different states of India.