

## Life course perspectives on women's autonomy and health outcomes \*



Monica Das Gupta

Center for Population and Development Studies, Cambridge MA

### Abstract

This paper examines how different patterns of kinship and inheritance affect intergenerational relationships and the ramifications of gender inequality. Peasant societies of pre-industrial Northern Europe are contrasted with those of contemporary South Asia to illuminate some of these relationships. While Northern European kinship and inheritance systems made for high status in youth and a loss of power and status as people aged, South Asian systems make for lower power and status in youth and a rise as people age.

From this follow more conflict-ridden relationships between the generations and a stronger conjugal bond in Northern Europe, while in South Asia intergenerational ties are strong and the conjugal bond is weak. This in turn leads to a greater potential for marginalizing women in South Asia, although gender inequality exists in both settings. The convergence of low autonomy due to youth as well as sex amongst young married women in South Asia means that women are at the lowest point in their life cycle in terms of autonomy during their peak childbearing years. As shown in this paper, this has considerable implications for demographic and health outcomes: in terms of poorer child survival, slower fertility decline, and poorer reproductive health.

In recent decades, a great deal has been written in the social sciences on the subject of female status and autonomy in both developed and developing country settings. A subset of this literature has specifically pointed out some of the negative demographic consequences of low female autonomy. In particular, low levels of female education and autonomy have been perceived to be barriers to improving child survival and reducing fertility.

Much of this literature focuses on the low status of women relative to that of males. Yet there is also a large body of evidence, especially in the anthropological literature, that a woman's status rises and falls over her life cycle. Several studies highlight the fact that in some societies, women have higher status when they are younger, while in others it is when they are older (Bart 1969; Foner 1984; Vatuk 1987; Yanagisako and Collier 1987). Bart views this as an intertemporal 'zero-sum game', in that status being high at one point of the life cycle is dependent on its being lower at another point.

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This statement can, of course, be extended to men. Both men and women spend part of their life cycle in a position inferior to that of others of their own sex. This is quite independent of the question of gender inequality, in which it is common for women to have less power and autonomy than men at any given point in their life cycle. Thus in many

societies, women spend part of their life cycle in a situation of double powerlessness: they are in a subservient position not only to *men*, but also to other *women* who are at a different stage of their life cycle.

This paper begins by contrasting patterns of household formation and inheritance in peasant societies of pre-industrial Northern Europe and Northern India, discussing how these patterns are linked to the acquisition or loss of power over the life cycle. It goes on to argue that whether women's status is higher in youth or in old age makes a critical difference to health and demographic outcomes. This is illustrated with data from my fieldwork in Northern India<sup>1</sup>, and from other studies in South Asia.

### **Household formation patterns and swings in life cycle autonomy**

Two basic patterns of life-cycle shifts in autonomy can be summarized crudely as follows:

	<b>Married youth</b>		<b>Older ages</b>
<b>PATTERN 1</b>	Higher autonomy	→	Lower autonomy
<b>PATTERN 2</b>	Lower autonomy	→	Higher autonomy

Societies falling into Pattern 1 are those in which autonomy is highest amongst young married adults, and falls with the process of ageing. The reverse is the case in societies falling into Pattern 2, where power and autonomy rise with age, and begin to dip again only at extremely old ages (the old-old). The distinction made between power, authority and autonomy (Lamphere 1974; Mason 1984; Vatuk 1987) is important to this discussion, although all three are subsumed under the shorthand of 'autonomy' in the above dichotomy.

The examples of both the 'Pattern 1' as well as the 'Pattern 2' societies discussed here are characterized by gender inequality, that is, of women being socially subordinate to men. This similarity highlights the importance of differences in power between women at different stages of the life cycle in influencing demographic outcomes.

#### ***Pattern 1 societies***

This discussion of Pattern 1 societies is based on Northern European peasant societies which had impartible inheritance and nuclear or stem families. It is based primarily on Berkner's (1972) study of eighteenth-century Austrian peasant households, but also uses similar accounts emanating from nineteenth-century Scandinavia (Gaunt 1987; Plakans 1989; Sorensen 1989) and from nineteenth-century Austria (Sieder and Mitterauer 1983).

Under this family system, property and managerial power were retained by the head of household until he retired. Retirement and property transfer typically took place at the time of the heir's marriage. It was common for a retirement contract to be drawn up, specifying where the old couple would live, and what obligations the heir had for providing the retired parents with food, fuel and other material support (Berkner 1972).

For the new couple, this meant that they started out with an independent economic base, and were in control of all decisions relating to their household. For the old couple, of course, it meant a very sudden reduction in power and status. The strong intergenerational conflict

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<sup>1</sup> This consisted of a study of village Ramput, which was originally studied by Oscar Lewis in the early 1950s, and of a study of eleven villages in Ludhiana District, Punjab, also earlier studied in the 1950s (Wyon and Gordon 1971).

arising out of this sharply discontinuous system of transfer of property and authority is discussed and illustrated with contemporary accounts by several historians, and summarized by Plakans (1989:177): '...there is now something like a consensus that the treatment of the old was harsh and decidedly pragmatic. Dislike and suspicion, it is said, characterized the attitudes of both sides'.

This discussion of intergenerational relationships focuses on the relationships between men, which follows from the fact that these societies were patrilineal in terms of inheritance and patrilocal in residence. This did not extend to having patrilineages, in the sense of corporate groups. Land was passed on to a son, so the tension over retirement contracts revolved essentially around the father and son. Much less information is available on how women fared under this system: 'the sources speak most revealingly of men and mention spouses as an afterthought and female heads as a transitory phenomenon' (Plakans 1989:191). However, it seems that the mother was also centrally involved in her role as the wife of the retiring farmer, who would share with him the comforts or discomforts of retired life.

The incoming wife was of course an outsider to the household. Depending on how far away her own family was, she might have considerable or negligible contact with them. In describing the position of the new wife in mid-twentieth century rural Ireland, Arensberg and Kimball (1968) recount how strongly some of these women missed their homes and the familiar people there. However, the emphasis on a strong conjugal unit facilitated the woman's situation:

Nevertheless, stranger as the new woman may be, the norms of the community in ordinary cases demand that the young husband take the part of his wife. The bond between them is stronger than that between son and parent (Arensberg and Kimball 1968:128).

Thus the independence of the new couple meant that the woman had a high degree of autonomy in household matters, subject only to her husband's acquiescence.

Of course, there was considerable variation over time and place in the details of the operation of kinship and inheritance in Northern Europe. A somewhat stylized version of it has been presented here, highlighting its essential features in order to throw into relief the contrast with inheritance and household formation patterns in Northern India. Others have earlier found it useful to draw stylized contrasts between these systems (Goody 1990; Hajnal 1982). Moreover, only the lifecourse of the landowning peasants is discussed here. The lifecourse of those lower down in the socio-economic hierarchy could be entirely different: for example, the high prevalence of non-marriage meant that many never established a household of their own.

From the point of view of health and demographic outcomes, the important contrasts with Northern India hinge around the strength of the conjugal bond on the one hand, and the extent of intergenerational bonding on the other hand. Amongst these Northern European peasants, the conjugal unit seems to have been the most important in economic, social and emotional terms. The viability of the farm itself depended on the joint viability of the couple in charge. The couple *was* the joint enterprise, recruiting help as needed through childbearing and hiring servants. Though women might come as strangers into their husband's home, they came as the important and explicitly-acknowledged partner in the husband's enterprise. The strong focus on the conjugal bond was paralleled by weak and inherently conflict-ridden intergenerational links.

### ***Pattern 2 societies***

This discussion of Pattern 2 societies is based largely on contemporary rural Northern India. Occasional references are made to Bangladesh and to China, as their family and inheritance

forms have much in common with Northern India. Household formation in such societies follows the model of the multiple or joint family (Laslett 1972), in which the transfer of managerial power and property is made gradually as the head of household ages. The sons work the land along with the father, then gradually take over managerial decisions, and finally the property is transferred to them, frequently after the father's death.

The gradual nature of the transfer of power and authority makes for much less intergenerational conflict than is described in the case of Northern Europe<sup>2</sup>. The new couple typically lives with the husband's parents and does not have an independent economic base of its own. Bonds between patrikin are strong, both intergenerationally (between parents and children) and intragenerationally (between siblings). Concomitantly, there is far less emphasis on the conjugal unit. Indeed, the marital bond is viewed as a potential threat to these other bonds, and is not given much opportunity to thrive. The basic unit is the joint-household, and not the couple, as it is in Northern European peasant societies. These contrasts are essentially those between what Linton (1936) called the 'conjugal' versus the 'consanguinal' family.

The position of women in Northern Europe and Northern India have some commonalities. They are clearly in a subservient position to men. Sons ensure the continuance of the family line. An extreme but nevertheless telling example of this in Northern Europe is given by Sorensen (1989:201):

... a particular property in Hessen, Germany, was occupied continuously for more than 400 years... by a Johannes Hoss. This remarkable stability was achieved by naming all sons in the family Johannes (with varying second names to provide individual identification) through this whole period.

These similarities highlight the differences in women's position in the two settings. The emphasis on the marital bond and weakness of intergenerational ties meant that the Northern European peasant wife had considerable autonomy in the running of the household and could care for her own and her family's health as best she could. In Northern India, women have highly limited autonomy in these matters until late in their life course. Close bonds between patrikin work to marginalize the young married woman.

Another factor contributing to this difference in autonomy is the age at which women typically married in these two settings. In Northern Europe the age at marriage was higher than in Northern India, and marriage was a contract between two adults. However, the marginalization of the bride continues even when the age at marriage rises: the data presented here showing the negative health outcomes of low female autonomy are based on Punjabi villages where women's average age at marriage is close to 22 years.

It can be hypothesized that to the extent that gender-based discrimination might have existed in Northern Europe, it is likely to have been volitional in nature. For example, a man might choose to mistreat his wife, or parents might choose to favour boys over girls. In Northern India, there would in addition to this be non-volitional forms of discrimination, leading to unintended negative outcomes. For example, in caring for a cherished son, a woman and her in-laws may share the same goals but fail to reach them because of poor communication.

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<sup>2</sup> Goody (1976) has argued persuasively that kinship is not an autonomous system, but that productive processes and the transmission of property shape domestic groups.

### **The phases of the female life cycle in a North Indian village**

The following description gives some idea of the experience of being female, from childhood to old age, in Rampur, a village in Northern India.

From birth, less trouble is taken over a girl than over her brothers. The birth of a girl is not celebrated ritually as is that of a boy, and even the payments to the midwife are less. It is openly acknowledged that if a female child falls ill, she is far less likely to get prompt and high-quality treatment than a male. The young girl is trained to be tough and hardworking, yet completely subservient to the decisions of her male kin. Nevertheless, she enjoys a certain amount of personal freedom and autonomy, which she will not regain after marriage until her old age. A girl can move freely in her own village, where all the men are her classificatory brothers.

There is a tremendous discontinuity when she marries and moves to her husband's village. A girl's behaviour has to undergo a dramatic overnight transition upon marriage, and she loses almost all voice and autonomy. In her husband's village she does not know anyone, and custom requires that she remain with her head bowed and not speak. On her first visit, she has to sit silently while all the women of the family and their friends come to scrutinize her and comment loudly on whether or not she is beautiful, examine the jewellery and the dowry she has brought, and in general behave as if she were an inanimate object. Upon returning to their own village, girls say that this was a real ordeal. The spiritual rebirth of a girl when she goes to her husband's family is sometimes emphasized by their giving her a new first name. Once back in her parents' village, she is once again free to run around, to be mobile and vocal as before. These sudden transitions in the total personality must be very difficult to achieve.

A young bride's personal and public behaviour is monitored by a whole array of women, including her husband's mother, aunts, grandmother, sisters and sisters-in-law. This is not to mention all the men in the household older than her husband, who are in a position of remote authority over her, and in whose presence she cannot speak. She is at the bottom of the household hierarchy, and the more onerous household tasks are given to her, such as waking up before dawn to fetch water or churn the butter. She never knows when she will be allowed to visit her parents: this, as well as the day of her return, will be decided suddenly and capriciously by her in-laws. Cut off from the rest of her affinal village, she is usually very lonely.

Many ways are used to keep the young wife and her husband apart, to delay the growth of a bond between them. Their daily tasks have mostly to be performed in different locations. Other occasions for marital privacy are also restricted. For example, after completing the long day's chores, a young woman is expected to massage her mother-in-law's legs at night before going to sleep.

A woman's status begins to rise when she has her first son. As her sons grow, her status increases, and continues to increase as the mother of grown sons, and then as a mother-in-law. Finally as an asexual woman, a grandmother, and the female head of the household, she can have a considerable amount of say in domestic matters. Freedom increases with age, as the number of people superior to the woman in the household hierarchy decreases. This is reflected symbolically in the fact that a woman has to cover her face in her husband's village from all men who are older than her husband, and obviously as she gets older, the number of such men decreases.

When she becomes too old to work, she gradually gives up the managerial duties in the household, and takes to spending more time on less physically demanding activities such as child-minding. She is now at a stage of her life when she is free to make leisurely visits to other houses, and spend time with her grandchildren. When she is too old to move, she sits on her bed in the winter sunshine or the summer shade, in the company of her grandchildren. She

continues to enjoy a great deal of respect and autonomy until she dies *if* she has sons who are openly supportive of her.

How strong a position a woman can command in her old age depends greatly on the support of her sons. This becomes especially important if she is widowed. If a widow has no sons, or her sons take the unusual step of refusing to look after her, her position is extremely vulnerable. If her sons respect her, the rest of the household will follow suit and her position within the household will be reasonably assured until she dies.

In brief, a young married woman in Northern India is in a highly subservient position vis-à-vis her mother-in-law and other older women in the household, as well as to the men. The rules of exogamy, ensuring that women marry outside their kin group and outside their village, make it easy to understand how such subservience can be enforced. As Dyson and Moore (1983) have pointed out, one factor contributing to the higher status of women in South India is the fact that women can marry within their kin group and village, thereby retaining many of their previous relationships in their new marital situation.

### **The mother-son bond**

Sons represent much more to their mothers than a source of support in old age. They represent almost the only means for women to build up some independent standing in the household. Women are the moving, peripheral parts of their society, while men are the permanent members of the lineage. Thus women have little intrinsic source of standing, other than as the mothers of the future men of the lineage.

Every effort is made not only to bear sons, but also to ensure that they are emotionally attached to the mother, firm supporters of the mother as they themselves grow in stature in the household. The woman is careful to bind her son to herself through a variety of measures. She can be solicitous of his needs, the gentle nurturer who cooks foods that he likes. She can allow her son to see how she suffers at the hands of her in-laws, and even her husband. She can allow him to see how hard she works and what suffering is her lot in life. She can be careful to communicate that all her sacrifices will be rewarded if only her son has a successful life, while also subtly communicating that she expects unquestioning loyalty from him in compensation for her sacrifices.

Similar strategies are reported from China (Wolf 1974; Hsiung 1993), where women are similarly deprived by virtue of their sex of other avenues for self-assertion. Unfortunately, the successful self-assertion of women through this route involves the sons' loyalty to her at the expense of their wives. Thus it contributes to perpetuating the cycle of subordination of women.

### **'Double powerlessness' and health outcomes**

The description of the stages of the woman's life cycle in Rampur, and in other studies of Northern India<sup>3</sup>, shows a clear pattern of how a woman's status and autonomy vary over the life cycle. Briefly stated, it is low in early childhood; rises during adolescence; drops sharply upon marriage and remains low during the early reproductive years; and rises during the later reproductive years to a high in the older ages when the woman becomes a mother-in-law and grandmother, followed by a small drop at extremely old ages.

This pattern is reflected remarkably faithfully in the comparison of female and male age-specific death rates in India (see Fig. 1). Female mortality is substantially higher than male

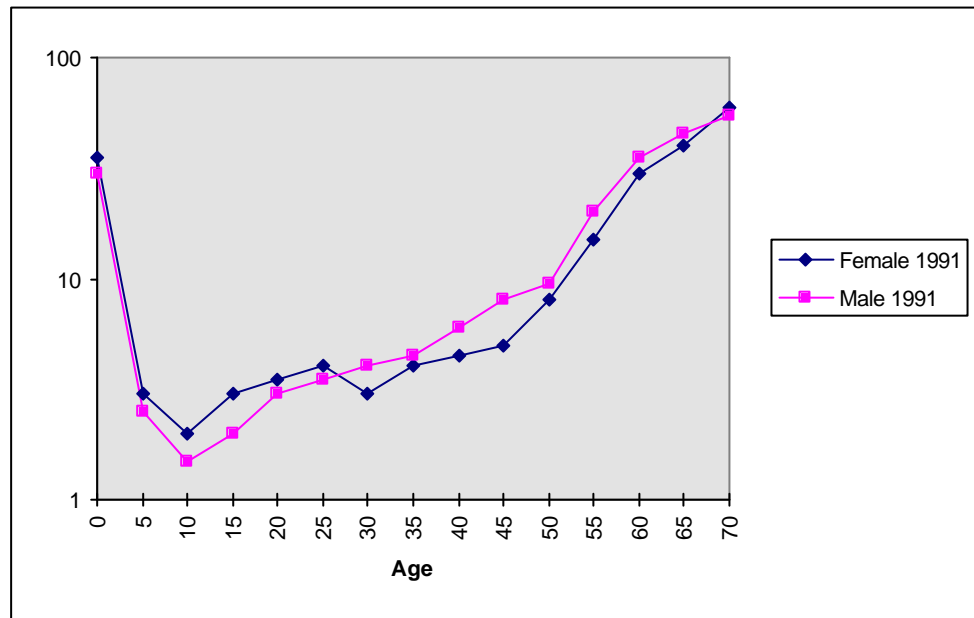
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<sup>3</sup> Others who have looked at women's position in North Indian villages have broadly similar descriptions (see for example Vatuk 1987; Jeffery, Jeffrey and Lyon 1989; Wadley 1994).

mortality in childhood, becomes similar during adolescence, and rises again during the peak reproductive years, after which it remains lower than male mortality rates over the remainder of the life span. In societies without strong gender discrimination, female survival rates are higher than male rates throughout life. The only exception commonly found to this is in populations with high fertility, where female mortality is sometimes higher than that of males during the reproductive years. In South Asia, however, the normal biological advantage of women is offset by social and behavioural factors.

The following is a description of how women and children's health can be affected in each stage of a woman's life by the 'double powerlessness' of women in Pattern 2 societies with strong gender inequality.

**Figure 1**  
Age-specific death rates by sex, India 1991



### *Child survival*

#### *Children of both sexes*

It is not easy to test the hypothesis that differences in maternal autonomy influence child survival. To compare this between peasant societies of Northern Europe and present-day India would require controlling for several aspects of economic conditions and exposure to disease, which would be difficult.

One currently available option is to compare differences between women within a given society, in personal autonomy and child survival. The results are very striking. As Table 1 shows, children born in the woman's in-laws' home (the children's father's home) have over double the infant mortality rate of those born in their mother's parental home. This relationship is significant even after controlling for several factors influencing child survival,

including the household's socio-economic status, the child's sex, mother's education, and much information on the circumstances of delivery and child care (Das Gupta 1990).

The selectivity in which births take place in whose home would tend to increase the apparent gap in infant mortality between births in the mother's own home and her husband's home. The custom is for first births to take place in the mother's own home, and for later births to take place in the husband's home. First births are known to be at higher risk of dying, followed by improved survival amongst second and third births and subsequent rise in mortality of higher-order births. Given that the births on which Table 1 is based took place when the Total Fertility Rate was below 3.26, there would be relatively few higher-order births, and the preponderance of high-risk births would be among the first births. The higher mortality of children born in hospitals and clinics is explained by the fact that the great majority of births take place at home, and deliveries in hospitals or clinics contain a high proportion of emergency cases rushed to the doctor when it became clear that the labour was very complicated.

**Table 1**  
**Infant mortality rates by place of delivery, Khanna 1984-88**

Place of delivery:	(deaths in the first year of life, per 1000 live births)		
	0 months	1-11 months	0-11 months
Mother's home	15	31	37
Husband's home	34	67	86
Clinic/hospital	27	38	41

The place of birth is an objective measure of the mother's autonomy at the time of the birth. In her parents' home, a woman is accorded the status and freedom she had before marriage. She is better able to care for her child's health because it is easy for her to ask for help if she feels that her baby is having difficulties. In her husband's home, she is much more constrained. If she says that her child needs help, this judgement may be overlaid by the judgement of her mother-in-law and others superior to her in the household hierarchy before a decision is reached<sup>4</sup>. The young husband, even if he is close to his wife, may not be much help because he is trained to defer to his elders, and especially to his mother where childrearing is concerned. The young mother's judgement may thus be ignored, or action may be delayed. Infants are so vulnerable that even a brief delay can mean the difference between life and death. For example, an infant with diarrhoea can die of dehydration within a couple of days.

Female autonomy as measured by a woman's own assessment of her role in household decision-making is also correlated with child survival. In an analysis of the determinants of child mortality (Das Gupta 1990), it emerged that the mother's autonomy was significantly negatively related to the probability of her children dying: the children of women who had greater decision-making authority in the household were less likely to die.

#### *Female children*

Female children suffer an additional burden because of the strong son preference in this society and discrimination against daughters. There is a large body of work on the different

<sup>4</sup> Interestingly, Greenhalgh and Liang (1988) attribute high child mortality in pre-revolutionary China partly to the low status of young wives.

treatment of boys and girls in early childhood in Northern India and Bangladesh. Girls suffer from substantially higher levels of mortality during childhood, except for the first month of life. For example in Bangladesh, females experience 22 per cent higher postneonatal (1-11 months of life) mortality than boys, while in Punjab the level is nearly double that of boys (Table 2).

The crossover between the male-female ratio in neonatal and postneonatal mortality is clearly indicative of different care of boys and girls. During the neonatal period biological factors preponderate amongst the causes of death, and the higher male mortality is consonant with their being biologically weaker than females. After this first month of life, environmental factors and care-related factors become more important determinants of survival, so the substantial gender gap in survival indicates that girls receive much less care than boys. Studies in South Asia indicate that there is greater discrimination in health care than in food, and that this is the main mechanism leading to excess female mortality (Wyon and Gordon 1971; Chen, Huq and D'Souza 1981; Das Gupta 1987).

**Table 2**  
**Infant and child mortality rates by sex, Khanna and Bangladesh**

	Age at death (in months)					
	<1	1-11	0-11	12-23	24-59	0-59
Khanna 1965-84						
Males	50.7	27.1	77.7	9.4	8.2	95.3
Females	43.0	51.3	94.3	18.5	12.6	125.4
Male/female ratio	1.18	0.53	0.82	0.51	0.65	
0.76						
Matlab, Bangladesh 1974-77						
Total	73.0	58.2	131.2			
Male/female ratio	1.16	0.82	1.00			

Sources: Das Gupta (1987) for the data for the Khanna Study villages, Punjab, India; D'Souza and Chen (1980) for the data for the Matlab Project data, Comilla District, Bangladesh.

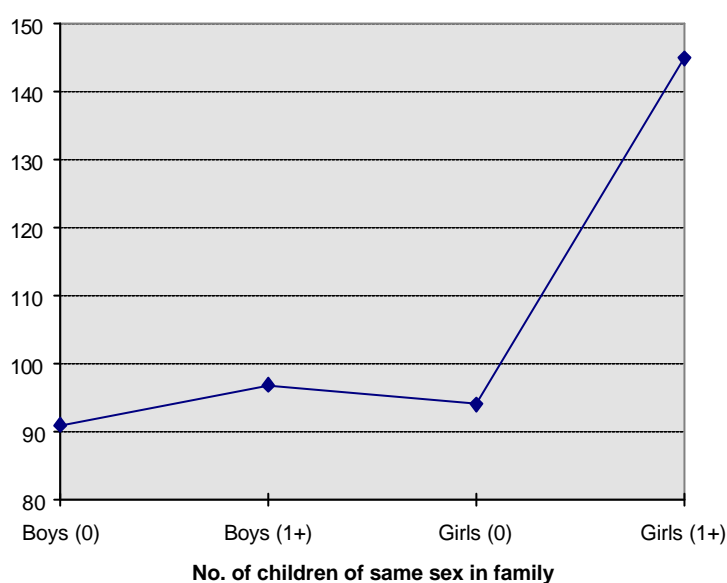
An increasing volume of evidence is emerging to suggest that this sex differential in child mortality is not the result of *unconscious* neglect of girls. It is higher-parity girls (i.e. those girls born into families which already have a girl) who bear the brunt of the excess mortality (Das Gupta 1987, see Fig. 2). This has been confirmed by studies in Bangladesh (Muhuri and Preston 1991) and elsewhere in Punjab (Pebley and Amin 1991). Female excess mortality appears to be a part of the explicit strategy parents use to obtain their desired family size and sex composition. The Chinese data suggest that similar considerations are at work there (China 1984; Hull 1990). It seems, then, that some daughters are more unwanted than others, and that the excess female child mortality is concentrated amongst them.

Given the patriarchal nature of Northern European peasant family organization, it is not surprising to find that there was excess female child mortality in eighteenth and nineteenth century Germany (Klasen 1994) and Sweden. Klasen also found that excess female mortality rose with the birth order of the child. Apparently family-building strategies in historical Germany had similar goals to those of contemporary South Asia: not to have too many children, and some preferences about their sex composition. The evidence for son preference is one manifestation of the potential discussed above for *volitional* gender discrimination in Northern Europe.

### ***Marriage and the early reproductive years***

A young woman is handicapped in coping with the stresses caused by childbearing. She lacks the autonomy to avert the consequences of reproductive stress through improved nutrition and health care, as well as a reduction in workloads. This aggravates problems of reproductive health. The substantial physical stress during the early reproductive years is reflected in poor reproductive health and high maternal mortality.

**Figure 2**  
Child mortality rate by sex and birth order



**Table 3**  
Excess of male over female age-specific death rates, Sri Lanka

Age-group	1952-54		1962-64		1970-74	
	A	B	A	B	A	B
15-19	-26	-11	- 1	+ 8	+ 8	+11
20-24	-41	-18	-29	-12	+18	+31
25-29	-44	-23	-26	- 6	+ 6	+20
30-34	-41	-21	-26	- 7	+ 5	+19
35-39	-28	-10	-14	+ 2	+23	+35
40-44	- 8	0	+ 4	+11	+52	+58

A= all causes of death B= all causes of death excluding maternal deaths  
Derived from: Nadarajah (1983), Tables 2 and 3.

Female mortality in India during the peak reproductive years is substantially higher than male mortality (Figure 1). It should be noted, however, that this is not in itself necessarily indicative of neglect of women's needs. Excess female mortality during the childbearing years is to be expected in societies where fertility is high and modern medical facilities are sparse.

As fertility declines, the sex gap in survival at these ages closes because of the reduced physiological stress of childbearing. Over time, the extra mortality of young adult males from causes such as accidents and violence comes to predominate over the stresses of reproduction, such that male mortality at these young adult ages becomes higher than that of females. This crossover of male and female mortality is commonly found in the course of the demographic and health transition. Data from Sri Lanka (Nadarajah 1983) illustrate this point very well (Table 3).

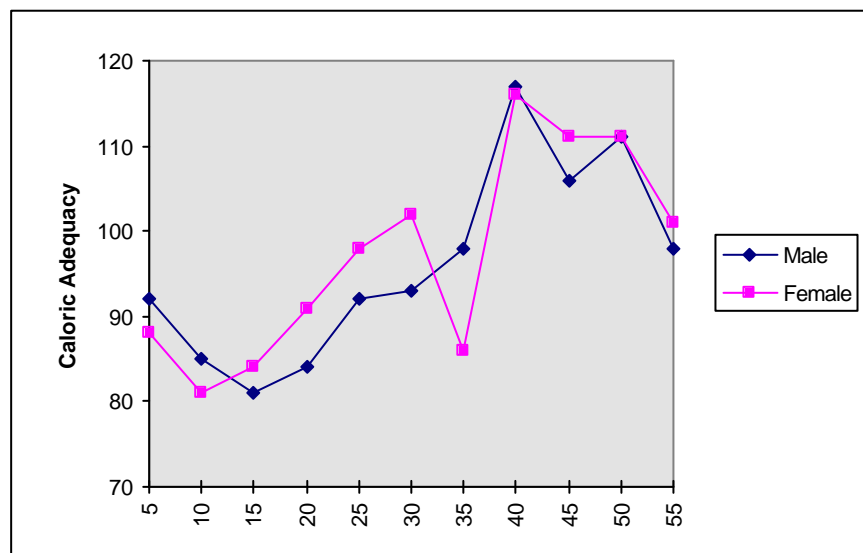
However, low female status can exacerbate the effects of reproductive stress, and slow down the pace of improvement in women's health when fertility declines and the physical toll of reproduction is reduced. This natural effect can be dampened by lack of care during the process of childbearing. Such neglect can take place in several ways.

*Inadequate nutrition*

The stresses of childbearing are exacerbated by inadequate nutrition and heavy workloads. As Figure 3 shows, adult women in Punjab are generally adequately nourished, except during the peak reproductive years. This dip in nutritional status is due to the fact that women's average consumption does not rise during pregnancy and lactation, although their nutritional requirements at such times are far higher. This results in startling levels of undernutrition (Figure 4), in a society which is otherwise quite well nourished.

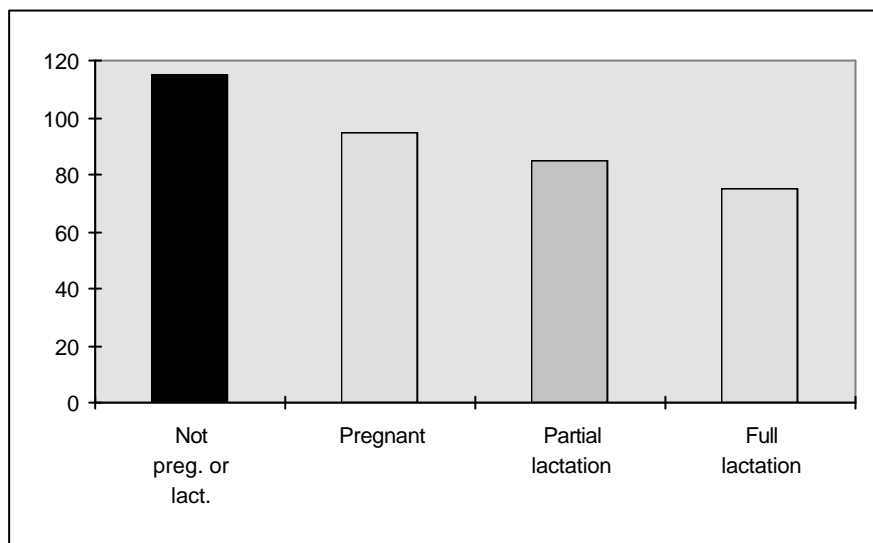
This lack of adequate nutrition has little or nothing to do with food taboos or other reasons such as wanting to keep the foetus small to ensure an easy delivery. This was evident from answers to a prospective survey of these pregnant women. The problem seems to lie in the fact that the regular diet is bulky (bread, with some lentils and milk), and it is difficult to increase consumption of such foods enough to reach dietary sufficiency, especially during pregnancy. Pregnant and lactating women need to eat nutritionally more dense foods. Such foods, rich in milk, fats and sugars, are available in the local diet. The fact that they are not given to pregnant and lactating women suggests that their needs are being neglected.

**Figure 3**  
Caloric adequacy in Punjab

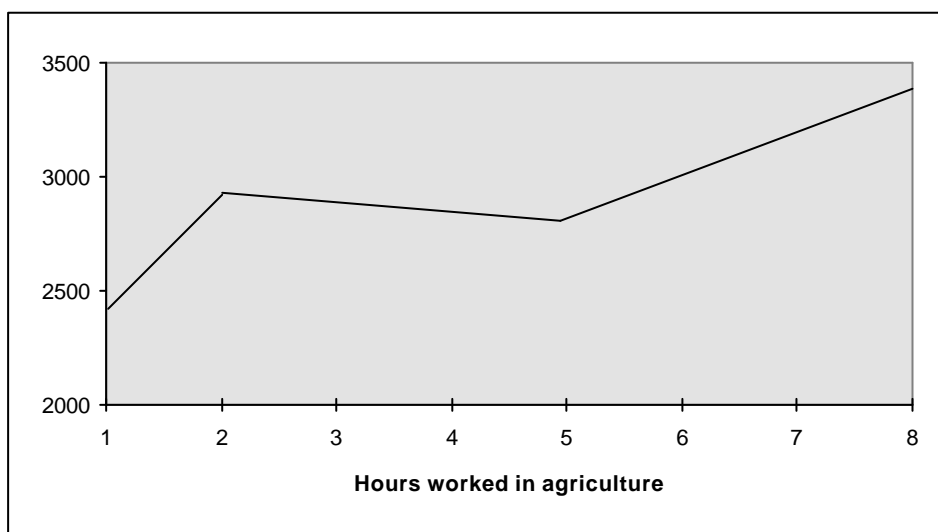


It is not as though the connection is not made in this society between physical stress and increased nutritional needs. This is recognized for the sick, for whom special and expensive foods are bought; for cows, which are given extra oilseed cake when they are lactating; and for the research worker, who is told to eat more butter to counter the exhaustion of interviewing. Above all, it is recognized for men. Figure 5 shows how the nutritional intake of men rises with their number of hours of hard physical labour.

**Figure 4**  
Per cent of caloric requirement met in Punjab



**Figure 5**  
Male caloric intake in Punjab



Nor is it that the connection between childbearing and physical stress is not recognized. When women lose their teeth and age prematurely, it is clearly recognized that this is related to having borne children. Women are explicit in their recognition of this effect: in response to a question in my survey, a high proportion said that high fertility is bad for the health of the mother. Talking with women showed that they clearly understand that they need a nutritionally more dense diet during pregnancy and lactation, but that little effort is made to provide this to them, and they themselves feel unable to demand it. Similar findings were reported in a study elsewhere in Northern India (Jeffery et al. 1989). It is only during the days immediately following a delivery that a rich diet of fats and sugars is given to the woman, and appropriately enough this has to be sent by the woman's parental home.

Nutritional deprivation during pregnancy and lactation exacerbates the natural effect of maternal depletion from childbearing. This affects women's own health as well as increasing the probability of having low-birthweight babies, whose survival rates are far lower than children of normal birth weight. Thus the neglect of women's health translates directly into worsened child survival, as well as poorer reproductive health.

#### *Workloads during pregnancy*

Inadequate nutrition during pregnancy is exacerbated by heavy workloads, which further increase the gap between nutritional requirements and intakes. It is common for women not to reduce their normal workload much until towards the end of the second trimester, and in some cases into the third trimester of pregnancy. Many of their chores require a great deal of physical strength, energy and stamina.

As in other matters, young women are not free to choose to take more leisure on account of their pregnancy. For example, I happened to visit a woman called Surjit one day when she was over six months pregnant with her second child. Surjit was cutting fodder, a very heavy task, and her face looked pale. She told me that she had fallen down some steps a couple of days before and haemorrhaged, but was better now. Surjit would obviously have preferred to rest or do lighter tasks, but the choice was not hers. Nor was her mother-in-law uninterested in the fate of her grandchildren. In fact, she had breastfed Surjit's first child because Surjit herself had had very little milk. It is just that in chopping fodder, Surjit was doing no more than is expected of women in her society. These conditions can be imposed on women because they can usually absorb such abuse without necessarily threatening the child's life-chances. Surjit herself helped reinforce this view by giving birth to another healthy boy.

#### *Care at delivery*

Given the availability of health services in India, which is high by developing-country standards (Government of India 1987:303), it is astonishing to find that the vast majority of deliveries are carried out at home by traditional midwives. This is true even in Punjab and Haryana, wealthy states in which almost every village has good public and private health facilities within easy reach. A woman is likely to be taken to a clinic or have a doctor called only if she has serious complications of delivery. By this time, it may be too late.

A telling example of the difference in response to health problems of men and women occurred in a wealthy household in one of the study villages, located less than two miles from a fully equipped primary health centre with a delivery ward. A woman in this household had a difficult delivery, and eventually the problem was acknowledged to be bad enough to be beyond the abilities of the midwife. Arrangements were made to take her to the clinic, but she died of haemorrhage before reaching there. Yet in the same household, a private doctor was

summoned to attend to the old father who was not feeling at his best. In fact, as is frequently the case with older people who feel under the weather, there was little more to be done but give a 'strengthening injection', that is, a shot of vitamin B-complex.

Maternal mortality is, of course, a small part of the totality of women's reproductive health problems (see Jejeebhoy and Rama Rao 1995). A study in Maharashtra found that over 90 per cent of the rural women examined suffered from one or more gynaecological diseases, and that only a trivial fraction of these women had received treatment for them (Bang et al. 1989). Lack of interest among other members of the household, and among health personnel, create a situation in which a woman feels that her reproductive health problems must be borne silently as a 'woman's problem'.

The fact that a high proportion of births are still attended by poorly-trained women leads to widespread reproductive health problems in the form of complications of delivery, including prolapsed uterus and pelvic inflammation. This in turn increases the potential complications of delivery and raises infant mortality.

The combination of poor conditions of delivery and nutritional deprivation during childbearing must go a long way towards accounting for the extraordinarily high proportion (two-thirds) of infant deaths in India which occur in the first month of life (Table 4). At such high levels of infant mortality, a much lower proportion of infant deaths should be taking place in the first month of life. As many as 30 per cent of these early deaths are attributed directly to 'prematurity', and an additional 20 per cent are attributed to 'other causes peculiar to infancy'. Of this, a substantial proportion must result from low-birthweight babies as well as incompetent delivery practices. Of course, in large parts of India, poverty and chronic undernutrition make for increased reproductive stress. However, the fact that women in such an affluent and developed state as Punjab are undernourished during reproduction and have poor conditions of delivery suggests that the effects of poverty in poorer regions of India are exacerbated by neglect of women's needs.

**Table 4**  
**Infant mortality rates by age and cause of death, India 1984**

	Mortality rates by age at death (in months):		
	<u>≤1</u>	<u>1-11</u>	<u>0-11</u>
	65.8	38.2	104.0
<b>Cause of death:</b>	<b>Percentage of infant deaths</b>		
Respiratory disorders	15.2		
Fevers 6.2			
'Diseases peculiar to infancy'			
Prematurity	30.4		
Respiratory infection of newborn	10.4		
Diarrhoea of newborn	6.0		
Others (peculiar to infancy)	20.3		
Other causes of infant death	11.6		

Sources for: age at death: Sample Registration Survey data, quoted in Government of India (1987:104); cause of death: Registrar-General of India, Survey of Causes of Death, quoted in Government of India (1987:125-126).

The unpalatable fact is that it is mostly through the agency of *women* that the needs of young women during pregnancy and delivery are neglected. Day-to-day decisions about allocation of household food are made by the senior woman of the household. Decisions about delivery arrangements, the preparation of the delivery room, when to call the midwife and

whether to seek more skilled help, also fall largely within the jurisdiction of the senior woman.

The question then arises: does the senior woman not care about the fate of the child, who is often her own grandchild? Unfortunately, as illustrated by Surjit's story, the connection between care of the mother and the fate of the child is diffused by the fact that the mother can absorb much of the consequences of undernourishment and other neglect without necessarily jeopardizing the child's survival. This biological fact can be exploited in a system which is far less concerned with the welfare of the mother than of the child. After birth, the speed with which children are taken for care can be slowed down by involuntary factors, springing from the mother's necessary circumspection when communicating with her in-laws, and her low credibility as a judge of appropriate actions. The change that education brings to the balance of power between younger and older women is an important reason why educated women's children have higher survival rates.

#### *Slower fertility decline*

Yet another way in which low status of women during their early adult years is deleterious to reproductive health is that it slows the process of fertility decline. Older women formed their ideas about ideal family size a generation earlier, when family size norms were higher. While some older women are alive to the changing needs of the times, and the need to reduce fertility, others are not. Their power in household decision-making can stand between the desire of the young to have small families, and their ability to implement it. Besides, the fact that young women have limited opportunity to communicate with their husbands, and limited freedom of expression and movement, places some obstacles in the path of effective contraception. Just as in the case of child survival, a woman's ability to implement fertility decisions is reduced by her low position in the household hierarchy.

#### *The later reproductive years and old age*

In the later stages of the life cycle, women's power and autonomy in the household rise, making them better situated in terms of caring for their own needs. They are free to choose to eat, seek health care and enjoy leisure according to their wishes and the financial circumstances of the household. This makes it possible for their natural biological advantage over men to manifest itself in terms of lower mortality. As Figure 1 shows, women in India have lower mortality rates than men for all ages above the reproductive years.

It is at this late stage of their life cycle that women in Northern India gain full access to the household's resources, just as women in Northern Europe had at an earlier stage of their life cycle. Moreover, given the more complex household structure and stronger intergenerational bonds, they have access to physical and emotional support from the presence of their children and grandchildren. Thus at the later stages of the life cycle, women in Northern Indian have considerable advantages over their Northern European peasant counterparts in terms of conditions of life.

However, these women's vulnerability can rise when they are widowed, especially if they do not have the support of grown sons. Data from Matlab, Bangladesh, indicate that widowhood had the effect of raising mortality levels above those of married women of the same age-groups (Rahman, Foster and Menken 1992). A study in Bangladesh showed how widows can be rendered highly vulnerable to destitution (Cain 1981). This vulnerability is substantially reduced where there is less gender inequality, as in rural Maharashtra (Cain 1981; Vlassoff 1990).

## **Conclusions**

The potential ramifications of gender inequality are strongly influenced by patterns of household formation and inheritance. This paper highlights this by contrasting patterns of women's life-course autonomy in two types of kinship and family systems, that of peasants in pre-industrial Northern Europe and that of contemporary Northern India.

In Northern Europe, families were nuclear or stem in form, and property and managerial power were typically transferred to the heir at the time of marriage. The conjugal bond was emphasized, while intergenerational bonds were weak and inherently conflict-ridden. Women's autonomy was thus relatively high in early adulthood, and declined in later life. Despite gender asymmetry, then, women had considerable autonomy and power in household matters during their childbearing years. Thus they were well-placed to maintain their own health and that of their children to the best of their ability.

The joint family system of Northern India makes for strong intergenerational bonds, while de-emphasizing the conjugal bond. Property and managerial power are transferred very gradually to the younger generation. Status and autonomy are low in youth and rise with age. The double marginalization of young women on account of their youth as well as their sex means that women have the greatest dip in their life cycle status and autonomy during the early years of marriage, when they are undergoing the stresses of reproduction, and rearing children through the most vulnerable years of early childhood. The young mother is constrained in voicing or responding to her own or her children's needs. Layers of people can intervene between her perceptions of need and actual decisions: her sisters-in-law, her mother-in-law, her husband, the other men in the household. This has negative effects on child survival, reproductive health, and control over fertility.

Child survival is adversely affected by the fact that the mother has limited control over crucial child care decisions. Differences in women's autonomy are clearly reflected in differences in child survival. This affects children of both sexes alike. However, female children suffer additionally from the strong son preference in this society, which results in discrimination against daughters and substantial excess mortality of girls.

Women's reproductive health suffers because the normal stresses of pregnancy and lactation are exacerbated by neglect of the women's needs. Even in a prosperous region like Punjab, which is well-nourished and well-covered by health facilities, a high proportion of women are undernourished during pregnancy and lactation, and give birth with the help of poorly-skilled midwives. In large parts of India, poverty adds to the burden of undernutrition and poor health. A toll of poor reproductive health and high maternal mortality rates ensues. Controlling fertility and thereby improving reproductive health is hampered by restrictions on husband-wife communication and on women's autonomy. Neglect of women's needs during pregnancy and delivery also contributes to stunningly high neonatal mortality rates, which constitute as much as two-thirds of India's high infant mortality rates.

It is only at the later stages of the life cycle that a woman gains autonomy and authority in the household, and the female biological advantage in survival can manifest itself. Unless she is so unfortunate as to have no sons, a woman in her old age has fuller access to the household's financial resources, as well as much physical and emotional support from younger household members. This is the stage of the life cycle at which the situation of women in Northern India and pre-industrial Northern Europe is reversed.

The spectre of widowhood without the support of sons is a powerful force making for discrimination in favour of boys, as well as for building up a strong mother-son bond and marginalizing the son's young bride. In short, the vulnerability of women in Northern India is well-designed for reinforcing and perpetuating itself with little need for direct reinforcement from the male world.

This paper has explored some of the ways in which patterns of kinship and inheritance can affect health and demographic outcomes. While gender inequality exists in both Northern Europe and Northern India, its ramifications are greatly magnified in the latter by the fact that status rises with age. This enormously increases the potential for marginalizing women, as well as for adverse demographic consequences of their marginalization, except at later ages.

## References

- Arensberg, Conrad and S.T.Kimball. 1968. *Family and Community in Ireland* (2nd edition). Cambridge MA: Harvard University Press.
- Bang, R.A., A.T. Bang, M. Baitule, Y. Choudhary, S. Sarmukaddam and O. Tale. 1989. High prevalence of gynecological diseases in rural Indian women. *Lancet* 14 January:85-87.
- Bart, Pauline. 1969. Why women's status changes in middle age: the turn of the social ferris wheel. *Sociological Symposium* 3:1-18.
- Berkner, Lutz K. 1972. The stem family and the developmental cycle of the peasant household: an eighteenth century Austrian example. *American Historical Review* 77:398-418.
- Cain, Mead. 1981. Risk and insurance: perspectives on fertility and agrarian change in India and Bangladesh. *Population and Development Review* 7:435-474.
- Chen, Lincoln C., E.Huq and S.D'Souza. 1981. Sex bias in the family allocation of food and health care in rural Bangladesh. *Population and Development Review* 7:55-70.
- China Population Information Centre. 1984. *Analysis of China's One-Per-Thousand Population Fertility Sampling Survey*. Beijing.
- Das Gupta, Monica. 1987. Selective discrimination against female children in rural Punjab, India. *Population and Development Review* 13:77-100.
- Das Gupta, Monica. 1990. Death clustering, mothers' education and the determinants of child mortality in rural Punjab, India. *Population Studies* 44:489-505.
- Das Gupta, Monica and Sara Millman. 1994. Intrahousehold differences in nutritional intake. Manuscript.
- D'Souza, Stan and L.C. Chen. 1980. Sex differentials in mortality in rural Bangladesh. *Population and Development Review* 6:257-270.
- Dyson, Tim and M. Moore. 1983. On kinship structure, female autonomy and demographic behavior in India. *Population and Development Review* 9:35-60.
- Foner, Nancy. 1984. *Ages in Conflict: A Crosscultural Perspective on Inequality between Old and Young*. New York: Columbia University Press.
- Gaunt, David. 1987. Rural household organization and inheritance in Northern Europe. In *Family History at the Crossroads*, ed. T. Hareven and A. Plakans. Princeton: Princeton University Press.
- Goody, Jack. 1976. *Production and Reproduction: A Comparative Study of the Domestic Domain*. Cambridge: Cambridge University Press.
- Goody, Jack. 1990. *The Oriental, the Ancient and the Primitive: Systems of Marriage and the Family in the Pre-industrial Societies of Eurasia*. Cambridge: Cambridge University Press.
- Government of India, Ministry of Health and Family Welfare. 1987. *Family Welfare Programme in India Yearbook 1986-87*. New Delhi.

- Greenhalgh, Susan and Q.Liang. 1988. The family revolution and child mortality in rural Shaanxi, 1940s-1980s. Paper presented at IUSSP seminar on Mortality Transition in South and East Asia, Beijing.
- Hajnal, John. 1982. Two kinds of preindustrial household formation system. *Population and Development Review* 8:449-494.
- Hsiung, Pingchen. 1993. The formation of mother-son bond in traditional China. Manuscript.
- Hull, Terence. 1990. Recent trends in sex ratios in China. *Population and Development Review* 16:63-83.
- Jain, S.P.1982. Mortality trends and differentials. In *ESCAP Country Monograph Series No.10: Population of India*. New York: United Nations.
- Jeffery, Patricia, R. Jeffery and A. Lyon. 1989. *Labor Pains and Labor Power: Women and Childbearing in India*. London: Zed Books.
- Jejeebhoy, Shireen and S.R.Rao. 1995. Unsafe motherhood: a review of reproductive health. In *Women's Health in India: Risk and Vulnerability*, ed. M. Das Gupta, L.C. Chen and T.N. Krishnan. Delhi: Oxford University Press.
- Klasen, Stephan. 1994. Gender inequality and survival: excess female mortality past and present. PhD. dissertation, Harvard University.
- Lamphere, Louise. 1974. Strategies, cooperation and conflict among women in domestic groups. In *Woman, Culture and Society*, ed. M.Z. Rosaldo and L. Lamphere. Stanford: Stanford University Press.
- Laslett, Peter. 1972. Introduction. In *Household and Family in Past Time*, ed. P. Laslett. Cambridge: Cambridge University Press.
- Linton, Ralph. 1936. *The Study of Man: An Introduction*. New York: Appleton-Century Co. Inc.
- Mason, Karen O. 1984. The status of women: a review of its relationships to fertility and mortality. New York: Rockefeller Foundation.
- Muhuri, Pradip K. and S.H. Preston. 1991. Effects of family composition on mortality differentials by sex among children in Matlab, Bangladesh. *Population and Development Review* 17:415-434.
- Nadarajah, T. 1983. The transition from higher female to higher male mortality in Sri Lanka. *Population and Development Review* 9:317-325.
- Pebley, Ann and S. Amin. 1991. The impact of a public-health intervention on sex differentials in childhood mortality in rural Punjab, India. *Health Transition Review* 1:143-169.
- Plakans, Andrejs. 1989. Stepping down in former times: a comparative assessment of retirement in traditional Europe. In *Age Structuring in Comparative Perspective*, ed. D.I. Kertzer and K. Warner Schaie. Hillsdale N.J.: Lawrence Erlbaum Associates.
- Rahman, Omar, A.Foster and J.Menken. 1992. Older widow mortality in rural Bangladesh. *Social Science and Medicine* 34:89-96.
- Sieder, Reinhard and M.Mitterauer. 1983. The reconstruction of the family life course: theoretical problems and empirical results. In *Family Forms in Historic Europe*, ed. R. Wall, J. Robin and P. Laslett. Cambridge: Cambridge University Press.
- Sorensen, Aage B. 1989. Old age, retirement and inheritance. In *Age Structuring in Comparative Perspective*, ed. D.I. Kertzer and K. Warner Schaie. Hillsdale NJ: Lawrence Erlbaum Associates.
- Vatuk, Sylvia. 1987. Authority, power and autonomy in the life cycle of the North Indian woman. In *Dimensions of Social Life*, ed. P. Hockings. New York: de Gruyter Press.
- Vlassoff, Carol. 1990. The value of sons in an Indian village: how widows see it. *Population Studies* 44:5-20.

- Wadley, Susan S. 1994. No longer a wife: widows in rural North India. In *From the Margins of Hindu Marriage*, ed. P. Courtright and L. Harlan. New York: Oxford University Press.
- Wolf, Margery. 1974. Chinese women: old skills in a new context. In *Woman, Culture and Society*, ed. M.Z. Rosaldo and L. Lamphere. Stanford: Stanford University Press.
- Wyon, John B. and John E. Gordon. 1971. *The Khanna Study*. Cambridge MA: Harvard University Press.
- Yanagisako, S.J. and J. Collier. 1987. Introduction. In *Gender and Kinship: Towards a Unified Analysis*, ed. J. Collier and S.J. Yanagisako. Stanford: Stanford University Press.