Fertility and women’s autonomy

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Ranjana, an articulate woman with a Masters degree in English Literature, was married into a well-to-do business family from a small town in Uttar Pradesh. In the first four years of marriage she gave birth to two daughters. Her parents-in-law were unhappy, but decided to wait. During the third pregnancy Ranjana was persuaded to undergo a sex-determination test. She was gently asked to abort the baby. Seeing her upset and horrified, they let her go through her pregnancy. The fourth time they gave her an ultimatum – to be turned out of the house or abort the baby girl. Ranjana complied.

The sixth pregnancy turned out to be another nightmare. Finally, the seventh pregnancy yielded a baby boy. She could not get herself to hold the baby or breast-feed him – the guilt of killing two girls to beget one boy filled her with revulsion. Around the same time newspapers carried pictures of three girls who had hanged themselves to death in Kanpur the day their mother gave birth to a baby boy after three daughters and three abortions. She reached out to the three sobbing daughters. The bewildered mother-in-law was left holding her precious grandson.

Rehana, a strong-willed middle-school graduate from the green revolution area of western UP was married into a family of artisans. She gave birth to five beautiful daughters in the first seven years of marriage. Her husband and parents-in-law wanted her to try again with the hope of a boy. Rehana resisted. She went to a local doctor and got contraceptive pills, which she took every morning. She started working in a non-formal education programme for girls run by a voluntary organisation. Over the years she gained self-confidence. Moving around her locality persuading women to send their daughters to school gave her a totally new perspective. Her husband became jealous of her celebrity status and told her that unless she agreed to have another child he would prevent her from working. He even threatened to turn her out of the house with her daughters. She struck a deal, only one pregnancy. As luck would have it the sixth child was a boy.

Sumira, an illiterate woman from an arid region of Uttar Pradesh was married before she turned fifteen. However she was sent to her
husband’s home only when she turned nineteen. Within three years she produced two girls. At this point she came in contact with a women’s empowerment programme. Some months later she went to a local nurse and got a year’s dose of contraceptive pills. She used to hide them under the thatch of the roof. After almost eight months, during the monsoon, the pills dropped on the floor. Her husband saw them and started beating her, accusing her of taking the pills in order to have affairs with other men. He also accused her of misleading him because he was upset that he could not impregnate his wife. Apparently he even sought out a local quack to boost his virility. Sumira was broken. She left home for a few months. She returned on the condition of just one more pregnancy, after which she chose to have a tubectomy operation. The third child was a girl. He husband threatened to leave her but did not do so because it was her regular income that sustained the family.

Ever since 1952 the rationale, thrust and objective of India’s population policy has been demographic control. The main vehicle has been family planning. The primary indicator: couple protection rate. The chief mechanisms: method specific family planning targets, incentives and disincentives. The target group: women. Notwithstanding the changing rhetoric over five decades, there has been little change in the mindset of political leaders, policy-makers and administrators.

Why have women’s organisations and other social activists working among women been pitted against the population control lobby within the government and national and international organisations promoting birth control? Do women alone, to the exclusion of men, produce children? For all practical purposes women have been treated as independent agents with the power to determine the number of children they produce. Groups of women came together to discuss population policy and women’s autonomy; herewith reproduced are a few anguished statements:

* ‘Discussions on development, education, health and other related issues invariably lead to women’s status in Indian society. Since India became independent our leaders have been talking about women’s position in our society. Yet, when it comes to birth control, why do they conveniently forget that a woman does not have the freedom to decide when she should marry, how many children she should have or how her children should be brought up. Women are not autonomous entities. Husbands, parents-in-law, other relatives, the immediate community and caste and religious leaders decide what a woman will wear, where she will go, whom she will marry, whether she will work outside the house, how much she can eat – the list is endless. Any effort to change the rules of the game is met with stiff resistance. It is this hypocrisy and blatant contradiction that have pitted women against the government’s population control programme.’ (Teachers from a university
‘You ask me about my health – where do I start? I am ill because I do not get adequate food, adequate sleep, and the dust from the stone quarry settles in my lungs. I do not have water to keep clean, my children are exposed to the cold, the heat and to the rain. My husband gets drunk and beats me and I am bruised all over. I work from dawn to dusk, and I have produced more children than what my emaciated body can handle – yet I fear how many will actually survive. When I seek doctors – they do not listen to my story – they give me some tablets that make me sick. They never explain what is wrong. When I complain of exhaustion, they say women complain too much. The only time they seek me out is to persuade me to get sterilised. You still want to know what ails me – look at my life, it is the cause of my illness.’ (Stone quarry worker on the outskirts of Delhi)

‘The nurse tells me that we are poor because we have too many children. I tell her that we have many children because we are poor and afraid about how many children will live to take care of us when we are old.’ (Tribal woman from Orissa)

‘From the day I got married it is my husband who takes all decisions. I do not have the freedom or the courage to tell him that I do not want any more children. He wants at least three sons... Babies do not fall into our wombs on their own – why are we women chased like animals? Why can’t the nurse chase my husband? I have to undergo the pain of pregnancy and childbirth – why can’t my husband undergo the pain of sterilisation?’ (Rural woman from the UP Hills)

‘Pregnancy and childbirth is treated like a disease. Looking at the malaria eradication campaign, I could not help drawing a parallel between mosquitoes and babies. If we pay a little attention to water logging around the tap, the open nula that flows outside our doors and the general cleanliness in our streets – as a community we will be able to arrest the spread of malaria. We can do a lot as a community – instead we expect the government to clean our drains! And the government, well, they then treat us like mosquitoes.’ (Rural woman from Rajasthan)

‘I got pregnant when I just could not afford to have another baby – the little one was barely eight months old. I went to the government hospital for an abortion. The doctor performed the operation. I had a lot of pain and used to bleed frequently. I went back to the same doctor. She told me everything would be fine. The pain did not subside but I got used to it. A year later I went to a private doctor because of excessive bleeding. During the examination she discovered the Copper-T. I was horrified. When I was talking about it to my friends in the village we realised that they had played a similar trick on women who went for an abortion and
in one case after delivery. One of them said that her husband used to beat her because she did not conceive for almost three years; he even threatened to throw her out of the house. Luckily she went to a private doctor who removed the Copper-T. Her husband still does not believe that her consent was not taken. I will never go back to a government hospital – they treat us like animals who are incapable of taking decisions.’ (Rural woman from Tamil Nadu)

Voices like these are heard across the country. It is almost as if the government and women are speaking a different language. Women’s organisations have been arguing for a more holistic approach to women’s lives, including their reproductive lives. Their ability to take decisions and exercise choice does not change overnight with literacy or information on contraception. The process of building one’s self-esteem and self-confidence is a painfully long process of collective struggle. The government’s knee-jerk approach to search for magical solutions like contraceptive technologies, quick literacy drives, awareness generation camps and so on has only wasted precious time.

For over 50 years we have been saying that we do not have time for long-winded complicated processes that would enhance women’s status, create conditions where every child has access to eight years of education and every citizen has access to good quality primary health care. For 50 years we have been jumping from one slogan to another – with little effect. Our primary education system is in shambles and innumerable ‘illiteracy eradication drives’ have consumed enormous energy and resources with little impact. Primary health care has been sacrificed at the altar of family planning targets, women’s health confined to pre- and post-natal care and children well-being limited to immunisation, ORS and indifferent nutritional supplements.

Since the early ’70s the women’s movement was pushed into a reactive mode, raising voices against violation of human rights of women in the name of sterilisation camps, clinical trials of new contraceptive technologies and poor quality of care. There was little room for positive dialogue. However, from the early ’90s women across the country have clearly articulated alternative approaches by questioning myths perpetuated by the government.

Researchers and activists argue that women have little autonomy within families to make decisions. A large body of literature generated over the last 30 years, especially since the publication of a GOI report on the status of women in India, have convincingly argued that a complex range of variables determine women’s autonomy in decision-making. But notwithstanding the wealth of research, there has been a tendency to reduce fertility behaviour to few variables like literacy, years of schooling and access to information on contraceptives. The government’s reliance on data
related to ‘unmet needs’ of contraception has, for all practical purposes, reduced the variables further to one – namely access to contraceptives for spacing children and terminal solution through sterilisation.

Factors influencing family size: Ranjana is a postgraduate and Rehana has five years of schooling. Yet the decision about family size was influenced by the family need for a male child. Sumira is illiterate; her husband was concerned about demonstrating his virility by producing more children. He was also suspicious of his wife’s fidelity because she was taking the pill. Many families across the country opt for large families in the hope of one surviving male adult as the only insurance in old age. As a result, women are apprehensive about terminal methods till they are relatively sure of survival of their children. Availability of reliable spacing methods, counselling and management of side effects have prevented many women from using the pill and IUD. Men shy away from condoms because they find them inconvenient or believe they reduce sexual pleasure. Lack of privacy and conditions under which families live, compound the problem of using barrier methods. There is a wide gap between people’s need for contraception and their actual use, captured in government data as unmet needs.

Do all couples make a rational choice about family size? Micro studies and anecdotal evidence have shown that most couples do not talk about and make a conscious decision about the number and spacing of children. It is generally believed that educated couples make rational choices, but women’s organisations working in urban areas have repeatedly pointed out that couples do not always discuss sex. The first few children arrive in an unplanned manner. Many women get pregnant when they are not ready, resorting to abortion as a means to limiting family size. Wide publicity for family planning and an aggressive sterilisation programme has enabled many couples to resort to terminal methods after they are relatively sure a number of children will survive. This does not always reflect desired family size.

Why does this happen? Most economists and demographers treat the household as a homogeneous unit despite compelling evidence that resource allocation is unequal within the household – with a strong gender bias. Girls are disadvantaged from the moment of birth and in many cases even at conception. Women are treated as a burden on household resources. A strong son preference dictates family size. The cost of reproduction is not equally shared between men and women – high maternal mortality and morbidity rates result in an unfair burden on women. Cultural and social practices add additional burden on women to maintain family status and uphold cultural and religious norms. Purdah, reduced mobility and limited access to knowledge and education make women invisible in the larger economy.
When it comes to decisions about reproduction, it is assumed that the two partners are equal. These decisions are constantly renegotiated depending upon the relative bargaining power of the woman in the family. In poor households women and children’s contribution towards subsistence activities like fetching fuel, fodder, water and minor forest produce ensure survival. Yet the impact of repeated pregnancies on her productivity as an economic agent invariably outweighs the benefits of producing more children who can take over survival chores.

As we have seen in Sumira’s case, even a little exposure to the outside world and women’s coming together to share their experiences can shift the balance – increasing her bargaining power within the household. A few years of education coupled with increased mobility and self-confidence enabled Rehana to bargain for a more humane solution. Despite almost 17 years of education, Ranjana’s bargaining power was obviously lower than Rehana and Sumira’s. Education alone does not make the difference – it is education plus mobility, access to information, knowledge and increased self-esteem and self-confidence.

When women have been able to negotiate frequency of reproduction, they come across yet another barrier – contraception. Despite international commitment towards population control, contraceptive technologies are loaded against women. The pill may have dramatically changed women’s status in many developed countries. Given the state of women’s health in India – nutritional disparities, poor nourishment, anaemia, reproductive tract infections, malaria, tuberculosis and a host of other health problems – women’s ability to tolerate hormonal contraceptives is limited. Long-acting hormonal contraceptives and implants have played havoc with women’s health. The tendency to treat side effects as being of minor significance has undermined the credibility of spacing methods. Insertion of IUD’s without checking for pelvic inflammation or RTIs has led to very high rates of rejection.

So what are we left with? Condoms for men. Here again, dominant perceptions of pleasure and perceived inconvenience coupled with male attitude to sex being a pleasure seeking exercise without concomitant responsibility has made condom use an exception rather than a norm. Despite the alarm bells sounded in the wake of the HIV/AIDS pandemic, condoms continue to be seen at best as a safety device for men. Many organisations and programmes working with women have pointed out that men do not like to use condoms during intercourse with their wives. Here the pleasure principle seems to predominate.

So we are left with one solution – sterilisation after the couple is relatively sure of the survival of at least two male children. As we have seen above, the major burden of sterilisation is borne by
women, with vasectomy accounting for a minuscule minority in our statistics. The unhygienic conditions in sterilisation camps and women’s loss of dignity when they are herded into camps is captured in Deepa Dhanraj’s film – *Something like a War*. Men shy away from vasectomy because of a fear of impotency and loss of stamina. Therefore, a family’s decision on which partner will undergo sterilisation is linked to the relative bargaining power of the woman within the household. The larger family invariably supports the man and after innumerable pregnancies and abortions, it is the woman again who is asked to undergo a tubectomy operation.

At every stage in the reproductive cycle of the woman, her status and bargaining power within the family is the deciding factor. Conceptions, abortions, access to health care, nutrition, rest and recuperation, education, mobility – all these become a tussle for power. The trump card is invariably violence, desertion and in some cases, straightforward murder. The family is the ultimate frontier in the society’s quest for equality and justice. Renegotiating power relations within the household is the key. The government’s intervention in the arena of family planning has not been able to address women’s empowerment issues in any systematic or sustained manner. Some efforts through a few programmes like Women’s Development Programme in Rajasthan and Mahila Samakhya, have been few and far between. Despite wide acceptance of the concept in policy circles there is little effort to ensure such empowerment initiatives are taken on a larger scale.

What are the components of women’s autonomy? Women’s organisations, social activists, administrators and other concerned citizens working among women have tried to spell it out. Autonomy is determined by the following:

* Women’s position within the family and in society determines her own sense of self, confidence and self-esteem.

* Access to resources – economic (income, employment), material (productive assets like land, credit, finance), intellectual (education, knowledge, information).

* Control over her own labour – her ability to determine how she uses her time, demand payment, have control over her income and make her contribution visible.

* Control over her body – ability to decide when she gets married, with whom, how many children and the desired spacing.

* Availability of reliable health care facilities and safe contraception.
* Mobility and ability to move beyond her immediate environment for accessing income, knowledge and self-confidence.

* Personal laws which determine her rights within the family – especially those relating to marriage, divorce, maintenance, inheritance, share of family assets and so on.

* Opportunity to come together as a collective to realise and assert power to fight for their rights and demand their entitlement; question dominant ideologies that justify subordination in the name of religion, culture and status reproduction; transform existing institutions and gendered spaces in society; and deal with daily loss of dignity through domestic and societal violence – including violation of women’s human rights in the name of family planning – lack of real choice in contraceptives, unethical trials of new technologies and systematic effort to reduce women to reproductive machines.

As seen above, a wide range of variables determine women’s autonomy in decision-making and their position within society. Studies from different parts of the country show that there is a broad correlation between women’s position and fertility. However, innumerable studies also show that other factors like declining maternal and child mortality, access to reliable health care facilities, confidence over the survival of children, access to contraception and five to eight years of schooling leading to delay in the age of marriage exert a strong influence on family size, even in situations where women are not empowered or enjoy a good status in society.

This has encouraged some demographers and policy-makers to argue that women’s empowerment is a desirable long-term goal, but in the short run improving the quality of primary health care and enhancing the basket of contraceptives (especially for spacing) would turn the tide. Kerala and Tamil Nadu are cited as examples of successful demographic transition without systematic efforts towards women’s empowerment.

The ‘next-best’ policy intervention is promoting women’s education, employment and income generation programmes, credit and saving schemes and so on. Almost all such interventions in the above areas are justified on the expected impact on fertility, infant and child mortality and morbidity and maternal mortality rates. This takes the discourse outside the realm of the family. Despite recognition of the complexities of the situation, most schemes continue to target women as perpetuators of the population problem. Women are still viewed as autonomous agents. Little effort is made to address male responsibility and male involvement in child survival, survival chores, reproduction, girls’ education and so on.

Women’s involvement is the key to improving access to water and sanitation, household income, primary education, and family health
– the list is endless. Women as hand-pump mechanics, primary school teachers, women’s self-help groups women’s literacy – these are the magic bullets of today. Government programmes are increasingly adding to the responsibility of women – with little effort to address male responsibility or male involvement.

Whether such interventions ultimately improve women’s position within the family is an open question. Unless women’s access to productive assets is addressed though legal rights to property, ownership of land, decision-making positions within local self-government institutions, there will be little impact. The much publicised 30% reservation for women in panchayats too will have little impact unless serious efforts are made to correct centuries of subordination through well-planned strategies to enhance women’s status within the household.

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