



Human development, disparity and vulnerability: women in South Asia

By Ayesha Banu



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ABSTRACT

This paper provides a literature review of intrahousehold gender disparities in South Asia. The paper draws on quantitative and qualitative research focusing on three countries—Bangladesh, India and Sri Lanka—as well as Pakistan to a lesser extent. The paper captures the disparities within households between men and women as well as boys and girls. It also examines the short- and long-term impacts of these disparities on intragenerational and intergenerational inequalities, and differences of capabilities and opportunities among genders. The main areas of exploration are inequalities in health, education and work. The paper concludes with a selection of policy recommendations, actions and lessons learned from the region that can help close gender gaps based on household inequalities.

Introduction: incredible progress yet persisting inequalities

Today's world has experienced incredible strides forward in combating hunger, ensuring good health, providing access to drinking water and sanitation, offering education, and establishing human rights and dignity. Immense progress has been made in communication technology and scientific innovations. The world has become small and at the same time has grown in ways unimaginable even in the recent past. This global whole is not without its edges, however. Progress has not been even for all. Deprivation, discrimination, subordination, marginalization, disparity, and unequal social, political and economic relations among and within countries and regions, cutting across gender, class, ethnicity, race, religion, disability, age and sexuality, persist.

Anthropological evidence shows that egalitarianism was a primary feature of the longest period of human civilization. Disparity and discrimination started to grow and become institutionalized only in the recent past, about 10,000 years ago. Progress and development came with human deprivation and contradictory indicators of well-being, ensuing a complex and ambiguous scenario often hard to neatly summarize. Persisting inequalities, particularly gender inequalities, remain among the most crucial challenges. Many related issues remain unexplored but are of critical importance for human development. This paper tries to locate these concerns, with a special emphasis on gender.

Among all forms of marginalization, gender inequalities between men and women, and boys and girls demand special attention. Gender disparities are not directly correlated with income poverty, and many studies show that often there is no correlation between per capita income and gender disparities in health and education outcomes (Filmer et al. 1998). Other dimensions of inequality touch on freedom, personhood, dignity, mobility, autonomy, choice and options, space to express ideas and orientations, rights and access, decision-making capacities in relation to the allocation of resources, and the ability to control one's own body and life choices. Many of these human rights and choices are denied to women even in developed countries.

Gender inequalities stem from the household or family—the oldest and most persistent social institutions. Family and household come with a package of material and non-material activities, expectations and ideologies that are rooted in social norms and values, often fuelled by religious norms and sanctions, and a patriarchal mind set—fossilized and rigid, creating unyielding boundaries, and perpetuating and reproducing the same old deeply entrenched rules of the game.

Patriarchy pervades all institutions, reinforcing both formal and informal arenas of everyday lives, manoeuvring access, control, choice and options, freedom and mobility, rights and power. Gender disparity, in particular, is related to people's mindsets, longstanding habits, and the internalization and perpetuation of patriarchal values both by men and women. Patriarchy is embedded in the

household and family, and in formal and informal institutions and organizations, policy-making bodies and ideological discourses, where it creates an unending chain of deprivation and inequality across generations.

In South Asia, the focus of this paper, women find themselves in subordinate positions to men, dependent socially, culturally and economically. They are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility and are often under threat of violence from male relatives (sometimes from female relatives/in-laws as well). Son preference has economic, social and religious utility, while daughters are seen as an economic liability because of the dowry system (Fikree and Pasha 2004).

This paper examines intrahousehold sources of gender disparities in South Asia, looking at both quantitative and qualitative data and research from secondary sources on Bangladesh, India and Sri Lanka as well as Pakistan to some extent. The emphasis is on disparities within households between men and women as well as boys and girls, and their short-term and long-term impacts in creating intragenerational and intergenerational inequalities, and differences in capabilities and opportunities. The main areas of exploration will be issues related to health and education, but the paper will also touch upon violence against women and girls, and work and gender.

Methodological issues

This paper is based on secondary sources, mainly focussing on qualitative studies as well as quantitative data on intrahousehold dynamics with a gender lens. Available literature on intrahousehold data and narratives are not uniform in nature, and could not be captured under a single timeline across countries. A snapshot view, however, mostly ranging from 2010 to 2015, illustrates both positive and negative dimensions of human development, revealing the paradoxes, surprises, bottlenecks and barriers that lead to exclusion and deprivation. Human Development Indexes for the last 25 years have revealed that statistical data and information related to growth and production are not enough to explain and understand the ‘richness of lives’ and human well-being, livelihoods, human potentials and choices. As discussed above, gendered exclusion, marginalization, deprivation and boundary setting are deeply rooted in social and cultural factors embedded in values, norms, religious sanctions and barriers, and these are not always reflected in quantitative macro-data alone.

Capturing these critical issues, which are often unquantifiable, requires tapping qualitative research and insights to understand the inner dynamics of intrahousehold gender disparities. This paper will draw upon secondary sources of qualitative research findings to speculate on gender deprivation scenarios and to outline tentative suggestions to overcome barriers and exclusion.

Qualitative exploration and in-depth case studies, although not representative, and while often making it difficult to reach a generalized conclusion, can still be very crucial in revealing layers of deprivation otherwise blurred in macro-data. They can illuminate the intricate power relations between men and women that shape human capacity, access and control, and reveal the nuances of human lives, enriched with indications of a forward-looking journey. They allow the exploration of new issues, new indicators, new horizons, and new methods and techniques for further refinement, emphasizing the quality of human development in addition to its quantity.

This paper attempts to compare and analyse a series of indicators in terms of exclusion and deprivation, with a particular emphasis on gender, and largely by looking at intrahousehold data available in national statistical systems as well as relevant qualitative studies. The first section considers gender and health, including intrahousehold gender disparities in food intake and nutritional status, anaemia, access to health facilities, child and maternal mortality rates, maternal morbidity, nutritional disparities, intrahousehold investment decisions, health outcomes, etc. The second section, on gender and education, will consider issues related to school attendance or enrolment, drop outs, expected years of schooling, intrahousehold decision-making, asset access, etc. Both the first and second sections highlight the roles of norms and values, and harmful practices and attitudes in shaping intrahousehold health and education outcomes.

The third section of the paper examines violence against women and girls as among the major detrimental factors for health and education, with a special emphasis on Bangladesh. A fourth section explores a few issues related to women and work. The paper concludes with reflections on ways forward.

Gender and health: a multifaceted issue

Gender discrimination at each stage of the female life cycle contributes to health disparities, taking forms that include sex selective abortions, especially in India and Pakistan; the neglect of girl children; reproductive mortality and morbidity; poor access to health care for girls and women; etc. Many health indicators are relevant for gender disparities. They include life expectancy, infant mortality, the birth weight of babies, the prevalence of child malnutrition, maternal mortality, the prevalence of anaemia among pregnant women, pre- and postnatal access to medical facilities, antenatal care coverage, access to safe drinking water and sanitation, immunization, institutional responses, and so on.

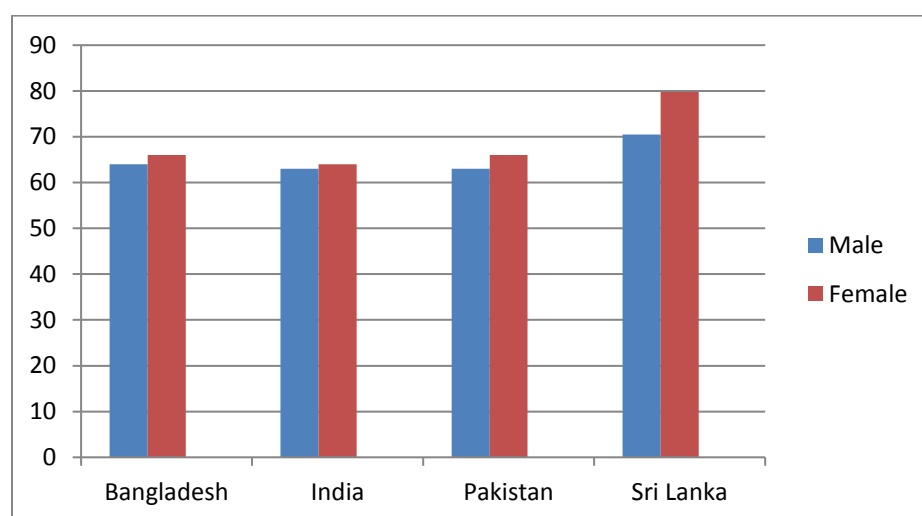
This section will present some statistical data (based on national data/statistics) to reveal the gender dimensions of health status in South Asia, followed by qualitative analysis from secondary sources.

LONGEVITY, LIFE AND LIVELIHOODS

Gender-disaggregated data clearly show the comparative advantage of females over males in terms of life expectancy at the age of 70. As Table 1 shows, Sri Lankan women have scored highest compared to Bangladesh, India and Pakistan.

Table 1. Life expectancy at age 70, 2009

Country	Male	Female
Bangladesh	64	66
India	63	64
Pakistan	63	66
Sri Lanka	70.5	79.8



Source: Selected Health Statistics of India, October 2012. See also the Annual Health Bulletin of the Government of Bhutan, 2011.

These data need to be complemented with qualitative data exploring the status of elderly women in these countries, however. What does it mean to have a long life? What are the livelihood options and opportunities, access and rights of the elderly? What is the quality of a long life for women compared to men in South Asia?

As more women survive into old age, gender differences among older adults become critical. South Asian women experience greater ill health and loss of activities in daily living as they age. Many are illiterate, unemployed, widowed and dependent on others.

A study on elderly people in a Dhaka slum (Mannan and Banu 2016) found that most elderly women are either widowed, single or abandoned by their male partners. Men, by contrast, are mostly

with their wives (who may be a second or third wife), enjoying the support of female partners much younger than themselves during their old age.

While elderly women across class rankings mostly live in isolation and neglect compared to men, those who are poor are in even worse condition, denied any monetary or material safety net as well as medical and psychological support. Access to health facilities or state support, however meagre, is a great challenge due to medical conditions, old age and disability. Without formal structures such as old-age homes and state support, including specially tailored medical support, longevity, particularly for elderly women, becomes a complex issue.

Increased urbanization, rural to urban migration, slum dwellings and urban household structures often limit the scope for accommodating the elderly. The traditional social role of *murubbi* or respected elderly person has also undergone enormous changes in urban contexts, where elderly people, particularly women, have little or no social utility. In many cases, elderly women are engaged in care work for their grandchildren and thus bear increased workloads. Women's reproductive roles at large perpetuate their dependency on their children or other family members, with many viewed as a burden. With elderly people comprising a growing share of populations, children are increasingly burdened with the responsibility of looking after their parents. Younger women in the household bear the responsibility for care work for the old and disabled.

In general, social and cultural norms prevalent in South Asia put women in a vulnerable situation throughout their lives, and thus by the time they become elderly, higher life expectancy is often challenged from the perspective of quality of life and well-being, including in terms of the right to enjoy a life with honour and dignity, happiness and a sense of worth.

All of these factors underscore that statistical data showing higher life expectancy may not be enough to explain the quality of life and well-being of the elderly in South Asia. More in-depth qualitative research and exploration of the intrahousehold division of labour and the distribution of both tangible and intangible resources can reveal areas for intervention to ensure a life of dignity, self-respect and self-esteem, with a particular focus on old age. State policy interventions designed to address the multiple issues of old age are important.

REPRODUCTIVE HEALTH

All societies have health-care systems, formal or informal, that comprise beliefs, customs, norms and values, techniques and responses in preventing and curing illness. Gender and reproductive health issues are at a crossroads of biology and social constructs that profoundly shape women's roles and status.

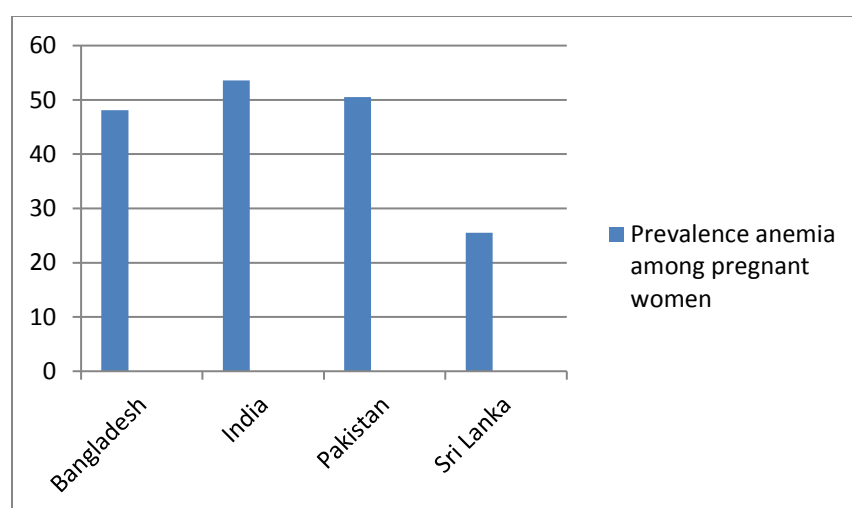
The health-care seeking behaviours of mothers vary across cultures in South Asia. In many South Asian countries, pregnancy and giving birth are considered ‘natural’ phenomena requiring no extra attention to ensure a safe delivery (Akhter 2015). Maternal health outcomes depend on the complex interaction of factors at various levels, such as government policies and actions, access to the health system, service delivery, distance to the health care centre, transport and infrastructure, financing, asset access, and, most importantly, ideologies related to women’s bodies and birthing dominating the structure of households and communities.

The general health situation of a mother in South Asia has far-reaching implications. The prevalence of anaemia; lack of adequate nutrition, rest and leisure; the age of the mother, the mother’s weight, diabetes, depression or mental or psychological problems, maternal morbidity and births attended by skilled health professionals are crucial factors in the pre- and antenatal stages.

According to Table 2, except for Sri Lanka, more than 50 percent of pregnant women are anaemic in South Asia, with the highest percentage in India. Pregnant women who are anaemic are at higher risk of maternal mortality and morbidity, a situation that contributes as well to the high prevalence of underweight children with lower life expectancy and stunted growth.

Table 2. Prevalence of anaemia among pregnant women, 2011

Country	Prevalence of anaemia among pregnant women
Bangladesh	48.1
India	53.6
Pakistan	50.5
Sri Lanka	25.5



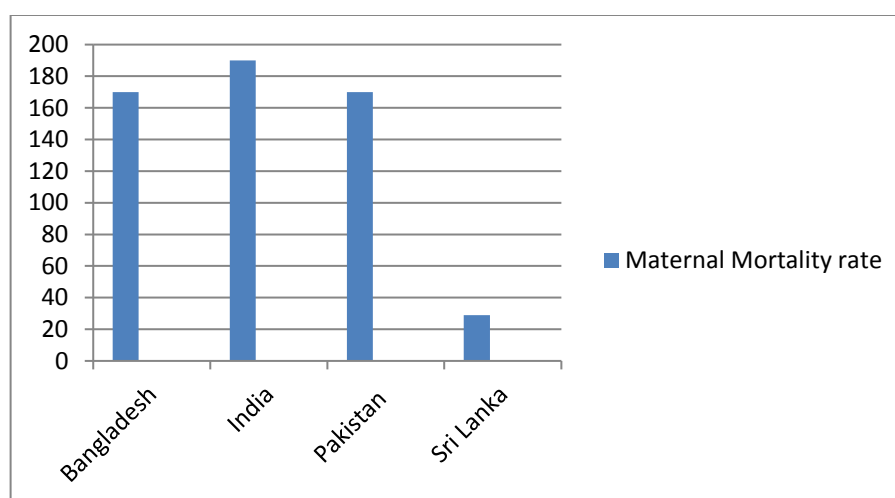
Source: World Health Statistics 2015.

MATERNAL MORTALITY VS. MATERNAL MORBIDITY

Literature on gender and health are overwhelmingly biased towards the rate of maternal mortality, which is crucial to human development. Table 3 shows that Sri Lanka has significantly lowered its rate of maternal mortality. Bangladesh and Pakistan have fared better, but India is lagging behind.

Table 3. Maternal mortality rate in 2013

Country	Maternal mortality rate per 100,000 live births
Bangladesh	170
India	190
Pakistan	170
Sri Lanka	29



Source: Trends in Maternal Mortality, WHO (World Health Organization), UNICEF (United Nations Children's Fund), UNFPA (United Nations Population Fund) and World Bank estimates, 2014, <http://blogs.worldbank.org/health/south-asia-s-quest-reduced-maternal-mortality-what-data-show>.

Maternal mortality is often regarded as the tip of the iceberg in women's reproductive health, however. Maternal morbidity may reveal more about gender and health issues. Akhter (2015) mentions that for every woman who dies of pregnancy-related complications, 20 to 30 others experience acute or chronic morbidity, often with permanent health damage that can affect physical, mental, sexual and/or productive and reproductive capabilities. Unlike maternal mortality, no time frame for maternal morbidity can be set, as it can occur and continue throughout a women's life span (Bhatia and Cleland 1996).

Maternal morbidity can include severe bleeding, anaemia, pelvic inflammatory disease, damage of reproductive organs, fistula, genital prolapse, uterine rupture, nerve damage, chronic hypertension, kidney failure, complications in future pregnancy and much more. In most cases, maternal morbidity is caused by a birth not attended by a trained midwife or *dai*. Fistula or other post-delivery injury occurs during child birth and continues to affect the health of mothers for years, with the effects worsening in subsequent births.

The consequences of maternal morbidity affect the health of mothers as well as their children, families and finally the entire country, but most health programmes are still primarily aimed at reducing maternal mortality. Akhter (2015) showed that in spite of the remarkable decline in maternal mortality in Bangladesh over the last decade, as many as 76.6 percent of mothers still deliver their babies at home. Mortality during pregnancy declined by 50 percent between 2001 and 2010, but post-partum mortality (within 42 days of delivery) was reduced by only a third.

Maternal morbidity is entwined with women's empowerment, social norms and values, the culture of shame and silence, and negligence—with her entire existence and positioning as a woman in the community.

“In our village there is lots of hard work. I had six normal child deliveries. After the birth of the fourth child, this (fistula) happened. I had to work hard after she was born. I had to cook food for 10-15 kilo rice, had to carry 20 jars of water. I brought up younger sister in law and also many other jobs. Can't tell you how many” (words of Afroza, cited in Akhter 2015, p. 149).

The treatment-seeking behaviour of mothers is largely shaped by their secondary position within the household. Fikree and Pasha (2004) state that women often cite economic circumstances and spousal or familial opposition to delivery in the hospital as the most common reasons for delivery at home, despite higher risks of morbidity and mortality. Decisions about seeking care are made largely by the husband or older members of his family. Long distances to medical centres and a lack of good communication infrastructure and transport are other reasons for fewer number women visiting health centres in South Asia.

Over and above economic reasons, fear and apprehension about modern health facilities for child delivery, a culture of silence and shame, and mistrust of medical services and the quality of the services also circumvent women's health-seeking behaviour.

“...We will die, but we will not go to hospital for delivery. There, I heard, male doctors do this (CS). I know, female doctors deliver the baby but male doctors remain with them. Is it not a matter of shame...? If any trouble happens, can a female doctor handle that? She will call a senior male doctor. People say that if we go to hospital for delivery they will do something that

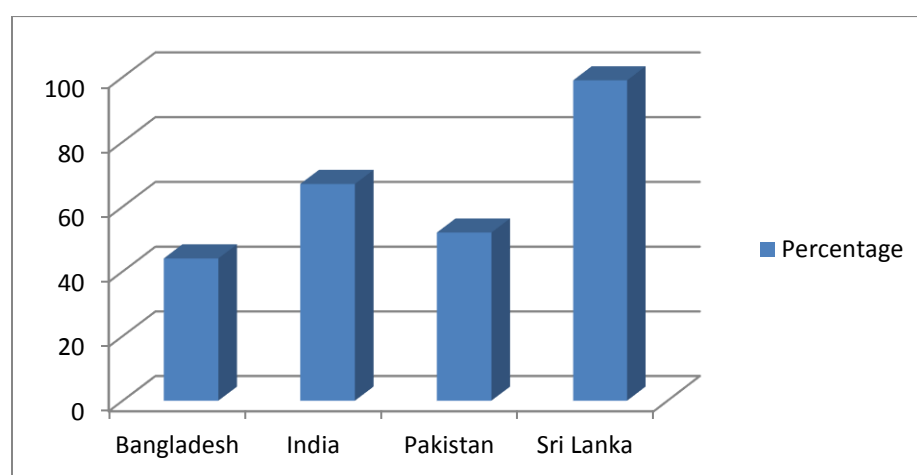
we will never be able to have any more babies. You know, the Government asks us to have fewer children, that's why they do something during delivery. We heard about this from people around us.” (Sheher Banu aged 35 years, mother of four children, Sona Mia Slum, cited in Akhter 2015, p. 133).

Many studies have found that education, access to property and resources, participation in income-earning activities and gainful jobs, access to knowledge about opportunities, and control over their own body and sexuality are critical for women's health. A positive association, for example, exists between women's education and the likelihood that they will seek treatment for childbirth complications and post-partum illness.

The share of births attended by skilled health professionals is a crucial indicator to measure maternal health. As shown in Table 4, Sri Lanka again is successful in ensuring births are attended by skilled health professionals, while in Bangladesh and Pakistan, around 50 percent of women on average remain outside this service. In India, almost 70 percent of births occur with skilled health professionals. Antenatal care coverage has achieved better scores, but on average, except for in Sri Lanka, around 30 percent of pregnant women do not make at least one visit to a health-care provider during their pregnancy (Table 5).

Table 4. Births attended by skilled health professionals, percentage, 2015

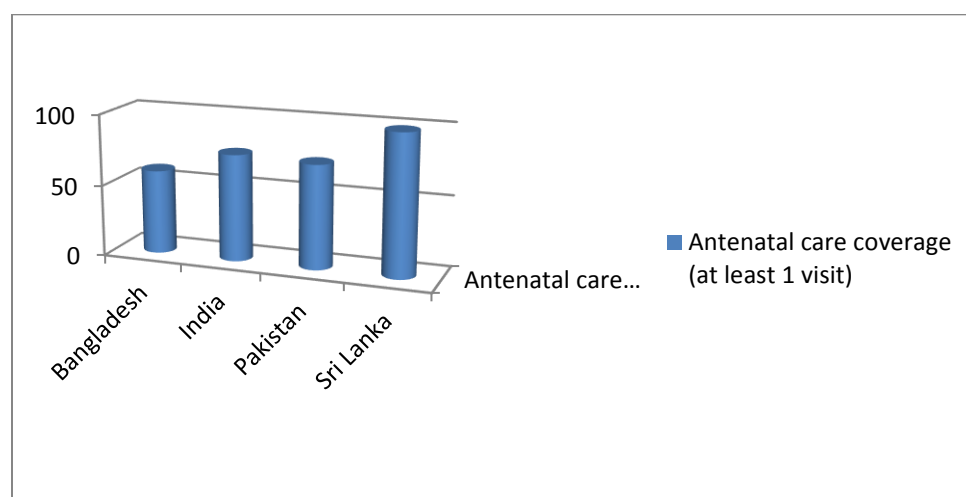
Country	Percentage
Bangladesh	44
India	67
Pakistan	52
Sri Lanka	99



Source: World Health Statistics, 2015.

Table 5. Antenatal care coverage (at least one visit)

Country	Antenatal care coverage (at least one visit)
Bangladesh	59
India	75
Pakistan	73
Sri Lanka	99



Source: World Health Statistics, 2015.

In Bangladesh, only 37 percent of births take place in a hospital. In 2014, midwives attended to 42 percent of deliveries (*Daily Prothom Alo* 2016). In many cases in South Asian countries, maternal mortality and morbidity can be reduced to a great extent just by ensuring the presence of skilled birth attendants during delivery. Putting too much emphasis on *dais* is also problematic, however. Perceptions around childbirth, and its association with shame and silence may lead to shortfalls even in the presence of a ‘skilled’ birth attendant in rural Bangladesh.

“.. I have been doing this (working as birth assistant) for the last 20 years. I myself don’t know which way the baby comes out. I mean I have never seen. I always cover the mother’s body with a big chador (wrap) and try to feel the baby using my hand. But in hospital, everyone sees, doctors, nurses, and other hospital people. You cannot keep your somman (honour) if you deliver at hospital” (words of a dai, cited in Akhter 2015, p.135).

Monitoring the activities, expertise and role of *dais* is another area that should be pursued with immediate urgency. According to a respondent in the rural areas of Bangladesh, the *dai* tried to pull the baby out manually, tearing the area and creating a hole. The mother, Jahanara, states,

“I got married at the age of 13. I got pregnant two years later. I went to my parents’ house for delivery. Then I had Gorbho tonka (convulsion). The convulsion was so much that the baby’s head could be seen at my cervix. Then the dais, who were present there thought the baby should be born right then. Then they tried to pull out the baby using their hands. But the baby did not come out. It died inside. I stayed conscious for the following three days. Then my family took me to the district hospital. They brought the baby out by cutting a bit in the cervix. I think, ...my bladder got somehow cut at that time. Soon I realised that my urine is coming out without any control. When I tried to stand up, faeces came out too” (cited in Akhter 2015, p. 188).

FOOD INTAKE, SOCIAL NORMS, AND THE CULTURE OF EATING LAST AND LEAST

In the recent past, Bangladesh increased food grain production from 11 million to 39 million metric tonnes. But such an increase may not translate into better nutritional outcomes in South Asian countries, since the traditional family structure breeds forms of social exclusion and deprivation. Women often eat last and the least. A household ideology perpetuates the role of the altruistic mother who is the provider of food to the children and other members of the household. The mother-child unit thus becomes central to any health intervention in South Asia.

The gender politics of food, fuelled and nurtured by assumptions, norms and values where mothers and women need fewer calories, as well as women’s roles as providers within the household, push women into a perpetual state of malnutrition and protein deficiency. South Asia is the only region in the world where gender disparities are prevalent even in child malnutrition, further demonstrating the clear link between food insecurity and gender inequity.

Food remains the biggest item in the budget of poor households. It is as high as 50 percent in South Asia compared to 17 percent in the United States (Narayan 2011). In most cases of food deficiency due to price hikes, households limit their food intake, with a direct impact on the nutritional status of mothers and children.

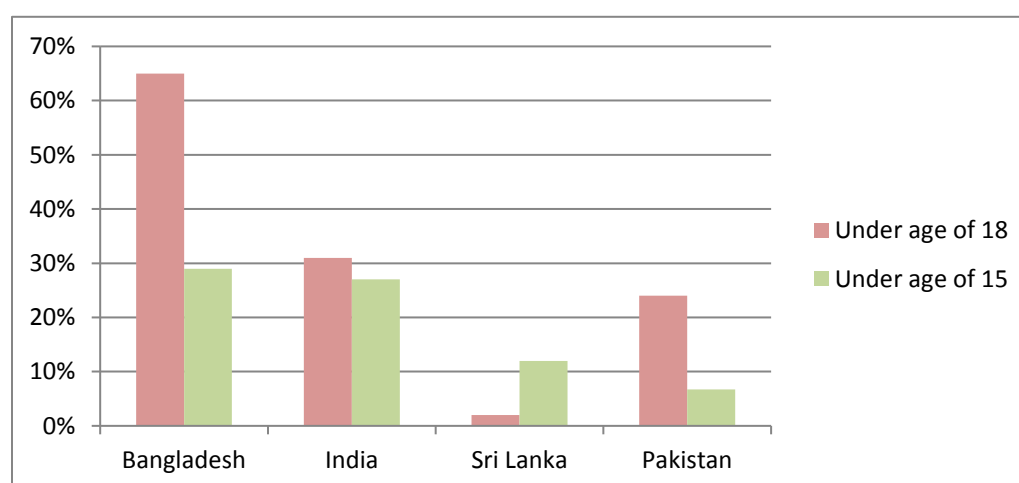
CHILD MARRIAGE

Child marriage is a global phenomenon that denies girls’ right to make decisions about their sexual health and well-being, leads to early pregnancy and forces them out of education and into a life of poor prospects, with increased risk of violence, abuse, ill health and/or early death. According to Raj et al. (2010), 15 million girls marry before the age of 18 each year—the equivalent of one every 25 seconds. If current trends continue, more than 140 million girls will become child brides by 2020. Child marriage is most common in South Asia and in West and Central Africa, where 46 percent and 41 percent of girls become child brides, respectively.

Table 6 shows that Bangladesh has the highest prevalence of child marriages among the four countries analysed in this report. Two-thirds of girls in Bangladesh are married as teenagers. Sri Lanka has managed to lower its child marriage rate to 2 percent and 12 percent for ages 15 and 18, respectively.

Table 6. Child marriage by country

Country	Female		Male
Bangladesh	Under age 18	65%	----
	Under age 15	29%	
India	Under age 18	31%	-----
	Under age 15	27%	
Sri Lanka	Under age 18	2%	-----
	Under age 15	12%	
Pakistan	Under age 18	24%	-----
	Under age 15	6.7%	



Source: www.hrw.org/news/2015/06/09/bangladesh-girls-damaged-child-marriage, www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf, www.girlsnotbrides.org/child-marriage/sri-lanka/, www.unicef.org/infobycountry/pakistan_pakistan_statistics.html.

Maternal health is linked with the age at marriage and teenage pregnancy. Early age at child birth with an immature pelvis and poor nutritional status contributes to obstructed labour and pre- and post-natal complications, and is one of the most detrimental factors for the health of both mothers and children. It's a development paradox that Bangladesh brought down its maternal mortality rate with such a high prevalence of child marriage.

Illiterate, malnourished and impoverished mothers are also more likely to perpetuate the intergenerational cycle of hunger and ill health (Narayan 2011). Teenage pregnancy can cause a vicious

cycle of maternal mortality, maternal morbidity, high incidence of child mortality, and generations of underweight children suffering from stunted growth, malnutrition and vulnerability.

Child brides are often more controlled by husbands and in-laws, which may make them less able to advocate for adequate nutrition for their children, perhaps in the context of their own limited access to food and other resources. This combined with the limited nutritional reserves stored within the bodies of adolescent mothers probably places their offspring at substantial risk for low birth weight and inadequate access to breast milk. Research suggests that the effects of inadequate foetal nutrition and reduced breastfeeding among neonates born to adolescent mothers extend into infancy and early childhood, maintaining an ongoing risk for malnutrition-related health problems that can result in vulnerabilities accumulating over a life time.

Early motherhood, in India and elsewhere, is associated with the increased likelihood of neonatal death and stillbirth, low birthweight infants, and child and infant morbidity and mortality. These disproportionate risks seem to be related to social and health-related vulnerabilities among adolescents, including increased rates of poverty, maternal depression and malnutrition. Lack of education and inadequate access to health care may also account for adolescents' lower use of antenatal care, skilled delivery care and complete infant vaccination schedules.

According to Wall (1998, p. 1,206):

“The likelihood of obstructed labour is increased in areas where early marriage and childbearing are common, because although growth in height stops or slows with the onset of menarche¹, the capacity of the bony pelvis normally continues to expand after the epiphysis² growth plates of the long bones have fused. These problems are worsened if girls have been undernourished throughout childhood and adolescence. Thus, although girls are capable of becoming pregnant at a relatively early age, their pelvis do not develop their full capacity to accommodate childbearing until much later, and many will have their lives destroyed by obstetric injury before they have even crossed the threshold into true adulthood.”

While exploring associations between child marriage before age 18, and the morbidity and mortality of infants and children under five in India, research shows that the majority of births, or 73 percent, were to mothers married as minors. Although Raj (2010) found significant associations between maternal child marriage and infant and child diarrhoea, malnutrition (stunted, wasted, underweight), low birth weight and mortality, only stunting and underweight remained significant in

¹First menstrual cycle.

²Rounded end of a long bone and its joint with adjacent bones in the pelvic area.

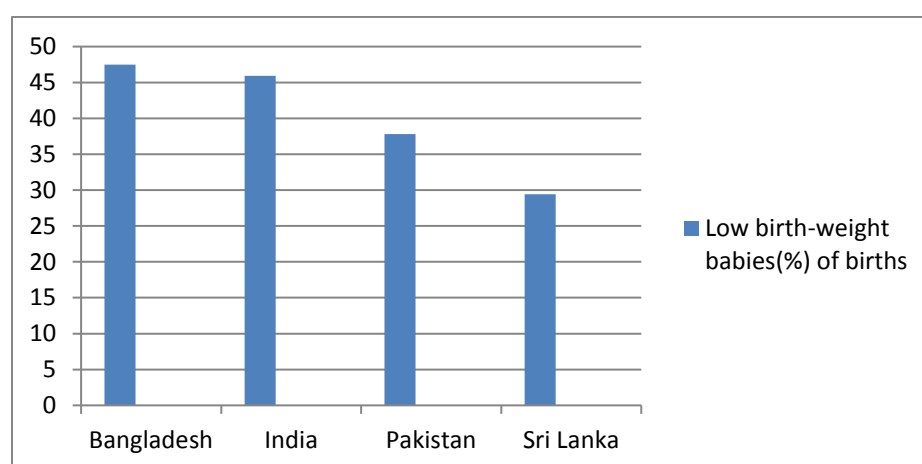
adjusted analyses. No direct effect of maternal child marriage on the health of boys versus girls was found. The study concluded that the risk of malnutrition is higher in young children born to mothers married as minors than in those born to women married at a majority age, but child mortality was not directly related to child marriage.

Married adolescent women, however, are more likely than those marrying in adulthood to remain poor, uneducated and within rural communities, and to have low access to health care, all factors that contribute to increased risks for infant and child morbidity and mortality. Furthermore, women who marry and begin childbearing at a younger age are more likely to have a greater number of children, which is also linked to increased likelihood of poor maternal, infant and child health outcomes. Such findings show the need for analysis of the relative contribution of child marriage to child mortality, and poor infant and child health, beyond that accounted for by the demographic vulnerabilities of the mother.

Bangladesh is the only country in South Asia that has been successful in reducing child malnutrition, from 56 percent to 43 percent from 1996 to 2009 (Narayan 2011). More than 45 percent of children in Bangladesh and India are still born underweight, however (Table 7). Pakistan has managed to lower the share to around 38 percent.

Table 7. Low birth-weight babies 2000-2005

Country	Low birth-weight babies, percentage of births
Bangladesh	47.5 (2004)
India	45.9 (2005)
Pakistan	37.8 (2002)
Sri Lanka	29.4 (2000)

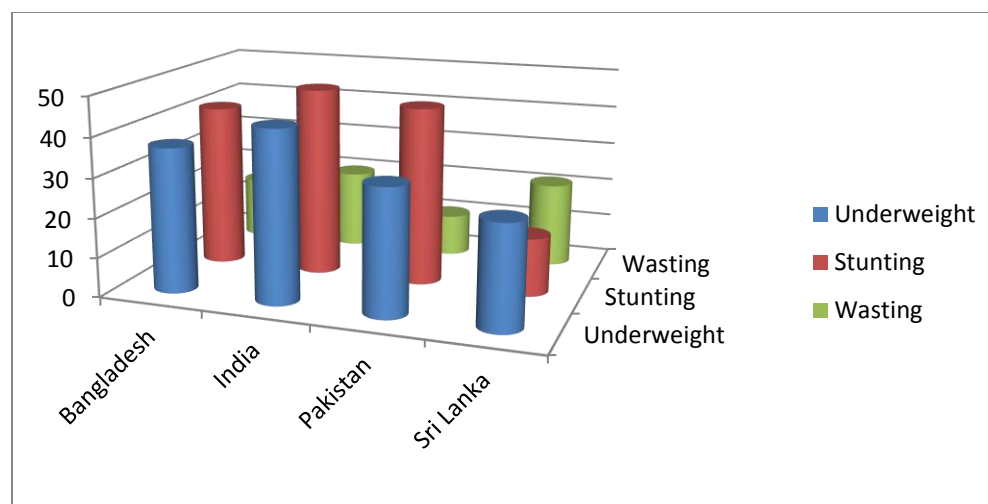


Source: UNICEF 2015, Country Statistical Information.

Table 8 shows the shares of children who are underweight, stunted or experiencing wasting. Lactating women and children have special nutritional needs, with young children needing to be fed several times a day in the first two years of life, which offer a critical window of opportunity to establish a foundation for a healthy life (Narayan 2011). Mothers, especially young mothers suffering from malnutrition, are often not in a situation to ensure breastfeeding. The ideology of son preference may lead to further neglect of girl children, creating a cross-generational chain of deprivation and gender disparity.

Table 8. Prevalence of malnutrition among children under five, percentage

Country	Underweight	Stunting	Wasting
Bangladesh	36.8	41.4	15.7
India	43.5	47.9	20
Pakistan	32	45	10.5
Sri Lanka	26.3	14.7	21.4



Source: WHO Global Targets Tracking Tool, accessed 11 May 2016, www.pc.gov.pk/wp-content/uploads/2015/06/Ch21-Nutrition.pdf.

Table 9 shows the comparative advantage of girls over boys in terms of mortality rates in Bangladesh and Pakistan. In Sri Lanka, the gender disparity and overall percentages of mortality are lowest. In South Asia, however, gender disparities based on social, cultural and in some cases legal constructs and practices override the biological advantages of being born female. This underscores

that while calculating infant mortality rates is important, it does not tell the entire story, and is not an end in itself for human development.

Table 9. Infant mortality rate per 1,000, 2015

Country	Infant mortality rate
Bangladesh	Boys: 44 Girls: 38
India	Boys: 54 Girls: 59
Pakistan	Boys: 90 Girls: 82
Sri Lanka	Boys: 10 Girls: 9



Source: UNICEF 2015, Country Statistical Information.

IMBALANCED SEX RATIO: THE PHENOMENON OF MISSING WOMEN

Gender-related disparities in health status have led to an imbalanced sex ratio for the past 100 years, which is still worsening (Banthia 2001). An estimated 60 million to 1 billion girls are ‘missing’ worldwide, with South Asia’s imbalanced sex ratios contributing to a large portion of this number. In some parts of the Indian subcontinent, the sex ratio has fallen as low as 770 women per 1,000 men. Gender discrimination at each stage of the female life, the ideology of son preference and the lower value of female children contribute to this imbalance. Sex selective abortions, the neglect of girl children, reproductive mortality, and poor access to health care for girls and women have all been cited by many qualitative studies as reasons for the difference (Watts and Zimmerman 2002, Allahbadia 2002, Sharma 2003).

Table 10. Missing women in South Asia, based on sex ratio estimates, 2014

Country	Total population	At birth
Bangladesh	0.95 male(s)/female	1.04 male(s)/female
Pakistan	1.06 male(s)/female	1.05 male(s)/female
India	1.08 male(s)/female	1.12 male(s)/female
Sri Lanka	0.96 male(s)/female	1.04 male(s)/female

Source: www.indexmundi.com/bangladesh/sex_ratio.html,
www.indexmundi.com/pakistan/sex_ratio.html, www.indexmundi.com/sri_lanka/sex_ratio.html,
www.indexmundi.com/india/#Demographics.

According to Sen (1990b), “more than 100 million women are missing in South Asia, West Asia and North Africa.” These numbers, he said, “...tell us, quietly, a terrible story of inequality and neglect leading to the excess mortality of women.” Almost all the missing women belong to Asian countries where there is a long history of son preference.

Sen was primarily focussing on health care and medical attention, and access to food and nutrition and its relation to the mortality rate of women. After conception, biology on the whole favours women, but in South Asia, West Asia and North Africa, the failure to give women medical care similar to what men get, and to provide them with comparable food and social services results in fewer women surviving than would be the case if they had equal care.

Asfew et al. (2007) argue that intrahousehold gender discrimination in the receipt of medical attention can be one of the most important factors behind the imbalanced sex ratio. Their rigorous statistical exercise reveals that the probability that infant and very young girls with live female siblings will die in hospital is extremely low. Girls are highly discriminated against in access to hospital treatment, however, and in the number of times that they are hospitalized before their death compared to boys. The probability of girls being hospitalized before their death was found to be 12 percent less than boys.

An economic analysis does not explain much, since many poor countries do not, in fact, have deficits of women. “A combined cultural and economic analysis would seem to be necessary, and, I will argue, it would have to take note of many other social conditions in addition to the features identified in the simple aggregative theses,” says Sen. In fact, cultural norms, the ideology of son preference and the lower value of women lead to the phenomenon of ‘missing women’ even before they are born.

Aruvamudan (2007) revealed another side of this phenomenon through her research in India with a special focus on the ‘female infanticide belt’ stretching from Tamil Nadu to Punjab, Rajasthan and Gujarat. She narrated trends in missing women from infanticide to foetus killing over time. Infanticide was found to be a well-entrenched social practice in many communities, fuelled by religious scriptures

like the *Veda*, *Manu Sanghita* or the epic mythology of the *Mahabharat* and *Ramayan* that made son preference central to the ideological basis of ancient India.

By 2001, an alarming and radical change was observed: “A careful analysis of census data showed that over the decades, while the adult sex ratio in India has improved marginally...more women were staying alive, but fewer girls were being born” (p. 13). This was happening using ultrasound scans to perform sex selective abortions in many parts of India. An unholy alliance between tradition and technology coupled with profit maximization was underway. Sex selective abortions had replaced female infanticide, historically the accepted method of disposing of unwanted girl children.

Following Sen’s article, *The Lancet* came out with a startling article written by two researchers, Prabhat Jha of St. Michaela Hospital at the University of Toronto, Canada and Rajesh Kumar of the Postgraduate Institute of Medical Research in Chandigarh, India. According to their findings, around 10 million female foetuses may have been aborted in India over the past two decades because of ultrasound scanning and traditional preferences for boys. This kind of preselection, they said, had caused the loss of about 50,000 female foetuses every year. Although there was disagreement over this data as being an exaggeration, the research helps delve into the difficult problem of sex-selective abortion.

In some communities, the killing of daughters and female foetuses is seen as an act of compassion, freeing daughters from the hardship they would otherwise face. Doctors have also thought that they were performing a humanitarian service for mothers.

“Better to kill her before she knows this miserable life, better to send her straight to heaven rather than make her endure this beating and kicking around. What joy we got by staying alive?” (voice of a grandmother from the Kellar community, India, cited in Aravamudan 2007, p. 10).

The systematic elimination of girl children became widespread after India’s Independence in 1947, and can be traced to the rise of commercialization and the subsequent marginalization of women in their communities. This has spurred violence against women for giving birth to a girl child, fear of abandonment, and the devaluing of women who have no son, both in her birth family and by her in-laws. Girls are considered a burden, including through the dowry system. Investments in daughters are transferred to her in-laws.

Infanticide cuts across all castes and communities, and knows no economic barriers. Girl children are missing from educated affluent urban areas, just as they are from poor and illiterate rural areas. In rare cases, the first daughter is allowed to stay alive, but not a second daughter.

Many consequences have emerged from ‘woman famine’ in a ‘son hungry’ land, including bride selling from poor *adivasi* communities, wife-sharing by brothers named the ‘Draupadi syndrome’,

polyandrous marriages, the mutual exchange of girls, and the commodification of women, whose bodies are used as barter in marriage transactions (Aravamudan 2007).

INTRAHOUSEHOLD DISPARITIES AND ALLOCATION OF RESOURCES

Women's subordinate position within households can be a profound barrier to all forms of health care. Gender inequalities enshrined in households and in their material and ideological frameworks lead to systematic devaluation and neglect of women's health, leaving women less likely to seek appropriate and early care for diseases. Decision-making capacity mostly lies with a husband or other family members. Beliefs and practices insisting on seclusion and/or restriction on mobility play a role as well.

Gender discrimination in the intrahousehold allocation of resources means that parents may spend more on men than women, and on boys than girls. Parents in India may wait longer before going to the hospital with their baby girl than they do with their baby boy, for example. Patterns like these have resulted in gender-based health disparities among children under five that are larger than anywhere else in the world. A girl between her first and fifth birthday in India or Pakistan has a 30 percent to 50 percent higher chance of dying than a boy. This is the result of poor nutrition, lack of preventive care and delays in seeking healthcare (Filmer et al. 1998).

As reviewed by Seth (1997), many empirical studies on disparities in the intrahousehold consumption of non-food resources have focused on health and education. Bangladesh, India and Pakistan show a pro-boy bias in health. This was apparent for issues such as the duration of breast-feeding, the quantity and quality of health care, and survival probabilities after diarrhoeal episodes, all of which are reported to favour boys. In India and Pakistan, breast-feeding duration is longer for boys, partly because there is less urgency to have another child after a boy. In Nepal, mothers were more frequently concerned about the adequacy of their milk for boys. In Pakistan, lower income households sought care more often for boys than for girls, and were likely to use higher quality providers for boys, although this difference in frequency and quality of care disappeared as income increased.³

Rahman (n.d.) discusses intrahousehold resource allocation issues related to nutrition and food distribution, nutrient demand, and child health and nutrition outcomes in rural Bangladesh. Using a measure of bargaining power—spouses' assets at marriage—that is culturally relevant and (weakly) exogenous to household decision-making, Rahman finds strong evidence of intrahousehold bargaining on nutrient allocation and on the distribution of food from relatively expensive sources. A wife's bargaining power positively affects allocation to adult females at the expense of that to adult

³See Seth 1997 for details.

males. Spouses' preferences and bargaining power also tend to vary at different income levels. Rahman illustrates that at the low-income level, a wife prefers preschooler boys to preschooler girls in intrahousehold food distribution, while at the middle-income level, preschooler girls are preferred to preschooler boys. Son preference in intrahousehold food distribution is also guided by cultural norms and appears to be prominent in non-poor households in Bangladesh. According to Rahman (n.d.), calorie intake appears to be highly inelastic for both poor and non-poor households, while both the macro- and micronutrient intakes of the poor, compared to those of the non-poor, are more responsive to implicit macro- and micronutrient prices. These findings have important implications in terms of malnutrition, food policy and human capital formation in rural economies.

Schmidt (2012) on the other hand contends that trends in developing economies worldwide suggest that as relative female intrahousehold bargaining powers improve, consumption preference favours basic needs that promote child welfare. A positive correlation exists between children in families where mothers have decision-making authority and child health outcomes. Empirical evidence for the study reveals that women who enjoy decision-making power in the household, especially in large purchases, have children with better height-for-age ratios. Enhancing women's status leads to more investments in children's education, health and overall well-being. Schmidt suggests that women's empowerment and promotion of gender equality are key ingredients to achieving sustainable development.

Households are often assumed to be an altruistic unitary category ensuring the well-being of all members, where all resources are pooled to be distributed equally by the benevolent household head, who is usually male. In other words, the household is seen as a site of cooperation that will automatically ensure the well-being of all its members. This view has been challenged by many. An alternative approach illustrates the possibilities of conflicting preferences, and looks into household decision-making taking place through bargaining and negotiation, where the household is described as a locus of "cooperative conflict" (Sen 1990a). Seth (1997) argues that the following are critical determinants of an individual's ability to negotiate and bargain for a greater share of household resources: size and composition of the household, actual and perceived contributions to the household, control over income and other fall-back positions.

Lloyd and Gage-Brandon (1993, cited in Seth) found in Ghana that on average female-headed households spent a higher proportion of income on food than male-headed households, even at higher income levels. They argue that this indicates a tendency for women to allocate a larger share of their own resources to the food needs of their children. Men and women tend to spend their incomes in different ways, with women spending on consumption goods for the entire household, and men spending a higher proportion on items for themselves (entertainment, cigarettes) (Seth 1997).

Roger (1996) compared food expenditures of female- and male headed-households in the Dominican Republic, and found that although female-headed households allocated the same amount or less of their budgets to food than male-headed households in absolute and proportional terms, the former consumed higher quality, more expensive and more protein-dense foods (more animal products, fewer beans and rice) than the latter. And even though the average caloric adequacy per adult-equivalent was equal or lower in female-headed households, children's anthropometric status was the same or higher, possibly due to an intrahousehold allocation of food that favoured children.

IN SUMMARY

Summing up cross-country intrahousehold data on gender and health shows that considerable progress has been made in reducing maternal mortality, but maternal morbidity and the general health status of both women and children have not been adequately addressed. Anaemia and other reproductive health problems have negative impacts on women's health, infant mortality, and child growth and development in the long run; skilled birth attendants play very important roles in safe delivery. While women enjoy a comparative advantage in terms of higher life expectancy and longevity, protecting this requires specifically designed health and social security measures.

Certain social norms and cultural practices are detrimental to women's health and perpetuate disparities across generations. Child marriage creates long lasting inequalities in health and education, and failing to address this issue can lead to a generation of girls and women trapped in a vicious cycle of poor health and lost human development. Breaking the hold of patriarchal norms and values that determine intrahousehold resource allocation patterns and decisions related to gender and health depends on empowering women. Their ability to access and control resources and make choices can make a big difference in their own lives and those of their daughters.

Gender and education

Education is a powerful agent of social transformation and human development. It empowers people, and helps to develop the knowledge, skills and capacity to perform as full human beings and live with self-respect and dignity. Education is also an equality issue. The constitutions of many countries, including in South Asia, express the intention of ensuring equal opportunity for education to all, irrespective of gender, race, ethnicity, religion and/or sexual orientation.

Education has been declared a basic right of all people in the Universal Declaration of Human Rights. Many other national and international conventions and declarations, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), call for eradicating

gender discrimination in education. CEDAW stresses eliminating discriminatory gender stereotypes from educational materials to ensure positive images of women in text books, and for including women's issues and women's studies in curricula from the primary level to higher studies (Titumir and Hossain 2004).

Most South Asian countries still have large populations in poverty, along with mass illiteracy, unemployment and economic backwardness, and gross gender disparities in every sphere of social, political and economic life. In spite of immense achievements during the last decades, and despite many positive policy efforts by both governments and non-governmental organizations, much more needs to be done in working towards gender quality in education. Women are disadvantaged in access to education and in the ability to remain in school.

Stereotypical gender roles, the gender division of labour, and gender separations between public and private spheres have encouraged a notion in South Asia that women are dependent on their father, husband or son. They are mostly assessed in terms of their reproductive rather than their productive roles. Women are also marginalized by multiple other constraints such as unequal inheritance laws, religion-based family law, dowry, early marriage, the responsibility of girls for household chores and care of younger siblings, son preference, the general decline in law and order, stalking and sexual harassment, and insecurity in the region and specific countries. While the patriarchal state plays a significant role in terms of entitlements, and access to power and benefits, household decision-making remains the most crucial factor shaping the future of girls.

All of these issues are inextricably linked with gender parity and equity in education. Issues with more direct impact include the distance of schools, infrastructure development, road and transport facilities, access to digital facilities, school building and toilet facilities, the timing of class hours, student-teacher ratios, the number of female teachers in a school, the number of female students, and so on.

Most studies and statistics related to gender and education in South Asia emphasize the primary level of education. It is also important to look at higher studies in public and private universities as well, however, where intrahousehold decisions and actions remain as crucial as for primary school. This section explores opportunities and constraints faced by female students in South Asia, highlighting gender disparities moulded by intrahousehold constructs.

ACHIEVEMENTS AT THE PRIMARY LEVEL

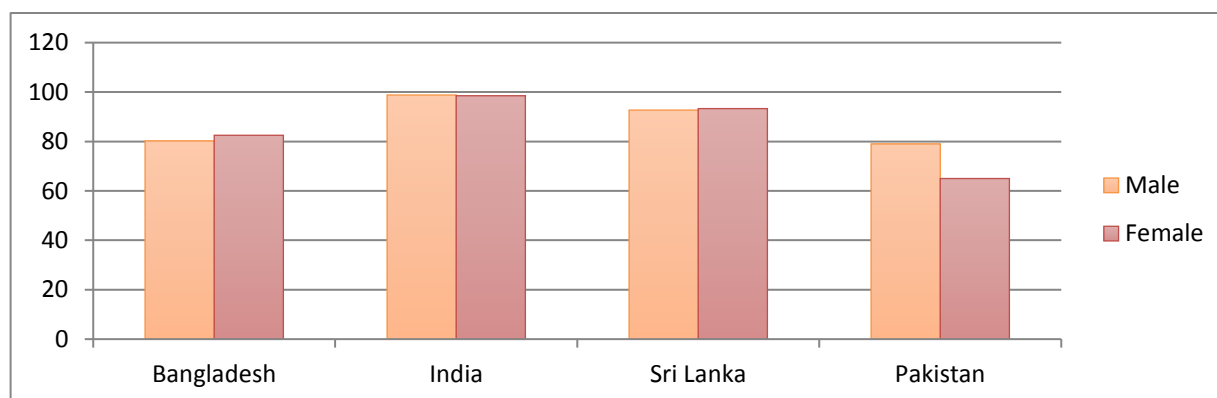
Incredibly positive changes in decreasing the gender gap in primary education have occurred recently in South Asia. Table 11 shows success in India and Sri Lanka in terms of ensuring primary education almost for all and closing the gender gap in the net enrolment ratio. Bangladesh similarly has made it

to more than 80 percent for all, with a slight tilt in favour of the girl child. Bangladesh has also fared well in terms of bringing down the dropout rate to less than 15 percent. The dropout rate for girls has also been reduced compared to India (Table 12).

In Pakistan, given the difficult socioeconomic and political situation, the enrolment of 79 percent for boys and 65 percent for girls in primary school, along with dropout rates of 33 percent and 20 percent for boys and girls, respectively, are still achievements.

Table 11. School participation and net enrolment ratio for primary education, percentage

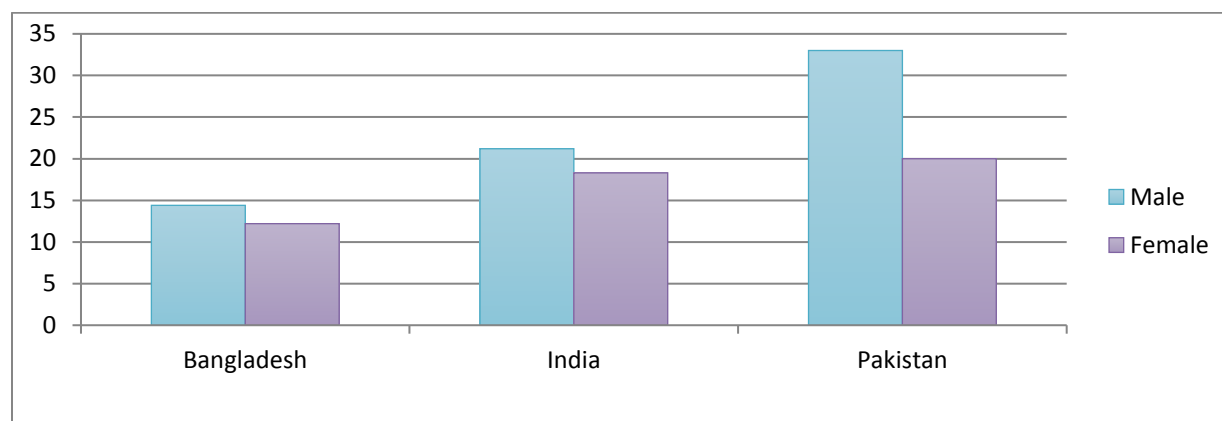
Country	Primary level	
	Male	Female
Bangladesh	80.2	82.5
India	98.8	98.5
Sri Lanka	92.7	93.3
Pakistan	79	65



Source: Government of Bangladesh 2012, UNICEF 2013.

Table 12. Drop-out rate for primary school, percentage

Country	Male	Female
Bangladesh	14.4	12.2
India	21.2	18.3
Pakistan	33	20



Source: Government of Bangladesh 2012, UNICEF 2013, Government of India 2013, www.sundaytimes.lk/130630/education/2-of-children-sans-formal-education-50413.html.

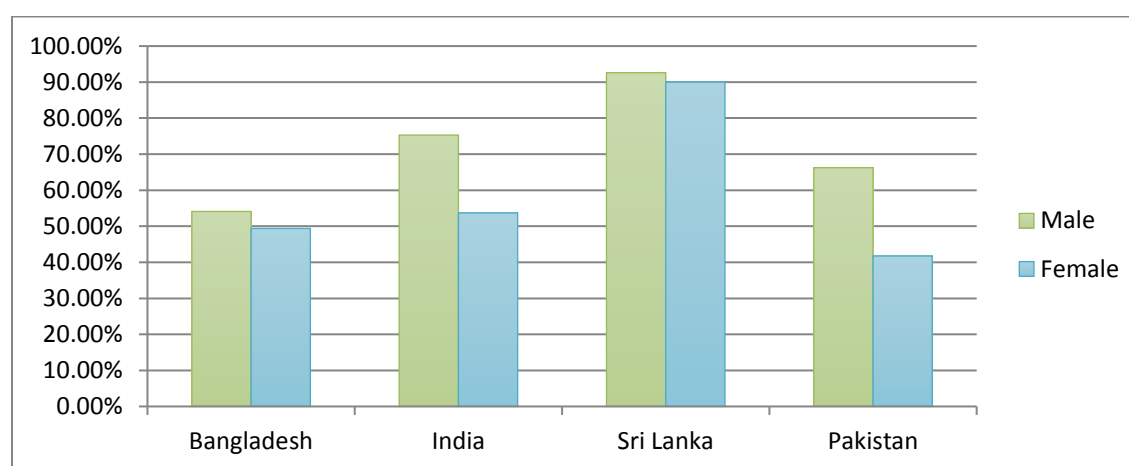
This relatively rosy primary school picture fades, however, when it comes to consecutive years of schooling. Only India and Sri Lanka sustain the enrolment rate, contributing to higher literacy rates among children age seven and above (Table 13). More than 90 percent of boys and girls are literate in Sri Lanka, whereas the percentages are 54 percent for boys and 49 percent for girls in Bangladesh. Sri Lanka is the only country that has shown a consistent pattern in ensuring universal primary education for all and bringing down the gender gap at the primary level almost to zero, with a higher literacy rate.

Bangladesh could manage to close its gender gap in literacy to less than 4 percent, having achieved considerable progress in basic education over the past decades. Perhaps most noteworthy, it has closed the once vast gender gap in school enrolment at the primary and secondary levels (Adams 2015).

With a population of over 130 million in 2011, Bangladesh has nearly 20 million children between the ages of 6 and 10. Almost half are girls. The country has one of the largest primary education systems in the world. There are 81,508 primary level educational institutions—not including non-formal education schools. Since 1990, primary education has been free and compulsory for all children, with remarkable progress made in increasing primary enrolment.

Table 13. Literacy rate, age seven and above, percentage

Country	Male	Female
Bangladesh	54.1	49.4
India	75.3	53.7
Sri Lanka	92.6	90.0
Pakistan	66.25	41.75



Source: Government of Bangladesh 2012, UNICEF 2013, Government of India 2013.

Enrolment rates do not show what children are actually learning, however. Low attendance, high drop-out rates and low levels of achievement indicate significant problems in terms of the quality of education and retention in school. Further, Bangladesh still has approximately 1.5 million primary age girls out of school. Secondary education shares many of the problems of primary education (Government of Bangladesh et al. 2010). Quantity has to be complemented by quality, such as through reforms that consider the content of reading and how to ensure learning.

Table 14 shows a positive bias towards girls in secondary schools, except for Pakistan. In Bangladesh, female stipend programmes have been a direct cause of a major increase in female education, but limitations on the success of these programmes include relatively low retention and pass rates. The proportion of women going to tertiary and higher education has been much lower, with entry to this level essentially limited to socioeconomically privileged women (Kabir 2011). The recent trend in Bangladesh, however, shows better achievements by female students in tertiary or higher levels of education compared to male students. More in-depth studies are required to discern patterns and factors behind these developments.

Further, in many South Asian countries, remarkable achievements in some arenas such as education are still accompanied by an increasing rate of child marriage, violence against women, and lack of women's voice in politics and policy. Bangladesh has one of the highest rates of child marriage and adolescent motherhood in the world, and violence against women remains a pervasive phenomenon (Adams 2015). This development riddle needs more research and scrutiny, using rigorous frameworks, and applying statistics and numbers as important political tools. A change in age at marriage from 16 to 18 years can substantially decrease the percentage of child marriages, for example.

Table 14. Secondary school participation, net enrolment ratio, percentage

Country	Secondary level	
	Male	Female
Bangladesh	42.8	50.6
Sri Lanka	85.8	90.7
Pakistan	39.7	29.2

Country	Male (%)	Female (%)
Bangladesh	42.8	50.6
Sri Lanka	85.8	90.7
Pakistan	39.7	29.2

Source: Government of Bangladesh 2012, UNICEF 2013.

EDUCATION, CULTURAL NORMS, VALUES AND HARMFUL PRACTICES: A SOUTH ASIA PERSPECTIVE

Discrimination against women is rationalized by the fact that they are seen as an economic burden. In extremely poor families, where frequently there is not enough for everyone, this means that women and girls are most likely to go without a meal, eat fewer calories, go without warm clothes in the winter, and receive minimal health care and education.

Nutritional deprivation has profound impacts on learning capacity, weighing down the potential of girls to perform well. This is coupled with the preference for boys in education. In most South Asian countries, it is not seen as necessary for girls to receive a formal education, especially not beyond the primary level. In Bangladesh, most parents allow their daughter to learn and recite the Quran. Where a decision has to be made about which children to send to school, parents in most cases decide to invest in their sons rather than their daughters.

Sultana (2010) revealed a scenario in Bangladesh that is common to most of the South Asian countries covered in this paper. Girls from a very young age learn domestic skills and begin to take on domestic duties and reproductive work, including child care. They supplement the household income with cottage craft income if there is any. In rural areas, there is a strong belief that a son should be educated because, unlike daughters, who after marriage serve another family, a son will remain to support his aged parents. Most families thus prepare girls for marriage, teaching them to be docile so they can take up the role of 'good' wife and mother. Dowry is another detrimental factor that further reduces household investment.

Highly unequal gender relations and discriminatory attitude were noticed by Sultana (2010) in access to equal opportunity in education:

"I was 14 years old. That time I was in secondary school, I have two brothers and we all went to school. At the time, I was about to be married, but I did not know anything. At last, I asked my parents, they did not tell me. Finally, I told my parents that I am not ready to be married. I want to continue my study. They assured me that after marriage I can continue my study. Nonetheless, that was not true. They cheated me. After 12 days of my marriage, I wanted to go back to school, but my in-laws refused. They had promised that I would go to school after marriage. They broke their promise. I could not continue my study. On the other hand, my two brothers are now well educated" (interview with Sharla Begum, cited in Sultana 2010, p. 34).

Another important reason for gender discrimination in education is related to the role of women and girls in traditional agriculture-based societies. In most cases, women carry out subsistence agriculture or domestic work, which is very tiring and repetitive, and entails walking for long hours to find water, fuel and fodder, essential cost-saving activities for poor households. These tasks do not require particular knowledge, so families perceive girls' education as a waste of time and resources. Further, higher education, beyond the primary level, is often perceived as a threat to traditional male authorities, and may make it more difficult to find a bridegroom.

Girls' and women's education is also affected by ideologies associated with *purdah* or seclusion, mobility, women's body and sexuality, purity and pollution. Women and their bodies have long served as an important projection of honour in South Asia. Ensuring women's 'purity' and moral integrity is

often considered critical in maintaining the status and reputation of a family, community and society. Traditionally, this has been ensured through the practice of *purdah*, which seeks to limit interaction with non-kin men. *Purdah* can be broadly understood as a set of norms and strictures that exclude women from or restrict their activities within public spaces. It takes two main forms: the physical confinement of women in the home and the veiling of women in public. Women's rights advocates claim that by restricting women's access to public spaces, *purdah* is often used as a means of limiting women's social agency (Adams 2015). *Fatwas* or religious decrees also limit women's and girls' participation in public, including in attending educational institutions.

HOUSEHOLD RESOURCE ALLOCATION AND THE BARGAINING POWERS OF MOTHERS

As Kabeer (2005) has mentioned, subordination of women and girls is a consequence of the existing patriarchal social system, which determines power relations within households, and the bargaining power of household members through the organization of family, kinship and marriage, inheritance patterns, gender segregation and associated ideologies.

An IFPRI study (Quisumbing and Maluccio 2000) using new household data sets from Bangladesh, Ethiopia, Indonesia and South Africa presents measures of individual characteristics that are highly correlated with bargaining power, namely, human capital and individually controlled assets, evaluated at the time of marriage. Apart from wealth, the study indicates that a mother's schooling has a positive and significant coefficient for younger children; both a father's and mother's schooling coefficients are significant for older children. While the interaction terms do not indicate any parental gender preference for younger children, older daughters of better educated fathers complete fewer years in school. This may be linked to the South Asian pattern of wealthier families withdrawing females from public life, or from wealthier parents' desire for their daughters to marry early. In this society, wealthier fathers would be able to accumulate a dowry sooner than poorer fathers.

Regarding household wealth and bargaining, studies have indicated that wealth gaps in educational outcomes are large in many developing countries. In some South Asian countries with a female disadvantage, household wealth interacts with gender to create an especially large gender gap among the poor. Using internationally comparable household data sets (Demographic and Health Surveys), Filmer (2000) investigates how gender and wealth interact to generate inequalities in educational enrolment and attainment. This interaction is not necessarily shaped by national policy or national wealth status.

Women's assets have been found significant in shaping the future of education of their daughters. Women appear to bring far fewer assets to marriage, both in terms of physical and human capital, including less schooling than their husbands. While expenditure share analysis focuses only on

physical capital (assets) brought to the marriage, there is much evidence that differences in human capital between husband and wife, such as education, have significant effects on intrahousehold allocation, according to Agnes and Maluccio 2000. The study reveals that across countries under the research, the most consistent effect is that relative resources controlled by women tend to increase the shares spent on education, particularly in South Asia. Although the authors are tempted to say that mothers are more altruistic than fathers, this behaviour may have a sound economic basis. Given age differences at marriage (women are younger) and gender differences in life expectancy, it is possible that women invest in the education of their children more heavily since they are more likely to rely on them for old-age support.

In societies where key assets that assure lifetime consumption-smoothing are controlled by men (land, in many cultures; pensions and social security in countries with low female participation in the formal labour market), women may attempt to meet the same long-term needs with other instruments, such as investment in the human capital of healthy and educated children.

Agarwal (1994) highlighted the role of women's land and property rights in securing women's empowerment and bargaining power within the household. Agarwal contends that gender inequality takes both material and ideological forms. A critical neglected dimension of the material form is embedded in who commands public and private property, especially land. Social norms and perceptions are two hidden dimensions of the ideological form.

Zimmerman, in a study on India, noted that detecting gender discrimination among children in the intrahousehold allocation of goods from household surveys has often proven to be difficult. Nevertheless, in general, girls experience severe gender discrimination, especially from age 10 onwards in all parts of the analysis, with an almost universal disadvantage in the amount of education expenditures among those aged 15 to 19. In every age group, gender bias is robust to the use of different education expenditure measures for the majority of states. Studying the existence and extent of gender bias in intrahousehold allocation has potentially important policy implications for improving outcomes for girls.

Singh (2011) also noted positive correlations between intrahousehold gender inequality and education in India. Using households with a pair of male-female siblings aged 8 to 11 from a nationally representative survey, Singh surveyed gender-based intrahousehold inequality of opportunity in academic skills by comparing the test scores of siblings in reading and mathematics. The study found substantial gender-based intrahousehold inequality in both skills. The paper also estimated household fixed-effects models for reading and mathematics, and found significant differences between male and female children, with female children in a disadvantaged position. Further support for a bias against female children was provided by analysis of household expenses on education, which were

substantially lower for female children. This may negatively shape skill development for girls at the very beginning of their educational life.

The India Human Development Survey 2005 addressed intrahousehold allocations of education expenditure, covering both urban and rural areas. It found that pro-male gender bias exists in the primary school age group for several states, but that the incidence of gender bias increases with age—it is greater in the middle-school age group (10 to 14 years) and greater still in the secondary school age group (15 to 19 years). Gender discrimination in the secondary school age group takes place mainly through the decision to enrol boys and not girls, and not through differential expenditures on girls and boys. The results also suggested that the extent of pro-male gender bias in educational expenditure is substantially greater in rural than in urban areas. The survey noted that an important mechanism through which households spend less on girls than boys is by sending sons to fee-charging private schools and daughters to free government-funded schools.

The same trend regarding the choice of schools was revisited by Sahoo (2015), who explored gender inequality within households in choosing private versus government schools. The results showed an intrahousehold gender gap of 5.4 percentage points in private school enrolment among children aged 6 to 19 years. Female disadvantage in private school choice is significant among both younger and older children, and is rising over time. Moreover, a larger cost difference between private and government schools is associated with a significantly higher gender gap. A village-specific difference in direct costs, particularly school fees, is the most prominent factor in explaining the gender gap.

Many important decisions that affect economic development outcomes take place at the household level, including fertility decisions, the education of children, labour force participation, and production activities in various agricultural and non-agricultural household enterprises. Fuwa et al. (2006) looked into what happens within the household in Andhra Pradesh, India, such as how decisions are made and how resources are allocated among household members. Some of the findings confirmed known tendencies, such as less educated parents and poorer parents being more likely to send their children to work.

Fuwa et al. (ibid.) examined more closely the status of the child and showed clearly that girls are less favoured than boys, which is apparent in household spending patterns, including on school-related goods. Gender discrimination against girls is clearly demonstrated in their sample. It takes the form of lower school enrolment rates, longer working hours, shorter leisure and schooling time, and less spending. Girls are set to work at a younger age with less investment in their capabilities. To ameliorate the inequality, mothers cut their own consumption for their daughters. This led us to ponder again whether the household follows the norm of unitary or collective models. From a policy perspective, for example, a transfer of resources will increase an individual's bargaining position in

the household, and should be directed to those who care about weak and vulnerable household members.

It is not sufficient to make girls' education more affordable; it must also be made more important as a social preference. Gender disparities in education should be considered beyond numbers and simple statistics, especially in terms of intrahousehold disparities that create intergenerational disparities and disadvantages. The quality of education, education beyond primary levels, retaining students in school, and ensuring competencies and skill development remain big challenges.

VIOLENCE AGAINST WOMEN: AN OVERARCHING ISSUE

Violence against women and girls is a global phenomenon. It entails physical, psychological and sexual violence detrimental to women's health, life and potential as a human being, and is one of the most systematic and widespread human rights violations. Grounded in gendered social structures rather than individual and random acts, violence against women and girls cuts across age, socioeconomic, educational and geographic boundaries; affects all societies; and is a major obstacle to ending gender inequality and discrimination globally (United Nations 2006).

The United Nations defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (General Assembly resolution 48/104, Declaration on the Elimination of Violence against Women, 1993). A broader definition of violence covers economic violence as well as losing rights and access to financial and other resources. Any act or threat impeding the creativity of a human being is also part of this broader definition.

Most acts of violence against women and girls take place in households, making this a crucial issue in discussing intrahousehold disparities and the perpetuation of violence across generations. The general assumption that women are more vulnerable in public places and outside the household is largely a myth, but one that is prevalent in South Asia. While women's access to assets and properties, decision-making capacities, level of education, enjoyment of reproductive health and rights, etc. can positively mitigate gender disparities within the household, violence can easily reverse these and other gender equality gains.

Data on violence against women and girls increasingly indicate the contentious nature of families, which can be a locus of exploitation, undercutting the popular assumption of the family as a locus of cooperation and security, ensuring equal opportunity to all of its members. Embedded in cultural norms, and religious and patriarchal value systems, violence is often justified and internalized by both

men and women, who legitimizes it as ‘natural’ and ‘right’. One of the major reasons for continued inequality within the household is that women may perceive that it is their interests to maintain and favour existing power relations, even though such beliefs and behaviours are in reality harmful to them in the long run.

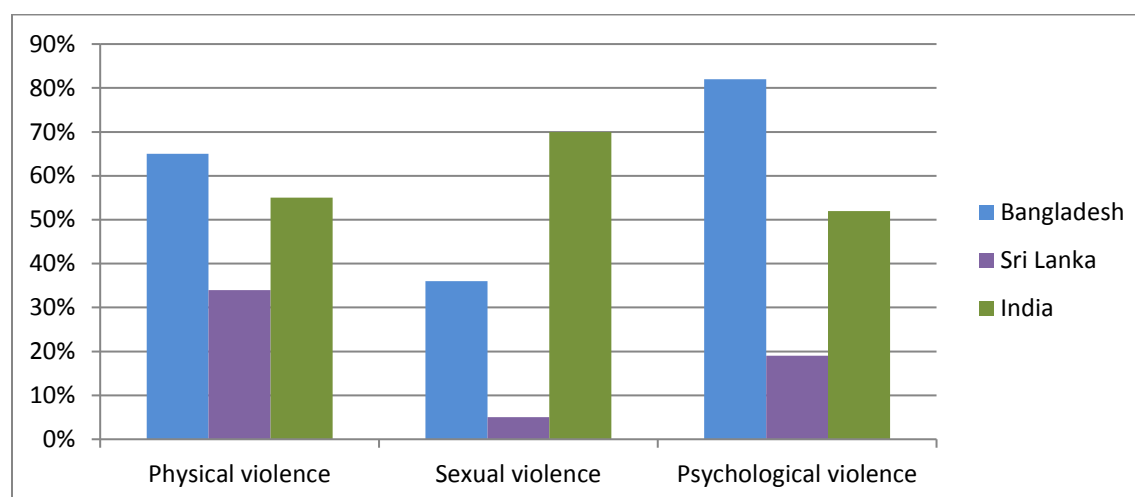
A survey conducted by the Bangladesh Bureau of Statistics and the Statistics and Information Division of the Ministry of Planning in Bangladesh (Government of Bangladesh 2013) found that up to 87 percent of currently married women have experienced any type of violence by their current husband, and 77 percent reported any type of violence in the past 12 months. Among different types of violence, psychological violence was most common, followed by physical violence. Prevalence was higher than previously available data suggested.⁴ Demonstrating the persistent nature of spousal violence, 98 percent of ever-married women across age groups reported that they have been violated by either current or previous husbands. Interestingly, rural-urban differences were not statistically significant, nor was there a clear trend by age groups in the prevalence of spousal violence.

Table 15 demonstrates mixed results in types of violence committed against women. Nevertheless, the prevalence is alarming for all countries reviewed in South Asia. Even Sri Lanka shows a relatively high prevalence of physical violence at 34 percent, despite its excellent performance on other indicators like health and education. Despite comprehensive efforts by the Government, NGOs and development partners in Bangladesh (Mannan and Zohir 2009), rates of violence against women continue to be alarmingly high.

⁴According to the Bangladesh Demographic and Health Survey in 2007, the percentage of ever married women aged 15 to 49 who have ever experienced physical or sexual violence committed by their husband was 48.7 percent and 17.8 percent, respectively.

Table 15. Violence against women and girls, percentage

Country	Physical violence	Sexual violence	Psychological violence
Bangladesh	65	36	82
Sri Lanka	34	5	19
India	55	70	52



Source: <http://tribune.com.pk/story/189294/pakistan-ranks-3rd-on-list-of-most-dangerous-countries-for-women/>, <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-129>, Ellsberg 2013, Hossen 2012.

Statistical or numerical data on violence against women and girls may be underestimated, as the phenomenon is still often hidden and very difficult to measure. Only an in-depth survey with complete assurance of confidentiality and triangulation methods following qualitative approaches might unearth the true nature, extent and prevalence of violence and its implications. Carefully designed research frameworks with feminist approaches, highlighting qualitative methods, are of great importance.

HONOUR KILLING

So-called 'honour killing' is another demonstration of misogyny and the powerlessness of women. Human rights defenders were alarmed by a 15 percent jump in 'honour killings' of girls and women in

Pakistan recently, according to statistics from the Human Rights Commission of Pakistan. Such killings have been practiced for decades, usually by the victims' families to protect family honour if a woman is assumed to have had premarital or extramarital sex, married of her own will or refused a marriage arranged by her family. The Commission's report chronicled 1,005 'honour killings' in 2014, with the victims including 923 women and 82 minor girls. The number of cases reported is low, as the vast majority are never reported or registered, especially in rural areas.

The persistence of 'honour killings' is mainly due to feudalism, tribalism and the continuing presence of elder councils, especially in rural Pakistan. The councils allow families to settle cases among themselves so that there is no legal punishment; the victim's family is given monetary compensation instead. Girls' and women's lack of education and independence contribute to the continuation of the practice.

Pakistan enacted a law in 2004 against 'honour killings', but the police are often unwilling to enforce it, due to the overwhelming social acceptance of the act and the influence of power holders. The 1997 Retribution and Compensation Act allows a victim's legal heir to close a case at any point in the court, take monetary compensation for the killing and pardon the accused (Ullah 2015).

The issue of 'honour killing' is a serious violation of human rights that calls for immediate attention, taking into account country specific issues and phenomenon. Otherwise, human development progress, even where indicators are largely positive, will remain incomplete.

WOMEN AND WORK

The issue of work and human development was dealt with in the 2015 *Human Development Report* (UNDP 2015), which noted women's disadvantages, including in terms of work load, wage discrimination, opportunities and the protection of their rights. These gaps need to be closed, for reasons that include positive impacts on intrahousehold allocations of resources when women gain access to gainful paid work and control income.

Table 16 shows that more than 80 percent of men in the four countries examined by this paper participate in the labour market, while the share of women is around 30 percent. An exception is Bangladesh, where the share of women is 61 percent, mostly in the garments sector and as migrant workers outside the country. Surprisingly, women's labour force participation in Sri Lanka is much lower than Bangladesh, at 39 percent.

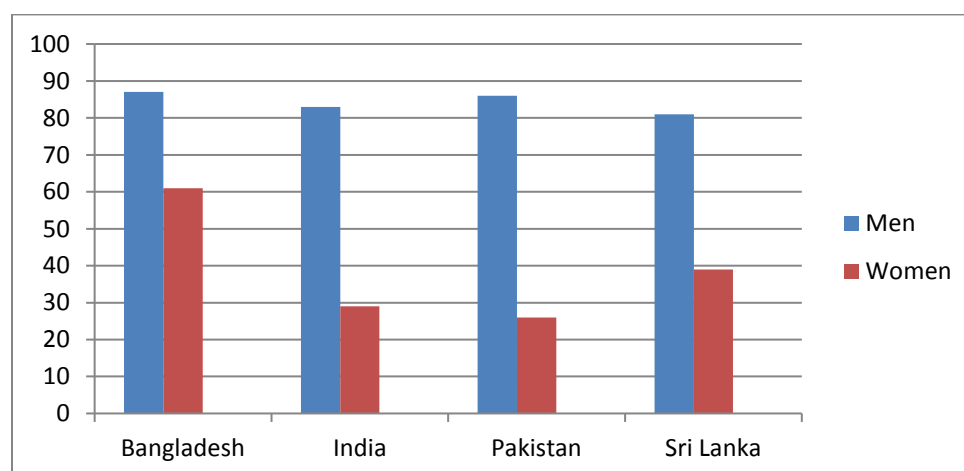
In Bangladesh, women's labour force participation has been a catalyst for women's empowerment, which might be reflected in health and education data with more positive leanings towards gender equality. Women in public have a demonstration effect as well. A few decades ago, who

could ever have imagined hundreds of young women briskly walking towards their homes in the deserted streets of Dhaka in the middle of the night? Who could have imagined a young single woman coming to Dhaka from a remote village of Rangpur, staying on her own and sending money to her parents, paying education fees for her younger siblings or securing money for her own dowry?

Patriarchal norms are there, and the construction of gender has not been radically challenged, but a certain acceptability has grown in relation to women's roles, mobility and choice. That said, critical hurdles to women's empowerment through paid work remain, including wage discrimination, double days, the burden of care and reproductive work, the glass ceiling, an overwhelming concentration of women in repetitive and stressful work due to their 'nimble fingers', and lack of access to training, credit or other facilities.

Table 16. Labour force participation, 2014

Country Name	Year	Men	Women
Bangladesh	2014	87	61
India	2014	83	29
Sri Lanka	2014	81	39
Pakistan	2014	86	26

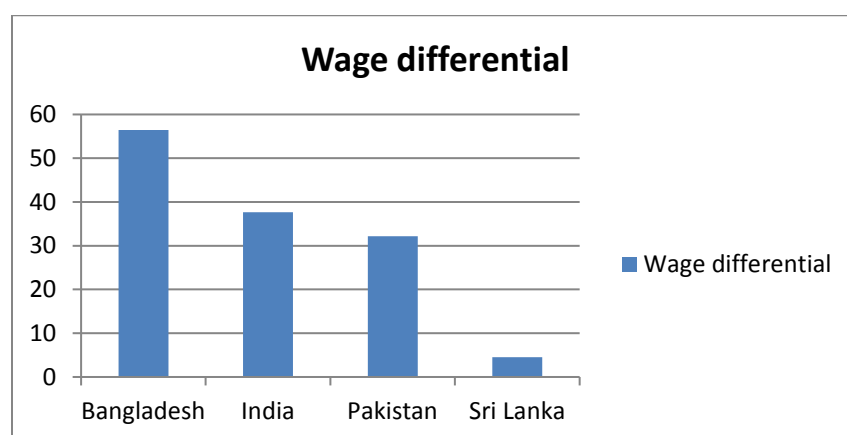
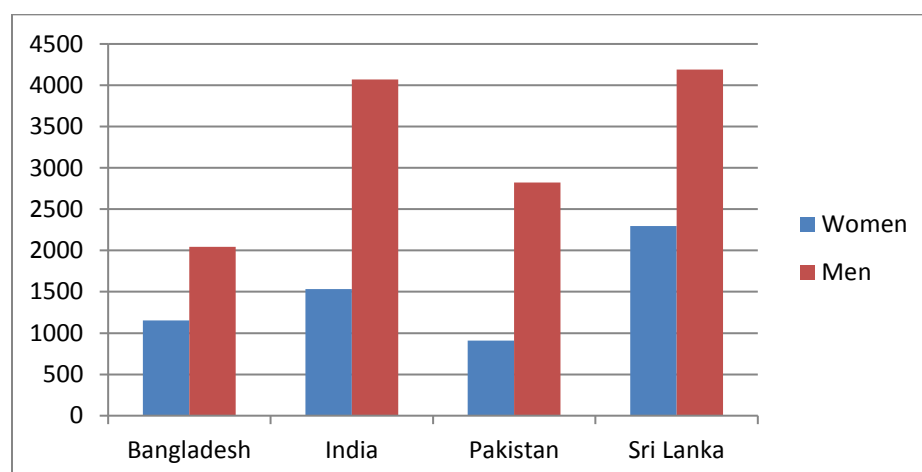


Source: UN-DESA 2010, Government of Bangladesh 2012.

Table 17 shows that the wage differential between men and women is more than 56 percent. It is 50 percent in Sri Lanka. The wage difference is greatest in Pakistan, where the absolute status of women is the lowest.

Table 17. Estimated wage difference between women and men (purchasing power parity US\$) in 2001

Country	Women	Men	Wage differential, %
Bangladesh	1,153	2,044	56.41
India	1,531	4,070	37.62
Pakistan	909	2,824	32.19
Sri Lanka	2,295	4,189	50.01



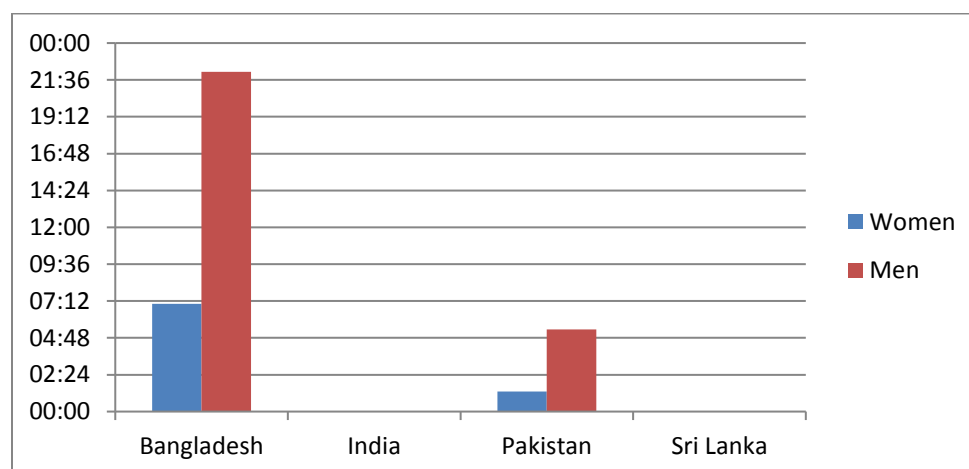
Source: Shridhara 2009.

An issue related to wage differentials is time spent on paid and unpaid work, and the gendered division of labour in the everyday lives of men and women. Women's disproportionate involvement in unpaid care work has been a longstanding concern for feminists and economists. Tables 18 and 19

show the imbalances in time spent in unpaid work by women across the four countries. Sri Lankan women and men spent the highest number of hours in unpaid work, but the difference between men and women is not significant.

Table 18. Time spent on paid work (average in hours and minutes)

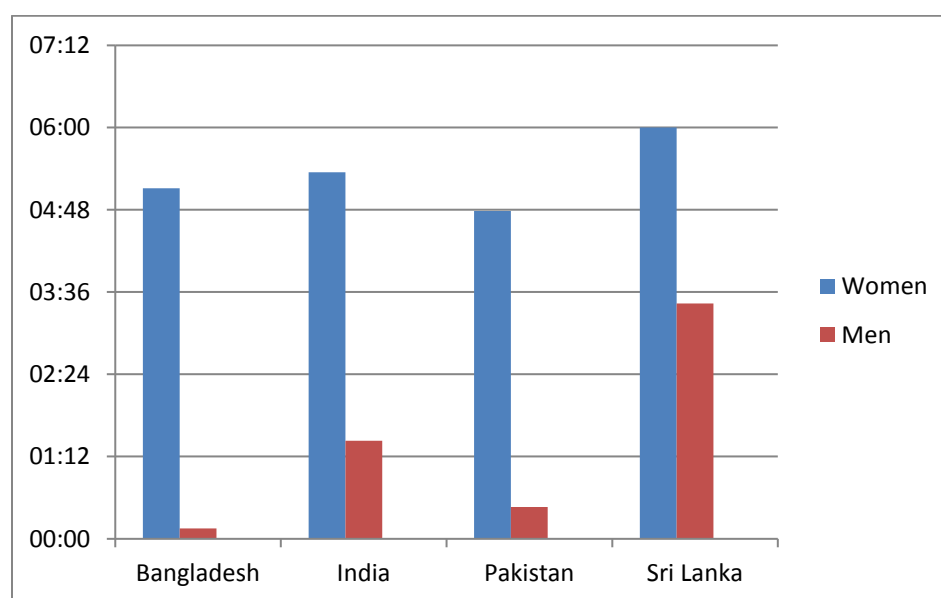
Country	Year	Paid	
		Women	Men
Bangladesh		7:1	22:7
India			
Pakistan	2007	1:18	5:21
Sri Lanka			



Source: UN-DESA 2010, Government of Bangladesh 2012.

Table 19. Time spent on unpaid work (average in hours and minutes)

Country	Unpaid	
	Women	Men
Bangladesh	5:7	0:9
India	4:81	0:86
Pakistan	4:47	0:28
Sri Lanka	6:0	2:86



Source: UN-DESA 2010, Government of Bangladesh 2012.

Women's integration in the labour market cannot be analysed in any linear way. An increasing number of women in paid jobs might be shadowed by wage discrimination or burdens of extra work, both in the home and outside. Other issues might include job insecurity and harassment at work or in transit to the place of employment. Women's options are limited in the world of paid jobs and often still track gendered divisions of labour.

A definition of 'work' that acknowledges the range of work, from paid to unpaid, from productive to care and reproductive work, is critical for any policy intervention in connection to women and work. Adding up women in the job market has to be complemented with positive measures such as quotas, equal pay, maternity leave, flexible work hours, options to make informed decisions, and the

recognition of human creativity, pleasure and satisfaction, leisure and freedom. Taking care of the old and young has to be affirmed as a contribution to the human race, and not the sole responsibility of women. The role of the state, policy inputs and institutional responses to achieve gender justice in relation to work and well-being are of great importance for human development. Challenging the gender division of labour and questioning the mindset of society are also crucial.

CONCLUDING COMMENTS AND WAYS FORWARD

This paper explores intrahousehold gender disparities in South Asia, with particular emphasis on Bangladesh, India, Pakistan and Sri Lanka. It is based on secondary sources, and a literature review of both quantitative and qualitative data. The focus of discussion, broadly, has been health, education, violence against women and girls, and work.

The study revealed mixed results, especially in terms of statistical data. One country may be doing better than others on one issue, but falling behind on others. Generally, Sri Lanka performs well on almost all the indicators, while Pakistan does poorly. Bangladesh and India are gradually making progress. Across all the indicators presented, however, most of the qualitative in-depth studies show a clear pattern of patriarchal norms and values shaping gender relations, even in high-performing Sri Lanka. These define the bargaining power of women within the household, which in turn has a major influence on human development.

The extent to which women can exercise bargaining power is linked with a range of issues, including engagement in gainful employment, decision-making capacity, the full range of laws and public policies on issues from property rights to maternity leave to income transfers, and social support systems and other social networks. Addressing all of these to achieve women's greater empowerment is a complex task, requiring multi-pronged initiatives, and the collaboration of governments, non-governmental organizations (NGOs) and international organizations, as well as the full engagement of men and civil society. Since each country has its own unique characteristics (Annex 1), each will need different responses and interventions accordingly. No blueprint is applicable to all.

Gender differentials have layers of inequalities not always demonstrated in numbers. In-depth qualitative data on household interactions can reveal scenarios otherwise hidden. The literature review for this paper also revealed the paradoxes and ambiguity around issues related to norms and values, and the role of religion and heritage. Violence, injustice and other forms of discrimination against women largely emanating from the patriarchal socioeconomic system and mindset are common phenomena in many South Asian countries. On the other hand, many have significant constitutional provisions and national and international statutory laws guaranteeing human and fundamental rights,

and equal rights to women. Poor quality governance and non-implementation, however, have undermined these pledges.

Despite global concern about gender equality, women continue to occupy a marginalized place in development thought and policy. Institutions within which development policies are made and implemented are male biased. The overwhelming presence of NGOs and dictation of international agencies are also seen by many activists in Bangladesh as an instrument in marginalizing the voices of women. Prioritization is often molded by external forces and a lack of strong indigenous voices, especially voices from the women's movement, in the policy discourse. This can be counterproductive for women.

Laws and legal supports are of critical importance. Despite many women-friendly laws in South Asia, Bangladesh and India retain personal laws that can negatively impact women's rights and opportunities. The demand for a Uniform Family Code by the women's movement in Bangladesh and India has long been abandoned, even though the incongruity and inconsistency that exist between constitutional pledges and personal laws continue to be problematic. The relationship between the state and citizen is gendered and contentious, and is mostly expressed in areas of marriage, inheritance and the custody of children, i.e., around the institution of family and the household. Moreover, international conventions are not fully ratified, leading to a discriminatory situation for women in terms of these instruments as well.

If the legal, political and ideological structures in society do not reinforce women's rights to own land, get access to credit and family planning, and so on, development for women and the spillover of well-being to the next generation will be restricted. Many scholars have emphasized the strength of gender ideologies in governing the distribution of resources and responsibilities within the household (Agarwal 1994, Kabeer 1995)—for better or worse. Seth (1997) noted that while paid employment may constitute a base for independence, the wife's inclination towards deference may not be affected by her work experience, particularly if she is involved in a relation of authority and deference in the work place. Whitehead's study on British households (1981) found that the relative power of husbands and wives did not simply mirror their relative wages in the market, because familial ideologies about roles and responsibilities intervened to differentiate how men and women accessed and controlled resources (also Sen 1990a, Seth 1997).

Women's political participation is another important issue, including to inject gender equality more forcefully into policy-making. Insofar as women's access to and control over income is threatened, gender wage differentials remain in place and the gender division of labour assigns women primary responsibility for child-care, the lack of an active state role in gender equality and women's empowerment will likely ensure that women's intrahousehold bargaining power remains relatively weak.

It is imperative to ensure women speak in the policy arena, including through a strong women's movement that articulates an indigenous voice not solely guided by donor priorities. Voices need to be raised and generated from within, involving more men, and women across the lines of gender, class, ethnicity, age, ability and sexual preference, with a vision towards equity, equality and an egalitarian framework for human development. In Bangladesh, incredible progress has taken place in terms of women's participation in the paid labour force, which has had a demonstration effect in moulding mindsets and led to positive changes in the labour law. Working women in the formal sector now enjoy six months of maternity leave. Women's presence in the labour market has the potential to make their concerns a critical policy agenda, both at the national and international levels.

More women are now seen in high-level policy-making, and heading the ministries and Parliament in Bangladesh. Although female leadership per se is not indicative of gender equality, the presence of so many women in leadership positions demonstrates both qualitative and quantitative changes. At least the current generation of youth will find it difficult to be apprehensive about female leadership.

This study has indicated that patriarchal values, harmful norms and attitudes are the main impediment in ensuring gender equitable relationships within households. Norms and values are hard to change. So are tangible factors like health and education outcomes or access to resources—which are moulded by norms and values. These are not insurmountable obstacles, however. Violence and injustice, and harmful norms, values and practices have been tackled through numerous laws and conventions in almost all of the South Asian countries. Changes have taken place, and equity has been established in many areas of everyday life for women during the last two decades. To address intangible issues such as ideology and its impact upon women's autonomy, freedom, choice and empowerment, more research and in-depth studies with a feminist perspective are necessary. Action research, including the component of consciousness raising, on addressing ways to shift impediments would be one way forward. Gender awareness training programmes for policy makers, high officials and secretaries of ministries are crucial to make an impact at the top.

Revising curricula and incorporating gender issues from the primary level to every sphere of formal education is an essential policy consideration. The training of trainers is also important. In Bangladesh, teachers are not comfortable discussing issues related to women's body and sexuality. Despite the incorporation of gender issues in the syllabus, it is not taught due to social and cultural restrictions and cultural margins. Establishment of departments of women and gender studies in higher education, both in public and private institutions, and funding and assistance for PhD research on women and gender issues would help create a generation of gender-sensitive men and women who will pave the way to gender equity and equality, starting from the household to the nation, and eventually contributing to freeing the world from injustice and discrimination.

It is apparent from the above review that numbers are important, especially for policy-making, but must be considered as indicative, rather than in any exact and absolute sense. Numbers may vary due to methodological issues. They are easy to manipulate to access political gains, and the ‘truth’ may blur while compiling statistical data and building models. There are nuances and ambiguities, hidden layers and unseen shades in human lives that are not always quantifiable, but have far-reaching impacts on people and nature. Human development is complex, varied and rich in diversity and difference that is often hard to encapsulate in one single model or prescription. It is a process enshrined in trial and error, tinted with loss and gain, situated in a context—a journey long and difficult, but continuously progressing with new concepts, new challenges and new ways forward.

CASE OF SRI LANKA

Before closing, it feels right to highlight the case of Sri Lanka. Across all the indicators presented here, Sri Lanka stands out for faring incredibly well in health and education, and doing better than its neighbours on curbing violence against women. Life expectancy, including healthy life expectancy, is equivalent to what is found in industrialized countries (Fikree and Pasha 2004). In this respect, Sri Lanka might a role model for other South Asian countries.

Mere statistical indicators may not be enough to grasp the true nature of gender disparities, however. Unequal gender relations are often hidden and concealed in the everyday lives and experiences of women. Sri Lanka is not free from patriarchal values and norms. Research on the pattern of food intake revealed significant differences among the calorie adequacy ratios of fathers, mothers and children. Fathers have the highest and children have the lowest mean ratios, showing that malnutrition is not common among the fathers (Rathnayake and Weerahewa 2002). Patriarchal values permeate marriage as a social institution, and although Sri Lankan laws related to marriage and property rights are gender sensitive, practices vary among communities in terms of the freedoms allowed to women.

Sri Lankan women of all backgrounds continue to be constructed as the reproducers, nurturers and disseminators of tradition, community and nation, as in many other South Asian countries. The main ideological message emanating from the rigid patriarchal system, which cuts across ethnic and religious lines, is that of a good ‘wife’ and ‘mother’ (Militzer 2008). The notion of the ideal woman is deeply vested with traditional ideas of purity, fertility and virginity.

Militzer discusses the role of Buddhist philosophy in shaping gendered ideology in Sri Lanka. Although Buddhism offers more freedom to women than many other religions, the patriarchal structure within Sri Lankan society supersedes the philosophical principles of equality upheld by Buddhism. The popular belief is that women are born inferior as a result of bad ‘karma’. The culture

of shame and silence is prevalent, and socially accepted norms expect women to adjust, accept and tolerate abuse. As in some other patriarchal societies, Sri Lankan women have to bear the negative impact of son preference and dowry.

Among the resources distributed by households, time plays a crucial role in determining the well-being of individual members. Another study on Sri Lanka clearly shows that males in rural farming families in the Udukumbura area allocate more hours for both paid and unpaid work, and fewer hours for care work. Results showed that the total workday is longer for women than for men, however, and as a result, women have less leisure time than men (Rathnayaka and Weerahewa 2015).

Sri Lanka is on track to halve income poverty by 2015. Even so, 15 percent of all Sri Lankans remain in consumption poverty, and national figures mask considerable gender-related, sector and regional variations (Gunatilaka et al. 2009). More in-depth studies are required to reveal the nature of gendered vulnerability faced by Sri Lankan women in times of war, conflict and natural disaster. And despite the presence of female leadership in Sri Lanka, women's political participation is astonishingly low. Less than 5 percent of parliamentarians are women, indicating a lack of women's voice in the national policy discourse (Bhagat 2005).

Despite some persistent shortfalls and vulnerabilities among women, the major indicators clearly show a minimum level of gender disparity, both in terms of macro and micro data. Feminist literature on the status of women in Sri Lanka (de Alwis 2000, Bhagat 2005, de Alwis and Jayawardena 1999) asserts that in comparison to women in other South Asian countries, Sri Lankan women are relatively well positioned as a result of nearly six decades of social programmes providing universal education and healthcare, as well as food subsidies.

Policy choices have likely played a deciding role, demonstrating their potential to bring about transformation when coupled with implementation. Policy per se is often important in demonstrating conceptual understanding, and acknowledging issues and contexts related to human development and gender justice. Other factors include institutional norms, cultural norms and intrahousehold values, but population size and density play roles as well. Sri Lanka is a small country compared to Bangladesh or India, with the lowest population density of all the countries addressed here. Investigating Sri Lanka's success could provide important insights and lessons helping other South Asian countries accelerate the pace of human development.

Appendix: Country profiles

Country	Population	Total land area km ²	Population density per km ²	Birth rate per 1,000 people	Death rate per 1,000 people	Life expectancy in years
Bangladesh	162,795,266	130,172 (50,260 square miles)	1252	21.61	5.64	Male: 68.75 Female: 72.63
India	1,325,850,024	2,972,892 (1,147,839 square miles)	446	19.89	7.35	Male: 66.68 Female: 69.06
Pakistan	192,575,253	770,998 (297,684 square miles)	250	23.19	6.58	Male: 65.16 Female: 69.03
Sri Lanka	20,805,358	62,702 (24,209 square miles)	332	16.24	6.06	Male: 72.85 female: 79.99

Source: www.indexmundi.com/factbook/countries,
www.worldometers.info/population/asia/southern-asia/

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