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Gender Disparity in Education and Health in India: A Comprehensive Analysis

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Abstract— *Gender disparity is a pervasive issue in India, affecting various sectors but most notably education and health. Despite significant economic progress and social reforms, the inequalities between men and women remain deeply entrenched. This paper explores the various dimensions of gender disparity, drawing on empirical studies and policy reports to provide a comprehensive overview. In the educational sector, women continue to lag behind in enrollment and literacy rates, largely due to societal norms, economic constraints, and safety concerns. Similarly, in the realm of healthcare, women face higher mortality rates and have limited access to medical services. These disparities are not uniform across the country and exhibit significant state-wise variations. For instance, states like Kerala and Himachal Pradesh have made commendable progress in gender parity, whereas Uttar Pradesh and Bihar lag considerably. Policy initiatives have been introduced to address these disparities, yet their effectiveness has been limited. The paper concludes by emphasizing the need for multi-faceted interventions that adopt a gender-sensitive approach. Policymakers, civil society, and all other stakeholders must collaborate to address the root causes of these disparities, including societal norms and economic barriers, to foster a more equitable society.*

***Keywords—* Gender Disparity, Educational Inequality, Health Outcomes, Indian Society, Policy Interventions.**

I. INTRODUCTION

Gender is distinguished from sex in that it encompasses the social and cultural constructs associated with being male or female, rather than biological distinctions. These constructs dictate opportunities, responsibilities, and rights, which are acquired through societal socialization (The world's women, 2000). Gender disparity refers to the inequalities between men and women in various domains, including but not limited to education, health, and professional life. While some disparities stem from biological differences, the majority are socially constructed and have severe repercussions on women's development and freedom (UNDP; UNFPA).

In India, gender disparity is a pervasive issue that has significant ramifications across various sectors, notably in education and health. This inequality persists despite the country's accelerated economic development and progress in diverse fields. The Global Gender Gap Index of 2020 places India at a concerning 112th rank among 153 nations, underscoring substantial disparities in areas such as economic participation, education, health, and political involvement. The exigency of addressing these disparities in education and health is palpable; both sectors are foundational to individual well-being and societal growth. Notably, these inequalities extend beyond their immediate impact on women, reverberating through the broader social and economic fabric of the nation (Ioannidou & MacDougall, 2014; Kurian, 2007.

II. GENDER DISPARITY IN EDUCATION

In contemporary economies, the role of education, particularly for women, is indispensable for their substantive contributions to society. Female illiteracy not only hampers societal progress but also acts as an obstacle to national development (Jha, 2005). Furthermore, literacy among women is integral for sustaining a robust democratic system, as it fosters awareness of democratic rights and obligations. Hence, examining gender disparities in education within the Indian context is crucial. The value of education has been historically endorsed by various philosophers, with Aristotle positing that effective governance is intrinsically linked to the caliber of education imparted to the youth.

Despite the rapid expansion of educational systems, a gender literacy gap remains glaringly evident. Events such as the International Conference on Population and Development (ICPD) in 1994 and the Women's Summit in Beijing in 1995, both under the United Nations' auspices, underscored the imperative of enhancing women's access to education as a developmental strategy (Pong, 1999).

The advocacy for narrowing the gender gap is empirically substantiated, positing that promoting female education can effectively mitigate disparities in employment, empowerment, and health sectors (Mason, 1985; Duraisamy, 2002; Mohanty, 2009).

Various metrics such as literacy rates, enrollment figures, and duration of schooling disclose salient trends in female education within developing nations. Approaches founded on capabilities, as proposed by Sen (1987) and Nussbaum (2002), emphasize the necessity of educational access. Given the pivotal role of female education in economic self-sufficiency, educational objectives should aim to equip women with the skills and knowledge required for both daily living and professional roles (Meier and Rauch, 2007).

2.1. Enrollment Rates:

The gender gap in Indian education may be clearly seen in enrollment rates. However, the Census of India 2011 data does not directly compare the number of males and girls enrolled in school. However, it was noted that only 26% of girls, as opposed to 50% of boys, finished high school between 2006 and 2010. Furthermore, the literacy statistics for kids revealed that 82% of boys and just 65% of girls are literate. These statistics show a gender gap in educational achievement, reflecting persistent cultural biases in favour of male education. Furthermore, the literacy statistics for kids revealed that 82% of boys and just 65% of girls are literate. These statistics show a gender gap in educational achievement, reflecting persistent cultural biases in favour of male education. The Ministry of Human Resource Development (MHRD) and the Department of School Education and Literacy in India periodically release educational statistics, including enrollment ratios, which support this tendency even further. According to the All India Survey on Higher school (AISHE) 2020–2021, which was issued by the Ministry of Education, enrollment is more beneficial for females in elementary and secondary school since the associated Gender Parity Index (GPI) has beyond the threshold of one (1). But, on positive side, the total enrollment in higher education has increased to nearly 4.14 crore in 2020-21 from 3.85 crore in 2019-20. Moreover, the Gender Parity Index (GPI), which is the ratio of female GER (The Gross Enrolment Ratio) to male GER, has increased from 1 in 2017-18 to 1.05 in 2020-211. This indicates that the gender gap in higher education enrollment is narrowing.

But the divide exacerbates in rural settings, where conventional gender roles and societal norms serve as barriers to girls' educational access (Rammohan & Vu, 2018). Social and gender norms have a role in attaining gender equity in education, according to the UNICEF Gender Action Plan (2014-2017). They might create hurdles but they can also open doors to education. They operate as hurdles to females much too frequently, restricting and undervaluing girls and their contributions and leading them to a lifetime of hardship.

2.2. Literacy Rates

The literacy rates in India serve as another salient indicator of gender inequality in education. According to the 2011 Census, female literacy is markedly lower at 65.46%, in comparison to male literacy rates, which stand at 82.14%. This 17% differential is emblematic of the systemic obstacles that impede female educational progress and is indicative of entrenched gender biases within both the educational framework and broader society (Kumar & et al, 2016).

The trajectory towards development is inherently linked with the promotion of female education; however, its progress in India remains constrained by various historical, social, and economic factors. Particularly in rural settings, females are disadvantaged due to poor educational infrastructure, domestic responsibilities, child labor, early marriage, and cultural perceptions influenced by caste and religion (Vaid, 2004; Unni, 2008).

Additional variables exacerbate the gender gap in enrollment and retention rates. Notably, societal preferences for single-sex educational settings contribute to lower female enrollment (Bandyopadhyay & Subrahmanian, 2008). Furthermore, the gender-sensitive nature of school infrastructure, such as the absence of separate sanitary facilities for girls and inadequate safety

measures, adversely affects female education. Rani (2010), however, advocates for co-education as a strategy to dismantle gender stereotypes and narrow the gender gap in educational outcomes..

III. BARRIERS TO EDUCATION FOR WOMEN

Female education in India is obstructed by a multifaceted array of barriers, including economic limitations and ingrained social norms. The financial burden of education, encompassing tuition fees and ancillary costs, often leads families to prioritize male education (Kriplani, 2023).

Key Obstacles: Social norms, economic constraints, and safety concerns are among the primary obstacles (Sen & Dreze, 2002).

- Sociocultural Norms: Particularly in rural sectors, deep-rooted cultural ideologies and social constructs often result in a preferential treatment of sons over daughters in educational investment.
- Economic Constraints: The prohibitive cost of education frequently necessitates familial choices that favor boys, exacerbating the gender disparity in educational access.
- Safety Concerns: The potential for harassment and violence towards females en route to educational facilities serves as a significant deterrent for families.
- Early Marriages: Certain communities engage in the practice of early marriage, leading to premature cessation of girls' formal education to assume domestic roles. (Lee-Rife et al., 2012)

3.1. Policy Initiatives:

Recent policy measures, such as the Union Ministry of Human Resource Development (MHRD), Government of India, in order to create the New Education Policy (NEP) in 2015 underwent an unprecedented collaborative, multi-stakeholder, and multi-pronged consultation process, initiated with the slogan "Educate, Encourage, Enlighten," aim to adapt to changing demographic dynamics. Concurrently, the Twelfth Five-Year Plan (2012-2017) is committed to elevating the overall literacy rate to over 80% and diminishing the gender literacy gap to below 10%. Aligned with the "National Vision for Girls Education in India: Roadmap to 2015," drafted by the United Nations Children’s Fund (UNICEF) and Ministry for Human Resource Development (MHRD), aimed at building a comprehensive approach towards girls’ education targeted investment in female education is planned to ensure gender equality in basic education.

IV. GENDER DISPARITY IN HEALTH

Health is a fundamental human right, intricately influenced by a myriad of factors such as economic conditions, social beliefs, and cultural paradigms, as well as genetic dispositions. Environmental variables further contribute to health disparities (Brulle & Pellow, 2006). Amartya Sen's seminal work in, ‘The many faces of Gender Inequality,’ from The New Republic (2001) elucidates multiple dimensions of gender inequality affecting women's health, notably natality and mortality disparities.

Both nationally and internationally, there is a lot of discussion on women's health issues. Studies (Basu, 1993; Habib, 1995; Pandit, 1997; Sen, 1998; Wang and Pillai, 2001) have identified a number of gender disparities in health and survival, including the preference for a son at birth, poor health and nutrition, and unequal access to health care, particularly reproductive health care. Women still have difficulties with their health because of barriers to education and work, high rates of illiteracy, poverty, social standards, and cultural influences.

A number of health indices, including the mortality rate for children under five, the death rate for people between the ages of 5 and 9, and the sex ratio, draw attention to the unequal treatment given to women in Indian culture. Evidence indicates significant gender differences in immunisation rates, access to healthcare, and nutrition (Malhotra and Parul, 2012). Gender imbalance in health is still a problem in many nations despite focused policies and programmes being adopted by the government to enhance women's health.

Klasen and Wink (2003) highlight the grim conditions faced by female children in rural areas, especially when the first-born is also female. A staggering 88 million women are deemed 'missing' in select Asian countries, aligning with Amartya Sen's earlier estimates (1990, 1992). Additionally, the UN Women – Asia-Pacific has published a report titled “Roadmap for Women’s Economic Empowerment in India” in 2020. The roadmap emphasizes that investing in women’s economic empowerment sets a direct path towards gender equality, poverty eradication, and inclusive economic growth.

4.1. On Sociocultural Constraints and Health in Indian Women:

According to Velkoff and Adlakha (1998), the social position of women in India affects their health. In Indian society, women are constrained by socio-cultural norms that ignore the labour they do at the family level. There they are also unable to make independent financial and health care decisions for herself (Ganjiwale, 2012). These actions damage a woman's health. Many Indian households prefer having sons due to socio-cultural issues.

This goal encourages illicit sex determination and female foeticides, which lowers the sex ratio and increases the sex ratio of children.

The preference for sons in India has a number of negative consequences for the health of women and girls. From birth, girls are often neglected and may not receive adequate nutrition or medical care. This can lead to malnutrition, delayed growth, and increased risk of death. In addition, the pressure to marry young means that many Indian women become mothers at a young age. This can be physically and emotionally demanding, and it can also increase the risk of complications during pregnancy and childbirth (Lee-Rife et al., 2012).

The lack of health facilities and knowledge in India also contributes to the high rates of maternal and infant mortality. Many women do not have access to quality healthcare, and they may not be aware of the importance of prenatal care and breastfeeding. The illness or death of a woman has serious and far-reaching consequences for the health of her children, family, and community. When women are healthy, they are better able to care for their families and contribute to the economic development of their communities.

4.2. Indicators:

4.2.1. Mortality Rates:

Gender inequality affects health outcomes, including death rates, in addition to educational achievement. According to Aghai et al. (2020), a secondary analysis of data from the Maternal Newborn Health Registry's Global Network data collected from two south Asian sites, two Indian sites, and one Pakistani site revealed that male infants had a significantly higher neonatal mortality rate than their female counterparts. Males also had greater rates of early neonatal death and stillbirths. The infant death rate for girls was, however, much higher than for men in a large database research from rural northern India (7.2% vs. 6.3%) (Chowdhury & et al, 2017).

Intriguingly, according to the Sample Registration System (SRS) Statistical Report 2020 released by the Registrar General of India (RGI), the Infant Mortality Rate (IMR) has registered a 2-point decline to 28 per 1,000 live births in 2020 from 30 per 1,000 live births in 20192. The Rural-Urban difference has narrowed to 12 points (Urban 19, Rural-31). No gender differential has observed in 2020 (Male -28, Female - 28).

Nevertheless, these statistics serve as a disquieting indicator of the fractured healthcare systems in these two countries, highlighting the urgent need for systemic reforms.

4.2.2. Access to Healthcare:

Another important lens for examining gender inequality is access to healthcare. Health-care expenditure on females was systematically lower than on males across all demographic and socio-economic groups (Saikia et al., 2016). This disparity expands even more in rural regions, where the infrastructure for providing healthcare is already constrained. Data from the National Family Health Survey (NFHS-4, 2015-16), which indicates that a quarter of women of reproductive age in India are undernourished, with a body mass index (BMI) of less than 18.5 kg/m2.

According to studies, access to nutrition and healthcare is biased in favour of boys and men, which has an impact on how differently men and women do when it comes to mortality. Boys and male family members are disproportionately favoured when it comes to receiving nutrient-rich meals (Das & Mishra, 2021; Jose, 2017). Women face significant obstacles to accessing healthcare due to cultural norms and financial limitations (Sen & Dreze, 2002). Further aggravating the issue is the lack of female healthcare professionals, which prevents women from getting prompt medical counsel and care (Verma, 2020).

V. SOCIOCULTURAL DETERMINANTS OF WOMEN'S HEALTH: A COMPLEX WEB OF BARRIERS

Sociocultural factors exert a considerable influence on women's health in India, exacerbating existing disparities. Early marriage and childbearing, along with poor nutritional status, are implicated in elevated maternal mortality rates (Lee-Rife et al., 2012; Sanneving & et al, 2013). Furthermore, societal stigmas associated with reproductive health issues act as deterrents to timely medical intervention (Cousins, 2019; Kabeer, 2005).

5.1. Reproductive Health Stigmas: Societal Barriers to Care

Cultural taboos, particularly those surrounding women's reproductive health, serve as formidable obstacles to healthcare access. These stigmas often deter women from seeking the medical attention they require, perpetuating a cycle of neglect and poor health outcomes (Hussein & Ferguson, 2019).

5.2. Autonomy in Healthcare Decisions: A Missing Privilege

In numerous households, women are denied the autonomy to make informed decisions about their healthcare. This lack of agency further restricts their healthcare access and perpetuates existing disparities (Sarojini et al., 2006).

5.3. Economic Constraints: A Financial Glass Ceiling

Economic barriers, akin to those observed in educational access, further constrain women's healthcare access. Familial reluctance to allocate resources for women's health, often considered a lower priority than men's health, exacerbates these limitations (Sarojini et al., 2006).

VI. GEOGRAPHICAL VARIABILITY IN GENDER DISPARITY

The landscape of gender disparity in India is far from homogeneous; it varies significantly across states. While some states like Kerala and Himachal Pradesh exhibit commendable gender parity in key areas such as education and health, others like Uttar Pradesh and Bihar display acute disparities (Singh & Verma, 2021).

6.1. Uttar Pradesh: A Case of Persistent Inequities

Uttar Pradesh presents a stark example of gender inequity, with one of the lowest female literacy rates in the country, recorded at 57.18 percent (Census, 2011). Furthermore, the state's healthcare infrastructure is suboptimal, contributing to elevated mortality rates among women.

6.2. Bihar: The Lingering Challenges of Disparity

Bihar shares the grim reality of gender disparity with Uttar Pradesh. With a female literacy rate of a mere 53.57%, the state also suffers from limited healthcare accessibility, exacerbating the systemic inequities faced by women (Census, 2011).

6.3. Kerala: A Beacon of Gender Equality

In contrast, Kerala exemplifies successful efforts in mitigating gender disparity. With a female literacy rate of 92% and a maternal mortality rate substantially lower than the national average, Kerala stands as a testament to what can be achieved through progressive policies and community engagement (WEF, 2023; WHO, 2018; Ghosh & Kundu, 2021; Census, 2011).

VII. CONCLUSION

The issue of gender disparity in India is complex and multi-dimensional, manifesting most prominently in the sectors of education and health. For instance, female enrolment and literacy rates are conspicuously lower than those for males. This is compounded by various societal, economic, and cultural barriers. In the health sector, the challenges are equally grim; women face higher mortality rates and are less likely to access healthcare services, partly due to state-specific factors that exacerbate these disparities.

The United Nations Development Programme (UNDP) has stated that gender inequality is a major source of inequality, and that women and girls often face discrimination in health, education, political representation, and the labour market. This discrimination can have negative consequences for women's development and their freedom of choice.

In India, gender disparities are a complex issue that affects many sectors, including education and health. The enrolment and literacy rates for women are significantly lower than for men, and cultural, economic, and social barriers often make it difficult for girls and women to access education. In the health sector, women face higher mortality rates and have less access to healthcare services. The situation is further complicated by state-wise variations, with some states showing more severe disparities than others.

The gender disparities in education and health in India are deeply entrenched and will require multi-faceted interventions to address. Policymakers must adopt a gender-sensitive approach that addresses the root causes of these disparities, including societal norms and economic barriers. This will require a concerted effort from all stakeholders, including governments, businesses, and civil society organizations (Bora & Saikia, 2015).

7.1. **Recommendations for Policy Changes and Future Research:**

- Interventions in policy: In places where there are sizable discrepancies, government policies should prioritise enhancing the educational and healthcare systems for women.
- Awareness Campaigns: Community-based awareness campaigns can aid in shattering social and cultural taboos that keep women from accessing healthcare and education.
- Financial Incentives: Offering families financial incentives to send their girls to school and to use healthcare facilities for women can be a successful tactic.
- Additional Research is Needed: Research is needed to identify the root causes of gender inequality in various states, which will aid in developing targeted remedies.
- Support initiatives to raise community understanding of social norms that support gender inequality.
- Increase the amount of money allocated to enhancing rural regions' healthcare and educational infrastructure.
- Form alliances with non-profit organisations to successfully carry out grassroots activities.

REFERENCES

[1] Bandyopadhyay M. and R. Subrahmanian (2008). "Gender Equity in Education: A Review of Trends and Factors", Consortium for Research on Educational Access, Transitions and Equity (CREATE), National University of Educational Planning and Administration, New Delhi.

[2] Basu, A.M. (1993). "Women's Role and Gender Gap in Health and Survival", Economic and Political weekly, Vol. 28, No. 43, pp. 98-114.

[3] Bora, J., & Saikia, N. (2015). Gender Differentials in Self-Rated Health and Self-Reported Disability among Adults in India. PLoS ONE, 10. https://doi.org/10.1371/journal.pone.0141953.

[4] Brulle, R., & Pellow, D. (2006). Environmental justice: human health and environmental inequalities. Annual review of public health, 27, 103-24. https://doi.org/10.1146/ANNUREV.PUBLHEALTH.27.021405.102124.

[5] Chowdhury R, Taneja S, Mazumder S, Bhandari N, Strand TA. Gender differences in infant survival: a secondary data analysis in rural North India. BMJ Open. 2017;7:e014179.

[6] Cousins, S. (2019). A Woman's Worth: Health, Stigma and Discrimination in India. India: SAGE Publications.

[7] Das, S., Mishra, A.J. Dietary practices and gender dynamics: understanding the role of women. J. Ethn. Food 8, 4 (2021). https://doi.org/10.1186/s42779-021-00081-9

[8] Drèze, J., & Sen, A. (2002). India, development and participation. Oxford University Press, USA.

[9] Duraisamy P. (2002). "Changes in Returns to Education in India, 1983-94: by Gender, Age- Cohort and Location", Economics of Education Review, Vol. 21, pp. 609-622.

[10] Ganjiwale, J. (2012). "Current Health Status of Women in India - Issues and Challenges", Health line, Vol. 3, No. 2, pp. 60-63.

[11] Ghosh, S., & Kundu, A. (2021). Women's Participation in Higher Education in India: An Analysis Across Major States. Indian Journal of Human Development, 15(2), 275–294. https://doi.org/10.1177/09737030211030048.

[12] Habib, A.L. (1995). "Women and Disability Don't mix! Double Discrimination and Disabled Women's Right", Gender and Development, Vol.3, No.2, pp. 789-801.

[13] Hussein, J., & Ferguson, L. (2019). Eliminating stigma and discrimination in sexual and reproductive health care: a public health imperative. Sexual and Reproductive Health Matters, 27(3), 1–5. https://doi.org/10.1080/26410397.2019.1697103.

[14] International Institute for Population Sciences and ORC MACRO (2000). National Family Health Survey II, India 1998-99, Mumbai. IIPS.

[15] International Institute for Population Sciences and ORC MACRO (2007). National Family Health Survey III, India 2005-06, Mumbai. IIPS- 2007.

[16] Ioannidou, E., D'Souza, R., & MacDougall, M. (2014). Gender Equity in Dental Academics. Journal of Dental Research, 93, 5 - 7. https://doi.org/10.1177/0022034513510178.

[17] Jha A. (2005). "Females Literacy in Rural India", in Social Sector Development in India, ed. by Raj Kumar Sen, Deep and Deep Publications, New Delhi.

[18] Jose, S. Decomposition of gender differential in malnutrition in Indian children. J. Soc. Econ. Dev. 19, 299–322 (2017). https://doi.org/10.1007/s40847-017-0047-x

[19] Kabeer, N. (2005). Gender Equality and Women's Empowerment: A Critical Analysis of the Third Millennium Development Goal. Gender and Development, 13(1), 13–24. http://www.jstor.org/stable/20053132

[20] Klesen, S. and C. Wink (2003). "Missing Women: Revisiting the Debate", Feminist Economics, Vol.9, No. 2-3, pp 263-299.

[21] Kriplani, J. (2023, July 9). Cost of education in India: Exploring expenses and inflation rates | Mint. Mint. https://www.livemint.com/money/personal-finance/factors-that-decide-the-right-school-for-your-child-boards-reputation-and-cost-structure-11688918023724.html

[22] Kumar, N., Kumar, N., & Rani, R. (2016). Gender Disparity in Literacy: Districts Level Evidence from Selected States of India. Educational Quest: An International Journal of Education and Applied Social Sciences, 7, 243. https://doi.org/10.5958/2230-7311.2016.00045.3.

[23] Kurian, N. (2007). Widening economic & social disparities: implications for India.. The Indian journal of medical research, 126 4, 374-80.

[24] Lee-Rife, S., Malhotra, A., Warner, A., & Glinski, A. M. (2012). What works to Prevent child Marriage: A review of the evidence. Studies in Family Planning, 43(4), 287–303. https://doi.org/10.1111/j.1728-4465.2012.00327.x

[25] Malhotra N. and Parul (2012)."Gender Disparities in Healthcare-An Inter-state Analysis", Madhya Pradesh Journal of Social Sciences, Vol.1, No. 1, pp. 82-100.

[26] Mason, K.O. (1985), The Status of Women: A Review of its Relationship to Fertility and Mortality, Rockefeller Foundation, New York.

[27] Meier, G.M. and James, E. Rauch (2000). Leading Issues in Economic Development, Oxford University Press, New Delhi.

[28] Mohanty, M.S. (2009). "Why Do Gender Differentials Differ Between Occupations? The Role of Education Reexamined", Journal of Quantitative Economics, Vol.7, No.1, pp.144-167

[29] Nussbaum, M. (2002). "Women and Equality: The Capability Approach" in Women, Gender and Work: What is Equality and How Do we get there?, ed. by Martha Fetherolf Loutfi, International Labour Office, Geneva, Rawat Publications, New Delhi, India.

[30] Pandit, V. (1997). Empowerment of Women: Through Distance Education: A case of Dr. B.R. Ambedkar Open University, Book lines Corporation, Hyderabad, India.

[31] Pong, S. (1999). "Gender Inequality in Educational Attainment in peninsular Malaysia" ed. in Gender, Education and Development: Beyond Access to empowerment by Christine Heward and Sheila Bunwaree, Zed Books Limited, London and New York.

[32] Rammohan, A., & Vu, P. (2018). Gender Inequality in Education and Kinship Norms in India. Feminist

Economics, 24, 142 - 167. https://doi.org/10.1080/13545701.2017.1364399.
[33] Rani G.S. (2010). “Females Education in India- An Analysis”, Asia- Pacific Journal of Social Sciences, Vol. II, No.1, PP. 106-124.
[34] Saikia, N., Moradhvaj, & Bora, J. K. (2016). Gender Difference in Health-Care Expenditure: Evidence from India Human Development Survey. PLOS ONE, 11(7), e0158332. https://doi.org/10.1371/journal.pone.0158332
[35] Sanneving, L., Trygg, N., Saxena, D., Mavalankar, D., & Thomsen, S. (2013). Inequity in India: the case of maternal and reproductive health. Global Health Action, 6. https://doi.org/10.3402/gha.v6i0.19145.
[36] Sarojini, N. B., Chakraborty, S., Venkatachalam, D., Bhattacharya, S., Kapilashrami, A., & De, R. (2006). Women’s Right to Health. In NATIONAL HUMAN RIGHTS COMMISSION. National Human Rights Commission.
[37] Sen A. (1987). Commodities and Capabilities, Oxford University Press, New Delhi.
[38] Sen A. (1998). "Mortality as an Indicator of Economic Success and Failure", The Economic Journal, Vol.108, pp.1-25.
[39] Sen A. (2001). "Many Faces of Gender Inequality", An Inauguration lecture for The New Radcliff Institute at Harvard University Published in The Hindu, Vol. 18-issue 22, Oct 27-Nov09, 2001.
[40] The Global Gender Gap Report 2023. World Economic Forum 2023. https://www.weforum.org/reports/global-gender-gap-report-2023.
[41] The world’s women, 2000: trends and statistics. ([3rd ed.]). (2000). United Nations.
[42] Unni J. (2008). “Are Gender Differentials in Educational Capabilities Mediated through Institutions of Caste and Religion in India?” Gujarat Institute of Development research (GIDR), Working Paper No.186, Ahmadabad.
[43] United Nations Development Programme (2010). Human Development Report 2010: The Real Wealth of Nations: Pathway to Human Development, UNDP, New York.
[44] United Nations Development Programme (2011). Human Development Report 2011; Sustainability and Equity: A Better Future for All, UNDP, New York.
[45] Vaid D. (2004). “Gender Inequality in Educational Transition” Economic and Political weekly, Vol.39, No. 35, PP. 3927-3938.
[46] Velkoff V.A. and A. Adlakha (1998). Women of the World-Women’s Health in India, International Programs Center, U.S. Census Bureau, the Official Statistic, WID/98-3, December 10, 1998.
[47] Wang, G. and V. K. Pillai (2001). “Women's Reproductive Health: A Gender -Sensitive Human Right Approach”, Acta Sociologica, Vol. 44, No. 3, pp. 231-242.
[48] WHO. (2018). World Health Organization Report on Maternal Mortality. https://apps.who.int/iris/bitstream/handle/10665/112318/WHO_RHR_14.06_eng.pdf
[49] Bibliography:
[50] Census 2011: Government of India. (2011). Census 2011.
[51] eStartIndia. (2021, May 26). Gender disparities in the Indian education system. Retrieved from https://www.estartindia.com/knowledge-hub/blog/gender-disparities-in-the-indian-education-system.
[52] International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS. https://dhsprogram.com/pubs/pdf/fr339/fr339.pdf
[53] Ministry of Education. (2023, January 29). Ministry of Education releases All India Survey on Higher Education (AISHE) 2020-2021. Retrieved from https://www.education.gov.in/sites/upload_files/mhrd/files/PressReleasePage.pdf
[54] National Family Health Survey 3 (NFHS-3): International Institute for Population Sciences. (2005-2006). National Family Health Survey (NFHS-3).
[55] National Family Health Survey 4 (NFHS-4): International Institute for Population Sciences. (2015-2016). National Family Health Survey (NFHS-4).
[56] State Planning Commission, Tamil Nadu. (2012). Twelfth Five Year Plan (2012-2017) Working Group on Elementary Education. Retrieved from https://spc.tn.gov.in/pdfs/wc_ele_edu.pdf
[57] UN Women – Asia-Pacific. (2020). Roadmap for Women’s Economic Empowerment in India. Retrieved from https://asiapacific.unwomen.org/en/digital-library/publications/2020/10/in-roadmap-for-womens-economic-empowerment-in-india
[58] UNICEF. (2014). Gender Action Plan 2014-2017. Retrieved from https://data.unicef.org/wp-content/uploads/2021/08/2018-21-Gender_Action_Plan-2017.07.14-Rev.1.pdf