A Socio-cultural Study of the Declining Sex Ratio in Delhi and Haryana

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FOREWORD

Son preference has been one of the most evident manifestations of patriarchal society. It has worked against the female sex particularly in their infancy and early childhood. A girl child is discriminated against in many ways - ranging from abandonment of girl children, fewer months of breast feeding, less of nurturing and play, lesser medical treatment if falls ill etc. all working against the very existence of girl child. Today, with the technological advancement in medical diagnosis this discrimination begins even before her birth. Various medical technologies have been put into practice to identify the sex of the child before the birth and selective abortion, if found female. The reasons behind the discrimination of girls crosses the spectrum of Indian regions, economic classes, and castes and are due to a complex mix of economic, social and cultural factors. Declining sex ratio has now been increasingly recognized as a complex and an urgent problem and needs to be addressed head on.

There is a historical deep-rooted mindset of undervaluing women that must be clearly understood and these realities must be woven into the strategies, in order to deal with the problem effectively. While studies on the declining sex ratio have tended to be quantitative, looking at biological or demographic factors, there has been a lack of data on prevailing socio-economic and cultural aspects. The present study conducted by NIPCCD has been an attempt to understand the socio-cultural factors that have traditionally undervalued daughters compared to sons. The study has helped gain insight on why sons are preferred and daughters not wanted; when is that a women decides that she cannot have the child if it is a female child; and what are the ways and means she adopts, to avoid having daughters and to beget sons. The report throws light on valuable information about the declining sex ratio, from Delhi and Haryana, on the immediate concerns, fears, perception of reality and consequences of decisions, both short term and long term. I am confident that this report would provide valuable inputs to planners, administrators, research scholars and other stakeholders working in the area of gender equality and women's empowerment for improving the status of women in the country.

Anil Kumar

(Anil Kumar)
Secretary

PREFACE

Declining sex ratio is an issue of grave concern in India. Family and social pressures to produce a son are immense. In most regions, sons are desired for reasons related to kinship, inheritance, marriage, identity, status, economic security and lineage. A preference for boys cuts across caste and class lines and results in discrimination against girls even before they are born. In a gross misuse of the technology that facilitates pre-natal diagnosis of any potential birth defects and associated conditions, female fetuses are selectively aborted after such pre-natal sex determination. This is happening across the country in spite of a massive influx of legal regulations banning the same.

The child sex ratio has declined drastically since 1961, from 976 to 945 in 1991 and 925 in 2001. In states like Delhi, Gujarat, Haryana, Punjab and Himachal Pradesh the ratio has declined to less than 900 girls per 1000 boys. If unchecked now, the present trend of decline in the sex ratio is sure to lead to serious demographic imbalances and adverse social consequences. In order to identify the socio-cultural factors contributing to the declining sex ratio, the Institute undertook a study in Delhi and Haryana. The study clearly brings to the fore various reasons for son preference, reluctance towards having daughters and other socio-cultural factors that discourage women to give birth to daughters. Declining sex ratio is a complex phenomenon which is an outcome several factors at play and needs to be responded to sensitively and uncompromisingly using all the means and resources at hand.

We appreciate the inputs provided by the Research Advisory Committee in finalizing the research design of the study. I would like to place on record my appreciation for the contribution and guidance given by Dr. Dinesh Paul, Additional Director and Dr. Neelam Bhatia, Joint Director. I acknowledge the painstaking efforts of Smt. Shanta Gopalakrishnan and Smt. Manju Khanna, both Assistant Directors and In charges of the Project in successfully completing the project in the stipulated time period with the able assistance of Ms. Nisha Saha, Ms. Smita Sinha and Ms. Meenakshi Sharma, Project Assistants. I also acknowledge the unstinting support provided by Shri P.S. Bhandari and Ms. Lucia Ekka to the Project In charges through the various stages of the project. I extend my deep gratitude to Ms. Jehanara Wasi for carrying out extensive editing of the document and to Shri A.J. Kaul for the layout and design of the report.

(A. K. Gopal)
Director

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

According to the 2001 Census there were 49 districts in the country, where, for every 1000 male children aged 0-6 years there were less than 850 female children. The majority, or 38 of these districts, were located in the three northern and western states of Punjab, Haryana, and Gujarat (Census of India, 2001). The juvenile sex ratio declined by 9 per cent in Haryana (from 902 in 1981 to 820 in 2001) and by nearly 13 per cent in Punjab (from 908 to 793 between 1981 and 2001). Himachal Pradesh and Gujarat states also experienced a decline in the juvenile sex ratio of the order of 7.5 per cent, which is higher than the national average of around 4.5 per cent. Thus, an almost contiguous belt extending from northwest India to parts of Rajasthan and Gujarat experienced a drastic decline in the juvenile sex ratio in recent decades. The decline of 60 to 83 points in the juvenile sex ratio between 1991 and 2001 or in a span of just one decade (observed in many of these districts) cannot be explained solely by the practice of discrimination against girls in this region, which has continued for several decades, because at no other time in the history of census taking has the sex ratio of children declined so drastically (UNFPA, 2003).

With this in view, the Institute undertook a study to ascertain the socio-cultural factors contributing to the declining sex ratio in Delhi and Haryana. The objectives of the study were to:

i. Assess the various socio-cultural, economic, demographic, cultural and other factors contributing to the declining sex ratio;

ii. Conduct a situational analysis of services available for abortion in the study area;

iii. Study the perception of stakeholders about the status of the girl child, gender discrimination, girl/women empowerment, adverse child sex ratio, sex determination and female foeticide (pre-birth elimination of females); and

iv. Identify strategies and suggest different measures to curb the menace of the declining sex ratio and thereby impact on the adverse child sex ratio.

The study was conducted in Delhi and Haryana. The data for the study was collected through the multi-stage stratified random sampling method. Perception of different stakeholders – women (15-45 years), men, mothers-in-law/elderly women, opinion leaders, *dais* (traditional birth attendants), health care providers of Integrated Child Development Services (ICDS) and health systems were

ascertained using interviews and focus group discussions. In all, the sample of the study comprised 300 women, 300 men, 300 mothers-in-law, 13 *dais*, 107 women opinion leaders, and 94 ICDS and health functionaries.

The major findings and conclusions of the study are presented in the following paragraphs.

Profile of the Respondents

- The educational status of women of the present generation was better than that of women of yesteryears. Roughly one-fifth of the women were illiterate. Surprisingly, a greater number of young women were unemployed compared to the women in the mothers-in-law category.
- A sizeable proportion of the respondents, vis-à-vis women, men and mothers-in-law owned some land.
- A majority (76.9%) of the *dais* in the sample were trained. On an average three-fourths of the *dais* conduct 1-5 deliveries per month and one-fourth reported getting an opportunity to conduct 6-10 deliveries in a month.

Socio-Cultural, Economic and Demographic Factors Relating to Adverse Sex Ratio

- The majority of the respondents were aware of the phenomenon of the declining sex ratio occurring throughout the country.
- Most of the women perceived non-availability of brides as the major repercussion of missing girls, followed by an increased rate of crime against women and polyandry.
- The various reasons for son preference, as mentioned by the women, include that a son is a support and provider in old age; brings in dowry instead of draining family resources; perpetuates the family name; for performing the last rites; when investing on sons, say on education or business, the wealth remains within the family itself.
- The main reason perceived for not wanting daughters has been 'dowry' by all the respondents.
- The factors essentially responsible for contributing towards the declining sex ratio were son preference and dowry. The interesting finding is that the mushrooming of ultrasound clinics and the ability to pay for abortions has been expressed by all the respondents as the major factors responsible for contributing to the declining sex ratio.

- The study revealed that the family, when deciding on a marriage did not seek the opinion of either the boy or the girl. It appears as though the freedom to exercise their choice in the selection of the bride/groom for themselves has been withdrawn from children in recent years.
- The study points to the fact that the practice of giving/taking dowry has not changed over the years. In fact, is constantly increasing, with developments in technology. The study reveals that the community is still tight-lipped about occurrences such as dowry harassment.
- The ideal family composition, as perceived by the majority (67.0%) of mothers-in-law, included one boy and one girl. About 27.8 per cent of mothers-in-law considered two boys and one girl an ideal family composition. Largely, the size of the family is determined by the presence of a son in the family.
- As elicited from the focused group discussions, women would go to any extent to have a son. Various rituals are performed across both the states to beget a son – to please the deities, who in turn are believed to grant a boon, i.e. a son.
- The celebrations on the birth a baby boy are definitely more joyous, with the banging of plates to announce his arrival, whereas those performed on the birth of a girl child are on a low key or missing altogether.

Knowledge and Awareness about Pregnancy and Childbirth and Child Care Practices

- Around 26.7 per cent of the women still believe that check-ups are not required during pregnancy. About 60 per cent of the women in Delhi and 88.7 per cent in Haryana were aware of the need to consume 100 iron and folic acid (IFA) tablets during pregnancy. About 74.0 per cent of the women in Delhi and 96.7 per cent in Haryana were aware that a woman needs to take two doses of tetanus toxoid during pregnancy.
- It is disheartening to note that around 65.3 per cent of the women in Delhi and 68.7 per cent in Haryana still believe that deliveries should be conducted at home.
- Women's knowledge in Haryana regarding problems encountered during pregnancy and childbirth was better than that of women in Delhi. Though awareness about reproductive health care was present, the attitude and practice is still sadly missing. This needs to be bridged urgently.

- Approximately 60 per cent of the women in Delhi and 64.7 per cent in Haryana responded that breastfeeding should be initiated within an hour of birth. About 60.7 per cent of the women in Delhi and 99.3 per cent in Haryana answered correctly about exclusive breastfeeding. Further, all the women (100%) in Haryana and 79.3 per cent in Delhi knew the ideal time for the introduction of complementary feeding.
- Home remedies (78.7%), consulting Anganwadi Workers (AWWs) (16.0%), Ayurveda/homeopathy/ other systems of medicine (37.3%), consulting Auxiliary Nurse Midwives (ANMs)/ Lady Health Visitors (LHVs) (7.3%), taking the child to a health facility (42.7%) and hospitalizing the child (51.3%) have been the modes of medical attention given to a child during illness as disclosed by women in Delhi. In contrast, 91.3 per cent reported hospitalization of the child in Haryana. Roughly 30 per cent of women in Haryana relied on home remedies, as against 78.7 per cent in Delhi.
- It was shocking to note that 97.3 per cent of women in Haryana and 87.3 per cent in Delhi decreased the food intake of a child during illness.
- There is evidence of gender discrimination at play, as reported from the focussed group discussions, which needs to be dealt with utmost urgency.

Abortion and Abortion Related Issues

- It is noteworthy to mention that the percentage of females decreased in the 4th order birth and 5th order birth in both Delhi and Haryana.
- Abortions, whether spontaneous or induced, were less in Haryana, as compared to Delhi. This finding needs to be taken with caution.
- There were 23.6 per cent, 30.8 per cent, 52.9 per cent, 66.7 per cent and 50.0 per cent induced abortions in the first, second, third, fourth and fifth order of birth in Delhi, pointing to the fact that the percentage of induced abortions increased with the birth order. Similarly, there were 33.3 per cent, 50.0 per cent, 33.3 per cent, 50.0 per cent induced abortions in the first, second, third and fourth order of birth in Haryana. There were no abortions reported in the fifth birth order pregnancy in Haryana.
- By and large abortions in Haryana have been performed in the hospital or in a private clinic. However, in Delhi apart from hospitals and private clinics, women are taking a high risk by getting abortions done through *dais* at home. The women of Haryana have been more open and articulate about the abortions

probably because of the social sanction given by the family and community, in general, whereas Delhi women were more discreet and subdued on the issue.

- The women in Haryana were mainly accompanied by their husbands for abortions, whereas in Delhi, husbands and in-laws are known to accompany them. This finding raises a question: is it a decision by the mother alone or is it a joint decision of/coercion by the family?
- It was surprising to discover that a majority of the *dais*, ICDS and health functionaries reported about the availability of services in private clinics/ mobile van services. This points to the fact that abortion services are freely available in spite of the laws in place. However, the abortions performed, as revealed by the women and mothers-in-law, do not corroborate this finding.
- Though a majority of the *dais*, ICDS and health functionaries were aware of the safe period for getting abortions done, there is still a need to update their knowledge.
- The availability of ultrasound facility for detecting a child's sex has been reported by women (88.0%), men (78.3%), *dais* (30.8%), Child Development Project Officers (CDPOs) (66.7%), supervisors (81.8%), AWWs (63.3%), MOs (33.3%), LHVs (70.0%) and ANMs (73.3%).
- There is a serious knowledge gap in the functionaries regarding the Medical Termination of Pregnancy (MTP) Act and the Pre Natal Sex Determination Test (PNDT) Act, which needs immediate attention.

Status of the Girl Child and Women's Empowerment

- The study has revealed that mothers-in-law are the major decision-makers on how the money earned at home is to be spent, more than the women themselves.
- The awareness level of health functionaries about the various laws was the highest, followed by ICDS functionaries, men, women, mothers-in-law and *dais*, in that order.
- In fact, men, mothers-in-law and *dais* were very firmly of the opinion that 'girls should remain indoors' which is not shared so much by the 'women' respondents.

- Another opinion that needs to be considered as against women is that a sizeable proportion of respondents either 'agree' or 'partially agree' with a man beating his wife. Also as a pointer, a sizeable proportion of men either 'disagree' or 'partially agree' that household work should be shared by men. When the mindset is that women have to be subordinated, it would be a difficult task, if not impossible, to confront it and to bring about any change.

Major Recommendations

The major recommendations drawn, based on the findings of the present study are as follows:

- The study has revealed the very shocking phenomena of high awareness of the declining sex ratio in the states as also its various serious repercussions. Yet a girl child is not valued, pointing towards an alarming volatile situation that would be hard to deal with in the times to come. However, it is an *emergency* and has to be addressed on a war footing using every means and efforts of communication.

- Women should also be socialized from early childhood to consider themselves equal to men. They should be encouraged to assume all those responsibilities, which are normally considered to belong to the male domain. This would have a positive influence on future generations, as today's girls would be tomorrow's mothers, as well as, mothers-in-law.

- Data on the child sex ratio available with anganwadis and updated continuously provides valuable information for action by the convergence of services of all sectors under one roof. The women who are elected *panches* in the village panchayats and organized women's groups at village and urban slum ward areas could take a serious view of the unfavourable child sex ratio in their settings to think, plan and act locally and share this with the village community. Collective action plans could be evolved to save the girl child and provide her adequate nutrition at home, balanced development in the village environment through appropriate household actions and health programme interventions. Since the ICDS programme is near universalization it has inherent strengths to ensure wider coverage.

- The legislative measures, such as the Prohibition of Dowry Act, PNDT Act etc., should be stringently implemented.

- Central/state governments should popularize schemes in operation in the states through economic benefits that could accrue to those families having a girl

child, similar to the *Shagan* scheme launched by the Government of Punjab, *Apni beti apna dhan*, *Balika samriddhi yojana*, and the newly proposed cradle scheme, etc.

- The proposed *Conditional Transfer Scheme (cash and non-cash)* of the government, with its two-fold objectives, the direct and tangible objective to provide financial incentives to encourage them to retain the girl child and the more subtle and intangible one to change the family's mindset towards the girl by linking cash and non-cash transfers to her well-being, it is hoped, would give the necessary impetus to improve women's status. The conditional cash transfers should be given on completion of certain conditionality such as birth registration, immunization, school enrolment, retention in primary and elementary school, entry into secondary school/vocational training and completion of 18 years without getting married. It is proposed to disburse Rs 16,000 per girl child per year under the scheme.
- Awareness about the Protection of Women from Domestic Violence Act, 2005 needs to be created.
- Sensitization programmes on prevention of female foeticide and infanticide for the functionaries of voluntary organizations and elected representatives of Panchayati Raj Institutions should be organised.
- Multimedia campaigns at the National and state levels should be launched against female foeticide to create awareness to curb the problem and synergize government initiatives to promote women-oriented programmes. There should be more such concerted efforts in the States where the sex ratio is gravely skewed against girls.

INTRODUCTION

INTRODUCTION

Sex ratio is an important social indicator to measure the extent of the prevailing equity between males and females in a society at a given point of time. Changes in sex ratio largely reflect the underlying socio-economic and cultural patterns of a society in different ways. Determinants of changes in sex ratio vary from sex differentials in mortality, sex selective migration, sex ratio at birth, and at times, sex differentials in population enumeration. India is one of the few countries in the world where males outnumber females. However, the high incidence of induced abortions and sharp decline in the child sex ratio in the last decade clearly proves the practice of female foeticide.

The increasing incidence of female foeticide has led to a drastic decrease in the number of girls to boys in India in the 0-6 age group. The practice of eliminating female foetuses is believed to be one of the main reasons for the adverse child sex ratio. Pre-birth elimination of females (PBEF) seems to be more prevalent in urban areas than in rural areas, but the gap is rapidly decreasing because of easy availability of sex determination tests in rural areas.

The declining sex ratio is a matter of great concern, as it will lead to serious demographic imbalances and adverse social consequences. Only a strong public awareness can curb the evil practice of female foeticide. Strengthening the implementation of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, which prohibits determination and disclosure of the sex of the foetus, is need of the hour. Also, the commitment of society in general, is even more important (UNFPA)[20]

1.1 Trends in Declining Sex Ratio

According to the 2001 Census, the sex ratio in India is 933 females per 1000 males. Although there is a marginal improvement from the 1991 Census, where it was 927, it continues to be significantly adverse towards women. India's sex ratio of 933 is the lowest amongst the most populous countries in the world, namely Pakistan (938), China (944), Bangladesh (953), Indonesia (1004), Nigeria (1016), Japan (1041), Brazil (1025), USA (1029) and Russia (1140). Of these 10 countries, six have a sex ratio above unity, meaning a population of 1000 females per 1000 males.

The sex ratio in India over the past 100 years has shown an alarming decline from 972 in 1901, to 946 in 1991 and 933 in 2001. The child sex ratio has declined drastically since 1961, from 976 to 945 in 1991 and 925 in 2001. A large number of states like Gujarat, Punjab, Himachal Pradesh, Delhi and Haryana have recorded a decline of 50 or more points in the ratio since 1991. The ratio has declined to less than 900 girls per 1000 boys in states like Delhi, Gujarat, Haryana, Punjab and Himachal Pradesh. Some of the most prosperous regions have the lowest ratios, such as the southwest district of Delhi (845) and Ahmedabad (814). The worst performing districts include Fatehgarh Sahib in Punjab (754), Kurukshetra in Haryana (770) and Mahesana in Gujarat (798).

The decline of child sex ratio (CSR) is so widespread that of the 29 states and 7 Union Territories only 4 states namely Kerala (+5), Tripura (+8), Mizoram (+2) and Sikkim (+2) and one Union Territory, Lakshadweep (+33) seem to be free from this socially harmful and degrading phenomenon. The states and Union Territories that have shown a sharp decline in CSR are Punjab (–82), Haryana (–59), Himachal Pradesh (–54), Chandigarh (–54), Gujarat (–50) and Delhi (–50), though they are economically quite developed with high female literacy rates.

1.2 Sex Determination Tests

India is indeed one of the few countries to have legalized abortions under the Medical Termination of Pregnancy Act in 1972. Abortion is legal in instances where pregnancy carries a risk to the foetus or to the mother, or in case of pregnancy caused by contraceptive failure or otherwise. However, the fact is that abortion services are being provided on demand by an increased number of registered and unregistered service providers. It is estimated that nearly six million abortions are performed every year outside the ambit of the Act.

Three major prenatal diagnostic tests that are being used as sex determination tests are: amniocentesis (normally performed after 15-17 weeks of pregnancy); chorionic villi sampling (more expensive and normally performed around the tenth week of pregnancy); and ultrasound (least expensive and normally performed around the tenth week of pregnancy). Amniocentesis and chorionic villi sampling were introduced in India for the determination of genetic abnormalities but they were soon used more commonly for sex determination. With the introduction of ultrasonography, sex determination has spread like an epidemic in many towns and villages.

After the introduction of these tests, hoardings appeared in different parts of India, which said 'invest Rs. 500 now, save Rs. 50,000 later' and sometimes the saving amount was mentioned as Rs. 5,00,000. The advertisements were designed

to encourage prospective parents to abort female foetuses in order to avoid future dowry expenses. Of late, sex determination test facilities are available in small towns and even villages.

1.3 Steps Taken to Curb Female Foeticide

The drive against female foeticide and sex determination techniques gained momentum in the 1980s. The partial ban on sex determination tests in government hospitals led to the proliferation of private clinics/hospitals offering the facility. The ban was imposed because the advent of amniocentesis in 1975 caused a dramatic increase in female foeticide cases. Since then, different parts of the country have witnessed several campaigns against the misuse of science and technology to continue discrimination against women. Campaigns like Forum Against Sex Determination and Sex Pre-selection (FASDSP) in 1985 in Maharashtra, and Campaign Against Sex Selective Abortion (CASSA) in Tamil Nadu came up. FASDSP lobbied to regulate the practice of sex determination in Maharashtra by formulating a separate legislation, instead of modifying the Medical Termination of Pregnancy (MTP) Act, 1971 that had the danger of curtailing women's right to abort. As a result, the Maharashtra Regulation of Use of Prenatal Diagnostic Techniques Act, 1988 came into being.

Serious drawbacks in the state legislation and poor implementation caused the awakening of interest in this issue across the entire country. A move for an all India ban on sex determination test gained momentum and the Prenatal Diagnostic Tests (Regulation and Prohibition of Misuse) Act, 1994, (the PNDT Act), came into existence. Though the PNDT Act came into force in January 1996, no evidence of decline in the practice of female foeticide was evident even after four years. Lack of concern and the political will to implement the legislation by the centre and states led to a Public Interest Litigation (PIL) case, in the Supreme Court (SC). The PIL was filed by three petitioners – Dr. Sabu George, a social activist, Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune and the Centre for the Enquiry of Health and Allied Themes (CEHAT), Mumbai, in February 2000. In May 2001, the Supreme Court directed the centre to implement the PNDT Act in all its aspect and called upon all state governments to take necessary steps to implement the Act. However, a further dip in the ratio in 2001 suggests that a lot more needs to be done in this regard.

In the light of new techniques available to determine sex before conception, it was felt necessary to amend the Act. With the result, the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002, came into force. Also the PNDT Act 1994 was renamed as the Pre-conception and Pre-

natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (National Commission for Women).[11]

1.4 Programme Perspective

India was the first country in the world to launch a National Family Planning Programme (subsequently named the National Family Welfare Programme). The objective was to stabilize the population at a level consistent with the requirements of the national economy. The Family Welfare Programme has completed five decades and has made significant contributions towards improving the health of mothers and children and providing family planning services. However, the Family Welfare Programme focussed purely on demographic goals and concentrated on numerical method specific contraceptive targets. Female sterilization accounted for three-quarters of the modern methods of contraception used in India. Only 3.4 per cent of couples rely on vasectomy and 2.4 per cent on condoms. Terminal methods and particularly female sterilization is being promoted consciously, while men's participation is lagging behind. Because of son preference, sex-selective sterilizations are chosen by most women acceptors (Lal, 1993).[9]

The Reproductive and Child Health Programme (RCH) initiated in 1994, focuses on gender issues. The RCH programme integrates all interventions of fertility regulation, maternal and child health, and reproductive health of both men and women. The programme tends to provide client-centred, demand-driven, high quality, need-based services through decentralized participatory planning as a target-free approach. Gender issues are in the forefront of the programme. Similarly, the National Population Policy 2000, documents increased participation of men in planned parenthood. In the past, the population programmes tended to exclude men (MHFW, 2000).[6] Gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members, age at marriage and education of girls, besides access to and utilization of health, nutrition and family welfare services. RCH makes a strong commitment to reduce the imbalance through effective programmes. (MHFW, 1994).[5]

The Eleventh Five Year Plan also stresses on elimination of all forms of gender discrimination, so as to enable women 'to enjoy not only de-jure but also de-facto rights and fundamental freedom on par with men in all spheres, viz. political, economic, social, civil, cultural and complete eradication of female foeticide and female infanticide through effective enforcement of the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.

2

REVIEW OF LITERATURE

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The declining sex ratio in the country has sent shockwaves across all sections of society. It seems that the socio-cultural factors are so embedded in the psyche of the people that they even accept wrong ways of life for the sake of social superiority. It is not poverty alone that kills baby girls – the choices made by her parents and family have a greater role to play in curtailing her life. Custom and tradition shape these choices and when resources are meagre, these can make a difference between life and death. Significantly, micro-level studies have shown that baby girls are more likely to die in a family where there is no older male sibling, pointing to strong circumstantial evidence of discriminatory care.

Girls in India are discriminated against in other ways as well – fewer months of breastfeeding, less nurturing and play, less medical treatment if they fall ill, less special food, less prenatal attention. As a result, girls are far more susceptible than boys to disease and infections, leading to poor health and a shorter lifespan. It is this lifelong discrimination in nurturing and care that is the real killer of girls, less visible and less dramatic, but as unequivocally lethal as female foeticide and infanticide (UNICEF, 1998).[19]

An attempt has been made to review studies which have focused on socio-cultural, demographic, and other factors related to this complex phenomena occurring in the country and the same has been presented in the following paragraphs.

2.1 Status of Women

The status of women in India has been a chequered one, as it has seen many ups and downs. In the Vedic Age, 1500-1000 BC, they were worshipped as goddesses. In the Muslim Age, 1026-1756 AD, their status suffered a sharp decline and in British regions they were looked upon as the slaves of slaves. Women in India have made some progress in the fields of education, health, economics, etc. as a result of technological developments. Though in very small numbers, today India has women in almost all spheres of life. Women today are doctors, engineers, pilots, journalists, teachers, administrators, judges including a woman judge of the Supreme Court, state governors, ambassadors, members of parliament and ministers. India has had a woman Prime Minister and a President of the UN Assembly. In spite of these achievements the fact is that ordinary women's condition is beset with difficulties.

2.1.1 Legal Awareness

Nayar (1995)[12] found that the level of awareness about various laws under which violence against women and their harassment is a punishable offence was very low among the women. MOHFW and TINNARI, (2002)[7] found awareness about laws to be higher amongst female respondents on the whole. Further, the level of legal awareness rose with the rise in income levels. Higher female respondents in income levels appeared to be the most aware group.

2.1.2 Women's Autonomy

Women's autonomy is likely to have a significant impact on the demographic and health-seeking behaviour of couples by altering women's relative control over fertility and contraceptive use and by influencing their attitudes and abilities. The National Family Health Survey 3, 2005-06 (NFHS 3) revealed that about 41 per cent women report that they make own decisions on how they use the money they earn. About 30 per cent reported that their husbands or other members of the family along with their husbands take the decision. The proportion that takes their own decision was higher in urban (57%) than in rural areas (37%).

The recently conducted National Family Health Survey 3 reveals that women who are employed and earn cash, say: they either alone (24%) or jointly with their husbands (57%); husbands alone (15%) or others is the household (3%) decide as to how the money they earn will be used. Only one in six women do not participate in the decision of how their earnings are used. Just 28-31 per cent of women mainly decide for themselves how their earnings are to be used (IIPS, 2007).[8]

2.1.3 Household Decision-Making

According to NFHS 3 (2005-06) just 27 per cent of currently married women make decisions about their own health care mainly on their own. Only 9 per cent of women take decisions mainly by themselves about major household purchases. Joint decision-making is most common for visits to the respondent's family or relatives followed by decisions about major household purchases. (IIPS, 2007).[8]

Women's participation in decision-making tends to be most common in several of the north-eastern states, men's approval of a wife's participation in decision-making is relatively high in only two north-eastern states (Sikkim and Meghalaya) as well as in the northern states of Haryana, Punjab, Delhi, Himachal Pradesh and Uttarakhand, (IIPS, 2007). [8]

2.1.4 Freedom of Movement

Freedom of movement outside the home is an important aspect of women's autonomy and empowerment. NFHS 3 (2005-06) found that only 33 per cent of

women were allowed to go alone to the market, health facility or places outside the village and about four per cent were not allowed to go out at all to any of them (IIPS, 2007). [8]

2.1.5 Women and Personal Choices

Control over one's own body and sexuality is perhaps the most basic element of personal freedom. Judging from the data on the number of married couples who actually use contraception, the majority of married women in the country do not have the luxury of exercising the most basic choice of deciding whether and when, they will have a child.

The Indian Constitution upholds the rights of each individual to exercise control over themselves and the circumstances of their lives. The constitutional rights to personal liberty, freedom of speech and expression, free movement and association, choice of residence and occupation, all imply that Indian women, equally with men, have the right to decide how they want to live their lives, what they want to do and be.

According to the findings of NFHS 3 (2005-06) the decision about how many children to have, the majority of men (89%) say that such decisions should be made jointly and the rest were of the opinion that the husband should have the greater say. Only a negligible percentage (2%) were of the opinion that the wife should be the main decision-maker regarding the number of children the couple should have. Also, most rural men are of the opinion that the husband should have a greater say in decision-making than the wife.

2.1.6 Perceptions on Domestic Violence

NFHS 3 revealed that the reason most commonly agreed to by women that justifies a husband beating his wife is 'if she shows disrespect for her in-laws' (41%), followed by 'if she neglects the house or children' (35%). The reasons least agreed with are 'if she refuses to have sex with him' (14%), followed by 'if she doesn't cook food properly' (20%). Agreement with the other three reasons, namely, if she goes out without telling him, if she argues with him, or if he suspects her of being unfaithful ranges from 25-30 per cent. One in two women agree with any specific reason justifying a husband beating his wife and more than one in two (54%) agree with at least one reason justifying wife beating (IIPS, 2007). [8]

2.2 Declining Sex Ratio

In a study conducted by Varghese, *et al*., (2005),[21] analysing the sex ratio at birth of hospitalized deliveries during 2000-2001 in Delhi, indicated that if the first

birth was a male child, the female to male sex ratio of the second birth was 959. But if the first birth was a female child, the sex ratio of the second birth was 542. Among the women who had delivered two daughters, the sex ratio of the third birth dropped to 219. These are clearly not chance occurrences.

A study conducted by MOHFW and TINNARI (2002)[7] in Delhi on 530 respondents revealed that there are on an average 115 male births to 100 female births recorded. Sudha and Rajan (1999),[18] on using evidence from a number of sources found that there was an increase in 'masculine' sex ratio at birth (SRB) and persistent (or even worsening) female mortality disadvantage, despite overall mortality decline, owing to selective neglect and the spread of female infanticide practices in some areas. Reports indicate the increasing use of prenatal sex selection in some regions.

Ghosh, Goel and Balda (2005)[4] in a study conducted in Allahabad district on 100 couples found that 64 per cent males and 74 per cent females had no knowledge about the sex ratio.

2.2.1 Factors Influencing Low Sex Ratio

Female foeticide was cited as the main reason for the decline in sex ratio. The other reasons included neglect of the girl child resulting in higher female mortality, maternal death, dowry death, female infanticide and male migration (Ghosh, Goel and Balda, 2005).[4]

Mathur, Rajagopal and Bhargava (2004)[10] on analysis of the relationship between livelihoods and childhood poverty and well-being in the State of Rajasthan found that the practice of female infanticide, female foeticide and strong son preference in most communities were the factors contributing to the imbalance in the sex ratio in Rajasthan, which is also indicative of the low value and secondary status of the girl child.

2.2.2 Reasons for Wanting a Son

Son preference was strongest among the middle income group. Reasons for son preference were that they perpetuate the family name and inherit property, they are providers in old age and to perform the last rites (MOHFW and TINNARI, 2002).[7] The reason for wanting a son is to attain *moksha* (Prasad, 2001; and Nayar, 1995);[15,12] power, prestige, to perform the last rites and to continue the family lineage (Yadav and Badri, 1997).[23]

In a study conducted by Anandalakshmy (1994)[1] on 100 girls between the ages 7-18 years found that the term 'expected' could be taken to be another expression

for 'desired'. Majority of the mothers (64%) mentioned that they did not expect any sex preference to the other, but half amongst them said that they expected a boy. Only a negligible percentage (2%) expected a girl.

Yadav and Badri (1997)[23] in a study conducted in Bangalore on the anxiety of 203 pregnant women related to the sex of the child found that only a negligible per cent preferred a daughter. The majority (96%) of women with two daughters, as also more than half the pregnant women with one daughter and one son, only preferred a son.

Srivastava, Dasgupta and Rai (2005),[17] in a study conducted on 200 married men and women to elicit their attitude towards the girl child and declining sex ratio in Bhopal found that preference for a male child was greater among lower and middle class respondents.

2.2.3 Reasons for Not Wanting Daughter

The reasons stated by the majority for getting the sex determination test done was for avoiding the problem associated with a girl child such as dowry. Parents feel that finding a suitable and good match for a daughter is difficult, otherwise life can become hell. Another belief parents have is that they should not expect support from daughters during old age and this also makes the girl child unwanted (Prasad, 2001).[15] The various reasons for not wanting daughters were: dowry, forbidding wedding expenses, long requirement of giving gifts and money to daughters, lack of availability of girls to look after parents after marriage, domestic violence, ill treatment by husbands and in-laws, ill treatment of women after they give birth to a girl, and not wanting to go through the same fate as them (MOHFW and TINNARI, 2002; and Nayar, 1995).[7 12]

Srivastava, Dasgupta and Rai (2005),[17] in a study conducted on 200 married men and women to elicit their attitude towards the girl child and the declining sex ratio in Bhopal, found that the reasons for not wanting girls include that bringing up girls is a costly affair and a wasted investment; they have to be married off; arranging for dowry is difficult; there is fear of providing safety even inside home; and she is subject to harassment.

The negligible few who wanted daughters mainly did so to fulfil religious obligations (Yadav and Badri, 1997).[23] Srivastava, Dasgupta and Rai (2005)[17] found that rearing a daughter is perceived to be more difficult than bringing up a son. The major difficulties perceived in bringing up a boy include: making him economically self-sufficient; keeping him away from bad habits; this responsibility continuing even after his marriage, towards his children and wife. The problems

perceived in bringing up a girl were even greater than for a boy. They included: arranging for her dowry; safeguarding her chastity; and socializing the daughter for the future role as daughter-in-law.

Yadav and Badri (1997)[23] found that pregnant women were pressurized more by their husbands than the mothers-in-law to bear a male child even if they already have two living children, one son and a daughter. The pressure is more when she already has two daughters. The level of anxiety of pregnant women with only daughters was rated very high.

2.3 Fertility Behaviour and Family Composition

Arnold, Choe and Roy (1998),[3] on examining National Family Health Survey data, to ascertain the effect of son preference on parity progression and ultimately on child mortality, found that son preference fundamentally affects fertility behaviour in India. Family composition has affected fertility behaviour in every state.

Nirbhawane (1996),[13] in a study of sex preference and reproductive behaviour among 2000 couples in Mumbai found that a much larger proportion of educated women whose firstborn was not a male, terminated the second pregnancy, as compared to those with no education. This suggested that women wanted to have at least one male child but also a family size of not more than two.

In a study conducted by Lal, (2003),[9] in the rural area of a community development block in Haryana found that over 97 per cent of sterilizations were adopted by females, while men's participation in sterilization was marginal. Son preference was an acknowledged fact as 99.36 per cent of sterilizations were adopted after having given birth to at least one son. Nearly 27 per cent of women accepted the sterilization operation after bearing two or three sons only and thus avoiding effectively the birth of a girl child.

2.3.1 Birth Order of the Girl Child

In a study conducted by Anandalakshmy (1994), on 100 girls between the ages of 7-18 in Delhi found that almost 65 per cent of the girls in the sample were firstborn and 20.4 per cent were second born. The percentage of the third and fourth born were 8 and 3.3 per cent respectively (Anandalakshmy, 1994).[1]

2.3.2 Family Size and Composition

Anandalakshmy (1994),[1] found that more families have two sons (38.5%) than two daughters (32%). Srivastava, Dasgupta and Rai (2005),[17] reported that about 5

per cent families desired one child, while a majority (68.5%) wanted two children and about 13.5 per cent desired three children. A very few (3.5%) were in favour of larger families. There was a trend of limiting family size in respondents who were either graduates or postgraduates, wanting to provide a higher standard of living for their children. Yadav and Badri (1997),[23] in a study conducted in Bangalore on the anxiety level of 203 pregnant women related to the child's sex found that most of them considered an ideal family size to be three.

Nayar (1995),[12] found that opinion leaders, both male and female were of the view that at least one son is essential. A study conducted by Walia (2005),[22] found that men felt that a family should have only one female child. A women could not afford to fill her courtyard with female children in such an inflammatory environment.

Anand (1998),[2] conducted a comparative study of the attitude of 877 people from Haryana, Delhi, Rajasthan and Punjab towards female foeticide and female infanticide. He found that the majority of respondents from Rajasthan, followed by Haryana and Punjab, and few from Delhi had more than two children in their families. Nearly half the respondents had only one son in the family and nearly one-fourth had no son. Also, in each state, the percentage of respondents with more than two sons in the family was very low, with the exception of Haryana. The majority (70%) of the respondents had either none or one daughter in the family. There were very few families with two daughters. The higher percentages were from Rajasthan, Haryana, and Punjab, followed by Delhi.

2.3.3 Birth Registration

Although all respondents in the higher income groups reported the registration of births and deaths, it was 94 per cent for the middle income groups and only 25 per cent in the lower income group respondents (MOHFW and TINNARI, 2002).[7]

2.4 Perceptions about Female Foeticide and Female Infanticide

Most of the respondents felt that female foeticide was a good way to keep the girl population in check. They went to the extent of demanding easier and more accessible facilities for sex detection and consequent female foeticide. Only a few accepted female foeticide to be a heinous act that should be punished by law (Walia, 2005).[22] Just 25 per cent of the respondents felt strongly against these practices. Punjab (36%) had a higher percentage of respondents with a favour of female foeticide and infanticide followed by Rajasthan (28%), Haryana (23.7%) and Delhi (4.5%) (Anand, 1998).[2]

Even on moral grounds there were few respondents (13%) and (12%) respectively who felt positive or strongly positive towards female foeticide and female infanticide respectively. A higher percentage of such respondents were found in Punjab (5%, followed by Haryana (3.3%), Delhi (2.9%) and Rajasthan (2.7%), in that order for female foeticide (Anand, 1998).[2] A greater percentage of respondents with more than two daughters had a strongly positive overall attitude towards female foeticide and female infanticide (Anand, 1998).[2]

Walia (2005),[22] in a study conducted on 240 respondents from three districts of Punjab, namely Ludhiana, Bathinda and Ferozpur with low child sex ratios, revealed that a majority of the respondents approved of the heinous act of female foeticide. In a study conducted by Nayar (1995),[12] he revealed that elderly women repeatedly complained that young women/daughters-in-law go to the cities with their husbands without consulting them to get an ultrasound done, and that they do not approve of killing girls.

Anand (1998),[2] found the following as some reasons for female foeticide: ensuring the family's name through the male child; performance of last rites by sons only; girls unable to assume family responsibilities after marriage; expensive marriages of daughters; girls unable to provide economic security to the parents; parents' feeling of insecurity at the birth of a female child; sons ensuring better fortunes for parents; difficulty in finding suitable matches for girls; increasing incidence of violence against women; female children being more expensive to bring up; and birth of a female child lowering the status of the mother and family in society

2.4.1 Religious Aspect of Female Foeticide and Female Infanticide

Anand (1998),[2] found that the percentage of respondents holding a strongly negative attitude towards female infanticide (72.7%) was much higher compared to female foeticide (47.5%). Therefore, it seems that religious motivations could act as an influence in case of female infanticide, but in the case of female foeticide, the motivating factors would be more in the way of family planning decisions.

The strong patriarchal family system gradually gave rise to the practice of ancestral worship, resulting in a strong preference for sons. These have now become institutionalized values. Along with this, according to Hindu philosophy, a woman is to obey her father before marriage, her husband during married life and her son in widowhood. These traditions stress the importance of perpetuating the family lineage through sons. These values provided the justification for female infanticide in the past and female foeticide during contemporary times (Anand, 1998)[2].

2.4.2 *The Social and Financial Aspects of Female Foeticide and Female Infanticide*

Anand (1998),[2] found that social factors had a profound impact on the attitude of people in relation to female foeticide and female infanticide. The percentage of respondents with a strongly positive and positive feelings towards social aspects was higher in Punjab (27.8), whereas in the case of female infanticide, a higher percentage of respondents from Rajasthan expressed strongly positive and positive feelings (32.7%).

Anand (1998)[2] found that financially a majority of respondents expressed their attitude as negative or strongly negative, meaning that they felt no difference between a son and a daughter.

2.4.3 *Perceived Reasons for Female Foeticide*

Escalating demands of dowry was cited as the main reason for female foeticide by the majority of the respondents. The other reasons included inability of daughters to provide social security to parents (Walia, 2005).[22]

2.4.4 *Repercussions of Female Foeticide*

The various problems foreseen owing to increased female foeticide include non-availability of brides, rise in sexual violence against women, lack of female workforce and polyandry (Ghose, Goel and Balda, 2005)[4].

2.4.5 *Effective Strategies to Prevent Female Foeticide*

Allowing girls to opt for higher education, strict implementation of the law against dowry, incorporation of anti-dowry education at school and college levels, improving the facilities for providing education to girls and modifying laws to heavily fine people who perform female foeticide and female infanticide, restricting prenatal sex determination tests to disclose only genetic abnormalities, restricting availability of prenatal sex determination tests to government hospitals only; using the media to change peoples' opinions; creating public awareness about the equal capabilities of men and women; organizing campaigns on television and radio for equality of both sexes; economic empowerment of women; raising salaries and the status of careers which are particularly suited to women; overcoming traditional norms; and giving incentives to parents of only girl children, are effective strategies for preventing female foeticide (Anand ,1998).[2]

2.5 Abortion and Abortion-Related Issues

Indian women face covert violence before birth through sex pre-selection, and overt violence after conception through sex-selective abortions. While abortion is

legal in India, sex-selective abortion is not. Amniocentesis, chorionic villi biopsy (CVB), sonography, ultrasound and imaging techniques are used to determine the sex of the foetus. In-vitro fertilization (IVF) clinics for assisted reproduction are approached by infertile couples to produce sons. This has resulted in a decline in the juvenile sex ratio and 60 lakh missing girls in the age group of 0-6 years, according to the Census of India 2001 (Patel, 2004).[14]

2.5.1 Incidence of Abortions

Nearly 10 per cent of respondents had undergone abortions. The incidence of abortion was much higher in the upper and middle income groups as compared to lower income groups (MOHFW and TINNARI, 2002).[7]

2.5.2 Reasons for Abortions

Ravindran (nd)[16] analysed various aspects of abortion on the basis of 79 studies conducted in India during 1990-99. The three major reasons for terminating pregnancy found in almost all studies were: to avoid an additional birth after the desired family size had been reached; to ensure a reasonable birth interval after the previous birth; and to prevent the birth of a female child.

A majority of women (62%) had undergone induced abortion because they did not want another child. The majority were in the higher income group. One-fourth reported that they wanted only a son (MOHFW and TINNARI, 2002).[7]

2.5.3 Timing of Abortions

Nayar (1995),[12] in a study conducted in the villages of Punjab and Haryana, found that there was a very low female sex ratio in childhood. Women and men spoke about the widespread use of sex determination tests and abortions if the foetus was female. Those who wanted to space or limit births decided fairly early, by 8 weeks, although there was delay in actually availing themselves of the services. In contrast, those seeking to abort a female child had an abortion at a mean gestational period of 16.6 weeks because of the wait to have a sex detection test, which is done in the second trimester.

2.5.4 Facilities for Sex Determination Tests

A survey conducted by Prasad (2001)[15] of 10 diagnostic centres found that almost 80 per cent of the diagnostic centres conducted sex determination tests. On an average in a month, 15-20 tests were conducted at these centres. They were quite open about it. Most of the doctors replied that pressure from their clients compels them to perform sex determination tests.

Most of the respondents were reluctant to disclose the place of abortion. Of these more than half admitted using private clinics for the purpose and less than 40 per cent used government facilities (MOHFW and TINNARI, 2002; and Nayar, 1995).[7, 12] In Punjab and Haryana *dais* also conducted abortions on a small scale (Nayar, 1995).[12]

2.5.5 Opinion on Sex-Determination Tests

Some doctors were of the opinion that parents have a right to have a 'wanted child'. They believe that it is the parents' right to choose the sex of their child and one cannot stop them from exercising their right. A few others supported sex-determination tests on the pretext of the small family norm. Some doctors felt that banning the tests would only force people to go in for clandestine ones (Prasad, 2001).[15]

2.5.6 Source of Information about Sex Selection Test

Mostly respondents from all income groups were aware about sex selective abortions, mainly the ultrasound. But in the lower income groups the awareness was limited and they got this information from friends, the media, *dais*, private practitioners, etc. Advertisements, billboards and hoardings with catchy slogans about abortion and availability of such facilities, were the main sources of information (MOHFW and TINNARI, 2002; and Nayar (1995).[7, 12]

Other major sources of information regarding the methods and availability of the services were the health workers (Nayar, 1995).[12] In a few cases doctors referred the patients to a clinic conducting these tests, but for some, the source of information regarding the sex-determination test and the clinic were relatives, friends or neighbours (Prasad, 2001).[15]

2.5.7 Awareness about Methods of Sex Determination

In a study conducted by Nayar (1995),[12] all the respondents in both Punjab and Haryana were aware of ultrasonography as a method of sex determination. None of them were aware of other methods. There was total ignorance about the purpose of ultrasonography in pregnancy. They were not aware that these tests were meant for detecting malformation and other complications in the foetus. Nayar (1995)[12] further found that the common perception was that ultrasound facilities were made available to detect the sex of the unborn child, so that the family size can be reduced.

2.5.8 Decision Making Regarding Sex Determination Test

Prasad (2001)[15] found that it was the family's decision to undergo sex determination tests and mothers mentioned that they were not forced, as they too

wanted to give birth to a male child. Most (83.5%) respondents felt that the decision to undergo abortion should rest with the prospective parents; some felt the prospective mother should take it and only a negligible percentage (5%) believed that other members of the family should take the decision.

2.6 Child Care Practices

2.6.1 Causes of Infant and Child Deaths

Nayar (1995),[12] in a study conducted on the declining sex ratio in two states, Punjab (Amrisar, Faridkot and Patiala) and Haryana (Kaithal, Kurukshetra, Jind and Hissar), found that of the total infant and child deaths reported by the families in the age group 0-5 years, two-thirds in Punjab and 73 per cent in Haryana were girls. The major causes of infant and child deaths were found to be dehydration due to diarrhoea, typhoid and undiagnosed fever. In Punjab, of the 31 deaths owing to unspecified reasons, 23 were of girls indicating an attitude of indifference towards girls' illness.

2.6.2 Child Health and Nutrition

Home remedies were considered best for girls, whereas medical attention was sought immediately for boys. There was no gender discrimination in immunization in both Punjab and Haryana. However, girls were breastfed for a shorter duration compared to boys. Mothers, on probing, stated that this was more because pressure was built up for the next conception to take place early in order to bring in a son (Nayar 1995).[12]

2.7 Socio-Cultural Factors Contributing to the Declining Sex Ratio

2.7.1 Dowry

It is a universal truth today that the word 'dowry' has taken on a negative connotation and is a corrupt form of social custom related to marriage. Yet marriages, happy or unhappy, continue to take place and dowry, whether demanded or given willingly, continues to accompany the newlywed bride to her new home. To a vast majority of Indians, it is unthinkable that a bride can go to her husband's home after marriage, without taking anything with her from her parents' home. Hence, dowry continues to be an integral part of our lives in India.

A sizeable proportion of the respondents reported that they agreed with slogans by doctors – 'better to spend Rs. 1000 now and save Rs. 10 lakhs later. Girls take dowry while sons bring in a substantial amount of dowry. Girls were an unnecessary investment; even if they earned, parents had no right to that earning. It was shared by their in-laws (Walia, 2005). [22]

2.7.2 Dowry and Female Foeticide

The dowry system has always given rise to innumerable socio-economic problems of far-reaching consequences and wide-ranging ramification. It is said that in India on an average five women a day are burnt in dowry-related disputes and many cases are never reported. It is well known that legislations by itself cannot normally solve deep-rooted social problems. Nonetheless, legislation is necessary to exercise educative impact besides providing legal sanctions against this social evil of devastating consequences. Therefore, female foeticide is intrinsically linked to the dowry system. To eliminate female foeticide, it is essential to end the ritual of dowry.

2.7.3 Pregnancy and Contraceptive Use

The incidence of teenage pregnancies was 55 per cent in the lower income groups, 23 per cent in the middle income groups and only a minimal of 1.13 per cent in the case of higher income groups (MOHFW and TINNARI, 2002). [7] Knowledge of contraception was almost universal. About 43 per cent males used condoms and about 23 per cent women and 3 per cent men had undergone sterilization. (MOHFW and TINNARI, 2002).[7]

2.7.4 Celebrations on the Arrival of a Baby

The percentage of families (17 %) holding special celebration on the birth of a male child was more than on the birth of a female child (2%). Approximately one-fifth of the families had no celebration on the birth of the girl child. (Anandalakshmy, 1994) [1].

Srivastava, Dasgupta and Rai (2005)[17] found that the majority (86%) celebrated the birth of a child and a few (14%) said that they did not have enough money for celebrations. A negligible (3%) percentage said they welcomed girls by celebrating their birth, as against 20 per cent who welcomed the arrival of a boy while the remaining 77 per cent welcomed birth of the baby irrespective of its sex.

MOHFW and TINNARI, (2002)[7] found that the birth of a son was celebrated by performing all rituals (67%), distribution of sweets to friends and relatives (82%) and only very few (11%) reported 'no celebrations' for a male birth. Other ceremonies like feasting, singing, '*thali bajana'* (banging of plates), *jagarata*, special *pujas* and rituals *(Kuan Pujan, Chatti Chola* ceremony) and distribution of money and gifts were performed only at the birth of a male child. Gender discrimination was seen across all income groups. The birth of a girl was celebrated by rites and rituals (18%) and distribution of sweets (42%), but a sizeable percentage (43%) reported 'no celebrations' at the birth of a girl child (MOHFW and TINNARI,

2002). Nayar (1995)[12] found that in both Punjab and Haryana the announcement of the arrival of boy is done by banging a *thali* and for girls an earthen pot is broken by throwing it to the ground. Rites are performed on the births of both boys and girls but it was reportedly less for girls.

2.7.5 Reactions on the Birth of a Girl Child

Srivastava, Dasgupta and Rai (2005)[17] found that women welcome a girl child irrespective of their family type. But when it comes to welcoming a girl child by the entire family, the attitude of the women is greatly influenced by the attitude of the male members in the family.

2.7.6 Differential Treatment Given to Mothers of Daughters

Only 27 per cent of women in the lower income groups, 19 per cent in the middle income groups and a mere 7 per cent from the higher income groups reported differential treatment in terms of importance and gifts, etc. given to the mother when she give birth to a girl Anandalakshmy (1994).[1]

2.7.7 Restrictions Imposed on the Girl Child

Anandalakshmy (1994)[1] found that girls were scolded more often than boys. They were more likely not to receive any awards for good behaviour than boys. The study also found that the mother who had reached the secondary level of education were 10 per cent less strict than the fathers at the corresponding level of education. In general, she found that the less educated the mother; the more likely she is to restrict her daughter's movements.

2.8 Views on Various Issues

Nayar (1995) [12] found that respondents were not particularly in favour of giving equal freedom to boys and girls. They were also not in favour of giving an equal share of ancestral property. MOHFW and TINNARI (2002)[7] found that equal education, equal food and health care for boys and girls are favoured by most respondents; equal time for play and equal freedom to a limited extent. There was a growing acceptance that both sexes had equal intelligence and abilities, and that given a chance, both girls and boys can perform well. That both can enter the same occupations was somewhat less acceptable in some groups. While equal wages for equal work finds favour with most respondents, shared household roles, joint decision-making and joint holding of property and assets have relatively lower acceptance. Equal property rights find acceptance by the majority.

3

METHODOLOGY

METHODOLOGY

3.1 Rationale of the Study

According to the 2001 Census there were 49 districts in the country, where for every 1000 male children aged 0-6 years there were less than 850 female children. The majority, or 38 of these districts, were located in just three northern and western states – Punjab, Haryana, and Gujarat (Census of India, 2001). The juvenile sex ratio declined by 9 per cent in Haryana (from 902 in 1981 to 820 in 2001) and by nearly 13 per cent in Punjab (from 908 to 793 between 1981 and 2001). Himachal Pradesh and Gujarat states also experienced a decline in the juvenile sex ratio in the order of 7.5 per cent that is higher than the national average of around 4.5 per cent. Thus, an almost contiguous belt extending from the northwest to parts of Rajasthan and Gujarat has experienced a drastic decline in the juvenile sex ratio in recent decades. The decline of 60 to 83 points in the juvenile sex ratio between 1991 and 2001 or in a span of just one decade in many of these districts cannot be explained solely on the basis of discrimination against girls that has been practised in this region for several decades, because at no other time in the history of census taking has the sex ratio of children declined so drastically (UNFPA, 2003). [20]

It is important to understand why and how the juvenile sex ratio has declined in India. Other things being equal, the juvenile sex ratio, like the sex ratio at birth, does not undergo drastic changes over short periods of time. Women in India have experienced in the past, and continue to experience, higher mortality than men from late infancy to almost the end of their reproductive period. In recent years, there is enough evidence from the data collected by the Sample Registration System annually to show that in India the female child mortality, although higher than the male child mortality, has declined at a more rapid rate than the male child mortality. This welcome change should have made the juvenile sex ratio more favourable to girls compared to the past, although it cannot wipe out the overall deficit, which is a cumulative process of neglect of women over several decades.

However, in the contiguous region from the north to the west of the country, where historically the neglect of and discriminatory behaviour against girls leading to excess female mortality was prevalent. The deficit of girls increased (not decreased) between 1981 and 2001.

This anomalous situation alarmed many scholars and policymakers. The fact that in spite of some improvements in the survival chances of young girls in recent

decades, the deficit of girls in the population had increased has raised several questions, which need to be explored and understood. Have the socio-cultural factors that traditionally undervalue daughters compared to sons not altered? In spite of the evidence of a decline in the desired number of children in recent years, does son preference continue to persist in India? Are the traditional methods of neglect of female children leading to higher female child mortality being increasingly supplemented by additional measures that do not allow female children to be born?

To fully understand the dynamics of female foeticide, it is important to examine the available recent data on sex ratio at birth. It is important to understand why, when and which of the female children are not allowed to be born, and what means are used to avoid having daughters. Female foeticide is being perpetuated increasingly due to the existing attitude of the community, in general, as also the poor implementation of the PNDT Act. The factors contributing to it are many and complex, and require urgent redressal using multi-pronged strategies.

The distorted sex ratio in society is increasing sexual and social crimes against women, such as rape, abduction, bride-selling, forced polyandry, etc. There will be rise in prostitution, sexual exploitation and cases of STD and HIV/AIDS. Marked growth in crimes against women, physiological and psychological disorders among them; a decline in their health status due to repeated pregnancies; and forced abortions will also emerge slowly.

3.2 Implications of the Study

The Integrated Child Development Services (ICDS) Scheme, a flagship programme of the Ministry of Women and Child Development (MWCD), launched in 1975 is one of the world's most unique community-based reach programmes for catering to the nutritional, health and developmental needs of children, adolescents and women in India. With the expansion and universalization of ICDS on the anvil, it is one of the prime programmes to make a dent on the situation of the girl child in the country.

The *anganwadi* worker (AWW) is at the grassroots level and collects gender-based information of children in the 0-6 years age group and the sex ratio of young children, their nutritional status, mortality and school enrolment of eligible children. They continuously track women and young children through home contacts. Hence the services at the *anganwadi* centre offer a unique opportunity to address the problem of missing girls and gender inequalities/discrimination. Data on child sex ratio available with *anganwadis* and which is updated continuously provides valuable information for action by the convergence of services of all sectors under one roof. The village panchayats, elected women *panches* and organized women's groups in villages and urban slum wards could be made to take serious

view of the unfavourable child sex ratios in their settings to think, plan and act locally and share this with their communities. Such collective action plans could be evolved to save the girl child; to provide her adequate nutrition at home; and balanced development in the village environment through appropriate household actions and health programme interventions. All the stakeholders who are interested in child development could support the functions of village panchayats and *anganwadi* workers. Since the ICDS programme is near universal, it has the inherent strength to ensure wider coverage.

With the above in view, the Institute undertook a study to ascertain the socio-cultural factors contributing to the declining sex ratio in Delhi and Haryana with the objectives described below.

3.3 Objectives

The objectives of the study were to:

i. Assess the various socio-cultural, economic, demographic, cultural and other factors contributing to the declining sex ratio;
ii. Conduct a situational analysis of services available for abortion in the study area;
iii. Study the perception of stakeholders about the status of the girl child, gender discrimination, girl/women empowerment, adverse child sex ratio, sex determination and female foeticide (pre-birth elimination of females); and
iv. Identify strategies and suggest different measures to curb the menace of the declining sex ratio and thereby impact on the adverse child sex ratio.

3.4 Research Advisory Committee

A Research Advisory Committee comprising experts in the fields of community health, research methodology and statistics was constituted for the study. The Committee offered its suggestions on the design and methodology of the study and the development of tools for data collection. The list of Research Advisory Committee Members is at **Annexure I.**

3.5 Methodology

The study was conducted in Delhi and Haryana. The data for the study was collected through multi-stage stratified random sampling method. The perceptions of different stakeholders – women (15-45 years), men, mothers-in-law/elderly women, opinion leaders, *dais* (traditional birth attendants) and health care providers of the ICDS and health systems were ascertained. The data was substantiated with an analysis of policy instruments, programmes, legal provisions, enforcement machinery, media inputs, etc. on the issue, using secondary source data. Care was taken to maintain confidentiality at all costs.

Sample Selection

The sample sizes for the study were as given below:

SAMPLE

STATES (N=2)	Delhi	Haryana
DISTRICTS (N=2)	South-West Delhi	Rohtak
BLOCKS N=4	-Nazafgarh -Palam	-Rohtak -Sampla
VILLAGES N=12	**Palam**	**Rohtak**
	Palamgaon (PHC village) Nagli (Sub-centre village) Harijan Basti (remote village)	Bhallot (PHC village) Bahuakbarpur (Sub-centre village) Gadimajra (remote village)
	Nazafgarh	**Sampla**
	Dichaokalan (PHC village) Chawla (Sub-centre village) Jharoda (remote village)	Kharawal (PHC village) Kherisadh (Sub-centre village) Karor (remote village)
RESPONDENTS		
WOMEN (N=300)	150	150
MEN (N=300)	150	150
MOTHERS-IN-LAW (N=300)	150	150
DAIS (N=13)	8	5
WOMEN OPINION LEADERS (N=219)	107 (6 Focus Group Discussions of 15-20 Women Opinion Leaders)	112 (6 Focus Group Discussions of 15-20 Women Opinion Leaders
ICDS FUNCTIONARIES (N=63)		
CDPO-3	CDPO-1	CDPO-2
SUP- 11	SUP-6	SUP-5
AWW-49	AWW-23	AWW-26
HEALTH FUNCTIONARIES (N=31)		
MO-6	MO-4	MO-2
LHV-10	LHV-6	LHV-4
ANM-15	ANM-6	ANM-9

SAMPLE SELECTION

Tools for the Study

The following research tools were used for the study.

Sch. No.	Category	Scale/Tool	Parameter
1	• **Women (15-45 years)** • **Men** • **Mothers-in-law** • **TBA/*Dai***	Interview Schedule	- Profile of the respondent - Educational, occupational and marital status - Parity, birth spacing and foetal outcome - Foetal outcome with special emphasis on still birth and abortions (time and place) by birth order - Status of maternal health care - Status of health and nutrition of children (gender disaggregated by birth order) - Ideal vs. desired family composition - Fertility regulation - Decision making in relation to health of women and children - Perception about dowry, son preference, gender discrimination, declining sex ratio, MTP Act, PNDT Act – provisions thereof, etc.
	• **Opinion Leaders/SHG Members/PRI Members**	Focus Group Discussions	Discussion points - Ideal vs. desired family composition - Perception about dowry, son preference, gender discrimination, declining sex ratio, abortion-related practices; MTP Act, PNDT Act – provisions thereof, etc.

2	• **Health Functionaries** (MO, LHV, and ANM)	Interview Schedule	- Profile of the respondent - Educational, occupational and marital status - Status of maternal health care - Ideal vs. desired family composition - Status of health and nutrition of children (gender disaggregated) - Perception about dowry - Son preference - Gender discrimination - Declining sex ratio - Abortion-related practices MTP Act, PNDT Act – provisions thereof, etc.
	• **ICDS Functionaries** (CDPO, Supervisor, AWW)	Interview Schedule	- Profile of the respondent - Educational, occupational and marital status - Status of maternal health care - Ideal vs. desired family composition - Status of health and nutrition of children (gender disaggregated) - Perception about dowry - Son preference - Gender discrimination - Declining sex ratio - Abortion-related practices - MTP Act, PNDT Act – provisions thereof, etc.

3.6 Field Testing

The tools used in the study were field-tested before the study was undertaken. Orientation training of the investigators was carried out about the methodology of interacting with the community in the context of child and maternal health, abortion, sex ratio, PNDT Act, the research tools, etc.

3.7 Manpower Planning

A research team was deployed for data collection in the two identified sample states. It comprised of faculty members from NIPCCD and two project staff appointed for data collection.

The data was collected after a brief training of the investigators, which aimed at making them understand:

- The situation of women and children – India/state with special reference to Haryana and Delhi;
- The declining sex ratio and its medical and sociological implications;
- Basic knowledge pertaining to the MTP Act, PNDT Act, declining sex ratio, etc.
- Interacting with the community in the context of status of women; dowry, son preference, gender discrimination, declining sex ratio, the MTP Act, PNDT Act – provision thereof, etc.
- An introduction to the Integrated Child Development Services and RCH programme;
- Tools of communication;
- Establishing rapport; and
- Methods of eliciting information pertaining to sensitive areas such as foetal outcome, abortions, fertility behaviour and regulation, PNDT Act, etc.

4

RESULTS AND DISCUSSION

RESULTS AND DISCUSSION

The findings of the study have been presented under the following heads:

4.1 Profile of the Respondents
4.2 Socio-Cultural, Economic and Demographic Factors Relating to Adverse Sex Ratio
4.3 Knowledge and Awareness about Pregnancy and Childbirth and Childcare Practices
4.4 Abortion and Abortion Related Issues
4.5 Status of the Girl Child and Women Empowerment
4.6 Findings from Focus Group Discussions

4. 1 Profile of the Respondents

4.1.1 State-Wise Distribution of Respondents

In all, the sample comprised 300 women, 300 men, 300 mothers-in-law, 13 *dais*, 107 women opinion leaders, and 94 ICDS and health functionaries. The state-wise distribution of respondents is presented in **Table 1.**

4.1.2 Age-wise Distribution of Respondents

The age-wise distribution of respondents is depicted in **Table 2.** Most of the women were in the 20-25 year age group and men in the 30-34 year age group. The majority of mothers-in-law were in the 50-years-and-above category and the *dais* in the 45-49 year age group.

Regarding the ICDS functionaries, the majority of the CDPOs were in the 45-49 year age group, while the supervisors and AWWs were in the 40-44 year age group. Most of the ANMs were in the 30-34 year age group.

Table 1 : Category-Wise Distribution of Respondents

State	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women	Men	Mothers in-Law	*Dais*	CDPOs	Supervisors	AWWs	MOs	LHVs	ANMs
Delhi	150	150	150	8	1	6	23	4	6	6
Haryana	150	150	150	5	2	5	26	2	4	9
GRAND TOTAL	300	300	300	13	3	11	49	6	10	15
					ICDS Functionaries n=63 (67%)			**Health Functionaries n=31 (33%)**		

Table 2 : Age-Wise Distribution of Respondents

Age-group	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	*Dais* n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
15-19 years	5 (1.7)	-	-	-	-	-	-	-	-	1 (6.7)
20-24 years	89 (29.7)	31 (10.3)	-	-	-	-	1 (2.0)	3 (50.0)	1 (10.0)	-
25-29 years	93 (31.0)	85 (28.3)	-	-	-	-	1 (2.0)	-	-	3 (20.0)
30-34 years	47 (15.7)	87 (29.0)	1 (0.3)	3 (23.1)	-	-	9 (18.3)	-	1 (10.0)	6 (40.0)
35-39 years	31 (10.2)	49 (16.3)	1 (0.3)	1 (7.7)	-	3 (27.3)	14 (28.7)	1 (16.7)	3 (30.0)	4 (26.6)
40- 44 years	24 (8.0)	25 (8.4)	13 (4.3)	3 (23.1)	-	8 (72.7)	24 (49.0)	2 (33.3)	5 (50.0)	1 (6.7)
45 -49 years	11 (3.7)	23 (7.7)	38 (12.7)	6 (46.1)	3 (100.0)	-	-	-	-	-
50 years and above	-	-	247 (82.4)	-	-	-	-	-	-	-

4.1.3 Educational Status of Respondents

It was heartening to note that the educational status of women of the present generation was better then that of their mothers-in law, where 77 per cent were illiterate and the percentage of mothers-in-law who had passed schooling up to the primary, middle, Class X, and Class XII were 13.3 per cent, 4.4 per cent, 3.7 per cent, and 1.7 per cent respectively.

The distribution of illiterates, those who had passed the primary level, middle level, Class X, Class XII of schooling, and who were graduates and postgraduates among the women was 22.0 per cent, 14.7 per cent, 22.3 per cent, 22.3 per cent, 12.0 per cent, 6.0 per cent, and 0.7 per cent, respectively. Most of the *dais* were illiterate (**Table 3**).

Table 3 : Distribution of Respondents by Educational Status

Educational Status	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	Dais n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Illiterate	66 (22.0)	24 (8.0)	231 (77.0)	10 (76.9)	-	-	-	-	-	-
Schooling - primary	44 (14.7)	25 (8.3)	40 (13.3)	1 (7.7)	-	-	-	-	-	-
Schooling - middle	67 (22.3)	57 (19.0)	13 (4.3)	1 (7.7)	-	-	1 (2.0)	-	-	-
Schooling - Class X	67 (22.3)	61 (20.3)	11 (3.7)	-	-	1 (9.1)	28 (57.1)	-	5 (50.0)	6 (40.0)
Intermediate) (Class XII	36 (12.0)	75 (25.0)	5 (1.7)	1 (7.7)	-	1 (9.1)	17 (34.8)	-	4 (40.0)	5 (33.3)
Graduate	18 (6.0)	46 (15.4)	-	-	-	6 (54.5)	3 (6.1)	3 (50.0)	-	4 (26.7)
Postgraduate	2 (0.7)	12 (4.0)	-	-	3 (100.0)	3 (27.3)	-	3 (50.0)	1 (10.0)	-

4.1.4Occupational Status of Respondents

Figs. 1, 2, and 3, gives the occupational status of respondents, namely women, men and mothers-in-law. It is surprising to note that the percentage of unemployed women/ housewives (86.0%) were greater than the mothers-in-law (77.1%).

Fig.1 Distribution of Respondents by Occupational Status - Women

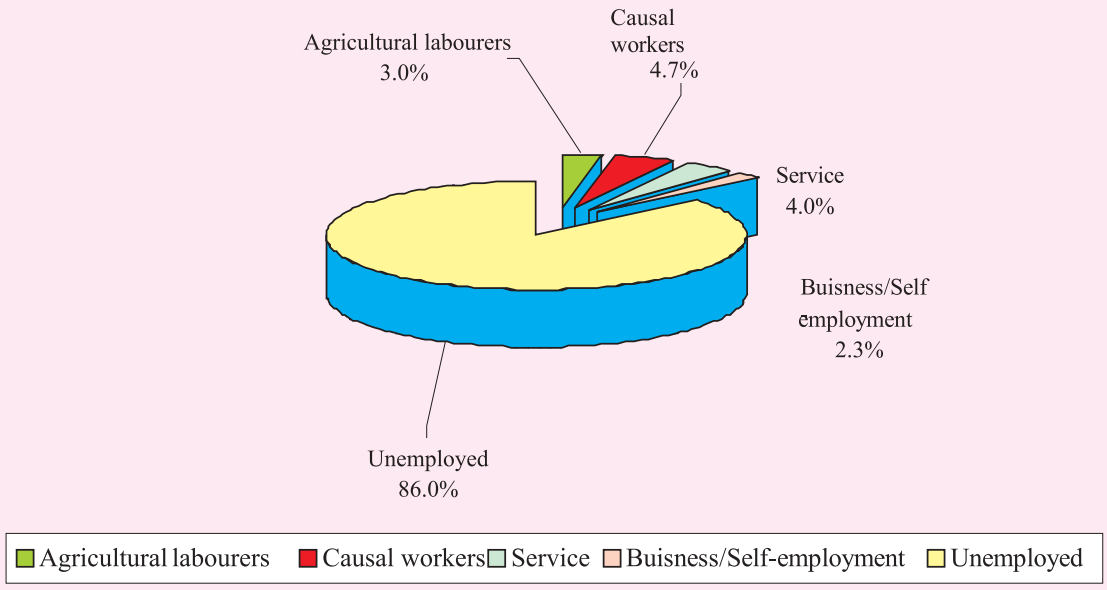


Fig.2 Distribution of Respondents by Occupational Status - Men

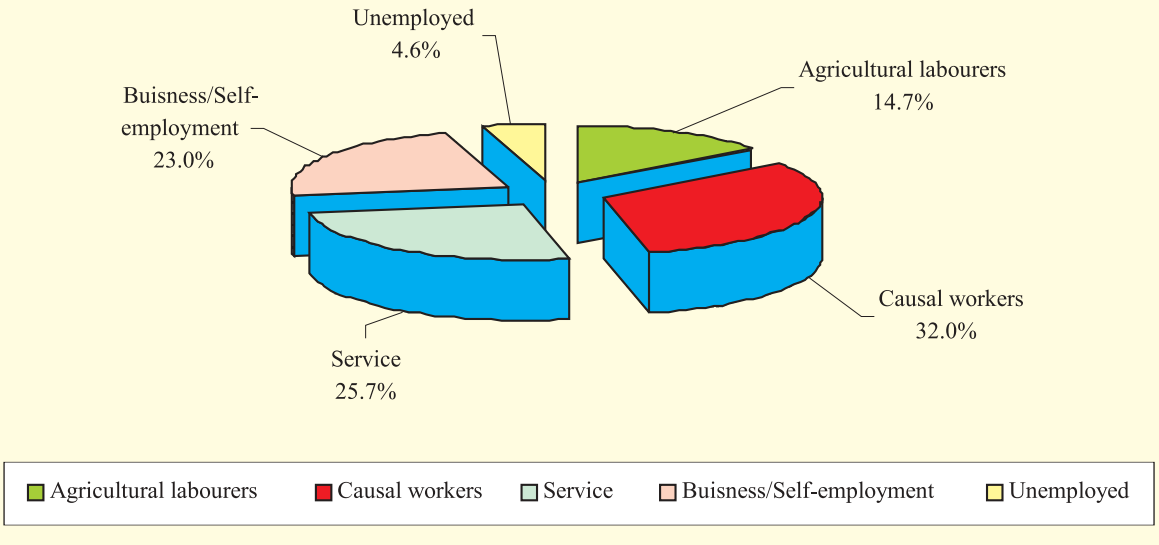
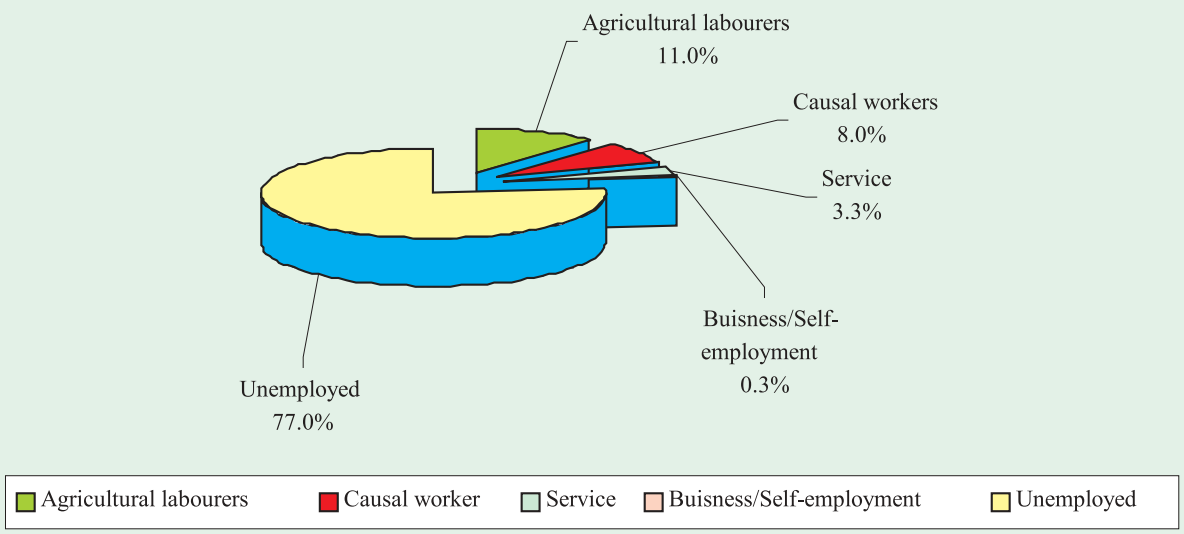


Fig.3 Distribution of Respondents by Occupational – Status Mothers-in-Law



4.1.5 Living Conditions

The study revealed that most of the respondents, viz. men (75.7%), women (90.3%) and mothers-in-law (95.7%) were staying in their own houses (**Table 4**).

4.1.6 Monthly Income of the Family

Table 4 also presents the monthly income of the family. The majority of women (41.7%) and men (54.0%) were in the monthly income bracket of Rs 2001-Rs 5000. Most of the mothers-in law (45.7%) reported that they drew a family income of less then Rs 2000 per month.

4.1.7 Details of Assets

About 37.0 per cent, 66.0 per cent, and 39.3 per cent of women, men and mothers-in-law respectively, owned some land **(Table 4).** About 69.7 per cent of women, 67.7 per cent of men and 73.3 per cent of mothers-in-law reported the possession of a television. About 66.7 per cent of men had a radio, compared to 39.3 per cent women and 48.3 per cent mothers-in-law **(Table 4).**

Table 4 : Distribution of Respondents by Details of Assets

Living Conditions	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)
Type of House			
Own	271 (90.3)	227 (75.7)	287 (95.7)
Rented	29 (9.7)	73 (24.3)	13 (4.3)
Monthly Income of the Family			
< Rs. 2000	105 (35.0)	35 (11.7)	137 (45.7)
Rs. 2001- Rs. 5000	125 (41.7)	162 (54.0)	104 (34.7)
Rs. 5001- Rs. 10,000	49 (16.3)	82 (27.3)	45 (15.0)
> Rs. 10.000	21 (7.0)	21 (7.0)	14 (4.6)
Details of Assets			
Land	111 (37.0)	198 (66.0)	118 (39.3)
Television	209 (69.7)	203 (67.7)	220 (73.3)
Radio	118 (39.3)	200 (66.7)	145 (48.3)
Two-wheeler	123 (41.0)	174 (58.0)	135 (45.0)
Three-wheeler	9 (3.0)	5 (1.7)	4 (1.3)
Four-wheeler	23 (7.7)	56 (18.7)	25 (8.3)
Livestock	25 (8.3)	6 (2.0)	50 (16.7)

4.1.8 Training Status of Dais

Figs. 4 and 5 give the training status of *dais*. Around 76.9 per cent of *dais* among the respondents were trained. On an average 76.9 per cent get to conduct 1-5 deliveries per month and 15.4 per cent reported getting an opportunity to conduct 6-10 deliveries in a month.

Fig.4 Training Status of *Dais*

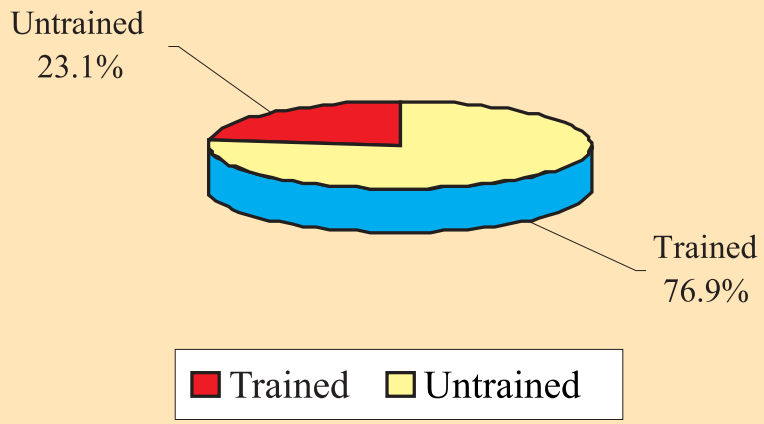
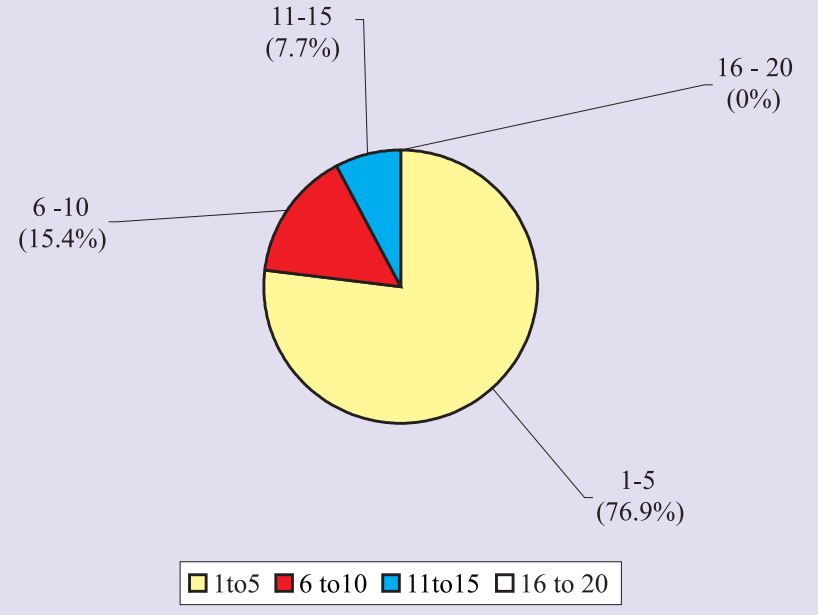


Fig.5 Average Number of Deliveries Performed in a Month by a *Dai*



- The educational status of women of the present generation was better than the women of yesteryears.
- Roughly one-fifth of women were illiterate.
- Surprisingly, a greater number of young women were unemployed compared to the women in the mothers-in-law category.
- A sizeable proportion of the respondents, vis-a-vis women, men and mothers-in-law owned some land.
- Most (76.9%) of the *dais* in the sample were trained.
- On an average three-fourths of the *dais* get to conduct 1-5 deliveries per month and one-fourth reported getting an opportunity to conduct 6-10 deliveries in a month.

4.2 Socio-Cultural, Economic and Demographic Factors Relating To Adverse Sex Ratio

4.2.1 Awareness about Declining Sex Ratio

It is also heartening to note that awareness about the missing girls in the country is near universal among the health and ICDS functionaries of the present study. Most of the respondents comprising women of Delhi (92.0%) and Haryana (78.7%); men of Delhi (89.3%) and Haryana (100.0%); and mothers-in-law of Delhi (80.7%) and Haryana (99.3%) were aware of the phenomena of the declining sex ratio throughout the country (**Tables 5, 6, and 7 and Figs. 6 and 7**).

4.2.2 Repercussions of Missing Girls

The various problems foreseen owing to increased female foeticide include non-availability of brides, rise in sexual violence against women, lack of female workforce and polyandry (Ghose, Goel and Balda, 2005).[4] The various repercussions of declining sex ratio as perceived by women, men, mothers-in-law and *dais* of the present study are presented in this section.

Most women perceived non-availability of brides (92.3%) as the major repercussion of missing girls followed by an increased rate of crime against women (67.0%) and polyandry (20.0%) (**Table 5**). However, there is a striking difference in the perception of women in Delhi and Haryana. The percentage of women who foresee increased crimes against women, especially sexual violence, was higher among the women in Haryana (80.7%) than in Delhi (52.3%). Similarly, more women in Haryana (94.0%) than in Delhi (90.7%) anticipate the situation leading to non-availability of brides. Polyandry was perceived by the women of Delhi (37.3%) more than the women of Haryana (2.7%).

Table 5 : Awareness of the Respondents about the Declining Sex Ratio

Awareness about Declining Sex Ratio	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	Dais n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about Missing Girls	286 (95.3)	284 (94.7)	270 (99.0)	9 (69.2)	3 (100.0)	11 (100.0)	49 (100.0)	6 (100.0)	10 (100.0)	15 (100.0)
Repercussions of Missing Girls										
Polyandry	60 (20.0)	182 (60.7)	82 (27.3)	4 (30.8)	1 (33.3)	4 (36.4)	19 (38.8)	4 (66.7)	4 (40.0)	9 (60.0)
Increased rate of crimes against women, especially sexual violence	201 (67.0)	236 (78.7)	165 (55.0)	6 (46.2)	3 (100.0)	10 (91.0)	37 (75.5)	4 (66.7)	6 (60.0)	12 (80.0)
Non-availability of brides	277 (92.3)	283 (94.3)	254 (84.7)	9 (69.2)	2 (66.7)	11 (100.0)	44 (89.8)	5 (83.3)	9 (90.0)	14 (93.3)
Lack of female workforce	3 (1.0)	142 (47.3)	111 (37.0)	5 (1.7)	-	6 (1.7)	19 (6.3)	2 (0.6)	5 (1.6)	10 (3.3)

Table 6 : Awareness of the Respondents about the Declining Sex Ratio - Delhi

Awareness about Declining Sex Ratio	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=150 No. (%)	Men n=150 No. (%)	Mothers in-Law n=150 No. (%)	Dais n=8 No. (%)	CDPOs n=1 No. (%)	Supervisors n=6 No. (%)	AWWs n=23 No. (%)	MOs n=4 No. (%)	LHVs n=6 No. (%)	ANMs n=6 No. (%)
Awareness about Missing Girls	138 (92.0)	134 (89.3)	121 (80.7)	4 (50.0)	1 (100.0)	6 (100.0)	23 (100.0)	4 (100.0)	6 (100.0)	6 (100.0)
Repercussions of Missing Girls										
Polyandry	56 (37.3)	43 (28.7)	50 (33.3)	3 (37.5)	1 (100.0)	3 (50.0)	13 (56.5)	2 (50.0)	2 (33.3)	3 (50.0)
Increased rate of crimes against women	80 (52.3)	86 (57.3)	66 (44.0)	1 (12.5)	1 (100.0)	5 (83.3)	12 (52.2)	2 (50.0)	3 (50.0)	4 (66.7)
Non-availability of brides	136 (90.7)	131 (87.3)	36 (24.0)	4 (50.0)	1 (100.0)	6 (100.0)	20 (87.0)	3 (75.0)	5 (83.3)	6 (100.0)
Lack of female workforce	2 (1.3)	139 (92.7)	110 (73.3)	4 (50.0)	-	2 (33.3)	7 (30.4)	1 (25.0)	3 (50.0)	2 (33.3)

Table 7 : Awareness of the Respondents about the Declining Sex Ratio-Haryana

Awareness about Declining Sex Ratio	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=150 No. (%)	Men n=150 No. (%)	Mothers in-Law n=150 No. (%)	Dais n=5 No. (%)	CDPOs n=2 No. (%)	Supervisors n=5 No. (%)	AWWs n=26 No. (%)	MOs n=2 No. (%)	LHVs n=4 No. (%)	ANMs n=9 No. (%)
Awareness about Missing Girls	148 (78.7)	150 (100.0)	149 (99.3)	5 (100.0)	2 (100.0)	5 (100.0)	26 (100.0)	2 (100.0)	4 (100.0)	9 (100.0)
Repercussions of Missing Girls										
Polyandry	4 (2.7)	139 (92.7)	32 (21.3)	1 (20.0)	-	1 (20.0)	6 (23.1)	2 (100.0)	2 (50.0)	6 (66.7)
Increased rate of crimes against women	121 (80.7)	150 (100.0)	2 (1.3)	5 (100.0)	2 (100.0)	5 (100.0)	25 (96.2)	2 (100.0)	3 (75.0)	8 (88.9)
Non-availability of brides	141 (94.0)	149 (99.3)	1 (0.7)	5 (100.0)	1 (50.0)	5 (100.0)	24 (92.3)	2 (100.0)	4 (100.0)	8 (88.9)
Lack of female workforce	1 (0.7)	3 (2.0)	1 (0.7)	5 (100.0)	-	4 (80.0)	12 (46.2)	1 (50.0)	2 (50.0)	8 (88.9)

Fig.6 Awareness about the Declining Sex Ratio as Perceived by the Beneficiaries

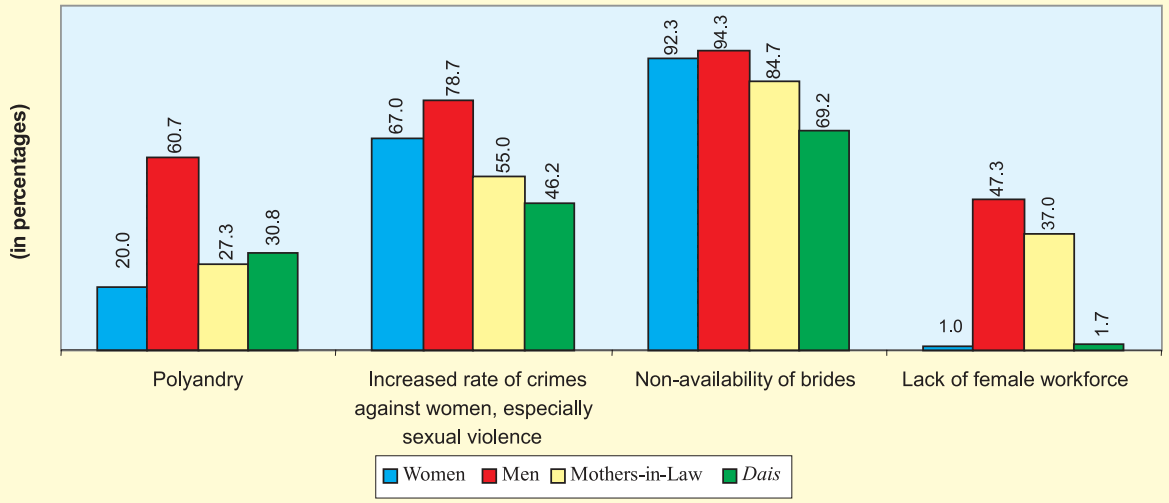
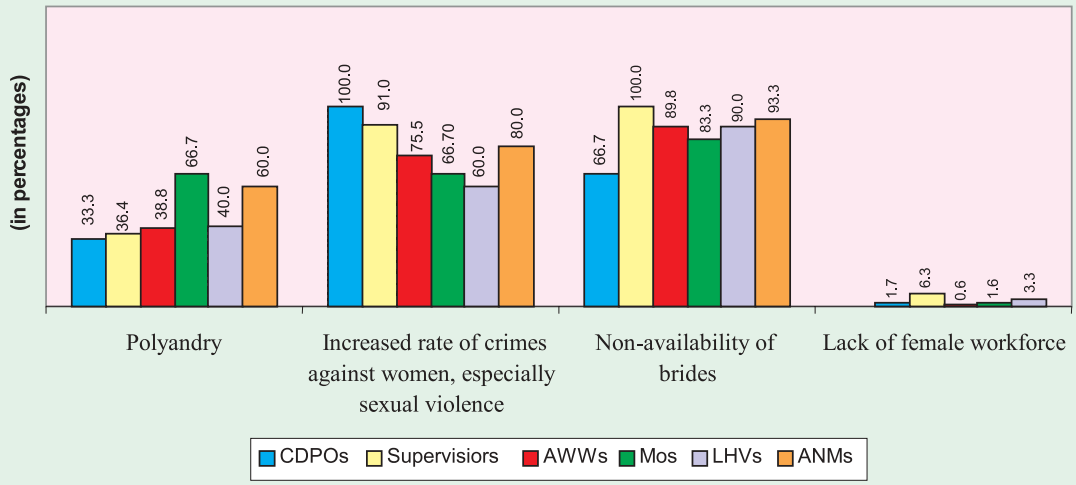


Fig.7 Awareness about the Declining Sex Ratio as Perceived by the Functionaries



The men of Haryana have been more articulate about polyandry (92.7%), increased crimes against women (100%) and non-availability of brides (99.3%), in fact, more than the men of Delhi. Similarly, the mothers-in-law of Delhi can foresee the problem of the lack of female workforce (73.3%) and an increased rate of crimes against women (44.0%) as compared to their counterparts in Haryana.

A significant finding of the study is the response of the *dais* of Haryana who claim that the crime rate against women would increase drastically (100%), there would be no brides available (100%) and there would also be no females in the workforce, if such a situation continues in the state (**Table 7**)

4.2.3 Functionaries

4.2.3.1 ICDS Functionaries

Both the CDPOs of Delhi and Haryana unanimously endorse that this trend of the declining sex ratio will lead to an increased rate of crimes against women [Delhi (100%) and Haryana (100%)] and non-availability of brides [Delhi (100%) and Haryana (50%)]. Polyandry has been perceived by the CDPOs of Delhi (100%) but not by those of Haryana, pointing towards a culture of silence imposed on the self and opting for more socially acceptable responses.

The various repercussions of the declining sex ratio as perceived by Supervisors are an increased rate of crimes against women [Delhi (83.3%) and Haryana (100%)]; non-availability of brides [Delhi (100%) and Haryana (100%)]; polyandry [Delhi (50%) and Haryana (20.0%); and lack of a female workforce [Delhi (33.3%) and Haryana (80.0%)].

The AWWs of Delhi and Haryana also perceive polyandry (56.5% and 23.1%); an increased rate of crimes against women (52.2% and 96.2%); non-availability of brides (87.0% and 92.3%) and lack of a female workforce (30.4% and 46.2%) as major repercussions of the declining sex ratio in the country **(Table 6 and 7 and Fig. 6 and 7**).

4.2.3.2 Health Functionaries

Medical officers of Haryana have stated emphatically stated that polyandry (100%), an increased rate of crimes against women (100%), non-availability of brides (100%) and lack of a female workforce (50%) are serious repercussions of the declining sex ratio in Haryana and in India (**Table 7**). The response of most of the LHVs and ANMs of both Delhi and Haryana had greater intensity on the non-availability of brides than on an increased rate of crimes against women (**Table 6 and 7**).

4.2.3.3 Reasons for Son Preference

Reasons for son preference were that they carry on the family name and inherit property; they are providers in old age and perform the last rites (MOHFW and TINNARI, 2002).[7] The reason for wanting a son is to attain *moksha* (Prasad, 2001; and Nayar, 1995);[15, 12] power, prestige, to perform the last rites and continuing the family lineage (Yadav and Badri, 1997).[23]

The reasons for son preference from all respondents and separately for Delhi and Haryana as elicited from this study are given in **Table 8, 9, and 10** respectively. The various reasons mentioned by women include that: 'he is a support and provider in old age' [Delhi (90.7%) and Haryana (98.0%)]; 'brings in dowry instead of draining family resources' [Delhi (75.3%) and Haryana (82.7%)]; 'continues the family name' [Delhi (36.7%) and Haryana (45.3%)]; 'to perform the last rites' [Delhi (48.7%) and Haryana (16.0%)]; and 'with investments on sons, say on education or business, the wealth remains in the family' [Delhi (40.0%) and Haryana (36.7%)].

The major reasons for son preference as perceived by men include 'continuing the family name' (89.7%); 'support and provider in old age' (87.7%); 'the wealth remains in the family' (60.0%); 'to perform the last rites' (54.3%); and 'brings in dowry and adds on to the family resources' (16.6%). These findings reveal a deep-seated mindset of son preference for perpetuating the family name and performing the last rites. A similar mindset emerges from the responses of mothers-in-law as well, as though it is being passed down from mother to the son (**Tables 8 and Figs. 8 and 9).**

Most of the *dais* both in Delhi and Haryana perceive that son preference [Delhi (100%) and Haryana (100%)] is more so because 'he is a support and provider in old age' [Delhi (100%) and Haryana (100%)] and that 'he brings in dowry' [Delhi (75.0%) and Haryana (80%)] (**Tables 9 and 10).** Most (80%) of the *dais* of Haryana also believe that a son continues the family name and hence he is preferred to a daughter (**Table 10).**

Table 8 : Reasons for Son Preference

Reasons for Son Preference	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=150 No. (%)	*Dais* n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
He is a support and provider in old age	283 (94.3)	263 (87.7)	275 (91.7)	13 (100.0)	2 (66.7)	10 (91.0)	40 (81.6)	4 (66.6)	9 (90.0)	13 (86.7)
Carries on the family name	123 (41.0)	269 (89.7)	276 (92.0)	7 (53.8)	3 (100.0)	10 (91.0)	46 (93.9)	5 (83.3)	9 (90.0)	15 (100.0)
For performing the last rites	97 (23.3)	163 (54.3)	112 (37.3)	5 (38.5)	- -	3 (27.3)	12 (24.5)	2 (33.3)	3 (30.0)	10 (66.7)
Brings in dowry	237 (79.0)	48 (16.0)	111 (37.0)	10 (76.9)	1 (33.3)	6 (54.5)	25 (51.0)	3 (50.0)	6 (60.0)	6 (40.0)
Wealth remains in the family	115 (38.3)	180 (60.0)	111 (37.0)	6 (46.2)	2 (66.7)	6 (54.5)	20 (40.8)	4 (66.6)	6 (60.0)	8 (53.3)

Table 9 : Reasons for Son Preference - Delhi

Reasons for Son Preference	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=150 No. (%)	Men n=150 No. (%)	Mothers in-Law n=150 No. (%)	Dais n=8 No. (%)	CDPOs n=1 No. (%)	Supervisors n=6 No. (%)	AWWs n=23 No. (%)	MOs n=4 No. (%)	LHVs n=6 No. (%)	ANMs n=6 No. (%)
He is a support and provider in old age	136 (90.7)	113 (75.3)	128 (85.3)	8 (100.0)	1 (100.0)	5 (83.3)	19 (82.6)	3 (75.0)	6 (100.0)	6 (100.0)
Carries on the family name	55 (36.7)	126 (84.0)	128 (85.3)	3 (37.5)	1 (100.0)	5 (83.3)	20 (86.9)	3 (75.0)	5 (83.3)	6 (100.0)
For performing the last rites	73 (48.7)	18 (12.0)	26 (17.3)	3 (37.5)	- -	1 (16.7)	1 (4.3)	1 (25.0)	1 (16.7)	1 (16.7)
Brings in dowry	113 (75.3)	42 (28.0)	50 (33.3)	6 (75.0)	-	4 (66.7)	7 (30.4)	3 (75.0)	4 (66.7)	4 (66.7)
Wealth remains in the family	60 (40.0)	77 (51.3)	76 (50.7)	3 (37.5)	1 (100.0)	3 (50.0)	11 (47.8)	2 (50.0)	3 (50.0)	3 (50.0)

Table 10 : Reasons for Son Preference - Haryana

Reasons for Son Preference	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=150 No. (%)	Men n=150 No. (%)	Mothers in-Law n=150 No. (%)	Dais n=5 No. (%)	CDPOs n=2 No. (%)	Supervisors n=5 No. (%)	AWWs n=26 No. (%)	MOs n=2 No. (%)	LHVs n=4 No. (%)	ANMs n=9 No. (%)
He is a support and provider in old age	147 (98.0)	150 (100.0)	147 (98.0)	5 (100.0)	1 (50.0)	5 (100.0)	21 (80.8)	1 (50.0)	3 (75.0)	7 (77.8)
Carries on the family name	68 (45.3)	143 (95.3)	148 (98.7)	4 (80.0)	2 (100.0)	5 (100.0)	26 (100.0)	2 (100.0)	4 (100.0)	9 (100.0)
For performing the last rites	24 (16.0)	145 (96.7)	86 (57.3)	2 (40.0)	-	2 (40.0)	11 (42.3)	1 (50.0)	2 (50.0)	9 (100.0)
Brings in dowry	124 (82.7)	6 (4.0)	61 (40.7)	4 (80.0)	1 (50.0)	2 (40.0)	13 (50.0)	1 (50.0)	2 (50.0)	2 (22.2)
Wealth remains in the family	55 (36.7)	106 (68.7)	35 (23.3)	35 (60.0)	1 (50.0)	3 (60.0)	14 (53.8)	1 (50.0)	3 (75.0)	5 (55.6)

Fig.8 Reasons for Son Preference as Perceived by the Beneficiaries

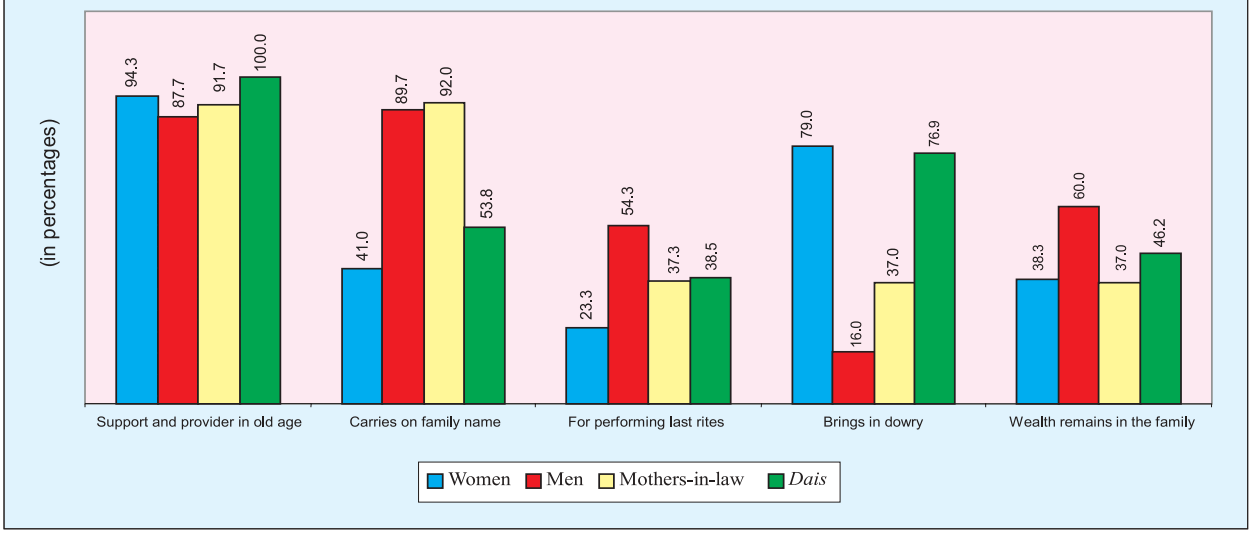
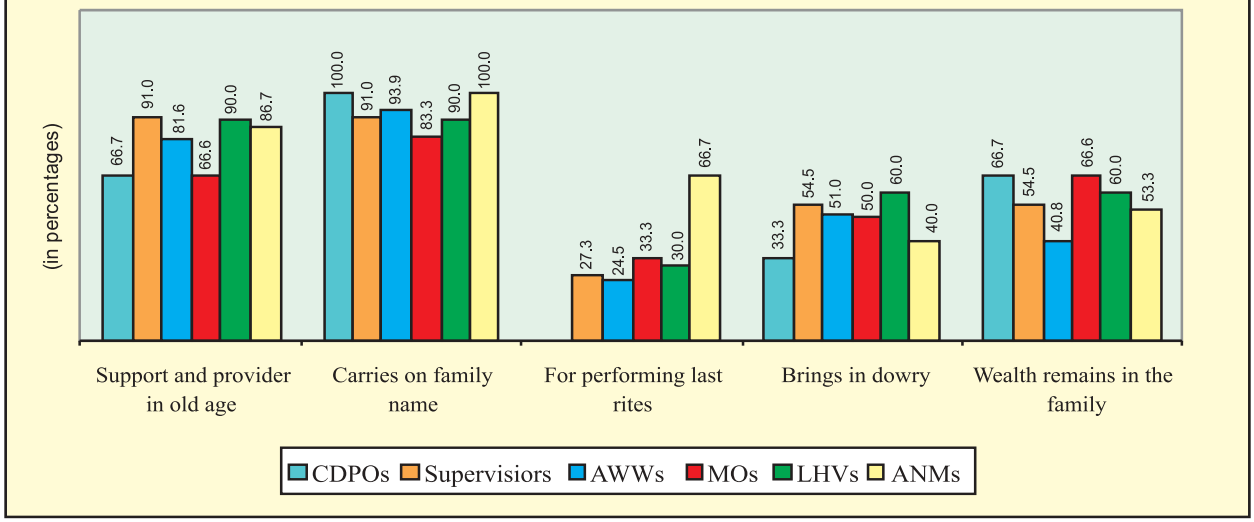


Fig.9 Reasons for Son Preference as Perceived by the Functionaries



4.2.3.4 ICDS Functionaries

All the CDPOs of Delhi perceive that a son is preferred because 'he is support and provider in old age' (100%); 'he perpetuates the family name' (100%); and 'that any investment made on him would remain within the family' (100%) **Table 9**. The responses of Supervisor and AWWs are dominated by the reason that 'he continues the family name' and 'he is support and provider in old age' **(Table 9 and 10).**

4.2.3.5 Health Functionaries

The reasons for son preference as perceived by the medical officers were that a son is seen as 'a provider of support in old age' [Delhi (75.0%) and Haryana

(50.0%)]; and 'carries on the family name' [Delhi (75.0%) and Haryana (100.0%)]. Reasons such as 'performing the last rites', 'bringing in dowry' and 'wealth remains in the family' were more evident in Haryana than in Delhi for all health functionaries **(Table 9 and 10).**

4.2.3.6 Reasons for Not Wanting Daughters

The various other reasons for not wanting daughters were, dowry, forbidding wedding expenses, long requirement of giving gifts and money to the daughter, lack of availability of girls to look after the parents after marriage; domestic violence and ill treatment by husbands and in-laws; ill treatment of women after she gives birth to a girl; and not wanting to go through the same fate as them (MOHFW and TINNARI, 2002; and Nayar, 1995).[7, 12]

The present study found that the main perceived reason for not wanting daughters is 'dowry' by women, men, *dais*, ICDS, and health functionaries across both states. The other reasons voiced by the ICDS and health functionaries include that 'investing in girls is seen as a waste, with no returns'. The same has been expressed by men (53.7%) and mothers-in-law (54.7%) louder than the women (43.3%). 'Lack of safety for girls' and 'fear of harm coming to the family honour' are also major reasons perceived by both the beneficiaries and functionaries **(Table 11 and Figs. 10 and 11).**

Table 11 : Reasons for Not Wanting Daughters

Reasons for Not Wanting Daughters	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=150 No. (%)	*Dais* n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Dowry	286 (95.3)	292 (97.3)	288 (96.0)	13 (100.0)	2 (66.7)	10 (90.9)	48 (98.0)	6 (100.0)	10 (100.0)	13 (86.7)
Investing in girls is a waste with no returns	130 (43.3)	161 (53.7)	164 (54.7)	6 (46.2)	2 (66.7)	8 (72.7)	37 (75.5)	3 (50.0)	8 (80.0)	11 (73.3)
Fear of harming family honour	167 (55.7)	183 (61.0)	115 (38.3)	9 (69.2)	2 (66.7)	4 (36.4)	21 (42.9)	2 (33.3)	2 (20.0)	11 (73.3)
Lack of safety	229 (76.3)	214 (71.3)	189 (63.0)	8 (61.5)	2 (66.7)	9 (81.8)	31 (63.3)	5 (83.3)	6 (60.0)	12 (80.0)

Fig.10 Reasons for Not Wanting Daughters as Percevied by the Beneficaries

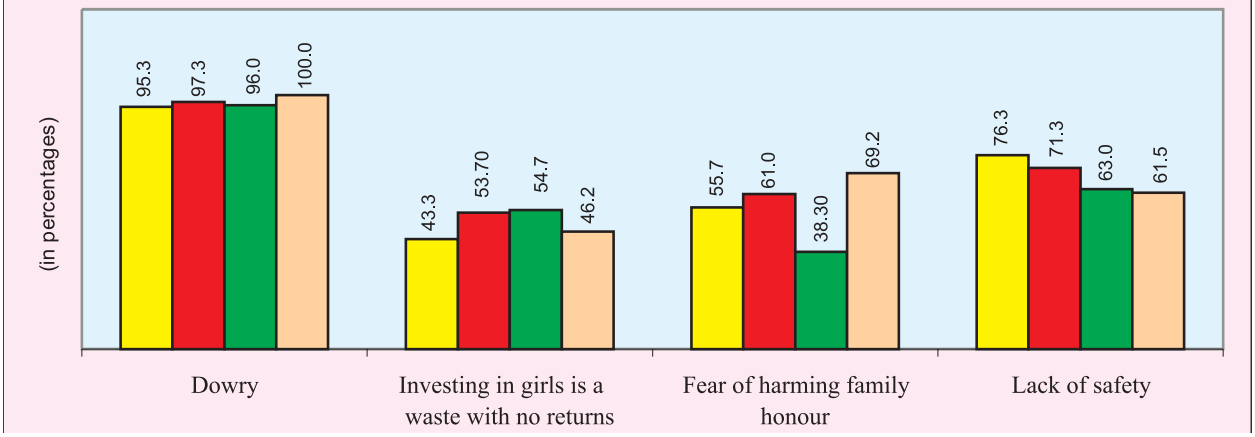
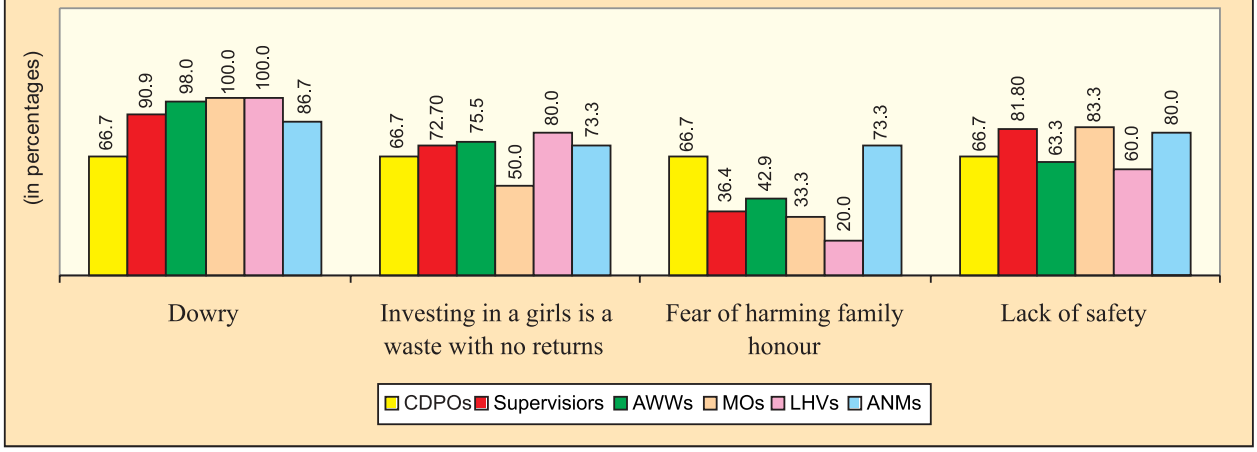


Fig.11 Reasons for Not Wanting Daughters as Percevied by the Functionaries



4.2.3.7 Factors Contributing to the Declining Sex Ratio

Female foeticide was cited as the main reason for the decline in sex ratio. The other reasons included neglect of the girl child resulting in higher female mortality, maternal death, dowry death, female infanticide and male migration. (Ghosh, Goel and Balda, 2005). [4]

The factors contributing to the declining sex ratio as perceived by the respondents of the study are presented in **Table 12 and Figs. 12 and 13.** The essential factors responsible were son preference and dowry. The interesting finding is that the mushrooming number of ultrasound clinics and the ability to pay for abortions was articulated by all the women, men, mothers-in-law, *dais* and ICDS and health functionaries as an important contributing factor. Poor implementation of the various acts and laws were mentioned by roughly only half the men and medical officers. However, it was not viewed as a major contributing factor by the remaining categories of respondents.

Table 12 : Factors Contributing to the Declining Sex Ratio as Perceived by the Respondents

Reasons for Not Wanting Daughters	Beneficiaries				Functionaries					
					ICDS Functionaries			Health Functionaries		
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=150 No. (%)	Dais n=13 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Son preference	236 (78.7)	257 (85.7)	229 (76.3)	8 (61.5)	3 (100.0)	10 (91.0)	36 (73.4)	5 (83.3)	6 (60.0)	14 (93.3)
Dowry	204 (68.0)	200 (66.7)	212 (70.7)	6 (46.2)	3 (100.0)	10 (91.0)	36 (73.4)	5 (83.3)	8 (80.0)	10 (66.7)
Poor implementation of MTP, dowry law, etc.	35 (11.7)	140 (46.7)	40 (13.3)	3 (23.1)	-	3 (27.2)	7 (14.2)	3 (50.0)	3 (30.0)	6 (40.0)
Mushrooming of ultrasound clinics	267 (89.0)	248 (82.7)	8 (61.5)	8 (61.5)	2 (66.7)	8 (72.7)	46 (93.9)	3 (50.0)	9 (90.0)	15 (100.0)
Ability to pay for abortion	127 (42.3)	152 (50.3)	8 (61.5)	8 (61.5)	1 (33.3)	6 (54.5)	33 (67.3)	2 (33.3)	5 (50.0)	12 (80.0)

Fig.12 Factors Contributing to the Declining Sex Ratio as Perceveived by the Beneficaries

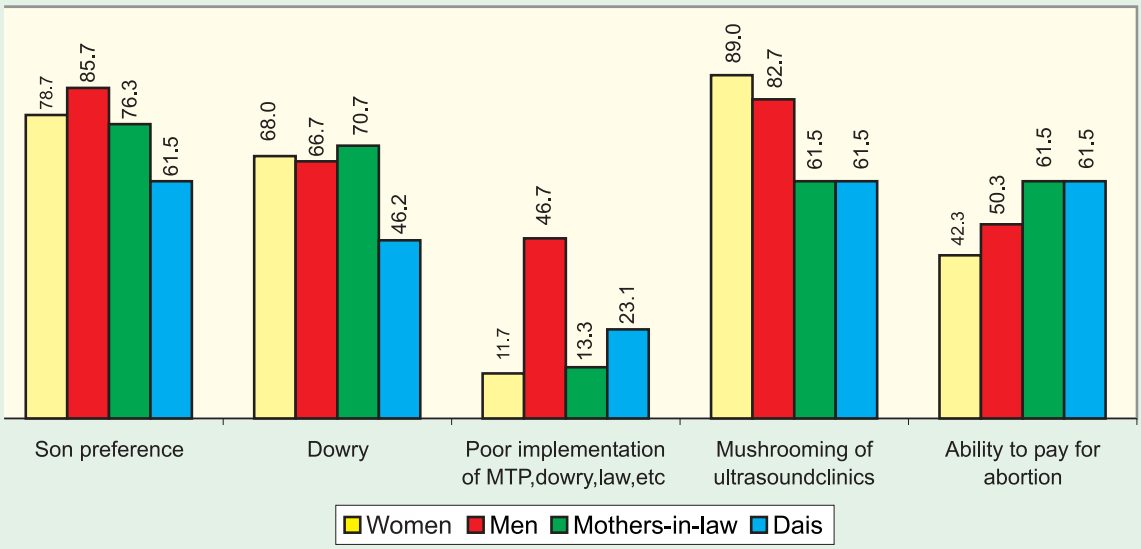
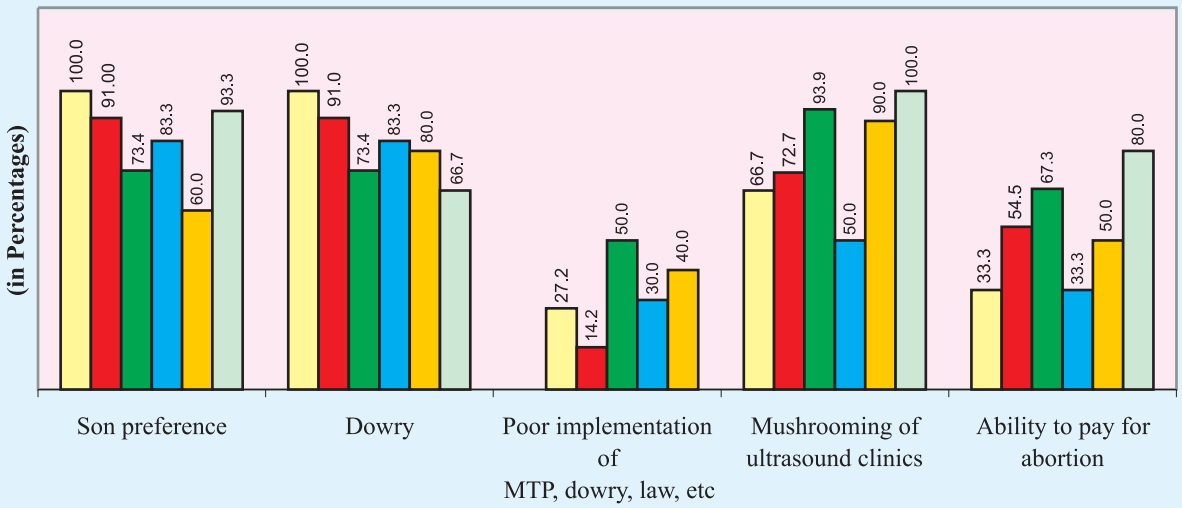


Fig.13 Factors Contributing to the Declining Sex Ratio as Percevied by the Functionaries



4.2.3.8 Perceptions on Family Size and Family Composition

Anandalakshmy (1994)[1] found that more families have two sons (38.5%) than two daughters (32%). Srivastava, Dasgupta and Rai, (2005)[17] found that about 5 per cent desired one child, the majority (68.5%) wanted two children, about 13.5 per cent desired three children and a negligible (3.5%) were in favour of larger families.

A trend could be seen to limit family size in respondents who were graduates and postgraduates, to provide a higher standard of living for their children. Yadav and Badri (1997)[23] found that most women considered three children as the ideal family size.

The present study revealed that the perception of the majority of mothers-in-law about ideal family size was two children (69.0%) followed by three children (28.3%), four children (1.4%), one child (1.0%) and six children (0.3%).

The ideal family composition as perceived by most (67.0%) of the mothers-in-law included one boy and one girl. About 27.8 per cent of mothers-in-law considered two boys and one girl as the ideal family composition. The other responses included one boy (0.3%); one girl (0.3%); two boys (1.0%); and two girls and one boy (0.3%). A negligible percentage (3.3%) stated that they had no preference, regarding the sex of the unborn child.

Most (85.3%) mothers-in-law were of the opinion that women have a right to decide about the family size and only 14.3 per cent felt that it is not the women's right to decide family size (**Table 13**).

Table 13 : Mothers-in-laws' Perception on Family Size and Composition

Perception on Family Size and Composition	Mothers-in-law n=300 No. (%)
Women's Right to Decide about Family Size	
Have a right	256 (85.3)
No	43 (14.3)
Don't know	1 (0.3)
Ideal Family Size	
One child	3 (1.0)
Two children	207 (69.0)
Three children	85 (28.3)
Four	4 (1.4)
Six	1 (0.3)
Ideal Family Composition	
One boy	1 (0.3)
One girl	1 (0.3)
One boy and one girl	201 (67.0)
Two boys	3 (1.0)
Two girls	-
Two boys and one girl	83 (27.8)
Two girls and one boy	1(0.3)
No preference for sex	10 (3.3)

4.2.3.9 Reactions of Mothers-in-law on the Birth of Grandchildren

About 95.0 per cent of the mothers-in-law were happy on the birth of a grandson and only 75.0 per cent felt happy on the birth of their granddaughters. Similarly, the mothers-in-law felt that the *sambhandhin's* happiness on the birth of a granddaughter (72.3%) was slightly lower key than on the birth of a grandson (83.3%) **Table 14.**

Table 14 : Reactions of Mothers-in-law on the Birth of Grandchildren

Reactions of Mothers-in-law on the Birth of Grandchildren	**Mother-in-Law n=300 No. (%)**
Reactions of Mothers-in-law on the Birth of a Grandson	
Happy	285 (95.0)
Reaction of Mothers-in-law on the Birth of a Granddaughter	
Happy	225 (75.0)
Upset	21 (7.0)
No reaction/apathy	9 (3.0)
***Sambhandins'* Reaction on the Birth of a Grandson**	
Happy	250 (83.3)
***Sambhandins'* Reaction on the Birth of a Granddaughter**	
Happy	217 (72.3)

4.2.3.10 Reactions of Dais on the Birth of a Girl Child

Statistics reveal that even today, roughly 50 per cent of deliveries are conducted at home by *dais*, relatives, traditional birth attendants, etc. Since *dais* attend to a sizeable number of births in the villages, an attempt was made to elicit their reactions on the birth of a girl child. Around 38.5 per cent of the *dais* mentioned that the birth of a girl child does not affect them. Yet, a similar percentage said that they feel sorry for the women and feel bad for her when a girl child is born (30.8%). About 46.2 per cent of the *dais* mentioned that they ended up consoling the women on the birth of a girl child. A few (14.4%) mentioned that gifts offered to her were curtailed or not given at all, by the family on birth of a girl child **(Table 15).**

Table 15 : Reaction of *Dais* on the Birth of a Girl Child

Reactions of *Dais* on the Birth of a Girl Child	Dais n = 13 No. (%)
Feel bad	4 (30.8)
Feel sorry for the woman	5 (38.5)
No gifts given by the family	2 (14.4)
Console the woman	6 (46.2)
No effect	5 (38.5)

4.2.3.11 Awareness and Practices Related to Birth Spacing

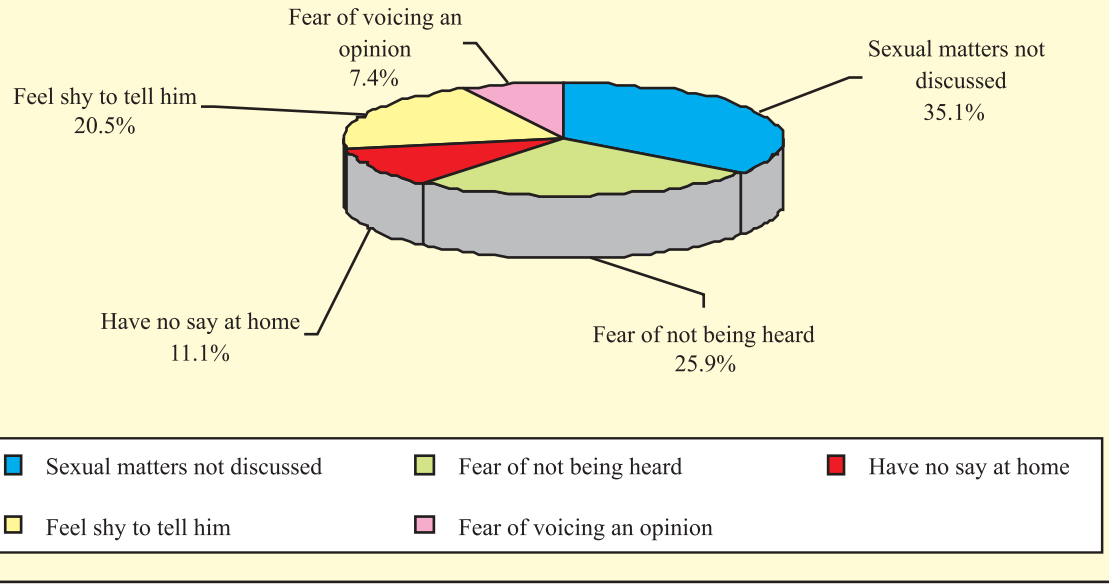
It was heartening to note that about 97.0 per cent of the women and 99.7 per cent of the men were aware of birth spacing methods. The awareness about the different birth spacing methods, except diaphragm, was high among both women and men. The decision to have the first child/ subsequent children 'by choice' was expressed by 47.3 per cent of the women and 23.7 per cent of the men. The 'chance' occurrence of the first child/ subsequent children was reported by 28.3 per cent of the women and 59.3 per cent of the men **(Table 16)**.

The desire to use spacing methods was expressed by 81.3 per cent of the women and 52.7 per cent of the men **(Table 16)**. However, the various reasons mentioned by women for not expressing their desire to use birth spacing methods were that the couples have no discussions on sexual matters, fear of not being heard, having no say at home, a feeling of shyness and fear of voicing an opinion **(Fig. 14).**

Table 16 : Awareness and Practices Related to Birth Spacing

Awareness and Practices	Women n=300 No. (%)	Men n=300 No. (%)
Awareness about Birth Spacing Methods		
Aware	291 (97.0)	299 (99.7)
Not aware	9 (3.0)	1 (0.3)
Awareness about Methods of Birth Spacing		
Diaphragm	7 (2.3)	6 (2.0)
Copper T	281 (93.7)	225 (75.0)
Oral pills	274 (91.3)	290 (96.7)
Tubectomy	229 (76.3)	293 (97.7)
Condom	244 (81.3)	296 (98.7)
Vasectomy	223 (74.3)	292 (97.3)
Abstinence	89 (29.7)	169 (56.3)
Decision to Have the First Child/Subsequent Children		
By choice	142 (47.3)	71 (23.7)
By chance	85 (28.3)	178 (59.3)
Had Desire to Use Spacing Method		
Yes	244 (81.3)	158 (52.7)
No	56 (18.7)	142 (47.3)
Which Method of Family Planning was Adopted		
Diaphragm	-	6 (2.0)
Copper T	74 (24.7)	225 (75.0)
Oral pills	98 (32.7)	290 (96.7)
Tubectomy	67 (22.3)	293 (97.7)
Condom	55 (18.3)	296 (98.7)
Vasectomy	44 (25.7)	292 (97.3)
Abstinence	77 (25.7)	169 (56.3)

Fig.14 Reasons for Not Voicing the Desire for Using Birth Spacing Methods



4.2.4 Practices Related to Marriage and Dowry

4.2.4.1 Selection of Bride and Groom

Women of today (71.7%) and mothers-in-law (41.7%) revealed that the family did not seek the opinion of either the boy or the girl for whom they were planning a marriage. It appears that the freedom to exercise their choice in the selection of the bride/ bridegroom for themselves has been withdrawn from children in recent years.

About 39.3 per cent of the mothers-in-laws however observed that she alone decides on the selection of her daughter-in-law. Another 33 per cent revealed that the husband/ the head of the household decides on the selection of the daughter-in-law. A negligible percentage (4.7%) mentioned having allowed their sons to decide. Another 38.3 per cent stated that it is the elders in the family who decided on the daughter-in-law of the house. Daughters are never given a chance to choose their own groom **(Table 17).**

Table 17 : Perception of Women and Mothers-in-law on Practices Related to Marriage

Selection of Spouse	Mothers-in-law n=300 No. (%)
Self (mothers-in-law)	118 (39.3)
Husband	99 (33.0)
Son himself	14 (4.7)
Daughter herself	-
Elders in the family	115 (38.3)

Opinion Sought from Children Regarding Selection of Spouse	Women n=300 No.(%)	Mothers-in-law n=300 No. (%)
Yes	85 (28.3)	168 (56.0)
No	215 (71.7)	125 (41.7)
Question does not arise	-	5 (1.7)
NA	-	2 (0.6)

4.2.4.2 Dowry and Dowry Related Practices

Table 18 gives details of gifts given as dowry to a girl during marriage in present times and in earlier days as revealed by the women and mothers-in-law. The various gift items given as dowry to a girl include cash, gold/silver items, car/scooter, land/house and household items. The table reveals that gifts in terms of cash have increased over the years. The practice of giving gold/silver ornaments/items and vehicles, land/house seems to have declined over the years. But the custom of giving household items like refrigerators, television, cupboards, furniture, washing machines, etc. of the latest models that come into the market has increased over the years, pointing to the fact that the practice of giving/taking dowry has not changed over the years.

Table 18 : Practices Related to Dowry

Practices Related to Marriage and Dowry	Women n=300 No. (%)	Mothers-in-law n=300 No. (%)
Gifts Given as Dowry to a Girl		
Cash	69 (23.0)	58 (19.3)
Gold/silver	172 (57.3)	226 (74.4)
House/ land	-	2 (0.7)
Car/scooter	55 (18.3)	73 (24.3)
Household items	298 (99.3)	284 (94.0)

4.2.4.3 Perceptions about Dowry and the Dowry System

The perception of men and mothers-in-laws were elicited about dowry and the dowry system existing in the country. Most (89.3%) men today consider it a major problem as compared to mothers-in-law (64.3%). Roughly half of both men and mothers-in-law however feel that dowry is essential to start a family. A negligible percentage of men as well as mothers-in-law felt that it is 'right of a man' to demand/ accept dowry **(Table 19)**.

Table 19 : Perceptions of Beneficiaries about Dowry

Perceptions about Dowry and the Dowry System	Beneficiaries	
	Men n=300 No.(%)	Mothers-in-Law n=300 No. (%)
General Perceptions about Dowry		
A major problem	268 (89.3)	193 (64.3)
Essential to start a family	148 (49.3)	175 (58.3)
Right of a man	12 (4.0)	23 (7.7)

4.2.4.4 Awareness of the Existence of Dowry and Dowry Harassment

The cultural practice of demanding dowry from a girl's family has been the major deterrent for families not wanting a girl child. Hence an attempt was made to elicit information about dowry and its related issues from the respondents. Most of the respondents, mainly men (74.3%), mothers-in-law (91.7%), CDPOs (66.7%), Supervisors (100.0%), AWWs (95.9%), MOs (83.3%), LHVs (100.0%) and ANMs (86.7%) were aware of the existence of the dowry system in society.

However, awareness about dowry harassment in the neighbourhood ranged from 37.3 per cent among men to 55.0 per cent among mothers-in-law. The awareness was 66.7 per cent, 72.7 per cent and 71.4 per cent among CDPOs, supervisor and AWWs and 50.0 per cent, 80.0 per cent and 73.3 per cent among MOs, LHVs and ANMs respectively **(Table 20).** The study reveals that the community is still tight lipped about the occurrences of dowry harassment.

4.2.4.5 Views about the Existing Dowry System

About 91.7 per cent of the men and 79.3 per cent of mothers-in-law were of the view that the existing system of dowry should be abolished. This view was shared by CDPOs (100.0%), Supervisors (72.7%), AWWs (89.8%), MOs (100.0%), LHVs (80.0%) and ANMs (93.3%).

4.2.4.6 Average Amount of Money Spent on the Marriage of a Daughter

Table 21 gives the average amount of money spent on the marriage of a daughter. Roughly 50 per cent of the respondents reported an expense of Rs. 1,00,000 to Rs. 3,00,000 on the marriage of daughters in their community. Another 32.3 per cent, 13.0 per cent and 1.3 per cent reported an expenditure of up to Rs. 1,00,000; between Rs. 3,00,000 and Rs. 5,00,000; and more than Rs. 5,00,000 respectively on the marriage of daughters.

Table 20 : Perceptions about Existence of Dowry System and Dowry Harassment

Awareness about Dowry and Dowry System	Beneficiaries		Functionaries					
			ICDS Functionaries			Health Functionaries		
	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about Dowry and Dowry System								
Awareness about its prevalence	223 (74.3)	275 (91.7)	2 (66.7)	11 (100.0)	47 (95.9)	5 (83.3)	10 (100.0)	13 (86.7)
Awareness about dowry harassment in the neighbourhood	112 (37.3)	165 (55.0)	2 (66.7)	8 (72.7)	35 (71.4)	3 (50.0)	8 (80.0)	11 (73.3)
Views about the Dowry System								
Should be abolished	275 (91.7)	238 (79.3)	3 (100.0)	8 (72.7)	44 (89.8)	6 (100.0)	8 (80.0)	14 (93.3)
No need	25 (8.3)	61 (20.3)	-	3 (27.3)	5 (10.2)	-	2 (20.0)	1 (6.7)

Regarding how such an amount is arranged for the marriage, the men reported that it was mainly from savings (99.0%), loan (73.7%) and selling property, if any (10.3%).

Table 21 : Perceptions of Men about Dowry

Perceptions of Men about Dowry	Men n=300 No. (%)
Existence of Dowry	
Yes	223 (74.3)
No	77 (25.7)
Amount of Money Spent on the Marriage of a Daughter	
Up to Rs. 1,00,000	97 (32.3)
Rs. 1,00,000-Rs. 3,00,000	160 (53.4)
Rs. 3,00,000-Rs. 5,00,000	39 (13.0)
More than Rs. 5,00,000	4 (1.3)
Source of Arranging Money for Marriage	
Savings	297 (99.0)
Loan	221 (73.7)
Selling of property	31 (10.3)

4.2.5 Suggestive Measures for Curbing the Problem of Dowry

Table 22 depicts the suggestive measures for curbing the problem of dowry as reported by men and ICDS and health functionaries. The various suggestive measures as reported by the respondents include strict implementation of laws; removal of poverty; improving the status of literacy; creating awareness about the evils of accepting dowry; and improving the value of the girl child. The responses like removal of illiteracy and improving the value of the girl child were expressed more strongly, implying that society is desirous of a long-term solution to the problem.

Table 22 : Suggestive Measures for Curbing the Problem of Dowry

Suggestive Measures for Curbing the Problem of Dowry	Men n=300 No. (%)	Functionaries					
		ICDS Functionaries			Health Functionaries		
		CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Strict implementation of laws	226 (75.3)	1 (33.3)	5 (45.5)	14 (28.5)	3 (50.0)	5 (50.0)	10 (66.7)
Removal of poverty	179 (59.7)	-	6 (54.5)	23 (47.0)	6 (100.0)	8 (80.0)	10 (66.7)
Removal of illiteracy	224 (74.7)	2 (66.7)	11 (100.0)	37 (75.5)	6 (100.0)	2 (20.0)	13 (86.7)
Creating awareness about the evil of accepting dowry	248 (82.7)	3 (100.0)	10 (91.0)	42 (85.7)	5 (83.3)	10 (100.0)	14 (93.3)
Improving the value of the girl child	190 (63.3)	3 (100.0)	11 (100.0)	48 (98.0)	5 (83.3)	8 (80.0)	13 (86.7)

4.2.6 Rituals Performed to Beget a Son

Table 23 highlights the various rituals performed to beget a son as reported by the women and *dais* of Delhi and Haryana. The various rituals performed across both the states include the performance of a special *puja*, *hawan* (fire rituals), *mannat* (seeking a boon), visiting temple and observing fasts which are considered as done to please the deities who in turn grant a boon, vis-à-vis, a son. The *dais* of Haryana have articulated more forcefully than the other respondents, that the rituals are performed by women to beget a son.

Table 23 : Rituals Performed to Beget a Son

Rituals Performed to Beget a Son	Delhi		Haryana	
	Women n=150 No. (%)	*Dais* n=8 No. (%)	Women n=150 No. (%)	*Dai* n=5 No. (%)
Rituals Performed to Beget Son				
Perform *puja*	117 (78.0)	7 (87.5)	118 (78.7)	5 (100.0)
Hawan	110 (73.3)	7 (87.5)	133 (88.7)	5 (100.0)
Mannat	122 (81.3)	8 (100.0)	95 (63.3)	5 (100.0)
Visiting temples	134 (89.3)	-	103 (68.7)	-
Observing fasts	106 (70.7)	-	56 (37.3)	-

4.2.7 Celebrations on the Birth of a Baby

The percentage of families (17 %) holding special celebrations on the birth of a male child was more than on the birth of a female child (2%). Approximately one-fifth of the families had no celebrations on the birth of a female child. (Anandalakshmy, 1994).[1] But many studies have found that the birth of a son was celebrated by performing rituals like distribution of sweets to friends and relatives, feasting, singing, *'thali bajana'* (banging of plates), *jagarata*, special *pujas* and rituals (*Kuan Pujan, Chatti Chola* ceremony) and the distribution of money and gifts (NIHFW and TINNARI, (2002)[7] and Nayar (1995).[12]

Table 24 and Figs. 15 and 16 depict the celebrations held across both the states vis-à-vis, Delhi and Haryana on the birth of a baby boy and baby girl as

ascertained from the present study. The celebrations on the birth a baby boy is definitely more joyous with banging of plates to announce his arrival whereas those performed on the birth of a girl child is low key or missing altogether, pointing towards the low status meted to a girl from birth itself.

Table 24 : Celebrations on Birth of a Baby

Celebrations on Birth of a Baby	Delhi	Haryana
	Women n = 150 No.(%)	Women n = 150 No.(%)
Celebrations on the Birth of a Boy		
Perform *puja*	150(100.0)	149(99.3)
Banging of plates to announce to the community	150(100.0)	149(99.3)
Distribution of sweets/rejoicing/singing	149(99.3)	140(98.0)
Distribution of clothes, money, ornaments	148(98.7)	116(77.3)
Celebrations on the Birth of a Girl		
Perform *puja*	46(30.7)	58(38.7)
Banging of a plate to announce to the community	1(0.7)	7(4.7)
Distribution of sweets/rejoicing/singing	13(8.7)	27(18.0)
Distribution of clothes, money, ornaments	17(11.3)	16(10.7)

Fig.15 Celebrations on the Birth of a Baby Boy

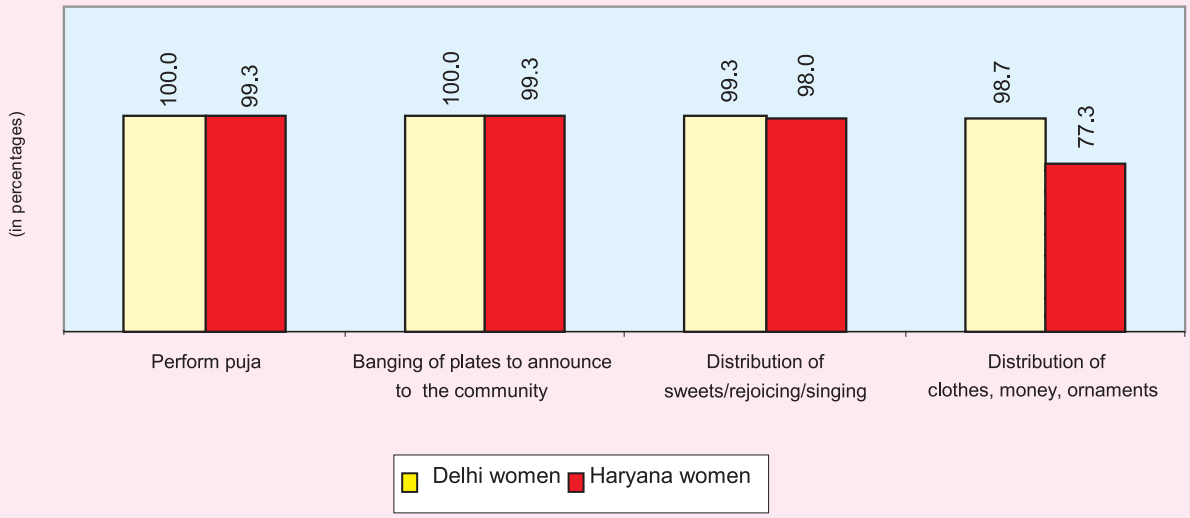
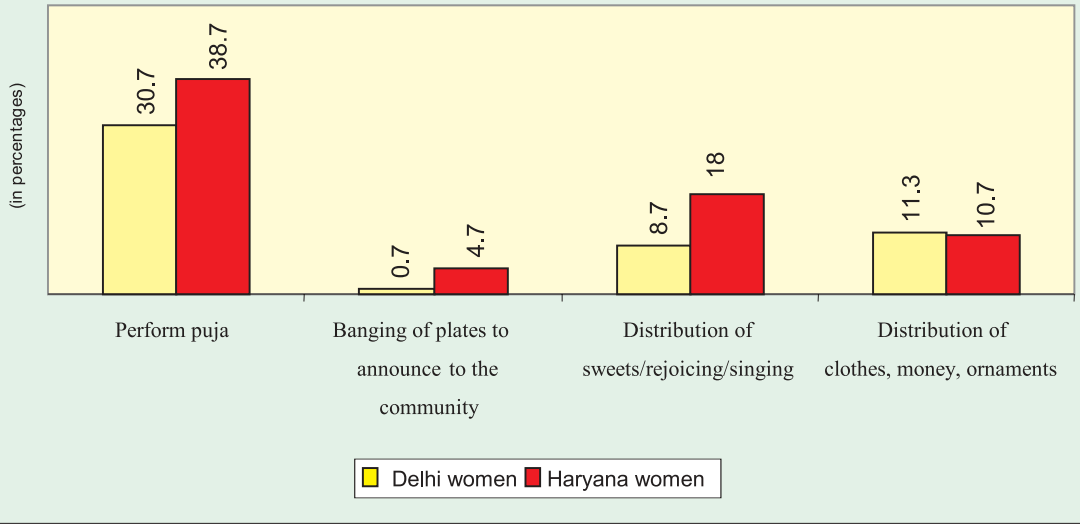


Fig.16 Celebrations on the Birth of a Baby Girl



- Most of the respondents were aware of the phenomena of the declining sex ratio throughout the country.
- The majority of the women perceived non-availability of brides as the major repercussion of missing girls followed by an increased rate of crimes against women and polyandry.
- The various reasons for son preference, as mentioned by the women include that he is the support and provider in old age; brings in dowry instead of draining family resources; perpetuates the family name; performs the last rites; and on investing in sons, say on education or business, the wealth remains within the family.
- The main reason perceived for not wanting daughters has been 'dowry' by all the respondents.
- The factors essentially responsible for contributing towards declining sex ratio were son preference and dowry. The interesting finding is that the mushrooming of ultrasound clinics and the ability to pay for abortion has been expressed by all respondents as the major factors responsible for contributing towards the declining sex ratio.
- The ideal family composition as perceived by the majority (67.0%) of mothers-in-law included one boy and one girl. About 27.8 per cent of mothers-in-law considered two boys and one girl as an ideal family composition.
- The study revealed that the family did not seek the opinion of either the boy or the girl whose marriage they were arranging.
- The study points to the fact that the practice of giving/accepting dowry has not changed over the years.
- Various rituals are performed across both states to please the deities who in turn are believed to grant a boon, viz. a son.
- The celebrations on the birth of a baby boy is definitely more joyous with the banging of plates to announce his arrival, whereas those performed on the birth of a girl child are low key or missing altogether

4.3 Knowledge and Awareness about Pregnancy and Childbirth, and Childcare Practices

4.3.1 Knowledge and Awareness about Pregnancy

4.3.1.1 Awareness about Minimum Number of Health Check-Ups during Pregnancy

The minimum number of check-ups a woman should have during pregnancy as reported by the women of Delhi include one (2.7%), two (8.7%), three (23.3%), more than three (60.7%) and none (2.0%). The women of Haryana reported that a woman should have a minimum of one (4.7%), two (36.7%), three (14.0%), more than three (24%) check-ups during pregnancy. Around (26.7%) women still believe that check-ups are not required during pregnancy (Table 25).

4.3.1.2 Awareness about Consumption of IFA Tablets

About 60 per cent of women in Delhi and 88.7 per cent in Haryana were aware of the need to consume 100 IFA tablets during pregnancy (Table 25).

4.3.1.3 Awareness about Tetanus Toxoid Injection

About 74.0 per cent of women in Delhi and 96.7 per cent in Haryana were aware that a woman needs to have two doses of tetanus toxoid during pregnancy (Table 25).

4.3.1.4 Knowledge about Place of Delivery

It is a disheartening to note that around 65.3 per cent of the women in Delhi and 68.7 per cent in Haryana still believe that deliveries could be conducted at home. A sizeable proportion also mentioned that trained *dais* [Delhi (64.7%) and Haryana (68.0)] and family members [Delhi (68.7%) and Haryana (68.7%)] could conduct the deliveries (Table 25).

Table 25 : Knowledge and Awareness about Care during Pregnancy and Delivery

Knowledge and Awareness about Care during Pregnancy and Delivery	Delhi Women n = 150 No. (%)	Haryana Women n = 150 No. (%)
Minimum Number of Check-ups during Pregnancy		
One	4 (2.7)	7 (4.7)
Two	13 (8.7)	46 (36.7)
Three	35 (23.3)	21 (14.0)
More than three	91 (60.7)	36 (24.0)
None	3 (2.0)	40 (26.7)
Consumption of IFA Tablets		
100 tablets	90 (60.0)	133 (88.7)
Incorrect	60 (40.0)	17 (11.3)
Dose of Tetanus Toxoid Injections		
Two doses	111 (74.0)	145 (96.7)
Incorrect	39 (26.0)	5 (3.3)
Place of Delivery		
Home	98 (65.3)	103 (68.7)
Nursing homes/private hospitals	33 (22.0)	22 (14.7)
Government hospitals	72 (48.0)	55 (36.7)
Who Conducts Deliveries		
Trained *Dais*	97 (64.7)	102 (68.0)
ANM/LHV	3 (2.0)	103 (68.7)
Family members	103 (68.7)	103 (68.7)
Problems Encountered during Pregnancy and Childbirth		
High blood pressure	56 (37.3)	118 (78.7)
Swelling of the feet/body	91 (60.7)	106 (70.7)
Albuminaria	15 (10.0)	13 (8.7)
Obstructed labour	44 (29.3)	62 (41.3)
Anaemia	103 (68.7)	119 (79.3)
Baby not growing well	17 (11.3)	65 (43.3)
Fever	99 (66.0)	110 (73.3)
Convulsions	5 (3.3)	1 (0.7)
Excessive bleeding	39 (26.0)	81 (54.0)
Nausea and vomiting	56 (37.3)	7 (4.7)

4.3.1.5 Knowledge about Problems Encountered during Pregnancy and Childbirth

Table 25 also provides the various problems encountered during pregnancy and childbirth which need immediate attention. The knowledge of women in Haryana was better than those of women in Delhi. The problems encountered during pregnancy and childbirth as enumerated by women include high blood pressure, swelling of feet/body, albuminuria, anaemia, lack of foetal movements, fever, convulsions, excessive bleeding, etc.

4.3.2 Knowledge and Awareness about Childcare Practices

Table 26 presents the details of knowledge and awareness of women in Delhi and Haryana regarding the childcare practices.

4.3.2.1 Low Birth Weight Baby

About 68.7 per cent of women from Delhi and 77.3 percent from Haryana could define a low birth weight baby.

4.3.2.2 Initiation of Breastfeeding

Roughly 60 per cent of women from Delhi and 64.7 per cent from Haryana replied that breastfeeding should be initiated within an hour of birth **(Table 26)**.

4.3.2.3 Exclusive Breastfeeding and Complementary Feeding

About 60.7 per cent of the women in Delhi and 99.3 per cent in Haryana answered correctly about exclusive breastfeeding. Also, all the women (100%) in Haryana and 79.3 per cent of the women respondents in Delhi knew the ideal time for introduction of complementary feeding (**Table 26**).

4.3.2.4 Immunization

The level of knowledge of women in Haryana was a shade better than that of the women in Delhi regarding the immunization schedule (**Table 26**).

Table 26 : Knowledge and Awareness about Childcare Practices

Knowledge and Awareness about Childcare Practices	Delhi	Haryana
	Women n = 150 No. (%)	Women n = 150 No. (%)
Low Birth Weight Baby		
Weight < 2500 gms.	103 (68.7)	116 (77.3)
Incorrect	47 (31.3)	34 (22.7)
Initiation of Breastfeeding		
Within half an hour	89 (59.3)	97 (64.7)
Within a day	24(16.0)	26(17.3)
Within 2-3 days	27 (18.0)	24 (16.0)
After 3 days	10 (6.7)	3 (2.0)
Exclusive Breastfeeding		
Correct	91 (60.7)	149 (99.3)
Incorrect	59 (39.3)	1 (0.7)
Initiation of Complementary Feeding		
Correct	119 (79.3)	150 (100.0)
Incorrect	31 (20.7)	-
Immunization Schedule		
BCG	124 (82.7)	147 (98.0)
DPT 1 dose	110 (73.3)	117 (78.0)
DPT 2 doses	109 (72.7)	115 (76.7)
DPT 3 doses	109 (72.7)	115 (76.7)
OPV 1 dose	109 (72.7)	113 (75.3)
OPV 2 doses	108 (72.0)	111 (74.0)
OPV 3 doses	109 (72.7)	112 (74.7)
Measles	124 (82.7)	143 (95.3)

4.3.2.5 Awareness about Childhood Illnesses

Nayar (1995) [12] found that the major cause of infant and child deaths were dehydration caused by diarrhoea, typhoid and undiagnosed fever. Home remedies were considered best for girls whereas medical attention was sought immediately for boys.

The various childhood illnesses experienced by their children as reported by the women of Delhi and Haryana are presented in **Table 27.** They include acute respiratory infections (ARI), diarrhoea, fever, malnutrition, skin disease, worm infestation, vaccine-preventable diseases, etc. Acute respiratory infection was

mentioned by 60.7 per cent of the women in Delhi as against 22.0 per cent in Haryana. About 50.7 per cent of women in Haryana reported skin diseases as against 20.7 per cent of women in Delhi. Similarly, worm infestation was reported by 44.7 per cent in Delhi as compared to 11.3 per cent in Haryana.

4.3.2.6 Medical Attention Given to a Child during Illness

Home remedies (78.7%), consulting AWWs (16.0%), Ayurveda /homeopathy/ other systems of medicine (37.3%), consulting ANMs/LHVs (7.3%), taking the child to a health facility (42.7%) and hospitalizing the child (51.3%) have been the mode of medical attention given to a child during illness as reported by women in Delhi. In contrast, 91.3 per cent of women reported hospitalization of a child in Haryana. Roughly 30 per cent of women in Haryana relied on home remedies, as against 78.7 per cent in Delhi **(Table 27)**.

Table 27: Knowledge and Awareness about Childhood Illnesses and Care during Illnesses

Knowledge and Awareness about Childhood Illnesses and Care during Illnesses	Delhi	Haryana
	Women n=150 No. (%)	Women n=150 No. (%)
Awareness about Childhood Illnesses		
ARI	91 (60.7)	33 (22.0)
Diarrhoea	128 (85.3)	112 (74.7)
Fever	145 (96.7)	145 (96.7)
Malnutrition	8 (5.3)	33 (22.0)
Skin disease	31 (20.7)	76 (50.7)
Worm infestation	67 (44.7)	17 (11.3)
Vaccine preventable disease	17 (11.3)	2 (1.3)
Awareness about Medical Attention Given to a Child during Illness		
Home remedies	118 (78.7)	44 (29.3)
Consult AWW	24 (16.0)	11 (7.3)
Ayurveda/homeopathy/ other systems of medicine	56 (37.3)	35 (23.3)
Taken to a health facility	64 (42.7)	28 (18.7)
Hospitalization	77 (51.3)	137 (91.3)
No attention given	-	3 (2.0)
Consult ANM/LHV	11 (7.3)	42 (28.0)

4.3.2.7 Food Intake during Illness

It was shocking to note that 97.3 per cent of the women of Haryana and 87.3 per cent of the women of Delhi decreased the food intake of a child during illness **(Fig. 17 and Fig. 18).**

Fig.17 Food Intake During Illness-Delhi

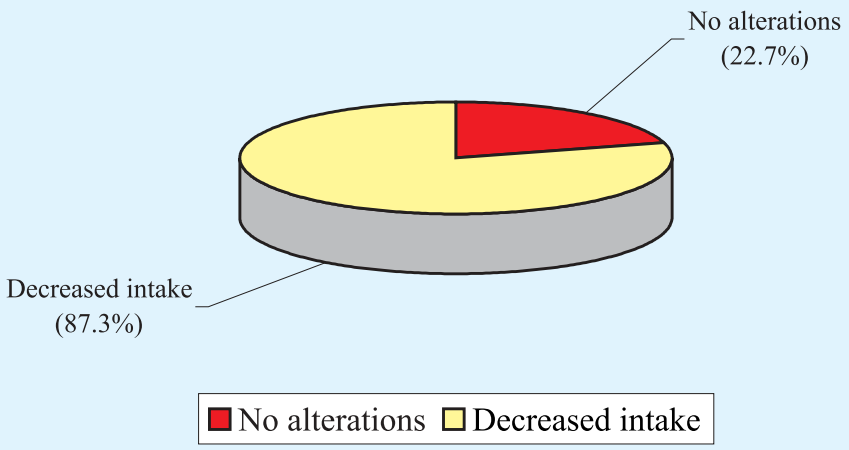
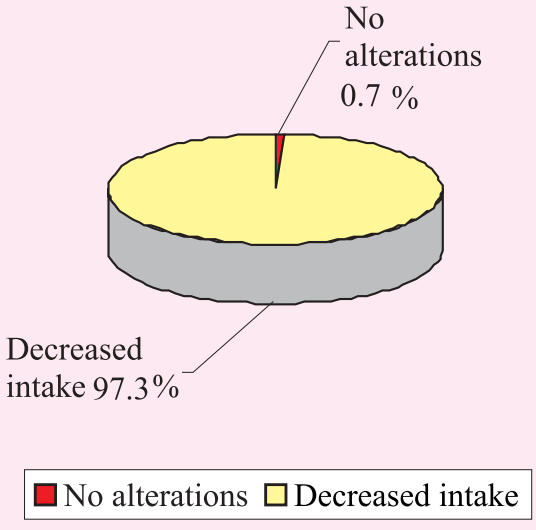


Fig.18 Food Intake During Illness -Haryana



- Around 26.7 per cent of women still believe that check-ups are not required during pregnancy.
- About 60 per cent of women in Delhi and 88.7 per cent in Haryana were aware of the need to consume 100 IFA tablets during pregnancy.
- About 74.0 per cent women in Delhi and 96.7 per cent in Haryana were aware that a woman needs to take two doses of tetanus toxoid during pregnancy.
- It is a disheartening to note that around 65.3 per cent women in Delhi and 68.7 per cent in Haryana still believe that deliveries should be conducted at home.
- The knowledge of women in Haryana regarding the problems encountered during pregnancy and childbirth was better than those of women in Delhi.
- Roughly 60 per cent of women from Delhi and 64.7 per cent from Haryana replied that breastfeeding should be initiated within an hour of birth.
- About 60.7 per cent women in Delhi and 99.3 per cent in Haryana answered correctly about exclusive breastfeeding. Also, all the women respondents (100%) in Haryana and 79.3 per cent in Delhi knew the ideal time for introduction of complementary feeding.
- Home remedies (78.7%), consulting AWWs (16.0%), Ayurveda / homeopathy/ other systems of medicine (37.3%), consulting ANMs/LHVs (7.3%), taking the child to a health facility (42.7%) and hospitalizing the child (51.3%) has been the mode of medical attention given to a child during illness as reported by women of Delhi. In contrast, 91.3 per cent women reported hospitalization of the child in Haryana. Roughly 30 per cent of women in Haryana relied on home remedies, as against 78.7 per cent in Delhi
- It was shocking to note that 97.3 per cent women in Haryana and 87.3 per cent in Delhi decreased the food intake of a child during illness.

4.4 Abortion and Abortion-Related Issues

The three major reasons for terminating pregnancy found in almost all studies are to avoid an additional birth after the desired family size had been achieved; to ensure a reasonable birth interval after the previous birth; and to prevent the birth of a female child [Ravindran (nd).[16]] A majority of the women respondents (62%) had undergone induced abortion because they did not want another child. The majority were in the higher income group. One-fourth reported that they only wanted a son. Most of the respondents were reluctant to disclose the place of abortion. Of these, more than half admitted using a private clinic for the purpose and less than 40 per cent had used government facilities. In Punjab and Haryana, *dais* also conducted abortions on a small scale. Advertisements, billboards and hoarding with catchy slogans about abortion and the availability of such facilities, were the main sources of information (MOHFW and TINNARI, 2002; and Nayar (1995).[7, 12]

4.4.1 Details of Pregnancy and Childbirth by Birth Order

Table 28 presents the details of pregnancy and childbirth by birth order as elicited from the study.

4.4.2 Sex of the Child

There were 46.7 per cent males and 42.7 per cent females in the first order births in Delhi; and an equal percentage (48.0%) of males and females in Haryana. The percentage of males and females in the second birth order in Delhi and Haryana were 38.7 per cent and 41.3 per cent; and 34.0 per cent and 37.3 per cent respectively. Similarly, there were 20.7 per cent males and 22.0 per cent females in the third birth order in Delhi and 17.3 per cent males and 16.7 per cent females in Haryana.

It is noteworthy to mention that the percentage of females decreased in the fourth and fifth order births in both Delhi and Haryana.

Table 28 : Details of Pregnancy and Childbirth by Birth Order

	Delhi					Haryana				
	First Birth Order	Second Birth Order	Third Birth Order	Fourth Birth Order	Fifth Birth Order	First Birth Order	Second Birth Order	Third Birth Order	Fourth Birth Order	Fifth Birth Order
Sex of the Child										
Male	70(46.7)	58(38.7)	31(20.7)	26(17.3)	12(8.0)	72(48.0)	51(34.0)	26(17.3)	14(9.3)	6(4.0)
Female	64(42.7)	64(41.3)	33(22.0)	14(9.3)	4(2.7)	72(48.0)	56(37.3)	25(16.7)	9(6.0)	3(2.0)
Outcome of Pregnancy										
Abortion	17(11.3)	13(8.7)	17(11.3)	3(2.0)	2(1.3)	3(2.0)	4(2.7)	6(4.0)	2(1.3)	-
Still birth	2(1.3)	1(0.7)	2(1.3)	-	-	3(2.0)	5(3.3)	1(0.7)	1(0.7)	-
Normal delivery	100(66.6)	101(67.3)	55(36.7)	33(22.0)	17(11.3)	136(90.7)	106(70.7)	50(33.3)	21(14.0)	10(6.7)
Caesarean Section	16(10.7)	13(8.7)	5(3.3)	3(2.0)	-	4(2.7)	1(0.7)	-	-	-
Forceps delivery	1(0.7)	-	-	-	-	-	-	-	-	-
Condition of the Child										
Alive	117(78.0)	114(76.0)	60(40.0)	36(24.0)	17(11.3)	140(93.4)	107(71.3)	50(33.3)	21(14.0)	10(6.7)
Dead	19(12.7)	14(9.3)	19(12.7)	3(2.0)	2(1.3)	6(4.0)	9(6.0)	7(4.7)	3(2.0)	-
NA	14(9.3)	22(14.7)	71(47.3)	111(74.0)	131(87.4)	4(2.6)	34(22.7)	93(62.0)	126(84.0)	140(93.3)
If Dead, When did the Child Die										
Within 7 days	8(5.3)	9(6.0)	8(5.3)	-	1(0.7)	2(1.3)	2(1.3)	3(2.0)	2(1.3)	-
Within a month	-	2(1.3)	1(0.7)	1(0.7)	-	3(2.0)	4(2.6)	2(1.3)	1(0.7)	-
Within a year	2(1.3)	3(2.0)	2(1.3)	2(1.3)	1(0.7)	1(0.7)	2(1.3)	1(0.7)	-	-
Within 5 years	4(2.8)	-	6(4.0)	-	-	-	1(0.7)	1(0.7)	-	-
Beyond 5 years	5(3.3)	-	2(1.3)	-	-	-	-	-	-	-
NA	131(87.3)	136(90.7)	131(87.4)	147(98.0)	148(98.7)	144(96.0)	141(94.1)	143(95.3)	147(98.0)	150(100.0)

Table 28 : Details of Pregnancy and Childbirth by Birth Order (Contd.)

	Delhi					Haryana				
	First Birth Order	Second Birth Order	Third Birth Order	Fourth Birth Order	Fifth Birth Order	First Birth Order	Second Birth Order	Third Birth Order	Fourth Birth Order	Fifth Birth Order
What was the cause of Death										
Prematurity	1(0.7)	-	1(0.7)	-	-	-	-	-	-	-
Acute respiratory infections (ARI)	3(2.0)	-	-	-	-	-	-	-	1(0.7)	-
Diarrhoea	2(1.3)	2(1.3)	-	-	-	-	-	-	-	-
Tetanus	1(0.7)	1(0.7)	-	-	-	-	-	-	-	-
Malaria	1(0.7)	-	-	-	-	-	-	1(0.7)	-	-
Typhoid	-	-	-	-	-	-	-	-	-	-
Unspecified	1(0.7)	1(0.7)	2(1.3)	1(0.7)	-	1(0.7)	2(1.3)	1(0.7)	-	-
Other causes-drowning, jaundice, accidents, cord sepsis	5(3.3)	-	1(0.7)	2(1.3)	1(0.7)	4(2.6)	1(0.7)	-	-	-
NA	136(90.6)	146(97.3)	146(97.3)	147(98.0)	149(99.3)	145(96.7)	147(98.6)	148(98.7)	149(99.3)	150(100.0)

4.4.3 Details of Pregnancy and Outcome of Pregnancy

Details of pregnancy and its outcome were elicited from the women respondents more so to ascertain the pattern of abortions and its details.

4.4.4 Details of Abortions

There were 17, 13, 17, three and two abortions in the first, second, third, fourth and fifth order births respectively in Delhi and three, four, six and two abortions in the first, second, third and fourth order births respectively in Haryana.

The study revealed that the abortions, whether spontaneous or induced, were fewer in Haryana than Delhi. This does not corroborate with the data available on sex ratio, hence this finding should be taken with a pinch of salt.

4.4.4.1 Type of Abortions

There were 23.6 per cent, 30.8 per cent, 52.9 per cent, 66.7 per cent and 50.0 per cent induced abortions in the first, second, third, fourth and fifth order births respectively in Delhi. Similarly, there were 33.3 per cent, 50.0 per cent, 33.3 per cent, 50.0 per cent induced abortions in the first, second, third and fourth order births respectively in Haryana. There were no abortions reported in the fifth birth order pregnancy in Haryana **(Table 29).**

4.4.4.2 Place of Abortions

By and large, the abortions in Haryana were performed in hospitals or private clinics. However, in Delhi apart from hospitals and private clinics, women are taking a great risk by getting abortions done through *dais* at home **(Table 29).**

Table 29 : Details of Abortions

Details of Abortions	Delhi					Haryana				
	First Birth Order No. (%)	Second Birth Order No. (%)	Third Birth Order No. (%)	Fourth Birth Order No. (%)	Fifth Birth Order No. (%)	First Birth Order No. (%)	Second Birth Order No. (%)	Third Birth Order No. (%)	Fourth Birth Order No. (%)	Fifth Birth Order No. (%)
Outcome of Pregnancy										
Abortion	17(11.3)	13(8.7)	17(11.3)	3(2.0)	2(1.3)	3(2.0)	4(2.7)	6(4.0)	2(1.3)	-
When was the Baby Aborted										
Within 2 months	5(29.4)	4(30.8)	5(29.4)	-	-	3(100.)	2(50.0)	3(50.0)	2(100.0)	-
Within 3 months	5(29.4)	5(38.5)	5(29.4)	2(66.7)	1(50.0)	-	1(25.0)	3(50.0)	-	-
Within 4 months	-	3(23.0)	4(23.5)	1(33.3)	-	-	1(25.0)	-	-	-
After 4 months	7(41.1)	1(0.8)	3(17.6)	-	1(50.0)	-	-	-	-	-
Type of Abortion										
Spontaneous	13(76.4)	9(69.2)	8(47.1)	1(33.3)	1(50.0)	2(66.7)	2(50.0)	4(66.7)	1(50.0)	-
Induced	4(23.6)	4(30.8)	9(52.9)	2(66.7)	1(50.0)	1(33.3)	2(50.0)	2(33.3)	1(50.0)	-
If Induced Where was it performed										
At home by a *dai*	1(25.0)	1(25.0)	1(11.1)	-	-	-	-	-	-	-
Hospital	2(50.0)	3(75.0)	5(55.6)	2(100.0)	1(100.0)	-	1(50.0)	2(100/0)	1(100.0)	-
Private clinic	1(25.0)	-	3(33.3)	-	-	1(100.0)	1(50.0)	-	-	-
Who Performed the Abortion										
Doctor	4(2.7)	5(3.3)	5(3.3)	-	1(0.7)	2(1.3)	3(2.0)	4(2.7)	2(1.3)	-
Nurse	-	-	1(0.7)	-	-	1(0.7)	-	-	-	-
Dai	2(1.3)	1(0.7)	1(0.7)	2(1.3)	1(0.7)	-	-	-	-	-
Sex of the Aborted Foetus										
Male	4(23.5)	3(23.0)	4(23.5)	1(33.3)	-	-	-	-	-	-
Female	4(23.5)	4(30.8)	2(11.8)	-	1(50.0)	-	-	-	-	-
DK	9(52.9)	6(46.2)	11(64.7)	2(66.7)	1(50.0)	3(100.0)	4(100.0)	6(100.0)	2(100.0)	-

Table 29 : Details on Decisions Relating to Abortions (Contd.)

	Delhi					Haryana				
	First Birth Order No. (%)	Second Birth Order No. (%)	Third Birth Order No. (%)	Fourth Birth Order No. (%)	Fifth Birth Order No. (%)	First Birth Order No. (%)	Second Birth Order No. (%)	Third Birth Order No. (%)	Fourth Birth Order No. (%)	Fifth Birth Order No. (%)
Self-Decision to Abort the Child										
Yes	4(23.5)	4(30.8)	9(52.9)	2(66.7)	1(50.0)	1(33.3)	2(50.0)	2(33.3)	1(50.0)	-
Reasons for Wanting Abortion										
Limiting family size	-	1(0.7)	4(2.7)	1(0.7)	-	-	-	1(0.7)	1(0.7)	-
Do not want female child	-	-	-	-	1(0.7)	-	-	-	-	-
Heavy bleeding/ conceived the child too soon	9(6.0)	10(6.7)	11(7.3)	2(1.3)	2(1.3)	4(2.7)	4(2.7)	-	2(1.3)	-
Who Accompanied You for the Abortion?										
Husband	5(3.3)	8(5.3)	10(6.7)	2(1.3)	2(1.3)	3(2.0)	-	3(2.0)	2(1.3)	-
Mother-in-law	1(0.7)	2(1.3)	3(2.0)	-	1(0.7)	-	1(0.7)	-	-	-
Father-in-law	4(2.7)	2(1.3)	2(1.3)	-	-	-	-	-	-	-
Relatives	-	-	-	1(0.7)	-	-	2(1.3)	2(1.3)	-	-

4.4.4.3 Who Performed the Abortion

The induced abortions were performed mainly by qualified doctors in Haryana, whereas, in Delhi a sizeable proportion of women are still getting abortions done through nurses, *dais* or untrained people, exposing themselves to greater risks of infection and death. What is that greater desire which allows women to undertake such a journey? Probably it is that desire for a son **(Table 29).**

4.4.4.4 Sex of the Foetus

There is a culture of silence as seen from the data obtained in Haryana. Women of Haryana claim that they do not know the sex of the aborted foetus, whereas the women of Delhi have shared the information without hesitation, if they had the information.

4.4.4.5 Decision to Abort the Child

Women in Delhi and Haryana claimed that it was singularly their own decision to get the foetus aborted **(Table 29)**.

4.4.4.6 Who Accompanied the Women for the Abortion

The study has revealed that the women of Haryana were mainly accompanied by their husbands, whereas in Delhi, husbands and the in-laws are known to accompany the women for abortions. This poses a question as to was it a 'woman's decision alone' as has been mentioned by her above? **(Table 29)**.

4.4.4.7 Reasons for Wanting Abortions

The various reasons for getting abortions done included: limiting family size; birth spacing; the foetus was not developing well; and heavy bleeding, so to avoid any further complication got the foetus aborted **(Table 29)**.

4.4.4.8 Indigenous Methods of Sex Determination

Table 30 presents the indigenous methods of sex determination as perceived by the *dais*.

Table 30 : Indigenous Methods of Sex Determination as Perceived by *Dais*

Indigenous Methods of Sex Determination as Perceived by *Dais*	***Dais*** **n = 13** **No.** (%)
If the belly protrudes outwards	9 (69.2)
If the line from the navel to the pit of the stomach is straight, it is a boy otherwise it is a girl	5 (38.5)
By observing the position of the foetus – girls to the right, boys to the left	4 (30.8)
Foetal movement is weak in the case of girls	3 (23.1)
By feeling the ribs of the pregnant woman	2 (15.4)

4.4.4.9 Awareness and Perception of Mothers-in-Law about Abortion and Abortion Related Issues

In a study conducted by Nayar, (1995)[12] all the respondents in both Punjab and Haryana were aware of ultrasonography as a method of sex determination. None of them were aware of other methods. The majority were not in favour of getting sex determination tests (Srivastava, Dasgupta and Rai, 2005).[17] Prasad (2001)[15] found that it was the family's decision to undergo the sex determination test while the mothers stated that it was not a forced decision, as they wanted to give birth to a male child. Most (83.5%) of the respondents felt that the decision to undergo an abortion should rest with the prospective parents; some felt that the prospective mother should take it and only a negligible percentage (5%) felt that other members of the family should take the decision.

4.4.4.10 Awareness about Availability of Abortion Services in Earlier Days

Only 11.3 per cent of mothers-in-law had heard about abortion services in the earlier days **(Table 31).**

4.4.4.11 Perception about the Need for Abortion Services

About 11.7 per cent of mothers-in-law were aware of the abortions performed on the women in the family. The remaining 88.3 per cent mothers-in-law reported that no abortions were performed in their families **(Table 31).**

4.4.4.12 Type of Abortions

There were 62.8 per cent spontaneous abortions among those reported by the mothers-in-law. The remaining 37.4 per cent were induced **(Table 31).**

4.4.4.13 Places of Abortions

Of the total percentage of induced abortions, 61.55 per cent were performed in private clinics, 23.07 per cent in hospitals and 15.38 per cent were performed at home **(Table 31).**

4.4.4.14 Decision-Maker for Getting Abortions Done

The study revealed that the decision-makers for getting the abortions done were the fathers-in-law (38.46%) followed by sons (30.77%), daughters-in-law (23.08%) and mothers-in-law (7.69%), in that order, as reported by the mothers-in-law **(Table 31).**

4.4.4.15 Awareness about the Sex of the Foetus Aborted

Among the total abortions reported by the mothers-in-law, 54.28 per cent were those of females and 17.15 per cent were of males and the rest were those wherein sex of the foetus was not known **(Table 31).**

Table: 31 : Awareness and Perception of Mothers-in-law about Abortion and Abortion-Related Issues

Perceptions of Mothers-in-law	Mother-in-law n=300 No. (%)
Awareness about Availability of Abortion Services in Earlier Days	
Aware	34 (11.3)
Perceptions about the Need for Abortion Services	
Needed	129 (43.0)
Awareness about Abortions in the Family	
Awareness of abortions in the family	35 (11.7)
Abortions happened in the family	265 (88.3)
Types of Abortions	
Spontaneous	22 (62.9)
Induced	13 (37.1)
If Induced, Where was it Performed	
At home	2 (15.4)
Hospital	3 (23.1)
Private clinic	8 (61.5)
Decision-Maker for Getting Abortion Done	
Respondent	1 (7.7)
Respondent's husband	5 (38.5)
Daughter-in-law	3 (23.1)
Son	4 (30.8)
Family members together	-
Awareness about Sex of the Child Aborted	
Male	6 (17.1)
Female	19 (54.3)
Don't Know	10 (28.6)

4.4.5 Awareness of Functionaries about Abortion and Abortion Facilities

4.4.5.1 Safe Period for Abortions

Most of the *dais*, ICDS and health functionaries were aware of the safe period for getting abortions done. A negligible percentage needed their knowledge to be updated. The majority of the respondents, namely the dais, ICDS and health functionaries were aware of women in the community going for abortions **(Table 32)**.

4.4.5.2 Awareness about Abortions Services

It was surprising to know that the majority of the *dais,* ICDS and health functionaries reported the availability of services in private clinics /mobile van services. This points to the fact that abortion services are freely available in spite of the laws, in place. However, the abortions performed, as revealed by the women and mothers-in-law do not corroborate this finding **(Table 32)**.

4.4.5.3 Awareness about Who Accompanies the Women

Table 32 also gives details of who accompanies the women getting abortions performed. The most dominant figures in this have been the husband followed by mothers-in-law.

Table 32 : Awareness about Abortion and Abortion Facilities

Awareness about Abortion and Abortion Facilities	Dai n=13 No. (%)	Functionaries					
		ICDS Functionaries			Health Functionaries		
		CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Safe Period for Abortion							
12 weeks	13 (100.0)	3 (100.0)	11 (100.0)	48 (98.0)	5 (83.3)	9 (90.0)	13 (86.7)
16 weeks	-	-	-	1 (2.0)	1 (16.7)	-	2 (13.3)
20 weeks	-	-	-	-	-	1(10.0)	-
Awareness about women going for abortions	13 (100.0)	3 (100.0)	10 (91.0)	42 (85.7)	4 (66.7)	8 (80.0)	10 (66.7)
Awareness about Abortion Services							
Health centre	1 (7.7)	-	5 (45.5)	2 (4.1)	2 (33.3)	1 (10.0)	1 (6.7)
Private clinics/ mobile vans	12 (92.3)	3 (100.0)	11 (100.0)	42 (85.8)	6 (100.0)	9 (90.0)	15 (100.0)
Government hospital	8 (61.5)	2 (66.7)	10 (91.0)	30 (61.2)	5 (83.3)	8 (80.0)	10 (66.7)
Quacks	4 (30.8)	1 (33.3)	4 (36.4)	8 (16.3)	1 (16.7)	1 (10.0)	2 (13.3)
Awareness about Who Accompanies Women							
Husband	10 (76.9)	2 (66.7)	9 (81.8)	43 (87.8)	5 (83.3)	7 (70.0)	14 (93.3)
Mothers-in-law	10 (76.9)	3 (100.0)	7 (63.6)	33 (67.3)	2 (33.3)	2 (20.0)	7 (46.7)
Relatives	3 (23.1)	2 (66.7)	5 (45.4)	12 (24.5)	1 (16.7)	4 (40.0)	5 (33.3)
ANM/AWW/Nurse	2 (15.4)	-	3 (27.2)	7 (4.3)	1 (16.7)	3 (30.0)	3 (20.0)
Fathers-in-law	2 (15.4)	1 (33.3)	1 (9.1)	1 (2.0)	1 (16.7)	-	-

4.4.5.4 Awareness about the Availability of Ultrasound Machines in Hospitals

Nayar (1995)[12] found that there was total ignorance about the purpose of ultrasonography in pregnancy. People were not aware that these tests were meant for detecting malformation and other complications in the foetus. It was also discovered that the common perception was that ultrasound facilities were made available to detect the sex of the unborn child, so that the family size can be reduced.

Table 33 presents information about the awareness of women, men, *dais* and ICDS and health functionaries about the availability and purpose of ultrasound machines in hospitals. The various responses were: to detect problems in the baby, to detect complications in the mother, to discover the sex of the baby, to determine if there were twins and to view the position of the baby. The availability of ultrasound facility for detecting the sex of the child was reported by women (88.0%), men (78.3%), *dais* (30.8%), CDPOs (66.7%), Supervisors (81.8%), AWWs (77.6%), MOs (33.3%), LHVs (70.0%) and ANMs (73.3%).

4.4.5.5 Awareness and Practices Related to Various Sex Determination Tests

Srivastava, Dasgupta and Rai (2005)[17] found that about two-thirds of the respondents were aware of the PNDT Act 1994 and the MTP Act.

Table 34 presents the awareness of respondents regarding various sex determination tests. Ultrasound as a method of sex determination was known to all the respondents, viz. women (98.3%), men (99.3%), *dais* (100.0%), CDPOs (100%), Supervisors (91.0%), AWWs (100.0%), MOs (100%), LHVs (66.7%) and ANMs (100.0%). Amniocentesis (100.0%) and chronic villi biopsy (66.7%) were mentioned by CDPOs as a method of determining the sex of the foetus.

Table 33 : Awareness about Availability of Ultrasound Machines in Hospitals

Awareness about Availability of Ultrasound Machines in Hospitals	Women n=300 No. (%)	Men n=300 No. (%)	Dais n=13 No. (%)	Functionaries					
				ICDS Functionaries			Health Functionaries		
				CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
To detect problems in the baby	277 (92.3)	277 (92.3)	7 (53.8)	3 (100.0)	10 (91.0)	47 (96.0)	6 (100.0)	10 (100.0)	15 (100.0)
To determine if there are twins	52 (17.3)	164 (54.3)	13 (100.0)	-	2 (18.1)	14 (28.6)	4 (66.7)	2 (20.0)	10 (66.7)
To discover the sex of the baby	264 (88.0)	235 (78.3)	4 (30.8)	2 (66.7)	9 (81.8)	38 (77.6)	2 (33.3)	7 (70.0)	11 (73.3)
To view the position of the baby	-	-	-	2 (66.7)	9 (81.8)	31 (63.3)	5 (83.3)	8 (80.0)	15 (100.0)
To detect complication in the mother	200 (66.7)	251 (83.7)	13 (100.0)	3 (100.0)	10 (91.0)	39 (79.6)	6 (100.0)	8 (80.0)	15 (100.0)

Table 34 : Awareness and Practices Related to Various Sex Determination Tests and Abortions

Awareness and Practices Related to Various Sex Determination Tests and Abortion	Women n=300 No. (%)	Men n=300 No. (%)	*Dais* n=300 No. (%)	Functionaries					
				ICDS Functionaries			Health Functionaries		
				CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about Methods of Sex Determination Tests									
Ultrasound	295 (98.3)	298 (99.3)	13 (100.0)	3 (100.0)	10 (91.0)	49 (100.0)	6 (100.0)	10 (66.7)	15 (100.0)
Amniocentesis	1 (0.3)	4 (1.3)	-	-	2 (18.2)	-	6 (100.0)	2 (13.3)	1 (6.7)
Choronic villi biopsy	3 (1.0)	2 (0.7)	-	-	1 (9.1)	-	4 (66.7)	-	1 (6.7)

Table 35 : Awareness and Practices Related to Various Sex Determination Tests and Abortions (Contd.)

Awareness and Practices Related to Various Sex Determination Tests and Abortion	Women n=300 No. (%)	Men n=300 No. (%)	Dai n=300 No. (%)
Awareness about Conditions under which Abortion is Permitted			
Risk to life of pregnant women	211 (70.3)	246 (82.0)	9 (69.2)
Grave injury to physical or mental health	232 (77.3)	254 (84.7)	10 (76.9)
Pregnancy as a result of rape	86 (28.7)	172 (57.3)	2 (15.4)
Failure of family planning method	189 (63.0)	131 (43.7)	8 (61.5)

4.4.5.6 Awareness about the Conditions Under Which Abortion is Permitted

Awareness about the conditions under which abortion is permitted was elicited from all respondents, and revealed a serious knowledge gap. **Table 35** presents the various conditions under which abortion is permitted as reported by women, men and *dais*. They include conditions, which pose grave injury to physical or mental health; risk to the life of pregnant women; failure of family planning methods; and in a pregnancy resulting from rape.

4.4.6 Sources of Information about the Sex Determination Method

Table 36 highlights the various sources of information about the sex determination methods as reported by women, men and mothers-in-law in Delhi and Haryana. Friends/relatives and doctors/private clinics were the major sources of information about the sex determination methods in both Delhi and Haryana.

Table 36 : Sources of Information about the Sex Determination Methods

Sources of Information about the Sex Determination Methods	Delhi			Haryana		
	Women n=150 No. (%)	Men n=150 No. (%)	Mothers-in-law n=150 No. (%)	Women n=150 No. (%)	Men n=150 No. (%)	Mothers-in-law n=150 No. (%)
ICDS/health workers	33 (22.0)	4 (2.7)	34 (22.7)	7 (4.7)	-	5 (3.3)
Friends/ relatives	108 (72.0)	98 (65.3)	113 (75.3)	107 (71.3)	98 (65.3)	104 (69.3)
Hoardings/pamphlets	-	3 (2.0)	27 (18.0)	2 (1.3)	1 (0.7)	41 (27.3)
Media (TV, radio)	76 (50.7)	71 (47.3)	77 (51.3)	43 (28.7)	1 (0.7)	77 (51.3)
Private practitioners	45 (30.0)	52 (34.7)	-	107 (71.3)	140 (93.3)	2 (1.3)
Doctors/private clinics	8 (5.3)	107 (71.3)	-	21 (14.0)	146 (97.3)	5 (3.3)

4.4.6.1 Knowledge of Functionaries about the Harmful Effects of Sex Determination Tests on the Mother and the Baby

Table 37 presents the awareness level of ICDS and health functionaries about the harmful effects of the sex determination tests on the foetus and the mother. The various harmful effects of sex determination tests on the foetus as reported by the ICDS and health functionaries include premature abortions, haemorrhage, permanent disability in foetus and breathing problems.

Table 37 : Knowledge of Functionaries about the Harmful Effects of Sex Determination Tests on the Mother and the Baby

Knowledge about Harmful Effects of Sex Determination Tests on the Foetus and the Mother	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about Harmful Effects of Sex Determination Tests on the Foetus and on the Mother						
Aware	3 (100.0)	8 (72.8)	40 (81.6)	6 (100.0)	10 (100.0)	12 (80.0)
On the Foetus						
Can lead to premature abortions	2 (66.7)	6 (54.6)	28 (57.1)	6 (100.0)	9 (90.0)	9 (60.0)
Foetus may have haemorrhage	-	3 (27.3)	25 (51.0)	4 (66.7)	7 (70.0)	8 (53.3)
Breathing problem in foetus	-	2 (18.2)	21 (42.9)	2 (33.3)	4 (40.0)	6 (40.0)
Cause permanent disability (Physical and mental)	3 (100.0)	5 (45.5)	34 (69.4)	5 (83.3)	9 (90.0)	9 (60.0)
On the Mother						
Incomplete abortion leading to haemorrhage	1 (33.3)	4 (46.4)	20 (40.9)	4 (66.7)	5 (50.0)	4 (26.7)
Injury to internal organs	3 (100.0)	5 (45.5)	24 (49.0)	4 (66.7)	5 (50.0)	10 (66.7)
Septicaemia	2 (66.7)	4 (36.4)	19 (38.8)	5 (83.3)	5 (50.0)	8 (6.7)
Tetanus	1 (33.3)	2 (18.2)	15 (30.6)	4 (66.7)	5 (50.0)	5 (33.3)
Convulsions	-	-	2 (4.1)	2 (33.3)	2 (20.0)	2 (13.3)
Enhanced risk of miscarriages in future	2 (66.7)	3 (27.3)	21 (42.9)	3 (50.0)	7 (70.0)	9(60.0)
Mental trauma	1 (33.3)	6 (54.5)	25 (51.0)	5 (83.3)	8 (80.0)	10 (66.7)
Sexual dysfunction	1 (33.3)	3 (27.3)	8 (16.3)	2 (33.3)	1 (10.0)	6 (40.0)

The various harmful effects on the mother as reported by the ICDS and health functionaries include incomplete abortions leading to haemorrhage, injury to internal organs, septicaemia, tetanus, convulsions, mental trauma, sexual dysfunction, etc.

Knowledge of the MOs amongst the health functionaries and CDPOs amongst the ICDS functionaries regarding the harmful effects of sex determination tests on the foetus and on the mother was better than the other functionaries.

4.4.7 Knowledge of Functionaries about the MTP Act

Table 38 gives the level of knowledge of functionaries about the MTP Act. Most of the ICDS and health functionaries, viz. CDPOs (100.0%), Supervisors (90.9%), AWWs (81.6%), MOs (100.0%), LHVs (100.0%) and ANMs (93.3%) were aware of the MTP Act.

The terms and conditions laid down under the MTP Act to perform abortions, as enumerated by ICDS and health functionaries, are: if continuing the pregnancy poses a risk to the pregnant women; there is a danger of the baby being handicapped; there is a risk of a baby born with mental abnormalities; the pregnancy resulted from rape; and the pregnancy has occurred as a result of the failure of family planning methods. The awareness level of health functionaries was better than that of ICDS functionaries, understandably so, as the subject is primarily a concern of the health department.

As far as the knowledge about permissibility of abortions beyond 12 weeks is concerned barring the MOs and LHVs, the others did not have complete information about where and how an abortion could be performed. This area needs special attention.

Table 38 : Knowledge of Functionaries about the MTP Act

Knowledge of Functionaries about the MTP Act and PNDT Act	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about the MTP Act						
Aware	3 (100.0)	10 (90.9)	40 (81.6)	6 (100.0)	10 (100.0)	14 (93.3)
Not aware	-	8 (72.8)	27 (55.1)	-	-	1 (6.7)
Awareness about the Terms and Conditions Laid under the MTP Act						
If continuing the pregnancy involves a risk to the pregnant women	3 (100.0)	10 (90.9)	40 (81.6)	6 (100.0)	10 (100.0)	13 (86.7)
If there is a risk of the baby being handicapped	3 (100.0)	5 (45.5)	22 (44.9)	5 (83.3)	8 (80.0)	13 (86.7)
If there is a risk of baby having mental abnormalities	3 (100.0)	5 (45.5)	26 (53.0)	6 (100.0)	8 (80.0)	13 (86.7)
If the pregnancy is as a result of rape	1 (33.3)	2 (18.1)	15 (30.6)	6 (100.0)	9 (90.0)	12 (80.0)
Failure of family planning method	-	8 (72.7)	26 (53.0)	5 (83.3)	8 (80.0)	10 (66.7)
Knowledge about Permissibility of Abortions beyond 12 Weeks						
Yes, Constitution of Appropriate Authority	2 (66.7)	4 (36.3)	27 (55.1)	6 (100.0)	9 (90.0)	8 (53.3)
No	1 (33.3)	7 (63.6)	22 (44.9)	-	1 (10.0)	7 (46.7)
If yes, where it can be performed?						
How can it be performed?						

4.4.8 Knowledge of Functionaries about the PNDT Act

Table 39 provides details regarding the knowledge of functionaries about the PNDT Act and its provisions. The level of knowledge of health functionaries was better than that of ICDS functionaries. However, there is a serious knowledge gap in the functionaries about the provisions of the PNDT Act, which needs immediate attention.

4.4.9 Awareness about Permissible Conditions for Prenatal Diagnostic Techniques

Table 39 also presents the awareness level of ICDS and health functionaries regarding the permissible conditions under which prenatal diagnostic techniques can be carried out. The various permissible conditions to carry out prenatal diagnostic techniques as reported by the functionaries include: the age of the woman is over 35 years; a woman has had 2-3 spontaneous abortions or foetal losses; the woman has been exposed to teratogens (drugs, radiations, infections, chemicals, etc.); and the woman has a history of mental retardation, genetic diseases, physical deformities, etc.

4.4.10 Awareness of Functionaries about Advertisements on Availability of Sex Determination Tests

Only 33.3 per cent of CDPOs, 18.2 per cent of supervisors, 18.4 per cent of AWWs, 16.7 per cent of MOs, 20.0 per cent of LHVs and 26.7 per cent of ANMs had seen any advertisement about the availability of sex determination tests. This points to performing the sex determination tests on the sly. The few who had seen advertisements, said that they were in the form of notices/circulars and hoardings. The respondents mentioned that some time ago they saw advertisements everywhere, but now due to fear of being fined these were withdrawn or was done discreetly **(Table 40).**

Table 39 : Knowledge of Functionaries about the PNDT Act

Knowledge of Functionaries about the PNDT Act	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about the Provisions under the Amended and Renamed PNDT Act						
It prohibits sex selection before or after conception	2 (66.7)	4 (36.4)	24 (48.9)	5 (83.3)	8 (80.0)	11 (73.3)
It regulates the use of prenatal diagnostic techniques (like ultrasound and amniocentesis)	2 (66.7)	7 (63.6)	28 (57.1)	4 (66.7)	7 (70.0)	8 (53.3)
No lab or clinic to conduct ultrasound for sex	2 (66.7)	8 (72.7)	35 (71.4)	6 (100.0)	9 (90.0)	11 (73.3)
Sex of the foetus not to be divulged to pregnant women/or concerned, by words, signs or other methods	2 (66.7)	6 (54.5)	25 (51.0)	5 (83.3)	6 (60.0)	8 (53.3)
No advertisement on availability of service	2 (66.7)	7 (72.7)	31 (63.3)	5 (83.3)	8 (80.0)	10 (63.7)
Prenatal diagnostic techniques to be conducted by qualified persons	1 (33.3)	6 (54.5)	19 (38.8)	4 (66.7)	7 (70.0)	8 (53.3)
Qualified person can conduct abortion only after explaining all the side effects	1 (33.3)	6 (54.5)	26 (53.0)	6 (100.0)	7 (70.0)	8 (53.3)
Procuring consent in the language she understands and give a copy to the pregnant woman	1 (33.3)	1 (9.0)	11 (78.6)	4 (66.7)	7 (70.0)	6 (40.0)

Table 39 : Knowledge of Functionaries about the PNDT Act (Contd.)

Knowledge of Functionaries about the PNDT Act	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
All ultrasound machines including mobile ones to be registered	2 (66.7)	4 (36.3)	20 (40.8)	4 (66.7)	8 (80.0)	10 (66.7)
Constitution of Appropriate Authority	1 (33.3)	1 (9.0)	5 (10.2)	3 (50.0)	4 (40.0)	4 (26.7)
Awareness about Permissible Conditions for Pre-natal Diagnostic Techniques						
Age of woman above 35 years	2 (66.7)	10 (90.9)	37 (75.5)	6 (100.0)	8 (80.0)	9 (60.0)
A woman with 2-3 spontaneous abortions or foetal losses	2 (66.7)	9 (81.8)	37 (75.5)	5 (83.3)	8 (80.0)	14 (93.3)
Exposure of pregnant women to teratogens (drugs, radiation, infection, chemicals etc.)	1 (33.3)	1 (9.0)	9 (18.3)	6 (100.0)	3 (30.0)	9 (60.0)
A woman or her spouse with family history of mental retardation or physical deformities, genetic diseases	2 (66.7)	4 (36.3)	27 (55.1)	6 (100.0)	9 (90.0)	13 (86.7)

4.4.10.1 Awareness about the Fine Imposed on Advertising about Availability of Sex Determination Tests

There was greater awareness about the imprisonment and the fine imposed, among all the ICDS and health functionaries **(Table 40).**

4.4.11 Perception of Functionaries about Measures to Combat the Declining Sex Ratio

Table 41 presents the perception of the ICDS and health functionaries about measures to combat the declining sex ratio in the country. The various measures suggested to combat it include creating awareness about the declining sex ratio in the state; creating awareness about the Act; creating awareness about the value of the girl child; stringent measures to implement the PNDT Act; impose a ban on the use of sex determination tests in government hospitals and private hospitals/ clinics; and lobbying to reduce the practice of sex determination.

4.4.12 Perception of Functionaries about Developing Positive Attitude Towards Women and Girls in the Country

Table 42 presents the perception of functionaries about developing a positive attitude towards women and girls in the community. The various responses of the functionaries include the effective implementation of all laws especially dowry prohibition, property and inheritance, and sex determination and abortion; a positive portrayal of women in the media; giving importance to girls' education; ensuring reservations for women in government jobs/state/national legislations; imparting life skills education to girls and women; creating awareness about the laws/programmes/ schemes that are operational in the state for girls and women; and ensuring better coverage of women with services.

Table 40 : Awareness of Functionaries about Advertisements on Availability of Sex Determination Tests

Awareness about Advertisements on Availability of Sex Determination Tests	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Awareness about Advertisements on Availability of Sex Determination Tests						
Aware	1(33.3)	2(18.2)	9(18.4)	1(16.7)	2(20.0)	4(26.7)
Not aware	2(66.7)	9(81.8)	40(81.6)	5(83.3)	8(80.0)	11(73.3)
Nature of Advertisements						
Notices/circulars/ labels/ wrappers	1(100.0)	2(100.0)	8(88.8)	1(25.0)	2 (100.0)	4(100.0)
Through the Internet	-	-	-	1(25.0)	-	1(25.0)
Hoarding	-	1(50.0)	2 (22.2)	1(25.0)	-	1(25.0)
Paintings	-	-	-	1(25.0)	-	1(25.0)
Awareness about the Fine Imposed on Advertising the Availability of Sex Determination Tests						
Imprisonment up to 3 years	3(100.0)	10(90.0)	40(81.6)	4(66.7)	9(90.0)	15(100.0)
Fine of Rs. 10,000	3(100.0)	9(81.8)	35(71.4)	5(83.3)	10(100.0)	15(100.0)

Table 41 : Perceptions of Functionaries about Measures to Combat the Declining Sex Ratio

Perception of Functionaries about Measures to Combat the Declining Sex Ratio	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Perception of Functionaries about Measures to Combat the Declining Sex Ratio						
Stringent measures to implement the PNDT Act	-	3 (27.3)	5 (10.2)	5 (83.3)	5 (50.0)	9 (60.0)
Impose ban on use of sex determination test in government hospitals	-	9 (81.8)	42 (85.7)	6 (100.0)	10 (100.0)	12 (80.0)
Impose ban on use of sex determination test in private hospitals/clinics	-	9 (81.8)	36 (73.5)	6 (100.0)	9 (90.0)	14 (93.3)
Creating awareness about the Act	1 (33.3)	5 (45.5)	21(42.9)	4 (66.7)	5 (50.0)	12 (80.0)
Creating awareness about the declining child sex ratio in the state	3 (100.0)	10 (90.9)	38 (77.6)	4 (66.7)	5 (50.0)	14 (93.3)
Creating awareness about the value of the girl child	2 (66.7)	9 (81.8)	47 (95.9)	4 (66.7)	8 (80.0)	13 (86.6)
Lobbying to reduce practice of sex determination	3 (100.0)	4 (36.4)	16 (32.7)	4 (66.7)	6 (60.0)	8 (53.3)
Schemes and benefits from the government (*Ladli*, monetary benefits for parents having only girls for education and marriage)	3 (100.0)	4 (36.4)	15 (34.9)	1 (16.7)	2 (20.0)	3 (20.0)

Table 42 : Perceptions of Functionaries about Developing a Positive Attitude towards Women and Girls in the Community

Perception of Functionaries about Developing a Positive Attitude towards Women and Girls in the Community	Functionaries					
	ICDS Functionaries			Health Functionaries		
	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Effective implementation of all laws relating to:						
-Dowry prohibition	1 (33.3)	7 (63.6)	27 (55.1)	6 (100.0)	6 (100.0)	14 (93.3)
-Property and inheritance	-	6 (54.5)	12 (24.5)	6 (100.0)	4 (40.0)	10 (66.7)
-Sex determination and abortion	1 (33.3)	7 (63.6)	26 (53.0)	6 (100.0)	5 (50.0)	13 (86.7)
Positive portrayal of women in the media	3 (100.0)	10 (90.9)	35 (71.4)	4 (66.7)	9 (90.0)	13 (86.7)
Create awareness about laws/ programmes/schemes in the state related to the girl child	-	5 (45.5)	17 (34.7)	3 (50.0)	2 (20.0)	10 (66.7)
Better coverage of beneficiaries with services	2 (66.7)	6 (54.5)	8 (16.3)	4 (66.7)	3 (30.0)	7 (46.7)
Girls' education to be given importance	3 (100.0)	11 (100.0)	46 (93.9)	6 (100.0)	10 (100.0)	14 (93.3)
Reservation for women in government jobs/ state and national legislatures	1 (33.3)	9 (81.8)	34 (69.4)	5 (83.3)	7 (70.0)	13 (86.7)
Implementation of life skills education to girls and women	1 (33.3)	7 (63.6)	18 (36.7)	3 (50.0)	6 (60.0)	11 (73.3)

- It is noteworthy to mention that the percentage of females decreased in the fourth and fifth order births in both Delhi and Haryana.
- Abortions, whether spontaneous or induced, were fewer in Haryana than in Delhi.
- There were 23.6 per cent, 30.8 per cent, 52.9 per cent, 66.7 per cent and 50.0 per cent induced abortions in the first, second, third, fourth and fifth birth orders in Delhi, showing that the number of induced abortions increased with the birth order. Similarly, there were 33.3 per cent, 50.0 per cent, 33.3 per cent, 50.0 per cent induced abortions in the first, second, third and fourth birth orders in Haryana. There were no abortions reported in the fifth birth order pregnancy in Haryana
- By and large the abortions in Haryana were performed in a hospital or private clinic. However, in Delhi apart from hospitals and private clinics, women are taking a high risk by getting them performed by *dais* at home.
- The women in Haryana were accompanied mainly by their husbands, for their abortions, whereas in Delhi, husbands and in-laws are known to accompany the women.
- Though the majority of the *dais*, ICDS and health functionaries were aware of the safe period for performing abortions, there is still a need to update knowledge.
- The availability of ultrasound facilities for detecting the sex of a child has been reported by women (88.0%), men (78.3%) *dais* (30.8%), CDPOs (66.7%), supervisors (81.8%), AWWs (63.3%), MOs (33.3%), LHVs (70.0%) and ANMs (73.3%).
- There is a serious knowledge gap in the functionaries as regards the MTP Act and the PNDT Act, which needs immediate attention.

4.5 Status of the Girl Child and Women's Empowerment

Women's autonomy is likely to have a significant impact on the demographic and health -seeking behaviour of couples, by altering their relative control over fertility and contraceptive use, and by influencing their attitudes and abilities. The NFHS 3 (2005-06) revealed that about 41 per cent of women report that they make their own decision on how they use the money they earn. About 30 per cent of women reported that their husbands or other members of the family, along with their husbands, took the decisions.

Freedom of movement outside the home is an important aspect of women's autonomy and empowerment. NFHS 3 (2005-06) found that only 33 per cent of women were allowed to go alone to the market, a health facility or places outside the village and about 4 per cent were not allowed to go out at all to any of these places (IIPS, 2007).[8]

4.5.1 Decision-Making Abilities

Table 43 gives the distribution of decision-making abilities of women.

4.5.1.1 Children's Education

Decisions regarding the education of children are generally taken by the husband (26.0%); jointly with the woman's husband (25.3%); by the woman (19.0%); or jointly with other members of the family (19.3%).

Mothers-in-laws' responses point towards joint decisions by the family members (32.0%) followed by son (17.3%), self (15.3%), daughters-in-law (14.3%) and husbands (12.0%).

4.5.1.2 Taking the Child to Health Facilities when Ill

The data reveals that mainly women take the decision on their own (28.0%) or jointly with their husbands (22.0%) whereas mothers-in-law rely on joint decisions by the family members to take a child to a health facility when unwell.

4.5.1.3 Seeking Health Care for Self

About 27 per cent of women take decisions on their own to seek health care for themselves as compared to 37.3 per cent of mothers-in-law.

4.5.1.4 Buying Clothes or Jewellery for Self

Over 50 per cent of mothers-in-law observed that it was their decision alone when it came to buying clothes or jewellery for themselves or at times it was her husband's decision (19.7%).

4.5.1.5 Decision to Go and Stay with Parents or Siblings

It has emerged loud and clear that mothers-in-law (64.0%) are the decision-makers in the family and the women (0.3%) have no voice or say whatsoever in such decisions. This is a serious pointer towards distribution of the power structure in the family.

4.5.1.6 Decision on How to Spend the Money Earned by the Women

Again the study has revealed that mothers-in-law are the major decision-makers on how to spend the money earned at home, more than the women themselves.

Table: 43 Distribution of Decision-Making Abilities among the Respondents

Distribution of Decision-Making Abilities among the Respondents	Women n=300 No. (%)	Mothers-in-law n=300 No. (%)
Children's education		
Respondent	57(19.0)	46(15.3)
Daughter-in-law	-	43(14.3)
Son	-	52(17.3)
Respondent's husband	78(26.0)	36(12.0)
Jointly with husband	76(25.3)	27(9.0)
Mother-in-law	19(6.3)	-
Father-in-law	11(3.7)	-
Jointly with others in the family	58(19.3)	96(32.0)
Taking Child to Health Facility when Ill		
Respondent	84(28.0)	62(20.7)
Daughter-in-law	-	66(22.0)
Son	-	32(10.7)
Respondent's husband	61(20.3)	22(7.3)
Jointly with husband	66(22.0)	30(10.0)
Mother-in-law	23(7.7)	-
Father-in-law	11(3.7)	-
Jointly with others in the family	55(18.3)	88(29.3)
Seeking Health Care for Self		
Respondent	81(27.0)	112(37.3)
Daughter-in-law	-	27(9.0)
Son	-	47(15.7)
Respondent's husband	81(27.0)	36(12.0)
Jointly with husband	50(16.7)	29(9.7)
Mother-in-law	49(16.3)	-
Father-in-law	2(0.7)	-
Jointly with others in the family	37(12.3)	49(16.3)

Distribution of Decision-Making Abilities among the Respondents	Women n=300 No. (%)	Mothers-in-law n=300 No. (%)
Buying Clothes or Jewellery for Self		
Respondent	84(28.0)	156(52.0)
Daughter-in-law	-	20(6.7)
Son	-	33(11.0)
Respondent's husband	72(24.0)	59(19.7)
Jointly with husband	54(18.0)	16(5.3)
Mother-in-law	57(19.0)	-
Father-in-law	2(0.7)	-
Jointly with others in the family	29(9.7)	15(5.0)
Going and Staying with Parents or Siblings		
Respondent	31(0.3)	192(64.0)
Daughter-in-law	-	18(6.0)
Son	-	43(14.3)
Respondent's husband	99(33.0)	18(6.0)
Jointly with husband	29(9.7)	6(2.0)
Mother-in-law	97(32.3)	-
Father-in-law	7(2.3)	-
Jointly with others in the family	35(11.7)	20(6.7)
Decisions on How to Spend the Money Earned by Respondent		
Respondent	75(25.0)	170(56.7)
Daughter-in-law	-	41(13.7)
Son	-	43(14.3)
Respondent's husband	92(30.7)	23(7.7)
Jointly with husband	29(9.7)	12(4.0)
Mother-in-law	84(28.0)	-
Father-in-law	1(0.3)	-
Jointly with others in the family	19(6.3)	9(3.0)
NA	-	1(0.3)

4.5.2 Awareness about the Various Laws

Nayar (1995) [12] found that the level of awareness about the various laws under which violence against women and their harassment is a punishable offence was very low among the respondents. MOHFW and TINNARI, (2002)[7] found awareness about the laws was higher among female respondents on the whole.

Table 44 presents the awareness levels of all the respondents of the present study, namely women, men, mothers-in-law, *dais*, CDPOs, Supervisors, AWWs, MOs, LHVs and ANMs. The awareness level of health functionaries was the highest, followed by ICDS functionaries, men, women, mothers-in-law and *dais*.

Table 44 : Awareness about Various Laws

Awareness about Various Laws	Beneficiaries			Functionaries						
				ICDS Functionaries				Health Functionaries		
	Women n=300 No. %	Men n=300 No.%	Mothers-in-law n=300 No.%	Dais n=13 No.(%)	CDPOs n=3 No. (%)	Supervisors n=11 No. (%)	AWWs n=49 No. (%)	MOs n=6 No. (%)	LHVs n=10 No. (%)	ANMs n=15 No. (%)
Abortion is legal	184 (61.3)	226 (75.3)	128 (42.7)	5 (38.5)	3 (100.0)	9 (81.8)	42 (85.7)	6 (100.0)	9 (90.0)	15 (100.0)
Dowry is illegal	251 (83.7)	292 (97.3)	192 (64.0)	10 (76.9)	3 (100.0)	11 (100.0)	47 (95.9)	5 (83.3)	10 (100.0)	15 (100.0)
Violence against women is punishable by law	231 (77.0)	269 (89.7)	179 (59.7)	5 (38.5)	3 (100.0)	11 (100.0)	44 (89.9)	5 (83.3)	10 (100.0)	15 (100.0)
Hindu law permits equal share in ancestral property for males and females	195 (65.0)	250 (83.3)	102 (34.0)	5 (38.5)	3 (100.0)	11 (100.0)	42 (85.7)	5 (83.3)	9 (90.0)	13 (86.7)

4.5.3 Opinions of Respondents on Various Issues

Table 45 presents the opinions of respondents on various issues. The salient finding of the study regarding this issue is that the responses were those that were socially acceptable. But on two issues, namely 'girls should not be allowed to play outside as it is not safe' and 'older girls should remain indoors' the older and more empowered women, the mothers-in-law and *dais* agreed more vehemently than women and men. In fact, men, mothers-in-law and *dais* were of the very firm opinion that 'girls should remain indoors' which is not shared so much by the 'women' respondents. Another opinion that goes against women is that a sizeable proportion of respondents either 'agree' or 'partially agree' with a man beating his wife. Another pointer is that a sizeable proportion of men either 'disagree' or 'partially agree' that household work should be shared by men. When the mindset is such that women have to be subordinated, it will be a difficult task, if not impossible to confront it, to bring about any change.

Table 45 : Opinions of Respondents on Various Issues

Awareness about Various Laws	Beneficiaries			
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	*Dais* n=13 No. (%)
By Birth Girls are Stronger				
Agree	43(14.3)	28(9.3)	55(18.3)	8(61.5)
Partially agree	27(9.0)	41(13.7)	77(25.7)	-
Disagree	229(76.3)	231(77.0)	168(56.0)	5(38.5)
It is All Right if Girls Do Not Go to School				
Agree	14(4.7)	4(1.3)	45(15.0)	1(7.7)
Partially agree	1(0.3)	25(8.3)	4(1.3)	-
Disagree	285(95.0)	271(90.3)	251(83.7)	12(2.3)
Boys Need More Food Than Girls				
Agree	6(2.0)	14(4.7)	19(6.3)	-
Partially agree	5(1.7)	43(14.3)	14(4.7)	-
Disagree	289(96.3)	243(81.0)	267(89.0)	13(100.0)

Awareness about Various Laws	Beneficiaries			
	Women n=300 No. (%)	Men n=300 No. (%)	Mothers in-Law n=300 No. (%)	*Dais* n=13 No. (%)
Girls Should Not be Allowed to Play Outside as it is Not Safe				
Agree	38(12.7)	39(13.0)	102(34.0)	5(38.5)
Partially agree	36(12.0)	91(30.3)	61(20.3)	5(38.5)
Disagree	226(75.3)	170(56.7)	137(45.7)	3(23.1)
Older Girls Should Remain Indoors				
Agree	114(38.0)	194(64.7)	198(66.0)	10(76.9)
Partially agree	29(9.7)	66(22.0)	18(6.0)	1(7.7)
Disagree	157(52.3)	40(13.3)	84(28.0)	2(15.4)
Boys Are More Intelligent Than Girls				
Agree	21(7.0)	24(8.0)	86(28.7)	2(15.4)
Partially agree	5(1.7)	48(16.0)	19(6.3)	-
Disagree	273(91.0)	228(76.0)	195(65.0)	11(84.6)
It is Acceptable if a Man Beats His Wife				
Agree	14(4.7)	5(1.7)	7(2.3)	2(15.4)
Partially agree	54(18.0)	100(33.3)	37(12.3)	1(7.7)
Disagree	232(77.3)	195(65.0)	256(85.3)	10(76.9)
Males and Females Should Get Equal Pay for Equal Work				
Agree	271(90.3)	281(93.7)	216(72.0)	9(69.2)
Partially agree	8(2.7)	8(2.7)	51(17.0)	2(15.4)
Disagree	21(7.0)	11(3.7)	33(11.0)	2(15.4)
Household Work Should Also Be Done by Males				
Agree	222(74.0)	173(57.7)	228(76.0)	11(84.6)
Partially agree	42(14.0)	103(34.3)	28(9.3)	-
Disagree	36(12.0)	24(8.0)	44(14.7)	2(15.4)

- The study has revealed that mothers-in-law are the major decision makers on how the money earned at home is spent, more than the women themselves.
- The awareness level of health functionaries about the various laws was the highest, followed by ICDS functionaries, men, women, mothers-in-law and *dais*.
- In fact, men, mothers-in-law and *dais* were very firmly of the opinion that 'girls should remain indoors' which is not shared so much by the 'women' respondents.
- Another opinion that goes against women is that a sizeable proportion of respondents 'agree' or 'partially agree' with a man beating his wife. There is also the pointer that a sizeable proportion of men 'disagree' or 'partially agree' that household work should be shared by men. When the mindset is that the women have to be subordinated, it will be a difficult task, if not impossible to confront it, to bring about any change.

4.6 Findings from Focus Group Discussions

In all, 12 focus group discussions were conducted, six each in Delhi and Haryana, of opinion leaders/SHG members/PRI members. The main purpose of conducting these discussions were to elicit the perceptions of opinion leaders on the phenomenon of 'missing girls' being witnessed in both states, freely without any inhibitions. A total of 107 opinion leaders from Delhi and 116 from Haryana participated in the focus group discussions. The discussion points included: ideal vs. desired family composition; perceptions about dowry; son preference; gender discrimination; the declining sex ratio; views on remedial measures/action to be taken to tackle the problem of the declining sex ratio; abortion-related practices; the MTP Act; the PNDT Act – provisions thereof, etc.

The salient findings of the twelve focus group discussions are presented in this section.

4.6.1 Ideal vs. Desired Family Composition

- Most of the women said that they prefer two children – one boy and one girl. The remaining mentioned that they prefer three children – two boys and one girl. If there were only girls in a house, boys were definitely preferred and the number of children depended on the presence of a son. If there were two girls in the house then they would opt for a third child, with the hope that it would be a boy. If there was one girl then the other should be a boy.
- The majority maintained that a boy was essential as he perpetuates the family name. Girls are married off and sons take care of their parents in old age. They affirmed that if there were two girls in the family then one son was definitely desired. The ideal family size always depended on the presence of a son in the house.
- Very few respondents stated that two girls were adequate and they would not want a son, as daughters are at par with sons.
- A minority said that in today's times couples prefer fewer children but a son was still considered an important asset in the family. The women stated that one should continue to try, till one has at least one son.

- None of the respondents preferred a one-child-family composition. One feeling that emerged strongly by a negligible few was that sons are necessary for festivals and a sister also requires a brother for protection.

4.6.2 Perceptions about Dowry

- A majority of the women mentioned that those who were wealthy tried to give anything in the name of dowry with the hope that their daughters would remain happy after marriage and lead good lives. They also expressed the view that irrespective of how much is given more is always demanded.
- A substantial number considered dowry an evil practice and felt that it should be eliminated from the face of the earth. However, it would be difficult as it was a deep-rooted practice in Indian culture.
- Youth should be the motivators (both girls and boys) to spread awareness about the evil effects of dowry. They should be the ones to refuse to accept dowry in the first place and be an effective 'change agent' in this area.
- The majority noted that the government should be strict in implementing laws.
- A sizeable proportion stressed that it was a practice followed by the elite classes and they should avoid this practice for the economically backward classes to follow.
- The majority were of the opinion that dowry should be given to the daughter even if one has to take a loan.
- They felt that since girls/daughters are part of the family they should also be given something (depending on their economic standards) in the form of household items, jewellery, vehicles, such as cars and motorbikes, etc. during the marriage.
- They felt that violence/force should not follow after marriage if dowry is not given, as it was the will of the parents to bestow on their daughters whatever they could.

- Some did consider it a matter of pride in the community. *Kanyadaan* is considered auspicious; it is a *dharm* that has to be strictly practised. The majority state that families of the bride-to-be should not encourage families who make unrealistic demands.

4.6.3 Son Preference

- The majority noted that the son is important as he perpetuates the family for seven generations, whereas the daughter is married off.
- Sons are supporters in old age and they perform the last rites. A handful mentioned that with a son, the home remains open (*ghar khula reheta hai*) and during the time of death the son performs the last rites. He brings in dowry and the wealth remains within the family.
- A small number noted that nowadays boys and girls are equal and it is actually the girls who take care or have the time to be interested in their old parents' well-being. Some expressed the opinion that the age-old tradition of sons looking after parents is slowly dying out. Boys do not care for their old parents any more.
- Only the son takes care of the mother and sisters in case of the father's death and not the daughters. It was also noted that if a daughter-in-law gave birth to only daughters, she was threatened with dire consequences, such as eviction from the house or sharing her husband with another woman. Very few commented that the concept of son preference is wrong.

4.6.4 Gender Discrimination

- A majority of the opinion leaders felt that there is strong gender discrimination in the village in relation to food, education and other areas such as freedom to play and go outside. It was found that it is the women themselves who discriminate between a son and the daughter.
- Older girls are subjected to restrictions on movement in the locality, going to relatives or friends' houses alone, etc.

- The majority stated that society had become unsafe for young girls. All were of the view that they were more concerned about their girls as compared to their sons since it was a matter of safety and the honour of the family.
- The elderly women (mothers-in-law) were more vociferous than the women belonging to younger generation, about the discrimination that takes place in all spheres, such as food, education etc.
- A few respondents felt that daughters were considered ill fated and were said to be born with a bad life. Many felt that since the boys remain in the family and girls go to the other houses, boys were given more to eat than their sisters.
- A substantial number felt strongly that no discrimination should be practised against any offspring in the family, as all children are gifts from God.
- They expressed the view that families were unhappy with the worry of the fate that awaited their daughters after marriage.

4.6.5 Declining Sex Ratio

- All the respondents expressed the view that they were aware of the declining sex ratio.
- The majority said that there were various techniques available at private clinics for sex-selective abortions, such as ultrasound.
- Most of them stated that since many people can pay for such facilities, sex-selective abortions are on the rise.
- A considerable number said that polyandry and crimes against women would increase if the situation is not attended to urgently or dealt with on a war footing.
- Girls were considered a burden and a liability to the family, whereas boys carry the family name forward and bring honour to it; hence they were preferred. This preference was deep-rooted in the socio-cultural attitudes. They were apprehensive about the type of life their daughters would lead after marriage, and so they would not want to give birth to a girl child.
- A handful of respondents mentioned that growing inflation and dowry as the main reasons for the same.

Remarks

Women do seek the help of dais, in case it is a secret affair and they do not want other members in the family or neighbours to know. Whereas in families where the basic temperament is such that the son is given preference, women readily opt for abortions in hospitals and private clinics.

4.6.6 Views on Remedial Measures/Action to be Taken to Tackle the Problem of the Declining Sex Ratio

- The majority said that there should be a ban on the facilities available in private clinics where sex-selective abortions are carried out. They were of the view that prenatal diagnostic techniques should be banned.
- A few expressed the view that female foeticide was a crime and should not be carried out as both children are gifts from God. Some conveyed the opinion that as it has been a practice for centuries, it is engraved in people's thinking and it cannot be changed.
- Dowry is one of the major factors why couples opt for abortions, thus the practice should be abolished. The manner of looking at girls and boys in the family should change. Girls should be treated equally with boys in all spheres.
- Women felt the medical practitioners conducting deliveries at hospitals and clinics should not divulge the sex of the foetus as they do presently.
- Abortions should be reduced, and should be done only in circumstances where it is necessary. Many maintained that in earlier days the economic pressure was less, the population was limited and one did not think of having abortions performed. However, today, with inflation rising, the picture is totally different.
- The women felt that the government was not strict, thus they were faced with several problems.

4.6.7 Abortion-Related Practices

- Most of the women opt for sex selective abortions in private clinics or nursing homes. Some go to government hospitals.
- A substantial number try home remedies if they prefer to have a male child (*desi elaaz* – to boil carrot seeds/ajwain and drink it within one and a half months or to boil bamboo sticks wrapped in jute pieces plus three-year-old jaggery plus carrot seeds in one litre of water and consume it when it is reduced to 1 cup, at night).
- The majority felt that sex selective practices (medical and home remedies) should be banned. They however noted that societal and family pressures greatly influenced the views of the people.
- People usually rely on home remedies to conceive a son; they also go to the extent of consulting *tantriks* and *vaids*.
- Women in Haryana were aware as to where facilities were available. In fact they wanted the researchers to convey to the women in Delhi that if they could not get abortion facilities in Delhi they should come to Bahadurgarh, Haryana.

4.6.8 MTP Act and PNDT Act

- None of the women were aware or had heard of the Acts, *per se*.
- A minority did say that sex selective abortion was illegal and punishable under the law.
- The majority said that it has been banned in government hospitals as well as private clinics but many private clinics still conduct abortions illegally.

> ***Observation***
>
> *One woman refused to feed her newborn (18 days) girl child as the doctor had told her she would give birth to a son. Since she did not, she disowned her newborn healthy child. She refused to claim it as her own child.*

CONCLUSIONS

CONCLUSIONS

The major findings of the study are presented in the following section.

5.1 Profile of the Respondents

- The educational status of the women of this generation was better than that of those of yesteryears. Roughly one-fifth of the women were illiterate. More young women were unemployed compared to the women in the mothers-in-law category. A sizeable proportion of the respondents namely, women, men and mothers-in-law owned some land.
- A majority (76.9%) of the *dais* in the study sample were trained. On an average three-fourth of the *dais* conducted 1-5 deliveries per month and one-fourth reported getting an opportunity to conduct even 6-10 deliveries in a month.

5.2 Socio-Cultural, Economic and Demographic Factors Relating to the Adverse Sex Ratio

- Most of the respondents were aware of the phenomenon of the declining sex ratio throughout the country. The majority of the women perceived non-availability of brides as the major repercussion of missing girls followed by an increased rate of crimes against women and polyandry
- The various reasons for son preference mentioned by the women include that he is the support and provider in old age; brings in dowry instead of draining family resources; keeps the family name alive; performs the last rites; on investing in sons, say on education or business, the wealth remains in the family. The main perceived reason for not wanting daughters was dowry by all the respondents.
- The factors essentially responsible for contributing towards the declining sex ratio were son preference and dowry. The interesting finding is that the mushrooming of ultrasound clinics and the ability to pay for abortions was expressed by all the respondents as the major factors responsible for contributing to declining sex ratio.
- The study revealed that the family did not seek the opinion of either the boy or the girl for whom the marriage was being arranged. It seems as though the

freedom to exercise their choice in the selection of their bride/ groom has been withdrawn from children in recent years.

- The study points to the fact that the practice of giving/accepting dowry has not changed over the years. In fact, it is increasing, with development in technology. The study reveals that the community is still tight-lipped about occurrences such as dowry harassment.
- The ideal family composition as perceived by the majority (67.0%) of mothers-in-law included one boy and one girl. About 27.8 per cent of the mothers-in-law considered two boys and one girl as the ideal family composition. Largely, the size of the family is determined by the presence of a son in the family.
- As elicited from the focus group discussions, women would go to any extent to have a son. Various rituals are performed across both states to beget a son, to please the deities, who in turn are believed to grant a boon, viz. a son.
- The celebrations on the birth a baby boy are definitely more joyous with the banging of plates to announce his arrival whereas those performed on the birth of a girl child are low key or missing altogether.

5.3 Knowledge and Awareness about Pregnancy and Childbirth and Childcare Practices

- Around 26.7 per cent of women still believe that check-ups are not required during pregnancy. About 60 per cent of women in Delhi and 88.7 per cent in Haryana were aware of the need to consume 100 IFA tablets during pregnancy. About 74.0 per cent of the women in Delhi and 96.7 per cent in Haryana were aware that two doses of tetanus toxoid were to be taken by a woman during pregnancy. It is disheartening to note that around 65.3 per cent of the women in Delhi and 68.7 per cent in Haryana still believe that deliveries should be conducted at home.
- The knowledge of women in Haryana regarding the problems encountered during pregnancy and childbirth was better than that of the women in Delhi. Awareness about reproductive health care was present, but the attitudes and practices were still sadly lacking. This needs to be bridged urgently.
- Approximately 60 per cent of the women in Delhi and 64.7 per cent in Haryana responded that breastfeeding should be initiated within an hour of birth. About 60.7 per cent of women in Delhi and 99.3 per cent in Haryana responded correctly about exclusive breastfeeding. Also, all the women (100%) in Haryana and 79.3 per cent in Delhi knew the ideal time for introduction of complementary feeding.

- Home remedies (78.7%), consulting AWWs (16.0%), Ayurveda /homeopathy/ other systems of medicine (37.3%), consulting ANMs/LHVs (7.3%), taking the child to a health facility (42.7%) and hospitalizing the child (51.3%) have been the mode of medical attention given to a child during illness as reported by women in Delhi. In contrast, 91.3 per cent reported hospitalization of the child in Haryana. Roughly 30 per cent of women in Haryana relied on home remedies, as against 78.7 per cent women of Delhi.
- It was shocking to note that 97.3 per cent of the women in Haryana and 87.3 per cent in Delhi decreased the food intake of a child during illness.
- There is an evidence of gender discrimination at play, as reported from the focus group discussions, which needs to be dealt with utmost urgency.

5.4 Abortion and Abortion-Related Issues

- It is noteworthy to mention that the percentage of females decreased in the fourth order birth and fifth order birth in both Delhi and Haryana.
- The abortions, whether spontaneous or induced were fewer in Haryana, than Delhi. This finding needs to be taken with caution.
- There were 23.6 per cent, 30.8 per cent, 52.9 per cent, 66.7 per cent and 50.0 per cent induced abortions in the first, second, third, fourth and fifth orders of birth in Delhi, pointing to the fact that the percentage of induced abortions increased with the birth order. Similarly, there were 33.3 per cent, 50.0 per cent, 33.3 per cent, 50.0 per cent induced abortions in the first, second, third and fourth orders of birth in Haryana, where there were no abortions reported in the fifth birth order.
- By and large the abortions in Haryana were performed in hospitals or private clinics. However, in Delhi apart from hospitals and private clinics, women are taking a great risk by getting abortions done through *dais* at home. The women in Haryana have been more open and articulate about abortions, probably because of social sanction given by the family and community, in general, whereas women in Delhi were more discreet and subdued on this issue.
- Women in Haryana were mainly accompanied for abortions by their husbands, whereas in Delhi, husbands and the in-laws are known to accompany them. This finding raises a question as to whether it was the decision of the mother alone or a joint decision or coercion by the family.

- It was surprising to know that the majority of *dais*, ICDS and health functionaries reported the availability of services in private clinics /mobile van services. This points to the fact that abortion services are freely available in spite of the laws, in place. Though the abortions performed, as revealed by the women and mothers-in-law do not corroborate this finding.
- Though most of the *dais*, ICDS and health functionaries were aware of the safe period for getting abortions done, there is still a need to update their knowledge.
- The availability of ultrasound facilities for detecting the sex of the child has been reported by women (88.0%), men (78.3%), *dais* (30.8%), CDPOs (66.7%), Supervisors (81.8%), AWWs (63.3%), MOs (33.3%), LHVs (70.0%) and ANMs (73.3%).
- There is a serious knowledge gap in the functionaries as regards the MTP Act and the PNDT Act, which needs immediate attention.

5.5 Status of the Girl Child and Women's Empowerment

- The study has revealed that mothers-in-law are the major decision-makers on how money earned at home is spent, rather than the women themselves.
- The awareness level of health functionaries about the various laws was the highest, followed by ICDS functionaries, men, women, mothers-in-law and *dais*, in that order.
- In fact, men, mothers-in-law and dais were firmly of the opinion that 'girls should remain indoors' which is not shared so much by the 'women' respondents.
- Another opinion that needs to be considered as against women is that a sizeable proportion of respondents either 'agree' or 'partially agree' with a man beating his wife. Also, it is a pointer that a sizeable proportion of men either 'disagree' or 'partially agree' that household work should be shared by them. When the mindset is that women have to be subordinated, it will be a difficult task, if not impossible to confront it, to bring about any change.

RECOMMENDATIONS

RECOMMENDATIONS

The major recommendations drawn, based on the findings of the present study are as follows:

- The study has revealed a shocking phenomena of high awareness about the declining sex ratio in the states, as also the several serious repercussions of the declining sex ratio, yet the girl child is not valued, pointing to an alarmingly volatile situation that would be hard to deal with in the times to come. However it is an *emergency* and has to be dealt with on a war footing, using all means and efforts of communication.
- Women should also be socialized from early childhood to consider themselves equal to men. They should be encouraged to assume all those responsibilities, which are normally considered to belong to the male domain. This would have a positive influence on the coming generations, as today's girl would be tomorrow's mothers as well as mothers-in-law.
- Data on the child sex ratio available with *anganwadis* is updated continuously and provides valuable information for action by the convergence of services of all sectors under one roof. The village panchayats, elected women *panches* and organized women's groups at village and urban slum ward areas could and should take serious view of the unfavourable child sex ratio in their settings. They should think, plan and act locally and share this with the village community. The collective action plans could be evolved to save the girl child and provide her adequate nutrition at home, balanced development in the village environment through appropriate household actions and health programme interventions. Since the ICDS programme is near universalization it has the inherent strength to ensure wider coverage.
- Mapping should be done and villages with a child sex ratio of less than 850 should to be kept under vigil.
- All the stakeholders who are interested in bringing about a meaningful change in the current scenario should join heads and hands and work together in tandem.
- Laws have been passed declaring female foeticide illegal. Advertising for prenatal information on the sex of the foetus has also been declared illegal. Efforts

should be made to implement these laws effectively. Strict punishment needs to be given to the defaulters as per the PNDT Act.

- MTP should only be permitted only after the approval of the PNDT authority/ committee/ gazetted female officer/mahila panchayat members/NGOs implementing RCH.
- Women's right to own and inherit property and the social obligations of daughters to support parents in the same way as sons, can be spread by policy interventions to inculcate these new values in households. Legal support to implement these values should also be provided.
- Legislative measures, be it the Prohibition of Dowry Act or the PNDT Act, should be stringently implemented.
- The trend of accepting and giving dowry, which takes place mainly in educated and upper class homes, cannot be discouraged by law alone. It is entrenched in the mindset of people and no amount of propaganda would stop it unless, the youth joins hands and fights this menace.
- Free and compulsory education should be provided to female children so that they can support themselves during exigency. Also it would remove the attitude that 'investing in girls is unnecessary'.
- Women should be imparted skills and training through various vocational programmes.
- Central/state governments should popularize schemes in operation in the states through which economic benefits accrue to those families who have daughters, similar to the *Shagan* scheme launched by the Government of Punjab, *Apni beti apna dhan*, *Balika samriddhi yojana*, etc.
- The proposed *Conditional Transfer Scheme (cash and non-cash)* of the government, with its two-fold objectives, the direct and tangible objective to provide financial incentives to encourage them to retain the girl child and the more subtle and intangible one, to change the mindset of the family towards the girl by linking cash and non-cash transfers to her well-being, it is hoped, would give the necessary impetus to improve the status of women. The cash transfers are to be given on completion of certain conditionalities such as birth registration, immunization, school enrolment, retention in primary and elementary school, entry into secondary school/vocational training and completion of 18 years without getting married. It is proposed to disburse Rs. 16,000 per girl child per year under the scheme. It also proposes an insurance cover for the girl child.

- Banks need to be encouraged to give loans for a female child's higher education at low rates of interest.
- The effort towards the awareness and sensitization campaigns for the girl child, as is being carried out by the central and state governments should be intensified and continued.
- Efforts and provisions should be made to provide social security to parents, who are above 65 years and have only daughters. They should be provided with an old age pension if they do not have a son.
- With the growing awareness about the crucial role women play in the overall development scenario, the issue of gender equality assumes far greater significance. When we speak of gender equality there is a whole gamut of issues such as discrimination in every aspect of life, be it education, health, work, social and religious ceremonies, exercising legal rights and so on. Therefore, there is a need to sensitize members of society towards gender issues, especially the lawmakers, members of parliament and legislative assemblies, law enforcement agencies, educators and administrators.
- In recent years issues related to domestic violence are no longer considered as private ones, rather it has been recognized as a social and human rights issue. Many interventions have been initiated in India to prevent violence against women. The latest enactment of the Protection of Women from Domestic Violence Act, 2005 is a major milestone in this direction. Considering the importance of the issue, awareness on the Protection of Women from Domestic Violence Act, 2005 needs to be created.
- Although a large number of NGOs are involved in preventing female foeticide and infanticide, the magnitude of the problem still persists. Sensitization programmes on prevention of female foeticide and infanticide for the functionaries of voluntary organizations and elected representatives of Panchayati Raj Institutions should be organized.
- Multimedia campaigns at the National and state levels should be launched against female foeticide to create awareness to curb the problem and synergize government initiatives to promote women-oriented programmes. There should be more such concerted efforts in the States where the sex ratio is gravely skewed against girls.

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7.	Shri A. K. Nanda Joint Director NIPCCD Hauz Khas New Delhi – 110016	Member
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