CHAPTER-5
PREVENTING FEMALE FOETICIDE:
ROLE OF GOVERNMENT AND NGO’S
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Two distinct approaches to combating female foeticide have emerged in India. These are the provision of equal opportunities and addressing technological determinism. The underlying assumption of both these approaches is that the existing development standard has an integrated mechanism to capacitate or incapacitate women's empowerment and has a varying impact on female foeticide. In keeping with the liberal-equilibrium view generating by the understanding of universal equality among individuals, thus both men and women, by virtue of their being humans, are equal and the uplift of society depends on ensuring that the rights of individuals and safeguarded. Such a position argues that the key problem for women is discrimination, including both unconscious and indirect discrimination. This strategy is adopted to provide equal developmental benefits to women by promoting and protecting individual women and by checking discriminatory practices. The effort as analyzed by the researcher is directed at policies and mechanisms to enhance women's right of entry and control over resources\(^1\). Technological determinism, on the other hand, locates the causes of the declining sex ratio in the spread of new reproductive technologies, particularly sex determination, and targets the access of these to check female foeticide.

5.1 Approaches in Combating Female Foeticide in India

Under the equal opportunities approach further tress to take shape. Equal value represented by the Draft National Advocacy Strategy (NAS) for pre-birth elimination of females in India. ‘Ending the Practice Changing the Attitude’ aims at giving equal

\(^1\)Kabeer, Naila, “Reversed Realities: Gender Hierarchies in Development Thought”, (1995) 80-82 New Delhi: Kali for women
value to a male and a female child with a seemingly creative use of a demand and supply model. Another string is represented by the more conventional transformation of gender placements by enhancing right to use and participation of women to resources. This approach manifests in gender policy prescriptions. This is also being characterized by an alternative right to entitlements-women’s effective command over resources is expected to place them on an equal footing with men. While yet another position within the equality approach is of reproductive rights for women that promote women’s control over their bodies and reproductive choices to check the practice of female foeticide. The liberal equality approach finds widespread acceptance among governments and international conventions. According to the Planning Commission:

The constitution of India provides for equal rights and privileges for men and women and makes special provisions for women to help them improve their status in society. A number of social enactments have been put on the statute book for removing various constraints which hindered their progress. In spite of these measures, women have lagged behind men in different spheres. The National Commission for Women, through its objectives, functions, powers and priorities, follows the approach for providing women with equality of opportunity. It has been set up with the main objective of safeguarding the interest of women, giving for them equal status and opportunity and eliminating, as far as possible, any discrimination against them. Similarly the national policy for the empowerment of women 2001 identifies as its goals:

(i) Creating an environment through positive economic and social policies for full development of women to enable them to realize their full potential.

(ii) The de jure and de facto enjoyment of all human rights and fundamental freedoms by women on equal basis with men in all spheres-political, economic, social cultural and civil.

This policy goes on to elucidate the basic needs strategy aimed at investment in humans (in this case woman) through a greater emphasis on health, education and equitable distribution of wealth and resources to empower women. It further identifies masculinisation of the sex ratio, and by, inference female foeticide as a reflection of this inequality. 'Gender disparity manifests itself in various forms, the most obvious being the trend of continuously declining female ratio in the population in the last few decades.' In doing so, it highlights the need for an alternative perspective to combating female foeticide address the phenomenon.

Female foeticide, indicator and violence are mentioned as symptom of gender disparity and women’s adverse placement is to be countered by empowerment of women, and women’s and equality with men is the maxim. Entitlement to rights through laws and international institutional mechanism such as CEDAW(Convention on the Elimination of All Forms of Discrimination against Women) are ratified to eliminate unequal treatment and unequal opportunity. The convention ratified by India provides, the basis for realizing equality between women and men through ensuring women’s equal access to, and equal opportunities, in political and public life-including the right to vote and to stand for election as well as education, health and employment. State parties agree to take all appropriate measures, including

legislation and temporary special measures, so that women can enjoy all their human rights and fundamental freedom.

These development measures have been promoted by policy interventions with reference to women. To illustrate, the programme of action (POA) from the International Conference on Population Development (ICPD), to which India is a signatory, visualize 'empowering women and providing them with more choices through expanded right to education and health services. No doubt, women's education, a vital component of enhance capacity, has shown positive linkages to the decline in fertility rates. The infant and child mortality and demographic frameworks in particular have pointed at the importance of female literacy, female workforce participation, and female autonomy. Yet socio-economic development has been unable to stop the tide of female foeticide. It has argued that the socio-economic development has more responsible factors of fertility decline.

To empirically investigate the dependence of female foeticide on socio-economic development in comparison with the parameter of Gender Equity Index (GEI). The macro analysis is based on data from secondary sources including the Census of India, the Human Development Report, India, supported by published empirical studies. Primary data is drawn from surveys forming four reports confined to Punjab between 1995 and 2003.

Development, it is assumed, has different relationship with phenomena of a different kind, including women’s empowerment\textsuperscript{12}. This assumption has been challenged by the phenomenon of foeticide as experienced by both developed and developing states. Economically developed states with a high per capita income and relatively better infrastructure have registered a decline in the sex ratio, particularly in the 0-6 age groups. Similarly, the higher income groups, urban populations and the educated have been found to practice a relatively higher extent of female foeticide. The view that economically developed states that over advanced infrastructure facilities are in a position to provide easy access to scientific technologies of sex determination and these states reflect a collusion of development and technology through a sharp decline in their 0-6 sex ratios is well submitted. Those familiar with the field situation in Punjab, Haryana, Himachal Pradesh, Chandigarh and Delhi know that the ready availability of doctors during the ultrasound test and consequent female foeticide, the good transportation network and the ability to pay for the services of the mobile doctors are factors responsible for the widespread recourse to ultrasound in rural areas also. States such as Maharashtra, Gujarat, Punjab and Goa, no doubt, would affirm to the proposition that developed states have registered the highest decline in their child sex ratios (if per capita income is taken as an indicator of economic development). Further explorations of data reveal female foeticide is prone to the most economically backward states also, while states with similar development indicators reflect dissimilar child sex ratios, and child sex ratios are affected by cultural neglect practiced in populations in lower income groups, where female foeticide may or may not be widespread.

States such as Rajasthan and Bihar, which are among the state with the lowest per capita income in the country, also reflect the same trend, and even a sharper decline in the 0-6 sex ratio than, for instance, the 'developed' state of Maharashtra. Again, states with a moderate per capita income (near India's average) may report a sharp or a marginal decline in their child sex ratios. West Bengal is found to have the most drastic decline in its 0-6 sex ratio of 186 points between 1981 and 2001 as given in Table-1. On the other hand, Kerala, Karnataka and Andhra Pradesh, with similar per capita incomes, show a decline of only 7, 25 and 28 points respectively in the same period. Clearly, if per capita income is an indicator of economic prosperity, it has no defining role in determining the declining child sex ratio.

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According to studies on female foeticide, urban and upper income groups, who have access to medical facilities; utilize these to practice their preference for the desired sex of their child\textsuperscript{14}. The sharper decline in the urban birth sex ratio at the all-India level, as in many other states, is cited as evidence. Estimates of sex-selective abortions calculated by a study report that urban areas in Haryana and Punjab witnessed a five-fold and an 18 per cent increase, in contrast to the declining trends in the rural areas\textsuperscript{15}.

A number of micro studies have found that the particular form of gender abuse of female foeticide is reported to be higher among the upper income groups and educated groups. A study in Mumbai reports that the in 1986 doctor performing the sex determination test revealed that the majority of their clients were from the middle class and others from the upper class, with a very small number from the lower classes\textsuperscript{16}. Moreover, some of the medical procedures for sex selection are so expensive that the clientele perforce from the upper income groups can afford. The Foundation for Research in Reproduction in Mumbai, while performing the Ericsson technique charged Rs.4000 per insemination, which on an average requires 3-4 insertions for a pregnancy. Ninety six per cent of its initial clients wanted a son and two-thirds of them were from the business community. Similar reporting is done by a doctor who had a diary of 450 ‘cases’ of sex determination tests. According to the doctor, ‘initially, only wealthy people from the middle castes came for the tests. They keep coming even now, but our main clientele has changed. Now it is the educated middle class’ . Another study in Delhi reports a substantial clientele from educated women.

\textsuperscript{14} Gill, P.P.S., "Abortions More Prevalent in Urban Punjab", The Tribune Chandigarh; July 4, 2002
Not only developed states and groups choose to female foeticide but also people from empowered populations, with relatively better resources and rights, are its practitioners. It is a challenge to the entitlements approach to combat female foeticide in ethnic groups who resort to birth sex preference practices in developed societies. These groups enjoy safe donation and female entitlements to resources. Yet they resort to female foeticide. In the Netherlands, the issue of ethnic minorities seeking male children by aborting female foetuses created sufficient uproar to be reported in newspapers in 1994. The debate found support from some medical practitioners on grounds of a right to exercise a cultural preference, with others arguing against this choice, since these people now lived in Netherlands did not need sons as old age insurance. The demand found reflection in sex selection choices being made by ethnic minorities through the facilities offered by the Gender pre-selection Clinic opened in Utrecht in 1995. The reports of the 19 per cent ethnic minorities, significantly with a higher education using the clinic services, predominantly desired a son, contrary to other clients of the clinic. Such instances indicate that even when the benefits of development increase, son preference remains unabated, even manifesting in the phenomenon of female foeticide. Further doubts about the development agenda arise when analyzing data of states ranking high on the gender equality index (GEI). In fact, states improving on the Gender equality index are simultaneously boosting the masculine sex ratio. Himachal Pradesh, for instance, was ranked 4 on the gender equality index in the 80s and in the 90s became the most gender equitable state. Yet it recorded one of the most dramatic declines in the child sex ratio, a fall of 74 points from 1981 to 2001 as shown in table no.2. In other words, while gender enjoys increasing equality on the development parameters, female foeticide also increases. Himachal Pradesh has registered a substantial increase in its

17 Supra n.16
female literacy rate (from 37.7 in 1981 to 68.08 in 2001), as also a vast improvement in its female work participation rate (31.86 in 1981 to 43.7 in 2001) but during the same period it has been masculinisation of its child sex ratio.

Himachal Pradesh is not the only state to have simultaneously enhanced female capacities, including female life expectancy, and also a deteriorating child sex ratio. Maharashtra, Orissa, Punjab, Gujarat are some of the other states that believe the popular linkage of development with gender status as given in table-2. Clearly, development parameters such as female education, access to facilities, particularly health facilities, do not protect women from gender abuse. Obviously then, gender equity is not criterion for gender empowerment. The analysis cautions against an isomorphic dependence on development to dismantle the structure of gender dominance. Education, work participation rates, enhanced health, declining fertility have been considered under the existing gender hierarchies to manifest in the phenomenon of female foeticide.

Table -2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gujarat</td>
<td>20.14</td>
<td>-72</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>30.36</td>
<td>-74</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>26.5</td>
<td>-39</td>
</tr>
<tr>
<td>Orissa</td>
<td>25.83</td>
<td>-45</td>
</tr>
<tr>
<td>Punjab</td>
<td>26.91</td>
<td>-115</td>
</tr>
<tr>
<td>India</td>
<td>24.41</td>
<td>-35</td>
</tr>
</tbody>
</table>

Source:-


Moreover, socio-cultural contexts shape the forms of gender subjectivities, thus male child preference may manifest as female infanticide in some areas and as
female foeticide in other populations. Blanket categorization of 'developed state’s as the basis of particular phenomenon is reductionist and also gender neutral.

Access to development has been unable to transform the gender position and bring about a change in the power equilibrium of society. Yet gender related policies continue to promote and even achieve their specified targets of increased access but are unable to counter female foeticide. For instance, the National Health Policy 2000 targets controlling infant mortality rates (IMR) and promoting the two child family norm \(^{20}\). The IMR rates are declining, but so is the birth of the girl child. Also, addressing the IMR gender gap seems to be outside the scope of its authorization. While in 1981 infant mortality rates in accordance to biological vulnerability of male children were favourable to the girl child with mortality rates of male 122 and female 108, increasing penetration of health facilities bypassed the survival rate of males to that of females in 1991 (male IMR 74 and female IMR 79). The trend continued in 2001 (male IMR 64 and female IMR 68). In other words, developmental benefits increase differentially to males and females. The two-child norm is also becoming a reality, but at the cost of displacing the girl child. The reproductive health approach to population stabilization and sustainable development adopted by the Department of Family Welfare and UNFPA India, calls for increasing ‘women’s control over their bodies and lives’ \(^{21}\). Is ‘women’s right to choice’ a protection against an informed choice to undergo female foeticide? The Women’s Empowerment Policy-2001 views women’s unfavourable status as an entitlement failure—lack of woman right to use the resources, facilities and infrastructure. Yet if increasing female literacy rates, enhancing life expectancy, increasing health benefits to women, increasing female employment, were the basis of realizing equality, then states like Haryana, Punjab,

\(^{20}\) Ibid


Himachal Pradesh, Orisa, West Bengal, Maharashtra should not have witnessed large numbers of missing girls children. Clearly, the existing gender-related policies do not have an answer to the gender-differentiating hierarchies as highlighted by the increasing female foeticide even though policy objectives are being met\textsuperscript{22}.

If empowerment is merely to provide access, participation and skills within the existing gender differentiating system, it will be absorbed within the gender hierarchies. 'Social activity is the ideological setting within which skills are used and power is exercised'\textsuperscript{23}. These efforts to empower women are being included under the prevalent gender ideology to appropriate the value of female education to promote health of the male offspring, female income and property rights as dowry and absorption of female labour in the unorganized sector at the cost of exclusion from the formal sector. If power is a derivate of skills, then empowerment consent transformation and reallocation of skills from gender based functions. Thus access to livelihood, increased resources or increased participation in decision-making itself may not have the capacity to change women’s unfavourable social placement.

Economic independence has been purchased at the cost of doing a double day and increased exposure to sexual harassment. In fact, participation per se of women in socio-economic processes may just lead to newer forms of violence.

In spite of the contradictions that emerge from the ‘entitlement failure’ to arrest female foeticide, the proposed initiatives to halt female foeticide by NAS (National Advocacy Strategy) ‘Ending the practice changing the Attitude’ and related frameworks is boosted by the same liberal assumption of gender equality. In this instance, for the male and female child by placing the discriminatory manifestation of female foeticide in a demand and supply frame work. To quote the draft strategy

\textsuperscript{22} Government of India; “National Policy for the Empowerment of Women (2001) p.53
while no scientific study has been conducted to identify rank and reasons for Pre-Birth Elimination of Female (PBEF), it is agreed that there are many obvious demand and supply side factors. The category of the demand and supply model depends upon addressing the gender power hierarchies at the level of manifestation, in this instance, the form of female foeticide. The differentiation of genders, structural placements, cultural practices, role typing and causation of gender conditions are segregated from the phenomenon. It is the by passing of social conditions of dominance that allows a demarcation of supply and demand factors or the supply has to be curtailed and the form will be eradicated— as the short-term strategy elucidates. Yet even without the so-called supply factors of technology, the birth of a female child was being socially determined. A crowd of traditional methods, ranging from religious prejudice to the Chinese calendar were practiced prior to the advent of the new reproductive technology of sex selection. There are no separate factors of demand or supply of the male child. The assumption behind both is the same— the practice of gender discrimination. Both ‘practitioners’ and ‘users’ of the Pre-Birth Elimination of Female (PBEF) techniques are filled with the same thinking— it works in collusion, like dowry exchange— the givers and seeker, like fathers who do not give property rights and daughters who do not seek the rights. There are no separate factors— the small family norm does not seek to promote female foeticide, the male child preference continues to run its writ— be it large or small families and it is always at the cost of the female child, be it female foeticide or cultural neglect.

Similarly, there are no socio-economic imperatives to a girl’s birth— the costs of raising a son—from celebration to expenses to acquire degrees/jobs, are not perceived as costs since the perceived advantages in terms of income, status and security accrue to the ‘family’ not the ‘other’ as in the case of the girl. Given this socio-cultural context, an enforcement approach that targets only technology, may

24 Supra n.22
25 Supra n.23
perhaps succeed only in the services go underground. In Maharashtra, the public campaign against inhumanity and brutality against the girl child was successful in clamping down the initial spread of Pre-Birth Elimination of Female (PBEF) technologies, but with the increasing legitimacy of pre-birth selection and sex determination technologies, a legal enforcement alone will not work unless it is proactively imposed26.

Moreover, the strategy is behaviour oriented rather than addressing the more structural interests and values that articulate male child preference. The National Strategy recommends the ways to achieve changes in the behaviour of the multiple stakeholders on account of whose acts of mission or commission the practice of the pre-birth elimination of females continues unabated and is on the rise. The strategy links with broader efforts to progress towards the vision of gender equality. This vision of gender equality finds expression in another sequence to curtail the phenomenon of female foeticide which is centred on the right of women to make their own choice about reproduction and sexuality; in other words to exercise control over their bodies27. In theory, the conceptualization of equality is conceived on grounds of universal uniformity and in operative reality, it grants the existence of an established standard as the prescribed order for the human species. Spike Patterson argues that the principle of equality enshrined in human rights conversation is imposed by taking the standpoint of men. Human rights are gender specific. This is established empirically by reference to gender-differentiated human rights practices, and conceptually by reference to the model of human nature supporting the rights traditions. Both in application and in theory, human rights are based on the male as the norm.

26 Supra n.25
27 Supra n.3
The dominant notion of women’s rights is individual-oriented and its negation that difference between male and female may be recognized and each is given control over his/her body, is gender-perpetuating.\(^{28}\)

The institutionalization of discrimination is saturated with a bias, a differentiation, and a hierarchy. And power hierarchies are expected to be transformed by a change in the mindset. Such a strategy is corrective in nature. The state is targeted as an active medium for distributing equal opportunities, and at the same time, for providing measures for the redress of violation of these efforts. No causation, only manifestations of women’s existing status is addressed. By assuming that equal opportunities can be availed of by adjustments in the systemic functioning, whereby prejudices, stereotypes and sex roles can be combated by awareness programmes, provision of health, education and income, the approach ignores the underlying ideology, values and social practices that determine women’s unfavourable placement and therefore restricted access to opportunity. Liberal solutions can only improve the access of a relatively small number of women to the prizes of existing society. However, if women as a whole are to be liberated, a fundamental transformation of the structure of society is needed. Such restructuring would involve not only liberating women from their domestic and encouragement roles, but also changing the goals of the public and politics.

Even if women are ‘empowered’, they would continue to take gendered decisions. Intervention is made to rectify the imbalances at the level of visible impact, namely discrimination and the physical abuse.\(^5\) It presupposes that discrimination and abuse is directed at defined ‘victims i.e. women, by defined ‘perpetrators’. The problem is thus dealt within the preview of ‘radical individualism’ rather than any

social pattering or manifestation of structural conditions. Focus is thus on individual and segregated aspects of society for redress—where at the micro level at “users” and “service” providers of female foeticide from the center strategy. These acts, if seen as only individual acts and described as abnormality, result only in corrective justice being bestowed whereby the victims is provided with relief and the person behind is targeted for punishment. In fact the NAS strategy focuses on short and medium-term goals that revolve around an effective implementation of the law with some provisions for formal equality. Thus, corrective methods which are individual and relief-centred are practiced. The underlying thrust of the equality of opportunities approach in particular has been to ensure that women have access to and control over resources and an increase in income and decision making would result in greater access for women to health, education and other material resources. The availability of infrastructure and services does not ensure their utilization by females. The availability of infrastructure is reflected in male access to health and education, yet females are discriminated in varying proportion to their socio-economic settings. Thus the opportunity to equal rights does not ensure their availment. In fact, given the increased access to development benefits witnessed by women, it would be fair to observe that, ‘In spite of dramatic changes in economic and political relation, the ideology of gender hierarchy has not been eliminated but simply modernized’.

The systemic discrimination against women operates through the incorporation of values and norms that are ideologically determined and based on the gender system. This prescribes differential placement and roles for males and females on the basis of biology. Empowerment, therefore, is a function of transforming the gender based system, which is shaped by anonymous social mechanisms which provide invisibility to the deprivation, discrimination and abuse that women face. As

30 ibid
a analysis, ideology, in this case the gender system, is a process by which ideas, values and purposes act to influence behavior and is essentially a mechanisms of social control31. It is these gender values that are socially codified, anonymously institutionalized and practiced as cultural capital that manifest as systemic discrimination.

The normative acceptance of power hierarchies renders the systemic deprivation and discrimination as decrees of nature, unchangeable, and outside the purview of decision-making. This institutionalized power has its basis in gender equation, and provides visibility only to brutal acts. Built in prejudices and biases promote the gender system and even share the interests of disenfranchised groups to present conflicts as invisible32. The function of ideology is defined where interests and ideas are shaped to determine not only the areas of decision-making and prescribing an agenda for decision-making but also to determine the ‘socially structured and culturally patterned behaviour of groups and practices of institutions’33.

5.2 Deficiency of Girls in Indian Population

The deficiency of girls in India’s population has been recognized ever since the first decennial enumeration of people was conducted in the late 19th century. Over the period of more than 100 years, the deficiency has progressively increased as evident from the sex ratio of the population; the number of women per 1,000 men steadily declined from 972 in 1901 to 933 in 2001. India shares with China (and other South Asian countries with the exception of Sri Lanka) this phenomenon of deficiency of women in the population. Both the large oriental societies of India and China are structurally patrilineal, exhibit strong son preference and here men enjoy

31 Supra n.29
higher status relative to women. Throughout the rest of the world, women outnumber men by 3 to 5 per cent. In India, according to the 2001 Census, there were 7 per cent more men than women.

The deficiency of women in India and the possible factors responsible for it has produced a lot of attention among demographers, social scientists and women activists who have tried to understand the phenomenon in terms of women being under enumerated in the census counts, sex-selective migration, sex ratio at birth, as well as sex differentials in mortality. Historically, under-enumeration, especially of child brides in certain regions, where child marriages are customary, has found favour with many analysts of census data as one of the factors accounting for deficiency of girls ages 10-14 years. On the other hand, there has been no evidence to support the likelihood of sex differentials in migration (implying greater out migration of women) or greater than the usual masculinity of sex ratio at birth. What has been convincingly demonstrated is that the primary factor contributing to the deficit of women in India is the irregular higher mortality among women compared to men. According to the data from the Sample Registration System of the past 30 years, Indian women have been experiencing higher mortality than men from the age of 12 months to almost up to the end of the reproductive period. Again, elsewhere in the world, women generally experience lower mortality than men at almost all ages such that the life expectancy at birth of women is greater by 5 to 8 years compared to that of men. In India, until the 1980s the life expectancy of women was lower by 2-3 years than that of men. It is only in the 1990s that the trend has begun to reverse.

The sex differential in mortality in India, resulting from the discriminatory treatment received by girls and women, more than balance their natural or biological

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advantage over men. Within India, the social practices and cultural ethos that undervalue women are stronger in some regions than in others. In an almost contiguous belt extending from north-west of India to parts of Rajasthan, Gujarat and Maharashtra, the undervaluation of women is evident in the sex ratio of their population and in their juvenile sex ratio. In fact, an increase in the deficit of young girls noted that in the three decennial Censuses of 1981, 1991 and 2001, is indicative of a strong possibility that the traditional methods of neglect of female children are increasingly being replaced by not allowing female children to be born.

In this research it has attempted to estimate the magnitude of deficiency of girls in India as a whole and in some of the female disadvantaged states and have compared the situation in them with that in Kerala, which is considered a female-advantaged state. The Medical Termination of Pregnancy (MTP) Act and the Pre-Natal Diagnostic Techniques prevention (PDNT) Act are discussed at some length because the recent manifestation of son preference and daughter non-preference needs to be understood in the context of these acts. After briefly discussing some indirect evidence of female-selective abortion from primary data collected from one district each Gujarat and Haryana, the voices of women are documented to understand what compels women or their families to abort female fetuses36.

If all births in the country or a region were registered, one would be able to calculate the sex ratio at birth and guess the extent to which female births are prevented from occurring, since sex ratio at birth is biologically determined and globally ranges between 102-107 male births to 100 female births. Unless there is a conscious effort at intervention by human beings, the sex ratio at birth is most unlikely to change even over to a long time. However, in India except for states like Kerala, Tamil Nadu and Goa, where registration of births is nearly complete,

36 Supra n.33
elsewhere births are far from systematically or fully registered. A significant proportion of births occurring at home are missed from being registered.

In the absence of accurate information on vital events, we have to depend on other sources such as the decimals Censuses, which have provided in record short time after the conduction of each Census, data on number of children in the age group 0-6 by sex and region (up to district level) to estimate juvenile sex ratios. Other things being equal, the juvenile sex ratio also does not undergo significant changes over time. In India, with a somewhat faster decline in female child mortality compared to male child mortality in the past 10-15 years, as evident from the Sample Registration, System data, the juvenile sex ratio should have in recent years become more favorable to girls\(^\text{37}\). However, contrary to this expectation, in the contiguous region from north to west of the country, the deficit of girls increased (and not decreased) between 1981 and 2001. This is also the region where historically the deficiency of women in the total population is reported to be quite significant. So the adverse juvenile sex ratio in itself was no surprise\(^\text{38}\). What triggered the alarm bell was that in spite of the overall improvements in mortality situation, and a greater increase in life expectancy of women compared to that of men, indicating that the women have gained more than men from the improved health care, the deficiency of girls increased. The states in question are: Himachal Pradesh, Haryana, Punjab, Rajasthan, Gujarat and Maharashtra. Delhi also very much fall in this league of states but it is not considered here because being a capital area, it experiences heavy in-migration that can vitiate our analysis to an unknown extent.

\(^{37}\text{Census of India 2001 Series-1 India, Provisional population Totals, paper 1 of 2001 Supplement, District total. New Delhi: Office of the Registrar General of India.}\)

Table-3
Sex Ratio (FMR), All Ages and 0-6 Years for Selected States, 1981-2001

<table>
<thead>
<tr>
<th>States/Census year</th>
<th>All Ages</th>
<th>Children 0-6 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>All India</td>
<td>935</td>
<td>927</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>973</td>
<td>976</td>
</tr>
<tr>
<td>Haryana</td>
<td>870</td>
<td>865</td>
</tr>
<tr>
<td>Punjab</td>
<td>879</td>
<td>882</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>923</td>
<td>910</td>
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<tr>
<td>Gujarat</td>
<td>942</td>
<td>934</td>
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<tr>
<td>Maharashtra</td>
<td>937</td>
<td>934</td>
</tr>
<tr>
<td>Kerala</td>
<td>1038</td>
<td>1036</td>
</tr>
</tbody>
</table>

Source:- Census of India 2001 Series-1 India, Provisional population Totals, paper 1 of 2001

Table-3 also gives figures of sex ratio of the population along with that of children 0-6 years of age\textsuperscript{39}. It is quite evident that between 1981 and 2001, the sex ratio of the total population at the all-India level as well as in the six states in the northern and western parts of the country, remained virtually the same with minor fluctuations. The exception was Gujarat where the deficiency of women somewhat increased during this period. At the same time, the deficiency of young girls, which was not at all evident in 1981 except in the traditionally and historically masculine states of Haryana and Punjab, became quite severe by 2001 in Himachal Pradesh, Gujarat, Rajasthan and also Maharashtra. The sex ratio in Haryana and Punjab deteriorated even further. In Table-4, estimates of the percentage of deficiency of women in the total population and that of the girls in the 0-6 age group during 1981 to 2001 has been shown for the seven states is calculated in percentage terms of women or girls fewer in the total population in relation to the assumption that in the hypothetical situation the number of both sexes would be the same.

\textsuperscript{39} Supra n.37
Two salient facts emerge from Table-4. One, among the selected states with the exception of Kerala where there were female more than men and therefore a deficiency of men in the population, and in Himachal Pradesh where the percentage deficiency of women in the total population was relatively small, a fairly high deficit of women was noted at the all India level and in the other selected sates. The deficiency of women ranged from 3 to more than 7 per cent in 2001. Two, in the 20-year period between 1981 and 1991, the percentage deficiency of women did not increase very much but the deficiency of girls aged 0-6 years increased greatly in the country as a whole as well as in all the states for which, except for Kerala, the state to which the proportionate magnitude of deficiency of women and girls is compared. In Haryana and Punjab there were 10-12 per cent fewer girls than boys.

In spite of the overall faster decline in mortality among women in India registered in the past two decades, the deficiency of girls has progressively and dramatically increased in the last 20 years. Compared to 1981 when there were 1.9

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Table 4
Percent Deficit of Women and Girls (0-6 years) by Select States, 1981-2001

<table>
<thead>
<tr>
<th>States/Census year</th>
<th>Deficiency of women in total population</th>
<th>Deficiency of girls in 0-6 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>All India</td>
<td>3.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Haryana</td>
<td>6.9</td>
<td>7.2</td>
</tr>
<tr>
<td>Punjab</td>
<td>6.5</td>
<td>6.3</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>4.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Gujarat</td>
<td>3.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Maharastrhra</td>
<td>3.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Kerala</td>
<td>-1.6</td>
<td>-1.8</td>
</tr>
</tbody>
</table>

Source:- Census of India 2001 Series-1 India, Provisional population Totals, paper 1 of 2001

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40 Ibid
per cent fewer girls than boys, the percentage doubled to 3.8 by 2001. The states of Haryana and Punjab enumerated 4.8 to 11.6 per cent less girls than boys in 2001, respectively, up from around 5 per cent in 1981. In three other states, the deficiency of girls increased to close or more than 5 per cent in 2001 from around 2 to 2.7 per cent in 1981. In absolute numbers, there were 23 million fewer woman compare to man in 1981, but by 2001, the increased to nearby 36 million. At the same time the absolute deficiency of young girls increased by two and half times; from 2.4 million in 1981 to 5.9 million in 200141.

In fact, 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. Majority or 38 of these districts were located in just three northern and western states of Punjab, Haryana and Gujarat. 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 discrimination against girls that has been practiced in this region for several decades because at no other time in the history of census-taking of the region, has the sex ratio of children declined so drastically.

The distortion in the sex ratio was brought out severely also by an analysis of the data from the second National Family Health Survey NFHS-2 conducted in 1998-99. They showed that at the all-India level, the male to female sex ratio of the last births was 1,434 (or 697 girls for every 1,000 boys), among currently married women who did not want any more children, which was much higher than the sex ratio of 1,069 (FMR of 935) for all the other births. However, there were significant interstate variations and in the states of Haryana and Punjab and Gujarat. The strong son preference was manifested in the sex ratio of last births, which ranged between 1,752,

and 2,173 implying that for every 1,000 girls who were last births, there were more than 1,750 boys who were last births, reflecting a strong effect of gender preference on the reproductive behaviour.\(^{42}\)

In a recently completed study in Mehsana district in Gujarat and Kurukshetra district in Haryana, undertaken with the support of Health Watch Trust, it was also observed that the last births had a stronger dominance of boys than all other births. Although more than twice as many boys as girls were reported among the last births by most groups of women, among those women who belonged to upper castes, whose families were landed, and who were literate, there were more than 240 males for every 100 girls in the last births. The overall claim made by many that sex ratio is much more adverse to females among the better-off population group in relation to others, does indeed hold true according to the study conducted in Gujarat and Haryana. This distortion is very likely due to the use of sex selective abortions, which helps parents get rid of unwanted due to the use of sex selective abortions, which helps parents get rid of unwanted daughters before birth or due to avoiding crowded children once the minimum desired number of sons were born. In either case, the preference for sons was evident in the behaviour of the couples. The results for Gujarat are presented in Table 5 and for Haryana in Table 6.

As shown in table-5 for Gujarat one of the noteworthy findings is that overall, the preponderance of male children increased as the birth order increased. Although the sex ratio of the first birth was greater than the normal acceptable range of 104-107 boys per 100 girls, by the time women have fourth or higher parity child, the chance of that birth being a male birth was greater by almost 30 percent. The

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### Table -5

Sex Ratio of Births and Birth order by Women surveyed in Gujarat Villages

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sex ratio of all live births</th>
<th>Sex ratio of five live birth</th>
<th>Sex ratio of second live birth</th>
<th>Sex ratio of third live birth</th>
<th>Sex ratio of fourth &amp; higher order births</th>
<th>Sex Ratio of the last birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>844</td>
<td>867</td>
<td>853</td>
<td>849</td>
<td>780</td>
<td>479</td>
</tr>
<tr>
<td>Age of women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>927</td>
<td>882</td>
<td>917</td>
<td>1098</td>
<td>1072</td>
<td>732</td>
</tr>
<tr>
<td>25-34</td>
<td>860</td>
<td>983</td>
<td>841</td>
<td>722</td>
<td>824</td>
<td>460</td>
</tr>
<tr>
<td>35+</td>
<td>799</td>
<td>716</td>
<td>839</td>
<td>974</td>
<td>730</td>
<td>353</td>
</tr>
<tr>
<td>Women Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>900</td>
<td>892</td>
<td>993</td>
<td>947</td>
<td>783</td>
<td>557</td>
</tr>
<tr>
<td>Primary level</td>
<td>824</td>
<td>698</td>
<td>838</td>
<td>1143</td>
<td>788</td>
<td>612</td>
</tr>
<tr>
<td>Upper Primary level</td>
<td>767</td>
<td>887</td>
<td>707</td>
<td>562</td>
<td>944</td>
<td>366</td>
</tr>
<tr>
<td>Above primary level</td>
<td>742</td>
<td>893</td>
<td>659</td>
<td>618</td>
<td>286</td>
<td>360</td>
</tr>
<tr>
<td>Women’s Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultivator + Animal husbandry</td>
<td>747</td>
<td>769</td>
<td>822</td>
<td>769</td>
<td>539</td>
<td>421</td>
</tr>
<tr>
<td>Agriculture/manual labour</td>
<td>931</td>
<td>891</td>
<td>926</td>
<td>949</td>
<td>972</td>
<td>598</td>
</tr>
<tr>
<td>Other misc. economic activity</td>
<td>967</td>
<td>1053</td>
<td>1000</td>
<td>1100</td>
<td>714</td>
<td>360</td>
</tr>
<tr>
<td>Housework</td>
<td>820</td>
<td>928</td>
<td>787</td>
<td>772</td>
<td>667</td>
<td>431</td>
</tr>
<tr>
<td>Caste composition</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper Caste</td>
<td>727</td>
<td>838</td>
<td>654</td>
<td>678</td>
<td>588</td>
<td>358</td>
</tr>
<tr>
<td>Other backward castes</td>
<td>886</td>
<td>883</td>
<td>952</td>
<td>935</td>
<td>773</td>
<td>565</td>
</tr>
<tr>
<td>SC+ST</td>
<td>971</td>
<td>889</td>
<td>1143</td>
<td>769</td>
<td>1138</td>
<td>524</td>
</tr>
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<td>Yes</td>
<td>800</td>
<td>874</td>
<td>778</td>
<td>824</td>
<td>642</td>
<td>409</td>
</tr>
<tr>
<td>No</td>
<td>893</td>
<td>857</td>
<td>95</td>
<td>881</td>
<td>887</td>
<td>578</td>
</tr>
</tbody>
</table>

**Source:** Visaria, L. 2003. ‘Sex Selective Abortion in the States of Gujarat and Haryana: Some Empirical Evidence’, new Delhi, Health Watch Trust, Typescript

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Table -6
Sex Ratio of Births and Birth order by Women in Haryana Villages

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sex ratio of all live births</th>
<th>Sex ratio of five live birth</th>
<th>Sex ratio of second live birth</th>
<th>Sex ratio of third live birth</th>
<th>Sex ratio of fourth &amp; higher order births</th>
<th>Sex ratio of the last birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>853</td>
<td>951</td>
<td>824</td>
<td>829</td>
<td>774</td>
<td>553</td>
</tr>
<tr>
<td>Age of women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>863</td>
<td>1020</td>
<td>742</td>
<td>560</td>
<td>800</td>
<td>755</td>
</tr>
<tr>
<td>25-34</td>
<td>836</td>
<td>962</td>
<td>833</td>
<td>716</td>
<td>716</td>
<td>434</td>
</tr>
<tr>
<td>35+</td>
<td>866</td>
<td>935</td>
<td>848</td>
<td>859</td>
<td>824</td>
<td>385</td>
</tr>
<tr>
<td>Women Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>870</td>
<td>903</td>
<td>883</td>
<td>906</td>
<td>782</td>
<td>483</td>
</tr>
<tr>
<td>Primary level</td>
<td>852</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>500</td>
</tr>
<tr>
<td>Upper Primary level</td>
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<td>1168</td>
<td>649</td>
<td>482</td>
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<td>404</td>
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<tr>
<td>Above Upper primary level</td>
<td>854</td>
<td>887</td>
<td>934</td>
<td>583</td>
<td>-</td>
<td>614</td>
</tr>
<tr>
<td>Women’s Activity</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture/manual labour</td>
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<td>904</td>
<td>907</td>
<td>990</td>
<td>775</td>
<td>576</td>
</tr>
<tr>
<td>Housework</td>
<td>839</td>
<td>978</td>
<td>813</td>
<td>700</td>
<td>761</td>
<td>420</td>
</tr>
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<td>Caste composition</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Upper Caste</td>
<td>801</td>
<td>973</td>
<td>792</td>
<td>571</td>
<td>686</td>
<td>414</td>
</tr>
<tr>
<td>Other backward castes</td>
<td>853</td>
<td>867</td>
<td>778</td>
<td>918</td>
<td>873</td>
<td>612</td>
</tr>
<tr>
<td>SC+ST</td>
<td>926</td>
<td>1067</td>
<td>935</td>
<td>903</td>
<td>789</td>
<td>443</td>
</tr>
<tr>
<td>Land ownership</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>815</td>
<td>980</td>
<td>786</td>
<td>573</td>
<td>782</td>
<td>415</td>
</tr>
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<td>970</td>
<td>858</td>
<td>882</td>
<td>773</td>
<td>503</td>
</tr>
</tbody>
</table>


Ibid
situation in Haryana is very similar to that observed in Gujarat. Sex-selective abortion during the first pregnancy was not practiced, but by the time women had their second or third children, almost 50 per cent more boys were born compared to girls. This preponderance of males was observed more among those women who were better educated, who belonged to higher castes and whose families were landed. As in Gujarat, the Haryanvi women also belong to the dominant Chaudhary caste. Interestingly, the Chaudhary Patels of Mahesana district informed during the study that they migrated into this region from Haryana area some 200 years ago. They brought some of the social practices and customs, and till today have adhered to their caste-specific traditions. The similarity between the two groups as far as treatment of women is concerned is striking. The practice of female infanticide was known to exist in both the groups. With the advent of new technology, this inhuman practice has apparently been replaced by sex-selective abortion country, followed by, because of simplicity of the tests and their easy availability.

However, in spite of putting monitoring systems in place, both at the state and the central levels and the Act has been violated with impunity. Since the two activities of sex detection of the foetus and abortion need not be linked at the stage of using the services. It has become possible to evade the law in connivance with the clinics having ultrasound facilities and doing sonography in north-western belt. The open advertisements have abated by simply going underground as evident from the continued decline in the sex ratio of children 0-6 years of age.

Judging by the hoardings even in small towns and the regular advertisements in the local newspapers and magazines, before the passing of the PNDT Act in 1994,

it was evident that clinics conducting sex determination tests had mushroomed in many towns in the states. The easy access is, to a certain extent, a response to an increasing demand and female foeticide apparently has replaced the old tradition of culture of neglect of girl child, practice of infanticide among certain communities and sex differentials in the provision of medical care.

Although the release of the 2001 census results has sparked serious concern about the widespread use of ultrasound and amniocentesis tests to detect the sex of the foetus, followed by sex-selective abortions, our understanding of many issues around this practice, at the level of the household or from the perspective of women who undergo such abortions, is extremely limited. It is also limited about what actually compels couples or their families to resort to such a practice, who the real decision makers in the family are, what impact does aborting female foetus have on the physical or mental health of the women who typically undergoes abortion in the second trimester of her pregnancy. Our understanding of how the inter linkages of sex-selective abortion and decline in fertility or in the desired number of children are perceived and articulated is also very limited. The question often raised is: does the desire for fewer children compel parents to produce children of the sex that they want or that conform to the societal norms and regulate their fertility behaviour accordingly? The qualitative data collected by conducting 44 focus group discussions in which more than 400 women belonging to diverse socio-economic and educational groups in rural Gujarat and Haryana have provided insights on some of these issues. During the discussions with women both in Gujarat and in Haryana, it was clearly indicated that majority of the women accepted the outcome of the first pregnancy—whether it was a boy or a girl. However, if the first-born child was a daughter, then the upper caste women were overtly or covertly pressurized to ensure that the second and or the third child was a boy and to take appropriate measures. Although the women from lower castes experienced this pressure from the family to a much lesser
extent, many among them have started either emulating the women from the upper castes or have started thinking the same way47.

Thus, the son preference was very evident among all social groups in both Gujarat and Haryana states even when the desired number of children had come down to two or three. No groups of women indicated that they would want more than two or three children. They came up with fairly rational explanations about why many children are not desired in the present times and situation. However, in spite of wanting fewer children compared to their parents, women candidly admitted preference for male children. In order to minimize the influence of the other members of the family on the decision of women, women were asked to imagine a hypothetical situation of having all the freedom to choose the number and the sex composition of their children. Among those who indicated that they would like to have three children, the overwhelming response was for two sons and one daughter. However, some who indicated that they would like to have only two children preferred at least one of them to be a son. However, if the two children turned out to be girls then they would almost certainly opt for a third child with a hope that it would be a boy. Women did discuss the possibility that not all sons may support parents in their old age, and yet, the desire for a son was very strong among women of all social groups. As one backward community woman in Gujarat put it: “Yes, we wait for the son. We must have a son, however he may be turn out to be. We would always hope for a son. After all, the daughter will go away after her marriage. The son will stay with us and take care of us”.

Women from the upper castes that practice dowry (Chaudhary in Haryana and Chaudhary Patel in Gujarat) even voiced that if the first child born to them was a boy, then they would be satisfied with just one child. The menace not of the dowry system

but of lifelong presents that have to be given to the girls from the day she marries to her death and also to her children, was a strong restriction to having girls. Along with that a fear was articulated that the daughter might be sent back to the parental house if her in-laws were not satisfied with the presents that have been demanded or that she has been given on various occasions by her family or for any other reasons.48

There is trouble for daughters. They may find a good family or a bad family after their marriage. They (daughters) may come back home. If they have trouble with their in-laws, they may be sent back by their in-laws. In earlier times, the women used to do backbreaking labour, look after the cattle after their marriage. These days girls do not do that. If there is an economic problem, the in-laws will send the girl back to her parental home. So, a girl is always the reasons for the tension of her parents. A girl requires a dowry when she has to be married which is a cause for anxiety. Finding a suitable groom and hoping that she will settle down happily in her new home is always a source of worry for parents.

This almost universal desire for more sons than daughters does get translated in actual behaviour as was evident from the sex ratio of live births that was discussed earlier. In the focus group debate also, women from all communities categorically indicated that if the first-born child was a daughter, then the couples would want to and do find out the sex of the next child. Women knew where to get for sex determination tests, how much the test cost, etc. They were aware that such tests are not done in public hospitals. One had to go to private facilities, majority of which according to them also provided abortion services. In fact, almost all women were able to describe the sex determination procedure quite accurately and in great detail.

Women also indicated that after the birth of a daughter, when they became pregnant again, there was some pressure from the elders in the family to ensure that

48 Supra n.45
the next child was a boy. Women themselves also wanted to produce a son. There is a deep internalization of patriarchal values that are linked to their sense of security. The son preference was internalized to such an extent that women had no hesitation in saying that they would want the sex of the foetus to be known if they had already given birth to one daughter. Although almost all of them had to consult and get permission of their husbands (partly because the sex determination test involved a cost of few hundred rupees), they themselves saw nothing wrong in finding out the sex of the foetus. As expressed by a Kshatriya woman from Gujarat or a Chaudhary woman from Haryana. We have to go for test if the first child is a girl. If we don’t go for the test, we may end up giving birth to three or more daughters in the false hope of getting a son. Women definitely get the test done.... If it is a girl they abort the foetus and if it is a boy, they kept the baby. Everybody knows about the test..... the women themselves want to know whether they are carrying a male or a female child.\footnote{Supra n.22}

Although the parents or parents-in-law of the women very probably had given birth to several children, it appears that they do not wish their daughters-in-law to do so. As the women indicated, the facilities (for sex determination and abortion) did not exist in the earlier times and so the parents had no choice but to bear several children. But in present times, the mother-in-law herself often suggests that the daughter-in-law should get the sex determination test done, especially after producing one daughter. The parents of the woman, however, generally have no say in the matter, except for wishing that their daughters produce at least one son because their well-being and status in the families of the in-laws depends; to a great extent, on bearing sons. Mothers-in-law also have changed with the time. They are also aware of the price rise. They might have had raised their several children, but it is difficult to raise more
children today. A Backward caste woman from Haryana has expressed\textsuperscript{50}. If we already have one son and one daughter, the in-laws would ask us to go in for test and if it were a daughter, they would even ask us to go for abortion. A Chaudhary Patel woman from Gujarat has expressed.

When women were asked about the decision-making process if the foetus was found to be that of a female child, the overwhelming response was that after one or two daughters, if the woman was found to be pregnant with another girl, the pressure on her to abort was enormous from her extended conjugal family. Women indicated that the decision to abort a female foetus was almost entirely that of their husbands and/or mother-in-law. By themselves, women could not decision-making power, apparently accepted whatever was desired by her conjugal family, including husbands. They simply accepted and went along with the decision made for them by others. However, was observed some differences between women belonging to higher social groups those who belonged to scheduled castes and other backward communities with regard to the influence of the in-laws in this matter. Higher caste women had to inform and consult their in-laws but low caste had to obtain the consent of only their husbands for abortion. The influence of the extended joint family was not so strong on the decision of the women from lower caste groups.

A woman cannot take a decision on abortion on her own. If the husband does not want a daughter then he would ask us to go in for abortion. And if he wants a daughter, then we keep the daughter. If the husband is ready to support us and stand by us, we can be firm and go for abortion or not for abortion. In any case, we need to consult our husbands. A Backward caste woman from Gujarat has expressed. If the first two children are girls and the third one too is a girl then we need to take the

\textsuperscript{50} Ibid

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permission of the elders to go for abortion. We have to follow the advice of the elders.

Women also reported that sometimes they themselves desire to abort a female foetus because they already have had one or two daughters. This feeling was stronger among women belonging to social groups such as Patel and Kshatriya, who valued sons much more than daughters. Although they themselves, without much hesitation, would opt for abortion, they still would have to get the permission of the elders of the family to exercise their wish. The analysis clearly points to a collusion of culture or social norms and technology that is all pervasive. On the one hand the son preference is so strongly entrenched in Indian society especially in the north-western region and on the other hand the well-being and status of girls is so precious, once they are married, that couples avoid having girls at all costs. Facilities conducing sex detection tests with ultrasound machines have proliferated and are found even in some of the relatively large villages.

Despite the spread of schooling among girls in recent decades, the patriarchal social structure survives. Women derive value and status only as mothers of sons. Their happiness and social status in the conjugal homes is dependent on producing sons. Women have internalized these roles and values to such an extent that even when they say that daughters take better care of parents or are more emotionally attached to the mothers, these statements have a ring of hollowness because in spite of such feelings, more sons than daughters are desired. In the quest of sons, they have become, with some pressure from the families, consumers of the new technology of ultrasound, which allows them to choose and bear sons. The possibility of declining availing legal abortion services from finding and revealing the sex of the foetus provides an opportunity to abort the child of an unwanted sex. The shift to small family size, evident in India more recently, has not, however, been accompanied by a

51 Supra n.38
shift at the same time in the economic and social pressures to have sons and avoid daughters. As was stated by women in both Gujarat and Haryana, they desire and want few children while ensuring that at least one if not two of those children are sons. This has also led to increased acceptance and use of sex selection tests to achieve parental preferences to have sons while not exceeding the desired number of children\textsuperscript{52}.

At the same time, the awareness about a ban on sex determination tests is fairly widespread among women in our study area. Many women also felt that the ban should be removed and couples should have the choice to decide the sex composition of their children. Women were very well aware that the services are easily available from private providers and are within easy access. Government legislation against the use of ultrasound technology for sex determination has only driven it underground and raised the cost but it is extensively available and used for sex detection. The cost is still affordable and in any case, as many respondents indicated, the cost of the test and related abortion is much lower than the cost of providing dowry and other lifelong presentations to a daughter after marriage. As researcher also pointed out: ‘the alarm bells ringing in the corridors of power about the missing girls do not find an echo in the dusty by-lanes of the villages of these districts’.

The patriarchal structure and values are ingrained for centuries and the practice of getting rid of daughters is known to exist in these regions. The certain social groups in both Haryana, Punjab and Gujarat have started feeling the deficit of brides for their sons. According to some women, a few men are forced to remain bachelors and for some, brides are being brought or bought by paying bride price from scheduled tribes and other groups from far away places including other states. The researcher has hard evidence on the extent of this practice but it may become a

\textsuperscript{52} Supra n.29
lesson in social integration. However, in spite of the deficit of women, whose impact is being felt in procuring brides, the social norms do not yet seem to be responding.

As it evident, legislation banning the use of sex determination tests has not succeeded in avoid couples from seeking these tests or preventing the medical practitioners from performing them. The prevalent social norms and practices do raise a number of questions. Is passing of a national legislation to regulate pre-natal diagnostic technologies and their misuse an answer? Thus far, the law has been largely ineffective but will regulatory mechanisms clamped at all levels or better implementation prevent its misuse? Will impounding ultrasound machines in unregistered clinics and to maintain detailed registers about their use in registered clinics help in reducing their use for sex detection of foetus? It believes, what is needed, is an intensive effort to address the bias against girls at the source and changing the underlying conditions that promote sex-selective abortions. However, it is an uphill task and every action and every group that can address this would contribute to improving the status of women in our society.

5.3 The Government Policies for Eradicating this Evil from the Society

A sex ratio that is lower for women is an indicator of a socio-economic situation unfavourable to females. It indicates the ratio of women to men in a given population. The definition of sex ratio used here is the number of females per thousand males. A lower sex ratio is said to be indicative of a lower status for women. The reasons for a sex ratio that is unfavourable to females could be due to a greater undercount of female relative to males, greater emigration of females, more adverse mortality conditions for females than for males, and sex ratio at birth becoming more favourable to males than in the past the world over, sex ratio is favourable to females. In India, South Asia, West Asia, and Africa, the situation is different. In India the

The overall sex ratio has been favourable to males, and since 1901 the sex ratio has fallen from 972 to 933 in 2001\textsuperscript{54}. The state has sought to overcome these imbalances by seeking to empower the disadvantaged. The policies, plans and legal measures of the government are a statement of this intent. It becomes the social and more responsibility of the state to try and rectify these imbalances. Since a sex ratio unfavourable to women is attributed to poor health of women (among other things), interventions in the sphere of health is one of the ways through which the government seeks to improve the status of women. In the initial Census, a lower female count was attributed to an incomplete enumeration, particularly in the northern and northwestern regions of the country. It is pointed out that differential male and female undercount has narrowed down from 1951, 1971, 1981 and 1991. It indicates that these reasons are not substantial enough to explain the unfavourable sex ratio. In most populations,

A sequel to the non-starter \textit{Balka Samriddhi Yojana} of 1997 in which cash payments to poor families were taking long to be disbursed, the new scheme offers money to parents who fulfil four conditions linked to a girl's survival and welfare. These are ensuring her birth and registering, completing her immunization, educating her and delaying her marriage till 18 years.

The scheme will be launched as a pilot in 10 economically backward blocks of Andhra Pradesh, Chhattisgarh, Jharkhand, Bihar and Orissa. One prosperous block (Punjab's Sirhind in Fatehgarh Sahib, with the lowest female ratio in India) has been included to compare results of cash offers in poor and rich areas vis-à-vis impacts on sex ratio. The Eleventh Five Year Plan has already provided Rs.9.11 crore to benefit 99,000 girls in the current year under the scheme. Besides, the Centre is developing a group housing scheme worth Rs.1 Lakh with the LIC. "We will have different

\textsuperscript{54} Ibid
premium rates depending on whether the girl’s mother is dead or disabled. One lakh will be given to a girl only after she attains 18 years. Every girl entering secondary school will also get a solar lantern from the Ministry of Non-conventional Energy”, says Nandita Mishra, Joint Secretary, Women Child Development Ministry55.

The women and child development minister announce the cradle policy. In this policy the women who is not like to look after the female baby, can put the baby in the cradle. The government will look after the girl child and takes the initiative to save the girl child. Recently in March-2008 the government has announced ‘Dhan Laxmi’ scheme in the seven states. In order that a parent consider their daughter an asset and not a liability, the Central Government has launched a new scheme called “Dhan Laxmi”, a conditional cash transfer scheme, to benefit the girl child and improve the sex ratio in the country. The pilot project of “Dhan Laxmi” will be launched in 11 educationally backward blocks of seven states-Punjab, Andhra Pradesh, Chhattisgarh, Orissa, Jharkhand, Bihar and Uttar Pradesh. An outlay of Rs.10 crore has been proposed for the fiscal 2008-09 to benefit 1,01,970 girl children.

Women and child development minister Renuka Chowdhary said the scheme is designed to change the traditional mindset of parents towards their daughters by linking cash and non-cash transfers to her well-being.

“Dhan Laxmi” will ensure that a significant amount is given to the family on fulfilling specified conditions like ensuring birth registration, immunization and school enrolment of their daughter and delaying her marriage till the age of 18 years.

In addition, an insurance cover of Rs.1lakh will also be provided to the newborn. In all under the scheme, a cash package of around 2lakh will be provided to the family, preferably the mother, Financial incentives will be given in a staggered

55 Ibid
way to encourage them to bring up their daughters in a better way. The scheme will help change the traditional mindset towards their daughters by linking cash and non-cash transfers to her well-being. This will encourage families to consider their daughters as an asset rather than a liability since it is her well-being that will lead to cash inflow in the family.

5.4 The Health Policies: - The Role of Health Workers in Altering Sex Ratio

It focus on the manner in which the government intervenes through the health services in the rural areas in the state of Punjab and the impact of this on the number of women. Punjab is one of the most prosperous states of India. In 1996-97 Punjab had a per capita net state domestic product of Rs.18,1213/- at current prices; second only to Goa. Only 12 per cent of the total population of Punjab is below the poverty line. The figure for India is 36 per cent. Agriculture is the single largest sector of the economy with 83.5 per cent of the total geographical area under cultivation (International Institute of Population Sciences 2001). In addition, Punjab is a patriarchal and patrilineal society. An agricultural economy is indicative of a society with son preference. Given the predominantly agriculture based economy, the economic prosperity of Punjab and the nature of kinship relationships, it is critical to examine the extent to which the implementation of the health programmes has taken in the intent and objective of the health policies and the Primary Health Care approach adopted by the Government of India in 1978. The focus would be on examining the implementation of the programmes in the field, by the health workers in the backdrop of patriarchy and economic prosperity. The study examines the implementation of the policies and plans only in as much they are relevant to the issues. It is based on data collected through intensive in a Primary Health Centre, in Roopnagar district in Punjab.

56 Supra n.46
5.5 Programmes Relevant to Women’s Reproductive Health

The path that India set out for herself for attaining health for all, envisioned a hierarchial referral system imparting health care to the people. The health service sector in India functions in the context of the Primary Health Care approach. Planning for health services started with the planning era in 1951. The broad objections of the policy of health care delivery system are to provide universal coverage and to enable the whole population to have access to the services. It aims at providing comprehensive, preventive, curative, and rehabilitative health services for those who require them. To ensure that services from primary to specialized level are accessible provided through a health team composed of health professionals, administrative, technical and paramedical staff.

Involvement in the sphere of health is through health programmes directed specifically towards women, viz Maternal and Child Health Services, Reproductive and Child Health Project (RCH) and the Family Welfare programme. The programmes aim at providing complete and adequate care to women in terms of their reproductive health. The Family Welfare programme aims at providing better Maternal and Child Health Services (MCH) to women, encourage institutional deliveries and spacing between children. Since 1996 the Target-Free Approach has been introduced and it has been renamed as the Community Needs Assessment Approach (CNAA) from 1997. The aim to encourage decentralized participatory planning. The Universal Immunization Programme (UIP) aims at achieving universal immunization and reducing the mortality and morbidity resulting from vaccine preventable diseases. With effect from 1992, the Child survival and Safe Motherhood Programme, with the assistance of World Bank and UNICEF, has been introduced to supplement the gains of the UIP. Iron and folic acid tablets are being regularly supplied to mothers and children. The Child Health Services project funded by the World Bank aims at

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57 National Health Policy of India
looking after the reproductive health of women and encouraging the participation of women in planning for their own health. The World Bank Project aided India Population Project VII was started in 1991 to improve trained manpower and buildings for both imparting training and for the working environment and residences within the villages.

These programmes are not merely restricted to the curative aspect but are also directed towards health education. The health education component of these programmes is addressed by the information, Education & Communication Activities (IEC). Through health education, the government aims to positively intervene in improving the status of women in the sphere of family planning and maternal and reproductive health. There has been an improvement in living conditions and medical facilities throughout the country. This has led to a greater survival of both males and females. However, in spite of programmes directed specifically to women’s health, the sex ratio indicates a situation unfavourable to females. The National Health Programmes being implemented by the directorate of Family Welfare in Punjab are given below.

5.6 Family Welfare Programme

It is a 100 per cent centrally sponsored programme. The National Health Policy aims at stabilizing the growth of population and for that purpose the goals have been set to curtail both fertility and mortality so as to achieve a Net Reproduction Rate of unity. The government of India has implemented the target-free approach towards family planning from the year 1996-97. There are no specific targets for various methods of family planning but family planning services have to be provided to the public as per their requirements. An action plan has been prepared to motivate

58 Ibid
the couples for family planning through spacing and the use of terminal methods in the age groups of 20-29 years with low parity.

In order to provide better Maternal and Child Health Services all pregnant women are required to be registered for ante-natal care; high-risk mother are to be referred for better care; institutional deliveries are to be encouraged; high-risk babies are to be referred to institutions for treatment. In order to take health services beyond the pursuit of targets the Government of India introduced the Target Free Approach (TFA) all over India on 1st April 1996 and under the system of decentralized participatory planning.

Target Free Approach (TFA) has been renamed as Community Needs Assessment Approach (CNAA) from 1997. Under this approach, planning of family welfare services will be formulated in consultation with the community at the grassroots level. Decentralized participatory planning implicates close association of the community and its opinion leaders such as Village Pradhans, Mahila Swasthya Sanghs, primary school teachers etc., in the formulation of the PHC-based family welfare and health care plan. Each state has to prepare an Annual Action Plan in the beginning of each year and circulate it at various levels.

5.7 Universal Immunization Programme

In 1974 the WHO launched the ‘Expanded Programme on Immunization (EPI)’ against six most common preventable childhood diseases viz. Diphtheria, Pertussis, Tetanus, measles Tuberculosis and Poliomyelitis. The UNICEF, in 1985, renamed it as ‘Universal Child immunization (UCI). There is no difference between the two, the goal was the same i.e. to achieve universal in 1978 with the aim of reducing the mortality and morbidity resulting from vaccine-preventable diseases and to achieve self-sufficiency in the production of vaccines. Universal Immunization

59 Supra n.42
Programme (UIP) was started in India in 1985. It has two components; immunization of pregnant women against tetanus and immunization of children against the six EPI target diseases. The aim was to achieve 100 per cent coverage of pregnant women with two doses of tetanus toxide (or a booster dose) and at least 85 per cent coverage of infants with three doses each of DPT and OPV and one dose each of BCG and the measles vaccine by 1990.

The department of health, Punjab is trying to immunize all newborn infants against the above six preventable diseases. Immunization days have been fixed and services are provided through the health care delivery system on these days. The strategies to eradicate poliomyelitis include strengthening routine vaccination coverage and supplementing routine immunization services with National Immunization Days, i.e. Pulse Polio Immunization. In the first phase, pulse polio immunization days were observed on 9th December, 1995 and 20th January 1996. Punjab too was a part of the nationwide campaign. The aim is to immunize children up to 5 years of age against Polio. The campaign is held regularly every year on pre-fixed National Immunization Days60.

5.8 Maternal and Child Health Services (MCH)

MCH services are provided for the health and care of mothers and children. The government provides these services by organizing prenatal and well baby clinics. The small family norm is propagated through home visits and by ascertaining the confidence on the survival of a few but healthy children. With effect from 1992 Child Survival and Safe Motherhood programme, with the assistance of World Bank and UNICEF, has been introduced to supplement the gains of the Universal Immunization Programme(UIP). Regular supply of iron and folic acid tablets for mothers and children is being made. Vitamin A solution is being administered twice a year to

children up to three years of age so as to prevent night blindness. Efforts are being made to control diarrhea and Acute Respiratory Infections (ARI) through the distribution of ORS packets and through efforts to control pneumonia. The programme is introduced as part of the overall strategy to reduce infant mortality to below 60 per 1,000 live births, childbirth to below 10 per 1,000 population, reduction of percentage of low-birth-weight babies to less than 10 per cent and maternal mortality to below two per 1,000 live births by the year 2000\textsuperscript{61}.

5.9 Reproductive and Child Health Project (RCH Project)

The RCH Project, funded by the World Bank, was launched in the ninth plan period. The Project has three major components:

i) Decentralized Participatory Planning,

ii) Institutional Strengthening:

iii) Programme Implementation Enhancing

These components are being implemented in the state on two tiers;

i) District sub-project

ii) State-wise component

The main objectives of the project are:

i) Provision of family planning services in terms of access and choice;

ii) Prevention and management of unwanted pregnancies;

iii) Intervention to reduce infant mortality;

iv) Prevention and management of Reproductive Tract Infection (RTI) and Sexually Transmitted Infections (STI);

v) Establishment of effective referral and follow up services;

5.10 World Bank Projects

The World Bank Project aided India Population Project-VII, was started in 1991 in Punjab. The project meant to improve the quality of Family Welfare and

\textsuperscript{61} Ibid
Maternal Child Services in the state by providing trained manpower and building, both for imparting training and for the working environment and residences within the villages. Under the project Sub-Centre buildings, Lady Health Visitor residential quarter, primary health centre training annex has been built62.

5.11 Information, Education and Communication (IEC) Activities

The Director, Health Services, Family Welfare is responsible for state wide planning, implementing and monitoring of family Welfare, UIP (including Pulse Polio immunization), MCH, World Bank Project and Primary School health Check-up Campaign). The director is supported with a statewide IEC organization, which starts from the grassroots with the Mahila Swasthya Sanghs (MSS) and is officially managed by IEC professionals from block to state level. The IEC component of the family welfare programme uses newspapers, radio television, and all other means of communication to support community participation.

5.12 Government 20-Point Programme

In addition to the five-year plans and programmes, in 1975 the government of India initiated a special twenty-point programme. The programme was described as an agenda for national action to promote social justice and economic growth on 20th August, 1986 the existing programme was restructured. The government spelt out its objectives as’ eradication of poverty, raising productivity, reducing inequalities removing social and economic disparities and improving quality of life’. At least three of the twenty points related directly or indirectly to health. These are:

a) Health for all;
b) Two-child norm;
c) Expansion of education

62 Supra n.13
There are thus at least seven programmes that are directed towards women's health directly or indirectly. The various health care programmes are to be carried out at all levels of the health care delivery system. The articulation of the policies and plans takes place at the level of the union and state government and various other planning and advisory bodies. The allocation of resources, the setting of priorities and goals are all articulated at this level. These decisions are then conveyed to the secondary level of the health care delivery system i.e. the district authorities. A mere articulation of policies and plans and allocation of resources is a meaningless unless they reach the people and the community. The community is the ultimate beneficiary of this entire planning and implementation process. It is at the primary level that the health care is the most vital. The primary level that the health care services are delivered through a network of Community Health Centres (CHC), Primary Health Centres (PHC), subsidiary Health Centres (SHC), and Sub-Centres (SC). The intent of the state is conveyed through these programmes at various levels to ensure an equitable all round healthy development of all women63.

Staff to provide health care at the paramedical level was introduced as and when the various vertical disease control programmes were introduced. The health workers in their present form were introduced on the recommendations of the Kartar Singh Committee Report in 1977. The scheme was adopted in the Sixth Plan period (1978-1983).

In the field, it becomes difficult to supervise the workers as they do not sit on one place but are constantly on the move as per their schedule. After training, the workers are posted to a sub-centre and they are then expected to build a rapport with the community, live within the community and discharge their duties64. The workers

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63 Supra n.14
carry out their duties by touring the areas under the sub-centre on a daily basis. This involves visiting thirty to thirty five homes by the ANM (Auxiliary Nursing Mother) and 100-120 homes by the male worker on all working days. This means that the ANM comes back to the same house after two months and the male worker revisits the same house after fifteen days. Nowhere else in the health hierarchy in the urban as well as in the rural areas does anybody come into such a close contact with the people on a daily and prolonged basis. In the policy and plan documents they are predicted as the foundation of the entire structure of the health services in India. In a sense, they are the torch-bearers of India's vision of Health for all. They thus form a very vital link in the chain for imparting health care to the people. 5.

Given their importance in India's vision, it is important to study the workers. Hence, it focuses on these health workers (men and women) and the manner in which they implement the various health programmes in the field. Is their implementation in the spirit of the noble intent of promoting equality of both sexes and do they get implemented in an alter and modified form? Such an analysis becomes important given the dismal sex ratio of 874 (as per the 2001 Census) females per thousand males in Punjab. This is lower than the sex ratio of 882 in 1981 and is lower than the sex ratio of 933 for the country as a whole. Analysis of the sex ratio in the sphere of health may help to pinpoint some of the causes for the lower number of women in all age groups in North India. It is only by identification of the shortcomings that viable solutions can be found.

5.13 Factors Influencing the Implementation of the Programmes

An examination of the manner in which the programmes get implemented in the filed revealed that the Family Welfare Programme, to a large extent, is the major one that is carried out in the field at the cost of all other programmes. The other

\[\text{Ibid}\]
programmes that get implemented to some extent are those for which targets have been set. The health personnel at all levels admit the fact that the entire thrust of the health care services at the village level is confined to the achievement of targets; targets that have been set for family planning, immunization and making of malaria slides by the male workers. The entire focus of their beat programme too is on pursuing these targets. The performance of the worker is judged on the basis of her/her targets met. The entire effort of the worker is directed towards meeting targets at the cost of the rest of the health services. The target-based approach meant that health care services have been reduced to the detection of targets66.

As far as the temporary methods of family planning like Copper-T, Oral Pills and Condoms were concerned, there was an unwritten and unspoken acknowledgement of the fact that most the data was fabricated. Many workers, in fact, felt that temporary methods of family planning should be excluded from their duty list since they constituted nothing more than figures to be cooked up for their reports. The workers neither advocated spacing between children through the use of temporary methods nor was it an option, which was acceptable to the average villagers. People in any case did not adopt any temporary methods for family planning till they had the desired family composition, which necessarily included at least two sons. Temporary methods of family planning were never a real option in the minds of the workers. In reality, the workers only promoted sterilization as the method of family planning.

The phrase, ‘family planning’ was, at an informal level, just another term for sterilization. In order to achieve targets workers advocate female foeticide because if the desired family size and composition is met then it is easier to influence women to go in for sterilization. Even though the target-free approach has been adopted, there continues to be an emphasis on targets. A communication from the Civil Surgeons

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66 Ibid

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Office at the district headquarters to the primary health centre in 1996-97, states that in order to bring down the child birth ratio by one unit per thousand population per year, the performance should be of the order of: Sterilization: thirty-six per year and IUD: sixty per year, in a population of 5,000.

This was categorically conveyed to the workers by the Senior Medical Officer of the primary health centre and the District Family Planning Officer (DFPO) at a meeting held at the primary health centre to explain the target free approach to the workers. To achieve the targeted birth rate it was important for them to achieve the sterilization target of three to four per month or thirty six in a year and sixty copper-T in a year, that is five in a month. It was also conveyed to them that some emphasis was also to be given to temporary methods of family planning since they were equally important. The reaction on the part of the workers as far as the target-free approach was concerned was that things, nothing had changed except that they were now more liable to targets continued to be verbally conveyed to the workers. The feeling amongst the workers was that their task had become more difficult since the cases now had to belong to their area of operation. This, in fact meant that the workers could now no longer buy motivation slips registering them as the motivators for sterilization from the General Hospital; they could now have to meet the targets from within their own sub-centre area. By introducing the target-free approach and by emphasizing that the targets have to be from sub-centre area of the worker the government is trying to ensure two things.

Firstly, it is trying to ensure that the worker in the field genuinely tires to control fertility by temporary methods of family planning. Secondly, by limiting the cases to the area of the workers, the government is further trying to put a stop the

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68 Ibid
corrupt practice of buying false motivation slips to falsely show the worker as the motivator for a particular sterilization. At an informal and oral level, the Senior Medical Officer at a monthly meeting conveyed to the workers that in reality it was sterilization, which would help them to achieve the desired rates.

5.14 Cultural Framework Responsible for Female Foeticide

As per the official conversation, the rules say that the workers should work towards promoting a family with two children only. The workers on the other hand, by virtue of being a part of the same patriarchal society, have modified and negotiated the rules to fit in with the fertility behavior and desires of the people. It is within the context of this culturally-determined fertility behaviour framework that the workers try to meet their targets for family planning and sterilization.

In a patriarchal society like Punjab, where descent and succession is through the males, a son is very important. Sons are considered assets for their parents whereas daughters are a burden. Sons are considered as a support in old age, as a means of salvation. According to mythology, cremation at the hands of a son ensures a direct passage to heaven. On the other hand, a daughter is considered a burden. A daughter's marriage require dowry giving which is an economic burden on the parents. After marriage, she goes to live with her husband and his family and the parents have no rights over her fertility. A son, on the other hand continues to stay with his parents. His marriage brings in dowry into the family. His bride, i.e. the daughter-in-law, produces a male heir to carry forward the name of the lineage. Typically, within a year to carry forward the name of the lineage. Typically, within a year of marriage a woman's childbearing years start. Her childbearing years continue till she bears a minimum of two male children. The number of children she has is not important, what is important is the number of male children she bears. The

interval between children too is dependent on the number of male children she has. If the last child is longer. If the last child born is a girl then the attempt for the next child starts almost immediately. Her child-bearing decisions are not hers. Her husband and in-laws make decisions for her. In addition, the male child, till he reaches a certain age, is considered weak to supernatural dangers; hence he is surrounded by a number of superstitious beliefs. He has to be protected from the evil eye.

A woman is considered to be un-established in her husbands’ lineage until and unless she bears male children. It is through a son that a woman is secure in her in-laws house. A son is the key to a woman’s establishment in her husband’s descent group. In Punjabi kinship, a son is considered to be very important for the continuation of the lineage. In the event of a woman becoming a widow without any male heirs, she is sent back to her natal home. She is not given among his collateral. In the event of the widow having sons of the right age, she may gain control of the estate. In some cases a women is know to adopt the son of her sister and is surrounded with a lot of taboos, since he is prone to mystical dangers. Special care is taken to ward off the evil eye during the time of the first three to five years of his life.

A look at the profile of a village the PHC somewhat underlines the importance of a male child. As per the Anganwadi Worker’s register the village had a population of 983 with 509 males and 474 females. The sex ratio for the village as a whole is 931. Out of a total of 113 households, there are 24.7 per cent Jat households and the number of Scheduled Caste (Harijans, Jhoors and Valmiks) households is 75.22 per cent. Thus the majority of the population is of Scheduled Castes. The age and sex-wise population of children in the village is given in table 770.

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70 Ibid

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From table-7 what emerges is that the maximum numbers of children are in the age groups of 1-3 years followed by the age group of 3-6 years. The number of boys in all the age groups is higher than the number of girls. The sex ratio (i.e. the number of women per 1,000 males) for the above age groups is 584 in the village. In all the age groups categories of children, the caste-wise break up is presented in table-8.

**Table-7**  
**Children in the Village by Age and Sex**

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>10(52.63)</td>
<td>9(47.36)</td>
<td>19(13.47)</td>
</tr>
<tr>
<td>6 Month-1 year</td>
<td>10(62.5)</td>
<td>6(37.5)</td>
<td>16(11.34)</td>
</tr>
<tr>
<td>1-3 Years</td>
<td>38(67.8)</td>
<td>18(32.14)</td>
<td>56(39.7)</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>31(62)</td>
<td>19(38)</td>
<td>50(35.46)</td>
</tr>
<tr>
<td>Total</td>
<td>89(63.12)</td>
<td>52(36.87)</td>
<td>141(100)</td>
</tr>
</tbody>
</table>

Note: Figures in brackets indicate percentages.

**Table-8**  
**Caste-wise Distribution of Children by Age**

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>16(84.2)</td>
<td>3(15.78)</td>
<td>19(13.47)</td>
</tr>
<tr>
<td>6 Month-1 year</td>
<td>16(100)</td>
<td>0(0)</td>
<td>16(11.34)</td>
</tr>
<tr>
<td>1-3 Years</td>
<td>45(80.35)</td>
<td>11(19.64)</td>
<td>56(39.7)</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>42(84)</td>
<td>8(16)</td>
<td>50(35.46)</td>
</tr>
<tr>
<td>Total</td>
<td>119(84.39)</td>
<td>22(15.6)</td>
<td>141(100)</td>
</tr>
</tbody>
</table>

Note: Figures in brackets indicate percentages.
A comparison of Table-8 with Table-7 indicates that for 85 Scheduled Castes Households (Harijans, Valmiks and Jhoors) there are 119 pre-school children. This means that there are 1.4 pre-school children per household. For the 28 Jat households there are 22 pre-school children, which mean that there are 0.7 children per household. This indicates that the number of pre-school children per Jat household is half of the number of pre-schoolers in scheduled caste households. This is significant in the light of the lower number of girls as compared to the number of boys amongst the pre-school children.71

Hence, they have given the importance of the son in a family it is but natural that the health workers are not looked at in a positive light. This is truer since the primary task carried out by the workers is that of family planning. The workers are therefore no viewed positively; they are known as the ‘bacha band karanwale’ or child stoppers. The Multiple Health Workers end to target the eligible couples i.e. the men and women in the age group of 16 years to 45 years. Sons and son-bearing is surrounded by a lot of superstitions and taboos. Any suggestions to stop child bearing particularly in the absence of a son are therefore considered to be ill-fated. A women’s position is endangered without a son. Any number of daughters, even after many years of marriage, does not secure her position in the house. In such a scenario, even the thought of trying to stop the birth of a son is filled with dangers and supernatural sanctions. The senior kinswomen exercise complete control over her fertility. They resort to all means to discourage the Multiple Health Workers. Some young women in the village do adopt temporary methods of family planning but this is very rare, generally without the consent of the senior kinswomen and on the sly. But given the low status of the daughter-in-law in the family, particularly if she is a new entrant to the family, there is a tendency to avoid doing things that would jeopardize their already exposed status. The health of women is not of any concern to

71 Supra n.57
anyone, including the women themselves. There is only one aspect of a women’s health that is important and that is her son-bearing. Other aspects of a women’s health are invisible. Her health is important is after son-bearing. In case a daughter is born, she starts her household tasks the very next day. Her guilt-ridden conscience does not let her rest beyond a day or so. It is only after bearing a son that she can legitimately rest. Psychologically too, she is at rest that the guilt of having borne a daughter does not rest heavy on her conscience.\textsuperscript{72}

There is generally no voluntary case of sterilization. The cases are motivated through repeated visits. It generally takes three to four users to motivate a case. In the process another child or two may be born. Some women adopted temporary methods of family planning, generally on the advice of the workers or on the advice of a satisfied, known female user. Temporary methods are adopted only if they have the requisite number of sons (while they made up their minds to go in for sterilization) or while they wait for their sons to grow up to a safe age. Given the kind of supernatural sanctions and beliefs that surround the male child and the preferred family composition, the workers have to be cautious in their approach. The health workers first estimate whether the desired family size and composition has been achieved or not. It is only then that they approach the prospective client. They have to be careful not to be considered as casting an evil eye on the male child.

The workers too do not approach couples for sterilization, till they have a minimum of two sons. The workers feel that sons are very important and it would not be right for them to approach a couple till their family is ‘complete’ with sons. The workers sympathized with this need and in fact did not advocate fertility control to those who did not have the requisite number of boys. In above reality, they only target those people who already have two sons above five years old. The worker too

\textsuperscript{72} Ibid
felt that the need for two sons was very valid. The poorer families compromised at one son if they had three to four daughters. The few Muslim families in the area did not accept family planning at all, as it went against their religious beliefs. As one worker put it, ‘The government should think of the futility of family planning. Without a male child, there is no point in asking them to undergo sterilization. “Operations” should only be carried out after two to three male children. The slogan for family planning should be for three children’.

The health workers’ family composition also reflected the same belief. Their own family composition is the same as that of the people they serve. They practice that they preach. They preach limiting family size by MTPs and sex selection. The health workers themselves and their family members too follow the same practices. An analysis of Table-9 shows that out of 41 married workers, 26.8 per cent have one or two sons. An equal number of workers have one or two daughter. All the workers have sons and those who do not have sons have not yet adopted methods of family planning. None of the male workers follow the two-child family norm they are supposed to propagate to the public as part of their duties. Seven workers have two or more than two sons. All these workers also have a minimum of one daughter. Two male workers have more than two daughters and four of them have two daughters. As far as the female workers are concerned, eight of the female workers have two children. Of these rights, two have daughters only.

Out of these two, one has not yet adopted any method of family planning since she intends to have another child as she put it ‘Rabdi mehar rahi taan agli bar munda hoyega. It munda taan hona chahida hai’ (if God is kind, next time I will have a son. There should be at least one son).

73 Ibid
74 Supra n 69

359
Table-9
Number of Children of the Multiple Purpose Health Worker

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Male MPWs</th>
<th>Female MPWs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero Daughter</td>
<td>1 (6.25)</td>
<td>5 (22.7)</td>
<td>6 (14.6)</td>
</tr>
<tr>
<td>1 Daughter</td>
<td>5 (31.25)</td>
<td>4 (18.18)</td>
<td>9 (21.9)</td>
</tr>
<tr>
<td>2 Daughter</td>
<td>5 (31.25)</td>
<td>4 (18.18)</td>
<td>9 (21.9)</td>
</tr>
<tr>
<td>More than 2 daughters</td>
<td>4 (25)</td>
<td>5 (22.7)</td>
<td>9 (21.9)</td>
</tr>
<tr>
<td>0 sons</td>
<td>2 (12.5)</td>
<td>1 (4.5)</td>
<td>3 (7.3)</td>
</tr>
<tr>
<td>1 son</td>
<td>4 (25)</td>
<td>7 (31.8)</td>
<td>11 (26.8)</td>
</tr>
<tr>
<td>2 sons</td>
<td>5 (31.2)</td>
<td>6 (27.27)</td>
<td>11 (26.8)</td>
</tr>
<tr>
<td>More than 2 sons</td>
<td>1 (6.25)</td>
<td>1 (4.5)</td>
<td>2 (4.8)</td>
</tr>
</tbody>
</table>

Note:- The percentages have been calculated out of a total of 41 married workers.

As far as the other six are concerned, two have one sons and one daughter, the other four have two sons only and daughters. As far as the other ANMs are concerned, eleven of them have more than two daughters and one son. Three ANMs have been married for the past two years and have only one child, two have one daughter, and one has one son. These ANMs have not yet completed their families. The above data shows that the majority of the workers do no practice the two-child family norm that they are supposed to propagate to the public. None of the male workers has only two children. All of them by their own admission felt the need for having sons, irrespective of the number of daughters they have in the process. Some of them felt the need to have a minimum of two sons; 31.2 per cent had two sons and 6.2 per cent have more than two sons. At least some of the female workers who two sons admitted to having used the ultrasound technique to determine the sex of the
foetus. They also admitted to having undergone Medical Termination Pregnancies when the foetus was a female one. They have also taken some ‘medicines’ for having a male child\textsuperscript{75}. As far as the number of children is concerned, none of the male Multiple Purpose Health Worker has only two children and eight of the ANMs have only two children. The majority of them have a minimum of two sons.

One of the ANMs, who has daughter, had returned from maternity leave after the second daughter almost all the male and female health workers, including the Block Extension Educator (BEE), sympathized with her for having borne a second daughter. They also demonstrated with her for being foolish enough not to use the latest technology (i.e. the ultrasound technique), when she herself was in the same field as one of the male workers put it. Another ANM had stopped family planning motivation altogether since one of her ‘case’ had lost both sons in an accident. She felt morally responsible for it since the lady could not have any more sons and she had undergone tubectomy (she had two daughters)

This means that the ANM felt that the health workers were not responsible for bringing up other people’s children. The workers should not propagate family planning as it was against God’s will. He (God) who gives will also provide. For those clients of her sub-centre area, who had a minimum of two children (inclusive of one daughter), she recommended sex-determination and sex-selection of the foetus through ultrasounds and abortion of the female foetus.

These quotes illustrate that the workers do not feel it is correct to propagate the two-child norm. On the other hand, they do feel that planning a two-child family, with only male children. It was possible through sex determination tests. In case the foetus was a female, then one could go in for abortions. Some workers felt that because of family planning their respect had gone down. She felt that asking people

\textsuperscript{75} Ibid
to limit the size of the family was an amoral practice. They could not ask people to stop having children if they do not have sons. The worker felt that sons are an important part of the family, daughters after marriage, in any case, go to their husband’s homes. Daughters cannot compensate for the loss of a son. The family composition of the female workers shows that their independent economic status has not translated into social independence. The women workers continue to attach importance to a son. Their attitude, fertility decisions and behaviour are very significant since they themselves are meant to educate the population about the importance of family planning and the equality of the male and the female child. For the female worker, economic independence and an occupational status (in the health sector) have not made a difference in their own family composition and planning.

5.15 Middle Path Between the Family Planning and the Size of the Family

Workers have negotiated the bureaucratic rules by finding a middle path. They have adapted their operational styles in a way that had modified the governmental definition of family planning from limiting fertility to limiting the number of girl children.

In the field the only programme that actually gets carried out is the family planning (and no the family welfare programme). The phrase ‘family planning’ means two things- For the government it means controlling fertility by limiting the number of children to two, irrespective of the sex of the children. To the people and the workers too it means planning families, but in a different way. It means having a minimum of two sons. For the latter category, it does not mean controlling fertility by limiting the number of children to two. The majority of the workers feel that a family size of three children is a comfortable one. Having one daughter in the quest for two sons is acceptable or one son and two daughters are also tolerable. The worker does not feel that feel that there is anything wrong with foeticide. They empathies with the people and identify themselves with their thinking. As one of the workers said, ‘we
are not different from the people whom we serve'. All the workers try to help those couples that have daughters and have been unable to bear sons. They guide them about the effective methods' of getting sons. The workers empathies with the need for having sons. Some quotes from the villagers further emphasize the widespread practice of female foeticide76.

As we have seen, above approximately 39 per cent of the workers have two or more male children. All the male workers have more than two children and only eight out of the 25 ever married female workers have only two children. Only two male workers and four female workers had no sons. Their families were not yet complete and none of them by their own admission was using any method of family planning. i.e. they were still trying for sons. All the other workers had a minimum of one son (27 per cent had only one son). The workers, on the other hand, are also aware of the two-child norm, which they are supposed to propagate as a part of their official duty. The workers have found a middle part between the need to have son and need to limit the family size.

5.16 Participation of the Women in Medical Termination of Pregnancy Act and Sex Selection.

According to the reliable and informal source of information, it has been observed that the sex determination of the unborn fetuses through ultrasound and subsequent Medical Termination of Pregnancy techniques had become popular for female planning. The people use varied devices, ranging from modern technique like ultrasound to religious technique like visiting holy places, to have sons, the whole thing depend upon state of mind and the economic status of an individuals77.

76 Supra n.12
77 Supra n.23
According to an ANM, most of the well to do people prefers ultrasound technique for performing this task. It is becoming popular among the land-owning jat families. According to an observation, normally two to three ultrasound and Medical Termination of Pregnancy per month, per sub-centre. Subsequent to Medical Termination of Pregnancy, the people their names deleted from the list of pregnant ladies. What should be the ideal family composition, it depends upon the individual level of income, what devices they use to perform this task. Among daily wages earners, being poor, it is not possible to afford expensive ‘ultrasound technique’ for determination of sex in want for the son for their family. There are some of exceptional cases, where we can observe that the numerical strength of their daughters, goes up to seven, in quest for son for their family. The desired family composition was that of a minimum of two sons in the family. This was irrespective of the number of girls born in the endeavor. In case of the family, like jats, then at time the family size is limited to only two children.

The poor people, due to their poverty, they are not in a position to afford expensive Medical Termination of Pregnancy (MTPs) technique, and therefore prefer less expensive techniques like ‘village Dai’. These untrained ‘Daies’ prove cost-effective to performance Medical Termination of Pregnancy in various areas. These ‘daies’ usually use ‘crude methods’ like insertion of sticks dipped in kerosene oil into the uterus. This type of techniques leads to ruptured uteruses even and prove fatal to the women.

They are very well aware of this very facts that repeated Medical Termination of Pregnancy are not good for woman’s health that sex-selection tests are illegal. However, given the desire for son and planning of the family to have a minimum of two sons, the workers have rationalized in their own mind that Medical Termination of Pregnancy are a safer option for this task. Even after the option which they are
rising in not better for their women. But even they use this device, because no other better option is in their mind to perform this task to full fill their desire for son\(^{78}\).

In some of cases, the desire for son was too intensive to for loan for undergoing to ultrasound and Medical Termination of Pregnancy even. The workers felt that the next time that they wanted a son they should follow the ‘correct’ methods to have son. These ‘correct methods’ are sex-selection techniques and other ‘special medicines’ are lead to ‘son bearing’. There are numerous of such clinics’ who indulge in such type of practices. They claim that the son-bearing medicine are having costly ingredients like ‘gold-Bhasam’ even after knowing the facts, which adversely affects the women health, but they are still going on without any legal restriction.

The workers as well as the doctors help the people by recommending some ‘good’ ultrasound clinics. In some of cases they help to transport these people to these clinics. A lot of workers act as middlemen and get commission of Rs.25% (of the ultrasound fee), per case from the doctors who adopt this procedures. In some of cases they charge Rs.100 per case. In some cases particularly if the women & her family are poor, the workers either reduced their fees or entirely waived it.

By reviewing the implications, it has been observed that the Medical Termination of Pregnancy is expected in the desire to have the right kind of family planning. In order to fulfill the desire for the right family composition, and desire to limit the number of daughters, people were ready to undergo as many Medical Termination of Pregnancy’s as they want. It is very astonishing to note that the women are always ‘guilty’ for the ‘crime’ of conceiving a daughter\(^{79}\). The workers reflect their feelings, as they themselves are an integral part of the same society and their approach and attitudes of the people towards them. It is because of interaction with them during this period, have reflected in such a way that the workers had

\(^{78}\) Ibid
\(^{79}\) Supra n.42
negotiated the official rules and regulation, so that they may be fitted with the ground reality.

Official definition of family planning is a means controlling fertility. From the people’s point of view, it is a means of controlling the number of daughters, couples has what number of daughters that should have with a family. It controlled through the process of ultrasounds and foeticide. The doctors and the entire health hierarchy share an understanding that family planning and/or control of fertility is not possible till a couple has the desired number of sons. The sources of information, which has derived from Civil Surgeons office, indicate that they also understand that Medical Termination of Pregnancy’s are popular methods of family planning.

The personnel of department of health and family welfare are well acquainted with ‘whole process’ of temporary method of family planning until the requisite family composition’ standard is achieved. The phenomenon of ‘desire for son’ is well acquired with the various levels of the personnel of department of health. The traditional social structure is manifested in the primary health care delivery system is controlled by the health authorities. The senior Medical Officer is also integral part of this ‘hard reality’ when he direct to his staff members to bring down the birth rates through sterilization process. The personnel perform their work in accordance with the cultural traits of Punjab. The process of socialization becomes a catalytic factor to make the ‘situation’ conform to the Punjabi culture. It has been observed that the personnel avoid targeting women; who do not have a son. It is only if the woman has had five to six daughters had if she is very week that the Multipurpose Health Workers suggest sterilization. In this situation, they suggest that the ultrasound technique should be adopted after the third pregnancy, if the earlier children are daughters. In some of cases they target for ultrasound in the second pregnancy.

80 Ibid
Some time wrong education disseminated by the personnel of health department ‘leave’ a ‘pernicious effect’ on the health of the women. This thing is frequently occur in sex-selectivity practices. The health workers are supposed to bring a ‘positive change’, but they encourage this ‘mal-practices’ by propagating this wrong practice. In order to achieve their time-burnt targets, they compel to keep the family size and composition in accordance with the desired norms. Motivating for sterilization is a time-consuming process; often it takes four to five years to motivating the people. Sex-selectivity practices have been proved conducive to encourage the people for sterilization. The phenomenon of desired sex-ratio at micro level, and the desired composition of both the sexes at a macro level are quite different. The personnel of different hierarchy always want to keep the desired sex-ratio composition at family levels, as well as, at the same time they make efforts to reduce the numerical strength of the children in the family. This ‘paradoxical situation’ resulted in almost all the states of India.

Though the process of Medical Termination of Pregnancy’s are not illegal, abortion, selecting behaviour has to be evaluated in terms of broader perspective. Status of women and gender dynamics and the broader implications for national sex-ratio norms. There should be some of ethical values, which are to be needed to appraise in a true sense. It is an obvious case of son preference versus daughter dis-preference. There is not just a son preference but there is also a daughter dis-preference, which leads to take extreme steps like elimination of unwanted female fetuses. Hence, the science and technology is a integral part of culture which can play a positive role for eliminating the ‘discriminating behaviour’ of birth of boy or girl in the society.

There are some of ‘pit falls’ which are still prevailing in the social system. There are some what distorted, vertical and top to down conviction, which rarely emerged out of the related aspects of women’s health. The only solution on this front
is a women’s health ‘Maternal Health’. This is often confides to distributing iron and folic acid tablets and to tetanus toxide injection\(^{81}\). There are the women, who have targeted for sterilization by the health workers receive iron supplements to pump up their hemoglobin levels prior to sterilization operation. Poverty, illiteracy and rural background have cumulatively given rise to marginalization of women. The other factors are the gender and generational control which indicate some of addition factors for deteriorating the status of women in the Indian society. The tendency of the people should be ‘refuted’ for son preference, which are the consequences of lop sided development of science and technology. The rights of women should be a part of the culture, so that the women may get her full rights in the society.

There has been a ‘pit-falls’ which lie under social structure, which become a ‘hindrance’ for empowering women. A co-operation among different department and active people- participation can help to elevate the status of women. A ‘Female Autonomy’ should be a priority, so that the women may acquire social and economic freedom. Structural reform and land ownership can improve the existing position of women in Indian society. The social system which contains some of ‘rigid system’ of dominance in partrichal society which should be modified, so that it may become ‘conform’ to women community’.

5.17 Population Control Policies:

It is very imperative to review the existing population policy with respect to global funding, medical market and marketization of the nation/states with developing ‘the plural society’ at a global level.

A recent study carried out in Haryana, which indicate a meaningful inference. According to this study based on 160 mothers and grandmothers; indicate that the 40% supported sex determination on the ground that it has contributed to population

\(^{81}\) Ibid
control and prevented families from having a series of females in an attempt that a male was born. This will further widen the gap between the number of girls and boys in the country\textsuperscript{82}.

Hence, we observe that the prevailing social system, which is full of rigidness & prejudicious against women's mobility. All these cumulative factors have given rise to deteriorating the status of women in Indian society, resulted in aggravated the female foeticides in most of the states of northern Indian. It is a matter of serious thinking. Unless a ‘considerable change’ in attitude towards the sex discrimination, it is likely to lead social instability in Indian society.

As a result of 50 years of propaganda on the merits of a small family norm, there is today general awareness of family planning and the need for adopting a small family norm. Our fieldwork reveals that men and women in Punjab, Haryana and Himachal Pradesh do accept the idea of a two-child family and they are also aware of the technology of pre-birth sex determination tests. As in most parts of India, two sons constitute the cut-off point for accepting sterilization (Patel 1994 reports the same trend for rural Rajasthan)\textsuperscript{83}. The people seem to be quite puzzled that the government wants a small family norm to be practiced yet opposes the conduct of these tests and subsequent abortions. They argue that since every family wants at least one son, if not two, the best way to ensure a small family is to go for the test and act according to the results. A well-meaning and prominent doctor, having a flourishing private practice in Himachal Pradesh, told us that government was that in case the second child is a daughter. His argument was that in case the second child is a son, the family will be satisfied and will opt for sterilization. This will help in stabilizing

\textsuperscript{82} Supra n.23

the population. The doctor argued that the merit of this formula was that it would reduce quackery and maternal mortality, and would also achieve the national goal of population stabilization. This doctor had a large private practice and was not at all keen to take abortion cases, let alone conduct sex determination tests. In fact, he narrated how he was pressurized to conduct this test and abortions by several VVIPs whose names he could not divulge. In the eyes of the people, there is a dichotomy between the governments’ sustained advocacy of family planning and shall family norms, with legislation prohibiting the conduct of sex determination tests and sex-selective abortions. This mix-up is the creation of circumstances and neither the government nor the people can be blamed. If an enlightened doctor, who commends great respect and is not a greedy person, genuinely believes that the government should allow such cases and abortions to be conducted on demographic grounds, his views deserve serious consideration. One must pause and think how best to counter such an argument. Under the PNDT Act, very often the appropriate authority is the Chief Medical Officer and it is very unlikely that a doctor will prosecute a fellow doctor. One must not the solidarity of doctors in remote areas where social life is confined to playing cards and/or drinking. Besides, it is often pointed out that since a person has to spend so much money in private medical institutions to get trained as a doctor, he is unlikely to forego efforts to make quick money; sex determination tests and abortions provide perhaps the best opportunity to make such money. According to rough estimates of people who are knowledgeable, in many places 90 per cent of the income of several doctors (mostly those in small towns) comes from these tests abortions. It was clear to us that the legal machinery in the districts was not equal to us that the legal machinery in the districts was not equal to the task of effectively implementing the PNDT Act, where higher level officials are busy with pressing administrative problems.84

84 Ibid
5.18 Initiatives by the State and NGOs

Twenty years ago a controversy around Sex determination and sex pre-natal started as a result of several investigative reports published in popular newspapers and magazines such as India Today, Eve's Weekly, Sunday and other national and regional English language journals. The article by Achin Vanaik, 1986 in Times of India revealed that almost 100 per cent of 15914 abortions during 1984-85, by a well known abortion centre in Bombay, were undertaken after sex determination tests. All private practitioners in the sex determination tests, who used to boast that they were 'doing social work' by helping miserable women, exposed their hypocrisy when they failed to provide facilities of amniocentesis to pregnant women during the Bhopal gas tragedy (1984) in spite of repeated requests by women's groups, and many reported cases of the birth of deformed babies as a result of the gas carnage. Thus it is clear that this scientific technique is in fact not sued for humanitarian purposes, not because of 'empathy towards poor Indian women' as has been claimed.

Forced sterilization of males during the emergency rule brought about politically disastrous consequences for the Congress party. As a result, in the post-emergency period, there has been a shift in policy and women have become the main target of population control. The after-effects of sex determination and sex pre-selection harmful effects of hormone-based contraceptive pills and anti-pregnancy injections and camps for mass IUD insertion and mass sterilization of women under unhygienic conditions are always overlooked by enthusiastic of the Family Planning policy. Most population control research is conducted on women without consideration for the harm caused by such research to the women concerned.

In a patrilocal, patrilineal society son preference is highly pronounced. In the power relations between the bride's and groom's family, the bride's side always has to give in and put up with all taunts, humiliation, indignities, insults and injuries perpetrated by the groom's family. This factor also results in further devaluation of daughters. The uncontrollable lust of consumerism and commercialization of human relations, combined with patriarchal power over women, have reduced Indian women to easily dispensable commodities. Dowry is easy money, 'get rich quick' formula spreading in the society as fast as cancer. By the late eighties, dowry had not been limited to certain upper castes only but had spread among all communities in India irrespective of their class, caste and religious backgrounds. Its extreme manifestation was seen in the increasing state of dowry-related murders.

The shortcomings of the PNDT Act 2003 lie in the criteria set for establishing a genetic counseling centre, genetic laboratory and genetic clinic/ultrasound clinic/imaging centre and person qualified to perform the tests.

i. The terms genetic clinics/ultrasound clinic/imaging centre cannot be used interchangeably. But the Act does so.

ii. Moreover, the amended Act should have categorically defined person, laboratories, hospitals, institutions involve din pre-conception sex-selective techniques such as artificial reproductive techniques and pre-implantation genetic diagnosis.

iii. Who is a qualified medical geneticist? As per the Act, 'a person who possesses a degree or diploma or certificate in medial genetics in the field of PNDT or has a minimum of two years experience after obtaining any medical qualification under the MCI Act 1956 or a P.G. in biological sciences.' Many medical experts feel that a degree or diploma or two years experience in medical genetic cannot be made synonymous.
iv. As per the Act, an ultrasound machine falls under the requirement of genetic clinic, while it is widely used also by the hospitals and nursing homes not conducting Pre-implantation Genetic Diagnosis (PGD) and PNDT.

The decisive battle against feticide has to be fought in the minds of people since son preference has its roots in prejudices and an anti-women mindset. The answer lies in creating awareness about the true worth of women, the irrelevance—and also the illegality—of sex selection, and the need to question old and outdated rituals and social behavior. The Ministry of Health and Family Welfare works with a variety of partners including civil society groups, the National commission for Women (NCW), Centre for social Research (CSR), CEHAT, Population foundation of India (PEI), NGOs as well as development partners such as UNFPA, to raise the level of public discourse and build alliances to highlight the issue of sex selection. Recent activities included the following.

5.19 Valuing the Girls Child:

The solution to the problem of female foeticide and feticide is inextricably linked to enhancing the status of women and, more specifically, the efforts of the Government and its partners in this girl-saving exercise, therefore, focus on making families value the girl child and convincing them to the need to treat daughters at par with sons, give girls equal opportunity for education and equal right in the property.

One of the Government’s efforts on this direction is the ‘Save the Girl Child Campaign’, highlighting the achievements of girls. In 2003-2004 and 2004-2005, tennis star Sania Mirza and CBSC topper, Aruna Kesavani were brand ambassadors for the Campaign. Joshna Cinnappa, Jr., senior National Asian Squash Champion, is the brand ambassador for 2005-2006. In line with the same approach, the theme of the tableau of the Department of Family Welfare at the 2004 Republic Day parade was

\[\text{\textsuperscript{86}Ibid}\]
‘Save the Girl Child’. The idea of such initiatives is to make people aware that today girls can achieve as much, if not more than boys; that girls can make a family/a village/a nation proud; that girls matter that a girl is not a liability but an asset87.

Working with the Media and Entertainment Industry: Apart from organizing workshops and seminars through voluntary organizations at the state/regional/district/block levels to create awareness against the practice of pre-natal sex selection, the Government is using the outreach of the broadcast, electronic and print media to do the same. National and local media were sensitized to the issue of sex selection through a series of medi workshops organized by UNFPA, UNICEF and some NGOs in Delhi, Manesar, Orchhal, Sarnath, Rajgarh, Agra and Bhubaneshwar. A national, meeting of IEC officers of States/UTs also focused on the issue. In addition, UNFPA is supporting Public Services Broadcasting Trust’s bid to commission films on the issue to sensitize young people. The Indian Television Academy (ITA), with the support of UNFPA, is producing public serve spots against sex selection and will also advocate the issue with the entertainment industry. Rabbi Shergill, the popular singer, has written and recorded a song on UNFPA initiative that can potentially be coupled with a music video to communicate the issue to young people88.

Reaching the Masses Through Religious/Spiritual Leaders: Keeping in mind the vast multitudes that India’s religious and spiritual leaders reach out to, UNFPA made an effort to get them involved in spreading awareness on the issue of sex selection. Two such partnerships were with the Art of Living Foundation (AOL) led by Sri Sri Ravi Shankar and the World Council of Arya Samaj led by Swami Agnivesh. AOL hosted a conference of inter-faith religious leaders who deliberated on the issue and pledge to take the message forward through their discourses. There is a proposal to follow this up with padyatras (marches) across the States where the

87 Times of India (New Delhi), December 5, 2006
88 Times of India (New Delhi); December 25, 2007
Child Sex Ratio is very high. Swami Agnivesh has already led padyatras to focus on the issue across the States of Gujarat, Rajasthan, Delhi, Haryana, Chandigarh and Punjab. UNFPA also supported Population First, an NGO, in its initiative to use festivals such as Ganesh Chaturthi to advocate the issue of sex selection in Mumbai.

Connecting with Young Persons: Since it is the youth that will shape tomorrow, it is essential to see that their attitudes to gender issues are not coloured by old prejudices and social behavior. UNFPA’s efforts to reach out to young people included collaborations with HT Passive (a division of the Hindustan Times Group of Newspapers), Delhi Public Schools (DPS) Society and the National Institute of Information Technology (NIIT). HT Pace organized a series of theater workshops in 850 schools across Delhi on the issue of sex selection. Many thought-provoking ideas and some useful communication material emerged through this process. The DPS Society undertook the training of about 100 teachers and 200 peer educators in order to integrate the message of life skill, gender sensitivity and discrimination against girls (including sex selection) in the school curriculum. The resulting module has already been shared with the national Council of Education Research and Training (NCERT). NIIT is also working on a programme to sensitize young people to these critical issues. Their expected outreach is about 10,000 youth.

Advocacy with Parliamentarians and Autonomous Commissions: UNFPA’s advocacy initiatives included brainstorming sessions with the National Commission for Women (in partnership with the Centre for Social Research) and with a group of Parliamentarians (in partnership with the Confederation of Indian Industry). Partnership with NGOs: UNFPA continued to support and partner several NGOs in their activities aimed at eliminating female foeticide and infanticide and improving the status of the girl’s child. The NGOs included Population Foundation of India, Voluntary health Association of Punjab, Sutra-In Himachal Pradesh, CEHAT in

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89 Ibid
Maharashtra, Chetna in Gujarat, Prayas in Rajasthan and Action Indian in Delhi. The Government of India supported the Family Planning Association of India (FPAI) in its ongoing activities.

All these efforts spreading awareness and sensitivity on the issue, couple with the firm determination to implement the provisions of PNDT Act in spirit and tone, are bound to have an impact on the situation and will, hopefully, be reflected in the Sex Ratio in the Next Census. “Missing”: A brochure, titled ‘Missing’, showing maps of areas with an adverse child Sex Ratio in India, was released by the Minister for Health and Family Welfare in October-2003. The brochure, highlighting the ‘missing’ girl children, is a joint effort of the Ministry of Health and Family Welfare, UNFPA and the Office of the Registrar General India. Handbook on PNDT Act: A Handbook on the PNDT Act 1994 and its amendments (revised edition) was released on February 17, 2003 and sent to all State governments and Appropriate Authorities. The Act and the Rules, including the amendments, have also been put on the website of the Department, where the general public can access it.

The drive against female foeticide and sex determination techniques gained strength in the 1980s. The 1976 partial ban on sex determination tests in government hospitals had only 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 in country have witnessed several campaigns against the misuse of science and technology to continue discrimination against women. In 1982, the Centre for Women’s Development Studies (CWDS) launched the first campaign. It was initiated by Dr. Veena Mazumdar and Dr. Lortika Sarkar in Delhi as protest against an

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advertisement for Bhandari anti-natal sex determination clinic, Amritsar, Punjab. The clinic was openly advertising its services through the press, in railway compartments and other public places. The advertisement referred to daughters as ‘liabilities’ to the family and a threat to the nation, and exhorted expectant parents to avail of the services of the clinics to rid themselves of this ‘danger’.

More campaigns like the Forum Against Sex Determination and Sex Pre-Selection (FASDSP) in 1985 in Maharashtra and the Campaign Against Sex-Selective Abortion (CASSA), Tamil Nadu came up. FASDSP 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, 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 the issue across the entire country. A move for an all-India ban on sex determination tests grained momentum, and the Pre-natal Diagnostic Tests (Regulation and Prohibition of Misuse) Act, 1994 (called the PNDT Act) came into existence. Through the PNDT Act entered into force in January 1996, no evidence of decline in the practice of female foeticide came forth even after four years. Lack of concern and political will to implement the legislation by the Centre and states led to a Public Interest Litigation (PIL) in the Supreme Court (SC). The PIL was filed three petitioners-Dr. Sabu George a social activist, Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune, and 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 aspects and called upon all state governments to take necessary steps and to implement the Act. However, a

further dip in the 2001 sex ratio suggests that a lot of more needs to be done in this regard. In the light of new techniques available to determine sex before conception, it was considered necessary to amend the Act. From February 14th 2003, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002 came into force. The PNDT Act 1994 was renamed as ‘the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.

Keeping in view multifaceted role of government and non-government organizations in combating female foeticide, we may assess the different approaches, strategies and preventive programme to overcome this problem. There are various statistical parameters which throw an adequate light on deficiency and sex-selective approaches for aborting the ‘female foeticide’. Amongst various preventing programmes of this social evil, various government policies, health policies have been played a significant role to eradicate this problem. Aiming at ameliorating the women’s reproductive health, various programmes have been executed in the urban as well as in the rural areas. State sponsored family welfare programme, which includes the family planning, women health care, child health care, have been operating through its various primary and Control Health Centres in both the states. In addition, universal immunization programme, maternal and child health services and reproductive and child health project have been playing a notable role to achieve the desired results92.

Apart from above mentioned health infrastructural facilities, the various mode of information education and communication (IEC) has a vital significant for disseminating the relevant information to the masses. In addition, the state sponsored 20-point program has been proved conducive to be benefited to care of the health of the girl child, women and the needy people.

92 Ibid
Reviewing various influencing factors for execution process, we find that the efforts are being made to execute various health policies in a judicious manner. Various empirical studies indicate that the cultural factors, which also determine for the tendency of the people, who indulge themselves in female foeticide in various strata of society.

It has been advocated that the middle path between the family planning and size of the family has been chosen, so that we may get to desired results. By adopting this mode of implementation, we observe that the family may get maximum benefits through natural adoption. In context to active participation of women in Medical Termination of Pregnancy Act for sex-selection, we observe that the women's are now become more aware of the facts, so that she may make a wisely decision for deliberate selection of the sex of her child\textsuperscript{93}. Hence, we have seen that the different devices used for adopting various family planning programmes. In this context, a wall knit cohesive and integrated programmes have been executed so that the population control policies may be achieved through its administrative machinery.

Review

There are two distinct approaches in combating female foeticide in India. First, equal opportunities may be offer to both the sexes and simultaneously strong steps must be taken to prevent misuse of technological advancement. This strategy is adopted to provide equal developmental benefits to women by promoting and protecting individual women and by checking discriminatory practices\textsuperscript{94}. On other side efforts are being made to curb misuse of technological advancements. Therefore, it is common says that ending the practice changing attitude aims at giving equal

\textsuperscript{93} Ibid
\textsuperscript{94} Supra n.4
value to a male and female child with a seemingly creative use of a demand and supply model.\textsuperscript{95}

The National Commission for Women, through its objectives, functions, powers and priorities, follows the approach for providing women with equality of opportunity. It has been set up with the main objective of ‘safeguarding the interest of women, gaining for them equality of status and opportunity and eliminating, as far as possible, any discrimination against them. Similarly the national policy for the empowerment of women 2001 identifies as its goals:

I. Creating an environment through positive economic and social policies for full development of women to enable them to realize their full potential.

II. The de jure and de facto enjoyment of all human rights and fundamental freedoms by women on equal basis with men in all spheres-political, economic, social cultural and civil.\textsuperscript{96}

A sex ratio that is lower for women is an indicator of a socio-economic situation unfavourable to females. It indicates the ratio of women to men in a given population. The definition of sex ratio used here is the number of females per thousand males. A lower sex ratio is said to be indicative of a lower status for women. The reasons for a sex ratio that is unfavourable to females could be due to a greater undercount of female relative to males, greater emigration of females, more adverse mortality conditions for females than for males, and sex ratio at birth becoming more favourable to males than in the past the world over, sex ratio is favourable to females. In India, South Asia, West Asia, and Africa, the situation is different. In India the overall sex ratio has been favourable to males, and since 1901 the sex ratio has fallen from 972 to 933 in 2001.\textsuperscript{97}

\textsuperscript{95} Supra n.5
\textsuperscript{96} Supra n.10
\textsuperscript{97} Supra n.54

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On the same lines a sequel to the non-starter Balka Samriddhi Yojana of 1997 in which cash payments to poor families were taking long to be disbursed, the new scheme offers money to parents who fulfil four conditions linked to a girl’s survival and welfare. These are—ensuring her birth and registering, completing her immunization, educating her and delaying her marriage till 18 years.

The scheme will be launched as a pilot in 10 economically backward blocks of Andhra Pradesh, Chhattisgarh, Jharkhand, Bihar and Orissa. One prosperous block (Punjab’s Sirhind in Fatehgarh Sahib, with the lowest female ratio in India) has been included to compare results of cash offers in poor and rich areas vis-à-vis impacts on sex ratio. The Eleventh Five Year Plan has already provided Rs.9.11 crore to benefit 99,000 girls in the current year under the scheme. Besides, the Centre is developing a group housing scheme worth Rs.1 Lakh with the LIC. “We will have different premium rates depending on whether the girl’s mother is dead or disabled. One lakh will be given to a girl only after she attains 18 years. Every girl entering secondary school will also get a solar lantern from the Ministry of Non-conventional Energy”, says Nandita Mishra, Joint Secretary, Women Child Development Ministry. In March-2008 the government has announced ‘Dhan Laxmi’ scheme in the seven states. In order that a parent consider their daughter an asset and not a liability, the Central Government has launched a new scheme called “Dhan Laxmi”, a conditional cash transfer scheme, to benefit the girl child and improve the sex ratio in the country. The pilot project of “Dhan Laxmi” will be launched in 11 educationally backward blocks of seven states-Punjab, Andhra Pradesh, Chhattisgarh, Orissa, Jharkhand, Bihar and Uttar Pradesh. An outlay of Rs.10 crore has been proposed for the fiscal 2008-09 to benefit 1,01,970 girl children. Women and child development minister Renuka Chowdhary said the scheme is designed to change the traditional mindset of parents towards their daughters by linking cash and non-cash transfers to her well-being.

98 ibid
“Dhan Laxmi” will ensure that a significant amount is given to the family on fulfilling specified conditions like ensuring birth registration, immunization and school enrolment of their daughter and delaying her marriage till the age of 18 years. In addition, an insurance cover of Rs.1 lakh will also be provided to the newborn. In all under the scheme, a cash package of around 2 lakh will be provided to the family, preferably the mother, Financial incentives will be given in a staggered way to encourage them to bring up their daughters in a better way. “The scheme will help change the traditional mindset towards their daughters by linking cash and non-cash transfers to her well-being”. This will encourage families to consider their daughters as an asset rather than a liability since it is her well-being that will lead to cash inflow in the family,”

Further the government intervenes through the health services in rural areas in the state of Punjab and the impact of this on the number of women. Punjab is one of the most prosperous states of India. In 1996-97 Punjab had a per capita net state domestic product of Rs.18,1213/- at current prices; second only to Goa. Only 12 per cent of the total population of Punjab is below the poverty line. The figure for India is 36 per cent. Agriculture is the single largest sector of the economy with 83.5 per cent of the total geographical area under cultivation (International Institute of Population Sciences 2001). In addition, Punjab is a patriarchal and patrilineal society. An agricultural economy is indicative of a society with son preference. Given the predominantly agriculture based economy, the economic prosperity of Punjab and the nature of kinship relationships, it is critical to examine the extent to which the implementation of the health programmes has taken in the intent and objective of the health policies and the Primary Health Care approach adopted by the Government of India in 1978. The focus would be on examining the implementation of the programmes in the field, by the health workers in the backdrop of patriarchy and

99  Supra n.94
economic prosperity. The study examines the implementation of the policies and plans only in so much as they are relevant to the issues. It is based on data collected through intensive interviews in a Primary Health Centre, in Roopnagar district in Punjab.

There are a number of programs which are relevant to women's productive health. These programs include Primary Health Care, Maternal and Child Health Services, Reproductive and Child Health Project and the Family Welfare Program. The programs aim at providing complete and adequate care to women in terms of their reproductive health. The Family Welfare program aims at providing better Maternal and Child Health Services (MCH) to women, encourage institutional deliveries and spacing between children. Since 1996 the Target-Free Approach has been introduced and it has been renamed as the Community Needs Assessment Approach (CNAA) from 1997. The aim to encourage decentralized participatory planning. The Universal Immunization Programme (UIP) aims at achieving universal immunization and reducing the mortality and morbidity resulting from vaccine preventable diseases. With effect from 1992, the Child survival and Safe Motherhood Programme, with the assistance of World Bank and UNICEF, has been introduced to supplement the gains of the UIP. Iron and folic acid tablets are being regularly supplied to mothers and children. The Child Health Services project funded by the World Bank aims at looking after the reproductive health of women and encouraging the participation of women in planning for their own health. The World Bank Project aided India Population Project VII was started in 1991 to improve trained manpower and buildings for both imparting training and for the working environment and residences within the villages.\(^{100}\)

These programmes are not merely restricted to the curative aspect but are also directed towards health education. The health education component of these programmes is addressed by the information, Education & Communication Activities

\(^{100}\) _Supra n.58_
Through health education, the government aims to positively intervene in improving the status of women in the sphere of family planning and maternal and reproductive health. There has been an improvement in living conditions and medical facilities throughout the country. This has led to a greater survival of both males and females. Family Welfare Program which is a Centrally sponsored program is mainly aimed at stabilizing the growth of population and for that purpose the goals have been set to curtail both fertility and mortality so as to achieve a Net Reproduction Rate of unity. The government of India has implemented the target-free approach towards family planning from the year 1996-97. There are no specific targets for various methods of family planning but family planning services have to be provided to the public as per their requirements. An action plan has been prepared to motivate the couples for family planning through spacing and the use of terminal methods in the age groups of 20-29 years with low parity. In order to provide better Maternal and Child Health Services all pregnant women are required to be registered for ante-natal care; high-risk mother are to be referred for better care; institutional deliveries are to be encouraged; high-risk babies are to be referred to institutions for treatment. In order to take health services beyond the pursuit of targets the Government of India introduced the Target Free Approach (TFA) all over India on 1st April 1996 and under the system of decentralized participatory planning.

Target Free Approach (TFA) has been renamed as Community Needs Assessment Approach (CNAA) from 1997. Under this approach, planning of family welfare services will be formulated in consultation with the community at the grassroots level. Decentralized participatory planning implicates close association of the community and its opinion leaders such as Village Pradhans, mahila Swasthya sanghs, primary school teachers etc., in the formulation of the PHC-based family welfare and health care plan. Each state has to prepare an Annual Action Plan in the

101 Supra n.59
beginning of each year and circulate it at various levels. The World Health Organization (WHO) launched the extend program against six most common preventable childhood diseases viz. Diphtheria, Pertusis, Tetanus, measles Tuberculosis and Poliomyelitis. The UNICEF, in 1985, renamed it as ‘Universal Child immunization (UCI). There is no difference between the two, the goal was the same i.e. to achieve universal in 1978 with the aim of reducing the mortality and morbidity resulting from vaccine-preventable diseases and to achieve self-sufficiency in the production of vaccines. Universal Immunization Programme (UIP) was started in India in 1985. It has to components; immunization of pregnant women against tetanus and immunization of children against the six EPI target diseases. The aim was to achieve 100 per cent coverage of pregnant women with two doses of tetanus toxide (or a booster dose) and at least 85 per cent coverage of infants with three doses each of DPT and OPV and one dose each of BCG and the measles vaccine by 1990.

Medical and Child health services are provide for the care and health of mother and children. The government provides these services by organizing Pre-natal and well baby clinics. The World Bank Project aided India Population Project-VII, was started in 1991 in Punjab. The project meant to improve the quality of Family Welfare and Maternal Child Services in the state by providing trained manpower and building, both for imparting training and for the working environment and residences within the villages. Under the project Sub-Centre buildings, Lady Health Visitor residential quarter, primary health centre training annex has been built. In addition to the five-year plans and programmes, in 1975 the government of India initiated a special twenty-point programme. The programme was described as an agenda for national action to promote social justice and economic growth on 20th August, 1986 the existing programme was restructured. The government spelt out its objectives as:

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102 Supra n.59  
103 Supra n.60  
104 Supra n. 63
eradication of poverty, raising productivity, reducing inequalities removing social and
economic disparities and improving quality of life'. At least three of the twenty points
related directly or indirectly to health. These are:

d) Health for all;
e) Two-child norm;
f) Expansion of education

At the lowest level in the health services sector is the Multipurpose Health Worker (MPW). Each health worker looks after a population of 5,000 people. The health workers operate from a sub-centre located in a village. Each sub-centre looks after four to five villages. The sub-centers are under the Primary Health Centre (PHC), which looks after a rural population of 30,000. The policy and the plan documents have visualized the workers as implementing the programmes by saying with the people of the sub-centre area and becoming one of them. These workers are meant to be staying in the sub-centres in the villages. Their duty structure is such that they are implementers of all the national health programmes. The health workers posted at the sub-centre go from door to door imparting health care to the people in the rural areas. The Multipurpose Health Worker health workers scheme was conceptualized in a manner to ensure that they provide health services to the people in an integrated manner. The worker is supposed to identify and treat people suffering from T.B., malaria goiters, sprains, leprosy etc. The identification of the person suffering from any disease, the initial treatment, and then, if need be, the final decision to refer the patient are all the official responsibilities of the Multipurpose Health Worker.

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105 Supra n.63