Study to Explore the Causes of Declining Sex Ratio in the Age Group of 0-6 Years in Himachal Pradesh

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FOREWORD

The "Study to Explore the Causes of Declining Sex Ratio in the Age Group of 0-6 years in Himachal Pradesh" will help in reframing the policies and programmes aimed at not only arresting the declining trend but also in improving sex ratio particularly in the age group of 0-6 years. The objective of this study was to know the reasons of declining trends in sex ratio noticed from the Census 1971 to 2011. The report highlights the low sex ratio in the border Districts of the State neighbouring other States. It has been highlighted in the study that stringent measures taken by the State Government have helped in improving the situation to some extent. I sincerely hope that the policy makers and social scientists will use the findings of the study as a useful tool for bringing out more effective policies for the betterment of the female child sex ratio.

I express my gratitude to the Population Centre of the Himachal Pradesh University, Prof. N.S. Bisht, in particular, who was the Principal Investigator for undertaking the field survey and writing the draft report. I also thank Dr. SumitMazumdar, Institute of Public Health, Kalyani, Government of West Bengal, who reviewed the draft report and gave his valuable suggestions and comments which have made this report more meaningful. I also extend my special thanks to Ms.RituMathur and Ms.Swayamprabha Das from the UNDP whosecontinuous and encouraging support helped bringing out this report. I also appreciate the team of Himachal Pradesh Human Development Research and Coordination Society of the Planning Department headed by Sh. BasuSood, Joint Director, Department of Planning which coordinated the efforts and helped in providing information and data required for bringing out the report.

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PREFACE

Sharp increase in the masculine sex ratios in Himachal Pradesh has drawn intense public engagement.

The present survey is an attempt to undertake an in depth analysis of the declining sex ratio in the State. Sex ratio has declined from Census 1971 to 2011. This is a threat to the social structure of Himachal Pradesh. As per 2001 data, 3 Districts namely Kangra, Hamirpur and Una were in the very low category having sex ratio less than 850 and 3 Districts namely Solan and Bilaspur were in the low category.Four Districts i.e. Kinnaur, Kullu, Chamba and Lahaul&Spiti were in high category. No District had very high sex ratio.

An objective approach has been followed in examining the situation from different perspectives and in collecting the field level data. The recommendations contained in this survey made are based on actual findings and analysis of the observed and collected information. The views contained in the report are based on the findings of the research project conducted by Prof. N.S. Bisht and his team of Population Centre of H.P. University. No part of the findings of the report and recommendations made in report are derived opinions of the Planning Department of Himachal Pradesh Government.

The broad objective of the present study was to map the trends in sex ratio particularly in the age group of 0-6 years and to explore the causes of decline in this sex ratio during the last two decades in Himachal Pradesh. The present study is based on both primary and secondary data. The team of the Planning Department, who are members of the Himachal Pradesh Human Development Research and Coordination Society (Registered), coordinated various aspects of the study. The Population Research Centre of the Himachal Pradesh University, Shimla did the field survey, data analysis and report writing; and the United Nations Development Programme, New Delhi provided financial and technical assistance under the Project “Human Development for Bridging Inequalities” for conducting the study. Valuable comments and suggestions provided by Dr. SumitMazumdar, Institute of Public Health, Kalyani,Government of West Bengal, who reviewed the draft report, have contributed in improving the Report.

The study will help the policy makers, various Government departments, and academicians, NGOs, other agencies and all those who are engaged in reducing the gender gap in children in the State and help to curb sex-determination to improve the child sex ratio.

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LIST OF ABBREVIATIONS

AGs	Adolescent Girls
APL	Above Poverty Line
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWW	Aanganwari Worker
BBBP	BetiBachao – BetiPadhao
BPL	Below Poverty Line
BTF	Block Task Force
CBR	Crude Birth Rate
CEHAT	Centre for the Enquiry of Health and Allied Themes
CHCs	Community Health Centres
CNAA	Community Need Assessment Approach
CPR	Couple Protection Rate
CSR	Child Sex Ratio
CSSM	Child Survival and Safe Motherhood Programme
CWDS	Centre for Women's Development Studies
DAA	District Appropriate Authority
DFPO	District Family Planning Officer
DIMC	District Inspection and Monitoring Committee
DLHS	District Level Health Survey
DLSA	District Legal Services Authority
DPO	District Programme Officer
DTF	District Task Force
FGDs	Focus Group Discussions
FMR	Female Male Ratio
FPP	Family Planning Programme
FWP	Family Welfare Programme
GEI	Gender Equality Index
HDI	Human Development Index
ICDS	Integrated Child Development Scheme
ICPD	International Conference on Population Development
IEC	Information, Education & Communication Activities
IFA	Iron and Folic Acid Tablets
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
IUD	Intra Uterine Device
KAP	Knowledge, Attitude & Practice
KSY	Kishori Shakti Yojana
MCH	Maternal & Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health & Family Welfare

MOHRD	Ministry of Human Resource Development
MPW	Multipurpose Health Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NHE	Nutrition and Health Education
NIMC	National Inspection and Monitoring Committee
NRHM	National Rural Health Mission
NSDP	National Skill Development Programme
NSSO	National Sample Survey Organisation
PARA	People Awareness for Rural Action Society
PC-PNDT	Pre-conception and Pre-Natal Diagnostic Techniques
PHCs	Primary Health Centres
PIL	Public Interest Litigation
PNDT	Pre-Natal Diagnostic Techniques
POCSO	Protection of Children from Sexual Offence
PRIs	Panchayati Raj Institutions
RCH	Reproductive and Child Health Project
SAA	State Appropriate Authority
SCs	Sub - Centres
SDFF	Sex Determination and Female Foeticide
SHGs	Self Help Groups
SMCs	School Management Committees
SRB	Sex Ratio at Birth
SRS	Sample Registration System
SSE	Sex Selective Elimination
TFA	Target Free Approach
TFR	Total Fertility Rate
UCI	Universal Child Immunisation
USG	Ultra Sonography
VHAI	Voluntary Health Association of India
VHND	Village Health and Nutrition Day
VSHNC	Village Health Sanitation and Nutrition Committee

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EXECUTIVE SUMMARY

The sharp increase in the masculine sex ratios in India has drawn intense public engagement but female foeticide continues unabated. The concerns vary to include implications for demographic imbalance, increased victimization of women, continuity of gender hierarchies and the challenge to the popular development paradigm- which in spite of the expanding infrastructure and its availment, has witnessed widespread female foeticide. A number of competing discourses attempt to confront the spread of female foeticide. Theseinclude technological determinism which identifies the proliferation of new reproductive technologies that preclude male sex selection as the bane of female foeticide. The enforcement agenda that is spearheading intervention seeks punitive measures to regulate the social norms that legitimise male child preference. The entitlements failure that views women's disadvantaged status and subsequent female foeticide as a lack of access to resources and facilities and the attainment of female reproductive rights that aims to provide women control over their lives and bodies, are some dominant endeavours to tackle female foeticide.

The pronounced concern emanated from the increased visibility acquired by missing girl children in census reports; the development paradox-whereby the developed states registered a decline in the child sex ratio and the use of life-enhancing technological innovations for life aborting purposes.

It is well-known that FMR (Female-Male Ratio) in India has declined through much of the twentieth century. More precisely, India's FMR declined almost monotonically from 0.97 to 0.93 between 1901 and 1971 and has remained close to 0.93 since 1971, reaching to 0.927 in 1991 and 0.933 in 2001. Since then there has been some increase: the latest figure, from the 2011 census is 0.943.

At the state level, twentieth-century trends in female-male ratios exhibit diverse patterns since 1901, the female-male ratio has steadily declined in some states (e.g. Bihar, Orissa, Tamil Nadu), steadily increased in others (mainly Kerala and Himachal Pradesh) and followed intermediate patterns elsewhere. Broadly speaking, changes in state-specific FMR in the twentieth century, have partly taken the form of a convergence effect involving a particularly large decline in states starting off with a high FMR, and some increase in states with the lowest initial female-males ratios.

For majority of the districts of Himachal Pradesh, juvenile sex ratio has declined from census 1971 to census 2011. This is an alarming sign for the women of

Himachal Pradesh. As per 2001 census data, 3 districts namely Kangra, Hamirpur and Una were in the very low category having sex ratio less than 850 and 2 districts namely Solan and Bilaspur were in low category and remaining four districts i.e. Kinnaur, Kullu, Chamba and Lahaul&Spiti were in high category. There was not a single district in very high category. On the intervention of Supreme Court and strong implementation of PNDT act, the situation slightly improved in 2011 census. The 3 districts earlier falling in very low category slightly improved their position and moved to low category. Now five districts namely Kangra, Hamirpur, Una, Solan and Bilaspur were categorized as low status districts. There was no change in the three moderate districts. Lahaul&Spiti district moved up from high category to very high category.

Himachal Pradesh has progressed very fast in terms of socio-economic and demographic indicators like over all sex ratio, IMR, MMR and couple protection rate, extent of immunization and achieving replacement level fertility. Himachal is considered as a state having very high level of social development. But the declining sex ratio is an alarming problem. Seeing the gravity of the situation, the present study was formulated to examine the problem more deeply and highlight the reasons for declining sex ratio.

The broad objective of the present study was to map the trends in sex ratio particularly in the age group of 0-6 years and to explore the causes of decline in this sex ratio during the last two decades in Himachal Pradesh. The present study is based on both primary and secondary data. In order to see the trends in the juvenile sex ratio, districts and blocks have been mapped on the basis of 1991, 2001 and 2011 census reports of Himachal Pradesh. In order to explore the causes of decline in Juvenile sex ratio, primary survey has been conducted by ranking the districts as very low, low, moderate, high and very high. On this basis, four districts have been selected. Care has been taken to include those districts which are showing declining trend. On the same analogy blocks, panchayats and villages have been selected.

Una district consists of five blocks, out of them Gagret, Una and Amb development blocks showed lowest sex ratio and therefore field study has been conducted in these three blocks by taking one per cent of the total households which came out to be 637 household. Out of 15 blocks of the Kangra district, 7 blocks were selected on the basis of lowest sex ratio. These selected blocks included Nurpur, Fatehpur, NagrotaSurian, Indora, Kangra, Pragpur and Lambagaon. On the basis of

one per cent sample of households, a total of 1371 households were selected from these blocks.

From Sirmour district, 3 blocks namely Sangrah, Shillai and Rajgarh were selected on the basis of highest juvenile sex ratio out of 6 blocks. The sample size came out to be 287 households. Out of 3 blocks of Kinnaur district, 2 blocks namely Kalpa and Pooh were selected on the basis of highest sex ratio and 132 sampled households were selected for detailed survey. A total of 2663 households were interviewed in order to know the causes of declining juvenile sex ratio with the help of interview schedule prepared after keeping in mind the socio-economic and demographic indicators of the selected districts.

The following Perception Surveys were conducted:

- Perception survey of doctors (both male and female) in the public sector and private sector.
- Perception survey of PRI members (both male and female members of Panchayats).
- Perception survey of married women in each of the household surveyed in the villages selected for intensive study.
- Perception survey of ASHA workers and Anganwari workers.

Himachal Pradesh stands tall among the states of the Indian Union in the field of literacy. The literacy rate in Himachal Pradesh was 77.13 percent in 2001 and rose to 82.8 per cent in the year 2011. The corresponding rates in Punjab, Haryana and Utter Pradesh are 76.68 per cent, 76.64 per cent and 69.72 percent, respectively. The relative development of the state in terms of other indices like expectation of life and infant mortality rate, which are indicative of the health aspect of social development, reveals a much better picture. In fact, Himachal Pradesh is well ahead of other states in terms of expectation of life and infant mortality rate. This is in striking contrast with states like Gujarat and Haryana, which rank higher in terms of economic development but do not enjoy commensurate ranks in social development.

Responses of Women Respondents in Kinnaur District

Son preference is quite high in both the blocks of Kinnaur district. It was 70 per cent in Kalpa, 71 per cent in Pooh. More than 50 percent were of the opinion that son is economic security for them. More than 60 percent were of the opinion that

having a son means ensuring old age security. Daughters are equally important for a family was opined by majority of respondents. It was 84, 73 and 79 percent in case of Kalpa, Pooh block and aggregate respectively.

Many factors responsible for disadvantage of daughters were highlighted by the respondents. Daughter as economic burden to family was opined by 39 percent and 31 per cent of the respondents in Kapla and Pooh blocks and in aggregate as 36 per cent. Dowry as one of the main problem was highlighted by 28 per cent and 36 percent in case of Kalpa and Pooh blocks respectively and 31 percent in aggregate. Many respondents expressed physical security of girls as a disadvantage. This was expressed by 31 per cent respondents in Kalpa block and 29 percent in Pooh block.

Awareness about low sex ratio in district Kinnaur was there in case of 50 per cent of the respondents. Steps taken by State Government to improve child sex ratio was highlighted by 53 percent respondents in case of Kalpa and 35 percent in Pooh block and in aggregate 45 percent.

Responses of Women Respondents in Sirmour District

Son preference was indicated by 37 per cent respondents in case of Rajgarh block, 38 per cent in case of Sangrah and 48 per cent in case of Shillai block. In all, it was indicated as 41 per cent. Many respondents opined that son was needed for economic security and this was indicated by 31, 33 and 43 per cent respondents in case of Rajgarh, Sangrah and Shillai blocks respectively. Old age security was expressed by 36, 35 and 47 percent of respondents in respective blocks.

Disadvantages of daughters were reflected in the form of economic burden to family. This opinion was expressed by 35 per cent respondents in Rajgarh, 40 percent in Sangrah and 53 percent in Shillai block and 42 percent in aggregate. Dowry problem as one of the major disadvantage was expressed by 25, 50 and 46 percent of respondents in Rajgarh, Sangrah and Shillai blocks, respectively. Physical security was highlighted by 57 percent respondents in Shillai block, followed by 41 per cent in Sangarh and 32 percent in Rajgarh blocks.

More than 40 percent respondents had awareness about very low sex ratio. Steps taken by State Government to check the declining sex ratio were expressed by 29, 15 and 22 percent of respondents in these blocks respectively. More than 70 per cent respondents were in favour of giving quality education to girls.

Responses of Women Respondents in Una District

Information regarding ideal family size was sought from the respondents. Majority of them opted for two children and the percentage was 86 per cent, 83 and 87 per cent in case of Amb, Gagret and Una blocks, respectively. In all, it came out to be 86 per cent. The preference for male child was expressed by 29, 13 and 6 per cent respondents in case of Amb, Gagret and Una blocks, respectively. Ultrasound of the mother was done during pregnancy to know the sex of the child by 19 per cent households in Amb, 8 per cent in Gagret and 6 per cent in Una block. In aggregate this was 11 per cent. More than 50 per cent people had awareness about low sex ratio with 49, 73 and 76 per cent in case of Amb, Gagret and Una blocks, respectively. In aggregate, it was 67 per cent. The respondents who acknowledged that the steps were taken by State Government to improve the sex ratio to the extent of were 45 per cent in Amb block, 24 per cent in Gagret and 50 per cent in Una block. In all, 41 per cent respondents opined that State Government was taking steps to arrest declining sex ratio.

Son preference was exhibited by 60 per cent respondents in Amb block, 33 per cent in Gagret and 15 per cent in Una block. Son would provide economic security to the family was opined by 58 per cent, 30 per cent and 6 per cent of the respondents, respectively, in these blocks. Son as a symbol of social status was expressed by 30, 32 and 12 per cent respondents in case of Amb, Gagret and Una blocks, respectively.

Daughters' importance was emphasized by almost every respondent. It was cent per cent in Una block, 98 and 90 per cent in case of Amb and Gagret blocks. In aggregate 91 per cent of the respondents expressed in favour of girls for completeness of family. Reproductive value of daughter was opined by 71, 68 and 98 per cent of respondents in case of Amb, Gagret and Una blocks,respectively.

Many reasons were sighted as disadvantages of daughters. Dowry problem was opined by 48 per cent respondents in aggregate. It was quite high (78%) in case of Amb block, 69 per cent in case of Gagret and 10 per cent in case of Una block. Social security was expressed as another reason. It was 59 per cent in Amb block, 68 per cent in Gagret and 18 per cent in Una block and aggregate 45 per cent. Physical security of daughters was highlighted as one of the disadvantage of daughters by 40 per cent respondents in Amb block, 66 per cent in Gagret and 15 per cent in Una block.

In Una district, awareness among people was quite high about the very low sex ratio. It was 72 per cent in case of Amb, 60 per cent in case of Gagret and 61 per cent in case of Una block and in aggregate it was 64 per cent. Steps taken by Government to arrest the declining sex ratio were acknowledged by 42 percent, 23 per cent and 24 per cent respondents, respectively, in these development blocks. More than eighty per cent were in favour of giving quality education to girls.

Responses of Women Respondents in Kangra district

More than 70 per cent respondents in all the blocks of Kangra district indicated their preference for two children. Son preference was highest in Kangra block i.e.59 percent, followed by 34 per cent in Fatehpur, 32 per cent in Indora and 33 per cent in Pragpur block. Old age security was the main reason for son preference. It was 84 per cent in Kangra block, 66 per cent in Indora, 56 per cent in Lambagaon and in aggregate it was 52 per cent. Religious security was the next reason for the preference. It was 71 per cent in Kangra block, followed by 49 per cent in Indora block, 47 per cent in Lambagoan and 44 per cent in Nurpur block.

Daughters' importance was highlighted by 90 per cent of the respondents. It was 94, 93, 91 and 90 per cent in case of Fatehpur, Lambagaon, Kangra and Pragpur blocks, respectively. Religious value of daughters was opined by 78 per cent of respondents in Kangra, followed by 70 per cent in Fatehpur, 68 per cent in Pragpur and 65 per cent in Lambagaon. Among the disadvantages of having daughters, dowry problem was highlighted by 64 per cent of respondents in aggregate and 76 per cent in Kangra, 71 per cent in Pragpur and 64 per cent in NagrotaSurian block. Daughters as economic burden to family were opined by 53 per cent respondents in Kangra, 42 per cent each in Fatehpur and Indora blocks. Physical security of daughters was expressed by 51 per cent respondents in Kangra block, followed by Pragpur (42%), Lambagaon (36%) and NagrotaSurian (36%).

Awareness about low sex ratio in Himachal Pradesh was there in 66 per cent of the respondents. It was 77 per cent in Lambagaon block, followed by 73 per cent in Fatehpur, 71 per cent in Pragpur, 69 per cent in NagrotaSurian and 68 per cent in Kangra block. Steps taken by State Governmentto improve child sex ratio were in the knowledge of 58 per cent respondents in Lambagaon block, followed by 43 per cent in Kangra and 42 per cent in Fatehpur block. Majority of the respondents (80%) were in favour of giving quality education to girls. It was highest in case of Fatehpur block (94%), followed by Kangra (85%), Pragpur (82%) and NagrotaSurian(78%). Quite a

good percentage of respondents were willing to send girls outside the State for education or jobs as revealed by 78 per cent respondents in Fatehpur developmentblock, 76 per cent in Pragpur, 71 per cent in Kangra and Lambagaon developmentblock.

Birth order Parity in Kangra and Una Districts

Kangra district indicated a sex preference in the birth of the second child. When Kangra and Una districts were combined together, Chi-Square Test rejected the Null Hypothesis, indicating to a clear preference for the sex of the second child. In case of third order parity, Null Hypothesis was accepted both in case of Kangra and Una district and also when both districts were combined together. This clearly indicated no sex preference in case of third child.

Birth order Parity in Kinnuar and Sirmaur Districts

Perusal of data of Kinnaur and Sirmaur districts did not give any evidence of sex preference. Application of Chi-Square Test for second order and third order birth got accepted indicating to existence of no sex preference in Kinnaur district. Similar results were shown in Sirmaur district. The hypothesis also got accepted in case of Kinnaur and Sirmaur districts taken together.

Child Sex Ratio at various Birth Orders

The child sex ratio at various birth orders showed a sharp decline from first birth order to third order in case of Una and Kangra districts. In case of Una district, the sex ratio declined from 765 (First Order) to 526 (Third Order). The corresponding decline in Kangra district was from 819 to 599. Moreover, the sex ratio for the third order is considerably low. This means, majority of the couples who went for third order births desired to have a son only. Similar trend was not observed in case of Kinnaur and Sirmour districts. Child sex ratio increased from 960 (First Order) to 1030 (Second Order) and further to 1455 (Third Order) in case of Kinnaur district. Similar trend was observed in Sirmaur district where it increased from 607 (First Order) to 751 (Second Order) and further to 1075 (Third Order).

The sex ratio had declined drastically over a period of time in Una and Kangra districts. The data indicates quite convincingly, that there is absolutely no desire for daughters when it comes to third order birth, more so in case of Una district. This extremely low sex ratio for third order births could be possibly be because of the fact that, only couples who want to have a son opt to go for more number of children. In

short, there is convincing evidence that the phenomenon of female foeticide is indeed very acute in Una and Kangra districts.

Perception Surveys of Doctors

The focus of the present study is more on perception than on demographic or socio-economic status of the people of the four selected districts. A total of 93 doctors in four sample districts of Himachal Pradesh namely Una, Kangra, Sirmaur and Kinnaur were interviewed with the help of a structured questionnaire. Doctors were selected from both the sexes in different age groups, practicing in public and private sectors.

When the respondents were asked if they were aware of the PNDT Act, 90 per cent replied in affirmative and the rest in negative. 89 per cent doctors felt that the Act could be implemented. All the respondents strongly stated that sex determination and female foeticide were illegal and unethical practices. Over 95 per cent doctors strongly felt that the ultra sound machines were being misused for sex determination in their respective region. A majority of doctors (62%) accepted the fact that there were some doctors in the districts who were referring pregnant women to the ultrasound centres for sex determination tests, 24 per cent responded contrary to this and the rest (14%) preferred not to respond. 86 per cent expressed their ignorance about the commission, doctors are getting for referring pregnant women to ultrasound clinics, 10 per cent felt it depended on clinics and doctors and 4 per cent felt the commission was very high.

Maintaining the focus further it was asked if the doctors were aware of the sex of the child while conducting abortions, 72 per cent doctors did not respond. However, the remaining 28 per cent stated that the doctors were aware of the sex of the foetus while conducting abortion. More specifically, when they were asked about their perception about the percentage of aborted female foetuses, majority of respondents expressed their unawareness (89%). The remaining mentioned that 50 to 70 per cent of aborted foetuses were of females. More than half (59%) stated that doctors were pressurized for conducting female foeticide. However, there were 31 per cent doctors who did not think so.

Perception Survey of the Panchayat Members

Panchayat Members play an important role in opinion building in the society, so it was thought necessary to know their viewpoint on declining child sex ratio and importance of the girl child. A total of 50 Panchayat Members comprising of 30 males

and 20 females were interviewed. All the respondents reported that it was parents who took the decision regarding the marriage of their daughters. The cost of marriage is very high as reported by 30 Panchayat Members and is increasing day by day. It ranged from two to five lakhs. Seventy two per cent Panchayat Members (22 males and 14 females) felt that the dowry system was spreading in their respective villages. Occurrence of female foeticide was accepted by 55 per cent Panchayat Members in their villages. 42 (84%) Panchayat Members (25 males and 17 females) admitted that the cost of ultrasound was between Rs. 500 to Rs. 1000.

Perception Survey ofAnganwariWorkers and ASHA Workers

A total of 52AnganwariWorkers and 52 ASHA Workers were interviewed and a structured questionnaire was canvassed on them. Majority of them (84%) talked about the awareness of programmes organiazed by Education, Health, Social Justice &Empowerment departments. Almost all of them were spreading awareness about the girl child among the pregnant and lactating mothers. Two children formed the ideal size of the family for most of the households as revealed byAnganwariworkers and ASHA workers. Majority of people in Kangra and Una (82%) preferred two children family, 12 per cent favoured one child family and only 6 per cent were in favour of three or more children. In Kinnaur and Sirmaur this percentage was around 76 per cent, 8 per cent and 16 per cent, respectively. This clearly indicated that three children were also welcomed in the family in some districts of the state.

In Una district, around 40 per cent pregnant mothers go for ultrasound test, this percentage was slightly less in Kangra district i.e. 36 per cent as revealed byAnganwariand ASHA workers. In Kinnaur district, it was 14 per cent and very less i.e. 8 per cent in case of Sirmaur district. In Una and Kangra districts, high importance was given to son because of social and economic security. In Kinnaur and Sirmaur districts, though people gave preference to male child but they did not go for ultrasound test to know the sex of the child. In Sirmaur there were households with 3 children also but no one had gone for sex determination test.

Though there was a substantial decline in the juvenile sex ratio in Kangra and Una districts, a majority (65%) ofAnganwariand ASHA workers showed ignorance about the occurrence of female foeticide in their villages. This led one to think that these workers were afraid to state the facts regarding female foeticide because of the Supreme Court and State Government's proactive stand on the implementation of the

PNDT Act. All these workers blamed the family for the occurrence of female foeticide.

When the respondents were asked whether they considered a son to be a blessing and the daughter a burden, the reasons given for considering a son to be the preferred choice were; to run the family name, make the family and parents respectable in the society, for social and economic support, to inherit the family property and take care of the parents in their old age. The majority of respondents, in both the districts (Kangra and Una) considered dowry as a major factor responsible for the deteriorating condition of women which is increasing with increasing cost of living.

Though the practice of female feoticide is quite prevalent in Kangra and Una districts, it was shocking to realize that 60 per cent ofAnganwariand ASHA workers in these districts were not aware of the legal provisions against the practice of pre-natal sex determination and foeticide, i.e. PNDT Act, 1994. In Kinnaur and Sirmaur districts, this proportion was 52 per cent. Efforts were made to assessAnganwariand ASHA workers' perceptions about the repercussions of this continuous decline in the female to male child sex ratio. The likely ill-effects would be, increase in atrocities on women, social imbalance with a decline in moral values, polyandry, purchasing brides from other states thus affecting the state's culture and more men remaining unmarried.

Causes of Female Foeticide

The survey tried to ascertain the causes of female foeticide through our surveys. The general perception is that the cost of marriage and dowry had gone up and so daughters have become greater financial liabilities. The dowry system is invariably blamed. It was not convincing reason that dowry alone was the main cause of female foeticide. Families that are well-off and do not have to depend on dowry to augment their income are also opting for female foeticide. The real reason seems to be the high status of families with several sons and the low status of families with no sons. Another interesting factor for the preference for sons is that the prospect of migration of sons to, say the Gulf or Western countries, is much higher for men than for women. In the eyes of the local community, a family with children abroad has a higher status and certainly a higher income level than non-migrant families. Globalization is thus adding to the miseries of the girl child.

In short, there are numerous causes for the spread of female foeticide and it will be unscientific to believe that dowry alone is the only cause, as is the general perception. Nevertheless, the perception during the fieldwork did reveal that people are aware of the upward swing in dowry demand and the rising cost of marriage. Greed has increased in our society and numerous TV channels and endless advertisements increase this greed further.

Female foeticide is a symptom of increasing crime against women. It would be manifestly wrong if it is concluded that female foeticide is a matter of medical technology alone. There is no doubt that easy access to ultrasonography has been largely responsible for the spread of female foeticide throughout the country. During the survey, it was revealed that many women opted for female foeticide not because they were heartless but because they were genuinely concerned about the fate of girls who are being increasingly subjected to eve-teasing, molestation and sexual harassment and after marriage, exposed to the risk of bride burning and dowry death, in the unending demand for dowry from the emerging consumerist society. This calls for a good look at gender issues in all their ramifications in an increasingly dysfunctional society.

Initiatives of Centre and State Governments

On 22nd January, 2015, Government of India has announced BetiBachao - BetiPadhao (BBBP) Programme to address the issue of decline in CSR through a mass campaign across the country, and focused interventions and multi-sectoral action in 100 gender critical districts. Main focus of this scheme was to prevent gender biased sex selective elimination and ensure survival and protection of the girl child. Una was ranked among the lowest of 100 districts of India in adverse child sex ratio. As a result BetiBachao - BetiPadhao project was sanctioned for Una district by Government of India. District Task Force and Block Task Force were constituted in the district. Deputy Commissioner Una with the support of District Programme Officer (DPO) conducted orientation programmes of District Officers / ZilaParishad Members / PNDT Cell / Judiciary / District Legal Services Authority / Block Officers / Block Parishad / Panchayat Members and members of School Management Committees once in each quarter for each category.

Outcome of BetiBachao- BetiPadhaoAbhiyan

In order to see the impact of this Abhiyan, District Administration conducted a Head Count Survey with the help of Health Department in the last quarter of year 2015. There was a marked improvement in child sex ratio. It improved from 875 in 2011 to 900 in 2015 indicating a rise of 25 points within a short span. With the current increase of 6.25 per cent points per annum it will become 937.5 by the year ending 2021. This is a small beginning, but a long way to go. Sustainability of these efforts require a strong and continuous replication in each and every part of Una district and whole of Himachal Pradesh.

Initiatives of Directorate of Women and Child Development

The Directorate of Women and Child Development has launched four schemes in Himachal Pradesh for improving the status of the girl child. These schemes are namely Beti Hai Anmol Yojana, BetiBachao - BetiPadhao Scheme, Kishori Shakti Yojana and Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA). Under these schemes various incentives are given to girl child and adolescent girls.

Initiatives taken by Directorate of Health Safety and Regulations

Government of Himachal Pradesh had created a separate new Directorate of Health Safety and Regulation on 1st June, 2009. The role of this Directorate becomes quite significant in the wake of declining sex ratio in Himachal Pradesh. Four prosecutions have been started under PC-PNDT Act, one each in the Hon'ble CJM Courts of District Kullu, Shimla, Hamirpur and Bilaspur and are under trial. One conviction has been secured under PC-PNDT on 1st April, 2013 at CJM Court, Amb, District Una for a case initiated in 2008, whereby an imprisonment of one year and fine of Rs. 1000 was imposed on the violator. The Directorate has gone all out for strict enforcement of the PC-PNDT Act in Himachal Pradesh.

The economics of the socio-cultural system is equally responsible for the decline in CSR. With a son, enormous values are attached; daughters are considered as an economic liability. In terms of income earnings, females' contribution to the family prosperity is negligible, since female's participation in various economic activities is far below than their male counterpart. The low economic participation as well as wage differentials between men and women give a clear perception to the

couples about the importance of sons. Similarly, in the organized sector, public sector and at the decision making level and also in politics, women's participation is too little. The increasing violence against women is yet another manifestation of the low and unequal status of women and girl children, parents consider having a girl as an additional security risk. The institution of dowry makes girl's position more vulnerable and girlan economic burden to the parents.

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. The fieldwork reveals that men and women in 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. The shift to small family size, evident in India more recently, has not, however, been accompanied by a shift at the same time in the economic and social pressures to have sons and avoid daughters. As was stated by women in both Una and Kangra, 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.

The easy access to technology has made it easy to produce only sons. In this regard, abortion laws and the PNDT Act do not have effective control over couples and service providers. For them commercial considerations play an important role. Therefore, the functioning of the private ultrasound clinics should be banned and these facilities should be made available only in government-controlled centres, such as public hospitals, primary health centres and health and family welfare related centres.

Since, the biases against the girl child are based on socio-economic and cultural considerations, the solution lies only in socio-cultural reforms. From an economic point of view, efforts should be made to change the perception of girl child from that of an economic liability to an economic asset to the parents so that the desire for an excessive son preference could be reduced. There is also a need to change the prevailing social notion that a son is the only old age security through strengthening the social safety net by the Government. All these measures will have a desired effect through the laws and acts rather than using a sting operation. At the

cultural and social levels: traditions, values and customs that are governed by the patriarchal interest of a son preference be mediated through intervention of state, individuals and social and religious organizations.

It is suggested that there is a need to evolve a comprehensive strategy to reduce the gender differential in child mortality in India, and curb sex-selective abortion so as to improve the child sex ratio. Targeted interventions will help to reduce the fertility level in high-fertility districts and strict implementation of the existing law on sex-selective abortion throughout the state will be helpful to improve the child sex ratio.

CHAPTER-I

PROBLEM IDENTIFICATION AND STUDY DESIGN

Inequality between men and women is one of the crucial disparities in many societies and this is particularly so in India. Differences in schooling opportunities between boys and girls, illustrate one aspect of this broader phenomenon of gender-based inequality in India. In much of the country, women tend in general to fare quite badly in relative terms compared with men, even within the same families. This is reflected not only in such matters as education and opportunity to develop talents, but also in the more, elementary fields of nutrition, health, and survival. One of the manifestation of this disparity is in the form remarkably low ratio of females to males in the Indian population compared with the corresponding ratio not only in Europe and North America but also in Sub-Saharan Africa. The problem is not, of course, unique to India, but it is particularly serious in this country, and certainly deserves public attention as a matter of major priority.

There are, in fact, striking variations in the ratio of females to males in the population (FMR for short) in different regions of the world. While there are important social and cultural influences on survival rates there is fairly strong medical evidence to the effect that given similar care, women tend to have lower age-specific mortality rates than men (indeed, even female foetuses are relatively less prone to miscarriage than their male counterparts). Even though males outnumber females at birth (and even more at conception), women tend to outnumber men substantially in Europe and North America, with average ratios of around 1.05. In contrast, many parts of the developing world have female-male ratios well below unity, for example, 0.98 in North Africa, 0.95 in West Asia, 0.95 in Bangladesh, 0.94 in China. In India and Pakistan, the FMR is among the lowest in the world-about 0.93 in both countries. There is much direct evidence, in India and in many other countries with a sharp "deficit" of women, of relative neglect of the health and well-being of women (particularly young girls including female infants), resulting in a survival disadvantage of females vis-à-vis males over long periods.

It is easily calculated that no matter what female-male ratio we use as a benchmark for comparison (whether the FMR in contemporary Europe, or in Sub-Saharan Africa, or one based on the historical experience of parts of Europe), it is found that there are many millions of **Missing Women** in India. Dreze and Sen suggested a number closer to 60 million, on the basis of historical experience of Europe.

1.1 A Review of Literature

Awareness about and mention of gender has become inescapable in recent years in studies of demographic processes, i.e. fertility, mortality and migration. As bearers of children, women have been the focus of attention both by demographers and policy makers. Gender formed an important category of interest in studies by Agnihotri (2000), Cassen (1978), Chen, Haq and D'souza (1981), Das Gupta and Bhat (1997), Dyson and Moore (1983), Kishore (1993).

Mitra (1978), Mazundar and Krishnaji (2001), Visaria (1971), Das Gupta (1987) and Miller (1981, 1984, 1991) had studied gender discrimination through sex differences in mortality and child survival, quite early. Besides Sen's (1990) famous "missing women" phrase, economists had focused on gender discrimination, some of them being Agarwal (1988), Bardhan (1982), Cain (1984), Harris (1989, 1999), V. Patel (1984), Sen (1984). The historical practice highlighted during the colonial period in India, and presumed to have died out down time, resurfaced in pockets in India, not only before the new reproductive technologies (NRTs), particularly foetal-ultrasound came into the country, but even after their entry and popularity (Bumiller, 1990).

Some demographers intend to emphasize the subordination of third world women and its profound ramifications on childbearing options. Women are portrayed as passive victims of patriarchal institutions where these women have little choice but to go for more children (Caldwell, 1978, cited in Green Halg, 1995). While there is a large element of truth in these portrayals, they paint too passive a picture of women in patriarchal societies. There are often instances where women are not just victims of oppressive systems but are also social actors who use the resources at their disposal to devise strategies that challenge and sometimes alter the systems.

Avoidable dowry expenses as an argument justifying elimination of female foetuses, has gained common currency in both journalistic reporting and academic research. Among many middle and lower castes in India, there has been a spur in adoption of the practice of dowry increasingly replacing that of bride price. This shift seems to have brought about the additional perception of the female as an economically expensive category overlapping with her more polluted though not inauspicious status as receiver and reproducer of the lineage seed. Kapadia (1995) mentions the unhappiness of lower caste parents of marriageable daughters in South India, owing to their inability to meet the increasing demand from prospective grooms, to 'put more gold' on brides. North India has, of course been infamous for dowry demands, the persistence lasting much after the wedding and even bride-burning for the purpose of dowry. The deep rooted consideration is, after all, the field is replaceable.

Demographic studies on the value of children, the costs and benefits of children, were taken up by the Human Capital, Micro-Economic School (Becker, 1981 and others) and by Arnold et.al. (1975) for psychological values of children. Comparisons between fertility in societies at different stages of economic growth and between groups within societies in recent times have thrown up data that do not follow the predicted directions claimed by the theory of demographic transition. Fertility reductions were explained as a function of economic development, prosperity, education and reduced mortality through the demographic transition model. Unnithan-Kumar (2004) examines the intervention of state health policies with women's reproductive agency. In the context of female foeticide in India, the agency and passivity of women as reproducers remains an enigma as educated, gainfully-employed women prioritize their reproductive careers in unexpected ways. When it comes to the unrelenting desire to produce sons as against daughters, women's agency poses challenging questions. This feature of Indian society takes us beyond the issue of weaknesses of the theory of demographic transition as it baffles and contradicts the assumptions of status, position, autonomy and agency of women.

The deficit of women in India and the possible factors responsible for it have aroused 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 deficit of girls aged 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 anomalous higher mortality among women compared to men (Visaria, 1971). 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 (Visaria, 2002). In India, until 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.

Despite the spread of schooling among girls in recent decades, the patriarchal social structure survives (Visaria, 2007). 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 pursuit of sons, they have become, with some pressure from the families, consumers of the new-technology of ultrasound, which allows them to choose and hear sons. The possibility of delinking availing legal abortion services from finding and revealing the sex of the foetus provides an opportunity to abort the child of an unwanted sex.

Miller's work opened up many important lines of inquiry, well beyond the domain of demography (1981). Miller emphasized upon the effect of female labour participation on, sex ratios. This 'work' as determinant of 'worth' line of inquiry has been followed by many others, notably Rosengweig and Schultz (1982). The female-male ratio and female labour participation relation is further analyzed using the overall population figures at the district level. The importance of female labour participation had earlier been highlighted by Bardhan (1974) in his wildly conjectured wheat-rice divide in sex ratio patterns. Briefly, the argument suggested that the predominantly wheat growing regions in north-western India required much less female labour participation compared to the predominantly rice growing south-east. As a consequence, women were valued less in the former, leading to the lower status and higher discrimination against them. In the south-east, they are valued more on account of their high participation in agricultural activities, and therefore face less discrimination. This was the main underlying cause of the north-south divide observed in the sex ratio patterns across the country.

However, the north-south divide was brought to the centre state of discussion by Dyson and Moore (1983) who highlighted the role of cultural factors in determining the status of women. The north and south are characterized by two different cultural and kinship systems. The 'male-centered' kinship system (a term used by Kishore, 1993) in the north undervalues and subordinates females while the southern kinship system values them more and allows them to retain their ties with their natal kin. The difference in their status, which is culturally mediated, plays an important role in determining their access to resources both within the household and at the level of the society. The culture-as-determinant-of-status argument has been-followed, among others, by Basu (1992), Berreman (1993), Dasgupta, M. (1987, 1995), Papanek (1990) and Madan (1993).

The cultural and economic explanations of variations in sex ratios had assumed competing posture for some time. The need to integrate these two was explicitly recognized by Bardhan (1986). He felt that the dispute about the primacy of one set of factors over the other was pointless (1986). However, in-depth attempts to integrate the two sets of factors took place only recently (Basu, 1992; Kishor, 1993).

Miller (1989) incorporated the role of prosperity in her analysis through a distinction between the 'propertied' and 'un-propertied' classes, highlighting the pattern of low female-male ratios among the propertied groups in the north. She identified dowry as one of the major culprits which creates the perception of the girl child as a liability. While the ill effects of dowry in the north have been discussed for quite some time (Sharma, 1993), the role of dowry in the south has also come under scrutiny in recent years. Notable among these are Heyer (1992), Kapadia (1994), Rao (1993) and Subramanium (1996).

Dowry is one manifestation of the role of capital, inheritance in another. The role of inheritance has been emphasized by Agarwal (1994). She traces the roots of status to property rights and the inheritance system. The north-south divide according to her is closely related to the issue of property rights. The northern social structure denies women any significant property rights which lower their status and consequently their access to resources. In the southern or the eastern system, women have significant property rights and therefore enjoy a better status than their northern counterparts. However, the question of why different property rights regimes or inheritance patterns prevail in different regions brings us back to issue of ecology and culture.

Sex ratio at birth is one of the 'initial conditions' which determines the sex ratio of the overall population. It is nearly constant-within a range of 104-107 male live births per 100 femlae live births- in the absence of any sex-selective human intervention (Visaria, 1971; Mckee, 1984). Various biological, environmental and socio-economic factors affect sex ratio at birth. Important among these are birth order and the child-bearing conditions which are reflected in the proportion of still births to live births.

It is widely believed that the 'primary' sex ratio (sex ratio at conception) is much higher than the sex ratio at birth or the 'secondary' sex ratio (Klasen, 1994; Miller, 1981). Owing to higher biological vulnerability of male foetuses, 3-37 per cent more male foetal deaths take place over female foetal deaths (Ramchandran and Deshpande, 1964). The sex ratios of still births decline as the proportion of still births to live births decreases. As a

result, sex ratios at births becomes more masculine as the conditions of childbearing become more optimum, health care improves and proportion of still birth come down (K Lassen, 1994). This is quite small in magnitude, however, the ratio of stillbirths to live births is quite low i.e. less than 50 still births per 1000 live births. The secondary sex ratio at birth increased in Sweden, for example, by less than 3 points over 200 years (1780-1980) and by less than 4 points in the U.K. between 1861 to 1980 (Ananthram, 1989; Klassen, 1994). The improved health environment, as reflected in the life expectancy at birth, indicates an increase of one percentage point in the sex ratio at birth for every increase of 13 years in life expectancy (Klassen, 1994).

As regards birth order, there is clear evidence that the sex ratio at birth among the first born is universally higher than among the subsequently born children (Ramachandran and Despande, 1964; Klassen, 1994).

Most analyses of sex ratio patterns in India use data not corrected for migration. The reason perhaps lies in use of state-level data. At the state level, effects of sex-selective migration are assumed to be insignificant, which may not necessarily be the case (Agnihotri; 1995). While female migration in India mostly arises on account of marriage, most long distance migration is heavily male dominated and arises out of economic necessities (Desai, 1969; Srivastava, 1979). High net male in-migration in metropolitan cities and male dominated in-migration among non-Scheduled Tribes in some of the north eastern states bear this out. This results in considerable variation in the female-male ratios (FMRs). For instance FMR is 772 for Mumbai, 1032 for Kerala and 558 for non-tribal Nagaland (Agnihotri, 1996).

Most literature, including Agnihotri (1996), has emphasized the absence of the sex-selective migration as the primary reason for using juvenile age group data. However, the focus on the juvenile age group is important for one more reason. This is the age group where the female disadvantage is most pronounced in India (Chatterjee, 1990; Bennet, 1991; Harriss, 1989). Therefore, the pattern of discrimination against females can be effectively studied through the sex ratios in the juvenile age group.

Societies where gender bias against females operates can experience large sex differentials in child mortality rates (Caldwell and Caldwell, 1990; Harriss, 1989). The 'access disadvantage' to life sustaining inputs, for example, mother's milk, nutrition, immunization and health care, negates the biological advantage that the girl child has. Harris describes excess female mortality in the 1-4 age group as the most sensitive and specific measure of female disadvantage (1987).

The Scheduled Castes and Scheduled Tribes constituting about 16 per cent and 8 per cent respectively of the country's population (Agnihorti, 1995), represent historically disadvantaged sections of the society. Both Scheduled Castes and Scheduled Tribes share certain common economic features. They are both, for example, poor, have marginal land assets both qualitatively and quantitatively, and are major suppliers of casual and agriculture labour (Boserup, 1970; Miller, 1981). But socially and culturally the two are quite different. Scheduled Castes are quite evenly spread across the country.

The Scheduled Tribe population is unevenly spread and confined to specific clusters. Nearly three-fourths of the country's STs are concentrated in central India along with north-south divide (Nanda, 1993). Differences in sex ratio patterns among the ST, SC and the general category have not attracted serious attention in the literature. Generally high FMRs among this population has been noted in old census reports from time to time (Natarajan, 1972). High FMRs among the STs in Madhya Pradesh is explicitly discussed by Dange (1972). But this has not been followed up further. Miller herself explicitly opts out of this line of analysis preferring to use older (1981) data on individual castes rather than the data from more current census which used 'just three categories'.

The available literature suggests that a combination of factors namely: the urge to have a son, acceptance of the small family norm as a result of fertility transition, access to pre-natal sex determination tests and abortion has worsened the situation relating to a girl child (George and Dahiya, 1998; Goodkind, 1999; Ganatra et al; 2001; Bhat, 2002 and Mallik, 2003). The prevailing socio-economic and cultural milieu including the impact of modernization has further aggravated the situation with regard to these factors.

Over the last two decades, fertility transition and a decline in the child sex ratio are concomitant in all the states of India. Fertility transition in India began in the early 1970s, intensified in the 1990s and is now taking place across all socio-economic groups. The Total Fertility Rate (TFR) in the country has declined by 34 per cent over the last two decades, from 3.8 in 1990 to 2.5 in 2011, and the recent decline in fertility in largely contributed by poor and uneducated women (Bhat, 2002; Arokiasamy, 2009; Mohanty and Ram, 2011). The population stabilization in India is now contingent on the future fertility scenario in the states of Bihar and Uttar Pradesh, which have shown little reduction in their fertility levels (Das and Mohanty, 2012). On the other hand, the fertility decline over the last two decades has intensified gender discrimination before birth, leading to a sharp decline in the child sex ratio.

Though fertility reduction and gender bias have been dealt with extensively in the demographic literature, there have been only a limited number of studies focusing on India at the district level. This is perhaps due to the non-availability of direct fertility estimates and developmental indicators and the complexity involved in district-level analyses in India. Based on district-level analysis (Mohanty and Rajbhar, 2013), it emerged that Indian districts with low fertility have recorded a decline in CSR but the reduction is larger in high-fertility districts. In fact, the transitional districts are experiencing excess female mortality and increased sex-selective abortion and are at higher risk of a deepening sex ratio in the future. The results confirm the findings of micro-level studies on the linkages of declining fertility and child sex ratio in India. Though the reproductive and child health programme has been successful in reducing under-five mortality, the gender differentials in under-five mortality seem to have widened during 1991-2011.

Mohanty and Rajbhar (2013) pointed out that along with increased sex ratio at birth and the gender differential in mortality, region is central in explaining the variation in CSR in India. While one-third of the variation in the CSR can be explained by the sex ratio at birth and the gender differential in mortality, region explained about a quarter of the

variation in CSR. Though the fertility transition is universal in Indian districts, the fertility reduction has been lowest in the districts with highest fertility.

India as a whole has an exceptionally low female-male ratio. This problem, is not, of course, equally serious in every region of India. This ratio is particularly low in large parts of North India, especially the north-western states (e.g. 0,.86 in Haryana and 0.87 in Punjab), and comparatively high in the south (e.g. 0.99 in Tamil Nadu, 0.98 in Andhra Pradesh, 0.96 in Karnataka). In Kerala, the FMR is well above unity; in fact, it is as high as 1.06, that is, higher than in any of the world's major regions except Eastern Europe.

These regional patterns of female-male ratios are consistent with what is known of the character of gender relations in different parts of the country. The north-western states, for instance, are notorious for highly unequal gender relations, some symptoms of which include the continued practice of female seclusion, low female labour-force participation rates, a larger gender gap in literacy rates, extremely restricted female property rights, strong son preference in fertility decisions and widespread neglect of female children. In all these respects, the social standing of women is relatively better in South India (and also in much of the eastern region). Kerala, for its part, has a distinguished history of more liberated position of women in society.

1.2Time Trends

It is well-known that FMR in India has declined through much of the twentieth century. More precisely, India's FMR declined almost monotonically from 0.97 to 0.93 between 1901 and 1971, and has remained close to 0.93 since 1971, reaching to 0.927 in 1991 and 0.933 in 2001. Since then there has been some increase.The latest figure, from the 2011 census, is 0.943.

At the state level, twentieth-century trends in female-male ratios exhibit diverse patterns.Since 1901, the female-male ratio has steadily declined in some states (e.g. Bihar, Orissa, Tamil Nadu), steadily increased in others (mainly Kerala and Himachal Pradesh), and followed intermediate patterns elsewhere. Broadly speaking, changes in state-specific FMR in the twentieth, century, have partly taken the form of a **convergence effect** involving a particularly large decline in states starting off with a high FMR, and some increase in states with the lowest initial female-male ratios. The main exception to this pattern is Kerala, where the FMR increased from a high initial value. In addition to this convergence pattern, however, there has been a fairly broad-based decline of the FMR, not confined to any specific region.

All this points to the possibility that the decline of India's female-male ratio in the twentieth century relates to differential changes in male and female mortality rates. In this connection, it is useful to distinguish between two possible causes of major change in FMR. First, the ratio can change in response to a gender-neutral change in the mortality level in a particular age group, without there being any change in the ratio of female to male mortality in that age group. Since we are looking at a period over which mortality levels have declined in all age groups is being considered, this may be referred to as the **mortality decline effect**. Second, the FMR can change in response to a change in the ratio of female

to male mortality in a particular age group. This may be called the **changing mortality bias effect**.

It is possible, in some circumstances, for the mortality decline effect to pull down the FMR. For instance, if the infant mortality rate is lower among females than among males (as is often the case, even in India), then an equi-proportionate decline of male and female infant mortality rates would generally lead to some decline in the female-male ratio. This, and other aspects of the mortality decline effect, may well be a part of the explanation for India's declining FMR in the twentieth century.

This, however, does not mean that the decline in the FMR in India is some kind of **natural phenomenon** reflecting little more than the decline of mortality. Indeed, in other regions of the world, the decline of mortality in the twentieth century has usually gone hand in hand with an increase in the FMR, reflecting a sustained improvement in the survival chances of females relative to males. Even in Kerala, Sri Lanka and Himachal Pradesh (where gender discrimination is comparatively limited), recent demographic trends have followed this typical pattern. The all-India FMR decline seems to reflect a combination of the **mortality decline effect** with an adverse **changing mortality bias effect** or at the very least, a failure to remove the anti-female bias in survival. This applies particularly in the younger age groups, where the anti-female bias remains very strong. In countries where young males and females receive similar treatment in terms of food, health care, and related necessities, females have substantial survival advantages. India's persistently low FMR suggests some considerable anti-female discrimination, which in contrast with many other countries- has not gone away with the decline of mortality.

This failure to remove the female disadvantage in survival chances in the younger age groups persists today, and that is one major reason why the FMR remains low, despite improved survival chances of women vis-à-vis men in the older age groups. Given that early childhood is also a period of relatively high mortality, this persistent survival disadvantage of young girls is bound to exert a major downward effect on the overall FMR. Meanwhile, however, another downward influence on the FMR has emerged: the steady decline of FMR at birth in many parts of the country is largely due to sex-selective abortion. Indeed, in societies where male children are valued more highly than female children and where it is considered essential to have at least one male child and preferably two, external pressures to limit births can sharply enhance the temptation to abort female foetuses. This is, in all likelihood, what has happened in China on a fairly large scale in recent years.

Given a preference for boys over girls that exists in many male-dominated societies, gender inequality can manifest itself in the form of the parents' wanting the new born to be a boy rather than a girl. There was a time when this could be no more than a wish, but with the availability of modern techniques to determine the gender of the foetus, sex-selective abortion has become common in many countries. It is particularly prevalent in East Asia, in China and South Korea in particular, and also in Singapore and Taiwan. It appears that this manifestation of **high-tech sexism** is now emerging as a statistically significant phenomenon in India as well.

In India, there has been some reduction of overall gender bias in mortality rates, and even though the progress is very uneven between the different regions of the country, nevertheless the average female life expectancy at birth is now about two years longer than the corresponding male life expectancy. There has been also some increase in the overall FMR in the total population between 1991 and 2001, but his has been restrained by a sharp decline in the FMR among young children. For India as a whole, the FMR of the population in the 0-6 age group has fallen from 94.5 girls per hundred boys in 1991 to 92.7 girls per hundred boys in 2001 and further to 91.9 girls per hundred boys in 2011. While there has been no such decline in some parts of the country (including Kerala), the ratio has fallen very sharply in others, such as Punjab, Haryana, Gujarat and Maharashtra, which are among the richer Indian states.

Taking together all the evidence that exists, it is clear that this change reflects not a rise in female vis-à-vis male child mortality, but a fall in female births as compared with male births, and is almost certainly connected with the spread of sex-selective abortion.

Between 1981 and 2001, the sex ratio of the total population at all India level as well as in the major states in the northern, western and southern parts of the country remained virtually the same with the exception of Gujarat where the deficit of women somewhat increased during this period as depicted in Table 1.1. At the same time, the deficit of young girls, which was not evident in 1981 except in the traditionally and historically masculine states of Haryana and Punjab, became quite stark by 2001 in Himachal Pradesh, Gujarat, Rajasthan, Maharashtra, Karnataka, Tamil Nadu and West Bengal. The deficit of girls further increased in Haryana and Punjab. Overall sex ratio has improved by 10 points for all India duringthe decade 2001-2011. All the states mentioned in the Table 1.1 also showed increase in overall sex ratio during the same period. The highest sex ratio was registered in the state of Kerala (1084) followed by Tamil Nadu (996) and Andhra Pradesh (993).

Table 1.1

Sex Ratio (females per 1000 males) of Population for all age Groups and for 0-6 Age Group for India and Selected States, 1981-2011.

State /Census Year	1981		1991		2001		2011	
	All ages	0-6 years	All ages	0-6 years	All ages	0-6 years	All ages	0-6 years
All India	935	971	927	945	933	927	943	919
Himachal Pradesh	973	971	976	951	968	896	972	909
Haryana	870	902	865	879	861	819	879	834
Punjab	879	908	882	875	876	798	895	846
Rajasthan	923	954	910	916	921	909	928	888
Gujarat	942	947	934	928	920	883	919	890
Maharashtra	937	956	934	945	922	913	929	894
Kerala	1038	970	1036	958	1058	963	1084	964
Karnataka	963	974	960	960	965	946	973	948
Andhra Pradesh	975	992	972	975	978	961	993	939
Tamil Nadu	977	967	974	948	986	942	996	943
West Bengal	911	981	917	967	934	960	950	956

Source: Census of India, Registrar General and Commissioner, Govt. of India, New Delhi. Various years' **Census Reports.**

The juvenile sex ratio has shown mixed trends in case of these major states.At allIndia level, a decline was noticed from 927 in the year 2001 to 919 in the year 2011. In case of Rajasthan, Maharashtra, Andhra Pradeshand West Bengal; a decline of 21, 19, 18 and 4 points respectively, was noticed. Himachal Pradesh has slightly improved its performance from 896 in 2001 to 909 in 2011. There was significant increase in case of Haryana and Punjab state, where it has increased from 819 to 834 and 798 to 846, respectively. Gujarat, Kerala, Karnataka and Tamil Nadu showed slight improvement in juvenile sex ratio during 2001-2011.

1.3 Child Sex-Ratio in Himachal Pradesh from the year 1971 to 2011

It is difficult to examine juvenile sex-ratio data for all the census years right from 1971. As the 1971 census provided 0-4 years age group data, 1981 and 1991 census provided data for 0-9 years. It is only from 2001 census onwards that 0-6 age group data was made available. District-wise sex-ratio of the child population of Himachal Pradesh from census 1971 to census 2011 is depicted in Table 1.2.

Table 1.2

District-wise Sex-Ratio of the Child Population from the Census 1971 to 2011

S.N.	Districts	1971 (0-4 Population)	1981 (0-9 Population)	1991 (0-9 Population)	2001 (0-6)	2011 (0-6)
1	Bilaspur	966	953	856	882	900
2	Chamba	101	984	891	955	953
3	Hamirpur	--	978	821	850	887
4	Kangra	981	968	849	836	876
5	Kinnaur	1006	990	NA	979	963
6	Kullu	966	965	867	960	962
7	Lahul&Spiti	987	958	--	961	1033
8	Mandi	971	981	848	918	916
9	Shimla	970	982	840	929	925
10	Sirmour	983	975	903	934	928
11	Solan/ Mahasu	996	951	882	900	899
12	Una	--	928	835	837	875
13	Himachal Pradesh	982	969	858	896	909

Source: Census of India, Registrar General and Commissioner, Govt. of India, New Delhi. Various years' **Census Reports**

For majority of the districts of Himachal Pradesh juvenile sex ratio has declined from census 1971 to census 2011. This is an alarming sign for the women of Himachal Pradesh. Sex ratios have been examined using five levels as low, very low, moderate, high and very high as shown in Table 1.3.

Table 1.3

Ranking of Districts on the basis of Juvenile Sex-Ratio

S. N.	Level of Sex Ratio	Status of District on the Basis of		Name of Selected Districts for Study
		Census 2001	Census 2011	
1	Very Low	Kangra, Hamirpur, Una		
2	Low	Solan, Bilaspur	Kangra, Hamirpur, Una, Solan, Bilaspur	Una, Kangra
3	Moderate	Mandi, Sirmour, Shimla	Mandi, Sirmour, Shimla	Sirmour
4	High	Kinnaur, Kullu, Lahaul &Spiti, Chamba	Kinnaur, Kullu, Chamba	Kinnaur
5	Very High		Lahaul &Spiti	

Note:

Levels:

Very low (VL) - Below 850

Low (L) - 850-900

Moderate (M0) - 900-950

High (H) = 950-1000

Very High (VH) = Above 1000

As per 2001 census data, 3 districts namely Kangra, Hamirpur and Una were in the very low category having sex ratio less than 850 and 2 districts namely Solan and Bilaspur were in low category having sex ratio between 850 and 900. Mandi, Sirmour and Shimla were in Moderate category and remaining four districts i.e. Kinnaur, Kullu, Chamba and Lahaul &Spiti were in high category. There was not a single district in very high category. On the intervention of Supreme Court and strong implementation of PNDT act, the situation slightly improved in 2011 census. The three districts earlier falling in very low category slightly improved their position and moved to low category. Now five districts namely Kangra, Hamirpur, Una, Solan and Bilaspur were categorized as low status districts. There was no change in the three moderate districts. Lahaul & Spiti moved up from high category to very high category.

Himachal Pradesh has progressed very fast in terms of socio-economic and demographic indicates like over all sex ratio, IMR, MMR and couple protection rate, extent

of immunization and achieving replacement level fertility. Himachal is considered as a state having very high social development. But the declining juvenile sex ratio is an alarming problem. Seeing the gravity of the situation, the present study has been formulated to study the problem more deeply and highlight the reasons for declining sex ratio.

1.4 Objectives of the Study

The broad objective of the present study is to map the trends in Sex Ratio particularly in the age group of 0-6 years and to explore the causes of decline in the sex ratio in the age group of 0-6 years during the last two decades in Himachal Pradesh. The specific objectives of the study are as below:

1. To map the trends in the sex ratio particularly in the age group of 0-6 years in Himachal Pradesh.
2. To find a relationship between the socio-economic conditions of Himachal Pradesh with the declining trend.
3. To explain the observed trend with the help of appropriate tools and indicators.
4. To do in-depth exploration into the causes of declining sex ratio in the age group of 0-6 years in Himachal Pradesh.
5. To analyze the existing policy framework in Himachal Pradesh that aims at arresting the declining trend in the 0-6 year sex ratio.
6. To give policy recommendations to improve the sex ratio in the age group of 0-6 years in Himachal Pradesh.

1.5 Methodology

The present study is based on both primary and secondary data. In order to see the trends in the juvenile sex ratio, districts and blocks have been mapped on the basis of 1991, 2001 and 2011 Census Reports of Himachal Pradesh. They have been classified as very low, low, moderate, high and very high districts and blocks.

In order to study the relationship between the declining trend in juvenile sex ratio and socio-economic development indicators of the state, data have been taken from Economic Survey, Statistical outline of Himachal Pradesh, Block-wise Indicators, Human Development Report, District Development Reports, Education Data and PROBE Report.

In order to explore the causes of decline in Juvenile sex ratio primary survey has been conducted by ranking the districts as very low, low, moderate, high and very high. On this basis four districts have been selected. Care has been taken to include those districts which are showing rising trend and those which are showing declining trend. On the same analogy blocks, panchayats and villages have been selected.

The following perception surveys have beenconducted:

- Perception survey of doctors (both male and female) and doctors in the public sector and private sector.
- Perception survey of PRI members (male and female members of panchayats).

- Perception survey of married women in each of the household surveyed in the villages selected for intensive study.
- Perception survey of ASHA Workers and Anganwari Workers.

The methodology is having the following main elements:

1. Quick analysis of the results of 1991, 2001 and 2011 Census of Himachal Pradesh.
2. Launching field surveys in selected districts, blocks and finally villages.
3. Selection of 4 districts based on the ranking of very low, low, moderate, high and very high in terms of juvenile sex ratios. As districts have moved up from very low ranking to low ranking and their number stands at five according to 2011 census, two districts have been selected from this category. Since Una and Kangra districts are having the lowest juvenile sex ratio they have been purposely selected from low sex ratio category. In the moderate category, out of three districts, one has been selected and Sirmour is purposely selected from this category. Three districts namely Kinnaur, Kullu and Chamba fall in high category districts and from these Kinnaur has been selected because of very high juvenile sex ratio. Only one district i.e. Lahaul & Spiti falls in very high category so it has not been included in the study. The sampling procedure is depicted in Table 1.4 and Table 1.5.More than 50 per cent blocks have been selected from these districts.
4. Una district consists of five blocks; out of them,Gagret, Una and Amb showed lowest sex ratio and therefore field study has been conducted in these three blocks by taking one per cent sample of the total householdson random basis which comes out to be 637 households. Out of 15 blocks of the Kangra district, 7 blocks have been selected on the basis of lowest sex ratio. These selected blocks include Nurpur, Fatehpur, Nagrota Surian, Indora, Kangra, Pragpur and Lambagaon. On the basis of one per cent random sampling of households, a total of 1,371households have been selected from these blocks.
5. From Sirmour district, three blocks namely Sangrah, Shillai and Rajgarh have been selected on the basis of highest juvenile sex ratio out of 6 blocks. On the basis of one per cent size of the sample, 287 households were selected on random basis. Out of three blocks of Kinnaur district, two blocks namely Kalpa and Pooh have been selected on the basis of highest sex ratio and from these blocks 132 households were selected on random sampling basis.
6. Perception surveys of doctors, panchayat members,ASHA Workers, AnganwariWorkersand married women in each selected household have been carried out intensively. These perception surveysare in addition to the household survey.

1.6Procedure of Selection of District, Blocks and Households

The procedure of finally selecting the households for detailed survey is shown in Table1.5. A total of 2663 households have been covered which included637 households from Una district, 1607 from Kangra, 287 from Sirmour and 132 from Kinnaur district.

Table 1.4

Juvenile Sex Ratio in the Selected Districts and Blocks of Himachal Pradesh (on the basis of 2011Census)

Status of Sex Ratio	Name of Selected Districts	Sex Ratio 0-6 years	Name of Selected Blocks	Sex Ratio 0-6 years
Low	Una	875	Gagret	850
			Una	859
			Amb	865
	Kangra	876	Nurpur	815
			Fatehpur	831
			Nagrota Surian	834
			Indora	839
			Kangra	854
			Pragpur	871
			Lambagaon	883
Moderate	Sirmour	928	Sangrah	969
			Shillai	947
			Rajgarh	926
High	Kinnaur	963	Kalpa	996
			Pooh	947

Table 1.5

Selection of Districts, Blocks and Households for field Survey on the Basis of 2011 Census

Status of Sex Ratio	No. of Districts	Name of Districts	Name of Selected District	Name of Selected Blocks	No. of H. H.	1 % of the H.H.	District-wise Total Sampled H.H.
Very low	-						
Low	5	Bilaspur, Hamirpur, Kangra, Solan, Una	Una	Gagret	18,395	184	637
				Una	24,694	247	
				Amb	20,668	206	
			Kangra	Nurpur	25,400	254	
				Fatehpur	23,709	237	
				Nagrota Surian	21,150	212	1,607
				Indora	22,774	228	
				Kangra	22,291	222	
				Pragpur	25,940	259	
				Lambagaon	19,511	195	
Moderate	3	Mandi, Sirmour, Shimla	Sirmour	Sangrah	11,567	116	287
				Shillai	8,173	81	
				Rajgarh	9,025	90	
High	3	Kinnaur, Kullu, Chamba	Kinnaur	Kalpa	7,824	78	132
				Pooh	5,471	54	
Very High	1	Lahaul-Spiti	-	-	-	-	
Total	**12**	**12**	**4**	**15**	**2,66,592**	**2,663**	**2,663**

To know the deep rooted causes of declining juvenile sex ratio, detailed primary data has been collected with the help of interview schedule prepared and finalized keeping in mind the socio-economic and demographic indicators and socio-cultural and geographical situation of the selected districts.

The interview schedulesare of four types:

(a) **Household Interview Schedule**. (Covers all birth, death, marriage and migration report of the family)

(b) **Women Schedule**. (Covers fertility history of the married women and socio cultural practices and attitude toward family size and upbringing of the children,

(c) **Institution Schedule.**(Health Institution that covers the selected village to see the Attitude and practice towards health services).

(d) **Village Schedule.** (Captures details of the selected village data).

CHAPTER-II

QUALITY OF LIFE IN HIMACHAL PRADESH

Himachal Pradesh has recorded impressive achievements in both social and economic development, especially when seen in relation to the situation at the time of independence. The State then was beset with wide economic disparities and such conditions that blocked any rapid or drastic improvements in the prevailing social situation for a large group of population. After fifty years, Himachal Pradesh has achieved high level of social development and has shown that the well-being of the people can be improved, and social, political and cultural conditions transformed, even at low levels of income, when there is appropriate public action. The transition is perhaps most striking in the field of basic education. Along with this spectacular schooling expansion, there has been impressive progress in many other fields, too.

The significance of Himachal Pradesh's achievements becomes obvious only in the context of a comparative setting. One of the smaller States in the Indian Union, Himachal Pradesh is doing substantially better in terms of basic social indicators. The relative performance of the state in terms of economic and social development, in comparison with other major states of India for the year 2000-01, can be seen in Table 2.1. In 1999-2000, 7.63 per cent of Himachal's population was estimated to be below the poverty line compared to 25.02 per cent for Maharashtra. Himachal Pradesh stands tall among the states of the Indian Union in the field of literacy. The literacy rate in Himachal Pradesh was 77.13 per cent in 2001 and rose to 82.8 per cent in 2011. The corresponding rates in Punjab, Haryana and Uttar Pradesh are 76.68 per cent, 76.64 per cent and 69.72 per cent, respectively. The relative development of the State in terms of other indices like expectation of life and infant mortality rate, which are indicative of the health aspect of social development, reveals a much better picture. Infact, Himachal Pradesh is well ahead of other States in terms of expectation of life and infant mortality rate. This is in striking contrast with states like Gujarat and Haryana, which rank higher in terms of economic development but do not enjoy commensurate ranks in social development.

Table 2.1

Some Key Indicators of Development

State	Per capita SDP, Current Prices, 2000-01 (Rs.)	Persons Below Poverty Line (%) (1999-2000)	Literacy Rates 2001	Infant Mortality Rates (2001)	Life Expectancy (1993-97)
Andhra Pradesh	16,373	15.77	61.11	66	62.40
Assam	10,198	33.77	54.28	78	56.70
Bihar	5,108	42.60	47.53	67	59.60
Gujarat	19,228	14.07	69.97	64	61.90
Haryana	23,742	8.74	68.59	69	64.10
Himachal Pradesh	18,920	7.63	77.13	64	64.90
Jammu & Kashmir	12,399	3.48	54.46	45	N.A.
Karnataka	18,041	20.04	67.04	58	63.30
Kerala	19,463	12.72	90.92	16	73.30
Madhya Pradesh	10,803	37.43	64.11	97	55.50
Maharashtra	23,726	25.02	77.27	49	65.50
Orissa	8,547	47.15	69.94	98	57.20
Punjab	25,048	6.16	61.03	54	67.70
Rajasthan	11,986	15.28	73.47	83	60.00
Tamil Nadu	19,889	21.12	73.66	53	64.10
Uttar Pradesh	14,348	31.15	57.36	85	57.60
West Bengal	9,721	27.02	69.22	53	62.80
India	16,072	26.10	65.38	70	61.10

Sources: Economic Survey (various issues)

Himachal Pradesh is still predominantly rural, and between 1993-94 and 2011, rural poverty (using the poverty line suggested by the Tendulkar Committee) declined from 36.8 per cent to 8.5 per cent - a fourfold drop, which is impressive by any standard. Yet, while rural poverty continued to consistently decline after 2004, urban poverty changed only marginally between 2004and 2011.

The overall poverty decline has benefitted all social groups across rural and urban areas, but some noticeable patterns emerge. While poverty among SCs and STs in rural areas declined, in terms of levels, rural poverty was still highest among SCs at 16.5 per cent and among STs at 9.5 per cent (Table 2.2). STs residing in urban areas, and, to some extent, SCs, who had very low poverty rates to start with, nevertheless saw an increase in poverty. The biggest gains in poverty reduction were recorded for Other Backward Classes (OBCs) in rural areas, among whom the poverty headcount dropped from 19 per cent in 2004 to a mere 2.3 percent in 2011.

Table 2.2

Poverty Decline benefitted all Social Groups

Category	Rural		Urban	
	2004-05	2011-12	2004-05	2011-12
STs	35.4	9.5	2.4	4.0
SCs	39.5	16.5	9.2	9.9
OBCs	19.0	2.3	10.8	9.9
Others	18.3	7.0	2.5	1.7
All	25.0	8.5	4.6	4.3

Sources: NSS rounds 61 and 58.

Note: Data refer to poverty headcount, that is, the ratio of the poor population to total population.

2.1 Demography of Himachal Pradesh

District wise percentage distribution of population as per 2011 census is given in Table 2.3. Kangra is the highly populated district (22%) followed by Mandi (14.56%) and Shimla (11.86%). Lahaul & Spiti district is inhabited by minimum number of people i.e. 0.46 per cent, followed by Kinnaur (1.23%) and Bilaspur district (5.56%). Percentage of SC population is also maximum in Kangra, Mandi and Shimla districts i.e. 18.47, 16.99 and 12.48 per cent, respectively. Scheduled tribe population is highest in Chamba district (34.56%) followed by Kangra (21.57%) and Kinnaur district (12.43%). Hamirpur (0.78%) and Una (2.19%) are having less tribal population.

Table 2.3

District-wise Percentage Distribution of Population in Himachal Pradesh (Census 2011)

District	Total Population	Scheduled Caste	Scheduled Tribe
Himachal Pradesh	100.00	100.00	100.00
Chamba	7.56	6.46	34.56
Kangra	22.00	18.47	21.57
Lahaul&Spiti	0.46	0.13	6.56
Kullu	6.38	7.09	4.29
Mandi	14.56	16.99	3.26
Hamirpur	6.62	6.32	0.78
Una	7.59	6.68	2.19
Bilaspur	5.56	5.72	2.73
Solan	8.45	9.51	6.54
Sirmaur	7.72	9.30	2.87
Shimla	11.86	12.48	2.23
Kinnaur	1.23	0.85	12.43

Source: Census of India, Himachal Pradesh, 2011.

On the basis of percentage of population to total population in Himachal Pradesh, Kangra (22%), Mandi (14.56%) and Shimla (11.86%) are the top 3 districts and Lahaul & Spiti (0.46%), Kinnaur (1.23%) and Bilaspur (5.56%) are the bottom 3 districts. Exactly similar is the situation in respect of scheduled caste population as depicted in Table 2.4. Top 3 districts in terms of scheduled tribe population are Chamba (34.56%), Kangra (21.57%) and Kinnaur (12.43%), Hamirpur (0.78%), Una (2.19%) and Shimla (2.23%) are at the bottom.

Table 2.4

Percentage to Total Population in Census 2011 – Top 3 and Bottom 3 Districts of Himachal Pradesh

Top 3 Districts	Percentage	Bottom 3 Districts	Percentage
Total Population			
Kangra	22.00	Lahaul&Spiti	0.46
Mandi	14.56	Kinnaur	1.23
Shimla	11.86	Bilaspur	5.56
Scheduled Caste			
Kangra	18.47	Lahaul&Spiti	0.13
Mandi	16.99	Kinnaur	0.85
Shimla	12.48	Bilaspur	5.72
Scheduled Tribe			
Chamba	34.56	Hamirpur	0.78
Kangra	21.57	Una	2.19
Kinnaur	12.43	Shimla	2.23

Source: Census of India, Himachal Pradesh, 2011.

In Himachal Pradesh, there is gender balance in the total population and also in SC and ST population (Table 2.5). It is nearly 50 per cent in all these cases. The gender balance is more close in respect of ST population whereas in case of India, the difference is more than 3 percentage points in respect of total population and SC population and it is almost equal in case of ST population.

Table 2.5

Proportion of SC/ST Population by District - 2011

District	Scheduled Caste (Per cent)	Scheduled Tribe (Per cent)
Chamba	21.52	26.10
Kangra	21.15	5.60
Lahaul&Spiti	7.08	81.44
Kullu	28.01	3.84
Mandi	29.38	1.28
Hamirpur	24.02	0.67
Una	22.16	1.65
Bilaspur	25.92	2.79
Solan	28.35	4.42
Sirmaur	30.34	2.13
Shimla	26.51	1.08
Kinnaur	17.53	57.95

Source: Census of India, Himachal Pradesh, 2011.

Gender-wise Total SCs and STs population of India and Himachal Pradesh is shown in Table 2.6. The gender balance is better for Himachal Pradesh as compared to India. Himachal is having 50.72 per cent male and 49.28 per cent female in its population, whereas this proportion is 51.47 per cent and 48.53 per cent in case of India.

Table 2.6

Gender-wise Distribution of Population of India and Himachal Pradesh

	Population			Proportion	
	Total Population	Male	Female	Male	Female
India					
Total Population	1,21,05,69,573	62,31,21,843	58,74,47,730	51.47	48.53
Scheduled Caste	20,13,78,086	10,35,35,165	9,78,42,921	51.41	48.59
Scheduled Tribe	10,42,81,034	5,24,09,823	5,18,71,211	50.26	49.74
Himachal Pradesh					
Total Population	68,64,602	34,81,873	33,82,729	50.72	49.28
Scheduled Caste	17,29,252	8,76,300	8,52,952	50.68	49.32
Scheduled Tribe	3,92,126	1,96,118	1,96,008	50.01	49.99

Source: Census of India, Himachal Pradesh, 2011.

Gender-wise child population in the age group of 0-6 years is depicted in Table 2.7 and rate of growth of increase / decrease over the period 2001-2011 isdepicted in Table 2.8. Gender imbalance was quite high in Kangra, Mandi, Una and Shimla districts in respect of

total SC and ST population. Lahaul & Spiti had shown highest decline in growth rate of 0-6 years population i.e. (-)14.71 per cent, followed by Kinnaur (-11.37%) and Mandi (-6.57%). The highest increase was inSolan (2.56%), Sirmaur (1.74%), Chamba (1.12%) and Kangra (0.02%).

Table 2.7

Child Population in the Age Group 0-6, Himachal Pradesh - 2011

District	Total			Scheduled Caste			Scheduled Tribe		
	Person	Male	Female	Person	Male	Female	Person	Male	Female
Himachal Pradesh	793137	418426	374711	215377	111230	104147	33575	17176	16399
Chamba	69579	35594	33985	15174	7682	7492	18427	9402	9025
Kangra	164566	89635	74931	36920	19618	17302	182	97	85
Lahaul&Spiti	3664	1868	1796	302	141	161	2829	1439	1390
Kullu	52820	26955	25865	16672	8484	8188	1048	545	503
Mandi	119949	62535	57414	38116	19429	18687	1493	771	732
Hamirpur	50699	27398	23301	12609	6699	5910	28	14	14
Una	59712	32505	27207	14624	7667	6957	6	3	3
Bilaspur	42890	22795	20095	11159	5841	5318	1215	650	565
Solan	66434	34959	31475	20000	10434	9566	445	238	207
Sirmaur	68431	35376	33055	22848	11525	11323	952	504	448
Shimla	85089	44105	40984	25872	13157	12715	354	200	154
Kinnaur	9304	4701	4603	1,081	553	528	6596	3313	3283

Source: Census of India, Himachal Pradesh, 2011.

Table 2.8

Growth Rate in Population Age Group of 0-6 Years, 2001-2011

District	Total			Scheduled Caste			Scheduled Tribe		
	2001	2011	Growth Rate	2001	2011	Growth Rate	2001	2011	Growth Rate
Chamba	69579	70359	1.12	15174	17200	13.35	18427	18152	-1.49
Kangra	164566	164607	0.02	36920	37557	1.73	182	10261	5537.91
Lahaul&Spiti	3664	3125	-14.71	302	240	-20.53	2829	2608	-7.81
Kullu	52820	50431	-4.52	16672	16213	-2.75	1048	1422	35.69
Mandi	119949	112074	-6.57	38116	36588	-4.01	1493	1764	18.22
Hamirpur	50699	48548	-4.24	12609	12271	-2.68	28	365	1203.57
Una	59712	59231	-0.81	14624	13971	-4.47	6	1017	16850.00
Bilaspur	42890	41956	-2.18	11159	11541	3.42	1215	1258	3.54
Solan	66434	68137	2.56	20000	20469	2.35	445	3465	678.65
Sirmaur	68431	69620	1.74	22848	24410	6.84	952	1932	102.94
Shimla	85089	81564	-4.14	25872	24572	-5.02	354	1055	198.02
Kinnaur	9304	8246	-11.37	1081	1819	68.27	6596	4614	-30.05

Source: Census of India, Himachal Pradesh, 2011.

Percentage distribution of 0-6 population among different districts of Himachal Pradesh is shown in Table 2.9. In total child population in 2011, Kangra district had the highest share (21.16%), followed by Mandi (14.41%), Shimla (10.49%) and Chamba (9.04%). Child population was minimum in Lahaul & Spiti (0.40%), followed by Kinnaur (1.06%). SC child population was maximum in Kangra district (17.32%), followed by Mandi (16.87%), Shimla (11.33%) and Sirmaur (11.26%). Share of tribal in child population was 37.88 per cent in Chamba district, 21.42 per cent in Kangra and 9.63 per cent in Kinnaur district.

Table 2.9

Percentage Distribution of 0-6 Population among Districts -2011

District	Total Population	Scheduled Caste	Scheduled Tribe
Himachal Pradesh	100.00	100.00	100.00
Chamba	9.04	7.93	37.88
Kangra	21.16	17.32	21.42
Lahaul&Spiti	0.40	0.11	5.44
Kullu	6.48	7.48	2.97
Mandi	14.41	16.87	3.68
Hamirpur	6.24	5.66	0.76
Una	7.61	6.44	2.12
Bilaspur	5.39	5.32	2.63
Solan	8.76	9.44	7.23
Sirmaur	8.95	11.26	4.03
Shimla	10.49	11.33	2.20
Kinnaur	1.06	0.84	9.63

Source: Census of India, Himachal Pradesh, 2011.

Percentage-wise distribution of 0-6 years population showed Kangra (21.16%), Mandi (14.41%) and Shimla district (10.49%) on the top and Lahaul & Spiti (0.40%), Kinnaur (1.06%) and Bilaspur district (5.39%) on the bottom (Table 2.10). Exactly similar was the situation in respect of SC population. Percentage share of ST child population was highest in Chamba (37.88%), followed by Kangra (21.42%) and Kinnaur (9.63%). Bottom 3 districts were Hamirpur (0.76%), Una (2.12%) and Shimla (2.20%).

Table 2.10

Percentage Distribution of 0-6 Years Population, Himachal Pradesh, 2011

Top 3 District	Percentage	Bottom 3 District	Percentage
Total Population			
Kangra	21.16	Bilaspur	5.39
Mandi	14.41	Kinnaur	1.06
Shimla	10.49	Lahaul&Spiti	0.40
Scheduled Caste			
Kangra	17.32	Bilaspur	5.32
Mandi	16.87	Kinnaur	0.84
Shimla	11.33	Lahaul&Spiti	0.11
Scheduled Tribe			
Chamba	37.88	Shimla	2.20
Kangra	21.42	Una	2.12
Kinnaur	9.63	Hamirpur	0.76

Source: Census of India, Himachal Pradesh, 2011.

The gender gap in total, SC and ST child population is almost equal in India and Himachal Pradesh. It varies between 51.10 to 52.38 per cent for males and 47.62 to 48.90 per cent for females as shown in Table 2.11.

Table 2.11

Gender-wise Distribution of 0-6 Population of India and Himachal Pradesh

	Population			Proportion	
	Total Population	Male	Female	Male	Female
India					
Total Population	16,44,78,150	8,5732,470	7,87,45,680	52.12	47.88
Scheduled Caste	2,92,00,529	1,51,03,346	1,40,97,183	51.72	48.28
Scheduled Tribe	1,67,04,825	85,35,570	81,69,255	51.10	48.90
Himachal Pradesh					
Total Population	7,77,898	4,07,459	3,70,439	52.38	47.62
Scheduled Caste	2,16,851	1,12,200	1,04,651	51.74	48.26
Scheduled Tribe	47,914	24,823	23,091	51.81	48.19

Source: Census of India, Himachal Pradesh, 2011.

Though overall sex ratio of Himachal Pradesh in respect of total population, SC and ST population is better than India, it is less in case of children in the age group of 0-6 years. India's child sex ratio in 2011 was 919 and in case of Himachal Pradesh it was 909. The decline is quite significant in case of urban areas. It was 905 for India and 881 for Himachal Pradesh. Similarly, in case of urban SC and ST population, the difference was quite significant (Table 2.12).

Table 2.12

Sex Ratio and Child Sex Ratio (Females per 1000 males)

Indicator	INDIA				HIMACHAL PRADESH			
	Sex Ratio		Child Sex Ratio		Sex Ratio		Child Sex Ratio	
	2001	2011	2001	2011	2001	2011	2001	2011
Total Population								
Total	933	943	927	919	968	972	896	909
Rural	946	949	934	923	989	986	900	912
Urban	900	929	906	905	795	853	844	881
Scheduled Caste								
Total	936	945	938	933	968	973	936	933
Rural	939	945	941	936	976	978	939	934
Urban	923	946	924	922	864	911	894	905
Scheduled Tribe								
Total	978	990	973	957	996	999	955	930
Rural	981	991	974	959	1002	1003	956	934
Urban	944	980	951	940	809	923	899	816

Source:Census of India, Himachal Pradesh, 2011.

District-wise overall sex ratio is highest in case of Hamirpur (1095), followed by Kangra (1012) and Mandi (1007) as per 2011 Census (Table 2.13). It improved from 968 to 972 over the decade 2001 to 2011. This decade also showed improvement in overall sex ratio from 968 to 973 and from 996 to 999 in case of SC and ST population, respectively. During the same decade, child sex ratio improved from 896 to 909; declined from 936 to 933; and, 955 to 930 in case of total, SC and ST population, respectively. The significant increase has been observed in Lahaul & Spiti (from 961 to 1033), Kangra (from 836 to 876), Hamirpur (from 850 to 887) and Una (from 837 to 875). Kinnaur district had shown a significant decline from 979 to 963 (Table 2.14).

Table 2.13

Sex Ratio by District – Total, SC & ST – 2001-2011

District	Total		Scheduled Caste		Scheduled Tribe	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	968	972	968	973	996	999
Chamba	959	986	968	989	998	996
Kangra	1025	1012	999	1000	838	1026
Lahaul&Spiti	802	903	880	937	1028	1017
Kullu	927	942	949	957	1004	981
Mandi	1013	1007	993	995	991	1015
Hamirpur	1099	1095	1022	1034	685	988
Una	997	976	955	971	275	935
Bilaspur	990	981	966	969	937	949
Solan	852	880	926	925	815	921
Sirmaur	901	918	931	936	869	905
Shimla	896	915	943	947	779	922
Kinnaur	857	819	920	984	1040	1065

Source:Census of India, Himachal Pradesh, 2011.

Table 2.14

Child Sex Ratio by District – Total, SC & ST – 2001-2011

District	Total		Scheduled Caste		Scheduled Tribe	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	896	909	936	933	955	930
Chamba	955	953	975	984	960	936
Kangra	836	876	882	897	876	920
Lahaul&Spiti	961	1033	1142	1034	966	1023
Kullu	960	962	965	984	923	864
Mandi	918	916	962	951	936	900
Hamirpur	850	887	882	928	1000	862
Una	837	875	907	914	1000	842
Bilaspur	882	900	910	912	869	918
Solan	900	899	917	902	870	865
Sirmaur	934	928	982	948	889	919
Shimla	929	925	966	927	770	994
Kinnaur	979	963	955	956	991	987

Source: Census of India, Himachal Pradesh, 2011.

In terms of overall sex ratio, the top 3 districts are Hamirpur (1095), Kangra (1012) and Mandi (1007) and bottom three districts are Kinnaur (819), Solan (880) and Lahaul & Spiti. Same trend was witnessed in case of SC population. In case of ST, the top 3 districts were Kinnaur (1065), Kangra (1026) and Lahaul & Spiti (1017) and bottom 3 were Sirmaur (905), Solan (921), Shimla (922) (Table 2.15).

The situation is differnt in case of child-sex ratio in these districts of Himachal Pradesh. Lahaul & Spiti had the highest child sex ratio (1033), followed by Kinnaur(963) and Kullu (962) as shown in Table 2.16. The lowest child sex ratio was in Una (875), followed by Kangra (876) and Hamirpur (887). Lahaul & Spiti also had the highest SC and ST child sex ratio i.e. 1034 and 1023, respectively. Kangra district had the lowest SC child sex ratio (897) and Una had the lowest ST child sex ratio (842).

Table 2.15

Sex Ratio – Top 3 and Bottom 3 Districts, Himachal Pradesh - 2011

Top 3 Districts	Percentage	Bottom 3 Districts	Percentage
Total Population			
Hamirpur	1095	Kinnaur	819
Kangra	1012	Solan	880
Mandi	1007	Lahaul&Spiti	903
Scheduled Caste			
Hamirpur	1034	Solan	925
Kangra	1000	Sirmaur	936
Mandi	995	Lahaul&Spiti	937
Scheduled Tribe			
Kinnaur	1065	Sirmaur	905
Kangra	1026	Solan	921
Lahaul&Spiti	1017	Shimla	922

Source: Census of India, Himachal Pradesh, 2011.

Table 2.16

Child Sex Ratio – Top 3 and Bottom 3 Districts, Himachal Pradesh - 2011

Top 3 Districts	Percentage	Bottom 3 Districts	Percentage
Total Population			
Lahaul&Spiti	1033	Una	875
Kinnaur	963	Kangra	876
Kullu	962	Hamirpur	887
Scheduled Caste			
Lahaul&Spiti	1034	Kangra	897
Chamba	984	Solan	902
Kullu	984	Bilaspur	912
Scheduled Tribe			
Lahaul&Spiti	1023	Una	842
Shimla	994	Hamirpur	862
Kinnaur	987	Kullu	864

Source: Census of India, Himachal Pradesh, 2011.

2.2 Education

That Himachal Pradesh has outperformed other Indian states in education is well known in the policy literature. Dreze and Sen (2011) pointed out that Himachal Pradesh started its journey much later than Kerala or Tamilnadu, but has rapidly caught up, pointing to a "revolution" in education. Data from the NSSO (2011-12) suggest that among northern states, Himachal Pradesh has the lowest share of individuals with no education, a trend that holds across all social groups in rural areas. Himachal Pradesh made substantial progress in improving its primary and secondary schooling outcomes in the decade between 1993-94 and 2004-05, and thereafter in post-secondary educational attainment, which doubled for all social groups. While less than one-third of Himachal Pradesh's rural population had no education in 2011, in most other neighbouring states, that number was nearly two-fifths or half of the population. Furthermore, the overall proportion of residents with post-secondary education was the highest in Himachal Pradesh in 2011 across northern states. Nearly 15 to 17 per cent of the rural population and 31 per cent of the urban population had received post-secondary education.

Himachal Pradesh's success in increasing female education is also noteworthy, but there are remaining disparities between men and women in rural areas. Nearly 17 per cent of urban and 30 per cent of rural women in Himachal Pradesh had received no education in 2011. While these figures are better than those of other states, there are large gender inequalities when comparing men's and women's educational opportunities in rural areas. The proportion of uneducated rural women in Himachal Pradesh is twice as large as the proportion of uneducated rural men. But these gender differentials disappear at secondary level, suggesting that the inequality in education is primarily driven by older cohorts.

The total literate population and male, female literate population for India and Himachal Pradesh are depicted in Tables 2.17 to 2.22. There is significant difference in the overall literacy rate, male-female literacy rate of India and Himachal Pradesh. Total literacy rate of Himachal Pradesh is 82.8 per cent as compared to 73 per cent for India. Male and female literacy rate for Himachal Pradesh is 89.5 per cent and 75.9 per cent, respectively which is much higher than the literacy rates for males and females of 80.9 and 64.6 per cent in case of India.

Table 2.17

Literates and Literacy Rate (Persons)

Indicator	INDIA				HIMACHAL PRADESH			
	Literates		Effective Literacy Rate		Literates		Effective Literacy Rate	
	2001	2011	2001	2011	2001	2011	2001	2011
Total Population								
Total	560687797	763498517	64.8	73.0	4041621	5039736	76.5	82.8
Rural	361870817	482653540	58.7	67.8	3567456	4471736	75.1	81.9
Urban	198816980	280844977	79.9	84.1	474165	568000	88.9	91.1
Scheduled Caste								
Total	75318285	113759907	54.7	66.1	904795	1193612	70.3	78.9
Rural	55806266	82020232	51.2	62.8	834429	1098757	69.5	78.3
Urban	19512019	31739675	68.1	76.2	70366	94855	81.1	86.4
Scheduled Tribe								
Total	32386821	51635423	47.1	59.0	138216	253475	65.5	73.6
Rural	28294749	46431645	45.0	56.9	132292	239263	64.8	73.0
Urban	4092072	7003778	69.1	76.8	5924	14212	87.2	87.4

Source: Census of India, Himachal Pradesh, 2011.

Table 2.18

Literates and Literacy Rate (Male)

Indicator	INDIA				HIMACHAL PRADESH			
	Literates		Effective Literacy Rate		Literates		Effective Literacy Rate	
	2001	2011	2001	2011	2001	2011	2001	2011
Total Population								
Total	336533716	434683779	75.3	80.9	2278386	2752590	85.3	89.5
Rural	223551641	281281531	70.7	77.2	2004134	2437821	84.5	89.1
Urban	112982075	153402248	86.3	88.8	274252	314769	92.0	93.4
Scheduled Caste								
Total	47432887	66476908	66.6	75.2	521742	658899	80.0	86.2
Rural	35823885	48672140	63.7	72.6	481014	606686	79.4	85.9
Urban	11609002	17804768	77.9	83.3	40728	52215	87.3	90.9
Scheduled Tribe								
Total	20564605	30066912	59.2	68.5	81887	142461	77.7	83.2
Rural	18192766	26247871	57.4	66.8	789413	134682	77.2	82.7
Urban	2371839	3819041	77.8	83.2	3474	7779	92.0	92.5

Source: Census of India, Himachal Pradesh, 2011.

Table 2.19

Literates and Literacy Rate (Female)

Indicator	INDIA				HIMACHAL PRADESH			
	Literates		Effective Literacy Rate		Literates		Effective Literacy Rate	
	2001	2011	2001	2011	2001	2011	2001	2011
Total Population								
Total	224154081	328814738	53.7	64.6	1763235	2287146	67.4	75.9
Rural	138319176	201372009	46.1	57.9	1563322	2033915	65.7	74.6
Urban	85834905	127442729	72.9	79.1	199913	253231	85.0	88.4
Scheduled Caste								
Total	27885398	47282999	41.9	56.5	383053	534713	60.4	71.5
Rural	19982381	33348092	37.8	52.6	353415	492073	59.4	70.7
Urban	7903017	13934907	57.5	68.6	29638	42640	73.8	81.5
Scheduled Tribe								
Total	11822216	21568511	34.8	49.4	56329	111014	53.3	64.2
Rural	10101983	18383774	32.4	46.9	53879	104581	52.5	63.4
Urban	1720233	3184737	59.9	70.3	2450	6433	81.2	81.9

Source: Census of India, Himachal Pradesh, 2011.

Table 2.20

Literacy Rate by District – Total, SC & ST – 2001-11 (Person)

District	Total Literacy Rate		SC Literacy Rate		ST Literacy Rate	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	76.5	82.8	70.3	78.9	65.5	73.6
Chamba	62.9	72.2	58.5	69.6	57.1	69.1
Kangra	80.1	85.7	74.2	81.4	64.0	74.1
Lahaul&Spiti	73.1	76.8	76.0	79.9	73.5	76.9
Kullu	72.9	79.4	64.9	75.1	79.2	83.1
Mandi	75.2	81.5	68.6	77.5	68.0	75.9
Hamirpur	82.5	88.2	79.1	85.9	60.6	85.4
Una	80.4	86.5	75.9	84.7	56.7	80.0
Bilaspur	77.8	84.6	73.0	81.2	67.3	75.5
Solan	76.6	83.7	71.0	79.9	70.2	73.1
Sirmaur	70.4	78.8	63.6	74.7	53.0	59.7
Shimla	79.1	83.6	70.7	78.8	87.0	75.5
Kinnaur	75.2	80.0	72.1	77.3	74.6	80.0

Source: Census of India, Himachal Pradesh, 2011.

Table 2.21

Literacy Rate by District – Total, SC & ST – 2001-11 (Male)

District	Total Literacy Rate		SC Literacy Rate		ST Literacy Rate	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	85.3	89.5	80.0	86.2	77.7	83.2
Chamba	76.4	82.6	71.4	79.7	71.6	80.3
Kangra	87.5	91.5	82.8	88.1	69.3	82.8
Lahaul&Spiti	82.8	85.7	86.2	90.0	85.6	86.9
Kullu	84.0	87.4	76.8	93.6	87.8	90.2
Mandi	85.9	89.6	80.0	85.9	78.5	83.8
Hamirpur	90.2	94.4	86.4	91.9	69.2	92.6
Una	87.7	91.9	84.2	90.8	45.9	87.8
Bilaspur	86.0	91.2	81.4	88.0	78.1	84.6
Solan	84.8	89.6	80.4	86.7	79.9	82.5
Sirmaur	79.4	85.6	72.4	81.4	63.7	69.7
Shimla	87.2	89.6	80.6	85.9	91.2	79.8
Kinnaur	84.3	87.3	81.7	85.6	85.0	89.2

Source: Census of India, Himachal Pradesh, 2011.

Table 2.22

Literacy Rate by District – Total, SC & ST – 2001-11 (Female)

District	Total Literacy Rate		SC Literacy Rate		ST Literacy Rate	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	67.4	75.9	60.4	71.5	53.3	64.2
Chamba	48.8	61.7	45.0	59.3	42.7	58.0
Kangra	73.0	80.0	65.8	74.7	57.7	65.6
Lahaul&Spiti	60.7	66.8	64.0	69.1	61.7	67.1
Kullu	60.9	70.9	52.4	66.1	70.6	76.0
Mandi	64.8	73.7	57.1	69.1	57.6	68.2
Hamirpur	75.7	82.6	72.2	80.3	46.9	78.2
Una	73.2	81.1	67.3	78.5	50.0	71.8
Bilaspur	69.5	78.0	64.3	74.2	55.8	66.0
Solan	66.9	77.0	60.8	72.5	58.2	63.0
Sirmaur	60.4	71.4	54.0	67.5	40.7	48.7
Shimla	70.1	77.1	60.2	71.4	81.7	70.7
Kinnaur	64.4	71.0	61.5	69.0	64.7	71.5

Source: Census of India, Himachal Pradesh, 2011.

As per 2011 census, top 3 districts in terms of overall literacy wereHamirpur (88.2%), Una (86.5%) and Kangra (85.7%) and bottom 3 wereChamba (72.2%), Lahaul & Spiti (76.8%) and Sirmaur (78.8%). Almost similar trends were followed in respect of SC and ST literacy rate. Male literacy was highest i.e. 94.4, 91.9 and 91.5 per cent in case of Hamirpur, Una and Kangra districts, respectively and lowest in Chamba (82.6%), Sirmaur (85.6%) and Lahaul & Spiti (85.7%). Almost the same trend was observed in respect of female literacy. Hamirpur, Una, Kangra were on the top showing female literacy as 82.6, 81.1 and 80.0 per cent, respectively. Lowest literacy rate was again in Chamba district (61.7%), followed by Lahaul & Spiti (66.8%) and Kullu (70.9%) (Tables 2.23, 2.24, 2.25).

Table 2.23

Literacy Rate – Top 3 and Bottom 3 Districts – 2011 (Person)

Top 3 Districts	Literacy Rate	Bottom 3 Districts	Literacy Rate
Total Population			
Hamirpur	88.2	Chamba	72.2
Una	86.5	Lahaul&Spiti	76.8
Kangra	85.7	Sirmaur	78.8
Scheduled Caste			
Hamirpur	85.9	Chamba	69.6
Una	84.7	Sirmaur	74.7
Kangra	81.4	Kullu	75.1
Scheduled Tribe			
Hamirpur	85.4	Sirmaur	59.7
Kullu	83.1	Chamba	69.1
Kinnaur	80.0	Solan	73.1

Source: Census of India, Himachal Pradesh, 2011.

Table 2.24

Literacy Rate – Top 3 and Bottom 3 Districts – 2011 (Male)

Top 3 Districts	Literacy Rate	Bottom 3 Districts	Literacy Rate
Total Population			
Hamirpur	94.4	Chamba	82.6
Una	91.9	Sirmaur	85.6
Kangra	91.5	Lahaul&Spiti	85.7
Scheduled Caste			
Hamirpur	91.9	Chamba	79.7
Una	90.8	Sirmaur	81.4
Lahaul&Spiti	90.0	Kullu	83.6
Scheduled Tribe			
Hamirpur	92.6	Sirmaur	69.7
Kullu	90.2	Shimla	79.8
Kinnaur	89.2	Chamba	80.3

Source: Census of India, Himachal Pradesh, 2011.

Table 2.25

Literacy Rate – Top 3 and Bottom 3 Districts – 2011 (Female)

Top 3 Districts	Literacy Rate	Bottom 3 Districts	Literacy Rate
Total Population			
Hamirpur	82.6	Chamba	61.7
Una	81.1	Lahaul&Spiti	66.8
Kangra	80.0	Kullu	70.9
Scheduled Caste			
Hamirpur	80.3	Chamba	59.3
Una	78.5	Kullu	66.1
Kangra	74.7	Sirmaur	67.5
Scheduled Tribe			
Hamirpur	78.2	Sirmaur	48.7
Kullu	76.0	Chamba	58.0
Una	71.8	Solan	63.0

Source: Census of India, Himachal Pradesh, 2011.

2.3 Gender Gap in Literacy

As India has progressed, gender gap in literacy has reduced across rural / urban, SC ant ST groups. Still the gender gap is quite significant in case of rural population, rural SC and ST population. Himachal Pradesh has been able to reduce the gender gap in all categories of literates as per 2011 census. In case of total urban population, SC urban and ST urban, the gender gap in literacy has reduced to 5, 9.4 and 10.5 per cent, respectively (Table 2.26).

Table 2.26

Gender Gap in Literacy Rate – India and Himachal Pradesh

Indicator	India		Himachal Pradesh	
	Gender Gap in Literacy Rate		Gender Gap in Literacy Rate	
	2001	2011	2001	2011
Total Population				
Total	21.6	16.3	17.9	13.6
Rural	24.6	19.2	18.8	14.5
Urban	13.4	9.7	7.0	5.0
Schedule Caste				
Total	24.7	18.7	19.7	14.8
Rural	25.8	20.0	20.0	15.1
Urban	20.4	14.7	13.4	9.4
Schedule Tribe				
Total	24.4	19.2	24.4	19.0
Rural	24.9	19.9	24.7	19.3
Urban	17.9	12.8	10.9	10.5

Source: Census of India, Himachal Pradesh, 2011.

District-wise gender gaps in literacy are depicted in Table 2.27. In respect of total population, Chamba district has the highest gender literacy gap (20.9%), followed by Lahaul&Spiti (18.9%), Kullu (16.5%), Kinnaur (16.3%) and Sirmaur (14.2%). Una district has the minimum gender gap in literacy (10.8%), followed by Kangra (11.5%) and Hamirpur (11.7%). Similar trend was observed in SC population of these districts also. Gender gap was minimum in Hamirpur (11.6%), Una (12.4%) and Kangra (13.4%). Gender gap is quite high at 22.3 per cent in Chamba district and 21 per cent in Sirmaur, It is also high in tribal districts of Himachal Pradesh at 19.7 per cent in Lahaul & Spiti and 17.7 per cent in Kinnaur district.

Table 2.27

Gender Gap in Literacy Rate by district – Total, SC and ST

District	Gender Gap in Literacy Rate of Total		Gender Gap in Literacy Rate of SC		Gender Gap in Literacy Rate of ST	
	2001	2011	2001	2011	2001	2011
Himachal Pradesh	17.9	13.6	19.7	14.8	24.4	19.0
Chamba	27.6	20.9	26.4	20.5	28.9	22.3
Kangra	14.5	11.5	17.1	13.4	11.6	17.2
Lahaul&Spiti	22.1	18.9	22.2	20.8	23.9	19.7
Kullu	23.1	16.5	24.4	17.4	17.2	14.2
Mandi	21.1	15.9	23.0	16.8	20.9	15.6
Hamirpur	14.5	11.7	14.1	11.6	22.3	14.4
Una	14.5	10.8	16.9	12.4	14.1	15.9
Bilaspur	16.5	13.2	17.1	13.8	22.3	18.7
Solan	17.9	12.6	19.6	14.1	21.7	19.5
Sirmaur	19.0	14.2	18.4	13.9	23.0	21.0
Shimla	17.1	12.5	20.5	14.5	9.5	9.1
Kinnaur	19.9	16.3	20.2	16.6	20.3	17.7

Source: Census of India, Himachal Pradesh, 2011.

2.4 Quality of Life of Women and Children in Himachal Pradesh

Himachal Pradesh, one of the Himalayan states, was granted the status of a full-fledged state of the Indian Union in January 1971. Following statehood, Himachal Pradesh started making concerted efforts to improve the human conditions in the state. The state has made significant strides in developing an educational and health infrastructure and transport and communication networks. These advances have had a positive impact on the socio-economic and demographic status of its people. The third National Family Health Survey (NFHS-3) conducted in 2004-05, provides information on fertility, mortality, family planning and important aspects of health, nutrition and health care which are important components of quality of life.

Himachal Pradesh is mainly agrarian economy with 91 per cent of its population living in rural areas. The age distribution is typical of high-fertility populations that have

recently experienced some fertility decline, with relatively high proportions in the younger age groups. Thirty-two per cent of the population is below 15 in the state. In Himachal Pradesh the sex ratio is 1024 females for every 1000 males in rural areas and 912 females for every 1000 males in urban areas, suggesting that rural to urban migration in Himachal Pradesh has been dominated by males. The overall sex ratio for the state is 1013 females per 1000 males.

2.4.1 Health

Health indicators in Himachal Pradesh have also shown steady progress and are yet another testament to strong state commitment and efficient service delivery. Himachal Pradesh has made massive investments in the health infrastructure, which is one of the best in the country in terms of per capita availability. Infrastructure, although laudable, is merely an input. The state has recorded consistent progress in outcomes as well.

The key health indicators of Himachal Pradesh are presented in Table 2.28 on the basis of **District Level Household and Facility Survey 3 and 4,** conducted by I.I.P.S. Mumbai. Women in Himachal Pradesh tend to marry later than women in India as a whole. In Himachal Pradesh, only 5 per cent of women age 15-19 years are already married, compared with 34 per cent in the country as a whole. The proportion of women who marry young is declining. The mean age at marriage for girls has increased from 2.9 years during DLHS-3 to 22.3 years during DLHS-4. Similarly, the mean age at marriage for boys has also increased from 26 years to 26.2 years during the same period. Mean number of children ever born to women age 40-49 years declined from 3 in the year 2007-2008 to 2.3 in the year 2012-13. Female literacy has shown marked improvement as per the Census 2011. As a consequence, the percentage of currently married women who are illiterate declined from 22.2 per cent during DLHS-3 to 13.1 per cent during DLHS-4. Percentage of female sterilization is quite high in Himachal Pradesh.

Table 2.28

Key Health Indicators of Himachal Pradesh

Sr.No.	Indicators	DLHS-3 (2007-08)			DLHS-4 (2012-13)		
		Total	Rural	Urban	Total	Rural	Urban
1.	Mean Age at Marriage for Girls	21.9	21.8	23.0	22.3	22.2	24.4
2.	Mean Age at Marriage for Boys	26.0	26.0	26.8	26.2	26.1	27.1
3.	Percentage of Women with two children wanting no more children	83.1	82.0	90.4	80.4	80.0	83.8
4.	Mean number of children ever born to women age 40-49 years	3.0	3.1	2.7	2.3	2.3	2.0
5.	Percentage of currently married women who are illiterate	22.2	23.0	12.7	13.1	13.8	7.1
6.	Percentage of current use of any method of family planning	70.2	70.2	70.4	58.8	58.7	60.3
7.	Percentage of female sterilization	45.1	46.1	34.2	41.8	42.3	37.6
8.	Percentage of male sterilization	7.1	7.5	2.9	3.9	4.0	2.9
9.	Percentage of total unmet need of family planning	14.9	14.9	15.5	20.6	21.0	19.5
10.	Sex ratio at birth (Males per 100 females)	111	115	111	105	105	106
11.	Percentage of pregnant women who received any antenatal check-up	86.6	86.2	90.7	92.3	92.1	94.4
12.	Percentage of Institutional Delivery	48.4	46.1	71.1	77.8	76.3	92.3
13.	Percentage of children age 12-23 months who received full vaccination	82.3	81.9	87.8	63.0	62.0	72.7
14.	Percentage of women who utilized antenatal care services	86.4	87.1	78.8	89.4	90.0	83.6
15.	Percentage of children below age 5 years having birth registration done	NA	NA	NA	86.8	86.5	89.4

*Source:***District Level Household and Facility Survey-4 (2012-13),** State Fact Sheet Himachal Pradesh, I.I.P.S., Mumbai

Sex ratio at birth (males per 100 females) declined from 111 to 105 during the years 2007-08 and 2012-13 which is also reflected in 2011 Census. Percentage of pregnant women who received any antenatal check-up went up from 86.6 to 92.3 per cent during DLHS-3 and DLHS-4. There is marked improvement in institutional delivery. It improved from 48.4 per cent to 77.8 per cent due to incentives provided by State Government and free transportation provided by emergency vehicle 108. In urban areas 92.3 per cent deliveries are being conducted in health facilities. The percentage of women who utilized antenatal care services also improved from 86.4 per cent during DLHS-3 to 89.4 per cent during DLHS-4.

2.4.2 Fertility Status

Fertility status too is a significant determinant of the quality of life of women and this continues to decline in Himachal Pradesh. According to NFHS-3, at current fertility levels women will have an average of 1.94 children each throughout their child bearing years in the state. This total fertility rate is one of the lowest in India (except Goa, Kerala and Karnataka). Fertility is high for illiterate women, scheduled caste women, and more importantly, women from households with a low standard of living. The total Fertility Rate during 2005-06 and 2015-16 has remained more or less same without any significant change. (NFHS – 4 at 1.9)

2.4.3 Contraceptive Prevalence

The knowledge of contraception is nearly universal in Himachal Pradesh. Himachali women are most familiar with female sterilization (100%), followed by male sterilization (almost 100%), the pill (94%) and the IUD (92%). More than one-quarter of women have used the pill. However, there still remains a sizable gap between knowledge and use.

In Himachal Pradesh, 72.6 per cent of the married women were currently using some method of contraception in 2005-06 (NFHS-3) much higher than the national level of 56.3 per cent. Contraceptive prevalence was higher in urban areas (74%) than in rural areas (72.5%). Female sterilization was the most popular method, 49 per cent of currently married women are sterilized. By contrast, only 6 per cent of women reported that their husbands were sterilized. Overall, sterilization accounted for less than half (46%) of total contraceptive use. In Himachal Pradesh, the prevalence of female sterilization is much higher in rural areas (51%) than in urban areas (32%). Himachal Pradesh in the country has the highest rate of male sterilization i.e. 7 per cent. Together, male and female sterilization accounts for 77 per cent of total contraception use in this state. (NFHS-3)

As per the NFHS-4 data, the female sterilization percentage has come down to 34.5 per cent and male sterilization percentage has come down to 2.4 per cent in 2015-16. There are notable variations in contraceptive prevalence among socio-economic groups everywhere. Contraceptive prevalence is much higher for urban women, less educated women, and women with at least two children who have one or more sons. Given the strong emphasis on sterilization, women tend to adopt family planning only after they have achieved their desired family size. As a result, contraceptive use can be expected to rise steadily with age and with the number of living children. In Himachal Pradesh,

contraceptive use does indeed go up with age, peaking at 88 per cent for women in the age group of 35-39 years. So preference appears to have some effect on contraceptive use. Women who have one or more sons are generally more likely to use contraceptive than those women who have the same number of children but have only daughters. For example, among women with two living children, current use of contraception rises sharply from 43 per cent among those with no sons to 84 per cent among those with two sons. (NFHS-3). As per NFHS-4, the contraceptive use by married women has come down to 57 percent in 2015-16 from 76.6 percent in 2005-06.

2.4.4 Infant and Child Mortality

Infant and child mortality and factors associated with the survival of young children have wide-ranging impact on the quality of life of children when they grow up as adults. During the five years preceding the survey, the infant mortality rate in Himachal Pradesh was 34 deaths at age 0-11 months per 1000 live births, this being one of the lowest levels of infant mortality in India (second only to Kerala). Nevertheless, 1 in 29 children in Himachal Pradesh die in the first year of life, and 1 in 24 die before reaching age of five years. In Himachal Pradesh infant mortality is two times higher among children born to mothers under age 20 than to older mothers. In fact, mortality is at least two and a half times as high among children born less than 24 months after a previous birth as among children born after a longer duration of time since the previous birth. Infant mortality rates have fallen sharply with the number of the recommended types of maternity-related medical care (antenatal care, trained delivery assistance and post-natal care) received by mothers (Table 2.29).

Table 2.29

Childhood Mortality in Himachal Pradesh

State	Neonatal mortality	Post-neonatal mortality	Infant mortality	Child mortality	Under-five mortality
Himachal Pradesh	27.3	8.9	36.1	5.6	41.5
Bihar	39.8	21.9	61.7	24.7	84.8
Haryana	23.6	18.1	41.7	11.1	52.3
Karnataka	28.9	14.3	43.2	12.1	54.7
Kerala	11.5	3.8	15.3	1.0	16.3
Madhya Pradesh	44.9	24.7	69.5	26.5	94.2
Punjab	28.0	13.7	41.7	10.8	52.0
Rajasthan	43.9	21.4	65.3	21.5	85.4
Tamil Nadu	19.1	11.2	30.4	5.3	35.5
Uttar Pradesh	47.6	25.0	72.7	25.6	96.4
Uttarakhand	27.6	14.3	41.9	15.5	56.8
India	39.0	18.0	57.0	18.4	74.3

Source: NFHS-3, 2005-06.

Childhood mortality in Himachal Pradesh also recorded steady improvements, particularly between 1971 and 2001, although it hit a plateau thereafter. While under five mortality rates are the lowest among north Indian states, they are still worse than those in Kerala and Tamil Nadu. A close look at childhood mortality patterns suggests that high

levels of neonatal mortality drive, Himachal Pradesh's somewhat lackluster performance compared to Kerala and Tamil Nadu. In fact, after the first month of birth until their first year, children in Himachal Pradesh have a clear survival advantage, even compared to Tamil Nadu (Table 2.29).

Infant Mortality Rate (IMR) is defined as the deaths of infants of age less than one year per thousand live births. The infant mortality rate in Himachal Pradesh has declined to 35 per 1000 live births in the year 2013 as per SRS 2013 as shown in Table 2.30. The data for the recent years clearly shows a decline in IMR from 69 in 1990 to 35 in 2013. The Infant Mortality Rate among male has declined from 62 in 1990 to 33 in 2013 and similarly in case of female, from 75 in 1990 to 36 in2013. With the yearly declining trend Himachal Pradesh has achieved the MDG target value of 23 in urban sector only and efforts are being made to achieve the same in rural sector.

Table 2.30

Infant Mortality Rate (IMR) per 1000 live birth in Himachal Pradesh

Year	Infant Mortality Rate				
	Total	Male	Female	Rural	Urban
1990	69	62	75	70	40
2000	51	57	45	52	35
2003	49	54	44	51	26
2004	51	56	45	53	23
2005	49	47	51	50	20
2006	50	45	55	52	26
2007	47	45	49	49	25
2008	44	43	45	45	27
2009	45	44	45	46	28
2010	40	35	47	41	29
2011	38	36	39	38	27
2012	36	35	38	37	25
2013	35	33	36	35	23

Source: SRS Bulletins

2.4.5 Maternal and Child Health Care

Since health care has a profound effect, and a long-term one, on the quality of life of both women as mothers and their progeny, promotion of maternal and child health has been one of the most important components of the reproductive and child health programme of the government of Himachal Pradesh.

One goal is for each pregnant woman to receive at least three antenatal checkups plus two tetanus toxoid injections and a full course of iron and folic acid supplementation.

In Himachal Pradesh, mothers of 86.4 per cent of the children born in the 5 years preceding the NFHS-3 received at least one antenatal checkup (much higher than the national level of 76.4 per cent) and mothers of 62.6 per cent of children received at least

three antenatal checkups. Eighty-six per cent of women received iron and folic acid supplementation during their pregnancies (this being one of the highest rates in India), the majority receiving an adequate supply and consuming the supply they receive. However, a much lower proportion of mothers received the recommended number of tetanus toxoid vaccinations (72 per cent).

In the state, only 43 per cent of births were delivered in a medical facility, 61 per cent were delivered in woman's own home and 10 per cent in her parents' home. (NFHS-3). Trained health professionals assisted the delivery in only 47.8 per cent of cases. Fifty-seven per cent of deliveries were assisted by a *dai* (a traditional birth attendant), and 3 per cent were attended only by relatives, friends and other persons who were not health professionals. Only 16 per cent of births delivered at home were assisted by a health professional. Post-partum checkups are not common for non-institutional births in Himachal Pradesh. Only 21 per cent of births that took place outside a medical facility were followed by a postpartum checkup within two months of delivery. Overall, these results show that though health services during pregnancy are reaching a large majority of women in Himachal Pradesh, yet most women are not receiving health services during delivery and in the postpartum period. The NFHS-4has reported 76.4 percent institutional deliveries in 2015-16 and the percentage of births assisted by any health personnel as 78.9 percent

Child immunization is an important component of child survival programmes in India, with efforts focusing on six serious but preventable diseases. In Himachal Pradesh, 74 per cent of children ages 12-23 months are fully vaccinated, another 14 per cent have received some but not all of the recommended vaccinations and only 2 per cent have not been vaccinated at all. Although Himachal Pradesh has not yet received full immunization coverage, it has made tremendous strides since 1992-93, when full immunization coverage was 64 per cent. The coverage of all vaccinations has improved considerably. (NFHS-3). However, the NFHS-4 reports the percentage of children in the age group of 12-23 months has come down to 69.5 percent.

Based on a weight for height index (the body mass index), 30 per cent of women in Himachal Pradesh are undernourished. Nutritional deficiency is particularly serious for younger women and women in disadvantaged socio-economic groups. Overall, 43.3 per cent of women in Himachal Pradesh have some degree of anaemia, and 11.7 per cent are moderately to severely anemic. (NFHS-3). Anaemia is a serious problem among women in every population group. In fact, NFHS-4 has reported an increase in incidence of anaemia among pregnant women, non-pregnant women and men in the age-group of 15-48 years.

The NFHS-4 indicate to improvement in the nutritional status of both men and women. Percentage of women with BMI below normal has been reported as 16.2 percent and that of men as 18 percent in the NFHS-4 indicating to considerable improvement in nutritional status. However, the incidence of obesity both in men and women has been reported to have increased in the State in NFHS-4. The percentage of obese women has increased from13.5 percent to 28.6 percent and of men from 10.6 percent to 22.0 percent between NFHS-3 and NFHS-4 reporting periods.

Malnutrition levels are relatively low in Himachal Pradesh compared to the national average, but more than one-third of the state's children continue to be underweight or stunted as depicted in Table 2.31. According to the NFHS-3, malnutrition levels in Himachal Pradesh are more or less in line with the levels observed in other northern states, although lower than the national average as depicted in Table 2.31. In fact, Himachal Pradesh has been among the best-performing states in reducing the proportion of underweight children between the two rounds of the NFHS surveys (1999 and 2006), from 43.6 per cent to 36.5 per cent. Yet, more than one-third of Himachal Pradesh's children continue to be underweight or stunted, that is, measure 2 standard deviations below the international norm for weight for age and height for age, respectively. Himachal Pradesh has taken steps to reduce malnutrition, primarily through its well-functioning Integrated Child Development Services (ICDS). Among the Anganwari Centres sanctioned in Himachal Pradesh to provide supplementary nutrition and preschool education to children, nearly all are operational, and absenteeism among workers is reportedly low. Further, Himachal Pradesh has a well-functioning Universal Public Distribution System (PDS) that provides not only food grains, but also pulses and oil to both below poverty line (BPL) and above poverty line (APL) families.

The status of nourishment among children between the NFHS-3 and NFHS-4 period has improved. The percentage of children under five years of age who are stunted (height for age) has come down from 38.6 percent to 26.3 percent in Himachal Pradesh during this period Similarly, the percentage of children under the age of five yearswho have wasted, severely wasted and underweight; has come down from 19.3 percent, 5.5 percent and 36.5 percent in 2005-06; to 13.7 percent, 3.9 percent and 21.2 percent, respectively. Thirty-four per cent of currently married women in Himachal Pradesh report some type of reproductive health problem, including abnormal vaginal discharge, symptoms of a urinary tract infection, and pain or bleeding associated with intercourse. Among these women, 47 per cent have not sought any advice or treatment.

Table 2.31

Malnutrition in Himachal Pradesh

State / Country	Height for age			Weight for height				Weight for age			
	% below - 3 SD	% below - 2 SD	Mean Z-score (SD)	% below - 3 SD	% below - 2 SD	% above +2 SD	Mean Z-score (SD)	% below - 3 SD	% below - 2 SD	% above +2 SD	Mean Z-score (SD)
Himachal	16.0	38.6	-1.5	5.5	19.3	1.1	-1.0	11.4	36.5	0.5	-1.6
Pradesh	29.1	55.6	-2.1	8.3	27.1	0.3	-1.4	24.1	55.9	0.1	-2.2
Bihar	19.4	45.7	-1.8	5.0	19.1	1.4	-1.0	14.2	39.6	0.2	-1.7
Haryana	20.5	43.7	-1.7	5.9	17.6	2.6	-1.0	12.8	37.6	0.5	-1.6
Karnataka	6.5	24.5	-1.1	4.1	15.9	1.2	-0.9	4.7	22.9	0.4	-1.2
Kerala	26.3	50.0	-2.0	12.6	35.0	1.0	-1.6	27.3	60.0	0.1	-2.3
Madhya	17.3	36.7	-1.5	2.1	9.2	1.5	-0.5	8.0	24.9	0.5	-1.2
Pradesh	22.7	43.7	-1.7	7.3	20.4	1.6	-1.1	15.3	39.9	0.4	-1.7
Punjab	10.9	30.9	-1.1	8.9	22.2	3.6	-1.0	6.4	29.8	1.9	-1.3
Rajasthan	32.4	56.8	-2.2	5.1	14.8	1.2	-0.8	16.4	42.4	0.1	-1.8
Tamil Nadu	23.1	44.4	-1.8	5.3	18.8	2.3	-0.9	15.7	38.0	0.3	-1.7
Uttar Pradesh	23.7	48.0	-1.9	6.4	19.8	1.5	-1.0	15.8	42.5	0.4	-1.8
Uttarakhand	16.1	43.2	-1.8	2.9	17.4	0.9	-1.0	11.8	41.0	0.3	-1.7
India	20.2	49.3	-1.9	2.6	12.6	-	-0.8	10.6	38.6	-	-1.7
Bangladesh											
Nepal											

Source: India NFHS-3, 2005-06; Bangladesh Demographic and Health Survey (DHS) 2007; Nepal DHS 2006.

Note: Percentage of children under age five classified as malnourished according to three anthropometric indices of nutritional status: height for age, weight for height, and weight or age.

Himachal Pradesh provides a remarkable illustration of the phenomenon of development and improvements in quality of life in the Himalayan region. In the early 1970s, birth and death rates in Himachal Pradesh were comparable to those of Orissa and Madhya Pradesh. Since then, Himachal Pradesh has gone through a rapid "demographic transition" from high to low mortality rates. Himachal Pradesh has achieved a remarkable decline in death rate of nearly 50 per cent and also in birth rate (almost 40 per cent). No other state has achieved a proportional reduction of more than 35 per cent on both the counts over the period.

The state has completed its fertility transition and fertility rates are well below replacement. Infact, Himachal Pradesh's total fertility rate (TFR) at 1.9 children per woman, looks exactly like that of France, and is lower than that of the United States. Fertility decline is not just an important health issue; it has broader social implications on women's status and gender equality. While there is little empirical evidence on what drove the fertility decline in Himachal Pradesh, it is likely that a mix of a well-implemented family planning programme, high levels of female education, and a general decline in demand for children

was responsible. In fact, the overall status of women, their participation in social movements, and their relatively higher levels of labour force participation all contributed to this outcome.

Today, Himachal Pradesh has the highest contraceptive prevalence rate, the second highest child immunization rate, and the third lowest fertility rate among all major states, and it is also doing better than most other states in many other aspects of social development which have positive impact on quality of life. Tables 2.32, 2.33 and 2.34 exhibit life/health index, education attainment index and income index respectively. The indices in the Tables 2.32 and 2.33 are for the years 1991 and 1997 whereas those contained in Table 2.34 are for the year 1991 only.

Table 2.32

Income Indices for Districts of Himachal Pradesh

District	1991	Rank	1997	Rank
Bilaspur	0.183	VI	0.337	V
Chamba	0.103	XI	0.284	VIII
Hamirpur	0.131	X	0.175	XII
Kangra	0.163	VII	0.255	IX
Kinnaur	0.349	II	0.476	III
Kullu	0.238	V	0.330	VI
Lahaul&Spiti	0.481	I	0.582	I
Mandi	0.132	IX	0.218	X
Shimla	0.304	III	0.429	IV
Sirmaur	0.155	VIII	0.313	VII
Solan	0.255	IV	0.564	II
Una	0.090	XII	0.187	XI
Himachal Pradesh	0.184		0.301	

Source: Computed by the Department of Planning, Government of Himachal Pradesh.

District-wise comparison of income indices as given in Table 2.32, clearly show that Bilaspur, Chamba, Sirmour, Solan and Una had registered improvement over the period between 1991 and 1997. Lahaul & Spiti district has maintained its position at number one whereas all other districts have deteriorated in terms of income index.

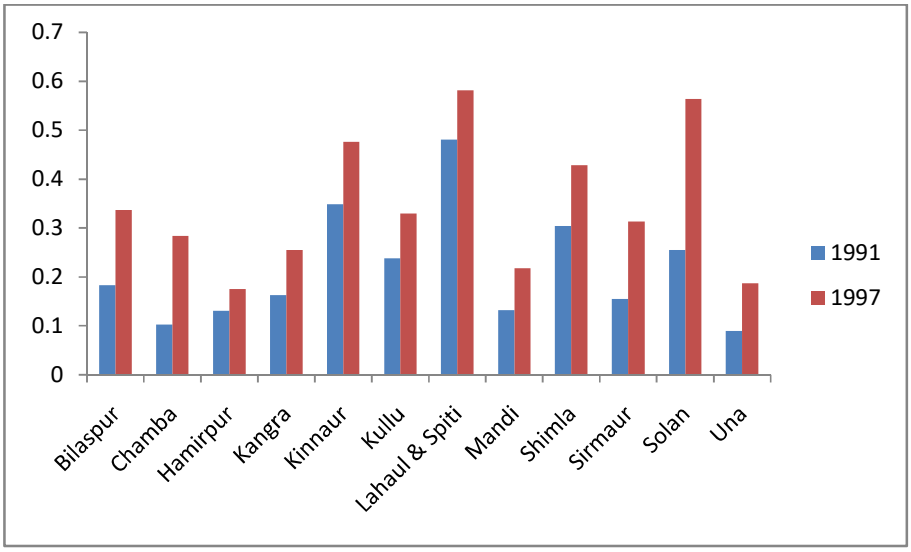

Fig. 2.1: District-wise Income Attainment Indices

Achievements made by the districts of Himachal Pradesh in terms of education attainment has been captured in Table 2.33 in the form of education attainment indices. It can be easily inferred from the table that in a period of six years between 1991 and 1997 all the districts of Himachal Pradesh have performed remarkably well in terms of education attainment. This index constitutes of indicators in terms of enrolment ratio and literacy rate. Districts of Bilaspur, Kangra, Kinnaur, Kullu and Shimla have improved their ranks in terms of education attainment. Hamirpur district has retained its rank whereas all other districts have deteriorated their ranks in 1997 if compared with those in 1991.

Table 2.33

Education Indices for Districts of Himachal Pradesh

District	1991	Rank	1997	Rank
Bilaspur	0.747	IV	0.789	IV
Chamba	0.510	XII	0.601	XII
Hamirpur	0.810	I	0.834	I
Kangra	0.752	III	0.833	II
Kinnaur	0.626	X	0.737	VII
Kullu	0.663	IX	0.734	VIII
Lahaul&Spiti	0.678	VII	0.703	X
Mandi	0.711	V	0.757	VI
Shimla	0.681	VI	0.720	V
Sirmaur	0.571	XI	0.720	XI
Solan	0.676	VIII	0.720	IX
Una	0.759	II	0.800	III
Himachal Pradesh	0.697		0.762	

Source: Computed by the Department of Planning, Government of Himachal Pradesh.

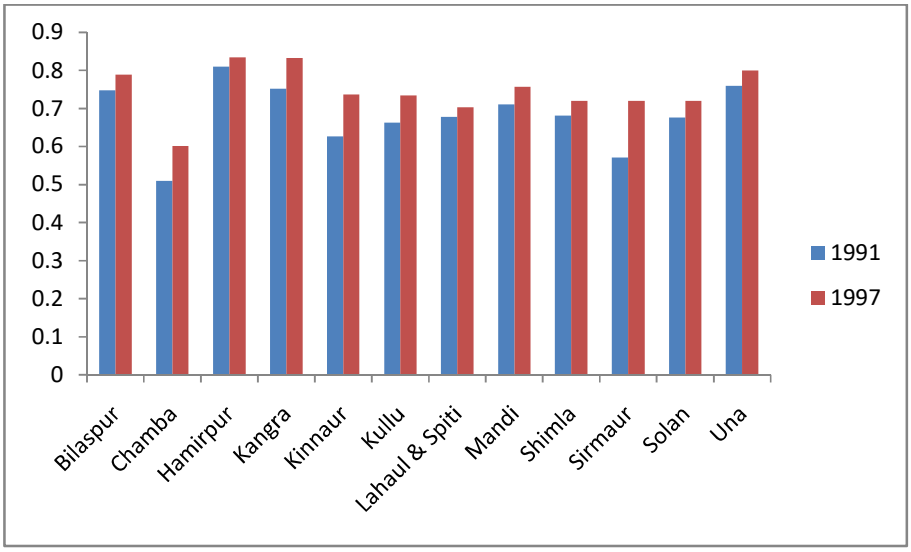

Fig. 2.2: District-wise Education Attainment Indices

Table 2.34 contains health / life indices for the year 1991 and these are same as contained in the **Himachal Pradesh Human Development Report, 2002**. Kullu district had attained the highest Health Index (0.701), followed by Chamba (0.569), Shimla (0.569) and Kinnaur (0.556). Kangra and Una had attained 7th and 8th rank.

Table 2.34

Health / Life Indices for Districts of Himachal Pradesh

District	1991	Rank
Bilaspur	0.340	IX
Chamba	0.569	II
Hamirpur	0.299	XI
Kangra	0.382	VII
Kinnaur	0.556	IV
Kullu	0.701	I
Lahaul&Spiti	0.257	XII
Mandi	0.326	X
Shimla	0.569	III
Sirmaur	0.50	V
Solan	0.431	VI
Una	0.347	VIII
Himachal Pradesh	0.417	

Source: Computed by the Department of Planning, Government of Himachal Pradesh.

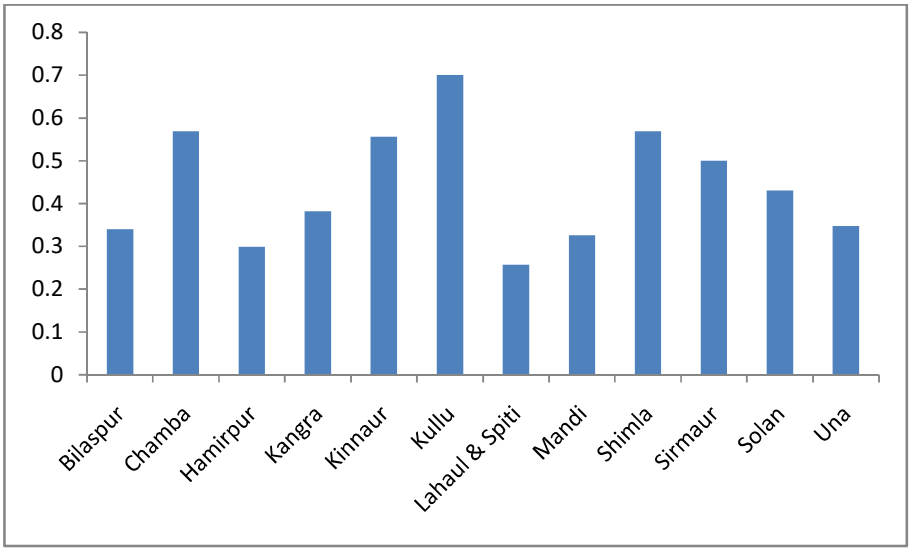

Fig. 2.3: District-wise Health / Life Attainment Indices

Table 2.35 shows district wise HDIs for the years 1991 and 1997. A cursory look at the table reveals that Una is the only district which has retained its rank. The ranks of majority of the districts like Bilaspur, Chamba, Hamirpur, Kangra, Kullu, Lahaul&Spiti, Mandi and Shimla have fallen from what they were in the earlier analysis. Kinnaur, Sirmaur and Solan are the only districts which have improved their ranks.

Table 2.35

District-wise HDIs for the years 1991 and 1997

District	1991	Rank	1997	Rank
Bilaspur	0.423	VI	0.487	VIII
Chamba	0.423	VII	0.485	IX
Hamirpur	0.404	IX	0.436	XI
Kangra	0.432	VI	0.490	VII
Kinnaur	0.510	III	0.590	I
Kullu	0.534	I	0.589	II
Lahaul&Spiti	0.469	IV	0.514	V
Mandi	0.390	XI	0.434	XII
Shimla	0.518	II	0.586	III
Sirmaur	0.409	VIII	0.491	VI
Solan	0.454	V	0.566	IV
Una	0.399	X	0.444	X
Himachal Pradesh	0.433		0.493	

Source: Computed by the Department of Planning, Government of Himachal Pradesh.

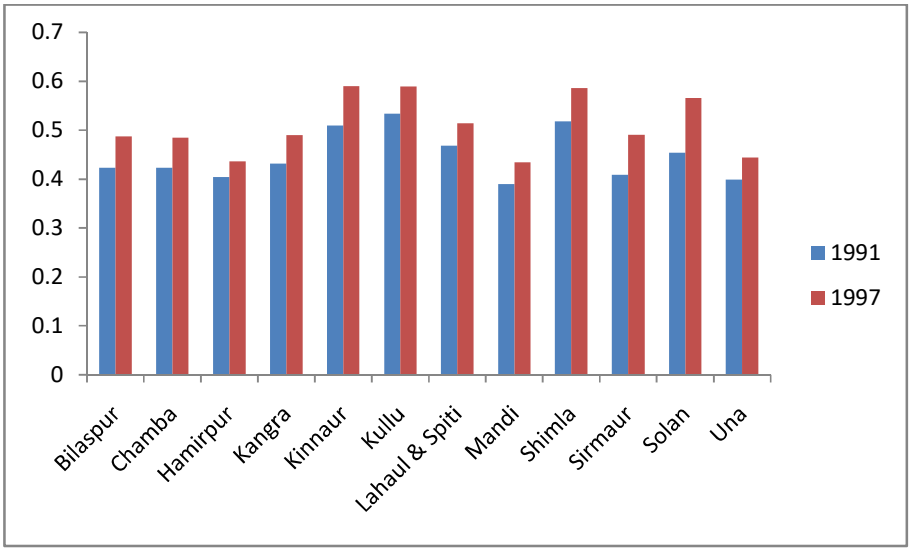

Fig. 2.4: District-wise Health / Life Attainment Indices

Education attainment indices for Hamirpur, Kangra and Una rank the highest i.e. first, second and third, respectively. Whereas Chamba, Sirmour and Lahaul & Spiti are having quite low indices and rank twelfth, eleventh and tenth, respectively. Literacy rates are quite high in case of Hamirpur, Kangra and Una. Theyalso have more knowledge and awareness about the small family norm and want to restrict their family to two children. If the first child is son, second child of any sex is welcome. But if the first child is a daughter they definitely want the second child to be a son. In order to be sure they go for sex determination test of the foetus and if it turns out to be a daughter they go for abortion.

It is also worth noting that in the tribal areas as well as in educationally backward areas, the Child Sex Ratio tends to be high, which is indicative of the absence of prejudice against the girl child. The highest values for the child sex ratio we got so far in our analysis, are in the tribal districts of Lahaul & Spiti and Kinnaur, at 1033 and 963 girls per thousand boys. In Kullu, Chamba and Sirmour districts this ratio stands at 962, 953 and 928, respectively.

It was in 1996, two years after 1994 that*Cairo International Conference on Population and Development* that Family Welfare Programme (FWP) adopted the target free approach (TFA) in 1996 i.e. targets for individual contraception were done away with. The small family norm was to be achieved in a more voluntary fashion. The population stabilization goal has been pursued through a few new initiatives in the 1990s.

By late 1980s and 1990s people could see for themselves that the well-off families were those where each couple had fewer children. By the mid-1980s, urban exposure, urbanization and mass media influence (culture industry) had increased in most parts of India. A small family with three children per couple, followed by sterilization, has been considered desirable by young Indians since the late 1980s and by the 1990s some prefer only two or even one child. Ultrasound technology has enabled them to get a firmer handle on the means to keep the family small. Of course, urban, rural, religious and socio-economic status differences are found in what is a desirable family, but as specified earlier,

such desegregation cannot be taken up here as the emerging common feature; all want fewer children than their mothers wanted, but not without a son. However, the lack of convergence between the state's small family size and that of the society's, remains across religious communities, notwithstanding their fertility differences. While a majority of the Hindus may be inching towards the state's model for the two children family, they are skewing the sex ratios terribly, the poor among the lower castes and Muslims may not yet be nearing the two children family, but they are not creating as severe demographic imbalances and ethical problems through the use of sonography. Further, on the whole, Muslims seem to resemble local patterns more closely than a categorically different pattern of their own. In both the cases, the state finds the society's response to its population stabilization goal challenging, rather than appreciative, despite 55 years of efforts.

Everyone in North India knows that it is better to spend a hefty amount now than to raise another daughter, who is in any case going to be someone else's property and drain the family resources all her life. Accumulating resources for dowry is the common anxiety expressed by most people in public, as well as, private conversation.

It is somewhat easier to find women, aged 40 and above, to have more than two daughters in the present times. Though such women would not have liked to have three or more daughters, they accepted them until they had at least a son. The historically infamous girl child neglect in many parts of India and female infanticide among many communities might be related with parents' acceptance of a girl's birth in the absence of the possibility of knowing the sex of the foetus. Younger women today prefer to use ultrasound test and abort the female foetus to have control on the number and sex composition of their children. They are less willing to accept daughters as they come. Ultrasound technology is incorporated into the culture of non-preference not for the daughter as such, but for more than one daughter.

Perhaps one of the most worrisome trends, and in many ways a puzzle in Himachal Pradesh, is the dramatic decline of female children compared to male. This is despite the fact that women's health and well-being have shown considerable progress in Himachal Pradesh over the years. The state has, for example, completed its fertility transition and fertility rates are well below replacement level. In such a context and one where education, health, sanitation and overall growth are all examples for others to emulate, the excess mortality of female children comes as a surprise.

Back in the late 1990s, Himachal Pradesh received international kudos because its female-to-male ratios seemed to be approaching parity since 1901, and demographers predicted this progress would continue (Cohen 2000). But in fact, the 2001 Census showed an unexpected dip in overall female-to-male ratios for Himachal Pradesh. Much more worrisome has been the sharp decline in child sex ratio. Indeed, from 1981 to 2011, the number of females to every 1000 males plummeted. Such a sharp decline implicates sex-selective abortions and gross neglect of female children, although not female infanticide, in a fertility regime that is characterized by a preference for small families and a preference for sons. Child female-to-male ratios remained adverse to girls across many parts of Himachal Pradesh especially in Una, Kangra, Hamirpur and Mandi districts.

It is difficult to measure the intensity of the son complex from Kashmir to Kerala, but it is our contention that a much more important factor is the access of the rural population to medical practitioners (including quacks) and facilities (e.g. ultrasound) to determine the sex of the unborn child and abort the female foetus. This in turn depends on the transportation network and the spatial distribution of cities and towns, in particular the big towns. Therefore, in small states like Himachal Pradesh where most of the villages are connected by road, the probability of the rural families taking recourse to female foeticide is high, given a high degree of preference for sons due to historical and socio-cultural factors. In short, a strong son complex is not enough to generate large-scale female foeticide unless rural masses have access to medical technology and there is a transportation network, which enables people to visit urban areas, or mobile doctors who visit rural areas.

In addition, families must have the money power to resort to such facilities (the cost of the tests plus abortion costs etc. is around Rs. 2000 to Rs. 3000 per case). If they don't have money, there will be a tendency to consult quacks and local dais to carry out the abortion, often leading to the death of the pregnant women.

When we combine these two factors, namely access to medical technology and ability to pay, we get a clue to the sharp decline in the child sex ratio in Panjab, Haryana and some districts of Himachal Pradesh adjacent to Punjab.

2.5 Mixing up Family Planning with Female Foeticide

As a result of 50 years of propaganda on the merits of a small family norm, there is today universal awareness of family planning (in general) and a wide acceptance of the small family norm. The fieldwork reveals that men and women in 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. Two sons constitute the cut off point for accepting sterilization. The people seem to be quite puzzled that while the Government wants a small family norm to be practiced, it is also opposing the conduct of those 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.

CHAPTER-III

HIGHLIGHTS OF HOUSEHOLD DATA

A total of 2,663 households have been selected for household survey out of total 2,66,592 households of Una, Kangra, Sirmour and Kinnaur districts of Himachal Pradesh. This included 637 households from Una district, 1,607 from Kangra, 287 from Sirmour and 132 from Kinnaur district. In Una, 3 development blocks namely Gagret (184 HH), Una (247HH) and Amb (206HH) were selected having the lowest child sex-ratio. Nurpur (254HH), Fatehpur (237 HH), Nagrota Surian (212 HH), Indora (228 HH), Kangra (222 HH), Pragpur (259 HH) andLambagaon development block (195 HH) have been selected from Kangra district. From Kinnaur and Sirmour districts five blocks have been selected with high child sex ratio namely Kalpa (78HH), Pooh (54 HH), Sangrah (116 HH), Shillai (81 HH) and Rajgarh (90 HH).

3.1 SOCIO-ECONOMIC PROFILE OF SAMPLED HOUSEHOLDS OF KINNAUR DISTRICT

Socio-economic profile of Kalpa and Pooh blocks of Kinnaur district is presented in Table 3.1. In Kalpa block, majority was of Hindus i.e. 86 per cent and 14 per cent were Buddhist; whereas, in Pooh block, 62 per cent were Buddhist and 38 per cent were Hindus. Overall out of 135 households, 90 (67%) were Hindus and 45 (33%) were Buddhist. In both the blocks, majority of people belonged to Schedule Tribe i.e. out of 135 households, 113 belonged to ST (84%) and remaining 14 (10%) belonged to SC. Very less i.e. 8 (6%) belonged to general category. In Kalpa block, 76 per cent of the households were nuclear families and 24 per cent were joint families. In Pooh block 82 per cent families were nuclear families and 18 per cent were joint families. In aggregate, 106 households (79%) were living as nuclear family and 29 (21%) were living in joint family.

Majority of them had televisions, followed by radio sets and newspaper facility. In Kalpa block, 76 households (95%) had access to televisions, 51 (64%) had access to radio sets and 37 households (46%) had newspaper availability. In Pooh block every household had televisions (100%), 29 (53%) had access to radio sets and 8 (15%) had access to newspaper. In aggregate 97 per cent hadaccess to televisions, 59 per cent had access to radio sets and 33 per cent had newspaper availability. Land ownership was quite high, 98 per cent in Kalpa and 96 per cent in Pooh were owning land and taken together in these two blocks, 97 per cent were owning land.

Table 3.1

Frequency and Percentage Distribution of Households with Selected Characteristics

Selected Characteristics		Development Block					
		Kalpa		Pooh		Total	
		Freq.	***%age***	***Freq.***	***%age***	***Freq.***	***%age***
Religion	Hindu	69	86	21	38	90	67
	Buddhist	11	14	34	62	45	33
Caste	General	3	4	5	9	8	6
	SC	8	10	6	11	14	10
	ST	69	86	44	80	113	84
Type of Family	Joint	19	24	10	18	29	21
	Nuclear	61	76	45	82	106	79
Media Facilities*	TV	76	95	55	100	131	97
	Radio	51	64	29	53	80	59
	Newspaper	37	46	8	15	45	33
Land Ownership	Yes	78	98	53	96	131	97
Total		***80***	***100***	***55***	***100***	***135***	***100***

**Indicates Multiple Responses.*

Age of women respondents is given in Table 3.2. Maximum women interviewed were in the age group of 30 to 36 years i.e. 24 per cent in Kalpa block, 29 per cent in Pooh and a total of 26 per cent in two blocks. Almost all of them were currently married. Majority of the women were high school pass as this percentage was 30 per cent, 35 per cent and 32 per cent in case of Kalpa, Pooh and overall, respectively. But there were illiterate women also. Majority of women were housewife i.e. 69, 65 and 67 per cent, respectively. Agriculture was revealed as their occupation by 15, 25 per cent of the women in Kalpa, Pooh blocks and 19 per cent in aggregate.

Maximum households told government service as their occupation i.e. 29 per cent in Kalpa, 15 per cent in Pooh and 23 per cent in total. This was followed by agriculture i.e. 18 per cent in case of Kalpa, 31 per cent in case of Pooh and 23 per cent aggregate.

Table 3.2

Demographic Characteristics of Women Respondents

Selected Characteristics		Development Block					
		Kalpa		Pooh		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Age of Women Respondent	16-22	2	3	1	2	3	2
	23-29	15	19	11	20	26	19
	30-36	19	24	16	29	35	26
	37-43	24	30	7	13	31	23
	>43	20	25	20	36	40	30
Marital Status	Currently Married	79	99	55	100	134	99
	Divorced	1	1	0	0	1	1
Educational Qualification	Illiterate	12	15	4	7	16	12
	Primary	7	9	3	5	10	7
	Middle	15	19	6	11	21	16
	High	24	30	19	35	43	32
	Graduate	9	11	5	9	14	10
	Post Graduate	2	3	3	5	5	4
Occupation	Nothing	0	0	1	2	1	1
	Housewife	55	69	36	65	91	67
	Agriculture	12	15	14	25	26	19
	Govt. Service	3	4	2	4	5	4
	Business	4	5	2	4	6	4
	Agriculture - SL/ML	5	6	0	0	5	4
	Labourer	1	1	0	0	1	1
Total		***80***	***100***	***55***	***100***	***135***	***100***

3.2 KNOWLEDGE, AWARENESS AND CAUSES OF DECLINING CHILD SEX RATIO IN KINNAUR DISTRICT

3.2.1 Responses of Head of Households

The message related to prevention of sex selection was heard/read by 36 percent and 31 per cent respondents in Kalpa and Pooh blocks, respectively as depicted in Table 3.3.

Respondents were asked about the ideal family size which they would have preferred. Ideal family size of one child was expressed by 15 per cent, two children by 64 per cent and three or more than three children was expressed by 21 per cent households in Kalpa block and in Pooh block this proportion was 16, 69 and 15 per cent, respectively. Overall 66 per cent were in favour of two children, 19 per cent in favour of three or more than three children and 16 per cent in favour of one child. Male child preference was revealed by 29 per cent in Kalpa, 35 per cent in Pooh and overall 31 per cent. Thirty-six per cent had gone for ultrasound of the mother to see the sex of the child in Kalpa, 31 per cent in Pooh and 34 per cent overall. Fifty per cent in Kalpa, 35 per cent in Pooh and 44 per cent overall had awareness about low sex ratio in Himachal Pradesh. That Himachal Government has been taking steps to improve sex ratio was revealed by 59 per cent, 53 per

cent and 46 per cent of the respondents in Kalpa, Pooh blocks and overall, respectively. The respondents had themselves taken steps to improve Child Sex Ratio as indicated by 54 per cent respondents in Kalpa block and 64 per cent in Pooh Block.

Table 3.3

Awareness, Sex Preference and Steps Taken by Head of the Household

Selected Characteristics		Development Block					
		Kalpa		Pooh		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Heard/Read About Prevention of Sex Selection	Yes	29	36	17	31	46	34
Ideal Family Size	One Child	12	15	9	16	21	16
	Two Children	51	64	38	69	89	66
	Three or More Children	17	21	8	15	25	19
Male Child Preference	Yes	23	29	19	35	42	31
Family Members Go for Ultrasound to See Sex of the Child	Yes	29	36	17	31	46	34
Awareness About Very Low Sex Ratio in HP	Yes	40	50	19	35	59	44
Steps Taken by State Govt. to Improve CSR	Yes	47	59	29	53	76	56
Steps Taken by Respondent	Yes	43	54	35	64	78	58
Total		***80***	***100***	***55***	***100***	***135***	***100***

3.2.2 Responses of Women Respondents

Ideal family size of one child was expressed by 13 per cent, two children by 64 per cent and three and more children was expressed by 9 per cent women respondents in Kalpa block and in Pooh block this proportion was 15, 55 and 4 per cent, respectivelyas revealed in Table 3.4. Overall 60 per cent were in favour of two children, 13 per cent in favour of one child and 7 per cent in favor of three or more children.

Son preference is quite high in both the blocks of Kinnaur district. It was revealed that 56 out of 80 mothers (70%) in Kalpa, 39 out of 55 mothers (71%) in case of Pooh and total 95 out of 135 mothers (70%) had preference for son. Respondents were asked many questions about the importance and utility of having a son. More than 50 per cent were of the opinion that son is economic security for them. In case of Kalpa block, it was 58 per cent and 53 per cent in case of Pooh block and aggregate 56 per cent. More than 60 per cent were of the opined that having a son means ensuring old age security. It was 65 per cent in case of Kalpa block and 60 per cent in case of Pooh block. In aggregate, it was 63 per cent.

A less number was of the opinion that it acts as religious security. It was 20 per cent and 13 per cent for Kalpa and Pooh block respectively. In aggregate, it came out to be 17 per cent. Social status also emerged as one of the reasons for son preference. It came out to be 45 per cent for Kalpa block and 55 per cent for Pooh block and in aggregate 49 per cent. Security of family was opined by 19 per cent respondents in Kalpa and 11 per cent in Pooh block and in aggregate, 16 per cent.

Daughters are equally important for a family was opined by majority of respondents. It was 84, 73 and 79 per cent in case of Kalpa, Pooh block and aggregate, respectively. Daughters have a religious value (Kanyadan). This was expressed by 48 per cent in Kalpa and 29 per cent in Pooh and 40 per cent in aggregate. Daughters are required for completeness of the family was expressed by 53 per cent respondents in Kalpa and 58 per cent in Pooh and in aggregate 55 per cent. Reproductive value of a girl child was expressed by 21 and 20 per cent respondents in Kalpa and Pooh blocks, respectively. In aggregate, it was 21 per cent. There is emotional attachment with girls and they are more caring. This was opined by 58 per cent in Kalpa and 36 per cent in Pooh block. In aggregate, it was 49 per cent.

Many factors responsible for disadvantage of daughters were highlighted by the respondents. Daughter as economic burden to family was opined by 39 per cent and 31 per cent of the respondents in Kalpa and Pooh blocks,respectively and in aggregate as 36 per cent. Dowry as one of the main problem was highlighted by 28 per cent and 36 per cent in case of Kalpa and Pooh blocks, respectively and 31 per cent in aggregate. Social security was highlighted by 49 per cent respondents in Kalpa block and 38 per cent respondents in Pooh block and in aggregate 44 per cent. Many respondents expressed physical security of girls as a disadvantage. This was expressed by 31 per cent respondents in Kalpa block and 29 per cent in Pooh block and in aggregate 30 per cent.

Awareness about low sex ratio in District Kinnaur was there in case of 50 per cent of the respondents. It was 49 per cent for Kalpa and 51 per cent for Pooh and 50 per cent in all. Steps taken by State Government to improve child sex ratio were acknowledged by 53 per cent respondents in case of Kalpa and 35 per cent in Pooh block and in aggregate 45 per cent. Do you want to give quality education to girls was asked and the answer was affirmative in 83 per cent and 71 per cent of cases for Kalpa and Pooh blocks, respectively. In aggregate, it was 78 per cent. The respondents were asked whether they are willing to send girl child outside the State. Majority of people were willing to send their girls outside the State. This was opined by 70 per cent in case of Kalpa and 64 per cent in case of Pooh block and in aggregate, 67 per cent respondents.

Table 3.4

Awareness, Sex Preference, Reasons and Steps Taken by Women Respondents

Selected Characteristics		Development Block					
		Kalpa		Pooh		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Ideal Family Size	One Child	10	13	8	15	18	13
	Two Children	51	64	30	55	81	60
	Three or More Children	7	9	2	4	9	7
Son Preference/Importance	Yes	56	70	39	71	95	70
Importance of Son*	Economic Security	46	58	29	53	75	56
	Old Age Security	52	65	33	60	85	63
	Religious Security	16	20	7	13	23	17
	Social Status	36	45	30	55	66	49
	Security of Family	15	19	6	11	21	16
Daughter's Importance	Yes	67	84	40	73	107	79
Importance of Daughter*	Religious Value (Kanyadan)	38	48	16	29	54	40
	Completeness of Family	42	53	32	58	74	55
	Reproductive Value of Girl Child	17	21	11	20	28	21
	Emotional Attachment and More Caring	46	58	20	36	66	49
Disadvantage of Daughter*	Economic Burden to Family	31	39	17	31	48	36
	Dowry Problem	22	28	20	36	42	31
	Social Security	39	49	21	38	60	44
	Physical Security	25	31	16	29	41	30
Awareness About Very Low Sex Ratio in HP	Yes	39	49	28	51	67	50
Steps Taken by State Govt. to Improve CSR	Yes	42	53	19	35	61	45
Steps Taken by Respondent	Yes	15	19	18	33	33	24
Quality Education to Girls	Yes	66	83	39	71	105	78
Willing to Send Girl Child Outside the State	Yes	56	70	35	64	91	67
Total		***80***	***100***	***55***	***100***	***135***	***100***

**Indicates Multiple Responses.*

3.3 SOCIO-ECONOMIC PROFILE OF SAMPLED HOUSEHOLDS OF SIRMAUR DISTRICT

In Sirmaur district, three blocks namely Rajgarh, Sangrah and Shillai were selected for the study which included 91, 114 and 81 households, respectively as depicted in Table 3.5. In all, 286 households were studied and all of them belonged to Hindu religion. In Rajgarh block, 70 per cent were from general category and 30 per cent from SC. In Sangrah block 74 per cent respondents were from general category, 17 per cent from SC and 10 per cent from OBC. Shillai block had almost all i.e. 95 per cent from general category, 4 per cent from SC and 1 per cent from OBC. In all 79 per cent belonged to general category, 17 per cent SC and 4 per cent OBC.

In Rajgarh block 86 per cent lived in nuclear family and 14 per cent in joint family, whereas in Sangrah block 81 per cent in nuclear and 19 per cent in joint family. In Shillai block, 75 per cent lived in nuclear family and 25 per cent in joint family. In aggregate, 81 per cent lived in nuclear family and 19 per cent in joint family. Ninety-eight per cent of the households own land. T.V. was quite popular as 91 per cent of households in Rajgarh, 82 per cent in Sangrah and 84 per cent in Shillai have access to T.V. and in aggregate 85 per cent have access to T.V. Radio facility was available to 43 per cent, 35 per cent and 16 per cent of households, respectively. Newspaper availability is quite less i.e. only 9 per cent, 4 per cent and 9 per cent households respectively had access to them. In aggregate 85 per cent had access to T.V., 32 per cent had access to radio and only 7 per cent to newspaper.

Table 3.5

Frequency and Percentage Distribution of Households with Selected Characteristics

Selected Characteristics		DEVELOPMENT BLOCK							
		Rajgarh		Sangrah		Shillai		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Religion	Hindu	91	100	114	100	81	100	286	100
Caste	General	64	70	84	74	77	95	225	79
	SC	27	30	19	17	3	4	49	17
	OBC	0	0	11	10	1	1	12	4
Type of Family	Joint	13	14	22	19	20	25	55	19
	Nuclear	78	86	92	81	61	75	231	81
Media Facilities*	TV	83	91	93	82	68	84	244	85
	Radio	39	43	40	35	13	16	92	32
	Newspaper	8	9	5	4	7	9	20	7
Land Ownership	Yes	89	98	112	98	80	99	281	98
Total		***91***	***100***	***114***	***100***	***81***	***100***	***286***	***100***

**Indicates Multiple Responses.*

Majority of women respondents were in the age of 23 to 29 years as depicted in Table 3.6. This included 26 per cent in Rajgarh, 22 per cent in Sangrah and 26 per cent in Shillai blocks and overall 24 per cent. This was followed by age group 30-36 years, whereas

this percentage was 25, 17, 23 and 21 per cent, respectively. Majority of the women were currently married. Majority of the women respondents were educated to the level of Matriculation. This percentage was 32, 30, 25 in case of Rajgarh, Sangrah and Shillai respectively and in aggregate it came out to be 29 per cent. The percentage of illiterates was 5, 11 and 38 per cent in the blocks, respectively. Overall illiteracy was 16 per cent. Majority of the women respondents were housewives i.e. 53 per cent in Rajgarh, 35 per cent in Sangrah and 32 per cent in Shillai and in aggregate 40 per cent. In Sangrah and Shillai blocks, a good proportion of women told agriculture as their profession. It was 18 per cent in Sangrah and 42 per cent in Shillai and in aggregate it was 22 per cent.

Table 3.6

Demographic Characteristics of Women Respondents

Selected Characteristics		**Development Block**							
		Rajgarh		**Sangrah**		**Shillai**		**Total**	
		Freq.	***%age***	***Freq.***	***%age***	***Freq.***	***%age***	***Freq.***	***%age***
Age of Women Respondents	16-22	4	4	10	9	4	5	18	6
	23-29	24	26	25	22	21	26	70	24
	30-36	23	25	19	17	19	23	61	21
	37-43	16	18	26	23	16	20	58	20
	>43	7	8	4	4	9	11	20	7
Marital Status	Currently Married	71	78	83	73	68	84	222	78
	Separated	1	1	1	1	0	0	2	1
	Widowed	1	1	0	0	1	1	2	1
Educational Qualification	Illiterate	5	5	12	11	31	38	48	17
	Literate	1	1	0	0	0	0	1	0
	Primary	16	18	18	16	5	6	39	14
	Middle	18	20	13	11	8	10	39	14
	High	29	32	34	30	20	25	83	29
	Graduate	5	5	4	4	4	5	13	5
	>Post Graduate	0	0	3	3	1	1	4	1
Occupation	Nothing	10	11	7	6	1	1	18	6
	Housewife	48	53	40	35	26	32	114	40
	Agriculture	7	8	21	18	34	42	62	22
	Govt. Service	0	0	3	3	3	4	6	2
	Business	1	1	1	1	1	1	3	1
	Horticulture	2	2	0	0	0	0	2	1
	Agriculture - SL/ML	5	5	8	7	4	5	17	6
	Labourer	1	1	4	4	0	0	5	2
Total		***91***	***100***	***114***	***100***	***81***	***100***	***286***	***100***

3.4 KNOWLEDGE, AWARENESS AND CAUSES OF DECLINING CHILD SEX RATIO IN SIRMAUR DISTRICT

3.4.1 Responses of Head of Households

The message related to prevention of sex selection was heard/read by 19, 21, 32 per cent respondents in Rajgarh, Sangrah and Shillai blocks, respectively. In all, 23 percent respondents have heard/read the message as shown in Table 3.7.

Respondents were asked about the ideal family size. In Rajgarh block, 4 per cent indicated one child, 81 per cent two children and 14 per cent three or more. InSangrah block, 15 per cent indicated one child, 68 per cent two children and 13 per cent three or more. In Shillai, 5 per cent indicated one child, 60 per cent two children and 32 per cent three or more. In aggregate 9 per cent were in favour of one child, 70 per cent in favour of two and 19 per cent in favour of three or more.

Male child preference was to the extent of 49 per cent, 46 per cent and 60 per cent in Rajgarh, Sangrah and Shillai blocks, respectively. In aggregate it was 51 per cent. Percentage of family members who had gone for ultrasound of the mother was 19, 22, 28 per cent, respectively and in aggregate 23 per cent. Awareness about very low sex ratio was among 34 per cent respondents in Rajgarh, 20 per cent in Sangrah and just 19 per cent in Shillai. On the whole out of 286 selected households, 69 (24%) were knowing about this. When they were asked whether State Government was taking any steps to increase sex ratio, 44 per cent in Rajgarh, 21 per cent in Sangrah and 35 per cent in Shillai were of affirmative opinion. On the whole 92 households (32%) out of 286 replied in affirmation. The respondents had themselves taken steps to improve Child Sex Ratio as indicated by 33, 29 and 41 per cent respondents in Rajgarh, Sangrah and Shillai blocks, respectively. In aggregate it was to the extent of 34 per cent.

Table 3.7

Awareness, Sex Preference and Steps Taken by Head of the Household

Selected Characteristics		Development Block							
		Rajgarh		Sangrah		Shillai		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq*	*%age*
Heard/Read About Prevention of Sex Selection	Yes	17	19	24	21	26	32	67	23
Ideal Family Size	One Child	4	4	17	15	4	5	25	9
	Two Children	74	81	78	68	49	60	201	70
	Three or More Children	13	14	15	13	26	32	54	19
Male Child Preference	Yes	45	49	52	46	49	60	146	51
Family Members Go for Ultrasound to See Sex of the Child	Yes	17	19	25	22	23	28	65	23
Awareness About Very Low Sex Ratio in HP	Yes	31	34	23	20	15	19	69	24
Steps Taken by State Govt. to Improve CSR	Yes	40	44	24	21	28	35	92	32
Steps Taken by Respondent	Yes	30	33	33	29	33	41	96	34
Total		***91***	***100***	***114***	***100***	***81***	***100***	***286***	***100***

3.4.2 Responses of Women Respondents

Respondents were asked about the ideal family size which they would have preferred. The responses are tabulated in Table 3.8. Ideal family size of two children was indicated by 63 per cent women respondents in Rajgarh block, 51 per cent in Sangrah block and 60 per cent in Shillai block and overall 57 per cent. In Shillai block, 22 per cent indicated their preference for three or more children which was just 11 and 10 per cent in Rajgarh and Sangrahblocks. Overall one child preference was indicated by just 8 per cent respondents.

Son preference was indicated by 37 per cent respondents in case of Rajgarh block, 38 per cent in case of Sangrah and 48 per cent in case of Shillai block. In all it was indicated as 41 per cent. Many respondents opined that son was needed for economic security and this was indicated by 31, 33 and 43 per cent respondents in case of Rajgarh, Sangrah and Shillai block, respectively. Old age security was expressed by 36, 35 and 47 per cent of respondents in respective blocks. A less proportion expressed their reason for son preference for religious security. This was 8 per cent in case of Rajgarh block, 11 per cent for Sangrah block and 16 per cent for Shillai block and in aggregate 12 per cent. Son increases the social status was indicated by a good number of respondents i.e. 23, 24 and 40 per cent in case of Rajgarh, Sangrah and Shillai blocks, respectively. In aggregate it was 28 per cent. A less proportion expressed their opinion about the security of the family as the reasons for son preference. It was just 7, 11 and 19 per cent, respectively in case of Rajgarh, Sangrah and Shillai blocks.

The daughters are important for the family was expressed by more than seventy per cent of the respondents. It was highest at 84 per cent for Shillai block, 81 per cent for Rajgarh and 72 per cent for Sangrah block and 78 per cent in aggregate. Importance of daughters for completeness of family was expressed by more than 50 per cent of the respondents. It was 69 per cent for Shillai block, 60 per cent for Sangrah and 46 per cent for Rajgarh block. Emotional attachment and more caring was the next reason for daughter's preference. On an average it came out to be 50 per cent for Sirmaur and 52, 53 and 44 per cent for Rajgarh, Sangrah and Shillai blocks of the district.

An equal proportion of people expressed their preference for daughters because of religious value. This percentage was 41, 51 and 44 per cent in case of Rajgarh, Sangrah and Shillai blocks, respectively. A less number of people expressed their preference for girl child because of its reproductive value. It was 15, 32 and 27 per cent, respectively in these blocks.

Disadvantages of daughters were reflected in the form of economic burden to family. This opinion was expressed by 35 per cent respondents in Rajgarh, 40 per cent in Sangrah and 53 per cent in Shillai block and 42 per cent in aggregate. Dowry problem as one of the major disadvantage was expressed by 25, 50 and 46 per cent of respondents in Rajgarh, Sangrah and Shillai blocks. Social security was opined by 45 per cent respondent in Rajgarh, 36 per cent in Sangrah and 54 per cent in Shillai blocks and in aggregate 44 per cent. Physical security was highlighted by 57 per cent respondents in Shillai block, followed by 41 per cent in Sangrah and 32 per cent in Rajgarh block.

More than 40 per cent respondents had awareness about very low sex ratio. It was 48 per cent, 42 per cent and 44 per cent in case of Rajgarh, Sangrah and Shillai blocks and in aggregate 45 per cent. Steps taken by State Government to check the declining sex ratio were in the knowledge of 29, 15 and 22 per cent of respondents in these blocks, respectively. More than 70 per cent respondents were in favour of giving quality education to girls. This was highest (84%) in case of Shillai, 78 per cent in case of Rajgarh and 67 per cent in case of Sangrah block and aggregate 75 per cent. Respondents' willingness to send girl child outside the state was 73 per cent in Rajgarh block, 61 per cent in Sangrah and 75 per cent in Shillai block and 69 per cent aggregate.

Table 3.8

Awareness, Sex Preference, Reasons and Steps Taken by Women Respondents

Selected Characteristics		Development Block							
		Rajgarh		Sangrah		Shillai		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Ideal Family Size	One Child	7	8	14	12	2	2	23	8
	Two Children	57	63	58	51	49	60	164	57
	Three or More Children	10	11	11	10	18	22	39	14
Son Preference/Importance	Yes	34	37	43	38	39	48	116	41
Importance of Son*	Economic Security	28	31	38	33	35	43	101	35
	Old Age Security	33	36	40	35	38	47	111	39
	Religious Security	7	8	13	11	13	16	33	12
	Social Status	21	23	27	24	32	40	80	28
	Security of Family	6	7	13	11	15	19	34	12
Daughter's Importance	Yes	74	81	82	72	68	84	224	78
Importance of Daughter*	Religious Value (Kanyadan)	37	41	58	51	36	44	131	46
	Completeness of Family	42	46	68	60	56	69	166	58
	Reproductive Value of Girl Child	14	15	37	32	22	27	73	26
	Emotional Attachment and More Caring	47	52	60	53	36	44	143	50
Disadvantage of Daughter*	Economic Burden to Family	32	35	46	40	43	53	121	42
	Dowry Problem	23	25	57	50	37	46	117	41
	Social Security	41	45	41	36	44	54	126	44
	Physical Security	29	32	47	41	46	57	122	43
Awareness About Very Low Sex Ratio in HP	Yes	44	48	48	42	36	44	128	45
Steps Taken by State Govt. to Improve CSR	Yes	26	29	17	15	18	22	61	21
Steps Taken byRespondent	Yes	9	10	10	9	14	17	33	12
Quality Education to Girls	Yes	71	78	76	67	68	84	215	75
Willing to Send Girl Child Outside the State	Yes	66	73	69	61	61	75	196	69
Total		***91***	***100***	***114***	***100***	***81***	***100***	***286***	***100***

**Indicates Multiple Responses.*

3.5 SOCIO-ECONOMIC PROFILE OF SAMPLED HOUSEHOLDS OF UNA DISTRICT

Amb, Gagret and Una blocks were selected from Una district and their selected characteristics are depicted in Table 3.9. In Amb block, out of 202 households, all were Hindus. In Gagret block, 98 per cent were Hindus and two per cent were Muslims and one per cent Sikhs. In Una block, 99 per cent were Hindus and one per cent were Sikhs. In all 99 per cent were Hindus.

The percentage of SC households was quite high in Una district. In Amb block, 55 per cent households were from general category, 42 per cent from SC and 3 per cent from OBC. In Gagret, 46 per cent from general, 32 per cent from SC category and 21 per cent from OBC.In Una block, 44 per cent from general category, 10 per cent SC and 46 per cent OBC. In the total sample of Una, 48 per cent households were from general category, 26 per cent from SC and 25 per cent from OBC category.

Most of the households belong to nuclear family as this percentage was 84, 80 and 82 in case of Amb, Gagret and Una blocks, respectively. In all 82 per cent households in Una district live in nuclear families and 18 per cent in joint families. In media exposure, it was found that majority of the households possessed T.V. It was to the extent of 99 per cent in Amb, cent per cent in Gagret and 98 per cent in Una block and 99 per cent in aggregate. Radio facilities were available to 21, 16 and 28 per cent of the households in Amb, Gagret and Una blocks, respectively. In aggregate, it was 22 per cent. Newspaper facility was available to less number of households i.e. 5 per cent in Amb, 11 per cent in Gagret and 22 per cent in Una and in aggregate just 13 per cent. Majority of people own land in Una district. It was 93 per cent each in Amb and Gagret blocks and 80 per cent in Una block. In aggregate, it was 87 per cent.

Table 3.9

Frequency and Percentage Distribution of Households with Selected Characteristics

Selected Characteristics		Development Block							
		Amb		Gagret		Una		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Religion	Hindu	202	100	164	98	252	99	618	99
	Muslim	0	0	3	2	0	0	3	0
	Sikh	0	0	1	1	2	1	3	0
Caste	General	111	55	78	46	113	44	302	48
	SC	85	42	54	32	25	10	164	26
	OBC	6	3	36	21	116	46	158	25
Type of Family	Joint	32	16	33	20	45	18	110	18
	Nuclear	170	84	135	80	209	82	514	82
Media Facilities*	TV	199	99	168	100	249	98	616	99
	Radio	43	21	27	16	70	28	140	22
	Newspaper	10	5	19	11	55	22	84	13
Land Ownership	Yes	187	93	156	93	202	80	545	87
Total		***202***	***100***	***168***	***100***	***254***	***100***	***624***	***100***

**Indicates Multiple Responses.*

Majority of women respondents were in the age group of 30-36 years as shown in Table 3.10. They were 23 per cent, 42 per cent and 31 per cent in case of Amb, Gagret and Una blocks, respectively. In aggregate, it was 32 per cent. Majority of them were currently married as is clear from the table. In respect of educational qualification, a High percentage was high school passed i.e. 44 per cent in case of Amb block, 40 per cent in case of Gagret and 38 per cent in case of Una block. For total this percentage was 41 per cent. The percentage of illiterates was low i.e. 4 per cent, 1 and 7 per cent in case of Amb, Gagret and Una blocks, respectively. In aggregate, it was 4 per cent. Occupation-wise, 80 per cent in case of Amb, 93 per cent in case of Gagret and 93 per cent in case of Una recorded themselves as housewives. In all this percentage was 89 per cent.

Table 3.10

Demographic Characteristics of Women Respondents

Selected Characteristics		Development Block							
		Amb		Gagret		Una		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Age of Women Respondents	<=15	1	0	5	3	3	1	9	1
	16-22	2	1	3	2	3	1	8	1
	23-29	44	22	38	23	36	14	118	19
	30-36	47	23	70	42	80	31	197	32
	37-43	53	26	30	18	58	23	141	23
	>43	34	17	24	14	38	15	96	15
Marital Status	Currently Married	195	97	159	95	250	98	604	97
	Separated	4	2	0	0	0	0	4	1
	Divorced	0	0	1	1	1	0	2	0
	Widowed	3	1	8	5	3	1	14	2
Educational Qualification	Illiterate	9	4	1	1	18	7	28	4
	Literate	1	0	7	4	7	3	15	2
	Primary	25	12	17	10	22	9	64	10
	Middle	57	28	32	19	71	28	160	26
	High	89	44	68	40	97	38	254	41
	Graduate	10	5	15	9	29	11	54	9
	>Post Graduate	11	5	28	17	10	4	49	8
Occupation	Housewife	161	80	156	93	236	93	553	89
	Agriculture	29	14	1	1	2	1	32	5
	Govt. Service	6	3	5	3	8	3	19	3
	Labourer	6	3	6	4	8	3	20	3
Total		***202***	***100***	***168***	***100***	***254***	***100***	***624***	***100***

3.6 KNOWLEDGE, AWARENESS AND CAUSES OF DECLINING CHILD SEX RATIO IN UNA DISTRICT

3.6.1 Responses of Head of Households

The message related to prevention of sex selection was heard/read by 15 per cent respondents in Amb, 28 per cent in Gagret and 76 per cent in Una block. In all 43 per cent respondents had heard/read this message as depicted in Table 3.11.

Information regarding ideal family size was sought from the respondents. Majority of them opted for two children i.e. the percentage was 86 per cent, 83 and 87 per cent in case of Amb, Gagret and Una blocks, respectively. In all, it came out to be 86 per cent. This percentage was 9, 20 and 10 per cent in case of a single child and 5, one and one per cent for three or more children respectively. In case of aggregate, it was 86 per cent for two children, 13 per cent for single child and 2 per cent for three or more children.

The preference for male child was expressed by 29, 13 and 6 per cent respondents in case of Amb, Gagret and Una blocks, respectively. In case of aggregate, 15 per cent showed their preference for male child. Ultrasound of the mother was done during pregnancy to know the sex of the child by 19 per cent households in Amb, 8 per cent in Gagret and 6 per cent in Una block. In aggregate, this was 11 per cent. More than 50 per cent people had awareness about low sex ratio i.e. 49, 73 and 76 per cent in case of Amb, Gagret and Una blocks. In aggregate, it was 67 per cent. Awareness about the steps were taken by State Government to improve the sex ratio to the extent of 45 per cent in Amb block, 24 per cent in Gagret and 50 per cent in Una block. In all, 41 per cent respondents opined that State Government was taking steps to arrest declining sex ratio. The respondents had themselves taken steps to improve Child Sex Ratio as indicated by 31 per cent respondents in Gagret, 23 per cent in Amb and 22 per cent in Una block. In aggregate, it came out to be 25 per cent.

Table 3.11

Awareness, Sex Preference and Steps Taken by Head of the Household

Selected Characteristics		Development Block							
		Amb		Gagret		Una		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Heard/Read About Prevention of Sex Selection	Yes	31	15	47	28	192	76	270	43
Ideal Family Size	One Child	19	9	34	20	25	10	78	13
	Two Children	174	86	139	83	221	87	534	86
	Three or More Children	10	5	1	1	3	1	14	2
Male Child Preference	Yes	58	29	21	13	16	6	95	15
Family Members Go for Ultrasound to See Sex of the Child	Yes	39	19	14	8	15	6	68	11
Awareness About Very Low Sex Ratio in HP	Yes	99	49	123	73	194	76	416	67
Steps Taken by State Govt. to Improve CSR	Yes	90	45	40	24	127	50	257	41
Steps Taken by Respondent	Yes	46	23	52	31	55	22	153	25
Total		***202***	***100***	***168***	***100***	***254***	***100***	***624***	***100***

3.6.2 Responses of Women Respondents

Information regarding ideal family size sought from the respondents is shown in Table 3.12. Majority of them indicated their preference in favour of two children i.e. 86, 76 and 93 per cent in case of Amb, Gagret and Una blocks, respectively. Overall this preference was 86 per cent. The preference in favour of three or more children was very less i.e. 5 per cent in Amb, just one per cent each in Gagret and Una blocks and overall two per cent. The preference for one child was slightly more i.e. 9, 11 and 5 per cent in case of Amb, Gagret and Una blocks, respectively.

Son preference was exhibited by 60 per cent respondents in Amb block, 33 per cent in Gagret and 15 per cent in Una block. Son would provide economic security to the family was opined by 58 per cent, 30 per cent and 6 per cent of the respondents, respectively in these blocks. Old age security was one of the major cause for son preference as revealed by data. It was opined by 63 per cent, 42 and 12 per cent respondents, respectively in Amb, Gagret and Una block. Religious security was expressed by 39 per cent, 40 per cent and 11 per cent respondents. Son as a symbol of social status was expressed by 30, 32 and 12 per cent respondents in case of Amb, Gagret and Una blocks. For aggregate this was 15 per cent. Son provides security to the family was opined by 24 per cent, 19 per cent and 5 per cent of the respondents, respectively.

Daughters' importance was emphasized by every respondent. It was cent per cent in Una block, 98 and 90 per cent in case of Amb and Gagret blocks. In aggregate, 91 per cent of the respondents expressed in favour of girls for completeness of family. It was 94 per cent in case of Amb block, 77 per cent in Gagret block and 97 per cent in Una block. Religious value of girl child was expressed by 75, 61 and 97 per cent respondents, respectively. Reproductive value of daughter was opined by 71, 68 and 98 per cent of respondents in case of Amb, Gagret and Una blocks. Emotional attachment of girls was also one of the strong reasons for importance of daughters. It was 55 per cent in Amb block, 74 per cent in Gagret and 98 per cent in Una block and aggregate 78 per cent.

Many reasons were sighted as disadvantages of daughters. Dowry problem was opined by 48 per cent respondent in aggregate. It was quite high (78%) in case of Amb block, 69 per cent in case of Gagret and 10 per cent in case of Una block. Social security was expressed as another reason. It was 59 per cent in Amb block, 68 per cent in Gagret and 18 per cent in Una block and aggregate 45 per cent. Physical security of daughters was highlighted as one of the disadvantage of daughters by 40 per cent respondents in Amb block, 66 per cent in Gagret and 15 per cent in Una block.

In Una district, awareness among people was quite high about the very low sex ratio. It was 72 per cent in case of Amb, 60 per cent in case of Gagret and 61 per cent in case of Una block and aggregate 64 per cent. Steps taken by Government to arrest the declining sex ratio were acknowledged by 42 per cent, 23 per cent and 24 per cent respondents, respectively. More than eighty per cent were in favour of giving quality education to girls. It was 80 per cent, 73 per cent and 88 per cent in case of Amb, Gagret and Una blocks, respectively. Willingness to send girl child Outside the State was expressed by 65 per cent

respondents in Amb block, 63 per cent in Gagret block and 80 per cent in Una block. In aggregate, it was 71 per cent.

Table 3.12

Awareness, Sex Preference, Reasons and Steps Taken by Women Respondents

Selected Characteristics		Development Block							
		Amb		Gagret		Una		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Ideal Family Size	One Child	18	9	18	11	13	5	49	8
	Two Children	174	86	128	76	237	93	539	86
	Three or More Children	10	5	2	1	2	1	14	2
Son Preference/Importance	Yes	121	60	55	33	39	15	215	34
Importance of Son*	Economic Security	117	58	50	30	15	6	182	29
	Old Age Security	128	63	70	42	30	12	228	37
	Religious Security	78	39	67	40	29	11	174	28
	Social Status	60	30	53	32	31	12	144	23
	Security of Family	48	24	32	19	12	5	92	15
Daughter's Importance	Yes	198	98	151	90	253	100	602	96
Importance of Daughter*	Religious Value (Kanyadan)	152	75	103	61	246	97	501	80
	Completeness of Family	190	94	129	77	247	97	566	91
	Reproductive Value of Girl Child	143	71	114	68	249	98	506	81
	Emotional Attachment and More Caring	112	55	124	74	249	98	485	78
Disadvantage of Daughter*	Economic Burden to Family	115	57	86	51	10	4	211	34
	Dowry Problem	157	78	116	69	26	10	299	48
	Social Security	119	59	115	68	46	18	280	45
	Physical Security	80	40	111	66	38	15	229	37
Awareness About Very Low Sex Ratio in HP	Yes	146	72	100	60	156	61	402	64
Steps Taken by State Govt. to Improve CSR	Yes	85	42	38	23	60	24	183	29
Steps Taken by Respondent	Yes	58	29	24	14	27	11	109	17
Quality Education to Girls	Yes	162	80	123	73	223	88	508	81
Willing to Send Girl Child Outside the State	Yes	132	65	105	63	203	80	440	71
Total		***202***	***100***	***168***	***100***	***254***	***100***	***624***	***100***

**Indicates Multiple Responses.*

3.7 SOCIO-ECONOMIC PROFILE OF SELECTED HOUSEHOLDS OF KANGRA DISTRICT

In all the seven selected blocks of Kangra, majority of households were Hindus as depicted in Table 3.13. In Indora, Nagrota Surianand Nurpur blocks, 11 per cent, 6 and 1 per cent, respectively were Muslims. In Pragpur block, 2 per cent households were Sikhs. In all out of 1558 households selected in Kangra district, 1,510 households were Hindus, 43 were Muslims and 5 were Shikhs. General households were maximum in Pragpur (68%) and Lambagaon blocks (60%). SCs were maximum in Nurpur (29%) and Pragpur (27%). ST were maximum in Fatehpur block (16%). As far as OBCs are concerned, Kangra district has a large OBC population. It was 61 per cent in case of Kangra block, 50 per cent in case of Fatehpur block, 49 per cent in case of Nagrota Surian block and 39 per cent in case of Indora block. In all the percentage of households selected in Kangra district comprised of 45 per cent general category, 35 per cent OBC, 16 per cent SC and 4 per cent ST category. Majority of them (89%) were living in nuclear family and 11 per cent in joint family.

Table 3.13

Frequency and Percentage Distribution of Households with Selected Characteristics

Selected Households		Development Block															
		Fatehpur		Indora		Kangra		Lambagaon		Nagrota Surian		Nurpur		Pragpur		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Religion	Hindu	217	100	197	89	223	100	199	100	204	94	234	99	236	98	1510	97
	Muslim	1	0	25	11	0	0	0	0	14	6	3	1	0	0	43	3
	Sikh	0	0	0	0	0	0	0	0	0	0	0	0	5	2	5	0
Caste	General	53	24	91	41	73	33	120	60	79	36	113	48	165	68	694	45
	SC	23	11	27	12	14	6	36	18	20	9	68	29	64	27	252	16
	ST	34	16	18	8	1	0	1	1	13	6	3	1	0	0	70	4
	OBC	108	50	86	39	135	61	42	21	106	49	53	22	12	5	542	35
Type of Family	Joint	23	11	22	10	30	13	18	9	25	11	11	5	38	16	167	11
	Nuclear	195	89	200	90	193	87	181	91	193	89	226	95	203	84	1391	89
Media Facilities*	TV	211	97	195	88	198	89	187	94	208	95	233	98	229	95	1461	94
	Radio	57	26	51	23	15	7	63	32	61	28	50	21	92	38	389	25
	Newspaper	21	10	16	7	10	4	63	32	15	7	18	8	37	15	180	12
Land Ownership	Yes	208	95	194	87	218	98	167	84	195	89	204	86	214	89	1400	90
Total		***218***	***100***	***222***	***100***	***223***	***100***	***199***	***100***	***218***	***100***	***237***	***100***	***241***	***100***	***1558***	***100***

**Indicates Multiple Responses.*

Media exposure was quite high in all the blocks of Kangra district. It was highest in Nurpur (98%) and Fatehpur (97%) and in all (94%). Radio facility was highest in Pragpur block (38%), followed by Lambagaon (32%) and Nagrota Surian(28%). It came out to be 25 per cent in aggregate. Newspaper facility was maximum in Lambagaon block (32%), followed by Pragpur block (15%). This was 12 per cent in case of all the respondents. Majority of households are landowner as it was 90 per cent for the aggregate and maximum i.e. 98 per cent in case of Kangra block. It was minimum i.e. 84 per cent in Lambagaon block.

Majority of women respondents were in the age group of 23 to 29 years, followed by 30 to 36 and 37 to 43 years as these were 28 per cent, 27 per cent and 24 per cent, respectively for the aggregate as depicted in Table 3.14. It was 30 per cent in case of Nurpur, 29 per cent each in case of Nagrota Surian and Indora block and 28 per cent for Pragpur block. Women respondents in the age group of 30-36 years were maximum i.e. 31 per cent in case of Fatehpur block, followed by Lambagaon (29%). In the age group of 37 to 43 years, maximum women were in Nagrota Surianblock (31%), followed by Lambagaon (25%) and Fatehpur and Pragpur each having 24 per cent. More than 84 per cent women were currently married and this percentage was highest (91%) in case of Fatehpur block. In aggregate it came out to be 88 per cent.

In aggregate, 44 per cent of women respondents were high school passed and 6 per cent were illiterates. Illiteracy was maximum in Indora block (14%), followed by Fatehpur (8%) and Nagrota Surian (5%). Illiteracy was least in Lambagaon block i.e. 1 per cent. The percentage of respondents who studied up to Matriculation was highest (48%) in Kangra and Nagrota Surianblock each, followed by Pragpur (45%) and Fatehpur and Lambagaon where it was 44 per cent each.

The analysis revealed that more than 80 per cent of the women respondents were housewives in each block. In Kangra district, a significant proportion also worked as labourer in the fields. This percentage was maximum i.e. 14 per cent in case of Nurpur and 12 per cent in case of Pragpur and 11 per cent each in case of Indora and Nagrota Surianblocks. In all, 85 per cent respondents were housewives and 10 per cent were labourers.

Table 3.14

Demographic Characteristics of Women Respondents

Selected Characteristics		Development Block															
		Fatehpur		Indora		Kangra		Lambagaon		Nagrota Surian		Nurpur		Pragpur		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Age of Women Respondents	<=15	0	0	0	0	0	0	1	1	0	0	1	0	0	0	2	0
	16-22	1	0	7	3	7	3	2	1	4	2	4	2	2	1	27	2
	23-29	54	25	65	29	62	28	49	25	63	29	71	30	68	28	432	28
	30-36	68	31	57	26	61	27	58	29	52	24	66	28	63	26	425	27
	37-43	52	24	49	22	48	22	50	25	67	31	49	21	59	24	374	24
	>43	43	20	44	20	45	20	39	20	32	15	46	19	49	20	298	19
Marital Status	Currently Married	198	91	187	84	204	91	180	90	190	87	206	87	212	88	1377	88
	Separated	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	0
	Divorced	1	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0
	Widowed	5	2	5	2	7	3	6	3	5	2	4	2	4	2	36	2
Educational Qualification	Illiterate	18	8	30	14	16	7	2	1	10	5	7	3	7	3	90	6
	Literate	14	6	33	15	12	5	16	8	23	11	29	12	23	10	150	10
	Primary	25	11	19	9	24	11	21	11	26	12	28	12	27	11	170	11
	Middle	47	22	36	16	43	19	37	19	38	17	42	18	28	12	271	17
	High	97	44	81	36	106	48	88	44	104	48	100	42	109	45	685	44
	Graduate	10	5	14	6	11	5	19	10	11	5	23	10	24	10	112	7
	>= Post Graduate	7	3	9	4	11	5	16	8	6	3	8	3	23	10	80	5
Occupation	Nothing	2	1	0	0	2	1	1	1	0	0	0	0	0	0	5	0
	Housewife	188	86	189	85	188	84	179	90	193	89	193	81	198	82	1328	85
	Agriculture	5	2	2	1	5	2	2	1	1	0	0	0	2	1	17	1
	Govt. Service	4	2	7	3	8	4	4	2	1	0	11	5	11	5	46	3
	Labourer	19	9	24	11	20	9	13	7	23	11	33	14	30	12	162	10
Total		***218***	***100***	***222***	***100***	***223***	***100***	***199***	***100***	***218***	***100***	***237***	***100***	***241***	***100***	***1558***	***100***

3.8 KNOWLEDGE, AWARENESS AND CAUSES OF DECLINING CHILD SEX RATIO IN KANGRA DISTRICT

3.8.1 Responses of Head of Households

People had heard/read about prevention of sex selected abortion to varying extent as revealed by Table 3.15. It was to the extent of 69 per cent in Nurpur block, followed by 63 per cent in Fatehpur block. It was just 45 per cent in Lambagaon block, 49 per cent in Pragpur and aggregate 57 per cent.

In aggregate terms, 82 per cent households preferred to have two children in the family, 13 per cent wanted just one child and 3 per cent wished to have three or more children. In Lambagaon block, 22 per cent households preferred having one child which was maximum among all the blocks. In Indora block, 8 per cent wanted to have one child. Two children preference was maximum in Fatehpur block (89%), followed by Indora (87%) and Kangra and Nurpur having equal preference i.e. 85 per cent each. It was minimum i.e. 73 per cent in Lambagaon block. Preference for three or more children was less than 7 per cent in all the blocks of Kangra district.

Male child preference was highest in Indora block (33%), followed by Pragpur (32%) and Nagrota Surian (25%). It was just 10 per cent in Nurpur block and was 24 per cent in aggregate. Quite significant households admitted that their family members went for ultrasound of the mother in order to check sex of the child. It was maximum i.e. 43 per cent in case of Kangra block, 34 per cent for Pragpur block and 33 per cent in case of Lambagaon block. Overall this came out to be 31 per cent. Awareness among households regarding very low sex ratio was quite high in all the blocks of Kangra district. It was highest i.e. 65 per cent in Lambagaon, 58 per cent in Nagrota Surian, 56 per cent in Pragpur and in aggregate it was 54 per cent. According to households, the awareness about steps taken by State Government and its functionaries to improve sex ratio were to the extent of 49 per cent in Pragpur and Lambagaon each, 39 per cent in Kangra and 36 per cent in Fatehpur. Overall it was 36 per cent. The respondents had themselves taken steps to improve CSR as indicated by 36 per cent respondents in Kangra block, 29 per cent in Pragpur and 22 per cent in Fatehpur block. A small percentage of respondents had taken steps to improve CSR in Indora (8%), Nagrota Surian(4%) and Nurpur (3%). Overall it was 18 per cent.

Table 3.15

Awareness, Sex Preference and Steps Taken by Head of the Household

Selected Characteristics		Development Block															
		Fatehpur		Indora		Kangra		Lambagaon		Nagrota Surian		Nurpur		Pragpur		Total	
		Freq.	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*	*Freq.*	*%Age*
Heard/Read About Prevention of Sex Selection	Yes	138	63	134	60	115	52	89	45	134	61	164	69	118	49	892	57
Ideal Family Size	One Child	20	9	18	8	25	11	44	22	33	15	28	12	42	17	210	13
	Two Children	193	89	193	87	189	85	146	73	177	81	201	85	186	77	1285	82
	Three or More Children	3	1	10	5	7	3	6	3	4	2	4	2	11	5	45	3
Male Child Preference	Yes	53	24	73	33	53	24	48	24	54	25	23	10	76	32	380	24
Family Members Go for Ultrasound to See Sex of the Child	Yes	70	32	71	32	97	43	66	33	52	24	39	16	83	34	478	31
Awareness About Very Low Sex Ratio in HP	Yes	110	50	122	55	97	43	130	65	127	58	118	50	134	56	838	54
Steps Taken by State Govt. to Improve CSR	Yes	79	36	62	28	86	39	98	49	72	33	47	20	117	49	561	36
Steps Taken by Respondent	Yes	47	22	18	8	81	36	41	21	9	4	6	3	71	29	273	18
Total		***218***	***100***	***222***	***100***	***223***	***100***	***199***	***100***	***218***	***100***	***237***	***100***	***241***	***100***	***1558***	***100***

3.8.2 Responses of Women Respondents

Information regarding ideal family size was sought from the respondents as revealed in Table 3.16. More than 70 per cent respondents in all the blocks of Kangra district indicated their preference for two children. A very small proportion i.e. less than 5 per cent indicated their choice in favour of three or more children. Ideal family size of one child was indicated by 22 per cent respondents in Pragpur block, 18 per cent in Lambagaon and 16 per cent in Nagrota Surian block and 12 per cent each in Fatehpur and Kangra blocks. Overall in Kangra district, 74 per cent respondents were in favour of two children, 14 per cent in favor of one child and just two per cent in favour of three or more children.

Son preference was highest in Kangra district (59%), followed by 34 per cent in Fatehpur, 32 per cent each in Indora and Pragpur and 33 per cent in aggregate. Old age security was the main reason for son preference. It was 84 per cent in Kangra block, 66 per cent in Indora, 56 per cent in Lambagaon and in aggregate 52 per cent. Religious security was the next reason for son preference. It was 71 per cent in Kangra block, followed by 49 per cent in Indora block, 47 per cent in Lambagaon and 44 per cent in Nurpur block. Another important reason for son preference was economic security which was expressed by 41 per cent of the respondents. It was again highest (82%) in Kangra block, 54 per cent in Indora, 44 per cent in Pragpur and 41 per cent in Lambagaon. Social status enhances by having a son was opined by 57 per cent respondents in Kangra block, followed by 34 per cent, 33 per cent and 32 per cent in Indora, Lambagaon and Pragpur blocks, respectively as the reason behind. Security of family was expressed by 54 per cent in Kangra district, followed by 28 per cent in Indora, 21 per cent in Lambagaon and in aggregate 22 per cent.

Daughters' importance was highlighted by 90 per cent of the respondents. It was 94 per cent, 93 per cent, 91 per cent and 90 per cent in case of Fatehpur, Lambagaon, Kangra and Pragpur blocks, respectively. Daughters are needed for completeness of family was expressed by 81 per cent of the respondents. It was 87 per cent each in case of Fatehpur and Kangra blocks, 85 per cent in case of Pragpur and 82 per cent in case of Lambagaon block. Religious value of daughters was opined by 78 per cent of respondents in Kangra, followed by 70 per cent in Fatehpur, 68 per cent in Pragpur and 65 per cent in Lambagaon. Reproductive value of girl child was opined by 51 per cent respondents in Nagrota Surianand Nurpur blocks each and 50 per cent in Fatehpur and 45 per cent in aggregate. Sixty per cent of the respondents were of the view that daughters have emotional attachment and they are more caring. This included 79 per cent in Nurpur, 75 per cent in Lambagaon and 70 per cent in Nagrota Surian block. In disadvantage of daughters, dowry problem was highlighted by 64 per cent of respondents in aggregate and 76 per cent in Kangra, 71 per cent in Pragpur and 64 per cent in Nagrota Surian blocks. Next disadvantage of daughters as social security problem was highlighted by 63 per cent respondents in Kangra block, 57 per cent in Fatehpur, 51 per cent in Pragpur and 50 per cent in Nagrota Surianblock. Daughters as economic burden to family was opined by 53 per cent

respondents in Kangra, 42 per cent each in Fatehpur and Indora blocks. Physical security of daughters was expressed by 51 per cent respondents in Kangra block, followed by Pragpur (42%), Lambagaon (36%) and Nagrota Surian(36%).

Awareness about low sex ratio in Himachal Pradesh was there in 66 per cent of the respondents. It was 77 per cent in Lambagaon block, followed by 73 per cent in Fatehpur, 71 per cent in Pragpur, 69 per cent in Nagrota Surianand 68 per cent in Kangra block. Steps taken by State Government to improve child sex ratio was highlighted by 58 per cent respondents in Lambagaon block, followed by 43 per cent in Kangra and 42 per cent in Fatehpur blocks. Steps taken by respondents themselves were reported by 21 per cent in aggregate and 30 per cent, 28 and 27 per cent in Lambagaon, Kangra and Pragpur blocks, respectively. Majority of the respondents (80%) were in favour of giving quality education to girls. It was highest in case of Fatehpur block (94%), followed by Kangra (85%), Pragpur (82%) and Nagrota Surian(78%). Quite a good percentage of respondents were willing to send girls outside the State for education / jobs as revealed by 78 per cent respondents in Fatehpur block, 76 per cent in Pragpur, 71 per cent in Kangra and Lambagaon block each.

Table 3.16

Awareness, Sex Preference, Reasons and Steps Taken by Women Respondents

Selected Characteristics		Development Block															
		Fatehpur		Indora		Kangra		Lambagaon		NagrotaSurian		Nurpur		Pragpur		Total	
		Freq.	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*	*Freq.*	*%age*
Ideal Family Size	One Child	26	12	21	9	26	12	36	18	35	16	17	7	53	22	214	14
	Two Children	173	79	158	71	173	78	142	71	154	71	188	79	161	67	1149	74
	Three or More Children	5	2	10	5	8	4	5	3	4	2	3	1	2	1	37	2
Son Preference/Importance	Yes	74	34	71	32	132	59	46	23	55	25	56	24	77	32	511	33
Importance of Son*	Economic Security	42	19	119	54	183	82	82	41	30	14	69	29	107	44	632	41
	Old Age Security	67	31	146	66	187	84	112	56	56	26	114	48	130	54	812	52
	Religious Security	64	29	109	49	159	71	94	47	51	23	104	44	101	42	682	44
	Social Status	52	24	76	34	127	57	66	33	28	13	46	19	77	32	472	30
	Security of Family	23	11	62	28	120	54	41	21	8	4	48	20	39	16	341	22
Daughter's Importance	Yes	204	94	188	85	204	91	185	93	191	88	209	88	216	90	1397	90
Importance of Daughter*	Religious Value (Kanyadan)	153	70	116	52	173	78	130	65	135	62	140	59	163	68	1010	65
	Completeness of Family	189	87	150	68	193	87	163	82	171	78	187	79	204	85	1257	81
	Reproductive	110	50	98	44	108	48	92	46	112	51	121	51	67	28	708	45

	Value of Girl Child																
	Emotional Attachment and More Caring	107	49	125	56	133	60	149	75	152	70	187	79	89	37	942	60
Disadvantage of Daughter*	Economic Burden to Family	92	42	93	42	119	53	72	36	54	25	64	27	99	41	593	38
	Dowry Problem	144	66	118	53	170	76	116	58	140	64	131	55	171	71	990	64
	Social Security	125	57	77	35	140	63	77	39	110	50	93	39	124	51	746	48
	Physical Security	71	33	72	32	113	51	71	36	79	36	65	27	101	42	572	37
Awareness About Very Low Sex Ratio in HP	Yes	160	73	121	55	151	68	154	77	150	69	117	49	171	71	1024	66
Steps Taken by State Govt. to Improve CSR	Yes	92	42	55	25	96	43	115	58	72	33	41	17	100	41	571	37
Steps Taken by Respondent	Yes	48	22	32	14	63	28	60	30	42	19	22	9	66	27	333	21
Quality Education to Girls	Yes	206	94	154	69	189	85	153	77	170	78	170	72	198	82	1240	80
Willing to Send Girl Child Outside the State	Yes	171	78	121	55	158	71	142	71	127	58	136	57	182	76	1037	67
Total		***218***	***100***	***222***	***100***	***223***	***100***	***199***	***100***	***218***	***100***	***237***	***100***	***241***	***100***	***1558***	***100***

**Indicates Multiple Responses.*

3.9 BIRTH ORDER PARITY

3.9.1 BIRTH ORDER PARITY IN KANGRA AND UNA DISTRICTS

Preference for the sex of the second child in Kangra and Una district is given in Table 3.17. In case of Kangra district when the sex of the first child was male, the sex of the second child was male in 254 cases and female in 243 cases, showing a preference of 51.16 per cent for the male child and 48.96 per cent for the female child. But when the first child born was female, preference for second child was male in 246 cases (59.7%) and female only in 166 cases (40.3%). This clearly indicated a higher preference for male child when the first child born was female. Similarly, in case of Una district, when the first child was male, the preference for second male child was in 103 cases (53.1%) and for a female child was in 91 cases (46.9%). Preference for male child was quite visible if the first child was already female. In 106 cases, the preference was for a male child and only in 66 cases the preference was female child, amounting to 61.6 per cent and 38.4 per cent, respectively.

Further this preference was also evident if the cases of Kangra and Una districts are combined together. For this combination if the first child was male, then the preference for second male child was in 357 cases (51.7%) and if the first child was male preference for female child was in case of 334 cases (48.3%). If the first child was female, then the preference for male as second child was in 60.3 per cent of cases and preference for female child was in 39.7 per cent of the cases.

Table 3.17

Preference for Sex of Second Child - Absolute & Percentage Values

DISTRICT	SEX OF FIRST CHILD	SEX OF SECOND CHILD		
		Male	Female	Total
Kangra	Male	254 (51.1)	243 (48.9)	497 (100)
	Female	246 (59.7)	166 (40.3)	412 (100)
	Total	**500**	**409**	**909**
Una	Male	103 (53.1)	91 (46.9)	194 (100)
	Female	106 (61.6)	66 (38.4)	172 (100)
	Total	**209**	**157**	**366**
Total (Kangra + Una)	Male	357 (51.7)	334 (48.3)	691 (100)
	Female	352 (60.3)	232 (39.7)	584 (100)
	Total	**709**	**566**	**1275**

Note: *Values in parentheses represent percentages of children preferred after one child.*

Preference for the sex of third child in absolute and percentage values in case of Kangraand Una districts is depicted in Table3.18. If the first child was male followed by a female child, then the preference for the third child was male in 35 cases (66%) and female in 18 cases (34%), clearly demonstrating a preference for male child in Kangra district. If the first child was female followed by another female child, then the preference for a male

child in the third delivery was quite high i.e. 65.8 per cent and 34.2 percent in case of third female child.

In case of Una district, if the first child was male followed by female, then the preference for the third child was equal in case of both male and female i.e. 50 per cent each. If first two children were female, then the sex of the third child was male in 23 cases (67.6%) and female in 11 cases (32.4%), clearly indicating a preference for male child.

Similar trend was substantiated in Kangra and Una district taken together. If the first child was male followed by female child, then the preference for the third child as male was quite high i.e. in 62 per cent cases and 38 per cent in case of third female child. If the first two children were females, then the preference for male child in the third birth was quite high i.e. in 98 cases and female in 50 cases, indicating a preference order of 66.2 per cent and 33.8 per cent respectively.

Table 3.18

Preference for Sex of Third Child - Absolute & Percentage Values

District	Sex of Two Children ever Born	Sex of Third Children		
		Male	**Female**	**Total**
Kangra	Male Male	20 (54.1)	17 (45.9)	37 (100)
	Male Female	35 (66.0)	18 (34.0)	53 (100)
	Female Male	27 (57.4)	20 (42.6)	47 (100)
	Female Female	75 (65.8)	39 (34.2)	114 (100)
	Total	**157**	**94**	**251**
Una	Male Male	8 (80.0)	2 (20.0)	10 (100)
	Male Female	9 (50.0)	9 (50.0)	18 (100)
	Female Male	17 (68.0)	8 (32.0)	25 (100)
	Female Female	23 (67.6)	11 (32.4)	34 (100)
	Total	**57**	**30**	**87**
Total (Kangra + Una)	Male Male	28 (59.6)	19 (40.4)	47 (100)
	Male Female	44 (62.0)	27 (38.0)	71 (100)
	Female Male	44 (61.1)	28 (38.9)	72 (100)
	Female Female	98 (66.2)	50 (33.8)	148 (100)
	Total	**214**	**124**	**338**

Note: *Values in parentheses represent percentages of children preferred after two children.*

In order to study this phenomenon, 'Null Hypothesis' was set as there is no preference for sex of the child and 'Alternate Hypothesis' as there is preference for sex of the child. The hypotheses were tested with the help of Chi-Square. As evident from Table 3.19, the Null Hypothesis got rejected in case of Kangra district indicating a sex preference in the birth of second child. But in case of Una district the Null Hypothesis got accepted

meaning thereby that there is no preference for sex in the second child. This may be because of small number of cases in Una district. Keeping this in mind, when Kangra and Una districts were combined together, the Null Hypothesis again got rejected. Thus, showing a clear preference for the sex of the second child.

Again Chi-Square was applied to see the preference for the third child shown in Table 3.20 and 3.21. In case of Kangra and Una districts separately, the Null Hypothesis was accepted in both of the cases. Null Hypothesis was also accepted when Kangra and Una districts were combined together. The only explanation for this is that numbers of cases of child born in the third birth order were very small. So, the results were not significant.

Table 3.19

Chi-Square Tests for Judging the Male Preference for Second Child

DISTRICT	N	*Chi-Square* Value	d.f.	*p*-Value
Kangra	*909*	*6.735**	*1*	*0.009*
Una	*366*	*2.711***	*1*	*0.100*
Total (Kangra + Una)	*1275*	*9.504**	*1*	*0.002*

**p<0.01 & ** p>0.05*

Table 3.20

Chi-Square Tests for Judging the Male Preference for Third Child

DISTRICT	N	*Chi-Square* Value	d.f.	*p*-Value
Kangra	*251*	*2.449***	*3*	*0.485*
Una	*87*	*2.983***	*3*	*0.394*
Total (Kangra + Una)	*338*	*1.025***	*3*	*0.795*

*** p>0.05*

Table 3.21

Chi-Square Tests for Judging the Male Preference for Second and Third Child

NULL HYPOTHESIS (H_0): *There is no preference for sex of the child.* *ALTERNATIVE HYPOTHESIS (H_1):* *There is preference for sex of the child.*			
Sex Preference	**District**	**Chi-Square Tests**	**Hypothesis**
Second Child	***Kangra***	$(X^2_{(1, N=909)} = 6.74) > (X^2_{(1, 0.05)} = 3.84)$ & $p=0.009 < 0.05$	Rejected
	Una	$(X^2_{(1, N=366)} = 2.71) < (X^2_{(1, 0.05)} = 3.84)$ & $p=0.100 > 0.05$	Accepted
	Total (Kangra + Una)	$(X^2_{(1, N=1275)} = 9.50) > (X^2_{(1, 0.05)} = 3.84)$ & $p=0.002 < 0.05$	Rejected
Third Child	***Kangra***	$(X^2_{(3, N=251)} = 2.45) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.485 > 0.05$	Accepted
	Una	$(X^2_{(3, N=87)} = 2.98) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.394 > 0.05$	Accepted
	Total (Kangra + Una)	$(X^2_{(3, N=338)} = 1.03) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.795 > 0.05$	Accepted

3.9.2 BIRTH ORDER PARITY IN KINNAUR AND SIRMAUR DISTRICTS

Perusal of data of Kinnaur and Sirmaur districts are not giving any evidence of sex preference as shown in Table3.22. In Kinnaur district, if the first child was male, preference for second male child was to the extent of 47.1 per cent and for the female second child was 52.9 percent. If the first child was female, preference for male child in the second order birth was 51.1 per cent and for female child was 48.5 per cent. In Sirmaur district, if the first child was male, preference for the second male child was 53.7 per cent and second female child was 46.3 percent. If first order birth was a female child, preference for male child in the second order birth was 47.5 per cent and female child was 52.5 per cent.

Table 3.22

Preference for Sex of Second Child - Absolute & Percentage Values

District	Sex of First Child	Sex of Second Child		
		Male	**Female**	**Total**
Kinnaur	Male	16 (47.1)	18 (52.9)	34 (100)
	Female	17 (51.5)	16 (48.5)	33 (100)
	Total	**33**	**34**	**67**
Sirmaur	Male	44 (53.7)	38 (46.3)	82 (100)
	Female	38 (47.5)	42 (52.5)	80 (100)
	Total	**209**	**157**	**366**
Total (Kinnaur + Sirmaur)	Male	60 (51.7)	56 (48.3)	116 (100)
	Female	55 (48.7)	58 (51.3)	113 (100)
	Total	**115**	**114**	**229**

Note: *Values in parentheses represent percentages of children preferred after one child.*

In case of third birth order, if the first two children were male in Kinnaur district, third order was female to the extent of 83.3 per cent and male to the extent of 16.7 per cent as revealed by Table 3.23. If the first two births were female, third order birth was male in 54.5 per cent of cases and female in 45.5 per cent of cases. Sirmaur district also did not reveal any clear cut preference for male child. If the first birth was male, followed by female, then the preference for third child as female was 60.7 per cent and male was 39.3 per cent. If the first two children were female, then also preference of third female child was more i.e. 53.1 per cent as compared to male child (46.9%). Similar trend was observed in Kinnaur and Sirmaur districts taken together. If the first child was male, followed by a female child, then the preference for third female child was 65.6 per cent and third male child was 34.4 per cent. If the first two children were females, then the preference for another female child was 51.2 per cent and male child was 48.8 per cent.

Table 3.23

Preference for Sex of Third Child - Absolute & Percentage Values

District	Sex of Two Children Ever Born	Sex of Third Child		
		Male	**Female**	**Total**
Kinnaur	Male Male	1 (16.7)	5 (83.3)	6 (100)
	Male Female	0 (0.0)	4 (100.0)	4 (100)
	Female Male	4 (66.7)	2 (33.3)	6 (100)
	Female Female	6 (54.5)	5 (45.5)	11 (100)
	Total	**11**	**16**	**27**
Sirmaur	Male Male	14 (56.0)	11 (44.0)	25 (100)
	Male Female	11 (39.3)	17 (60.7)	28 (100)
	Female Male	13 (52.0)	12 (48.0)	25 (100)
	Female Female	15 (46.9)	17 (53.1)	32 (100)
	Total	**53**	**57**	**110**
Total (Kinnaur + Sirmaur)	Male Male	15 (48.4)	16 (51.6)	31 (100)
	Male Female	11 (34.4)	21 (65.6)	32 (100)
	Female Male	17 (54.8)	14 (45.2)	31 (100)
	Female Female	21 (48.8)	22 (51.2)	43 (100)
	Total	**64**	**73**	**137**

Note: *Values in parentheses represent percentages of children preferred after two children.*

Application of Chi-Square for second order and third order birth got accepted indicating no sex preference in Kinnaur district. Similar is the case for Sirmaur district. The Hypothesis also got accepted in case of Kinnaur and Sirmaur districts taken together as evident from Tables 3.24, 3.25 and 3.26.

Table 3.24

Chi-Square Tests for Judging the Male Preference for Second Child

DISTRICT	N	Chi-Square Value	d.f.	p-Value
Kinnaur	67	0.133**	1	0.715
Sirmaur	162	0.614**	1	0.433
Total (Kinnaur + Sirmaur)	229	0.213**	1	0.644

** *p>0.05*

Table 3.25

Chi-Square Tests for Judging the Male Preference for Third Child

DISTRICT	N	Chi-Square Value	d.f.	p-Value
Kinnaur	251	6.729**	3	0.081
Sirmaur	87	1.797**	3	0.644
Total (Kinnaur + Sirmaur)	338	2.945**	3	0.409

** *p>0.05*

Table 3.26

Chi-Square Tests for Judging the Male Preference for Second and Third Child

NULL HYPOTHESIS (H_0): *There is no preference for sex of the child.*
ALTERNATIVE HYPOTHESIS (H_1): *There is preference for sex of the child.*

Sex Preference	District	Chi-Square Tests	Hypothesis
Second Child	Kinnaur	$(X^2_{(1, N=67)} = 0.133) < (X^2_{(1, 0.05)} = 3.84)$ & $p=0.715 > 0.05$	Accepted
	Sirmaur	$(X^2_{(1, N=162)} = 0.614) < (X^2_{(1, 0.05)} = 3.84)$ & $p=0.433 > 0.05$	Accepted
	Total (Kinnaur +Sirmaur)	$(X^2_{(1, N=229)} = 0.213) < (X^2_{(1, 0.05)} = 3.84)$ & $p=0.644 > 0.05$	Accepted
Third Child	Kinnaur	$(X^2_{(3, N=27)} = 6.729) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.081 > 0.05$	Accepted
	Sirmaur	$(X^2_{(3, N=110)} = 1.797) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.644 > 0.05$	Accepted
	Total (Kinnaur + Sirmaur)	$(X^2_{(3, N=313)} = 2.945) < (X^2_{(3, 0.05)} = 7.82)$ & $p=0.409 > 0.05$	Accepted

3.10 CHILD SEX RATIO AT VARIOUS BIRTH ORDERS

Looking into the sex ratio for different birth orders for these districts, it can be observed from Table 3.27 that, the sex ratio followed a sharp decline from first birthorder to third order in case of Una and Kangradistricts. In case of Una district, the sex ratio declined from 765 (First Order) to 526 (Third Order). The corresponding decline in Kangra district was from 819 to 599. Moreover, the sex ratio for the third order is considerably low. This means, majority of the couples who went for third order births desired to have a son only.

As is evident from the Table 3.27, similar trend was not observed in case of Kinnaur and Sirmaur districts. Child sex ratio increased from 960 (First Order) to 1,030 (Second Order) and further to 1,455 (Third Order) in case of Kinnaur district. Similar trend was observed in Sirmaur district where it increased from 607 (First Order) to 751 (Second Order) and further to 1075 (Third Order).

Table 3.27

Child Sex Ratio at various Birth Orders

DISTRICT	FIRST ORDER			SECOND ORDER			THIRD ORDER		
	Male	Female	CSR	Male	Female	CSR	Male	Female	CSR
Kinnaur	50	48	960	33	34	1030	11	16	1455
Sirmaur	112	68	607	209	157	751	53	57	1075
Una	281	215	765	209	157	751	57	30	526
Kangra	701	574	819	500	409	818	157	94	599

It is apparent that, the sex ratio has declined drastically over a period of time in Una and Kangra districts. The table clearly brings out the negative correlation between birth order and child sex ratio. This data indicates quite convincingly, that there is absolutely no desire for daughters when it comes to third order birth, more so in case of Una district. This extremely low sex ratio for third order births could possibly be because of the fact that, only couples who want to have a son opt to go for more number of children. In short, there is convincing evidence that the phenomenon of female foeticide is indeed very acute in Una and Kangra districts.

CHAPTER-IV

PERCEPTION SURVEYS

The focus of the present study is more on perception than on demographic or socio-economic status of the people of four selected districts. It is important to know the view point of various functionaries about the status of girl child in their society and the problems related to this issue.

It was decided to conduct the following perception surveys:

(a) Perception survey of doctor's (both men and women) and doctors working in the public sector and private sector.

(b) Perception survey of Panchayat Members (men and women members of Panchayats).

(c) Perception survey of married women in each of the households that were surveyed.

(d) Perception survey of Anganwari Workers and ASHA Workers.

4.1 Doctors' Perception Survey

A total of 93 doctors of four districts of Himachal Pradesh namely Una, Kangra, Sirmaur and Kinnaur were interviewed with the help of a structured questionnaire. While selecting the respondents, care was taken to include doctors from both the sexes in different age groups, practicing in government, public and private sectors. The following tables present the respondents profile:

Table 4.1

Distribution of Doctors by Age and Sex

Age Group (in years)	Male	Female
25-35	12	14
35-45	23	17
45-55	15	6
55-65	4	2
Total	**54**	**39**

Table 4.2

Distribution of Doctors by Place of Work

Working with	Male	Female	Total	Percentage
Government	32	20	52	56
Private	5	3	8	9
Own Practice	17	16	33	35
Total	**54**	**39**	**93**	**100**

Table 4.3

Distribution of Doctors by Place of Work

Doctors	Rural Area	Urban Area	Total
Male	42	12	54
Female	26	13	39
Total	**68**	**25**	**93**

Table 4.4

Educational Qualifications

Educational Qualifications	Male	Female	Total	Percentage
BAMS	4	5	9	10
GAMS	8	6	14	15
MBBS	35	23	58	62
MD	7	5	12	13
Total	**54**	**39**	**93**	**100**

From the aforesaid tables it can be observed that most of the doctors were found to be associated with Government institutes (56%). Only eight doctors (9%) were found to be associated with private institutions. About three fourth doctors were practicing in the rural areas of the state. It is also clear from Table 4.4 that majority of the doctors (62%) were MBBS, and of these doctors 12 were either MD or MS. Majority of them i.e. 56 per cent doctors were in government service, 9 per cent in private service and 35 per cent were doing private practice.

Highlights of Doctors Perception Survey

1. Perception Questions

* When the doctors were asked about the main health problems in the districts, 58 per cent felt that anaemiawas a major health problem. Also tuberculosis (36%), water borne diseases (26%) and malnutrition (23%) were stated as the other health problems.
* Realizing the correlation between anaemia and reproductive health of women, the doctors were asked to assess the incidence of anaemia among women. As many as 43 per cent doctors replied that it was to a moderate extent among women, followed by 38 per cent who felt that it was severe and the rest considering it to be mild (4%).

* 49 per cent respondents expressed their ignorance about the contribution of anaemia to maternal mortality. Of the rest, only 18 per cent opined that it was high; 9 per cent felt it was medium and 24 per cent stated it was low.

2. PNDT Act- Knowledge, Awareness and Perception about PNDT Act and Views on the Implementation of the Act

* When the respondents were asked if they were aware of the PNDT Act, 90 per cent replied in affirmative and the rest in negative. 89 per cent doctors felt that the Act could be implemented.
* On exploring further it was found that in the opinion of a majority (59%) of the doctors, women were mainly responsible for the sex determination test, thus suggesting her to be punished under the PNDT Act.
* It was considered pertinent to know the opinion of doctors about the practice of sex determination test and female foeticide. All the respondents strongly stated that sex determination and female foeticide were illegal and unethical practices.

3. Discussion on the practice of Ultrasound Tests during Pregnancy

* According to 43 per cent doctors, sex of the foetus could be determined before 12 weeks, showing the general lack of awareness as sex of the foetus cannot be determined before 12 weeks of pregnancy.
* When the respondents were asked if the ultrasound machine should be banned, a majority of doctors (92%) told that it should not be banned.
* Over 95 per cent doctors strongly felt that the ultrasound machines were being misused for sex determination in their respective region.
* All the doctors (100%) suggested the need for ultrasound during pregnancy to know the health status of the foetus with a varying number as depending on the duration of pregnancy.
* Doctors' views were also enumerated on the impact of the Family Planning Programme (FPP) with its two-children norm on the phenomenon of female foeticide. The responses could generate an interesting finding as 50 per cent of the sample size affirmed that it has promoted.

4. Response to sex Determination Test

* Instead of asking direct questions to the doctors about conducting ultrasound, they were asked an indirect question "Are you aware of the doctors who refer women to ultrasound centers"? If yes, how much commission they get from these ultrasound centres?
* The response revealed that a majority of doctors (62%) accepted the fact that there were some doctors in the districts referring pregnant women to the ultrasound centres for sex determination tests. 24 per cent responded contrary to this and the rest (14%) preferred not to respond.

* 86 per cent expressed their ignorance about the commission, doctors are getting by referring pregnant women to ultrasound clinics, 10 per cent felt it depended on clinics and doctors and 4 per cent felt the commission was very high.

5. Sex of Unborn Child while Conducting Abortion

* Maintaining the focus further it was asked if the doctors were aware of the sex of the child while conducting abortions, 72 per cent doctors did not respond. However, the remaining 28 per cent stated that the doctors were aware of the sex of the foetus while conducting abortion.

* Becoming more specific, when they were asked about their perception of the percentage of aborted female foetuses, majority of respondents expressed their unawareness (89%). The remaining comprising of as small as 7 out of 93 doctors, mentioned that 50 to 70 per cent of aborted fetuses were of females.

6. Awareness Regarding Use of MTP and MTP Act

* All i.e. 100 per cent doctors were familiar with the MTP Act, 1971.

7. Female Foeticide, Who is Responsible?

In the whole phenomenon of sex selective abortions and female foeticide where the doctors are considered the main culprits, their viewpoint was sought by posing the question, "Do you think doctors are sometimes pressurized by family, pregnant women for female foeticide?"

* More than half (59%) stated that doctors were pressurized for conducting female foeticide. However, there were 31 per cent doctors who did not think so.

* Realizing the need to confirm the causal mechanism, the respondents were asked, who was responsible for pregnant women going for female foeticide. It was opined by 64 per cent doctors that it was the women herself, 72 per cent said it was husband, 70 per cent felt that it was the in-laws, 53 per cent held community responsible for this and 17 per cent felt that it was others.

8. Punishment for Conducting Sex Selective Abortions

* According to 45 per cent doctors, pregnant women opting for sex selective abortion should be punished for this act. Amongst other responsible persons who must be punished were doctors (74%) and in-laws (68%).

* Despite of having read the Act, hardly 8 per cent doctors could state the prescribed punishment for the defaulters under the PNDT Act, 1994.

9. Steps for Curbing Female Foeticide

* All doctors unanimously opined that there is a need for an attitudinal change towards the girl child, with an increase in educational and awareness programmes. Also media needs to play a more proactive role in enhancing community participation.

10. Suggestions to Curb Female Foeticide

* It was suggested by the respondent doctors (53%) that intervention should be made at medical and professional level and 72 per cent suggested that Indian Medical Association and other forums should discourage the practice of female foeticide and strict guidelines should be given to the doctors. Whereas 72 per cent doctors opined that intervention should be made at the family and community level with a focus on women empowerment.

* Although cent per cent doctors were of the opinion that pre-natal sex determination tests were illegal and unethical, a high percent (92%) accepted that the ultrasound machines were being misused for sex determination. This confirms the prevalence and depth of the situation. Further it goes on to prove that although doctors perceive these tests as sin they still continue doing this for financial gains. This raging conflict in doctors' minds needs to be given a positive turn by creating a vibration in their souls and weighing heavy in their conscience that the practice of female foeticide is a crime against nature and humanity and it becomes their moral duty to curb this menace.

4.2 Perception Survey of the Panchayat Members

Panchayat members play an important role in opinion building in the society, so it was thought necessary to know their viewpoint on declining child sex ratio and importance of the girl child. The following table gives details of the total number of panchayat members interviewed in the four districts of Himachal Pradesh. The sample of the state comprised of 50 panchayat members comprising of 30 male and 20 female members. Their distribution on the basis of age and sex is shown in Table 4.5.

Table 4.5

Distribution of Panchayat members by Age and Sex

Age (in years)	Male	Female	Total
25-35	10	8	18
35-45	8	6	14
45-55	5	4	9
55-65	4	2	6
65 And above	3	0	3
Total	**30**	**20**	**50**

The following section presents a brief overview of the findings:

1. Status of girls' education in the village, reasons for not going to school.

* It had been found that in all the villages explored, girls were being sent to school, at least till 10+2 level. However, the responses from all the Panchayat Members revealed that the percentage of girls studying till 10^{th} and 10+2 level was ten times higher as compared to the number going to colleges for B.A. or M.A.

2. Status of Government Policies and Programmes for Women Income Generation and Skill Training

* Majority of the panchayat members reported of not having any programme or scheme in their villages functioning for women empowerment.
* 12 per cent panchayat members mentioned that there were sewing centers in their villages.
* According to 40 (80%) panchayat members (24 males and 16 females), there were no schemes for both income generation and skill development.
* Sixteen female and twenty-eight male Panchayat members mentioned that there were AnganwariCentres in their villages.
* Regarding the employment status of women in the village, it was revealed that there were few from their villages working outside their homes in sectors other than agriculture. These sectors were namely education and health.

3. Expectations from the Government for Women Empowerment

* As representatives of the villages, for the overall development of the village and its people, 26 Panchayat members (nearly 50 per cent) felt that more employment opportunities should be provided for the villagers through setting up of industries in the village.
* Getting specific by asking about the desired intervention by the Government for the women empowerment, it was found that a majority of the Panchayat members (15 women and 26 men) strongly felt that more employment opportunities should be provided for women by setting up small scale industries. Thus, helping them to improve their general economic status for an overall development.
* Both male and female Panchayat members viewed education as an important tool for women empowerment and raising the status.

Reflecting on the strong preference for improving the educational status of women in Himachal villages by women panchayat members, the correlation between female literacy and the overall development of the village cannot be denied. As female literacy reflects the level of development of any region, it is related to childcare, access to health, fertility, reproduction, mortality and so on.

4. Marriage and Dowry

1. Marriage Decisions

* All the respondents reported that it was parents who took the decision regarding the marriage of their daughter.

2. Type of Marriage

* 60 per cent Panchayat members (18 males and 12 females) opined that there was no barrier for love marriage, inter-caste or inter-religion marriages.
* 80 per cent panchayat members (30 males and 10 females) opined that the bride and the bridegroom should have say in the matters concerning with their marriage.

3. Criteria for looking for the Bridegroom

* The main criteria considered by all the Panchayat members are caste, religion, education, income, job and land ownership.

4. Discernment about the cost of Marriage

* The cost of marriage is very high. As 30 Panchayat members comprising of 17 male and 13 female members felt that it was very high and increasing day by day. Eighty per cent Panchayat members which included 25 males and 15 females mentioned that cost of marriages was ranging from two lakhs to five lakhs.
* At the same time, 10 per cent Panchayat members stated that the cost of marriage mainly depended on the families in consideration.
* Some of the reasons mentioned by the Panchayat members for a formidable increase in the cost of marriage were:
  - To show off
  - Demonstration Effect
  - To enhance 'Social Status'
  - To ensure the 'Security' of the girl in her in-laws' house.
  - Price rise.

5. Approval for Widow Marriage

* Almost all respondents expressed their approval for this.

6.Prevalence of Dowry

* Seventy-two per cent Panchayat members (22 males and 14 females) felt that the dowry system was spreading in their respective villages. The rest felt that the system of dowry was declining.

Dowry earlier regarded with contempt and as a form of greed had acquired a new legitimacy today. It is being considered as all that a woman is entitled to and to establish herself in the new family, dowry is looked upon as a necessary contribution. With increased commercialization in Himachal's villages, dowry has become a sign of 'social rank'. Thus

investment in a girl clearly over rides her contribution, as by the time they are old enough to economically contribute to the family they are married off, making them the permanent assets to the in-laws.

7. Perception, Knowledge, Attitude towards Female Foeticide

* Though there is substantial decline in the child sex ratio in Kangra and Una district, 55 per cent accepted about the occurrence of female foeticide in their villages and 45 per cent Panchayat members denied it.

8. Cost of Ultrasound

* 42(84%) Panchayat members (25 males and 17 females) admitted that the cost of ultrasound was between Rs. 500 to Rs. 1000.
* 16 per cent Panchayat members (5 males and 3 females) admitted that the cost of ultrasound was below Rs. 500.

9. Communities Practicing Female Foeticide in the Village

* All the Panchayat members admitted that female foeticide was practiced equally in all the communities.

10.Reasons for Practicing Female Foeticide

* All the Panchayat members held the families responsible for the occurrence of female foeticide.

11.Gender Violence

* According to 12 male and 14 female Panchayat members (13 per cent) women face different types of violence against them like eve-teasing, domestic violence, more agricultural work pressure on women and many others.
* Around 36 per cent (10 males and 8 females) Panchayat members expressed their ignorance about atrocities against women in their villages.

12.Understanding about the Number of Girls in the Area

* 90 per cent of the respondents (26 males and 19 females) felt that the number of girls in their area was decreasing. Ten per cent of the respondents felt that it was increasing.

13. Dependence of Status of Mother on the Birth of a 'Son'

* 16 out of 20 women and 24 out of 30 men Panchayat members accepted the fact that the status of mother increases only with the birth of a male child.

14.Awareness about the Law on Pre-Natal Sex Determination Test

* It was shocking to realize that a majority of the respondents were not aware of the legal provisions against the practice. Only 18 per cent were aware of the law against pre-natal sex determination practice.

15.Source of Information

A little more than half of the respondents (58%) who knew about the law revealed that they came to know about the Act through television. And another 24 per cent came to know about the law through newspapers.

* The other sources of information were hoardings and posters in clinics/ hospitals and relatives/Friends / neighbours.

16.Effects on Society

Efforts were made to assess people's perception about the repercussions of this continuous decline in the female-male child sex ratio.

* It generated some interesting findings like an overwhelming majority of respondents felt that such selective abortions were bound to lead to a decrease in the number of females thus more men remaining unmarried.
* The likely ill-effects were increase in atrocities on women (23%) social imbalance with a decline in moral values (12%).
* Thus a majority felt that all the above ills (i.e. more men remaining unmarriedfall in moral values and increase in crime against women) would accrue in the coming years because of female foeticide.

4.3 Perception Survey of Anganwari Workers and ASHA Workers

A total of 52 Anganwari workers were interviewed and a structured questionnaire was canvassed on them. These workers were from Kangra, Una, Kinnaur and Sirmaur Districts of Himachal Pradesh and their age-wise distribution is depicted in Table 4.6. Majority of the Anganwari workers i.e. 35 per cent were in the age group of 25 to 35 years, followed by 27 per cent in the age group of 45 to 55 years and 19 per cent each in age group 25 to 45 and 55 to 60 years. As ASHA workers in Himachal Pradesh were appointed during the last two years, all of them were falling in the age group of 25 to 35 years.

Table 4.6

Distribution of Anganwari Workers and ASHA Workers by Age

Age (in years)	Anganwari Workers	ASHA Workers
25-35	18 (35%)	52
35-45	10(19%)	-
45-55	14(27%)	-
55-60	10(19%)	-
Total	52	52

Highlights of Perception Survey

1. Immunization Records

- Immunization records were maintained by cent per cent Anganwari workers in these four districts of study. They were also maintaining record of pregnant mothers.

2. Where generally women prefer to go for delivery

- Almost 45 per cent women prefer to have deliveries in District Hospital, 30 per cent in CHC and 25 per cent in Private Hospitals.

3. Do you encourage Institutional Deliveries?

- Both Anganwari workers as well as Asha workers motivate and encourage women to have delivery in an institution.

4. Information about Low Sex Ratio

- Majority of these workers know about low sex ratio in Himachal Pradesh.

5. Steps taken by government to improve child sex Ratio

- Majority of them (84%) talked about the awareness programmes organized by Education, Health, Social Justice and Empowerment departments. 16 per cent had no idea about the awareness programmes in Kangra, Una, Sirmaur and Kinnaur districts.

6. Steps taken by you to improve child sex Ratio

- Almost all of them were spreading awareness about the girl child among the pregnant and lactating mothers.

7. Do people of your area want to give quality education to girls?

- Eighty per cent Anganwari workers and ASHA workers in Kangra district revealed that people were in favour of giving quality education to girl child. This percentage was 78 per cent, 72 per cent and 68 per cent in case of Una, Kinnaur and Sirmaur districts, respectively.

8. Ideal size of the Family

- Two children formed the ideal size of the family for most of the households as revealed by Anganwari workers and ASHA workers. Majority of people in Kangra and Una (82%) preferred two children family, 12 per cent favoured one child family and only 6 per cent were in favour of three or more children. In Kinnaur and Sirmaur this percentage was around 76 per cent, 8 per cent and 16 per cent, respectively. This clearly indicated that three children were also welcomed in the family in some districts of the state.

9. Do they prefer to go for Ultrasound Test?

- In Una district, around 40 per cent pregnant mothers go for ultrasound test, this percentage was slightly less in Kangra district i.e. 36 per cent. In Kinnaur district, it

was 14 per cent and very less i.e. 8 per cent in case of Sirmaur district. Sirmaur is one of the most backward district of Himachal Pradesh, people are less educated and primarily engaged in agriculture. They had very less awareness about ultrasound and sex determination and hardly any access to these facilities.

10. Do you think son is more important than girls?

- In Una and Kangra district, high importance was given to son because of social and economic security. In Kinnaur and Sirmaur districts though people gave preference to male child but they did not go for ultrasound to know the sex of the child. In Sirmaur, there were households with three children also but no one had gone for sex determination test.

11. Empowerment of Women

- Anganwari workers and ASHA workers had mixed opinion regarding the empowerment of women. Majority of workers told that reservation of seats in PRIs had led to empowerment of women. Around 18 Anganwari workers and 14 ASHA workers denied this.
- Status of girl's education in the village: In the villages surveyed, girls were sent to schools at least till the 10+2 level.
- Status of Government policies and programmes of women's income generation and skills training: A majority of ASHA workers reported that they did not notice any programme or schemes in these villages for women's empowerment.
- Regarding the employment status of women in the village, a negligible number of women were working outside their homes in sectors other than agriculture.

12. Marriage and Dowry

- Marriage Decision: Although the question was open-ended, both Anganwari Workers and ASHA Workers unanimously opined that marriage matters were mainly decided by the parents.
- **Criteria for looking for the Bridegroom:** The main criteria revealed by all the Anganwari and ASHA Workers were caste, religion, income, education and land ownership.
- **Cost of Marriage:** The cost of marriage was very high about Rs. two lakhs. The workers also felt that there was no limit as it varied with economic status of the family.
- **Child Marriage:** Child marriage was not practiced in any of the villages, studied in the survey.
- **Prevalence of Dowry:** According to all (100%) Anganwari worker and ASHA Workers, the dowry system is spreading in their respective villages.

13. Perception, Knowledge, Attitude towards Female Foeticide

- **Awareness about Female Foeticide:** Though there was a substantial decline in the female male sex ratio in Kangra and Una districts, the denial by a majority of Anganwari and ASHA Workers (65%) showed ignorance about the occurrence of female foeticide in their villages. This led us to think that these workers were afraid to state facts regarding female foeticide because of the Supreme Court and State Government's proactive stand on the implementation of the PNDT Act.
- **Cost of Ultrasound:** Cost of an ultrasound test varied between Rs 250 to Rs 750 as per 42 per cent of the Anganwari and ASHA Workers. The cost varied between Rs 500 to Rs 1000 as told by 37 per cent of the workers.
- **Community Practising Female Foeticide in the Villages:** Around 80 per cent Anganwari and ASHA Workers did not give any response to this question, only 20 per cent felt that female foeticide was practiced equally in all the communities.
- **Reasons for Practicing Female Foeticide:** All Anganwari and ASHA Workers blamed the family for the practice of female foeticide.
- **Gender Violence:** The majority of workers in Una and Kangra districts told that women face different types of violence such as eveteasing, more agricultural work pressure on women, wife beating and other forms of domestic violence.

The majority of respondents, in Kangra and Una districts considered dowry as a major factor responsible for the deteriorating condition of women. How dowry is lowering the existing status of women in our society can be judged by the following responses:

- With increasing cost of living, dowry is also increasing.
- Even if the girl's parents are poor, they have to give dowry to get the girl married.
- It is necessary to give dowry to make their daughter happy and respectable in the in-laws' family.
- Dowry is given as a mark of respect to self and in-laws.

14. Reasons for Son Preference

When the respondents were asked whether they considered a son to be a blessing and the daughter a burden, the reasons given for considering a son to be the preferred choice were; to run the family name, make the family and parents respectable in the society, for social and economic support, to inherit the family property and take care of parents in their old age.

14. Practice of Pre-Natal Sex Determination

- **Decision to go in for a Sex Determination:** On the whole, 74 per cent mentioned the women's husband to be responsible for this and 65 per cent considered the women responsible.

- **Supporting Abortion due to Financial Reasons:** To get a better insight of the various push factors compelling families to go in for sex-selective abortion, the varied responses to open-ended query had led to important findings. Nearly half i.e. 47 per cent respondents in Una and 42 per cent in Kangra expressed their support for abortion due to various financial reasons. It was just 3 per cent in case of Sirmaur and almost negligible in Kinnaur district. In Una and Kangra, majority of the respondents felt that in case of a girl child, dowry is an additional expenditure; with the increasing cost of living it is difficult to manage a large family.

- **Awareness about the Practice of Sex Determination Test and Female Foeticide:** To get an understanding about the occurrence of female foeticide in the respective areas, an indirect question was posed, i.e. who conducts abortions in your area? In Kangra and Una districts, the responses held mainly the doctors responsible for conducting abortions, confirmed the prevalence of the practice of female foeticides in these districts with involvement of the medical practitioners. The role of quacks, ANMs and dais was negligible in these areas.

  In case of Sirmaur and Kinnaur districts just 4 per cent blamed the doctors.

16. Awareness about the Law on Pre-Natal Sex Determination Test:

Though the practice of female feoticide is quite prevalent in Kangra and Una districts, it was shocking to realize that 60 per cent of Anganwari and ASHA Workers in these districts were not aware of the legal provisions against the practice of pre-natal sex determination and foeticide, i.e. PNDT Act, 1994. In Kinnaur and Sirmaur districts this proportion was 52 per cent. Main source of information was television and newspapers.

Effects on the Society

It was attempted to assess Anganwari and ASHA workers' perceptions about the repercussion of this continuous decline in the female to male child sex ratio. According to them, the likely ill-effects would be, increase in atrocities on women, social imbalance with a decline in moral values, polyandry, purchasing brides from other states thus affecting the state's culture and more men remaining unmarried.

Despite realizing the dire consequences ranging from an increase in crime against women to difficulty in getting boys married and major social imbalances, it is very clear that the practice of sex determination and female foeticide is continuing and 'dowry' is one of the important factors perpetuating it.

CHAPTER-V

LEGAL PROVISIONS AND ISSUES RELATED TO ENFORCEMENT

It was following several years' demand for the regulation of the growing misuse of medical technology for sex determination and sex selective abortion that a bill to regulate the technology was tabled. The draft bill was vociferously debated. Initially the technology most used was amniocentesis and therefore most of the contents of the Bill were around definitions of genetic centres, genetic clinics and the qualification of the geneticist and the norms for the genetic centres, their structure and functioning. It was to regulate the genetic centres and also lay down qualifications and requirements of personnel working in the genetic clinics and centres and genetic labs.

As a follow-up during the Parliamentary hearings on the PNDT Bill i.e., prior to the enactment of the Act, women groups asked for;

1. Regulation of ultrasound and sex pre- selection techniques (the former was included not the latter)
2. Not to victimize the victim and punish the women who were undergoing the tests due to the subtle family and societal pressure to produce a male child; and,
3. Inclusion of the advertisements of the training centres besides the advertising of the testing clinics in the ban.

Women activists from various organizations, VHAI, SAHELI, Jagori, Action- India, JWP. MFC etc. working on women's health addressed the technical, medical, legal and gender dimensions of the issue in a co-ordinated and effective manner. Such strenuous unified effort could include ultrasound under the provisions of the Act.[1]

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was announced on September 20, 1994. It was brought into operation from January 1, 1996 and the rules were framed under the Act. Unfortunately, the PNDT Act remained unimplemented like many other Social Acts which attempt gender justice e.g., dowry, rape, age of marriage, equal wages for equal work etc.

The Act came under legal and official scrutiny only when CEHAT, MASUM and Dr. Saboo George filed a Public Interest Litigation (PIL) in the Supreme Court, New Delhi against the rampant misuse of medical techniques like Ultrasound for sex selective abortion, which was mainly used for selectively aborting girl child. Lawyer on record being Ms. Indira Jaising. On realizing that the PNDT Act was neither being implemented nor its implementation was monitored because information about the ownership and the number of ultra sound machines was not available, the Supreme Court ordered for the registration of all ultrasound machines, place of use, including mobile ultrasound machines. SC ordered that all these would be recognized as the already existing legal entities i.e., genetic clinics.

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[1] *Based on the Handbook on PNDT Act, 1994 by PNDT Cell, 'PNDT Act, 2002, Addendum to the Act.'

The PNDT Act amended as PNDT Amendment Oct 2002 No. 14 of 2003 was published on January20, 2003 as Gazette Notification.

In section 1 of the principal Act Pre-Natal Diagnostic Techniques (Regulation and prevention of Misuse) Act, the pre-natal Diagnostic Techniques is to be substituted by the **Pre-conception and Pre-Natal Diagnostic Technique (Prohibition of the Sex Selection)** Act. Thus incorporating sex pre-selection in its name itself.

Substitution of the long title in the Act "to provide for the prohibition of sex selection, before or after conception and for regulation of pre-natal diagnostic technique for the purpose of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected there with an incidental thereto,"[2]

The PNDT Act lays down norms for the genetic centres and clinics. It also clarified conditions in which pre-natal diagnostic techniques could be used during pregnancy e.g., to detect abnormalities like chromosomal abnormalities, sex linked genetic disease, genetic metabolic disease etc.

The PNDT Act encompasses of the following provisions:

(i) **Advertisement** of sex determination tests **in any form** is ILLEGAL.

(ii) **Conduction of sex determination tests** by doctors and others is **illegal.**

(iii) It made **seeking sex determination testing** and **pressurizing the pregnant women to do so illegal.**

(iv) PNDT Act was enacted to

- Regulate the use of pre-natal diagnostic technique.
- Techniques like Ultrasound could only be used for the detection of genetic and metabolic and chromosomal abnormalities or certain congenital mal- formation or sex linked disorders.
- For prevention of the misuse of such techniques for the purpose of pre-natal sex determination, female foeticide.

The Act also laid down the directions for setting up of a Central Supervisory Board (CSB) and the constituents of the CSB.

Constitution of Central Supervisory Board

The CSB would comprise of:

1. The Minister-in-charge of the Ministry of Department of Family Welfare as Chairman ex-officio member.
2. The Secretary to the Government of India-in charge of Department of Family Welfare Vice-Chairman, ex officio member.

[2] PNDT Amendment Act 2002 addendum

3. Two members appointed by the Central Government and representing the Ministries of Central Government in-charge of Women and Child Development and Law and Justice ex- officio member.

4. Director General Health Services of the Central Government ex-officio.

5. Ten members appointed by the Central Government, two each from amongst eminent, medical geneticist, eminent gynaecologists and obstetricians, eminent pediatricians, eminent social scientists, representatives of women welfare organizations.

6. Three women members of Parliament, two elected from Lok Sabha and one from RajyaSabha.

7. Four members appointed by the Central Government on the recommendations of the respective State Government or the Union Territory by rotation to represent the States and Union Territories.

8. An officer not below the rank of Joint Secretary or equivalent of the Central Government, in-charge of Family Welfare who is member secretary ex- officio member.

The **CSB** was directed to meet at least **once in every 6 months.**

Functions of Central Supervisory Board

The Act lays down its functions:

1. To advise the Government on policy matters relating to pre-natal diagnostic techniques

2. To review implementation of the Act and the rules and recommended changes.

3. To create public awareness against pre-natal sex determination and female foeticide

4. To lay down code of conduct for persons working at genetic counseling centres, genetic laboratories and genetic clinics.

Role of Appropriate Authorities

The PNDT Act also lays down the role of the implementing authorities i.e., Appropriate Authorities at State, District level as well as for Union Territory.The functions of Appropriate Authority are:

1. To grant, suspend or cancel registration.

2. To enforce the standards for genetic counseling centres clinics and genetic laboratories.

3. To take complaints to the court.

The Act also provided for the appointment of the **Advisory Committee at the Central and State level.**The powers of Appropriate Authority to register clinics, centres and counseling centres, collection of registration, application, fees etc. is given under the Act.

Comprehensive forms were developed to be maintained by genetic centres.

1. The Appropriate Authority concerned or any officer authorized on his behalf by the Central Government or State Government, as the case be or the Appropriate Authority.
2. A person in the definition, a person includes or a **social organization** who has given notice of not less than 30 (decreased to 15 days in the Amendment) days in the manner prescribed to the Appropriate Authority of the alleged offence and of his intention to make a complaint to the court.

Penalisation for the Violation of the PNDT Act

1. The offences of violation of the PNDT Act are:
    - Cognizable
    - Non-bailable
    - Non- compoundable

Cognizance of offences

1. No court shall take cognizance of an offence under this Act except on a complaint made by a third party i.e., persons or social organization.
2. No court other than that of a metropolitan magistrate or judicial magistrate of the 1st class shall try any offence punishable under the Act.
3. Where a complaint has been made under clause (b) of the subsection, the court may, on demand by such persons direct the Appropriate Authority to make available copies of the relevant records in its possession to such person. **All records are expected to be preserved for a period of 2 years** or as prescribed under the Act.

Appropriate Authority is expected to take action on a complaint.

On failure of any action taken by Appropriate Authority, a complaint can be made to the magistrate by 3rd party i.e., person or social organization. (Amendment PNDT Act)

The power to search and seize.

The Appropriate Authority has this power to search and seize records at all reasonable times if there is a reason to believe that an offence has been committed.

Penalties

- Any violation of the prohibition of sex determination and advertisement etc., under PNDT is liable to **imprisonment**, which may extend to 3 years and fine which may extend to Rs. 50,000(Rs. 10,000 earlier).
- Subsequent convictions entail **imprisonment**, which may extend to 5 years and fine which may extend to Rs. 11 lakh (it was Rs.50,000 earlier).[3]

[3] Ref.: Section 23(3) addendum to the Amendment.

- In case of registered medical practitioner who has been convicted by the court, his name can be removed from the register of the Medical Council for a period of 5 years (2 years earlier) for the 1st offence

Suspension of Registration if Charges are framed by the Court till Case is disposed off

- **Permanently** for the second offence Ref: Section 23(2) Addendum to the PNDT Amendment
- **Husband and relatives of pregnant women** will be presumed to have compelled the women to undergo Pre-natal diagnostic technique unless contrary is proved. (Section-24)
- If the contrary is proved **pregnant women undergoing sex deterioration can be also punished.**

If any person contravenes any provision of the Act or the Rules made there under for which no penalty has been specified, he will be liable to be punished withimprisonment which may extend to 3 months and fine which may extend to Rs. 1,000 or with both (Section -25).

Minimum Requirement for Registration

Minimum requirements for registration have also been drawn up. Process of certification has been drawn up. The certificate of registration shall be non- transferable. Para 6(6) of PNDT rules:

"All centres, laboratories, clinics registered under the PNDT Act shall give an **AFFIDAVIT AFFIRMINGTHAT THEY WILL NOT INDULGE IN PRENATAL DETERMINATION** of sex as mandated by Supreme Court" (k) handbook "The Registration Certificate must also mention the number of ultrasound machines in the saidcentre".

Who can make a complaint?

- An Appropriate Authority concerned;
- Any officer authorized in his behalf by central Government or State or State Government or Appropriate Authority;
- A person who has given notice of at least 30 days to the Appropriate Authority of the alleged offence and of his intention to make complaint in the court;
- If the appropriate Authority fails to take action on the complaint made by a person on the lapse of 30 days that person can directly approach the court. (Section 28(1) (a) of the Act.
- Every public-spirited person can activate the PNDT law for the violation of the same and he/she can seek the assistance of a lawyer or NGO and even a group of persons can file a complaint together. Once the complaint is made in the court the public

prosecutor will take on from there and the complainant need not be present on every date of hearing.[4]

The Act prohibits employment of any person who does not possess prescribed qualification. The Amendment adds or takes services of any of the person whether on an honorary basis or on payment.

PNDT Amendment Act adds:

- Validity of Registration is for 5 years.
- Conditions for conducting Pre-Natal Diagnostic procedures:

  "No person" shall sell, distribute, supply, rent, allow or authorize the use of any ultrasound machine or imaging machine or scanner or any other equipment capable of detecting sex of foetus whether on payment or other use to any Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic or any other person or body **not registered** under the Act Section 3B read with Rule 3A as per PNDT Amendment Act addendum.

"Person" includes manufacturer, importer, dealer or supplier of ultrasound machines/ imaging or any other equipment capable of detecting sex of foetus as also any organization including a commercial organization. Further according to the PNDT Amendment Act the provider of such machine / equipment to any person/body registered under the Act shall

1. Send to the concerned State or UT Appropriate Authority and to the Central Government **once in three months** a list of those to whom the machine/ equipment has been provided and
2. Take an affidavit from such body or person purchasing or getting authorization for using such machine/ equipment that the machine/ equipment shall not be used for detection of sex of foetus. Rule 3A (2) and (3) PNDT Amendment Act addendum.

Pre-natal Diagnostic Procedures Approved for GENETIC CLINIC are:

1. Ultrasound
2. Amniocentesis
3. Chorionic Villi Biopsy
4. Foetoscopy
5. Foetal Skin Organ Biopsy
6. Cordocentesis

Pre-natal diagnostic tests approved for Genetic Laboratory molecular studies, chromosomal studies.

[4] A person includes a social organization. (Explanation to Section 28 of the Act) Ref: Handbook on PNDT Act, 1994, p. 22.

PRE-NATAL DIAGNOSTIC TECHNIQUES ARE ALLOWED to be conducted for purpose specified under the act.

These are for detection of:

- Chromosomal abnormalities
- Genetic metabolic diseases
- Haemoglobinopathies
- Sex linked genetic diseases
- Congenital abnormalities
- Other abnormalities or diseases specified by the CSB.

Pre-natal diagnosis is permissible under following circumstances i.e., if:

- Age of the pregnant women is above thirty-five years.
- Pregnant woman has undergone two or more spontaneous abortions
- Pregnant woman has been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals.

Any other conditions specified by the CSB.

Important Note:

(i) Ultrasound is not indicated / advised / performed to determine the sex of the foetus except for diagnosis of sex-linked diseases such as Dachenme Muscular Dystrophy.

(ii) During Pregnancy, Ultasonography should only be performed when indicated.

The following is the representative list of indicators for ultrasound during:

1. To diagnose intra-uterine and / or ectopic pregnancy and confirm viability.
2. Estimation of gestational age (dating).
3. Detection of number of fetuses and their chorionicity.
4. Suspected pregnancy with IUD (Intra Uterine Death) in-situ or suspected pregnancy following contraceptive failure / MTP failure.
5. Vaginal bleeding / leaking.
6. Follow-up cases of abortion.
7. Assessment of cervical canal and diameter of internal organs.
8. Discrepancy between uterine size and period of amenorrhoea.
9. Any suspected adenexal or uterine pathology / abnormality.
10. Detection of chromosomal abnormalities, foetal structural defects and other abnormalities and their follow-up.
11. To evaluate foetal presentation and position.

12. Assessment of liquor amnii.

13. Preterm labour / preterm premature rupture of membranes.

14. Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental hemorrhage, abnormal adherence etc.)

15. Evaluation of umblical cord—presentation, insertion, nuchal encirclement, number of vessels and presence of trut knot.

16. Evaluation of previous Caesarean Section scars.

17. Evaluation of foetal growth parameters, foetal weight and foetal well-being.

18. Color flow mapping and duplex Doppler studies.

19. Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc. and their follow-up.

20. Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVS), amniocenteses, foetal blood sampling, foetal skin biopsy, amino-infusion, intrauterine infusion, placement of shunts etc.

21. Observation of intra-partum events.

22. Medical / surgical conditions complicating pregnancy.

23. Research / scientific studies in recognized institutions.[5]

Written consent of the woman should be taken before conducting a pre-natal diagnostic test.

Advertisement

Advertisement includes any notice, circular, label, wrapper or other document and also includes visual representation made by means of any light, sound, smoke or gas.[6]

Medical Termination of Pregnancy

Abortions prior to 1971, were considered illegal under Indian Penal Code

The MTP Act 1971 permitted medical termination if the length of the pregnancy did not exceed 12 weeks on the opinion of a RMP and it was permitted if pregnancy did not exceed twenty weeks: in this case opinion of 2 registered medical practitioners in favour of the termination of the pregnancy is required.[7]

MTP was permitted

If the continuation of the pregnancy would involve a **risk to the life of the pregnant woman**or of grave injury to her physical or mental health.[8]

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5 Ref.: Addendum PNDT Act Amendment 2002.
6 Ref.: Section 22(2) of the Act Amendment.
7 Ref.: Section 3(a) of the MTP Act.
8 Section 3(1) of the MTP Act.

If there is substantial risk that **ifthe child is born**, it would suffer from such physical or mental abnormalities as to be **seriously handicapped.**[9]

Anguish caused by pregnancy due to **rape** shall be presumed to constitute a **grave injury to the mental health** of the pregnant woman.[10]

Similarly, pregnancy resulting from **failure of method of family planning** may be presumed to constitute grave injury to be mental health of the pregnant woman.

Pregnancy can be terminated if the RMP's opinion is formed in good faith that the termination of the pregnancy is immediately necessary to save the life of the pregnant woman.[11]

MTP Act Amendment

On Thursday December 5, 2002 bill on amendments in the MTP Act was passed by RajyaSabha. The powers for sanctioning MTP clinics, which according to the MTP Act 1971 Section 4 (a) (b) lay with the State may be delegated to **government constituted district health committees, headed by CMO/DHO.** This was done since large number of MTP clinics which had applied for registration had not been recognized and many who did not fulfill the criteria continued to conduct abortions.

Punishment isbeing prescribed for owners of clinics which are not authorized to conduct abortions and the persons who are not registered medical practitioners even if they conduct MTPs in approved pleas amending sub-section (2) of section 5 of the MTP Act 1971.

Punishment prescribed for all such cases will be rigorous imprisonment of not less than 2 years, which may extend to a maximum of 7 years.

Following the PIL filed by MASUM, CEHAT and Dr. Sabu George, Supreme Court gave series of orders where Central and State health authorities had to make submissions.

After Section 16 of the PNDT Act following sections to be inserted

16 (A) (1) Each state and Union territory having Legislature shall constitute a Board to be known as the **State Supervisory Board** or the Union Territory Supervisory Board which shall have the following functions.

I. To create public awareness against the practice of pre-conception, sex selection, pre-natal determination of sex of the foetus leading to female foeticide in the State.

II. To review the activities of Appropriate Authorities functioning in the State and recommending appropriate action against them.

III. To monitor the implementation of provisions of the Act and the rules and make suitable recommendations relating thereto to the Board to send each consolidated

[9] Section 3(ii) of the MTP Act.
[10] Section 3 of the MTP Act.
[11] Ref.: Section 5 of the MTP Act.

reports as may be prescribed in respect of the various activities undertaken in the State under the Act to the Board and the Central Government.

IV. Any other functions as may be prescribed under the Act. (PNDT Amendment Act 2000, Gazette Notification).

The State Board shall consist of:

(a) The Minister in-charge of the Department of Health and Family Welfare in the State - Chairman ex-officio.

(b) Secretary in-charge of Department of Health and Family Welfare who shall be the Vice-Chairperson ex-officio.

(c) Secretaries or officio, Commissioners in-charge of departments of Women and Child Development, Social Welfare, Law and Indian System of Medicines and Homeopathy ex-officio or their representatives.

(d) Director of Health and Family Welfare or Indian System of Medicines and Homeopathy of the State Governments, ex-officio.

(e) Three women members of Legislative Assembly or Legislative Council.

In the Amendment 16 A (2), out of the 10 members to be appointed as State Supervisory Board by the State Government, 2 each shall be from the following categories:

(i) Eminent social scientists and legal experts;

(ii) Eminent women activists from non-governmental organizations or otherwise;

(iii) Eminent gynecologists and obstetricians or experts of stri-roga or prasutitantra;

(iv) Eminent pediatricians or medical geneticists;

(v) Eminent radiologists or sonologists;

(vi) An officer not below the rank of Joint Director, in charge of Family Welfare, shall be Member Secretary, **ex officio Section 16 A (2).**

(f) The State Boards are directed to meet at least once in 4 months.

(g) The term of office of a member other than ex-officio member is 3 years.

(h) It is stated that presence of 1/3 of the total number of members shall constitute the quorum.

(i) The State Board may **co-opt a member** as and when required, provided that the number of co-opted members does not exceed one third of the total strength of the State Board.

(j) Co-opted members have the same powers and functions as other members except right to vote (PNDT Amendment Act 2002, Gazette Notification).

Powers of Appropriate Authority

A new section is inserted to Section 17 related to the Powers of Appropriate Authority.

17 A. The Appropriate Authority shall have the powers in respect of the following matters:

(a) Summoning of any person who is in possession of any of the provisions of this Act or rules made there under;

(b) Production of any document or material object relating to clause (a);

(c) Issuing search warrant for any place suspected to be indulging in sex selection technologies or pre-natal sex determination; and,

(d) Any other matter which may be prescribed.

PNDT Amendment Act 2002, Gazette Notification

MTP Act was aimed at eliminating abortion by untrained persons, under unhygienic conditions, at an early stage in pregnancy to decrease hazards for the mother and decrease maternal mortality.

24. New substitute

"Notwithstanding anything in the Indian Evidence Act 1872 the Court shall presume unless the contrary is proved that the **pregnant woman was compelled by her husband or any other relative,** as the case may be, to undergo pre-natal diagnostic technique for the purposes other than those specified in sub-section 2 of section 4 and such person shall be liable for abatement of offence under sub-section (3) of section 23 and shall be punishable for the offences specified under that section." PNDT Amendment Act, 2002-Gazette Notification.

CONCLUSION

The positive impact of the PNDT Act has been seen in vanishing of the numerous hoardings and advertisements urging people to go in for the testing of boy or girl. It is also true that with the enactment of the PNDT Act and Supreme Court orders, ultrasound machines, clinics and centres have been registered besides the genetic centers and clinics. General public is better aware about the existence of the PNDT Act making sex determination tests illegal besides them being 'unethical'. Infact, some doctors concerned about their reputation, as a precautionary measure have decided not to do any ultrasound tests instead refer the pregnant women to maternity homes.

However, there are many others indulging in sex-determination, female foeticide, so much so that Census figures have shown a dramatic decline in female-male sex ratio. Even though there has been a decline in the sex ratio right through the century, the most dramatic drop and that too in the 0-6 age group has been in the last decade.

Some of the major changes noticed during the last decade have been:

(a) Increasing medicalization and privatization of health care;

(b) Proliferation of nursing homes, maternity clinics and ultrasound clinics i.e., easy access and affordability of technology used for sex determination;

(c) Greater pressure for two children norm;

(d) Economic globalization, new Economic Policy, increased materialism, consumerism, decrease in human values, devaluation of women, poor, disabled, elderly;

(e) Increased dowry demands.

It is also clear that even though gender discrimination has been there for long. It has been the easy availability of medical technology, mainly Ultrasonography that has exacerbated the practice of sex determination and female foeticide.

Regulating this misuse was obviously an important objective of the PNDT Act. Unfortunately, there are some major problems related to the implementation of the Act. The most important has been the difficulty in **buildingevidence** and proving violation of the Act. Only the **doctor** conducting Ultrasonography, and the client desirous of the sex determination for female foeticide are involved in the transaction and aware of what transpires i.e. whether or not the sex of the unborn baby is communicated or not by the doctor, to be or not to be followed by the abortion of the 'unwanted sex child'.

The otherwise important applications of ultrasound technology in monitoring the viability of the foetus make it difficult to differentiate between the legitimate and illegitimate use of ultrasound for sex determination and female foeticide. ***The obvious and most widely prevalent reason for sex selective abortion of course in the deep rooted gender discrimination and the male fixation- a mentality shared by the health professionals as well as the public.*** This biased attitude is also reflected in the relaxed implementation of the Act by the Appropriate Authority, who themselves have an acceptance to the widespread ***son preference*** phenomenon and therefore quite understanding to (Sex determined female foeticide) SDFF. The serious societal ramifications of this demographic imbalance are not realized. Even if realized it is a matter of little choice. Thus revealing the most probable reason for the failure in the implementation of the Act in its true letter and spirit as the demand of SDFF is high and so is the supply.

The trivialization of abortion, because of it being used as a substitute for family planning has resulted in the procedure of abortion being treated as lightly as 'blowing of the nose' by many. It is estimated that 10-14 million abortions are conducted every year. Chronic violation of the MTP Act of 1971 is well known where neither the abortion clinics are registered nor the medical personnel conducting MTPs aretrained. Since sex determination testing is usually done after 14 weeks i.e., in the 2nd trimester which makes the procedure most hazardous for the mother, delayed abortion if not conducted properly result in maternal mortality and complication of abortion, e.g., bleeding, infection, rupture

of uterus for conducting abortion. After 12 weeks according to the MTP Act two doctors are required to be consulted. This is rarely done and thus is a clear violation of the MTP Act.

It is also very clear that ***legal instruments exist in a social milieu***. In presence of increasing discrimination and violence against women, increasing dowry demands, increasing materialism, consumerism, women are further devalued and seen as a liability, except for a small privileged percentage. Conscious selective blindness to their contribution continues. Educated men continue to desert wives for their failure to produce a son. The two children norm has further increased the pressure on women to produce' 'sons only' or 'sons mainly' and also to comply with the two children norm. Disincentives as a Population Control Measure; especially in Panchayati Raj system has made the conflict and pressure on women much more.

Most of the PNDT violations registered so far are related to procedural concerns e.g., non-registration, not keeping consent forms, not putting up the Board of the right size claiming that sex determination is not done in this clinic.

Keeping records was fine as long as they were kept accurately. Providing the reason for conducting ultrasound test, 'as assessing viability of the foetus' is an absolutely legitimate reason according to the Act. If in the process, the sex of the unborn baby is communicated to the mother who is there to witness it and there is no one else to complainthe procedure itself become questionable. Regarding non-registration of ultrasound being seen as violation of the PNDT Act—the non-registration of nursing homes many of whom are conducting surgery and diagnostic labs is being questioned. Representation made by women and health groups was to focus on the 'prevention of misuse'. Preferable self-regulation by the medical fraternity may lead to changes in the masculinization of the mindset of the society resulting in masculinization of the sex ratio.

With 80 per cent healthcare being in private hands and medical care emerging as the second most common cause of rural indebtedness there is an urgent need for effective regulations to prevent the gross misuse of medical malpractices. It also highlights that the increasing medicalization of childbirth is equally associated with its increasing commercialization.

Efforts have been made to educate and orient the authorities at the national and state level. Guideline to understand and implement the PNDT Act has been brought out by the PNDT Cell. Slots have also been shown on Doordarshan and other channels about the illegality of sex determination. Posters have been prepared by the Ministry and also by other Organizations. Flip charts, posters, booklets, fact sheets have been prepared by numerous groups and organizations about the increasing sex determination and femalefoeticide. Several workshops, seminars explaining the role of health institutions, health personnel and society have been held for a proper implementation of the PNDT Act.

Central Supervisory Board constituted two technical committees; one to look at the amendments in the PNDT Act. 1994 and second to look at the implementation after the amendments. The Technical Committees have met several times and discussed and debated controversial issues. Parliamentary hearings have been held.On representation by doctors,

radiological associations and representatives from ultrasonography clinics to detect abnormalities, assess viability of foetus etc. the PNDT amended Act clearly gives a list of conditions during which ultrasound can be done during pregnancy.

The Act has been passed and the credit goes to some of the social activists, some sensitive and committed bureaucrats, organizations and some sensitive media personnel who have doggedly pursued the issue. The preventive and punitive provisions of the Act are required to be enforced stringently. However, that alone cannot work. The mindset of the population is also required to be changed which still reflects clear cut preference for sons.

REFERENCES

GAZETTE Notification **PNDT Act 1994**, Ministry of Law and Justice, Gazette Notification, **PNDT Amendment Act 2002**, Ministry of Law and Justice No. 14 of 2003.

Handbook on PNDT Act 1994&Addendum on PNDT Act 2002, Department of Family Welfare.

CHAPTER-VI

INITIATIVES OF CENTRE AND STATE GOVERNMENT

The census 2011 showed a significant decline in the Child Sex Ratio (CSR), calculated as number of girls for every one thousand boys between the age group of 0-6 years, with an all-time low of 918. The decline in CSR has been unabated since 1961. A skewed CSR indicates that number of girls is getting disproportionately less in comparison to the boys. It reflects both, pre-birth discrimination manifested through gender biased sex selection, and post-birth discrimination against girls. The decline is wide spread across the country and had expanded to rural areas also.

Though the CSR is influenced by number of factors such as under-registration of girls, differential infant and child mortality, strong socio-cultural and religious biases, preference for sons and discrimination towards daughters, it is in large measure determined by Sex Ratio at Birth (SRB). SRB is defined as number of girls born per 1000 boys. The SRB for the period 2008-10 was 908 as against the internationally observed normal SRB of 952 clearly pointing out to lesser number of girls born than by the boys in India. A low SRB is directly linked to easy availability and affordability of diagnostic tools leading to increasing Sex Selective Elimination (SSE).

6.1 Beti Bachao–BetiPadhao (BBBP) Scheme

The sharp decline as pointed by Census 2011 data was a call for urgent action, as it highlighted that the girl child was increasingly being excluded from life itself. Coordinated and convergent efforts were needed to ensure survival protection and education of the girl child. On 22nd January, 2015 Government of India has announced Beti Bachao – BetiPadhao (BBBP) Programme to address the issue of decline in CSR through a mass campaign across the country, and focused intervention and multi-sectoral action in 100 gender critical districts. The overall goal of this scheme is to celebrate the girl child and enable her education.

6.1.1 Objectives of the Scheme

- Prevent gender biased sex selective elimination.
- Ensure survival and protection of the girl child.
- Ensure education of the girl child.

6.1.2 Monitorable Targets

- Improve the SRB in 100 gender critical districts by 10 points in a year.
- Reduce gender differentials in Under Five Child Mortality Rate from 8 points in 2011 to 4 points by 2017.
- Improve the Nutrition status of girls by reducing the number of underweight and anaemic girls under 5 years of age (from NFHS-3 levels).
- Ensure universalization of ICDS, girl's attendance and equal care monitored, using joint ICDS NRHM Mother Child Protection Cards.

- Increase the girl's enrolment in secondary education from 76 per cent in 2013-14 to 79 per cent by 2017.
- Provide girl's toilet in every school in 100 low CSR districts by 2017.
- Promote a protective environment for girl children through implementation of Protection of Children from Sexual Offence (POCSO) Act 2012.
- Train Elected Representative / Grassroot functionaries as community champions to mobilize community to improve CSR and promote girl's education.

6.1.3 Strategies

The strategies include:

(i) Implement a sustained social mobilization and communication campaign to create equal value for the girl child and promote her education.

(ii) Place the issue of decline in CSR / SRB in public discourse, improvement of which would be an indicator for good governance.

(iii) Focus on gender critical districts and cities low on CSR for intensive and integrated action.

(iv) Mobilize and train Panchayati Raj Institutions / Urban local Bodies / Grass root workers as catalysts for social change in partnership with local community / women's / youth groups.

(v) Ensure service delivery structures / schemes and programmes are sufficiently responsive to issues of gender and children's rights.

(vi) Enable Inter-sectoral and Inter-institutional Convergence of District / Block / Grassroot levels.

6.1.4 Components of the Scheme

(a) Mass Communication Campaign on BetiBachao-BetiPadhao

The programme will be initiated with the launch of "BetiBachao –BetiPadhao", a nation-wide campaign to increase awareness on celebrating the Girl child and enabling her education. The campaign will be aimed at ensuring girls are born, nurtured and educated without discrimination to become empowered citizens of this country with equal rights. The campaign will interlink National, State and District level interventions with community level action in 100 districts, bringing together different stakeholders for accelerated impact.

(b) Multi-Sectoral Intervention in 100 Gender Critical Districts

Multi-sectoral actions have been drawn in consultation with MOHFW and MOHRD. Measurable outcomes and indicators will bring together concerned sectors, states and districts for urgent concerted multi-sectoral action to improve the CSR.

(c) Planning, Implementation and Monitoring at District/ Block and Gram Panchayat levels:

- Constitute District Task Force (DTF) headed by DC with representatives of Line Departments (Health, Education, Panchayati Raj / Rural Development)
- Develop District Action Plans through a consultative process involving Departments of Women and Child Development, Health and Education.
- Nominate Nodal Officer (Senior Official) from each Department for formulation, implementation and monitoring of District Action Plans under overall supervision of DC / DM.
- Designate a coordinating officer amongst them to facilitate the process of formulations of District Action Plan.
- Undertake overall responsibility for measureable changes in identified indicators related to CSR / SRB.
- Review the implementation of PC-PNDT Act.
- Follow-up with District Judge on PNDT cases and submit monthly report to the state Authority with copy to PNDT Division, GOI.

(d) Block Level Task Force (BTF)

(i) Constitute Block Task Force (BTF) headed by Sub-Divisional Magistrate / Sub Divisional Officer / Block Development Officer.

(ii) Ensure that quarterly meetings of BTF are held on a regular basis.

(iii) Ensure follow-up actions are taken in a time-bound manner.

6.1.5 Implementation Activities

Orientation

(i) Orientation of District Officers / ZilaParishad members / Judiciary / District Legal Services Authority / NGOs / Doctors for identifying role and responsibility.

(ii) Orientation of Block Officers / Block Parishad / PanchayatPradhans / Sarpanches / Front line workers / SHG members.

(iii) Orientation of Panchayat members, Village Health Sanitation and Nutrition Committee (VHSNC) members on tools for data collection / community mobilization / dissemination of information on schemes and programmes.

Sensitization

(i) Sensitization of Members of Parliament / Members of Legislative Assembly / Elected Representatives / Religious Leaders / Community Leaders (within 1st quarter of the roll out of the scheme).

(ii) Sensitization of teachers on Child Sex Ratio through SarvaShikshaAbhiyan (within 1st quarter of the roll out of the scheme).

6.1.6 Effective Implementation of PC-PNDT Act

(i) Strengthen District PC-PNDT cells by recruitment of at least five human resources (cell Administrator, Legal Consultant, Inspector for monitoring and Data Entry Operators-2) with office equipments and space within the DM's office.

(ii) Map all the available ultra-sonography machines (individual machines not the clinics) in the districts and update of this data after every three months.

(iii) Ensure statutory institutional bodies (District Appropriate Authorities, District Advisory Committees) and also ensure District Inspection and Monitoring committees are set up in the districts.

(iv) Analyze both records, at IVF centres, Surrogacy clinics, and genetics counseling centres in the district, with a view to know the percentage of births of male and female child there. This will be done by the District Appropriate Authority and the report submitted to the State Appropriate Authority (SAA).

(v) Ensure functioning of anonymous online complaint portal.

(vi) Institute Rewards for the informers to help in identify the unregistered / illegal ultrasound machines and the clinics indulging in illegal practice of sex selection.

6.2 Initiatives in Una District (Gender Critical District)[12]

Una district was considered as the worst affected in Himachal Pradesh in terms of adverse child sex ratio (875 girls per 1,000 boys in 0-6 age group). In some of the Panchayat, the CSR was less than 600 as per 2011 census, Una was ranked among the lowest 100 districts of India in adverse child sex ratio. This fact was taken note of by the Supreme Court and National Human Rights Commission and notices were issued to the Government. Government of India gave directions to the District Administration to make some positive interventions.

District level workshop of Panchayats with low female sex ratio at birth was held in which all PRI members, AWW's, ASHA workers, Panchayats secretaries and Block Development Officers were invited. Detailed discussion was held with them. The factors that came up in the discussion in favour of male child were:

- The religious belief.
- Family and social pressure.
- Social Security and dependency in old days.
- Insecurity among women.
- Better health care for boys after birth.
- Dowry system.
- Over the counter availability of abortion pills.

[12] Based on the inputs provided by ShriAbhishek Jain, Deputy Commissioner, Una.

- USG examination without prescription.
- Medical malpractices in adjoining states.
- Quacks / Dais doing abortions.
- Females having little decisions making powers.

6.2.1 Interventions

- Project of BetiBachao – BetiPadhao got sanctioned for district Una.
- District Task Force constituted.
- Block Task Forces constituted.
- Annual Action Plan formulated.
- Nodal Officers appointed.
- Study got conducted with the help of Health Department.

The details of Interventions done in Una District are as follows:

Deputy Commissioner with the support of District Programme Officer (DPO) conducted orientation programmes of District officers / ZilaParishad members / PNDT Cell / Judiciary / District Legal Services Authority (DLSA), Block Officers / BlockParishad / Panchayat Members, Village Health, Sanitation and Nutrition Committee(VHSNC), members of School Management Committees once in each quarter for each category.

- Conducted sensitization exercise of religious leaders, elected representatives and community leaders in the first and third quarter of the year 2015-16.
- Conducted stakeholder meetings in all the four quarters and also discussed the follow up actions.
- Mainstreamed gender equality related concerns in all training curriculums.
- Undertaken training of Frontline Workers (AWWs / ASHAs) in every quarter.
- Training of Youth / Sabha Groups / Volunteers / SHG / MahilaMandals / NYKs to act as volunteers. This training was done quarterly with the help of Nodal Officer (WCD).
- Trained District Appropriate Authority (DAA) and other functionaries on PC-PNDT act biannually with the help of Nodal Officers.
- With the help of National Legal Services Authority, provided quarterly legal counseling / aid / awareness on PC-PNDT Act and other legislations.
- With the help of NIC inserted e-mail signatures with BBBP Logo.
- With the help of Sarpanch / SDM, organized the celebration of birth of girl child in every quarter. This was done in order to reinforce the value of girl child and drive home the message of need for mind-set change.

- District Administration in collaboration with other line departments celebrated Nation Girl Child Day on 24th January, 2015. This was done in order to culminate the advocacy / IEC activities and highlight the plight of the girls in the country. It also created awareness about welfare and empowerment of girl child.
- District administration in collaboration with other line departments celebrated International Women's Day on 8th March, 2015. It highlighted the need for gender equality and empowerment of women and girls.
- In every quarter organized **Naari KiChaupal / Mann Ki Baat** across the district. It helped in creating enabling environment for engaging with the community on issues related to women, through discussion, debate and interactions.
- District Administration in collaboration with other line departments displayed and disseminated IEC materials like BBBP hand book, Badges, Posters, audio video content available at the BBBP You Tube Channel and attracted and engaged all. In addition, National Campaign related activities like Mobile Video Exhibition Vans and Field Publicity activities for awareness generation and change in mindset of people were also organized.
- Meritorious girls in the field of academics / sports / culture and social work etc. were encouraged by felicitating them on National Girl Child Day / International Women's Day / Independence Day / Republic Day.
- Developed MIS to collect data from various departments on indicators that will help in tracking progress of CSR in the district.
- Nodal Officer PNDT cell has been appointed and District PC-PNDT cell has been established at CMO Office, Una. Standard Operating Procedures for members, Training Manual, Panel of Experts and Resource Persons identified for training are in place.
- DC along with CMO and PNDT cell State Appropriate Authority have been holding monthly meeting at district level doing registration of all pre-conception and pre-natal diagnostic centres includingART / IVF, ultrasound imaging centre, sperm banks etc. Review of PC-PNDT Act implementation is also done in this meeting and monthly report is submitted to the State Government. Quarterly progress report is submitted to the Centre.
- District appropriate authority has been appointed along with members of district advisory Committee as per PC-PNDT Act. They hold quarterly meetings and submit the report to the centre.

6.2.2 Mapping of Ultra-Sonography Machines

There is monitoring of compulsory registration of ultra sound machines. There is cent per cent registration of all machines in the district and has registered 14 USG clinics in the district working both in Public and Private sectors.Cases have been filed against the individuals operating unregistered machines.

- Monthly update of all information on implementation status, online form F option and complaints are on the state web-portal.
- DAA and PNDT cell ensures compliance of maintenance of records by registered clinics and ensures submission of records by 5th of every month by the registered clinics.
- DAA with District Legal person-PNDT cell review all pending cases before district court every month, follow court cases and ensure early disposal and conviction against the violations under PC-PNDT Act.

6.2.3 Formation of District Inspection and Monitoring Committee (DIMC)

DAA along with DIMC take follow-up action in terms of sealing, showcause notices and cases filed, suspension / cancellation of registrations of erring medical professionals.

- DAA analyze birth records-IV F centers, surrogacy clinics and genetics counsellingcentres on monthly basis (% age of birth of girls and boys).
- District Education Officers have activated SMCs to conduct special drives to promote universal enrolment of girls, link out of school with back to school or alternative education options in order to increase their enrolment. By August 2015, it was ensured that every elementary and secondary schoolshad toilet facility for girls. In order to increase participation of girls, **BalikaManch**were created in all schools by District Education Officer and also district level awards were instituted for promoting girl's education.
- Under Community Mobilization and Awareness generation programme, Village Health and Nutrition Day (VHND) was observed at Anganwari levels on 2ndWednesday of every month. In order to incentivize pregnant mothers for registration of pregnancy in the first trimester a cash incentive of Rs. 3,500 is given. Birth registration has increased through intensive campaigning, counselling and home visits.

6.2.4 Specific Activities Undertaken under Beti Bachao – Beti Padhao in Una District

(i) Gudda-Guddiya Board

Every Panchayat of the district has been given Gudda-Guddiya Board. Panchayat Secretary is supposed to write the number of boys and girls born every month in their Panchayat. This gives an idea to the visitor about the children born in a village. These boards are displayed at prominent places like Panchayat Offices / Tehsils / Hospitals and widely publicized in the community.

(ii) WhatsAppGroup: A group with the name of **BetiBachao** has been started in Una district with mobile number +91-9418407111. People can exchange their views under this group.

(iii) Prize to Industrial Houses: The industrial units employing maximum number of women have been rewarded with one lakh prize.

(iv) Formation of District Task Force: Under the chairmanship of District Collector, District Task Force and under the chairmanship of Sub-Divisional Magistrate, Block Task Force have been constituted. Their meetings are organized regularly.

(v) Vinyal Flexi Board: All HRTC busses in District Una have been fixed with Vinyal Flexi Board bearing the slogan Beti Bachao – Beti Padhao in order to connect the passenger boarding the bus with this movement.

(vi) Organization of Girl Child Day: Girl child day is celebrated on 10th of every month in those Schools, Health Facilities and Panchayats where CSR is low.

(vii) Display of Flex Board: Flex Boards have been displayed in every Primary, Middle schools, District and Block Level Offices in the district.

(viii) Organization of Workshops and Camps: Under the chairmanship of Deputy Commissioner, many workshops, interactive sessions have been organized on saving girl child and PC-PNDT Act.

(ix) BetiHaiAnmolYojana: Under this scheme, up to the birth of two daughters in a BPL family, a sum of Rs 10,000 is deposited in the form of fixed deposit in her name. The money is being deposited in bank/ post office and can he drawn by the girl after completing 18 years of age. They are also given scholarships ranging from Rs. 450 to Rs. 2,250 from class first to 10+2.

(x) Chief Minister KanyadanYojana: Under this scheme, financial help of Rs.25,000 is given for marriage of girls whose father have died or who are orphan or 100 per cent disable or bed ridden. This is given to those girls whose income is less than Rs. 35,000per year.

(xi) Involvement of Scouts and Guides: In Una district, volunteers of Scouts and Guides of colleges/ schools are activity associated with BetiBachao – BetiPadhao campaign for spreading awareness among masses.

(xii) Incentives for Girl Education: Cash awards have been announced to schools achieving highest girl student retention after 10thstandard.

1st Prize - Rs 50,000

2nd Prize - Rs 30,000

3rd Prize - Rs 20, 000

This has motivated many schools to enhance their girl student retention at 10+2 level.

(xiii) Toilets Constructed: Toilets have been constructed in all schools and Anganwaricentres of Unadistrict.A total of 4,062 toilets got constructed in the year 2015-16.

(xiv) Distribution of BetiBachao Insignia: The following BetiBachao Insignia were distributed:

- 3,000 BetiBachao Dental kits
- 5,000 BetiBachao Pens

- 5,000 BetiBachao Note pads
- 1,100 BetiBachao Boards in Schools /Colleges
- 100 BetiBachao Boards in Buses
- 100 BetiBachao Caps

(xv) Strong Administrative Support: Strong Administration support and guidance for the project at the state level has been received from the Chief Secretary, the Chief Minister Office, Health Department, Social Justice and Empowerment Department. There has been constant monitoring, review, feedback and guidance from these quarters.

(xvi) Red Cross Society Activities: With the help of Red Cross Society, Hospital Welfare Section has been activated. Many health camps have been organized in different parts of Una District with the active support of Red Cross Society. The thrust of these camps is on mother's and child health and also to enhance institutional deliveries. Now institutional deliveries in Una district is to the extent of 90 percent. Border vigilance has been enhanced in nearby districts like Ropar, Hoshiarpur and Nawanshahr to check for female foeticide.

Outcome of BetiBachao – BetiPadhaoAbhiyan

In order to see the impact of this Abhiyan, District Administration conducted a **Head Count Survey** with the help of health department in the last quarter of year 2015. This survey was conducted through ASHA and other health workers at the village level in Una district. Survey included the name of boys and girls under 0-6 age group alongwith their date of births. The data was compiled at village level and consolidated at the block and District level. There was a marked improvement in child sex ratio.

It improved from 875 in 2011 to 900 in 2015 indicating a rise of 25 points within a short span. With the current increase of 6.25 per cent points per annum it will become 937.5 by the year ending 2021.

This is a small beginning, but a long way to go. Sustainability of these efforts require a strong and continuous replication in each and every part of Una District and whole of Himachal Pradesh. There is a need to have more effective Mother and Child Tracking System throughout the state and digitization of relevant data. This requires committed health workers, strong and effective follow up.

6.3 Initiatives of Directorate of Women and Child Development[13]

The Directorate of Women and Child Development has launched four schemes in Himachal Pradesh for improving the status of the girl child. The detail about these schemes is as below:

6.3.1BetiHaiAnmolYojana

With a view to change the negative family and community attitude towards the girl child and mother and to improve enrolment and retention of girl children in the schools, BetiHaiAnmolYojana is being implemented in the State w.e.f. 5th July, 2010. Under this

[13] Based on the inputs provided by Director, Directorate of Women and Child Development.

scheme, Post Birth grant of Rs. 10,000/- is provided to two girls taking birth in BPL families, which is deposited in the Bank or Post office and can be drawn by the girl after attaining 18 years of age.

Scholarship ranging from Rs. 450/- to Rs. 2,250/- per annum is also provided for classes from 1st to 10+2, when these girls start going to school. During financial year 2014-15, an expenditure of Rs. 932lakhswere incurred benefitting 23,436 girls. For the current financial year, budget provision of Rs. 946.70 lakh has been kept.

6.3.2Beti Bachao – Beti Padhao Scheme

This scheme is being implemented as centrally sponsored scheme in Una District of the State w.e.f. 22nd January, 2015. Overall goal of the scheme is to celebrate the girl child and enable her education. Preventing gender biased sex selective elimination; ensuring survival and protection of the girl child are main objectives of the scheme. Under the scheme, activities like **Nari Ki Chaupal,** celebration of **Girl Child Day**, awareness camps, development and distribution of IEC material, intersect oral meetings / sensitization workshop with line departments / stakeholders are organized. Further, incentive to individuals / schools / organizations / industries is also given for promoting girls' education / employment. During financial year 2014-15, an amount of Rs. 36.34 lakh was received from the Government of India in the fag end of the year, which remained unspent. This amount has been revalidated for utilization during current financial year (2015-16). Besides, Rs. 8,45,750/- has been also received from the Government of India during 2016-17

Now, Government of India has also approved this scheme for Kangra and Hamirpur Districts from February 2016.

6.3.3 Kishori Shakti Yojana

Kishori Shakti Yojana (KSY) is a centrally sponsored scheme for empowerment of the Adolescent Girls (AGs) in the age group of 11-18 years. The main objectives of the Scheme are to improve their nutrition and health status; spread awareness among them about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH), and family and child care; upgrade their home-based skills, life skills and vocational skills. The scheme was cent per cent centrally sponsored scheme up to financial year 2014-15 which has been revised to 90:10 between the centre and the state from financial year 2015-16. The scheme is functional in 8 Districts of the state viz. Shimla, Sirmaur, Kinnaur, Mandi, Hamirpur, Bilaspur, Una and Lahaul & Spiti.

Table 6.1

Adolescent Girls Benefitted under Kishori Shakti Yojana

Sr.No.	Component	No. of Beneficiaries	
		2014-15	2015-16 (up to December 2015)
1.	Supplementary Nutrition	35230	34159
2.	Vocational Training	1163	436
3.	Nutrition and Health Education	152990	104888

Table 6.1 depicts the number of adolescent girls benefitted from various components of Kishori Shakti Yojana in Himachal Pradesh. The beneficiaries of vocational training are quire less i.e. 436 as compared to Supplementary Nutrition (34,159) and Nutrition and Health Education (1,04,888).

6.3.4 Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA)

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls- SABLA is being implemented **in four districts which are Solan, Kullu, Kangra, and Chamba since December, 2010**. In districts Kullu, Solan and Chamba, the scheme has replaced the existing Kishori Shakti Yojana (KSY) and NPAG in Kangra District whereas in other districts KSY scheme is continuing as before. SABLA scheme is being implemented through ICDS platform and AnganwariCentresare the focal points for the delivery of services.

The scheme aims at empowering adolescent girls (AGs) of 11-18 year age with special emphasis on out-of-school girls by improvement in their nutritional and health status and upgrading various skills like home skills, life skills and vocational skills. The scheme also aims at equipping the girls on family welfare, health, hygiene etc. and information and guidance on existing public services. Keeping in view the need of different ages and in order to give age appropriate attention for certain components of Adolescent Reproductive and Sexual Health (ARSH) and family matters, the target group has been further sub-divided into two categories, viz., 11-14 and 15-18 years. It also aims to mainstream out of school girls into formal or non-formal education. All the girls of age 15-18 years and out of school AGs of 11-14 years who are not covered under Mid-day meals are being provided nutrition through AWCs as per the norms of the scheme.

Objectives of SABLA

The objectives of the Scheme are to:

(i) Enable the AGs for self-development and empowerment.

(ii) Improve their nutrition and health status.

(iii) Promote awareness about health, hygiene, nutrition, AdolescentReproductive and Sexual Health (ARSH) and family and child care.

(iv) Upgrade their home-based skills, life skills and tie up with National Skill Development Program (NSDP) for vocational skills

(v) Mainstream out of school AGs into formal / non formal education

(vi) Provide information / guidance about existing public services such as PHC, CHC, Post Office, Bank, Police Station, etc.

There are two major components under the Scheme:

(i) Nutrition Component

(ii) Non-Nutrition Component

i) Nutrition Component

- 11-14 years AGs: Out of school girls
- 14-18 years AGs: All girls (School going and out of school)

ii) Non Nutrition Component: For Out of school AGs

a) 11-18 years

- IFA supplementation,
- Health check-up and Referral services,
- Nutrition & Health Education (NHE),
- Counselling / Guidance of family welfare, ARSH, child care practices,
- Life Skill Education and accessing public services

b) 16-18 Years

- **Vocational trainings under National Skill Development Programme (NSDP)** For School going AGs of 11-18 years, the Services at ii (a) will be provided twice a month during School days and four times a month in vacations (as per scheme).

The cost sharing ratio of nutrition component of the scheme was 50:50 and non-nutrition component was 100 per cent central share up to financial year 2014-15 which has been revised to 90:10 between the centre and the state from current financial year 2015-16.

Table 6.2

Number of Adolescent Girls benefitted under the scheme

Sr. No.	Component	No. of Beneficiaries	
		2014-15	2015-16 (up to December 2015)
1.	Supplementary Nutrition	1,02,496	1,02,673
2.	Nutrition and Health Education	1,64,146	1,45,136
3.	Vocational Training	178	247
4.	Counselling / Guidance of AGs on Family Welfare / ARSH and Child Care Practices	1,20,051	1,14,483
5.	Life Skill Education	25,587	11,243
6.	Guidance on Accessing Public Services	967	2,409

The performance under Supplementary Nutrition, Nutrition and Health Education, Counselling / Guidance of AGs on Family Welfare in terms of number of beneficiaries is quite good in the year 2015-16 as compared to year 2014-15 as shown in Table 6.2. But performance is lacking in Vocational Training and Life Skill Education where the number of beneficiaries is only 247 and 11,243 respectively.

6.4 Initiatives taken by Directorate of Health Safety and Regulations[14]

Government of Himachal Pradesh had created a separate new Directorate of Health Safety and Regulation on 1st June, 2009 for the effective implementation and monitoring of

[14] Based on the inputs provided by Director, Directorate of Health Safety and Regulations.

various Acts applicable to Health sector in Himachal Pradesh. This also include PC-PNDT Act, 1994 and Medical Termination of Pregnancy Act. The role of this Directorate becomes quite significant in the wake of declining sex ratio in Himachal Pradesh. Since the establishment of this body, following activities have been undertaken:

- The State Supervisory Board chaired by the Hon'ble Health Minister of State have been constituted to monitor the implementation of the act at the state.
- The strict enforcement of the PC-PNDT Act in the state is of utmost importance due to skewed CSR in the state.
- To enforce PC-PNDT Act and to improve the child sex ratio, 262 clinics have been registered, out of which 86 are government institutions and 176 are private institutions.
- Meetings of the notified State Supervisory Board, State Appropriate Authority and Advisory Committee are being held regularly as required under the Act.
- The Chief Medical Officers have been notified as District Appropriate Authorities for the registration of Ultrasound machines and implementation of the Act in their respective districts.
- The Government is undertaking various awareness activities so as to promote girl child and prevent female foeticide in view of improving the Child Sex Ratio in the state.
- At the district and block level, focus is on extensive awareness activities of the general public with the involvement of Anganwari Workers (AWW), ASHAs, FHWs and PRIs.
- In a state level function held on the occasion of International Women Day on 8th March, 2015, 50 Panchayats which have shown maximum improvement in CSR as per census 2011 in comparison to Census 2001 were awarded by the Hon'ble Health Minister.
- As a state specific initiative a sensitization workshop was held under PC-PNDT on 1st April, 2015 for all the MLAs of H.P. VidhanSabha which was attended by Hon'ble Chief Minister, Hon'ble Speaker, Leader of Opposition, and Cabinet Ministers besides MLAs of various political parties of H.P.
- Government has accorded permission for extensive awareness activities to **Save the Girl Child** in Drang and Sadar blocks of Mandi district for one year through People Awareness for Rural Action Society (PARA).
- On 26th October, 2015 during the International Dussehra Day celebrations on the historic Dhalpur ground of Kullu district, 9892 females clad in traditional Kullu dresses, participated in local folk dance (Naati) called as **Pride of Kullu** with a theme dedicated to the promotion of girl child which was a world record and has got accreditation in the Guinness Book of Records for largest number of participants ever gathered at one place for folk dance.

- Radio jingles on promotion of girl child and against adverse child sex ratio have been/ aired through All India Radio, FM Shimla and TV today Network in the months of July, August, November, December 2015 and February, March 2016.
- Four prosecutions have been initiated under PC-PNDT Act, one each in the Hon'ble CJM Courts of District Kullu, Shimla, Hamirpur and Bilaspur and are under trial.
- One conviction has been secured PC-PNDT on 1st April, 2013 at CJM Court, Amb, District Una for a case launched in 2008, whereby an imprisonment of one year and fine of Rs. 1000 was imposed on the violator.
- **The CSR in H.P. (909) which was below the national average (919) as per Census of 2011 has improved to 933 as per Household Survey conducted in all districts of Himachal Pradesh in the year 2015.** This survey was conducted door to door with the help of ASHA Workers and Anganwari Workers. District-wise comparison of sex ratio as per Census 2011 vis-à-vis Household Survey is depicted in Table 6.3.

Table 6.3

District-wise Registration of Ultrasound Machines and Child Sex Ratio

Sr.No.	Name of District	Ultrasound Machines	CSR (as per Census 2011)	CSR (as per Household Survey 2015)
1.	Bilaspur	12	900	919
2.	Chamba	14	953	988
3.	Hamirpur	18	887	929
4.	Kinnaur	06	963	991
5.	Kangra	62	876	899
6.	Kullu	21	962	1001
7.	Lahaul&Spiti	07	1033	977
8.	Mandi	26	916	910
9.	Shimla	42	925	983
10.	Sirmaur	15	928	930
11.	Solan	25	899	934
12.	Una	14	875	900
	Total	262	909	933

The Table clearly reveals a marked improvement in the CSR of all the districts except Mandi and Lahaul & Spiti. The districts with low sex ratio have crossed the 900 mark as it has improved to 929 in case of Hamirpur, 899 in case of Kangra, 934 in case of Solan and 900 in case of Una district.

Details of Appeals heard at State Appropriate Authority under PC&PNDT

Sr. No.	Particulars of Appeal	Date of hearing	Date of decision	Reason	Out come
Year 2014-15					
1.	Appeal preferred by Mrs. UrvashiFakay, wife of Dr. Sunil Fakay, Proprietor of 4th Dimension-an-Ultrasound Clinic, Bhagirath Complex, Behind Regional Hospital, Kullu, H.P. under section 21 of PC&PNDT Act against the orders dated 04.03.2014 & 06.03.2014 passed by the DAA Kullu.	19.05.2014 28.06.2014	28.06.2014	Suspension	Action taken by DAA up held
2.	Appeal preferred by Dr. R.D. Sharma, proprietor Leelawati Hospital, Ghumarwin under section 21 of PC&PNDT Act against the orders dated 07.07.2014 passed by the DAA Bilaspur.	12.08.2014 09.09.2014	09.09.2014	Sealing	Do
3.	Appeal preferred by Mrs. UrvashiFakay, wife of Dr. Sunil Fakay, Proprietor of 4th Dimension-an-Ultrasound Clinic, Bhagirathi, Complex, Behind Regional Hospital, Kullu, and H.P. under section 21 of PC&PNDT Act against the orders dated 20.08.2014 passed by the DAA Kullu.	29.10.2014	29.10.2014	Cancellation	Do
Year 2015-16					
1.	Appeal preferred by Dr. Amit Kumar, S/O Sh. TashiChhering Proprietor of DevBhumi Medical Centre, Dhalpur, Kullu, and H.P. under section 21 of PC&PNDT Act against the order dated 27.02.2015 passed by the DAA Kullu.	29.04.2015 22.05.2015 15.06.2015	15.06.2015	Suspension	Do
2.	Appeal preferred by Dr. Shobha Thakur, M/S Thakur Surgical & Maternity Home, Ward NO. 8 near Petrol Pump, Hamirpur, Himachal Pradesh, against the orders Dated 12.06.2015 passed by the DAA-cum-CMO Hamirpur, H.P.	04.08.2015 18.08.2015 16.09.2015	16.09.2015	Suspension	Do
3.	Appeal preferred by Dr. R.D. Sharma, proprietor Leelawati Hospital, Ghumarwin under section 21 of PC&PNDT Act against the orders dated 30.09.2014 passed by the DAA Bilaspur.	22.09.2015	13.11.2015	Cancellation	Action taken by DAA up held

6.4.1 District-wise Violations, Status of Cases under PC&PNDT Act

District-wise status of cases registered under PC-PNDT Act are as follows:

District Shimla

The National Inspection and Monitoring Committee (NIMC) during its visit to Himachal Pradesh in June, 2014, following inspection, observed violations under PC&PNDT Act and recommended action against Sachdeva Clinic, Shimla including suspension of registration of Ultrasound machine. The CMO Shimla has launched prosecution in the court of CJM Shimla on dated 16.03.2015.

District Bilaspur

The registration of Leelavati Hospital, Ghumarwin was cancelled on dated 30.09.2014 by DAA on basis of complaint and FIR lodged by a patient on 16.05.2014 against the said clinic for violation of PC&PNDT Act. Prosecution has been launched by the DAA on dated 16-10-2015 in the Hon'ble Court of ACJM Ghumarwin, DistrictBilaspur.

District Kullu

Dr. Sunil Fakay case regarding shifting of two Ultrasound machines from New Delhi to Kullu and further grant of registration by the DAA Kullu against the provisions contained under PC&PNDT Act for which the matter was moved by Dr. Sunil Fakay into Hon'ble High Court, H.P. whereby the Hon'ble Court had while dismissing the case held not only Dr. Sunil Fakay but his entire family including his father and wife guilty in matter and accordingly passed orders on dated 06.08.2014.

Dr. Sunil Fakay has filed Special Leave Petition in the Hon'ble Supreme Court of India which is still pending

The DAA-cum-CMO Kullu has filed case in the court of CJM Kullu against Dr. Sunil Fakay for violations under PC&PNDT Act in March, 2015.

During the investigation of the complaint made by Sh.Maneesh, Post Box 702, Sector 19-C, Chandigarh, DAA Kullu found irregularities in record maintenance by Dr. Amit Thakur, owner cum radiologist in DevBhumi Medical Centre, behind Regional Hospital Kullu and suspended the registration on dated 27.02.2015. During the hearing of appeal at SAA, the document referred by complainant was referred to Forensic Laboratory Dharamshala for handwriting verification. SAA while deciding the case on 3.08.2015 upheld the decision of DAA Kullu and directed to take further action.

District Hamirpur

On dated 25.04.2015, a sensitization workshop was organized at HamirBhawan, Hamirpur under the chairmanship of Deputy Commissioner, Hamirpur which was attended by 25 officer / members including Dr. Surekha Chopra, the then OSD, PNDT. After workshop, the Deputy Commissioner, Hamirpur asked the DAA to conduct visit/inspection of at least one USG Centre in the town along with OSD, BMOs, SDMs and CDPOs and take appropriate action as per provision of the Act, if so required. The team inspected the M/S Thakur Surgical & Maternity Nursing Home, Petrol Pump, Hamirpur and found

violations of the Act. The DAA on that day sealed USG machine along with record, suspended the registration and subsequently filed the case against the clinic in the court of CJM Hamirpur on dated 20.06.2015.

District Kangra

In District Kangra, DAA gave permission to Dr. VijenderNathUpadhayay (Sonologist) for doing Ultrasound at Surya Hospital, Raja-Ka-Talab on dated 28.08.2014. The same sinologist applied to another clinic named as Saxena Hospital Jassur for which the DAA sought clarification from the SAA. On 30th January, DAA was directed that the permission to the second centre could not be given because of the new amendment Rules. Hon'ble High Court has decided the case on 22.09.2015 and has directed the respondents to pass appropriate orders after hearing the writ petition for which DAA Kangra has been directed.

District Solan

In district Solan, on complaint by one Sh. Mast Ram, Ex MHS regarding degree of sinologist Dr. Ranjeet Singh Rana of Rana Health Clinic, Solan possessing invalid qualification from CMJ University, Meghalaya used to run the USG clinic. An enquiry was conducted and clarification received from Medical Council of India indicating the degree to be inappropriate, DAA, Solan was advised to take action accordingly. This case was deliberated in detail during the last SAA meeting held on 06-10-2015. On the recommendation of the house, DAA Solan was directed to take action as per provisions of the Act. DAA Solan has not taken any action so far, however has requested the complainant for verification of the aforesaid charges.

State

The Hon'ble High Court has admitted 33 CWPs by different Sonologistspracticing on the basis of six-month training rules or one-year experience against the implementation of six months training rules 2014 which mandated these practitioners to appear and qualify in a competency based examination. Replies have been filed in the Hon'ble High Court for each of the CWPs as this being a central act, the state government is implementing the same in letter and spirit.

CHAPTER-VII

CONCLUSIONS

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. The sharp decline in the urban birth sex ratio at the all-India level, as in many other states, is cited as evidence (Gill, 2002). Estimates of sex-selective abortions calculated by a study (UNFPA, 2001), 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.

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 by Kulkarni in Mumbai reports that in 1986, doctors performing sex determination tests 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 (Gupta, 2000). Not only do developed states and groups resort to female foeticide but also people from empowered populations, with relatively better resources and rights, are its practitioners.

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 GEI are simultaneously boosting the masculine sex ratio. Himachal Pradesh was ranked fourth on the GEI 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. 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 female literacy rate (from 37.7 in 1981 to 68.08 in 2001 and further to 75.90 in 2011), as also a vast improvement in its female workparticipation rate (31.86 in 1981 to 43.7 in 2001 and further to 44.8 in 2011) but during the same period it has seen 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 belie the popular linkage of development with gender status. 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 no criterion for gender empowerment. Education, work participation rates, enhanced health, declining fertility have been subsumed under the existing gender hierarchies to manifest in the phenomenon of female foeticide. 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.

Access to development has been unable to transform the gender positions 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. Clearly, the existing gender-related policies do not have an answer

to the gender-differentiating hierarchies as highlighted by the increasing female foeticide even when policy objectives are being met.

The present study to explore the causes of declining **Child Sex Ratio** in Himachal Pradesh is based on the analysis of 1991, 2001 and 2011 census data of Himachal Pradesh. Field Survey was launched in 4 districts of Himachal Pradesh based on the ranking of very low, low moderate, high and very high juvenile sex ratios. The selected four districts were Kangra, Una, Kinnaur and Sirmaur and a total of **2,663** households were selected for detailed survey. In addition,**Perception Survey** of Doctors, PRI members, Anganwari and ASHA Workers had also been conducted. The main conclusions of the present study are summarized as below:

7.1 Ideal Family Size

Ideal family size of twochildren was revealed by more than 60 per cent of male respondents in each of the district studied in the present survey. It was maximum i.e. 86 per cent in Una district, followed by Kangra (82%), Sirmaur (70%) and Kinnaur (66%). Preference for three or more children was equal i.e. 19 per cent each in case of Kinnaur and Sirmaur districts and just 2 per cent in Una and 3 per cent in Kangra. This indicated that the idea of two children norm is deep rooted in Kangra and Una districts. Similar trend was observed when the same question was asked to married women/ female respondents. For majority of women in Una, ideal family size of twochildren was revealed by 86 per cent of women, followed by Kangra (74%), Kinnaur (60%) and Sirmaur (57%). Preference for three or more children was maximum in case of Sirmaur district i.e. 14 per cent, followed by Kinnaur (7%) and just 2 per cent each in Una and Kangra districts.

7.2 A Son Meaning Space under the Sun

A son's birth is a means of privileging the mother. Thus the dilemma of being the second sex and yet craving for the first is resolved through the practice of patriarchy. Majority of the Indian women would be shattered to only have successive daughters. The birth of a son is perceived as an opportunity for upward mobility while the birth of a daughter is believed to result in downward economic mobility of the household and the family.

The **stigma of sonlessness** is not an abstract one, but rests on very hard ground, it is very palpable. The misery of not being able to produce a son is not limited to the household or the mother-in-law but spills rather quickly beyond the family. It is a failure to perform. Infertility is a curse, next is inability to bear a son. Despite what science of reproduction might say about the sex of the baby being dependent on the Y chromosome, people blame the women for her inability to provide a son to the family.

Having a son means ensuring old age security to the extent of 60 per cent respondents in Kinnaur, 52 per cent in Kangra, 37 per cent in Una and 35 per cent in Sirmaur as revealed by the married women of these districts. Economic security was another predominant cause for having a son. It was revealed by 50 per cent women respondents in Kinnaur, 41 per cent in Kangra, 35 per cent in Sirmaur and 29 per cent in Una. Religious security was another cause of desiring to have a son. It was revealed by 44

per cent respondents in Kangra district, followed by 28 per cent in Una, 17 per cent in Kinnaur and 12 per cent in Sirmaur districts. Upward movement in the social status of the family is another strong point which emerged during the survey as revealed by 49 per cent women respondents in Kinnaur, followed by 30 per cent in Kangra, 28 per cent in Sirmaur and 23 per cent in Una.

7.3 Daughter as a Burden

It is quite clear that female foeticide is not approved and practised for the first female foetus. As majority of the births in India still take place at home, ultrasound is rarely conducted as part of the antenatal routine examinations. The first baby is accepted with joy. It is a relief for the families, both conjugal and natal, that the mother and baby are fine. Of course, if the first born were to be a son, the families are overjoyed. Fifty years ago when a daughter came first, there was joy and relief, except perhaps among the castes notorious for female infanticide. Like at present, it was even then accompanied with earnest hope that the second baby would be a boy. Mothers and families with successive daughters were sympathized with as they had to continue to have babies until at least one son was born.

What has changed in the past fifty years is the ability of parents to modulate the composition of one's children, especially with the introduction of foetal-sonography. Parents now do not consider it worthwhile to have daughters until a son happens to arrive. Presently, they usually want only two children and wish that at least one among them is a son.

The importance of a daughter for the parents, who find her emotionally closer and who is more concerned about the parents than a married son, is also commonly heard. More than 70 per cent of the female respondents realized the importance of daughters. It was 96 per cent in Una district, followed by 90 per cent in Kangra, 79 per cent in Kinnaur and 78 per cent in Sirmaur district. Eighty per cent respondents in Una district voted in favour of daughters because of their religious value (*Kanyadan*). This percentage was 65, 46 and 40 per cent in case of Kangra, Sirmaur and Kinnaur districts respectively. A very high proportion of respondents i.e. 91 per cent in Una and 81 per cent in Kangra responded by saying that daughters are required for completeness of the family. This was supported by 58per cent respondents in Sirmaur and 55 per cent in Kinnaur districts. Emotional attachment of girls with their parents and their caring nature was expressed by 78 per cent, 60 per cent respondents in Una and Kangra districts and 50 and 49 per cent in Sirmaur and Kinnaur districts.

Appreciating the aforesaid qualities of daughters, the female respondents also pointed out the disadvantages of daughters. Daughters as economic burden to family were opined by 42 per cent respondents in Sirmaur, 38 per cent in Kangra, 36 per cent in Kinnaur and 34 per cent in Una districts. Dowry system is one such social evil which is a major cause of occurrence of many other social evils. Fear of inability to meet dowry demands leads to killing of girls, abandoning of girls, occasionally selling girls, foeticide, and infanticide by parents themselves. Also, a fear of losing one's daughter in a dowry death or having to face physical and mental torture for not bringing adequate dowry also was

maximum. The fear of dowry looms large in case of Kangra district (64%), followed by Una (48%), Sirmaur (41%) and Kinnaur (31%).

Social security was highlighted as another disadvantage of daughters as revealed by 48 per cent women respondents in Kangra, 45 per cent in Una and 44 per cent each in case of Kinnaur and Sirmaur districts. Sexual assault on unescorted girls and female children are on the rise, and is frequently reported in the media. Parents are always worried about the safety and well-being of their daughters. Physical security of daughters as a disadvantage was reported by 43 per cent respondents in Sirmaur, 37 per cent each in Kangra and Una and 30 per cent in Kinnaur districts. In spite of the numerous disadvantages of daughters, more than 60 per cent respondents were willing to send their daughters outside the state for education and job. A very high percentage was willing to give quality education to their daughters. This was as high as 81 per cent in Una and 80 per cent in Kangra districts followed by Kinnaur (78%) and Sirmaur (75%).

7.4 Birth order Parity in Kangra and Una Districts

Male sex bias is reflected in the birth order parity in Kangra and Una districts. When the first child born was female, preference for second child was male in 59.7 per cent of cases and female in 40.3 per cent cases. This preference was more in case of Una district i.e. 61.6 per cent and 38.4 per cent respectively. When Kangra and Una districts were taken together, if first child was female, preference for male as second child was in 60.3 per cent of cases and female child in 39.7 per cent of cases. Same tendency was noticed in the sex of the third child. If the first child was male followed by female child, then the preference for the third child was male in 66 per cent of cases and female in 34 per cent of cases in Kangra district. If first child was female, followed by female, then preference for third child was male in 65.8 per cent of cases and female in 34.2 per cent of cases.

In Una district, if the first two children were female, then the sex of the third child was male in 67.6 per cent of cases and female in 32.4 per cent of cases. In order to increase the cases, Kangra and Una districts were combined together and birth order parity was observed. If first child was male, followed by female, then preference for third child was male in 62 per cent cases and female in 33.8 per cent cases. If the first two children were females, then the preference for third child was male in 66.2 per cent and female in 33.8 per cent of the cases.

Null Hypothesis was formulated, indicating that there is no sex preference. It got rejected in case of Kangra district, indicating a sex preference in the birth of second child. But in case of Una district, Null Hypothesis got accepted, meaning that there was no preference for sex in the second child. When Kangra and Una districts were combined together, the Null Hypothesis got rejected.

Again, Chi-Square was applied to see the preference for the third child. In case of Kangra and Una districts taken separately the Null Hypothesis was accepted. It also got accepted when both the districts were combined together. As the number of cases of child birth in third order parity was very small, so the results were not significant.

7.5 Birth order Parity in Kinnaur and Sirmaur Districts

In Kinnaur districts, if the first child was male, preference for second male child was to the extent of 47 per cent and for the female child was 52.9 per cent. If the first child was female, preference for male child in the second order birth was 51 per cent and for female child was 48.5 per cent.

In Sirmaur district, if the first child was male, preference for second male child was in 53.7 per cent of cases and female in 46.3 per cent of the cases. If the first order birth was a female child, preference for male child in second order birth was 47.5 per cent and female child in 52.5 per cent of the cases. Sirmaur district did not reveal any clear cut preference for male child in second and third order parity.

Application of chi-square for second and third order birth got accepted, indicating no sex preference in Kinnaur and Sirmaur districts. The Hypothesis also got accepted when Kinnaur and Sirmaur districts were combined together to increase the number of cases.

7.6 Child Sex Ratio at Various Birth Orders

Child Sex Ratio at second and third birth orders had declined in Una and Kangra districts. In Una it declined from 765 in the first order to 526 in the third order. In case of Kangra district, it declined from 819 (First Order) to 599 (Third order). Similar trend was not observed in case of Kinnaur and Sirmaur districts. There is negative correlation between birth order and child sex ratio. This data indicates quite convincingly that there is absolutely no desire for daughters when it comes to third order birth, more so in case of Una district. This clearly indicates the phenomena of female foeticide taking place in Una and Kangra districts.

7.7 Perception Surveys

In order to know the opinion of various functionaries about the status of girl child in the society and the problems related to this issue, perception surveys of Doctors, Panchayat Members,Anganwari and ASHA workers were conducted.

Over 95 per cent of the doctors felt that the ultrasound machines were being misused for sex determination in their respective areas. A little more than 50 per cent of the doctors affirmed that the impact of family planning programmes with its two children norms had led to female foeticide. Majority of doctors (62%) accepted the fact that there were some doctors in the districts who were referring pregnant women to ultrasound centers for sex determination test. More than half (59%) stated that doctors were pressurized for conducting female foeticide.

A larger number of Panchayat Members (72%) felt that dowry was spreading in their respective villages due to demonstration effect and to ensure the security of the girls in her-in-laws home. Eighty per cent Anganwari Workers and ASHA Workers in Kangra district revealed that people were in favourof giving quality education to girl child. This percentage was 78, 72 and 68 per cent in Una, Kinnaur and Sirmaur districts, respectively. Majority of couples (82%) were in favour of two children family and only 6 per cent were in favour of three or more children.

In Una district, 40 per cent of pregnant mothers go for ultrasound. This proportion was slightly less in case of Kangra (36%), Kinnaur (14%) and Sirmaur district (8%). In Sirmaur district, people are less educated and primarily engaged in agriculture. They had very less awareness about ultrasound and sex determination tests and hardly any access to these.

In Una and Kangra districts, high preference was given to son because of social and economic security. In Kinnaur and Sirmaur, though people gave preference to male child but they did not go for ultrasound to see the sex of the child. In fact, in Sirmaur, there were households with three children also but no one had gone for sex determination test. ASHA Workers and Anganwari Workers denied female feoticide in their areas. Probably they were afraid to state facts regarding female foeticide because of the Supreme Court and State Government's proactive stand on the implementation of the PNDT Act. All these workers blamed the family for the occurrence of female foeticide.

Nearly half of these workers i.e. 47 per cent in Una and 42 per cent in Kangra expressed their support for abortion due to various financial reasons. It was just 3 per cent in case of Sirmaur and almost negligible in Kinnaur district. In Una and Kangra districts, majority of the respondents felt that in case of a girl child, dowry was an additional expenditure. With the increasing cost of living it was difficult to manage a large family.

According to Anganwari and ASHA Workers of these districts, the likely ill-effects of declining Child Sex Ratio would be increase in atrocities on women, social imbalance with a decline in moral values and purchase of brides from other states.

7.8 Focused Group Discussion

The universal desire for more sons than daughters does get translated in actual behavior as was evident from the sex ratio of live births that was discussed earlier. In the **focus groups discussions** 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. They indicated that there was some pressure from the elders in the family to ensure that 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, they themselves saw nothing wrong in finding out of the sex of the foetus.

It has been tried to ascertain the causes of declining Child Sex Ratio through this survey. The general perception is that the cost of marriage and dowry has gone up and so daughters have become greater financial liabilities. The dowry system has been invariably blamed. However, the dowry alone is the main cause of female foeticide does not appear to be very convincing. Families that are well-off and do not have to depend on dowry to augment their income are also opting for female foeticide. The real reason seems to be the high status of families with several sons and the low status of families with no sons. Another interesting factor for the preference for sons is that the prospect of migration of

sons to, say the Gulf or Western Countries, is much higher for men than for women. In the eyes of the local community, a family with children abroad has a higher status and certainly a higher income level than non-migrant families. Globalization is thus adding to the miseries of the girl child.

In short, there are numerous causes for declining child sex ratio and it will be unscientific to believe that dowry alone is the cause, as is the general perception. Nevertheless, our perception during the field work did reveal that people are aware of the upward swing in dowry demand and the rising cost of marriage. Greed has increased in our society and numerous TV channels and endless advertisements increase this greed further.

Female foeticide is a symptom of increasing crime against women. It would be manifestly wrong if we conclude that female foeticide is a matter of medical technology alone. There is no doubt that easy access to ultrasonography has been largely responsible for the spread of female foeticide throughout the country. Many women opted for female foeticide not because they were cruel or heartless but because they were genuinely concerned about the fate of girls who are being increasingly subjected to eve-teasing, molestation and sexual harassment and after marriage, exposed to the risk of bride burning and dowry death, in the unending demand for dowry from our emerging consumerist society. This calls for a good look at gender issues in all their ramifications in out increasingly dysfunctional society.

CHAPTER-VIII

POLICY IMPLICATIONS AND RECOMMENDATIONS

The preceding chapter have examined the causes of female foeticide as perceived by Doctors, Panchayat members and married women in the villages, which have been intensively studied. In a country of India's size and incredible diversity, it would be realistic to come out with recommendations, which will restore gender balance. Nevertheless, several suggestions have been made that require action at the national, state and local levels to fight the menace of the female foeticide.

It is clearly recognised that the whole issue of female foeticide must be understood in the much wider perspective of gender issues and not merely in terms of evolving medical technology and the consequent attempts to suppress this by invoking the PNDT Act of 1994 with amendments in 2002. There are limits to what the law can do. We have the sad experience of ineffectiveness of legal provisions to prevent the Child Marriage. Dowry Prohibition Act and similar other legislations in combating social evils. Legal action can certainly be a powerful deterrent to irregularities on the part of doctors and paramedical staff, both in the Government and Private Sector but unless, law is backed by unrelenting social action and the fullest involvement of men and women with a vision, the situation will not improve it may even worsen.

At the conceptual level, one must realise that while gender balance is a worthy macro objective, at the family level, it only becomes a rhetoric. Millions of men and women stricken with poverty are not really disturbed about gender imbalance, their main concern is with survival and income and hence economic security. However, the intriguing question is that the prosperous States like Punjab, Haryana and Himachal Pradesh have the highest incidence of female foeticide as exhibited from the Census statistics and confirmed by field surveys.

The present study gives a glimpse of field reality but at least three observations merit attention:

1. The force of **"Demographic fundamentalism"** (son complex which cuts across religion. caste, socio-economic group, place of residence etc., with some exceptions) is strong in Kangra and Una districts of Himachal Pradesh.

2. And probably, it is increasing with the rise of **mindless consumerism** propagated by commercial advertising, T.V. etc., and the growing greed reflected in higher and higher demands of dowry and the high cost of marriage.

3. The spread of female foeticide has been facilitated by at least 3 - factors, all of which are prevalent in Himachal Pradesh, namely (i) access to medical technology (sex determination test and abortion) (ii) Capacity to pay for the test and abortion and (iii) Good transportation network which enables women to travel to the nearest town for female foeticide and the mobility of doctors who can reach villages with their equipment.

In short the whole phenomenon is the culmination of an unholy alliance between tradition and technology, the increasing greed of doctors;the rising demand of dowry, making daughters increasing liability, the ineffectiveness of the PNDT Act and other social legislations and lack of any serious involvement by Civil Society.

Gender imbalance cannot be restored unless we make a frontal attack on all the players and stakeholders on the scene. It calls for concerted action involving Government, NGOs, Civil Societies, Social Reformers and individual men and women with vision. One possible way could be reservation of jobs both in the public and private sector for women (say 33%). Political empowerment is not enough without economic empowerment but in the prevailing environment in the country when the Women's Bill could not be passed in the Parliament, it is therefore, debatable whether Bill making reservation for women in jobs will be acceptable to all political parties.

There is clear evidence that the small family norm advocated by the Government for the last 50 years is generally acceptable to people but the two children norm advocated in the population policies implicitly or explicitly suggest having a family with one son if not two sons. Therefore, the people seem to justify sex determination test leading to female foeticide as an effective step towards the practice of having small family leading to population stabilisation. This poses a serious policy issue. Having advocated two-childern norm as ideal, it would be difficult for the Government to take a stand that the number does not count. By this logic, it would be difficult to convince the people that they should not go in for sex determination and female foeticide (SDFF).

An interesting field observation was that there are no moral hang-ups about SDFF. In fact people tend to treat it as blood test for detecting malaria parasite. It is also interesting to note that there are no moral hang ups about abortion as it is perceived as a solution to medical problems diagnosed by doctors as per the MTP Act. Abortion per se will still be criticised by people on moral and religious grounds but by medicalising abortion, the people are socially sensitised. Intervention strategy must take note of this field reality.

Below given the recommendations:

Recommendation 1

The visible face of powerlessness in the gender system are women. Instead of empowering women with male support, it is the social context that disempowers them, which has to be addressed. The exercise of bias is ideologically rooted in institutions, gender norms, roles, practices and beliefs and exercised through ‘anonymous social mechanisms’. Social processes and the web of structural and cultural institutions have to be dismantled to allow the empowerment project to root out gender hierarchies. So it is not women or men that have to be ‘sensitised’ but practices such as dowry, manifestation of masculinities, transforming sexual division of labour and women’s rights to inheritance that have to be targeted.

Male child, per se is a value and ‘male child preference’ a socio-cultural norm. Gendered practices derive their sustenance and justifications from gender hierarchical system. The concern for female foeticide emerging from the declining child sex ratio

brought the visible distortions to the forefront of the interventionist framework. Rather than addressing the practice and expecting it to change the value accorded to the male child, the need is to confront the norms and their representation beyond the gender identities such as caste, ethnic and religions.

Recommendation 2

Leading Health NGOs in State/Country, should take the responsibility of a massive campaign throughout the State/Country, using the print as well as the electronic media and suitable films to generate awareness about this social evil spreading in Indian society, The nodal Ministry of Health and Family Welfare should give the fullest technical and financial backing to such organizations without diluting their responsibility of strictly enforcing the PNDT Act through various State ministries of Health and Family Welfare.

Recommendation 3

Social scientists in Indian universities and research institutions should give high priority to field studies and research to understand the deep rooted son complex in Indian society and only then we can come out with meaningful intervention strategies which are conceptually sound. UGC and ICSSR should likewise give the highest priority to such research while giving grants to scholars, The Universities and research institutes should collaborate with outstanding NGOs in this regard. Many NGOs have a better grasp of field realities than the scholars, On the other hand most NGOs do not have adequate Knowledge of methodology of social science research. To the extent possible, such collaborative efforts should be on an institutional basis and not on an individual basis through hiring consultants from Universities etc. The donor agencies should also encourage such collaborative effortsDemographic fundamentalism is a very complex phenomenon and has roots in the history, geography and social ethos of the country. The force of this type of fundamentalism is strong in all the Northern States and somewhat diluted in the Southern States of India and at one time it was even absent in Kerala.

In spite of numerous National and International Conferences and Seminars on the girl child and also numerous projects and programmes funded by the Government and donor agencies to help the girl child in India, there is very little evidence to suggest that the status of the girl child has improved substantially. In fact, it has worsened as the study indicates. There appear to be an absence of understanding the grip of demographic fundamentalism in Indian society, nor have our sociologists and behavioral scientists done enough research on this subject. It is understood that, the force of demographic fundamentalism has increased all over India, but more so in the Northern States.

Recommendation 4

The answer to life-enhancing mechanisms resulting in life-depriving outcomes, lies in the understanding that pre-natal diagnostic techniques do not exist in a vacuum but function in accordance with social conditions of patriarchy. The appropriation of medical technology to diagnose the sex of a child is part of the systemic gender discrimination, since scientific intervention is not exempt from social predispositions. Addressing only technological practices, a form of social differentiation would not undermine the differential

per se. In other words, female foeticide occurs because there is male child preference in society. The male child preference emanates from the perceived higher relative worth of the male over the female. Not only does the male have more developed capacities but has culturally -accumulated, normative hegemony. It is ingrained that the male has more developed capacities than the female. Therefore, addressing 'reversal of flows of inter-generational wealth is unable to capture the symbolic value of a male child. In order to combat the male child preference, not only has the female productive worth in society got to be enhanced, but her identity as the 'other' has also to be abolished.

Recommendation 5

We must make a two-pronged attack simultaneously on the age-old tradition of favouring sons and modern medical technology, which is being misused for perpetuating demographic fundamentalism. Legislation, though important in creating an enabling environment is not enough in changing the societal norms and behavioral patterns. Apart from legal intervention, cognitive intervention in a bigger way is a task, which can best be handled by psychologists and behavioral scientists.In the modern world, media, print and the electronic and especially the film media will be the best single instrument to carry on this two-pronged attack. This in turn calls for a high degree of professionalism in film making which is mostly absent in advocacy in literature and visual material (T.V., ads,. films, etc.) produced by Government departments, The Government should encourage the best film producers and to seek the active help and co-operation of informed NGOs, individual scholars, social and health activists working in this field.

Recommendation 6

Preceding recommendation, in no way, suggest that committed bureaucrats cannot enforce the PNDT Act. All that is suggesting is that a committed social activist will fare better than a committed doctor in enforcing the Act if he / she is given the power to act. In fact, would compare the situation regarding curbing female foeticide through legislation can be compared to the unsuccessful attempts of the various State Governments to curb drinking through legislations. Prohibition tends only to pave the way for undercover activities where there is a black-market price and bootleggers selling illicit liquor flourish. Without a social orientation and a vision merely enforcing the law will lead to quackery, secret deals and will push up the price of conducting tests and abortions. This is precisely what is happening in some of the districts of Himachal Pradesh and possibly in other states (Punjab and Haryana).

Recommendation 7

It would be very difficult to undo the mindset of masses of people who equate family planning with sterilisation - a situation which is the creation of 50 years of Government publicity and implementation of a programme of popular ion control centered around stabilization. It is not to suggest that we give up this approach, which is largely responsible for making a real dent on the birthrate in Kerala, Tamil Nadu,Andhra Pradesh, and Karnataka and also to a considerable extent in Himachal Pradesh, Maharashtra, Gujarat etc. Every effort must be made to improve the sterilization programme and in particular, the

quality and extent of prior check-up and follow-up. At the same time, the message of ICPD (Cairo 1994) must be kept in mind and the target approach abandoned. Secondly, 50 years of publicity has convinced Indian masses about the merits of adopting a small family norm and there is enough evidence throughout the country that one son and one daughter is the ideal family composition and family size. In the State under study most people would be content with two sons and will go for sterilisation though generally speaking, one daughter is considered desirable (but never two daughters). It is believed that Government programmes which offer financial incentives to couples who stop after two daughters (meaning thereby accept sterilisation) are counter-productive and just a waste of money. Reproductive behaviour cannot be manipulated by such financial incentives. The new schemes on which the Government should work must consider special incentives for girls in the employment market or in short, empower women in terms of their earning capacity. Then only women will be valued. This calls for a paradigm shift from the present contraceptive oriented approach. This is a bash, which goes beyond the mandate of the nodal Ministry of Health and Family Welfare, and can best be earmarked for Niti Aayog. Meanwhile, the Ministry of Health and Family Welfare can continue to emphasize that the National Population policy does not put any number like two children and there is no reason to opt for female foeticide to stick to this magic number of two. Our planners and policy makers must also realise that more than the number of children, what is relevant in the eyes of the masses is the sex composition of children and the most favoured sex composition of children in large parts of India is two sons and possibly one daughter. How to get out of this complex puzzle? There cannot be a standard solution, given the striking demographic, socio-economic and cultural diversity of India. It is recommended that the Government should opt for a decentralised model and leave the matter to the ZilaParishads, PanchayatSamitis, Panchayats and Gram Panchayats. Let this be sorted out at the local level as the 73rd and 74th Amendments to the Constitution have empowered the local bodies.

Recommendation 8

Registration of ultrasound machines, no matter how strictly it is enforced does not guarantee that pre-birth sex determination tests will not be conducted. The doctor knows how to dodge the appropriate authorities. What is required is vigilance at the local level. Thereforerecommendation is made for empowerment of selected NGOs or health activists with a proven track record to deal with the cases of female foeticide subsequent to tests. At least as a trial, the Government may explore alternative strategies to introduce appropriate legal machinery at the district level.

Recommendation 9

The unethical and corrupt alliance between Government and private doctors with assistance from ANMs, dais, paramedical staff and medical representatives must be broken with summary punishment. All suspected cases of female foeticide and violence against women must be investigated by the State Commissions for Women and action against the guilty initiated. In short, the whole issue of female foeticidemust be comprehended in the wider context of gender issues and rising violence against women.

Recommendation 10

Concerted efforts must be made by Governments, NGOs, social reformers, health activists and individual men and women to counteract the perverse trend of declining child sex ratio. A massive national campaign must be launched to spell out the disastrous consequences of this demographic imbalance.

Recommendation 11

The Government should sanction large funds for the TV channels (which are enormously popular all over India and even in the rural areas) and the film producers to make imaginative films (professionally produced) to be continuously shown on TV and cinema halls. The radio and T.V. (private and public) should be used extensively in changing the unprogressive mindset of the people. At the same time, relentless efforts should be made to implement the PNDT Act and impose heavy punishment including cancellation of registration of erring doctors. Medical ethics must dominate the scene.

Recommendation 12

A three-sector model involving the Government, NGOs and Local Bodies (Panchayats etc.) with technical back up from academic experts, social activists and management experts known for their competence and integrity is suggested. Instead of making only Government agencies responsible for implementing relevant schemes and programmes, NGOs and local bodies can be involved by granting need/ situation based procedural flexibility to them. Local level initiatives sparked off by individuals with vision and dedication and run by people who have professional expertise in management are recommended. Success stories from across the world can be shortlisted and replicated in the State.

Recommendation 13

Policy measures suggested to empower women invariably consist of schemes of more work for them. There is much debate on this link between empowerment and work-for example the patterns of employment available to women and the status of this employment in society, duration and conditions of work, wages etc. Trends and patterns in employment will thus indicate if any improvement in work conditions of women is occurring, that may in the long run, empower them and add value to their lives.

Since, the biases against the girl child are based on socio-economic and cultural considerations, the solution lies only in socio-cultural reforms. From an economic point of view, efforts should be made to change the perception of girl child from that of an economic liability to an economic asset to the parents so that an excessive son preference could be arrested and subsequently, reversed. There is also a need to change the prevailing social notion that a son is the only old age security through strengthening the social safety net by the Government. All these measures will have a desired effect than a sting operation through the laws and acts. At the cultural and social levels; traditions, values and customs that are governed by the patriarchal interest of a son preference be mediated through intervention of State, individuals and social and religious organizations.

It is suggested that there is a need to evolve a comprehensive strategy to reduce the gender differential in child mortality in Himachal Pradesh and in India and curb sex-selective abortion so as to improve the child sex ratio. Targeted interventions will help to reduce the fertility level in high-fertility districts and strict implementation of the existing laws on sex-selective abortion throughout the State will be helpful to improve the child sex ratio.

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ANNEXURE

QUESTIONNAIRES CANVASSED DURING FIELD SURVEYS

SCHEDULE-I

Study to Explore the Causes of Declining Child Sex Ratio in the Age of 0-6 years in Himachal Pradesh

Village Schedule. (From PRI Member only)

(Village Pradhan/Up-Pradhan/Member/Teacher/Gram Sevek, Anganwari Worker)

1. State _____ District _____ Block _____
2. Village _____
3. Name and address of Respondent;_____
   _____

4. Current Population of Village.

S. N.	Age	Total	Male	Female
1	<1 year			
2	1-6 years			
3	6-18 years			
4	18-60-			
5	60+			

5. Number of Household _____
6. Major caste groups in the village _____
7. Source of drinking water _____
8. Is there drainage system? Yes/No
9. Electricity Yes/No
10. Major source of income of the villagers _____
11. Distance from nearest Town _____
12. Distance from nearest head quarters _____
13. Nearest health institution. SC/PHC/CHC/DH
14. Distance from village. SC_____PHC_____ CHC_____DH_____
15. Source to reach to SC_____PHC_____CHC_____DH_____
16. Education facilities available in the village.
    1. _____2. _____ 3. _____ 4. _____
17. Number of private health institutions.
    1. Clinic _____ 2. Doctor only _____ 3. Other _____
18. Availability of Sonography/Ultrasound facility (in kms.)
    1. In the Village _____ 2. Outside the Village _____
19. Whether the village is covered by mobile health clinic. Yes/No
20. If 'Yes' number of visits of mobile health clinic in the last three months.
21. Number of health or family welfare camps organized by you and your institution related to child sex ratio in the last six month in the village_____
22. Availability of health provider in the village (Staying and/or visiting).

Anganwari Workers.

Availability	Yes/no	Availability	Yes/no
Village Health Guide.		Homeopathic Doctor.	
Accredited Social Health Activist (ASHA)		Sidha Doctor.	
Trained Birth Attendant (TBA).		Registered Medical Practitioner.	
AUXILIARY NURSE MIDWIFE (ANM).		Traditional Heater.	
Lady Doctor.		Untrained Dai.	
Private Doctor.		Unani doctor.	
Ayurvedic Doctor.		Any other	

23. Other facility available in village.
    1. Telephone 2. Computer 3. Ambulance 4. Mobile Menial 5. Self Help Group 7. Medical Shop 8. Bank.
24. According to you what is the ideal family size?
    Total_____Male _____ Female_____
25. Do you think boy is more important than girl child? Yes/no.
    Please give reasons_____
    _____
    _____
26. Whether your village people go for Ultrasound to know the sex of the child? Yes/no.
    * If yes, where do they go
    _____
27. Do you know that the child sex ratio of Himachal Pradesh is very low? Yes/no.
28. What steps state Government has taken to improve the child sex ratio of your area?
    _____
    _____
30. What steps you yourself is taking to improve the child sex ratio.
    _____
    _____

31. Results of discussion with suggestions.

SCHEDULE-II

Study to Explore the Causes of Declining Child Sex Ratio in the Age of 0-6 years in Himachal Pradesh

Facility Survey

A. 1. State _____ 2. **District** _____ 3. **Block** _____

4. Name of Village _____ Institutions _____PHC/CHC/SC
5. Number of villages covered by the institutions _____
6. Whether connected by road? Yes/No
7. Distance from DH/CHC _____
8. Population covered by the institution _____
9. Whether function's for 24 hours (Yes/No)

B. Human Resource:

Sr. No.		Post Sanctioned	In Position	Vacant
1	Medical Officer			
2	Staff Nurses			
3	Pharmacist			
4	Male Health Assistant			
5	LHV/Health Assistant			
6	Laboratory Technician			
7	Female Health Workers			
8	Gynecologist			
9	Surgeon			
10	Nurses			
11	Accountant/Ministerial Staff			
12	Class IV Employee			
13	Any Other			

C. Infrastructure

1. Where the Health Institution is located?

   1. within village, 2. Outside village Distance _____

D. Building

1.Functioning in: 1. Govt. Building Yes/No 2. Rented

2. Type of Building: 1. Kachha 2. Semi-Pucca 3. Pucca

3.Present Condition of Building: 1. Good 2. Satisfactory 3. Not Satisfactory

4. General Cleanliness: 1. Good 2. Fair 3. Poor

E. Residential Quarters:

1.	Medical Officers:	Available	Residing	If not Reasons
2.	Pharmacist			
3.	LHV			
4.	Staff Nurse			

F. Physical Facilities:

Sr. No.	Available/Not Available	Functional	If not give Reason
1.	Delivery Room		
2.	Operation Theatre		
3.	Drug Store		
4.	Separate waiting area for patient		

G. Water/Electricity/BMWM (FS)

1. What is the main source of water supply?
   1. Piped 2.Bore Well/HandPump/Tube Well. 3.Well, 4.Other _____

1.1 Is there water supply for 24 hours? Yes/No

H. Electricity

2. Is electricity connection available? Yes/No

2.1 Is the electricity supply regular? Yes/No

I. Toilet facility:

1. Is toilet available? Yes/No
2. Separate toilets functional for male/female? Yes/No

J. Communication Facilities:

1.	Telephone	Yes /No-	Functional
2.	Computer with Net.	Yes /No-	Functional
3.	Vehicle on Roads.	Yes /No-	Functional
4.	Ambulances.	Yes /No-	Functional
5.	Complaint Box.	Yes /No-	

K. Bio-Medical Waste Disposal:

1. Whether using different dustbins for bio-medical waste? Y/N
2. How is the bio-medical waste disposed?
   1. Buried in pit/Thrown in common/public disposal pit/Out sourced management
   2. Other _____

L. Availability of Selected Furniture:

Sr. No.	Items(functional)	Y/N	Sr.No.	Items(functional)	Y/N
1	Examination Table		9	Macintosh for Labour & OT Table	
2	Delivery Table		10	Wheel Chair	
3	OT Table		11	Stretcher on Trolley	
4	Foot Step		12	Oxygen Trolley	
5	Bed Side Screen		13	Instrument Cabinet	
6	Stool for Patient		14	Instrument Trolley	
7	Shadow less Lamp Light.		15	Almirah/Cupboard	
8	Sterilization Instrument		16	Bio-Medical Waste Management	

M. Availability of Equipments:

Sr. No.	Items(functional)	Y/N	Sr. No.	Items(functional)	Y/N
1	IUD Insertion Kit		9	Equipment for New Born Care and Neo-Natal Resuscitation.	
2	Normal Delivery Kit		10	Standard Surgical Set (for minor procedures)	
3	Equipment for Assisted Vacuum Delivery		11	Equipment for Manual Vacuum Aspiration	
4	Equipment for Assisted Forceps Delivery		12	Baby Warmer/Incubator	
5	HB Estimation		13	Reagent Strips for Urine Albumin and Urine Sugar	
6	Reagent for Peripheral Blood Smear Examination for MP		14	Centrifuge	
7	Auto Analyzer		15	Light Microscope	
8	Binocular Microscope		16	**Any other**	

N. Availability of Essential Drugs

Sr.No.	Drugs	Availability	Sr. No.	Drugs	Availability
1	Diazepam Ing. IP		8	Amoxicillin Trihydrate IP	
2	Lignocaine hydrochloride Ing. BP		9	Salbutamol Tab. IP	
3	Dexamathasene Sodium Phosphate Ing. I		10	Hemostatic Drug	
4	Promethazine Hydrochloride Ing. IP		11	Oxytocin	
5	Aminophylline Ing. BP		12	Ohlorpromazine	
6	Adrenaline BitartrateIng. IP		13	Dextrose Ing. IPI.	
7	Cotrimoxazole combination of Trimethoprim IP (Suphamethoxazole IP)		14	V. Solution Sodium Chloride Ing. IPI.	
P.	**RTI/STI Tablet**				
1	Tab. Norfloxaline		4	Doxyeycline/Hydrochloride Capsules	
2	Benzathine Penicillin Injection		5	Tab. Metronidozole	
3	Tab. Flucinazole		6		
Q.	**Essential Laboratory Services**				
1	Blood Grouping		5	Rapid Tests for Pregnancy	
2	Bleeding Time, Clothing Time		6	Blood Smear Examination for Malaria Parasite	
3	Diagnosis of RTI/STI with Wet Mounting Groms Stain etc.		7	RPR Test for Syphillis	
4	Sputum Testing for TB		8	Others	

R. Essential Services: (2008to till date)

1. Number of mothers registered for Ante Natal Care._____
2. Number of Deliveries Performed (Outcome)
   Live Birth _____M_____F_____T_____
   Still Birth _____M_____F_____T_____

Dead Child _____M_____F_____T_____

3. **Number of children below 6 years died in the institution.**

Sr.No.	Age of children	No. of children dead	Reasons of death
1	0-1 week		
2	1week- 1 month		
3	1 month - one year		
4	1 year- 6 years		

4. Number of children treated for ART Male _____Female_____Total_____
5. Number of children treated for ART Male _____ Female _____Total_____
6. Number of children immunized Male_____Female _____Total _____
7. Number of MTP performed_____ Detail of MTP conducted.(Use separate sheet if needed.)

Sr.No.	Name/age	Edu.	Caste	Occupation	Children born. M/F/ Total	Month of Pregnancy	Reason for MTP
1							
2							
3							
4							
5							
6							
7							

8. Pre-diagnostic test conducted here. Yes/No
   If 'Yes' Number of test conducted with the detail of the patient. _____

9. Number ofPre-diagnostic test conducted _____ Detail ofPre-diagnostic test conducted **(Use separate sheet if needed.)**

Sr. No.	Name/age	Edu.	caste	Occupation	Children born. M/F/Total	Month of Pregnancy	Reason forPre-diagnostic test

10. Do you think people give preference to boy then girl child in your area? Yes/No.
11. Do your area people approach to you or your institution for Ultrasound to see the sex of the child? Yes/no.
    * If no, do you know where do they approach._____
12. Do you know that the child sex ratio of Himachal Pradesh is very low? Yes/no.
13. What steps state Government has taken to improve the child sex ratio of your area?_____

    _____
    _____
14. What steps you/ yourself is taking to improve the child sex ratio. _____

    _____
    _____

15. Results of discussion with suggestions.

SCHEDULE-III

Study to Explore the Causes of Declining Child Sex Ratio in the Age of 0-6 years in Himachal Pradesh

(Schedule for Anganwari workers and ASHA workers.)

1. State _____2. District _____ 3. Tehsil _____

4. Block _____5. Village_____

6. Name of Respondent_____7.Age_____

8.Education _____

9.Address:_____
_____
_____

10. How many children are enrolled in your Anganwari _____Total_____ Male_____ Female_____
11. How many villages you/your Anganwari is covering _____
12. How far the nearest health institution is from your place/your Anganwari _____ (Distance in Kms.)
13. Are you also engaged in health related work? Yes/No
    a. If yes what type of work.
    (1) Recording of population. Yes/No
    (2) Recording of birth/death of children. Yes/No
    (3) Maintaining immunization records of;
        3.1 Pregnant mothers. Yes/No
        3.2 Children below one year. Yes/No
        3.3 Children above one year. Yes/No
14. Do you also keep record of pregnant women? Yes/No
15. Where generally women prefer to go for delivery. _____Home_____ SC _____ PHC _____ CHC _____ DH _____ Private Hospital _____
16. Do encourage for institutionalized deliveries?
17. Do you know that the child sex ratio of Himachal Pradesh is very low? Yes/no.
18. What steps state govt. has taken to improve the child sex ratio of your area_____19. What steps you/ yourself is taking to improve the child sex ratio._____
_____
20. Do people of your area want to give quality education to girls? (Professional/higher education)_____

21. Generally how many children a couple prefers.

Total_____ Male_____ Female _____

22. Do they prefer to go for ultrasound for sex detection of the child? Yes/No

22.1 If yes, where, _____ (Name of Institution)

23. Do they think son in more important than girl. Yes/No

23.1 If Yes – Why_____

_____

_____

24. **Results of discussion with suggestion.**

SCHEDULE-IV

Study to Explore the Causes of Declining Child Sex Ratio in the Age of 0-6 years in Himachal Pradesh

Household Schedule

(To be canvassed on Head of the Family)

1. State _____ 2. District _____3. Block _____
4. Village _____
5. Name of Head of Household _____
6. Religion:1.Hindu.2.Muslim.3.Christen.4.Sikh.5.Buddhist. 6.Jain. 7. Other _____ (Specify)
7. Caste: 1.General.2.Scheduled Caste.3.Scheduled Tribe.4.Other Backward Class.5.None of them
8. Source of Drinking Water. 1. Public Tap. 2. Own Well 3. BouliLocal. 4. Natural Spring Water 5. Any Other
9. Toilet Facility:1. Flush 2. Dry /Pit Latrine3. Outside Field/Open Space.4.Shared Toilet
10. Fuel used for cooking. 1. Electricity2. LPG/Natural Gas 3. Bio Gas 4. Kerosene5. Wood. 6. Dung Cakes 7. Agricultural Crop Waste.
11. Type of Family: 1. Joint 2. Nuclear
12. Type of House (Record by observation). 1. Kachha 2. Semi-Pucca 3. Pucca
13. How many room's are there in your household? ---------- Rooms. Separate Kitchen. Y/N.
14. Do you own this room?

    1. Own House. 2. Rented House
15. Do you have T.V., Radio and Newspaper facility in your house?

    1. T. V. Yes/No. 2. Radio. Yes/No 3. News Paper Yes/No
16. Does this household own any land? Yes/No

16.1. If yes, How much?

1. Agricultural (a) Cultivable---------- (b) Non-Cultivable ----------Total-------

17. When you or your family member get sick, where do they generally go for treatment?

1. DH_____ Distance from House_____

2. CHC_____ _____

3. PHC _____ _____

4. SC _____ _____

5. Private _____ _____

18. Have you ever heard/read the messages related to the prevention of sex selection? Yes/No

19. How many marriages took place in your house for the past eight years since January, 2008?

Boys_____ Girls _____ Total _____

20. How many Birth's took place in your house for the last eight years since January, 2009?

Boys_____ Girls _____ Total _____

20.1. Detail of Birth in House for the last six years (since January, 2009).

Sr. No.	**Date/Year Birth**	**Status of Birth**	**Live/Still Birth/Dead**	**Place of Birth**	**Sex of Child**	**Current age of Child**
1						
2.						
3.						
4.						

21. Did any usual resident of this household die since January, 2009?

Male _____ Female _____ Total _____

21.1 Detail of the deceased person.

Sr. No.	**Sex**	**Age at the time of death**	**In which months & year name died.**	**Place of death**	**Reason of death**
1.					
2.					
3.					
4.					

2. Now I would like to have information about the people who usually live in your household.

Sr. N	Name	R/S to Head	Age	Sex	Marital Status	Education Status	Occupation	women 15-49
1								
2								
3								
4								
5								

VERIFICATION: **No. ofeligible women (EW) _____**

3. According to you what should be the ideal family size?
Total _____Male _____Female_____

22. Do you think male child is more important than girl child? Yes/No

Please give reasons: _____

_____

23. Does your family members go for Ultrasound to see the sex of the child? Yes/no.

23.1. If yes, where do them go._____

24. Do you know that the child sex ratio of Himachal Pradesh is very low. Yes/no.

25. What steps state govt. has taken to improve the child sex ratio of yourarea. _____

26. What steps you yourself is taking to improve the child sex ratio.

_____

27. Results of discussion with suggestion.

SCHEDULE-V

Study to Explore the Causes of Declining Child Sex Ratio in the Age of 0-6 years in Himachal Pradesh

Women Questionnaires

(For Ever Married Eligible Women)

Section: I

1. State _____ District _____ Tehsil _____

   Block _____ Village_____

2. Type of Locality _____Rural/Urban

3. Head of Household. Name and Address _____
   _____
   _____

4. Name of Respondent _____

5. Serial No. of women in Household Schedule _____

6. Serial Number of Village Questionnaire _____

7. Serial Number of Household Questionnaire _____

8. Name and Signature of Investigator _____

9. Name and Signature of Supervisor/Monitor_____

Section: II Women Characteristics

1. Name and Serial Number of Women in Household Questionnaire _____Name_____ Sr. No._____
2. Age of Respondent: _____
3. **Marital Status**:
   1. Currently Married 2. Separated 3. Divorced 4. Widowed 5. Any Other _____
4. **Educational Qualification**:
   1. Illiterate 2. Literate 3. Primary 4. Middle 5. High 7. B.A. 8. M.A. 9. M.Phil/ Ph. D. 10. Professional Qualification equal to High 11. Professional Qualification upto B. A. 12. Professional Qualification upto M. A. 13. Professional Qualification more than M. A.
5. **Occupation:**
   1**.** Nothing 2. Housewife 3. Agriculture 4. Govt. Service of Class IV/Class III/Class II/Class I. 5. Business: Low Level/Middle Level/High Level. 6. Horticulture: Self Consumption/Low Level of Marketing/Middle Level of Marketing/High Level of Marketing. 7. Agriculture: Subsistence Level/Market Assented – Low/Middle High Level. 8. Labourer: Agriculture/Horticulture/Vegetable Work/Other Specify _____

Check: Check question No. 3 if currently married go ahead otherwise go to question No. 7.

6. Are you living with your husband? Yes/No

6.1 If Yes, how old he is _____

6.2 What is his education qualification:

1. Illiterate 2. Literate 3. Primary 4. Middle 5. High 7. B.A. 8. M.A. 9. M.Phil/ Ph. D. 10. Professional Qualification equal to High 11. Professional Qualification upto B. A. 12. Professional Qualification upto M. A. 13. Professional Qualification more than M. A.

6.3 What is his occupation status?

1. Nothing 2. Housewife 3. Agriculture 4. Govt. Service of Class IV/Class III/Class II/Class I. 5. Business: Low Level/Middle Level/High Level. 6. Horticulture: Self Consumption/Low Level of Marketing/Middle Level of Marketing/High Level of Marketing. 7. Agriculture: Subsistence Level/Market Assented – Low/Middle High Level. 8. Laborer: Agriculture/Horticulture/Vegetable Work/Other Specify _____

7. How many times you had pregnancy in your married life._____ or nil

7.1. If 'Yes' please provide detail.

Fertility History: (Please give me detail of all pregnancies you had till today).

No. of Pregnancy	Age of Pregnancy	Outcome *	Single /Multiple	Sex of Child	Name of Child	D.O.B. of Child	Place of Delivery	Go to Q. No.
1								
2								
3								
4								
5								
6								
7								
8								

***Outcome of pregnancy: Live birth/Still Birth/Dead Child/Abortion//Induced /Spontaneous**

***Now I understand you had _____pregnancies**

1. Live Birth _____ Male _____ Female _____
2. Still Birth _____ Male _____ Female _____ (go to Qn.8)
3. Dead Child _____ Male _____ Female _____(go to Qn.9)
4. Abortion : * Spontaneous_____ *Induced_____(go to Qn.11)

8. Still Birth: (I understand that you had – still birth. Please give me some more information about still birth).

8.1 You have – pregnancies which registered into still birth? Yes/No

8.2 Please tell the reason for your still birth_____

8.3 Detail of Health Check up during pregnancy.

1. Had Ante natal Check-up. Yes/No
2. Had ultrasound after pregnancy? Yes/No
3. Doctors told before about the condition of child.
4. Negligence of parents/Health Staff found.
5. Any other (Give details)_____

9. Dead Child: (you had given birth to _____ dead children).
   (Total _____Male _____Female_____)

9.1 Can you give us the reason of your child death _____

9.2 Health Status of women and child.

a. Had Ante natal Check-up. Yes/No

b. Immunization of women during pregnancy. Yes/No

c. Had ultrasound before delivery. Yes/No

d. Ultrasound done in which month of delivery _____

e. Doctors description before the birth of child _____

f. Negligence of parents/Health Staff.

g. Any Other. Specify _____

10. Abortion: I understand that you had _____abortion. Out of which _____induced and _____ spontaneous.

10.1 How many months you were pregnant when you had your abortion.

1	2	3	4	5	6	7	8	9
Sr. No.	Nature of Abortion	Month of Pregnancy	Place of Abortion *	Had Ultrasound	Place of Ultrasound *	Who advised for Abortion	Any idea about the sex of Child	Reason for abortion
1								
2								
3								
4								

Q. No. 4* 1. Government Hospital/Dispensary/UHC/CHC/PHC/SC/Other_____

Q. N. 6* Place of Ultrasound: Govt. Institution/Private Institution/Mobile Van/Outside /Inside State.

11. Value of Children:

11.1. What is your ideal family size? -------children, Male---------- Female---------

11.2 Whether you think that son is more important than a daughter? Yes/No

11.3. If Yes, Give Reason.

1. Economic Security: _____
2. Old age Security: _____
3. Religious Utility: _____
4. Social Status: _____
5. Security of family especially females _____
6. Any other (record verbatim) _____

12. Do you think daughter is also important for a family? Yes/No

12.1 If Yes, Give Reasons.

1. Religious Value (Kanyadan) _____
2. Completeness of family _____
3. Reproductive value of girl child _____
4. Emotional attachment and more caring_____
5. Any other _____

12.2 Disadvantages of girl child.

1. Economic burden to family _____
2. Dowry Problem _____
3. Social Security _____
4. Physical Security _____
5. Any Other _____

13. Breast Feeding: You have _____children right.

13.1 When did you start breast feeding your children?

1	2	3	4	5	6	7	8	9
Sr. No.	Name of Child	Sex of Child	Time of Start of B.F.	Exclusive B.F.	Duration of breast Feed	Total Breast Feed	Immunization Status *	Type of weaning Feed #
1								
2								
3								
4								

Q NO.8*1. Fully Immunized/partially immunized.

Q.NO.9, #2. Rich diet/poor diet

Diet given to Boys _____

Diet given to Girls _____

14. Do you know that the child sex ratio of Himachal Pradesh is very low? Yes/no.

15. What steps state govt. has taken to improve the child sex ratio of your area_____?

_____

16. What steps you/ yourself is taking to improve the child sex ratio. _____

_____

17. Do you want to give quality education to girls (Professional/higher education?)_____

18. Are you willing to send your girl child outside the state for specialized courses/ training?

19. Results of discussion with suggestion.

SCHEDULE-VI

Perception Survey of Doctors (Govt. and private)

This is a survey on the status of health in your region being conducted by Population Research Centre, Shimla.

We will be grateful of you could answer a few questions which will help us to prepare a health profile of Una / Kangra / Kinnaur / Sirmaur district. Your individual answers will be treated as confidential.

i. Name .....

ii. Sex.....

iii. Age.....

iv. (a) Educational Qualifications:.....

(b) Are you a member of IMA, GOGSI or IAP?.....

v. Work status (CMO, BMO, private practice): .....

vi Place of work.....

Questions:

1. What are the three main health problems in your region?

2 (a) Do women in your area suffer from anemia? (Y/N). If yes, to what extent?

(b) How much do you think is the contribution of anemia to maternal mortality in your area? (Rough estimate of percentage)

3. Are you familiar with the PNDT Act? Yes / No

4. Have you read the PNDT Act? Yes / No

5. Do you think it can be implemented? Yes / No.

6. (a) Do you think women undergoing sex selective abortions should be punished? Yes / No

(b) Who should be punished?

7. (a) What modifications do you suggest in the PNDT Act? Is sex determination illegal / unethical?

(b) Is female foeticide illegal / unethical?

8. Can the sex of the feotus be determined before 12 weeks?

9. Should ultrasound machines be banned and if so, why?

10. Is ultrasound being misused for sex determination in your area?

11. Should ultrasound be used routinely during pregnancy and if so, how many times and if not why?

12. Do you think the family planning programme with its two-child norm is promoting female foeticide?

13. Are you aware that some doctors are referring women for sex determination tests to private doctors / ultrasound clinics?

14. How much are they getting as commission from these clinics?

15. (a) Are these doctors aware of the sex of the unborn child when they conduct abortion? If yes, are they aware before or after the abortion?

    (b) What percentage of the aborted fetuses are female?

16. (a) What method of MTP do they use? What are the different ways of conducting abortions?

    (b) Do you conduct abortions?

17. Are you aware of the MTP Act?

18. Are you aware of cases where the ultrasound clinics refer cases to doctors for abortions?

19. What do you think is the punishment (a) for the doctors conducting sex determination and female foeticide (b) in-laws forcing SD FF (c) pregnant women going for SD FF?

20. Do you think that doctors are sometimes pressurized by the families and pregnant women themselves to conduct sex determination test and female foeticide?

21. Who do you think is responsible for a pregnant woman undergoing sex determination test and female foeticide? (Multiple answers allowed)

    1) Husbands

    2) In-laws

    3) Community

    4) Others

    5) The pregnant woman herself

22. What steps do you suggest for curing female foeticideat?

    a) Medical / professional level

    b) Family level

    c) The community level

    Name of investigator:

    Place:

    Date:

    Quality of data: investigator's assessment

SCHEDULE-VII

Perception Survey of Panchayat Members

This survey on the status of health in your region, being conducted by Population Research Centre, Shimla.

This is a confidential questionnaire. Your personal details will not be disclosed to any party or in our report.

Village Profile

We will ask a few questions about your village. Do you have?

1. Road connection to any town / district headquarters.....
2. Drinking water facilities.....
3. Toilets and sanitation. .....
4. Electricity .....
5. Schools .....
6. Health facilities.....
7. Telephones.....
8. TV/ cable TV .....
9. Is there a panchayat in your village?.....
10. No. of women members .....

Name of the Pradhan / Sarpanch: .....

Name of the panchayat member interviewed.....

Sex: Age:

1. Has the reservation of the 1/3 quota for women led to the empowerment of women? Can you give examples?
2. What are the main problems related to health in your area?
3. Are all the girls (6-14 years) in your area going to school? If not, why?
4. Are there women in your village which are matriculate and above? (10+2, BA, MA etc.).
5. Who tales the decisions about getting a girl married? What are the criteria in looking for a bridegroom?

(a)	Caste	(b)	Religion
(c)	Income	(d)	Rural / Urban residence
(e)	Education	(f)	Land ownership

6. Do you approve of love marriages, inter-caste marriages, inter-religious marriages?
7. Do you think the bride and bridegroom must have a say in deciding their marriage? Do you approve of widow remarriage?
8. Is there any scheme for income generation and skill development for adolescent girls in your area? Do you think that there should be special schemes? What should the govt. do for the empowerment of women? Are the special schemes working satisfactorily in your village?
9. Are you aware of female foeticide in your area?
10. What do you think is the cost of the ultrasound test?
11. What are the different communities practicing's female foeticide in your area?
12. Is foeticide being practiced because of society's pressure or is it the family's choice?
13. Are you aware of cased of rape, dowry demand, bride burning, abduction and other violence against women in your area?
14. What is the nature of violence against women in your area?
15. What are the main causes of suicide and dowry deaths in your area?
16. Is the dowry system spreading or declining in your area?
17. What is the cost of marriage in your area? Is it increasing or decreasing? If yes, why?
18. Do you know of women who are working outside their homes in your area, except in agriculture? If so, in which sector?
19. Is the number of girls in your area decreasing?
20. In your view, how can women be empowered? e.g.: through higher education, equal property inheritance rights, etc.?

Name of investigator:

Place:

Date:

Quality of data: investigator's assessment