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Short Communication

"Gender Gap": Where are we..?

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In India, sex ratio becomes a most issue in important recent Indian demography because of its worst condition.¹'Better Rs 5000/- now than Rs 5 lakh/- later' i.e. its better to spend Rs 5000 now to get rid of the female infant than to spend Rs 5 lakh in her dowry. With the birth of the female child, parents undergo a mixture of emotions, which includes happiness of adding a new member to the family as well as worry to collect dowry at the time of marriage. Discrimination is more evident in so called well educated and prosperous society. For example in some of the district of Haryana, Punjab sex ratio in 0-6 age group is even below 800 for every 1000 males. For this reason North- Western States of India i.e. Harvana, Punjab and Himachal Pradesh are called by some as 'Bermuda Triangle' i.e. the triangle where girls vanish.^{1,2}

In 1871, when India held its first census, there were 5.5 million fewer females than males.³ One hundred and twenty years later, in 1992, Amartya Sen estimated a deficit of 37 million females in India, drawing attention to the "missing women" of South Asia.⁴Some 10 million female fetuses are estimated to have been aborted over the last two decades in India.⁵

Due to discrimination against females, particularly female children, relative to males, in the allocation of food and health care within the household, There is a excessive mortality of females has been occurred.⁶

Though use of the new technology and advances are wide spread in all social sector but it is more in the well-educated and well off society. In a study conducted by Voluntary Health Association of India (VHAI) in the States of Punjab, Haryana and Himachal Pradesh, it was suggested that though use of sex selective abortion techniques were facilitated by their easy access to the medical facilities and good road network, but more determining factor was their paying capacity for the procedure⁷. Deficit for the girls in the second and third order child was more evident among women who were either educated beyond primary school level or from upper income group and not engaged activities^{3,4,,8} economic any in Demographic imbalance created because of the declining sex ratio in India is a cause of concern to policy makers, implementers, demographers and social reformers.⁴

According to UN report 2010⁹, "The World's Women", ratio of women per 1000 men is highest in Europe & North America region (1050), then Caribbean region (1030), Sub Saharan Africa (1020), Central Asia (1020), South East Asia (1000), India (940) & China (920).

Table 1	1: Den	ographic	information:
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	India (in crore)	Gujarat (in crore)
Population	121.0	6.03
Males	62.4	3.14
Females	58.6	2.89
Deficient of	3.8	0.25
women in		
year 2011		
Sex ratio	940	918
(no. of women		
per 1000 men)		

[Census 2011, provisional data, India]

There is large deficiency of women in India (3.8 crore) & in Gujarat (0.25 crore) (Table 1). Given the traditional preference for a male child^{10,11,12,13}, it is not surprising that right from the first census of 1871, India has consistently shown an abnormal sex ratio (940 women for every 1000 men). Pregnancy-related morbidity and mortality account for 136,000 maternal deaths annually¹⁴ and tend to further distort sex ratios. A steep decline in the sex ratio in recent years has coincided with an increased availability of ultrasound machines.^{15,16} About 70% of all performed in Delhi abortions are terminations due to the foetus being female.17

 Table 2: Districts of Gujarat where sex

 ratio decreased in 2011 census

No	Name of district	2011	2001	No. of decrease
1.	Kuchchh	907	942	35
2.	Amareli	964	987	23
3.	Surat	788	810	23
4.	Rajkot	924	930	6
5.	Bhavnagar	931	937	6
6.	Jamnagar	938	941	3
7.	Junagadh	952	955	3
8.	Mehsana	925	927	2

[Census 2011, provisional data, India]

Table 3: Districts	of Gujarat where sex
ratio increased in	2011 census

No	Name of	2011	2001	No. of
	district			increase
1.	Banaskantha	930	936	6
2.	Patan	932	935	3
3.	Sabarkantha	947	950	3
4.	Gandhinagar	913	920	7
5.	Ahmadabad	892	903	11
6.	Surendranagar	924	929	5
7.	Porbandar	946	947	1
8.	Anand	910	921	11
9.	Kheda	923	937	14
10.	PanchMahals	938	945	7
11.	Dohad	985	986	1
12.	Vadodara	919	934	15
13.	Narmada	949	960	11
14.	Bharuch	921	924	3
15.	The Dangs	98 7	1007	20
16.	Navsari	955	961	6
17.	Valsad	920	926	6
18.	Тарі	996	1004	8

[Census 2011, provisional data, India]

Table 4: Simple regression analysis was done to determine the nature of correlation and future trend of sex ratio in India and Guiarat.

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	Regression	Correlation
	Equation	coefficient
India	Y = 1599.26 + (-	- 0.87*
	0.335) X	
Gujarat	Y = 1450.74 + (-	- 0.84*
	0.261) X	

[Y = Sex Ratio, X = Year, * = p value < 0.05]

After the implementation of PC & PNDT Act, many of the districts in Gujarat showed increase trend in sex ratio however overall sex ratio is still less compared to National data (Table 3 Fig 1). Simple regression analysis was done to determine the nature of correlation and future trend of sex ratio in India and Gujarat which shows nagative correlation between year and sex ratio if current situation is not changed.

Implementation status of the PNDT Act:

In 1970, Pre-natal testing was introduced in India. The centre had partial ban on sex determination tests in 1976. But it was applied on the government facilities, not on the private ones. During 1977-1982, 78000 female foetuses were aborted in India¹⁸. In Bombay during 1982 -1987 ⁴ sex determination clinics increased to 248 and from 8000 abortions 7999 were female fetuses¹⁸.

After that, the centre passed the Pre Techniques (Regulation Natal and Prevention of Misuse) Act in 1994 covering the entire country. The law came into the operation on January 1, 1996. The act was amended in the year 2003 to include sex-determination at preconception stage and action against advertisements promising a male child. The amended act received the assent of the President on the 17th January, 2003. The act is now called PC & PNDT Act (Pre-Conception and Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse)Act as amended by Amendment Act of 2002. 3,19

Figure : Correlation of sex ratio with time before and after implementation of PNDT Act 1971 in India and Gujarat



Before PNDT Act

After PNDT Act



Figure shows that, in India there is improvement in sex ratio after implementation of PNDT act but in Gujarat there is still decrease in the sex ratio.

References:

- 1. Natarajan D. Changes in sex ratio. New Delhi: Census of India, 1972.
- 2. Sen A. Missing women. BMJ 1992;304:587–8
- 3. S V Subramanian and S Selvaraj. Social analysis of sex imbalance in India: before and after implementation of PNDT Act. J Epidemiol Community Health 2009;63;245-252.
- A.Dave, S. Dave, G.S. Preetha, B. Pant. Why Me? A Missing Girl. Indian Journal of Public health 2009; 53(4): 259-263.
- Govt. of India. Census 2001. Available from <u>http://www.mapsofindia.com/census2001/se</u> <u>xratio/</u> sexratio-india.htm. (Accessed on March 2008).
- 6. Monica Das Gupta. Selective Discrimination against Female Children in Rural Punjab, India. *Population and Development Review* 1987:13(1);77-100.
- 7. Kulkarni S. Sex determination tests in India: a survey report. Radical J Health 1986:1:99.
- Jha P, Kumar R, Vasa P, et al. Low female (corrected)-to-male (corrected) sex ratio of children born in India: national survey of 1.1 million households. Lancet 2006;367:211– 18.
- 9. The World's Women Trends and Statistics, Dept of Economic and Social Affairs, United Nations, NY, 2010
- Miller Barbara D. The Endangered Sex: Neglect of Female Children in Rural North India, Cornell University Press, Ithaca, New York; 1981.
- 11. Gupta D, Monica and Mari Bhat PN. Fertility decline and increased manifestation of sex bias in India. Population Studies 1997; 51(3): 307-315.
- Oldenberg P. Sex ratio, son preference and violence in India: A research note. Economic and Political Weekly 1992; 27 (49-50): 2657-2662.
- 13. ManjuToppo, AvadheshDiwakar, D.K. Pal. A Study of sex ratio in relation to birth order

in Bhopal city. healthline 2012:3(1);45-49, ISSN 2229-337X.

- 14. Central Bureau of Health Intelligence, Health Information of DGHS, Government of India, New Delhi: 2003.
- 15. Bardia A, Paul E, Kapoor SK, Anand K. Declining sex ratio: Role of society, technology and government regulation in Faridabad district, Haryana. Natl Med J India. 2004;17:207-11.
- 16. Sahni M, Verma N, Narula D, Varghese RM, Sreenivas V, Puliyel JM. Missing girls in India: infanticide, feticide and made-toorder pregnancies? Insights from hospitalbased sex-ratio-at-birth over the last century. PLoS ONE 2008;3:e2224.c2008.
- India Go. Sample design and estimation procedure, employment–unemployment situation in India. New Delhi: National Sample Survey Organisation, Ministry of Statistics and Programme Implementation, 2006.
- India Go. Annual report on implementation of the Pre-conception and Pre-NatalDiagnostic Techniques (Prohibition of Sex Selection) Act. New Delhi: PNDT Division, Ministry of Health and Family Welfare, Government of India, 2005.

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