Demographers for long have been trying to study the determinants of infant and child mortality in specific context. In India also, there are few good studies on the determinants of infant and child mortality. Many of the south Asian countries, especially, India, are patriarchal in nature and are marked by profound preference for bearing sons. This preference for bearing sons results into the neglect of the female child and the discrimination against the female child leading to higher mortality of female child during infancy and childhood. Autonomy and the status of women have also often been cited as important determinants of infant and child morality in any specific setup. But the impact of women's autonomy and status of women on sex differential in infant and child mortality is a least explored area of research. Does autonomy or status of women have any impact on sex differential in infant and child mortality? If the status of women is high, then whether there is no sex differential in child mortality? In which group of women female child is more likely to experience high mortality than the male child? The present paper tries to discuss some of these issues when there is a hue and a cry about empowering women not only for improving their own health but also the health and well-being of their babies.

The present analysis is restricted to the state of Madhya Pradesh in India. Madhya Pradesh lies in the central part of the country and is typically a patriarchal society. Also, Madhya Pradesh is marked by high level of son-preference among the states of the country. Data from National Family Health Survey 1998-99 data for Madhya Pradesh has been used for this study. We have used data for women who are in the age group15-49 at the time of the survey and have given birth to at least one child in the last five years preceding the survey. Birth history data has been used to get the information on births and child deaths in the five years preceding the survey. The dependent variable in the present analysis is 'whether the child is alive or dead'. We were interested to analyze data separately for 0-12 months (infant mortality) and 13-60 months (child mortality). But due to small number of observations in certain categories of the independent variables, we have restricted our analysis to 0-60 months, which we call in our subsequent write up as child mortality.

A variable named 'status of women' was created with the help of a number of other variables like: whether woman needs permission to keep money aside; whether woman needs permission for going to market or relatives' home; whether woman can

decide about obtaining health care for herself; whether she is involved in decision making on what to cook, purchasing jewelry, and going and staying with the parents and siblings. This variable is further categorized into 'high' and 'low'. Using this variable we divided the total number of women in the sample into two groups. One having relatively higher status in the household and another having relatively low status. The independent variables used in the analysis are caste, education of women, their exposure to the mass media, sex of the child, type of place of residence, standard of living of the household, age of the women at the time of delivery, birth order, preceding birth interval, whether the delivery was safe or not, whether the woman has gone for antenatal care or not, use of safe drinking water, and availability of toilet facility in the household. Some community level variables like availability of health facility in the locality, and availability of transport facility in the locality are also included in the analysis.

To fulfill the objectives of the paper, bivariate and multivariate techniques have been used. At first total number of women in the sample were divided into two strata namely 'high status women' and 'low status women'. Cross tabs are made taking the variable 'whether the child is alive or dead' as the dependent variable and the independent variables mentioned above. Again, separate logistic regressions have been run to study the impact of different independent variables on the dependent variable. The analysis reveals that when the status of women is high, sex of the child does not make any difference to child mortality. Whereas, when the status of women is low, female child is more likely to experience child mortality compared to male child after controlling for other confounding variables. The other important determinants of child morality that came out to be significant from the analysis are preceding birth interval, utilization of antenatal care, age of the mother at the time of delivery, etc. We are planning to extend this analysis to the states of Punjab and Haryana that are well known for discrimination and the neglect of the female child. The census 2001 sex ratio for the states of Punjab and Haryana are very disturbing and are highly biased against the females. Further, detailed analysis is being done to pass any judgment about the relationship between the status of women and sex differential in child mortality.

The findings of the study are very important from the policies and programmes point of view keeping in mind the type of society and the kind of preference for having a male child. Empowerment of women as advocated by the women activists' could have serious implications for the health and survival of the female child. May be that the women who are empowered enough or who have high status in their household irrespective of their socio-economic status are less concerned about the sex of their babies and thus are less likely to experience differential child mortality by sex. On the basis of the preliminary analysis, it can be concluded that empowering women may lead to less discrimination and neglect of the female child and thus helping in better survival of the female child.