



**Sex Selection
&
Pre-birth Elimination of Girl Child**
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“Eliminate Inequality, not Women”

“Destroy Dowry, not Daughters”

Say “No” to Sex-determination, Say “Yes” to Empowerment of Women

Say “No” to Sex Discrimination, Say “Yes” to Gender Justice

Abstract

Consumerist culture oriented economic development, commercialisation of medical profession and sexist biases in our society, combined together have created a sad scenario of 'missing girls'. Global comparisons of sex ratios shows that Sex ratios in Europe, North America, Caribbean, Central Asia, the poorest regions of sub Saharan Africa are favourable to women as these countries neither kill/ neglect girls nor do they use NRTs for production of sons. The lowest sex ratio is found in some parts of India.

Deficit of women in India since 1901 - Violence against women throughout the Life Cycle, from womb to tomb - female infanticide, neglect of girl child in terms of health and nutrition, child marriage and repeated pregnancy is taking heavy toll of girls' lives. *Selective Elimination of Female Foetuses and selection of male at a preconception stage* – the legacy of continuing declining sex ratio in India in the history of Census of India has taken a new turn with widespread use of new reproductive technologies (NRTs) in India. NRTs are based on principle of selection of **the desirable** and rejection of **the unwanted**. In India, the desirable is the baby boy and the unwanted is the baby girl. The result is obvious. The Census results of 2001 have revealed that with sex ratio of 927 girls for 1000 boys, India had deficit of 60 lakh girls in age-group of 0-6 years, when it entered the new millennium - **Female infanticide was practiced among selected communities, while the abuse of NRTs has become a generalised phenomenon encompassing all communities irrespective of caste, class, religious, educational and ethnic backgrounds**. Demographers, population control lobby, anthropologists, economists, legal experts, medical fraternity and feminists are divided in their opinions about gender implications of NRTs. NRTs in the context of patriarchal control over women's fertility and commercial interests are posing major threat to women's dignity and bodily integrity. The supporters of sex selective abortions put forward the argument of "Women's Choice" as if women's choices are made in social vacuum. In this context, the crucial question is - can we allow Asian girls to become an endangered species?

Prenatal Diagnostic Techniques Act was enacted in 1994 as a result of pressure created by Forum Against Sex-determination and Sex – preselection. But it was not implemented. After another decade of campaigning by women's rights organisations and public interest litigation filed by CEHAT, MASUM and Dr. Sabu George, The Pre-natal Diagnostics Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002 received the assent of the President of India on 17-1-2003. The Act provides "for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto". The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Rules, 2003 have activated the implementation machinery to curb nefarious practices contributing for MISSING GIRLS. We have a great task in front of us i.e. to change the mindset of doctors and clients, to create a socio-cultural milieu that is conducive for girl child's survival and monitor the activities of commercial minded techno-docs thriving on sexist prejudices. Then only we will be able to halt the process of declining sex ratio resulting into deficit of girls/women.

**Eliminate Inequality, Not women
Destroy Dowry, Not Daughters
Daughters are not for Slaughter**

Introduction

Asian countries are undergoing a demographic transition of low death and birth rates in their populations. The nation-states in S. Asia are vigorously promoting small family norms. India has adopted two-child norm and China has ruthlessly imposed 'one child per family' rule.

Historically, most Asian countries have had strong son-preference. The South Asian countries have declining sex ratios. This presentation tries to examine gendered socio-cultural and demographic implications of new reproductive technologies, with special focus on sex-determination and sex-pre-selection technologies.

Sex Ratios – A Global Scenario

Sex ratios in Europe, North America, Caribbean, Central Asia, the poorest region- sub Saharan Africa are favourable to women as these countries neither kill/ neglect girls nor do they use (New Reproductive Technologies) NRTs for production of sons. Only in the South Asia the sex ratios are adverse for women as the following table reveals. The lowest sex ratio is found in India.

Table 1- Women per 100 men

Europe & North America	105
Latin America	100
Caribbean	103
Sub Saharan Africa	102
South East Asia	100
Central Asia	104
South Asia	95
China	944
India	93

Source: The World's Women- Trends and Statistics, United Nations, NY, 1995

There is an official admission to the fact that "it is increasingly becoming a common practice across the country to determine the sex of the unborn child or foetus and eliminate it if the foetus is found to be a female. This practice is referred to as pre-birth elimination of females (PBEF). PBEF involves two stages: determination of the sex of the foetus and induced termination if the foetus is not of the desired sex. It is believed that one of the significant contributors to the adverse child sex ratio in India is the practice of female foetuses."¹

Historical Legacy of Declining Sex Ratio in India:

¹ "Missing...Mapping the Adverse Child Sex Ratio in India", **Office of the Registrar General and Census Commissioner, India, Ministry of Health and Family Welfare and United Nations Population Fund, 2003**

In the beginning of the 20th century, the sex ratio in the colonial India was 972 women per 1000 men, it declined by –8, -11, -5 and –5 points in 1911, 1921, 1931 and 1941 respectively. During 1951 census it improved by +1 point. During 1961, 1971, 1981 and 1991 it declined by –5, -11, -4, -7 points respectively. Eventhough the overall sex ratio improved by +6 points, decline in the juvenile sex ratio (0-6 age group) is of –18 points which is alarmingly high.

Table-2 Sex Ratio in India, 1901 to 2001

Year	Number of Women per 1000 Men	Decadal Variation
1901	972	
1911	964	- 8
1921	955	-11
1931	950	-5
1941	945	-5
1951	946	+1
1961	941	- 5
1971	930	-11
1981	934	- 4
1991	927	-7
2001	933	+6

Source: Census of India, 2001

Prof. Amartya Kumar Sen, in his world famous article “MISSING WOMEN”, has statistically proved that during the last century, 100 million women have been missing in South Asia due to ‘discrimination leading to death’ experienced by them from womb to tomb in their life cycles.

Dynamics of Missing Women in the contemporary India

Legacy of continuing declining sex ratio in India in the history of Census of India has taken new turn with widespread use of new reproductive technologies (NRTs) in urban India. NRTs are based on principle of selection of **the desirable** and rejection of **the unwanted**. In India, the desirable is the baby boy and the unwanted is the baby girl. The result is obvious. The Census results of 2001 have revealed that with sex ratio of 933 women for 1000 men, India had deficit of 3.5 crore women when it entered the new millennium.

Table-3 Demographic Profile

Population of India	102.7 crores
Males	53.1 crores
Females	49.6 crores
Deficit of women in 2001	3.5 crores
Sex ratio (no. of women per 1000 men)	933

Source: Census of India, 2001.

Political Economy of Missing Girls

The declining juvenile sex ratio is the most distressing factor reflecting low premium accorded to a girl child in India.² As per the Census of India, juvenile sex ratios were 971, 945 and 927 for 1981, 1991 and 2001 respectively. In 2001, India had 158 million infants and children, of which 82 million were males and 76 million were females. There was a deficit of 6 million female infants and girls. This is a result of the widespread use of sex determination and sex pre-selection tests throughout the country (including in Kerala), along with high rates of female infanticide in the BIMARU states, rural Tamilnadu and Gujarat. Millions of girls have been missing in the post independence period. According to UNFPA (2003)³, 70 districts in 16 states and Union Territories recorded more than a 50point decline in the child sex ratio in the last decade.

To stop the abuse of advanced scientific techniques for selective elimination of female foetuses through sex -determination, the government of India passed the PNDDT Act in 1994. But the techno-docs based in the metropolis, urban and semi-urban centres and the parents desirous of begetting only sons have subverted the act.

Sex determination and sex pre-selection, scientific techniques to be utilized only when certain genetic conditions are anticipated, are used in India and among Indians settled abroad to eliminate female babies. People of all class, religious, and caste backgrounds use sex determination and sex pre selection facilities. The media, scientists, medical profession, government officials, women's groups and academics have campaigned either for or against their use for selective elimination of female foetuses/ embryo. Male supremacy, population control and moneymaking are the concerns of those who support the tests and the survival of women is the concern of those who oppose the tests. The Forum Against Sex Determination and Sex Pre Selection had made concerned efforts to fight against the abuse of these scientific techniques during the 1980s.

Science in Service of Femicide :

Advances in medical science have resulted in sex-determination and sex pre-selection techniques such as Sonography, fetoscopy, needling, chorion villi biopsy (CVB) and the most popular, amniocentesis and ultrasound have become household names not only in the urban India but also in the rural India. Indian metropolis are the major centres for sex determination (SD) and sex pre-selection (SP) tests with sophisticated laboratories; the techniques of amniocentesis and ultrasound are used even in the clinics of small towns and cities of Gujarat, Maharashtra, Karnataka, Uttar Pradesh, Bihar, Madhya Pradesh, Punjab, West Bengal, Tamil Nadu and Rajasthan. A justification for this has been aptly put by a team of

² Patel, Vibhuti (2003) "The Girl Child: Health Status in the Post Independence Period", **The National Medical Journal of India**, AIIMS- Delhi, Vol.16, Supplement 2, pp. 42-45.

³ UNFPA (2003) **Missing**, New Delhi.

doctors of Harkisandas Narottamdas Hospital (a pioneer in this trade) in these words, "...in developing countries like India, as the parents are encouraged to limit their family to two offspring, they will have a right to quality in these two as far as can be assured, Amniocentesis provides help in this direction"⁴. Here the word 'quality' raises a number of issues that we shall examine in this paper.

At present, ultrasound machines are most widely used for sex determination purposes. "Doctors motivated in part by multinational marketing muscle and considerable financial gains are increasingly investing in ultrasound scanners."⁵ But for past quarter century, Amniocentesis, a scientific technique that was supposed to be used mainly to detect certain genetic conditions, has been very popular in India for detection of sex of a foetus. For that purpose, 15-20 ml of amniotic fluid is taken from the womb by pricking the foetal membrane with the help of a special kind of needle. After separating a foetus cell from the amniotic fluid, a chromosomal analysis is conducted on it. This test helps in detecting several genetic disorders, such as Down's Syndrome, neurotube conditions in the foetus, retarded muscular growth, 'Rh' incompatibility, haemophilia, and other physical and mental conditions. The test is appropriate for women over 40 years because there are higher chances of children with these conditions being produced by them. A sex determination test is required to identify sex specific conditions such as haemophilla and retarded muscular growth, which mainly affect male babies.

Other tests, in particular CVB, and preplanning of the unborn baby's sex have also been used for SD and SP tests. Diet control method, centrifugation of sperm, drugs (tablets known as SELECT), vaginal jelly, 'Sacred' beads called RUDRAKSH and recently advertised Gender Select kit are also used for begetting boys.⁶

Compared to CVB and pre-selection through centrifugation of sperm, amniocentesis is more hazardous to women's health. In addition, while this test can give 95-97% accurate results, in 1% of the cases the test may lead to spontaneous abortions or premature delivery, dislocation of hips, respiratory complications or needle puncture marks on the baby.⁷

Popularity of the test

Amniocentesis became popular in the last twenty-five years though earlier they were conducted in government hospitals on an experimental basis. Now, this test is conducted mainly for SD and thereafter for extermination of female foetus through induced abortion carried out in private clinics, private hospitals, or government hospitals. This perverse use of modern technology is encouraged and boosted by money minded private practitioners who are out to make Indian women "male-child- producing machines." As per the most conservative estimate made by a research team in Bombay, sponsored by the Women's

⁴ Patanki, M. H., Banker, D. D. Kulkarni, K. V. & Patil, K. P. (1979, March). "Prenatal Sex-prediction by Amniocentesis- Our Experience of 600 Cases", Paper presented at the First Asian Congress of Induced Abortion and Voluntary Sterilization, Bombay.

⁵ George, Sabu and Ranbir S. Dahiya (1998) "Female Foeticide in Rural Haryana", **Economic and Political Weekly**, Vol. XXXIII, No.32, August 8-14, pp. 2191- 2198.

⁶ Kulkarni, Sanjeev (1986) "Prenatal SD Tests and Female Foeticide in Bombay City- a Study", **Foundation for Research in Community Health**, 64-A, R.G. Thadani Marg, Worli, Bombay – 400018.

⁷ Ravindra, R.P. (1986, January) "The Scarcer Half – A Report on Amniocentesis and Other SD Techniques, SP Techniques and New Reproductive Technologies" **Centre for Education and Documentation**, Health Feature, Counter Fact No. 9, Bombay.

Centre, based on their survey of six hospitals and clinics; in Bombay alone, 10 women per day underwent the test in 1982.⁸ This survey also revealed the hypocrisy of the ‘non-violent,’ ‘vegetarian,’ ‘anti-abortion’ management of the city’s reputable Harkisandas Hospital, which conducted antenatal sex determination tests till the official ban on the test was clamped in 1988 by the Government of Maharashtra. The hospital’s handout declared the test to be ‘humane and beneficial’. The hospital had outpatient facilities, which were so overcrowded during 1978-1994 that couples desirous of the SD test had to book for the test one month in advance. As its Jain management did not support abortion, the hospital recommended women to various other hospitals and clinics for abortion and asked them to bring back the aborted female foetuses for further ‘research’.

Scenario During the 1980s:

During 1980s, in other countries, the SD tests were very expensive and under strict government control, while in India the SD test could be done for Rs. 70 to Rs. 500 (about US \$6 to \$40). Hence, not only upper class but even working class people could avail themselves of this facility. A survey of several slums in Bombay showed that many women had undergone the test and after learning that the foetus was female, had an abortion in the 18th or 19th week of pregnancy. Their argument was that it was better to spend Rs. 200 or even Rs. 800 now than to give birth to a female baby and spend thousands of rupees for her marriage when she grew up.

The popularity of this test attracted young employees of Larsen and Tubero, a multinational engineering industry. As a result, medical bills showing the amount spent on the test were submitted by the employees for their reimbursement by the company. The welfare department was astonished to find that these employees were treating sex determination tests so casually. They organized a two-day seminar in which doctors, social workers, and representatives of women’s organisations as well as the family planning Association were invited. One doctor who carried on a flourishing business in SD stated in a seminar that from Cape-Comorin to Kashmir people phoned him at all hours of the day to find out about the test. Even his six-year-old son had learnt how to ask relevant questions on the phone such as, “Is the pregnancy 16 weeks old, etc.”⁹

Three sociologists conducted micro-research in Bijnor district of Uttar Pradesh. Intensive field work in two villages over a period of a year, and an interview survey of 301 recently delivered women drawn from randomly selected villages in two community developed blocks adjacent to Bijnor town convinced them of the fact that “Clinical services offering amniocentesis to inform women of the sex of their foetuses have appeared in North India in the past 10 years. They fit into cultural patterns in which girls are devalued”.¹⁰ According to the 1981 Census, the sex ratio of Uttar Pradesh and Bijnor district respectively, were 886 and 863 girls per 1000 boys. The researchers also discovered that female infanticide practiced in Bijnor district until 1900, had been limited to Rajputs and Jats who considered the birth of a

⁸ Abraham, Ammu and Shukla, Sonal (1983) “Sex Determination Tests”, **Women’s Centre**, 104 B, Sunrise Apartment, Nehru Road, Vakola Santacruz (E), Bombay.

⁹ Abraham, Ammu (1985, October). “Larsen and Turbo Seminar on Amniocentesis”, **Women’s Centre Newsletter**, Bombay, 1 (4), 5-8.

¹⁰ Jeffery, Roger and Jeffery, Patricia & Lyon, Andrew (1984) “Female Infanticide and Amniocentesis” **Social Science and Medicine**, (U.K) 19(11), 1207-1212.

daughter as a loss of prestige. By contrast, the abuse of amniocentesis for the purpose of female foeticide is now prevalent in all communities.

In Delhi, the All India Institute of Medical Science began conducting a sample survey of amniocentesis in 1974 to find out about foetal genetic conditions and easily managed to enroll 11000 pregnant women as volunteers for its research.¹¹ Main interest of these volunteers was to know sex of the foetus. Once the results were out, those women who were told that they were carrying female fetuses, demanded abortion.¹² This experience motivated the health minister to ban SD tests for sex selection in all government run hospitals in 1978. Since then, Private sector started expanding its tentacles in this field so rapidly that by early eighties Amniocentesis and other sex selection tests became bread and butter for many gynaecologists.

A sociological research project in Punjab in 1982 selected, in its sample, 50% men and 50% women as respondents for their questionnaire on the opinions of men and women regarding SD tests. Among male respondents were businessmen and white-collar employees of the income group of Rs. 1000/- to Rs. 3500/- per month, while female respondents were mainly housewives. All of them knew about the test and found it useful.¹³ Why not? Punjab was the first to start the commercial use of this test as early as in 1979. It was the advertisement in the newspaper regarding the New Bhandari Ante-Natal SD Clinics in Amritsar that first activated the press and women's groups to denounce the practice.

A committee to examine the issues of sex determination tests and female foeticide, formed at the initiative of the government of Maharashtra in 1986, appointed Dr. Sanjeev Kulkarni of the Foundation of Research in Community Health to investigate the prevalence of this test in Bombay. Forty-two gynecologists were interviewed by Dr. Sanjeev Kulkarni, who is himself a gynaecologist. His findings disclosed that about 84% of the gynaecologists interviewed were performing amniocentesis for SD tests. These 42 doctors were found to perform on-an-average 270-amniocentesis tests per month. Some of them had been performing the tests for 10-12 years. But the majority of them started doing so only in the last five years. Women from all classes, but predominantly middle class and lower class of women, opted for the test. About 29% of the doctors said that up to 10% of the women who came for the test already had one or more sons. A majority of doctors feel that by providing this service they were doing humanitarian work. Some doctors feel that the test was an effective measure of population control. With the draft of the 8th Five-Year Plan, the Government of India aimed to achieve a Net Reproduction Rate of one (i.e. the replacement of the mother by only one daughter). For this objective SD and SP were seen as handy; the logic being a lesser number of women means less reproduction.¹⁴

¹¹ Mazumdar, Veena (1994), "Amniocentesis and Sex Selection", **Centre for Women's Development Studies**, Delhi, Occasional Paper Series No. 21.

¹² Chhachhi, Amrita & Stayamala, C. (1983, November) "Sex-determination Tests: A Technology, Which Will Eliminate Women", **Medico Friend Circle Bulletin**, India; No. 95, 3-5.

¹³ Singh, Gurmeet and Sunita Jain (1983). "Opinion of Men and Women Regarding Amniocentesis", College of Home Science", Punjab Agricultural University, Ludhiana, India.

¹⁴ Kulkarni, 1986, opcit.

Controversy Around Amniocentesis and other SD & SP Tests

Twenty years ago a controversy around SD and SP started as a result of several investigative reports published in popular newspapers and magazines such as India Today, Eve's Weekly, Sunday and other national and regional English language journals. One estimate that shocked many, from academicians to activists, was that between 1987 and 1983, about 78000 female fetuses were aborted after SD tests as per Times of India editorial in June, 1982. The article by Achin Vanayak¹⁵ in the same paper revealed that almost 100% of 15914 abortions during 1984-85 by a well-known abortion centre in Bombay were undertaken after SD tests.

All private practitioners in the SD tests who used to boast that they were "doing social work" by helping miserable women, exposed their hypocrisy when they failed to provide facilities of amniocentesis to pregnant women during the Bhopal gas tragedy, in spite of repeated requests by women's groups and in spite of many reported cases of the birth of the deformed babies as a result of the gas carnage. Thus it is clear that this scientific technique is in fact not used for humanitarian purposes, not because of "empathy towards poor Indian women" as has been claimed. Forced sterilization of males during the emergency rule brought politically disastrous consequences for the Congress Party. As a result in the post emergency period, there has been a shift in the policy and women became the main target of population control. SD and SP's after effects, harmful effects of hormone based contraceptive pills and anti-pregnancy injections and camps for mass IUD insertion and mass sterilization of women with their unhygienic provisions, are always overlooked by enthusiasts of the Family Planning Policy. Most population control research is conducted on women without consideration for the harm caused by such research to the women concerned.¹⁶

India has had a tradition of killing female babies (custom of DUDHAPITI) by putting opium on the mother's nipple and feeding the baby, by suffocating her in a rug, by placing the afterbirth over the infant's face, or simply by ill-treating daughters.¹⁷ A survey by *India Today*, 15.6.1986, revealed that among the Kallar community in Tamilnadu, mother who gave birth to baby girls may be forced to kill their infant by feeding them milk from poisonous oleander berries. This author is convinced that researcher could also find contemporary cases of female infanticide in parts of western Gujarat, Rajasthan, Uttar Pradesh, Bihar, Punjab and Madhya Pradesh. In addition, female members of the family usually receive inferior treatment regarding food, medication and education.¹⁸ When they grow up, they are further harassed with respect to dowry. Earlier, only among the higher castes, the bride's parents had to give dowry to the groom's family at the time of engagement and marriage. As higher caste women were not allowed to work outside the family, their work had no social recognition. The women of the higher castes were seen as a burden. To compensate the husband for shouldering the burden of his wife, dowry was given by the girl's side to the boy's side. Lower class women always worked in the fields, mines, plantations, and factories and as artisans. Basic survival needs of the family such as collection of firewood and water, horticulture and assistance in agricultural & associated activities; were

¹⁵ Vanaik, Achin (1986, June 20) "Female Foeticide in India", Times of India.

¹⁶ Mies, Maria (1986 August) "Sexiest and Racist Implications of New Reproductive Technologies", Paper presented at XI World Congress of Sociology, 18-22, New Delhi.

¹⁷ Clark, Alice (1983) "Limitation of Female Life Chances in Rural Central Gujarat", **The Indian Economic and Social History Review**, Delhi 20 (1), 1-25.

¹⁸ Kynch, Jocelyn & Sen, Amartya (1983) "Indian Women: Well-being and Survival", *Cambridge Journal of Economics*, 7, 363-380.

provided by the women of lower castes and lower classes. Hence women were treated as productive members among them and there was no custom of dowry among the toiling masses.

Historically, practice of female infanticide in India was limited among the upper caste groups due to system of hypergamy (marriage of woman with a man from a social group above hers) because of the worry as to how to get a suitable match for the upper caste woman?¹⁹

Males in the upper class also thought that a daughter would take away the natal family's property to her in-laws after her marriage. In a patri-local society with patri-lineage, son preference is highly pronounced. In the power relations between the brides and grooms family, the brides side always has to give in and put up with all taunts, humiliations, indignities, insults and injuries perpetrated by the grooms family. This factor also results into further devaluation of daughters. The uncontrollable lust of consumerism and commercialisation of human relations combined with patriarchal power over women have reduced Indian women to easily dispensable commodities. Dowry is an easy money, 'get rich quick' formula spreading in the society as fast as cancer. By the late eighties, dowry had not been limited to certain upper castes only but had spread among all communities in India irrespective of their class, caste and religious backgrounds. Its extreme manifestation was seen in the increasing state of dowry related murders. The number of dowry deaths was 358 in 1979, 369 in 1980, 466 in 1981, 357 in 1982, 1319 in 1986 and 1418 in 1987 as per the police records. These were only the registered cases; the unregistered cases were estimated to be ten times more.

Academicians Plunged in the Debate:

In such circumstances, "Is it not desirable that a woman dies rather than be ill-treated?" asked many social scientists. In Dharam Kumar's²⁰ words: "Is it really better to be born and to be left to die than be killed as a foetus? Does the birth of lakhs or even millions of unwanted girls improve the status of women?"

Before answering this question let us first see the demographic profile of Indian women. There was a continuous decline in the ratio of females to males between 1901 and 1971. Between 1971 and 1981 there was a slight increase, but the ratio continued to be adverse for women in 1991 and 2001 Census. The situation is even worse because SD is practiced by all-rich and poor, upper and the lower castes, the highly educated and illiterate - whereas female infanticide was and is limited to certain warrior castes.²¹

Many economists and doctors have supported SD and SP by citing the law of supply and demand. If the supply of women is reduced, it is argued, their demand as well as status will be enhanced.²² Scarcity of women will increase their value.²³ According to this logic, women will cease to be an easily replaceable commodity. But here the economists forget the socio-cultural milieu in which women have to live. The society that treats women as mere sex and

¹⁹ Sudha, S. and S. Irudaya Raja (1998) "Intensifying Masculinity of Sex Ratios in India: New Evidence 1981-1991", Centre for Development Studies, Thiruvananthapuram.

²⁰ Kumar Dharm (1983, June 11) "Amniocentesis Again", **Economic and Political Weekly**, (Bombay).

²¹ Jeffery Roger and Jeffery Patricia (1983, April) "Female Infanticide and Amniocentesis", **Economic and Political Weekly**, (Bombay).

²² Sheth, Shirish (1984, September) "Place of Prenatal Sex determination", Larson and Turbo Seminar, Bombay

²³ Bardhan Pranab (1982, Sept 5) "Little girls and Death in India", **Economic and Political Weekly** (Bombay).

reproduction object will not treat women in more humane way if they are merely scarce in supply. On the contrary, there will be increased incidences of rapes, abduction and forced polyandry.

Agents Hired to buy the Brides and Forced Polyandry:

In Madhya Pradesh, Haryana, Rajasthan and Punjab, among certain communities, the sex ratio is extremely adverse for women. There, a wife is shared by a group of brothers or sometimes even by patrilineal parallel cousins.²⁴ Recently, in Gujarat, many disturbing reports of reintroduction of polyandry (Panchali system- woman being married to five men) have come to the light. In villages in Mehsana District, the problem of declining number of girls has created major social crisis as almost all villages have hundreds of boys who are left with no choice but to buy brides from outside.²⁵

To believe that it is better to kill a female foetus than to give birth to an unwanted female child is not only short-sighted but also fatalistic. By this logic it is better to kill poor people or Third World masses rather than to let them suffer in poverty and deprivation. This logic also presumes that social evils like dowry are God-given and we cannot do anything about it. Hence, victimise the victims.

Another argument is that in cases where women have one or more daughters they should be allowed to undergo amniocentesis so that they can plan a 'balanced family' by having sons. Instead of continuing to produce female children in the hope of giving birth to a male child, it is better for the family's and the country's welfare that they abort the female foetus and produce a small and balanced family with daughters and sons. This concept of the 'balanced family' however, also has a sexist bias. Would the couples with one or more sons request amniocentesis to get rid of male fetuses and have a daughter in order to balance their family? Never! The author would like to clarify the position of feminist groups in India. They are against SD and SP leading to male or female foeticide.

What price should women pay for a 'balanced family?' How many abortions can a woman bear without jeopardising her health?

Do Women Have A Choice?

Repeatedly it has been stated that women themselves enthusiastically welcome the test of their free will. "It is a question of women's own choice." But are these choices made in a social vacuum? These women are socially conditioned to accept that unless they produce one or more male children they have no social worth.²⁶ They can be harassed, taunted, even deserted by their husbands if they fail to do so. Thus, their 'choices' depend on fear of society. It is true that feminists throughout the world have always demanded the right of women to control their own fertility, to choose whether or not to have children and to enjoy facilities for free, legal and safe abortions. But to understand this issue in the Third World context, we must see it against the background of imperialism and racism, which aims at control of the 'coloured population.' Thus, "It is all too easy for a population control advocate to heartily endorse women's rights, at the same time diverting the attention from the

²⁴ Dubey, Leela (1983, February) "Misadventure in Amniocentesis", **Economic and Political Weekly**, (Bombay).

²⁵ The Times of India, 8-7-2004.

²⁶ Rapp, Rayna (1984 April) "The Ethics of Choice", **Ms. Magazine**, USA.

real causes of the population problem. Lack of food, economic security, clean drinking water and safe clinical facilities have led to a situation where a woman has to have 6.2 children to have at least one surviving male child. These are the roots of the population problem, not merely desire to have a male child”²⁷.

Economics and Politics of Femicide

There are some who ask, “If family planning is desirable, why not sex-planning?”. The issue is not so simple. We must situate this problem in the context of commercialism in medicine and health care systems, racist bias of the population control policy and the manifestation of patriarchal power.²⁸ Sex choice can be another way of oppressing women. Under the guise of choice we may indeed exacerbate women’s oppression. The feminists assert; survival of women is at stake.

Outreach and popularity of sex pre-selection tests may be even greater than those of sex determination tests, since the former does not involve ethical issues related to abortion. Even anti - abortionists would use this method. Dr. Ronald Ericsson, who has a chain of clinics conducting sex preselection tests in 46 countries in Europe, America, Asia and Latin America, announced in his hand out that out of 263 couples who approached him for begetting off-springs, 248 selected boys and 15 selected girls.²⁹ This shows that the preference for males is not limited to the Third World Countries like India but is virtually universal. In Ericsson’s method, no abortion or apparent violence is involved. Even so, it could lead to violent social disaster over the long term. Although scientists and medical professionals deny all responsibilities for the social consequences of sex selection as well as the SD tests, the reality shatters the myth of the value neutrality of science and technology. Hence we need to link science and technology with socio-economic and cultural reality.³⁰ The class, racist and sexist biases of the ruling elites have crossed all boundaries of human dignity and decency by making savage use of science. Even in China, after 55 years of “revolution”, “socialist reconstruction” and the latest, rapid capitalist development SD and SP tests for femicide have gained ground after the Chinese government’s adoption of the “one-child family” policy.³¹ Many Chinese couples in rural areas do not agree to the one child policy but due to state repression they, while sulking, accept it provided the child is male. This shows how adaptive the system of patriarchy and male supremacy is. It can establish and strengthen its roots in all kinds of social structures- pre-capitalist, capitalist and even post-capitalist - if not challenged consistently.³²

²⁷ Chhachhi & Sathyamla, 1983, opcit.

²⁸ Wichterrich, Christa (1988) “From the Struggle Against ‘Overpopulation’ to the Industrialisation of Human Production”, **Reproductive and Genetic Engineering – journal of International Feminist Analysis**, RAGE , Vol.1, No. 1, pp. 21-30.

²⁹ Patel, Vibhuti (2003) “Locating the Context of Declining Sex Ratio and New Reproductive Technologies”, **VIKALP- Alternatives**, Vikas Adhyayan Kendra, Mumbai.

³⁰ Holmes, Helen Bequart & Hoskins, Betty B. (1984, April) “Pre natal and pre conception sex choice technologies – a path to Femicide”, Paper presented at the International Interdisciplinary Congress on Women, the Netherlands.

³¹ Junhong, Chu (2001) “Prenatal Sex Determination and Sex Selection Abortion in Rural Central China”, **Population and Development Review**, Vol. XXVII, No. 2, PP. 259-281.

³² Patel, Vibhuti (1984, September). “Amniocentesis – Misuse of Modern Technology”, **Socialist Health Review**, 1(2), 69-71.

Action against SD and SP

How can we stop deficit of Indian Women? This question was asked by feminists, sensitive lawyers, scientists, researchers, doctors and women's organisations such as Women's Centre (Bombay), Saheli (Delhi), Samata (Mysore), Sahiar (Baroda) and Forum Against SD and SP (FASDSP) - an umbrella organisation of women's groups, doctors, democratic rights groups, and the People's Science Movement. Protest actions by women's groups in the late 70s got converted into a consistent campaign at the initiative of FASDSP in the 1980s. Even research organisations such as Research Centre on Women's Studies (Mumbai), Centre for Women's Development Studies (Delhi) and Voluntary Health Organisation, Foundation for Research in Community Health also took a stand against the tests. They questioned the "highly educated", "enlightened" scientists, technocrats, doctors and of course, the state who help in propagating the tests.³³ Concerned group in Bangalore, Chandigarh, Delhi, Madras, Calcutta, Baroda and Bombay have demanded that these tests should be used for limited purpose of identification of serious genetic conditions in selected government hospitals under strict supervision. After a lot of pressure, media coverage and negotiation, poster campaigns, exhibitions, picketing in front of the Harkisandas Hospital in 1986, signature campaigns and public meetings and panel discussions, television programmes and petitioning; at last the Government of Maharashtra and the Central Government became activated. In March 1987, the government of Maharashtra appointed an expert committee to propose comprehensive legal provisions to restrict sex determination tests for identifying genetic conditions. The committee was appointed in response to a private bill introduced in the Assembly by a Member of Legislative Assembly (MLA) who was persuaded by the Forum. In fact the Forum approached several MLA's and Members of the Parliament to put forward such a bill. In April 1988, the government of Maharashtra introduced, a bill to provide for the regulation of the use of Medical or Scientific techniques of pre natal diagnosis solely for the purpose of detecting genetic or metabolic disorders or chromosomal abnormalities or certain congenital anomalies or sex linked conditions and for the prevention of the misuse of prenatal sex determination leading to female foeticide and for matters connected therewith or incidental thereto (L. C. Bill No. VIII of 1988). In June 1988, the Bill was unanimously passed in the Maharashtra Legislative Assembly and became an Act. The Acts preview was limited only to SD tests, it did not say anything about the SP techniques. It admitted that medical technology could be misused by doctors and banning of SD tests had taken away the respectability of the Act of SD tests. Not only this, but now in the eyes of law both the clients and the practitioners of the SD tests are culprits. Any advertisement regarding the facilities of the SD tests is declared illegal by this Act. But the Act had many loopholes.

Two major demands of the Forum that no private practice in SD tests be allowed and in no case, a woman undergoing the SD test be punished, were not included in the Act. On the contrary the Act intended to regulate them with the help of an 'Appropriate Authority' constituted by two government bureaucrats, one bureaucrat from the medical education department, one bureaucrat from the Indian Council of Medical Research, one Gynaecologist and one geneticist and two representatives of Voluntary Organisations, which made a mockery of 'peoples participation'. Experiences of all such bodies set by the government have shown that they merely remain paper bodies and even if they function they are highly inefficient, corrupt and elitist.

The Medical mafia seemed to be the most favoured group in the act. It, "has scored the most in the chapter on Offences and Penalties...last clause of this chapter empowers the court, if it

³³ Patel, Vibhuti (1987) "Sex Determination and Sex Pre-selection Tests in India- Recent Techniques in Femicide", **Reproductive and Genetic Engineering RAGE**, Vol. II, No. 2, 1989, pp. 111-119.

so desires and after giving reasons, to award less punishment than the minimum stipulated under the Act. That is, a rich doctor who has misused the techniques for female foeticide, can with the help of powerful lawyers, persuade the court to award minor punishment,” said Dr. Amar Jesani in his article in *Radical Journal of Health*, 1988. The court shall always assume, unless proved otherwise, that a woman who seeks such aid of prenatal diagnosis procedures on herself has been compelled to do so by her husband or members of her family.”³⁴ In our kind of social milieu, it is not at all difficult to prove that a woman who has a SD test went for it of her “free will”. The Act made the victim a culprit who could be imprisoned up to three years. For the woman, her husband and her in-laws, using SD tests became a “cognisable, non-bailable and non-compoundable” offence! But the doctors, centres and laboratories were excluded from the above provision. The Act also believed in victimising the victim. With this act, the medical lobby’s fear that the law would drive SD tests underground, vanished. They could continue their business above ground. A high powered committee of experts had been appointed by the Central Government to introduce a bill applicable through out India to ban SD tests leading to female foeticide.

The Forum accepted that with the help of the law alone, we can’t get rid of female foeticide. Public education and the women’s right movement are playing a much more effective role in this regard. Some of the most imaginative programs of the Forum and women’s groups have been a rally led by daughters on 22.11.86, a children’s fair challenging a sex stereotyping and degradation of daughters, picketing in front of the clinics conducting the SD tests, promoting a positive image of daughters through stickers, posters and buttons, for example, ‘daughters can also be a source of support to parents in their old age,’ ‘eliminate inequality, not women’, ‘Diminish dowry, not daughters’, ‘make your daughter self sufficient, educate her, let her take a job, she will no longer be a burden on her parents.’ The Forum also prepared “Women’s struggle to survive,” a mobile fair that was organised in different suburbs of Bombay, conveyed this message through its songs, skits, slideshows, video films, exhibitions, booklets, debates and discussions.

Recent Studies on Socio-Cultural Background of Son Preference and Neglect of Daughters:

Recent studies have revealed that, in South Asia, we have inherited the cultural legacy of strong son-preference among all communities, religious groups and citizens of varied socio-economic backgrounds. Patri-locality, patri-lineage and patriarchal attitudes manifest in, women and girls having subordinate position in the family, discrimination in property rights and low-paid or unpaid jobs. Women’s work of cooking, cleaning and caring is treated as non-work. Hence, women are perceived as burden.³⁵ At the time of marriage, dowry is given by the bride’s side to the groom’s side for shouldering ‘the burden of bride’. In many communities female babies are killed immediately after birth either by her mother or by elderly women of the households to relieve themselves from the life of humiliation, rejection and suffering. In the most prosperous state of Punjab, the conventional patriarchal preference of male children leads to thousands of cases of sex selective abortions.³⁶ Recently a man drowned and killed his 8-year old daughter and also tried to kill his wife for having borne him the girl child. According to the Chandigarh (Punjab) based Institute for Development and

³⁴ Jesani, Amar (1988) “ Banning Pre-natal Sex Determination – Scope and Limits of Maharashtra Legislation”, **Radical Journal of Health**, Vol. II, No. 4, March.

³⁵ Patel, Vibhuti (2003, July-August) “Declining Sex Ratio and New Reproductive Technologies”, **Health Action**, Vol.16, No. 7-8, pp.30-33

³⁶ Patel, Vibhuti (2003, June) “So Much for Son”, **One India, One People**, Vol 6, No.11, pp.45-46.

Communication, during 2002-2003 every ninth household in the state acknowledged sex selective abortion with the help of ante-natal sex determination tests.³⁷

Recently, Voluntary Health Association of India has published its research report based on fieldwork in Kurukshetra in Haryana, Fatehgarh Sahib in Punjab and Kangra in Himachal Pradesh that have worst child sex ratio as per 2001 Census. The study surveyed 1401 households in villages, interviewed 999 married women, 72 doctors and 64 Panchayat members. It revealed that “The immediate cause for the practice of female foeticide is that daughters are perceived as economic and social burden to the family due to several factors such as dowry, the danger to her chastity and worry about getting her married.”³⁸

In this context, commercial minded techno-docs and laboratory owners have been using new reproductive technologies for femicide for over two and half decades. Among the educated families, adoption of small family norm means minimum one or two sons in the family. They can do without daughter. The propertied class do not desire daughter/daughters because after marriage of the daughter, the son-in-law may demand share in property. The property-less classes dispose off daughters to avoid dowry harassment. But they don't mind accepting dowry for their sons. Birth of a son is perceived as an opportunity for upward mobility while birth of a daughter is believed to result in downward economic mobility. Though stronghold of this ideology was the North India, it is increasingly gaining ground all over India.

Table 4: Index of Son Preference for Major States in India, 1990

States	Index of Son Preference*	Rank
Andhra Pradesh	13.8	11
Bihar	24.5	4
Gujarat	23	6
Haryana	14.3	10
Karnataka	20	8
Kerela	11.7	12
Madhya Pradesh	27.1	2
Maharashtra	18	9
Orissa	23.4	5
Punjab	20.3	7
Rajasthan	25	3
Tamilnadu	9.2	13
Uttar Pradesh	21.6	1
West Bengal	14.3	10
All India	20	

Index of Son preference =100 (E/C)

Where, E =the excess number of sons over daughters considered ideal
C= the ideal family size.

Sources: Rajan S.I., U.S. Mishra and T.K. Vimla (1996) “Choosing a Permanent Contraceptives: Does Son Preference Matter?” Economic and Political Weekly, July p.20, p.1980. The Third All India Survey of Family Planning Practices in India, ORG, Vadodara,1990. Calculated by Eapen and Kodoth (2001).

³⁷ **The Asian Age**, Mumbai, 25-4-2003.

³⁸ **Voluntary Health Association of India** (2003) “Darkness at Noon- Female Foeticide in India”, Delhi.

BIMARU states (Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh) were at the top of the rank for son preference in 1990. Orissa was 5th in the rank. Avers Prof. Ashish Bose (2001), “The unholy alliance between tradition (son-complex) and technology (ultrasound) is playing havoc with Indian Society.”³⁹ Kerala ranked 12th in the index of son-preference. However the sharp decline in fertility and strong preference for small family norm does raise the possibility of enhanced gender bias. In several states of India- Maharashtra, Gujarat, Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Punjab, Haryana and Tamilnadu sex-selective abortions of female foetuses have increased among those who want small families of 1 or 2 or maximum 3 children.⁴⁰ Communities, which were practicing female infanticide, started using sex-selective abortions.⁴¹ Many doctors have justified female foeticide as a tool to attain Net Reproduction Rate (NRR) of 1 i.e. to attain population stabilisation; mother should be replaced by only one daughter.⁴² But here also there is a gender bias. To attain population stabilisation, a fertility rate of 2.1 is envisaged. There is an evidence to indicate a sex ratio in favour of males and a prolonged duration of gender differentials in survivorship in the younger ages, results in a tendency to masculining of the population sex ratio. Even this does not worry the western scholars who have no inkling of the ground reality in the subcontinent. For example, Prof. Dickens avers, “Son preference has produced, but might also mitigate, the sex ratio imbalance...If sons wish, as adults, to have their own sons, they need wives. The dearth of prospective wives will, in perhaps short time, enhance the social value of daughters, reversing their vulnerability and the force of male dominance.”⁴³

Table-5 Sex Ratio and Literacy Rate of different States & UTs of India

State	Overall Sex Ratio	Child Sex Ratio (0-6 yrs)	Total Literacy Rate	Male Literacy Rate	Female Literacy Rate
India	933	927	65	76	54
Andaman& Nicobar Islands	846	965	81	86	75
Andhra Pradesh	978	964	61	71	51
Arunachal Pradesh	901	961	55	64	44
Assam	932	964	64	72	56
Bihar	921	938	48	60	34
Chandigarh	773	845	82	86	77
Chhatisgarh	990	975	65	78	52
Dadra & Nagar Haveli	811	973	60	73	43
Daman & Diu	709	925	81	88	70
Delhi	821	865	82	87	75
Goa	960	933	82	89	76
Gujarat	921	878	70	81	59
Haryana	861	820	69	79	56
Himachal Pradesh	970	897	77	86	68

³⁹ Bose, Ashish (2001) “Without My Daughter- Killing Fields of the Mind”, **The Times of India**, 25th April.

⁴⁰ Patel, Vibhuti (2002) “Adverse Juvenile Sex Ratio in Kerala”, **Economic and Political Weekly**, Vol.XXXVII, No. 22 June 1, pp.2124-5.

⁴¹ Jeffrey, Roger, Patricia Jeffrey and Andrew Lyon (1984) “Female Infanticide and Amniocentesis”, **Social Science and Medicine**, Vol. 19, No. 11, pp.1207-12.

⁴² Patel, Vibhuti (2002) **Women’s Challenges of the New Millennium**, Gyan Publications, New Delhi.

⁴³ Dickens, B .M (2002) “Can Sex Selection be Ethically Tolerated?” **Journal of Medical Ethics**, No. 28, pp. 335-336.

Jammu & Kashmir	900	927	54	66	42
Jharkhand	941	966	54	68	39
Karnataka	964	949	67	76	57
Kerala	1058	963	91	94	88
Lakshadweep	947	974	88	93	82
Madya Pradesh	920	929	64	76	51
Maharashtra	922	917	77	86	68
Manipur	978	961	69	78	60
Meghalaya	975	975	63	66	60
Mizoram	938	971	89	91	86
Nagaland	909	975	67	72	62
Orissa	972	950	64	76	51
Pondicherry	1001	958	81	89	74
Punjab	857	793	70	76	64
Rajasthan	922	909	61	76	44
Sikkim	875	986	70	77	61
Tamil Nadu	986	939	73	82	65
Tripura	950	975	74	81	65
Uttarpradesh	898	916	57	70	43
Uttaranchal	964	906	72	84	60
West Bengal	934	963	69	78	60

Source: Census of India, 2001.

Overall literacy rates in all states and Union territories have gone up as compared with the 1991 census. Even states and Union Territories with high female literacy-Goa, Delhi, Mizoram, Pondicherry, Lakshadweep, Kerala, Andaman & Nicobar, Daman & Deo, Chandigarh have experienced decline in Child Sex Ratio. In a micro-study of Kolkata, the Census Report observes, “ Out of 141 municipal wards, the percentage of child population has declined in 134 wards since 1991. More importantly, the child sex ratio has declined sharply, from a high of 1011 females per 1000 male children in 1951 to abysmal 923 in 2001. This is the lowest child sex ratio for Kolkata in the last 50 years. A major cause for the decline is ‘sex selective foeticide’”.⁴⁴ Rates of female foeticide have increased along with the increase in female literacy rates.⁴⁵

This neo-classical logic of Law of Demand and Supply does not apply to the complex social forces where patriarchy controls sexuality, fertility and labour of women without any respect to her bodily integrity. Hence, the real life experiences speak to the contrary. In fact, shortage of women in Haryana, Punjab and the BIMARU states have escalated forced abduction and kidnap of girls, forced polyandry, gang rape and child-prostitution.⁴⁶

It has been noted that the fertility rates in Kerala have declined over the past few decades and currently the Crude Birth Rates (CBR) for the State is as low as 17.9 per thousand population in 1997 (RGI, 1998). The Infant Mortality Rates (IMR) is also one of the lowest experienced

⁴⁴ Sen, Vikram (2002) “2001 Census of India- Report for Kolkata”, **Director of Census Operations**, West Bengal.

⁴⁵ Chattopadhyay, Dhinman (2003) “Child sex Ratio on the Decline in Rengal: Report”, **The Times of India**, 10th March.

⁴⁶ Patel, Vibhuti (1992) “Girl Child- An Endangered Species” in Viney Kripal(ed) *The Girl Child in the 20th Century English Literature*, Sterling Publishers Private Limited, New Delhi.

among Indian States, about 12 per thousand live births again in 1997 (RGI, 1998). The indicators of human well being in Kerala are among the best in relation to the different states of India. With modernisation and changing life styles wrought by both external migration and incomes from remittances there has been a qualitative change in the lives of the people. There has been a proliferation of private health care in the state and this in addition to the demand driven factors has contributed to the better access to health care in the state. One of the factors associated with the proliferation of health care facilities, especially in the private sector, has been the improvement in the availability of medical diagnostics. Medical personnel have also sought the use of such facilities not only to improve diagnostics, but also to avoid the complications of expensive litigation in the light of the inclusion of private medical practice within the preview of Consumer Protection Act, 1986. All this has resulted in the increasing trend of use of medical diagnostic facilities and increasing the cost of health care for the consumer. A micro study in Trivandrum city found that the known number of ultra- sonographs in the city alone was about 37, of which only 6 were in the public sector.⁴⁷

Attitude Towards Women's Health

Social discrimination against women results into systematic neglect of women's health, from womb to tomb. Female infanticide and female foeticide are widely practiced in BIMARU (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) and DEMARU (Punjab, Haryana, Himachal Pradesh and Gujarat) states.⁴⁸ The overall sex ratio is favourable to women in Kerala. But, in Kerala also, in the 0-6 age group, the sex ratio was 963, as per 2001 census. Total 0-6 age-group population of Kerala was 36.5 lakhs. Out of this 18.6 lakhs were male babies and infants and 17.9 lakhs were female babies and infants. Thus, 79760 female babies and infants were missing in 2001 in Kerala. This masculinisation of sex ratio is as a result of selective abortion of female fetuses after the use of ultra-sound techniques to determine sex of the foetus.⁴⁹

In Andhra Pradesh, Chattisgarh, Goa, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Manipur, Orissa, Pondicherry, Punjab, Rajasthan, Tamilnadu, Uttaranchal and West Bengal; the juvenile sex ratio is lower than the overall sex ratio of the respective states. A community- based study conducted by a doctor couple revealed that 16.8 % of abortions were after detection that foetus female.⁵⁰

As a result of sex-determination and sex-preselection tests leading to selective abortions of female fetuses, sex ratio of the child population has declined to 927 girls for 1000 boys. Sixty lakh female infants and girls are "missing" due to abuse of amniocentesis, chorion villi Biopsy, sonography, ultrasound and imaging techniques. Sex pre-selection techniques prevent arrival of female baby at a pre-conception state. Even anti- abortionists use this method to get baby boys, as it does not involve "Blood-bath".

CEHAT study⁵¹ showed that 64% of providers of NRTs revealed that they were against sex selective abortions, 10 % of them stated that they too were against it but they had to do it,

⁴⁷ Sunita and Joy Elamon (2000) "Medical Technology: Its Uses and Abuses in Trivandrum City", **Achyutha Menon Centre for Health Sciences Studies**, Thiruvananthapuram.

⁴⁸ Bose, Ashish (2001) "Without My Daughter- Killing Fields of the Mind", **The Times of India**, 25th April.

⁴⁹ Eapen, Mridul and Praveena Kodoth (2001) Demystifying the "High Status" of Women in Kerala, An Attempt to Understand the Contradictions in Social Development, **Centre for Development Studies**, Kerala.

⁵⁰ Ganatra, B. R, S.S. Hirve, S.Walealkar et al (1997) "Induced Abortion in a Rural Community in Western Maharashtra": Prevalence and Patterns", Mimeograph, Pune.

⁵¹ Bandewar, Sunita (2003) "Abortion Services and Providers' Perceptions: Gender Dimensions", **Economic and Political Weekly**, Vol. XXXVIII, No. 21, May 24, pp. 2075-2081.

while 24% of them approved of sex selective abortions of female foetuses. Among them, gender –based responses were quite interesting. 28% of total male and 17% of total female providers supported sex selective abortions, 68% of total female and 61 % of total male providers were against it. Those who opposed it, also said that “It should be banned”, “It is inhumane & Criminal”, “It is against medical ethics and human rights” and “It amounts to discrimination against women”.

Table-6: Population in the age group 0 to 6 years in 2001, India

infants and children – all	15.8 crores
male infants and children	8.2 crores
female infants and children	7.6 crores
deficit of female infants and girls	60 lakhs
sex ratio of child population	927

Source: Census of India, 2001.

Sex ratio (number of women per 1000 men) of Greater Bombay has reduced from 791 in 1991 to 774 in 2001 in spite of rise in its literacy rate. Doctors are using code language so that they can not be booked by police. They don’t give anything in writing and nor do they maintain any records to avoid medico-legal complications later. Economic globalisation has made import of portable ultrasound machines and sonographic machines very easy. Bombay branch of Indian Medical Association has circulated posters for awareness generation to stop sex selective abortions of female foetuses.

Table-7 POPULATION OF GREATER BOMBAY

year	1991	2001
Population	99 lakhs	1 crore 19 lakhs
sex – ratio	791	774
literacy rate	84	87

Source: Census of India, 2001

To stop female infanticide, the Tamilnadu government introduced ‘Cradle Baby Scheme’ urging parents to leave their unwanted baby girls at cradles provided in hospitals, primary health centres and orphanages and encouraging them to take them back if they changed their minds.⁵² The cradle baby scheme was introduced in Tamilnadu in 2000.⁵³ Between July 2000 and March 2002, Eighty two (82) babies were dumped in the cradles. The number rose to 140 between 1992-1996. In addition to these babies received at Salem Reception Centre, 19 babies abandoned at railway stations and dustbins in other districts were rescued by the state. The babies are raised by shelter homes and orphanages run by NGOs. The government has also resolved to set up 188 extra reception cradles in 6 other districts.⁵⁴ Negative attitude towards women’s health is the major reason for high levels of perinatal mortality and morbidity including low birth weight babies.⁵⁵ Girl child is discriminated against, even when it comes to breast feeding, supplementary nutrition and care giving.⁵⁶

⁵² Sridhar, Lalitha (Women’s Feature Service) (2001) : **India: Killing in Cradle**, POPULI- The UNFPA magazine, Vol.28, No.2, September, pp.10-12.

⁵³ Philipose, Pamela (2000) “A Peddy Grain in the Mouth of An Infant”, **The Indian Express**, October,4.

⁵⁴ Kannan, Ramya (2002) “More Babies Being Abandoned Now”, **The Hindu**, 1st April.

⁵⁵ Wal, S. and Ruchi Mishra (2000) *Encyclopaedia of Health, Nutrition and Family Welfare*, Volume 1, Health and Family Welfare in Developing Countries, Sarup and Sons, New Delhi, 2000. Pp.254-255.

⁵⁶ International Institute of Population Science (2002) National Family Health Survey, **NFHS-2**, 1998-99.

Violence and Health Issues of Women Over the Life Cycle

As unborn children, they face covert violence in terms of sex-selection and overt violence in terms of female foeticide after the use of amniocentesis, chorion villai biopsy, sonography, ultrasound and imaging techniques.⁵⁷ IVF (In Vitro Fertilization) clinics for assisted reproduction are approached by infertile couples to produce sons. Doctors are advertising aggressively, “Invest Rs. 500 now, save Rs.50000 later” i.e. “If you get rid of your daughter now, you will not have to spend money on dowry”.

As girls under 5 years of age, women in India face neglect in terms of medical care and education, sexual abuse and physical violence. As adolescent and adult women in the reproductive age group, they face early marriage, early pregnancy, sexual violence, domestic violence, dowry harassment, torture in case of infertility; if they fail to produce son, then face desertion/ witch hunt. The end result is a high maternal mortality. Causes of maternal deaths in our country are haemorrhage, abortion, infection, obstructed labour, eclampsia (blood pressure during pregnancy), sepsis, and anaemia. Proliferation of NRTs should be analysed in this context.

Important Research Studies on Missing girls

Human Development Report in South Asia 2000: The Gender Question recorded 3178 cases of female infanticide in six districts of Tamilnadu in 1995. In Mumbai only, in 1984, 84% of gynaecologists admitted that they were performing amniocentesis and there were 40000 known cases of female foeticide. Supporters of sex-selection tests for selective elimination of girls/female foetuses, apply law of demand i.e., “reduction in the supply of girls will enhance their status.” but historical evidences don’t support this argument. There had been a continuous decline in the sex ratio since 1901 to 1971, from 972 women per 1000 men to 930 women per 1000 men respectively. In 1981 the sex ratio was 933 women per 1000 men, slight increase but in 1991 it became the lowest in the history of the Census, 929 women per 1000 men. In 2001, the sex ratio for the total population is again 933 women per 1000 men. Haryana had the most depressive scenario as a result of misuse of these tests. The current sex ratio in Haryana is 861 men for thousand women, the lowest among the major states in India. The current slogan is “Sons are rising and daughters are setting.” The techno-docs owning cars pay home visit to pregnant women’s home for extraction of amniotic fluid and deliver the results in the next visit. As per the UNFPA study female foeticide has been the main cause of widening sex ratio in Haryana. According to *The Hindu*, 19-10-2001. “In the last six years, number of sex-selective abortions has increased from 62000 to 69000 in Haryana and from 51000 to 57000 in Punjab. This reckless scale has pushed the fertility rate down from 3.2 to 2.9 in Haryana and from 2.9 to 2.2 in Punjab. “Reduction of birth rate, at what cost?”

A study was conducted in 9 provinces viz. Andhra Pradesh, Bihar, Gujarat, Haryana, Madhya Pradesh, Punjab, Rajasthan, Tamilnadu and Uttar Pradesh, which were known for high rates of abortion. This study revealed that the impact of sex-selective abortion is seen in terms of widening gender gap among (0-6) age group, in Punjab and Haryana, two of the most economically prosperous states.

⁵⁷ Patel, Vibhuti (1992) “Girl Child: An Endangered Species?” in Viney Kripal (ed) *The Girl Child in 20th Century Indian Literature*, Sterling Publications Pvt. Ltd., New Delhi, P.9.

Table 8 Sex Ratio among the States with Widespread Use of Sex Determination Tests (O-6 year age group)

States	1991	2001
Punjab	875	793
Haryana	879	820
Gujarat	928	878
Maharashtra	946	917

Source: Census of India, 2001.

Another argument that prenatal diagnostic tests give women a choice to select a child of desired sex is also unacceptable as women's "Choices" are made within the patriarchal compulsions to produce sons. Women are not taking decision autonomously. Threat of desertion, divorce and ill treatment force them to opt for sex-determination and sex-preselection tests.

Between 1975 and 2003, there has been gross violation of The Medical Termination of Pregnancy Act (1972) and Prenatal Diagnostic Techniques Regulation and Prevention of Misuse Act (1994). Amniocentesis, chorion villai biopsy and pre-conception sex-selection tests were provided by the technodocs on the door-to-door service basis in some states. Private nursing homes and laboratories in several towns and cities in Maharashtra, Punjab, Gujarat, Uttar Pradesh, Tamilnadu have provided these tests by charging extremely high fees and without maintaining records so that they can't be caught. Those who perform the SD and SP tests are different from those who perform abortion so that the link cannot be established.

New Reproductive Technologies (NRTs) and Women

NRTs perform 4 types of functions. In Vitro Fertilisation (IVF) and subsequent embryo transfer, GIFT (Gamete Intra Fallopian Transfer), ZIFT and cloning assist reproduction.⁵⁸ In Mumbai girls are selling their eggs for Rs. 20000. Infertility clinics in Mumbai receive 4-5 calls per day from young women who want to donate their eggs.⁵⁹

Contraceptive Technologies prevent conception and birth. Amniocentesis, chorion villai Biopsy, niddling, ultrasound and imaging are used for prenatal diagnosis.⁶⁰ Foetal cells are collected by the technique of amniocentesis and CVB. Gene technologies play crucial role through genetic manipulation of animal and plant kingdoms.⁶¹ Genomics is "the science of improving the human population through controlled breeding, encompasses the elimination of disease, disorder, or undesirable traits, on the one hand, and genetic enhancement on the other. It is pursued by nations through state policies and programmes".⁶²

It is important to examine scientific, social, juridical, ethical, economic and health consequences of the NRTs. NRTs have made women's bodies site for scientific experimentations.

⁵⁸ Nandedkar, Tarala D. and Medha S. Rajadhyaksha (1995): *Brave New Generation*, Vistas in Biotechnology, CSIR, Department of Biotechnology, Government of India, Delhi .

⁵⁹ The Asian Age, 11-6-2004.

⁶⁰ Patel, Vibhuti (2000): *Sex Selection, in Routledge International Encyclopedia of Women- Global Women's Issues and Knowledge*, Vol.4, pp.1818-1819.

⁶¹ Agnihotri Gupta, Jyotsana (2000) *New Reproductive Technologies- Women's Health and Autonomy, Freedom or Dependency?* Indo Dutch Studies in Development Alternatives-25, Sage Publications, New Delhi..

⁶² Heng Leng, Chee (2002) "Genomics and Health: Ethical, Legal and Social Implications for Developing Countries", *Issues in Medical Ethics*, Bombay, Vol.X, No. 1, Jan.- March, pp.146-149.

New Reproductive Technologies in the neo-colonial context of the third world economies and the unequal division of labour between the first and the third world economies have created a bizarre scenario and cut throat competition among body chasers, clone chasers, intellect chasers and supporters of femicide. There are mainly three aspects to NRT -assisted reproduction, genetic or pre-natal diagnosis and prevention of conception and birth. It is important to understand the interaction among NRT developers, providers, users, non-users, potential users, policy makers, and representatives of international organisations.⁶³

Assisted Reproduction

The focus of assisted reproduction experts is on the healthy women who are forced to menstruate at any age backed by hazardous hormones and steroids. The processual dimensions involve- Use of counsellors, technodocs and researchers to know the details of personal life of women to delegitimise victim's experience. Utter disregard for woman's pain, carcinogenic and mutagenic implications, vaginal warts, extreme back pain, arthritis, sclerosis, heavy bleeding, growth of hair on face, nose, chin, cheeks, joint pain associated with uterine contractions for production of egg-cells are dismissed as Mood-Swings. Network between stake groups has only one goal- impregnating women for embryo production which in the technodocs' language is *assisted reproduction*. Embryos and fetuses are used for cure of Parkinson's disease among influential and wealthy aging patriarchs. Side-effects on women's health are totally ignored. Growth of moustache, deformation of teeth and dietary requirements are totally ignored.

Political Economy of Assisted Reproduction

By using phallogocentric and misogynist psychologists, psychiatrists, state and the politicians (ever ready for plastic smile and neat presentation) have found a ruthless weapon to crenate, dehumanise, degrade, humiliate, terrorise, intimidate, and cabbagify women. Through advertisement in newspapers, poor/needy women are asked to lend their womb for IVF on payment of money. Through websites rich clients are sought.

Selective Elimination of Female Foetuses and Selection of Male at a Preconception Stage

Rapid advances in the field of new reproductive technologies has "created a situation where there has been a breakdown of the moral consensus"⁶⁴ with respect to medical ethics and gender justice. Techno-docs refuse to see larger contexts, future implications and gender implications.

Sharp remark of the Member Secretary of Maharashtra State Commission for Women represents the concerns of women's rights organisations in these words, "The attempt at legitimising the vetoing of female life even before it appears, is worse than the earlier abortion related violence in the womb, precisely because it is so sanitised and relies on seemingly sane arguments against the policing of 'human rights' in a democracy in the intensely personal matter of procreation. This needs to be resisted at all cost."⁶⁵

Diametrically opposite views come from Dr. Anniruddha Malpani, the most articulate proponent of sex-preselection tests. When asked, "Is it ethical to selectively discard female

⁶³ Finnarage-Feminist International Network of Resistance to Reproductive and Genetic Engineering, Germany, 2000 and UBINIG: Women's Declarations on Reproductive Technologies and Genetic Engineering", Dhaka, 2004.

⁶⁴ Rupsa, Malik (2003) " 'Negative Choice' Sex Determination and Sex Selective Abortion in India", **Urdhva Mula**, Sophia Centre for Women's Studies Development, Mumbai, Vol 2, No. 1, May.

⁶⁵ Thekkekara, T. F. (2001) "On the Road to Extinction", The Indian Express, December 5.

embryos?” he said, “Where does the question of ethics come in here? Who are we hurting? Unborn girls?”⁶⁶

My questions are: Can we allow Indian women to become an endangered species? Shall we be bothered only about endangered wild life- tigers, Lions, so on & so forth? Massive resources are invested in OPERATION TIGER. When shall we start OPERATION GIRL CHILD?

Population Control Policies

There is a serious need to examine Population policies and Global funding from the perspective of statisation of Medical Market and marketisation of the nation states in the context of newly emerging culture of daily changes of sponsors. Financial economists have reigned supreme to generate moment-to-moment existence among population so that they can get an unending supply of cannon fodder for the NRT experimentation. Budgetary provision on health has a hidden agenda of NRT. The victims are not given scientific details and by labelling them as parasites and beneficiaries, their consent is not sought. It has burdened women with backbreaking miseries. The nation states have been coached to implement the use of NRT in Secrecy -in line with the programmes executed by G8 in Thailand, Indonesia, Philippines and Bangladesh. To achieve population stabilisation, 2.1% growth rate of population and NRR -net reproduction rate of 1(i.e. mother should be replaced by 1 daughter only) are envisaged. These have inherent sexist bias because it desires birth of 1 daughter and 1.1 sons. Those who support sex-determination (SD) and sex-preselection (SP) view these tests as helpful to achieve NRR1. Recent study of Haryana revealed that out of 160 mothers and grand mothers interviewed by AIIMS study team, 40 % supported SD on the ground that it contributed to population control and prevented families from having series of females in an attempt that a male was born.⁶⁷

This will further widen the gap between number of girls and number of boys in the country .As it is 100 million women have been missing due to femicide (female infanticide, ill treatment and discrimination leading to higher mortality rate among women/girls in the first three quarters of 19th century and in the last quarter of 19th century due to misuse of SD and SP) over a period of 1901 to 2001.

Gendered Power-relations and NRT

Search for "perfect' baby through genetic screening, ante natal sex determination tests, pre-implantation diagnosis, commercialisation of sperm and /or egg donation, commercialisation of motherhood and hormonal contraceptives raise many socio-legal and ethical questions.

Division of labour among women to control women's sexuality, fertility and labour by utilising homophobia and pitting women of different race, religions, age and looks to suit the interest of NRT will serve the interest of patriarchy, medical mafia, pharmaceutical industries, scientists, technodocs at the cost of vulnerable human beings as raw material. If the NGOs don't want to get criminalised, they must dissociate from NRTs and divert the funding for public health, library, education, skill building, employment generation as a long-term investment and channelise their energies towards formation of self-help groups.

It is important to understand that reproduction has an individual and a social dimension. While examining birth control practices, an individual is a unit of analysis. While examining

⁶⁶ Banerjee, Piali (2001) “The Battle Against Chromosome X”, **The Times of India**, November,25.

⁶⁷ Bardia, A., Paul, E, Kapoor S.K. and Anand K (2004) “Declining Sex Ratio: Role of Society, Technology and Government Regulation in Haryana- A Cpmprehensive Study”, Comprehensive Rural Health Services Project, All India institute of Medical Sciences, New Delhi.

the population control policies we have to analyse pros & cons of NRTs, national governments, population control organisations, multinational pharmaceutical industries, public and private funded bodies, medical researchers and health workers who shape women's "choices"- women's autonomy or control at micro and macro levels. Thus choices are not made in vacuum. NRT as a choice for some women (educated career women) can become coercion for others (powerless and less articulate women). Hence it is important to be vigilant about power relations determined by race, age, class and gender while examining implications of NRT on different stake groups.

Informed consent and medical malpractice- Power relations in the medical market favour the technodocs and the clients are not given full details of the line of treatment and its consequences. . Respect for diversity, adoption of child/children is a far simpler and more humane solution than subjecting women to undergo infertility treatment. Obsession about creation of designer baby boys has made development agenda subsidiary.

Initiatives by the State and NGOs:

Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was enacted in 1994 by the Centre followed by similar Acts by several state governments and union territories of India during 1988 (after Maharashtra legislation to regulate prenatal sex determination tests), as a result of pressure created by Forum Against Sex-determination and Sex –preselection. But there was a gross violation of this central legislation.

In response to the public interest petition filed by Dr. Sabu George, Centre for Inquiry into Health and Allied Themes Mumbai) and MASUM fought on their behalf by the Lawyers Collective (Delhi)⁶⁸; the Supreme Court of India gave a directive on 4-5-2001 to all state governments to make an effective and prompt implementation of the Pre-natal Diagnostics Techniques (Regulation and Prevention of Misuse) Act (enacted in 1994 and brought into operation from 1-1-1996). Now, it stands renamed as “ The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act”.

Recently enacted Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act, 2003 tightens the screws on sex selection at pre-conception stage and puts in place a string of checks and balance to ensure that the act is effective.⁶⁹ The Pre-natal Diagnostics Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002 received the assent of the President of India on 17-1-2003. The Act provides “for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto”.

Under the Act, the person who seeks help for sex selection can face, at first conviction, imprisonment for a 3-year period and be required to pay a fine of Rs. 50000. The state Medical Council can suspend the registration of the doctor involved in such malpractice and, at the stage of conviction, can remove his/her name from the register of the council.

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Rules, 2003 have activated the implementation machinery to curb nefarious practices contributing for MISSING GIRLS. According to the rules this all bodies under PNDT Act namely Genetic Counselling Centre, Genetic Laboratories or Genetic Clinic cannot function

⁶⁸ Basu, Asmita: “Sex Selective Abortions”, Lawyers Collective, Vol.18, No. 11, Nov. 2003, pp.20-23.

⁶⁹ Kamdar, Seema “ Sex Selection Law Tightened”, Times of India, 6-6-2003.

unless registered.⁷⁰ The Bombay Municipal Corporation has initiated a drive against the unauthorised determination of gender of the foetus as per the directive of the Ministry of Law and Justice. All sonography centres are required to register themselves with the appropriate authority- the medical officer of the particular ward. The registration certificate and the message that under no circumstances, sex of foetus will be disclosed, are mandatory to be displayed.⁷¹

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

- The terms genetic clinic/ultrasound clinic/imaging centre can't be used interchangeably. But the Act does.
- Moreover, The amended Act should have categorically defined persons, laboratories, hospitals, institutions involved in pre-conception sex-selective techniques such as artificial reproductive techniques and pre-implantation genetic diagnosis.
- Who is a qualified medical geneticist? As per the Act, " a person who possesses a degree or diploma or certificate in medical genetics in the field of PNDT or has minimum 2 years experience after obtaining any medical qualification under the MCI Act 1956 or a P.G. in biological sciences". Many medical experts feel that a degree or diploma or 2 years experience in medical genetics can't be made synonymous.⁷²
- As per the Act, an ultrasound machine falls under the requirement of genetic clinic, while it is widely used also by the hospitals and nursing homes not conducting Pre-implantation Genetic Diagnosis (PGD) and PNDT.

Ban on the Advertisements of SD & SP Techniques

Another important initiative that has been taken is against any institution or agency whose advertisement or displayed promotional poster or television serial is suggestive of any inviting gestures involving/supporting sex determination. MASUM, Pune made a complain to the Maharashtra State Women's Commission against Balaji Telefilms because its top rated television serial's episode telecast during February 2002 showed a young couple checking the sex of their unborn baby. The Commission approached Bombay Municipal Corporation (BMC) and a First Investigation Report (FIR) was lodged at the police station. After an uproar created by the Commission, the Balaji tele-film came forward to salvage the damage by preparing an ad based on the Commission's script that conveyed that sex determination tests for selective abortion of female foetus is a criminal offence. Now there is another battle brewing. The women's groups insist that the ad should be telecast for 3 months before each episode, while the Balaji Tele-films found it too much.⁷³

⁷⁰ Handbook on PNDT Act, 1994, Department of Family Welfare, Government of India, for use by Appropriate Authorities in States/ Union Territories, New Delhi, 2002.

⁷¹ Patel, Vibhuti (2003) "Sons Are Rising- Daughters Are Setting", Humanscape, September.

⁷² Pradhan, Mandakini, Renu Singh, Manisha, Sarita Agrawal (2004) "The Shortcoming of Prenatal Diagnostic Techniques Act", Department of Medical Genetics, Sanjay Gandhi Post Graduate Institute of Medical Science, Lucknow, India.

⁷³ The Indian Express, Mumbai, 19-5-2003.

Conclusion:

We need to counter those who believe that it is better to kill a female foetus than to give birth to an unwanted female child. Their logic eliminates the victim of male chauvinism, does not empower her. The techno-docs don't challenge anti-women practices such as dowry, instead display an advertisement, "Better Rs.5000 now than Rs.5 lakhs later" i.e. Better spend Rs.5000 for female foeticide than Rs. 5 lakhs as dowry for a grown up daughter. By this logic, it is better to kill poor people or third world masses rather than let them suffer in poverty and deprivation. This logic also presumes that social evils like dowry are God-given and that we cannot do anything about them. Hence victimise the victim. Investing in daughter's education, health and dignified life to make her self dependent are far more humane and realistic ways than brutalising pregnant mother and her would be daughter. Recently series of incidents in which educated women have got their grooms arrested at the time of wedding ceremony for demand and harassment for dowry, is a very encouraging step in the direction of empowerment of girls. Massive and supportive media publicity has empowered young women from different parts of the country to cancel marriages involving dowry harassment. They have provided new role models.

Philosophical and medical details of NRT need public debate without iron wall of secrecy, in all Indian languages as NRT is penetrating even in those areas where you don't get even safe drinking water or food. Technologies for population control are primarily concerned about efficiency of techniques to avert births rather than safety of women. Women have to put up with the side effects of NRTs. New reproductive technologies are provider/doctor controlled, not women controlled. Hence the women's groups repeatedly state that NRTs have inherently anti women bias. In the petition filed by CEHAT-MASUM in the Supreme Court of India and supported by the women's rights groups, Dr. Sabu George, the petitioner's demand of expansion of the scope of the Pre Natal Diagnostic Techniques Act to include sex pre-selection techniques and effective implementation of the PNDT ACT⁷⁴ has not only been accepted but also rules have been formulated for its implementation. The state governments are also organising state level seminars for doctors from the government and private sectors to focus on raising awareness to the fact of sex selective foeticide as a discriminatory practice. They are also trying to deal with the issue from the point of view of responsibility of science towards gender justice, medical ethics and human rights. Recent publication of CEHAT "Sex Selection- Issues and Concerns" selected important writings of spokespersons, who have examined the problem of "missing girls" from these angles.

There is a need to clarify the gender-just position from the anti- abortionist position. "Women should have a right to their bodies and unconditional access to abortion is not in conflict with the claim that sex selection and sex selective abortions are unethical. It is not the abortion which makes the act unethical, but the idea of sex selection."⁷⁵

We have a great task in front of us i.e. to change the mindset of doctors and clients, to create a socio-cultural milieu that is conducive for girl child's survival and monitor the activities of commercial minded techno-docs thriving on sexist prejudices. Then only we will be able to halt the process of declining sex ratio resulting into the phenomenon of missing girls. To stop a gender imbalanced society we will have to convince doctors and clients, state and civil society that **"Daughters are not for slaughter"**.

⁷⁴ Contractor, Qudsiya (2002) "Sex Selection and the Law", *Combat Law*, Vol.1, No. 1, , April-May.

⁷⁵ Madhiwalla, Neha (2001) "Sex Selection: Ethics in the Context of Development", *Issues in Medical Ethics*, October- December.