

Negative choice

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[C]hoices exist that did not before, people make decisions about procreation in the context of an expanding range of possibilities... the arenas of decision-making have proliferated, there are new domains and social actors involved, new alliances of medicine, ethics and law, not to speak of commerce (Edwards, et al. 1999:2).

NO engagement with abortion in India can be undertaken without considering first the issue of sex determination (SD) and sex selective abortion (SSA).¹ SSA underscores the profound complexities that surround the abortion debate in India. Today, more than ever, there is wide-ranging consensus in India that this practice is morally and ethically unacceptable and the urgency to address it has gained tremendous momentum. However, the intersecting 'spaces' occupied by sex selective abortion and women's right and access to safe abortion create a number of thorny overlaps that make the consensus urging a ban on sex determination *appear* laden with ambivalence and contradictions.

The right to bodily integrity, defined as the inalienable right of women to have control and autonomy over their bodies, has been central to arguments made by reproductive health advocates to demand for women's

access to reproductive technologies (RTs) including abortion. Access to reproductive and genetic technologies has indeed provided women with expanded choice as well as numerous benefits with regard to reproductive decision-making. At the same time, unregulated provision and use of RTs has served to create new challenges and exacerbate gender-based inequities.

In this paper, a three-part analysis of the practice will be undertaken. First, the context – son preference, growth in the political economy of diagnostic technologies and enforcement of a small family norm through population policies – is discussed. Second, the key debates on the issue – with regard to development of RTs, the regulation of these technologies as well as the discourse on abortion – is examined. In conclusion, the emerging regional patterns with regard to SD and SSA have been illustrated.

For women, family based relationships are a source of support as well as sanction. However, support often rests on conformity with predetermined norms. Traditionally, childbearing, in particular the birth of a son, is one such norm that a large number of women in India have to abide with.

Contemporary developments like the availability of diagnostic technologies for sex selection coupled with the desire for smaller families (as a result of population policies that enforce a two-child norm) have served to create new dynamism in family building strategies. The use of RTs creates the potential to alter what was once considered the 'immutable processes' of repeated child-birth (Edwards 1999:2) to have sons to include 'discretionary childbearing' (Goodkind 1996:115) to prevent the birth of daughters.

The emergence of this phenomenon, however, should not be viewed as a *sudden* consequence of the availability of diagnostic technologies. It should be seen as an additive strategy (Goodkind 1996) within the existing continuum of discrimination against women and female children that has resulted in excess female mortality and the decline in the sex ratio.

* This is an abridged version of a paper with the same title written for the Abortion Assessment Project.

1. While SD and SSA can mean the selective abortion of foetuses of either sex, this paper discusses the widely prevalent trend of aborting female foetuses in India.

Discrimination against girl children is the direct outcome of son preference. Mutharayappa, et al. have described three major factors that result in sons being favoured over daughters in India. First, the continued belief in the economic utility of sons as family labour, wage earners as well as support for parents during old age. Dowry also serves as an economic incentive to have sons just as it serves as a disincentive to have daughters. Second, socio-cultural factors like patrilineal descent and inheritance as well as other aspects of kinship building serve to create conditions that sustain female disadvantage and inequality. Third, within religion sons have been accorded the unique privilege of performing various rituals, including the last rites for deceased parents. All these together create a higher premium on having sons.

Other related factors identified as intensifying discrimination against girls during the past decades include marginalization of female labour as a result of the shift to mechanized forms of agriculture. The shift to cash crops too served to create enormous wealth within certain communities, particularly in North India, which led to higher demands for dowry and a heightened perception of female liability within the household (George 1997, Miller 1981).

Modernization, defined as increased access to education and communication technology, has also contributed in the diffusion of SD and SSA. This is notable in the role that mass media plays in the spread of upper caste values and the accompanying anti-female bias. Adoption of these norms by communities that have traditionally been more egalitarian towards women has also served to intensify discrimination against women (Agnihotri 2000).

It is within this adverse setting that the political economy of diagnostic technologies needs to be examined. Currently, three types of technologies are available to screen and identify the sex of the foetus – amniocentesis, chorionic villous sampling and obstetric ultrasound. Amongst these ultrasound is non-invasive and currently the most widely used method for sex determination. It is important to note that the use of ultrasound to monitor foetal and maternal health has become almost a routine and recommended component of prenatal care. Simultaneously, there is little that distinguishes the provision of the test for legitimate reasons and those for the purpose of SD. Much rests on the ethical conduct of medical practitioners and radiologists.

By the mid-eighties, ten years after the technologies were first introduced in the country, clinics had proliferated in most parts of the country, though mainly restricted to urban centres. For example, one study (1986) estimated that there were 248 clinics and laboratories, and approximately 16,000 tests were performed in Mumbai metropolitan region annually (Lingam 1998). The growth in the number of clinics continued throughout the nineties. In a single district of Haryana, 65 ultrasound clinics have been registered (Pushkarna, *The Week*, 2002). With growth in the number of clinics and easy availability of these tests there has been a corresponding drop in the price of obtaining a test, which fluctuates between Rs 500 to 1500, though some have pointed out that recent efforts to ensure effective implementation of the ban on SD has served to double the cost of clandestine SD tests.

Recent efforts by the government to enforce a two-child norm as well as voluntary desire for smaller families can potentially serve to exacerbate SD and SSA. Scholars have pointed out

that the desire for fewer children is not necessarily accompanied by a preference for a fewer number of sons. Till date, son preference continues to be a significant determinant of family planning strategies, although this is strongest for birth orders two or more (IIPS and ORC Macro 2000).

As India undergoes its fertility transition the conditions exist for an intensification in SD and SSA. Retherford and Roy (2003) use NFHS data on the sex ratio at birth as an indirect indicator to assess prevalence and determinants of the practice. They argue that multiple factors influence the levels of SSA confounding the effect of any single variable. Some of the important predictor variables identified by them include a composite variable of the child's birth order and the mother's number of living sons, education levels of women as well as rural-urban residence. The authors also point out that the potential for SSA to increase is greatest in states like UP, Bihar and Rajasthan where there is continued evidence of strong son preference. Currently, these states have low sex ratio at birth but with increased availability of information and technology for SD this can change.

For over two decades there has been a sustained campaign against SD and SSA. A significant focus of activism has centred on the demand for laws that ban sex determination and regulate the medical use of diagnostic technologies. Recently, the focus has simultaneously been on the effective implementation of the law. The history of the activism can be broadly divided into two phases. The first decade of activism was dominated by the campaign by the Forum Against Sex Determination and Sex Pre-Selection (FASDSP) and resulted in the formulation of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994.

The second decade of activism has been symbolized by renewed activism on the issue of SD and SSA but most importantly on the implementation of the PNDT Act, 1994 and subsequent public interest litigation (PIL) filed in the Supreme Court of India resulting in improved implementation as well as amendments to make the existing law more effective. A main feature of the amendment was bringing within its purview new technologies used at the preconception and preimplantation stage for sex selection.

Contention and controversy have characterized key debates amongst the various constituencies, in particular the activists who urged a ban and the medical community, some of whom opposed the ban. Three broad themes underpin these debates and are discussed in some detail. First, the role of RTs and the gendered context in which they find use; second, the usefulness of regulatory frameworks to guide their use; and finally, the dual agenda of promoting the right and access to safe abortion while curbing sex selective abortion.

‘FASDSP does not believe in saying a categorical “no” to technology. But certain questions have to be asked: Is there a qualitative difference between the various technologies? If so, how does one identify it and if not, how does one evolve criteria by which a distinction can be made to help determine those technologies that are desirable and appropriate?’ (FASDSP 1992: 91).

The reproductive technologies need to be examined through a lens that extends beyond the procedures to include the socio-cultural and economic context in which they find use. The most significant contribution of feminist analysis of RTs has been to demonstrate the gendered context within which these technologies are often used. However, RTs continue to

be often seen as scientific progress that helps reduce women’s reproductive burden. This shortsighted view of technologies as magic bullets makes little or no effort to address the unequal arrangement and disproportionate burden that women bear with regard to reproduction (Birke et al. 1990). The case of SD and SSA is a stark example of how RTs can result in reinforcing women’s oppression.

Feminist advocates remain divided with regard to defining a position on new reproductive technologies. Some in the past (e.g. Feminist International Network of Resistance to Reproductive and Genetic Engineering) have advocated a blanket ban. Others emphasize the ambivalent effects that RTs have on women’s lives. As a way out of this deadlock the debate on science and technology can and should be framed around two broad issues – that of political control and of morality and ethical standards (Nelkin 1992: x). For example the FASDSP’s demand to regulate diagnostic technologies and ban SD tests is an effective strategy that highlighted the disproportionate control of the medical community over the provision of these technologies and the absence of moral or ethical standards in the use of that power.

The medical community, till date, remains slow to acknowledge its role in fuelling SD. Doctors claim that the use of amniocentesis and ultrasound is a part of routine antenatal care to judge the quality of the pregnancy. They resist any attempts through law to curb the free provisions of these tests, and over the years many have continued to provide them freely in spite of the existing law.

‘Dr M.L. Verma, the attending doctor on Saturday, met this reporter when she visited the hospital posing as a pregnant woman. The story trotted out was that she and her husband did not want the baby. But as her in-laws

insisted on a boy, she wanted to get the test done. Dr Verma was willing to do it, assuring that the test was very simple. He added that if the sex of the baby was “not satisfactory”, they would carry out an abortion the next day... he did not even conduct a cursory medical examination and when asked about the well-known dangers of the test dismissed it... “Today in the morning I have done three tests.” He said that they had conducted 20 tests in a week’ (Chaturvedi, *The Statesman*, 1994).

Often doctors who admit to providing SD claim they do it as a result of client pressure. They cite instances when they have refused tests and been labelled ‘bad’ doctors which in turn affects their practice. Many others have argued that they are in fact doing a good deed by preventing the birth of a female infant who will subsequently be the victim of gender-based violence.

‘Dr V.K. Vats in charge of the Hiralal Nursing Homes is completely unabashed about carrying out sex determination tests. “It has been going on for a long time and a handful of city people cannot decide what the rural people want. In my opinion, it is better to abort a female foetus rather than give birth to her. In all probability, she will be burnt for not bringing enough dowry’ (Dasgupta, *The Telegraph*, 1994).

‘It is one thing to legislate that an individual should not be forced to procreate against her will, and thereby protect legal access to contraception or abortion. It is quite another to derive from this legal protection the belief that individuals have the right to procreate by any means possible. Hidden in this discourse of means is the female person who is used’ (Raymond 1993: 79).

To some, viz., members of FASDSP, the need for regulation appears self-evident. But there are many who oppose regulation. The opposition comes from two quarters –

the medical community and certain feminist groups. The latter fear that regulation of these technologies by law can potentially undermine the hard fought gains with regard to women's reproductive rights, in particular the right to abortion. This does not mean that these groups condone the practice but rather that they differ on the strategy to address it.

In spite of efforts by the medical community to water down the law, the PNDT Act sets an important legal precedent to regulate RTs. One positive effect of this law has been its ability to curb rampant growth and advertisement of SD clinics. Another important outcome has been to highlight the negative role of the medical community in the widespread misuse of diagnostic technologies.

Framing a social problem in the formal and specific language of law has first clearly defined all the key players and their roles in promoting the practice and, second, put in place institutional mechanisms to enforce norms that will regulate the practice. Legislation and regulation provide a framework within which the role of multiple actors and institutions can be concretely measured and evaluated. For instance, regulation has a critical impact on the larger medical and pharmaceutical industry that has sprung up around reproduction in general and SD in particular, of which doctors are only a part.

The difficulties and gaps in regulating the use of technologies like obstetric ultrasound for SD should not become the basis for an argument against regulation. A number of measures can be taken to ensure effective implementation. For example under both the MTP Act, 1971 and the PNDT Act, 1994, specific sites have been classified for legal provision of these services. Universal registration of these sites and listing of diagnostic equipment, granting licenses and

requiring that they be prominently displayed, among others, could help curb misuse.

The PNDT Act can be the first step in a broader effort to regulate the private health care sector. The law, as currently implemented, fails in that it does not specify the role that has been played almost single-handedly by the private sector in spreading SD and SSA across the country. It is worth noting that SD was banned in all public facilities in the mid-seventies.

Having discussed the usefulness of laws it is important to point out that they are at best a first step in addressing deep-rooted injustice. George (2002), one of the three petitioners of the PIL, points out that a law and effective use of the judiciary can bring pressure on the executive branch of government to do a better job of monitoring use of these technologies, guide medical ethics that till date have been seriously lacking with regard to SD and SSA, and at the same time serve as a catalyst to address deep-rooted patriarchal norms within Indian society. Other policy and programmatic efforts, however, need to be simultaneously made to address the factors that serve to sustain discrimination and violence against women.

The non-medical use of technology and abortion for the sole purpose of sex selection must be distinguished from women's right and access to safe abortion. Some within the medical community have argued that if women have the right to abortion then by extension they also have the right to choose the sex of the offspring and therefore SSA.

Sex selective abortion is, however, not the result of an unintended or unwanted pregnancy. It is in fact the gendered preference for a certain type of pregnancy that guides the decision to undergo sex selective abortion (Mallik 2002). The discussion

of strategies to address unsafe abortion is often conflated with the discussion on SSA resulting in demands to 'tighten' the MTP Act.

'Yes, it is true that women seek amniocentesis to have female foetuses aborted, but should the state compel a woman to rear a daughter she does not want? A ban on sex determination tests will impose unwanted pregnancies on women... [it] will restrict the right of Indian women for having abortions. It will tell women that they can decide the number of children, but not their sex' (Kala, *The Statesman*, 1994).

Type A Driven by Cultural Factors and Family Planning Goals (e.g. Tamil Nadu)	
Women's Parity (number and sex of living children)	
State Population Policies (e.g. two-child norm)	Cultural Norms (e.g. son preference)
High Rates of Sterilization	
Type B Driven by Economic Factors (e.g. Punjab and Haryana)	
Prosperity (High Per Capita Expenditure)	
Low Female Labour Participation	High Gender Gap in Literacy
Upward mobility/Consumerism (increase in dowry payments)	
Type C Driven by Notions of Choice and Autonomy (e.g. Delhi and Chandigarh)	
High Levels of Female Education	
Access to Information and Technology	Prosperity (high per capita expenditure)

Sex selective abortion currently accounts for roughly 11 per cent of late-term, unsafe abortions in India (Johnston 2002). It is important to recognize that SD and SSA cannot be addressed by placing limits on the availability of abortions for women. Rather, it will serve to heighten their vulnerability. When SD and SSA are viewed as a continuum it is evident that effectively curbing SD will automatically lead to a reduction in SSA and thus in unsafe abortions. On the other hand it is easy to see that arguments that favour curbing abortion do little to address or reduce SD.

Health risks posed by SD and SSA that might otherwise not occur also need to be highlighted. Tests like amniocentesis carry with them the risks of spontaneous abortion and infection. Amniocentesis requires trained medical technicians to carry out the test, and even in those instances the possibility of injury to the placenta or to the foetus remains. There is evidence of tests being performed by untrained persons with inadequate equipment and in poor conditions (Ravindra 1995).

Separate laws – MTP Act to reduce unsafe abortion and PNMT Act that bans SD – and the varied implementation strategies that stem from the diverse objectives of the two acts provide the possibility of emphasizing the difference between the two. Unsafe abortions can be reduced through access to contraception, in particular spacing methods as well as emergency contraception, improving the efficacy of those methods, better antenatal care, among other things. SSA, on the other hand, is part of a family building strategy to ensure the birth of only sons and can be addressed by strategies that focus on empowerment and education of women. Finally, there is critical need to build on women's own perspectives and

dilemmas with regard to seeking abortion and, in particular, SSA.

As India goes through a fertility transition, regional patterns are emerging with regard to factors that appear to fuel sex determination and sex selective abortion within those specific contexts (see diagram). The inter-relatedness of these various factors cannot be emphasized enough. The intention, however, is not to generalize or strictly allocate any one type to a particular region/state but to illustrate the complexity embedded in the host of issues that constitute the terrain within which SD and SSA takes place in India. The objective is to illustrate the need for a multi-pronged policy and programmatic approach within which laws and their effective implementation have an important role to play.

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