

The Practice of Sex Selective Abortion in India: May You Be the  
Mother of a Hundred Sons

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## **Historical Context**

Although sex selective abortion is a fairly recent phenomena, its roots can be traced back to the age old practice of female infanticide. Infanticide was initially documented by British officials in the late eighteenth century who recorded it in their diaries during their travels. One British official, James Thomason, while speaking to a group of landowners in Uttar Pradesh in 1835 referred to one of them as a son-in-law of another. His remark “raised a sarcastic laugh among them and a bystander briefly explained that he could not be a son-in-law since there were no daughters in the village. Thomason was told that the birth of a daughter was considered a most serious calamity and she was seldom allowed to live” (Miller, 1981). Realization of the occurrence of this practice prompted the British to pass the Infanticide Act in 1870, making it illegal.

It was not until 1871, however, in the setting of India’s first census survey, that the scope of the problem of infanticide became evident. At that time it was noted that there was a significantly abnormal sex ratio of 940 women to 1000 men. Since this ratio was the inverse of what had been observed in England and other countries where women outnumber men, the paucity of women in India invited much speculation. Theories ranged from an Indian genetic predisposition towards having sons to a purposeful under-reporting of women from families who distrusted the British motives. One commissioner even stated that “male births increase in proportion to the warmth of the climate” (British government, 1870, as quoted in Miller, 1981). Others realized that the abnormal ratio was secondary to the fact that Indian women had a higher mortality rate than men from both natural causes such as childbirth, as well as unnatural causes such as infanticide and sati (the practice of a widow throwing herself on her husband’s funeral pyre).

Subsequent census reports showed no improvement in the abnormal sex ratio despite attempts to ensure that all women were reported. Some Sikh villages had ratios as low as 31 women to 100 men (Miller, 1981). Regionally the practice of female infanticide was confined

mainly to the northern part of India, although some areas in the south were also known to practice it. The Infanticide Act was difficult to enforce in a country where most births took place in the home and where vital registration was not commonly done. Autopsies were not performed on corpses except in the unusual circumstance in which the police were notified. Given the high infant mortality rate due to natural causes in India, a female infant could easily be suffocated, poisoned, or starved without arousing the suspicions of others. Moreover, because of the seemingly widespread acceptance of the practice, it is unclear whether anyone would feel morally compelled to report a suspicious incident.

Aware of the limitations of legislation, the British made other attempts to curtail the incidence of infanticide. They established a government dowry fund to aid destitute families who felt that they could not afford another daughter. They held conferences with the princely families. They threatened with imprisonment and fines. Their efforts may have curtailed the incidence of outright infanticide, but many felt that it was supplanted by more subtle neglect:

Even if there is no deliberate design of hastening a girl's death, there is no doubt that, as a rule, she receives less attention than would be bestowed upon a son. She is less warmly clad, and less carefully rubbed with mustard oil as a prophylactic against the colds and chills to which the greater part of the mortality amongst children in India is due; she is probably not so well fed as a boy would be, and when ill, her parents are not likely to make the same strenuous efforts to ensure her recovery (1901 Indian Census, as quoted in Miller, 1981).

The other effect of the British policies was that the act of female infanticide became secretive for fear of legal retribution. As a result, much of the evidence as to the prevalence of infanticide had to be extrapolated from the census data rather than direct surveys.

The sex ratio continued to decline until 1981 at which time a small improvement was noted from 930 to 934 women per 1000 men. This improvement was attributed to the rising status of women as evidenced by the birth of several feminist groups. It was also felt to be the result of better health care and decreasing maternal mortality during a period of economic growth. Projections were optimistically made for a ratio of 944 women to 1000 men by the

year 2001 (Kanitkar,1993). It was therefore a great shock to many when the 1991 census instead showed a decrease in the ratio to an all-time low of 929 women to 1000 men.

### **Sex Selective Abortion Methods**

The further decline in the sex ratio, according to many groups, is at least partially attributable to the introduction of methods of prenatal sex determination to India in the 1970's. The technology of prenatal testing had evolved chiefly to inform parents about the existence of genetic disorders, some of which were linked with the sex of the child, most of which were not, so that prospective parents could make a decision whether or not to terminate the pregnancy. In India, the testing was used for another purpose: to allow sex determination of the fetus so that prospective parents could selectively abort female fetuses regardless of their genetic health.

Sex selective abortion, also called female feticide by some, is a two-step process. The first step involves determination of the sex of the fetus in one of three ways: amniocentesis, chorionic villus sampling, or ultrasound. The second step consists of the therapeutic abortion which, in India, was legalized in 1971 under the Medical Termination of Pregnancy Act and is readily available and free of charge in government hospitals and clinics throughout the country (Solapurkar, 1991).

In amniocentesis, fluid containing fetal cells is extracted by inserting a catheter into the sac surrounding the fetus. Amniocentesis is normally performed at 15-17 weeks of pregnancy. The fetal cells from the amniocentesis are examined for genetic defects in the fetus and a sex determination can be made at the same time. The results are usually complete within 1-2 weeks which allows for an early second trimester abortion if desired. The test is conducted in clinics and hospitals in most of the cities in India. Although rural areas have limited access to such technology, many of the rural health centers have the capability to obtain the amniotic fluid and then send it by messenger to an urban center (Kusum,1993).

Chorionic villus sampling is a slightly more technically difficult test than amniocentesis. Its major advantage lies in the fact that it can be performed earlier in the pregnancy (around the tenth week of gestation), thus allowing for an earlier and safer abortion, if desired. This test, similar to amniocentesis, is performed in many clinics and hospitals though it is more costly and is thus utilized chiefly by the wealthy.

Ultrasound is less commonly used as a method of sex determination since it is not reliable until the second trimester of pregnancy. Even at that point, it is less accurate than either amniocentesis or chorionic villus sampling. This test is relatively simple to perform, however, and is available throughout India. Some entrepreneurs have even established traveling vans which can perform the procedure (Burns, 1994).

### **Sex Selective Abortion Practice**

The availability of prenatal sex determination tests and abortions was a boon for those desiring to rid themselves of daughters. Infanticide, although widely practiced, was associated with a certain amount of guilt. Elaborate rituals were established to cleanse the parents of their sin:

An infant girl was killed, buried in the room in which she was born, and the floor then plastered with cowdung for purification. On the 13th day after the death, a village priest, a Brahman, cooked and ate his food in the room. By eating food cooked in ghee (clarified butter), it was believed that the priest took the sin of killing the baby upon himself (Freed, 1989)

Since many Indians believe that the soul does not enter the fetus until the end of the second trimester of gestation, sex selective abortion removes the stain of sin and guilt and is therefore far more morally acceptable.

Sex determination tests became big business shortly after their introduction in India in the 1970's. Billboards stating, "Invest Rs. [rupees] 500 now, save Rs. 50,000 later" were designed to encourage prospective parents to abort female fetuses and save on a future dowry (Kusum, 1993). Posters in train stations promoted sex determination together with an abortion for just Rs. 70. Clinics distributed flyers advertising their services (Appendix A). As the

number of clinics grew, competition pushed down the prices of the services, making them more affordable to the lower middle class. From 1982 to 1987, the number of clinics for sex determination increased from less than 10 to 248 in Bombay alone. Even more alarming was a study of centers in Bombay which revealed that out of 8000 abortions in six hospitals preceded by amniocentesis, 7,999 were female fetuses. Between 1978 and 1982, according to one report, 78,000 female fetuses were aborted after a sex determination test (Kusum, 1993; Shah, 1992). In another study, 430 out of 450 female fetuses were aborted in one hospital, while none of 250 male fetuses were aborted even when there was evidence of a genetic problem (Ramanamma, 1980).

### **Social Context**

To understand the social context in which the practice of sex selective abortion exists and, in fact, flourishes, one must first examine the cultural basis of son preference in India. The reasons behind what has been called “son mania” are both multifaceted and deeply imbedded in Indian culture (Ramanamma, 1980). They are also unfortunately inextricably entwined with a corresponding discrimination against daughters. In the ancient Indian text, the Atharva Veda, mantras are written to change the sex of the fetus from a girl to a boy. A son’s birth is likened to “a sunrise in the abode of gods” and “to have a son is as essential as taking food at least once a day,” whereas a daughter’s birth is a cause for great sadness and disappointment (Ramanamma, 1980).

Indian society is patrilineal, patriarchal and patrilocal. Sons carry on the family name. They are also charged with the task of supporting their parents in old age. Parents live as extended families with their sons, daughter-in-laws, and grandchildren. Daughters, on the other hand, become part of their husband’s family after marriage and do not make any further contributions to their birth parents. Indian sayings such as, “Bringing up a girl is like watering a neighbor’s plant,” and “The girl who has married is like the spittle which has been spat out,

and no longer belongs to the parents,” exemplify the feeling of wasted expenditure on raising a daughter (Jeffery, 1984).

Indian men are also responsible for the funeral rites of their parents and are the only ones who can light the funeral pyre. Some feel that they will only be able to achieve *moksha* (transcending the circle of reincarnation via the performance of good deeds) through their sons. Thus the importance of having sons continues beyond even this life in Indian culture.

A very important factor contributing to son preference is that of economics. Daughters, for several reasons, are an economic liability to families whereas sons are a great asset. One of the most publicized reasons for this disparity is the dowry system. In many parts of India, particularly in the North, the parents of the bride must give money and gifts to the groom’s family as part of the marriage agreement. Formerly, dowries were only expected in high caste marriages where the bride would not be expected to work in the fields and was thus presumed to be an economic burden on her husband. The bride’s family, therefore, compensated the groom’s family with a dowry.

Presumably in an attempt to emulate higher castes, the custom of dowry giving has, over the past several decades, spread throughout the social structure in India. Lower castes, viewing dowry as a status symbol, have adopted the custom with even more zeal than the upper castes: “the Brahmanical form of marriage with dowry is often considered more prestigious and when castes attempt to upgrade themselves they frequently assume this form of marriage payment” (Miller, 1981). The dowries, in present times, frequently cost the bride’s family two to three times their yearly income. Refusal to offer a dowry seals a girl’s fate as a spinster and shames the family name. Failure to deliver the offered dowry or honor further requests may result in a so-called “dowry death” or “bride burning” in which the groom’s family kills the bride to allow the groom to remarry and bring in a more substantial dowry. Furthermore, in some groups, the gift-giving continues after the marriage.

Another economic disadvantage of daughters in India is their relatively low earning potential. As in many other countries, although the women work as hard or harder than their

male counterparts, they make very little money. The long hours spent cooking, cleaning, and caring for the children are viewed as “sitting at home all day.” Even the time spent in the fields is not considered significant since the men do much of the heavy lifting. Frequently illiterate, due to lack of schooling, women in India are generally unable to obtain high-paying work and are therefore financially dependent on the men in the family. As a result, it is felt to be to a family’s economic advantage to minimize the number of daughters.

Since many of the reasons behind son preference are economically based, it is ironic that the most extreme sex ratios are seen in the higher castes who tend to have most of the wealth (Miller, 1981). The reason for discrimination against daughters in these groups seems to be related more to issues of family pride than to concern over money. Indian culture requires that a girl marry into a family with a caste equivalent to or, preferably, higher than her own. She then adopts that caste as her own and is thus “elevated.” Boys, conversely, are encouraged to marry below their castes to maximize dowry potential. As a result, it is frequently difficult to find an appropriate husband for a daughter of an upper class family, which has the potential for putting great shame on the household.

In addition, some of the higher castes, such as the Rajputs, are Kshatriyas which translates as warriors. These groups take great pride in their fierceness. Daughters do not fit well into their culture and are potentially a source of vulnerability in the family. Sons, on the other hand, are a source of pride and strength: “the role of sons in exerting control over farm resources, in protecting the community against dacoits, and in the army of the state...may have been factors militating for the generalized preference for sons” (Machlachlan, 1982). The Rajputs and the other warrior castes are cited throughout the literature for their liberal use of infanticide prior to the advent of sex determination techniques (Freed, 1989; Miller, 1981; Machlachlan, 1982).

The need for men as protectors may also partially explain the geographic differences in the practices of infanticide and sex selective abortion (Machlachlan, 1982). The history of northern India, where son preference is the strongest, is characterized by numerous foreign

invasions requiring the men to fight. Women did not contribute to the defense and were thus a source of weakness in the community. The relatively unscathed south, on the other hand, did not have a similar need to protect itself against foreign invaders and has a correspondingly low incidence of infanticide and sex selective abortion.

Another reason given for the prevalence of sex selective abortion is India's attempt to control its population. Although the government has not adopted coercive methods since the "Emergency" in the 1970's under Indira Gandhi's rule, it has become increasingly unfashionable to have a large family in India. The ideal family size, particularly among the high socioeconomic classes, is two children. Given that at least one son is necessary, families with two daughters become increasingly anxious about the sex of their expected child. Studies have supported this theory, demonstrating that sex selective abortion occurs most frequently in families with two or more daughters (Ramanamma, 1980).

Multiple surveys have been undertaken to determine the general population's view towards the practice of sex selective abortion. In one study of middle class Indians in Punjab, 63% of women and 54% of men felt that amniocentesis should be undertaken if the couple has no son and more than two daughters. If that test shows that the fetus is female, 73% of women and 60% of men felt that it should be aborted. The top three reasons cited for aborting a female fetus include "a male dominated society" (23%), "social stigma attached to having a daughter" (19%), and "difficult to afford a dowry" (17%) (Singh, 1992).

Several interesting conclusions can be drawn from this study. First of all is the startling finding that women are more likely than men in this middle class, fairly well-educated population to support sex selective abortion. This finding may be secondary to the fact that these women can better empathize with both the ostracized, guilt-ridden mother with no sons as well as the unwanted daughter who may be made to suffer by virtue of her sex. Another result of interest is that dowries were only the third most cited reason for aborting a female fetus. This has important implications for policy-making, since legislation to eliminate the dowry

system, according to these data, would likely have only a moderate impact on the demand for sex selective abortion.

Attitudes towards sex selective abortion in a highly educated sample from cosmopolitan Delhi were examined in another study by Shah and Taneja. In this population, 59% of women and 63% of men held highly negative opinions towards sex selective abortion, 36% of women and 37% of men had somewhat negative opinions, and 5% of women and 0% of men had positive opinions. Again, women tended to support sex selective abortion more than men; however, the population overall seemed not to agree with the practice. When asked what steps might be taken to prevent its occurrence, the vast majority stated that the key component for change was education of individual women, as well as the general public (Shah, 1992).

Physicians in India have been strong supporters of sex selective abortions since their inception. Their arguments include that it is the family's right to make this personal decision, that the mother will suffer if she has too many daughters, and that the daughter will have a very difficult life. One Bombay gynecologist states, "How can you deny her [the mother] the right to have a son instead of a third or fourth daughter? You can't wish away centuries of thinking by saying that boys and girls are equals . . . it is better to get rid of an unwanted child than to make it suffer all its life" (Kusum 1993). They also argue that it is unreasonable to make abortion of female fetuses illegal if abortion of male fetuses is not. Furthermore, doctors raise the concern that "barring of these tests could lead to mushrooming of private clinics headed by quacks where sex-detection tests and abortions will be carried out clandestinely and prove to be extremely hazardous to the mother and fetus alike" (Kusum, 1993). Equally worrisome is the possibility that it might lead to a resurgence of the still utilized female infanticide (Jayaraman,1994).

Although gynecologists certainly have a financial interest in the practice, their views generally reflect those of much of the rest of the country (Singh, 1992; Shah, 1992; Kusum, 1993). Another frequent argument used by supporters of sex selective abortion is that the decline in the sex ratio as a result of this practice will result in an elevation of the status of

women and reform of the dowry system. Feminists have responded to this disturbing contention by saying that a decreased ratio does not improve the status of women; it simply reflects it. Moreover, there are no indications that the declining ratio over the past century has elevated the position of women or eliminated dowries. In fact, despite the lowest sex ratio in the past century, the status of women in India arguably has never been lower, as demonstrated by the recent increased incidence of bride burning and dowry deaths.

### **Implications of Sex Selective Abortion**

A continuing decline in the sex ratio secondary to sex selective abortion has many potentially serious consequences. According to the data from the 1991 census survey, there are approximately 35-45 million missing Indian women. This figure is calculated by determining the number of women that would be expected in any population given the number of men and the usual sex ratio. The actual number of women determined by census is then subtracted from this figure resulting in the number of “missing women.” This number may be due to a decreased birth rate of female infants, increased mortality of women throughout their lifecycle, census measurement errors, or a combination of any of the preceding. At the present rate of decline, an anticipated additional 5 million women will be unaccounted for by the end of this decade.

Although there are no historical models by which to learn about the implications of a lack of women relative to men, one fairly obvious social consequence is that there are not enough women for the men to marry. This paucity of potential brides might result in girls being married at a younger age. Increasing numbers of child brides will further contribute to the poor status of women, as they will be less likely to finish school or develop job skills before marriage. Young brides and their children are also more likely to suffer from the increased morbidity and mortality associated with early childbirth (Makinson, 1985).

Another potential consequence of a surplus of unmarried men is an increase in acts of sexual violence against women. Although grossly under-reported, sexual violence is already a

major problem in India, particularly in the cities where men migrate from the villages without their wives and families to find work. These men who are separated from their wives, frequently for years, may resort to using of commercial sex workers or to engaging in sexual violence. Sexual violence would likely become more of a problem as the number of unmarried men increases.

A custom which has been historically utilized during times of male surplus is the marrying of a woman to several brothers. Although polygamy is officially illegal in India and the woman is technically married to only one man, her brother-in-laws share the household and are cared for by her. No data exist as to whether this type of family structure exists in present-day India, but it would seem to be a logical social change in the setting of a low sex ratio.

Women are also a vital part of India's labor force. As anyone who has spent time in an Indian village can attest, women perform a majority of the work. In addition to keeping the house, they spend many hours in the field and are generally working long after the men are asleep. Moreover, as an important part of the medical profession, women deliver the majority of babies and provide most of the nursing care. Other professions, such as teaching, rely heavily on women. It is unclear what kind of impact a continued decline in the sex ratio will have on the Indian economy, but one might assume the loss of women would have negative consequences.

### **Government Response**

The Indian government has opposed the practices of female infanticide and sex selective abortion, but has been slow and ineffectual in bringing about reform. The Dowry Prohibition Act was passed in 1961 approximately a decade before sex determination technology was introduced in India. Despite revisions in 1983 and 1985, this law has been poorly enforced and is thus completely ignored. Many feel that the giving of dowries has actually become more prevalent in the past twenty years (Bumiller, 1990).

Under pressure from feminist groups, the Indian government prohibited prenatal sex determination testing in government hospitals. This measure had little or no effect other than encouraging the proliferation of private sex test clinics. As previously mentioned, the competition between these clinics actually served to make the services more affordable for lower middle class Indians.

In 1988, the Maharashtra government enacted the Maharashtra Regulation of Prenatal Diagnostic Techniques Act. The salient features of the Act are as follows (Kusum, 1993):

1. Prenatal diagnostic can only be conducted to detect *genetic abnormalities* (including sex linked genetic diseases).
2. The test may only be undertaken by a *high risk pregnant women* who meet at least one of the following criteria:
  - a. Age over 35 years.
  - b. History of 2 or more abortions/miscarriages.
  - c. History of exposure to hazardous substances.
  - d. Family history of genetic disorder.
  - e. "Any other condition as specified by the authorities."
3. Use of prenatal diagnostic *techniques for indicating the sex of the fetus are banned*. Offenses are punishable by both imprisonment and a fine.
4. Three committees to operationalize the policy will be established: State Appropriate Authority, State Vigilance Committee, and Local Vigilance Committees.

Two loopholes in this Act immediately leap to mind. Firstly, a woman can easily manufacture a high risk history of inherited disorders or exposure to teratogens. Moreover, the history of two or more abortions criterion does not specify whether these abortions had to be spontaneous. A woman who had had two or more therapeutic abortions in the past would technically become eligible under the Act. Secondly, the determination of sex-linked genetic disorders could theoretically result in the physician revealing the sex of the fetus. Needless to

say, with the above loopholes and the increased availability of illegal services and services in neighboring states, the practice continued unabated.

Also in 1988, the Indian government established a committee to study sex selective abortions and make recommendations on how best to deal with them. In response to this task, the committee introduced the Prenatal Diagnostic Techniques Regulations and Prevention of Misuse Bill in 1991. The Bill essentially mirrors the Maharashtra Act with two small changes. The high risk criteria were changed to “history of *spontaneous* abortions” and “exposure to teratogenic substances (omitting history of . . .).” Clinics, hospitals, and laboratories offering prenatal testing are all covered by the law. This bill finally passed three years later in the Indian Parliament in August, 1994 (Burns, 1994).

The Central Government Bill has some of the same limitations as the Maharashtra Act. The high risk criteria are susceptible to fabrication by the pregnant woman. In addition, over the past decade, enforcement of a ban on sex determination techniques has become a Herculean task. In Delhi alone, there were over 2000 sex test clinics in 1994 (Imam, 1994). Furthermore, “no provision is made [in the bill] for the registration of the thousands of ultrasound machines installed by entrepreneurs in vans that travel from village to village charging rural women exorbitant fees for the procedure” (Burns, 1994).

### **Other Possible Interventions**

The above legislation is certainly a valuable, albeit tardy, step towards eradicating the practice of sex selective abortion, but it clearly is not enough. There are no statistics available since the passage of the bill regarding changes in the practice; however, one might extrapolate from experiences with the infanticide and dowry laws that passing a law does not necessarily effect reform. Given that 50,000-80,000 female fetuses are being aborted every year, based on conservative estimates (Jayaraman, 1994), there is a major financial incentive for private clinics to find a way to remain in business. Furthermore, minimal regulatory practices with the Indian medical infrastructure lend themselves to the development of an illegal sex test market.

What measures other than legislation might the government take to abolish sex selective abortion and female infanticide? As stated by the participants in the survey by Shah and Taneja, the most important tool for change is improving the status of women through education. Education at the primary school level focused on women's rights and building girls' self esteem, increased programs for literacy and job training, more opportunities for higher education for women, and public education campaigns about women's issues are the only ways to begin to effect true reform. As testimony to the importance of education, states such as Kerala with the highest female literacy rate in India do not practice sex selective abortion. Kerala is further benefitted by its matrilineal social structure and associated tradition of sexual equality; unfortunately, such cultural traditions are unique to Kerala and would not be amenable to policy and programmatic changes. Literacy for Indian women, in contrast, is an achievable goal.

Changes at the primary school level might include developing programs that encourage educated women to spend time in village schools instructing children on women's issues and acting as role models. Curricula targeting the problems of violence against women from womb to grave must be incorporated into schooling at an early age. Although some of the teaching might be negated by what the child sees at home, this will at least provide a glimpse into another way of thinking. Education for young girls can be enhanced by making school hours flexible so that they may continue learning even when they must work at home.

Literacy and job training programs as well as increased access to higher education for women are vital in empowering women and increasing their status. As was observed in the two surveys conducted in Delhi and Punjab, the more highly educated group (both men and women) was less likely to support sex selective abortion. Moreover, women who have means to support themselves may be more likely to voice objections to pressure from in-laws and husbands.

Public education campaigns are also an important part of the equation. It is unclear, however, whether the usual methods of public service announcements on television,

newspaper articles and slogans on billboards are effective. A more powerful medium is necessary. One potential approach might be utilizing a very important part of modern Indian culture: the movie industry. More movies are produced in Bombay than anywhere in the world and movie stars are frequently idolized. Indian movies unfortunately tend to glorify oppression towards women. If movie stars, producers, and directors could be persuaded to deliver the message, they would surely reach a bigger audience.

In addition to education programs, further promotion of credit and loan programs for women is an effective way to increase self-sufficiency. These programs, by providing small loans for items such as sewing machines or looms, allow women to use their skills to contribute to the household income and thus better their status within the family and community. These programs have been proven successful in many countries, including India.

## **Conclusion**

Although eradicating sex selective abortion may seem like a daunting task in a country with such limited resources, it is a vitally important one, morally, socially and economically. Women are the cornerstone of the Indian family. They are an essential part of India's labor force. "Women [have] to be recognized because no less than the future of India [depends] on it" (Bumiller, 1990). India has begun to address the problem of sex selective abortion with legislation as well as by participating in the Fourth World Conference on Women in Beijing. A Platform for Action was developed during the conference which includes issues related to sex selective abortion and can be used as a tool by women's groups and advocates.

Barbara Miller eloquently summarizes the cultural basis of sex selective abortion and infanticide in India:

It has often been noted that in Indian thought, the processes of creation and destruction are inseparable, that one is the necessary counterpart of the other, indeed, that creation can come only from destruction. Fertility and mortality, growth and decay, female and male are likewise conjoined in a dramatic dynamic that unfolds in this book [*The Endangered Sex*]. For this is a story of how the birth of some inexorably brings the death of others, of how the survival of males feeds on the demise of females, of how the intense desire for sons is directly tied to the fatal neglect of daughters. The light and dark of

Indian culture, the giving and taking, the benign and malign are simultaneously expressed in a twisted, tortured dance whose tempo continually increases.

It is time for the dance to end.

**Appendix A** (Jeffery, 1984)

**Antenatal Sex Determination and Fertility Clinic**

Most prospective couples in quest of a male child, as the social set up in India demands, keep on giving birth to a number of female children, which in a way not only enhances the increasing population but also leads to a chain reaction of many social, economical and mental stresses on these families. Amniocentesis and Antenatal sex determination has come to our rescue and can help in keeping some check over the accelerating population as well as give relief to the couple requiring male child.

*General Guidelines for Amniocentesis and Sex Determination*

1. Assessment of the foetus sex has been made possible by Amniocentesis after completion of the 16th week and upto [sic] 20th week of pregnancy, when therapeutic abortion is medically feasible and legally permissible.
2. The procedure involves withdrawing of amniotic fluid and transferring it to an autoclaved vial in aseptic condition.
3. The prediction of sex is done by conducting sex chromatin studies (Barr body and Y-chromatin body) of the withdrawn amniotic fluid cells.
4. In spite of all precautions, the procedure can be fraught with dangers of abortion, in 0.1% of cases only.
5. Due to technical limitations as our trial studies indicate, our test is successful in 98.2% of cases.
6. A charge of Rs500/- only will be levied by the clinic for doing amniocentesis, sex chromatin studies and theatre charges.
7. Even if the fluid collected fails the above-mentioned charges will have to be borne by the patient and repeat study will be done free of cost.
8. No MTP [medical termination of pregnancy] is done in our Antenatal Sex Determination Clinic.
9. Sex determination is done in those patients having one or more than two female children.
10. A,B,O, and Rh Blood Grouping is essential and is done before the test on extra charges.
11. Prior appointment is necessary to avoid inconvenience to patients.

With regards,

M/s New Bhandari Hospital

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