

## INTRODUCTION

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If a memorial was made for every girl eliminated before birth in India alone, it would be twice the number of persons killed during the Holocaust. Indeed, some scholars have termed the practice of sex determination and selective pre-birth elimination of girls as ‘female foeticide’, ‘gendercide’ and ‘femicide’ (Purewal and Eklund, 2018; Kumar, 2017; Patel, 1989). A recent UNFPA (United Nations Population Fund) document accounts for about four million girls in the age group 0–6 years who were missing in India as per the 2011 census data. Among these, 2.5 million were missing specifically due to sex selective abortions and 1.5 million girls were lost to excess mortality of girls caused after birth (as a combined effect of neglect and discrimination) (Kaur et al., 2020). Another recent study revealed that a total of 13.5 million female births were missing during the three decades of observation (1987–1996, 1997–2006, and 2007–2016) (Saikia et al., 2021).

Amniocentesis and ultrasound technologies were primarily introduced to provide prenatal genetic information in order to support possibilities for treatment and cure before birth and to prepare parents for post-birth medical support, but have been misused for sex selective abortions. The known reasons for selective abortions include attributes such as (un)desirable sex of the child (George, 2002), sensory, cognitive, or physical impairment (Wolfram, 2000), or certain selected desired genetic properties (H-Dirksen, 2005). In recent times, technologies such as sperm pre-sorting, Pre-implantation Genetic Diagnosis (PGD) and Non-invasive Prenatal Testing (NIPT) further aid sex-determining and sex selective abortions at a global level, contributing to the diminishing of girls. Several studies have concluded that son preference is the main cause of female foeticide or female sex selective abortions in India. Four key words are the basic characteristics of the use of

prenatal technology for sex determination and sex selective abortions of female foetuses: desire – for a son; awareness – regarding the technology; access – to the technology; and affordability – to purchase the technology. Social constructs which discriminate against girls, easy availability and affordability are factors promoting the misuse of prenatal technology. The strong socio-cultural bias against daughters and preference for sons resulting in discrimination towards daughters has accentuated the problem. In ancient India however, female foeticide and female infanticide was not known to be prevalent, nor was it sanctioned by religion (John, 1993). Chapter 1 of this book traces the history and social context of female foeticide in India, the present trends of child sex ratio and its impact.

Presently, in the largely patriarchal system in India, sons are considered the only form of lineage and are called *Vamsam* or *Vansh*. Sons are socially associated with lineage, ancestral property ownership and old age care (Visaria, 2007; Bhalla, 2004; Das Gupta et al., 2003; Arnold et al., 2002; Bose, 2001; Oldenburg, 1992; Das Gupta, 1987; Levine, 1987). In the patrilineal-patriarchal systems, the daughters move to the husbands' house after marriage and dowry practice became widespread in this system. Daughters came to be considered as a socio-economic burden, a transitory family member. The matriarchal system is also followed by some communities in India: the Khasi and Garo community in Meghalaya State; the Nairs and the Ezhavas in Kerala State; and the Tuluvu, known as Aliyasantana, in Karnataka State. The Ezhavas and the Nairs are descendants of the Brahmin community in Kerala. The daughters are associated with the lineage in terms of property, responsibility of looking after the elderly members of the family and as the protectors of the traditions and land belonging to the community. The ideology of the matriarchy is not to favour women but rather that men and women are biologically different but not unequal. The incidence of sex selective abortions is the lowest and the child sex ratio (0 to 6 years) is the highest in these states that follow the matriarchal system.

Sex determination and sex selective abortions for non-medical reasons is observed by some feminists as 'sexist' and sex selective abortion is considered a form of 'femicide', regardless of the preferred sex of the child, the location of the practice, or the birth order of the child (George, 2006; Dube et al., 1999). Ethical voices, feminists and activists worldwide have raised concerns that prenatal tests for selecting attributes of children based on sex, disease

or disability is morally problematic as it embodies and reinforces prejudices and sends a hurtful message to those living with these attributes (Whittaker, 2011; Lippman, 1991; George, 2006; Parens and Asch, 1999). Chapter 3 further discusses the various debates of this ethical and feminist discourse.

The notion of *Vansh/Vamsam*, considering sons as the accepted form of lineage, is not merely a desire in the minds of individuals, it is the result of an entire spectrum of socially construed notions developed over a period of time through day-to-day experiences. In a patriarchal system, a child that is considered part of a lineage, a line of descent from a father to a son, is also commonly called *Vansh*, or *Vamsam* in various parts of India, and this notion of *Vansh* has direct implications on the sex selective behaviour among people (Singh, 2022; Nanda et al., 2022; Rawal, 2022; Singh, 2017; Madan, 2012).

Drawing on Naila Kabeer's (2005) concept of women's empowerment, the research examined the expectations in pregnancy of their forthcoming child (desired sex, aspirations) or notions of *Vansh/Vamsam* among pregnant women in the context of women's denial of agency reflected in their self-esteem, women's denied agency in existing power inequalities and women's empowerment, by examining women's individual experience of the three forms of transformative agency: agency, analytical thought and achievement. This research examined individual (micro level) as well as collective level notions through group discussions with men and mothers-in-law. There is an increasing understanding that individual notions are socially construed through embodied experiences (Lippman, 1991; Abel and Browner, 1998). Collective ideals also drive parental desires for preferred attributes in their children (Chipman, 2006; Overboe, 1999). Chapter 4 of this book explains the characteristics and shortcomings of the women's empowerment concept applied in this research. The chapter elaborates the meanings of women's 'denial of choice' and 'transformative agency' in their reproductive and life course decision making.

The objectives of the research were: to examine the 'denial of choice' and 'transformative agency' among pregnant women in India, drawing on Naila Kabeer's (2005) conceptualisation of women's empowerment; to explore notions of *Vansh* among expectant mothers; to examine the relationship between 'women's empowerment' and notions of *Vansh*, with discussion of maternal age, number and sex of existing children, location, and the expectations and fears expressed by pregnant women in order to understand

patterns of denial of choice and transformative agency among pregnant women in India; and to examine notions of motherhood.

## **Research Methods**

Naila Kabeer draws on Millennium Development Goals (MDGs) to identify three main variables of women's empowerment: education, employment and political participation. She divides the process of transformative agency into three stages: agency, resource and achievement. This method has been applied by several researchers to understand women's empowerment among migrant women in Sweden, refugee women in Canada, women in Nepal, and women in Bangladesh (Bhattacharyya, 2022; Afif Hossain, 2016; Kunka, 2019; Kulczycka, 2015). Secondary data on variables of women's empowerment and child sex ratio was analysed to examine the spatial pattern in order to identify study areas within India. Based on this analysis three states were selected in India: Maharashtra, Delhi and Odisha. The pregnant women in India were contacted through clinics providing Prenatal Screening (PNS) services or through NGOs (Non-governmental organisations). A total of 33 pregnant women were interviewed about their expectations of their forthcoming child: 12 in Delhi, 12 in Maharashtra and 9 in Odisha. Seven gynaecologists (3 in Delhi, 2 in Maharashtra and 2 in Odisha) were interviewed for their opinion on sex determination, the incidence of sex selective abortions, the Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act 1994 and its implementation, and the prevalence of son preference among their patients (the pregnant women) and their family members. Drawing on Hycner's (1985) analytical method, the in-depth interviews were analysed, the findings of which are presented in Chapter 5 (Delhi State), Chapter 6 (Maharashtra State), Chapter 7 (Odisha State) and Chapter 8 (analysis of interviews with doctors from all three states).

## **Imbalance of Sex Ratio Globally**

A deficit of girl children has been observed not only in India and other Asian countries, but also among the Asian diaspora living in Canada, Australia and the UK (Brar et al., 2017; Edvardsson et al., 2021; Dubuc and Coleman, 2007). Sex determination and

female selective abortions is not merely a phenomenon limited to Asia (India, China, South Korea, Taiwan, Hong Kong, Nepal, Jordan, Bangladesh and Pakistan) and among the Asian diaspora communities living abroad; there is evidence of a re-emergence of son preference also in South-East European countries, which is reflected in the skewed sex ratios at birth in the countries of Albania, Kosovo, Macedonia and Montenegro (Meslé et al., 2007).

A study on the persistence of son preference in India, China and Korea to explore possible policy inputs found that rapid urbanisation, increase in educational attainment of girls and women, and an increase in women's employment can bring about changes (Das Gupta et al., 2003). Moreover, the study found that initiatives such as legislation, mass media and social movement can bring about changes in the mindset towards perceiving sons and daughters as equally valuable to the family and society. The study concluded that the implementation of inheritance law and one-third reservation for elected positions and an overall change in media representation of women can have a positive impact on the attitudes towards women and a change in women's own self-confidence and self-esteem (Das Gupta et al., 2003).

### **Policy Initiatives to Restrict Sex Determination and Enhance Equality in India**

The 'Beti Bachao Beti Padhao' Scheme – BBBP (Save the Girl Child, Educate the Girl Child) Scheme – launched in 2015, with a key mass media campaign, has tremendous potential to bring about changes in society. Since the launching of the BBBP Scheme, the average sex ratio at birth in India has improved by 19 points from 918 in 2014–2015 to 937 in 2020–2021. However, it is still lower than the normal sex ratio at birth of 952 girls born per 1000 boys as defined by demographers (UNFPA, 2020). The key elements of the BBBP scheme include the enforcement of Pre-Conception & Pre Natal-Diagnostic Techniques (PC&PNDT) Act, a nationwide awareness and advocacy campaign, and multi-sectoral action.

The overall sex ratio at birth for India has also gone up according to the National Family Health Survey (NFHS) data, from 919 to 929, NFHS-4 2015-16 to NFHS-5 2019-21 respectively (IIPS and ICF, 2021). The HMIS (Health Management Information System) data source reveals that 422 out of 640 districts covered under BBBP districts have shown improvement in sex ratio at birth from

2014–2015 to 2018–2019. Some districts of India that were very low in sex ratio at birth have shown major improvements. After implementation of the BBBP scheme the sex ratio at birth in several districts improved between 2014–2015 and 2019–2020: Mau (Uttar Pradesh) from 694 to 951, Karnal (Haryana) from 758 to 898, Mahendergarh (Haryana) from 791 to 919, Rewari (Haryana) from 803 to 924, and Patiala (Punjab) from 847 to 933. This reveals that State and District level implementation of this scheme is paramount for effective outputs. With effort and effective implementation, positive results can be seen in some states of India.

In India, enrolment of girls in secondary education increased from 75.51% to 79.46% (IIPS and ICF, 2020–2021). The percentage of first trimester antenatal care (ANC) registration increased from 61% to 73.9% between 2014–2015 and 2019–2020. The percentage of institutional deliveries increased from 87% to 94.8% between 2014–2015 and 2019–2020 (MoWCD, 2022a).

However, a cause of concern is that the overall child sex ratio in India has steadily shown a declining trend since 1981. The overall child sex ratio in India was 962 in 1981. From 1991 onwards the child sex ratio has dropped below normal, to 945 girls per 1000 boys and has further declined in the following decades. While 945 was the national average of child sex ratio in 1991, some states in the Northern and Western regions of India have recorded abysmally low child sex ratios in favour of boys (Census of India, 1991; 2001). In 2011, India's child sex ratio was the lowest since independence, at 919 girls per 1,000 boys (Census of India, 2011).

The child sex ratio in India declined steadily to 927 in 2001. Another source of data is the sex ratio at birth collected by Sample Registration System (SRS), Government of India. In the period 2016–2018 only two states had a normal sex ratio at birth (Chhattisgarh, 958 and Kerala, 957) (MoHA, 2019). In the period 2016–2018, the lowest sex ratio at birth was recorded in Uttarkhand State (840 per 1000 males) and Haryana (843).

## **Child Sex Ratio and Correlating Variables**

Until 2011, in most of the States of India, the urban areas had a lower child sex ratio in favour of boys as compared to rural areas (see Figure 0.1). People in urban areas in general have better knowledge and better access to sex determination technology. However, this trend is now slowly changing; the rural areas of India, on average,

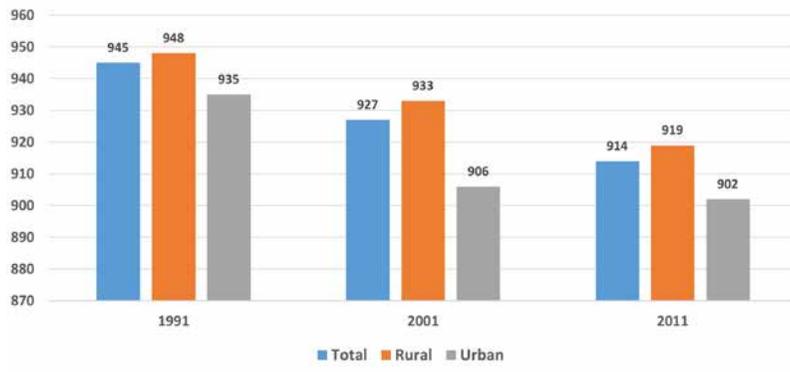


FIGURE 0.1. Child sex ratio in India 1991, 2001, 2011 (total-rural and urban). © Sheela Suryanarayanan

have a slightly lower sex ratio at birth (907 girls/1000 boys) as compared to urban areas (910) (MoHA, 2020). It is worrying that in some states of India (Assam, Bihar, Haryana, Uttar Pradesh, Punjab and Madhya Pradesh) there is such a trend of lower sex ratio at birth in rural areas as compared to urban areas.

The 2011 census data reveals that child sex ratio in districts with more than 25% of tribal population data is declining (MoHA and UNFPA, 2014). The concern is that, with the present spread to rural and tribal areas, the knowledge and use of this technology is now penetrating areas that were previously more inaccessible. The child sex ratio was observed to be lower and more masculine among the richest wealth index group as compared to the poorest group (IIPS and ICF, 2017). This corroborates the hypothesis that affordability (income) to purchase and awareness (education) of the prenatal screening technology increases its use. One study found that son preference among mothers put girls' educational opportunities at a disadvantage and that mothers' educational attainment reduces son preference and bias against daughters (Bose, 2012). In contrast, another study found that there was no correlation between income or education with relation to preference of male child (Warade et al., 2014).

The sex ratio at birth becomes increasingly masculine at the second birth order and even more at the third birth order (Bhat et al., 2007). A lower sex ratio at birth in higher birth orders was also noted in the NFHS-4 data (IIPS and ICF, 2017). This trend indicates that after the birth of a first girl, a second girl would be more likely

to be aborted while a second boy would be retained, and there was higher probability that a third girl would be aborted, while even a third boy would not result in male foeticide (IIPS and ICF, 2017).

The overall pattern in India reveals that the child sex ratio was lower in urban areas (902) as compared to rural areas (919) and lower among high-income groups as compared to low-income groups (UNFPA, 2020). Illiterate mothers had a higher fertility rate and a higher number of girls, while literate mothers had a lower fertility rate and fewer girls. The geographical location, urban location, higher birth order of the child, higher income and mothers' higher educational status are some of the important correlating indicators associated with a lower child sex ratio.

## **Women's Empowerment**

Naila Kabeer's (2005) concept of women's empowerment is relevant because not all decisions made by women under any circumstances can be defined as empowering. The approach to women's empowerment and policy making in India is in ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993 and the Beijing Declaration and Platform for Action (1995) as well as Sustainable Development Goals (SDGs). Since independence, the Government of India has implemented several interventions and important transformative laws to this effect, to ensure a dignified life for women in India, such as: the Equal Remuneration Act, 1976; the Dowry Prohibition Act, 1961; the Immoral Traffic (Prevention) Act, 1956; the Maternity Benefit Act, 1961; the Medical Termination of Pregnancy Act, 1971; the Commission of Sati (Prevention) Act, 1987; the Prohibition of Child Marriage Act, 2006; the Pre-Conception & Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994; the Sexual Harassment of Women at Work Place (Prevention, Protection and) Act, 2013; and several more.

Naila Kabeer's (2005) concept of women's empowerment highlights education, employment, and political participation as the three important resources required to achieve gender equality and women's empowerment. Naila Kabeer (2005) refers to 'transformative agency' as women's ability to question, analyse and act on the detrimental impacts of the structures of patriarchy on their lives. The social pressures on women to provide a boy child and abort female foetuses may be immense; to call this an autonomous choice

is a misinterpretation of the context. Reproductive rights advocate for individual rights, while reproductive justice focuses on social justice along with individual rights.

A recent study in India found that urban, middle-class women in Delhi and Haryana accepted son preference as a natural phenomenon, which signifies that they have internalised the subordination of their own (female) gender to the extent that they consider men to be socio-culturally and biologically superior to them (Kohli, 2018). It is the social construction of women that drives them into understanding that women are subordinate beings. According to Naila Kabeer (2005), this mindset equates to a denial of agency rather than women's empowerment.

In their study, Paul et al. (2017) found that some women internalise the need for a son; 'a son is necessary', said a pregnant woman in the study, referring to machines in the city that can establish the sex of the child, as a last resort. An 'ideal family', according to the women, consisted of two children – one boy and one girl. Another woman in the study had been forced by her parents-in-law to have an abortion without her consent.

Younger married women in India are known to have the lowest autonomy and agency in their own reproductive health and use of contraceptives; other powerful members of the family hold the power to make these decisions for them (Paul et al., 2017). Most of the women faced with making decisions regarding sex determination and sex selective abortions are younger married women in the household.

One case study comes to my mind about young daughters-in-law with lesser decision-making power. This is a case study from my study visit to a village near Jaipur city in Rajasthan in 2019. I conducted a group discussion (GD) with Auxiliary Nursing Midwives (ANMs), Accredited Social Health Activists (ASHAs) and women of reproductive age group in this village on the potential use of mobile technology to enhance women's access to maternal health care services. I observed that a woman with a baby was engrossed in a discussion with other women. After the GD, I asked her what the discussion was about; she shared her predicament with me (Figure 0.2).

She had one daughter, less than a year old, and the doctor had warned her that she could not survive another pregnancy as it would be a risk for her to do so. But her in-laws and husband were insisting that she should have another child since they wanted a son. They had warned her that her husband would rather remarry



FIGURE 0.2. A lady with her baby girl in Rajasthan.  
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if she didn't try for a second pregnancy. Her peer group sitting around her were advising her 'why not give it a try when your in-laws are insisting so much'. She had no educational background, no assets, no employment as resources. This was a life and death situation for her. Apart from the risk to her life, her concern was 'what will happen to my daughter, if something happens to me. Who will look after her?'

This case study brings out the vulnerability of women, especially younger women in their position as daughters-in-law. She understood the inequalities in her situation, but she was being forced to take a decision between life and death because she had no resources to resist or change her present situation. In the above given instance, the peer group who were advising the lady to go ahead with another pregnancy in order to please her in-laws and husband were also in a state of 'denial of agency'. They were coercing her to put her life at risk to please the familial and societal desire.

Kabeer (2005) conceptualises three resources for women's empowerment: education, employment and political participation – all essential for women's equality. According to Kabeer (2005), education helps in providing women with access to knowledge, information and new ideas that are required in order for them to question, reflect, and act on the detrimental impacts of the structures of patriarchy on their lives. Education up to at least higher secondary level is known to be positively correlated with enhanced health care choices and knowledge about public health messages and health care services (Kabeer, 2005). Education helps women to focus on their own well-being along with that of their family. However, according to Naila Kabeer (2005), poverty-driven choices or any such life and death choices that result in dependence situations on powerful others rules out 'meaningful agency'. This is because poverty and other such situations further intensify women's inequalities and their impact is experienced differently and more intensely by women as compared to men (UNWomen, 2022).

Female foeticide is only the tip of the iceberg; beneath it lies the social conditioning of patriarchy that devalues women. Female foeticide is a form of violence and inequality against girls that begins even before birth. The larger context of this violence is the inequalities that girls and women experience in society at large. Girls are prevented from attaining their educational goals, which translates into reduced skills and limited employment opportunities. Boys too in India are pulled out of schools early, but with girls this impacts their familial and social position, since they have no other resources to depend on. Women's empowerment is necessary for economic growth and for overall social development of the society. Women's inequalities are also influenced by the physical, emotional and sexual violence that they face, their limited access to political participation, and their limited access to control over resources, land ownership and informed decision making regarding sexual relations, contraceptive use and reproductive health care.