Chapter-II

Review of Literature and Objectives of Study
Chapter-2
Review of Literature and Objectives of Study

After surveying and weighing the available set of literature one gets the film impression that strong preference for sons over daughters exists in the Indian subcontinent, East Asia, North Africa and West Asia quite unlike the western countries (Muthurayappa et al., 1997;1 Lancet, 1990;2 Okun, 1996).³ People achieve small family size with relatively greater number of sons by abuse of medical technologies. Pregnancies are planned by resorting to the ‘differential contraception’ -- contraception is used on the basis of the number of surviving sons irrespective of family size (Okun, 1996).⁴ Following conception, foetal sex is determined by prenatal diagnostic techniques after which female foetuses are aborted (Park and Cho, 1995;5 Arora, 1996̅).

Anthropological and sociological literature from various developing regions of the world amplifies parental reluctance to have a baby girl. Therefore, amniocentesis and ultrasound have become necessary, reliable and effective tools for sex selection. Sex determination test followed by abortion is widely suspected to have replaced female infanticide in certain cultures.

The major and salient features of the available literature and related studies, thus collected, were compiled under the following heads:

1.1 Female Foeticide
   1.1.1 Amniocentesis and other sex determination tests.
   1.1.2 Legal aspect of female foeticide

1.2 Son preference
2.1 Female foeticide

Ramanamma and Bambawali (1980) in their research article titled “The Mania for Sons: An Analysis of Social Values in South Asia” report the findings of their studies carried out in two hospitals in a city of western India. The data of termination of pregnancy after determining the sex of the foetus and in the height of the sex of the foetus and also the number and sex of existing children, for a period of one year, it was found that four hundred individuals used the genetic service by the physicians. The 20 per cent who came on their own initiative were well educated. The 90 women who consulted the service to find if the expected child was male or female, all wanted to retain the foetus if it was a male child, even when there was a chance of genetic defect. In the hospital (B) 700 women determined the sex of the foetus. Out of these 450 were informed that they would have a daughter and 430 out of this lot (95.5%) had the foetus evacuated. As in the former case, here too, they wanted to retain the male foetus even when there were chances of same genetic disorder.

Similar findings were reported by (Jeffery-Jeffery and Andrew, 1984). They conducted a micro research in Bijnaur district of Uttar Pradesh. Intensive fieldwork for over a period of one year in two villages drawn from eleven randomly selected villages, was carried out. An interview survey of 301 women, who had recently delivered, convinced them of the fact that clinical services offering amniocentesis had informed women of the sex of their foetus have in North India during the past ten years. These findings fit into the culture pattern in which the girls are devalued. For the purpose of the present investigation which is a survey study to know the attitudes of people from Northern-Western states of India towards female foeticide and female infanticide. The investigators explored several sources like books, journals and reports, regarding female foeticide and female infanticide. Besides various
research studies, newspapers and magazine articles. As per the 1981 Census, the sex ratio of Uttar Pradesh and Bijnaur district were 885 and 863 respectively. They also found that female infanticide that was practised in Bijnaur district till 1900 was limited to the Rajputs and Jats who considered birth of a daughter as a loss of prestige. However, abuse of amniocentesis for female foeticide was prevalent in all the communities.

In their report on the findings of a Survey conducted by All India Institute of Medical Sciences, Delhi, Chhachhi and Satyamala (1983)\(^9\) stated that as soon as the parents were told that the foetus was of a girl, they started making arrangements for abortion. This view gets supported by another micro study conducted in Punjab by Jain and Singh (1983).\(^10\) They sought the opinion of men and women regarding sex determination tests with the help of questionnaire. Among men, respondents were either businessmen or white-collar employees of the lower income group. The women respondents were mainly housewives. All of them knew about the test and found it useful.

Manmeet, Kaur (1993)\(^11\) conducted a study on the topic “Female Foeticide – A Sociological Perspective in Village Daun.” This village, situated at a distance of eight kilometres from the Chandigarh-Ludhiana Road, was selected for the said study. In all, 126 women representing nearly 98% of the married women in the age group of 20-45 years were interviewed. In-depth perspective of the problem was obtained by way of case studies done at Chandigarh; the objective of this study was to understand the attitude of women towards female foeticide and to know the underlying reasons for the practice. The findings of the study are that nearly (i) three-fourth of the women in the suburban area knew about the sex determination test and female foeticide is favoured by both rural and urban respondents. (2) The case studies in the urban area reveal that the middle class women of the area are obsessed with the idea of a two child family and that one of the two children must be a son (3)
The socio-economic pressures are such that even those who consider abortion to be a sin, are prepared to abort a female foetus. This study makes it clear that a woman, whether educated or uneducated rich or poor, is not conscious of her own identity which is as indispensable for progress as that of a man. In the end, it may be concluded that the banning of this test, through an essential and urgently required step, is not the final solution to the problem. In the long run, some prejudices against women have to be overcome by improving their overall status in society.

An investigation by Adithi, (1995) on NGOs working in the rural areas of Bihar state, revealed that female infanticide, foeticide and excess female child mortality due to selective neglect, were widespread in the eight districts there. Such studies on infanticide were carried out by ‘dais’ (traditional female birth attendants) who were coerced by the senior male kins of the women giving birth. Overriding the protests of the women in the family, tears of reprisals, poverty and lack of alternative occupation led the ‘dais to comply with other medical practitioners, compounders and doctors also carried out infanticide processes when approached by the family members of a newly born girl child. There was no difficulty in committing infanticide because the birth and death followed quickly upon each other, with no certificate recorded for either event. The report also describes how the traditional skill of ‘dais’ in identifying the sex of foetus in the seventh or eighth month of pregnancy is used to avert the birth of pregnancy. It is especially used to avert the birth of a daughter. Such averted births are conducted by approximately 68,000 dais in contiguous and culturally similar districts of Bihar. On the average each ‘dai’ killed about two infants a month. According to the interview, Adithi estimates that number of female infanticide each year in these districts could total as many as 16,32,000.
The Adhithi report also noted that earlier, only upper castes such as Rajputs and Brahmins practised female infanticide, but it had now spread to scheduled tribes, Christians and Muslims. The main reasons indicated were the spread of dowry with exorbitant demands; due to marginalization of women from traditional occupations and concentration of income in the hands of men with the consequence that women’s seclusion and dependence on men increased and men began to assert their right to emulate upper caste customs including female infanticide. Violence against women is growing within and outside the homes.

Prem Chowdhary (1993)\(^{13}\) reported that historically there has been a marked preference for boys over girls in Haryana. However, in the present times this practice of foeticide can be seen in rampant use of amniocentesis and ultrasound tests involving sex determination and resulting in medical termination of pregnancy. Not only are the samples of the amniotic fluid of pregnant women from rural areas sent to city centres, now even mobile van service is available. Private doctors make use of such means to offer services to about 20-40 patients per day for sex determination. He further said that chiefly the decisions to get such tests and consequent abortion is of women themselves. Also women who have been pressurized to go for such tests will never blame their husbands or family for the fear of being ostracized. Therefore, women should also be responsible for the crime. This view seems to have been taken care of by the new act passed in 1994 for the regulation and prevention of the misuse of sex determination techniques whereby a woman found guilty can be imprisoned and fined upto Rs. 10,000.

Dahiya and George (1998)\(^{14}\) conducted a study on “Female Foeticide in Rural Haryana”. This field research is therefore a further step in the systematic effort to follow upon indication of rampant female foeticide and was initiated in June 1996 in six villages of Rohtak district in Haryana. In the course of field
work, qualitative information and sociological data related to the practice of female foeticide were obtained. The findings of these surveys strengthen some of the earlier information relevant to caste differential infanticides. They also throw light on the fact that foeticide is not an isolated phenomenon but one of the several ways in which patriarchy demeans women; others being violence against women (Jefeebhoy and Cook, 1997)\(^1\), women-unfriendly inheritance practices, customary marriage conventions which result in significant proportion of women being married before the permitted eighteen years of age and coercion of widows to undergo levital marriages facilitated by state administrative directive. Virtually all (99.5\%) study women were interviewed and 94\% of the respondents were mothers themselves. The study showed that each woman had a maximum of five live born sons while the maximum number of live born daughter was nine. It was found that parents tend to be calculative in choosing the sex of the next child, and the decision is based on the birth order, sex sequence of previous children and number of sons. Some families resort to aborting even the first pregnancy if the foetus is female. In the cohort born in the last five years the sex ratio at birth (SRB) of boys to girls for upper caste was 1.27, suggesting that about 17\% of females were aborted. The intensity of son preference appeared to be less among the harijans. Women, in group discussions, accepted that incidence of female foeticide has been on the rise in recent years. The SRB for the Harijans was 1.02 while among upper castes it was 1.27. The SRB of upper caste children rose from 1.26 to 1.89 as birth order went up from 1 to 5 (above 5 numbers are too small and therefore the ratio is not dependable). A similar rising trend was not seen in Harijans. The SRB kept increasing over the last 5 years among the upper castes. It increased from 1.15 to 1.42 from the first 25 years to the next 2.5 years. In fact, in the last years, the SRB was as high as 1.80.

We presented the results of individual women – interviews of discussion held in the hamlets. There was universal awareness of SDTs and most knew,
where to go for the tests and abortions. In upper caste hamlets there was open admission of the widespread practice of female foeticide. At a few places the women blamed doctors who are doing this for money. Some women complained that the first concern of their families following pregnancy is to put pressure on them to determine the sex of the unborn. If it is a boy, then only is the need for ante-natal care felt. In Harijan areas where the distortion in sex ratios were least, there were denials about the practice. We found greater discrimination towards females in the upper castes as compared to the Harijans.

Khanna (1995)\textsuperscript{16} conducted a micro study in an urbanised village in Delhi. He reported that it was apparent that sex selective abortions following ultrasound is a common practice and is increasing in incidence through techniques of SD tests are also used but ultrasonography is the primary technique in use and that other techniques are used less often. This particular village consisted dominantly of Jats in terms of numbers and economic status. Earlier, they owned agricultural land but in 1964, the government acquired their land and gave them compensation. However most of the residents seek employment as wage earners in Delhi. Here the birth of son is considered as a “gift” or an economic and political honour of family, whereas a daughters is born as (Ek Lakh Ki Karhi). Son represents the strength of the family in the community. A family with fewer sons is perceived as economically and politically week. Traditionally, in this Jat agricultural community, sons were highly valued as agricultural labourers and for political dominance in the village. Although a shift in the economic and occupational base of the village has occurred, son preference continues and hence women and their contributions continue to be devalued.

Popular perceptions among the respondents were found to be:

- Most individuals know that the ‘machine’ can tell about the sex of the child to be born after three months of pregnancy.
There was a popular opinion that in order to avoid accidentally aborting a male foetus, ideal time period for pre-natal sex determination should be during the fourth month.

There was little concern over the effect of repeated late abortions on women’s health.

George (1992) conducted a study “Female Infanticide in Rural Area of Tamil Nadu State”. The research was carried out in 12 villages of K.V. Kuppam block of North Arcot Ambedkar district, Tamil Nadu State, South India, for four years beginning in September 1986. Most villagers are Hindu by caste and a small proportion are Christian converts. While individual villages in the study area differ slightly from each other in their caste composition the average distribution is 56 percent gounders caste, 31 per cent harijan, 11 per cent backward castes and 2 per cent forward castes. Sixty per cent of the mothers in the study are illiterate. Literacy rates of women are higher in South than the north and currently all new teachers in government primary schools in Tamil Nadu must be women. Fertility rates tend to be lower in south as compared to the north. The study includes a total of 773 births outcome involving 772 married women and one unmarried woman. There were 776 singletons and seven sets of twins. Total live births were 759 of which 378 were male and 381 female. The observed sex ratio at birth is not significantly different (at p < 0.05) from the standard ratio at births of 105 males to 100 females, observed in large populations worldwide of the 21 still births, 8 were male and 13 female. The workers in all cases were local residents of the village and had been trained at RUHSA (Rural Unit for Health and Social Affairs) headquartered in Kahanur village. The fact that if an infanticide has been committed it is widely discussed among the village women. To the outsider, however, the cause of death is misreported though the village worker, is from the same village and is aware of the possibility of infanticide. This is confirmed with the mother and immediate relatives. After about five months following the
establishment of excellent rapport with the study families the field team had knowledge of the intent of infanticide even before the birth occurred in many cases. The father or some other family member of the family would tell the village workers that if the current pregnancy resulted in the birth of a female, it would be killed.

Bose (2001)\textsuperscript{18} conducted a study on “Fighting Female Foeticide” He explained that the recent data, in 1991, the overall sex ratio declined and so also the child sex ratio, while in 2001, the overall sex ratio increased but the child sex ratio declined. In the absence of field surveys specifically aimed at finding out the incidence of female foeticide (as extremely difficult proposition in the face of legal ban on sex determination tests), one can not comment with confidence on the magnitude of the problem. In his other articles “Curbing Female Foeticide” (2002) he explained that the supreme court’s tough stand on implementation of pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act is likely to be effective in dealing with female foeticide given the indifference of governments especially of the states with the worst records in this regard and the silence of civil society. He pointed out that the term “child sex ratio” is somewhat misleading. The definition of child is not restricted to six years. Usually, the cut off point is fourteen years. Indian Census data percentage distribution in five yearly age group like 0-4, 5-9, 10-14 and so on. The sex ratio data for the 0-6 years age group is by product of the literacy data. Literacy ratio is calculated in the Indian Census since 1991 for the age group seven plus. Therefore, the 0-6 years age group population is subtracted from the total population. For a proper study of the child sex ratio, one needs data on sex ratio at birth and at ages one, two, three, four and five but single year age data are not very reliable. The decline in child sex ratio is assuming an alarming proportion in certain districts of Punjab and Haryana, Himachal Pradesh and the decline in majority of districts in other states and union territories – across the country (Uttar Pradesh, Madhya Pradesh, Orissa,
Karnataka, Assam, Delhi etc.) is rather intriguing. The social, cultural bias against the girl child might have been possibly aggravated by the recent medical support in terms of sex determination tests and requires further field investigation. Those familiar with the field situation in Punjab, Haryana, Himachal Pradesh and Delhi know that the ready availability of doctors during the ultrasound test and consequent female foeticide, the good-transportation network and the ability to pay for the services of the mobile doctors are factor responsible for the widespread recourse to ultrasound in rural area also. The researcher would argue on the basis of field work that it is not that son preference is confined to Punjab and Haryana, it has rather spread all over India and is also creeping in such of the enlightened state as Kerala. However, the ready availability of doctors and the paying capacity of the client is conspicuous in Punjab and Haryana. It is further argued by the researcher that the field situation is that the chief medical officers, who are authorised and expected to prosecute the guilty doctors are normally not inclined to go against a fellow doctor. There are ethical aspects concerning the misuse of ultrasound machines. It can be further concluded that the child sex ratio is very likely to go down further in the years to come. The shortage of women will distort society. The crime against women will increase, polyandry will emerge on the scene and there will be growing conflict and violence. The secretary of family welfare, A.R. Nanda (2001) got into trouble for saying that population stabilization can wait, it is more important to correct the sex imbalance. Population stabilization achieved through producing only two sons is not the social goal, the demographic imbalance is sure to result in social disaster.

2.1.1 Amniocentesis and other Sex Determination Tests

The following findings present the view which have been expressed regarding amniocentesis and other sex determination tests by various researchers.
Singh and Jain (1985) conducted a study on the topic, "Opinions of Men and Women Regarding Amniocentesis" in Ludhiana, Punjab. They selected in its sample 50 per cent men and 50 per cent women as respondents for their questionnaire on opinions of men and women regarding sex determination tests. Among men, the respondents were either businessmen or white collar employees of the income group of Rs. 1000 to 35000 per month, whereas while women respondents were mainly housewives. All of them knew about the test and had found it useful. Punjab was the first to start commercial use of this test way back in 1979. There was a newspaper advertisement regarding New Bhandari Antenatal Sex Determination Clinic in Amritsar that activated the process and the women groups to denounce it equivocally. According to them, comparatively if there are smaller numbers of women, there will be less growth of runaway population. The government and private medical practitioners involved in this lucrative trade, justify the sex determination test as a measure of population control. Women have always been at the receiving end of all family planning policies. Ninety nine percent of population control researches are conducted on women without any consideration about the harmful effect of research on the women concerned. Advocates of population control will continue cashing on socio-cultural values that treat the birth of a daughter as a great calamity and perpetuate modern methods of massacre of female foetuses on a massive scale.

Kotala (1986) expressed the view that various sex determination and sex pre-selection cases have been discovered during the last fifteen years. To this, Ravindera (1986) adds that techniques such as sonography, jetoscopy, choricerbiopsy and the most popular one, amniocentesis are increasingly becoming household names in India.

Mascarenhas (1998) reported that one clinic in Wabar, Bombay performed 15, 914 such abortions in 1984-85. In a short while, a small district
town in Northern Maharashtra with a population of 2.5 lakhs, five clinics for sex tests have sprung up in the span of three years. Other small towns such as Jalgaon and Amarawati also have such clinics. She found that, women even sold their mangalsutras to get the test done. According to the first state level committee on sex determination, it is estimated that about 78,000 cases of post amniocentesis female foeticide had occurred in the country between 1972 and 1982. The phenomena of misuse of sex determination of tests does not seem to be limited to India only. It is reported to have spread in Korea, China, Hong Kong and some other South Asian countries too.

In one Chinese experiment in which sex determination and abortion were offered, 29 out of 30 chosen cases opted to abort female foetuses. This was found in a study conducted in Tietung hospital in China 1975. Similarly, in Singapore too, in a clinic based on sex selection programme only six percent of women attending the clinic were actively seeking daughter (Sohoni, 1994). According to a report of an interview with “the correspondent of the news daily” The statesman, the controversial doctor couple of Amritsar (Punjab) who first started the commercialization of Amniocentesis Test, told that they received letters of gratitude from patients from states such as Kerala, Rajasthan, Gujarat, Jammu & Kashmir and Madhya Pradesh. They claimed to have conducted about 500 such tests in one year (prior to 1987). They maintained that their tests were helpful in checking the baby born and also that they have failed in only one out of many cases carried out so far. On the contrary, a senior doctor from the government hospital in the same city, who is against this test, says that “she was aware of at least cases in which the tests, proved wrong causing immense psychological trauma” to the mother who got a male foetus aborted after the clinic had declared is to be a female. She also added ironically all those women were educated and came from enlightened families.
Kusum (1988) in her article, entitled “Are Indian Women becoming an Endangered Species”, pointed out that Indian women seem to be heading towards becoming an (endangered species) in another 100 years if the misuse of medical techniques like amniocentesis is not stopped. She also puts forth an interesting though a sad comment. She has observed that malaise of sex determination tests has been very popular. It is believed that there are courier services to send samples of amniotic fluid of pregnant women from rural health centres in some states to big towns and cities. She insists, therefore, that such a practice is to be attacked on many counts. The practice referred to above is clearly against a constitutional mandate. She quotes article 51A (e) of the constitution which say that it is the fundamental duty of every citizen to renounce their practices derogatory to the dignity of women. Surely a practice or a device which permits or seeks to do away with a foetus is derogatory and very much against human dignity.

An investigative research carried out by a news service of a reputed daily brought out startling facts about the high popularity of amniocentesis test in Delhi. She claimed that advertisements are made in newspapers by doctors carrying out such tests in bold letters with catchy promise: “Boy or Girl, know the sex of your unborn child.” After collecting addresses fifteen nursing homes, maternity or general clinics from telephone directory, were contracted in parts of Delhi for the purpose of investigation. Out of these, nine eagerly offered to do the test, amniocentesis or the techniques of CVB (Chrion Villus Biopsy) which has became popular recently. Its special advantage is that it can be done only after eight weeks of pregnancy. This makes abortion safer, whereas amniocentesis involves quite some risks because it cannot be done earlier than fourteen weeks of pregnancy. Among the others, who did not carry out the test are immediately offered to get it done and promptly furnished phone numbers of establishments where the job could be done. The investigator reported that the same names recurred in “references provided by these clinics which shows
the close nexus between doctors performing sex determination tests and others, who carry out abortions."

She also reported that in Delhi charges for an amniocentesis test is Rs. 1,000 were as in Bombay, the rates are much lower i.e. about Rs. 250 and for CVB, the fee is close to Rs. 3,000. However, at the test cum abortion centres, inflated prices are charged for the convenience of an immediate abortion. Prices do not seem to affect the demand because government hospitals do not carry out the tests after the government direction to stop it. Even other hospitals of repute do not provide any such “facilities” and so private operators flourish. Most clinics claimed to get from 20-30 patients per month.

A study done by Kulkarni (1986)\textsuperscript{26} of the Foundation Research in community Health brings a shocking fact to light. About 5,000 amniocentesis tests are carried out in Bombay annually to detect the foetal sex. According to Kulkarni there is a growing number of abortions consequent on amniocentesis or foetal sex determination test and majority of women who go in for this test are middle class housewives with two or three daughters. Thus, the rich and educated middle class people, in collusion with private practitioners, are perpetually doing the atrocity against women people get rid of their unborn child only if it is a girl.

A study undertaken by the government of Maharashtra revealed that at least 50,000 amniocentesis tests for sex determination were conducted annually in Mumbai city alone. If a test showed a female foetus, the next step was termination of the pregnancy (Anjali, 1987).\textsuperscript{27} A case study from a hospital in a city in western India conducted from June 1976 to June 1977 revealed that of the 700 women who sought prenatal sex determination, 250 were found to have male foetuses and 450 females. While all the foetuses were kept to term, 430 of the 450 female foetuses were aborted (Ramanamma and Banbawali, 1980).\textsuperscript{28}
According to Kuntal Agarwal, 'amniocentesis test and female foeticide have been prevalent since 1977, but have become popular (only) since 1982 and thereafter small towns and cities are also experiencing their effect.

Shah and Taneja (1991) carried out a study to know the opinions of males and females of Delhi city regarding female foeticide. The sample population consisted of purposively selected 150 males and 150 females. The practice of female foeticide was studied and analysed with respect to their moral and social aspect. The opinions of the respondents were categorised in three categories — highly negative, somewhat negative and positive. It was found that more than 60% of the respondents had highly negative opinion regarding female foeticide, both overall as well as aspect wise. Significant differences were found in the opinions of male and female respondents with respect to their sex. The females were found to be having positive opinion (5%). It was also found that age-wise, old female respondent held positive opinion. A higher percentage of respondents belonging to families have one and two or more sons held highly negative opinion regarding female foeticide. About (60%) of the respondents felt that insurance of family’s name through male child was mostly the cause for female foeticide. More than 60% of the respondents felt that allowing girls to go for higher education, implementing anti-dowry laws strictly and creating public awareness about equality of sex can be effective measures to prevent the practice of female foeticide.

2.1.2 Legal aspect of female foeticide

Kumar (1988) an advocate in the High Court of Nagpur pointed out that under the Maharashtra Act, the husband and the family members of women can be punished with imprisonment of one to three years and fine varying from Rs. 1000 to Rs. 3000. Under this Act, the women can be prosecuted only as a better, not as main accused and can be fined. Generally,
woman is a victim and not the real perpetrator of the crime. The medical practitioners can be prosecuted and punished with imprisonment of one to three years and fine of Rs. 1000 to Rs. 3000, if they disclose the sex of foetus and perform abortion with specific knowledge that it is a female a foetus. Under the Act, gynaecologist, registered medical practitioner or any one owning centres, laboratories or clinics has to be registered with appropriate state authority if he wants to carry out the pre-natal test.

The forum against sex determination and pre-selection techniques demanded, on woman day (March 8, 1989) that such tests should be made conditional since these violate article 14 and 15 of the constitution. Those Acts guarantee protection against discrimination to women. The forum welcome of the decision of the Maharashtra government to ban the misuse of medical techniques for sex determination. It startled that in a society like ours, with extreme discrimination with the woman, progressive legislation must precede social reform. The proposed legislation, if also taken up by the centre would halt the alarming proportion of sex determination clinics. The forum said that the public opinion needed to be mobilised and publicity given to the issue as doctor and other members of the medical community had a certain degree of responsibility and answer ability.

South Korea is another country in the world which banned sex tests only two years ago. In Jan 1988 the British Medical Association and the general Medical Council announced that the name of any doctor found performing an abortion solely on the ground that the foetus was the “wrong sex” would be struck off the medical register. On the contrary. Dharma Kumar (1989) strongly claims that the zeal of the social reforms to ban such malpractice is misplaced because it brings more unwanted girls into the world. Surely it would be better to improve the lives and status of those who are born. Banning SD (sex determination) clinics will be ineffective (except in raising the costs of
tests) and if it is effective, it will choke off powerful method of lowering the birth rate with coercion. The government of Punjab also banned all sex determination tests in the state. This has been the result of efforts by social reformers who emphasize the declining sex ratio of the state which now stands at 882 female for 1000 males. The situation in the neighbouring state of Haryana is still worse where sex ratio stands at 874 females for 1000 males.

Some others are of the view that the passage of the bill banning the use of pre-natal diagnostic techniques in order to determine the sex of foetus, may not result in ending the pernicious practice of aborting female children. However, instead of making it a cognizable and non-bailable offense they should make it harder for those who engaged in the business to continue doing so with impunity, they have so far enjoyed. Also, legislation of the kind passed has to be backed with efforts to correct social perceptions and adopting stringent measures against related evils like dowry. The battle to correct the gender bias is not likely to be easy.

Bose, (1999)\textsuperscript{32}, speaking on “what Awaits the Girl child in the twenty first century Demographic Trend”, elaborated on the “unholy alliance between technology and tradition to perpetuate the gender bias”. Bose squarely blamed ignorance and the flawed family planning programmes for the rising demographic disparity.

“Ninety five percent of the people who go for contraception are women.” She opined that “every one here has been talking about the missing women, I want to know where the missing men are.” Instead of giving monetary incentives to encourage family planning, he suggested that government should give incentives like scholarships and free education to improve literacy rate, which is very low among women in Rajasthan. He also warned that where the practice of any profession (here medical) tend to
reinforce social prejudices and cultural backwardness, the professionals will have to accept the responsibility of regulating practices. He suggested that:

1. The Ministry of law, government of India, should modify the existing Law (Prenatal Diagnostic Techniques Act 1994) to make it more realistic in the light of recent experience.

2. The National Commission for women gives priority to exposing the practice of female foeticide and work out a strategy to deal with all aspects of the problem.

3. IMA should immediately set up a surveillance cell to keep track of members practising female foeticide and positive action needs to be taken against errant doctors and quacks.

4. IMA, in collaboration with UNICEF, ought to set up a seven member study team to prepare a report on this issue and submit a plan of action within a year.

Buckshee (1999) speaking on "Medical Perspective of Female Foeticide," said that the near explosion in incidence of female foeticide is adding fuel to fire as far as the declining sex ratio is concerned, so it is imperative to critically analyze the different techniques and aspects of prenatal sex determination and female foeticide and make recommendations. Technology should not be accepted blindly. The emergence of sophisticated reproductive technologies have put an enormous responsibility on the medical profession to use them in an ethical manner. Unfortunately, however, they are being abused/misused for purely commercial reasons. These have to be stopped.

She listed the main methods of prenatal sex determination:

1. Amniocentesis
2. Chorion Villous biopsy

3. Ultrasoundography

Buckshee listed the complications arising from medical termination of pregnancies such as psychological problems, perforation of uterus, infertility and even death. She warned that second trimester abortions are risky and could harm the reproductive health of women. The acceptance of female foeticide as a family planning method is not merely derogatory to women’s status and harmful to maternal health but also repulsive to human nature. Kiswar (1994)\textsuperscript{34} reported that Parliament should enacted another law, and also pointed out that pre-natal diagnostic technique (Regulation and Prevention of Misuse) Act is response to the pressure of women’s organisations demanding a central legislation regarding this.

The law prohibits any genetic counselling centre, laboratory or a clinic from performing any of the PND techniques unless the doctor is registered under the Act. They must also satisfy one or more of the criteria which the law establishes for determining the test.

- The age of the pregnant woman is above 35 years.

- The pregnant woman has undergone two or more spontaneous abortions or foetal losses.

- During her pregnancy, the pregnant woman had been exposed to substances potentially harmful to the foetus such as certain drugs, infection or exposure to certain dangerous chemicals.

- The pregnant woman has a family history of mental retardation or physical abnormalities.
“The law further states that no person conducting PND procedures shall communicate to the pregnant women concerned on her relatives the sex of the foetus by words, signs or in any other manner.” Any person violating this law can be sentenced to imprisonment upto three years and a fine upto Rs. 10,000. Also unless the pregnant woman herself can prove that she was compelled to undergo the test, she is no longer exempted from punishment. In case of second offence, the term of imprisonment can go up the five years and fine upto Rs. 50,000.

Bumiller (1995)\textsuperscript{35} made a journey among the women of India to see the prevalence of female infanticide among the poor of Tamil Nadu and sex selective abortion among the rich of Bombay. She met couples in Delukkorichi in Salem district who confessed of having killed their daughters. These were poor farm labourers, with many hardships in life and also the expense of marrying of daughters was astronomical. Mothers justify this Act by saying that she had done the right thing. Why should a child suffer like her. The practice was not uncommon but was also the custom of majority. Most of the people considered it wrong. Bumiller met four couples. First was a Harijan couple uneducated and was desperately poor. They did not have enough to eat.

They had hired an old man to kill them. They felt but at the same time they thought it was better to save her from a life time of suffering. The second couple was from a slightly higher caste and had little more money. They had killed their second daughter. The reason given by the mother was that abortion was costly and also one has to take rest. So instead of spending money and losing income they preferred to deliver the child and kill her. Perhaps her harsh economic plight had made her callous. Her mother-in-law gave the child poisonous milk of some plant. The third couple, both of whom were illiterate and belonged to a low caste. Here again, the mother-in-law had given the same type of milk to ensure the end of the baby. The husband had a schooling upto
the fourth standard. The fourth couple was not so poor, and could afford two square meals a day especially because they had an acre of land.

The possession of land gave them security and they seemed to have a plan for the future. This in fact, seemed to be the reason for killing their second daughter which would have made their future bleak. A female child was given cold milk with five sleeping pills, and this dose was sufficient to end its life. so that the child can die.

Vaid (1995)\textsuperscript{36} reported the instance of female infanticide from a village in Rajasthan. A woman after giving birth to twins, a boy and a girl, elected to keep the boy and throw her live girl into a well. This incident was reported from the same village Dodhana, which is notorious for gang rape of Bhanioari Devi and Roop Kanwar “Sati” incidents. These incidents clearly point towards the practice of female infanticide in the present time. Though it may be concentrated in few pockets which are economically backward wherever facilities for SDT’s are available, they have taken over this practice of female infanticide.

Sunanda (1995)\textsuperscript{37} has reported in an article titled, “Born to Die in killing Fields” which constitutes a part of a research study conducted in Madras to probe into the problems associated with female foeticide. A total of 118 case histories were observed pertinent to the 47 respondent families that had committed female infanticide and 82 percent had felt that it was a common practice. The major social reasons were considered to be dowry (42 percent) while 25 percent of the respondents felt that it was because girls were perceived to be a social burden. The economic reasons given by 55 percent of respondents for killing the girls was the cost of rearing and high marriage costs; other reasons included a big number of children (55 percent respondents) and lack of male child as their preference (51 percent). 56 percent of the respondents said that the husband was the decision maker regarding female
infanticide whereas 34 percent said it was the husband’s mother. The husband’s mother, in about one-third of the cases, committed the infanticide, and it was usually done in the husband’s house.

To conclude, it can be said that in anticipation of boys any number of girls were eliminated. If an astrologer predicted that the girl would bring doom, the girl was rejected and done away with. Usually, only the first child was allowed to survive. Economic and socio-cultural reasons accounted for most of the infanticide incidents.

2.2 Son preference

Sohoni (1994)\(^3\) reported the parental preference surveys in Bangladesh and Nigeria which revealed that a majority of parents aspiring for a son to such practices. It is further reported by Sohoni that in Korea also, it had been found that 58 per cent of couples, with two sons practiced family planning as against 31 per cent of couples with two daughters. In an empirical study, Arnold (1975)\(^3\) found a clear preference for sons among the respondents drawn from countries of Asian origin. A large proportion of respondents from Japan, South Korea, Taiwan, Thailand and Philippines has shown preference for son. The study consisted of personal interviews with approximately 400 couple in each country. They considered it more important to have at least one son than one daughter. The above study also noted a keen desire for a son among rural respondents. Then, there are cases of strong son preference reported from some other countries too. The wife of an Israeli officer was reported to be bursting with joy when she gave birth to a son after two daughters and said now her family was complete. In Iran, the birth of son is celebrated as they do in India. In a developed country such as Japan children’s Day is celebrated on 5\(^{th}\) May. This is the day of boys and a holiday is observed throughout the country while no holiday is declared for Girl’s day which falls
on 3rd march every year. In Germany, sons are known as “Sterner Halter” i.e. those who continue the family. Even though attitude have changed for the better in most of the developed countries including the U.S.A. U.K. and U.S.S.R, the British social scientists claim that parents still prefer boys so that the name of the family continues, though they may not be worried when a girl is born.

The Chinese government has severely criticized the practice of female infanticide and meted out appropriate punishment for it. The crime of female infanticide can result in prison sentence of as long as 13 years (Gaangming Daily, 2 Jan 1983) Traditionally, sons in china were considered advantageous for two economic reasons i.e. to support their parents in old age and for the provision of labour for the farm or family business to the farmer. The birth of a son is still an important consideration, despite the recent introduction of some forms of social security provisions. In state owned institutions old people receive an annual pension ranging from 75% to 100% of wages they were earning at the time of retirement. In rural areas, the childless elderly peasants are cared for by the government in regard to food, clothing, medical care, housing and burial expenses. Although the marriage law of 1980 makes both sons and daughters liable for support of their parents in old age; sons are still preferred for providing old age security.

Poffenberger and Proffenberger (1973) in their study, “The Social Psychology of Fertility Behaviour in a village in India” investigations in Gujarat village also pointed to higher son preference amongst the women. A majority of women, i.e. 62 percent, said that they would have six or more daughters if necessary in order to get a son while only 35 percent of the men felt the same. They also emphasized the need to have a son as a support in old age and perceived more advantages in having sons and more disadvantages in having daughters.
An analysis of the social demographic and economic determinants of the sex preference scale was done by Lahiri (1974) in the write up titled, "preference for sons and ideal family in urban India." The sample mainly consisted of currently married men from urban areas in India. A high son preference was found in all the groups. There were striking regional differences in the preferences with men from Jammu and Kashmir and Kerala wanting four sons per one daughter while men from Maharashtra and Madras wanted three sons per two daughters. Son preference was highest among men under 16 years of age or those over 62 years of age, amongst men with no children, those with many sons and those with the highest or lowest education. Son preference was also high among Muslims and other non-Christian minorities.

Findings of a study carried out by Zoixiang (1986) reflect acceptance of one child certificate by families having one son. Because, China's population policy encourage couples to have no more than one child, the one child certificate programme initiated in 1979 incorporates benefits for those who agree not to have a second child and penalties for those who violate the agreement after they have accepted the one child certificate. This survey after years of initiation of one child certificate programme revealed that only 37% of all one child couples had accepted the one child certificate. Out of these, 60% had first child as a boy compared with 40% of those whose first child was a daughter. It was also found that the extent of son preference also varies substantially by place of residence and by educational attainment of the respondent. Son preference is strongest in towns and rural farm villages and weak in cities. This is owing to the perceived importance of sons for agricultural work concern about support in old age and generally more traditional attitude among peasants. It is interesting to note that in rural areas son preference was weaker in non farm villages, where women often play a vital role in the operation of small scale factories. Some degree of son, preference is evident in every educational group, but its magnitude is
substantially weaker among women who have gone beyond the elementary level. Researchers presumed that because educational attainment is rapidly increasing among the younger generation who have not yet entered the child bearing years, it is likely that the strength of son preference may continue to decline in coming years. 73.4% of women who got education up to university level obtained this certificate compared to 15.5% illiterate women. World wide preference for sons over daughter is a common phenomena. Son preference has been well documented in a large number of countries, but the degree of son preference varies substantially from one country to another depending on factors such as economic development, social norms, cultural and religious practices, marriage and family systems, degree of urbanization and natural social security system.

The preference for sons tends to be particularly strong in (1) developing countries in rural area and (2) among more traditional couples and couples of lower socio-economic status. Sohoni (1994)\textsuperscript{43} quotes (Benett, 1983)\textsuperscript{44} that although in economically developed countries, this preference of son exists side by side with parent’s desire to have at least one child of each sex in some countries. Couples exhibit little or no son preference and there are even a few instances where daughters are preferred e.g. world Fertility survey found that considerably more women wanted a daughter for their next child than a son in Jamaica and Venezuela (Clelant Verrale and Vaessen, 1983)\textsuperscript{45} son preference has been found to be prevalent the entire East Asia.

Pavalam (2004)\textsuperscript{46} Campaign against Sex Selective Abortion (CASSA) conducted a survey of unmarried girls belonging to the different communities in Usilampatti area (Madurai district) in the last quarter of 2002. The study draws attention to the impact of new economy on women, marriage customs that add to gender discrimination; dowry, physical and mental violence; and the relationship of all of these to female infanticide. The CASSA survey also found
that a majority of young girls preferred sons but opposed female infanticide and favoured family planning.

Bachi Karkaria as quoted by Kapur (1996)\textsuperscript{47} has pertinently summed up the abuse of the girl child by commenting that she is an unknown intrusion. The cause of sorrow when she is born is a burden on parents who have to arrange for a dowry. She is also the convenient work horse. The one, who has to be fed less than her male counterparts and an easy prey to sexual exploitation. In a society, where women and children have few rights. She by virtue of being both, has none. Despite all developmental measures and constitutional and legal guarantees, girls and women still log for others in almost all sectors including education. Furthermore, about 70 per cent of Indian women suffer from malnutrition and anaemia. India has a maternal mortality rate of 400-500 per one lakh births. Against this backdrop, the possibility of women from weaker sections of society going in far reported abortions after sex determination tests in fraught with grave consequences.

This review of studies and statistics on the girl child indicates adverse female-male ratio, low enrolment of girls in schools and high rate of school drop outs amongst girls. The socio-cultural variables influence the rearing of the girl child right from the birth and restrict her role in the primary groups such as family and friends. The girl child at home shares the responsibilities of the household. She contributes substantially to the sustenance and growth of the household economy but her contribution is hardly acknowledged.

**OBJECTIVE OF THE STUDY**

The following are the objective of the study.

1. To know the relationship between socio-economic conditions of the respondents and female foeticide.
To what extent the practice of dowry and other factors are responsible for large-scale female-foeticide over the years, creating dangerous situations of declining sex-ratio.

To know that who decides in the family about female foeticide.

How far education has contributed to the misuse of scientific knowledge for female foeticide.

To what extent the existing laws are effective in checking female foeticide.

Whether the declining sex ratio will lead to the promotion of inter-caste marriage.

HYPOTHESES

The following are the hypotheses formulated keeping in mind the objective of the study.

Female foeticide is more common among educated people because of their knowledge about modern technology.

In addition to other factors dowry is one of the major reason for female foeticide.

Because of patriarchal society the desire to have at least one son may be one of the major reason responsible for female foeticide.

The declining sex ratio may lead to inter-caste, inter-state marriages because many of the young boy may not get bride in their own community/state.

The existing laws are not sufficient to check female foeticide and therefore, change in the mind set by the people may help in checking the increasing problem by female foeticide.
REFERENCES


33. Kamal Buckshee (1999), Medical Perspective of Female Foeticide, National Workshop on Gender Bias, Female - Foeticide/Infanticide, 7-8 Aug., New Delhi.


46. P. Pavalam (2004), *Campaign Against Selective Abortion* (CASSA) in Madurai district, Tamil Nadu