

Unwanted daughters

Discrimination and elimination of the girl child in India

Jyotsna Agnihotri Gupta

A daughter is born, it's a howling disgrace
Misery and pain is writ large on her face.
The in-laws are wild, at the female child
The neighbours come to mourn
That a girl, alas! is born.
They groan and they cry
'Start worrying about her marriage,
And prepare to bid her good bye'.¹

Harmful gender-discriminatory practices are broadly speaking social and cultural practices that have negative physical and psychosocial consequences for a specific gender (in this case female). They often reflect deep-rooted gender expectations and the inferior status of women in societies and include discrimination against the girl child in, for example, access to education, food allocation, and healthcare. In India, manifestations of discrimination against the girl child include harmful practices like the seclusion of women and girls, menstrual taboos, early marriage, and early childbearing. All of these have serious consequences for the survival, health, development, and well-being of the girl child. Certain extreme forms of gender discrimination, such as sex selection in favour of males, abortion of female fetuses, and female infanticide begin even before conception and continue until after birth, and have far-reaching demographic and social consequences.

In this article I examine the cultural and socio-economic reasons for discrimination and elimination of the girl child in India from a historical point of view. I highlight the role that modern reproductive technology plays by providing the scientific tools to perpetuate the embedded gender bias. Thereafter, I discuss some policy and legislative interventions made by the government, as well as actions taken by non-governmental organisations (NGOs), particularly women's rights advocates, that aim to discourage the perpetuation of these harmful practices or to counteract their harmful implications. I warn against the dangers of the 'culture trap' and 'cultural relativism' and argue that it is necessary to look beyond culture in seeking both the causes and solutions for discrimination and elimination of girls in India.

This article is based on literature study, government policy documents, media reports, and empirical research that I conducted in India for the World Health Organization. Fieldwork was conducted in New Delhi, Mumbai and Ahmedabad and comprised meetings and open-ended interviews with government officials, medical practitioners, feminist academicians and researchers, women's health and rights advocates, and representatives of relevant NGOs.

Harmful gender-discriminatory practices

India is a conglomerate of heterogeneous communities with diverse customs and traditions and their own distinctive personal laws. Uneven and inequitable development between different regions of the country and between rural and urban areas; widespread poverty, high illiteracy, and caste, class, and religious inequalities provide the larger context for discrimination. The situation of women varies significantly according to the socio-economic status of the household and its position in the caste hierarchy. Socio-cultural values are generally more heavily biased against women in the north than in the south and more prejudice exists among caste Hindus than Scheduled Castes or Scheduled Tribes and among land-owning cultivators than landless labourers. The social construction of gender, therefore, may vary widely across different parts of India. However, almost all communities discriminate against women, ranking India at 119 among 169 countries on the Gender Inequality Index (UNDP, 2010).

Despite the provision of equality enshrined in the Indian Constitution of 1952, patriarchal structures aid the prevalence and perpetuation of gender inequalities (Agrawal & Rao, 2004). The role of the family is very strong in India. It is a source of strength for many family members and the most important arena where socialisation takes place. However, it is also in this arena that discrimination and subordination of females primarily occurs. Girls are often considered unproductive liabilities and therefore dispensable. Their birth is unwelcome, shunned and even prevented. In childhood, they are discriminated against in household food allocation, healthcare, nurture, and education (Rustagi, 2003).

Son-preference and investment in sons and the consequent neglect of daughters occurs both in poor families in rural areas and in more wealthy urban families. It comes from members (including the female members – the mother and grandmother), who have themselves imbibed patriarchal biases and pass them on. Often the mother has neither the money nor the authority to take decisions regarding food allocation, access to schooling, and medical care for her daughter. As a result, girls remain physically stunted and psychologically under-developed.

Females become victims of discriminatory feeding practices in early childhood. As babies, they may be breastfed for a shorter time than their brothers and denied access to supplementary and nutritious food. Nutritional anaemia among adolescent girls and women is high. Undernourishment leads to nutritional stunting and cephalo-pelvic disproportion in adulthood. Both these factors are correlated with low birth-weight babies and perinatal complications and are responsible for maternal, infant, and child mortality. This inter-generational undernourishment cycle is often perpetuated. Fewer girls than boys receive timely and adequate healthcare, as reflected in referral and admission figures of hospitals (Gangolli, Duggal & Shukla, 2005). Social attitudes, value systems and cultural ideas restrict the participation of girls in activities such as education, sports, and recreation and hinder them in taking up occupations where they have to interact with males. They create a state of dependency and severely constrain their prospect of an all-round healthy development (Gupta, 2002).

Women are also more often than men victims of violence. Violence against girls and women through sexual harassment,



Seen on a wall in India in 1994:

'Boy/Girl Test/ Rs 1500/Surya Scan

Every Saturday: Moradabad, Kunwar Cinema

Every Sunday: Courts (near liquor godown)'

Source: J.A. Gupta

rape, sexual abuse, incest, wife-beating, physical and mental torture occurs in all parts of the world. It is often known as 'gender-based violence' because it evolves partly from women's subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimise and therefore perpetuate violence against women. In India, other forms of violence against women include physical, psychological and sexual abuse, and dowry-related violence. In certain parts of India, prostitution and sexual exploitation in the name of religion take place through customs such as dedicating girls and women to the deity (the *devadasi* system or *jogins*) (Gupta, 2002). Kidnapping and rape of girls, trafficking in women and children, and commercial sexual exploitation in the production of pornography are increasing. This brings vulnerability to sexually transmitted diseases such as HIV/AIDS. Increasing levels of state, community, and family violence are also reported. However, these practices are beyond the scope of this article.

Here I will focus on those specific forms of gender-based violence that aim to eliminate girls and which include female infanticide, pre-conceptual sex selection, and pre-natal sex detection with the use of advanced technologies. These practices undermine the demographic balance, and the human rights of women and girls. Moreover, they have long-term negative consequences for social, economic and gender parity, which, in turn, also indirectly affect men.

Wanted sons; unwanted daughters

Son preference

Son preference is not confined to India alone. Cross-cultural studies by social scientists (cf. Parikh, 1989: 8 for references) show a marked bias in favour of sons. The birth of a boy (especially the first-born) is announced and received with more exhilaration than when it is 'only a girl'. Folklore and proverbs from various countries are evidence of this bias for sons. This is

hardly surprising given the patriarchal nature of most societies. Modern science not only reflects this bias, but also provides the scientific tools to perpetuate it. Although some countries, like China and India, record female infanticide, the use of modern technologies for sex detection and selection exacerbates the situation. This leads to a further devaluation of girls.

Traditionally, in most societies in South and Southeast Asia, boys are preferred over girls for economic, social and cultural reasons. A son is considered an asset, while a daughter is considered a liability. In patriarchal and patrilineal societies, like in India, sons carry on the family name as well as the craft, trade or profession of the father; they help to maintain the family property, and they are expected to provide economic security and care for their parents in old age. In contrast, girls are considered to cost money by way of dowry payments and the giving of gifts to a married daughter and her conjugal family on various occasions throughout life. No payment is necessary for a son's marriage; in fact a son brings in a dowry with his bride. According to the Census of India in 1961, the majority of the population still practised bride price or bride wealth rather than dowry.² By 2001 the practice of dowry had become more widespread and expanded to communities which had not practiced it earlier (Agnihotri I., 2003; Patel, 2007). The consumerist lifestyle encouraged by rising economic prosperity has led to more numerous and intensified dowry demands.

There are also other social and cultural reasons for not wanting daughters, such as the perceived danger to a daughter's chastity, which is a question of the family's honour, and the concern of getting her married before she is 'too old'. Among upper caste Hindus certain religious ceremonies may

only be performed by males. According to the Hindu scriptures, sons are required to light the funeral pyre of their parents, releasing them from the trammels of this world and ensuring their souls' entry into heaven. With the birth of a son the father is released from his debt to his ancestors. Besides, it is often believed that 'having sons signifies masculinity' (Williamson, 1976).

All the aforementioned reasons for son preference do not apply equally to different geographical regions; religious groups, and social strata. There are, in fact, important variations between them. Although women often express a personal preference for daughters, they may be forced to adopt male values of son preference for ideological and practical reasons, including enhanced identity and acquiring status and security within their marital home. Bearing only daughters may lead to abandonment and remarriage by their husbands.

Three studies, which used evidence from a variety of sources, reported that discrimination against girls had increased in India despite economic development and fertility and mortality decline. Das Gupta and Mari Bhat (1995) analysed juvenile sex ratios (0-4 years), mortality sex ratios, and fertility decline between 1981 and 1991. They concluded that parents were not substituting prenatal for post-natal discrimination against unwanted girls, as posited by Goodkind (1996), but were combining these two practices. Sudha and Rajan (1999) argue that social and economic development worsened the situation of women in India and increased the preference for boys. The Green Revolution, which was ushered in by mechanised farming (marginalising female labour) and resulted in rising levels of prosperity and education in Punjab and Haryana, did not raise the status of women significantly. This notion

is reflected in the increased masculinization of sex ratios, an indicator of the state of gender relations at birth, particularly in rural Punjab, Delhi, Haryana, Rajasthan, and Himachal Pradesh. These indicate a continuing practice of sex-selective abortion, resurgent female infanticide, and persistent excess female child mortality, particularly in the 1-4 years age group.

'Although fertility has declined and child mortality for both sexes has decreased, female disadvantage persists and may have become more widespread, even reaching the more egalitarian South' (Rajan, Sudha & Mohanchandran, 2000, p. 1085). Male bias seems to be intensifying and penetrating also into South India (Hudson & Den Boer, 2004); so is the rise in dowry practice and marginalisation of women from paid employment. The latter practices are now also recorded in Tamil Nadu, Karnataka and Kerala. Satish Agnihotri (2000; 2003) argues that 'female contribution to prosperity is a more crucial determinant of her entitlements than the overall prosperity of the household' (2000, p. 45). Increasing prosperity goes with 'high culture' and the female subordination associated with it as women are withdrawn from the workforce to increase the status of the family. However, within the household, the status of these women does not increase. Rather their intra-household bargaining power decreases. Female labour participation increases their bargaining power within the household, ensuring a greater share of household resources, increasing female-male ratios.

Analysis of data obtained from the Special Fertility and Mortality Survey undertaken in 1998 in 1.1 million households revealed that based on conservative assumptions there are 0.5 million missing female births a year. This demonstrates

what Amartya Sen (1990) has called the phenomenon of 'missing females', which was in total more than 35 million in India alone in 2001. Although interest in sex selection is not new, use of modern technologies for sex detection and (pre)selection make the interventions more precise, so much so that the right of the girl to be born is threatened and in turn leads to a further devaluation of women (Gupta, 2000). Pre-conceptual sex selection in favour of boys, abortion of female foetuses, and female infanticide, are various practices that form a continuum, and which result in the elimination of girls. I will begin with the other end of the continuum.

Female infanticide

In colonial times, the prevalence of female infanticide – the practice of killing female infants immediately or within a few days after birth by suffocating or poisoning – was recorded in the states of Rajasthan, Gujarat and Uttar Pradesh. Steps were taken to outlaw the practice in 1870 (Miller, 1981). It was not known to be prevalent in South India. In the 1980s its resurgence was reported in several regions, particularly in Northwest India (Rajasthan and Gujarat), and in the South (some districts of Tamil Nadu). In June 1986, a leading Indian weekly, *India Today*, published a cover story, 'Born to Die', on the existence of female infanticide in Usilampatti in Madurai district of Tamil Nadu. The article suggested that nearly 6,000 female babies had been killed in the previous decade, mainly amongst the poorer members of the Kallar community. Two processes that were responsible for the rapid destruction of the traditionally high and near equal status of women in this community were identified: the reduction of women's status from cul-

tivator to wage labourer and the adoption of new values, including dowry, by the upwardly mobile section of the community. A correlation was found between the rise of dowry practice and 'women's loss of traditional rights in land, their displacement and discrimination in the labour market, the destruction of traditional handicrafts that employed women, and their marginalization in the new economy' (Vasanthi, 1987, cited in Mazumdar, 1994, p. 12).

In Salem district, perpetrators of female infanticide mentioned extreme poverty, lack of opportunities for earning a livelihood, and the economic burden that girls pose as the main reasons for this practice. In the words of one of the interviewed women: 'Even a useless male buffalo calf fetches a hundred rupees. A girl child means nothing but expenses'. She referred here to the expenses incurred for various life cycle rituals for females (Surya, 1992). While in the rural areas female infanticide was more common, in the urban areas girls were not even allowed to be born. Those who were poor found it cheaper to kill their daughters after birth, whilst those who had the money went for sex detection tests and abortion afterwards.

It is difficult to get true estimates of female infanticide because these crimes are carried out in the domestic sphere. However, the juvenile sex ratio can be used as an indicator of the incidence of this practice. The constant decline in the female to male sex ratio bears witness to a resurgence of the practice. According to the Indian Population Census of 1941, the sex ratio of children in the 0-6 age group was at that time 1,010 girls per 1,000 boys. In 1991, this number had declined to 945 girls per 1,000 boys (Chunkath & Athreya, 1997). Salem district in the state of Tamil Nadu had the worst sex ratio of 849 girls per 1,000 boys.

Despite sustained efforts by the government and NGOs, some areas in the district continued to report exceptionally high female infant mortality rates in the 1990s. Even the threat of punishment appears to be an inadequate deterrent to offenders (Srinivasan & Bedi, 2009).

Pre-conceptual and pre-birth elimination of females

Pre-conceptual sex selection (through sperm sorting or sex selecting the embryo in favour of males) and pre-natal sex detection followed by abortion of female foetuses form the first two stages of a continuum of practices contributing to the elimination and discrimination of the girl child. In India, prenatal testing technologies, such as ultrasound scanning, chorionic villus sampling (screening of placental tissue), and amniocentesis (screening of amniotic fluid), have been advertised as 'boy/girl test' since the 1970s and are primarily used as such. They are *not* used for their medical purpose, *id est* detecting genetic diseases and disorders. If foetuses were detected to be female, they were generally aborted (Patel, V., 1984). In 1975, reports appeared of private gynaecologists from Amritsar (Punjab) and Bombay who were offering the test. The slogan 'Spend Rupees 500 now and save Rupees 50,000 later' – meaning, spend a paltry sum now on a sex detection test and, by comparison, save a huge amount later (presumably for dowry) – by a clinic in Amritsar was a call for sex selective abortion without explicitly saying so. The advertisement referred to daughters as a 'liability' to the family and a 'threat to the nation' and exhorted women to avail themselves of the services of the clinic to escape this danger (Mazumdar, 1994, p. 3). Cashing in on the demand for sex deter-

mination tests, partially also generated by the media reports, a doctor started his own genetic laboratory in New Delhi. All the leading newspapers carried the advertisement 'Normal Boy or Girl?' almost daily for several years. This marked the beginning of privatisation and commercialisation of prenatal diagnosis technology which has since grown into a thriving business of sex detection for the purpose of selective abortion of female fetuses.

Private clinics providing prenatal diagnosis through amniocentesis and ultrasound scans have mushroomed even in the remotest corners of India. Since the mid-1990s pre-conceptional sex selection techniques within assisted reproduction have also proliferated. Most people appear to be completely unaware that the tests they know as 'sex tests' or 'Boy-Girl tests' are meant primarily to diagnose birth defects (Gupta, 2000). Public (government) hospitals do not provide sex detection and sex selection services for non-medical reasons; only in the private healthcare sector are they available for reasons other than health. Although illegal, they are a major source of revenue for service providers, which is the main driving force for their spread. The proliferation of registered clinics offering ultrasound scans from 600 in 2000 to 35,000 in 2009, as well as the increase in mobile services brought to a client's home and the use of agents by medical practitioners to lure clients since the 1990s, affirms this (George, 2009).

Earlier, a girl child used to be accepted by most families as a first child, although with subsequent births the family was less willing to accept a daughter until a son was born (Das Gupta & Visaria, 1997). Data indicate that the proportion of families aborting female fetuses even in the first pregnancy has increased (George & Dahi-

ya, 1998). 'Indications are that the problem may become further accentuated with the desire to limit family size superimposed upon a society with male preference' (Ravindran, 1997, p. 32). Women are caught between the ideologies of population control (implying state control) and the ideology of motherhood (implying family control). A large number of families in rural and urban areas not only want smaller families, but also have a clear preference for a desired sex, birth order, and composition of children: two sons and a daughter (Sudha & Rajan, 1999). Most doctors and health workers also believe that sex (pre)selection technologies provide an effective method of family planning and are an important tool in the promotion of population control programmes in India. Sex selection is advocated as a method to obtain the desired 'family composition' and 'family balancing' when a family has one or more children of one sex and also wants a child of the opposite sex. A woman is more likely to have abortions to achieve this so-called 'balanced' family – which among Indians has a clear sexist bias – than for medical or social reasons.

Often poverty and illiteracy are cited as the main reasons for gender bias against girls; it is believed that economic development and education would help change these harmful attitudes. But studies showing that it were in fact economically better-off and higher educated women and men who were keenly interested and willing to use these technologies for daughter elimination contradict this notion (Shah & Taneja, 1991). These men and women considered themselves consumers who should be able to get the service they wanted as long as they could afford it. Women who already had one or more girls were more likely to seek testing and abortion after-

wards. This was the case in rural and urban areas in several states, irrespective of religion (Jha et al., 2006). Apparently, Indians in the diaspora, in the United Kingdom and the United States, in particular skilled professionals, also practice sex selection. Its 'ready availability and legality in the United States increased the pressure and even obligation to use it' (Darnovsky, 2011).

While some acknowledge that sex selection is wrong, it is considered to be unavoidable in the Indian social set-up. A majority of providers of sex determination tests acts on the ground that they are offering a humane service to women who do not want any more daughters and others allegedly hold that they offer it on the principle of a woman's right to choose (Malpani, 1998, and personal communication, 2001). Also, sex selective abortion is often considered the lesser of two evils, the other being female infanticide (Macklin, 1999). It is argued that if abortion is legal, how can a democratic state interfere in a woman's or couple's decision to abort a female foetus. 'What is interesting to note is how increasingly procreative liberty linked arguments permeate medical discourse, ascribing to individuals (particularly women) an independent moral value and decision-making power detached from any relational context – familial, community or social' (Mallik, 1999). The role of the family in reproductive decision-making processes in India seems to remain under-highlighted. In a traditional society the importance of children and sons, in particular within marriage, for both women and men should not be underestimated. Children strengthen the conjugal and kinship bonds and are crucial for achieving a satisfying identity, gaining status, and for present and future emotional and economic security and upward mobility.

Bare branches

In a patriarchal kinship structure a woman's status in the household is determined by her ability to produce male offspring so as to carry on her husband's lineage. It is difficult to untangle the direct and indirect pressures of patriarchal family structures and values in a society where gender relations are largely unequal. What is known, however, is that women have very little negotiating power within the family, both in their natal family and even more so in relation to their husbands and in-laws. Women may join in perpetuating these practices, believing them to be a form of protection for their children and themselves, exercising some sort of agency. Reproductive decision-making, including opting for sons instead of daughters, occurs under difficult circumstances and is seldom an expression of a woman's right to choose. In this setting, technology serves to reinforce patriarchal biases, not to change social relations (Gupta, 2000).

Since 1994, 10 million female fetuses have been aborted in India (Jha et al., 2006); this has far-reaching demographic and social consequences. India has a low female-male sex ratio in contrast to most developed countries. This was 972 to 1000 in 1901, declined to 933 to 1000 in 1981, 927 to 1000 in 1991 and rising marginally again in 933 to 1000 in 2001 (Registrar General of India, Census figures 2001). The provisional figures from the decadal census held in 2011 report a further decline of 914 to 1000. Regional variations in sex-ratio are further evidence of the bias against girls. This bias is particularly sharp in states where female literacy is low. Also worrisome is the sharp decline in the under-6 sex ratio (Agnihotri S., 1999; 2000; Sudha & Rajan, 1999) in cer-

tain states such as Punjab, Haryana, Himachal Pradesh and Delhi.^{3,4}

In the 1980s there was a debate in the *Economic and Political Weekly* on the possible consequences of the falling sex ratio in India (Kumar, 1983a, 1983b; Dube, 1983a, 1983b; Jeffery & Jeffery, 1984). Some argued that the market forces of supply and demand would raise the value of women and others that it would devalue women further. Recent figures show there is a surplus of males and a shortage of females, particularly of marriageable age (future brides). Men already face difficulty in finding a wife in states like Delhi, Punjab and Haryana where the sex ratios are highly skewed in favour of boys. Demographic consequences of sex (pre)selection have reportedly far-reaching social consequences such as an increase in rape and violence against girls and women, bride buying, wife sharing, abduction and trafficking of girls and women across state borders, as well as inter-community trafficking, and kidnapping and sale of much desired boys.

Some studies go even further and argue that a surplus of unmarried men, called 'bare branches' because they are branches of the family tree that will never bear fruit. Scarcity of women leads to a situation in which rich, skilled and educated men will marry, but poor, unskilled and illiterate men will not. A permanent subclass of bare branches from the lowest socio-economic classes is created, aggravating societal instability, violent crime and gang formation, which has security implications for countries. Conservative estimates of the number of young adult bare branches in India are about 28 million, id est 12-15 per cent of the young adult male population (Hudson & Den Boer, 2004). Although I agree with the 'bare branches' theory, the implications for security seem to me rather far-fetched.

In sum, those who are in favour of sex detection and selection do so on various grounds – that it offers a 'solution' to the 'population problem' of India, that abortion is a woman's right, and that it is an individual's and couple's right to choose the sex of one's child. Those who oppose the practice and demand state intervention in terms of legislation and its enforcement do so on various counts such as arguing that the practice constitutes gender discrimination, that it harms women's health and that it violates women's dignity and human rights, the reasons for which lie not in the x-chromosome which determines biological sex, but in the cultural meaning given to it, id est gender.

Is legislation the answer?

On 10 May 1988, in response to a strong campaign by the Indian women's movement, health activists, and some progressive groups and individuals united under the Forum Against Sex Determination and Sex-Preselection (FASDSP), the State Government of Maharashtra banned sex detection tests. However, due to a lack of enforcement machinery, the practice was either driven underground or to the neighbouring states, which had continued to provide the service openly. This led to a demand for a nation wide ban on the tests. On 26 July 1994, the Indian Parliament finally passed the desired legislation: The Pre-Natal Diagnostic Techniques Regulation and Prevention of Misuse Act (PNDT Act), which became effective from 1 January 1996 and seeks to regulate the use of pre-natal diagnosis for medical purposes and to prevent its misuse.

Soon it became apparent that there was a great interest in pre-conceptual sex selection by means of artificial insemination

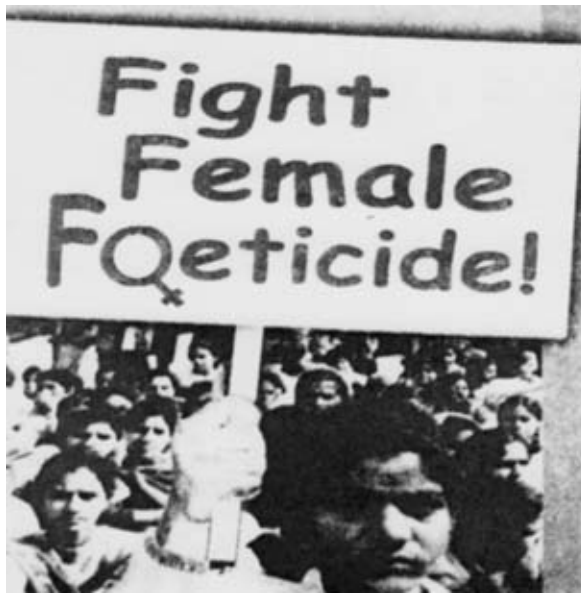
and through pre-implantation diagnosis of embryos in IVF. Strong demands from women's advocacy groups led to the PNDT Act being amended in 2002 so as to include technologies for pre-conceptual sex selection. The amended Act 'The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act' became effective from 14 February 2003. Under this Act advertisement, in any form, of facilities for pre-conceptual selection or prenatal sex detection is prohibited. Medical practitioners or laboratories performing the tests are likely to lose their licence to perform medical procedures if found guilty of the aforementioned practices. Moreover, not only the women requesting such tests, but also their husbands and relatives are considered offenders. There were conflicting opinions about whether legislation would have the desired effect in curbing the practice (Kishwar, 1993). Sting operations conducted by women's activists at several clinics using decoy pregnant women and my own empirical research show that clinics now communicate test results only verbally and in code language (personal communication, Dr Ganguly, 2006). This makes it difficult to prove that they are still performing the tests. Due to lack of an effective enforcing and vigilance agency, it has become a clandestine practice offered at exorbitant rates at clinics where quality of care cannot be guaranteed. This poses an additional risk to women's health. The extremely skewed under-6 sex ratio in several Indian states proves moreover that legislation does not act as a deterrent.

Many women's rights organisations assert that the medical profession should have been more forthcoming in abandoning its non-judgemental stance by publicly condemning this misuse of technology. In India this did not happen, as they

acknowledged themselves (Jain, 1999). In 1999, the Indian Medical Association and the Medical Council of India abandoned their earlier apathy and launched a massive campaign with the support of UNICEF urging in particular the medical community to take their responsibility. Also they proposed the adoption of a law that would de-recognise all medical practitioners found guilty of conducting amniocentesis and ultrasound for sex detection for non-medical purposes. In 2001, the aforementioned organisations, together with the National Commission for Women and religious leaders held a meeting at which sex selection was widely condemned. Women's health and rights activists went to the Supreme Court of India to demand enforcement of the legislation. Since then a number of medical practitioners have been prosecuted (in 2009 there were 454 cases in court) and a few convicted. Going by the still declining sex-ratio data, this clearly is only the tip of the iceberg.

Legislation to regulate the use of prenatal diagnosis technologies has made it subject to checks and balances outside the medical profession. Banning it makes it a criminal offence and gives a powerful weapon in the hands of those opposing it and working towards eliminating it, justifying and valourising their efforts in this direction. The judiciary is playing an interventionist role in advancing the cause of gender justice in India. In recent years, 39 women-related laws have been passed, and at the same time public interest litigation has led to increased executive accountability. All the measures undertaken so far have led only to a marginal improvement in the situation of women; there is, therefore, still a long, long way to go. Apparently, eliminating harmful gender-discriminatory practices requires more than

Source: J.A. Gupta



legal action. Strategies at various levels in different sectors and collaboration between various actors and involving various constituencies at national and local levels are necessary.

Partnerships

There are four sets of actors who intervene on behalf of the girl child:

- 1 the State, by way of Constitutional provisions, ratification and implementation of international conventions and rights, legislation, policies, programmes and schemes;
- 2 multi- and bilateral donors and international institutions;
- 3 civil society groups, including NGOs, in particular women's rights advocates and organisations working for girls'/women's empowerment and
- 4 the private sector comprising business and charitable institutions.

The state plays a primary role. It intervenes by adopting, strengthening, enforcing

and monitoring legislative measures (including prosecuting offenders); by way of amendment of laws (e.g. inheritance law) that create and support conditions where women are seen as a burden and by targeted programmes (health and education) for development of the girl child. Recently, an increase in public-private partnerships and greater synergy between different actors is visible. Most interventions that specifically address the situation of females are a result of years of intensive lobbying and pressure by women's organisations. Although these are positive steps, inadequate implementation and the influence of macro economic forces combined with the resilience of entrenched attitudes and practices have diminished their effectiveness.

Already in 1988 at the South Asian Association for Regional Cooperation (SAARC) summit it was acknowledged that in South Asia discrimination against the girl child was pronounced and pervasive and that the issue had been neglected in policy-making. It declared 1990 as the

Year of the Girl Child in the SAARC region and 1991-2000 as the SAARC Decade of the Girl Child. This sparked off a number of activities that stressed girls' and women's right to life, safety, development, and to participate as partners. The Government of India also developed a Decadal Action Plan for the girl child 1991-2000. The Cradle Baby scheme in Tamil Nadu to counter female infanticide,⁵ financial incentives, support to families who welcome girls (e.g. the 'Laadli' scheme⁶), and support to local NGOs' activities for female empowerment are some recent initiatives.

On 8 March 2009, the President of India launched the Save Girl Child campaign. The campaign, which ended on International Women's Day 8 March 2010, had a new slogan 'My daughter – Nation's pride', much different from the ministry's usual slogan 'Save the girl child'. Also it was announced that 24 January, the date on which Indira Gandhi was sworn in as the first woman Prime Minister of India, would be observed as National Girl Child Day so as to highlight the plight of the country's girl child. 'This day will be celebrated every year till there is a gender balance in the country and till the time we match the required sex ratio', said Renuka Chowdhury, Minister of State for Women and Child Development. She announced that gender budget cells had been set up by 56 ministries.

The role of print and electronic media is also important: they can be used to influence public opinion by highlighting the issue, reporting 'bad practices' and violations of women's human rights, embarrassing the State internationally, and holding it accountable. Moreover, they can be used as a means to publicise positive initiatives and 'good practices'. Whilst constitutional, legal, administrative, welfare and develop-

mental measures are indispensable pre-conditions for change, it is even more important to effect a change in the attitudes and mind-sets of men and women. This is undoubtedly a challenging and long-term process. Social attitudes cannot be changed by legislation alone; passing laws banning such practices and raising awareness regarding such issues and working towards changing the social climate which nourishes these practices ought to go hand in hand. Educational institutions can play an important role in terms of schooling for gender equality. An important level at which the struggle needs to be conducted is the questioning of socio-economic structures, ideologies, and traditions which lie at the root of such practices, as well as the socialisation of girls and boys. It is crucial to raise awareness, in particular among men and mothers-in-law! That is where the role of gender studies and women's rights activists becomes important. The women's movement in India, comprising both activists and academicians, plays a major role and is growing in influence. It has challenged the government on several occasions and forced it to adopt legislation and policy measures to empower women. The Indian Association of Women's Studies, which hosts a conference every two years, strives to improve the links between academic research and activism so as to encourage a cross-fertilisation of ideas that can strengthen each other's work. A key element is to promote and channel action through women's leadership and participation as actors and agents of social change in alliance with other groups of civil society, including boys and men.

Beyond the culture trap

Harmful gender-discriminatory practices may be culture-specific, but, as I have tried to demonstrate above, the reasons for their perpetuation are social, economic and political. While most gender discrimination against girls occurs within the household (the so-called purveyor of culture), social institutions – inheritance and legal systems, economic and educational systems and political systems – are also instrumental in creating and perpetuating gender inequality. This needs to be taken into account because the same institutions may be used to redress the situation. Non-cultural explanations, or rather, looking beyond culture can be more useful. That is why I would like to argue that it is important to be warned against ‘the dangers of relying on simplistic cultural explanations which divert attention from wider socio-economic processes and contexts’ (FORCES, 2009).

To regard practices that discriminate against females as traditions that are culturally bound is to view cultures as static and monolithic, uninfluenced by global forces and technological advancements. ‘Understanding culture as fixed, uniform and unchanging ignores the impacts of globalization in the present and historical transfers of cultural beliefs and practices in the past’ (UNFPA, 2008, p.21). India embraced the liberal free market economy in the 1990s, allowing easy import of medical equipment such as ultrasound machines as well as other consumer goods. The rise of materialism and consumerism has resulted in increased dowry demands including modern electronic household goods and cars et cetera. Another interesting aspect is the outsourcing of services to India in a globalised world market economy. This

has brought very large numbers of young women into the urban work force. These women often work in night shifts, with the consent of the family, defying prevailing social norms and control regarding young women’s mobility and freedom. The fact that they bring in relatively fat pay checks is instrumental in this and confirms my argument that visible female contribution to the household economy is a *sine qua non* for their positive worth and empowerment and weakens arguments regarding resilient and unchanging cultures and attitudes. Selectively blaming culture causes one to overlook specific relations of power which operate in society. ‘Power operates within cultures through coercion that may be visible, hidden in the structures of government and the law or ingrained in the perceptions people have of themselves. Power relations are therefore the glue which holds and moulds gender dynamics, and underpins both the rationale and the ways cultures interact and manifest themselves...’ (UNFPA, 2008, p. 3).

Also, the ‘culture trap’ can blind us to the universal aspect of discrimination against women as a historical fact and a present day reality, to a greater or lesser degree, in almost all cultures. There is an inherent danger of cultural relativism in branding some cultures as ‘traditional’ – generally understood as backward. Cultural relativism serves to justify practices oppressive to women, deters nations from embracing total equality for women, and inhibits elimination of gender discriminatory practices through the use of universal human rights principles and instruments.

I would like to conclude by saying that besides the historical socio-cultural reasons for son preference and daughter discrimination, the main reasons for discrimination and elimination of the girl child in

India lie currently in the two-fold strong familial and societal pressure on women to bear male children and the Indian government's population policy, which puts pressure on couples to have only one or two children. Although the demand for sex selection and detection technologies is culturally driven, their provision is a major source of revenue for service providers, forming the main driving force for the wide proliferation of these technologies to eliminate girls. Therefore, besides adopting legislation and prosecuting offenders, solutions are best sought in cooperating with the medical community and in mass public information campaigns enlisting the support of religious and other community leaders and grassroots organizations. Strategies aimed at the elimination of gender-discriminatory practices require continued political will and holistic policies for investing in the girl child's survival, health and education. It means recognising the (self)worth of girls and women and undertaking action geared towards empowering them in order to enable them to take control of their bodies and their lives.

Notes

- 1 A verse from the play 'A Girl is Born', a translation of Jyoti Mhapsekar's *Mulgi Zhali Ho* in Marathi.
- 2 The giving and receiving of dowry was banned in 1961 under the Dowry Prohibition Act of Parliament, which was further amended in 1984 and 1986. However, the practice has flourished, increased in magnitude, and instead of being given with goodwill as gifts by the parents it has turned into a financial transaction that is even considered a rightful demand on the part of the bridegroom and his family.
- 3 Missing: Mapping the adverse child sex ratio in India, Office of the Registrar-General and Census Commissioner, India, Ministry of

Health and Family Welfare and United Nations Population Fund, New Delhi, November 2003.

- 4 'Female foeticide rampant in Delhi', *The Times of India*, New Delhi, 15 July 2005.
- 5 The Cradle Baby Scheme (CBS) was introduced in Salem district in 1992. Instead of resorting to female infanticide, parents who were unwilling to bring up their female babies could place them anonymously in cradles located in noon meal centres, primary health centres, selected orphanages, and NGOs. Subsequent to their placement in cradles, babies were to be placed for adoption. Between 1992 and 1996, 140 babies were placed in government cradles. The scheme had a short life and following elections and a change of government in May 1996, it was shelved. In May 2001, the Cradle Baby Scheme was reintroduced. The new version of the scheme which was extended to the entire state recorded a sharp increase in the number of babies. Between May 2001 and November 2007, 2410 baby girls had been received. While the well-being and placement of 'cradle babies' are issues that merit attention, given the post-2001 increase in the number of female babies handed over to the scheme and the sharp reduction in daughter deficit during the same period, it does seem that the CBS has played an important role in reducing daughter elimination.
- 6 The girl child protection scheme launched by Delhi State in 2008 envisages to build awareness in society for changing attitudes considering the girl child as an asset and not as liability; to ensure proper education and all round development of the girl child; to ensure a better rehabilitation and economic security for her; and to protect her from discrimination and deprivations. The benefit of the scheme is open to all. An amount of Rupees 5,000 is deposited in the name of each girl child born in a government hospital, which can be drawn after attaining the age of 18 years subject to her completing school education up to class ten.

References

- Agnihotri, I. (2003). The expanding dimensions of dowry. *Indian Journal of Gender Studies*, 10(2), 307-319.
- Agnihotri, S.B. (1999). Inferring gender bias from mortality data – a discussion note. *Journal of Development Studies*, 35(4), 175-200.
- Agnihotri, S.B. (2000). *Sex ratio patterns in the Indian population: a fresh exploration*. New Delhi: Sage.
- Agnihotri, S.B. (2003). Survival of the girl child: tunnelling out of the Chakravayuha, *Economic and Political Weekly*, 33(41), 4351-60.
- Agrawal, R. & Rao, B.V.L.N. (2004). *Gender issues: a road map to empowerment*. Delhi: Shipra Publications.
- Chunkath, S.R., & Athreya, V.B. (1997). Female infanticide in Tamil Nadu: some evidence. *Economic and Political Weekly*, 32(17) WS, 22-29.
- Darnovsky, M. (2011). Selecting for sons: Indian women in the US., *Biopolitical Times*, 27 April 2011.
- Das Gupta, M. & Mari Bhat, P.N. (1995). *Intensified gender bias in India: a consequence of fertility decline*. Harvard Centre for Population and Development Studies, Working Paper 95.02.
- Das Gupta, M. & Visaria, L. (1996). Son preference and excess female mortality in India's demographic transition', in *Sex Preference for Children and Gender discrimination in Asia*. Research Monograph 96.02, Seoul: Korean Institute for Health and Social Affairs and United Nations Population Fund, January.
- Dube, L. (1983a). Misadventures in amniocentesis, *Economic and Political Weekly*, 18(8), 279-80.
- Dube, L. (1983b). Amniocentesis debate continued, *Economic and Political Weekly*, 18(38), 1663-65.
- FORCES (2009). *Undoing our future. A report on the status of the young child in India*. New Delhi: Forum for Crèche and Child Care Services.
- Gangolli, L.V., Duggal, R. & Shukla, S. (2005). *Review of health care in India*. Mumbai: CEHAT.
- George, S.M. & Dahiya, R.S. (1998). Female foeticide in rural Haryana. *Economic and Political Weekly*, 33(32), 2191-98.
- George, S. (2009). Sex selection as genocide. In FORCES (2009) *Undoing our future. A report on the status of the young child in India*. New Delhi: Forum for Crèche and Child Care Services, 41-59.
- Goodkind, D. (1996). On substituting sex preference strategies in East Asia: does prenatal sex selection reduce postnatal discrimination. *Population and Development Review*, 22(1), 111-125.
- Gupta, J.A. (2000). *New reproductive technologies, women's health and autonomy: freedom or dependency?* New Delhi: Sage.
- Gupta, J.A. (2002). *Windows of opportunity: the girl child in India. Challenges and responses to Discrimination*. Geneva: World Health Organization, monograph.
- Hudson, V.M. & Boer, A.M. den (2004). *Bare branches: the security implications of Asia's surplus male population*. (BCSIA Studies in International Security), John F. Kennedy School of Government, Cambridge, Mass.: Harvard University.
- Jain, S. (1999). Female foeticide: a blot on our noble profession, *IMA News*, Official Publication of the Indian Medical Association, New Delhi, November, 4-5.
- Jeffery, R. & Jeffery, P. (1984). Female infanticide and amniocentesis. *Social Science and Medicine*, 19(11), 1207-12.
- Jha, P., Kumar, R., Vasa, P., Dhinga, N., Thiruchelvam, D. & Moineddin R. (2006). Low male-to-female sex ratio of children born in India: national survey of 1.1 million households. *The Lancet*, January 9, 2006, published online.
- Kishwar, M. (1993). Abortion of female fetuses: is legislation the answer? *Reproductive Health Matters*. No. 2, November, 113-15.
- Kumar, D. (1983a). Male utopias or nightmares? *Economic and Political Weekly*, 18(3), 61-64.
- Kumar, D. (1983b). Amniocentesis again, *Economic and Political Weekly*, 18(24), 1075-76.
- Macklin, R. (1999). *Against relativism: cultural diversity and the search for ethical universals in medicine*. Oxford: Oxford University Press.

- Mallik, R. (1999). *Pre-natal victimisation of the female lifeworld: analysis of discourses on sex determination test and sex selective abortion in India*. M.A. Thesis, The Hague: Institute of Social Studies.
- Malpani, A. (1998). Sex selection by IVF: the freedom to choose, *Issues in Medical Ethics*, 6(2), April, 54.
- Mazumdar, V. (1994). *Amniocentesis and sex selection*. Occasional Paper 21. New Delhi: Centre for Women's Development Studies.
- Miller, B.D. (1981). *The endangered sex: neglect of female children in rural North India*. Ithaca: Cornell University Press.
- Parikh, M. (1989). The challenge of sex selection: controversy over amniocentesis tests in India. *Women and Politics*, Women's Studies Department, University of Arizona: Tempe.
- Patel, T. (Ed.) (2007). *Sex-selective abortion in India: gender, society and new reproductive technologies*. New Delhi: Sage.
- Patel, V. (1984). Amniocentesis and female foeticide: misuse of medical technology. *Socialist Health Review*, 1(2), September, 69-71.
- Rajan, S.I., Sudha, S. & Mohanchandran, P. (2000). Fertility decline and worsening gender bias in India: is Kerala no longer an exception? *Development and Change*, 31(4), 1085-92.
- Ravindran, T.K.S. (1997). *Health implications of sex discrimination in childhood: unravelling the complexities*. Geneva: World Health Organization.
- Rustagi, P. (2003). *Gender biases and discrimination against women. What do different indicators say?* New Delhi: UNIFEM.
- Sen, A. (1990). More than 100 million women are missing. *The New York Review of Books*, 37(20), December 20.
- Shah, A. & Taneja, S. (1991). What do males and females of Delhi City think about female foeticide? *The Journal of Family Welfare*, 37(2), June, 28-39.
- Srinivasan, S. & Bedi, A.S. (2009). *Ensuring daughter survival in Tamil Nadu, India*. The Hague: ISS Working Paper Series/General Series, volume 477.
- Sudha, S. & Rajan, S. I. (1999). Female demographic disadvantage in India 1981-1991: sex selective abortions and female infanticide, *Development and Change*, 30, 585-618.
- Surya, V. (1992) Fire in the lap, *The Deccan Herald*, 20 December 1992.
- UNDP (2010). *Human development report. The real wealth of nations: pathways to human development*. New York: United Nations Development Programme.
- UNFPA (2008). *State of world population*. New York: United Nations Population Fund.
- Williamson, N.E. (1976). *Sons or Daughters? A cross-cultural survey of parental preferences*. Beverly Hills, CA: Sage Publications.