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## **Sex Detection Tests and Female Foeticide: Discrimination Before Birth**

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The high female infant mortality rates (Miller, 1985), the practice of female infanticide (Krishnaswamy, 1988), the neglect of female children with regard to access to health services, nutrition (Sen and Sengupta 1983) and education (Mankekar, 1985), and the sexual abuse of girls (Bhalerao, 1985) are manifestations of a deep-rooted patriarchal bias against women. This negative bias has assumed an alarming dimension in the recent past, with the utilisation of the amniocentesis test for detecting the sex of the foetus, followed by a selective abortion of the foetus if the test shows it is female. Apart from considerable risk to the foetus and the woman, the utilisation of pre-natal diagnostic techniques for the selective abortion of female foetuses perpetuates the negative social worth of women. This essay makes a case against the test and positions it as a critical issue to be confronted.

### **Amniocentesis and its Implications**

Among the several pre-natal diagnostic techniques (like sonography and chorionic villi biopsy) that are being utilised in India, the amniocentesis test<sup>1</sup> has achieved dubious popularity as the one which provides quick 'results' and is 'accurate'. Health-wise, these tests can cause a great deal of damage. Very often, the clinical preconditions of following aseptic procedures and ultrasonic monitoring are not followed during the incision and piercing of the amniotic sac for amniotic fluid. This leads to high chances of sepsis in the reproductive tract, hip dislocation and respiratory problems (Ravindra, 1986). This test can also cause considerable damage to the foetus and placenta, resulting in spontaneous abortion or premature labour. However, the commercial viability of these tests and the glamour of being in the medical business have overtaken ethical considerations.<sup>2</sup>

It has been observed that sex detection (SD) tests are not confined to big cities but have also proliferated in small towns. Before the Maharashtra legislation regulating the use of pre-natal diagnostic techniques came into force, it had been observed that SD tests were conducted in small towns like Dhule, Jalgaon, Amravati, Nasik and Nagpur (Ravindra, 1986). Pathology laboratories became collection centres for amniotic fluid, which were then sent to Bombay for

analysis. Ironically, the SD test was provided to women as a 'human service' by doctors and certain hospitals in Bombay before it was legislated against in the Maharashtra Assembly.

Through blatant advertisements, private medical professionals had created 'supply-induced' demand for amniocentesis. Bill-boards and advertisements in vernacular languages assuring the birth of sons, were not uncommon. Dr Bhandari of Amritsar, for instance, advertised: 'Spend Rs 500 now and save Rs 50,000 later,' harping on the expenses of the test vis-a-vis the cost of dowry at the time of marriage of a daughter.

Medical practitioners conceal the fact that these tests 'detect' but do not 'determine' the sex of the foetus. Therefore, having an abortion or multiple abortions in the sixteenth and eighteenth week (third month and after) of pregnancy if the foetus is of the 'wrong' sex is risky; and the test is not always foolproof. Further, this puts the woman's health at stake. The news of the death of a woman 20 weeks pregnant after an abortion following an amniocentesis in a private clinic in Bombay, illustrates the unacknowledged risk that is involved (Natarajan, 1986-87).

Moreover, selective abortions following the SD test after the twelfth week of pregnancy is gross misuse of a liberal legislation. The Medical Termination of Pregnancy Act, 1971, permits abortion up to the twelfth week of pregnancy. However, amniocentesis can be performed only during the fourteenth and sixteenth week of pregnancy and an abortion thereafter can be conducted only between the fifteenth and eighteenth week of pregnancy.

### **Sketchy Statistical Data**

Considering the sensitivity of the issue, there is difficulty in collecting data on the number of users, the profile of the users, the purpose of the test, the results of the test, the decision to retain or abort and other relevant information.

The scanty research evidence points to the extensive use of the test for sex detection purposes, followed by sex selective abortion of female foetuses. Ramanamma and Bambawali's study (1980) of the records of three hospitals in the city of Pune indicates that between June 1976 and June 1977, 700 women sought sex detection in hospital 'B'. Of the 450 women who were informed that they would have a daughter, 430 (95.5 per cent) went in for an abortion. On the other hand, all the 250 women (100 per cent) who were informed that they bore a male foetus carried on with the pregnancy, even though they were warned of a chance of genetic disorder in certain cases. Kulkarni's study of 50 gynecologists in the city of Bombay reveals that 27 (i.e., 64.3 per cent) carry out amniocentesis

tests solely for sex determination. On an average, 42 gynecologists perform 271 SD tests per month. The remaining doctors (35.7 per cent) reported that only in less than 10 per cent of the cases is the test performed to detect genetic defects.

With the mushrooming of clinics conducting this test, it was estimated, in 1986, that there were 248 clinics and laboratories, and approximately 16,000 tests being performed in the Bombay metropolitan region each year. It is estimated that selective abortions must have claimed 78,000 female foetuses between 1983 and 1986 (New Scientist, 1986).

### **Campaign against Sex Detection Tests**

Between 1976 and 1985 the campaign and protests against sex detection techniques were sporadic. However, a broad-based campaign, especially in Bombay, constituting activists from women's groups, health groups, science groups, human rights groups, legal action groups and concerned individuals commenced during the end of 1985. The Forum Against Sex Determination and Sex Preselection (FASDSP) was born as a broad, joint-action group. Concerted campaigning raised public awareness on the issue and set in motion a debate in the print media (Lingam, 1988). Through lobbying, the FASDSP brought into being, on 10 May 1985, the Maharashtra Regulation of the Use of Pre-natal Diagnostic Techniques Act, 1988 (to be discussed in a later section).

The call for a legal ban on sex detection tests gave rise to a debate on the issues discussed in detail in the following sections.

#### *Is the availability of a sex detection test a 'choice' for women?*

Most technological options in the area of reproduction (whether pills, intrauterine devices or injectables) are heralded as adding to the range of 'choices' for women. The basic question is- do women really enjoy an unfettered 'choice'? Can choice exist in a context where women are socialised to subordinate their interests to those of men; where women attain status only through marriage and by giving birth to children (preferably sons); where they largely bear the burden of cooking, collecting firewood, fetching water, bearing and rearing children, tending cattle; where they eat last, and the least, and have less access to education and health services?

'Choice' is only meaningful if it can be exercised in the context of material, social and gender equity. The availability of sex detection tests creates a situation where women are forced to undergo the test either by external pressure from family members or by internalised social values.

### *Does a negative sex ratio increase the status Of women?*

It is a well-documented fact that the Indian population is pre-dominantly male i.e., there is an adverse sex-ratio which registered a decline from 1901 to 1981 (Government of India, 1985). Census data indicate that there were 972 women per 1,000 men in 1901, which declined to 933 women per 1,000 men in 1981. In other words, in 1901, there were 9 million more men than women and, by 1981, there were 22 million more men than women (Kishwar, 1985). Therefore, the sex selective abortion of female foetuses has a high likelihood of having serious demographic repercussions, in terms of tilting the sex ratio further against females (Patel, 1984; Hariharan, 1987).

In the light of the evidence, the issue of amniocentesis and its implications for the sex ratio was a major point of debate. The supporters of sex detection tests argued that, based on the theory of demand and supply, an excess of males over females, achieved with the reduction of unwanted and hence, neglected women, would actually raise the status of women (Kumar, 1983).

This is a simplistic understanding of complex social issues. If mere numbers were to dictate status then, in several states of India where adverse sex ratios exist, the status of women should be high. On the contrary, one observes that there is a high incidence of dowry deaths, rape and other atrocities being committed in these states, indeed as much as in the other states (newspaper reports from all states of India prove this point). Based on anthropological evidence, Leela Dube (1983) observed that societies with adverse female sex ratios have indicated the presence of customs like polyandry, abduction and the purchase of women. It is strongly felt that, contrary to raising the status of women, adverse sex ratios increase the incidence of rape, prostitution and violence against women.

### *Cure social prejudices or ban sex-detection tests: Which should come first?*

Several objections have been raised regarding a legal ban on sex-detection tests, for example by Dharma Kumar (1983, 1988). In one of her articles (1988) she states:

One cannot cure social prejudice merely by legislation, especially in countries like India where the governmental machinery is weak and corruption rampant... is female infanticide preferable to female foeticide? Instead of bringing more unwanted girls into the world, surely it would be better to improve the lives and status of those who are born. Banning amniocentesis clinics will be ineffective. It will choke off a powerful method of lowering the birth rate without coercion.

In response to Dharma Kumar's views, Vibhuti Patel (1989) argues:

Yes, we are aware of this. But, at the same time, legislation banning sex-detection tests would definitely take away the respectability attached to this scientific advancement aggressively advocated by our doctors with crude, anti-women advertisements. Because Indian women are ill-treated or are forced to commit sati, why not kill them before they are born? By this logic she can also recommend to get rid of the poor [sic]... for Dharma Kumar, female foeticide is a powerful method of lowering the birth rate without coercion. But the Forum asks: 'Is not female foeticide a coercion?'

Curing social prejudices is very important, but it is not possible if a parallel practice of annihilating women exists.

*Amniocentesis: An aid to plant a 'balanced family'?*

Amniocentesis and other diagnostic techniques are viewed as important ways of arriving at a 'balanced family' which, in turn, will reduce the birth rate and control population growth. The assumption here is that couples have more children in the process of wanting to have sons. (Examples of couples making repeated attempts to have a son and ending up with daughters, are numerous.) This assumption has serious shortcomings. Though the need to have sons in patrilineal societies cannot be undermined, several studies have observed the reasons why the poor have more children (Mamdani, 1972). Reasons like the economic contribution of children and the buffer of more children to face the exigencies of infant mortality and morbidity cannot be overlooked. Therefore, the proposal to provide sex-detection tests to people to enable them to arrive at a 'balanced family', while neglecting changing socioeconomic and environmental conditions, is a lopsided priority.

Further, the notion of a 'balanced family' is not as simple as posited. If an equal representation of a male and female child for a couple can be considered as constituting a 'balanced family', in reality, the presence of only male children is not considered an 'imbalanced family'. While data on the number of children and of couples opting for sterilisation are rarely recorded, the scanty data provide pointers to the sex bias that exists. An examination of hospital records (Ramanamma and Bambawali, 1980) shows that 2.5 per cent of the couples consented to sterilisation even though they did not have a son (as against 15 per cent of the couples who underwent sterilisation in spite of not having a female child). The majority of the couples underwent sterilisation after attaining an average of 4.1 children.

There are problems in promoting notions of what constitutes a 'balanced family' and equating planned parenthood with the choice of the sex of the child.

### **The Maharashtra Legislation and After**

Due to relentless campaigning and pressure, the Government of Maharashtra passed the Maharashtra Regulation of the Use of Pre-natal Diagnostic Techniques Act, 1988. The Act explicitly bans the use of medical techniques and technologies. However, even after the Act was passed, pre-natal diagnostic techniques can be carried out on a pregnant woman if she is above 35 years of age, has a history of two or more abortions or foetal loss, has been exposed to potentially teratogenic drugs, radiations, injections or hazardous chemicals, or has a family history of mental retardation or physical deformity. The Act declares illegal any advertisements regarding the availability of facilities for the pre-natal prediction of sex at clinics/laboratories/health centres.

The regulation of these centres, laboratories and clinics is expected to be achieved through government-appointed bodies, namely, the State Appropriate Authority (SAA), State Vigilance Committees (SVC) and Local Vigilance Committees (LVC). However, these bodies have not been set up to date.

The legislation, though a small victory for public campaigning, has serious limitations and loopholes (FASDSP, 1989; Jesani 1988; Setalvad, 1988, 1989). The Act, rather than abolishing all private genetic laboratories and clinics, provides for the registration of these. The Act can be criticised for being shortsighted, in the sense that it restricts itself to regulating the existing technologies and techniques. The rapid growth of research in reproduction and the introduction of new diagnostic techniques and sex preselection methods will make the legislation outdated and obsolete in a few years. The lack of a comprehensive understanding of the underlying philosophy of these technologies leaves out of its purview related issues like sperm banks, in vitro fertilisation programmes (babies born via IVF are popularly known as 'test-tube' babies) and ova donation, and ensuing issues like womb-hiring or surrogate motherhood, and trafficking in ovaries, placentas and aborted fetuses (Lingam, 1990; Balasubrahmanyam, 1982). The proliferation of sex detection tests in Gujarat, Punjab, Haryana, Uttar Pradesh, Rajasthan and Delhi vouches for the limits to state legislation. A comprehensive single central legislation is of crucial importance.

### **Conclusion**

The focus on the issue of the girl child would be incomplete if such medical technologies and their utilisation are not scrutinised. The campaign for a central

legislation should gain momentum as a social concern for the girl child and future women.

### **Notes and References**

1. Amniocentesis (amnio: membrane, kentesis: pricking) refers to the removal of about 15 cc of amniotic fluid from inside the amniotic sac covering the foetus, through a long needle inserted into the abdomen. Chromosomal analysis for sex determination involves checking, for the presence of a stainable dot in the nucleus of the cells. The spot (known as the Barr body) is usually present in females and absent in males. Another test, using a dye called quinacrine, looks for what is called fluorescent bodies in the nucleus. The presence of these bodies indicates a male foetus (Ravindra, 1986).
2. The amniocentesis test costs anything between Rs 150 and Rs 1,500, based on market competition and the utilisation of techniques like sonography. In 1985, Harkishandas Hospital, a private hospital, claimed to have conducted 2,767 tests, at an average of 25 tests per day (Gentleman, November 1987).

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