Amniocentesis and Sex Selection

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Introduction

How does one analytically locate the social phenomenon manifested in India during the last few years since the advent of sex-selection technology in the mid-70s? We must seek to contextualise it within several value debates (which aspire to become systems) - of gender equality, reproductive freedom, the role of state control over private lives (ostensibly for the public good), medical responsibility and social justice. Other elements in this contextual canvas, to increase its complexity, are certain dynamic social institutions - the family, law, culture, religion, the social construction of gender, public policies and the social role or use of technology. Three other broader issues that help determine the texture and shape of the canvas are the widely differing perspectives in the global debates on the population-development relationship, the past and future roles of science and rationalism per se, and the problems of management of power - economic, political, technological (or knowledge-based) - in a period of dissolving political entities that had provided a semblance of balance and shape of global power relations.

Can we really say that the issues emerging from developments in reproductive technology affect only women in poor countries? Is there no panic against genetic engineering among women in the western industrialised world? Has the ideologically loaded terminology in the literature of sex-selection sciences, using words like "valuable/non-valuable", "superior/inferior", "breeder", "incubator" to rationalise the selection process and its implementation come out of the "underdeveloped" third world? Or have third world intellectuals criticised the UNICEF's child survival strategy for having promoted the "population trap"? A dichotomised approach between the "developed" and "the developing" world assumes that their problem and debates are basically different. We in the developing world are also warned that "in some countries, the social position of women will make the issues particularly urgent. Sex selection may be used to ensure the birth of many more boys than girls." And yet, the news we get from Dr. Ronald Ericsson from California is that nearly 94 per cent of couples seeking the services of his selection techniques wanted a male child. By his own admission his technique is better adapted to the selection of male offspring. The method of selecting females "is complicated", and is "still being developed".

I am not trying to be polemical - but we need to be clear as to whether the issues of control, use or impact of these technologies are to be addressed as universal ones, to be debated at the ideological level of human or civilisational values, or to

be dealt with in the relativist framework of culture, religion or stage of "development" - with the possibility of their absorption into the politics of hegemonism versus group identity. The international move for human rights and gender equality is already threatened by these developments.

This paper examines the introduction, spread and impact of amniocentesis (and more recently other sex-selection technologies) in India roughly since the mid-70s, to isolate the key actors, the driving forces of propulsion, and the historical context for the phenomenon of female foeticide following such tests. An attempt is made to demystify the runaway spread of the practice by comparing it with the emergence of female infanticide, also within the last two decades, in a region and a community with no previous history of such a practice. The two stories are presented as manifestations of the same process - though some of the actors are widely different - in terms of class. culture, ethnic traditions, gender role history, population, geography and exposure to debates on reproductive rights, freedom and the autonomy of choice. In the last section, some questions are raised on these philosophical concepts and their social implications.

Boy or Girl? Technology can Help you Choose!

Amniocentesis and sex-selection in India has a very short history. Reproductive biology was identified as a major thrust area for R & D by the Government of India, as well as the medical research establishments from the 1960s,as the hysteria about the population crisis began to affect perceptions of the Indian intelligentsia. The All India Institute of Medical Sciences (AHMS) was one of the major centres of research in this field, and received substantial financial support for this purpose from national and international sources. The Institute also had a Department of Human Cytogenetics which found it possible to acquire access to some of the new sex selection technology by riding the band-wagon of the population panic. In 1974, the Department started a sample survey with the aid of amniocentesis to detect foetal abnormalities. By 1975, the AIIMS knew that the tests were being followed by abortion of female foetuses. An article In Indian Pediatrics (5th May 1975) commented that such abortion of female foetuses may not be acceptable to persons in the West but in our patients this plan was followed in 7 out of 8 persons, who had the test carried out primarily for determining the sex of the foetus. The parents elected for abortion without any undue anxiety.

Abortion was legalised by the Medical Termination of Pregnancy (MTP) Act (1971). Though the statement of objectives projected the legislation as an attempt to reduce criminal abortions in unsafe conditions, and maintained that the primary objective of the law was to protect the physical and mental health of women seeking abortion, there was little doubt that in the perception of the

medical establishment and of the majority of the general public, it was viewed primarily as an instrument of population control. One of the conditions under which abortion services could be provided by authorised hospitals and health centres was 'failure of contraception'. Studies on abortion under-taken by various scholars indicate that most abortions were performed on this ground in such institutions. Abortions for other reasons continue to be performed mostly by unauthorised doctors and clinics and/or unqualified practitioners.

The AIIMS tests were eventually stopped by the Indian Council of Medical Research (ICMR). But the advent of the new reproductive technology (NRT) and its fall-out had been noted by some medical entrepreneurs. By 1979,a group of such entrepreneurs set up the New Bhandaris' Antenatal Sex Determination Clinic in Amritsar, Punjab. It began to advertise its services openly through the press and handbills distributed in public places, railway compartments, etc. One copy of the handbill reached the Centre for Women's Development Studies (CWDS) in the summer of 1982. The advertisement referred to daughters as a "liability" to the family and a "threat to the nation," and exhorted expectant parents to avail of the services of the clinic to rid themselves of this danger. We informed seven national organisations of women which had their headquarters in Delhi, and with whom the CWDS had developed a close association since 1980.7 In July 1982 a joint meeting convened by these organisations condemned this misuse of scientific technology. After a heated debate, the meeting recommended three lines of action:

a) the government was requested to restrict the use of amniocentesis only to teaching and research establishments and to ban its use in private practice;

b) the Indian Medical Council was requested to take severe action against members of the medical profession who indulged in such unethical practices; and

c) women's organisations and civil rights groups were requested to be vigilant against the spread of this practice for commercial purposes.

Present at this meeting was a young woman reporter (Ritambara Shastri) from the United News of India, who had already brought out an excellent investigative report of the conditions in the New Bhandaris' Clinic, the attitude of the staff and the reactions among several patients who had undergone the test as well as abortion. The title of her long report, which came out on the morning of the meeting was "Amniocentesis: A Money Spinner". Virtually everyone at the meeting had read her story. Revolted by the account of the brutal display of aborted foetuses in the clinic, several of the speakers demanded a total ban on amniocentesis. A few, however, pleaded that the women's movement should not

declare itself opposed to scientific research per se, since it was possible for amniocentesis to play a positive role in the detection of certain sex-specific genetic disorders in unborn children. The real culprits in this crime, in their view, were the medical personnel who misused science and women's powerlessness to increase their profits.

I had the unfortunate responsibility of chairing this meeting. In my summing-up, however, I could not help pointing to the language of the advertisement and raising the question whether amniocentesis was going to be used as "a 'final solution' to the population question."

Also present at this meeting was Mr. Ved Marwah, Joint Secretary to the Government of India, in-charge of the Women's Bureau within the Ministry of Social Welfare. Ritambara Shastri's story and the information provided by some of the speakers at the meeting shocked him greatly. He obtained copies of the resolutions adopted at the meeting and promptly sought the intervention of the Union Health Minister. A Conference of State Ministers of Health took place shortly afterwards. The Union Minister made a strong statement expressing his deep concern over the "highly unethical, unjust and immoral practice." He exhorted the State Ministers to take appropriate preventive action. The District Medical Officer, Amritsar, interpreted this statement at its face value and threatened the management of the New Bhandaris' Clinic with legal action. In reply, he received a cool question, asking what law had the clinic violated? At a later stage, a local unit of one of the women's organisations filed a suit against the proprietor for negligence.

It is reported that prior to 1985, the Government of India had Issued three circulars to the States and to concerned departments at the Central level, making the use of the technology of prenatal sex determination (SD) for the purpose of abortion a penal offence. 10 In his statement to the Lok Sabha, however, the Health Minister ruled out a ban on amniocentesis, saying that "it was for the people to change their attitude to female children."

The man who had assisted the Bhandaris to set up the first sex-determination clinic In the private sector was Dr. K.K. Loomba, a chemical pathologist. In 1984 Loomba decided to quit Amritsar and set up shop in Delhi. The Loomba Clinical Laboratory and Genetic Centre at Patel Nagar is the largest Centre of its kind in the capital, and his charges are among the highest in the country. He now says,

> My investment in this sophisticated laboratory in Delhi is around Rs.6 lakhs, but I am presently earning over Rs.50,000 every month. To those who repudiate my work, I can only say that this is one of the ways in which the population explosion in the country can be controlled and a safe

> method adopted by which couples can plan a balanced family ...How can you say that we are doing something illegal when abortion itself is legalised in India and is not being done in the clinic.

The argument given by Loomba is repeated at every clinic practising sex scanning. The ostensible reason for getting the tests done is to identify genetic disorders in the foetus, but all the evidence indicates that 95 per cent of the clientele is anxious only to know the sex of the unborn child. "The second cover-up is a plea that after the results of the test are given, the clinic does not take the responsibility for performing the abortion ... The other detail missed out by those visiting the clinic is the deletion of the word sex-determination from the application form. Advertisements have been released ... in daily papers with the headline - 'Healthy Boy or Girl - Know the Sex of the Unborn Child' in bold type." Dr. Loomba goes on to argue that any attempt by the government to impose a ban on sex determination will force the clinics to go underground : "Those who are willing to pay Rs.1,000 to me today will also pay Rs.5,000 if the tests are carried out clandestinely." A gynaecologist at the Marie Stopes Clinic stated that the proliferation of sex determination clinics in the capital has encouraged many couples to go in for a scan after the birth of one daughter. In her view, both causes: (a) sexist bias in the minds of Indians, and (b) unscrupulous doctors performing the tests, are responsible for female foeticide.

The debate and the heat generated by the 1982 meeting subsided after a few months. The New Bhandari Clinic toned down its aggressive advertisements and despite the statements made by the Health Minister and the circulars, no concrete action was taken by the Central Government.

The State Governments, having realised that there was no legal provision to back such action, also remained inactive. Instead, "the Government of India's circular banning the misuse of medical technology for sex determination in all government institutions, marked the beginning of privatisation and commercialisation of the technology. The 1982 debate further accelerated this process all over India, specially in northern western India. The SD 'epidemic' spread rapidly in Maharashtra, Gujarat. UP, Punjab. Haryana, Delhi, Bihar and even to Goa and West Bengal. Gujarat topped the list with SD clinics spreading even to small towns. After the initial phase of cautious 'lull', the 'clinics' started advertising aggressively. Within six years, the SD 'business' came to stay."

The Forum Against Sex Determination and Sex Pre-Selection (FASDSP) was formed in Bombay in October 1985, its members were from varied backgrounds -- feminists, health and human rights activists, persons involved in the people's science movement, etc. Wiser after the failure of the 1982 protest in Delhi, the Forum decided not to confine its opposition only to amniocentesis, but to the

entire spectrum of new reproductive technologies. The Forum also decided not to treat amniocentesis purely as a women's issue but to seek wider alliances by emphasising technical, social, demographic, legal, ethical and policy dimensions of SD. Thirdly, the Forum decided to avoid trivialisation of issues in the media debate (this had been one tendency after the 1982 protest). It drew on campaign techniques to generate public support developed by other social action groups, such as street theatre, posters, marches, social awareness advertising, etc. It filed public interest litigation to sensitise the judiciary in favour of their campaign objectives and support for a new law. It drafted a private member's Bill with the help of a Senior Officer from the State Assembly and had it introduced in the State Assembly by three members. "The Introduction of the Bill added an entirely different dimension to the campaign and forced the State Government to give serious consideration to the Issue. This Bill laid the foundation of the entire legislative exercise at the State and Central Government levels."

The Bill also forced the State Department of Public Health to commission a survey of SD Clinics in Bombay. Dr. Sanjeev Kulkarni of the Foundation for Research in Community Health, who undertook this study, reported that 42 out of 50 gynaecologists whom he contacted admitted to performing SD tests. 37 had begun this practice since 1982. Between them, they were performing over 270 tests per month. An examination of their replies to Dr. Kulkarni's questionnaire made it clear that cases of genetic defects were marginal, and that the overwhelming majority came merely to obtain information about the sex of the foetus. A majority of the patients came from the upper and middle classes. Six doctors, however, reported that they had a few cases from the lower class also.

Costs of these tests vary. Two doctors charged between Rs. 70 and 150, 33 between Rs. 200 and 400, and 7 between Rs. 400 and 600. 37 of them also admitted that they performed abortions after the tests. Five, however, declared that they did not perform mid-trimester abortions. A majority of the doctors also stated that very few of the patients coming to them had only daughters and no sons.

Kulkarni tried to obtain the doctors' assessment as to whether the women were pressurised to come for the tests. 27 answered in the negative, but 15 believed that many of their patients were under pressure. Some women had admitted as much to the doctors in confidence. Two of the doctors admitted their awareness that at least 30-50 per cent of their patients were under pressure from their families.

As for the doctors' views on the SD tests - eight (nearly 20 per cent) considered it to be an effective method for family planning. 19 considered the practice to be wrong, but 'unavoidable' in the current social set-up. 31 tried to salve their

consciences by claiming that they were offering a humane service to women who do not want daughters. Kulkarni's report quotes a pediatrician, who supported SD tests for "a balanced and small family. ... Thus, the SD tests can help family planning programmes also." Four doctors categorically stated that they were not bothered if the tests were followed by abortions of female foetuses: "that is not my problem." Kulkarni did, however, find one doctor who had given up performing SD tests after the debate started In the press, undertaking them only for detection of genetic deformities. This doctor even wrote articles in Marathi papers condemning the tests. Having informed Kulkarni that virtually every gynaecologist these days performs these tests, he went on to say:

> It is the doctors ... sitting in the chairs of authority who should use their judgement. It is not correct to say that doctors are helpless, they are forced to do the tests. After all who made it known to the public that such tests can be used in such a way? Who put up the advertisements in the local trains?

He strongly supported the legislation to ban the tests and abortion of female foetuses.

Kulkarni's report quotes books on obstetrics which condemned the use of amniocentesis or other SD tests "for such trivial reasons as choosing the sex of the offspring." He also argues that in the absence of the government's failure to take necessary legal or administrative measures, the public debate had only resulted in the spread of the practice. It was no longer confined to big cities, but had spread to many smaller towns as well.

An analysis of abortions performed during 1984-85 by one abortion centre in Bombay revealed that nearly 100 per cent of 15,914 abortions had followed SD tests. However, the new President of the Obstetrical and Gynaecological Society called it "a social problem like dowry and child marriage," and argued that there was no point in blaming the doctors or asking them to discipline themselves. A woman Head of the Obstetrical and Gynaecological Department (Bokaro General Hospital, Bihar) said, "Our priority is population control by any means. Amniocentesis should be used as a method for family planning and made available to everyone at a minimum cost or even free."

Kulkarni's report exposes the hollowness of much of the rationalisation put forward by doctors to justify their conduct. He points to the falseness of the propaganda that most of their patients had several daughters, to the advertisements which focus on the expenses involved in rearing daughters including the expenditure on dowry in the future. "Gynaecologists have tried to

convince people of all classes that spending Rs.70 to 500 is a pittance as compared to the cost of bringing up a daughter and marrying her." He concludes his report by raising several questions. The most important of them, in my opinion, are the following:

1. Is there any relation between the drive for population control and the emergence of such a practice?

2. In what way has the liberalisation of abortions contributed to the emergence of this practice, and how does one see this practice in relation to women's right to abortion?

3. Is this practice an effect of the adverse sex ratio, or will it further worsen the sex ratio or are both true?

An important outcome of Kulkarni's study and the efforts of the FASDSP was the formation of Doctors Against Sex Determination (DASD), an independent forum of conscientious doctors to support the campaign. The DASD publicly asked the Indian Medical Association (IMA), the Indian Medical Council (IMC) and the Federation of Organisations of Gynaecologists' Societies of India (FOGSI) to take a stand on this matter. The IMA and the IMC never responded, just as they had not responded to the appeals of the women's organisations in 1982.

The introduction of the private members' Bill in Maharashtra led to the constitution of an Expert Committee on Sex Determination and Female Foeticide which included some members of the FASDSP. The report submitted in May 1987 contained the following recommendations:

1. The misuse of prenatal diagnostic techniques for SD should be totally banned;

2. These techniques should be allowed only for the detection of congenital anomalies; and their use restricted to Government and public institutions, (like municipal laboratories; private laboratories should be, if required, channelised through Government institutions licensed for the purpose);

3. The State Government should enact a special law for this purpose, and pressurise the Central Government to enact a similar legislation at the national level;

4. The MTP Act, if required, may be amended so as to include in it a clause explicitly stating that sex-selective abortion (except where it is therapeutically justified) is a legal offence;

5. The law can succeed only if it is supported by a well-planned. long-term movement for health education and consciousness raising. The Government should take suitable measures to that effect.

On 31st December 1987, the Chief Minister of Maharashtra announced that the Cabinet had accepted all the Committee's recommendations and an official Bill would be introduced in the legislature. However, the Bill that was presented in April 1988 included many clauses in contravention of the Committee's views:

a) The Committee (like the women's organisations in 1982) had recommended that sex determination tests should be restricted to Government and public institutions. The Bill provided for granting licences to private centres/laboratories.

b) The Committee had argued against punishing the women patients on the ground that the majority were pressurised by their families. The Bill, however, provided for the punishment of the women rather than the family members who pressurised them.

c) The Committee was in favour of public pressure and Intervention to strengthen the enforcement of the law. The Bill restricted the right to move the court only to official organs of the implementing machinery i.e. the State Appropriate Authority (SAA) and the State and Local Vigilance Committee (SLVC). Others could move the court only if the SAA or SLVC failed to act within 60 days after receiving a complaint. The official Committees could also refuse to divulge documents to such public groups in the 'public interest'.

d) The Bill gave blanket powers to State Governments to exempt any institutions under its control from the requirements prescribed in the Act.

e) No time limit was fixed for the constitution of the SAA and the SLVC. In fact, these bodies were constituted after more than a year, and did not include any of the FASDSP members, or reputed professionals who had taken a firm position on the female foeticide issue. A year after the Committees were formed, a government officer stated "that the major reason for the non-implementation of this Act Is the inability of busy members to attend meetings.

f) The Bill prescribed conditions under which the use of prenatal diagnostic techniques could be allowed. The Committee had recommended "exposure to potentially teratogenic drugs/radiation/infections/hazardous chemicals" as one of the conditions. The Bill dropped the words 'potentially teratogente' altogether, thus allowing the tests on the pretext of even minor infections.

The FASDSP, while pressing for amendments, did not want the Bill to be shelved. Two amendments were finally accepted. The words 'potentially teratogenic' were restored to Clause 4, and the clause giving blanket exemption powers to the government was totally dropped. The Bill was unanimously passed by the Maharashtra Legislature in April 1988.

The enactment of this law produced many spin-off effects. A Forum Against Sex Determination was formed in Gujarat, and after a long-drawn-out struggle, an Improved version of the Maharashtra Act was passed in Gujarat. A similar campaign was started In Goa and an official bill was introduced, though it could not be enacted because the State Assembly was dissolved. In Karnataka, a scandal about an SD clinic run by a private practitioner within a University Department was exposed by the Press. The clinic had to close and the findings of an Enquiry Committee led to a number of resignations.

The number of SD Clinics in Maharashtra declined significantly after the passage of the Bill, and aggressive advertisements ceased. However, some doctors in Bombay continued the practice at exorbitant rates. Since legal actions have been virtually absent, one may assume that the practice is on the increase again. Both the SD clinics and the government have found various means of refusing information to bodies like the FASDSP. Ravindra reports a novel method adopted by one gynaecologist in Bombay. He asks for an advance of Rs.5,000. The charges for the test are Rs.3000. If the foetus Is found to be male, then Rs.2,000 is refunded. However, surprisingly, all reports turn out to be 'daughters'. This is because the amniotic fluid is not sent to the laboratory for analysis. There is little or no record of all these activities.

According to Ravindra's estimates while "SD business" continues to expand in the northern states of India, it has not made much headway in the south and the east. Some Census analysts are however not so sure.

In December 1986 the Union Minister for Health and Family Welfare convened a National Conference on SD. This was followed in 1987 by the constitution of an Expert Committee. The Committee finalised a draft legislation which was circulated to State Governments for their comments. A final draft of the Bill was introduced In Parliament in 1991 and is being currently reviewed by a Joint Select Committee which has called for reactions and memoranda from various bodies, including women's organisations.

Ravindra's report on the Campaign Against Sex Determination, like Kulkarni's study, concludes with a question about the relationship between SD tests, high female mortality and the sex ratio in India's population. Other important views of Ravindra also need to be recorded here:

a) organised public opinion from broad-based groups can bring about desirable changes in social biases, the government's attitudes, and the priorities of political parties;

b) the increasing market orientation of the medical profession now requires checks and balances on the use of medical technologies from outside the profession:

c) a successful campaign against SD requires a combination of research and activism.

'If we succeed in getting a law against SD on the grounds of the Constitutional Right to Equality, and on Society's right to intervene for restoration of sex ratio balance, we can challenge sex pre-selection on the same grounds. It can also pave the way for a better understanding of issues relating to NRTs as a whole

Female lnfanticide Among the Pramalai Kallars of Madurai, Tamil Nadu

While there is a history of female infanticide in the Indian sub-continent, the South has been in the main free of this tradition. It, therefore, came as a great shock when India Today (15 June, 1986) published a report on the existence of female Infanticide in Usilampatti Taluk in Madurai district of Tamil Nadu. The author cited interviews with doctors and common people, and painted a horrifying picture of poverty- stricken parents killing their new-born daughters out of fear of the expenses of rearing a daughter including the eventual dowry. According to one doctor's estimate, over 95 per cent of women giving birth to daughters absconded immediately after the birth. "We can come to our own conclusion about the motive of absconding". The Usilampatti Government Hospital recorded an average of 600 female births in the Kallar group every year, out of which 570 babies vanish with their mothers. Hospital sources estimated that nearly 80 per cent of these become victims of infanticide. The article suggested that the practice was rampant in all the 300 villages of Usilampatti Taluk, that nearly 6000 female babies had been killed in the Taluk in the last decade (though very few had been recorded), that this was being practiced only amongst the poorer members of the community, and that the practice was essentially related to the dowry evil. "Family planning is yet to catch up with the Kallars".

The press played a very supportive role in the campaign against dowry violence since the late 70s. However, it did not question why the practice of dowry had expanded and spread to communities which had never practiced it before, or had in fact practiced the opposite form of bride wealth or bride price. A study

undertaken by the Census of India in 1961 had concluded that the majority of the Indian population still practiced bride price rather than dowry. As for the Kallars or the Pramalai Kallars - the particular sub-caste concentrated in the Usilampatti Taluk-I shall depend on professional anthropologists and historians. Louis Dumont, who undertook a detailed study of this group in the mid-50S described them as mercenary soldiers, guardians of fields, houses and cattle in the employ of higher caste landowners, and traditionally believed to be shudras. A seventeenth century king had granted them some land. Over the next 200 years, some of them also acquired land 'deserted' by their employers. Dumont described them as traditional cattle lifters and burglars, whose thieving activities were reduced under British rule." A recent study by a Tamil historian, however, presents a somewhat different perspective. According to this account, Kallars were categorised as a tribe in the 20s under the Criminal Tribes Act which came into effect after the Kallars suffered their final defeat at the hands of the British in 1919 at Perungamanallur.

Despite this basic difference in perspective there are many common elements in the two studies. On the status of women, Dumont had recorded that the Pramalat Kallars prefer matri-lateral, cross-cousin marriages, that there was nuclearisation of families on marriage and a lack of a parilineage solidarity - manifested in the lack of dependence on patri-kin. In fact, husbands depended far more upon their wives and their wives' families for occasional loans. All these are characteristic features that have been described as remnants of a matriarchal culture System'.

Dumont as well as Pauline Kolenda comment on the great freedom enjoyed by women in this community. 'Patrilineages are important in the rural political domain, especially in connection with the traditional Organisation of courts and councils, but are not very powerful in controlling their members or resources in their domain". The community practiced bride price. The right of divorce was enjoyed by both men and women with considerable weight age in favour of women. Divorce initiated by the woman without the husband's permission involved the return of the bride price as in many other communities which follow this custom. But if the groom initiated divorce proceedings, he lost all the gifts given by his family to the bride's family. He also had to return all that he had received from the bride's family and still pay Rs.25 as compensations. Divorce rates as well as the rates of subsequent marriages were high. Such changes were especially high in the early years of a marriage, before the wife's jewelry became the husband's property and before the wife's family provided the household pots. Kolenda comments that in the combined dowry-bride-wealth system, husbands stood to lose hopes of future resources from the bride's family in case of divorce. Between Dumont's study in the 50s and Kolenda's in the 60s, we note the beginning of a change from bride price to a bride price-cum-dowry

system. V. Vasanthi's study was undertaken in 1987, in direct response to the reports on female infanticide. She throws some additional light on the position of women in this community, and the manner in which it has been changing over the last few decades. Two of the eight clans (Nadus) were founded by women, 'who have been deified and occupy a position of great importance among Kallar gods" . The community still retains tales of women's martial valour including their participation in the final Kallar resistance against the British.

Rapid agrarian changes, with the groups' "integration into the modernising economy" of Tamil Nadu, accelerated after the completion of the Vaigal Canal system towards the end of the 50s. Irrigation and the green revolution technology brought great prosperity to a section of the community which had land near the Canal. Before the opening of the Canal "the entire Taluk was a vast arid tract. Agriculture hardly sustained the population which took to petty thieving and highway robbery as a way of life, an easy transition from the traditional role played by the Kallars as the mercenary hordes of feudatories. There were no big landowners and a near equal distribution of land existed".

The Canal system created "a degree of differentiation of the agricultural community" with the "rise of a middle peasantry' and simultaneously the 'impoverishment of the lower levels of the peasantry'. Very high levels of land transfers and dispossession of the small peasantry are reflected in 'a big landless population among the originally land-owning community' joiningthe ranks of the scheduled castes who were until then the only landless groups. With the near total absence of any industrialisation In the area, the proportion of agricultural labourers in the rural population as a whole had almost trebled between 1961 and 1981. In the irrigated villages, the newly wealthy Kallar farmers, have also successfully entered other businesses(liquor and other contracts, cinema houses, transport etc.) despite the prevalent popular belief that this community is incapable of success in trading ventures, A sizeable section has also migrated to urban centres(mainly Madurai), taken to education and acquired considerable political influence. This was facilitated by the geographic concentration of the group.

Vasanthi traces two processes that have rapidly destroyed the traditional high and near equal status of women in this community - their economic devaluation and the new values adopted by the upwardly mobile section. These have consequently had an impact on the community's social institutions and practices.. Reduction from cultivator to wage labour status among women has been accompanied by wide wage disparities-in agriculture women earn Rs. 6 per day, while men get Rs 10-12, in quarrying, women may get between Rs. 10 and 12, while men earn Rs 25-35, in brick kilns, women's wages range between Rs. 6 and 8 but men's between Rs. 13 and 40.

"When a preponderant proportion of the peasantry were owner-cultivators women's contribution to labour on the family farm could not be quantified and ensured her a measure of respect, dignity and status in society. When they are reduced to wage earning, the considerably lower wage that woman earns leads to her devaluation and underlines her inferiority.

New avenues in the tertiary sector involve mobility, and are outside the reach of most rural women. At the same time, the newly enriched section of the community in agriculture or commerce have adopted values that are 'inimical to women's dignity and lead to her devaluation'. Domestication is followed by the adoption of dowry, initially "considered shameful and unworthy of the proud traditions of the community. It used to be compared to the selling of cattle to Kerala in the West. In such a community today, marriage of women of any class without dowry has become an impossibility'. Demands may range from Rs. 5,000 and 5 sovereigns of gold for a poor labourer to Rs.2 lakhs and 50 sovereigns for a doctor. Villagers are able to point out the first families that started the practice- the ones that prospered from contracts, money-lending illicit liquor trade etc. They were followed by the educated professionals. The killing of baby girls, according to Vasanthi's investigations, began in 'villages well served by transport and communication networks, with canal irrigation and with a growing neo-rich class. Remote and arid villages were, till a few years ago, not affected by the horror, though in the past two or three years even they are succumbing to a daughter- rejecting ethos'. While dowry is cited by everyone as the cause, Vasanthi has found a correlation between the rise of this 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 marginalisation in the new economy.

Her arguments are substantiated by a comparison of the sex ratio of villages in the prosperous areas with those in the interior, arid, poverty-stricken region, which are poorly connected by road and transport systems, but still retain some semblance of the old semi- tribal values. Of the 8 villages in the first category, the sex ratio In 1951 was alarming (965 per 1000males) in only one (Kalluthn). 3 of the 8 villages had more women than men (sex ratios were 1022, 1021, 1051). By 1971, a sharp decline was noted in all except two villages. By 1981, the sex ratio in these 8 villages had come down to 773, 862, 868, 877, 895, 890, 89 1, and 892 - all way below the ratio for the Usilampatti Taluk as a whole (96 1). The Kallars constitute about 80 per cent of the population of the Taluk.

All the ten villages from the arid interior area, however, had a high sex ratio in 198 1, (I 147. 1094, 1080, 1075, 1075, 1059 1049, 1046, 1040,1032) - higher not only than the Taluk or the district (989), but of the State (987) and the nation (933).

Vasanthi's study is still not complete. But her initial findings indicate that In the prosperous region "there is eagerness to reject the past and to claim comparability with upper caste culture'. Divorce and remarriage of widows have become rare - the process of Sanskritisation has apparently caught on. In the interior villages, however, traditional culture survives to a greater extent, with "the complete sway of caste panchayats." of the old instability of marriages, with frequent divorce and remarriage of women, the assertiveness, and inhibited ways of women and their 'social equality'."42

What is it that unites the two sections of a community that are so different in terms of economic 'development', cultural values, life-styles and behaviour patterns? The answer lies in the role of caste in marriages and political bargaining power. Caste endogamy was always rigidly followed by the group. Dumont noted that the few settlements of the Kallars outside the eight original Nadus were started by persons who were either illegitimate offspring of inter-caste unions or persons "communicated from the caste for some offence or other. In terms of political socialisation the dominant, well-to-do members are followers of the Forward Bloc" which does not enjoy much support in the State. Solidarity is therefore vital to ensure some access to the political bosses, to obtain lucrative contracts. Routing of the Canal through that particular part of the Taluk was Itself a political victory.

The political tightness of the community makes it react to the adverse publicity brought on by national exposure of the ignored in assessing the validity of the findings of journalistic studies like that of India Today. Some of the sources that provided much of the information in 1986 needed to be checked more closely: this was apparently not done. For example, how could 570 out of 600 female babies and their mothers keep disappearing from a Government Hospital without the knowledge or connivance of the Hospital staff? Or how did, the Hospital records indicate that these children died of 'social causes'? -What happened to professional responsibility or Government service conduct rules that prescribe accountability to higher authorities?

Some answers and insights for a number of my doubts were provided by a creative writer of Tamil literature who undertook an in-depth socio-psychological study of the people of different class of Usilampatti to understand what made mothers kill their own daughters. Her first finding casts doubt on the glib statistics, since "there is no proper record of births and deaths and as the entire community is united in its silent approval of the practice". The sex ratio is the only damning objective evidence. She did however get several statements saying that "there is hardly a house in Usilampatti which has not killed a female child". Some of the doctors in the hospital are from the guilty community. Their

statements are illuminating. "The female babies inevitably die, and we know how they die. It is very sad, but it keeps happening". No records are maintained in health centres or nursing homes where many deliveries take place although the law requires this. The majority of the births however still take place in households which "Keep the information to themselves". Social workers trying to prevent the practice say they are most of the time "too late". The principal of the local college, also a Kallar, admits to knowledge of the practice, but has "never felt it to be an issue". Of late, the community "tried to keep it as its private business and wants no interference from the press and the police.

Contrary to the general belief that female Infanticide is taking place only among the Poor, a nurse in a Primary Health Centre gave out that 'Even educated people and reasonably well-to-do people have no qualms about killing[infant girls]'. and gave instances of educated men forcing their wives to kill their babies, under threat of being "rejected". Several women told her (the nurse) of such pressure from their husbands. Some had complained to the police but had received no support. Often the men commit the crime themselves, if they cannot force the women to do so.

Though virtually everyone mentions 'the dowry menace', Vasanthi found one academic, Kothandapani (in Gandhigram Institute) who dismissed it as a "flimsy' reason. The system of giving presents on many occasions (Seimurai)- the birth of a child, ear-boring, circumcision, puberty and marriage- certainly places a financial burden on a woman's natal family, but Kothandapani claims that the system helps to rotate money. The Kallars are "a formidable lot": the community owns common property worth Rs. 5 crores and is politically very influential. He went on to say that there is no history of human sacrifice and the community rejects atheism (that was why they opposed E.V.R. Naicker and the Dravida Kazhagam). But killing is not considered a sin either by men or women. Principal Bose, who never felt disturbed by the practice, is very ready to offer reasons such as modernisation. money culture, decline of moral values, insecurity that young women -face, the coming of cinema, T.V., video etc.

Ordinary Kallar women, on the other hand, bemoan the disappearance of certain customs that protected their security (e.g. obligatory cross-cousin marriages - Murai Palyan). They are also very conscious of the community's emphasis on 'honour' - if a girl gets into any trouble, she will be killed anyway. Some voluntary agencies tried to arrange for baby girls to be 'given away' to orphanages but came up against the feeling that this would be a shameless thing" to do.

Vasanthi's search for a meaningful explanation for the beginning and spread of female infanticide in this area led her eventually to relate it to 'the period of

intensification of the Family Planning Programme in that area... Family Planning was propagated at a time when their social structure was already getting disrupted ... there was poverty... and affluence. As a people they are terribly prestige conscious and highly sensitive'. Contraception and abortion both appear to be out of reach of the poor-'Besides money, they are afraid to lose their time and health". Many told her :'Well-to-do people go for family planning methods, We limit our families in our own indigenous way. What is the difference? It if is legal killing of child in the foetus (which will harm the health of the mother) should It be wrong killing of new born baby? In this way you save the child from future hardship, and also the mother's health. And also you have the choice to keep the baby". Vasanthi blames the doctors for emphasising only sterilisation as a method of contraception, one that the people, especially women, are afraid of. It involves hospitalisation and post-operative care which they cannot afford, and they fear losing their health, or being 'rejected' by the husbands afterwards. For both men and women, in her view, the legalisation of abortion has provided a rationale for what they feel compelled to do for other reasons.

Conclusion

A comparison of these two social phenomena poses some obvious difficulties. Unlike the Infanticide story, our data on sex-selective abortions from Punjab. Delhi, Maharashtra or Gujarat tell us practically nothing about the communities indulging in this practice. We only know that the majority come from the upper and middle classes though reduction in costs in Bombay and Gujarat have now brought this practice within the reach of even the poorer sections. In the case of the Kallars, community approval and connivance are being, provided not by the traditional community institutions (which retain some authority only in the interior areas), but by the new leaders of the community in the prosperous areas-the well-to-do, the educated professionals, and the political leadership. In both cases, it is clear that the medical professionals are particularly guilty. Investigators in Usilampatti have not enquired whether any of the health professionals there have as yet recognised the commercial possibilities of the technology of amniocentesis. The indifferent role of the law enforcement agencies and governmental ambivalence as a whole at the local, State and national levels are also common actors in the two stories.

Both prosecution and defence in the two cases identify (a) the policy of population control and (b) the social perception of legalised abortion as primarily an instrument for population control as major causes of the two phenomena. Other reasons mentioned by the groups involved are : dowry, the expense of rearing daughters, and the age-old cultural culprit-son preference.
It is a pity that the foeticide studies do not provide us with more information on the caste/community/ culture background, or the life styles of the families

taking recourse to sex-selection. We do not really know how many of them actually need to pay dowry - according to the customs of their community or 'necessity'. Nor do we know how many of these families would have continued to defy the law" in spending lakhs or more on the weddings of their daughters so that they could justify even higher demands in the case of their sons. Nor can we estimate how many would have spent more than they could afford on the education of those daughters had they lived - to be faced thereafter with self-chosen marriages, often outside the caste/community prescribed norms - for which, theoretically at least, no dowry would be called for. The fear is more real and concrete in the case of the Kallars, because they are a small group, and want to maintain their communal solidarity for political survival.

In the melting pots of the metropolitan cities, with Increasing education and employment among middle class women, and the mushrooming of women's organisations fighting against the violation of women's rights, I have found it increasingly difficult to sympathise with the moans of middle-class families about "social pressure" to get their daughters married at all costs, even by paying dowry. Urban life styles these days leave little scope for such 'social pressure' to operate effectively. The proliferation of matrimonial advertisements, the contribution of the NRIs (non-resident Indians) to the marriage mart, and the speed with which marriage transactions are settled, often without any real enquiry into the antecedents or character of the two individuals involved, suggest far greater influence of market forces and a fear among parents - of losing control over their sons and daughters, than the upholding of any traditional' values or institutions. Projecting dowry as an abstract social menace has prevented critical exposure of its role in the circulation of capital, sealing business or political alliances, and in promoting competition in consumerist culture. The operation of a considerable degree of choice or voluntarism in the escalation of dowry has definitely been underestimated, even underplayed by analysts and activists alike.

To my mind, similar market forces are at work in the SD test-abortion front also, The high pressure sales promotion of the doctors is not intrinsically different from the sales campaigns for consumer durables, new fashions in clothes etc. The one difference is that it utilises the language of population control, and provides a touch of patriotic idealism to salve people's conscience. To draw an analogy from the high pressured promotion, and acceptance of baby formula in preference to breast-feeding, and the propagation of caesarian sections for perfectly normal cases of confinement, one may even expect a certain element of status competition operating among the patients and their families.

These are untested and unpleasant hypotheses, but testing them out with more painstaking research would be more advisable than turning dowry, son-

preference and that ubiquitous culprit, cultural or religious values, into abstract bogeys that are beyond our control or correction. A similar defence on the education front has provided the educational bureaucracy with a perfect cover to hide their acts of emission and commission.

Societies have always practiced demographic stimulation or control-designing values as their instruments. Religious and legal sanctions added weight to such values. But at the individual level, pragmatic reasons often pushed women and men into actions utterly in contravention of such values. Abortion was regarded as a sin in most South Asian cultures, and perhaps in others as well. Despite that, many women took recourse to abortion by indigenous or other methods at great risk to themselves. What the anti-natalist population policy and the marketing of the population - development debate, essentially from the perspective of the industrialised, powerful, rich nations of the world and their counterparts in the third world, has done is to provide a scientific rationale for investment in new reproductive technologies which are controlled by the providers, and not by the recipients. In many cases the women are not even informed about the possible side-effects on their general health and productive capacities. There is little doubt that there are inducements with offers of aid from donor agencies. It is also certain that the cur-rent policy of import liberalisation dictated by the IMF and World Bank will increase the import of sex-selection technology and that the propulsion of market forces can very easily defeat the objectives of the law now on the anvil. This would not be the first time that laws with humanitarian objectives are defeated by macro-policies in the economic or social sectors that result from other compulsions.

Safety of abortions, sterilisation and maternity care depends on the general state of the health services. The declining quality of public health services in India has been the subject of considerable debate. There is a growing feeling among many health scientists, and even bureaucrats, that placing the responsibility for restricting population growth on the health infrastructure has only brought about the degeneration of the infrastructure and the profession, without attaining the national objectives The present financial crisis and the pressures of SAP have already resulted in the slashing of the health budget: this trend Is likely to persist for sometime.

The Report of the Eighth Plan Working Group, however, states that women's status issues, and the improvement of the quality of life of the people are central in attempts to achieve demographic transition or population control. Similar views have been expressed by many, but little attempt has been made to probe the nature of this relationship, Approaches to the question have been fragmented and so have the slogans-women's education/literacy: women's employment. their integration In mainstream development; participation in decision- making-,

women's autonomy, options, choice, legal rights to equality in social, economic and political spheres in order to enhance women's capacity to influence development decisions that affect their lives. WID literature is replete with such concepts or policy approaches - often dealing with more than one issue.

The time has come to ask whether these approaches are all complementary, or are there contradictions between some? Is the insistence on autonomy or choice at the individual level possible or consistent with the goal of influencing collective, community, even national decisions? Going by the political experience of many, the answer is no. Research on empowerment actions at the grassroots, focussing on poor women, also indicates that collectively they display a higher sense of social responsibility, and a rationale for their familial and community roles that provide a basis for tremendous confidence, courage and strength of character. Mahatma Gandhi had intuitively grasped this strength and tried to harness it for nation-building.

But social and economic organisations, the dominant construction of gender, the development of. a market-oriented society, and technological advance, are all inimical to this notion of women's equality. After so many years of debate, development literature has not gone beyond viewing women as beneficiaries or victims of change, women are still not regarded as active partners and agents.

A basic point of difference between various brands of western and third world feminism has been in the Importance they assign to sexual and reproductive freedom for the individual in the quest for equality. Third world women have a historic awareness that individually their struggle would not get them very far. Such powerful systems cannot be changed by individual protests- though they have a historic role.

If the protest has to be collective, social and constructive - then we have to rethink the importance of sexual and reproductive freedom or rights at the individual level as the foundation and core of women's equality. Rights have to be interpreted within a historic, social context. Women's quest for equality today faces two challenges - a) reinforcement of hierarchic, unequal order from the global to the national level - the original destroyer of women's rights to equality: and b) the upsurge of various revivalist' fundamentalist' movements, projecting a group identity, based on religion, ethnicity, language, culture etc. By their very nature, they need to control women's reproductive capacity to preserve the 'purity' of the group.

Reproductive technology in the control of either or both these forces would destroy all hopes of women's equality. But fighting them by defending individual freedom may not receive full support even from all groups of women.

The counter ideology to motivate and mobilise women also needs asocial goal which provides them with a higher sense of self-worth and moral courage. Justice, dignity, the rights of child, the good of the community, and women's collective empowerment - along with participation to a achieve all these - may provide a stronger base for struggle today than the notions of sexual or reproductive freedom. Reproductive health needs to receive far greater priority than it has done so far and control of reproductive technology needs to be rescued from the clutches of market forces. But theories and instruments like intellectual property rights are no going to make the task easy.

In the Indian context, we have to resolve a debate among our allies. The FASDSP wants the national law against sex-selective abortions to exempt to concerned women from any punishment. The CWDS has already opposed this idea. We propose instead a campaign to inform women that they will have to stand trial for foeticide or child murder, (in case like the Kallars),whatever their class or economic status. If this is followed up by forcing the legal authorities to enforce the law, we anticipate that such measures would be an empowering effect on women, helping them to resist or community pressure.