

Sex-Detection Tests and Female Foeticide: Discrimination Before Birth

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The paper systematically unfolds the viewpoints expressed for and against the amniocentesis (a pre-natal diagnostic technique) test which was/is a leading factor in female foeticide. The paper highlights the urgency of the issue and positions it as a critical issue to be confronted during the 'Year of the Girl Child'.

Introduction

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 taken an alarming dimension in the recent past, with the utilization of the amniocentesis test for detecting the sex of the foetus, followed by a selective abortion of the foetus if detected a 'female'. Apart from the considerable risks the test can cause to the foetus and the women, the utilization of pre-natal diagnostic techniques for selective abortion of female foetuses perpetuates the negative social worth of women. The paper makes a case against the test and positions it as a critical issue to be confronted especially during the 'Year of the Girl Child'.

Amniocentesis and its Implications

Among the several pre-natal diagnostic techniques like sonography, chorionic villi biopsy and others, that are being utilized in India, the amniocentesis test {1} has achieved a dubious popularity as the one which provides quick 'results' and is 'accurate'. Even health-wise, these tests can cause a great deal of damage. Very often the clinical preconditions of following aseptic procedures and ultrasonic monitoring are often 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 or hip dislocation or problems (Ravindra, 1986). The test can cause considerable damage to the foetus and placenta, resulting in spontaneous abortion or premature labor. However, the commercial viability of these tests and the glamour of being 'in business' in the medical field, have overtaken ethical considerations. {2}

It has been observed that sex-detection (SD) tests are not confined to big cities but have proliferated to small towns also. 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, Nashik and Nagpur (Ravindra, 1986). Pathological laboratories became collection centers of amniotic fluid, which were then sent to Bombay for SD analysis and reports. Ironically, the SD test was provided to women as a 'human service' by doctors and certain hospitals in Bombay, before the legislation was passed Maharashtra (Kulkarni, undated).

Through blatant advertisements, private medical professionals had created the 'supply- induced' demand for the amniocentesis test. The sight of bill boards and advertisements in vernacular languages assuring the birth of sons are/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 16th and 18th week (third trimester) of pregnancy if the foetus is of the 'wrong' sex, is risky as the test is not always fool-proof. Further, this puts the women'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, speaks for the unacknowledged risk that is involved (Natarajan, 1986-1987).

Moreover, selective abortions followed by the SD test after the 12th week of pregnancy is a gross misuse of a liberal legislation. The Medical Termination of Pregnancy Act, 1971, permits abortion upto the 12th week of pregnancy. However, amniocentesis can be performed only during the 14th and 16th weeks of pregnancy and the abortion thereafter can be conducted only between the 15th and 18th week of pregnancy.

Sketchy Statistical Data

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

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 1980) study of records of three hospitals in the city of Pune, indicate that between June 1976 and June 1977, 700 women sought sex detection in a hospital 'B'. Four hundred and fifty women were informed that they would have a daughter and 430 of these women (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, 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 out of 42 doctors (i.e. 64.3 per cent) carry out amniocentesis tests solely for sex determination. The 42 gynecologists perform on an average, 271 SD tests per month. The rest of the 15 doctors (35.7 per cent) reported that only in less than 10 per cent of the cases, the test is performed for detection of genetic defects.

With the mushrooming of clinics conducting this test, it was estimated by 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

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

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

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

Most technological options in the area of reproduction, (whether pills, intra-uterine devices, or injectables), are heralded as adding to the range of 'choices' to women. Sex-detection tests are seen as providing a 'reproductive choice'-a choice to decide to have a boy or a girl! This is in line with the choice of commodities, consumer products and now the choice of the 'right' baby. The basic question is-do women really enjoy an unfettered 'choice'? Can choice exist in a context where women are socialized to subordinate their interests to those of men; where women attain a 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; eat last and the least, have lesser access to education and health services.

'Choice' is only meaningful if it can be exercised, in a 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 internalized social values.

Does a negative sex ratio increase the status of women?

It is a well documented evidence that the Indian population is predominantly masculine, i.e. there is an adverse sex ratio which registered a decline from the decades 1901 to 1981 (CSWI, 1975). Census data indicate that there were 972 women per 1000 men in 1901, which declined to 933 women per 1000 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 to 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 simplistic understanding of complex social issues. If mere numbers were to dictate status, then in several states in 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, as much as 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 ratio would increase the incidence of rape, prostitution and violence against women.

Cure social prejudices or ban sex-detection tests: which should come first?

Several objections are raised to a legal ban of sex-detection tests, for example by (Dharma Kumar 1988) in her articles. In one of her article 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 foeticid.... Instead of ringing 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 (Times of India).

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 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 ... 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?" (Social Health Review).

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

Amniocentesis: an aid to plan 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', at the neglect of changing socioeconomic and environmental conditions, is a lopsided priority.

The notion of a 'balanced family' is also not as simple as it is posed to be. If an equal representation of a male and a 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 so on, of couples opting for sterilization are rarely recorded, the scanty data provide pointers to the sex bias that exists. The examination of hospital records (Ramanamma and Bambawali, 1980) showed that 2.5 per cent couples consented to sterilization even though they did not have a son as against 15 per cent couples who underwent sterilization in spite of not having a female child. The majority of the couples underwent sterilization after attaining an average of 4.1 number of 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 the relentless campaign and pressure, the Government of Maharashtra passed the Maharashtra Regulation of 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, the pre-natal diagnostic technique can be carried 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, radiation, injection or hazardous chemicals, has a family history of mental retardation or physical deformities. The Act declares illegal any advertisements regarding the availability of facilities for pre-natal prediction of sex at clinics / laboratories / centers.

The regulation of these centers, laboratories and clinics is expected to be achieved through, Government appointed bodies, viz. 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); (Setalvad, 1988); (Jesani, 1988). The Act, rather than abolishing all private genetic laboratories and genetic clinics, provides for the registration of these. The Act can be criticized for being short-sighted, in the sense that, it restricts itself to regulating the existing technologies. The fast growth of research in reproduction and the introduction of new diagnostic techniques and sex pre-selection 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, the related issues like sperm banks, the invitro-fertilization programs (popularly known as 'test-tube babies'), ova donation, and ensuing issues like womb-hiring or surrogate motherhood, trafficking of ovaries, placenta, aborted foetuses, and others (Subrahmanyam, 1982); (Lingam, 1990).

The proliferation of sex-detection tests in Gujarat, Punjab, Haryana, Uttar Pradesh, Rajasthan and the union territory of Delhi vouches for the limits to state legislation. A comprehensive single central legislation is of crucial importance.

Conclusion

The focus on the issues of the girl child, during this year and in future, would be partial if these medical technologies and their utilization are not scrutinized. The campaign for a central legislation should gain momentum, as a social concern for the girl child and future women.

Notes

1. Amniocentesis (Amnio: membrane, kentesis, pricking) refers to the removal of about 15 c.c. 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 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 (Ravindnra, 1986).

2. The amniocentesis test costs anything between Rs. 150/- to Rs. 1500/- based on the utilization of techniques like sonography, and also on the market competition. In 1985, Harkishandas Hospital, a private hospital, crammed to have conducted 2,767 tests at an average of 25 tests per day (Gentleman, November, 1987).

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