CASE REPORT

'The more we change, the more we remain the same': female feticide continues unabated in India

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SUMMARY

In North India, preference for sons has been blamed for repeated incidents of female feticide, despite the legislation in the form of the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 2002. We describe how a team of local private doctors offer package deals to pregnant women and their families in rural areas. The fetal sex is determined at night using a portable ultrasonography machine.

If the fetus is a girl, an immediate induced abortion is offered in the clients' home. If complications arise, women are advised to attend hospital. Such a patient visited us with a history of bleeding per vagina following incomplete induced abortion. This case study highlights the fact that female feticide continues to occur in India.

INTRODUCTION

A preference for sons is reported in many regions of the world. Estimates suggest that feticide and infanticide, including newborn neglect and abandonment, have resulted in over 100 million missing women worldwide. China and India are thought to be responsible for 80 million missing women.[1] Female feticide has created gender gaps among the 0–19 years age group in many countries including India (12 618 000), China (25 112 000), Pakistan (206 000), Bangladesh (416 000), South Korea (336 000), Vietnam (139 000), Azerbaijan (111 000), Georgia (24 000) and Armenia (35 000).[2]

It is estimated that 100 000 sex-selective abortions are performed in India every year.[3]

Manu Smriti—'Her father guards her in her childhood; her husband guards her in her youth; and her sons guard her in her old age. A woman is not fit to act on her own'.

Tulsidas—'Dhol, gawar, shudra, pashu, nari, ye sab tadan ke adhikari'. ('Animals, illiterates, lower castes and women should be subjected to beating'. In other words, women were compared with animals.)

Several *Dharmashastras* (law books) and *Shlokas* ('hymns') in Hindu mythology refer to the restricted role of women in society.[4]

During the last millennium, further declines in women's status were seen as a result of Indian people wanted to protect women from Muslim invaders.

Child marriage was common with the aim of protecting young girls. Widows' remarriage was taboo in some communities. Many prevailing social and cultural norms reflected the low status of women in society, including 'purdah', the screening of women from men or strangers by means of veils; 'jauhar', the mass self-immolation by women among the *Rajputs* of Rajasthan to avoid capture, enslavement and rape by invaders when facing certain defeat during a war and 'sati', whereby a widow threw herself onto her husband's funeral pyre.[4 5]

South Asian culture remains largely gender stratified, characterised by patrilineal descent, patrilocal residence, inheritance and succession practices that exclude women. The patriarch has authority over family members.[6]

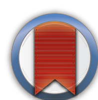
In India, there is considerable ethnographical evidence of regional differences in the situation of women, and female powerlessness is much more acute in North India than in South India.[7] The excessive mortality of females in India is ascribed to the prevailing norms within parts of Indian culture, whereby preference is given to sons, and daughters are discriminated against. Male children are considered to be in the interest of the lineage and family continuity, whereas daughters are regarded as more transitory members.[8 9]

Sons are also perceived to be a greater source of support to parents compared with daughters. A woman's position in her in-laws' home is low unless she produces at least one son.[10]

In North India, sex differentials in child mortality are greater than elsewhere. This is due to the extent to which women are marginalised in this region.[11] When a North Indian daughter marries and leaves the household, her ability to contribute to her natal household is virtually nil. The flow of resources is unidirectional from the woman's father's household to her husband's household (initially as dowry at marriage). This flow continues throughout her life, resulting in significant and mutually reinforcing incentives for parents to value sons more than daughters.[11]

Since 1991, 80% of districts in India have recorded a declining sex ratio, with most severe rates seen in the state of Punjab.[12]

Various means are used to beget a male child including serial pregnancies until a son is born, preconceptional sex selection techniques and postconceptional intake of sex selection *Ayurvedic* drugs followed by sex-selective abortions. During the preindustrial era, female infanticide was the most common method used.[13] Thus, though the means have changed, societal gender discrimination against girls continues.[13 14]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THE CASE

The first author (SB), a male doctor, was working in a subcentre as a resident doctor of the Community Medicine, School of Public Health, Postgraduate Institute of Medical Research (India). One day, a 25-year-old woman attended with a 24-hour history of vaginal bleeding. The bleeding was associated with palpitations, fever and pain in the lower abdomen. The patient was accompanied by her neighbour and two daughters. A history was taken by the author. Further details were recorded by a public health nurse. The patient was registered as an antenatal case in our outpatient department (OPD). Her case record revealed a gestation of 22 weeks. She had taken folic acid regularly. All laboratory investigations were normal. There was no history of any complications. Her two previous child births were full-term vaginal institutional deliveries. There was no history of chronic illness, hospitalisation or surgery.

When the nurse enquired about details of the bleeding, the patient explained that she already had two daughters and that the family did not want any more girls. Two days earlier, the patient's in-laws had consulted a local doctor who agreed to see the patient. The local doctor assured them that he would induce an abortion if ultrasound confirmed a female fetus. The in-laws agreed to pay the required amount for the abortion services. The doctor came on the stipulated date and time accompanied by an ultrasonologist. He initiated the abortion procedure after confirming the female sex of the fetus. The procedure lasted for 2 hours. Before leaving, the doctor told the family members that if any problem occurred, they should immediately call him. One hour later, the patient started bleeding. They dialled the doctor's phone number, but he could not be reached. The following day, the family attended our OPD with symptoms of incomplete abortion.

The patient's in-laws told us that a team of local private doctors with portable ultrasonography (USG) machine and Medical Termination of Pregnancy kits come to their area on request. They arrive in the evening to clients' homes as they know their activity is illegal. The mobile team offer a package deal. First, a USG-based sex determination test costing Rs 2500 (£ 30; US$ 39) is conducted. If a female fetus is detected, they offer an immediate induced abortion, for which they charge an additional Rs 15 000 (£182; US$234). On used, initiating the abortion procedure, the team leave, without waiting for the abortion process to complete. For any complications arising, clients are advised to attend hospital with a complaint of vaginal bleeding to avoid punishment under the Pre-Conception and Pre-Natal Diagnostic Techniques (PC-PNDT) Act, 2002.[15]

On examination, the patient was conscious and well-oriented. She had a high temperature with a rapid pulse rate. She was hypotensive. Her tongue was dry. There was no pallor. Her abdomen was concave in shape with no undue enlargement of the uterus. Striae were present. There were no scar marks. Owing to pain, deep palpation was not done. Inspection of the genital area revealed blood clots at the vaginal orifice. Vaginal examination by speculum was not done due to fear of excessive bleeding (it is better done in the operating theatre with arrangements for blood transfusion).

The patient was diagnosed as having bleeding per vaginum due to retained products of conception subsequent to incomplete induced abortion. Oral rehydration salt and antibiotics were prescribed as the first-line treatment. The patient required intravenous fluids and an ultrasound of the pelvis. For expert opinion, she was referred to the local civil hospital where our diagnosis was confirmed by the on duty gynaecologist.

GLOBAL HEALTH PROBLEM LIST

Health and social impact on the woman

This case reveals the suffering and risks to safety and health experienced by women subjected to female feticide. Women bear not only the physical medical risks of undergoing abortion but are also under tremendous psychological pressure.

Reproductive morbidity may also develop after abortion in the form of uterine prolapse, secondary infertility and other complications, and at worst, it can cause maternal death.

There are also significant social implications as a woman forced to undergo female feticide experiences loss of control over her own body and loss of decision-making power over her own reproductive life.

A preference for sons is the main driver of female feticide

In India, whether it was in Vedic or modern era, negative attitudes towards female babies remain. This is particularly true for central and northern parts of India. People want a son at any cost, and for this, they are willing to have female fetuses aborted.[4]

Role of legislation

Legislation has played an important role in changing attitudes, behaviours and practices towards female feticide in India. However, the complexity of this issue must be acknowledged. More stringent laws are required with a clear process of implementation. The enactment of legislation alone cannot address the problem of female feticide, as evidenced by the rise in illicit induced abortions, with serious implications for women's safety following the enforcement of the PC-PNDT Act.

New strategies are needed

Newer strategies such as geographical positioning system-based tracking of USG machines and more stringent laws may help in the future as a short-term measure. In the long run, much work is required to improve the status of women in society and promote women's empowerment.

GLOBAL HEALTH PROBLEM ANALYSIS

This case provides evidence of discrimination against women in Indian society. The problem of female feticide has its origins in the 1950s when the Indian government promoted population control via the National Family Planning Programme (NFPP).[16] Before then, the average family had five to seven children, and most families had at least one son. By 1970s, as per the NFPP two children norm, people in India reduced their family size to two to three children in accordance with the government's stipulations. It seems that this change in family structure and size created demand to exercise some choice regarding the sex of children in their small families. Given that the probability of having a son was significantly reduced in the new, smaller family structure, people resorted to sex determination technology in pregnancy including amniocentesis and USG machines.[16]

Societal perspectives on the status of women in patriarchal India are very different from those in more egalitarian, Western settings. Medical technologies such as USG machines were designed for the early detection of various conditions. Yet in India and other countries, these instruments were misused for sex determination and female feticide.[17]

Along with rapid urbanisation came the concept of the nuclear family. A family consisting of husband and wife living away from their parents with their one or two children became the norm. In a family, if the first child is a girl, the couple tries to get a male baby at any cost, including the use of selective abortions or sex-selecting drugs.[13]

The problem of sex selection and female feticide requires a multifaceted response. Legislation is required, but legislation alone is insufficient.

Indian legislation has played a notable role in bringing about improvement in the role and status of women. The severe disabilities from which Indian women suffered at the beginning of the 19th century were numerous and drastic and have been gradually removed through laws and successive amendments. The PNDT Act 1994 is one such example. The PNDT Act 1994 banned the detection of sex of the fetus. It was listed as a useful means to curb female feticide. However, it was amended in 2002 to become the PC-PNDT Act. This brought preconceptional sex selection techniques into its fold, which was necessary as people started using preconceptional sex selection methods to avoid punishment under the PNDT Act 1994.[18]

Besides India, many other countries have attempted to address the issue of sex-selective abortion. In Canada, for example, a resolution was proposed to condemn sex-selective pregnancy termination.[19] In Arizona, USA sex-selective and race-selective abortion is prohibited.[20] The issue of promulgation of a law on sex-selective abortion is still unresolved in the UK.[21] In 2005, sex-selective abortion was made illegal in China.[22]

In India, despite various measures undertaken, the declining sex ratio continues to be a concern. Haryana, in north India, has one of the lowest sex ratios: 879 women per 1000 men in comparison to the national figure of 933 women per 1000 men.[12]

To address this problem, raids were conducted on USG clinics. Doctors indulging in sex selection and female feticide were arrested. In response, and to avoid arrest, illicit modes of conducting USGs began. Sex selection tests in USG machine-equipped vans stationed at the people's doorsteps were offered.[23] Following raids on such vans also, USG tests began to be offered from mobile vans (USG on the go). Our case study illustrates that, in order to avoid punishment under the PC-PNDT Act, a newer strategy of sex determination test and female feticide by a mobile team with portable USG machines has been devised.

Patient's perspective

Mothers' verbatim response

- 'If we don't produce at least one male child, we will be neglected and isolated from society.'
- 'We are considered as a machine of reproduction.'
- 'We have also emotions. We do feel concerned about killing our daughters in our womb. But, we have no other choice.'

Learning points

- Female feticide is still widespread in northern part of India.
- Strategies adopted by private doctors for fetal sex determination and female feticide in response to people's demand for female feticide are rapidly changing.
- Short-term measures such as punitive actions on the private doctors for fetal sex determination and female feticide will not help in the long run.
- Since implementation of laws depends much on the social attitudes, legislation, in itself, cannot bring about social change.
- Long-term measures to uplift the status of women in society are needed.

Why this case study is important?

1. Our case study highlights the important and widely prevalent practice of female feticide in northern India.
2. In spite of legislation, people are devising newer strategies for female feticide (via a mobile van, in this case, to avoid punishment) to meet societal demands to beget a male child at any cost.
3. Female feticide is double tragedy for women. First, she has to bear loss of a fetus. Second, the process compromises her health as the procedure is done in an illegitimate and unsafe manner.
4. Along with legislations such as the Pre-Conception and Pre-Natal Diagnostic Techniques Act, empowerment and skill development of women are also necessary in order to bring an end to female feticide.

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