NATIONAL WORKSHOP ON MISSING INDIAN FEMALES: MAPPING THE ADVERSE SEX RATIO

16-17 December, 2003, Organized by Gender Resource Centre, Ahmedabad

A Report

Objectives:

1. To outline trends in sex ratio
2. To highlight sources of gender bias
3. To investigate inter-linkages between sex selective abortion and decline in fertility
4. Locating the resulting social impact
5. Work out framework of intervention in the areas of advocacy, legal system, reproductive health service delivery and research
6. Building a network on PNDT Act implementation involving different stakeholders.

Resource Persons

1. Dr. Divya Pande, SNDT Women's Studies and Research Centre, Mumbai
2. Dr. Irudaya Rajan, Centre For Development Studies, Thiruvanthapuram, Kerala
3. Dr. Leela Visaria, Gujarat Institute Of Development Research
4. Dr. Vibhuti Patel, Centre For Women's Studies, Department of Economics, University Of Mumbai
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6. Ms. Ila Vakharia, Programme Officer, Centre For Health Education, Training & Nutrition Awareness(CHETNA), Ahmedabad
7. Ms.Nupur Sinha, Executive Director, Centre For Social Justice, Ahmedabad
8. Dr. Trupti Shah, Secretary,Sahiyar Stree Sangathan, Vadodara
9. Ms. Sheela Maru, Kachchh Mahila Vikas Santhan (KMVS), Bhuj

Chairpersons

1. Ms. Indu Kapoor, Director, CHETNA
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3. Shri Binoy Acharya, Director, UNNATI, Gujarat
4. Dr. Arati Nanavati, Jt. Director, Women's Studies & Resource Centre, MS University, Vadodara, Gujarat
5. Ms. Asha Dalal, President, Jagrut Mahila Sangathan, & Chairperson, PNDT Committee, Anand, Gujarat
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Participant Profile: 140

NGOs:
Subhay Mahila Utharsh Trust (Bhavnagar), ANANDI, Vardh Gruh Udhyog Mahila Mandal (Wadhwan),Vikas Adhyayan Kendra, CHETNA, OLAKH (Vadodara), AWAG, Deepak Charitable Trust, Sarvodaya Matla Udyog Mandal, Jyoti Sangh, Sahiyar, SAMANVAY, TALEEM, SEWA, PARIVARTAN, Young India Association, VIKSAT, Gujarat Musturast Sewa Trust, Swadhar Widow Home, Navyuvak Seula Samiti, Jyoti Samaj, St. Xavier's Social Service Society, Swati, Bhagini Sahayak Sahakari Mandali (Visnagar), Association For Social Health.

INSTITUTIONS/
Gujarat State Law Commission, EMRC (Gujarat University), Gujarat State Disaster Management Authority, Gujarat State Crime Prevention Trust, DPEP (Gandhinagar), ICDS (Gandhinagar) , WLRP (Ahmedabad) Anjuman Islam Teacher Resource Centre (Ahmedabad).

REPRODUCTIVE HEALTH PERSONNEL:
Doctors: PS Medical College, Sheth VS Medical College, Sarjan Maternity & Nursing Home.
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MEDIA
Doordarshan (Ahmedabad), Times Of India, The Indian Post, Gujarat Samachar, India Today, Indian Express, Deccan Herald, Industrial Goal.

- **Acknowledgement: To OXFAM for printing posters in Gujarati & English, focusing on the theme of the workshop**

Report on Technical Sessions:

The concept of "missing women" presented by noted economist Amartya Sen eleven years ago, refers to the deficit of women in many parts of Asia and north Africa, which arises from sex bias in relative care. Even with the use of different standards for comparison of the female: male ratio, the number of missing women are very large. Had things changed in more recent times? Not much, at one level. The ratio of women to men in total population was changing slowly but had not altered radically in either India, Pakistan, Bangladesh and west Asia. The total number of missing women continued to grow, 101 million according to one estimate, for the world as a whole, owing mainly to the absolute growth in population.

However, much more significant change had occurred over the past decade. There have been two opposite movements:

a) female disadvantage in mortality had reduced substantially
b) new female disadvantage at birth through sex specific abortions directed against the female foetus was growing

The widespread use of new reproductive technologies had made sex selective abortions possible and easy and studies show its wide use in many societies. Despite the incompleteness of birth registration in India and the difficulties in calculating the sex ratio, the 2001 Census has revealed a sex ratio of 933 women to 1000 men, a deficit of 3.5 crores women as India entered the new millennium. These are yet early days and as sex determination is becoming more standard, touching all communities irrespective of caste, class, religious, ethnic, educational backgrounds, the sex ratio in India will continue to fall. These prospects look quite possible despite the Pre -natal Diagnostics Techniques (Regulation and Prevention of Misuse) Amendment Act (PNDT ACT), 2002 which provides for "prohibition of sex selection, before and after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or sex linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto". This amendment also provides a wider scope to the implementing machinery to curb the practices contributing to missing girls.

Also, the variations within India are large and all India averages conceal the fact that in several states, in the north and west of India, the child sex ratio (female children per 1000 male) in the 0-6 years age group is very much lower than the Indian average and lower than even China and Korea. The deficit of girl children has steadily increased and during 1991 and 2001, the decline was sharpest in some of the districts in the states of Haryana, Punjab, Gujarat and Maharashtra , suggesting the wide prevalence of the practice of sex selective abortions in these areas. During 1991-2001, the number of girls per 1000 boys has declined in almost all districts of Haryana, Punjab and Gujarat. In 13 of the total 19 districts in Haryana and 7 of the 25 districts in Gujarat, the decline was more than 5% or 50 or more per 1000 children and much more in certain districts in these states. According to the 2001 Census, in India there were 49 districts where for every 1000 male child in the 0-6 age group, there were less than 850 female children. A large

majority of these districts were located in the north and western states of Punjab, Haryana and Gujarat. The decline in the child sex ratio during 1991- 2001 in Haryana from 879 girls per 1000 boys, in Punjab from 875 to 793 and in Gujarat from 928 to 878 suggests higher incidence of sex specific abortions. A disturbing division of the country into two nearly contiguous halves, all states of west and north on the one hand, east (except pockets of Orissa) and south on the other, calls for intensive research today on sex bias in birth just as the sex bias in mortality- the original source of "missing women", did over a decade ago.

The "northernisation" of the adverse sex ratio (0-6 age group) was also rapidly taking the urban route. The concentration of new reproductive technologies in urban areas has made possible the selection of the desirable and rejection of the unwanted. Sex selective abortion has become the more acceptable mode of disposing of the unwanted girl child. Even as the business of such " service providers" thrives in the urban areas, it starts attracting clientele from nearby rural areas .They then start providing mobile services too. These services gradually touch the lives of larger sections of the rural population. The child population thus turns more and more masculine, as evident from the 2001 Census results of Punjab, Haryana, UP, Himachal Pradesh, Gujarat, Maharashtra.. Studies indicate that discernible clusters where rural female: male sex ratios are significantly more masculine may have had an earlier history and prevailing pattern of female infanticide co-existing with or replaced by sex selective abortion. Tamilnadu presents disturbing trends in 1991 and 2001. Here, rural female: male ratios among children in some districts have been lower than the urban ratios and even declined faster than the urban ones.

The trends discussed above are increasingly being situated in the literature on gender, education, paid work participation, changes in marriage systems, poverty, prosperity. Many sociological studies point to increased female subordination among sections of prosperous groups leading to unequal access to life sustaining resources: nutrition, food, health care for female members. The denial of life sustaining inputs itself may not follow uniform pattern. At some prosperity levels there may not be denial in consumption of a particular food, say rice or wheat, but there may be inequality in the access to health care. A more violent manifestation of this inequality among these groups is the denial of right to life of girl child through infanticide and sex selective abortion. Masculine sex ratios are seen among prosperous groups in rural and urban areas. However, was it prosperity per se or women's role and contribution to that prosperity or women becoming the marker of the new status and prosperity of households(through women's withdrawal from productive activities outside the household and enforced seclusion) that determined the girl child's survival chances?

Using gender sensitive indicators to conventional markers of development such as urbanization, studies have not only viewed sex selective abortion as part of gender based violence but also highlighted the resulting forms of domestic and social violence owing to the deficit of females. Linkages are also drawn between different forms of violence against women, thereby pointing to the need for evolving strategies of intervention at many levels to end all forms of violence and discrimination.

Conversely, studies using conventional gender sensitive indicators, such as education which is viewed as promoting women's agency, need to distinguish between the concepts of education for empowerment versus schooling for subordination and consider whether content and context of schooling/education reinforces rather than transforms traditional prejudices. Similarly, where women's paid work is associated with lower gender differences in child mortality, there was a need to look at gender biases in the labour market. While there was growing opportunities for skilled, educated urban women, these too are marked by occupational, wage and "pre-entry human capital discrimination." Despite gender bias in society acting as a barrier to the recognition of women's economic contribution to the household, economically active women are still best placed to overcome biases against daughters.

The persistence of gender bias in the form of infanticide and sex selective abortion has been linked to the processes of modernization and as continuation of family strategies noted in 19th century India, of parents' manipulation of family size, sex composition and children's marriage arrangements to maximize their families' economic and social status. Upward mobility is strategised by families/ households along kinship/ caste network ties and marriage of children forms a significant component. Also, the interlinkage of productive (work) and reproductive (marriage) domains result in women's work and education being subject to the needs of marriage. Marriage and motherhood remain markers of kinship and family identity and studies of urban Delhi and rural Rajasthan show how education and work decisions for females was made to guard female sexuality and inevitability of marriage.

Recent studies have focused on the need for deeper understanding of the issues surrounding the practice of sex selective abortions at the level of the household and from the perspective of women who undergo such abortions. What compels couples/ their families to resort to such practice, who takes the decisions in the family, what impact does female selective abortion have on the mental and physical health of the women who undergo abortion in second trimester of pregnancy? There was limited data on how the desired number of children are perceived and articulated Primary data (qualitative & quantitative) of low child sex ratio districts, Mahesana in Gujarat and Kurukshetra in Haryana by calculating sex ratio of all live births by birth order as well as the sex ratio of the last birth occurring to all women highlighted the following:

a) The preponderance of male children or deficit of girls increased as the birth order increased.
b) The deficit of girls among second and third child was much greater for women who were educated beyond primary level, women who were not economically active or women who reported themselves as housewives, women who were from the upper castes and women from landed and asset holding households.
c) Sex ratio of last births had greater deficit of girls than sex ratio of all other births. The sex ratio was most skewed among upper caste, landed women, among women with some education or those who were older in age. If the last birth was that of a son and if couples attained the desired number of sons, they refrain from having another child. Conversely, if the last conception/birth was

a girl, child bearing continued until a son was born. The girl may be allowed to be born or aborted.

d) Group discussions among diverse socio- economic, educational groups in the two districts of Gujarat and Haryana indicate that the majority of women would accept the outcome of first pregnancy- male or female. If the first child was a girl child, upper caste women were directly or indirectly pressurized by parents and mothers in law to go in for sex determination tests, to ensure that the second or third child was male.
e) Women widely and openly acknowledged son preference.
f) Dowry and fear of the married daughter being sent back to natal home for not meeting dowry and other demands, were cited as strong deterrent to accepting girl child.
g) After the birth of a girl as first child, couples resorted to sex determination tests. They were aware of its availability, costs, the details of its procedure and that such tests were not done in public hospitals
h) There was a deep internalization of patriarchal values and this was clearly linked to their sense of security

At a broader level, the concept of "choice" has been the site of several debates with a noted woman economist holding a fatalist view that it was better not to be born rather than face infanticide. The notion of " women's own choice" to abort the female foetus recalls an earlier, mid 1980s notion that women committed sati "voluntarily", notions which negate not only women's right to life but also mask the social conditioning that deny social worth to women. There was a need to differentiate these retrograde notions of "choice", from women's reproductive right to control their own fertility, to enjoy legal and safe abortions.

Professionals, including doctors citing a "law of supply and demand", have argued that if the supply of women were reduced, their demand would be higher, the scarcer the women, the higher their value! Studies of communities in Haryana, Punjab and in Gujarat have pointed to the resulting social impact of extreme adverse sex ratio- increasing incidence of violence against girls and women – abduction, rape, forced polyandry, bride being shared by patrilateral parallel cousins, sale of women. Also, in need of debate were notions of "balanced family" and the need to link it with a position opposing sex determination and sex pre-selection leading to female and male foeticide. While it may be felt that outreach and popularity of sex pre-selection tests may be greater than those of sex determination tests, as the former did not involve ethical issues related to abortion, the social consequence of sex selection as well as sex determination tests, shattered the myth of value neutrality of science and technology. Such tests for femicide have gained ground in China after its adoption of the "one-child family" policy, indicating that vestiges of patriarchy and its value systems can strengthen its roots in varied social systems. Recent studies on South Asia have indicated the cultural legacy of strong son preference among all communities, religious groups, citizens of varied socio-economic backgrounds. Patri-locality, patri-lineage, patriarchal attitudes are manifested in girls/ women having a subordinate position within the family/household, lack of

property rights, low paid/unpaid jobs and women's household work being treated as non-work. Women are perceived as burden and dowry was the grooms demand for shouldering " the burden" of the bride.

How can a stop be put to the deficit of women? There have been varied responses over time, since the late 1970s when umbrella organization of women's groups, medical personnel, peoples' science organizations , health groups, women's resource centres campaigned at many levels and in 1988, the Maharashtra Assembly passed a Bill to regulate medical and scientific techniques of pre-natal diagnosis. With the PNDT Act, 1994 and amended in 2003, regulatory structures are in place, certain loopholes in definitions within the Act itself included:

a) there was no definition of the term "genetics" so persons without a medical degree could qualify as "medical geneticist".
b) No training institute was recognised for imparting legally valid training
c) Qualifications prescribed were minimal in nature thereby enabling untrained/unqualified persons to practice under the Act
d) No explicit provision existed to penalize companies promoting sex selection products
e) The unequal bargaining position of the woman undergoing the sex determination within the family was not taken into account by the Act

There was a need to assess how effective the regulatory structures were and the loopholes in effective implementation of the Act, more so in urban areas. In many states including Gujarat, not a single case had been filed under the PNDT Act.

It was generally recognized that a framework for intervention would include elements (inter-linked) of advocacy, legal system, reproductive health service delivery and research. There was a need firstly for effective messages to different stakeholders through different levels of communication: inter-personal, group and mass communication. Strong advocacy- on the value of the girl child, needed to be backed by effective legal system, sensitization of reproductive health personnel and integrate research findings to raise awareness on the social consequences of declining sex ratio and to enhance the understanding of the value of the girl child. Secondly, to develop networks/ strategic alliances to take up issues at different forums.

The content of advocacy to include the following issues:

a) bias and discrimination against girl child
b) violence (mental/physical) inflicted for not bearing the male child
c) desire to have male child for old age security, family lineage, religious rites
d) resulting social impact such as marriage squeeze, lowering age of marriage , polyandry, kidnappings
e) issues linked with the laws relating to sex selective abortion- inheritance laws, anti-dowry laws

Advocacy also directed at service providers, including how to respond to threats of violence to the mother for not producing male child. Encourage development of self-

regulatory mechanisms in private sector reproductive health service providers through setting up of forums, peer pressure.

There was a need for a strong and positive mass campaign for the girl child. The campaign needed to reach every household/family, in particular among those groups/ regions where the sex ratio has reached alarming proportions and was posing a threat to social harmony. The need was to move to a mix of the possible solutions to mitigate the situation. In the short term, support for universal coverage of survival inputs (immunization, nutrition, registration of births) to minimize the gender gap was necessary. In the long term, the social environment and conditions which can minimize the "unwantedness" of the girl child has to be built alongside a forceful campaign, among all sections of civil society and institutions, to debate the ethical dimensions of sex based elimination of a segment of the population. Positive stories of development and role models where the girl child is valued and women considered as equal partners in development need to be highlighted.