

ON a Friday morning, a man in his mid-thirties quietly walked into a doctor's clinic located on the main road of Shahargaon*, Delhi. The doctor offered him a seat. The man asked, "Is it possible to get an ultrasound done here?"

Dr.: Yes; when do you want it?

Man: As soon as possible. The other doctor says it is already too late.

Dr.: Is that so? How late?

Man: She is around four months pregnant.

Dr.: From where have you come?

Man: I'm from here only. At what time do we have to come for the ultrasound?

Dr.: You can come around 10 a.m.

Man: How much time will it take?

Dr.: Only one hour, then you can go back.

Man: And if we need to get the *safai* (abortion) done? My wife is just four months pregnant.

Dr.: Even that can be done.

Man: How much time will that take?

Dr.: Just another hour.

Man: What about the quality of services.....?

Dr.: We provide the best services in Delhi.

Man: How much will the MTP (Medical Termination of Pregnancy) cost?

Dr.: It will cost you Rs 500-1,500 depending upon the extent to which the pregnancy has progressed. In your case, it is going to be Rs 1,000. We cannot reduce this amount.

Man: And how much is the ultrasound going to cost?

* Shahargaon is not the real name of the village. The accompanying photographs by Paige Passano are from a nearby, though similar village.

Prenatal Sex Determination

A New Family-Building Strategy

Sunil K. Khanna

Dr.: Rs 1,000, but for you it will be Rs 900.

Man: Do we have to come here for ultrasound?

Dr.: Yes. How many kids do you have already?

Man: Two daughters and a son.

Dr.: How old is your son?

Man: Three and a half years old. I am thinking that if it is a girl this time, we will go for the MTP and then we will not try again.

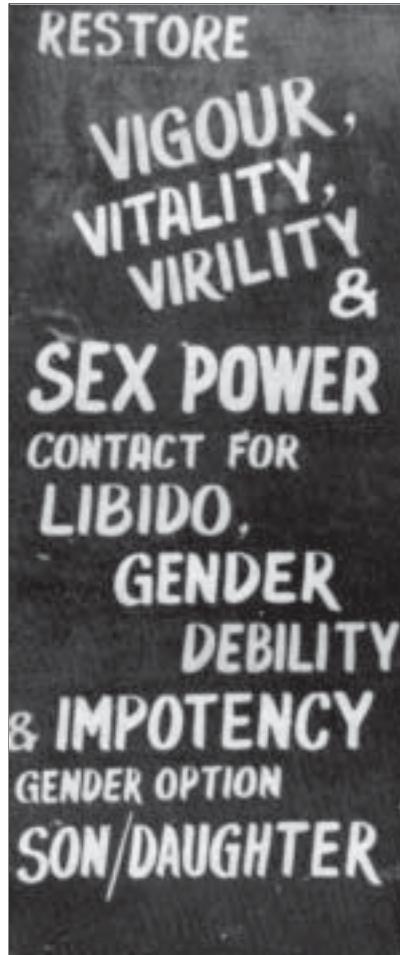
Dr.: That we can definitely tell you, and we will also do the MTP if required. We can also perform the tubectomy. Since she is going to be here and would require some rest anyway after the MTP, she should also undergo the tubectomy operation at the same time.

Man: No, no. First I want to get the abortion done and then we will give her some good *khurak* (healthy diet) and get the operation done after some time. The abortion would definitely weaken her and she would need some good food before the operation.

Dr.: I do not think it is necessary because she can rest at the same time for both the things. She doesn't need double rest.

Man: But she would be weak and we were thinking that we should first give her a good diet, and then get her operated on. If she gets a good diet, let us say for around one month, then she would be ready for the operation.

Dr.: Why don't you look at it this way? If we need to perform the abortion, she would have to rest for a week, and after the operation she would have to rest for



A billboard outside a private doctor's clinic in Delhi

the same time period. Now, if we get both things done at one time, she won't need to do double rest. Nowadays, who has the time to take double rest? There is so much household work for women.

Man: But, I still think that she needs to rest first before getting operated on.

Dr.: Fine, come at ten in the morning.

Man: I am a property dealer and the doctor on the other side of the road referred me to a clinic in a far-off colony. For us, this place is all right since it is closer. Besides, at the other clinic they may make some mistake and complicate things.

Dr.: That place is far away and they would charge a lot in comparison to what you will pay here.

●
I recorded this discussion at one of the clinics for ultrasound and other maternity services. The man left the clinic apparently quite satisfied.

The doctor runs a consultation clinic on the main road of the north Indian village of Shahargaon, a small, urbanising village in New Delhi. In addition to running a general practice, she also provides services and advice to persons seeking prenatal sex determination and medical termination of pregnancy (MTP). She was one of the few doctors I interviewed who was willing to talk about the extent to which different techniques for prenatal sex determination are being used in the area. We discussed the ethical and moral issues involved in prenatal sex determination. The doctor seemed unclear about the legal status of such testing.

In the last 10 years numerous hospital/clinic-based studies in India have documented an increase in the use of amniocentesis and ultrasonography to



Family composition is important

identify female fetuses, followed by abortion to avoid the birth of a daughter. The increased use of sex-selective abortion was confirmed in my ethnographic research in the Jat community of Shahargaon.

Long-term ethnographic investigation, rather than the analysis of census and hospital reports, can best expose the often under-reported and misreported frequency of the use of sex determination technologies. Such research also helps reveal the complexity of the decision-making processes and cultural values behind the practices of prenatal sex determination and sex-selective abortion. It is my contention that where communities that have tendencies towards strong son preference and daughter neglect, gain access to health care facilities and prenatal sex determination technologies without a shift in cultural values, there is an increase in the skewing of the sex ratio at birth towards males, and a more balanced sex specific infant mortality rate.

SDTs in North India

Since the 1970s there have been calls for strict government control over prenatal sex determination

techniques, seeking to limit their use to the detection of genetic abnormalities. The issue of prenatal sex-determination has sparked intense public debate in India. Many activist organisations, women's groups and voluntary agencies have condemned prenatal sex-determination as "female foeticide" and as a misuse of technology. In addition to ethical and discriminatory issues, there exists an ongoing debate on the demographic and social impact of prenatal sex determination followed by sex-selective abortion.

The residents of Shahargaon, a community undergoing rapid urbanisation and social change, have received increasing access to health care facilities and reproductive technologies. This has occurred over the past five years, as their rural village was engulfed by the expanding Delhi metropolis. The agricultural land of the village was acquired by the State. The recent availability of prenatal sex determination technologies in Shahargaon serves as an alternative to sex-specific mortality in regulating family composition. The new reproductive technologies offer the

Shahargaon Jat community a new strategy to create the “ideal family” composition in terms of sons and daughters without an increase in family size, within the context of a patriarchal system of son preference and control over women’s reproduction.

I observed that clinics the villagers attended providing prenatal sex determination and abortion facilities rarely maintained records. Test results were usually conveyed verbally. In-depth and repeated interviews with doctors providing these facilities helped me gain information usually not volunteered in briefer, formalised encounters. Furthermore, long-term participant observation served to establish rapport in the community, thus enabling me to collect and cross-check sensitive information.

A village census was conducted to collect basic demographic information. Reproductive histories of all Jat women in the village who have ever been married were recorded. Questions included age at menarche, age at consummation of marriage, pregnancy history, number of living and deceased children, reproductive complications, use of ultrasonography, place of delivery, use of birth control, induced and spontaneous abortion, desired family composition, and age at menopause. Interviews with family members were conducted in order to understand the intrafamilial dynamics in the decision-making processes surrounding prenatal sex determination and sex-selective abortion. The village midwife was interviewed, as well as eight doctors practising in ultrasound, maternity, and abortion clinics in the surrounding areas of Shahargaon.

It is apparent that sex-selective abortion following ultrasound is a common practice and is increasing in incidence in the area. Techniques like



A section of the village market

amniocentesis, ultrasonography, chorionic villus sampling (CVS), and foetoscopy are in wide use for prenatal sex determination in north India. This study of Shahargaon and the clinics providing such facilities suggests that ultrasonography is the primary technique in use and that other techniques are less often used for prenatal sex determination.

A Village in Transition

Jats form the dominant group in Shahargaon in terms of numbers and economic status. Other groups in the Shahargaon community include Brahmins, Nais, Chamars, Kumhars, and other Harijans. More recently, some refugee families from Bangladesh and Nepal have settled in the village. This particular section of the Shahargaon population usually live in the village for a short time before moving on (Table 1).

Prior to government land acquisition in 1964, Jats owned all of the agricultural land in the village and were given compensation by the Delhi Development Authority (DDA). Shahargaon retained its rural characteristics well into the 1970s despite the fact that many residents were

employed in New Delhi and that many development agencies targeted the region throughout the 1960s and 1970s.

Agricultural activities declined sharply in the 1970s, with a corresponding increase in the number of Shahargaon residents seeking employment as wage labourers in New Delhi. Some Shahargaon men obtained government positions while a large number are unemployed with occasional and part-time offers as bus drivers, security guards, and other low paying jobs. A high level of unemployment in the village has been a matter of concern at both the family and the village level. The village way of life has been considerably influenced by its close proximity to the surrounding DDA residential colony, which brought with it “modern” facilities such as ultrasonography and maternity centers.

Son Preference

In Shahargaon, what concerns the Jats most is whether the child is a *beta* (son) or *beti* (daughter). These terms constitute and invoke an entire set of cultural values and behavioral norms associated with the sex of the child.

Table 1: Population Composition* of Shahargaon

Caste	Population	Average Family Size
Jat	777	5.98
Others	289	6.57
Total	1066	6.13

*based on household census figures, Sep. 1993

For example, the birth of a son is considered to be a “gift”, or an economic and political asset associated with the honour of the family, whereas a daughter is born as *ek lakh ki larki* (An expense of Rs one lakh), and is a moral burden and threat to the honour of the family. In Shahargaon, sons represent the strength of their family in the community. A family with fewer sons is perceived as economically and politically weak. Due to unemployment, steadily decreasing job opportunities, and the exclusion of Jats from job reservation benefits, the Shahargaon Jats are facing severe economic strain and are finding it very difficult to manage in these days of *mehangai* (inflation). For most Jat families in Shahargaon, the only available occupations are shop keeping or some cottage industry like tailoring or book binding.

In the traditional Jat Shahargaon agricultural community, sons were highly valued as agricultural labourers and for political dominance in the village. Although a shift in the economic and occupational base of the village has occurred and the village is no longer a politically self-contained unit, son preference continues and women's roles have not changed much. Women and their contributions continue to be devalued in the community, perhaps as a demonstration of the tendency for ideological change

in gender relations to lag behind overall changes in a society. Entrepreneurial opportunities have expanded in Shahargaon, yet women are denied access because they have become more restricted to the household than they were when the community had an agricultural base and way of life. This was explained as due to fear of “outside influences” and a “corrupt and dangerous modern world” According to a Jat woman: “Most economic opportunities are for men; women can't work as shopkeepers and if we do such work, our *amir* (rich) relatives taunt our menfolk and say that *lugai se dhanda karvata hai* (they make their wives work for money).”

Traditions and practices surrounding the devaluation of women and son preference continue, as observed through current village folklore, despite changes in society and technology. Some of the commonly used proverbs expressing strong son preference in Shahargaon include: *Jitne ladke utne lath, jitne lath utna kabza*. (The number of sons is equal to the number of sticks and the number of sticks decides the amount of land controlled by a family), *Jisne gharka dudh bache diya, usne apna poot bache diya*. (Selling milk is like

selling a son) Common household names for daughters in the Jat community include: *Rambatheri* (Ram, this one is enough) and *Rambheji* (This one was sent by Ram, he will take care of her). As observed in Shahargaon, gender specific folklore and folk songs express the emotional and psychological distress of North Indian women who have given birth to a daughter, including stories of suicide, distress over patrilocality, psychological and emotional isolation, death wishes, and pain and sorrow associated with the role of a woman, especially as mothers and wives.

Traditional Practices

Before the introduction of ultrasound, Jat women in the village used traditional methods to determine the sex of a fetus. For example, a dream of a fruit or a flower was indicative of a male foetus while a dream of vegetables indicated a female foetus. My discussion with the village midwife from the Harijan community revealed that many traditional prenatal sex determination techniques are still used in the village (Table 2).

Abortion on the basis of results from traditional prenatal sex determination techniques was rare. Some of my informants also implied that families had insufficient confidence in the results gained through traditional methods. According to an informant: “There are some old women in the village who can accurately predict the sex of a child but nowadays people have more reliable machines which tell the sex of the foetus and it is much easier and prestigious.”

Families have a higher degree of confidence in the reliability of the results of ultrasound. The new reproductive techniques also provide a more private way to learn the sex of the unborn. Since decisions to use sex-selective abortion are made within the



Table 2: Traditional Prenatal Sex Determination Indicators

	Daughter	Son
Time of Conception	Krishnapaksh (Conceived during dark phase of the moon)	Shuklapaksh (Conceived during the bright phase of the moon)
Physical Changes	Nipples turn black Fetus can be felt on the left side More bulge Elongated bulge Dark lines below the naval region Mother would feel lazy Mother would sleep on her left side Mother would lift her right foot first	Nipples turn light Fetus can be felt on the right side Less bulge Round bulge No dark lines below the naval region Mother would feel active Mother would sleep on her right side Mother would lift her left foot first
Food Preference	Mother would like to eat washed pulse Mother would prefer spicy food	Mother would like to eat sweet food Mother would prefer mild food

family and there is greater confidence in the new technology, families are more inclined to seek sex-selective abortion of a female foetus with the advent of modern technology.

Demographic Trends

In 1993, the birth rate in the Shahargaon Jat community was 32.18 per thousand population. There exists a growing disparity between the number of boys and the number of girls. In the Jat community, boys significantly outnumber girls in both the 0-1 and 0-5 age categories (Table 3). This disparity cannot be explained on the basis of sex-specific infant mortality since, in the past five years, an almost equal number of boys as of girls have died (3 boys and 4 girls in the 0-1 age category).

The Shahargaon Jat community has responded to urbanisation, increased access to medical care, and family welfare facilities by lowering family size (average family size is now 5.98), and by increasing the number of sons per family relative to the number of daughters. These landless Jat families now consider two sons

and one daughter to be the ideal family composition. For them, one daughter is *bahut* (more than enough). Families rarely expressed preference for two daughters. What constitutes an “ideal family” in terms of birth order is also important to Jat families. Most Jat families prefer two sons before the birth of a daughter. In order to achieve the “ideal family” in terms of birth order and sex composition, prenatal sex determination and sex-

selective abortion are widely used in Shahargaon (Table 4).

If we reintroduce the aborted female foetuses the absence of daughters due to sex-selective abortion is taken into account; the number of boys and girls in the 0-1 and 0-5 age groups in the Jat population becomes approximately equal, as can be seen in Table 5. The lack of high female infant mortality and the high rates of abortion of female foetuses suggest



Table 3 : Age-Sex Profile of the Jat Child Population (0-5 years) in Shahargaon

	0-1 Age Category			0-5 Age Category		
	Male	Female	FMR	Male	Female	FMR*
Jats	15	10	667	94	65	691

*FMR= females per thousand males

that the highly skewed sex ratio in the Shahargaon Jat population of children five or younger can be largely attributed to an increase in the use of prenatal sex determination and sex-selective abortion of female foetuses, rather than to higher infant or child mortality among these girls as compared to the boys.

Among the Jat children ages 0-5, 78 per cent of the girls are first-born daughters, and in most cases follow the birth of one or two sons. Due to a strong preference for either an all-sons or two-sons-followed-by-a-daughter family, prenatal sex determination and sex-selective abortion are most often used to obtain a son as the first and/or second child born and is rarely used once two sons have been born into a family. A daughter is never selected for, yet if there are additional pregnancies a second daughter will be selected against. Once the desired family composition has been achieved, Jat couples consistently use contraceptive methods to avoid additional pregnancies.

Popular Perceptions

In interviews, both men and women in the 18-50 age group openly expressed their views on prenatal sex determination and sex-selective abortion. Almost every couple in the village knew about ultrasonography, the "machine which tells the sex of the foetus". Younger couples (20-35 years) were more informed about the availability and use of prenatal sex determination technologies. Most

women learned about ultrasonography through other women who went to a hospital or clinic for examination during pregnancy. Most individuals know that the "machine" can tell the sex of the foetus after the third month. General opinion holds that a woman should delay the examination as much as possible to reduce error in sex determination. Two widely known misreportings of the sex of a foetus determined through ultrasonography in earlier months led to the popular opinion that in order to avoid acci-



Table 4 : Reported incidence of the use of Ultrasonography and Sex-Selective Abortion among the Shahargaon Jats

Y e a r	PSD > XY	PSD > XX	PSD > XX > SSA
1 9 8 9	-	-	3
1 9 9 0	-	-	2
1 9 9 1	1	-	1 0
1 9 9 2	6	2	6
1 9 9 3	4	-	7

PSD > XY: Prenatal sex identification of a male fetus not leading to sex-selective abortion;

PSD > XX: Prenatal sex identification of a female fetus not leading to sex-selective abortion;

PSD > XX > SSA: Prenatal sex identification of a female fetus leading to sex-selective abortion

dently aborting a male foetus, the ideal time period for prenatal sex determination should be during the fourth month.

There is little concern over the effect of repeated late abortions on women's health. Through interviews, I routinely heard of one abortion per year and as many as three abortions per year to achieve the "ideal family". Regarding how many times abortion is safe, a young Jat woman responded in a manner which clearly demonstrates the harsh, life-threatening bargain which women must strike in order to survive in Shahargaon: "In order to get a son, the mother should be ready to undergo a lot of hardship, even face death. Once she gives birth to a son, everything will be all right and all the hardship will end, but if she does not have a son, her life is better not to have been lived."

This seemingly uniform and uncontested representation of women's compliance, so much supported by the data on the sex ratio, does have instances of resistance. One Jat mother in the village left her affinal home and went to her natal village because her husband was forcing her to go for an ultrasonographic examination. According to her: "This is a *pap* (sin). We should not interfere in God's design. Whatever God will give us,

Table 5: Sex Ratio as corrected for the reported incidence of Sex-Selective Abortion in 0-1 year and 0-5 year age groups among the Shahargaon Jats

Community	0-1 Age Group			0-5 Age Group		
	M	F	FMR	M	F	FMR
Jats	15	17	1,133	94	93	989

we will accept. This is my *bhagya* (fate), and one cannot win against fate. One must learn to accept it."

A young Jat mother in the village recalled talking to her unborn daughter the night before her abortion asking for her forgiveness and promising her that next time when she would come in her "belly" she will live. In yet another instance, a wife refused to cohabit with her husband after he forced her to undergo a sex-specific abortion.

To Sum Up

Shahargaon Jat families are replacing traditional fatal neglect of unwanted female children with sex-selective abortion as a strategy to achieve their desired family composition. Apart from a strong son preference at the family level, numerous community level characteristics such as caste, class, religion, and local village politics influence the formation of an ideology which devalues women, and in particular, daughters.

The new and widely available prenatal sex determination technologies are perceived as prestigious and reliable. These technologies allow women to avoid the disadvantages of carrying to full term and then producing unwanted daughters. For this reason, in Shahargaon, sex-selective abortion is becoming the main cause of an exceptionally highly skewed sex ratio in the child population of the village Jats.

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