A Less Valued Life: Population Policy and Sex Selection in India

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Introduction

In this policy analysis, based mainly on secondary data and documentary review, the link between population policies and use of sex selection as part of family building strategies will be examined. Recently, both the national and state governments have formulated population policies to hasten the transition to replacement level fertility. Implementation strategies include the use of incentives and disincentives and an inordinate focus on sterilization. At the same time recent shift to smaller families has not necessarily been accompanied by a concurrent shift in the social and economic pressures that underlie preference for sons over daughters. Therefore the implementation of coercive population policies could well result in the increased acceptance and reliance on the use of sex selection strategies to plan smaller families and ensure the birth of desired number of sons. It can be concluded that these policies often ignore the gender dimensions of reproductive decision-making, and thereby sustain and at times even exacerbate gender-based inequities.

Population Stabilization – Recent Developments

In India, the national government and a number of state governments are increasingly resorting to aggressive measures to implement the two-child norm (total fertility rate of 2.1). Most of the current policies include incentives and disincentives as part of a broader strategy to `motivate' large numbers of couples to adopt the small family norm. Incentives for example are in the form of preferential allocation of housing and other public funded programs for couples below the poverty line who undergo sterilization after the birth of the second child (NPP,2000; GOAP, 1997; GOUP, 2000). Disincentives range from debarring anyone who marries below age 18 to be eligible for government jobs to denying promotions or other job related benefits to those who have more than two children (GOUP;2000; GOAP, 1997). In several states, laws have already been adopted that disallows individuals who have more than two children from contesting local government elections and disqualifies officials if they violate the norm after they have been elected to office.[1]

Recently, politicians and judges at the highest level have come out in favor of the use of laws to hasten the government's population control efforts. The need to formulate national and state-level legislation similar to the existing legislation at the local government level has gained legitimacy and support within public policy dialogue. The Supreme Court of India (September, 2003) passed a judgment upholding the Haryana government's legislation that disqualifies individuals with more than two children from

[1] The Constitutional (Amendment) Act, 1993, commonly referred to as the Panchayati Raj Act, mandated the devolution of power to local bodies. The three-tier system of local governance is based on the district as the administrative headquarters, with power being further devolved to the block and village levels. Some states have since legislated to devolve power and the necessary finances for administration right down to the village level.

contesting local government elections. The Deputy Prime Minister of India speaking on the occasion of World Population Day also proposed the idea of legislating on a two-child norm using disincentives for those who violate the norm, including barring them from contesting elections (The Hindustan Times; 16 July, 2003). In a recent article in a leading Indian news magazine another aspect of this growing trend was brought to light. A draft document prepared by the Department of Family Welfare appears to reveal an implicit trend once again towards population stabilization and the adoption of a supply-side approach in its programs rather than continuing with the existing strategy of community needs assessment adopted as part of RCH-I (Rajalakshmi; Frontline, Volume 20(18), 30Aug-12 Sept,2003). This approach is also reflected in the Government of Rajasthan's recent formulation (2003) of district level action plans that has as its central objective the attainment of replacement fertility by 2011 and the inclusion of contraceptive targets to reach that goal with little or no emphasis on community needs nor any meaningful attempt to address the socio-cultural, economic and gendered context within which fertility-related decisions take place.[2]

Son Preference and Sex Selection in India

There are numerous accounts of the prevalence of strategies for discrimination against girl children. This has ranged from female infanticide (George, 1997; Venkatachalam and Srinivasan, 1993; Chunkath and Athreya, 1997; Das Gupta,1987) to care and food related deprivation. Further, there is growing evidence to suggest that excess female infant mortality currently contributes significantly to the overall decline in the sex ratio in India (Miller,1981; Sudha and Rajan,1999; Census of India,2001). Data collected in the 2001 Census of India reveal that the juvenile sex ratio has declined steadily over the past decade, from 945 girls per 1,000 boys age 0-6 years old in 1991 to 927 girls per 1,000 boys in 2001.[3] This decline has been attributed both to excess neo-natal female mortality, and to the rapidly expanding use of pre-natal diagnostic technology for the purpose of sex determination (SD) followed by use of sex selective abortion (SSA).

The root of son preference in India lies in deeply entrenched social, cultural, and economic discrimination against women and girls. The predominant system of patrilineal descent and inheritance legitimize and propel the desire for sons. Sons, for example, traditionally perform the last rites after the death of a parent. Indeed, a strict interpretation of Hindu tradition hold that salvation in the afterlife can only be achieved if a son lights his parent' funeral-pyre (Mutharayappa, et al.; 1997). As a result, many religious Hindus strive to ensure they have at least one son.

Economic calculations are increasingly a factor in the perpetuation of son preference. In much of the country, men and boy are more likely to work for cash wages than are women and girls. Although women often work longer hours than men, they are more likely to be engaged in unpaid subsistence and domestic work that, while critical to family survival, is ironically perceived to be less valuable. At marriage, daughter leave

[2] See CHANGE Action Alert http://www.genderhealth.org/rajasthan.php?TOPIC=PRG

[3] In India, by convention sex ratio is stated as the ratio of females to males. The same measure is used for the purpose of this paper.

their natal home and must bring a dowry to their husband's family, to which they are also expected to contribute economically, whether in the forms of paid or unpaid work. Sons are expected to support their parent in old age, and therefore are viewed as a source of social security.

Infact, the desire to accumulate wealth has become an important factor in son preference in recent years, in part as a result of the desire among the growing middle class for upward mobility. The spread of consumerism and the associated increase in the cost of dowry and marriage, plus the desire to maintain landholding within a family contribute to an environment that is extremely hostile to women and girl children, even among the educated middle and upper classes. Indeed, contrary to what might be expected, the most dramatic decline in the sex ratio over the past decade were found in Punjab, Haryana and Maharashtra, among the richest state in India (Census of India; 2001).

Evidence collected in the Eighties indicated widespread prevalence of clinics in urban centers that exclusively performed sex determination. For example one study (1986) estimated that there were 248 clinics and laboratories, and approximately 16,000 tests performed in the Mumbai metropolitan region annually (Lingam; 1998). In another survey conducted amongst 50 gynecologists in Mumbai, 27 admitted that they performed amniocentesis for the sole purpose of sex determination. It was further calculated that on an average, 42 gynecologists perform 271 SD tests per month (Kulkarni[4] quoted in Lingam; 1998). There are reports from Punjab that the state has close to 1500 ultrasound clinics (UNESCO Courier; 1999). This is in all likelihood a conservative estimate, as it has been pointed out that Punjab has one of the highest sex ratios at birth (1.20) in the world indicating a very high level of sex-selective abortion (Retherford and Roy; 2003b:2). In Haryana, in one district, Faridabad, alone 65 ultrasound centers have been registered (The Week; 2001). In Alwar, a small town in Rajasthan, there are close to 20 diagnostic laboratories (Outlook; 2002). The current cost of obtaining an ultrasound test for sex determination can fluctuate between Rupees 500-1500 ($10-30).

It is now indisputable that, as India enters the 21st century, SD and SSA have been integrated into the range of family building strategies used by couples to ensure a desired "imbalance" in the number of male and female offspring. What is less well understood are the ways in which population policies supported by both the government and international donor agencies can fuel the insidious use of modern technology to eliminate girl children even before they are born.

Small and `Gendered' Family Norm

Average family size in India has been declining over the past decades, in response to a number of economic and social changes, including rising aspiration for children coupled with the increased cost of rearing them, and the entry of large numbers of women into the formal labor force. Such changes have taken root more quickly among some segment of

[4] Kulkarni, S. n.d. `Prenatal Sex Determination Tests and Female Feticide in Bombay City- A Study.' Mumbai: Foundation for Research in Community Health. Mimeo.

the population than other, and families of three children remain the norm in a number of states.

The shift to smaller families now evident in India has not, however, been accompanied by a concurrent shift in the social and economic pressure that underlie the preference for sons over daughters (George;1997). The National Family Health Survey – 2 collected information on the role that son preference plays in determining family planning practices. At the all-India level 83 percent of ever married women age 15-49 with two sons and 76 per cent with one son said they did not want any more children. On the other hand significantly fewer women, 47 percent, with two daughters said they did not want more children (IIPS and ORC Macro; 2000:7).

Further, Retherford and Roy (2003b:3) use NFHS-2 data to point out that this trend currently appears to be strongest in families that already have two children. This they attribute to the fact that the current TFR for India is about three and as a large proportion of women wish to stop childbearing after having three children a strong sex preference, mainly for sons, clearly determines the third birth order. It is also worth highlighting that son preference and abortion can be linked in two distinct ways. In another analysis using NHFS data the authors suggest two specific ways son preference and abortion can be linked. First, through the specific use of SD and SSA to identify and eliminate female fetuses and second is abortion decisions that purportedly appear to be for family planning but the sex of living children constitutes an important basis for the decision (Arnold, Kishor, et al.; 2003:769).

The pressure to have sons has intensified as couples strive simultaneously to reduce family size and ensure the birth of the desired number of sons, leading to increased acceptance of and reliance on the use of sex selection strategies to achieve these results. The use of coercive measures in implementing population policies particularly undue emphasis on the use of terminal methods can easily lead to an intensifying trend towards sex determination and sex selective abortion.

Shifting Patterns and Intensification of SD and SSA

All of these factors - son preference; the unregulated spread in the political economy of diagnostic technologies and growing desire for smaller families as a result of the fertility transition that is currently underway in India - have served to create conditions where SD and SSA can flourish. This practice needs to be seen both as a shift as well as intensification of discrimination against females.

Data collected during NFHS-1 and NFHS-2 on the sex ratio at birth has been used as an indirect indicator of SSA to assess both prevalence and determinants of the practice. Retherford and Roy argue that different factors influence the levels of SSA confounding the effect of any single variable. Some of these important predictor variables include a composite variable of both the child's birth order and its mother's number of living sons before its birth; education levels and urban-rural residence. All of these characteristics are the one's most strongly associated with a skew in the sex ratio at birth. The evidence is the

strongest in the case of second and third order births for women with no sons (Retherford and Roy; 2003a).

The potential for this trend to intensify needs to be taken seriously. Retherford and Roy point out that the potential for SSA to increase is greatest in states like Uttar Pradesh, Bihar and Rajasthan where there is evidence of strong son preference but currently less imbalance of actual sex ratios at birth. On the other hand during this decade there might be an actual decline in SSA in states like Punjab and Haryana where the practice has already peaked. However, analysis of ideal sex ratios indicate that although there is an overall decline in son preference in many states the sex ratio at birth still substantially exceeds the naturally occurring SRB. Considerable potential therefore continues to exist even in states that record a decline in son preference for further increases in the prevalence of SSA.

Attaining a Two Child-Norm – Examining the Various Strategies

It is in the above context that enforcement of a two-child policy needs to be viewed. The need to design population policies to hasten the fertility transition has been a part of the policy discourse for several decades in India. During the Seventh Five-Year Plan (1985-89) the two-child norm or a total fertility rate of 2.1 was adopted as a desirable basis to calculate and set population stabilization goals. Since that time India's tryst with replacement fertility has been revised a number of times and as per the UN medium variant projection will now be reached by 2015-20 (Dyson;2002:6).

To most policy makers in India the challenge remains to bring the total fertility rate down from its current level of 3-4 to a level near 2. Demographers have often pointed to the fact that this phase of transition is particularly difficult. Unlike higher levels of fertility that declines as a result of change in mortality the shift to replacement levels is slower mainly as it requires a fundamental shift in desired family size which many believe can be achieved only through significant social transformation and a change in gender relations. In the case of India this appears more the case given the prevailing preference for sons that continues to predominantly influence family composition and size (Bhat; 2002:CP5-4; IIP and ORC Macro, 2000a).

It has also been pointed out take it is important to take into account the heterogeneous nature of India's fertility transition across regions and states while devising policies such that they do not cater only to a homogenous ideal nor presuppose identical outcomes. Family welfare has in the past been a centrally sponsored program, however, during the past decade control over planning and program implementation has been increasingly devolved to the state and district level linked to a broader process of political decentralization and the adoption of a community needs assessment approach (CNAA) as part of the Reproductive and Child Health (RCH) program. This devolution can be said to have been mainly positive although the formulation of state population policies (SPP) and the widely divergent position these take from the more comprehensive National Population Policy (NPP), 2000, point toward at least one detrimental aspect and varied outcomes of this type of decentralized decision-making.

A number of factors have been identified and included as part of the objectives of the NPP and SPP that will help lower current levels of fertility. Some of these objectives include increasing the age of marriage for girls, lowering infant mortality rates, addressing the unmet need for temporary methods for birth spacing and making comprehensive and quality reproductive health services available to women. However, recent developments, mentioned earlier, seem to point toward the fact that the centerpiece of the stabilization effort continues to be a focus on the need to prevent higher order births, defined as the birth of three or more children and a disproportionate emphasis placed on promoting terminal methods, mainly female sterilization, to all those who have two living children.

The `success' of deploying such a strategy is evident from the example of the South Indian states who have already attained replacement fertility or are well poised to do so in the immediate future. Recent population-based surveys point toward significant reduction in the number of years between the birth of the second child and age at which women obtain sterilization at the all-India level, but more markedly in the southern states where population stabilization has been attained. The average age of female sterilization at all India level went down from 26.6 years to 25.7 years between the five-year period 1992-93 and 1998-99 (IIPS and ORC Macro; 2000). Five years earlier (1987) it was placed closer to 30 years. In some states, like Andhra Pradesh, Tamil Nadu, the age is even lower than the national average.

Another strategy that has been used but met with more limited success has been efforts to lengthen birth intervals especially between the birth of the first and second child. This strategy has as an essential corollary the need to guarantee the availability of temporary methods for birth spacing and enable women to consistently use such methods The current data amply demonstrates the limited success of this particular strategy, the use of temporary methods for birth spacing is extremely low. Of the 48 percent of currently married women who use any type of contraceptive method, 34 percent use female sterilization. In the NPP, 20 percent of current and future population growth has been attributed to unmet need mainly for birth spacing methods given the large percentage of young adult population (MOHFW; 2000:6).

A third approach that is often placed high on a population stabilization agenda is the need to raise the age of marriage as a fundamental and integral component of attaining replacement fertility. Inspite of this, it is evident that this has remained mere tokenism in any real policy or programmatic context. In most states the average age of marriage of girls remains extremely low sometimes even less than the legal age, 18 years. 36.9 percent of girls continue to be marriage before they are 18 (MOHFW;2000). In addition, the age of cohabitation has also declined during the five-year period between the two NFHS surveys and contributes to early child–bearing. All of this together has devastating consequences for women and girl children trapping them in a vicious cycle of ill-health and poverty that has as inter-generational consequences and leads to high rates of maternal and infant mortality.

It is therefore worth reiterating that even if all the contraceptives currently deemed safe and effective were made available as part of the RCH program the fact remains that unless the government and donors equally emphasize and commit their resources to enabling women to control their own fertility by addressing inequitable, gender-based, socio-cultural and household arrangements the outcomes will always be less than desirable and result in little or no qualitative change in women's lives. Even from a purely demographic standpoint there is sufficient evidence that points toward the usefulness of gender-based strategies that focus on things like women's empowerment as contributing positively to contraceptive use which in turn directly impacts the pace of fertility transition (Cosio-Zavala;2002:95&98).

What are the Implications of Gender Blind Policies?

It is clear from the previous discussion, that numerous strategies can be used to address population growth. Current emphasis however, appears to be less on addressing gender-based inequities and women's empowerment and more on diffusing acceptance of a two-child norm through laws, penalties, incentives and disincentives. The adoption of these two routes needless to say results in two very different outcomes. It was in fact exactly the detrimental aspects of the latter that was central to the discussion at the International Conference on Population and Development (1994) and the articulation and adoption of a new paradigm as part of the Program of Action.

The new paradigm emphasizes the need to make reproductive health and rights central to population policies, address women's lack of power, increase her access to economic resources and reduce gender-based violence all of which in turn enable women to make informed and voluntary decisions with regard to their reproductive health and fertility. Lessons from the past in countries like India with a long history of implementing family planning programs allow us to conclude that contraceptive targets and the use of disincentives not only violate individual rights but also have a marginal effect on fertility decline (UNFPA;1994).

In spite of significant shifts in the Family Welfare Program since ICPD (1994) recent developments point once again to a growing trend toward a purely demographic approach. This reversal is mediated mainly by data that showed a decline in contraceptive acceptor rates immediately after the adoption of the target-free approach. This was immediately used to condemn the approach. The UP state population policy explicitly talks about TFA as an inadequate approach to help the state achieve its demographic goals (GOUP; 2000:19). Recent developments indicate that community needs assessment (CNA) as an integral component of the reproductive and child health program is once again losing out against a target driven population control agenda. The overall emphasis in almost all the state population policies remains on birth reduction as a central goal accompanied by a strategy that emphasizes extensive distribution of contraceptives, in particular sterilization as key to attaining this goal (GOAP,1997; GOUP,2000; GOR;1999).

The consequence of using laws to implement a two-child norm needs to be understood better. Findings of one study conducted by an Indian NGO, Mahila Chetna Manch, to assess the impact of the implementation of the existing law that bars individuals with more than two-children from contesting local government elections show disturbing trends. Some of the findings include adverse impact of the implementation of this law on women and other vulnerable sections of society. Second, evidence shows that the law is unlikely to significantly influence fertility decisions of the elected representative. Even in situations where individuals are taking decisions to have smaller families it is often as a result of preventing the birth of female children. Inspite of this evidence to the contrary about the effectiveness of such laws the national government appears undeterred about the need to draft laws that include a range of punitive measures for individuals who violate the two-child norm.

It might be worthwhile to turn back to some of the early studies conducted after the adoption of the target-free approach as part of the RCH program. The most significant change observed by the researchers was the fact that women for the first time felt they have a choice. This translated into women opting for temporary methods for birth spacing, which in turn has a direct bearing on reducing the number of unwanted pregnancies (Visaria and Ramachandran; 1999). This finding is particularly important, and acts as a reminder that a large young adult population is entering the childbearing age all of who will have the highest need for temporary methods for birth spacing. The RCH survey estimates that this young adult population will in the coming decades contribute to 60 percent of total population growth. In this context it is also worth noting that adopting a community needs assessment is perhaps the only realistic way of comprehending both the need for contraception, in particular of young women, but also the existing barriers to access and effectively use spacing methods.

It is also important to point out that individuals', in particular women and other vulnerable populations, do not need to be coerced into accepting the small family norm. According to the National Family Health Survey, 1998-99, 70 percent of currently married women with two children say they want no more children, including a majority of rural and illiterate women who are the target of most of the disincentives in the current population policies (IIPS and ORC Macro; 2000).

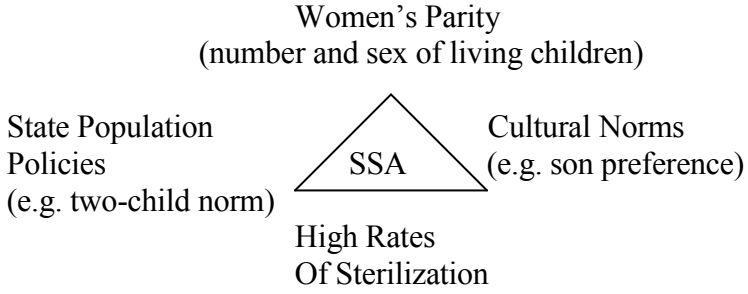
Often the case of the southern states is held up as an example of how emphasis on contraceptive distribution, in particularly sterilization, has led to most of those states attaining replacement or low fertility. But there are serious downsides to such an approach. For example, in Andhra Pradesh fertility declined sharply during the past decades, one of the highest rates of decline in India (James; 1999). However, this decline was mainly the result of female sterilization, the age for which is currently placed at 23 years, well below the national average. On the other hand there has been little or no increase in the age of marriage. The median age of marriage (15.4) continues to be well below the legal age of marriage (18) of girls. Both of which imply little or no change in the inequities and disadvantages that women face in the state.

Conclusion

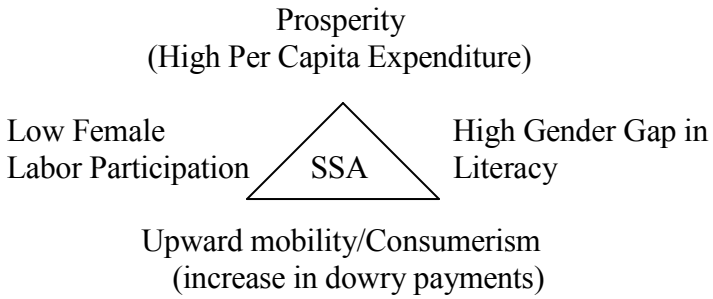
As India goes through a fertility transition regional patterns appear to be emerging that appear to fuel sex determination and sex selective abortion in different parts of the country (See diagrams below). Of these various factors the link between population policies and sex selection is perhaps the least understood not least because it is hard to collect discrete evidence on the subject. A number of factors mediate sex selection and the inter-relatedness of these various factors cannot be emphasized enough. The diagrams below serve to illustrate and highlight the complexity embedded in the host of issues that constitute the basis for sex selection.

In conclusion it might be worth noting that in the southern states that have attained replacement levels of fertility at birth order two there is a strong preference for balance that is evident also at higher birth orders. This indicates a growing trend towards family balancing in these states. This can result in an intensifying trend toward SSA as women who want to stop at two children are not only proportionally more but increasingly want to have one child of each sex. However, our greater concern needs to be for the northern states that continue to record high fertility as well as high son preference. It is the next stage of fertility transition in these states that needs to be watched carefully as that will be the moment when SD and SSA will be increasingly adopted (Retherford and Roy; 2003a). It is precisely for these reasons that coercive population policies has to be the least desirable strategy to implement a two-child norm.

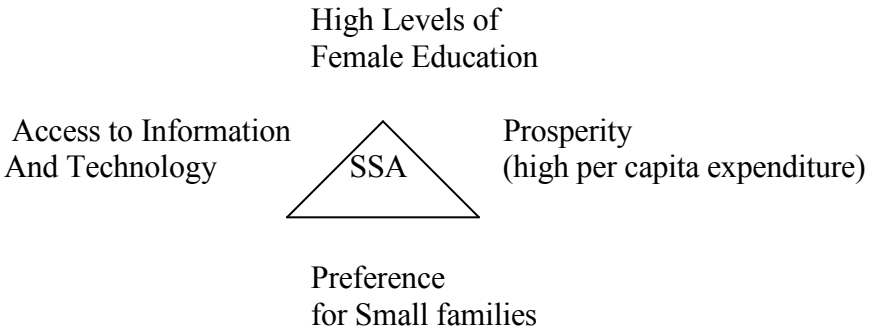
Type A: Driven by Cultural Factors and Family Planning Goals (e.g.Tamil Nadu)



Type B: Driven by Economic Factors (e.g. Punjab and Haryana)



Type C: Driven by Notions of Choice and Autonomy (e.g. Delhi and Chandigarh)



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