‘Gender Dynamics and Abortion Decision Making Behaviour in South Asian Region: A Case Study of Punjab, India’

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Introduction:

Abortion has been the subject of intensive debate among men, legal scholars, moralists, men of religion, and politicians. The voice of women have been drowned in this debate despite the fact that it is women whose bodies, psyche, health and life are directly concerned in the process. In India, everyday, hundreds of women lose their lives, because they are trying to terminate for unwanted pregnancies under unsafe circumstances. In India, women have access to legal abortion facilities, courtesy the Medical Termination of Pregnancy (MTP) Act, 1971. At the time of enacting the legislation on abortion, a number of studies have been done linked with abortion law, and profile of the abortion seekers were conducted. It is a difficult topic for research because abortion is a sensitive issue and topic in India. Here, even figures of births, deaths, and marriages are not accurate, complete and reliable and it is beyond imagination to have the exact data on abortion.

In India, not much and proper work has been done in this affair. Whatever has been done, done only based on the secondary data or on easily accessible urban hospital records, but not by the rural records of abortions, because government is unable to implement hard and fast rules, not taking much interest in this direction, and also not taking interest to impose Pre-Natal Diagnostic techniques Act strictly. It has been estimated that 5 to 6 million abortions occur annually in India and that roughly 90 per cent occur in unapproved facilities.

Sex-selective abortions takes place in two steps. The first step is assess the sex of the fetus. the second step is to obtain an abortion if the fetus is not of the desired sex. Methods for determining the sex of a fetus became available in the 1970s. Three such methods are commonly used: amniocentesis (normally performed after 15-17 weeks of pregnancy), chorionic villus sampling (more expensive and normally performed around the 10th week of pregnancy), and ultrasound (least expensive and normally performed around the 12th week of pregnancy). In some parts of India, Ultrasound is offered illegally by travelling vans. Shortly after the introduction of these tests in India in the 1970s, advertisement and provision of the tests began to spread.

The Indian government opposes sex-selective abortion, but it took a long time to pass legislation to combat it. In 1994, the Union Government enacted the Pre-natal Diagnostic Techniques Regulations and Prevention of Misuse Act, which mandates that Pre-Natal Diagnostic tests can be conducted only for high-risk

pregnant women and only for the purpose of depicting genetic abnormalities in the fetus. The law is easy to circumvent, however, and it is not clear that it has had much effect on the practice of sex-selective abortion.

The prevalence of sex-selective abortion is high in a number of states, especially those characterised by a strong preference for sons; but because of the illegal nature of the procedure, it is not known precisely how high. Sex-selective abortion manifests itself, however, in an altered sex ratio at birth (defined here as the ratio of male births to female births), which in the absence of sex-selection is about 105. This study trends and differentials in prevalence of sex-selective abortion indirectly through an analysis of trends and differentials in the sex ratio at birth.

Area of the Study

The area of the study is state of Punjab, where the deficit of girls has increased. Accordingly to the demographers, the sex ratio in Punjab has always been a matter of concern. The 2001 census revealed that six districts of Punjab were in the bottom ten (rural areas) when it came to child sex ratio (0 to 6 years). Mansa district, with 779 girls for every 1000 boys, is seventh lowest. In Bathinda, Faridkot, Muktsar and Ferozepur, other districts of Malula region, the sex ratio is 0-6 age group is 779,805,807 and 819 respectively.

In Punjab state, the average sex ratio (in 0-6 age group) is 783 and male-female ratio is 874. the sex ratio (i.e., the number of females per thousand males) of

population has come down from 882 in 1991 to 874 in 2001 census. Mansa is slightly higher than the state figures with a sex ratio of 875.

Health department statistics show that in the months of January, February, March, April and May 2005, the number of girls born in Punjab were 792,822,794, 792 and 801, respectively. This shows no improvement in the sex ratio of 793 (in 0-6 age group) after the 2001 census.

Main Objects of the Study

1. Analyse the data of sex-selective abortion in Punjab (district-wise).

2. How modernity play the role in sex-selective abortion

3. Role of Private health Clinic and Private nursing Homes in abortions

4. Gender dynamics and abortion decision-making

5. Inter-generational differences in abortion-seeking behaviour

6. Estimate the extent of pregnancy wastage and socio-economic, cultural and medical factors associated with it.

7. The study will explore the decision making process and role of son preference in sex-selective abortion.

8. Data will be on the basis of female fetuses and trace out the roots of sex-selective abortions.

Data and Methodology

The study will focus on a part of the data from a rural and urban community-based study of induced and sex-selective abortions in the districts of Punjab. The study examine the effects of demographic and socio-economic factors on sex-selective abortions in Punjab. Two kinds of sex-selective abortion surveys were conducted by National Family Health Survey - (NFHS-I, 1993) and (NFHS-2, 1998-99). Both surveys has decorated along with the lines of Demographic and Health Survey (DHS). These surveys are nationally representative surveys that include a household sample, covering everyone in the sample of households, individual sample, and covering all ever-married women age-15-49 (13-49 in the case of NFHS-1) within those house-holds. These two sample as collected through household questionnaire and individual questionnaire. In case of the house-hold questionnaire, the household head or other knowledgeable adult in the household responded for the entire household. In the case of the individual questionnaire, each ever married woman responded for herself and her children. NFHS-1 and NFHS-2 were designed to provide state-level estimates as well as national-level estimates. This study comprises the data NFHS-1, 1213 households and 2,995 ever-married women, and, NFHS-2, 2,967 household and 2,796 ever-married women. Details of sample design are discussed in the basic survey reports of NFHS-1 and NFHS-2 in Punjab.

On the other side, the study analyses data from the Reproductive and Child Health (RCH) Project which conducted survey in all the districts of Punjab by

International Institute for Population Sciences (IIPS), Mumbai, with the help of various Regional Agencies (RAs). This survey has been conducted in two phases during the period of 1998-99. These two phases were covered 17 districts of Punjab through selected houses, eligible women aged between 15-44 years present in the household were interviewed. Data of the Rapid Household Survey (RHS) are available of the districts of Punjab. In Punjab, 15,933 eligible women (rural - 12,095 and urban-3,838) in the age group of 15-44 years were interviewed.

Conclusion

According to India's Sample Registration System, the sex ratio at birth in Punjab rose from 1.13 to 1.23 male births per female birth between 1981-2001, indication of substantial and increasing use of sex selective abortion. Compared with other countries, Punjab has one of the highest sex ratios at birth in the world. We analysed data from India's first and Second National Family Health Surveys (NFHS-1 and NFHS-2). These surveys indicate that socio-economic factors have no statistically significant effects on the sex ratio at birth in Punjab. The present paper, has attempted to analyse the prevalent pattern of abortion in all districts of Punjab. Socio-cultural and demographic variables and abortion seeking, post abortion scenario in all districts of Punjab were looked into.

The most important factors affecting the sex ratio at birth are birth order and number of living sons, indicating that gender preferences for sons and daughters are the major factors affecting the prevalence of sex-selective abortion in Punjab.

Son preference is much stronger than daughter preference, so that female fetuses are aborted much more frequently than male fetuses. Some mothers who have sons but no daughters, however, selectively abort male fetuses in order to get a daughter. In a very few cases, sex-selective abortion is aimed at getting daughters. The main predictor variable indicating birth order and number of living sons is mostly uncorrelated with the other predictor variables, with the result that the sex ratio at birth predicted by logistic regression are very close to the raw values of the sex ratio at birth by birth order and number of living sons, calculated directly from the data.

In Punjab, in recent decades, has not, however, been accompanied by a shift at the same time in the economic and social pressures to have sons and avoid daughters. As was stated by women in Punjab, they want fewer children, but only if at least one, if not two, of them is a son. This has led to increased acceptance and use of sex selection tests to achieve the parental preference to have sons while not exceeding the desired number of children. Such practice of getting rid of daughters, that is known to have existed in these regions for centuries, is such that certain social groups in Punjab state have started facing a deficit of brides for their sons. According to a number of women, men are forced to remain bachelors, while for others, brides are being imported or bought by paying bride price from scheduled tribes and other groups.

The sex ratio at birth in Punjab will soon start to decline, if it is not declining already. Then son preference is declining suggesting that the actual sex ratio at birth may also be declining. On the other hand, because the sex ratios at birth implied by stated preferences for sons and daughters are still much higher than the actual sex ratio at birth, and because the likelihood that a woman will resort to sex-selective abortion to realize her gender preferences may still be increasing, it is possible that the actual sex ratio at birth is still increasing. However, the pattern is different across men and women providers. Of the total men providers, about 28 per cent approved of sex-selective abortion practice whereas it much less in case of women providers (17 percent). Correspondingly, higher percentage of woman providers (68 percent) compared to men (16 percent) are against such a practice; and this providers (68 per cent compared to men (16 per cent see against such a practice; and this trend continues in case of the position taken 'disapprove but have to do it'.

Any how this conclusion draws the attention on the matter of sex-selective abortion. It is matter of principles (ethics and human rights), discrimination based on sex is objectionable. I feel agitated to realise such practices prevail. However, the majority who clearly stop against the practice do not always speak in terms of opposition to discriminatory practices. The various other explanations offered included, ill health to women, balance between men and women are getting

disturbed, tests are not reliable and thus it is futile, “for women to become mother is important and adequate”.

Thus, the views oscillated between opposition to and in support of sex-selective abortions; between those who were willing to forgo their practice by not engaging themselves in unethical medical care and those who were capitalizing on demand for sex selective abortions by indulging in themselves in unethical practices. Once again social compulsions and population control concerns featured prominently.

Table 1 shows the outcome of the last pregnancies of the interviewed women. The eligible women who had their pregnancies in the past three years from the date of interview were considered. In urban areas, live births were highest in Ludhiana (92.1%) while in rural areas the live births were highest in Jalandhar (93%). Irrespective of the background, induced abortions were lower in Ludhiana district (rural 2.9%, urban 3.3%). Overall, still births were 1.1% for both rural and urban women, however in urban women; approximately half of the districts reported no still birth. The Table reveals that women in Bathinda district had more spontaneous abortions than in other districts. Bathinda had maximum spontaneous abortions among urban women (13.4%) and second highest among rural women (5.4%). In spite of the increased outreach of the family planning programmes, abortion continues to exist in Punjab. Live births were more in rural (88.9%) than urban (83.7%) areas. Irrespective of the district, urban couples (10.7%) went more for induced abortion than rural couples (5.6%).

Table 1

Outcome of the Last Pregnancy in Punjab **(Percentage)**

Districts	Rural					Urban				
	Live Birth	Still Birth	Induced Abortion	Spontaneous Abortion	Total pregnancy	Live birth	Still Birth	Induced abortion	Spontaneous abortion	Total pregnancy
1	2	3	4	5	6	7	8	9	10	11
Amritsar	90.8	1.1	5.0	3.1	262`	83.8	0.0	11.1	5.1	99
Bathinda	87.9	0.8	4.9	6.4	265	76.1	0.0	10.4	13.4	67
Faridkot	90.1	0.0	4.0	5.9	253	81.6	0.0	10.4	13.4	67
Firozpur	87.3	1.8	7.2	3.6	332	80.8	2.6	14.1	2.6	78
Gurdaspur	90.8	1.5	4.8	2.9	273	89.4	0.0	10.6	0.0	85
Hoshiarpur	85.4	1.6	6.3	6.1	253	77.8	2.1	16.6	4.4	45
Jalandhar	93.0	1.1	4.3	1.6	186	82.1	1.9	11.3	4.7	106
Kapurthala	90.2	1.8	5.5	2.5	275	82.2	2.7	11.0	4.1	73

Ludhiana	90.4	0.0	2.9	6.6	136	92.1	0.0	3.3	4.6	152
Patiala	92.7	1.1	3.1	3.1	261	82.1	2.1	8.4	7.4	95
Roopnagar	85.6	1.1	8.9	4.4	271	84.9	0.0	15.1	0.0	73
Sangrur	90.6	0.0	3.6	5.8	278	90.6	0.0	5.9	3.5	85
Fatehgarh Sahib	85.9	0.4	7.4	6.4	283	82.1	2.4	10.7	4.8	84
Mansa	90.6	1.2	4.2	3.9	331	80.0	0.0	15.6	4.4	45
Moga	88.3	1.3	5.0	5.4	298	73.8	3.1	13.8	9.2	65
Muktsar	86.6	1.3	8.1	4.0	298	87.9	0.0	12.1	0.0	58
Nawanshahar	87.1	1.1	7.5	4.3	279	76.7	3.3	16.7	3.3	30
Punjab	88.9	1.1	5.6	4.5	4534	83.7	1.1	10.1	4.5	1327

Source: Reproductive and Child Health (RCH) Project by IIPS, MUMBAI

Table 2 shows that maximum abortions were induced in the second month of pregnancy are rural (37.6%) and urban (44.4%) areas of Punjab. Generally, couples opt for abortion in the first trimester only. In urban areas (81%), the percentage was slightly higher than in rural areas (79.9%). In rural Ludhiana district, cent per cent abortions were performed in the first trimester. In urban Punjab, no abortion was induced in the last trimester. In urban Bathinda (14.3%) and Sangrurj (20%) district, couples went for abortion in the sixth month also. It was true for rural Firozpur (4.2%) Muktsar (4.2%), and Nawanshahar (4.8%), districts also. In the seventh month, induced abortion was reported from rural Muktsar (4.2%) only.

It is not easy task to eradicate female infanticide in India especially in Punjab because such practices have been continuing since time immemorial and the alternative of sex selective feticides is now adopted. The 2001 census figures of the child sex ratio are a stark illustration of this reality. We are facing a national emergency, an epidemic that will have far reaching social consequences. Females are the cornerstones of any society. It is time that they are protected in order to maintain the social and cultural ethos of India. Besides, they even contribute to the economy of the country.

Table 2

Month of Last Pregnancy when Induced Abortion Occurred in Punjab **(Percent)**

Month of pregnancy when induced abortion occurred															
	Rural								Urban						
	1	2	3	4	5	6	7	Total cases	1	2	3	4	5	6	Total cases
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Amritsar	38.5	15.4	7.7	30.8	7.7	0.0	0.0	13	9.1	45.5	18.2	27.3	0.0	0.0	11
Bathinda	7.7	46.2	23.1	23.1	0.0	0.0	0.0	13	0.0	57.1	28.6	0.0	0.0	14.3	7
Faridkot	10.0	30.0	40.0	20.0	0.0	0.0	0.0	10	18.2	72.7	0.0	9.1	0.0	0.0	11
Firozpur	8.3	62.5	20.8	4.2	0.0	4.2	0.0	24	9.1	54.5	18.2	18.2	0.0	0.0	11
Gurdaspur	0.0	46.2	23.1	30.8	0.0	0.0	0.0	13	33.3	44.4	0.0	22.2	0.0	0.0	9
Hoshiarpur	12.5	37.5	31.3	12.5	6.3	0.0	0.0	16	42.9	42.9	0.0	14.3	0.0	0.0	7
Jalandhar	25.0	50.0	12.5	0.0	13.0	0.0	0.0	8	8.3	41.7	33.3	16.7	0.0	0.0	12
Kapurthala	13.3	40.0	20.0	26.7	0.0	0.0	0.0	15	25.0	37.5	12.5	25.0	0.0	0.0	8

Ludhiana	50.0	50.0	0.0	0.0	0.0	0.0	0.0	4	0.0	60.0	20.0	20.0	0.0	0.0	5
Patiala	25.0	25.0	37.0	0.0	13.0	0.0	0.0	8	25.0	37.5	12.5	25.0	0.0	0.0	8
Roopnagar	33.3	29.2	16.7	20.8	0.0	0.0	0.0	24	27.3	45.5	18.2	9.1	0.0	0.0	11
Sangrur	20.0	40.0	30.0	0.0	10.0	0.0	0.0	10	60.0	0.0	0.0	20.0	0.0	20.0	5
Fatehgarh Sahib	19.0	28.6	23.8	14.3	14.3	0.0	0.0	21	11.1	33.	22.2	33.3	0.0	0.0	9
Mansa	14.3	42.9	21.4	21.4	0.0	0.0	0.0	14	14.3	51.7	13.3	14.3	0.0	0.0	7
Moga	26.7	26.7	40.0	6.7	0.0	0.0	0.0	15	22.2	44.4	22.2	9.1	0.0	0.0	9
Muktsar	25.0	25.0	33.3	8.3	0.0	4.2	4.2	24	28.6	42.9	11.3	0.0	14.3	0.0	7
Nawanshahar	9.5	47.6	14.3	14.3	9.5	4.8	0.0	21	20.0	0.0	60.0	20.0	0.0	0.0	5
Punjab	18.6	37.6	23.7	14.6	3.9	1.2	0.4	253	19.7	44.4	16.9	16.9	0.7	1.4	142

Source: Reproductive and Child Health (RCH) Project by IIPS Mumbai

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