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The Girls Who Were Never Born: A Study of Sex-Selection and Healthcare Professionals in India

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Research Proposal: The Girls Who Were Never Born:
A Study of Sex-Selection and Healthcare Professionals in India

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Abstract

In this study, I focus on the role of healthcare professionals in the spread of sex-selective abortions in India. I first intend to study the impacts of sex selection on communities, the role of doctors as gatekeepers, and the ineffectiveness of governmental policies from the late 20th century in stopping sex selection. I utilize ideas from Seth Holmes' 2013 text, *Fresh Fruit, Broken Bodies*, including bad faith, normalization, and naturalization to analyze the psychology motivating Indian healthcare professionals to continue offering sex selection. I target three primary reasons for Indian healthcare workers' compliance with the discriminatory system: internal bias against daughters, the influence of government population control policies, and the lucrative nature of the sex selection business. By understanding the psychology behind the actions of healthcare professionals, I hope to suggest a means to reduce widespread acceptance and decrease the rate of sex selection through the medical community.

Research Context

While female infanticide has been a notable problem for centuries in India, sex-selective abortion is a relatively new phenomenon which is sweeping the nation at an alarming rate. Recent estimates state half a million female fetuses are aborted in India yearly (Rosenblum, 2014) and as ultrasound technology has grown cheaper and more accessible to the public, the number of sex-selective abortions has begun to climb despite attempts at government intervention. The natural ratio of males to females at birth is roughly 100 girls for every 105 boys. In 2011, the sex ratio in India reached a record 914.9 girls for every 1000 boys— an all

time low for the nation (Harrigan, 2014). The impact of sex selection is disastrous as the excess number of men are unable to marry, are forced into a life as outcasts from society, and are more likely to regroup to perpetrate violence or marry much younger women. The increase of sexual violence, human sex-trafficking, and child brides has been noted historically in areas where the number of men outnumber the number of women (Harrigan, 2014) and India is no exception to the statistic. Due to the wide acceptance and steady increase of sex selection over the years and its potentially disastrous resulting consequences, sex selection has risen as one of the most prominent issues India faces presently. It is necessary to find a solution quickly before the practice becomes widespread and socially acceptable beyond the scope of reversibility.

The factors which have brought India into a gender ratio crisis have roots in cultural discrimination against women, economics, and governmental policies. As outlined by both Harrigan (2014) and Rosenblum (2014), sons are preferred over daughters for a number of cultural and social reasons. Women who give birth to sons are viewed highly and having multiple sons raises a family's social status. In addition, commonly held religious beliefs only allow sons to take care of aging parents and perform their last rites after death. Daughters are traditionally considered a part of their in-laws' household after marriage, so parents view daughters as costly and with little return while sons are an investment. Sons can provide a source of income for their parents because they are more likely to be educated and can acquire higher paying jobs than daughters. Sons inherit property, carry on the family name, and have been shown to increase yearly income while lessening the chances that a household will fall beneath the poverty line (Rosenblum, 2014). However, a daughter can be an economic burden to a household as hefty dowries strip a family of up to five years of income, and a daughter mostly

provides labor to her in-law's household (Harrigan, 2014). The continued discrimination against women in India is reinforced by cultural and economic incentives that act alongside governmental population control policies which encourage abortion. These three elements ensure that the demand for sex-selection services— the demand for a son— remains high among the Indian population.

Sex-selective abortion continues to grow with influences from the past, but healthcare professionals are currently playing a major role in exacerbating the issue by allowing the practice to become more available and widespread. The ratio of sons to daughters within the families of medical professionals reveals an internal discrimination against daughters in those who hold the keys to allowing sex selection (Isalkari, 2013). By abandoning ethical practices and avoiding governmental prosecution (Mudur, 2006), doctors in India have turned sex-selective abortion into a lucrative practice and have answered the overwhelming demand from the Indian public. After realizing the long-term impacts of widespread sex-selection, the Indian government introduced the Pre-Natal Diagnostic Technique Act (PNDT) in 1994, which outlawed prenatal exams for gender determining purposes, prohibited doctors from communicating the sex of a fetus to their patients, and allowed only registered clinics to provide ultrasound services. However, the act has proven largely ineffective in halting the practice of sex selective abortion. Doctors have found a number of loopholes to the PNDT and continue to offer sex-selective services illegally, sometimes operating with code words or practicing in their cars. Those who are prosecuted for violations are rarely convicted because the medical community pressures the government to reduce charges in order to avoid tarnishing the reputation of fellow doctors.

Since the government has not been able to effectively curb sex-selection, I believe medical professionals are key to halting the practice. If Indian medical professionals shifted their focus to teaching and reinforcing ethical standards, the impact of peer pressure and harsher consequences for ethical violations could change the acceptability of sex-selective abortions within the medical community. In *Fresh Fruit, Broken Bodies*, Holmes explores inequities which stem from inherent racism and bad faith of individuals. He explores the methods in which people distance themselves from a practice, redirecting responsibility for inequities they may be perpetrating. I aim to explore the same concept of bad faith and the justifications within the Indian medical community in order to understand why medical professionals continue to support sex selective services. Such analysis may lead to a better understanding of what methods can be used to effectively deter doctors from continuing the practice.

Research Questions

1. What historical factors have lead to the widespread acceptance of sex selection among the medical community?
2. How do bad faith and the widespread acceptance of sex selection among Indian communities influence healthcare professionals by skewing their ethical standards and driving them to continue providing sex selective services?
3. What justifications might healthcare professionals provide for continuing to provide sex selection services and what psychological factors might be influencing their justifications?

Research Methods

In researching, I plan to focus on legal papers and studies or surveys conducted in India. The dramatic impacts of sex selection are best demonstrated through the figures which encompass the entirety of India. The widespread nature of discrimination against daughters across India, comparisons between the sex ratios of healthcare workers' families and average Indian families, and the economic incentives for doctors to continue providing sex selective services are best shown through figures collected by studies. I will also read into legal papers including primary sources like the original Pre-Natal Diagnostic Techniques Act and its amendments to gather clues on how healthcare professionals found loopholes in the act to continue their sex selective abortion practices. However, in addition to analyzing more empirical evidence, I will look for qualitative elements including quotes from healthcare professionals, observations from experts in gender inequality, anthropological perspectives on fertility and reproduction, and ideas from psychology to gain insight into how doctors are justifying, to themselves and to the public, the act of providing sex selective services. I have contacted several individuals in the San Francisco Bay Area who are activists against sex selection, including Preeti Shekar, a Berkeley-based activist who speaks out against healthcare professionals who offer sex selective services in California. I also hope to interview healthcare professionals in California who provide various advanced forms of sex selection such as preimplantation genetic diagnosis. Through personal interviews, I hope to obtain a clearer perspective on the psychology and reasons behind doctors' justifications for offering sex selective services.

My approach to analysis is similar to that of Seth Holmes in that I look into social and anthropological theory and combine empirical data with observational evidence to construct my theories. I will look into structural and symbolic violence against women. In particular, I aim to incorporate Holmes' ideas of bad faith, naturalization, and normalization in my analysis of Indian healthcare professionals.

Data Analysis

In analyzing my data, I will be searching for the most prevalent reasons influencing doctors to continue offering sex selective services. With each reason, I connect with ideas from Holmes, including the influence of bad faith and instances of normalization or naturalization. My analysis will emphasize how internal bias, governmental policies, and the lure of high profits establish a mindset within the medical community in which sex selection is acceptable and widespread. Indian medical professionals harbor bad faith in the way they delude themselves of the major consequences of sex selection such as continued discrimination against females, loss of womens' reproductive rights, increasingly skewed sex ratios, and masses of unmarried men prone to violence. Instead, doctors focus on the short term benefits, including a slightly higher status and economic benefits for a household. They normalize sex selection by pointing to the overwhelming demand for sex selective services as a natural order, and redirect blame by stating the demand is high while ignoring their own contributions to the system.

I will be looking for instances of bias among doctors to see if they believe in the same discriminatory ideas which cause families to favor sons over daughters. So far, I have encountered evidence from surveys and articles which state the sex ratio within doctors' families are more skewed than the national average in India (Isalkari, 2013). In this section, I will analyze

the various reasons why individuals in India choose to undergo sex selection and use qualitative evidence, including direct quotes from doctors, as well as quantitative statistics of sex ratios to verify how medical professionals may hold a bias against having daughters.

In looking into past governmental population control policies, I have found evidence of how improper implementation of such policies combined with internal bias held by doctors have led to healthcare professionals utilizing sex selection as a means to convince individuals to have smaller families. The healthcare professionals are paid and evaluated purely based on their successes in convincing a family to undergo sterilization— a process which often takes three to four years of convincing. In order to heighten their success rate and speed up the process, healthcare workers are convincing individuals to use sex selection in order to quickly obtain the “desired composition” of children— namely, two sons (Patel, 2007). I will analyze governmental population control policies and the impact they have had on the mindset of healthcare workers.

Lastly, I will look into the lure of the profitable nature of sex selection businesses. Since maternal wards are highly lucrative, doctors have transformed sex selection into a business of over 100 million dollars. Although doctors are faced with a number of regulations, they continue to practice despite laws and are rarely convicted because of support from the medical community (Harrigan, 2014). I aim to compare the benefits and drawbacks doctors face through this business to clarify why doctors choose to offer sex selection, despite legal consequences.

Discussion and Implications

Healthcare professionals are playing a major role in allowing sex selection to grow among the Indian community because they provide the means and legitimacy for the practice to

continue. By understanding the psychology and ethical defects within the Indian medical community, I aim to understand why healthcare professionals continue sex selection unlawfully. A better understanding of the driving forces which push doctors to continue sex selection can lead to insight on what changes can be made in the system to reduce widespread acceptance. Perhaps by instilling stronger ethical education which goes into depth about the negative ramifications sex selection is having on Indian communities, more doctors can be encouraged to follow ethical standards and halt sex selection. By encouraging more doctors to follow ethical standards, the peer acceptance which has allowed sex selection to remain justified among the medical community can be reduced and more doctors will be encouraged to stop sex selection or enforce harsher punishments for their peers who do continue to practice sex selection.

Sex ratios plummet in India despite efforts of the government and technology improves to make access to sex selection easier than ever before. Now is the time to influence the gatekeepers allowing the practice to continue. Since healthcare professionals are major perpetrators of sex selection, influencing them to halt the practice is an effective means to slow or reverse the skewing of India's sex ratio and avoid longer term consequences.

The Girls Who Were Never Born:

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Abstract

In this study, I focus on the role of healthcare professionals in the spread of sex-selective abortions in India. I first intend to study the impacts of sex selection on communities, the role of doctors as gatekeepers, and the ineffectiveness of governmental policies from the late 20th century in stopping sex selection. I utilize ideas from Seth Holmes' 2013 text, *Fresh Fruit, Broken Bodies*, including bad faith, normalization, and naturalization to analyze the psychology motivating Indian healthcare professionals to continue offering sex selection. I target three primary reasons for Indian healthcare workers' compliance with the discriminatory system: internal bias against daughters, the influence of government population control policies, and the lucrative nature of the sex selection business. By understanding the psychology behind the actions of healthcare professionals, I hope to suggest a means to reduce widespread acceptance and decrease the rate of sex selection through the medical community.

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Introduction

From the 2011 census of India's population, the world discovered how for every 1000 sons born in India, only 914.9 daughters were allowed a life. Half a million female fetuses are aborted every year in India and the sex ratio continues to skew (Harrigan, 2014). A central factor influencing the skewed sex ratio among India's population is the growth and widespread acceptance of sex selective abortion. Sex selective abortion is the intentional termination of a pregnancy due to the sex of a fetus, and in India, it is setting up the scene for a long term impending disaster. Doctors, who control the use of ultrasound machinery, have the power to mediate this ethical war ground, but they are often the enablers who are allowing sex selection to occur.

Impacts of Sex Selective Abortion

In nations where women are valued and educated, poverty rates are lower, child mortality rates are lower, and the economic state flourishes as this half of the population is equipped with the ability to contribute to society (McCarthy, 2015). Sex selective abortions end all prospects of equality by reinforcing the discriminatory cultural mindset that women are inherently less capable than men. The act of avoiding having a baby girl robs women of the chance to even exist, let alone aspire for equal opportunities in life and work to level the playing field between men and women. It feeds into a cycle of discrimination in which baby girls are seen with such contempt that female fetuses are aborted. The same contempt devalues women by

placing them at the bottom of the social hierarchy, minimizing their freedom, and reducing the impact they can make, which in turn makes the prospect of a daughter even less appealing. In addition, sex selective abortion is a major opponent to women's reproductive rights, since the decision to abort the baby is typically made by a woman's in-laws and husband, as noted by Filipovic (2016). Women, themselves, usually carry almost no weight in the decision-making process. A family's disdain towards having many baby girls is often manifested as physical violence and emotional abuse against women. In some instances, women are often forced into sex by their family or husband regardless of their personal choice. They suffer needlessly because of false societal constructs which place sons over daughters (Filipovic, 2016). As the ratio of daughters to sons continues its steep descent in India, sex selection is tightening the ropes tethering women to the ground.

The continued skewing of the sex ratio has the ability to dramatically impact the rates of violence, abuse, human trafficking, and child marriage throughout India. It is estimated that by 2020, over 25 million surplus males will not be able to find a bride in India (Chamie, 2008). Historically, it has been observed how the excess of men who are unable to marry are cast out from society. They group together and lead nomadic lives in which they perpetrate sexual violence. The excess of men correlates to an increase of human trafficking in order to supply more brides and prostitutes. In order to avoid a life without marriage, numerous men seek younger and younger brides to marry in a process known as "marriage squeeze" (Harrigan, 2014). Children are becoming brides to older men, and they face a life they are both physically and emotionally unprepared to handle. The skewed sex ratio is further exacerbating India's child marriage problem. India has yet to experience the full negative impact of the past decades of

discrimination through sex selection. As the rates of sex selection have progressively worsened over the past few decades, government officials have shifted their focus to regulating healthcare professionals. Even as some of the most educated, affluent, powerful members of society, healthcare professionals are giving in to the influences of discrimination and greed in enabling the practice of sex selection.

Attempts to Battle Sex Selection: the PNDT Act

In 1994, the Indian government recognized sex selection as an urgent national issue and established the Pre-Natal Diagnostic Techniques Act (PNDT Act) in an attempt to curb the alarming rates of female feticide. The Act focused on the role of healthcare professionals as gatekeepers in allowing sex selection to occur and sought to regulate their actions in order to curb sex selection rates. The PNDT's major components outlawed the use of ultrasound to determine the sex of a fetus and barred doctors from communicating the sex of a fetus to their patients. Under the Act, only licensed clinics were allowed to operate ultrasound machines and detailed records were to be kept of every interaction between doctors and patients (Bhaktwani, 2012). However, the 1994 version of the PNDT proved largely ineffective because doctors were able to easily find loopholes in the Act. While amendments were made in later years to amend the PNDT Act, they have proven to be insufficient in curbing feticide.

While laws are in place, they are nearly impossible to enforce since such enforcement is directed by previous doctors who are hesitant to incriminate their fellow healthcare professionals. The enforcers understand how widely-accepted and lucrative the practice of sex selection is and feel it is unfair to incriminate healthcare professionals for a business so many participate in. Also, doctors have easily found ways around the PNDT Act by avoiding direct

verbalisation of a baby's gender and utilizing indirect means to communicate the information. They use simple methods such as writing in pink or blue pen to indicate a female or male fetus. Additionally, doctors have used images of male and female deities including Ganesha and Lakshmi to demonstrate the sex of a fetus. Such images have been banned in ultrasound clinics since the discovery of their misuse (Harrigan, 2014). Finally, on the occasions when the government has prosecuted doctors for violating the PNDT Act, extremely few of the prosecutions led to convictions. Government officials have acknowledged the influence of the medical community in reducing the rate of convictions (Mudur, 2006).

In order for sex selection to be curbed effectively through laws, healthcare professionals must adhere to ethical standards instead of giving in to the lure of profits or the misguided, discriminatory beliefs which label women as inferior to men. They must be active and ethical participants in incriminating other healthcare professionals for violating the prohibition on sex selective abortion. When doctors are effectively monitoring their fellow doctors, the element of peer support, which is contributing to the widespread acceptance and normalization of sex selection, can be eliminated. However, doctors are not assuming the ethical stance required of them and are instead encouraging the growth of sex selection within India. Due to their position of authority in society and their education, doctors should be taking full responsibility for their actions and work to reverse the influx of sex selective abortions in India. By following bad faith, redirecting the blame for enabling sex selection, and normalizing sex selection among the healthcare community, they are abandoning their roles as leaders of society.

Perspective of Analysis

Healthcare professionals are the gatekeepers who can choose to open or close the door on sex selection. Due to their pivotal role in allowing or obstructing sex selection, a better understanding of their justifications and the psychology driving their justifications can aid in developing a more effective means of enforcing ethical standards within the medical community and curbing the rate of sex selective abortion in India. The issues behind healthcare ethics regarding sex selective abortion can be viewed through the anthropological lens outlined in Seth Holmes' 2013 text, *Fresh Fruit Broken Bodies*. Holmes' ideas center on the roles of bad faith, normalization, and naturalization in reinforcing structural and symbolic violence against individuals who are placed at the bottom of the social hierarchy. India's healthcare professionals harbor bad faith in the way they knowingly deceive themselves of the larger problems of discrimination and structural violence which occur due to sex selection. Instead, they focus on the short-term benefits in order to justify offering sex selection. Healthcare professionals also utilize bad faith when they normalize sex selective abortion by accepting son preference as the natural order of the world or view sex selection as acceptable because it is already a widespread practice within the healthcare industry. They naturalize sex selection by cloaking it with a veil of legitimacy and "science," making sex selection appear a more socially acceptable and educated decision, even though it is both highly discriminatory and illegal in India.

In the analysis of the factors influencing doctors to continue offering sex selection, psychological, legal, and economic perspectives come into play. Since doctors are steeped in the same cultural environment as their patients, it is likely they share similar beliefs which value sons over daughters. Even as some of the most educated members of society, healthcare workers are unable to see the equal value a daughter can bring if provided the same opportunities as a

son. Another possible influence in doctors' justifications lies in India's government-instilled population control policies which had unintended effects. Due to improper regulation of healthcare workers sent out to implement the population control policies, the incentives for providing sex selection increased drastically. A combination of doctors harboring son preference and population control policies allowed for the spread and normalization of sex selective abortions as a means to achieve the desired composition for a two-child family. Lastly, the economic incentives for sex selection are the most likely influencers driving doctors to continue to offer sex selection. As technology has become inexpensive and easier to transport, medical professionals have grown sex selection into an extremely lucrative business. The profitable nature of the sex selection business is another veil doctors use to buy into bad faith by focusing on temporary economic gain and ignoring the ethical values they are violating with their practice. In all three factors, the ideas proposed by Holmes of bad faith and normalization are visible factors contributing to the mindsets of healthcare professionals.

Discriminatory Beliefs

The elements which elevate the value of sons and devalue daughters have roots in India's cultural values. Doctors, who are also immersed in the same cultural and social environment as their patients, are likely to understand or share the beliefs which led to their patients' desire for a son over a daughter. Since healthcare professionals hold critical roles in enforcing the PNDT Act, indications of their own internal biases in favor of sex selection reveal their enforcement capabilities to be lacking. India's national average sex ratio hovers at an all-time low of 914.9 daughters per 1,000 sons (Harrigan, 2014), but studies show doctors utilize sex selection more frequently within their own families. In a study conducted by a Nagpur-based institute, the sex

ratio within the families of doctors fell to a mere 907 daughters per 1,000 sons (Isalkari, 2013). This information comes as no surprise since sex selection appears more frequently in affluent families that have the money to access sex selection (Isalkari, 2013). Since doctors are already highly connected with other healthcare professionals, it is likely they would know of a means to acquire ultrasounds and sex selective abortions without facing legal ramifications. The sex ratio among doctors' families, as well as the large-scale indifference of doctors in stopping sex selection, indicate doctors believe in the same arguments their patients have for utilizing sex selection. The mindset doctors may be using to justify sex selection is outlined by the Indian proverb, "Grooming a girl is like watering a neighbor's garden" (Harrigan, 2014). Sons are seen as elements of stability, while daughters are viewed as a burden. Sons are more likely to be given an education and are consequently likely to have a higher earning power (Rosenblum, 2014). They will carry on the family name, are the heir to their parent's belongings, will take care of their parents in old age, and will perform their last rites after death, which in India's predominant religion, must be conducted by a son to guarantee salvation. Mothers, who often hold a subservient position in their household, acquire a higher status after giving birth to a son and becoming a mother-in-law. Daughters are culturally viewed as property of her in-law's household after marriage, and require a substantial dowry which can sometimes add up to nearly five years of a family's income (Harrigan, 2014).

Healthcare professionals who are providing sex selective abortion are influenced by the same bad faith in distorted cultural values held by much of India's population. Their skewed ideologies lead them to view women as inherently below men instead of understanding the impact external factors such as less access to education and archaic traditional values which

force women to be treated as property to be traded to her in-laws for a sum of money. Healthcare workers have less to lose from having a daughter, since most are affluent and educated. They have the ability to provide an education for their daughters and improve their earning power. However, through the distorted lens of bad faith, healthcare workers buy into the belief that daughters are less capable than sons and begin to place more importance on the immediate, tangible benefits of temporary wealth and a slightly elevated status, than the large scale, long-term impacts and continued discrimination against women.

A cycle of normalization and naturalization is also strengthened by healthcare workers' readiness in receiving and compliance in offering sex selective services. If healthcare professionals accept discrimination as a natural function of society, they themselves begin to internalize discriminatory beliefs. They may utilize these discriminatory beliefs to justify offering sex selection. By doing so they legitimize and normalize sex selection as an acceptable practice to be conducted by other healthcare professionals. The influence of widespread peer acceptance among healthcare professionals of discriminatory beliefs and sex selective services, in turn motivates other healthcare workers to normalize sex selection and internalize discriminatory beliefs. The impacts of collective bad faith help healthcare professionals internalize discriminatory beliefs more readily and use their skewed beliefs to justify offering sex selective services to the public.

Population Control Policies

Throughout the late 20th century, the Indian government implemented a number of population control policies including the 1975 20-point program which set the goal of having a two-child norm for households in India. The population control programs were extremely

result-focused and pushed healthcare workers to produce successful results by any means necessary. Since the eligibility of healthcare workers for promotions was judged purely based on the number of successes they were able to churn out, workers resorted to the most extreme means of population control—sterilization. They used sex selection as a tool to convince individuals to undergo sterilization (Patel, 2007). By offering families a chance to obtain the “desired composition” of offspring, typically two sons, healthcare workers increased the incentives for undergoing sterilization. “[The healthcare workers’] attitude and their fertility decisions and their behavior are very significant since they themselves are meant to educate the population about the importance of family planning and the equality of the male and female child” (Patel, 2007).

Bad faith is prevalent in the way healthcare workers promote sex selection as an incentive for sterilization. By holding onto a one-sided goal of promoting the government’s ideal two-child family and mentally minimizing the impacts of sex selection, healthcare workers may view sex selection as a necessary means to achieve a greater goal of population control. Since the government’s system places the majority of importance on obtaining tangible results from the workers, namely successful sterilizations, the result-oriented environment as well as the pressure on workers to produce successes in order to keep their jobs could be another influence pushing workers to knowingly deceive themselves of the negatives of sex selection. The healthcare workers also utilize the distant authority of the government as a means to redirect blame and avoid guilt in sterilizing families. They justify sex selection as a middle path. The government is pushing for family planning to keep family size down to two, but health care workers feel guilty

for convincing individuals to undergo sterilization and lose their ability to bear children (Patel, 2007). They find a middle ground by helping individuals have sons as a means of compensation.

It's in Demand!

Sex selection has grown into business worth over 100 million dollars and healthcare professionals are taking advantage of its lucrative nature. Since maternity wards bring the most profitable business to hospitals, healthcare workers have much to gain by offering sex selective services (Harrigan, 2014). As technology has improved over the years, ultrasound machines have decreased in price, their production has increased manifold, and they have become easier to transport and maintain. The number of ultrasound machines manufactured yearly in India experienced a rapid increase from 1988 to 2003, with a noticeable spike after 1994—the same year the PNDT Act was first established (Akbulut-Yuksel & Rosenblum, 2012). The PNDT was largely ineffective in its ability to curb the sex selection process and statistics demonstrate doctors' indifference towards its regulations. Due to improvements in technology and accessibility, healthcare workers have been able to drive into rural areas and offer ultrasound services in their cars. Journalist Preeti Shekar, who has extensively covered the issue of sex selection in both India and the United States explains, “From a business point of view, it's just supply and demand.” She cites targeted advertising which takes advantage of discriminatory beliefs as a way in which healthcare professionals encourage families to utilize their sex selection services.

In growing their sex selection businesses, healthcare workers are able to avoid the guilt of breaking the law and enforcing discriminatory ideals. They are able to paint a justified,

seemingly ethical facade over their sex selective services. Shekar adds, “[Healthcare workers] don’t see this as bias. They also frame [sex selection] as ‘family balancing.’ There are very subtle ways they use to frame it as something else.” By justifying the use of sex selection as a means of “family balancing,” doctors are finding and focusing entirely on the aspect of sex selection which appears reasonable and they mindfully neglect the discriminatory aspects of sex selection. As Shekar explains, “People are not candid. The whole thing happens under the radar.”

Healthcare workers also reinforce their bad faith in the idea of sex selection as a normal state in society by redirecting the blame to their patients, who they blame for acting with discriminatory intent in hoping for a son over a daughter. However, they shield themselves from blame by stating they act as a separate entity, taking advantage of the system from a business perspective, but not directly contributing to the system. “Each party reasons that the other is responsible... saying that ‘parents tell themselves their doctor knows best, while doctors point to overwhelming patient demand for the procedure’” (Harrigan, 2014). They recognize the overwhelming demand for sex selection as “the way society is,” and ignore their own contributions to the system allowing sex selection to grow.

Impacts of Bad Faith and Solutions

When the most educated members of society act without a strong base of ethical values, the impact they have can be devastating. Since healthcare professionals act as leaders and are trusted by their patients, they serve to further the normalization of sex selection as a legitimate, acceptable practice. Their bad faith in buying into discriminatory beliefs which value sons over daughters, viewing sex selection as a necessary means to the greater good of population control,

redirecting blame to the government or their patients in order to avoid guilt, or justifying sex selection as acceptable due to the actions of their peers has allowed healthcare professionals to tune out the government's call to end sex selection. Instead, they focus only on the immediate benefits of the business. In order to effectively drive home the moral and ethical impacts of reinforcing the discrimination driving sex selective abortions, doctors must go through a more rigorous ethical training which will reduce the widespread acceptance of sex selection among the healthcare community. By holding healthcare professionals to more stringent ethical standards, the Indian government may be able to eliminate the element of peer support which is aiding healthcare workers in justifying offering sex selection. Without this peer support, the method of enforcement outlined in the PNDT Act would be far more effective, since healthcare workers would be more inclined to incriminate fellow healthcare workers. If the medical community were ethically on board with the government's sex selection policies, they might stop influencing trials of PNDT violations and the repercussions for violating the PNDT Act would be much more serious for healthcare professionals. Healthcare workers' ethical training must target and unsettle the collective bad faith which has developed from the normalization of sex selective abortion in India. They must wake up from their self-deceptive state to fully understand their role in creating a future in which daughters stand as equals with sons.

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