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"A Necessary Sin": An Ethnographic Study Of Sex Selection In Western India

Abstract
This dissertation analyzes sex-selective abortion in western India as a lived process with profound cultural, ethical, and demographic implications. Over the past three decades, selective elimination of female fetuses has emerged as a disturbing form of family planning across parts of Europe and Asia. In India, the practice remains widespread despite extensive efforts to combat it, with drastically skewed girl-to-boy ratios resulting in many locales. Drawing on eighteen months of ethnographic fieldwork with families and clinicians practicing sex selection, as well as with government officials and activists attempting to regulate it, this dissertation examines how prenatal sex determination marks fetuses with gender and incorporates them into local systems of kinship, biomedicine, and governance. Elucidating a kinship logic that renders daughters threatening and sons indispensable, I follow prospective parents and clinicians as they imagine divergent futures for children-to-be, navigate a clandestine black market, and employ specific biomedical techniques to produce and act on gendered fetuses. In the process of sex selection, fetuses become subject to complex ethical deliberations, familial struggles over reproductive decision-making, herbal and religious modalities of son production, and a host of public interventions aimed at saving daughters-to-be. I argue that the diverse actions around prenatal sex determination presuppose, shape, and intervene on a "gendered fetal subject"—an imagined or potential person whose liminal status (between human and non-human, between alive and un-alive) makes it a point of connection among households, clinics, and governance institutions. Tracing the production, transformation, and elimination of gendered fetal subjects reveals how kinship extends prenatally, as well as how fetuses become incorporated into social life. Furthermore, as suggested by prospective parents' fraught reflections on the notion of a "necessary sin" (profoundly unethical but nonetheless unavoidable), understanding gendered fetal subjects provides an entry point for untangling the moral complexities of sex selection as a liminal form of violence—a gendered violation at the very threshold of human social existence.

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"A NECESSARY SIN": AN ETHNOGRAPHIC STUDY OF SEX SELECTION IN WESTERN INDIA

Utpal Niranjan Sandesara

A DISSERTATION

in

Anthropology

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy

2017

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“A NECESSARY SIN”: AN ETHNOGRAPHIC STUDY OF SEX SELECTION IN WESTERN INDIA

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Utpal Niranjan Sandesara

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My dissertation committee helped shepherd this project from its inception as a difficult idea to its realization in this form. Adriana Petryna and Philippe Bourgois both offered invaluable guidance as advisers. Adriana's good humor, consistent enthusiasm, and unflagging encouragement sustained me even when the work proved difficult, and her intellectual influence has left an indelible mark on my approach to ethnography, theory, and the broader anthropological literature. Likewise, Philippe believed in this project from its very first stages, and our meandering conversations and his unwavering kindness provided critical sparks for many of its most important stages. Deb Thomas's tutelage in feminist and political anthropology has profoundly shaped my thinking around issues of gender, power, and the state, and her faith in the project has repeatedly buoyed me. Fran Barg's medical anthropological expertise, grantwriting instruction, and firm support propelled me forward at every stage of the process. With her administrative support, infinite wisdom, and admirable willingness to engage in long conversations with a neophyte, Leela Visaria proved a better local mentor than I possibly could have hoped for.

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And little Ruhi? Though she was yet unborn when I finished writing, her impending arrival provided an excellent motivation for efficient completion—just as her existence gives me a more profound appreciation of the material bound hereafter.

ABSTRACT

"A NECESSARY SIN": AN ETHNOGRAPHIC STUDY OF SEX SELECTION IN WESTERN INDIA

Utpal Niranjan Sandesara

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This dissertation analyzes sex-selective abortion in western India as a lived process with profound cultural, ethical, and demographic implications. Over the past three decades, selective elimination of female fetuses has emerged as a disturbing form of family planning across parts of Europe and Asia. In India, the practice remains widespread despite extensive efforts to combat it, with drastically skewed girl-to-boy ratios resulting in many locales. Drawing on eighteen months of ethnographic fieldwork with families and clinicians practicing sex selection, as well as with government officials and activists attempting to regulate it, this dissertation examines how prenatal sex determination marks fetuses with gender and incorporates them into local systems of kinship, biomedicine, and governance. Elucidating a kinship logic that renders daughters threatening and sons indispensable, I follow prospective parents and clinicians as they imagine divergent futures for children-to-be, navigate a clandestine black market, and employ specific biomedical techniques to produce and act on gendered fetuses. In the process of sex selection, fetuses become subject to complex ethical deliberations, familial struggles over reproductive decision-making, herbal and religious modalities of son production, and a

host of public interventions aimed at saving daughters-to-be. I argue that the diverse actions around prenatal sex determination presuppose, shape, and intervene on a "gendered fetal subject"—an imagined or potential person whose liminal status (between human and non-human, between alive and un-alive) makes it a point of connection among households, clinics, and governance institutions. Tracing the production, transformation, and elimination of gendered fetal subjects reveals how kinship extends prenatally, as well as how fetuses become incorporated into social life. Furthermore, as suggested by prospective parents' fraught reflections on the notion of a "necessary sin" (profoundly unethical but nonetheless unavoidable), understanding gendered fetal subjects provides an entry point for untangling the moral complexities of sex selection as a liminal form of violence—a gendered violation at the very threshold of human social existence.

TABLE OF CONTENTS

ACKNOWLEDGMENT ..... **III**

ABSTRACT ..... **VI**

TABLE OF CONTENTS ..... **VIII**

LIST OF TABLES ..... **XI**

LIST OF ILLUSTRATIONS ..... **XII**

A NOTE ON TRANSLATION, TRANSLITERATION, AND NAMING ..... **XIII**

INTRODUCTION **1**

Prologue: Asha-Ben and Jiten-bhai **1**

Situating the Problem **9**

Studies of Sex Selection **12**

Place and Person **25**

Constructing the Field **35**

The Gendered Fetal Subject **39**

CHAPTER 1: THE MARKET FOR SEX SELECTION **56**

"A Secret Thing" **56**

The Rise of Sex Selection: From the 1980s to 2001 ..... **59**

The Rise of Sex Selection Governance: From Antecedents to 2005 ..... **66**

An Evolving Market: 2005 to 2012 ..... **78**

Chetna Clinic **83**

Requests, Deflections, Refusals, Referrals **95**

Everyday Knowledge and the Sex Selection Landscape **102**

Vectors of Blame 107

CHAPTER 2: THE MORAL ECONOMY OF GENDER-KINSHIP 114

"A Necessary Sin" 114

Descent, Marriage, and Alienation 120

A Modern Reproductive Regime 128

Ambivalence, Uncertainty, and the Imposition of Gender 154

CHAPTER 3: THE CLINICAL PRACTICE OF SEX SELECTION 160

Seeing Inside the Black Box 160

Learning to See Fetal Sex 163

"1,000%": Error and Uncertainty 174

Sex-Selective Abortion and Risk 181

Late-Term Sex Tracking and Selective Perinatal Care 191

The Cutting Edge of Biomedical Sex Determination 197

CHAPTER 4: FAMILY DECISION-MAKING AND WOMEN'S AGENCY..... 203

Situating Reproductive Decisions 203

Contentious Decisions, Collective Decisions 209

Coercion: Preeti-ben 212

Pressure, Prohibition, and Coping: Pushpa-ben 219

Shifting In-Laws, Shifting Agency 223

Consensus, Divergence, and Women's Reasons 226

Constrained Agency, Impossible Choices: Kavita-ben, Again 235

CHAPTER 5: THE LOCAL ECOLOGY OF SON PRODUCTION 238

Struggling with Sonlessness 238

Biomedical Techniques: Reproductive Exhaustion 244

Herbal Techniques: Proactive Son Production **251**

Religious Techniques: Fate, Divine Will, and Bargains with God **260**

Coda: "A Necessary Sin," Again **275**

CHAPTER 6: ANTI-SEX SELECTION DISCOURSE **286**

The Backward Family **288**

The Imbalanced Population **296**

The Threatened Daughter **301**

CONCLUSION **322**

BIBLIOGRAPHY **325**

LIST OF TABLES

Table 1 – Child Sex Ratio (0-6) of Indian States and Territories 51

Table 2 – Child Sex Ratio Comparison: Northern/Kadva versus Central/Leua 53

Table 3 – Caste Composition of Baroda State Northern Division, 1931 54

Table 4 – Sex Ratio of Births in Three Mahesana-Area Villages (Early-2000s Survey) 159

LIST OF ILLUSTRATIONS

Figure 1 – Vectors of Blame Around Sex Selection 113

Figure 2 - Child Sex Ratio and Total Fertility Rate, 1981-2011 158

Figure 3 – Ultrasound Images of Fetal Genitalia, 12 Weeks 202

Figure 4 – “Can You Imagine a World Without Girls?” 313

Figure 5 – “Those Killing Girls in the Womb—Wake Up!” 314

Figure 6 – “A girl is an inalienable, necessary part of society” 315

Figure 7 – “Isn’t innocent laughter on your doorstep dear to you?” 316

Figure 8 – “These eyes full of feelings and the innocent face” 317

Figure 9 – “A few dreams, a few hopes” 319

Figure 10 – Silhouette and Skeleton 320

Figure 11 – “What Is My Flaw?” 321

A Note on Translation, Transliteration, and Naming

Throughout the text, most quotes are my own translations from Gujarati. While striving for English comprehensibility, I have attempted to preserve some of Gujarati speech's distinctive flavor (e.g., the use of juxtaposition to imply "and" or "or": "mother-father," "five-six," "boy-girl"). Conversations with doctors, government officials, and other professionals sometimes involved a mix of Gujarati and English, with switches between the two languages frequently occurring even within a single sentence; in such instances, I have not attempted to mark linguistic specificity. Rare instances of Hindi conversation are identified in the text.

Gujarati, Hindi, and Sanskrit words have been italicized wherever they appear in the text. In the interest of balancing readability and disambiguation, I have avoided diacritical marks save for the macron distinguishing "long" and "short" versions of 'a' (i.e., 'ā' versus 'a').

In naming persons, I have followed the same conventions of reference and address I followed during fieldwork, suffixing kinship terms as a sign of respect: generally *-ben* [sister] or *–bhāi* [brother, hereafter "–bhai"], and occasionally *–māsi* [mother's sister, hereafter "–masi"] or *–kākā* [father's brother, hereafter "–kaka"], for older figures with whom I bore relationships of closeness, affection, or deference. The word *sāheb* [boss, hereafter "saheb"] was used ubiquitously to refer to or address doctors, and I have preserved it in translation. For readability's sake, I have used the construction "Dr. [Name]" when referring to doctors in the text, even though this was rarely used in everyday conversation (the more common constructions being "[Name]-saheb," "[Name]-bhai," or "[Name] Doctor"). I have used pseudonyms for all persons and clinics, except when referring to the deceased or to widely known facts about public figures.

Introduction

Prologue: Asha-Ben and Jiten-bhai

We stood waiting under the full moon's cool light. It was late. The highway was deserted save for the occasionally passing truck and its attendant dust cloud.

Shivering under her sweater, Uma-masi looked pensive. When I asked her thoughts, she smiled: "Just thinking it'll be good if it's a boy! That's it—we want a good report."

Eventually, a car pulled up. A man and a woman sat up front, and another man behind them. Uma-masi and I crammed into the back seat. She provided just enough information to set the driver in the right direction.

Then, she asked, "How many girls do you have?"

"One girl, four years old," the man next to us replied.

"Caesarean, or normal?"

"Normal, normal." After a pause, the man continued, sounding concerned, "Why? Does it make a difference?"

"No, it's just—with a Caesarean, then..." Uma-masi's voice trailed off, and she stared out the window.

We stopped at a petrol pump. Under the bright lights, I could see the group better. The woman—Asha-ben—had a slight build, with a narrow face, an aquiline nose, and wire-rimmed glasses. She was wearing a salvaar-kameez, a tan cardigan, and a red headscarf. The man from the back seat—her husband, Jiten-bhai—was tall, with a boyish face, the faintest mustache, and a parted mop-top. He was wearing a rumpled blue blazer over a T-shirt and baggy corduroy trousers. The driver was Asha-ben's cousin.

Setting out again, the cousin drove slowly. He passed with caution and slowed to a crawl at speed bumps. Jiten-bhai murmured approval: "Yes, keep it slow, eh?... Be careful... We have to take care of this."

I learned that the family belonged to a local Prajapati (traditional potter) sub-caste. Jiten-bhai was a government engineer with an out-of-town posting. He and Asha-ben had returned to Mahesana, where their parents lived, just for this trip. They had found Uma-masi through the cousin's neighbor, a surgical assistant in one of the city's many clinics.

For most of the trip, the cousin and Uma-masi discussed their mutual acquaintance's futile pursuit of a son—thwarted by "damn luck," as his wife had now undergone two sex-selective abortions at great cost. Toward the end, the cousin mused, "I pray to God for him. But the universe doesn't let anyone off. If you have karma from prior births, you won't get a result no matter what you do." He added somberly, "And all this—getting rid of pregnancies—isn't that a sin, too?" Uma-masi grunted in agreement—"Of course."

As we approached the destination, Uma-masi's phone rang. Picking up, she murmured our location—"railway crossing"—and abruptly hung up.

"Saheb must be restless!" Asha-ben ventured. "Since he's sitting, waiting for this work. Would any other doctor be at his clinic like this, in the middle of the night? Wouldn't everyone ask why? There's a lot of risk in this work."

Uma-masi nodded gravely. "There's been a lot of checking lately."

"Who earns without taking risk?" the cousin asked with a smile.

Uma-masi instructed the cousin to park in an alley near the clinic. "In the daytime," she explained, "it'd be a problem. Who's checking now? Nothing to worry about!"

The couple, Uma-masi, and I entered the clinic. Throwing open the consultory door, Uma-masi marched in. We proceeded to the curtained-off examining area. Uma-masi directed Asha-ben onto the table, draped her lower body with a piece of cloth, and instructed her to expose her abdomen. Jiten-bhai stood directly across from the ultrasound machine. I sat by his side, on a short cabinet in the corner.

The doctor entered. With perfunctory greetings, he settled onto a stool in the center. Gripping the sonography machine's transducer, he slung the cord around his neck and began scanning Asha-ben's belly.

A grayscale image oscillated on the screen before us. At the center, a white-bounded space—the uterus—and around it, a background that pulsated rhythmically with Asha-ben's heartbeats and breathing. The doctor pressed buttons to zoom in on the fetus's thighs and then altered the transducer's position and angle to adjust the view. Jiten-bhai and Uma-masi gazed raptly at the screen. Asha-ben stared up at the ceiling, periodically closing her eyes and sighing.

After some minutes, the doctor shifted the image away from the fetal pelvis. He measured the skull to estimate the gestational age: fourteen weeks. Returning to the genital region and freezing the image, he reholstered the probe.

Asha-ben and Jiten-bhai looked at the doctor expectantly. Sighing, "*He Rām,*" he mumbled the result under his breath, so that only Uma-masi and I caught it: "Looks female." The couple turned toward Uma-masi. She shook her head. Covering her belly, Asha-ben swung her legs off the table and into to a sitting position. Uma-masi continued to frown and shake her head.

Turning to Jiten-bhai, the doctor declared, "It's a girl."

"Really, Saheb?" the husband asked weakly. Asha-ben stared down at the ground. Her jaw clenched.

The doctor continued speaking to Jiten-bhai. "Yes, definitely. No doubt. It's a girl." He pointed to the screen and began tracing. "Look. This is the child. This is the leg—thigh, knee, foot." Indicating a black area, he said, "This is the space between the thighs. Nothing's visible there. If it were male, you'd see the scrotum here." He pointed to the thigh. "The scrotum would be this color. But it would be"—now back to the black—"here. And you'd see a penis. You can see there's nothing here. Just black—blank space."

Jiten-bhai stared at the screen. "Yes, space..." he repeated, almost as if testing the idea out. Then, he scowled. "Certain?"

"Yes, yes. It's empty, so definitely female. 110%."

Gesturing toward the outside, Uma-masi commanded, “Let’s go! Talk it over outside. Decide what you want to do.”

Jiten-bhai shuffled out to the back corridor, and Asha-ben followed. Her cousin joined them from the waiting room. All three took verbal turns affirming abortion as the inevitable next step: “What else is left to think about?... No, it’s pretty much decided... What else is there?... Since we don’t want to keep it, what else?”

Asha-ben crossed her arms, folding her torso into itself. Jiten-bhai’s head hung, his eyes fixed on a floor tile.

Uma-masi emerged. They discussed abortion logistics. The cousin called the mutual acquaintance in Mahesana. Taking the phone, Uma-masi loudly reiterated the prices for scanning and selective abortion. After hanging up, she said with a scowl, “I made it clear to him! 15,000 if it’s a boy, 20,000 if it’s a girl.” The cousin objected, but she insisted.

Eventually, Jiten-bhai sighed and produced a stack of thousand-rupee notes. Taking them, Uma-masi returned to the consultory. Outside, the family debated abortion timing.

A moment later, Uma-masi summoned everyone in. Standing before the doctor’s desk, she declared that they could return in the early morning—before eight o’clock—or in the evening, after six. Asha-ben asked how long the abortion would take, and Uma-masi reassured her—no more than two hours. Jiten-bhai nodded and bowed to the doctor. We exited.

Walking to the car, Uma-masi emphasized the need to come at the prescribed times: “Otherwise, there could be checking happening. And the officials who do all this—their office is nearby. Got it?”

Then, in a hushed tone, she added, “The child is pretty big! It’s well-developed—more like four months.”

Appearing worried, both Asha-ben and Jiten-bhai asked, “Really?”

Adopting a pedagogic tone, Uma-masi said, “The child’s heartbeats and everything have started up. It’s pretty big!” After a pause, she smiled and said, “Keep it!” But we had reached the car, and the suggestion disappeared into the night air as everyone scattered to get into the vehicle.

As we rolled away, the cousin received a phone call. “Yes,” he shouted. “We’re coming back now.” He stated our location.

Uma-masi hissed at him, elongating each word: “*Don’t publicize it to everyone!*”

We all flew upward as the car went over a bump at high speed. “Watch it!” Asha-ben admonished sharply.

Raising one hand in a gesture of indifference, her cousin mumbled, “Well, now...” His voice trailed off. For the remainder of the trip, he continued driving jerkily.

Jiten-bhai’s phone rang—his mother. “Yes, yes...” we heard him say wearily. “Yes, that’s it... No, no. *That*... What else can we do? That’s it, right?”

After he hung up, Uma-masi shook her head and said, “I’m disappointed! I was thinking, ‘God’ll definitely give them a boy.’” She offered advice for the next day: “Be careful. Don’t say he’s an engineer, or where you live. I said he’s a teacher, with low pay. Don’t say anything, or Saheb‘ll take more!”

"But it's already too much!" the cousin protested. "Weren't you going to get the price reduced?"

"I got this done cheaply for you!" Uma-masi bellowed. "People aren't doing it for less than 50,000!"

The cousin raised his voice in response: "People do it for 10,000!"

"Where? You inquire, find a place, and then tell me, 'Masi, you got us too high a price!' You won't find it."

The cousin's voice softened a bit. "This time, we paid up. We'll have to go with you again, right? Get us an adjustment then. Right now, it is what it is." He continued in a more contemplative tone, "This time, we have to do wrong anyway. I mean, in the end, it's a sin, right? Usually I don't get involved in this work. I'll only do wrong if it's for my relatives. Just this, and then one time my wife's sister needed it—two years ago, she was pregnant, and very worried. She said, 'Find it for me, won't you?' I said no, but eventually I found it in Mahesana, and we got it done. He charged 5,000."

"Where'd you have it done?"

"Well, I don't want to name names—"

"Dr. Navin?"

"No, not there. He does it, too. But this was with Dr. Harnish."

"Oh, yes. Dr. Harnish used to look. He used to do abortions, too. But then he stopped everything."

"Right. This was two years ago. He said 5,000, and we paid 4,000."

"Right. But he doesn't do it anymore. Now our patients go to Dr. Navin, and he doesn't take less than 50,000. But his work is sloppy—a small machine, and he gets it wrong. You can't trust a man like that."

Here, Uma-masi pivoted. "Did you have any form filled?" she asked.

Jiten-bhai replied, "They take signatures when they do sonography, right? But—"

"With all your information—mobile number, address, all that?!"

"They always take that, no?

Uma-masi scowled. "Well, you'll have an inquiry after nine months!"

"Really?

"Yes, now they come for that. So say you had a miscarriage at home, at three months. Did you hear what happened recently? A doctor got caught in a raid. An Ahmedabad doctor was looking and sending patients to Gandhinagar for cancelling the pregnancy. There's intense checking going on right now!" Uma-masi seemed to be implying that if there were string operations in nearby Gandhinagar and Ahmedabad—Gujarat's state capital and largest city, respectively—the heightened policing might soon spread north to the smaller but infamous Mahesana District.

After a long silence, the cousin ventured a tentative inquiry: "Masi—Saheb's decision is sure, right? I'm just wondering if we should get it checked anywhere else—"

"1,000% sure! This doctor's never wrong. Especially since I was there—I can tell, too."

We passed the remaining journey quietly, save for Asha-ben and Jiten-bhai asking if I would return with them the next day—"for company." I said I would, albeit strictly as

a companion and researcher; I could not clinically or commercially facilitate, as Uma-masi might. They readily agreed.

Upon reaching Mahesana, the cousin drove to Uma-masi's neighborhood. When we reached her house, she got out. Motioning for Jiten-bhai to lower the window, she extended a hand: "You still have to give me mine!"

Jiten-bhai muttered an objection. Uma-masi persisted, now somewhat maternally: "No, no, that's not the way! After I got your work done?"

Jiten-bhai grudgingly pulled out a note. Squinting at it, Uma-masi asked incredulously, "What is this?!"

"We already gave Saheb so much!" the cousin yelled. "Why don't you get it from him tomorrow?" I caught a glimpse of the money: 100 rupees.

Shaking her head vigorously, Uma-masi countered, "No, no, he won't give! You have to give me mine separately."

In a tone both conciliatory and dismissive, the cousin retorted, "Well, we'll have to come to you again in the future, right?"

"No, no, that's no good. After I wasted my entire night for you? Come on—give me 500."

Jiten-bhai frowned. "I don't have 500."

Uma-masi frowned back. "That won't do."

"But if I don't have it, what do you want me to do?"

Uma-masi threatened to collect the money from their mutual acquaintance. The cousin reiterated that they would need her services in the inevitable next pregnancy. Shaking her head, Uma-masi turned brusquely and walked home.

After dropping Asha-ben at her parent's house, the men drove me to my apartment. As we rode, Jiten-bhai growled: "Honestly, Modi's wrong in doing all this. It should all be cleared away. People who really need it—people who already have one daughter—should have the freedom to get it looked at. People are going to have it done anyway."

His cousin-in-law suggested, "The government should fix a place, decide a price, and then give permission. All this secret activity wouldn't be necessary anymore—that much less headache. And especially for the poor class. Right now, those people can't get it done, and they don't have education, so they pop out five-six girls hoping a boy. If this were legal, it would protect the country's *ābādi* [population, prosperity] too."

"*Ābādi* is well and good," Jiten-bhai said. "But what's the sad state of the woman who has to do five-six deliveries? We educated people understand. We say, 'It's a girl? Okay, no problem.'" As if responding to the retort forming in my mind, he hastened to add, "Whether or not we *keep* it, that's a secondary issue! But the village public—no education, no literacy—they have this mentality: 'No, we *have* to have a boy.' What effect does that have on a woman? With this many deliveries, the body gets worn out, weak, ruined."

When we reached the apartment, Jiten-bhai took my number and said he would call in the morning.

I typed fieldnotes late into the night. I felt overwhelmed, unsure of how to understand my first observed "negative result," as Uma-masi called it. Her off-hand

suggestion—"Keep it!"—had gone unheeded. The mumbled "*He Rām*" and "female," the crestfallen faces, the blank stares and scowls, the grim decision, the reckless driving, the inevitability of the abortion, the shared sense of a pregnancy wasted—through all these, I understood, in a new way, the power of seeing gender prenatally.

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Jiten-bhai called shortly after 6:30 AM. After picking me up fifteen minutes later, he sped off toward the clinic.

Orienting myself in the car, I noticed a middle-aged woman in the back with Asha-ben—her mother-in-law. She introduced herself, explaining that she worked for a prominent obstetrician in Mahesana. We made some small talk.

During a lull in conversation, Asha-ben asked if the U.S. had a ban on "looking." I explained that, to the contrary, it was often a routine part of prenatal care. Jiten-bhai reiterated his view that the government ought to grant couples with daughters the "permission to look." He shook his head: "It'll never stop completely. The tool's there, so it's a way for doctors to make money. And people want a boy."

His mother interjected, "You know that neighbor—the one who came over to dry bean pods at our place? She had seven girls and got an abortion with the eighth!" Turning to her daughter-in-law, she said, "Twenty years ago, they did it by 'raw delivery'—the whole child came out!" I asked if her employer had provided sex selection services. Waving her hand dismissively, she snorted, "It was happening everywhere! Everyone was doing it. There were three-four a day at our clinic. Everyone'd be lined up! Back then, the whole child came out."

Asha-ben looked sharply out the window. She seemed uncomfortable. Her mother-in-law reassured her, "This is nothing. This'll be done in three hours. No need to worry. Back then, they put in medication, the pain started, and it happened slowly." She narrated the experiences of several acquaintances who had undergone sex-selective abortion by the old technique.

When we reached the clinic, a nurse pointed to a private room on a side corridor. The tile was dingy, the furnishing sparse—a stool, a cot, and a settee, with a window onto the street. Outside, crows cawed and sparrows sang. A faint light filtered through the diaphanous curtains.

The family sat down to wait, and I with them. They wondered aloud about where the doctor was. "We left Hetvi at home alone," Asha-ben explained. "And she doesn't do well without me. Since she has her cartoons, it's not a problem. But it's just them two—my father-in-law and Hetvi." She sighed. When a nurse entered, the mother-in-law confirmed the doctor would allow her, as a clinically experienced person, to accompany Asha-ben for the abortion.

Once the nurse departed, the older woman reassuringly observed, "The work'll be done in two hours! Not like the old era." Again, she rattled off numerous examples of "raw deliveries" among friends. Some cases were particularly gruesome, featuring perforated wombs or fetuses stuck inside due to clinician negligence.

Eventually, the mother-in-law shifted topics seemingly incongruously, detailing how her employer had paid for Jiten-bhai's education from elementary school through college. In concluding the long narrative, she turned toward me and said, "Even then,

when I talked to the doctor—'We need this work done for us'—it was a clear no! Not even a name!"

The nurse entered and summoned the two women. To my surprise, Asha-ben asked me to accompany them: "I'll feel more comfort." Afterward, she would explain that she had wanted another clinically trained person monitoring the doctor. Despite my disclaimer, I had not been able to fully set aside my biomedical identity.

After the abortion, sweepers shifted Asha-ben, still unconscious from sedation, back to the same room. Her mother-in-law and I followed behind. Once the sweepers left, Jiten-bhai turned to his mother and asked, "So does an entire soul come out—a whole girl? Does a whole child come out?" She furrowed her eyebrows: "No, no, you have to take out pieces."

Jiten-bhai sat alongside the cot. His mother and I lounged uneasily on the settee. From the window behind us, the tinny sound of a tea stall stereo playing Mohammed Rafi floated in: "*Chaudhvin kā chānd ho, yā āftāb ho*…" After a few minutes, the mother-in-law quietly stepped out. Sidling closer to the cot, Jiten-bhai picked up his wife's hand. Afterlooking at the pair—she unconscious, limp, breathing slowly; he slouched over, holding her hand, glancing between her face and the ground—I stepped out as well. Routine outpatient visits were in full flow, and I watched people come and go on the patio.

After fifteen minutes, we re-entered to find Asha-ben slowly waking. Her head writhed side-to-side, and she flapped her hands, communicating a message we could not grasp. Suddenly, her eyes shot open. A frown spread over her face. She gasped, and after a moment, we could make out the words: "Hetvi... Hetvi..." An urgency tinged the repetition of her daughter's name. Jiten-bhai quickly reassured his wife that Hetvi was alright; she was eating noodles and playing calmly, according to his father's report. Hearing this, the animation again left Asha-ben's body, and she slumped back to stillness.

When she stirred again after some minutes, she mumbled, "It hurts... It hurts..." Her mother-in-law's retort was flat: "Of course. Since they circled around in there, it's going to hurt."

Her eyes still closed, Asha-ben continued, "Was it a whole girl? Did a whole girl come out? Or was it pieces?"

Jiten-bhai shook his head and said, "Why do you want to know all that? We can discuss it after going home." He caressed his wife's head.

Asha-ben was just sitting up when a fortysomething man entered the room unannounced. Before we could say anything, he handed Jiten-bhai a pill packet and said, "If there's too much pain, give her these."

Finally receiving unhurried medical attention, Asha-ben grasped further: "So can I drink water?"

"Very little, or you'll feel nauseous. How many girls do you have? One? Well, now, before getting pregnant again, take Ayurvedic treatment." The newcomer pulled several brightly colored business cards from his shirt pocket. Handing them to the couple, he explained, "When you want to get pregnant, come see me. I'm a doctor. You'll get a result—1,000%! See, the women have no role in this, because the boy-girl thing depends

on XY-XX, and X and Y come from the man. So you have to start treatment for the man three months beforehand. 1,000%, you'll get a result." The couple nodded.

As they spoke further, Jiten-bhai handed me one of the cards. I turned it over and took in the information: "Dr. Rajen," an Ayurvedic fertility specialist, based in a neighboring district. My attention snapped back as I heard the doctor mention abortion: "... but there's so much headache in all this. Instead, better to get treatment for a boy from the beginning."

His phone rang, and he answered: "Arrived?... Okay, ask for 'Chetna Clinic'... Call when you're here."

After hanging up, Dr. Rajen continued his previous instructions: "And then, if you want to get it checked, we do that too. If you want it done in a different city, we can do that, too. But I have 1,000% success! I can give you thousands of names." Saying this, he left to find his clients.

Shortly thereafter, Asha-ben felt ready to leave. Swinging her legs off the cot, she willed herself up. Jiten-bhai and I supported her like human crutches, and she tottered forward. We exited to the patio. Jiten-bhai brought around the car. Asha-ben lay down in the back, her head on her mother-in-law's lap.

Some kilometers out, we hit a nail. As Jiten-bhai and I jacked up the car at a nearby petrol pump, I asked quietly, "So were you decided—with a girl, you weren't going to keep it?"

Removing the wheel nuts, he furrowed his brow momentarily. Then, with a sigh: "Yes, yes. We had decided. No question." After changing the tire, we rode back to Mahesana in silence.

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Some aspects of the encounter with Asha-ben and Jiten-bhai were atypical in my fieldwork with north Gujarat families—her relative taciturnity, for instance, or the opacity of the reasoning (Chapter 2) and familial decision-making (Chapter 4) around selective reproduction. But in other ways, the couple's story exemplifies important findings from my research: the prominence of intermediaries, bargaining, partial knowledges, and policing in the black market for sex selection (Chapter 1); the sonographic search for genitalia, the related uncertainties, and the ensuing clinical reactions (Chapter 3); the complementation of biomedical treatment with non-biomedical techniques for enhancing son production, and the ethical dilemmas of sin (Chapter 5); and just-out-of-sight regulation from the state and other governance bodies (Chapter 6). These were hallmarks of sex selection as process, problem, and human experience.

This dissertation attempts to *explain* a form of gendered violence by situating instances of that violence within ethnography and then situating that ethnography within broader social structures.[1] I illustrate how gendered fetuses tie together families, reproductive medicine, and governance institutions in various ways—some perhaps obvious, some unexpected, all deeply troubling. What follows is an effort to understand stories like Asha-ben and Jiten-bhai's in their poignancy, complexity, and social embeddedness.

[1] cf. Farmer 2003: 41.

Situating the Problem

The Public Secret

Over the past three decades, a troubling new form of family planning has emerged in India: the selective abortion of female fetuses. The practice has seismically shifted populations by preventing the births of millions of girls. This trend parallels developments in much of Eurasia, from the Balkan Peninsula to China. In all these places, and among significant sections of their worldwide diasporas, sex selection has become commonplace.

In India, as elsewhere, the magnitude of the problem is most commonly represented through sex ratio (SR). A staple figure of demography, the SR measures the number of female persons per 1,000 male persons in a particular population.[2] Two variations figure prominently in discourse on sex selection. One is the SR at birth (SRB). The other is the child SR (CSR), or the SR within a specified young age bracket; in Indian census statistics, for example, the CSR represents children aged 0-6. Demographers and other scientists generally agree that human biology favors the generation of slightly more boys than girls, leading to SRBs between 935 and 971 in the absence of outside intervention.[3] Perinatally and postnatally, a "female survival advantage" may countervail the skewing at birth, with girls better equipped to survive tribulations in late gestation, infancy, and early childhood—all other factors being equal.[4]

Historically, female infanticide, neglect, physical abuse, and other forms of gendered violence have erased or even reversed the early-life female survival advantage in India. But sex selection has inaugurated an unprecedented skewing of SRBs and CSRs by making it possible to eliminate girls prenatally—to prevent them from coming into full social existence. Between 1981 and 2011 the countrywide CSR fell from 962 to 914. In nearly a third of the country's states and territories—including Gujarat, where Asha-ben and Jiten-bhai's story unfolded—the 2011 figure was below 900 (Table 1). Forty-nine districts and seventy cities exhibited CSRs below 850.[5]

The falling CSR and the "disappearing daughter" have become the twin representational pillars of one of twenty-first-century India's chief public crises.[6] In his

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[2] The international demographic convention is to present sex ratio as the number of males per 100 females. Throughout this dissertation, I follow the Indian convention of females per 1,000 males for two reasons. First, it remains true to the representations circulating in my field site. Second, I also believe it facilitates an easier intuitive grasp of the number of "missing" women.

[3] Chahnazarian 1988; Waldron 1998: 53-63. For a detailed analysis of claims regarding "natural" SRBs, see Brian and Jaisson 2007.

[4] Hill and Upchurch 1995; Waldron 1983: 323-324, 1998: 64-108. For analyses based on neonatal mortality data from India during the 1990s and 2000s, see C. Kumar et al. 2013: 125; Million Death Study Collaborators 2010: 1855.

[5] The entities with CSRs below 850 represent 8.3% of the country's 593 districts and 15% of the 468 cities or urban agglomerations with populations greater than 100,000. Unlike most census statistics in the dissertation, which are drawn from the Census of India's final enumeration data, these figures are based on the provisional population totals.

[6] In characterizing sex selection as a "crisis," I mean to highlight the ways in which public construction of crises constrains the very terms available for thinking about them (Roitman 2013) while creating a form of "scandalous publicity" centered on affective mergers of state, citizen, society, and problem (Cohen 1999).

January 2015 speech announcing the launch of a national Beti Bachāo, Beti Padhāo ["Save the Daughter, Educate the Daughter"] campaign, Prime Minister Narendra Modi called sex selection a sign of "mental illness" and a harbinger of "terrible crisis."[7] Invoking historical practices of female infanticide, he declared, "From our mindset, we belong to the eighteenth century. We are not fit to be called people from the twenty-first century. In the eighteenth century, the girl child was allowed to see the mother's face and then [killed]. We are worse, as we kill our girls in the womb and don't let them be born... Like a beggar, this PM is begging you for the life of girls."[8]

While the countrywide campaign is recent, discourse on sex selection has pervaded Indian society for some time. Countless television segments, newspaper articles, and academic studies have focused on the problem. Various state governments and NGOs have implemented campaigns to "save the daughter," mobilizing diverse techniques from cash incentives to street theater and visual art. A national law has expressly prohibited prenatal sex detection for over two decades.

Nonetheless, selective abortion of female fetuses continues ubiquitously, a "public secret" whose enactment lies just outside official visibility.[9] The practice comprises two stages: sex determination (SD) and selective abortion. A biomedical test—usually an ultrasound scan in the fourth gestational month—materializes the sex of the fetus, establishing it as a son- or daughter-to-be. Male fetuses are subsequently nurtured to birth, while female fetuses are aborted.

Despite the hyper-proliferation of talk about sex selection, there remains a need for further description and analysis of the actions that families, clinicians, and governance institutions take with respect to the gendered fetus. This dissertation is a response to that need. In the following pages, I attempt to render visible the everyday, "on-the-ground" complexities of sex selection as a lived process.

Difference, Power, and "Family Values"

Upon hearing about my research, many American listeners have jumped to a common refrain: *But why can't they just see that boys and girls are the* same*? That they can do the same things?* I have frequently found myself pointing out the distinct but nonetheless pervasive ways in which gender inequality persists in the West. But I have also found myself returning to the contrasts Mahesana-area repeatedly drew between Gujarati and American kinship.

While granting that sex selection was not a problem in the U.S., many families situated the divergence as a function of fundamental differences in "family values," "rules," "social structure," "social system," or "culture"—differences that did not leave American families unindicted. Why, people asked, was "European" or "white" kinship so unreliable, with widespread divorce and a lack of normative closeness between siblings? How could Americans bear to live in a society that normalized the tragic separation of

[7] The Tribune 2015.
[8] The Tribune 2015.
[9] M. Taussig 1999.

sons from parents?[10] Why did we "throw" our elderly into "old age homes," rather than loving them, caring for them, and serving them till their deaths (at any cost)? How could anyone countenance kinship norms that prioritized a thin individual independence over thickness, extensiveness, and mutuality? In short, while acknowledging that Americans must see sex selection as deeply problematic, pregnant women and their relatives could readily point to what they saw as deeply problematic aspects of American kinship.[11]

It is a truism that every society's kinship system prioritizes some desiderata over others, rendering certain possibilities commonsensical and others highly unlikely, certain roles coveted and others tragic. Social order, personhood, and their reproduction rest on norms and practices that both potentiate and constrain, often building in forms of alienation and even violence.[12] Normative Gujarati and American kinship can each be caricatured as possessing certain predominant values (e.g., predictability versus freedom) and certain threatened figures (e.g., aborted female fetuses versus abandoned elders, gender inequality versus domestic stability). By no accident, the very forms of sociality that give rise to each order's characteristic problems also render the other's simultaneously more visible and less comprehensible.

I do not wish to overdraw the parallel between the social problems posed by each society's kinship structure—much less to normalize sex selection. But by invoking the comparison, I am arguing for coupling specificity and nuance with a broad approach that recognizes how *all* gender and kinship arrangements obviate some problems while raising others.

The rhetoric of "saving women" can prove dangerous, particularly when combined with a "consistent resort to the cultural" as an explanation for gender inequality.[13] For instance, while feminist discourse grants U.S. domestic violence victims social, political, and human specificity, it often portrays Indian counterparts as suffering a "death by culture."[14] A glance at colonial representations of sati, dowry, and female infanticide reveals how Orientalizing constructions like the "contentious tradition," the "cultural crime," and the "savage family" have historically obscured the inner workings of gendered violence while enacting new forms of sociopolitical oppression.[15] So, too, the neo-colonial discourses of hegemonic Western feminism have often subjected "the

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[10] Although I observed numerous cases of sons establishing separate households in Gujarat, the practice still faced a considerable degree of social opprobrium.

[11] That many of the "favorable" Gujarati regularities existed only in the ideal, with the messiness of everyday experience infinitely complicating them, does not reduce their rhetorical or (in my context) comparative force. I am reminded of the delightful opening to Parry's article on sex, marriage, and divorce among working class couples in Chhattisgarh: "I once met a man with a brief case on a train ... I forget between where and where. If you have travelled by train in India you may have met him too. He is conscious of cultural difference and wishes you to understand that Indians have family values—on account of which they don't go in for divorce or extra-marital sex. It was possibly he who first told me (though I have read it somewhere since) that actuarial calculations reveal that one in three marriages in Britain, and one in two in the United States, is destined to end in divorce" (2001: 783).

[12] cf. Pinto 2014.

[13] Abu-Lughod 2002.

[14] U. Narayan 1997: 81-117.

[15] Mani 1998; V. Oldenburg 2002; S. Sen 2002. See also Liddle and Joshi 1985.

third world woman" to "Western eyes," with lamentable consequences.[16] You and I must both resist facile fantasies of "saving" Indian women from Indian patriarchy.[17]

As a Gujarati-American man writing on sex selection, I seek to balance careful attention to difference with robust moral outrage, so that the combination may rectify tendencies toward insipidness and decontextualization, respectively.[18] This dissertation examines how patriarchy lodges in and reproduces itself through one practice, in all its historically and culturally constituted specificity. At the same time, as I discuss below, the narrow story presented here does tell us something broader about gender, power, and visibility.

Studies of Sex Selection

India's skewed SRs have garnered extensive scholarly attention. In a masterful review, Mary John has observed that the quest to understand sex selection has spanned an "obsession with numbers" (from demography) and an insistence on local, qualitative insights (from "micro-studies" and ethnographies).[19] Here, I sequentially discuss demographic, historical, and fieldwork-based research on skewed SRs, drawing out the conceptual tools and empirical findings that comprise scholarly understandings of sex-selective reproduction in India. (Comparative material from elsewhere in Asia appears in the notes.)

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[16] C. T. Mohanty 1986. See also Liddle and Rai 1998.
[17] Spivak 1988: 297.
[18] cf. Walley 1997.
[19] John 2014. In addition to John's review, several pieces provide helpful handles on the vast literature around skewed SRs. Hesketh and Zhu (2006) and Dyson (2012) have tackled the question of "abnormal" or "skewed" sex ratios generally, covering postnatal discrimination and sex disparity at various ages alongside prenatal sex selection. Guilmoto and Tovey (2015) have specifically addressed "masculinization of births," shepherding a vast array of evidence on SRB skewing in Asia and Eastern Europe. The essays in Attané and Guilmoto's *Watering the Neighbour's Garden* (2007) reflect the breadth and depth of quantitative and qualitative work on "female demographic deficit" across different Asian contexts. Though older, Croll (2000) and Miller (2001) remain valuable as anthropological reviews of 1990s literature on skewed CSRs and childhood gender discrimination. While smaller Indian syntheses exist, there remains a need for the sort of extended treatment Attané has given the "demographic masculinization" of China (2013).

I would add to John's comment on the "obsession with numbers" that demography's disciplinary emphasis on the notion of demographic transition has also played a decisive role in framing research and praxis on sex selection. (The literature on demographic transition theory itself is vast, and I cannot do it justice here; see Caldwell et al. [2005] for one synthetic account. Johnson-Hanks [2008] provides an overview of demographic transition theory for anthropologists, while Szreter [1993] and Greenhalgh [1996] offer historical analyses of the theory's centrality to the rise and functioning of demography as a research and policy enterprise.) The core presumption commonly embedded in demographic transition theory—that historically specific processes of development prompt populations to pass from pre-modern conditions of high fertility and mortality through a transitory population boom due to falling mortality and ongoing high fertility to a fully modern state of low mortality, low fertility, and low population growth—creates a triumphalist narrative that squares poorly with the proliferation of high-technology sex selection. Dichotomies emanating from unilinear demographic transition narratives—between "tradition" and "modernity," between the "bad" demographic behavior of the poor or rural and the "good" behavior of their affluent or urban counterparts—have plagued research and policy-making around the population manifestations of prenatal gender discrimination.

"Missing Women": Quantifying Gender Inequality

The prominence of skewed SRs in Indian discourses around gender inequality traces to three seminal publications of the 1970s. During that decade, a pair of demographic monographs tackled the longstanding pattern of overall male-female imbalance in India's population, ultimately concluding that it had to originate in "excess female mortality" (EFM), particularly during early-childhood and childbearing years.[20] Contemporaneously, the Committee on the Status of Women in India devoted the first substantive pages of its monumental report to "the decline in the sex ratio ever since 1901," deeming it "a disturbing phenomenon in the context of the status of women" and exploring its relation to unequal mortality rates and life expectancies.[21] Together, these three publications firmly established India's skewed SRs as a problem for further investigation.

By the 1990s, quantification of EFM increasingly took the form of counting "missing women."[22] Studies in this vein suggested differential mortality had produced a shortfall of 60 to 100 million women worldwide, with a third in India alone. A 2002 reanalysis argued that while EFM rates and proportions of missing women had both fallen, declining SRBs due to sex-selective abortion were partly offsetting the improvements.[23]

By that point, specific estimates of prenatal sex selection were emerging. Analyses of data from the 1990s suggested radical skewing of SRBs and CSRs, particularly in northwestern states like Punjab, Haryana, and Gujarat.[24] One investigation concluded India's proportion of "missing girls" aged 0-6 had risen from 1.9% in 1981 to

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[20] Mitra 1979; P. Visaria 1971. Both authors systematically refuted gender-differential migration, under-enumeration of women, or biological variations in SRB as possible causes of skewed overall SRs.

[21] CSWI 1974: 9-22.

[22] Originally proposed by Amartya Sen (1990, 1992), the "missing women" measure was soon taken up by several other scholars (Coale 1991; Klasen 1994).

[23] Klasen and Wink 2002.

[24] Arnold et al. 2002: 764-766; Bhat 2002b: 5254-5258; Bhat and Zavier 2007: 133-140; Das Gupta and Bhat 1997: 310-311; Retherford and Roy 2003; Sudha and Rajan 1999: 596-604, 612; Sudha and Rajan 2003. For similar examinations in China, see Banister 2004; Hull 1990; Johansson and Nygren 1991; Zeng et al. 1993. For South Korea, see Kim 1995; Park and Cho 1995. For a comparative analysis of CSRs and "missing women" across India, China, and South Korea, see Das Gupta et al. 2009. Skewing of SRB in Vietnam did not take off until the mid-2000s (Belanger et al. 2003), but it has since progressed rapidly (Guilmoto 2012b; Guilmoto et al. 2009; ISDS 2007). There is also clear evidence of skewed SRBs in the Caucasus (Duthé et al. 2012; Mesle et al. 2007; UNFPA 2013, 2014), Albania (UNFPA 2012), Hong Kong (Wong et al. 2010) and Nepal (Frost et al. 2013).

By contrast, studies in Bangladesh's Matlab district have demonstrated that despite a history of EFM and discriminatory treatment in health and nutrition (L. Chen et al. 1981; D'Souza and Chen 1980), sex selection has not taken hold, even with couples pursuing pregnancy largely to have a son (Bairagi 2001); EFM and fertility rates have fallen without any concomitant rise in SRB (Alam et al. 2007; Kabeer et al. 2013). Given Japan's patrilineal kinship system, agrarian-industrial economic history, and low fertility rates, its relatively balanced SRs also present a contrast to India and the rest of East Asia. Historical demography reveals "weak son preference" with no evidence of EFM from the 1600s through the early twentieth century (Kikuzawa 1999; Kureishi and Wakabayashi 2011), and Caldwell and Caldwell (2005) have discussed reasons why infanticide in Tokugawa Japan, though a common method of family planning, did not acquire a sex bias.

3.8% in 2001.[25] Estimates of countrywide sex-selective abortions around the turn of the millennium ranged from 100,000 to 500,000 annually.[26] Two studies hazarded approximations of cumulative prenatal sex selection since 1980, yielding figures of several hundred thousand annually and several million in aggregate. [27] Meanwhile, numerous analyses of large reproductive health datasets attempted to infer the relationship between prenatal ultrasound and selective abortion.[28] In short, measuring sex selection became a major pursuit.[29]

Causality and Patterning: Kinship, Economy, Value

Scholarship on skewed SRs and sex selection has aspired to more than just quantification of magnitudes and trends. Much research has tackled questions of *why, how*, and *in what pattern*. The kernels of present-day social scientific thinking on such questions may be found in two studies—an anthropologist's library analysis and a demographer's field investigation—from the 1980s, when selective abortion had yet to

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[25] L. Visaria 2007a: 64-66. For an earlier estimate of the "missing women" added to various state-level populations during the 1980s, see Das Gupta and Bhat 1997: 311.

[26] The 100,000 figure is from Arnold et al. (2002)., and the 500,000 figure from Jha et al. (2006). Other estimates for annual sex-selective abortion during the same period include 370,000 (Bhaskar and Gupta 2007) and 480,000 (Bhalotra and Cochrane 2010). For a similar attempt to quantify the extent of selective abortion in South Korea, see Kim 2002. For China, the quantification of sex-selective abortion has acquired a specific urgency in light of ambiguity in the relative contributions of prenatal sex selection, female infanticide and child death, and under-reporting of female births; for some contributions suggesting the importance of sex-selective abortion, see Banister 2004; Johansson and Nygren 1991; Wu et al. 2006; Zeng et al. 1993; Zhu et al. 2009.

[27] Jha et al. 2011; P. M. Kulkarni 2007.

[28] Arnold et al. 2002; Arnold and Parasuraman 2009; Bhalotra and Cochrane 2010; Bhat and Zavier 2007; Retherford and Roy 2003; Rosenblum and Akbulut-Yuksel 2012. Y. Chen et al. (2013) analyzed the relationship between ultrasound diffusion and prenatal sex selection in China.

[29] Although they are tangential to my analysis, it also bears mentioning two scholarly debates regarding sex selection that played out during the late 1990s and early 2000s. First, there was the continuing question of whether factors other than EFM and sex selection might account for "missing women." The most far-fetched and widely publicized hypothesis in this vein may have been Oster's proposal (2005) that much of the "missing women" problem in Asia could be explained by a SRB of 1.50 among carriers of hepatitis B, a notion that was resoundingly refuted (Das Gupta 2005). Agnihotri directed much of his work at closing "escape hatches" such as differential migration, under-enumeration, or variation in SRB (2000, 2003). Even those demographers who expressed skepticism regarding the veracity of pre-1951 overall SRs as indexes of gender discrimination ultimately agreed that the post-1980 CSR figures could only be understood as consequences of sex selection (Bhat 2002a, 2002b; Bhat and Zavier 2007).

The second debate concerned whether prenatal sex selection might, to some extent, act as a *substitute* for postnatal EFM, enhancing the survival chances of the girls that were born. Goodkind championed this possibility (1999, 2003) additionally venturing into normative territory by arguing that such substitutive effects might problematize the ethics of condemning sex-selective abortion. Drawing on a variety of quantitative data, Sudha and Rajan demonstrated that the "substitutive effect" did not prevail in India; instead, regions with high SRBs also tended to exhibit high EFM, creating a situation of "double jeopardy" (1999, 2003; see also Agnihotri 2001). More recent data suggest that while the practice of sex-selective abortion may help reduce EFM, the number of girls surviving due to a reduced mortality gap is more than offset by the number of girls eliminated prenatally (Rosenblum 2013). Li et al. (2007) find signs of an additive effect in the Chinese data as well.

capture the scholarly imagination and EFM remained the predominant mechanism of CSR skewing.

Barbara Miller's 1981 book *The Endangered Sex* evaluated regional EFM differences through a literature review-based synthesis.[30] Building on an economist's earlier hypothesis, Miller argued that northwestern India's predominant agrarian production mode—low-labor-intensity wheat cultivation—led to women's productive exclusion and social seclusion, along with intense "son preference" and "daughter discrimination"; by contrast, the southeast's rice-paddy agriculture required more labor, resulting in women's economic inclusion, moderate son preference, and daughter appreciation.[31] Miller distinguished between the "emic" reasons given for son preference—dowry, marriage costs, threats to honor, old age care, ritual needs—and the "etic" factor underlying gender discrimination—devaluation of women's work. Presaging the advent of prenatal sex selection, Miller warned, "A form of birth control which regulates the sex of offspring... would find a wide audience of acceptors in rural India... There is the strong possibility that such a method would have the undesirable result of an even more drastic imbalancing of the sex ratio."[32]

Miller's work anticipated subsequent attention to the "demographic divide" separating northwestern and southwestern India.[33] Her focus on agrarian systems foreshadowed subsequent work on associations between SR skewing and production and prosperity. And the emic motivations she cataloged would remain, virtually unchanged, the same ones recapitulated in superficial twenty-first century analyses of selective abortion. Curiously, though an anthropologist, Miller did not mention differences in systems apart from the narrow issue of marriage costs and gifts.[34] Her thesis was straightforward: social value and survival prospects rested on gendered allocation of work.

Appearing as amniocentesis and sex-selective abortion first became visible in public culture, *The Endangered Sex* sparked a famous scholarly debate in the journal

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[30] Miller 1997.

[31] The agrarian production hypothesis appeared in conjectural form in Bardhan 1974: 1303-1304. (Interestingly, in noting that states with high female death rates also tended to exhibit drastic EFM, Bardhan singled out Uttar Pradesh, Punjab, Rajasthan, and Gujarat.) Miller cautioned that property-holding mattered, with non-propertied families in different regions behaving more similarly to each other than to their propertied neighbors.

[32] Miller 1997: 35-36.

[33] The seminal work for bringing the northwest-southeast dichotomy into demographic debate was Dyson and Moore 1983. Citing Miller as a precedent, Dyson and Moore argued for geographical division of India into two broad demographic regimes, with the northwest characterized by skewed SRs, high fertility, and high infant and child mortality, and the southeast by the inverse. They posited that the regional bifurcation rested on sociocultural variation in kinship patterns, which led to differing levels of female autonomy and, more distally, different demographic behavior. (More specifically, they characterized north Indian kinship as favoring exogamy, agnatic cooperation, women's non-inheritance, inferiority of wife-givers to wife-takers, dowry payments, and a preoccupation with seclusion and honor; they then contrasted south Indian kinship as favoring endogamy, affinal cooperation, women's property rights, affinal equality, bridewealth or weak dowry, and less rigid control of female sexuality.)

[34] As just one glaring example, matriliny—a major sociocultural feature distinguishing some parts of the south—did not receive mention except in a footnote on dowry in Kerala (Miller 1997: 148fn149).

Economic and Political Weekly. Responding to a book review reiterating Miller's fears about prenatal sex selection,[35] economist Dharma Kumar asked, "Why conclude that all of North India will go in for mass female foeticide in the twenty-first century?"[36] Labeling "absurd" the assumption that "a desire for at least one son... will lead to the 'demise of the female,'" she argued "supply of and demand for women" would eventually lead to a reproductive equilibrium.[37] Her essay, which concluded with provocative questions—"Is not female foeticide better than female infanticide, or even than severe ill-treatment of little girls? What are the alternative policies of improving the treatment of women?"[38]—prompted responses that congealed around several core questions: Was sex selection an "economic" (i.e., self-correcting) or "cultural" (i.e., non-self-correcting) problem? Was the separation of "cultural" and "economic" itself misguided? Was prenatal sex selection preferable to infanticide? Or was the comparison inapt, given the low likelihood of people resorting to the latter as uniformly or easily? Given sex selection's apparent acceptability and compatibility with family-building desires, how rapidly would it spread if made more accessible? And how might one imagine alternative social arrangements—ones in which female fetuses might not be aborted?[39] The contention ignited by Miller's book foreshadowed contemporary discourses around sex selection in the resort to "supply-and-demand" arguments,[40] the salience of the infanticide comparison, the disputation of culture-versus-economy framings, and the acknowledgement of prenatal sex selection's rapid proliferation.

The family-building strategies discussed in the *Economic and Political Weekly* debate appeared empirically in the second representative investigation from the 1980s, Monica Das Gupta's 1987 analysis of child mortality in eleven Punjabi villages.[41] Das Gupta found EFM concentrated in particular reproductive scenarios: sex differentials in mortality rose with birth order and especially for girls with a living sister. The study also correlated fertility decline, education and prosperity with lower child mortality but *greater* EFM, suggesting a greater selectivity. Das Gupta speculated about possible explanations for gender discrimination, ultimately tracing EFM to the locally dominant Jat caste's "culture" and other castes' emulation of it. In this view, women's displacement to conjugal households after marriage, along with the economic and political organization resulting from this kinship pattern, rendered girls of limited value to their parents. Echoing the notion of a demographic divide, Das Gupta contrasted Punjab with south India, which exhibited lower EFM amid kinship structures that did not uproot daughters as radically from natal families.

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[35] Bardhan 1982: 1450.
[36] D. Kumar 1983b: 62.
[37] D. Kumar 1983b: 63.
[38] D. Kumar 1983b: 64.
[39] For the contributions to this debate, see Dube 1983a, 1983b; R. Jeffery and Jeffery 1983; D. Kumar 1983a; Vishwanath 1983. For a follow-up essay by the authors of one of the contributions, see R. Jeffery et al. 1984.
[40] For a recent review of "supply-and-demand arguments", see P. Jeffery 2014. I ethnographically analyze such arguments in everyday talk around Mahesana elsewhere (Sandesara ms).
[41] Das Gupta 1987. The villages had been included in the Khanna Study, made (in)famous in anthropology by Mamdani (1973).

Das Gupta's investigation established that falling fertility, rising education, and high prosperity—hallmarks of "modernization" or "development"—could coexist with and even exacerbate EFM. The study situated EFM as a family planning mechanism: older sisters diminished the survival prospects for additional girls. The pattern was more extreme among the affluent, who could better modulate their children's well-being through selective investments. Moreover, by highlighting Jat "culture," Das Gupta championed kinship as an explanatory factor to rival Miller's agrarian economy.[42]

Subsequent quantitative research on SR, EFM, and sex-selective abortion has largely echoed Das Gupta's findings. As I discuss in Chapter 2, various studies have associated EFM and prenatal sex selection with falling fertility, higher-order births to parents with daughters, and higher levels of prosperity.[43] Put differently, couples like Asha-ben and Jiten-bhai—urban, educated, and affluent, with one or more daughters—were disproportionately likely to pursue sex selection.

Over the past fifteen years, a plethora of demographic analyses have further examined the patterns and consequences of sex selection. Several have attempted to

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[42] Much subsequent research would treat kinship and economics as competing, rather than complementary (see, for instance, the debate addressed in Banerjee and Jain 2001), despite Kishor's forceful argument for considering the two together (1993). Examining local-level patterning of EFM in relation to spatial exogamy and female labor force participation, Kishor found greater exogamy was associated with higher EFM (the result anticipated by Das Gupta) but that the effect was weakened by interaction with higher rates of women's work (a result with echoes of Miller). She also found an independent effect of rice cultivation in reducing EFM.

[43] For the association between falling fertility and intensification of sex selection, see A. Basu 1992, 1999; Das Gupta and Bhat 1997; Sudha and Rajan 1999, 2003. Similar patterns have been identified, at different time-points, in South Korea (Park and Cho 1995) and Vietnam (Guilmoto 2012b; Guilmoto et al. 2009). In China, the drastic fertility decline associated with implementation of the One-Child Policy in the early 1980s greatly exacerbated SR skewing (e.g., Eklund 2011b; Greenhalgh 2001; Greenhalgh and Li 1995; Li et al. 2007; Zeng et al. 1993: 29-33). Guilmoto has recently formalized this effect with the notion of a "sex ratio transition" due to "fertility squeeze" (2009).

For the association of higher birth order (and existing daughters) with discriminatory behavior, EFM, and prenatal sex selection, see Arnold et al. 1996; Arnold et al. 2002; Arokiasamy 2004; Jha et al. 2011; Jha et al. 2006; V. Mishra et al. 2004; Muhuri and Preston 1991; R. Pande 2003; Retherford and Roy 2003. A careful analysis of data for Tamil Nadu by Srinivasan (2015) found "daughter deficit"—due to both prenatal sex selection and female infanticide—rising with birth order. See also Diamond-Smith et al. (2008), who found female infanticide concentrated in higher-order births and among families with daughters. Similar effects have been demonstrated for prenatal sex selection in China (Banister 2004; Li et al. 2007: 27-29; Poston et al. 1997), South Korea (Kim 2002; Park and Cho 1995), Vietnam (Guilmoto et al. 2009), and the Caucasus countries (Duthé et al. 2012; Mesle et al. 2007).

For the association of EFM and sex-selective abortion with markers of affluence (urban residence, maternal education, wealth expenditure, landholding, high standard of living, and upper-caste status), see Agnihotri 2000, 2003; Arokiasamy and Goli 2012; Guilmoto 2008: 100-109; Jha et al. 2011; Jha et al. 2006; Murthi et al. 1995; Retherford and Roy 2003; Siddhanta et al. 2003. In contrast to the Indian data, Chinese data reveal greater sex selection in rural areas (Banister 2004; Guilmoto and Attané 2007). While the Chinese material suggests an inverted-U (Kuznets-type) curve for the relationship between SRB and socioeconomic status, the Indian material lends support to the notion of a monotonic decrease in SRB with rising affluence (Guilmoto and Ren 2011). Although this conclusion at the countrywide level may mask more complex regional patterns, the analysis in Siddhanta et al. (2003) suggests a similar pattern of monotonic decrease for many states, including Gujarat.

measure how the PCPNDT Act or government incentive programs have impacted SRs.[44] Many others have modeled future marriage patterns, with one recent paper projecting the proportion of involuntary bachelorhood among Indian men aged 50 to reach as high as 10% by 2065.[45] A detailed field survey in North India has associated perceived shortage of brides with various changes in gender and kinship practices, including reduced dowry, shifting inheritance patterns, greater flexibility in post-marital residence, reduced restrictions on women, and lower stated son preference.[46] Research has demonstrated sex skewing in births to Indian-born women in England and Wales, Canada, and the United States.[47] And building on calls for "disaggregated analysis" and attention to inter-regional "convergence," numerous recent works have focused on the spatial patterning of skewed SRs, challenging the northwest-southeast dichotomy by demonstrating differences within the two regions and commonalities across them.[48] In short, quantitative analyses have helpfully delineated diachronic trends and synchronic patterns in SR skewing due to sex selection, as well as some of its consequences.

While drawing on demography's insights, I wish to avoid the discipline's notion of "son preference." Deriving from the survey practice of soliciting "fertility preferences" from reproducing subjects, the construct—usually measured as some variation on the proportion of "sons desired" to "daughters desired"—pervades debates around skewed SRs. But it suffers from two fundamental problems. First, in collapsing multifaceted desires and unknown futures into straightforward figures, it masks ambivalence, uncertainty, and social desirability bias; use of son preference as outcome or explanatory variable gloss over the uncomfortable fact that solicited preferences and future behavior (or inner desires) may interrelate in nuanced and contradictory ways. More importantly, "son preference" misses precisely those qualitative complexities that provide purchase for understanding selective reproduction. Scholars have noted how it may be more appropriate to speak of "son necessity," "son compulsion," or "indispensable sons"; conversely, many have called for more explicitly examining "daughter discrimination," "daughter aversion," "daughter disfavor," "daughter dispreference," or "dispensable daughters."[49] Adoption of "son preference" as an

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[44] For attempts to measure the impact of the PCPNDT Act on SRs, see Nandi 2015; Nandi and Deolalikar 2013. For evaluation of incentive schemes' impacts on SRs, see Anukriti 2014; C. Mazumdar 2012; Sinha and Yoong 2009.

[45] Guilmoto 2012b. Kashyap et al. (2015) estimate that while bachelorhood will rise, the proportion of women never married will rise even more due to rising women's education and non-marriage of highly educated women. See also Guilmoto 2010, 2012a; Kashyap et al. 2015. For similar estimates of the Chinese "marriage market," see Guilmoto 2010, 2012a; Jiang et al. 2007; Poston and Glover 2005; Tuljapurkar et al. 1995.

[46] M. Larsen and Kaur 2013.

[47] A U.K. study (Dubuc and Coleman 2007) found skewing in overall SRB. A Canadian study (Almond et al. 2013; Ray et al. 2012) showed skewing among firstborns as well as higher-order births. A U.S. study (Abrevaya 2009) demonstrated skewing in higher-order births only.

[48] Agnihotri 2003; Guilmoto 2008; Srinivasan and Bedi 2008, 2009b. For the importance of disaggregated analysis, see Agnihotri 2000. For importance of attention to convergence, see A. Basu 1999.

[49] For "son necessity," see M. Larsen 2012: 111-112. For ""son compulsion," see Eklund 2011c. For "indispensable sons," see Belanger 2002. For "daughter discrimination," see Croll 2000; Hatti et al. 2004. For "daughter aversion," see Diamond-Smith et al. 2008; John et al. 2008. For "daughter disfavor," see

anthropological term is dangerous, for it may truncate the very richness that must be examined. In this dissertation, then, I use a combination of the above terms to discuss the familial affects driving sex selection.

Contentious Legacies: Histories of Female Infanticide

Whereas demographers have generated extensive insights on the "female deficits" due to selective abortion, historical scholarship permits situation of the biomedical practice within a longer legacy. During the colonial era, female infanticide became a focus of administrative preoccupation in parts of northwestern India. [50] Drawing on historical records, researchers have analyzed killing of newborn girls and the denunciatory discourses through which it became visible, problematic, and intervention-worthy.

The earliest work compiled details of SRs and interventions for areas where female infanticide prevailed, including present day Gujarat.[51] Much subsequent research has focused on colonial Punjab, analyzing how British administrators generated moralizing, civilizing, and ultimately interventionist discourses about infanticide while indirectly encouraging it through land and revenue policies.[52]

At the same time, in writings spanning four decades, L.S. Vishwanath has grappled with female infanticide among the Leua Kanbis, a dominant peasant sub-caste of central Gujarat.[53] Seeking to understand "the relationship between female infanticide, hypergamy, polygyny, lineage system, and other social institutions," Vishwanath has treated infanticide "not as an isolated social phenomenon... but... in the framework of the social system."[54] His analysis foregrounds the decisive role of caste-internal prestige hierarchies centered on land, wealth, and reputation, along with marriage practices that articulated and sustained the hierarchies. Leua Kanbis exhibited a *de facto* status and marriage ranking that permitted familial mobility; households aspired to ultimately join the Patidars—the wealthy, prestigious families whose designation would eventually

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Khanna 1997. For "daughter dispreference," see T. Patel 2007c: 135-136; Sangari 2012: 39, 43. For "dispensable daughters," see R. Kaur 2008.

[50] Again, the regional demographic divide appears. British observers reported female infanticide among the Todas of South India (Marshall 1873; Rivers 1906), but it did not become an intervention-worthy problem as it did in the territories of present-day Gujarat, Rajasthan, Punjab, Haryana, and Uttar Pradesh.

[51] Panigrahi 1972.

[52] Malhotra 2002; P. Oldenburg 1992; S. Sen 2002.

[53] Vishwanath 1973, 1983, 1998, 2000, 2004, 2007. The Leua Kanbis are the same sub-caste described in Pocock's *Kanbi and Patidar* (1972); Vishwanath's analysis of aspiration and hypergamy poses a historical counterpoint to Pocock's seemingly timeless descriptions.

The Leua Kanbis are a second-order division according to the typology presented in Shah (1982). Throughout this dissertation, I use the term "sub-caste" to refer to both second-order divisions (groups historically observing commensality but not intermarriage with other members of the same first-order division) and third-order divisions (local endogamous units). Context should generally suffice to clarify the operative order.

[54] Vishwanath 1973: 404. While occasionally comparing the Kanbis with the other prominent "infanticidal caste" of Gujarat, the Rajputs of Kutch and Kathiawar, Vishwanath emphasized that different marriage and property systems rendered the dynamics of the two cases considerably different. Bhatnagar et al. (2005) have analyzed female infanticide and its "suppression" among the Kutch and Kathiawar Rajputs, adopting a historical-discursive approach that parallels much of the Punjab work.

become, by assimilation, the entire caste's moniker. But upward maneuvering came at a high price: lavish marriage expenditures and dowries to secure hypergamous alliances. In Vishwanath's analysis, Leua Kanbis resorted to female infanticide to manage household social and economic prospects—especially among families of high rank, given the impossibility of an honorable (hypergamous) marriage, but also among middle- and low-class families unable to bear ruinous costs.[55] As a result, Leua Kanbis exhibited markedly skewed overall SRs and CSRs, with some of the latter dipping close to 500.[56]

Vishwanath meticulously documented British administrators' "discovery" of female infanticide through censuses, administrative investigations, and Kanbi reformist activism. Colonial authorities promoted anti-infanticide compacts and formation of small endogamous circles (*gols*) to combat hypergamy, but ongoing status striving consistently undercut such efforts. Because female infanticide still made sense as a kinship practice in political-economic context, it continued behind closed doors. In a pattern with striking contemporary echoes, individual cases defied detection, and the practice remained visible primarily in aggregate statistics. Eventually, administrators applied the Female Infanticide Act of 1870 to Kanbis, subjecting them to heightened surveillance and hefty penalties for infanticide and hypergamy.[57]

Contemporary field researchers have found a significant prevalence of female infanticide in the southern state of Tamil Nadu—again, concentrated among higher-birth-order daughters.[58] Several have drawn explicit connections between infanticide and "development," as exemplified by the political economic changes of the green revolution

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[55] In treating female infanticide as a property management strategy situated within a longer political-economic history, Vishwanath has argued that Muslim rulers' dissipation of Rajput power and subsequent Maratha and British land and revenue policies had both engendered and constrained Kanbi agrarian prosperity (2000: 93-94; 2004: 2317en2312; 2007: 276-277). This more *longue durée* approach stands in contrast to other analyses that have primarily or exclusively emphasized the British contribution to the political economy of female infanticide (e.g., A. Clark 1983; V. Oldenburg 2002).

[56] According to Vishwanath's description, "shortage" of girls compelled poor families to practice brideprice, exchange marriage, and even inter-caste marriage with Koli women. At the same time, marriageable women remained in surplus at high ranks, and polygyny, dowry, and infanticide persisted. Vishwanath thus illustrated a phenomenon that would remain woefully under-acknowledged in twenty-first-century discourses on selective abortion's relation to marital "supply and demand": "female deficit" can reinforce a *stratified* "marriage market", with lower-class men pushed into bachelorhood or socially non-normative unions due to selective reproduction in upper and upwardly mobile classes.

[57] Clark's essay on "female life chances" among the Leua Kanbis (1983) echoed Vishwanath's analysis and additionally framed female infanticide as a strategy for advancement of not only individual households, but the entire sub-caste. According to Clark, selective elimination of girls contributed to the Kanbis' ascendancy as a locally dominant caste by reducing land fragmentation, consolidating agrarian power, and facilitating subordination of more rapidly growing castes like the Kolis. EFM (largely through infanticide) was thus a reproductive strategy that enhanced not only the position of households within a sub-caste, but also that of the sub-caste relative to other groups. This analysis anticipated Clark's later argument that broad class and gender relations could decisively influence more "proximate" determinants of EFM in India (1987). Kaur has echoed Clark in her call to situate "daughter dispensability" vis-a-vis political economy, noting historical evidence of female infanticide, involuntary bachelorhood, and polyandry occurring together in nineteenth-century Punjab as pieces of a comprehensive strategy of gendered property management (2008).

[58] Chunkath and Athreya 1997; George et al. 1992.

and market liberalization.[59] But the latest research in Tamil Nadu has shown a shift to prenatal sex selection as the major contributor to skewed SRs.[60] Even in regions of more recent female infanticide, sex-selective abortion has become predominant.

As in Prime Minister Modi's speech announcing the national Beti Bachao campaign, present-day governance discourses often invoke nineteenth-century female infanticide to condemn sex-selective abortion. In Gujarat, such invocations most often refer to "making girls *dudh-piti* [milk-drinking]," or killing them by drowning in a tub of milk; this technique was practiced among the Rajputs of Western Gujarat, while Leua Kanbis more frequently employed strangulation, starvation, or opium administration. I found that the historical image of the drowned newborn carried considerable affective force for north Gujaratis. But as I discuss in Chapter 6, its facile deployment within anti-sex selection representations also elided the historical and cultural specificities separating nineteenth-century infanticide and twenty-first century selective abortion, often leading to substitution of "dowry," generalized "discrimination," or a monolithic "tradition" for the pressures that actually drove families to sex selection.

The Work of "Culture": Qualitative Scholarship on Sex Selection

What unique contribution can contemporary qualitative research—particularly the subset characterized by an anthropological theoretical lens and an empirical commitment to ethnographic fieldwork—add to the above-enumerated demographic and historical insights?[61]

John has lamented how even field studies on sex selection tend to fall into well-worn analytic ruts:

> Unfortunately, many... give generic and repetitive explanations for the prevalence of son preference and daughter dispreference. There is a tendency to simply repeat the usual list for son preference in patrilineal and patrilocal societies—as security in old age, for carrying on the family name, for lighting the funeral pyre and so on, compared to an equally generic view of daughters as a burden...
>
> In much of the literature,... terms are used generically and loosely, with little explanatory value. Thus, "tradition", "culture", "mindsets", "son preference", and more generally "gender discrimination and bias", continue to be the most frequently cited. Interestingly, were we to compare the contemporary situation with the colonial period,... one may

[59] George 1997; Harriss-White 1999.

[60] Srinivasan and Bedi 2008, 2009b.

[61] The specification of theoretical and ethnographic commitment distinguishes the scholarship I am highlighting from the extensive armchair debates regarding philosophical and bioethical implications of sex selection (e.g., Dickens et al. 2005; O. Jones 1992; Kusum 1993; Milliez 2007; Moazam 2004; Weiss 1995; Wertz and Fletcher 1989, 1998; Zilberberg 2007). Much of this work, uninformed by ethnographic perspective, has replicated ethnocentric discourses of radical alterity, static "culture," and Western individual autonomy versus non-Western social constraint. For an example of bioethical debate informed by field experience, see the essays in Oomman and Ganatra 2002.

> well get a feeling of déjà vu—what, apart from the new technologies, has really changed?[62]

Here, I review qualitative scholarship that avoids these traps, concluding with a statement of what my study adds to it.

Journalists have produced some rich analyses of sex selection. Most notably, Mara Hvistendahl has used multi-sited research to link the rise of sex selection in Asia with transnational processes of population control and technological development.[63] The Indian mass media have also generated innumerable written and audiovisual articles regarding selective abortion, though many of these simply rehearse stock narratives of gender bias and essentialized "tradition."[64]

Numerous ethnographic essays have documented aspects of the sex selection process.[65] Two mixed-methods studies from the turn of the millennium, remarkable for the degree of researcher-respondent rapport, remain among the best sources for mapping abstract SR patterns onto lived experiences of household decision-making and clinical sex selection.[66] Contributions to the 2007 volume *Sex-Selective Abortion in India* analyzed multiple dimensions of the practice, such as the "mindset" behind eliminating female fetuses and abetment from government health workers.[67] Other ethnographic research has connected the pursuit of biomedical sex selection in south India with falling fertility, rising dowry, and agrarian change.[68] And recent work among women in urban Rajasthan and the Punjabi-American diaspora has illuminated sex selection as a pragmatic response to both familial pressure and internalized gender inequality.[69]

Of note, in the early 2000s, Leela Visaria conducted a mixed-methods study of fertility behavior, skewed SR, and selective abortion in three villages near Mahesana.[70] She found SRB skewing in higher-order births, and an amplification of this skewing with higher caste, education, and landholding status. Women in focus groups cited small-family norms, high cost-of-living, a daughter's alienation at marriage, the burden of lifelong gifting, and potential abuse by a daughter's in-laws as reasons for pursuing selective abortion. Visaria documented widespread awareness of and access to sex selection services, along with a pattern of husbands and in-laws wielding decision-making power regarding such services. Here, too, selective reproduction emerged as a pragmatic response to familial pressure and personal desires for a son. Chapters 1, 2, 3, and 4 of this dissertation pick up the threads left by Visaria's research, offering in-depth

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[62] John 2014: 21-22, 35-36.
[63] Hvistendahl 2011. For a book-length journalistic work with a focus on India, see Aravamudan 2007.
[64] For a sampling of periodical articles spanning three decades, see CWDS 2009: 24-49.
[65] In addition to the below-cited essays from Indian contexts, see Chu (2001) on routinization of sex selection in China and Gammeltoft (forthcoming) on the psychoanalytic dimensions of "selecting for sons" in Vietnam.
[66] Ganatra et al. 2001; George and Dahiya 1998.
[67] T. Patel 2007d. For the "mindset" behind eliminating female fetuses, see T. Patel 2007c. For abetment from government health workers, see Bhatia 2007.
[68] Sekher and Hatti 2007.
[69] For urban Rajasthan, see Unnithan-Kumar 2011. For the Punjabi-American diaspora, see Puri et al. 2011.
[70] L. Visaria 2007b.

explorations of the sex selection market, kinship motivations for the practice, the technicalities of clinical sexing, and diversity of familial decision-making patterns.

The past decade has also seen publication of four fieldwork-based books exploring the underpinnings and practices of sex selection. Navtej Purewal's *Son Preference* analyzes the titular construct (and knowledge production around it) in Punjabi culture, tracing the discursive formation through colonial and postcolonial configurations of statistics, gender ideologies, governance norms, and reproductive choices.[71] Sunil Khanna's *Fetal/Fatal Knowledge* leverages long-term ethnography in peri-urban Delhi to tie use of sex selection technologies to local histories of gender, economic change, and family planning.[72] Mattias Larsen's *Vulnerable Daughters in India* pairs focus group data from eight Himachal Pradesh villages with a fuzzy-set qualitative comparative analysis of kinship norms and socioeconomic change to address the apparent paradox of SRs falling alongside rising appreciation for daughters; he ultimately concludes that rapid socioeconomic transformation, rising uncertainty in intergenerational expectations, and fertility decline have combined to reinforce valorization of boys, with "son necessity" leading to skewed SRs when co-occurring with either changing familial authority structures or a conjunction of dowry and minimal women's empowerment.[73]

The most wide-ranging and ethnographically deep study is the 2008 report *Planning Families, Planning Gender*.[74] Drawing on fieldwork in fifteen villages of Punjab, Haryana, Himachal Pradesh, Rajasthan, and Madhya Pradesh, the authors have analyzed quantitative statistics alongside qualitative data on gender roles, family reproductive strategies, and sex selection practices to illuminate the "underlying dynamics of persisting adverse child sex ratios in North India."[75] Consistently foregrounding the micro/qualitative as a vital complement to the macro/demographic, the report provides a practice-theory analysis of persistence and change in gender-kinship institutions and documents biomedical and non-biomedical strategies of sex selection. The authors have argued that in their fieldsites, "family planning" means planning for sons and avoiding daughters; that women's agency in sex selection must be understood vis-a-vis household structures and broader social norms that devalue women; and that explaining skewed SRs demands examination of complex arrays of social factors and transformations rather than single, static causes.

Finally, a burgeoning qualitative literature addresses consequences of sex selection in India, especially marriage transformations and governance responses.[76] Numerous scholars have engaged ethnographically with large-scale trans-regional marriage flows emerging in response to severely skewed SRs, particularly in Punjab and Haryana.[77] Extensive research—much in the form of reports—provides legal, policy, and

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[71] Purewal 2010.
[72] Khanna 2009.
[73] M. Larsen 2012.
[74] John et al. 2008.
[75] John et al. 2008: vii.
[76] For exemplars of such studies, including comparative perspectives from China, see R. Kaur 2016. Part II covers the "marriage squeeze," while Part III addresses policy responses.
[77] Blanchet 2005; Chaudhary and Mohan 2011; R. Kaur 2004, 2010, 2012; Kukreja and Kumar 2013; P. Mishra 2013. Srinivasan (2015) examines cross-region marriage between two south Indian states. Hugo and

sociological analysis of anti-sex selection efforts.[78] Several scholars have appraised programs aimed at curbing female infanticide in Tamil Nadu, noting some positive impact on SRs but also critiquing overly restrictive eligibility requirements, misguided conceptualizations of the problem, and tacit endorsements of gender disparity.[79] Particularly helpful is Rajeshwari Sunder Rajan's nuanced analysis of how such programs run up against "the futility of treating [infanticide] as a crime," rearticulate stereotypical narratives about backwardness and dowry, and ultimately render unwanted girls "children of the state."[80] Beyond India, Susan Greenhalgh's work examines how the Chinese state has generated and responded to "missing girls" through rural reform and the one-child policy, opposition to and accommodation of son preference, and recent framings of "excess masculinity" and "surplus men."[81] I return to this material—particularly Sunder Rajan and Greenhalgh's contributions—in discussing efforts to "save the daughter" in Chapter 6.

In concluding her comprehensive review, John describes "three broad orientations that need to be probed": "culture" (echoes of Das Gupta), "political economy" (echoes of Miller), and "violence" (the unique contribution of feminist praxis around violence against women).[82] She also calls for further efforts to investigate five "domains... that are caught up in one way or another in aiding sex selection or possibly in combating the practice": families, clinics, governance institutions, women's education, and women's labor.[83] As I explain below in introducing the *gendered fetal subject* and the *moral economy of gender-kinship* as conceptual tools, I aim to bring culture, economy, and violence into the same frame through a careful examination of bodies, kinship, and value. The foundation for such an analysis lies in deep ethnographic engagement with three of John's domains: families pursuing sex selection services, clinics providing them, and institutions attempting to combat them. I bring to the analysis of these domains corresponding bodies of anthropological literature on gender and kinship, biomedicine, and governance and the state. Using empirical material from the three domains and theoretical insights from the three literatures, I analyze the *process* of sex selection as lived, understood, and contested on the ground. The study's contribution rests largely on deep ethnographic embeddedness within a single site: the north Gujarat district of Mahesana.

Nguyen (2007) analyze the socioeconomic characteristics and lived experiences of Vietnamese wife-Taiwanese husband pairings, while Le et al. (2007) consider the messy overlap of migration, marriage, and trafficking at the Vietnam-China border. I address North Gujarat marriage transformations outside this dissertation (Sandesara ms).

[78] E.g., Jaising et al. 2007; Joseph and CYDA 2007; PHFI 2010; Purewal 2014; Sekher 2010.

[79] George 1997; Srinivasan and Bedi 2009a, 2010.

[80] Sunder Rajan 2003: 177-211.

[81] Greenhalgh 2001, 2012; Greenhalgh and Li 1995. For overviews of the Chinese state's interventions to address "imbalanced" SRBs, see Eklund 2011a; Nie 2010; Zheng 2007.

[82] John 2014: 41-43.

[83] John 2014: 43-46.

Place and Person

"Why Gujarat?"

At a family wedding some months before I commenced full-time research, an acquaintance—a prominent U.S. fundraiser for the Bharatiya Janata Party—asked my plan. He interrupted my response several times to suggest I study a community in Punjab or Haryana: "That's where this problem's really bad... They're much worse than Gujarat... They have so much dowry, and they really do this more." As I continued, he grew more agitated, until he finally blurted out, "This'll just make Gujarat look bad! With all the work that Narendra Modi's put into making Gujarat a good example, why do you want to dig up something bad? Why don't you focus on where it's actually a problem?" The prime minister, he reminded me, hailed from Vadnagar, a town in Mahesana District; how could the problem possibly be so bad within Modi's homeland?

During fieldwork, I repeatedly heard the same motifs from government officials, community leaders, doctors, and families. Even while actively pursuing SD scans and aborting female fetuses, many couples told me, "You know, this problem isn't that bad here." They suggested I shift my study from Gujarat (2011 CSR: 890) to Punjab (846) or Haryana (834), where exorbitant dowry meant that "no one lets their daughters live." Or perhaps some village in Uttar Pradesh (902) or Bihar (935)—"backward states, where no one understands the value of a girl." They persistently constructed a "geography of blame"[84] in which sex selection always existed, at least in its worst form, *somewhere else*.

Given such admonitions, a focus on Gujarat stakes out a stance on fundamental matters of power, naming, and erasure. While doubtless a problem elsewhere, sex selection also plagues Gujarat. In 2011, Mahesana District's CSR was 842. The CSR for the district's urban areas was 793. Mahesana city had the most skewed CSR for any urban agglomeration in the entire country (760), and several local towns exhibited comparable figures. In an era when the "Gujarat model" has become a rallying slogan for a region, a powerful political current, and a national development trajectory, it remains imperative not to gloss over ongoing social problems in the state.

For me, the political is also deeply personal. In contending that "sex selection is a problem that *we* Gujaratis must face," as I often did during fieldwork, I claimed membership in an imagined community of language, culture, and power. As a Gujarati diaspora child, born and raised in the U.S., I approached this project as a "return home," obsessively working through and problematizing my own "hyphenated identity."[85] The research might be seen as "halfie anthropology," attuned to multiple constituencies, invested in reception across multiple audiences, and aware of the dubiousness of the native/non-native distinctions that have historically framed the anthropological enterprise.[86]

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[84] Cf. Farmer 1992.
[85] Visweswaran 1994: 114-142.
[86] Abu-Lughod 1991.

But, of course, things don't break so neatly into halves.[87] What did it mean to approach the fieldwork as a Gujarati? An American? A Patidar-by-descent? A child of inter-caste marriage? An elite-educated anthropologist? A doctor-in-training? A man? A feminist? Throughout my foray into Gujarati sex selection, I found myself pulling apart the "threads of a culturally tangled identity."[88]

A Personal Path

I grew up in an upper-middle class, mixed- but firmly upper-caste Gujarati-American household. There, while navigating American childhood, I simultaneously learned Gujarati language and culture. I also developed there an inchoate feminist consciousness.[89]

During my upbringing, I came to understand Gujarati gender and kinship norms, albeit as they became transformed through the dislocation of diaspora: Why did some acquaintances consider us strange for housing my mother's parents from time to time, as we did my father's parents all the time? Why so much conflict between my mother and her in-laws, and virtually none between my father and his in-laws? How had the world changed since an elderly relative's response to the birth of my mother—a second daughter—with the phrase "a stone is born"?

Finally, home was where I first became aware of sex selection. I frequently overhead as my mother and my father's mother talked in hushed tones about how in-laws had forced a distant relative, Preeti-ben, to undergo sex-selective abortion. (I describe Preeti-ben's experience in Chapter 4.)

In India for another research project as a teenager, I met with an old friend of my grandfather. Sitting across from me on a patio chair, the old man took my forearm in a vise-like grip and intoned, "You know what the biggest problem facing our society today is? We Patels don't even allow our daughters to be born! Get it checked, and get it out if it's a girl! That's it."

His words echoed during the rest of my three-month trip. I began noticing references to sex selection everywhere—in newspaper charts depicting falling SRs, in images of strangulated fetuses on the backs of state buses, in everyday conversation with friends and family. I soon realized I had woken up tardily: the state and mass media were already constructing the phenomenon as a public crisis, and a fast-growing academic

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[87] K. Narayan 1993: 673-674.

[88] K. Narayan 1993: 673.

[89] "Chauvinist" was one of the first "big words" I ever learned. My first political memory is my mother's firm declaration before the first 1992 presidential debate: "I support Bill Clinton, because he supports a woman's right to choose." Shortly thereafter, I responded to Mammi's surprise at my possession of some arcane, relatively banal knowledge of military transport by smugly declaring, "I am a boy, you know!" I can't recall what she said in dressing me down, but I've never felt so mortified in my life. Such experiences, along with my mother's recounting of her work as a social worker and numerous conversations with my maternal grandmother—the second woman in her sub-caste community to attend college—fostered a raw orientation toward gender equality. Of course, I simultaneously internalized much misogyny and toxic masculinity from Gujarati and American cultural sources. Everyday life and work, including this project, remain struggles to recognize, repudiate, and rework these problematic internalizations—to strive toward the gender ideals that my parents held up to me and my sister, even if they could not always fully actualize them.

literature was analyzing it. Upon beginning dual training in medicine and anthropology, I resolved to undertake an ethnography of sex selection in Gujarat.

Histories of Person, Histories of Place

Born into an affluent Leua Patidar family, my paternal grandmother spent her formative years in Mahesana.[90] When she was still young, her father, an official for the native Baroda State, moved the family from their nearby native village to the headquarters for the state's largest division.

My great-grandfather's administrative career came at the tail end of over a century of British indirect rule in north Gujarat. During the nineteenth century, when colonial officials and social reformers had preoccupied themselves with infanticide among central Gujarat's Leua Kanbis, such concern had been virtually absent in the north, despite a large Kanbi population.[91] In sharp contrast to both British and native central Gujarat, Baroda's northern division showed relatively balanced SRs (Table 2).

The difference originated largely in the distinct kinship practices of Kadva Kanbis, who were (my grandmother's community notwithstanding) the numerically preponderant Kanbi sub-caste in north Gujarat.[92] According to contemporary accounts, the few Kadvas in British central Gujarat were quickly exempted from the Female Infanticide Prevention Act after investigation revealed no infanticide among them.[93] But none of the accounts commented on the significance of this finding; nor has such comment emerged in later analyses of female infanticide or Gujarati society.[94] The Kadva-Leua discrepancy matters because it illuminates the sociocultural contingency of sex selection.

The key to resolving the north-central (Kadva-Leua) divergence was already present in the aforementioned colonial accounts. Ethnological descriptions of the Kadvas

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[90] I also bore a more superficial connection to Mahesana through my maternal grandparents, who wed just north of the city in 1954. While both their families hailed from a small Brahmin sub-caste in South Gujarat, my grandmother's father—a doctor in the erstwhile Baroda State's public health system—remained posted to the government dispensary in Unjha.

Only much later, in discussing my project with my mother's cousin, did I learn the dilemmas my great-grandfather had faced in Unjha. "Bapu-ji said that he always felt uncomfortable in Unjha," she told me. "He said it was too male-dominant. 'Every year,' he used to say, 'at least one daughter-in-law from the Patidar community jumped down a well.' And then local leaders of the community naturally approached him, as the doctor, to certify that she was crazy. That way, no one would get in trouble." My aunt and I could only speculate as to what our ancestor had done.

[91] For instance, in his early report on female infanticide in western India, Wilson hardly mentioned the Kadva Kanbis, save for a footnote on their marriage customs (1855: 424-425ff).

[92] In 1881, Kanbis made up 25% of the northern division's Hindu population; 92% of Baroda State's 175,000 Kadva Kanbis resided in the northern division, while the vast majority of the 185,000 Leua Kanbis resided in the central division (Bhatavadekar 1883: 167-169).

[93] Enthoven 1922: 149-150; Vishwanath 2000: 111. Interestingly, Vishwanath has noted that the inciting event for application of the Female Infanticide Act to Gujarati Kanbis was a petition from a *Kadva* Kanbi social reformer from Ahmedabad who was widely purported to be interested in obtaining government favor and promoting his name as a philanthropist.

[94] More than three decades later, A.M. Shah's observation still rings true: "While Levas have received considerable scholarly attention, Kadvas, an equally large and important peasant caste, have received no attention. This is part of the general neglect of north Gujarat by scholars" (1982: 22fn21).

almost always focused on two characteristics: first, a strong group identity constantly reiterated through ongoing connections to a shared mythic origin-place (Unjha) and patron goddess (Umiya Mata); and second, the practice of "bound marriages" [*bāndhyā* or *bandhukā vivāh*].[95] In a pattern confirmed by contemporary vernacular sources,[96] weddings occurred approximately once a decade.[97] All girls over forty days old were married in mass ceremonies at their home villages. According to one account, even unborn children could be married (contingent on their emerging one male, one female) by pregnant women walking around the sacred fire together.[98]

While caution is warranted regarding the colonial portrayals' precise details, a sufficient evidence base exists to confidently make six observations regarding Kadva Kanbi society and kinship. First, daughters almost inevitably married before puberty, though cohabitation would not commence till later. Second, since marriages took place simultaneously (and often *en masse*), there existed limited scope for status-seeking through lavish wedding expenditure. Third, dowries were modest and often came from groups much larger than individual households. Fourth, Kadva society's centralized, relatively egalitarian structure contrasted sharply with Leuas' decentralized hierarchies. Fifth, a certain prevalence of direct exchange marriages—more acceptable among Kadvas than Leuas—may have further negated tendencies toward hypergamy. Finally, these sociological factors articulated with an agrarian political economy in which the land could less effectively support dense populations or heavy agro-capital accumulation, decreasing the prospects for hypergamy, lavish dowry, and ruinous aspiration relative to central Gujarat. In combination, these factors made daughters, despite their out-marriage, less of a burden on Kadva families. The behavioral effects of this condition seem apparent from Table 2.

By the time bound marriages ceased in 1930 amid intense pressure from social reformers and the state to repudiate child marriage,[99] Kadva Kanbis (now Patidars) had achieved considerable prominence and status in the north. Following the practice of splitting castes into good and bad, hardworking and lazy, British and native administrators had long treated Kanbis as "the best husbandmen" in the region. Such

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[95] Bhatavadekar 1883: 116-117; Desai 1920: 163-164; Enthoven 1922: 145-148; Gazetteer of the Bombay Presidency 1883: 60-61, 620; Imperial Gazetteer of India 1908: 83-84; J. Wilson 1855: 424-425ff.

[96] See, for instance, the sources reviewed in M. Patel YEAR.

[97] The precise interval between bound weddings was determined through an elaborate ritual involving the collaboration of Brahmins, caste leaders, a virgin, and Umiya Mata. The obligation of bound weddings applied only to primary marriages. If a suitable groom was not found, the bride might be married to a stand-in husband who would immediately divorce her, or to a bunch of flowers that was thrown into a well, rendering her a nominal widow; in either case, she would then be eligible for the secondary *nātru* marriage, which could take place at any time.

[98] Enthoven 1922: 148.

[99] Kadva Kanbis did not escape the civilizing gaze. If dowry and female infanticide were the chief social ill among Leuas, child marriage was the corresponding evil among Kadvas. External reformist pressures, internal deliberations, and legislation by Baroda State eventually ended bound marriages after 1930. For administrators' and social reformers' lamentations regarding the high proportion of marriage among even very young Kadva Kanbi girls, see Desai 1911: 84-86, 1920: 199-200; Gidumal 1889: 16, 57, 85. For internal reform efforts and the state's gradual withdrawal of tolerance, see Baroda State 1924: 56, 1928: 35-36; Dudakiya 2001: 114-143.

favor, conjoined with solid landholdings, land consolidation, revenue reforms, and famine and credit crises from the early nineteenth century onward, had allowed Kanbis to control increasingly large portions of agrarian capital.[100] They had become the region's dominant caste.

Besides the ever-present fixation on Brahmins and Vaniyas, colonial documents also noted the importance of Chaudharys (Anjana Kanbis), a more cattle-focused peasant sub-caste; pastoralist groups like the Rabaris; the warrior Rajputs; several "Untouchable" groups; and numerous artisanal castes such as potters (the forebears of Prajapatis like Asha-ben and Jiten-bhai). Only the Kolis (increasingly known as "Thakardas" and eventually "Thakors") could numerically rival the Kadvas; but whereas the latter saw their fortunes rise with agrarian, industrial, and commercial development, Kolis often found themselves in immiseration, forced to farm small plots or rent out their labor.[101] Table 3 shows the proportions of different castes in Baroda's northern division in 1931—the last year with full caste enumeration. By that point, the various castes were forming or stabilizing marriage arrangements, often in the form of local endogamous *gols* [circles] of nominal equals.[102] At the time of my fieldwork, the numerically predominant groups in the Mahesana area remained those most prominent in Table 3, and marriage *gols* largely resembled the ones established in the early twentieth century.

By the time my grandmother married in 1941, Mahesana had grown immensely. When it first became a subdivision headquarters in the 1870s, it was still but a village (population: 7,825). But it held promise because of its location on the newly constructed railway between Delhi and Ahmedabad. Baroda's rulers had subsequently built three branch lines from the town to different parts of north Gujarat, and it had become the divisional headquarters in 1906.[103] It thereby acquired a political, commercial, and social import that would continue into the twenty-first century. It remained relatively small (14,762 souls in the 1931 Census), typifying a regional pattern of modest urbanism that caused administrative officials to remark, "Most of the places designated as towns in the Census Reports are merely overgrown villages, and are called towns because they happen to have a population of 5,000 or more or are the headquarters of [subdivisions]."[104] A century later, I still heard such comments, frequently delivered with warmth and glee, from denizens of Mahesana—many themselves recent rural-urban migrants.

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[100] For examples of native state and British bias in favor of Kanbis, see Desai 1920: 67-69; Enthoven 1922: 144; Nanavati 1913: 8-9, 22-24. For post-independence echoes of such attitudes, see Lobo 1995: 61-83, especially 78. Gidwani details a parallel process in central Gujarat (2008: 38-67), and A. Clark (1983) analyzes it from a specifically demographic perspective.

[101] Many of the late-twentieth-century upshots of this process come through clearly in Lobo's ethnography of Thakors in a Mahesana-area village (1995). Again, Gidwani (2008: 38-67) and A. Clark (1983) detail this process for central Gujarat.

[102] For a discussion of *gol* genesis in North Gujarat in the early twentieth century, see J. Cort 2004: 94-98. For situation of the *gol* vis-a-vis other social groupings in Gujarati society, see Shah 1982.

[103] For glimpses of the administrative history of Mahesana and the Baroda State northern division, see Desai 1920: 1-2, 148-149, 246-253; Gazetteer of the Bombay Presidency 1883: 21-22, 626-627; Imperial Gazetteer of India 1908: 37, 80.

[104] BEDC 1920: 10 .

Post-independence modification left the Mahesana District the 2010s with a territory of 4,401 square kilometers—2.2% of Gujarat's land area.[105] It was a place of "tubewell capitalism"-driven prosperity, with Kadva Patels and certain other groups having parlayed numerical strength, land, and agricultural prosperity into capital accumulation, educational attainment, commercial and industrial investment, and political dominance.[106] The region boasted a large commercial class and an extensive diaspora, both abroad and within the metropolises of western India.[107] By the 2011 Census, Mahesana comprised nine subdistricts, each headquartered at a town of the same name. The district contained 597 inhabited villages, and an overall population of 2 million—one-quarter urban, with one-tenth in Mahesana city alone. Rural, urban, and overall literacy rates were among the highest in Gujarat. And against 129,169 boys aged 0-6, there existed 108,763 girls.

Even though my family had long ago lost most connections to the region, even superficial references frequently gave others a basis for projecting an identity onto me: "Oh, so you're from around here... By caste?... No, no, just say you're Patel—mix-bix doesn't matter! You are whatever your father is... KP or LP?... Ah, Leua? So not one of us Umiya-*wallahs*... Still, our people will always welcome you, since you're Patel... What's your wife? Do Chinese people have castes?... America, eh? New Jersey, or Chicago?... I have cousins in Georgia and Australia..." Try as I might to contextualize my responses, my identity consistently came unmoored in conversation, allowing for a dizzying, sometimes maddening, and frequently productive oscillation among different states of belonging and alterity.[108]

But before reaching that point, I faced the challenge of accessing a field I had never visited. To begin, then, I finagled an observation opportunity at an obstetric clinic in Gandhinagar.

Glimpses from the Outside

The Gandhinagar clinic drew patients from a north Gujarat territory culturally similar to Mahesana. For six weeks in 2012, I observed a senior doctor and his junior partner in their daily routines.

I re-learned obstetric biomedicine in its local form—patterns of doctor-client interaction, vernacular terminologies, embodied practices, and norms of pregnancy management and termination. I also caught glimpses of themes that later appeared in

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[105] A small portion of Mahesana District's territory was excised and merged with a similar tract from Ahmedabad District to form the new district and planned capital city of Gandhinagar in the 1960s. The western half of the old northern division became Patan District in 1997. A small portion of the district's southern portion—Mansa Subdistrict—was more recently annexed to Gandhinagar District.

[106] The phrase is taken from Dubash (2011), who describes agrarian development in two villages of north Gujarat. Cf. Gidwani (2008: 68-137), who describes a similar postcolonial development trajectory among Leua Patels in central Gujarat.

[107] It is no coincidence that Basu begins her discussion of caste and commercial prosperity in Gujarat (2013) with a scene from a Kadva Patel jubilee in Unjha featuring lavish rituals and a laudatory speech from Narendra Modi himself.

[108] Cf. Narayan: "Unmoored from a certain base for identification, the extent to which *others* can manipulate an anthropologist's identity came into focus" (1993: 674).

Asha-ben's story: profound expressions of hope and despair; repertoires of request, refusal, and referral around SD and second-trimester abortion; partial but powerful knowledge about sex selection networks; and the ever-present specter of state surveillance.

Early on, I observed the senior doctor parry multiple families' SD requests. Many probed coyly: could he suggest someone who would "check," since he didn't have a machine himself? People cited similar reasons for seeking SD: desiring a son for old age care and lineage perpetuation, and avoiding another daughter who would inevitably depart after marriage and (in some castes) take with her a substantial dowry.

While refusing all SD requests initially, the senior doctor sometimes relented with persistent families, slyly promising to "name a doctor near Mahesana" when "the time is right—at three months." If unwilling, he blamed the state: "It's on the government! The government's made the law, so what can be done?"

One day, with his boss out, the junior doctor refused to perform a second-trimester abortion. Later, during a tea break, he explained, "This is risky business. You can't do it after three months. What if they had SD done elsewhere and then came here?"

Taking a long sip of *cha*, he ventured, "People with two girls should have permission to get SD. That'd help control population. Otherwise, they'll birth five-six children to get a boy! But then enforcement should be made tighter for others—those who don't need it." Another sip. "Anyway, that patient will find someone to do it. And I know who, too. Get it? Everyone knows you can find it at so-and-so place. From here, they'll probably go directly there."

Some days later, I circled back to the conversation. The junior doctor explained:

> It's happening on a large scale in a town near Mahesana—a doctor named Ganpat-bhai. He does everything openly. Everyone knows he's doing it, but he never has problems. He must be in cahoots with the government people there. And why would the public oppose him? They're getting it done with him! He must be feeding bribes. But he can do it openly.
>
> Honestly, people are doing it openly in many places. There are agents, too. They bring people for SD. The agent knows the patient, to the doctor can trust there's no problem. And these agents take a lot of money! If the SD costs 5,000, the agent'll take another 5,000 from the patient.

After taking a sip, the doctor surprised me: "I know because a friend—a medical school classmate—does it now. He has this kind of system." When I asked if he could put us in touch, he just laughed.

Eventually, I expressed a desire to conduct fieldwork in Mahesana. Both doctors warned of access difficulties: "The people doing it, they won't let you find out... Patients can go anonymously, but it's not that way for you, right? Patients pay, so the doctor'll do it for them. They won't tell you." Nonetheless, they eventually agreed to support what they laughingly began calling "the secret mission."

After placing some phone calls, the senior doctor instructed me to meet with his old friend, a Mahesana internist. It remaining unclear what would follow. I boarded a bus, beginning the journey that eventually connected me to Uma-masi and her clients.

Nandini Clinic

Following a chain of referrals, I found myself walking into Nandini Clinic. Several weeks had passed without rain, and the air felt oppressively humid. Entering, I encountered a spatial configuration that I soon recognized as typical for Mahesana obstetric clinics: a waiting room full of benches; through a door, a consultory containing the doctor's desk, family seating, and a curtained-off examining area; elsewhere, several fan-cooled general wards and air-conditioned private rooms for patients of differing financial capacities; down the corridor, an operative theater and delivery room; and adjoining, an associated medical store. Nurses moved briskly among the waiting room, the consultory, and various patient rooms. A pharmacist, a surgical assistant, a clerk, and several sweepers tended to different parts of the apparatus. Inside the consultory, the doctor and his assistant rapidly cycled through patients. Outside, women and relatives sat on the benches and fanned themselves, waiting to be seen for gynecologic, contraceptive, infertility, and pregnancy care.

I eventually learned that Nandini represented, in microcosm, a regime of commercialized biomedical reproduction that had arisen during the previous three decades.[109] Over and over, pregnant women and their older relatives used nearly the same words to describe the transformation: *Back in that era, none of this medicine! Deliveries happened at home, with a midwife—maybe the government hospital, if you lived in the city. No one took any pills, and women went back to work—in the fields, milking the cattle—right away. But now, with this sedentary life and education and junk food, bodies aren't the same. Everyone's delicate. A pregnancy only goes smoothly if you spend thousands on treatment.*

Between 2001 and 2010, clinic deliveries in Gujarat increased from just 40.7% of births to 89.3%,[110] but the biomedicalization of pregnancy and childbirth was both older and more complete in Mahesana. In a comprehensive early-2000s survey, Mahesana District had Gujarat's highest rates of clinical births (74.6%, against a state average of 52.5%) and births attended by biomedical personnel (80.7%, against 62.1%).[111] In a late-2000s follow-up, Mahesana continued to display the highest rates of "institutional" (84.3% against a 56.4% average) and "safe" (87.1%, against 61.6%) deliveries.[112] Data from the past few years suggest that 91% of pregnant women in Mahesana received at least three prenatal check-ups—again, the highest level in the state.[113]

Proceeding in lockstep with India's economic liberalization, the biomedicalization of local reproduction assumed a distinctively commercial character. This was generally true for Gujarat, where one-third of public referral facilities lacked an obstetrician despite

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[109] For a detailed account of reproductive biomedicalization in India, see Van Hollen 2003.
[110] De Costa et al. 2014: 3. Also see IIPS (2010: 12).
[111] CORT 2006: 68.
[112] IIPS 2010: 67.
[113] Vital Statistics Division 2014: 92.

2,000 practicing privately, and private-sector deliveries rose from 17% to 60.3% during the millennium's first decade (against just a marginal increase in public-sector deliveries, from 24% to 29%).[114] But it was especially true for Mahesana, which boasted Gujarat's highest rate of women receiving prenatal care in the private sector.[115]

Mahesana's first private obstetrician established his practice in 1981. After a half dozen others joined him during the 1980s, private clinics mushroomed in the 1990s and 2000s—again, in parallel with broader economic liberalization. By 2010, Mahesana District had over eighty private obstetric practitioners, with nearly sixty concentrated in the towns of Mahesana, Visnagar, Kadi, and Unjha. Roughly three-quarters were Patels or Brahmins, and the former alone comprised a simple majority. Well under one-quarter were women.[116] Most had completed medical training at one of two premier institutions in Ahmedabad. They were generally just one or two generations removed from agriculture, their fathers having been either farmers or new entrants to the commercial-professional middle class—merchants, teachers, and so on; for most, becoming a doctor had meant considerable upward mobility.

Within this local obstetric landscape, Nandini quickly became my base. The obstetrician, Dr. Dilip, was known for being welcoming and "jolly," with a puckish sense of humor. Sitting with him and his assistant in the consultory, I quickly learned the contours of commercial pregnancy care in Mahesana. Privacy was scant, with incoming and outgoing families often seated together even during exchanges about intimate matters. The average patient encounter lasted five minutes: entrance, complaint, basic questions, a quick exam, perhaps some more questions, and any necessary instructions or troubleshooting.

Dr. Dilip's interactions with clients reflected cross-cutting hierarchies of medical authority, social esteem, and commercial service: families performed deference, invariably referring to the doctor as "Saheb," but "the boss" remained ever-attentive to making his customers—particularly those from higher social strata—feel valued. Encounters often veered in a decidedly disempowering direction with respect to gender and autonomy. The key discussion and decision-making channel frequently ran between Dr. Dilip and husbands or mothers-in-law, marginalizing patients themselves. The conjugal "therapy management group"[117] could dictate when and how a woman should become pregnant (fertility treatment), whether a pregnancy should be ended (abortion), how a birth should take place (Caesarean), and so on. Relatives often talked over patients, verbally negating the latter's control over their own bodies: "She doesn't know anything!... Why don't you ask me what's to be done?" Such exchanges were far from the only pattern. Many women asserted themselves, even over family members'

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[114] For the understaffing of public referral facilities juxtaposed with extensive private-sector obstetric services, see Government of Gujarat 2009a. For the public and private sector delivery increases, see De Costa et al. 2014: 3.

[115] IIPS 2010: 64. The figure—67%—actually understates the rate of non-public-sector prenatal care, since it does not include the 9.4% of women receiving prenatal care obtained it in non-governmental, non-commercial institutions.

[116] The figures are my calculations based on the listings in B. Patel (2014).

[117] Cf. Janzen 1978, 1987.

objections. And sometimes, relatives spoke as mere spokespersons, relieving patients from talking about uncomfortable matters. But the underlying patriarchal current remained, especially since Dr. Dilip frequently spoke in terms that reinforced the gender-kinship norms of Gujarati Hindu society.

Time at Nandini also underscored sonography's centrality in local reproductive medicine. Despite acknowledging medical orthodoxy regarding the gratuitousness of more than three scans per pregnancy, Dr. Dilip and other local obstetricians typically performed sonography at every monthly visit and intervening "problem visits," so that many women underwent ten or more scans. Client expectations reinforced the extensive ultrasound use, with families expressing dismay if the doctor did not "look."[118] Moreover, the machine and its operation were status symbols. Doctor and clients alike discussed the costs of different devices, the importance of a "big TV," and the merits of "high-definition" and "3D-4D" imaging modalities. Ultrasound had become seamlessly incorporated into the everyday language of visuality: the sonography service was "looking," and obtaining it was "getting it looked at."[119]

Formation as a biomedical trainee profoundly influenced the observations and interviews resulting from my time at Nandini. My clinical orientation facilitated discussion of individual cases' medical details, as well as the practices, norms, and implicit knowledge embedded in biomedical obstetric care. It caused Dr. Dilip to oscillate between avuncular and collegial modes of relating to me—sometimes quizzing me on microbiological trivia, sometimes asking me to look up American guidelines regarding a certain drug's pregnancy safety, sometimes involving me in backstage deliberations on how to proceed in particularly thorny cases. Moreover, other local doctors routinely remarked that our shared medical background made them feel at ease in speaking about sex selection.

My deepest connection to sex selection came from the very first person I encountered at Nandini. Upon reaching the waiting room that first day, I learned that Dr. Dilip and most of the staff were occupied by a complicated Caesarean section. The news came from a woman who, grinning, identified herself as a staff nurse—Uma-masi. Over the next hour, as we waited for Dr. Dilip, she asked me countless questions about myself, and I did the same.

I eventually grew to know Uma-masi as I know few among even my closest friends. She was extremely gregarious, with a riotous sense of humor. It was impossible to walk even a hundred feet alongside her in the streets of Mahesana without stopping multiple times for her to greet acquaintances, crack jokes, and follow up on promises given and received. She could speak harshly, chiding patients and friends, but she was also quick to forgive, or to wave tension away and carry on. Like many local private-sector nurses, she possessed little formal education but thrived clinically on the basis of intense curiosity, extensive experience, and excellent patient rapport.

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[118] Scholars have documented similar patterns of high ultrasound use in diverse settings of biomedicalization and commercialization, including Vietnam (Gammeltoft and Nguyen 2007), Iran (Ranji and Dykes 2012), Syria (Bashour et al. 2005), and Greece (Georges 1996).

[119] Cf. the ethnographic perspectives on the visuality of ultrasound scans in Georges (1996), L. Mitchell and Georges (1997), and Draper (2002).

Over the months and years after our initial encounter, Uma-masi welcomed me into her life and family. I ate countless meals at her home. Her daughters-in-law embraced me as a brother, telling me wistfully about their home villages and poking fun at their mother-in-law whenever she stepped out of earshot. Uma-masi's sons took me out to eat and initiated me into Mahesana-area youth masculinity. Her husband showed me family albums and didactically told me about the social issues facing north Gujarat. The family and I would stay up late at night watching television, lounging on the patio swing, and gossiping. In short, Uma-masi and her family enveloped me in their domestic life. Largely due to them, Mahesana became like home.

Uma-masi also played a decisive research role. Through her, I moved from hearsay and sidelong observations to direct contact with Chetna Clinic, its doctor, and couples like Asha-ben and Jiten-bhai. Only with her revelation of her work as a sex selection facilitator, connecting families and doctors, did my field become fully constituted.

Constructing the Field

Methods

I initially imagined my Mahesana "field" as spanning three interrelated domains: clinics, households, and governance institutions. I then approached fieldwork and analysis with the aim of exploring, interrogating, and deconstructing the boundaries separating the three.

Assistance from Dr. Dilip and Uma-masi allowed me to access a relatively understudied part of the sex selection apparatus: obstetricians, commercial facilitators, and biomedical technology.[120] The heart of the clinical fieldwork lay in observation of 172 SD visits and twenty-nine selective abortions at Chetna Clinic, where Uma-masi took clients. Time at Nandini permitted me to observe routine obstetric care, which was pervaded by awareness and talk of sex selection. Countless informal conversations with Dr. Dilip, Uma-masi, other Nandini and Chetna personnel, and eleven facilitators illuminated otherwise shadowy practices. Finally, through Dr. Dilip's patronage, I arranged semi-structured qualitative interviews with thirty-three local obstetricians and radiologists;[121] the interviews covered the shifting sex selection market, the technical and social dynamics of SD and selective abortion, and perceptions of government regulation.

In working with doctors, I was largely "studying up," engaging research participants who outranked me in expertise, wealth, and local prestige and power.[122] My biomedical positionality proved helpful, as it allowed me to bridge clinical and

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[120] The work performed by actors like Uma-masi was a form of commercial brokerage—mediation between consumers and providers who would otherwise encounter difficulty in finding one another. However, given the negative connotations of the Gujarati words *dalāl* [broker] and *vachetiyo* [go-between] (cf. Huberman 2010), Uma-masi and her peers never used the terms to describe themselves. They generally avoided naming the role and occasionally glossed the social category as one of "people like me" or "people who take patients." (Doctors sometimes often called them "agents.") As such, I refer to them as "facilitators," a description consonant with both their self-characterization and my observation of their actions.

[121] cf. Inhorn 2004.

[122] Nader 1972.

ethnographic registers. I could speak to doctors as colleague, underling, and researcher. At the same time, my identity also necessitated greater vigilance—not only for common-sense elisions that demanded greater scrutiny ("*You* understand this is the only way..."), but also for my own careless capitulation to biomedical assumptions. I had to constantly make strange otherwise familiar practices and subject fellow clinicians to the same hermeneutic suspicions as others.

The clinical setting provided the chief entry-point to the household domain. Patronage from doctors played a pivotal role in facilitating recruitment of pregnant women and their families, though I met some through referrals by neighbors, friends, relatives, or other research participants. I conducted formal qualitative interviews with members of forty families, but the bulk of my understanding did not come from these encounters, which quickly veered into predictable rehearsal of socially desirable responses. Instead, the most important fieldwork with families centered on hundreds of informal conversations that transpired while cutting vegetables, lulling children to sleep, cleaning up "accidents," picking cotton, attending weddings and baby showers, admiring family albums, sipping *chā*, watching pirated movies, celebrating religious festivals, flying kites, or dining together. As per the demographic makeup of the sex selection clientele I observed, the vast majority of families with whom I engaged were Gujarati Hindu; I note in the text wherever I am speaking specifically of a Jain, Muslim, or non-Gujarati family.

I commenced fieldwork expecting to encounter immense difficulties in studying clinics and households and relatively easy access to the state government; precisely the inverse prevailed. Ultimately, perhaps it was for the best. Although I missed out on certain statistics, policy processes, and administrative insights, the diversion away from high-level perspectives forced careful attunement to the local representations and practices through which governance became palpable. I spoke with countless local bureaucrats, government doctors, community health workers, other public health staff, and activists. I frequented not only the tea stall near the local health department office, but also several primary health centres, health subcentres, and subdistrict-level health offices. Friendly local officials allowed me to accompany them for clinical inspection visits and village "awareness" seminars. Furthermore, I entered a "polymorphous engagement"[123] with governance discourses and practices through various mediatized artifacts: policy documents, case law, legal forms, inspection checklists, posters, pamphlets, books, billboards, and radio and television advertisements extolling the virtue of daughters.

Field experiences also led me to broaden my lens. Conversations with *gol* leaders yielded rich insights on community-level steps to combat sex selection. Similarly, short films, booklets, social media messages, and taped speeches from various non-governmental sources revealed how the "save the daughter" ideal entered wider circulation, generated new public audiences, and captured imaginations.

Numerous fieldwork events obviously bridged multiple domains: medico-legal workshops at obstetric conferences, for instance, or government seminars attended by

[123] Cf. Gusterson 1997.

village women. More significantly, overlaps among the three artificially bounded domains—clinics, households, governance institutions—emerged from engagement with everyday practices supposedly native to one, such as clinical recordkeeping, neighborhood discussion of state policy, or obstetric responses to patient demands. Indeed, the clinical and household components became a continuum of observed practice and in-depth conversations without any clear dividing line, with governance ever-present as a layered-on-top (and sometimes infiltrating) presence. This dissertation is an argument not only for taking a "jeweler's-eye view"[124] of each domain, but also for understanding how all three thoroughly blended together to constitute the phenomenon of sex selection.

Ethics

My fieldwork and subsequent writing have posed ethical dilemmas in three broad categories. First, the matter of *gendered positionality*. Feminist ethnography must always contend with the inherent potential for "inequality, exploitation, and even betrayal," since everything is "ultimately data, grist for the ethnographic mill, a mill that has truly grinding power"; the field situation places the participant-observer in a "ghoulish and structurally conflictual relationship to tragedy" that exposes the "conflicts of interest and emotion between the ethnographer as authentic, related person (i.e., participant), and as exploiting researcher (i.e., observer)."[125] These issues proved especially acute for me as a man working largely with women, and on gender.[126]

I approached fieldwork aware of the need to treat my own masculine identity as part of a system of power, rather than merely a form of difference.[127] Gender was not merely a barrier of "access" to be "overcome" or "minimized," but a central aspect of the fieldwork condition that required constant, reflexive attention.[128] I had to carefully interrogate and handle my gender identity as it intersected with caste, age, geographic provenance, technical expertise, clinical situation, and other crosscutting factors. Recruiting, engaging, and representing women and those around them called for hyper-awareness of gendered power.

My biomedical positioning and the patronage of trusted clinicians complicated matters. Both factors facilitated recruitment of families,[129] but I had to remain vigilant for and act against the additional layer of gendered power they introduced: Did a particular patient see conversing with me as linked to her ongoing care, or as a means to involve another biomedical (pseudo)expert in it? Was she agreeing to speak only out of a sense of

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[124] Marcus and Fischer 1999: 15.
[125] Stacey 1988: 23.
[126] A long line of feminist thought has considered the implications of a modern visual paradigm that installs the masculine as observer and the feminine as object (e.g., Mulvey 1975). In my case, I remained particularly conscious of this dynamic, given how the endeavor of studying hidden practices held particular potential to propagate a "masculine preoccupation with penetration, domination, and objectification" (H. Moore 2010: 31).
[127] Hackett 2008: 211.
[128] Kratz 2008.
[129] cf. Inhorn 2004.

obligation to the doctor—itself born from a relationship shot through with inequalities of gender, class, and authority?

Throughout the fieldwork, I strove to mitigate the ill effects of such dilemmas of recruitment and relation. Early on, I decided to approach families through the intermediation of a nurse or other female staff member, rather than the doctor's direct recommendation—a strategy that widened the scope for polite refusal. I observed clinical interactions only when I could obtain permission directly from the patient herself. Sometimes, gender dynamics necessitated that I speak only with men or older women in a family. In other cases, I could speak freely with pregnant women, and their husbands and in-laws appeared uninterested. Between these two extremes, a wide range of situations prevailed, with each household requiring an individualized approach.

In writing, I have attempted to avoid or mitigate objectifying representations of women. I do not harbor illusions regarding the feasibility of entirely avoiding objectification, given my triple constitution as a masculine, biomedical, and ethnographic subject. But I hope this dissertations denaturalizes and assails gender inequalities in greater measure than it reinforces them.

There is also the matter of *confidentiality and betrayal*. Manifesting in abandonment, erasure, and exposure, betrayal is an unfortunately pervasive aspect of ethnographic fieldwork and representation.[130] In my work, betrayal might intersect with issues of gendered power, manifesting in an unsettling of family dynamics through unwelcome attention or unwise disclosure. But the potential for indiscreet betrayals stretched beyond the household, into my navigation of collegial relationships, clinician-patient relationships, and state-citizen relationships. As I discuss in Chapter 1, I found myself obligated to traverse a web of discretion and deceit during fieldwork. After gathering and objectifying information, I took extensive data protection measures.[131] And in the text, I have modified or omitted many details regarding persons, places, and events.. Such changes do not warp the overall picture, but they bracket details that might further illuminate it.

Finally, this project has engendered dilemmas regarding *witnessing violence*. I have frequently castigated myself, asking what could justify my quasi-voyeuristic observation of a form of gendered violence. Of course, I was never a passive observer, nor "neutral": I consistently engaged in intense, lengthy conversations with people about the meanings of their practices. My contribution to such dialogues evolved as I learned more about sex selection, its underpinnings, and its context.

But I also restrained myself from intervening proximally in the face of sometimes-wrenching events. Such distancing was not a result of "suspending the ethical," but rather of determining that immediate action would presume an understanding of the very phenomenon, the very violence, the very complexity to be grasped—that the key moral intervention lay not in presuming and acting on "the

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[130] Bourgois 2001; G. Jones 2014: 61-62; Visweswaran 1994: 40-59.

[131] In order to protect participant confidentiality, I stored all research data exclusively on U.S. servers, identifyied key actors by numeric codes (e.g., "413") rather than names in fieldnotes and interview transcripts, and elided personally identifying details like residence or workplace. In the writing, I have used pseudonyms throughout for research participants.

primacy of the ethical," but rather in producing "excellent, reflexive, and critical" ethnography that could illuminate the sociocultural conditioning of violence and ethicality itself.[132] Assuming the position of ethnographic witness, I took it as imperative to engage with "perpetrators" as part of a critical anthropology committed to parlaying explanations of power into praxis.[133]

But how to responsibly represent witnessed violence? How to "give an account of these shocking events without giving in to a desire to shock"—to avoid a "pornography of violence"[134] in which "places, images and events flash by in rapid succession, an unintelligible pastiche of terror whose effect is to unsettle rather than enlighten"?[135]

In writing this dissertation, I have aimed to find a balance between "[fattening violence up] into prurience" and "flattening it down into theory."[136] In avoiding prurience, I have sought to steer clear of "lurid recountings that serve little other purpose than to show... that I was there"[137]—particularly when ghastly images and sensationalistic narratives already circulate widely in the "scandalous publicity"[138] that conjures sex selection as one of modern India's chief crises. More specifically, given that vivid anti-sex selection messages often become transformed into anti-abortion messages,[139] I have restricted description of selective abortion itself to the minimum necessary for analysis. I have also attempted to keep my writing accessible to a wide readership, mindful of the adage that a feminist ethnography of violent social formations faces two tasks: first, to deconstruct relations of domination and violence; and second, to begin constructing visions for more equal ways of being.[140]

The Gendered Fetal Subject

This dissertation's central argument is that actions around ultrasound sex determination both presumed and produced a *gendered fetal subject*—an imagined or potential person whose positioning at the limit of sociality made it the center of a whole assemblage of familial, medical, and regulatory activity. Prenatal SD practices incorporated the unborn into kinship systems. In doing so, they gave rise to a host of other practices that presupposed, shaped, and intervened on the gendered fetus. Sonographic gendering mobilized imaginings, visions, hopes, fears, evaluations, and deliberations, ultimately potentiating rejection or acceptance of specific fetal relatives.

In positing a gendered fetal subject, I am not ascribing the unborn a subjectivity. Rather, I am emphasizing its subjection to power. French philosopher Michel Foucault's work illustrates how knowledge production simultaneously produces subjects, subject positions, and social phenomena.[141] Anthropologists have widely used Foucauldian

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[132] Valentine 2003; cf. Scheper-Hughes 1995.
[133] Clarke 2010.
[134] Daniel 1996: 3, 4.
[135] Pedelty 2013: 25.
[136] Daniel 1996: 4; see also Scheper-Hughes and Bourgois 2004: 25-26.
[137] Farmer 2003: 26.
[138] Cohen 1999.
[139] Nidadavolu and Bracken 2006.
[140] C. Cohn 1987: 717-718.
[141] Foucault 1990, 1995, 2003.

theory to explore subjectification—the production of subjective consciousness—within systems of power. But *assujetissement,* the bivalent term that predominated in Foucault's early work carries another meaning in addition to "subjectification"—"subjection."[142] With connotations of fixing tightly, *assujettissement* (unlike the later *subjectivation*) foregrounds how power relations subjugate material bodies, tying them into broader social formations. In practices and discourses around sex selection, the fetus became subject to the power of kinship, biomedicine, and top-down regulation.

Prenatal classification according to binary sex—indeed, the very *possibility* of such classification—situated the fetal subject as a "boundary object"[143] on the borders among families, clinics, and governance institutions. Activity around prenatal gender in these domains sometimes converged and sometimes diverged, creating the resonances, tensions, and complexities that characterized sex selection. Brought into the force field of gender and kinship—henceforth, gender-kinship[144]—liminal beings became subject to further intervention and imagination.

Materializing the Fetal Body

In highlighting the constitution and circulation of a gendered fetal subject, I am building on overlapping lines of inquiry in philosophy and reproductive anthropology. The first contains considerable theorizing around the gendering of fetal matter, with a seminal instance appearing in Judith Butler's *Bodies that Matter*. Extending Louis Althusser's notion of "interpellation," which posits persons as "always already" subjected to ideologies through everyday processes, Butler has said of birth:

> Consider the medical interpellation which (the recent emergence of the sonogram notwithstanding) shifts an infant from an "it" to a "she" or a "he," and in that naming, the girl is "girled," brought into the domain of language and kinship through the interpellation of gender. But that "girling" of the girl does not end there; on the contrary, that founding interpellation is reiterated by various authorities and throughout various intervals of time to reinforce or contest this naturalized effect.[145]

This observation highlights how authoritative biomedical pronouncement subjects bodies to a gender system that both pre-exists them and becomes instantiated through their description. In Butler's view, bodily materialization is a process that "stabilizes over time to produce the effect of boundary, fixity, and surface";[146] as per her earlier work, such corporeal borders constitute the limits of the socially hegemonic and are hence always

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[142] For a helpful analysis of *assujettissement* and *subjectivation* in Foucault's evolving thought, see Kelly 2008.
[143] Bowker and Star 1999; Star 2010; Star and Griesemer 1989.
[144] In adopting this usage, I am recognizing gender and kinship a sometimes-separable components of an ultimately unified field (Yanagisako and Collier 1987; see also Carsten 2004: 57-82).
[145] Butler 2011: xvii. See also Butler 1997: 49. For interpellation, see Althusser 1971.
[146] Butler 2011: xviii.

vulnerable and dangerous.[147] Following this approach, SD sonography actually interpellated fetuses into local gender-kinship hegemony before birth, positioning them at the threshold of sociality.

Several philosophers have explicitly addressed Butler's bracketed sonogram. In analyzing the collective ideological "hallucination" of "fetus, fetal sex, fetal gender" through ultrasound, Lesley Larkin has written:

> The [fetus] is... compulsively sexed and gendered; the visual representations that precede—and substitute for—its physical entry into society are constructed as 'girls' and 'boys.'... Sex itself is constructed and naturalized through both authoritative medico-technological discourse and—ironically—the subordination of medical diagnosis of sex to social/familial constructions of gender... Authentic sex is first and most successfully constructed not on a 'real' body but on the technological image of a body... The ultrasound image... not only appears to make visible the fetus ('baby') and its genitals ('sex'), but, in the third layer of 'revelation,' it makes gender visible on the images of fetal genitals.[148]

Larkin's description of sonography's alchemy—image to body, body to genitals, genitals to sex, sex to gender—provides a useful handle for analyzing the clinical practice of SD. In fact, she has observed that the very language of "sex determination"—the prevalent idiom in Gujarati clinical and governmental talk—laminates together three actions: "'find out,' 'control,' 'decide.'"[149] Action around gendered fetal subjects in Mahesana certainly involved all three.

While philosophy offers helpful theoretical insights, contextualizing lived experiences of sex selection requires a turn to ethnography. Since the 1970s, scholars working at the intersection of feminist and medical anthropology have produced an extensive literature on reproduction as it relates to gender, embodiment, biomedicine, and power.[150] The literature's vast empirical and theoretical insights are a testament to the value of "[dragging] reproduction to the center of social theory."[151] Revitalizing and nuancing a longstanding anthropological interest, the sub-field highlights the importance

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[147] Butler 1999: 166-168. In this section of *Gender Trouble*, Butler uses insights from Douglas's *Purity and Danger* (2002) to drive home the significance of binary ideologies, boundary-setting, and transgression.
[148] Larkin 2006: 276-277, 281. See also Mills 2014: 99.
[149] Larkin 2006: 287en283. In making this point, Larkin notes that Rothman discusses the first two: "first, as ascertaining sex; and second as causing a particular sex child" (1986: 138). Larkin adds "decide" in order to highlight that "sex is a question that, in the context of the current sex/gender formation, demands an answer" (2006: 287en283).
[150] For a sense of the sub-field's blossoming and maturation by the 1990s, see the essays in Davis-Floyd and Sargent 1997; Ginsburg and Rapp 1995b; Jolly and Ram 2001; Lock and Kaufert 1998b. Rapp (2001), Taylor (2004), and L. Briggs (2010) offer insightful programmatic statements on the sub-field's development, trajectory, and significance. The books reviewed in the latter two, along with the essays in Browner and Sargent (2011), provide a sense of the breadth and richness of ethnographic work from the past fifteen years.
[151] Rapp 2001.

of analyzing the relationships between production of persons and production of the social order—of understanding how procreation and cultural formations situate and extend one another.[152] Furthermore, as Janelle Taylor argues, "what feminist ethnographers have shown, through their research into women's reproductive lives and experiences, is what anthropologists have long sought to demonstrate: that to study ordinary people in their everyday lives is, indeed, to address the big ideas."[153] In my case, sex-selective reproduction provides insight on how persons and relations are produced by and produce gendered social systems, even before birth.

Considerable feminist research has examined prenatal practices and processes to elucidate how reproductive technologies subject fetuses, embryos, gametes, and other nascent bodies to novel imaginings and strivings. This work describes how biotechnically mediated fetal images circulate among clinics, families, markets, governments, and broader public spheres, making fetal subjects visible as ontological artifacts, epistemological challenges, and socio-political possibilities.[154] It also shows how reproductive technologies and kinship reconfigure each other, generating new forms of sociality.[155] Scholarship specifically focused on prenatal diagnosis illustrates how it mediates recognition of children-to-be as particular types of future persons, facilitating their rejection (through abortion) or acceptance.[156] For instance, Barbara Katz Rothman has poignantly demonstrated how prenatal testing renders even wanted pregnancies

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[152] Ginsburg and Rapp 1995a: 2.

[153] Taylor 2004: 130.

[154] The general point is captured by the editorial syntheses by Morgan and Michaels (1999). For shifting bio-scientific understandings and uses of the unborn, see Isaacson 1996; Ivry 2009; Markens et al. 1997; Newman 1996; Oaks 2000. For the circulation of fetal and embryonic imagery in the context of anti abortion politics, see Hardacre 1997; Hartouni 1997: 51-67; Michaels 1999; Morgan 2009; Oaks 1999; Petchesky 1987; Stabile 1992. For fetal and embryonic imagery as a device of commercial advertising, see Morgan 2011; Taylor 1992. For juxtaposition of specimen collection, bio-art, and debates around embryo disposal, see Anker and Franklin 2011; Franklin 1999.

[155] The mutual shaping of kinship and technology is most apparent in research on assisted reproduction. The assisted reproduction is vast, and research prior to the past decade is reviewed by Inhorn and Birenbaum-Cirelli (2008). Bharadwaj's recent book *Conceptions* (2016) is the first to examine the phenomenon in India. For representative ethnographies that demonstrate the reconfiguration of kinship through assisted reproduction, see Becker 2000; Franklin 1997; Inhorn 2003; Roberts 2012b; Thompson 2005. The essays in Hampshire and Simpson (2015) consider diffusion of assisted reproductive technologies to non-elites globally. Building on previous ethnographies of surrogate motherhood (Ragoné 1994; Teman 2010), a rapidly growing of body of work focuses on transnational commercial surrogacy, with a particular focus on Gujarat. A. Pande (2014), Vora (2009, 2013), and Hochschild (2013: 165-180) describe centers in Gujarat, while Rudrappa (2015), Deomampo (2016), and Inhorn (2015), describe centers elsewhere in India or globally.

[156] Again, the ethnographic literature on prenatal diagnosis is vast. Some notable early works include Rothman (1986) on how it changes the experience of pregnancy, Browner and Press (1995) on how it becomes normalized, Markens et al. (1999) on discourses of "refusal," and Rapp's monumental study of how New York women navigate amniocentesis (1999). Subsequent works have examined pre-implantation genetic diagnosis (Franklin and Roberts 2006), clinicians' practices of secrecy around prenatal diagnosis (Ivry 2006), and religious interpretations of prenatally diagnosed conditions (Ivry et al. 2011; Teman et al. 2011). Many of the essays in Sleeboom-Faulkner (2010) examine specific instances of prenatal diagnostic technology use in Asia, and J. Gupta (2010a, 2010b) specifically examines India.

"tentative," while Rayna Rapp has evocatively described how women navigate the prospect of "chosen loss" that emanates from amniocentesis.[157]

Within prenatal diagnostics, ultrasound is the modality *par excellence* for "imaging and imagining the fetus"[158]—for materializing its body and personhood. Clinical ethnographers have demonstrated how sonography becomes a technology of "appraisal, acquaintance, and care," with its visual immediacy granting it a privileged role in prenatal knowledge production.[159] The "cyborg fetus" of ultrasound imagery is always a culturally specific achievement, created through real-time coordination of talk, touch, and vision.[160] "Seeing the baby" raises pleasures and dilemmas, activating intimate and collective meanings while forging relations among kin.[161] It is within these broader patterns that we must situate how Mahesana-area SD interlaced recognition of fetal subjects with powerful affects of hope, fear, disappointment, and satisfaction.

Three ethnographic books have analyzed sonography in practice. Lisa Mitchell's ethnography of Canadian obstetric ultrasound demonstrates how sonographic sight leads clinicians and families to personify the fetus and emplace it within kinship: "The fetus emerges as a social being, a social actor with a distinctive identity—'the baby'—enmeshed in a social network of kin."[162] Janelle Taylor has traced public circulation of fetal sonograms, analyzing how the ultrasound fetus becomes a personified, commodified fetish to which various cultural meanings attach; echoing Rothman and Rapp, she emphasizes how scanning paradoxically makes the fetus more connected but more contingent.[163] Most recently, Tine Gammeltoft's account of disability-selective abortion in Vietnam has highlighted how sonographic images become the subjunctive and anxiety-ridden medium for parents to meet their children-to-be. [164] Gammeltoft describes how abnormal scans generate an "existential aporia" in which parents must reject the bonds of either kinship or citizenship, prompting a turn to medical advice, scientific and cosmological meaning-making, everyday disability experiences, and collective deliberation to transform decisions around selective abortion into something bearable. She argues for the need to "emphasize the roles played by the inchoate, the invisible, the not fully articulated in human lives," given that "perhaps more than any other social figure, the fetus embodies the possible, the tentative, that which is not yet fully there; it exists and yet it does not, it affects others without being tangible or visible to the eye."[165]

Gammeltoft's ethnography exemplifies an emerging literature on selective reproductive technologies, which fulfill a role previously belonging to infanticide alone

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[157] Rapp 1999: 225; Rothman 1986: 101.
[158] The phrase is taken from the title of Nicolson and Fleming's posthumanist history of ultrasound's development as an obstetric technology (2013).
[159] Draper 2002; Georges 1996; Margarete Sandelowski 1994. The quote is from Sandelowski.
[160] For a masterful illustration of cultural specificity, see L. Mitchell and Georges 1997. For an analysis of real-time production, see Nishizaka 2011.
[161]Han 2013: 76-98; Harris et al. 2004; van Dijck 2005: 100-117.
[162] L. Mitchell 2001: 136.
[163] Taylor 2008. For the paradox of simultaneous personification and tentativeness, see pp. 52-76.
[164] Gammeltoft 2014a.
[165] Gammeltoft 2014a: 235.

by enabling "deliberate selection of new family members."[166] In their recent review, Gammeltoft and Ayo Wahlberg analyze selective reproduction vis-a-vis family-building practices, medical commercialization, and political control, ultimately emphasizing how it generates novel dilemmas as well as novel possibilities.

This dissertation extends feminist analyses of reproductive biomedicine by considering how technologies of sex selection materialized and acted on fetal bodies, subjecting them to gender-kinship norms, personification, and intervention. It considers how tentative pregnancies, chosen losses, fetishized fetuses, and inchoate persons appeared and disappeared in the reproduction of patriarchy.

Visibility, Potentiality, and the Moral Economy of Gender-Kinship

The story that emerged around the gendered fetal subject during my fieldwork was one of seeing and being seen, appearance and concealment, exposure and disappearance. In this, the visual nature of sonography was neither totally necessary nor totally incidental. Many of the same dynamics might have prevailed with SD by amniocentesis (as in the 1980s) or blood test (as in the possibly near future). And yet the pervasiveness of a visual knowledge paradigm—of "looking" and "getting it looked at, of manifesting and hiding—did influence constructions of the gendered fetal subject, as I discuss in Chapter 3.

In sex selection, as in other social phenomena, visibility was "not simply an image," but "a real social process" at the confluence of perception and power; it simultaneously mediated and confounded production of knowledge, control, and recognition.[167] The ethnography itself also involved "learning to see"—tracking persons and things across contexts, scrutinizing concealment and revelation, and analyzing how visible objects mediated relations.[168] Understanding the social life of the gendered fetal subject requires asking, "How is visibility possible? For whom, by whom, to whom and of whom? What remains invisible, to whom and why?"[169]

"Seeing," as Valerie Hartouni has stated, "is... a set of densely structured and structuring interpretive practices... that engages us in (re)producing the world we seem to apprehend only passively."[170] Visuality encompasses "not just the social construction of vision," but also "the visual construction of the social."[171] For instance, scholars have shown how biomedical imaging practices shape clinical problem solving, concepts of personhood and body, and broader health politics.[172] More generally, medical

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[166] Gammeltoft and Wahlberg 2014: 202.
[167] Brighenti 2011: 325.
[168] Strathern 2013. See also Strathern 1999: 29-86, 204-225.
[169] Haraway 1997: 51.
[170] Hartouni 1997: 3.
[171] W. J. T. Mitchell 2002: 170. Borrowing from visual and media studies in anthropology and beyond, I occasionally use the term "visuality" to highlight how visibility is embedded in culturally specific dynamics and conventions of visual form and meaning. I am indebted to the perspective that "a social theory of visuality [focuses] on questions of what is made visible, who sees what, how seeing, knowing and power are interrelated. It examines the act of seeing as a product of the tensions between external images or objects, and internal thought processes" (Hooper-Greenhill 2000: 14).
[172] Cartwright 1995; Dumit 2004; Kevles 1996; Saunders 2008; Treichler et al. 1998; van Dijck 2005.

anthropologists have illustrated how seeing and *being seen* reconfigure embodied social relations across a wide range of conditions, from pregnancy in rural India to inpatient hospital treatment in Papua New Guinea.[173] Building on these perspectives, the story contained in these pages is fundamentally about the visibility of the gendered fetal subject and its surrounding practices.

Vision matters largely because it is a medium of social recognition: seeing an object is a crucial moment in recognizing it—particularly so for persons.[174] Far from being a natural fact, personhood is always a cultural production, requiring social recognition to bring it into being.[175] Indeed, personhood "is a process conferred, attenuated, contested, and withheld by the collective"—particularly at the beginnings of life.[176] In discussing "the moral and social complexity that everywhere surrounds the beginnings of personhood," Wendy James has observed, "'Recognition' implies a pragmatic acceptance, conferring on the embryo, foetus, or infant at the least a provisional 'personhood' and an extension of basic physical care. This is not universal or automatic. Not all early human life is socially 'recognized' in this sense and partly as a consequence of the nature of such recognition not all survives."[177]

Lynn Morgan's extensive comparative work rearticulates, empirically substantiates, and extends James's argument by highlighting the culturally variable status of the unborn.[178] Morgan's scholarship shows that pre-birth body, personhood, and moral status—indeed, even (social) birth itself—depend on culturally specific collective action. It emphasizes how the unborn are always liminal or threshold beings, embodying both possibility and its incomplete actualization. Morgan's insights exemplify an extensive literature attesting how fetal ontologies, personhoods, and imaginaries—hence, recognitions as well—vary greatly with social and historical positioning.[179] Across different situations, recognition of the unborn may vary not only in degree, but also in *type*.[180] And since "the question of recognizing a child clearly anticipates its potential social place," recognition may not prove unambiguously positive.[181] For female fetuses in

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[173] Pinto 2008: 141-177; Street 2014: 115-140.

[174] Brighenti 2011: 329-330; Casper and Moore 2009. See also the essays in Part I of Dube et al. (1986). Here, and throughout my analysis, I generally use "recognition" to signify the first moment (identification and objectification) identified by Ricoeur (2005), rather than the third (ethical and political practice). But as Taylor (2009) notes while analyzing a somewhat different dynamic, the beginning and end of Ricoeur's dialectic have a tendency to collapse into one another, and I am attracted to the notion of "recognizing" a gendered fetus partly due to this provocative slippage.

[175] The social formation of personhood is a longstanding anthropological concern (Carrithers et al. 1985; Mauss 1985). Anthropologists of India have analyzed personhood with respect to everyday interactions (Marriott 1976), kinship norms (Ostor et al. 1982), aging and intergenerational relations (Cohen 1998; Lamb 2000), and everyday gender experiences (Busby 1997a, 1997b). See Loizos and Heady (1999) for a collection specifically focused on personhood vis-a-vis reproduction, and Carsten (2004: 83-108) for a recent synthesis.

[176] Kaufman and Morgan 2005: 320-321.

[177] James 2000: 170.

[178] Conklin and Morgan 1996; Morgan 1996a, 1996b, 1997, 2009, 2013.

[179] E.g., Duden 1993, 1999; Layne 2002; Lupton 2013; Sasson and Law 2009.

[180] Morgan 1996a: 59-60.

[181] James 2000: 185.

north Gujarat, social visibility could spell elimination, with rejection occurring both despite and *because of* recognition.[182]

People sought to visualize fetal subjects in order to recognize their gendered potentialities. Writing on potentiality in biomedicine, Karen-Sue Taussig and colleagues have recently observed that "to imagine or talk about potential is to imagine or talk about that which does not (yet and may never) exist."[183] Their exposition identifies three different meanings for potential: "a hidden force determined to manifest itself—something that with or without intervention has its future built into it"; plasticity; and "a latent possibility imagined as open to choice, a quality perceived as available to human modification and direction."[184] Reflecting Morgan's influence, the account then uses the embryo to illustrate how one object may embody all three meanings, and "how easily one meaning slides into another, so that a claim about potential as a hidden force... becomes subject to a (necessary) action or even choice."[185]

Building on this perspective, I propose that gendering made visible the unborn's potential in the first and third senses—as human matter inevitably destined to develop into a particular type of relative, and as a still-unactualized person subject to reproductive choice. Ephemerally materialized in multiple, often-contradictory forms, fetal potentiality prompted searching, recognition, and reaction. It became interpellated—within medicine as malleability, within kinship as relationality, and within governance as citizenship.

Once visible, the gendered child-to-be became subject to evaluation—to differential attribution of worth according to sociocultural logics. Anthropological studies have typically focused on two different senses of "value": worth as generated for and through material exchange relations, and fundamental principles that order ways of being and doing in the world.[186] In analyzing the relationship between Gujarati "family values" and the social values attached to different bodies, I am straddling these two senses. Spurring materially and ethically productive actions, the gendered fetal subject epitomized connections between the worth of potential persons and shared conceptions of the good life.[187]

Gendered fetus's became situated vis-a-vis value(s) through the functioning of a *moral economy of gender-kinship*. I adopt here Lorraine Daston's definition of "moral economy" as a "web of affect-saturated values that stand and function in well-defined relationship to one another"—an emotion- and value-laden system (moral) that follows explicable (though not always predictable) regularities (economy).[188] In Daston's view,

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[182] Here, Ricoeur's first and third moments split apart: because the female fetus is identified as a particular kind of external object, she is not accorded full ethical-political recognition within the family.
[183] K.-S. Taussig et al. 2013: S4.
[184] K.-S. Taussig et al. 2013: S4.
[185] K.-S. Taussig et al. 2013: S4-S5.
[186] Otto and Willerslev 2013: 1-2.
[187] Cf. Lambek 2013.
[188] Daston 1995: 4; see also Fassin 2012: 266en222. Coined by historian E.P. Thompson (1971) and popularized in anthropology by James C. Scott (1976), the notion of moral economy has typically centered on how a "legitmizing notion"—for instance, justice regarding conditions of production—can generate a political subjectivity that contends with the market (see also Edelman 2005). Daston admits that her approach differs considerably from that of Thompson, and that the common foundation remains the idea of

moral economies extend beyond individual psychology or ideologically veiled material interests. Instead, they represent balanced systems of emotional forces with equilibria, constraints, malleability, internal logics, and close ties to human activity. Moreover, they defy separation of instrumental and affect-laden actions.

Scholars have employed the moral economy concept to analyze practices from drug-related violence in the U.S. inner city to corruption in postcolonial governments.[189] Several have discussed moral economies of kinship or gender, with the most detailed account elucidating the intertwining of kin relations and property systems in community reproduction.[190] By invoking a moral economy of gender-kinship, I am highlighting that sex selection was not reducible to a straightforward process of households, communities, "gender bias," "discrimination," or "patriarchy" eliminating potential girls before they could come into existence. Rather, gendered fetal subjects acquired differential value amid complex systems of material and affective relations. Shared expectations and regularities regarding management of bodies, personhood, and household economy heavily conditioned the rejection of daughters-to-be.

How, then, did different processes interpellate the gendered fetal subject within a moral economy of gender-kinship? In part, visibility to the family facilitated the fetus's situation within gender-kinship logics. The potential child became conscripted into a system that converted bodily difference into hierarchies of domination and subordination.[191] The unborn became always-already subject to hegemonic norms of marriage and descent, inheritance and gifting, care and expenditure, and connection and separation. With sonographic materialization, prospective parents could read different future trajectories of reproductive labor, alienation, and retention from different fetal bodies. Daughters-to-be frequently settled "at the point of kinship's (never quite nonnormative dissolution,"[192] where severed bonds left behind only the negative residue of relations.

Family-building overlapped with clinical action: just as a *gendered* fetal subject required interpellation within a gender-kinship system, a gendered *fetal* subject presumed interpellation through biomedical technology and expertise. Much like the "unborn patient" of *in utero* surgery or the barely "viable" second-trimester fetus, the gendered child-to-be existed by virtue of and remained subject to clinical intervention.[193] It materialized through the activity of an apparatus extending from ultrasound machine,

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a "legitimising notion" that gives rise to regularities of value and activity (1995: 3fn1). Like my analysis, hers, which examines "the moral economy of science," does not conform to the view that "moral economy" must take a subjective (e.g., "peasant") rather than objective (e.g., "science") genitive (cf. Fassin 2014: 14).

[189] de Sardan 1999; Karandinos et al. 2014.

[190] Brandstädter 2003: 437. Of note, Brandstädter states that the focus on social reproduction within capitalist economies requires a divergence from Thompson and Scott, who hold the moral economy to stand in opposition to capitalist logics. For other uses with gender or kinship, see, e.g., Fassin et al. 2008: 234; Huberman 2011; Paxson 2006. In most such instances, the notion of moral economy provides an important framing device but is not unpacked *per se*.

[191] Rubin 2011.

[192] Pinto 2014: 256.

[193] Casper 1998; Christoffersen-Deb 2012.

sonographer, and pregnant woman toward clinical setting, family, and society.[194] In visualizing and interpreting genitals, the sonographer initiated the alchemic conversion that facilitated recognition (and acceptance or rejection) of a potential son or daughter. Commercialized biomedicine entered the moral economy as a site for capital accumulation through inscription of cultural logics on maternal and fetal bodies. The gendered fetal subject became tied to dynamics of profit and patronage that encompassed exploitation, entrepreneurship, mutual assistance, and pity.

Finally, the PCPNDT Act and anti-sex selection campaigns interpellated the potential child as a subject of reproductive governance, or "the mechanisms through which different historical configurations of actors... use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices."[195] Selective reproduction became the target of normalizing biopolitical interventions that linked corporeal control and population management.[196] Biomedically inflected governance discourses constituted female fetuses as "threshold subjects"—"fetal citizens... worthy of state protection" through legal-bureaucratic intervention on the social space of the womb.[197] Despite considerable resource expenditure, interventions organized around "seeing like a state" missed the black market and the shared moral-economic understanding that subtended it.[198] At the same time, governance remained intimately intertwined with the moral economy through histories of economic liberalization, obstetric commercialization, and ultrasound import; through measures promoting population control and gender-unequal economic development; and through the PCPNDT Act, which generated rent-seeking opportunities and a "politics of duplicity" by driving sex selection underground.[199]

Ultimately, the gendered fetal subject and the moral economy of gender-kinship mutually shaped each another. In SD, families and clinicians visualized the fetus amid the interpellating forces of gender-kinship, thereby materializing those forces prenatally. Practices of selective abortion and selective nurturance then differentially addressed gendered fetal potentiality, leading to a selective reproduction that favorably positioned families within the moral economy while simultaneously modifying its material (bodily) base.

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[194] Barad 1998.

[195] Morgan and Roberts 2012: 243.

[196] Foucault 1990: 139-157. Within the extensive literature on population politics, I have found particularly helpful certain works on population control and family planning (Anagnost 1995; Chatterjee and Riley 2001; Greenhalgh 2008; Greenhalgh and Winckler 2005; Maternowska 2006; cf. Kligman 1998), discourses and practices of "population quality" in (post)socialist contexts (Anagnost 2004; Gammeltoft 2008), the discursive construction of the womb as social space (Holc 2004; Stormer 2000), and the significance of reproduction for national imaginaries (Kahn 2000; Kanaaneh 2002; Paxson 2004).

[197] For the "threshold subject," see Weir 2006. For "fetal citizens," see Casper and Morgan 2004: 17. For other discussions of fetal citizenship, see Berlant 1994; Holc 2004; Mason 2000. For the significance of the womb as social space, see Holc 2004; Stormer 2000.

[198] J. C. Scott 1999. See also Foucault 1991.

[199] For the "politics of duplicity," see Kligman 1998.

The Matter of Violence

Countless activists and academics have advocated for understanding sex selection as a prenatal form of gendered violence.[200] The process certainly enacts a violent logic embedded in the moral economy of gender-kinship, which attaches lower value to female bodies. Like the neonatal deaths studied by Nancy Scheper-Hughes in Brazil, sex selection is a form of structural violence in which institutions of state, medicine, community, and family operate together to transform undervaluation of particular bodies intro social disappearance.[201] But locating the act of sex-selective reproduction on a continuum of violence that stretches from structural to intimate reiterates the need to theorize its proximate administration.[202] How should we ethnographically understand the recognition and rejection of daughters-to-be as a violent social process, particularly when anti-sex selection discourse always risks slippage into general anti-abortion discourse?[203] A focus on the gendered fetal subject as liminal person can help untie the knot.

As discussed above, the unborn exist at a threshold of human social life. Materializing or surfacing the fetal body always entails marking out a boundary that does not stand outside sociality, but rather defines it. The fetus's potentiality and liminality—not quite a person (but not quite *not*), not quite alive (but not quite *not*)—matter, for they pose a limit against which sociocultural forces press.

Veena Das's work poignantly illustrates how the limits of human life are a privileged site for the operation of violence, which both unmakes and makes sociality: "In the process of being articulated and sometimes practiced, violence seems to define the edges at which experimentation with a form of life as a *human form of life* occurs."[204] Elsewhere, Das has specified:

> The dangers that human beings pose to each other... relate to not only disputations over *forms* but also disputations over what constitutes *life*. The blurring between what is human and what is not human shades into the blurring over what is life and what is not life... Sometimes [denial] announces itself in... the fear of natality, and the thought that violence may be linked not only to handing out death but also in the refusal to allow another to be born.[205]

By oscillating along (and thereby problematizing or collapsing) the linear axis "person-nonperson," the gendered fetal subject of Mahesana inhabited an in-betweenness that made possible a particular form of selective reproduction while simultaneously rendering that form comprehensible as gendered violence. In SD and selective abortion, families recognized the female fetal subject as embodying a particular kind of potential

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[200] E.g., John 2014; Sangari 2012: 35-38.
[201] Scheper-Hughes 1992; cf. Farmer 2004.
[202] Scheper-Hughes and Bourgois 2004: 1, 19-22.
[203] Ganatra 2008; N. Menon 1995.
[204] Das 2007: 86, emphasis in original.
[205] Das 2007: 15-16, emphasis in original. In making the point regarding "fear of natality," Das is paraphrasing the philosophy of Stanley Cavell.

personhood and then eliminated it on the basis of its moral status as a non-actualized person.[206]

The argument for sex selection as a form of gendered violence is relatively easy to accept from a purely structural or systemic perspective, with no concrete families, clinicians, or fetuses in the picture. Ethnography opens up the possibility of theorizing the materiality of violence at the limit of human personhood, but it also makes any theorization about violence more complicated. Confronting the gendered fetal subject and the machinations entails elaborating and nuancing our understandings of the interplay between sex selection and the moral economy it embodies. Rather than simply locating the former within the latter, we must draw connections, mark separations, and theorize how the prevention of existence for certain imagined persons relates to a society-wide diminishment of female presence. The up-close perspective on sex-selective reproduction allows for analysis of it as a violent experiment at the limit of social life—the limit of violence itself.

Overview of the Dissertation

Each of the dissertation's six chapters elucidates a different part of the assemblage of actions surrounding the gendered fetal subject. Chapter 1 describes the history and functioning of the market for gendering and selectively eliminating fetuses, focusing on the roles of technologies, biomedical experts, and other personnel. It also describes the rise of a governance regime that has attempted to catch ongoing acts of sex selection and render them publicly visible. Chapter 2 delineates the moral economy of gender-kinship that gave meaning to clinical gendering, emphasizing the futures that families envisioned for potential children. Chapter 3 describes the concrete clinical practices that materialized and intervened on the gendered fetal subject, spanning sonographic SD and its uncertainties, selective abortion and its risks, and selective nurturance. Chapter 4 examines household power dynamics and women's agency around gendering and eliminating potential children, with a focus on seeing beyond stock narratives of family decision-making. Chapter 5 considers non-biomedical techniques that operated alongside conventional sex selection to shape gendered fetal subjects. It also closes the portion of the dissertation focused on clinical and familial action by considering practitioners' and families' perspectives on the ethicality of selective reproduction. Chapter 6 shifts the spotlight to construction of the gendered fetal subject within institutions and discourses of governance, analyzing public attempts to render visible, valorize, and thereby save threatened daughters. In the conclusion, I reflect on what the gendered fetal subject of north Gujarat contributes to our understandings of sex selection and prenatal personhood more generally.

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[206] While the temptation is strong to draw a contrast between qualified and bare life, I follow Deutscher (2007) in avoiding characterization of the fetus as bare life. For me, the temporal dimension is what distinguishes this situation from the various conditions discussed by Agamben (1998). While embodying bare life, the literal *homo sacer* of Roman law and his metaphorical successors are blocked from accession to qualified life. By contrast, gendering the fetus qualifies its (potential) life, telescoping future and present in a manner that allows for action on the fact that jurally, it is not yet even *bare* life. That being said, I see a limited affinity between the gendered fetal subject and *homo sacer*, insofar as both delimit social life and provide insight on the effects of imposing or withholding entry to forms of qualified life.

Table 1 – Child Sex Ratio (0-6) of Indian States and Territories

		2011 Child Sex Ratio	2001 Child Sex Ratio
INDIA		**919**	**927**
Western India			
	Gujarat	**890**	**883**
	Maharashtra	894	913
	Daman and Diu	904	926
	Dadra and Nagar Haveli	926	979
	Goa	942	938
North India			
	Haryana	834	819
	Punjab	846	798
	Jammu and Kashmir	862	941
	Delhi	871	868
	Chandigarh	880	845
	Rajasthan	888	909
	Uttarakhand	890	908
	Uttar Pradesh	902	916
	Himachal Pradesh	909	896
	Madhya Pradesh	918	932
	Chhattisgarh	969	975
East India			
	Bihar	935	942
	Orissa	941	953
	Jharkhand	948	965
	West Bengal	956	960
	Andaman and Nicobar Islands	968	957
South India			
	Lakshadweep	911	959
	Andhra Pradesh	939	961
	Tamil Nadu	943	942
	Karnataka	948	946
	Kerala	964	960
	Puducherry	967	967
Northeast India			
	Manipur	930	957
	Nagaland	943	964
	Sikkim	957	963
	Tripura	957	966
	Assam	962	965
	Mizoram	970	964
	Meghalaya	970	973
	Arunachal Pradesh	972	964

Source: Census of India

Table 2 – Child Sex Ratio Comparison: Northern/Kadva versus Central/Leua

NORTH	CENTRAL
1872 Child Sex Ratio (0-6)	
Kadi Subdivision: 941 Vijapur Subdivision: 928 Kheralu Subdivision: 954 Visnagar Subdivision: 941 Vadnagar Subdivision: 961	Petlad Subdistrict: 834 Khera District: 897
1881 Child Sex Ratio (0-9)	
Kadi Subdivision: 958 Vijapur Subdivision: 976 Mahesana Subdivision: 976 Visnagar Subdivision: 961 Kheralu Subdivision: 988 Vadnagar Subdivision: 917	Petlad Subdistrict: 866
1891 Child Sex Ratio (0-9)	
Kadi Division: 995	Baroda Division: 950
1901 Child Sex Ratio (0-10)	
Kadi Division: 970	Petlad Subdistrict: 777
1911 Child Sex Ratio (0-9)	
Kadi Division: 934	Baroda Division: 888
1921 Child Sex Ratio (0-12)	
Kadva Kanbis: 978	Leua Kanbis: 863

Source: Census of India

Table 3 – Caste Composition of Baroda State Northern Division, 1931

Caste	*Traditional Occupation*	*Population*	*Percent*
Higher Caste			
Brahmin Uttar	Priest	51823	5.30
Brahmin Dakshin	Priest	1109	0.11
Brahmin Adhogat	Priest of degraded caste	4743	0.45
Vania	Trader	16322	1.67
Rajput	Martial	44386	4.54
Intermediate Castes			
Kanbi/Patidar	Cultivator	215201	22.23
Chodra/Anjna	Cultivator	2223	0.23
Soni	Goldsmith	4411	0.45
Kumbhar	Potter	25685	2.63
Luhar	Blacksmith	14928	1.53
Suthar	Carpenter	13526	1.38
Darji	Tailor	8163	0.83
Bhavsar	Dyer/Printer	5534	0.58
Hajam	Barber	15545	1.59
Kansara	Coppersmith	1490	0.15
Gosai	Mendicant	5364	0.55
Bhat and Barot	Genealogist	13755	1.41
Sadhu	Ascetic	1948	0.20
Maratha	Martial	934	0.10
Sathwara	Gardener	5368	0.55
Mali	Gardener	2467	0.25
Others		13501	1.38
Lower Castes			
Koli/Thakor	Cultivator	224896	22.99
Rabari	Herder	44318	4.53
Vaghree	Fowler	19147	1.95
Ravalia	Drummer	10908	1.12
Ganchi	Oil pressor	7093	0.73
Bhavaiya	Folk actor	5850	0.60
Mochi	Shoe maker	3407	0.35
Bhajania	Folk Singer	1654	0.17
Jogi	Mendicant	1465	0.15
Charan	Bard	1211	0.12
Bharvad	Herder	1145	0.12
Untouchable Caste			
Dhed/Wankar	Weaver	46647	4.77
Bhangia	Scavenger	11192	1.15
Shenwa	Rope maker	6455	0.66
Garoda	Priest	5314	0.54
Chamar	Tanner	1203	0.12
Turi	Genealogist	1408	0.14
Khalpa	Tanner	18906	1.93
Aboriginal		2272	0.23
Muslim		63205	6.48
Jain		32125	3.28
Parsi		49	
Christian		44	
Total		978340	100.00

Source: Lobo 1995: 190-191

Note: 1911 Census of India found roughly 30,000 Anjana Kanbis (Chaudharys) out of 216,000 total in the northern division, suggesting an error in this table. The Chaudhary population was likely an order of magnitude larger—about 3% of the population.

Chapter 1: The Market for Sex Selection

"A Secret Thing"

It was Wednesday morning. I reclined against the richly upholstered sofa in Uma-masi's sitting room. She sat cross-legged across from me, taking string beans from a splayed newspaper sheet and cutting them into a steel bowl at her feet. We chatted about how many routine antenatal patients would come to Nandini Clinic that afternoon for "big sonographies"—detailed fetal anatomy scans performed twice or thrice per pregnancy. Rocking side-to-side, Uma-masi exclaimed, "There will be so many patients!"

Then, shaking her head, she smiled mischievously and whispered, "All of them, infatuated with boys!" I was startled: for the first time in our countless conversations, Uma-masi was mentioning the pursuit of sons. I asked whether patients requested Dr. Dilip to "take a look at *that*." Still smiling, she nodded emphatically: "*Huh-uh*! Of course. But Dilip-saheb doesn't say anything. For *that*, you have to go elsewhere." Picking up the bowl of cut vegetables and moving into the kitchen, she shouted over her shoulder, "I'll explain later!"

Since the previous monsoon, in 2012, Uma-masi had welcomed me to Mahesana's Nandini Clinic. But never in my many hours of clinical observation or my many evenings with her family had anyone even mentioned the ubiquitous but clandestine practices through which clinicians and families visualized and reacted to fetal sex.

A short time later, Uma-masi and I took a rickshaw to Nandini. During a lull in the morning's patient flow, when we were alone in the consultory, she whispered conspiratorially, "Don't tell Dilip-Saheb—I'm telling you this because you're like my son!—but to earn money I take patients elsewhere. I'm telling you this because you're like my son. My monthly earning ends up being 20,000." I was flabbergasted. 20,000 rupees—more than twice her regular salary as a nurse.

The next evening, Uma-masi and I sat on her patio swing, swatting away mosquitos and slowly drifting through the stagnant, humid monsoon air. I moved our conversation back toward sex determination (SD), and she said, "Well, it's gotten so that doctors do it inside-inside,[1] secretly. They do it, but they don't let it be known outside. And people pay twenty-five!" Widening my eyes, I asked if the cost was as high as twenty-five hundred rupees.

Her response was swift and incredulous: "Are you serious?! Twenty-five thousand!" I was astounded. 25,000 rupees could purchase about $1,500 of goods, but lower salary levels for the Gujarati middle class meant that the figure was even larger

[1] In Gujarati speech, reduplication like "inside-inside" is common, generally carrying an intensifying effect. I frequently reproduce it in my translations to convey something of the texture of the original Gujarati conversation.

than the comparison might suggest. 25,000 rupees was most of a senior government schoolteacher's monthly salary. [2] For a household dependent on manual labor, it could easily represent the bulk of a year's disposable income.

Before I could ask any more, Uma-masi peremptorily waved me into the house: "Come! Time for you to eat. We can talk later." My curiosity remained in suspension.

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Two days later, during a solitary moment in the consultory, I nervously asked Uma-masi whether we could chat at length about the "boy-girl test," since it was the chief focus of my research. Given the topic's sensitivity, I had not previously pressed it. But now, after her admission, I felt emboldened to raise new questions.

Cocking her head to the side, Uma-masi replied, "Of course! But not at the clinic—we should have that talk at home." Then, she smiled and added:

> And if you'd been there last night—oh, you'd have been able to see! I told the *other* saheb—a wonderful saheb!— there's a boy from the U.S. who's here to do a study, and he wants to talk, so will you talk? Well, he said, 'Definitely, I will. Just bring him, Sundays or evenings. If he's going to keep it secret, no problem. But you bring him yourself, and you take him away.'
>
> I went to that clinic yesterday, and you would've gotten to see in person if you were there! It was a patient for what we were talking about—looking. Dilip-saheb refused, since we don't do it. But then I explained to them, my way, and took them to that saheb—a wonderful saheb! Watch, you'll get to see everything yourself. But everything secret, eh?

Now I was certain: I was already inside a sex selection referral network. The kindly, maternal nurse who had warmly welcomed me to Mahesana was a facilitator for the very services I had come to study. I was beginning a new, embedded engagement—enlightening, fraught, often wrenching—with the practices that permitted families and clinicians to recognize and react to a gendered fetal subject.

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Two days later, after dinner, Uma-masi and I sat on opposite ends of her sofa, each with an arm up against the wall. It was already 11 PM. I timidly brought up the potential interview. In response, Uma-masi laughed, "Go ahead and ask! I'll answer the best I know."

We talked continuously for the next two hours, her detailed explanations of the local sex selection market tumbling forth in matter-of-fact descriptions, grand boasts, and clever quips. At some points, she lowered her voice and intimated that even her husband and sons did not know the information she was about to reveal. At others, she shouted

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[2] At the time of my fieldwork, the exchange rate hovered around sixty-to-one, and the purchasing power parity exchange rate just above fifteen-to-one. Thus, in terms of consumables, 25,000 rupees could purchase about $1,500 worth of goods. Put differently, 1,000 rupees exchanged to just under twenty U.S. dollars, and represented more like seventy dollars in terms of purchasing power.

proudly as her daughter-in-law sat next to us and listened, nodding along and smiling. In repeated asides, she told me she trusted me "because you are like my son"—"because Uma-masi always knows how to take the measure of people, and I know you're not going to do anything bad with this information!"

We began by discussing the "wonderful saheb." Uma-masi intimated that "the place for getting it looked at" was "a private clinic, just like Nandini," located in a nearby subdistrict headquarters. The obstetrician's sex selection practice was "a secret thing." He only "looked" and provided abortions on Sundays and in the evenings; at those times, it was "safe" in the small town, since "there can't be any government checking when the officials are off."

The prior week, Uma-masi had taken two Patel families who had contacted her "via-via"—in a roundabout fashion, after obtaining her mobile number from previous clients. Rendezvousing in Mahesana, they had set off for the small town together. "Once we take them," she added, "we can't ever leave them alone there! We have to stay together. If they get it *kenchhal*, we have to stay." Perplexed by the unfamiliar word, I asked for clarification. She elaborated, "If they don't want to keep it. Then I have to stay till the termination is finished. That's what you call"—and now, a clearer articulation, accompanied by a slashing gesture—"*cancel*." As I would learn, the English word was her favored term for the erasure of pregnancy that followed recognition of female fetuses.

Lowering her voice, Uma-masi intimated, "That saheb only takes 10,000—very little! People are taking 25,000 rupees, but he takes less!" After a pause, she chuckled, "And I earn 25,000 every month!" Looking around shiftily—presumably for her husband—she held up three fingers. "Saheb gives me this many out of 10,000!" Astonished, I opened my mouth to say the number, but she hushed me. Still whispering, she explained that her earnings were "enough for all the household costs": milk, vegetables, grains, spices, and sundry groceries; new clothing, jewelry, and shoes; cleaning supplies and toiletries; blankets, bedding, and small furniture; rags and mats; spending money for both sons; and "fashion" items for herself. While hiding the details of her earnings from family members, Uma-masi used her income to wield considerable domestic power and secure upward mobility in consumption and status for the entire household.[3]

Uma-masi and I continued talking until 1 AM. She drew me further into the world of sex selection than I could have imagined just days earlier, describing the slow rise, spectacular fall, surreptitious renaissance, and definitive end of the practice at Nandini; her own cultivation of a referral network for SD tests and sex-selective abortions; and the idiosyncrasies of various doctors who continued to furtively provide the illegal services.

Toward the end, she promised, "I'll talk to Saheb about bringing you. We're not looking to do him wrong, right? It's not like we're going to publicize—'Such-and-such doctor is doing it in this place!'—or tell people. We can't betray! Whatever house we eat bread and rice from, we can't treat badly."

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[3] A biographical analysis of Uma-masi's work and earning as gendered economic tactics situated in patriarchal household, community, and economic structures is the focus of a separate essay, currently in preparation.

That first extended conversation was the definitive inflection point in my initiation into seeing the market for SD and selective abortion. Over the next two years, I would piece together the history and contours of the Mahesana-area sex selection market, gradually developing a picture of how it connected technologies, expert operators, clients, facilitators, government officials, and gendered fetal subjects in complex relations of sight and concealment, control and evasion. While Chapter 2 explores the gender-kinship meanings projected onto the fetal image, and Chapter 3 the actual clinical processes of recognizing and reacting to gendered fetuses, here I describe the local network in which clinicians, facilitators, and families attempted to visualize and act on fetal sex even as governance institutions attempted to visualize and act on the crime of SD.

What was (or was not) made visible and knowledge in the Mahesana-area black market? Certainly fetal sex, but also technologies, practices, expertise, and enterprises for identifying it; the public crisis of sex selection, as understood through sex ratios (SRs) and embodied in the threatened female fetal subject; the "perfect" crime of sonographic SD, which defied detection; government power and impotence, as seen in enforcement actions both spectacular and mundane; and, targets of blame for the problem of selective reproduction.

In the first half of what follows, I trace the historical evolution of the Mahesana sex selection market. I examine the rise of technology, expertise, and social demand in the 1980s and 1990s; the rise of state prohibition and policing after 1994; and the market's gradual underground retreat after 2005. The goal is to trace "a history of the present"[4] for sex selection in a specific locale—a historical narrative with "an unequivocal and unabashed contemporary orientation."[5] In the chapter's second half, I focus on the market's contemporary workings. I begin with Chetna Clinic, my primary window for seeing how providers handled clients, evaded surveillance, distributed profits, and managed information around SD and selective abortion. After analyzing other obstetricians' wariness regarding participation in sex selection, I fill out the local landscape by examining what circulating knowledge and rumors revealed about market participants. In concluding, I confront how different actors assigned blame for sex selection's persistence and pervasiveness.

The Rise of Sex Selection: From the 1980s to 2001

Biomedical techniques of selective reproduction first became visible to Uma-masi during the 1990s. She would later recount:

> I accompanied one of my in-laws when she went to get it looked at twenty-five years ago! We went to the hospital. They took the woman inside, and they looked by sonography. (That boy is now married, with his own boy!) Back then, I didn't understand anything. How could I imagine this was a thing you could *see*? I didn't know what we had gone to do. Then, when they had a boy, I got suspicious—'They've done something.'

[4] Foucault 1995: 31.
[5] Dreyfus and Rabinow 1982: 119.

By the time of Uma-masi's trip, the market for SD in North Gujarat had already evolved considerably, transitioning through several modalities for seeing sex.

In the 1980s, the region's few private obstetricians began "looking at" fetal sex through amniocentesis, a markedly invasive procedure.[6] During the fourth gestational month, the doctor would pierce a patient's abdomen, uterine wall, and amniotic sac with a long needle to extract amniotic fluid. He would send the sample to a pathologist's laboratory for analysis of free-floating fetal cells. A few days later, he would relay the pathologist's written report of sex chromosomes: XX or XY. Amniocentesis was a taxing method of SD, requiring invasive sampling, laboratory coordination, and a waiting period between testing and receipt of results.[7]

Early on, doctors sent samples to laboratories in Ahmedabad (seventy-five kilometers away) or even distant Mumbai, since local pathologists did not possess the requisite expertise in chromosomal analysis. But one senior practitioner cynically recalled, "Once demand here increased, the pathologists got smart. They learned quickly. Most of this chromosomal analysis—98%—was bound to be for SD!" For their roles in rendering fetal sex visible and actionable, obstetricians and pathologists each collected between 500 and 1,000 rupees—substantial sums in those days.[8]

After amniocentesis, unwanted daughters-to-be had to be eliminated by initiating premature labor—what patients and practitioners called *"kāchi* [raw, premature, unripe] delivery."[9] For many women, *kāchi* delivery proved a harrowing ordeal, with ever-

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[6] Cowan (1994: 36-40, 2008) has anazlyzed social influences—and in particular, women's roles—in amniocentesis's development (through the 1970s) and diffusion (from the late 1970s onward) as a global technology. Of note here, Cowan has observed that pioneering work in both amniotic sampling and microscopic visualization of fetal chromosomes was motivated largely by a desire for a prenatal SD mechanism—interestingly enough, to identify potentially disabled *male* fetuses in women with family histories of X-linked diseases like hemophilia (1994: 36-39). Cowan has also noted that amniocentesis could not have moved from development to widespread diffusion in the U.S., Canada, and the U.K. without legalization of the only "therapy"—abortion—for "positive diagnosis" (1994: 40). Also see Rapp (1999: 23-29).

[7] See Rothman (1986: 86-96) and Rapp (1999: 113-118) for detailed descriptions of women's experiences with the test procedure in the U.S. Rapp has discussed women's anxiety-ridden experiences of waiting for amniocentesis results in the context of disability testing in the U.S (1999: 103-118). She has proposed the notion of "liminal dread" to describe the multi-layered existential concerns relating to "fear of causing a miscarriage, fear of learning bad news, and, perhaps, fear of having unbalanced the forces of nature which are presumed to be protecting a pregnancy" (Rapp 1999: 105). Rothman has proposed the notion of "suspended animation," noting how amniocentesis, whose results might not come back until after the start of fetal movement, fundamentally changed the meaning of such movement and the associated experience of attachment in pregnancy (1986: 100-115).

[8] A 1986 survey of forty-two amniocentesis practitioners in the metropolis of Mumbai (S. Kulkarni 1986) found that the fee for amniocentesis ranged from seventy to 600 rupees, with most doctors charging between 200 and 400. According to the survey, a vast majority of amniocentesis procedures were performed for the sole purpose of SD. Most practitioners also performed selective-abortions with a "female" result.

[9] Doctors used one of two primary methods to initiate *kāchi* delivery: injecting a saline solution into the amniotic cavity *per abdomen*, or instilling ethacridine lactate—an abortifacient—between the amniotic membrane and the uterine wall via a catheter threaded through the cervix. Both caused cessation of the fetus's vital processes and precipitated eventual expulsion. For a concise description of these methods in historical perspective, see Bygdeman and Gemzell-Danielsson (2008: 196-197, 198-199).

increasing labor pains stretching out for up to three days.[10] In some cases (like those narrated in gory detail by Asha-ben's mother-in-law), fetuses remained un-expelled. Furthermore, as performed in Mahesana during the 1980s, *kāchi* delivery entailed considerable risk; every older obstetrician could recall instances of severe complications.[11] A woman undergoing abortion after amniocentesis faced significant bodily suffering: hours to days of grim labor, and non-trivial chances of severe bleeding, life-threatening infections, or other fatal complications. The quest for a son could result in a woman's incapacitation or even death.

By the early 1990s, the local advent and proliferation of ultrasound technology enabled SD by chorionic villus biopsy (CVB). Loosely paralleling amniocentesis, CVB entailed sending a sample from the developing placenta for chromosomal analysis. The procedure could be performed earlier—within the first trimester—but sonographic guidance was required to maneuver the needle around the delicate early-pregnancy womb and conceptus.

Though CVB was, like amniocentesis, a multi-step process, it quickly gained in popularity because of its first-trimester timeframe.[12] Early detection allowed families to more quickly move beyond a "tentative pregnancy."[13] Furthermore, CVB's first-trimester timing allowed doctors to perform abortion through manual surgical procedures, which were generally quicker, easier, and safer. Avoidance of the painful, protracted, and often-dangerous *kāchi* delivery proved highly appealing to women.

During a brief period in the late 1980s and early 1990s, when ultrasound technology had arrived but not yet advanced beyond the rudimentary, CVB became the primary method of SD. As Dr. Dilip said when recalling his residency training, "those who were not aware got amniocentesis done at four months, and those were smart got CVB at two months."

The 1991 Census results showed the combined impact of amniocentesis and CVB on 0-6 child sex ratio (CSR) in Mahesana District. Among towns, Mahesana (868), Visnagar (861), Kadi (867), Vijapur (872), and Unjha (875) all exhibited CSRs below 900. The rural areas of some subdistricts also came in below 900. Rural and urban CSRs were nearly equally skewed in the subdistricts of Visnagar (869 against 861), Vijapur (886 against 882), and Mahesana (892 against 868), but overall there remained a

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[10] Rothman (1986: 189-216) and Rapp (1999: 238-248) offer moving descriptions of second-trimester abortion after "positive" amniocentesis results, including medical procedures, bodily and emotional pain, and aftermaths.

[11] The most common complications were amniotic fluid embolism, hypernatremia, disseminated intravascular coagulation, or uterine rupture. Amniotic fluid embolism is a condition in which amniotic fluid enters the maternal bloodstream, triggering a severe reaction. Hypernatremia is an abnormally high level of sodium in the bloodstream. Disseminated intravascular coagulation is a serious condition in which clotting-related proteins in the blood become over-reactive, leading to clots in small vessels throughout the body, as well as the potential for paradoxical bleeding.

[12] According to S. Kulkarni (1986), several Mumbai doctors had already started practicing CVB in the mid-1980s, with charges ranging from 1,000 to 1,5000 rupees. Cowan (1994: 36, 40-44) has characterized CVB as still in late development or early diffusion by the early 1990s; this characterization may be more apt for diagnosis of genetic disease in the West than for SD in Gujarat. Also see Rapp (1999: 29-30).

[13] Cf. Rothman 1986: 7, 96-115.

considerable rural-urban divide; in Kadi Subdistrict, for instance, the rural figure (921) was more than fifty points higher than the urban. Urban living—associated with education, affluence, lower fertility, and medical consumerism—correlated with a higher likelihood of undergoing SD.

Despite its first-trimester timeframe, CVB eventually waned in popularity due to its logistical complexity, technical difficulty, and medical risks. Like amniocentesis, CVB entailed laboratory coordination and delayed results. Intermingling of maternal and fetal tissue could produce "contamination" and inaccurate results. And because the procedure disturbed the fragile early-pregnancy conceptus, it frequently led to miscarriage, fetal injury, and other complications. For these reasons, CVB soon yielded to the very technology that had enabled its rise: ultrasound.

Sonography machines operated on the principle of echolocation.[14] Electrical current induced vibration in piezoelectric crystals, leading to propagation of inaudible sound waves into the maternal abdomen. On encountering materials with different densities, the waves bounced back differently. The reflections induced new vibrations in the crystals, resulting in electrical signals. The machine's processor then converted the signals into pixels for display.[15]

Ultrasound offered several key advantages over CVB and amniocentesis. First, it posed no known physical danger to the pregnant woman or fetus. Second, it freed obstetricians and patients from laboratory coordination and waiting; the sonographic screen instantaneously displayed results. Third, although its second-trimester timeframe necessitated a return to *kāchi* delivery, ultrasound SD could still take place earlier then the next-safest alternative, amniocentesis.

By the mid-1990s, obstetricians moved to visualizing sex by what a senior obstetrician of Unjha called the "reproducible image, where you look, I look, and we see the same thing." It was the beginning of "looking" and "getting it looked at," in a literal sense. Doctors' own words reveal the shifting sensorial modalities for clinical enactment of fetal gender: first, "blind" SD by amniocentesis; then, the hybridity of CVB, with sonographic sight providing "guidance" for sampling but the truth of sex remaining in microscopic visualization; and finally, "direct" seeing, with ultrasound allowing practitioners to simultaneously locate the site of sex (now genitalia rather than chromosomes) and interpret what was there.[16]

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[14] L. Mitchell (2001: 22-49) has provided an extensive historical-*cum*-technical analysis oriented toward making sense of contemporary ultrasound imaging. For further historical perspective, see Yoxen (1987), who has discussed experiments in ultrasound by a wide range of actors through the end of the 1950s, and McNay and Fleming (1999), whose four-decade history picks up where Yoxen's leaves off. Nicolson and Fleming (2013) have zoomed in on a specific element of this broad story—the pioneering work of Glasgow obstetrician Ian Donald.

[15] For more elaborate ethnographically oriented discussions of ultrasound technology's technical aspects, see Barad (1998: 87-89), and Taylor (2008: 3-5).

[16] Cf. Mol 2002.

Diffusion of ultrasound technology proceeded rapidly, as doctors felt "we had to purchase, because everyone else was purchasing."[17] Early on, devices came primarily from Japan's Shimadzu, U.S.-based ATL, and the Indian Wipro-General Electric partnership. Countrywide, imports and domestic production grew exponentially from the early 1990s onward, with countrywide annual sales exceeding 4,000 units and 3 billion rupees ($65 million) by 2006.[18] North Gujarat obstetricians could purchase basic machines for a few hundred thousand rupees (several thousand dollars)—a month or two of net clinical income. In Mahesana city, sonography became an essential part of private practice around 1990. In smaller towns, most obstetricians acquired machines within a brief span in the mid-1990s. After these points, ultrasound became a *sine qua non* of practice in each locale: new entrants like Dr. Dilip had to "settle in with sonography on hand from day one."

Most obstetricians had received minimal training in ultrasound. Through the late 1980s, even Ahmedabad's academic hospitals contained but a few of the newfangled devices, and "the sahebs" jealously guarded them. Some proprietors of new devices undertook observational apprenticeships with more experienced colleagues. Many attended professional association trainings seminars in Ahmedabad; one obstetrician recalled that instructors "showed SD, because there was no law, there was no government—this was going on routinely, so they showed the perineum and explained, 'This is how you look for clitoris-penis.'"

The same doctor remembered, "Because this was becoming the gynec's bread-and-butter, because of patient demand, you had to learn it. So everyone learned—everyone started knowing from experience." Echoing this statement, most obstetricians recalled developing expertise primarily through trial-and-error: "By looking, we became experts: this is penile shadow, this is scrotal shadow." "Slowly-slowly, in doing it, we learned: how the perineum looks, how a male child looks. And then we got a perfect grasp." By self-tutelage, older doctors became experts in seeing sex. And by 2000, with ultrasound's proliferation, young practitioners were learning to discern genitalia while still in training.

Within the mushroom market for sonographic SD, perceived expertise became a key competitive factor. While some doctors maintained that "everyone knew equally well, since everyone did it," many insisted that certain colleagues displayed exceptional visual gifts. Practitioners strove to cultivate positive reputations among prospective clients. In one illustrative case, a clinician publicized his second daughter's name prenatally, lest people think he had misinterpreted his wife's scan—after all, wouldn't any doctor with one girl use his own machine to identify and avoid a second?

Reputation was not merely a word-of-mouth phenomenon. Many clinicians formally publicized expertise. Although advertising eventually ceased with enforcement of the prohibition on sex selection, assorted artifacts—just barely hidden at the time of my fieldwork—testified to the era of open SD. Old letterheads listed "Expert in Boy-Girl

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[17] Being the first to acquire the necessary equipment and expertise, radiologists emerged as the earliest sonographic SD providers and, for a time, drew referrals from obstetricians. But the latter soon began procuring machines and honing their own vision.

[18] Mahal et al. 2006: 180; Wonacott 2007.

Diagnosis" as a qualification. On one clinic's main signboard, I found the first word in "Sonography Diagnosis Center" handwritten over tape covering older text—"Boy-Girl." Several doctors distinguished themselves by advertising "Boy-Girl at Three Months," since most sonographers initially could not perform SD until four months.

The last point underscores a client preference for *early* detection. As in the shift from amniocentesis to CVB, a shortening of the time from conception to sonographic SD allowed families to make earlier decisions. It also protected both doctors and women from the logistical difficulties and medical risks of late abortion. Throughout the 1990s, advancing operator expertise coupled with the development of better machines to drop the threshold for visualizing prenatal gender. As "high-resolution machines appeared, and people's eyes started seeing better," in one doctor's words, the limit gradually fell from eighteen weeks to thirteen.[19]

With fetal sex visible earlier, doctors reverted from *kāchi* delivery to the procedural abortions that had prevailed during CVB's heyday. Given the advent of supportive hormonal drugs, early-second-trimester surgical abortions were now even easier and safer.[20]

Nonetheless, bodily risks remained. Numerous obstetricians admitted to having perforated patients' uteruses while performing hasty procedures. Moreover, as government surveillance for sex selection rose in the 2000s, the pressure to minimize inpatient time would lead to quicker, rougher, riskier terminations.

Despite the dangers of selective abortions, most practitioners recalled sex selection in the 1990s and early 2000s as "nothing special"—"just part of routine practice." Obstetricians openly disclosed SD results and recorded them on charts—"likely XX," "likely XY." Patients regularly sought second opinions. And as many clinicians emphasized, "there was freedom to do SD"—since "there was no regulation, no law, nothing," "everything was going on openly." With prohibitions functionally nonexistent before 2005, sex selection services flourished openly.

Pricing reflected sex selection's banality: doctors typically charged the same fees for SD and selective abortion as for routine sonography and abortion.[21] Despite

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[19] For comparison, a study at a London university hospital in the late 1990s, using an SD method essentially similar to the one employed by Mahesana obstetricians, and on a high-quality (for the era) machine found it possible to accurately assign fetal sex in 79% of cases at thirteen weeks, and 90% at fourteen; excluding cases in which sexing was not even attempted, the accuracy at these gestational ages was 92% and 98%, respectively (Whitlow et al. 1999). I found a wide range of opinions on timing and accuracy in the 1990s, with some obstetricians claiming that errors must have been lower than the roughly one-in-ten rate in the contemporaneous West—"because we had the expertise!"—and others maintaining that the error rate may have been higher, albeit easily rectified by follow-up scans.

[20] See Lohr (2008) for a general discussion of second-trimester surgical abortion. The transition to quicker, easier abortion was aided by the arrival of prostaglandin agents in the Mahesana pharmaceutical market during the 1990s. Administered some time before the operation, these hormonal drugs promoted cervical softening and opening, making removal of the fetus more straightforward. See Lohr (2008: 154-155) and Bygdeman and Gemzell-Danielsson (2008: 199-200) for concise discussions of these agents.

[21] In a contrast from the early 1990s, Khanna recalled seeing a doctor and client in peri-urban Delhi settle on prices of 1,500 rupees for ultrasound SD and 1,000 rupees for selective abortion, the former almost certainly being higher than the price of a routine scan (2009: 2-3). George and Dahiya reported that the cost of ultrasound SD in rural Haryana rose to about 900 rupees by the late 1990s—double what it had been half

generating limited direct profits, selective reproductive services bolstered obstetric business by keeping clients pleased and attracting patients who might otherwise forego private pregnancy care. Performing sex selection also allowed doctors to fulfill social obligations to relatives, friends, and acquaintances.

Amid the liberalization of India's economy, the 1990s brought a burgeoning of social demand for private obstetric care generally, and sex selection specifically. Biomedical family planning increased, and fertility fell—a trend I discuss in Chapter 2. Simultaneously, public awareness of ultrasound technology spread in parallel with the devices themselves; an early-2000s study in rural Mahesana District noted:

> All women... knew exactly where to go for sex-determination tests, how much they cost, and so on. They were aware that such tests are... done... in private facilities, the majority of which also provide abortion services. The women could also describe the sex-determination procedure quite accurately and in great detail. [22]

At the intersection of family planning and medicalized pregnancy, families increasingly knew how to plan gender and kinship through selective elimination of female fetuses.

The 2001 Census data revealed the fruit of late-1990s sex selection: markedly skewed 0-6 CSRs. The overall number for Mahesana District was 801. A rural-divide persisted, but not because rural CSR was anywhere near normal. The district exhibited a rural CSR of 813, and the figure stood below 900 in every subdistrict; some district's rural CSRs had declined precipitously, as seen in Kheralu (-66), Vijapur (-74), Visnagar (-85), Kadi (-91), and Mahesana (-96) Subdistricts. But the divide persisted because urban CSRs had fallen as much, or even more. Towns' CSRs typically sat fifty points below those of their surrounding rural areas, and not a single one was above 830. The overall urban CSR was 751: only three girls for every four boys. The city of Mahesana had a CSR of 728, and even that was outstripped by Unjha (717) and Visnagar (713). At the turn of the millenium, expanding technology, expertise, and social awareness had spurred a drastic rise in selective reproduction.

It was in this period that Dr. Dilip and Uma-masi's careers took shape.

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On the day Nandini Clinic opened in the mid-1990s, Uma-masi was Dr. Dilip's very first patient. She soon began referring women from her extensive social network, sometimes receiving a small commission for her service. Eventually, she started spending half-days assisting at the clinic, "without taking any money—just for fun, because I had such an interest in learning!" Eventually, in the early 2000s, Dr. Dilip and Uma-masi agreed on a full-time job with regular salary.

Dr. Dilip had purchased an ultrasound machine when establishing Nandini, and SD and selective abortion quickly became large components of his practice. He charged

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a decade earlier and again, likely much higher than the cost of a routine scan (1998: 2194). The discrepant pattern in Mahesana seems unlikely to be due to recall bias or social desirability bias on the part of practitioners, since families also uniformly recalled nil or minimal premiums for SD and selective abortion.

[22] L. Visaria 2007b: 156.

minimal fees for the services. Both he and Uma-masi recalled, "It was nothing then... Just part of practice... There was no law... We did it for people for free."

While Dr. Dilip understandably displayed modesty on the topic, others informed me that he had attained prominence as a sex selection expert. Once, my casual mention of the doctor's name to a neighbor prompted her to smile and nod enthusiastically: "He is such a smart doctor! I was just short of three months with Mihir"—her son, born in 2003—"and he told me right then: 'It looks good—you'll have a boy.' Imagine! Before three months were even complete, he could look and tell me."

By the time of Mihir's birth, Dr. Dilip could discern fetal genitalia at twelve or thirteen weeks. Moreover, he had developed the skills to perform rapid procedural terminations, even at sixteen weeks, such that his post-abortion patients departed in mere hours. Reminiscing about the bygone era, Uma-masi widened her eyes and laughed, "Our saheb was quite the expert! Some days, there were ten—and never a day without one!"

But government regulations would soon transform both Dr. Dilip and Uma-masi's participation in the market for recognizing and reacting to fetal sex.

The Rise of Sex Selection Governance: From Antecedents to 2005

Two Pillars

As a sex selection market arose in the Mahesana area, various things became visible: ultrasound technology, practitioners and their expertise, fetal sex, and the possibility of prenatal gender-kinship planning. With the rise of sex selection governance at local, state, and national levels, very different things came into view: a population-wide threat to female births, a newly defined crime, and spectacles of government policing.

One pillar of the governance apparatus surrounding sex selection pre-dated biomedical SD in India. The Medical Termination of Pregnancy (MTP) Act of 1971 legalized abortion in case of "risk to the life of the pregnant woman or of grave injury to her physical or mental health," "substantial risk" of a "seriously handicapped" child, or pregnancy in a "lunatic"; clarifications resulted in broad interpretation of the "mental health" provision to include pregnancy due to rape and "contraceptive failure"—the latter eventually becoming the main grounds for terminating unwanted pregnancies.

The law was explicitly framed around "health," "humanitarian," and "eugenic" rationales. Indeed, the government-appointed Abortion Study Committee's 1966 report had recommended legalization of abortion for health and safety reasons, citing the high prevalence of dangerous procedures.[23] Half a century later, Mahesana obstetricians would generally foreground the same reasons in describing the MTP Act's importance.

But a shadow rationale haunted the law. Parliamentary debate around the bill, while showing that "there is no serious anti-abortion opinion in India," also revealed a heavy resort to overpopulation as a justification for permitting abortion.[24] The MTP Act

[23] Hirve 2004: 114. Hirve provides an excellent overview of the act's genesis and development, along with a discussion of related policy.
[24] N. Menon 1995: 374-376.

passed amid a domestic and global political climate in which reducing population growth at almost any cost had become a political imperative, partly as a result of pressure from Western governments, scientists, and population lobbyists.[25] Thus, with health and population control, respectively, as the chief stated and unstated purposes abortion became legal "quite independently of the women's movement."[26]

The "right to abortion" emanating from the MTP Act has always teetered on precarious legal grounds. Legally, an unwanted pregnancy is insufficient to justify abortion: it must become medically reinscribed as contraceptive failure.[27] In practice, Mahesana obstetricians categorized most abortions under this indication, and often did not even bother completing the mandatory forms that would make the procedures visible to the state. Consequently, women could generally count on termination of unwanted pregnancies. But this access was heavily dependent on doctors' will, due to both formal legal provisions[28] and "off-the-books" practices that relegated abortions to the purview of medical discretion.

Even in the 1970s, the emergent "right" to abortion—and its ever-present shadow, population control—quickly became tied up with sex selection. The population control movement contributed heavily to the development and diffusion of prenatal diagnostic technologies in India, with the premise that sex selection methods would encourage people to utilize abortion.[29] The first academic report of amniocentesis in India, from 1975, noted:

> In India cultural and economic factors make the parents desire a son, and in many instances the couple keeps on reproducing just to have a son. Prenatal determination of sex would put an end to this unnecessary fecundity. There is of course the tendency to abort the fetus if it is female. This may not be acceptable to persons in the West but in our patients this plan of action was followed in seven of eight patients who had the test carried out primarily for the determination of sex of the fetus. The parents elected for abortion without any undue anxiety.[30]

Within two years, researchers at a major hospital in western India were finding that families had aborted 430 of 450 prenatally determined female fetuses during a one-year span.[31] SD and selective abortion were taking off.

Consequently, abortion finally became "an issue for Indian feminists" in the 1980s, but "for quite a different reason" than pregnant women's bodily autonomy.[32] By

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[25] Connelly 2010. For discussion of population control discourses and practices in the twentieth century, also see Hartmann 1987 as a general source and M. Rao (2004) for India specifically.
[26] N. Menon 1995: 376, see also 374-375, 387-389. This was, as Menon notes, in marked contrast to contemporaneous developments in many Western countries, where feminist activists played a key role in liberalization of abortion law.
[27] Cf. Jesani and Iyer 1993: 2592.
[28] N. Menon 1995: 383-385.
[29] Hvistendahl 2011: 77-138.
[30] Verma et al. 1975: 384, quoted in Hvistendahl 2011: 82.
[31] Ramanamma and Bambawale 1980.

the time Barbara Miller's speculations regarding prenatal sex selection set off an intellectual firestorm in 1983, the practice had already become highly visible in some segments of public culture. Private clinics openly advertised SD while portraying daughters as a "liability" to the family and a "threat to the nation."[33] Stories of sex-selective abortion circulated in media reports, political debates, and everyday gossip.

In response, the Indian women's movement mobilized to condemn and combat the practice.[34] Several organizations mounted public activism campaigns. Activist-academics generated further evidence around amniocentesis and selective abortion in metropolitan cities.[35] The central government eventually issued a circular banning SD in state facilities; in response, private provision of the service proliferated, and commercial sex selection became a major business. It was during this period, too, that activists conceived and disseminated certain messages that, circulated in other contexts, would become resignified as anti-abortion—most notably, the shock-oriented labeling of sex selection as "female foeticide."

In 1988, after constant pressure from Mumbai activists, the Maharashtra government passed an anti-sex selection law—albeit one whose provisions diverged considerably from feminists' recommendations. Lobbying by the Gujarati women's movement subsequently led to passage of what many contemporaries called an "improved" version of the law in Gujarat.[36] Most Mahesana-area doctors remained unaware of the legislation.

Then, in 1994, the central government passed what would become the second pillar of sex selection governance: the Pre-Natal Diagnostic Techniques (PNDT) Act. The law was framed around establishing and regulating a clean separation between "use of pre-natal diagnostic techniques" for "detecting genetic or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex linked disorders"—the "eugenic" purposes earlier endorsed by the MTP Act—and the "misuse of such techniques" for "pre-natal sex determination leading to female foeticide."[37]

The PNDT Act mandated registration and regulation of clinics providing prenatal diagnostics. It prohibited prenatal testing save for detection of certain "abnormalities" in certain clinical situations. Performing SD, advertising it, bringing it about, and disclosing fetal sex all became forbidden. The law additionally required creation of national and state bodies to facilitate enforcement. Penalties for violation included suspension or revocation of medical licensure, imprisonment up to five years, and fines up to 50,000 rupees. While persons seeking SD could also face penalties, the law specified a presumption, "unless the contrary is proved," that "the pregnant woman has been compelled by her husband or the relative to undergo pre-natal diagnostic technique."

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[32] N. Menon 1995: 374.
[33] V. Mazumdar 1994: 2.
[34] There are many vivid, incisive, and moving reflections on this process. The account that follows is based on Ravindra (1993), V. Mazumdar (1994), Kishwar (1995), and Gupte (2003).
[35] E.g., Chhachhi and Sathyamala 1983; S. Kulkarni 1986.
[36] Joseph and CYDA 2007: 216; Ravindra 1993.
[37] Ghai and Johri (2008) have critiqued the legitimization of disability-selective abortion in the Act and its surrounding discourses.

Two years after the law's passage, Parliament framed rules and regulations for it. The supplemental legislation specified clinical recordkeeping protocols: doctors would have to maintain a register of all women tested and fill a "Form F" for every such patient. In addition to information about the clinic, a complete Form F would include the patient's identifying details, her pregnancy and family history, the specific indication for testing, the procedures performed and their results, and the clinician's signature. Ostensibly a record of *bona fide* reasons behind prenatal testing, the form would become a crucial tool for constructing "misuse."

With its focus on diagnostic technologies, the PNDT Act represented an attempt to thread a needle—leaving abortion in general untouched while curtailing sex-selective abortion. It was an approach fraught with tension.[38] In fact, early in the process leading to the law's formulation, some officials had actively advocated revising the MTP Act instead.[39] Years later, amid widespread recognition of the PNDT Act's ineffectuality in the early 2000s, the central government would again consider modifying abortion law—perhaps even by restricting abortion to the first trimester.[40] In both cases, the PNDT Act ultimately emerged as the site of legislative intervention. But the tension remained.

The choice to regulate prenatal *testing* definitively shaped the challenges of PNDT (and later PCPNDT) implementation. In a pattern with striking echoes of nineteenth-century female infanticide, sonographic SD was, by its nature, easy to conceal from the regulatory gaze: it was quick, requiring but a few minutes; opaque, enjoying seclusion within a private clinic and a private doctor-patient relationship; and ephemeral, leaving behind no telltale traces.[41] The official morality encoded in law did not harmonize with the gender-kinship and profit motives of families and doctors, and the interests of both consumers and providers aligned in favor of keeping the crime secret. Moreover, the injured party, whether conceptualized as the female fetus, womankind, or even all of society, could not act to prevent or expose the injury.[42] It was little wonder that numerous north Gujarat doctors referred to ultrasound SD as "the perfect crime." The central problematic of enforcement would always remain how to make visible the forbidden act of seeing.

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[38] While I have extensively cited N. Menon (1995) above in support of specific points, her broader legal-anthropological argument concerns the philosophical and political contradictions of this approach. Also see Ganatra (2008). For clinicians' and government officials' perspectives on the practical dimensions of the tension, see Joseph and CYDA (2007: 60-64).

[39] Ravindra 1993.

[40] Hirve 2004: 118.

[41] This is what Jaising et al. characterize with the phrase "behind closed doors": "The regulation of disclosure is problematic as the information on the sex of the fetus can be relayed behind closed doors and is most often the preferred way of imparting such information. Ideally the best way to guard against such disclosure would be for a legal authority to be present in the unit at the time such tests are being conducted. Needless to state, it is neither logistically possible for such a method to be put in place nor desirable. So instead the act had to be framed in a manner that will allow for the monitoring of the practices in all units providing ante-natal diagnostic services. This was done by the dual process of registration and record keeping" (2007: 15).

[42] John describes this as "a situation of all round collusion backed by power without a complainant" (2014: 12).

Rising Publicity: Accountable Implementation and Saving the Daughter

Sex selection in North Gujarat continued to flourish in the late 1990s. Though enacted, the PNDT Act carried no juridical force. As Dr. Dilip straightforwardly observed, "SD was not a crime." Most obstetricians "practiced openly," for the government was "not keen to act on this law"—"the act was there, but there were no active steps to implement."

The eventual impetus for implementation emerged from judicialization of the potential daughter's "right to live."[43] In 2000, a coalition of activists filed public interest litigation in the Supreme Court against the central government and states.[44] Drawing attention to flaws in the PNDT Act's language and its virtually non-existent implementation, the litigation requested the court to compel governmental bodies to constitute necessary administrative entities, enforce existing provisions, and initiate amendments to account for various loopholes.

The suit was still pending when provisional results from the 2001 Census underscored its urgency. The 0-6 CSR for all of India had fallen from 945 in 1991 to 927. Several states exhibited figures well below 900. Gujarat's was 878—fifty points lower than a decade earlier—and Mahesana was one of a few districts with CSRs below 800. In addition to galvanizing campaigning around sex selection, the Census results drew the attention of international organizations such as the United Nations Population Fund (UNFPA), which would thereafter become involved in India's "missing girls" problem.[45] The status of women, the civilizing mission, and the nation-state's need for international legitimacy were converging to compel action.[46]

On May 4, 2001, the Supreme Court issued the first of six judgments[47] on the public interest litigation. The ruling began:

> The practice of female infanticide still prevails despite the fact that the gentle touch of a daughter and her voice has a soothing effect on the parents... The traditional system of female infanticide whereby the female baby was done away with after birth... continues in a different form by taking advantage of advanced medical techniques. Unfortunately, developed medical science is misused to get rid of a girl child before birth. Knowing full well that it is immoral and unethical as well as it may amount to an offence, foetus of a girl child is aborted...
>
> It is apparent that to a large extent, the PNDT Act is not implemented by the Central Government or by the State Governments.

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[43] Cf. Biehl and Petryna 2013; John Comaroff and Jean Comaroff 2006: 26-31.
[44] For perspectives on the public interest litigation, see George (2002), Rajalakshmi (2003), Jaising et al. (2007: 9), Shalini Joshi (n.d.: 2-18), and CEHAT (nd).
[45] For UNFPA, see Joseph and CYDA (2007: xiii).
[46] Cf. Sunder Rajan 2003: 2-3.
[47] (2001) 5 SCC 577, (2003) 8 SCC 406, (2003) 8 SCC 409, (2003) 8 SCC 410, (2003) 8 SCC 412, (2003) 8 SCC 398.

The court ordered formation of regulatory entities at the national, state, district, and subdistrict levels; consideration of possible amendments to cover new diagnostic technologies; execution of "awareness campaigns against the practice of prenatal determination"; and ongoing submission of compliance reports by the concerned governments. In addition to issuing supplemental instructions, further rulings that year chastised nine sates, including Gujarat, for not taking timely action.

Within two years, amendments transformed the PNDT Act into the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act prevailing today. The law's titular purpose switched from "Regulation and Prevention of Misuse" to "Prohibition of Sex Selection," with sex selection defined as "any procedure, technique, test or administration or prescription or provision of anything for the purpose of ensuring or increasing the probability than an embryo will be of a particular sex." The amendments explicitly forbade pre-conception and pre-implantation sex selection. A new Form F incorporated signed declarations from the pregnant woman and the clinician at the bottom: "I do not want to know the sex of my fetus... I have neither detected nor disclosed the sex of her foetus to any body in any manner."

In conjunction with the Supreme Court orders, the changes to the law initiated the increased government activity that eventually drove sex selection underground. By the mid-2000s, states were undertaking the most obvious and publicly recognizable parts of PCPNDT implementation: appointing members to the requisite bodies, registering prenatal diagnostic centers, and promoting "awareness." Between 2001 and March 2005, Gujarat registered 2,315 clinics—the fourth highest total in the country.[48] In Mahesana District, Freshly trained officers took the mandated bureaucratic steps, forming a District Advisory Committee, mandating ultrasound machine registration, and requiring sonographers to fill out Form F and maintain a ledger of scans performed. Local officials also held "awareness" events and distributed literature to make doctors aware of legal provisions, abysmal SRs, and the intention to scale up enforcement.

The rise of PCPNDT implementation coincided with initiation of vigorous state and local campaigns for reducing sex selection demand.[49] Here, non-governmental organizations (NGOs) played a key role. In 2004, the Ahmedabad-based Centre for Health, Education, Training, and Nutrition Awareness (CHETNA) held a series of workshops for "sensitization" of community activists, corporate leaders, and politicians. In collaboration with UNFPA and the Population Foundation of India, CHETNA also launched a "Missing Girl" campaign—later renamed "Valuing the Girl Child"—focused on community surveys, information delivery, and community workshops in villages of Mahesana and one neighboring district. In one representative "communication campaign" from 2005 to 2006, the organization relied on "House-to-house contacts, neighbourhood meetings, street plays,... rallies, road shows, essay competitions, open dialogues, CD shows, social audit, fairs, Yuva Mela, and public meetings," as well as "exhibitions... on strategic pathways of pilgrims during popular religious events, malls and other public

[48] PNDT Division 2005: 15-16.

[49] For some details on the work in Gujarat, see Joseph and CYDA (2007: 186-241), Gulati (2007), Government of Gujarat (2009b: 44-45), and Vakharia (2009).

places."[50] State government officials, meanwhile, were meeting with local professional organizations and addressing community gatherings, urging citizens to eschew sex selection. Discourse on the practice was rapidly proliferating.

Given Mahesana's abysmal SRs, activists from the area quickly became involved in state- and national-level movements to combat sex selection.[51] Inspired by one of CHETNA's workshops, Unjha's Member of Parliament collaborated with local community members to organize a gathering of several thousand women on January 5, 2005. The event was officially publicized under the heading of "Social Awareness and Elimination of *Stribhrunhatyā*"—the last word being a rapidly spreading neologism directly translated from "female foeticide." Invitations for the event featured a "respectfully addressed letter to the cruel mother-father" from the "aborted daughter-fetus growing in the womb," penned "upon reaching heaven"; it asked about the mother's health after abortion, voiced the "former daughter's" shattered hopes for playing with and bringing joy to relatives, and closed with the lines:

> Think about it—you're wishing for my brother's birth in my place, but I'm asking you: where will you marry him? Because just like with me, all parents today see their happiness and convenience in killing their daughters before birth. *Is that appropriate? I hope that no one gets a mother and father like you.*

Posters for the event featured images of a fist crushing a fetus and prominently displayed local CSRs: 742 for the whole subdistrict, 717 for the town.

Attendees at the Unjha event listened to a series of speeches from "important guests," watched a "lamp-lighting as a sign of commitment," and followed as they—and the five doctors in attendance—were led in oaths to foreswear sex-selective abortion. They received booklets—again, adorned with a fist crushing a fetus—that informed them of Unjha's abysmally low CSR, the reasons "why daughters are unwelcome," "our role in stopping *stribhrunhatyā*," the possible consequences of falling SRs, and the need to "save our daughters" and "not mess with nature's work." The material reminded potential mothers that "the giving of a virgin [in marriage] is a great gift" and offered up several alarming statistics. A separate booklet offered an "Eyewitness Report of the Murder of a Child in the Womb," based on the American anti-abortion film *The Silent Scream*.

The Unjha event and its associated paraphernalia relied on a discursive coupling that would remain prominent in anti-sex selection appeals more than a decade later: emotional appeals from individual threatened daughters-to-be alongside sobering (or fear-mongering) presentation of aggregate SRs and their future implications. They also presaged another pervasive feature about latter-day campaigns to "save the daughter": "mixed messages"[52] around abortion and *stribhrunhatyā*. Numerous scholars have analyzed how *The Silent Scream* disembodies the fetus and establishes a separate personhood for it, predicating an affective appeal to the pregnant woman, community, or

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[50] Vakharia 2009: 32.
[51] See, for instance, Joseph and CYDA (2007: 187-188, 195).
[52] Nidadavolu and Bracken 2006. See also Ganatra (2008).

body politic to halt abortion altogether;[53] its use in Mahesana District—already noted as problematic by a contemporary evaluation[54]—underscores the blurring, in practice, of well-intentioned activism and anti-abortion rhetoric. And the Unjha usage was far from an isolated incident. Around the same time, a college-based anti-sex selection campaign in Mahesana condemned *bhrunhatyā* [foeticide] and employed posters depicting fetuses being killed, often by mothers.[55] Official Gujarat government posters relied on affective appeals to mothers, displaying "clearly anti-abortionist" messages that stressed the "utilitarian value" of future women as reproducers.[56] I return to these discursive features of anti-sex selection efforts in Chapter 8.

Fourteen months after the Unjha event, in March 2006, Chief Minister Narendra-bhai Modi took International Women's Day as the occasion for launching a campaign to "save daughters" in Gujarat—Beti Bachāvo. (The program's title would soon include "Beti Vadhāvo"—"celebrate daughters.") Within a short time, politicians, religious figures, and sub-caste leaders were invoking Narendra-bhai's slogan at mass rallies and sermons, motorcycle tours and marriages. In the early stages, governmental and non-governmental Beti Bachāvo efforts, like those in most parts of the country, focused on conveying SR figures; inspiring shock, fear, sadness, and affection around the potential daughter and her elimination; and delivering and eliciting slogans, artwork, mass oaths, and other publicly visible performances of anti-sex selection stances.

Many doctors and connectors would later suggest that Beti Bachāvo and related NGO programming paradoxically *encouraged* sex selection by increasing the practice's visibility: "The government itself provided the publicity for this thing!" "People in the village didn't know you could tell if it's a boy, but then it started coming on TV and everything, so the public became aware." Several doctors postulated a perverse reaction to repression, arguing that "the more you restrict something, the more people want it," so that "as there was more advertisement—'Beti Bachāvo, Beti Vadhāvo'—people were attracted to SD more."

At any rate, most doctors agreed that, despite the campaigns, demand for sex selection only grew in the early 2000s. For the first half of the decade, a rigorous national health survey found a sex ratio at birth (SRB) of 850 among women reporting prenatal ultrasound, and just 554 in the subset with two daughters and no sons.[57] At a time when child mortality could account for roughly an 11-point (or 1.1%) CSR skew, the same survey found a 0-6 CSR of 888 in Gujarat.[58] With PNDT enforcement efforts not yet restricting access to services, sex-selective abortion continued rampantly.

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[53] E.g., Berlant 1994: 171-176; Petchesky 1987: 266-277; Strathern 1992a: 50; Taylor 1992: 73-74, 76.
[54] Joseph and CYDA 2007: 83-84, 110.
[55] Joseph and CYDA 2007: 83.
[56] Joseph and CYDA 2007: 211.
[57] These figures are from Arnold and Parasuraman's analysis of National Family Health Survey-3 data (2009).
[58] IIPS 2008: 10, 30. The SRB skewing in Mahesana District—particularly in higher-order births to women without sons—was likely even more extreme, but existing data sources do not contain reliable estimates.

For providers, state regulation presented only a minor bureaucratic "nuisance." Doctors began keeping the mandated records and raised the price of SD to 500 rupees, but little else changed. Dr. Dilip recalled:

> It was only after 2000 that this system started—if we do a sonography, we have to fill Form F, all that. But even then, the doctor's awareness came slowly-slowly-slowly. Not until the government machine became more active—until there were raids, like mine—did we realize that we would have to work more cautiously.

The Spectacle of Enforcement: The "First Raids"

In many doctors' recollections, September 20, 2005 was a watershed moment for PCPNDT enforcement in Mahesana District. That day, a visiting team from New Delhi sealed five local doctors' ultrasound machines. These "first raids" shattered obstetricians' feelings of impunity.

Theatrical, mass-mediatized portrayals of crime and policing, in which states "devote considerable effort to staging illusory victories over the dark forces of violence and disorder," evince "a desire to condense dispersed power in order to make it visible, tangible, and effective."[59] Spectacular shows of "law enforcement" become a "site for staging efforts—the double entrendre is crucial here—to summon the active presence into being, to render it perceptible to the public eye, to produce both rulers and subjects who recognize its legitimacy."[60] Within such dramas, the violated female body may be deployed to craft "a collective sense of moral purpose in the face of a daunting world in which violence was thought to have become endemic, ubiquitous, even unpoliceable."[61] The "dramatic enactments of crime and punishment—both those disseminated by the state and those consumed by various publics"—become attempts to perform social order, representing and simultaneously creating it in situations where "technologies of governance—including technologies of detection and enforcement—are... under dire threat."[62]

The early Mahesana raids, premised on detecting high-tech violation of female citizens-to-be from the distinctly low-tech paper record, constituted just such a spectacle of enforcement. They brought the PCPNDT Act into force through publicly disseminated drama, thereby installing government prohibition as a visible aspect of the local sex selection market.

According to Uma-masi, at the time of the raids, Dr. Dilip "was doing ten-twelve curettings every day—looking and curetting, all over in five minutes." Dr. Dilip himself recalled, "At that time, we weren't thinking such a raid could come, because the government machinery was not doing all these things. We didn't imagine this could happen." Retrospectively, most clinicians maintained that the raids came as a complete surprise.

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[59] Jean Comaroff and John Comaroff 2006: 274, 276.
[60] Jean Comaroff and John Comaroff 2006: 280.
[61] Jean Comaroff and John Comaroff 2006: 289.
[62] Jean Comaroff and John Comaroff 2006: 292.

In fact, Gujarat's government had already sealed fifteen sonography machines for recordkeeping deficiencies between 2003 and September 2005. Just one day before the Mahesana raids, on September 19, officials sealed three doctors' machines in neighboring Gandhinagar District.[63] And according to several Nandini staffers, Dr. Dilip also received a private warning from a local Health bureaucrat who was a childhood friend: "'A team from Delhi is coming, so if there's anything, be careful. Otherwise, you're in for it.'"

The doctor did not heed the warning signs. He was in the midst of a sex-selective abortion when a dozen government officers arrived. Travelling in "VIP cars" and escorted by commandos, the team left bystanders in awe. Doctors began phoning one another: "They're checking all the gynecs' clinics, one after another!" PCPNDT enforcement had abruptly come into view as a spectacle.

At Nandini, the team "barged straight into the office, without even asking," in Uma-masi's recollection. The friendly local officer told Uma-masi to summon Dr. Dilip. When she went to convey the message—"This is trouble, come quick!"—she found the doctor still finishing the selective abortion. She confided as much to the official, who quietly told her to shift any patients "like *that*" elsewhere, "'or Saheb is dead!'" She later laughed while recalling, "There were so many MTP patients in the clinic that day! So the sweepers and I picked them up and carried them next door—onto the roof, across, and down." With state eyes finally positioned to directly witness serious legal violations, the Nandini staff acted quickly to make the evidence—patients themselves—disappear.

When Dr. Dilip finally entered the consultory, the central team demanded his PCPNDT records. He would later remember:

> They said, 'Give us your Form F, show us your records.' And then they looked for deficiencies. I tell you, Utpal, they *looked* for a reason! Nowadays, every doctor knows more of the requirement than the CDHO [Chief District Health Officer]. But back then?... Our system was very unorganized. We filled the forms, but not up to the mark—just patient name, address, reason for sonography. But not in detail. We were sending this much with a letter saying, let us know if there is any deficiency.
>
> Well, searching-searching-searching, they found deficiencies, negligence in four-five forms—signature, address, so on. It was not like we were caught *doing* SD. But the paperwork was not adequate. So on that basis, they told me, 'You are doing SD.' On the basis of a form, how can you tell that I am doing SD?! I asked, how can you get intention from that? They said, 'That's not for us to see—the court will see!'

At the other four clinics, as at Nandini, the raids did not detect and expose sex selection practices *per se*, but rather technical deficiencies in PCPNDT-mandated documents. Bureaucratic errors became stand-ins for the invisible crime. At all five sites, government

[63] Government of Gujarat 2009b: 14-22. These records also indicate sealing of an ultrasound machine in Kheralu, a subdistrict town of Mahesana, in 2004. No one, however, mentioned this event during my fieldwork.

officials sequestered the ultrasound machine and applied a wax seal to the room, officially forbidding sonography.

Once the equipment had been sealed, journalists arrived. Dr. Dilip recalled bitterly:

> The worst damn thing was that they brought in two journalists and a photographer. The next day, it was the headline in the papers! And then the headlines came every day. It was rubbish! It's the worst memory of my life: "Seal applied to five female-feticidal doctors' machines." "A central team has sealed female fetus-killers' machines..."
>
> Initially, this was just to set an example—they had the target to release after one week. The Supreme Court lawyer told me that the procedures would take place, and then everything would be open again. But then our government used this in a bad way; they decided they didn't want to let us go... And the wolves of our society, they kept it going to make money.

Among the "wolves," Dr. Dilip counted journalists eager to capitalize on the spectacle, NGOs seeking publicity through condemnation of sex selection, and a state keen to make PCPNDT governance visible. A wide range of interested actions seemed predicated on exposure of the targeted doctors as criminals.

The "wolves" also included government officers seeking bribes. Dr. Dilip recalled, "One of those officials gave an order by day and then did the opposite by night—seven days after helping seal our machines, the rascal came back to me, because he was hungry for money!" Several other targeted doctors independently corroborated the allegation. Heightened PCPNDT enforcement meant new opportunities for individual government officers to capitalize on criminal activity.

The five obstetricians ultimately refused to pay the local official, committing themselves to a "chronic legal process." The state government soon initiated cases against them under the PCPNDT Act, and the ensuing judicial proceedings dragged on for months. Dr. Dilip recounted:

> At court, they made us sit outside, with petty thieves who had stolen two-three thousand! And the judge would say, you are like this, and you are like that! We told him to prove it. But there was no proof. It was so bad! It was horrible! And that damn judge—he held our hearings at 11 AM, even though we could have clinic duty. The court gallery would be full, and if it wasn't, he called in others to fill it up. Then, he would shout, 'Call in the accused, the sinners, the female fetus killers!'

Various uninvolved obstetricians recalled the case as a seemingly arbitrary humiliation for their colleagues—"as if they were deadly killers." The process of making PCPNDT violations and PCPNDT enforcement visible—premised on the notion of reading the crime from paper records—had transitioned from a clinical and media spectacle to a

judicial one.

Eventually, the court ruled against the government, citing procedural lapses in equipment seizure and evidence collection, along with the rationale that "not having adequately filled the form was not a major crime," as Dr. Dilip recalled. The result fit into a Gujarat- and country-wide trend: in early cases under PCPNDT, prosecution efforts faltered due to evidentiary lapses, legal framing missteps, and judicial skepticism regarding the ultimate import of mere recordkeeping errors.[64]

Personalistic factors also played a role in some acquittals. Dr. Dilip later revealed:

> The government lawyer fighting the case against us, he used to take *cha* with us. He eventually took money to make the case weaker! And in the end, the judge turned out corrupt too! He sent his man to us to negotiate. Oh, after that, he kept saying, these men are such gentlemen, and they have met with such injustice, and this and that. Imagine!

Another colleague confirmed that of the several million rupees the five obstetricians spent during the legal proceedings, "almost everything was black—not on paper, but to speed up the decision." While failing to produce any convictions, the 2005 raids allowed lawyers and judges to extract PCPNDT-based profits from four of the five affluent clinicians.

Ultimately, Dr. Dilip and the other targeted doctors found the financial burden of legal fees and bribes compounded by loss of clinical revenue. With the sonography machines sealed, most patients went elsewhere for care. Because newspapers had printed zoomed-in photographs of doors with wax seals on them, many assumed that Nandini and other affected clinics had been "locked up" entirely. And, as Dr. Dilip later put it, "There was also bound to be a social shock, right? Because this was the first time?" Despite widespread acceptance of sex selection in everyday life, the negative publicity associated with the raids and subsequent legal proceedings stigmatized the five doctors.

The highly visible spectacle surrounding Dr. Dilip and his colleagues made state prohibition a palpable force, and sex selection an actual crime. While admitting to providing sex selection services, Dr. Dilip would lament, "This happened even though we were innocent!" His seemingly contradictory statements make perfect sense in light of the fact that "everyone was doing it" in the early 2000s. Though widely publicized, the PCPNDT Act had lacked juridical force, and clinicians had practiced SD and selective abortion openly. The law effectively acquired clout *through* the raids, making itself felt in the scrutinization, shaming, and prosecution of a subset of offenders, none of whom had previously hidden their activity.

Years later, local obstetricians were united in lamenting how the government had "set out to make an example." Almost everyone had been performing sex selection while

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[64] Policy and legal analysis of the factors hampering early prosecutions throughout India—particularly lack of awareness regarding Act provisions and evidentiary procedures among officials, flaws in case construction strategy, and unhelpful prosecutorial and judicial attitudes—can be found in Joseph and CYDA (2007: 15-17, 43-47, 49-50) and PHFI (2010: 65-70, 79-84, 87-90, 93-113). Shalini Joshi (n.d.) is a case law compilation oriented toward avoiding some of these pitfalls.

keeping inadequate records; in retrospect, almost anyone could have been targeted and caught.[65] That the government had "victimized" the five doctors for "technical causes" only reinforced the perception of the 2005 raids as an arbitrary show of power. The sense of arbitrariness was well encapsulated by a statement, perhaps apocryphal, that several observers claimed to have overheard from a central official responding to a local bureaucrat: ""Why are you so concerned about the details? Our purpose is to shut down, plain and simple!"

Though legal loopholes and corruption ultimately scuttled prosecution of the doctors, the "first raids" and their accompanying media frenzy pierced the ongoing banality of selective reproduction and pushed a previously conspicuous biomedical market underground. The spectacle gave Mahesana-area obstetricians a sobering demonstration of state power around selective reproduction: the government was finally "becoming serious" about the PCPNDT Act. It was a key milestone in the evolution of a local governance regime that eventually contributed to the end of sex selection at Nandini, and the rise of Uma-masi's career as a facilitator.

An Evolving Market: 2005 to 2012

A Black Market in Becoming

Following the 2005 raids, Mahesana-area obstetricians began leaving the sex selection market. Reflecting a decade later, many attributed their cessation of SD and selective abortion to desires to "abide by the law" or "behave ethically." They described a process of moral awakening in which increased "awareness" of "the law of the land" and "the very bad sex ratio" reshaped views on sex selection. A number emphasized the impact of realizing that individual sex selection events were aggregating to produce population-level demographic disparity, "a social nuisance" that portended "social destruction" and "social problems" such as rampant drug and alcohol use, rape, involuntary bachelorhood, and upper-caste men "having no choice" but to wed women from "tribal communities or other communities much lower than us, which disturbs our moral sense." Such recognitions, the doctors explained, spurred them toward following the law and "helping keep balance."

While moral concerns featured prominently in retrospective accounts, most obstetricians also cited fear of "the crackdown." One observed drily, "People stopped so the law's obstacles wouldn't get in the way. No one stopped by choice. But everyone's afraid of the law... If you don't stop, there's a chance of being trapped at any time." For many, an abstract legal morality intertwined with a hard-nosed legal pragmatism. Amid increases in state policing, even rising returns on sex selection became insufficient to offset the risks of PCPNDT violation. Numerous doctors noted that, having "established our practice," "built our patient base," and "gotten set with a proper income" while performing SD and selective abortion through the early 2000s, they now felt comfortable ceasing the practices without fear of financial collapse.

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[65] Explanations varied as to how the government actually chose the five clinics targeted—"random decision," caste-stratified sampling, retribution from offended government officials, "haphazard tips" from NGOs and public health workers.

Perhaps surprisingly, Dr. Dilip did not abandon sex selection after the Nandini raid. Recalling the early-2006 unsealing of his sonography machine, he once said to me:

> The loss was quite high during six months when the machine was sealed—practice came down by 60%, so there was 80% loss in net income... Plus, expenses—lawyer, so on. We were all discussing, and we said, 'This lawyer's fee, and money for the judge—where are we going to get it from? By doing *this* only, right?' So to recover losses, and to regain practice, SD was the only way.

Upon release of the equipment, SD at Nandini resumed.

Uma-masi recounted:

> Dilip-saheb wasn't afraid—there couldn't be a raid at our place immediately afterward, right? So he started up again, right away—he earned his! He took 3,500 for a girl, and 5,000 for a boy. Our business ran like crazy for a while. It was a daily income of 50,000! If we checked ten, with five good results, I got 500 in tips—100 from each patient—and some VIP patients happily gave 500 or 1,000!
>
> Now, Saheb didn't tell the patient or take the money. Saheb just made a signal to me—one finger raised for 'boy,' one finger down for 'negative.' We didn't let the patient realize—no words! He would tell them, 'Sit outside, and Ben will come, take the money, and tell you.' Then I would go outside for a bit—the next building over, or under the stairs somewhere, but not at the clinic. I would explain to the patient—boy or girl—and take the money.

With PCPNDT enforcement suddenly visible after the 2005 raids, the price of the black market service had jumped an order of magnitude, from 500 rupees to 5,000.[66] And the perception of intensified government surveillance had created an opportunity for clinical staff like Uma-masi to more integrally participate in and capitalize on the tests. Dr. Dilip and Uma-masi's method for indirectly conveying results exemplified the communicational codes that arose in clinical practice and public imagination. Journalistic articles abounded with speculative references to how doctors now communicated sex insidiously by pointing to photographs of boys or girls, invoking gods or goddesses, or

[66] Obstetricians and facilitators in Mahesana and other parts of north Gujarat corroborated that pricing for SD in the region developed as Uma-masi described it at Nandini: 0 to 200 rupees in the 1990s, 500 rupees in the early 2000s with the rollout of PCPNDT measures, and then roughly 5,000 after the first raids. Based on key informant interviews during the mid-2000s, Joseph and CYDA (2007: 38-39, 56, 87) found that enforcement of the PCPNDT Act had raised SD prices in many part of the country, with doctors pointing to the service's illegality to charge higher fees; the price in some parts of Punjab was allegedly as high as 20,000 rupees. During the same period, John et al. (2008: 61)found more modestly elevated prices, with SD costing 7,000 rupees in one district of Punjab and anywhere between 1,500 and 8,000 in parts of Haryana.

telling families to purchase *penda* or *jalebi*.[67] Several Mahesana-area doctors recalled being asked by government officials to remove pictures of babies from their consultories, lest they be suspected of using the images to quietly disclose sex.

Although Dr. Dilip resumed SD provision, the raids had left him wary of performing selective abortion. Uma-masi remembered:

> Saheb looked, but he didn't do the other part. For MTP, he always gave patients to me and sent me personally to Harnish-bhai. Saheb looked here, and the MTP happened there... Sometimes, I took four at a time! And I got good money for it. If the patient gave Harnish-bhai 5,000, he gave me 500. There were days when I made 4,000!

Dr. Dilip, Uma-masi, and Dr. Harnish disaggregated the two stages of sex selection across different sites—a pattern that was becoming increasingly common with rising surveillance.[68] Given the invisibility of sonographic SD, and the plausibility of claiming ignorance regarding an abortion patient's previous SD, spatiotemporal disaggregation dissipated some of the risk attached to sex selection services.

At some point, Uma-masi started diverting some SD patients from Nandini toward Dr. Vinay, a newly established obstetrician who promised, "'Come to me, and you will get what you deserve—1,000 rupees per patient!'" Instead of leaving Uma-masi to collect tips from patients, as Dr. Dilip did, Dr. Vinay guaranteed a 20% commission. Taking roughly fifty patients a month to Dr. Vinay and Dr. Harnish for sex selection services, Uma-masi earned over 40,000 rupees—more than six times her regular salary. Her work exemplified the rising importance and profitability of facilitation in a market that was rapidly moving underground.

Large-Scale Enterprises: Dr. Rohit and Dr. Ganpat

As many providers left the market, a doctor fifty kilometers east of Mahesana built up the largest sex selection enterprise the region had ever seen. Within a brief span, Vijapur's Dr. Rohit Patel[69] generated tremendous wealth—tens of millions of rupees, by many estimates—as families, aware that "the government is now getting strict about the boy-girl test," flocked to his high-profile practice.

Colleagues usually scowled when recalling the scale and methods of Dr. Rohit's practice. One remembered, "He used to do twenty or thirty patients daily! They would all be sitting, lined up, at his clinic. And he gave everyone four-five visiting cards—'You can send anybody for SD.'" Obstetricians who had abandoned sex selection found their patients consistently ending up in Vijapur, and Dr. Rohit began encouraging collegial referrals.

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[67] *Penda* and *jalebi* were the sweets traditionally associated with newborn sons and daughters, respectively. See Aravamudan (2007: 74)for citation of similar rumors.

[68] A number of accounts from the 2000s attest to use of separate clinics for SD and selective abortion for reasons of legal security, privacy, and convenience (Aravamudan 2007: 74; Ganatra et al. 2001: 116-117; T. Patel 2007a: 343; L. Visaria 2007b: 161).

[69] "Rohit Patel" was his real name.

According to one colleage, Dr. Rohit also stitched patients' cervixes closed "without reason" after "male" results, charging up to 5,000 rupees for the additional procedure and insisting on delivery in Vijapur. When families returned at full term, he would "claim that there was such-and-such problem, and that they needed to do a Caesarean or the boy would come out crazy, or with cerebral palsy." Since "everyone would want the child to survive and be healthy"—"the main purpose, after all, was to have a boy!"—most families acquiesced. If they did not, he allegedly administered the drug methylergonovine,[70] precipitating contractions against a closed cervix, fetal distress, and stillbirth—"the child would really die, and the patient would think, we should have gotten the Caesarean!" Dr. Rohit thus capitalized on selective reproduction not only by charging for scans and abortions, but also by extracting additional profit from unnecessary cervical stitches, ransom of the much-desired son, and forced Caesareans. Nonetheless, patients continued to frequent his clinic, for it was a conspicuously accessible enterprise in an otherwise-clandestine market.

In 2010, after Dr. Rohit's sex selection operation had flourished for several years, senior leaders of the Mahesana Obstetric-Gynecologic Society (MOGS)—a professional association encompassing dozens of doctors in Mahesana and Patan Districts—tipped off local government officials. Frustrated by the recordkeeping emphasis and "harassment of innocents" in PCPNDT implementation, MOGS members had decided in a full-body meeting to "name the culprit, provided the authority is prepared to take action." (Dr. Rohit had not been present.) Most local obstetricians later recalled the tip as a noble undertaking aimed at shifting state efforts away from bureaucratic technicalities and toward "catching red-handed the people who are doing." A few observers instead ascribed the action to jealousy: numerous MOGS members, like Dr. Dilip, were still offering small-scale sex-selection services, and most admitted envy regarding Dr. Rohit's earning. Either way, the professional association offered up the Vijapur doctor as a target for the regulatory gaze.

By the evening of April 13, 2010, Dr. Rohit's sonography machine had been sealed. Several days earlier, the Mahesana Anti-Corruption Bureau, in concert with the local PCPNDT Cell, had sent undercover officials to the clinic with a pregnant woman—a "dummy patient," in local parlance. In response to a request for SD, Dr. Rohit had quoted a 5,000-rupee charge and told the group to return on the 13th; unbeknownst to him, the conversation had been recorded. At the time of the scan, the group proffered chemically marked notes, but whoever accepted them quickly realized something was amiss and attempted to dispose of the money. After raiding the premises, government officials charged the doctor with PCPNDT violations, evidence tampering, and obstructing a public servant. Local newspapers heavily publicized the sting. Five years after the 2005 raids, government action—now supported by local obstetricians—again created a governance spectacle for public consumption.

The legal case against Dr. Rohit soon fractured. Within a month, the doctor had brought suit against local officials in Gujarat's High Court. Alleging evidentiary

[70] Methylergonovine maleate is a uterine smooth muscle constrictor, usually administered after or during delivery and abortion in order to prevent excessive bleeding.

improprieties, his petition asked the court to "quash and set aside the illegal procedure adopted and action taken by the respondent-authority," initiate removal of the seal, mandate compensation for lost income with 18% interest, and "direct the respondents not to take any coercive steps against the petitioner." By the end of May, district authorities had released the sonography machine. On July 19th, the High Court disposed of Dr. Rohit's petition without ruling on its merits, noting that the government had essentially admitted to giving up on the case. With that, state action against Mahesana District's most prominent sex selection practitioner ended.

Years later, speculation abounded regarding how Dr. Rohit had dodged punishment. Many colleagues claimed that the raid "turned out a failure" because "he had someone else take the money so nothing would happen to him, and the case was dismissed." Others alleged that the compounder had flushed the marked money down a toilet upon growing suspicious, thereby obliterating the key evidence. Still others offered speculations about bribery: "Rohit-bhai paid money in corruption—2 million!—and got the case thrown out and his machine opened up."

Shortly after the conclusion of legal proceedings, Dr. Rohit died of a heart attack. Although he had allegedly suffered from cardiac problems for years, some colleagues maintained that "tension" from the case had precipitated the attack. Others scoffed at this theory, observing that Dr. Rohit was "not the kind to take tension over anything." Given the doctor's young age, many ascribed cosmic significance to his sudden passing—"nature's punishment," "a blow from the universe." One colleague opined, "The universe—God only—killed the scoundrel! It's clear to me—the life of girls itself came back and killed him! If you looked at him, he could have lived 100 years. I believe it was the hand of the universe that took him." Dr. Rohit's death fit neatly into an emerging discourse of sex selection as both legal and moral crime: divine justice had succeeded where the law had failed.

After the Vijapur raid, Dr. Dilip stopped performing SD. Newspaper reports on the raid mentioned sixteen local doctors receiving PCPNDT warning notices, and Dr. Dilip later recalled being issued one around that time. In his and his staffers' tellings, the warning identified him as under suspicion of providing sex selection services, citing as warrant the conspicuously skewed SR among infants born at Nandini. Uma-masi recounted:

> Saheb stopped around April 2010. He was getting a lot of pressure. Our ratio was all boys... In the delivered issue, there were all boys. Just two or three girls a month—nothing but boys! So the Collector and all of them said, Dr. Dilip is looking... There was a notice: 'You are looking for people.' Then Saheb promised he would never look again. And since then, he doesn't. Once he made his money, he stopped—'Let other people do it; I don't want to.'

Reflecting the national construction of sex selection as a crisis of aggregate SRs, local surveillance efforts were now utilizing clinic-specific SRs as proxies for the invisible crime.

Dr. Dilip's withdrawal from the market was part of a broader wave of provider attrition that also included Uma-masi's referral partner Dr. Vinay. The gradual transformation of sex selection from plentiful and visible to scarce and secretive, which had begun with nominal PCPNDT implementation in the early 2000s and intensified with the 2005 raids, reached a new stage after the Vijapur raid, Dr. Rohit's death, and further state gestures toward vigorous policing. Most obstetricians now refused to provide SD or selective abortion on any substantial scale.

Following Dr. Dilip and Dr. Vinay's abandonment of SD, Uma-masi quickly found another collaborator: Dr. Ganpat, another small-town obstetrician who had quickly replaced Dr. Rohit as the region's most notorious practitioner. With him, she managed referrals by phone, visiting the clinic once a week to receive her commissions—thirty percent of the total collection. The doctor, meanwhile, charged 10,000 rupees per service, or twice the pre-2010 figure. Given high patient volume—sometimes as many as twenty selective abortions per day—Dr. Ganpat's daily earnings supposedly reached 300,000. Nurses at the clinic earned 50,000 per month, and even sweepers enjoyed salaries approaching 20,000—several times what their counterparts at other clinics earned.

Colleagues, facilitators, and clients later emphasized the "boldness" of Dr. Ganpat's "very large-scale" operation—an "epicenter" of sex selection in North Gujarat, "*the* destination for people from everywhere." Some reported that the doctor routinely served patients from every corner of Gujarat, as well as Rajasthan, Maharashtra, and other states. Many recalled how brazenly he distributed visiting cards to facilitate referral, sometimes pulling one out of a purse, wallet, or desk to show me. He supposedly showed little concern for discretion, "inviting everyone in, even if they came without reference," with "no saying no, no screening"—"as long as patients had money, he would just put them on the table straightaway." Colleagues speculated about regular bribes to government officials, with some declaring confidently that he "could not possibly do it like this except with the support of the authority—with the blessings of the authority."

Eventually, though, Dr. Ganpat's enterprise, too, came to an end. Thenceforth, no Mahesana-area obstetrician practiced sex selection as openly as him or Dr. Rohit. The market had shifted further underground.

Chetna Clinic

Accessing Sex Selection

By early 2013, Uma-masi was actively seeking a collaborator to replace Dr. Ganpat. Her search ended in a small town near Mahesana, with Chetna Clinic and Dr. Ranjit. In first describing the doctor to me, she explained:

> Five-six months ago, I went to see my cousin. Turns out, he farms this saheb's land. He told me, go meet with Saheb, and your work will be done. So I went. Saheb asked where I was from, who I was, all that. I told him how I was a nurse in Mahesana, what my father's village was, who my cousin was. Once he knew my cousin handled his fields—a connection

> through the village—he trusted me—that I wouldn't get him in trouble with anyone.

The thick sociality of kinship and patron-client relations helped forge the new referral relationship: the "axiom of amity"[71] ensured that Dr. Ranjit could rely on Uma-masi's discretion.

Recalling their first encounter, Uma-masi elaborated, "I told Saheb, 'This is how it is, and if you're prepared to give me mine, I'll give you good money—VIP patients, the kind who'll pay 12,000.' He was taking just 3,000 for looking—an overly low bill! He didn't know you could do like this. So then I taught him. I'm the one who made him smart!"

In fact, Dr. Ranjit himself credited Uma-masi with enlarging the scale of sex selection at Chetna. "Before two years," he once told me, "I was taking just 3,000. She was the one who started giving 10,000. She was the one teaching: 'This is demand, people are ready, they are paying 45,000, so we have to become opportunistic.'"

Dr. Ranjit began offering me such frank intimations only after months of wary aloofness. The process of establishing my ethnographic intention began shortly after my initiatory conversation with Uma-masi, when she took me to Chetna on an SD visit. After picking up the patient and her husband in Mahesana, Uma-masi's son drove us along a dark road, lined by fields and trees on both sides, until we reached Dr. Ranjit's town.

The young man parked the car in a narrow street lined by squat buildings of old and sometimes decaying construction. Dusk had settled over the town. The fragrant scent of *bidi* smoke filled the air. I followed Uma-masi and her clients as they picked their way past produce-laden wooden carts, dodging rickshaws and mopeds and running boys.

At the end of the dusty path stood Chetna Clinic. As at most local clinics, the waiting room contained a chipped wooden reception desk, benches, and a prominent bilingual sign: "Here prenatal SD (boy or girl before birth) is not done. It is a punishable act." A nurse showed us into the well furnished consultory. A nondescript man stood behind the desk. Grinning widely, Uma-masi introduced us. I explained my project briefly. As Dr. Ranjit stared at me, I bumbled verbally around the topic of sex selection. He eventually squinted and cut me off, mumbling that government regulations were now very tight.

My next visit to Chetna came months later, when I began full-fledged fieldwork. While scanning, Dr. Ranjit sporadically asked me questions about my research plan, confidentiality protocols, and work at Nandini. Following the sonography, Uma-masi encouraged me to "interview Saheb, if you like." Taken aback, laughably unprepared, and worried about the doctor's potential wariness, I thrust forward my advisors' official introduction letter and timidly asked if we could converse further "next time."

My third time to Chetna with Uma-masi, I finally asked Dr. Ranjit if I could speak with him or observe his activities in greater depth. "I can't do that," he said, shaking his head. "SD is a very hot issue right now!" Uma-masi reassured him it would "no problem"—the information was "for research only"—but Dr. Ranjit was adamant:

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[71] Fortes 1969: 219-249.

"After taking it for research, he will submit it in writing to the university, no?" His quiet voice grew louder as he continued:

> Do you know there were multiple complaints recently to the CDHO, BHO [Block Health Officer], local officials? 'People are coming from out of town, and then this doctor is looking in this way and taking 12,000.' It's very tight! I can't give an interview. Have Dilip-bhai arrange things with doctors in Mahesana—there are so many! This is a small town. I can't take the risk.

Attempting to inspire confidence, I started explaining my confidentiality protocols, but the doctor waved his hand dismissively: "People maintain Swiss bank accounts, and still the lists of black money come out! I can't take that kind of risk." I asked if I might simply continue to observe. Uma-masi jumped in to reiterate that there would be "no problem." Dr. Ranjit turned to her and said sternly, "Only if you bring him, huh? He must come with you and leave with you." As we departed, I was aware that only the doctor's trust in Uma-masi had prevented my complete banishment.

For several months, Uma-masi did not allow me to set foot inside Chetna. Even when taking me along, she had me sit outside the clinic. At the same time, during phone conversations with Dr. Ranjit, she frequently slipped in references to my coming over for dinner or "just to chat."

Perhaps due to the small insinuations of trustworthiness, Dr. Ranjit responded favorably when we met again, fifteen months after our initial encounter. After shouting, "Oh ho!" and reaching out to shake my hand, he asked questions about my ongoing research and nodded with each reply. Uma-masi restated her hope that he would grant me a meeting. He reiterated his "No," but now with a wry smile. Two days later, on another visit, he finally responded to Uma-masi's persistent request in the affirmative: "Okay, but he'll have to do night duty here!" A "night halt," he explained, would demonstrate both my commitment and my trustworthiness: what ulterior motives were strong enough to motivate sleeping over in one of the clinic's bare rooms?

Shortly thereafter, I visited Chetna without Uma-masi for the first time, while accompanying Asha-ben's family for her abortion. A week later, my completion of the overnight stay initiated a long series of observations. Over the subsequent months, Dr. Ranjit sought repeated assurance that I would not "submit my name and location to the university." Upon receiving my pledge of confidentiality, he inevitably recalled our early interactions: "There was no other problem. But we are worried about exposure. You know this is a very sensitive issue." The promise to never publicly identify Dr. Ranjit, bolstered by Uma-masi's authority and a long process of acquaintance, ultimately allowed me to observe and analyze the inner workings of an ongoing sex selection enterprise.

Situating Dr. Ranjit

There is no easy way to make sense of Dr. Ranjit. He was a deeply pious man, with Hindu religious icons filling every corner of his consultory and home. His clinical

days began in prayer, and pilgrimages and temple visits occupied much of his free time. He seemed to constantly ruminate—even perseverate—on the sinfulness of sex-selective abortion. Yet he quickly put a price on it when negotiating with patients: "Why would I commit sin for so little?!" He exhibited a gentler manner than any local obstetrician I knew, addressing routine patients with marked respect and sensitivity. Yet he could be very short with sex selection patients, sometimes expressing outright indifference to their anxiety and suffering. He professed what I perceived as genuine guilt and embarrassment about his notoriety. But he continued to act on what I could only understand as avarice, collecting hundreds of thousands of rupees (several thousand dollars) every Sunday for scan after scan, abortion after abortion.

Like many local doctors, Dr. Ranjit came from a family of modest means. A brilliant pupil, he had earned a merit scholarship to study medicine in Ahmedabad. Obstetrics "was not a line of preference" for him—in fact, he "had no desire to do this." But when he had consulted an astrologer regarding specialty selection, the latter had advised, "'You go into this line—you will have success in this line.'"

Following residency, Dr. Ranjit had established Chetna Clinic. The building was typical: a waiting room with adjoining patio; private and shared inpatient rooms; a dispensary—really more a closet—containing a small medication stock; and a consultory with the typical curtained-off area for examination and sonography.

For many years, Dr. Ranjit had focused on "bread-and-butter" practice: antenatal care, labor and delivery, Caesarean section, medical and surgical treatment of general gynecologic problems, and routine abortion. He had mostly avoided SD, instead referring patients to colleagues like Dr. Rohit and Dr. Ganpat. Nonetheless, recalling his early days in private practice, when many rural patients still gave birth at home, he admitted:

> Back in those days, if it was male—after four months, it's clear, right?— I used to tell them for free! Then, the patient would happily come for delivery. If it was female, I did not disclose. But if it was male, I told them even if they didn't ask! Because at that time, there weren't so many hospital deliveries—people delivered at home, or with midwives, or with Ayurvedic doctors. So if I told them it was male, they would insist for hospital delivery!

Long before beginning his large-scale sex selection practice, Dr. Ranjit had opportunistically profited from free, unsolicited SD on his poorest patients.

By the time we met, Dr. Ranjit was a major figure in the North Gujarat sex selection market. He drew patients from every caste and class. Upper-caste and affluent families were disproportionately represented, and especially so with SD on a potential second (versus third or fourth) child. Most clients came from Mahesana and the six adjoining districts, but some traveled from hundreds of kilometers away. Outside visitors frequently noted the irony of a major sex selection enterprise in Mahesana District—the homeland of the state health minister, Chief Minister Anandi-ben Patel, and Prime Minister Narendra-bhai Modi himself.

Like most local sex selection providers, Dr. Ranjit preferred to take clients at "awkward times" or "off hours"—evenings, Sundays, and holidays—due to the miniscule likelihood of government inspection visits. On arriving in the Chetna waiting room, clients encountered a hodgepodge of routine patients, sex selection facilitators, and sex selection patients, the latter often tending to young daughters—never sons—who crawled, ran, cried, shouted, and played on the floor. When registering with the reception nurse, some families feigned a routine visit, waiting to reveal their purpose to the doctor; others glanced around furtively before leaning over and whispering, "We're here to get it checked... We have to get it looked it... We're here for a test." The nurse wrote the patient's name (or the false name given) on a chit, which another nurse took inside. Connectors, who usually phoned beforehand, just waved at the reception nurse and herded clients toward an open bench. Once registered, families settled in to wait, sometimes for hours.

Inside the consultory, unfacilitated clients again used vague language—"check," "test," "looking"—to convey their aims. Dr. Ranjit responded by asking questions to probe their trustworthiness and ascertain how they knew of him. After vetting clients, Dr. Ranjit clarified pricing. He took pains to underscore the separate charge "if the result is not good—if anything else is to be done".

Dr. Ranjit then showed families into the examining area and performed SD. To obtain a definitive result, he often had to repeat the scan, making the patient cycle between consultory and waiting room. With "female" results, he asked clients "your decision," frequently precipitating discussion of options for selective abortion. He permitted and even encouraged return visits for confirmation, scrawling out a chit that the family could present to jog his memory: gestational age in weeks, obstetric history, town of origin, 'D' for "direct" or 'A' for "agent," payment quoted and collected, and a symbol for the tentative result—'^' for female, '-' for male. It was usually around this time, after the disclosure of the scan result, that Dr. Ranjit collected his payment.

Producing Profits

Dr. Ranjit generated massive profits from visualizing and acting on fetal sex—easily 200,000 rupees on a single Sunday. Factoring in scattered sonographies and abortions on regular workdays—most did not pass without at least one—he enjoyed a monthly income of 2 million rupees, or three to four times what his colleagues earned from routine practice.

Returns on sex selection fluctuated with the patient's economic class. While Dr. Ranjit usually collected between 8,000 and 15,000 rupees for a single test or abortion,[72] initial quotes varied based on clients' appearance and manner. With typical middle-class patients, the doctor might ask for 12,000; if clothing, accessories, and speech suggested affluence, perhaps 15,000; and from poor, beleaguered patients, sometimes "only" 7,000. Doctor and staff used various tactics—extracting promises of discretion, segregating simultaneous abortion patients to different rooms, instructing facilitators to collect

[72] For comparison, Mahesana-area obstetricians generally charged around 150 rupees for office visits, 100 or 200 for routine ultrasounds, and 3,000 for routine second-trimester abortions. Most abortions, which took place in the first three months, brought in considerably less.

different families' payments separately—to prevent intercommunication and sustain differential pricing.

Connectors collaborated with Dr. Ranjit to enact the sliding fee scale. In fact, many coached him on how to charge specific people: in accordance with an ethic of "help," "good work," or "service," they down-negotiated prices for acquaintances and poor patients while furtively whispering phrases like "They're VIP!" or "You have to get yours!" to encourage elevated pricing for others. Facilitators like Uma-masi praised Dr. Ranjit for the fact that "he will take whatever I give him—if I say, you will only get this much with this patient, but you still have to do it, he will do it." Uma-masi often pre-arranged a result-stratified fee structure: 15,000 "if it's positive," 10,000 "if it's negative," and 20,000 for a "package with cancel." Stratified pricing acknowledged both the misfortune of a "female" result and the superadded burden of paying for two different services.[73]

Of course, initial price quotes were subject to extensive bargaining, with discounts ultimately ranging from 1,500 to 3,000. Commencing after disclosure of the SD result, negotiations could become testy, with doctors and clients both raising their voices: "It can't be so little, Bhai!... It can't be so much, Saheb!... So am I to take whatever you say?... What, am I to give whatever *you* say, Saheb?... Why not just ask for it for free?... Are you even serious?!" More often, both parties bargained passive-aggressively, with smiling appeals to the other's "understanding." Clients cited household misfortunes—multiple daughters, a recent death, an ongoing illness, precarious income, failed investments—to justify fee reduction. Clients receiving "male" results frequently paid in full, with only perfunctory bargaining, while those with "female" results insisted on paying less: "If it had been the real deal, it would be different." "This is a third girl—try to understand, Saheb." "If it had been positive, we would happily have paid up." Occasionally, pity for "genuine cases"— poor patients with multiple daughters and a "pathetic life"—led Dr. Ranjit to accept as little as 5,000 rupees for SD; in such cases, he sometimes set up an interest-free installment system, permitting (and expecting) payment over a year.

Dr. Ranjit was less willing to reduce fees for selective abortion. Outside the "package deals" arranged by facilitators, he rarely granted more than a token discount. The timing of negotiations capacitated Dr. Ranjit's firmness: unlike with SD, where he often disclosed results before demanding his fee, he usual fixed and collected payments before providing abortion. Despite falling in more ambiguous legal terrain, every abortion carried a small-but-nontrivial threat of catastrophic exposure, given the greater potential (relative to SD) for bodily complications. Moreover, every selective abortion entailed significant sin—a problem I explore in Chapters 5. Given these risks, pricing for the second stage of sex selection was largely non-negotiable.

After the doctor, connectors profited most at Chetna, earning between 1,000 and 5,000 rupees per referral. Some collected Dr. Ranjit's fees from clients and skimmed off a portion before delivering the remainder. Others made clients pay the doctor directly,

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[73] For a comparative account of differential payment to midwives upon birth of boys and girls, see P. Jeffery et al. (1989: 6-7, 141). Colonial observers also described Gujarati Kanbis as paying different prices after births: one rupee for a boy, and half that amount for a girl (Enthoven 1922: 136).

returning alone later to claim their commissions. As in Asha-ben's case, facilitators also profited through tips; Uma-masi, for instance, typically extracted 500, even when clients felt despondent at the result.

Facilitators also capitalized when clients decided to obtain selective abortion somewhere other than Chetna. As I discuss in Chapter 3, Dr. Ranjit often encouraged patients to go elsewhere, especially in risky cases. Many connectors coordinated selective abortion with obstetricians who provided the service despite avoiding SD. Uma-masi typically channeled five or six patients per month to Mahesana's Dr. Harnish, who charged 5,000 to 10,000 rupees and gave a 20% commission. Linking Chetna with other clinics in the underground market, connectors profited from coordination work that pragmatically coupled the two stages of sex selection, thereby permitting their separation in space and time.

From Dr. Ranjit and connectors, smaller profits diffused outward to others in the Chetna sex selection network. With "good" results, connectors pressed clients to tip the nurses several hundred rupees. Staff sweepers consistently collected a 300-rupee "cleaning" fee after selective abortions, even though the work performed was indistinguishable from the cleanup following routine abortions. In rare cases, when *kāchi* delivery resulted in emergence of an intact fetus—too recognizable for disposal through routine biomedical waste systems—the sweepers might charge 500 to bury the remains at a remote location; though rarely discussed even by clinical stuff, this "dirty" labor by lower-caste women played a key role in invisibilizing and thereby supporting biomedical sex selection.[74]

Beyond the clinic, profits trickled to various peripheral actors. Connectors sometimes passed between 500 and 3,000 rupees to upstream referrers. Often, they also arranged for their own relatives or friends to transport clients to Chetna. While maintaining that she sought "to save patients money, to not let them spend one unnecessary paisa," Uma-masi sometimes forced even families possessing a car to travel in a vehicle of her appointment—her neighbor Gautam-bhai's rickshaw or her son's car. The "gas money," "driver cost," and "vehicle rental" frequently totaled several thousand rupees—an exorbitant amount for the distance covered.

The profiteering of various sex selection actors exacted a heavy toll on families. Ishwar-bhai Chaudhary, whose wife Nayna-ben underwent SD and subsequent abortion at Chetna, ran down the costs to me as he waited for a nurse to hand over post-abortion medications: "12,000 for sonography, 9,000 to get it taken out, 1,000 for a day's rickshaw fare, 1,000 for car rental the second day, 350 for medications, and 300 to the sweepers"—a total of nearly 25,000 rupees. Despite a recent family illness and some failed investments, Ishwar-bhai's household could absorb the cost, given his 30,000-rupee government teaching salary, 10,000-rupee private tuition income, and extensive social capital. But for families of manual laborers, farmers, and low-rung salaried workers, total costs between 15,000 and 30,000 could consume over a year of disposable income. Little surprise that countless clients mortgaged land, borrowed money at

[74] See P. Jeffery et al. (1989: 3-6, 65-68, 105-111) and especially Pinto (2008: 29-105) for extensive discussions of lower-caste women's labor in relation to reproducing bodies, reproductive remains (particularly the placenta), "dirtiness," monetary returns, and untouchability.

usurious interest, or sold family heirlooms and other liquid assets to pay Dr. Ranjit, Uma-masi, and others. For many families, visualizing the gendered subject of kinship—and eliminating her, if a potential daughter—proved ruinously expensive.

Knowing and Concealing

To whom was sex selection visible? Dr. Ranjit, his staff, and his ultrasound machine functioned as central points in a network of knowledge, constellating scattered referrers and clients. Colleagues referred patients to reinforce the obstetric patron-client relationship and fulfill various social obligations, but sometimes also for direct profit. Many clients came with clinical staffers, like Uma-masi, or with midwives, pharmacists, and other community-based facilitators. Finally, a motley assortment of figures who had crossed paths with Dr. Ranjit at some point—temple priests, train conductors, pharmaceutical representatives, insurance agents, a nearby charity hospital's trustees, dentists, a village veterinarian's wife, and myriad acquaintances of previous clients—made referrals to Chetna.

Dr. Ranjit constantly evaluated whom to authorize as a sex selection referrer. As with Uma-masi, formation of new connections entailed establishing trust and setting business terms. In acknowledging and activating potential facilitators, Dr. Ranjit entrusted and empowered them with knowledge of his practices, along with the privilege of participating in them.

Collaboration between the doctor and connectors rested on discretion—the "embodied practices that conceal and reveal potentially significant information and that performatively establish a subject's positionality within a specific community of practice," simultaneously encompassing both concealment and disclosure.[75] It was not through objectivized "secrets," but through a *process* of discretion that people moved between "inside" and "outside"—or rather, engaged in "forms of concealment and revelation... that, in fact, defied such simple binary logic."[76] Discretion concealed key information from public view while allowing controlled sharing of such information in ways that confirmed belonging within a specified community and produced "intimate relationality."[77] Discretion allowed for capitalization on market knowledge, with "the value of secret knowledge [becoming] apparent and [gaining] social force in the moment of its revelation, when it was no longer secret" for clients.[78] By allowing and trusting connectors to possess, conceal, and selectively reveal his practices, Dr. Ranjit established a working intimacy with them, setting up a loose network of information and information-bearers that was ostensibly insulated from public view.

Nevertheless, trust regarding discretion did not necessarily transfer to business practices, and Dr. Ranjit frequently lamented connectors' lack of commercial transparency. Some used their middle position to extract more money by misleading both doctor and client; for example, Uma-masi collected fees from clients, quietly pocketed 2,000, presented the rest to Dr. Ranjit as full payment, and took another 3,000 in

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[75] Mahmud 2012: 429.
[76] Mahmud 2012: 429.
[77] Mahmud 2012: 430, 434.
[78] Manderson et al. 2015: S184.

commission. Others claimed the need for large commissions to satisfy upstream referrers and then kept all the money, the second-degree connectors being either non-existent or unremunerated. Dr. Rajen—the Ayurvedic fertility specialist who approached Asha-ben after her abortion—was the most prolific facilitator at Chetna, bringing in half a dozen patients per week, but Dr. Ranjit and his staff privately detested the man, calling him "unreliable" and "not transparent." They often recounted how Dr. Rajen had attempted to "snatch" a longstanding patient from Dr. Ranjit's own *gol*, accosting her outside the clinic and insisting she would only receive SD if paying through him; the lie had come to light only because the client had complained to Dr. Ranjit, prompting him to confront Dr. Rajen and extract a confession. In general, the limited visibility of much of the SD business to even the central service provider created countless possibilities for connectors to profit through deception.

At the same time, facilitators' profitable middle position was constantly jeopardized by the leakiness of their specialized knowledge.[79] The problem of "direct patients"—people visiting Chetna without intermediation—brought connectors into pitched conflict with Dr. Ranjit, for when such patients appeared trustworthy, he had little incentive to turn them away. To avoid bypass, facilitators practiced numerous information management tactics, such as hiding the clinic's particulars until in transit or claiming that the doctor would never accept unfacilitated clients. Nonetheless, once families recognized Chetna as a sex selection site, the knowledge and trust that undergirded facilitation routinely leaked.

The leakiness of market knowledge posed not only financial, but also legal danger. Uma-masi used her phone to coordinate Chetna trips and to give prospective clients standardized instructions: "Yes, to get it looked at?... It can be done after three months and ten days... No, don't have the form filled, don't register it anywhere... Come meet me. Your work will be done." Toward the end of my fieldwork, however, she grew concerned about wiretapping. She talked often about obtaining a separate line for discussing SD, "so that our number doesn't keep circulating—what if someone from government gets it?" In fact, the circulation of her number, along with rumors of her efficacy, was one of her chief business assets; she could hardly afford to end it. But her anxiety underscored the danger of circulating information: what if one's market knowledge and participation became visible to the state?

Policing and Participating

The specter of government policing suffused clinical encounters at Chetna. Whenever a PCPNDT sting occurred anywhere in Gujarat, Uma-masi painstakingly recapitulated the televised coverage to Dr. Ranjit: had he heard about the Ayurvedic practitioner caught taking a "fake patient" to a Surat sonographer, or the obstetrician, broker, and rickshaw driver busted near the Ahmedabad bus depot? Dr. Ranjit and his collaborators exhibited a shared paranoia about the specialized technologies used in stings, such as chemical tracers and recording devices.[80] Rasila-masi, a midwife from Patan, always received, counted, and delivered patient payments in a handkerchief to

[79] Cf. G. Jones 2014: 54-55.
[80] For a discussion of stings in modern Indian public culture, see Sundaram 2015.

avoid contact with "powdered notes" and retain scope for "raising many doubts" in case "someone is recording on a mobile, or there's a camera": "Who knows what I've given in the handkerchief?" While describing the handkerchief method, Rasila-masi requested assurance that I was not recording our conversation. I heard the concern in identical form from many connectors: "You never know! Patients are so clever. We could be sitting here talking, I could be giving advice, and they could be recording me!" Dr. Ranjit expressed recurrent fear that someone might photograph or record his work, frequently snapping when patient relatives used mobile phones in the examining area. Although the state detection apparatus was largely ineffective, providers remained hyper-vigilant, given the possibility that officials might opportunistically pounce on circulating proof of sex selection.

Despite pervasive concern about surveillance, Dr. Ranjit and his referrers displayed remarkable laxity in vetting potential clients. While providers claimed to screen families carefully, I almost never saw them refuse prospective clients, even though the latter sometimes gave only the vaguest references: "Remember we came, that one time?... My sister's sister-in-law got it done here two years ago.... My uncle—the one with a business in Gandhinagar—he came to you fifteen months ago... My niece is married to that doctor in Mahesana." Even when Dr. Ranjit obviously could not recognize families, necessitating several minutes of follow-up questions, he did not turn them away. In response to my queries about how he ensured that clients were "authentic" (his term), he explained, "Usually, patients don't have *mala fide* intention. They have a genuine problem. From discussion, we can get a sense that a patient is genuine—'We came through this person, or this long ago.' We can sort it out. You can see it on their face, in their eyes." Most facilitators used a similarly vague intuition to explain their confidence: "I just know, from the way they talk... I can grasp someone's personality right away!... You can always tell, immediately." When Uma-masi and other connectors refused clients, it was not for perceived indiscreetness or potential government linkage, but for stingy, indecisive, or otherwise annoying behavior. Although generally professing great caution, sex selection providers rarely found cause for concern in any specific case.

In fact, with sex selection a ubiquitous part of everyday life, families often discussed Dr. Ranjit's services quite indiscreetly. On dozens of rickshaw or bus rides back from Chetna, I heard clients speak loudly—even shout—into the phone: "No, no, because there's a clinic there... We had to have my wife looked at, for *that*... It's called Chetna. He said it was a girl, so we stayed to get an abortion." Dr. Ranjit and facilitators implored clients to avoid exposing Chetna, but the information leaked constantly. While providers responded to public policing with secretive paranoia, clients sometimes treated sex selection as a banal, openly discussable matter.

Providers also clashed internally over discretion, in ways that highlighted the public secret's nature as a "'known-unknown,'" "almost demanding defacement" and always threatening to "erupt despite great strategies of concealment."[81] Connectors faulted one another for "always being there whenever I go," ironically opining that "someone who takes so many patients can't be trustworthy." If "any objectification,

[81] Sundaram 2015: S299.

instantiation, or entextualization of a secret—an ineluctable feature of its existence as a social phenomenon—[created] risks of unintended communicability,"[82] then more prolific facilitation surely signaled greater risk of public visibility.

Similarly, Dr. Ranjit frequently rebuked Uma-masi for barging into the consultory unannounced: "You have to be careful making entries like this! What if someone is inside?... You come in and say, it's like this, and we had this done, and this is left—if you start discussing like this, people can figure it out!... How do you know who is in here? Just now, I had the former mayor in here!" He privately expressed fear that some connectors' tendencies to "not think and just start talking" might expose his work to the wrong eyes.

From the other side, many connectors voiced concerns that Dr. Ranjit's network had become too open to remain secure. The notorious Dr. Rajen once told me:

> He looks freely, even with direct patients, but that's risky business. If some Health official makes an arrangement and sends a dummy client, then the doctor is trapped!... Rohit-bhai got shut down because he was famous. If you want to do this work, you have to do it in great confidence. The doctor who starts taking patients directly—his career will end within twelve months. Because ladies gossip. They'll say they got it checked with this doctor, they'll tell their neighbors, so the word will circulate, via-via... The doctor who cares about his career won't take direct patients, because there's too much risk.

Uma-masi voiced similar worries about Dr. Ranjit's willingness to "take anyone, direct, without asking any questions," noting that "his name is circulating a lot—all the patients, all the sahebs, everyone knows" and suggesting that "it would be good if Saheb reduced a little bit." Each major raid became an occasion for reasserting the value of preventing leaks—of concentrating capitalizable knowledge. Facilitators inevitably warning Dr. Ranjit to stay "vigilant," "stop accepting direct patients," and "take only through people like us." According to connectors, Dr. Ranjit's willingness to validate and act on leaky knowledge—to bypass them and their commissions—put him in danger of state apprehension.

But even as the state appeared to threaten sex selection and its practitioners, individual officials participated in the underground practice. Dr. Ranjit served myriad government functionaries—court clerks and police officers, teachers and engineers—whose only PCPNDT-related concern was how to skirt the law. City and village councilors, Collectors, judges, and others with at least some official responsibility for combating sex selection also frequented the clinic shoulder-to-shoulder with "the public." And various public health functionaries charged with forming the first line of surveillance sometimes appeared at Chetna seeking illegal services for friends, relatives, or themselves. Dr. Ranjit laughed at my astonishment upon seeing him perform SD for community health workers' relatives, inevitably noting, "I've known this person for a

[82] G. Jones 2014: 56.

long time, so I can trust!" He laughed, too, when recalling how a judge had hidden his official position until after his wife's SD was complete—"If he gave me his identity, I would've avoided completely!"—and how a neighboring district's collector had secured SD by concealing his identity, only to have Dr. Ranjit and others refuse abortion upon recognizing him. Government officials could access services at Chetna, but only if they inspired confidence that they were entering the hidden enterprise without intentions of exposing it.

The constellation of features that allowed ground-level public health workers to effectively cross the public-private divide—local origins, longstanding relationships with Dr. Ranjit, and official roles as interfaces between citizen-beneficiaries and the health sector—became clear one afternoon at Chetna.[83] A fortysomething woman in a rich sari entered the consultory and announced she had brought two patients. Having already performed SD for twenty-three clients in just a few hours, Dr. Ranjit wearily said he would see one before lunch, one after. As the woman nodded and exited, he turned to me, broke a smile, and said, "They are also provocating this type of thing!" Seeing my confusion, he grinned more broadly and clarified with three letters: "FHW"—a Female Health Worker. After some silence, he added, "Everyone is—opportunistic." When I asked how he could trust her, he explained, "I know her since '96."

Ushering in the first family, the FHW explained that the patient was from her mother-in-law's father's village. As Dr. Ranjit scanned, the FHW lowered her voice to a whisper and told him, "Last time we had a meeting, Babu-bhai said something, eh? 'We wanted to look with Ranjit-bhai, but my daughter refused.' How can you say this?!" Suddenly alarmed, the doctor asked if his sex selection practices had "become a rumor" among local Health officials. The FHW reassured him, "No, no." After a beat, she added with a snicker, "But Babu-bhai did say, 'Oh, it happens at nights and on holidays.'" The doctor furrowed his brow. Had Babu-bhai—a Health bureaucrat who knew of Dr. Ranjit's services—broken the code of silence, making a locally known practice visible to state policing?

After some minutes of silent scanning, Dr. Ranjit mumbled slowly, "Babu-bhai—well, I did his niece's. For free! So he was the one saying this?" The FHW averred. Dr. Ranjit continued, "You know, one time, Babu-bhai brought a medical officer! I said no. But he insisted: 'There's no problem. They won't discuss it.'" It appeared that Babu-bhai had filled a market niche much like the FHW's, channeling sex selection clients to Dr. Ranjit; now, in light of her revelation, the latter was reconsidering his trust.

Once the scan ended—a "good result"—the FHW handed over a wad of bills. Dr. Ranjit departed for lunch.

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[83] Many have documented the fact of public health workers aiding or abetting SD and selective abortion (Aravamudan 2007: 103; Bhatia 2007: 219-227; John et al. 2008: 62-63; Joseph and CYDA 2007: 32; T. Patel 2007b: 256-258). By conveying the texture of one such interaction in this vignette, I aim to shed further light on *how* public health workers play such roles, and how their specific positioning at the intersection of government, commercial medicine, and village communities may shape their involvement in sex selection providers. Also note that scholars working on sex selection in China have observed or inferred how local health workers have used SD to secure citizen compliance with family planning mandates (Bossen 2007: 216) or facilitated sex-selective abortion by misclassifying and not registering pregnancies (Wu et al. 2006: 175-177).

When he returned, I was alone in the consultory. Turning to me, he muttered contemptuously, "I did so much for Babu-bhai, and then he was the one talking in their meeting! 'Not during the day, but on Sundays, and evenings.' I did it for him for free! And then he went and told in their local Health meeting—'Saheb is doing it.'" He grunted. Dr. Ranjit happily allowed low-level government officers to bring new clients to Chetna, but it would be disastrous if those officers carried knowledge of his practice back to their official institutions.

The FHW's second patient was a "beneficiary" from her official area. During the scan, the FHW said, "You know, Chandu-bhai was telling, too! He started saying his relative got it done here. Saheb, there are some that you should not take, even by accident. I would never tell, Sir! And these two—you did it for them, and then they started telling." I wondered: was the FHW's revelation a way of reinforcing Dr. Ranjit's reliance upon her? Laughing, she continued, "They kept saying their relatives went directly—that way, they wouldn't get blamed! They said all this with the BHO listening."

Mention of the BHO startled Dr. Ranjit, who asked whether the two men "told the BHO directly." The FHW nodded: "Yes, the BHO! During a meeting!" Desperation in his voice, the doctor asked the officer's response. With a seemingly forced smile, the FHW recalled, "The BHO said, 'We'll have to pay a visit on a holiday!'" I later learned that the menacing statement prompted the same question in Dr. Ranjit's mind as in mine: when might the BHO come to Chetna, and how would doctor and staff ensure that he did not catch them "red-handed"?

After the second scan, Dr. Ranjit handed some cash back to the FHW. They had a mumbled conversation, inaudible to me, in which he appeared to speak with great urgency. Then, she left.

While exceptional in revealing the back-and-forth flow of knowledge between sex selection enterprises and the government institutions charged with uncovering them, the FHW's visit was otherwise typical of facilitated visits to Chetna. Although the state officially stood in opposition to sex selection, individual state functionaries frequently participated in the market for the practice just as other clients and connectors did—seeking, referring, profiting, expressing mistrust, and sometimes allowing information to leak.

Requests, Deflections, Refusals, Referrals

Confronting SD Requests

Mahesana-area obstetricians who did not provide sex selection services nonetheless faced constant pressure to visualize and reveal fetal sex, or to name someone who would—to participate in recognizing the potential subject of kinship. Doctors' responses to such pressure—refusal, polite deflection, surreptitious referral—implicitly staked out positions vis-a-vis the generation and transmission of knowledge. Refusal and deflection denied both a practitioner's willingness to produce knowledge of sex and his knowledge regarding who would; referral sidestepped the former while mobilizing the latter.

One afternoon, I was alone in the Nandini consultory when Sheela-ben, a patient from Dr. Dilip's *gol*, entered with her husband and Uma-masi. As the couple sat down to wait for the doctor, Sheela-ben asked hesitantly whether "Saheb will look for us." Uma-masi shook her head firmly: "No, he doesn't look!" When Sheela-ben noted that "he looked for us before," Uma-masi reminded her, "That was four years ago! Now he doesn't." Smiling smugly, she continued, "Watch! He'll send you with me."

Once Dr. Dilip arrived and began examining Sheela-ben, the following exchange ensued behind the curtain:

- Sheela-ben: Saheb, we have to get the test done.
- Dr. Dilip: Oh, we don't do it any more. We don't have the software! The government took it away.
- S: But you did it for us last time!
- D: But that was four years ago! The government took away the software after that.
- S: Oh, come on!
- D: Well, you look at the TV! Is anything visible?
- S *[chuckling]:* Oh, Saheb—we can't tell! You can.
- D: That's why I'm telling you, it's not visible.
- S: Oh, my! I was thinking, Saheb will do us this favor. Especially since you did it last time.
- D: But then the government took away the software, right?

Having deflected the request several times, Dr. Dilip emerged into the consultory, and the patient followed.

Once seated, Sheela-ben resumed her insistence. Dr. Dilip just shook his head. Eventually, he mused, "Now Uma, what will we do with her?" Uma-masi waved the couple out, and Dr. Dilip said, "Go outside. Uma will explain everything!" The assistant asked whether to fill a Form F for Sheela-ben's sonography, and Dr. Dilip sighed, "Now that they're going to get a test, how can we fill the form?" Despite lack of direct involvement in the couple's pursuit of a son, it was easier for Dr. Dilip if their pregnancy remained hidden from state surveillance.

Sheela-ben and her husband stepped outside with Uma-masi. After a brief silence, Dr. Dilip said contemplatively, "They were bound to insist—my community, right? They have just one girl, quite old—thirteen or fourteen. This is the last chance. They had one of *those*, but it must have been five years ago, because we stopped four years back." Nowadays, Dr. Dilip deflected or outright refused every SD request. He even eschewed referral, preferring to allow Uma-masi to assume both return and risk on utilization of market knowledge.

While most obstetricians had stopped providing SD years earlier, patients continued requesting it with regularity. Some families begged plaintively, pointing to one or more girls as proof of need: "It'll be good if you can tell us, so we know what to do." Others coyly insisted they were hoping for a girl—wasn't the law just for boys? Most

referenced longstanding kin-group, community, or therapeutic relationships, insisting that the doctor would "*have* to look, for *us*." Thick sociality sometimes proved irresistible: several doctors admitted that "if someone close to me comes, I may *have* to do it," with the primary motive being moral obligation rather than financial profit. More often, however, the PCPNDT Act trumped social bonds. Numerous obstetricians underscored their complete cessation of sex selection practices by highlighting how they turned away their own relatives. Dr. Dilip, for instance, once told me, "I have to be firm. Because if I do for even one person, then he will go out and tell... If I do for one, I may have to do for someone else. This is why I have kept the rule—do it for no one, even my own sister or brother." Obstetricians frequently violated the axiom of amity to avoid visibility as a sex selection practitioner.

In line with a policy of total refusal, Dr. Dilip often anticipated SD demands when confirming pregnancy for patients with daughters. "The child is good," he would say, "but I won't be able to tell you boy-girl. I have to warn you, since you may be hoping... I don't have the equipment... You can find out after three months, but not here—make your own inquiries." When families did request SD, Dr. Dilip sometimes refused flatly, telling people to "find it on your own." More frequently, he demurred by claiming to not have "the boy-girl software." As in Sheela-ben's case, the software excuse sometimes proved too transparent, eliciting skeptical looks, frustrated chuckles, and cries of "Just this once...!" or "You can see, you just don't want to say!" All the same, the dodge functioned to convey Dr. Dilip's unwillingness.

I gradually learned that the software excuse was a widely shared tactic, with several younger clinicians describing it as "a way our senior colleagues have taught us for telling patients no." One obstetrician explained:

> I tell patients—even my friends—that the Modi government removed the software for looking at boy-girl. See, if I say it's possible but don't do it, it's more of a hassle. Who wants to haggle with them? They'll say, 'We've come here for twenty years, and my delivery was here, and you have to do this for us!' Better to just not go there. I just tell them the government flipped the switch, so I can't see the boy-girl part. And people accept it. Even educated patients will accept: 'You need software to see, and the software was deleted.' How much do they know? We just look at the genitalia at twelve weeks, but do they know that? So they mostly swallow it.

The software explanation, whose plausibility rested on a presumed gap between the sonographer's expert sight and the lay person's understanding of the image, served as a polite deflection, particularly when thick, longstanding relationships made direct refusal uncomfortable. Moreover, it displaced the locus of decision-making authority from the obstetrician to the state, aligning the former with the patient as an empathetic but helpless figure. The doctor was not refusing to "look" for the family; rather, the government had deprived him of the visualizing capacity itself.

Various other tactics filled out the shared repertoire for denying requests, with some practitioners more forcefully discouraging SD through moral shaming, gestures toward the law, and invocation of SR-based uncertainties regarding future population "balance." Doctors often had to explicitly deny referral as well as SD, reminding families that sharing knowledge about the sex selection market was a crime just like sharing knowledge generated by the practice.

Of course, while obstetricians sometimes resorted to "blunt language," "strict speech," or "shocking words" in refusing, they also had to "take care not to have much harder words for our patients," since it could harm business to "make them hot" or "disturb them." And in speaking with me, many doctors immediately followed staunch disavowals of sex selection participation with lamentations about the "loss of practice" that such abstention brought. Dr. Dilip explained:

> Since we don't look, we're going to lose some patients. Some stay with us, but others leave, thinking, Saheb doesn't look, so let's go elsewhere. Patients who go to Ranjit come back. But doctors who are doing on a smaller scale, they will keep patients... So if there's a family of three-four women, and they find we don't do it at all, they'll all go elsewhere. There are plenty of people who'll look! That has a slow effect—not immediately, but as people come to know I'm not doing it.

Families' care-seeking patterns corroborated Dr. Dilip's subjective account. Many patients admitted that a regular obstetrician's steadfast refusal around SD had prompted a switch to another doctor in the "hope that he might do it for us."

As in Sheela-ben's case, Dr. Dilip mitigated losses by funneling patients toward Uma-masi. A similar pattern prevailed at many clinics. Some staffers, like Uma-masi, operated with employers' tacit approval, while others hid their channeling of patients into the sex selection market.

Additionally, doctors who generally refused to refer for sex selection might yield under various social influences: kinship, friendship, an exceptionally old doctor-patient relationship, or pity for a family's economic and social hardships (including multiple girls). In such cases, clinicians usually conveyed the names of practitioners without any referral charge, instructing patients and relatives to avoid disclosing the disclosure. Twice, on days when Uma-masi was absent from clinic, I saw Dr. Dilip tell close relatives to take a chit of paper and write down the names and addresses of Dr. Navin, Dr. Ranjit, and one other colleague—three options in three cities.

On another occasion, when I mentioned having interviewed Chandrika-ben Chaudhary, who had recently had a healthy boy after losing a previous newborn son, Dr. Dilip's eyes widened, and he abruptly silenced me with a hand on the shoulder. He recounted the circumstances surrounding the prior birth: Chandrika-ben had experienced contractions just before the doctor was to depart for vacation, he had performed a Caesarean delivery, and—despite having reached thirty-six weeks of gestation—the boy had died some hours later. Looking at me somberly, Dr. Dilip continued:

> They had a boy expire at our place. So *for them*, I arranged something... Since this happened, I had to come up with some damn setting for them. Her husband must still badmouth me to everyone, and that's understandable. But this way, I feel I took care of them. Otherwise, they would curse my name for the rest of their days—'Our boy died at Saheb's, and then we ended up with just three girls.' With a girl in this pregnancy, they would have been very sad. So I felt a little soft for them, and I made an arrangement.

The doctor arched his eyebrow, making his meaning clear. Uma-masi later confirmed that he had referred Chandrika-ben elsewhere for SD. Along with fulfilling a moral debt, the referral presumably assuaged the family's anger, helping restore Dr. Dilip's reputation within their wide social circle. Other doctors similarly admitted to committing "the small sin of pointing where to go" when faced with obligation, desperation, or persistence. Special circumstances could overcome practitioners' unwillingness to see or reveal.

Second-Trimester Abortion Requests and the Opacity of the Prior

Obstetricians found that avoiding the second stage of sex selection required greater vigilance. Whereas the selective intent behind SD requests was transparent, requests for selective abortion could arrive concealed as requests for routine abortion. The opacity of a family's prior activity forced clinicians to constantly apply a hermeneutics of suspicion, interpolating the possibility of prior SD onto every prospective second-trimester abortion. Doctors generally opted to steer clear of such abortions, with serious consequences for both selective reproduction and general abortion access.

One evening, a heavyset Rajput woman entered the Nandini consultory with her daughter-in-law, whose delicately embroidered sari completely covered her face. The older woman explained, "My daughter-in-law is pregnant. She doesn't want to keep it. She has been crying constantly for the past few days."

Dr. Dilip scowled when the mother-in-law said the pregnancy was already at three months. "How can it be," he asked, "that you realize only at three months that you don't want to keep it? How is that acceptable?" Raising her voice, the older woman objected that her daughter-in-law's period was irregular, but Dr. Dilip kept shaking his head: "How could she not know? How is that possible?"

The patient slid forward, adjusting her sari, but did not say anything. Groaning, the mother-in-law admitted, "Alright, we have to the tell the truth with you. We got the test done, and it's not good."

"Yes!" Dr. Dilip shouted sharply. "Then say that: 'We got the test done!'"

"But now, Saheb, we'll have to get rid of it somehow, right?"

The doctor shook his head vigorously and declared it "not possible here," to which the woman shook her head back and yelled, "For us, Saheb, you have to do it!" Dr. Dilip and the mother-in-law repeated these same words several times, their voices rising and running together.

Eventually, the woman softened her tone. "Saheb," she pleaded, "with you here for us, why would we have to go somewhere else?"

"Why don't you just get it done where you got the test done?"

"But Saheb, *you're* here, aren't you?"

Dr. Dilip scowled as he explained, "I have government problems. They come for inspection daily. I don't have the software, and still those uncles make their way here daily!" After a pause, he softened his expression and asked where they had obtained SD. Sighing in apparent resignation, the mother-in-law revealed that they had gone to Chetna. The doctor frowned: "Well, then it's certain. If it was someone else, I would still tell you that it might be wrong—that you should keep it. But his work is 100% accurate."

Now, it was Dr. Dilip's turn to sigh. He suggested a return to Chetna: "Join your hands in prayer and request him to do it for you as a package." The mother-in-law asked a few more questions—"Since she keeps having girls, is there any medication to have a boy?"—and the visit was over. The patient had not spoken a word.

The Rajput women's case raises two fundamental issues. One—the potential silencing of the pregnant woman's voice in sex selection processes—is a central concern of Chapter 4. Here, I analyze the other: how requests for selective abortion posed a different problematic than requests for fetal sexing.

Whereas an SD scan always had SD as its purpose, sex selection was but one use of second-trimester abortions. How, then, could doctors avoid inadvertent entanglement in selective reproduction? With disaggregation of SD and selective abortion possible, how could they be certain of avoiding elimination of a gendered fetal subject? Such concerns became especially consequential given the seeming nebulousness of local PCPNDT enforcement, which left unclear what legal consequences might attach to an unwitting sex-selective abortion.

Many doctors resolved the quandary as Dr. Dilip did, by providing abortions only in the first trimester; if fetal sex was still invisible by sonography, they reasoned, the abortion could not possibly be sex-motivated. One obstetrician explained:

> See, in the first trimester, it is their right. SD is impossible until twelve weeks, no?... Once it's the second trimester, if it's a normal pregnancy, I always say no. Because if they've kept the pregnancy for three months, it's always presumed—in 99% of cases, and unless and until otherwise proven—they've kept it to get the test done. Every woman knows when she gets pregnant. She doesn't want the pregnancy? She'll come within ten days—not at twelve weeks! At twelve weeks, you have to assume she's gotten it done....
>
> See, after three months, it's always a risky procedure—we're subject to government suspicion at any time. So I've just stopped. What am I going to lose? If it's a girl, the sex ratio will improve a bit. And if it's a boy, then that's their luck! What's it to me? I've developed this mentality: if they come after three months with a normal fetus, then assume they've gotten the test done and just say no.

Pragmatic legal considerations led most doctors to dismiss and curtail women's right to access abortion.

Feminist scholars have long observed how anti-sex selection activity can endanger the tenuous access emerging from the MTP Act's failure-of-contraception provision.[84] The refusals by Dr. Dilip and colleagues represent a realization of this threat. The impossibility of definitively seeing whether a patient had recently obtained SD, coupled with the pervasiveness of the practice, encouraged doctors to read "mal-intention" into every second-trimester abortion request—to adopt the reasoning that "if they come after three months, we know they have had SD done." Research elsewhere indicates that this is far from a locally isolated phenomenon.[85]

Mahesana-area doctors who still performed second-trimester abortions demanded a "good reason" or "clear indication" for doing so: "fetal anomaly," "hazard to the mother," miscarriage, or the like.[86] They often required "authentic proof"—either obvious signs of clinical emergency or a radiologist's report of sonographically diagnosed abnormality—"for our own safety, to keep a good reputation if there should be any government inquiry." As I discuss in Chapter 3, the fact that obstetricians considered miscarriage a reasonable basis for second-trimester abortion drove some women with "female" results to essentially stage emergencies by intentionally putting their bodies into precarious states.

Doctors' self-protective restriction of second-trimester abortion carried all-too-weighty consequences for women. In many cases, unwanted girls were born. In others, women visited unqualified abortionists, took abortifacient pills beyond the safe window for doing so, or staged bodily emergencies, assuming serious risks to eliminate daughters-to-be. Finally, in still other cases, the grave consequences of obstetricians' refusal had nothing to do with sex selection or unsafe abortion, and everything to do with the myriad circumstances under which women might desperately wish to end a pregnancy in the second trimester.[87] One obstetrician teared up as she told me a cautionary tale in her consultory, a sad smile running across her face:

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[84] Ganatra 2008; N. Menon 1995.

[85] A recent study from western Maharashtra—entitled "If a woman has even one abortion, I refuse to perform the abortion"—shows that uncertainty regarding PCPNDT enforcement actions has led doctors in multiple locales to deny abortions to women with daughters or second-trimester pregnancies, and professional organizations have even encouraged such denial (Potdar et al. 2015: 121-122, 123). Even more alarming, an unpublished field study from Maharashtra found that *public* health facilities were refusing to offer second-trimester abortion: "Members of the District Level MTP Committee said that most second trimester abortions are sex-selective, and as government officials they were responsible for not letting these happen. According to them, there was an informal understanding within public hospitals not to conduct any second trimester abortions. In some districts women were not only denied second trimester abortion but also tracked by health authorities till the time of their delivery" (cited in Ravindran and Khanna 2012: 12).

[86] Once again, the PCPNDT Act's legitimization of disability-selective abortion as a "use" of prenatal diagnostic technology set against the "misuse" apparent in sex-selective abortion (Ghai and Johri 2008) comes to the fore.

[87] A recent review notes that two national data sets concur in placing the proportion of second-trimester abortions in India just above ten percent of all abortions (Stillman et al. 2014: 17). Apart from sex selection, women may be especially likely to seek abortion later in pregnancy under circumstances of sexual abuse or incest; prior unsuccessful abortion attempts; adolescent, unmarried, widowed, or separated

> See, I avoid doing late MTP altogether, to stay away from all *that*. But I had one case—there was a woman, a widow. My patient for years. Extremely poor. She had a grown seventeen-year-old son, and she got pregnant. You understand? She was a widow, and she got pregnant. So she was in a very tricky situation. When she came to me, she was at twenty-four weeks. She said she wanted to get it taken out. I said, 'We don't do it.' She tried so hard to convince me! But since I just don't do it, what could I do? I told her she should inquire elsewhere; I wouldn't be able to do it. So she left.
>
> Four-five days later, I learned the woman's hut had burned down with her inside. So what happened? Someone killed her, or she killed herself—because of the pregnancy. So I feel—I keep thinking in my mind— what if I had done just this one?

Self-imposed bans on second-trimester abortion usually calcified in the manner implied by the doctor, with many obstetricians expressing the feeling that they had to "refuse everyone," lest "one patient tell two, and two tell four," producing an "inverted pyramid" of rumor that could harm one's reputation and produce increased patient pressure for late abortions. But a policy of categorical refusal, couched in terms of respect for a law aimed at saving women-to-be, often left clinicians unresponsive to conditions of life-and-death import for pregnant women.

Everyday Knowledge and the Sex Selection Landscape

The Tea Stall and the Circulation of Partial Knowledges

Chetna, Nandini, and most other clinics had at least one tea stall in the immediate vicinity. The stall was usually a cramped area, and numerous patrons crammed together and chatted while waiting for and sipping *cha*. The tea stall was a quintessential place of casual interaction and discourse—a site for generation and transmission of everyday knowledge about the sex selection market. It exemplified the social spaces—homes, clinics, and gathering places—where patients, relatives, and others circulated rumors, revealed the previously invisible, and cobbled together partial perspectives.

Although people often responded to my initial questions about selective reproduction with wariness and denialism, gradual insinuation into various literal and metaphorical tea stalls permitted me to piece together a map of the Mahesana sex selection market. Through conversations in these spaces, countless people brought me into confidence, imparting fragmentary knowledge while allowing me to interact with them as a member of a knowing public.[88] I immersed myself in the system, mimetically

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status; changing conditions of financial and familial stability; menopause or post-partum absence of periods; and limited access due to geographical distance, poverty, and limited decision-making power within the family (Dalvie 2008: 40-42; Stillman et al. 2014: 17; Zavier et al. 2012).

[88] In addition to providing substantive information about sex selection practitioners—names, notoriety, pricing, and methods—such conversations indexed complex relationships among doctors, patients,

following the paths that clients, connectors, and collaborators traversed in accessing sex selection services.[89]

Much knowledge of the landscape emerged from conversations with doctors and facilitators in their clinics and homes. Given their constant patient contact, many possessed a grounded sense of the black market's dynamics. Some information came to their attention when patients disclosed prior SD while requesting second opinions or selective abortions. Occasionally, clinicians could also draw inferences from observed patterns: an obstetrician might be providing sex selection services if his patients never came requesting SD, or if they frequently exhibited complications associated almost exclusively with second-trimester abortions. Dr. Dilip and Uma-masi could rattle off nearly a dozen local clinicians who continued to "check" and "cancel," and most doctors could name at least a few. Exchanges with practitioners therefore yielded partial knowledges of who, how, and how much.

Obstetricians seemed particularly eager to expose and denounce colleagues who ran major sex selection enterprises. Many named Dr. Ranjit as someone "who is doing a lot of these," with one's voice crescendoing to a bellow as he cried, "Everyone goes to Ranjit! People go from everywhere to that town—write it down, mark my words! Years ago, there was a dacoit born in Vijapur. After he was killed, Dr. Ganpat was born. He was born and finished off—story over. Now, a dacoit named Ranjit has been born!" Though seemingly invisible to official policing efforts, practitioners like Dr. Ranjit were all-too-visible to colleagues.

Of course, as invocation of the tea stall suggests, clinicians were not the only ones who possessed and shared fragmentary knowledge of the market. In fact, non-clinicians often spoke more openly: they were not direct subjects of government surveillance, and—in contrast to professional "insiders" in possession of specialized secrets—they could treat their knowledge as public information. Conversations with families in tea stalls, fields, and homes illuminated significant bits of the sex selection landscape. Clients were not the only ones to speak with confidence about who was and was not performing sex selection; pharmaceutical marketing representatives, sonography salespeople, journalists, a wealthy poultry farmer, and the boutique owner who tailored my wife's sari blouses could do so as well. Along with first- or second-hand experience, such people drew on widespread rumors that made various doctors' illegal activities publicly recognized. Given how such rumors circulated, the cynical saws generally proved true: "every rickshaw-wallah," "every *pān* parlour owner," and "every *cha*-wallah" could, indeed, "tell you who is checking."

From the everyday knowledge of clinics, homes, tea stalls, and various other spaces, I eventually stitched together a map of the sex selection landscape.

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connectors, and the state. Denial of a particular doctor's participation in the market, for instance, might reflect a factual state, but it might also reflect respect for the doctor, the speaker's obliviousness, or my status as an untrustworthy listener. Similarly, the reverse might suggest a negative view of the practitioner, the speaker's insider knowledge, or confidence in my trustworthiness. Moreover, claims about sex selection—who, how, and how much—also implied evaluations of the effectiveness and integrity of state regulations and the officials charged with enforcing them.

[89] Cf. Favret-Saada 1980, 2015.

Geographically, SD and selective abortion took place in places large and small throughout North Gujarat. Just as Ahmedabad families flocked to Chetna, many Mahesana-area families went to the megacity, where numerous enterprises flourished underground. District-level cities like Mahesana generally housed at least one large-scale practitioner, as did half the smaller towns in Mahesana District. Beyond geography, I learned about an array of characters: the "desperate" man, who performed SD for just 3,000 rupees because "he has no other business"; the "silent killer," who "takes very selectively, only two-three every month" but "makes a hefty pile" on those cases by charging 25,000 rupees; the former MOGS office-bearer who was clandestinely providing the services he had publicly denounced; the senior doctor who conducted multiple SD scans per day while complaining to anyone who would listen about Dr. Ranjit's "boldness"; and the woman who refused to disclose sex with female fetuses, but revealed it with males "so as not to lose the patient." Like Dr. Ranjit, most providers charged roughly 10,000 rupees for each stage of sex selection, albeit with considerable variation by clinic and client.

The distribution of clinicians in the market was such that that those foreswearing sex selection outnumbered those dabbling in it "here and there," who in turn outnumbered large-scale practitioners. In the space between abstainers like Dr. Dilip and "professional" providers like Dr. Ranjit, some obstetricians offered the service selectively, "taking care of" friends, relatives, and longstanding patients. Several doctors echoed Uma-masi's former referral partner Dr. Vinay, who casually told me with an upturned palm, "Of course people are doing it secretly! And that's not something that can be caught. I do it for my close patients, the longstanding ones, and it never gets out—no one objects. The problem is the people who do it on a large scale. As long as I do it for my own patients, the information doesn't get out." Thickness of social connection fostered faith in discretion.

I also found that the accumulating information placed me in a logistically, ethically, and legally vexing position. I carried around dangerous knowledge and, unlike my tea stall interlocutors, had to ensure it all remained confidential. Dr. Dilip joked that I had to "be like Sahadev," invoking a mythological character who possessed full knowledge of the future but was barred, on pain of death, from disclosing any of it. I learned to code, conceal, and selectively reveal my knowledge when speaking with Uma-masi in the presence of others, dispensing almost entirely with precise referents—only "that work," "over there," "that other saheb." In exchanges with providers, I learned to carefully calibrate my discretion, flashing shared prior knowledge to solicit greater comfort and openness without inadvertently disclosing new information.[90] I had to

[90] I was operating in a mode of discretion strikingly similar to that which Lilith Mahmud has described in reflecting on fieldwork among Italian Freemasons:

> Esoteric teachings are reserved for the initiated, and most of my informants never openly discussed with me the contents of that knowledge... At times, however, my interlocutors would make a small reference or comment that would prompt me to inquire about... esoteric practices—and most of the time they would answer me, if only vaguely... As exceptions increased with time, along with our sense of intimacy, I found that most Freemasons were generally comfortable talking with me about esotericism, as long as I could demonstrate some prior knowledge. What seemed to worry most of my

demonstrate my initiation very carefully: perform insider knowledge too hastily, and I might end up violating someone's confidentiality. It was the situation in which "the ethnographer has become a ritual extension of that which he studies," constantly perseverating over the question of "who knows what and how much... in this maze of deceit."[91]

Notoriety: Dr. Navin

Within the Mahesana-area sex selection landscape, one name circulated most prominently in clinical exchanges, neighborhood gossip, tea stall chats, and surreptitious phone conversations. Far outstripping Dr. Ranjit and every other practitioner, Dr. Navin was a near-mythical figure in local discourse. When obstetricians stated that "some people in Mahesana are doing huge practice" or that "everyone—even the government—knows who is doing it," they were inevitably referring to him. Any local facilitator could tell several stories about his brazenness and naked avarice. Government officials, from community health workers to the CDHO himself, grudgingly acknowledged the audacity of Dr. Navin's practice and the difficulty of apprehending him. And countless patients, relatives, and other community members pointed to him as a stand-in for sex selection as a whole. He was the illustration *par excellence* of selective reproduction's status as nominally forbidden and practically pervasive.

Dr. Navin operated out of a nondescript clinic in Mahesana city. I first heard mention of him from Uma-masi and other connectors, who harshly criticized his personality and behavior: "He's no better than a dog!" "He makes you put your mobile phone outside, all your stuff outside." "Navin-bhai is so lowly! He just takes everyone's money. You have to put the notes—25,000—on the table first!" According to the connectors, Dr. Navin's reputation and seeming immunity empowered him to demand high prices and maltreat patients without fearing apprehension or loss of practice.

I learned much more one day at the tea stall near Nandini. I was sitting with Sagar-bhai, a local medical supplies distributor whose wife had undergone SD and selective abortion with Dr. Navin. As we waited for *cha*, Sagar-bhai discussed their experience, which I examine in Chapter 2. At one point, he said:

> interlocutors was that that they might violate their oath by divulging esoteric secrets to a profane like me. If I could prove, however, that I was already somewhat informed about an esoteric topic, most Freemasons were typically willing to discuss it further with me. I therefore spent a lot of my time reading esoteric books, following up on clues, keywords, or strange phrases that I heard in conversation (2012: 422-423).

While not a formal society with officially coded "secrets," the Mahesana-area obstetric fraternity did mark out a certain collegial space.

[91] M. Taussig 1999: 121, 203. Occasionally, entanglement posed more obvious conundrums for me. Twice, Uma-masi asked me, for reasons of convenience, to take clients to Chetna for her—to "help me out by doing my work today." The first time it happened, I panicked and made an excuse to remain at home, forcing her to postpone the visit. The second time, I bluntly said I could not—would not—and braced for her anger. Instead, she smiled and acknowledged my refusal with a casual wave before moving on to an accounting of her recent earnings. Similarly, families I met at Chetna sometimes called me months later to request Dr. Ranjit's name, phone number, and address so that they might take "a ben who needs to get a check." I always deflected such inquiries, suggesting they contact their original referrer, and inevitably felt uneasy as I hung up.

> See, all Navin-bhai cares about is money. And looking is the only thing he does! He does less deliveries, surgeries, things like that... Once he's done with outpatient visits, time to go home! He closes up the hospital. Not like Dilip-bhai, who might be there all night. Navin-bhai makes plenty of money during the day, so why come running at night?
>
> At his clinic, you have to put the money on the table first! Otherwise, he assumes you might be linked with Health. Even with me—even though I knew him—he made us put the money on the table before doing anything!
>
> His is a huge operation. If you don't have a connection, it might cost you 25,000! He charged us only 10,000, because he knew me. But with VIP patients, or those who don't know better, he may even take 50,000! That's just for looking—if it's a girl and you have to do something, that's separate.

The first-hand account corroborated facilitators' portrait of a ruthlessly pragmatic earner.

I visited Dr. Navin's clinic toward the end of fieldwork, having delayed the trip after multiple colleagues warned (perhaps overly cautiously) that a meeting with him might set in motion forces—powerful forces—that could jeopardize my work and safety. The waiting room contained the PCPNDT-mandated sign publicizing that SD was a crime. The compounder withdrew to inform the doctor of my presence. On returning, he instructed, "Put down your mobile and everything else." I emptied my pockets onto a bench. As I started toward the consultory, the man suddenly asked, "Did you put down your phone?" I ran back and lifted my notebook to show that the potential recording device was safely outside. He nodded—"Yes, yes, okay"—and sent me back.

Inside, I finally saw Dr. Navin. He was aimlessly shuffling a few pharmaceutical advertisement cards on his desk. Reiterating that I wanted to speak privately, I asked whether to close the door. He shook his hand casually and laughed, "No, no. There's no need here. You can say whatever you like." I explained my research purpose, and the conversation was essentially over before it began. Dr. Navin sharply insisted he had "no interest in academic things" and suggested I leave. Once I got up, he rambled for several minutes about his "hate for research," one eyelid periodically twitching. Then, putting his hand on my back, he pushed me toward the door. After stepping out, picking up my belongings, and nodding toward the compounder, I departed, having received the harshest—and last—response of my research.

By the time I visited Dr. Navin, I had also heard much about him from colleagues. Almost every local obstetrician condemned him, whether obliquely or by name. Doctors spoke of him with a combination of wonder at the "fantastic amount" he earned and disdain for his "exclusive" practice of sex selection, which had allegedly made him so "single-minded" that he felt "afraid" of Caesareans, routine surgeries, and other fundamental obstetric-gynecologic procedures. Several speculated that he earned several million rupees per month—"a multiple of regular clinic income!"

Colleagues also expressed marked frustration at the persistence of Dr. Navin's practice. Several recounted a recent MOGS meeting in which he "was told to stop on behalf of all the doctors"; an officeholder in the society "even named him and made him stand up, and everyone said, you stop, because we are being harassed on account of you!" In response, "he threw a fit and started crying—what an actor!—'Yes, I am doing! But because I see the difficulties with girls in my extended family, I feel *pity* for people. That's why I do it. I understand the difficulties that a father of two girls experiences.'" Dr. Navin allegedly continued, "'I have so many household costs, and I have to gather this much cash, and I have to do this practice compulsorily!'" According to one doctor's recollection, "after admitting to doing it, he said, 'Others are doing too, including some of the bigwigs,' and started naming names."

Recollections of Dr. Navin's intransigence in professional meetings dovetailed with a suspicion that strategic bribes had made government officials willing to un-see his enterprise:

- "Why don't they ever check the scoundrel who is doing it?"
- "He has become confident. Everyone knows—the Collector, the CDHO, everyone—but nothing has been done. Maybe if a Delhi team comes. Otherwise, with millions in business a month, so what if he has to hand over 500,000 for corruption? He does it openly!"
- "Navin-bhai must have a setting—an understanding, an arrangement—with someone in the Health Department. He must be giving them money. Otherwise, how could he do it so boldly? How could it be that no one knows? He can do this much only if he has arranged something beforehand."
- "The government is not sincere… See, if any *cha-wallah* is knowing where SD is being done, then naturally, government machinery must be knowing!"

Such allegations fit into a broader sense, shared by doctors and patients, that the PCPNDT Act was vitiated by bribery. Notorious practitioners remained safe even as government officials painstakingly scrutinized others' clinical records for supposed proxy markers of criminal activity. Corruption seemed the only plausible explanation for how a practice so visible in everyday life—in the knowledge of tea stall and consultory, household and village plaza—could remain invisible to the state gaze.

Vectors of Blame

The persistence and prevalence of sex selection in Mahesana posed a troubling question for the various actors with whom I spoke: Who was really culpable? Technology? Biomedical practitioners? Clients and the communities to which they belonged? Or an ineffectual state?[92]

[92] In tracing "vectors of blame," I am undertaking a project akin to Sundar's "anthropology of culpability," which takes culpability as "guilt in a larger moral, and not merely legal sense" and seeks to "understand

Many observers endorsed some form of technological determinism when discussing sex selection in general terms, at some remove from the practice itself.[93] By contrast, in more embedded reflections, doctors, reproducing families, and the government officials charged with controlling them typically subordinated technology's key role to a more expansive moral world. Vectors of blame enunciated by these actors tended to alight on people (Figure 1). For instance, women and their relatives frequently remarked that "all this trouble started when sonography arrived, because in today's era, you have to get this done," but such statements primarily periodized, identifying a specific moment of technological possibility as the background for more proximal deliberations—social, economic, moral—around SD. Similarly, obstetricians almost universally ascribed responsibility for sex selection to colleagues, clients, or government officials. Many echoed a senior doctor who said:

> Once the technology was developed, this social problem became very profound. Take atomic energy—you can use it two ways. You can put it in a reactor and generate energy, and you can make a bomb—you can make Hiroshima-Nagasaki. It's a matter of who's using it, and how. Technology

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when and how and to what extent people become culpable for acts of violence they have committed or that are committed in their name—while at the same time exploring the inequalities in attributions of culpability that are an essential part of the new world order" (2004: 145). Like Sundar, I am interested in overcoming culturalist explanations of violence, understanding how state formations mask their own complicity in violent processes, and recovering how states may nonetheless become targets of blame.

[93] In invoking "technological determinism," I am referring to a set of explanatory discourses that concretize "a vivide sense of the efficacy of technology as a driving force of history: a technical innovation suddenly appears and causes important things to happen" (Marx and Smith 1994: x). In such narratives, "the thingness or tangibility of mechanical devices—their accessibility via sense perception—helps to create a sense of causal efficacy made visible," such that "'technology,' or a surrogate like 'the machine,' is made the subject of an active predicate," producing a "situation of inescapable necessity" (Marx and Smith 1994: xi, xii). Elaborating on this description, Marx notes:

> The chief hazard attributable to the concept of *technology*, as currently used, is the mystification, passivity, and fatalism it helps to engender... Although we cannot say exactly what that "it" really is, it nonetheless serves as a surrogate agent, as well as a mask, for the human actors actually responsible for the developments in question. Because of its peculiar susceptibility to reification, to being endowed with the magical power of an autonomous entity, technology is a major contributant to that gathering sense... of political impotence. By attributing autonomy and agency to technology, we make ourselves vulnerable to feeling that our collective life in society is uncontrollable (1997: 984).

More recently, Dafoe (2015) has argued for a recuperation of technological determinism as one pole of an explanatory spectrum also encompassing social constructivism, helpfully pointing out that that the approach may provide complementary analyses of social change at more macrosocial or emergent levels.

While mindful of Dafoe's corrective to blanket rejection of technological determinism, I focus on more experience-near explanations for two reasons. First, these were the ones most vividly invoked by the people with whom I spoke. And second, given the plethora of technological determinist explanations already in circulation in activist, governmental, academic, and media discourses about sex selection, I believe the granular perspective, examining how people embrace, reject, and otherwise contend with technology, provides a valuable corrective.

> is a weapon, made by man; it's his slave. It'll do whatever you tell it. And if you misuse that technology, sooner or later it'll burn you up.

Doctors tended to echo the law in neatly distinguishing "use" of ultrasound for "life-saving," "routine," or "fetal wellbeing" purposes from "misuse," with SD definitively placed outside the realm of "good practice." Several older practitioners said they had come to terms with ceasing SD by imagining it as a return to the earlier part of their careers, "when the technology was not there, and this was simply not a part of our earning"; in claiming this, they simultaneously acknowledged and denied the profound shift in expectations and possibilities that ultrasound technology had inaugurated.

Most obstetricians who had foresworn sex selection directed blame toward colleagues like Dr. Navin and Dr. Ranjit, whom they described as "greedy," "shameless," "unconcerned about reputation," "unethical," "criminal-minded," and "fearless." As long as such doctors provided services "openly" or "on a large scale," they said, sex selection would continue unchecked.

Collegial condemnation of practitioners consistently dovetailed with critique of an ineffectual state. One Unjha doctor pithily encapsulated such critique when he said any government body "failing as completely" as the Health Department was with PCPNDT enforcement "must be either inefficient, ignorant, or corrupt." On the matter of "inefficiency," doctors decried recordkeeping requirements as burdensome and useless, noting, "Where is it written that by mandating filling of Form F, you automatically stop SD?" According to clinicians, implementation efforts could better fulfill the PCPNDT Act's aims by reducing emphasis on paperwork and increasing emphasis on stings[94]—after all, what better way to stop the "large-scale criminals" and create a "deterrent effect" than to "knock down two-three" by catching them "red-handed"? Official "ignorance" was not a plausible excuse for inaction, given that the identities of sex selection providers were common knowledge. Many doctors explained persistent inefficiency amid the impossibility of ignorance by invoking the third option—"corruption." They murmured about bribes performing a "compensating" or "balancing" function between practitioners like Dr. Navin and the government officials tasked with monitoring them.

But most obstetricians also expressed a more fundamental critique of local reproductive governance, one that shifted blame from the state and colleagues toward "the public." Why, doctors asked, did the government focus so heavily on the supply of sex selection services, rather than tackling the demand for them?

One afternoon at Chetna, Dr. Ranjit passed me his phone and snorted, "Read this! It is for your topic." Looking at the screen, I saw a new message in his medical school class's Whatsapp messaging thread—a poem, attributed to a Maharashtra obstetrician. It read:

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[94] For early and recent echoes of this complaint regarding paperwork, see Joseph and CYDA (2007: 40-43) and Potdar et al. (2015: 119-120).

I am an Ultrasonologist,
Trained to help mothers know their baby is fine
That's all that is my concern,
Why should I be the one to pay the fine?

I don't have to raise your daughter,
I don't have to pay her fees,
I'm not the one who needs to raise her dowry,
It's not my job for her in-laws to please.

Neither is your son going take care for me,
When I am old and lame,
Nor is he going to carry forward,
My family name.

Why in the world would it matter to me,
Whether you have a daughter or son,
It is YOU who want to know,
Unless you ask, my interest is none!

And if I don't tell you,
You'll take the poor girl to some one,
Who is less trained or maybe a quack,
Her life is at stake for that much desired son!

So who is at fault here?
Me or your male chauvinism?
Then why is it that I am criminalized,
While you are having all the fun!

Wake up you murderers,
It's time you realized,
Don't ask us for the child's gender,
A daughter is more prized.

So allow us to do our job,
Helping mothers and babies...
Don't blame an entire nation's convoluted mentality
On us Ultrasonologists...

The message, which circulated widely among local obstetricians, captured a sentiment that Dr. Ranjit later voiced during our last meeting: "Actually, this is a social issue only. And only society has a solution—rather than doctors and government."

Characterization of sex selection as primarily a "demand problem"—a move that bracketed the role of clinicians and their technological property in creating possibilities for selective reproduction—was common among obstetricians. For example, Uma-masi's abortion referral partner Dr. Harnish told me:

> Instead of just doctors, you should focus on the public in your study... If you ask why doctors do it—well it's obviously for money, right? What else is there? It's a simple thing. Doctors do SD and MTP for money. What the patient's demand is—*that's* what you should ask.
>
> See, the law says you should get abortion without knowing sex. But the person having a need will say, this is my need!... Until that mentality is banished from the public, this supply-demand question will remain. Only when that issue ceases will the wish to see sex in sonography cease. Then, if people come to me for sonography, they will only look at whether the child is good or not, because that's the only thing they need... If this thing is banished from society, then there's no need for the law... Demand is the main thing.

In this view, clinicians' participation in sex selection boiled down to a simple economic act, and the thorny issues lay in the household and the community.

Placement of blame on "demand" implied, as a straightforward corollary, critique of government activity as overly focused on "supply." For example, one doctor said:

> The thing with this law is that our government prefers soft targets. If you want to really stop this practice, you have to educate the public, change attitudes, raise awareness—you have to intervene on tens of millions of people. But how many sonologists are there in all India? Maybe 40,000 gynies, and add in 10,000 radiologists—so 50,000. The problem is everyone's, but if you control this many people, everything will supposedly stop.

Numerous doctors lamented the fact that because "demand is mass population, while supply is only doctors," the latter became the "sole target of authority." Advocating a shift toward "highlighting the public," they called for "trapping" clients in stings and "bringing the law down on families." They noted that while the PCPNDT Act included provisions for prosecuting patient relatives, no such proceedings had ever been initiated in Gujarat.

Many doctors linked blame of the "public" and the state with a call to recognize and change the social factors that contributed to sex selection. They suggested transforming people's "mindset," "mentality," or "thoughts" regarding gender by raising "education," "awareness," and "understanding that the female is just as necessary a part of our society." In this view, pure supply-side regulation would prove meaningless without social transformation. As one doctor put it, invoking Gujarat's notoriously ineffective Prohibition: "Wherever there are alcoholics, there will be alcohol."

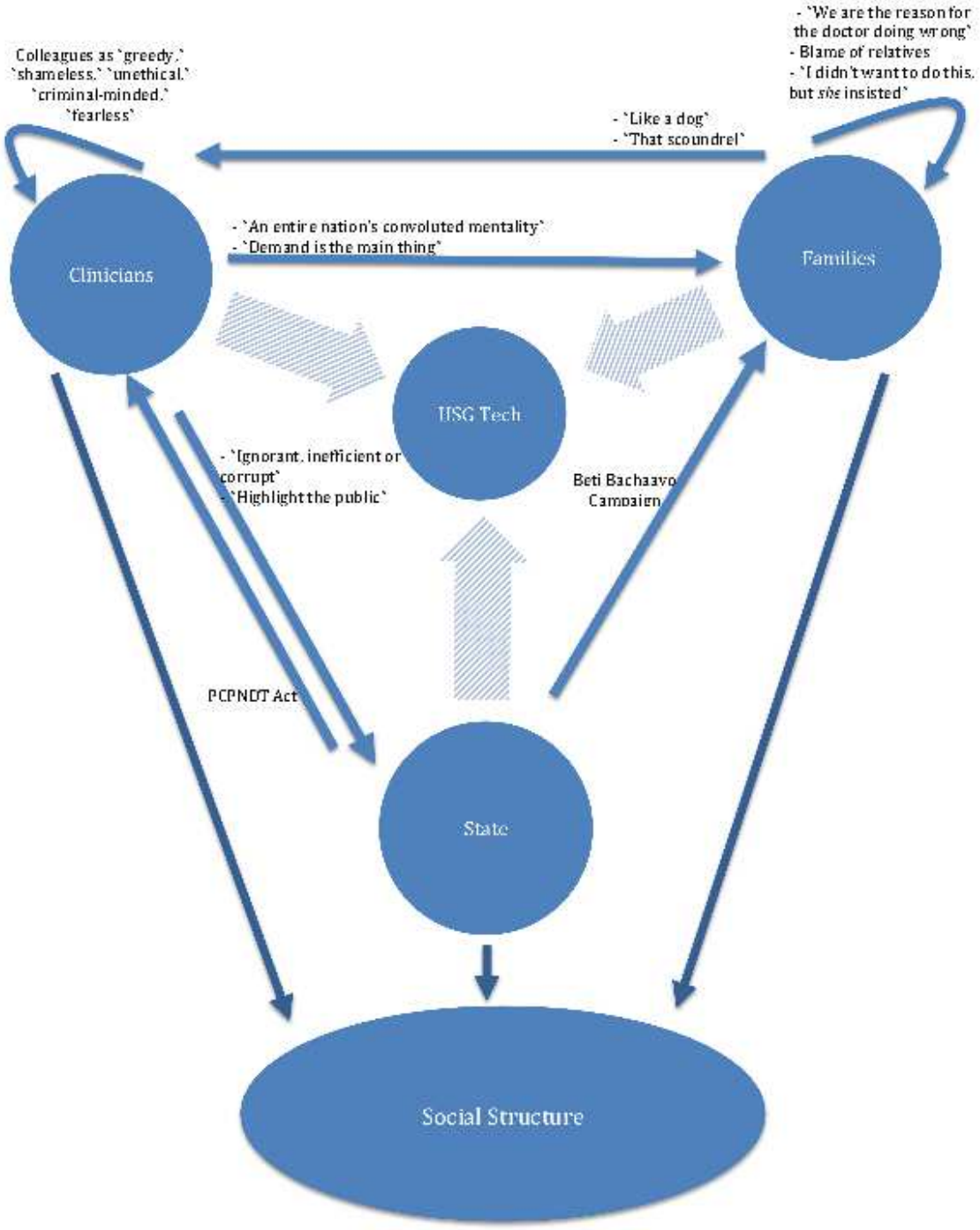
For their part, the state officials and activists with whom I spoke fully endorsed the importance of reducing demand for sex selection. Variously faulting "the public," "patients," "families," and "social structure," they recognized the need to couple PCPNDT enforcement with efforts to promote a different valuation of potential daughters. Their demand-side interventions form the heart of Chapter 8.

And what of "the public"—the families that sought sex selection? Like doctors, who drew vectors of blame to their own colleagues, women and relatives tended to ascribe responsibility for sex selection to themselves, or at least to others within the family. For instance, Ishwar-bhai—the teacher who lamented the 25,000-rupee cost of sex selection at Chetna—muttered while waiting for his wife to emerge from anesthesia, "This is us speaking the language of money. If you look at it, it's really one kind of corruption. *We* are the reason for the doctor doing wrong. We are making him weak. How? By asking him to look at it for money." Of course, not every client accepted culpability equally. Family members sometimes blamed women who insisted on pursuing sex selection, and women forced to endure the ordeal faulted the coercive relatives and complicit doctors. Yet even when people refused responsibility personally, their posited vectors of blame generally landed on someone in the family. I return to intra-familial accusations in Chapter 4, and to the anguish of self-blame at the end of Chapter 5.

But women and relatives did not blame solely themselves. Families seeking sex selection frequently explained their motives by pointing to the crushing force of gender-kinship arrangements that stretched well beyond the household. They identified various structural exigencies—sometimes explicitly identified as "social structure" or "society's rules"—that disadvantaged sonless families with multiple daughters. These exigencies made sex selection appear as a rational, tragically pragmatic choice, and families pursuing the practice tended to critique the state not for the ineffectuality of its prohibition, but for that prohibition's seeming indifference to the difficulties that compelled ordinary people to seek SD and selective abortion.

What, then, were the components of social demand for selective reproduction? How did women and their relatives come to see sex selection as an obvious, common-sense choice? What elements of the moral economy of gender-kinship drove differential valuation of sons and daughters? What, in short, made male and female potentiality manifestly unequal?

Figure 1 – Vectors of Blame Around Sex Selection



Chapter 2: The Moral Economy of Gender-Kinship

> *A: A daughter has more affection for her parents... Girls have more affection... A son should be there as a lamp, a creeper plant. There is expansion when a son is there.*
> *Q: What is the meaning of 'expansion'?*
> *A: He gets married, gets children, as the creeper grows. The girl goes out, if there is no son, what remains? Nothing. The house is locked and deserted. Who will be there? The daughter goes away, then who remains? A boy is the light of the family.*
> *Q: Does it mean that a girl is like darkness?*
> *A: Darkness. A girl is like the shade of a tamarind tree, a boy is like that of a mango tree. Mango is sweet and tamarind is sour...*
> *Q: But do you agree with these thoughts and beliefs about a girls and a boy?*
> *A: Yes, I do.*
> *Q: But don't you think that these belittle a girl? Seeing the girl as an outsider, a tamarind tree and so on? What does she lack for her to be considered of less importance?*
> *A: She belongs to others, she is not ours.*
> *Q: Why doesn't she have anything of her own?*
> *A: She doesn't have anything. Who is going to give her any land or property?...*
> *Q: Do you think it should be changed?*
> *A: How does it matter how I feel it or how you feel? The entire system should change... If I alone feel that, will they agree?*[1]
>
> — From Sharmila Joshi's "Interview with Satyabhama 'Nani' Lawand"

"A Necessary Sin"

One monsoon morning, I caught a rickshaw shuttle from Mahesana toward Patan. My destination was a village between the two cities, home to Nandini Clinic patient Viral-ben and her mother-in-law, Gita-masi. Uma-masi and Dr. Dilip had introduced us two days earlier, and they had invited me to visit to "chat about our experience."

[1] Sharmila Joshi 2008: 89-90.

The built environment soon gave way to trees and vast stretches of fields. Everything became highway, greenery, gray sky, and drizzle.

After half an hour, I stepped out into a thicket of trucks, buses, cars, motorcycles, mopeds, bullock carts, and people—the village's main intersection. Asking my way, I walked down twisting, muddy roads past wooden houses, tiny shops, and the occasional temple to arrive at a cluster of concrete-and-brick houses.

Gita-masi's house stood at one corner of the neighborhood. She, Viral-ben, and both young granddaughters were sitting on cots in the patio area. Greeting me with smiles, they ushered me into a plastic chair.

Squeezing her five-year old, Viral-ben proudly reported they had placed her in preschool. They were also paying a college student from the neighborhood 100 rupees monthly to give her basic "tuition." She named animals in Gujarati, cajoling the girl to repeat them in English: "Dog!... Cat!... Lizar!... Onkey!" Although the words themselves were foreign to the mother, she valued them as marks of her daughter's brightness and upward mobility. Over the ensuing months, Gita-masi and Viral-ben would elicit countless similar demonstrations of the young girl's educational prowess.

Before I even settled in fully, Gita-masi said, "You can ask whatever you want about checking!" Alarmed, I looked around and leaned forward. She laughed. "There's no problem. Who's listening? The government's not here, right?" I slowly relaxed my body. In everyday domestic spaces, talk of sex selection was hardly forbidden.

As I asked questions, the women narrated their experience. Viral-ben had become pregnant six months earlier. With two young children, she and her husband wanted to abort the pregnancy straightaway, but Gita-masi had suggested they instead wait some months: why "commit the sin of getting it taken out" if God might bestow a son? Given the limited income from the son's job as a shipping clerk and Gita-masi's farming on a meager plot of land, they had deemed the prices around Mahesana too steep and made inquiries with relatives elsewhere. Gita-masi's niece had found an obstetrician willing to perform the scan for 5,000 rupees. (From the name, I recognized the doctor as a leading figure of the Surat medical community.) After a quick scan, he had offered congratulations: "It's a boy! But don't tell anybody you came here."

By this point in the story, a crowd had gathered. One by one, a dozen young and middle-aged women from neighboring houses had trickled in and taken seats on the tiled patio. They nodded along as Gita-masi and Viral-ben narrated details they already knew.

After concluding the story, the two women introduced me to the crowd as a researcher from the U.S., visiting to "gather some experiences about getting it looked at." Upon explaining my study, I encountered immediate wariness. Some of the women laughed sardonically, while others asked pointed questions: "How do we know you're not going to cause problems for us?... With all the government checking, how can we trust anyone?" My reassurances regarding confidentiality protocols rang hollow, with many women murmuring, "How would we know about that?"

At that point, I stepped out of my chair and sat, cross-legged, on the floor. Gita-masi objected loudly, and several of the neighbors laughed awkwardly. But I insisted on remaining on the ground with them, and the dynamics shifted—tacitly and decisively. Finding me at their eye level, the neighbors grudgingly and then animatedly began

narrating known experiences with SD and selective abortion. Over the ensuing months, gossip-on-the-ground remained our standard interactional mode.

One woman declared, "My daughter-in-law's pregnant right now. If she has a girl, we'll have to get it checked next time." Before I could ask, the group generalized a pattern I would hear, nearly verbatim, hundreds of times: "Yes, yes. No one gets it checked in the first one. Whatever God gives... And even in the second, not with a firstborn boy... People check only after two daughters—maybe one." The women listed off neighbors and other villagers who had recently pursued SD or selective abortion. In some cases, they could recount in great detail when, how, for how much, and with what complications. Several cited instances of relatives who bore known girls because of a desire to avoid sinning.

At some point, a middle-aged man sauntered over, looked around quizzically, and asked his wife what was happening. After she explained I had come to "ask about pregnancy experiences," the man continued listening for a bit. Then he walked away, snorting, "What is there to listen to in all this lady-talk?"

During many subsequent visits, the men of the neighborhood hardly paid me mind. As we became closer, Gita-masi intimated that they thought me "not right" for sitting with women all the time. Given the group setting, they did not interpret my behavior as sexually threatening; rather, they considered me emasculated by "being so interested in this kind of talk." But as on that first day, the women consistently took it upon themselves to educate me and dispel my naiveté. "Even if you know your doctor stuff," they would tell me with a laugh, "we can teach you *our* stuff."

An hour into that first conversation, and with some goading from others, Gita-masi's next-door neighbor—initially the wariest of all—related her daughter's story:

> My daughter has a six-year-old girl. And after that, she got it checked and taken out twice. The first time, Dilip-saheb looked and did the taking out. I saw the child after it came out, and—oh!—how I cried. The second time, she got both things with Dr. Ganpat-bhai, but he didn't do it right. There was something left inside. She had bleeding and became so weak. Dilip-saheb had to clean out her uterus. I went to visit her in the hospital then, too. This ruins the body, but the doctor's not responsible, because we asked him to do something illegal.
>
> Honestly, it's hard to watch all this. I say she should accept whatever now, but she doesn't want another girl. Even her in-laws don't care! But she wants a son. And her daughter keeps asking for a brother, like all the other girls have.

The neighbor asked if I knew of medications to ensure a boy; I admitted I did not. Another woman suggested to "not even get it checked this time—just accept whatever it is." The neighbor smiled ruefully.

As if on cue, the neighbor's daughter appeared from next-door with a young girl in tow. Introducing herself and her daughter, she explained that they were visiting from Mahesana, where her husband co-owned a small electronics shop with his brother.

Pushing the girl toward me, she bragged about her intelligence and strong performance in kindergarten, rattling off the accolades from her teacher's reports.

Then, upon learning my research topic from her mother, she shook her head and renarrated her story. Hugging her daughter, she explained, "I'm tired of all this sin. But there's no point in gathering too many girls."

The others grunted and nodded in unison, setting off an animated discussion of reasons for "getting it looked at." For the next half hour, many statements from the group focused on the reasons for wanting a son: "He carries on our lineage... Our home remains open. Even after death, our name remains... And that way, your daughters have a place to go from their husband's home. A daughter needs someone to give her support... People have a bad habit of gossiping if you don't have a son. They say your house is *barren*... Also, in old age, our son is a staff—the son and daughter-in-law take care of us." Several women interjected that "there's no guarantee any more"—that many sons and daughters-in-law refused to care for aged parents, and that some even stuck them in "old age homes"; no one personally knew any cases like the latter, but "you hear about it all the time—in the paper, on TV." But caveats regarding the dominant reasoning circled back to the same refrain: "Still, with a son, you have the *hope*."

In contrast, "you can't expect anything from a girl, because she has to go care for her in-laws." The next-door neighbor's daughter explained:

> After marriage, a daughter becomes an outsider. And it takes lots of hard work to raise even one to that point! We have to feed her, clothe her, educate her, teach her housework, teach her how to speak politely to her in-laws, give her good *sanskār* [culture, manners] so she maintains our family's honor before and after marrying.
>
> And in this *jamāno* [era], these bad times, do you know how hard it is to take care of girls? They are so forward! We have to make sure she doesn't do any *bad deeds*—you understand me? Many girls get involved with boys while in school! After marriage, too—her husband may have vices. Drinking, gambling, affairs—all those things have increased. Then he may hit her, or even kick her out! What'll you do then? You have to witness your daughter's unhappiness. Even if he's good, what if her in-laws treat her poorly? After sending her to her husband's home, it's a matter of luck.

Murmuring assent, others cited corroborating examples: women stuck in downwardly mobile trajectories because of husbands' improvidence, girls tarnished by public gossip about college dalliances, acquaintances harassed into nervous breakdowns by mothers-in-law, and so on.

The women noted that times were changing rapidly, and that girls now attended college and even worked professionally. They quickly added, however, that many "abuse this, and stray onto the wrong path."

Eventually, the other women dispersed for lunch. Nodding toward the next-door house, Viral-ben muttered, "Watch, she says she wants to stop. But as soon as she's pregnant, she'll go get it looked at!"

Gita-masi snorted in agreement. Then she added, "But in this *jamāno* of high costs, who'll have more than one girl? Food, clothing, transport—everything's so expensive! Who can afford more than two kids?" Viral-ben groaned in agreement.

"In the old *jamāno*," Gita-masi told me, "people had four-five kids, no problem." She had borne four daughters before having a son and finally undergoing "the operation"—tubal ligation. Viral-ben was also one among four sisters with a youngest brother. "Now," Gita-masi said, "no one'll gather that many. Two—at most three. In this pricy *jamāno*, no one can afford it." Nodding toward her older granddaughter, she chuckled, "The girls in this era, they demand so much! Packets of Kurkure and wafers, Cadbury and Fanta. With that, and the cost of education rising, how can you take care of them? And the *jamāno* is *bad*—that too."

When we sat down to lunch shortly thereafter, Gita-masi mused, "It's good we got a good result. I didn't want us to accrue sin. Some people say it becomes living at three months, but that's wrong! The life's in it from the beginning." Viral-ben nodded along.

"But if it was a girl," Gita-masi said matter-of-factly, "we would've gotten it out." Viral-ben repeated the words.

"What about it being a sin?" I asked.

Gita-masi practically shouted her answer: "We would've had to do some penance, but we would've had to get it done! It's a sin. But it's a necessary sin."

*

Viral-ben, her neighbor's daughter, and countless others sought SD on the basis of certain imaginings. Reciprocally, they interpreted the clinical practice's results through those imaginings. This chapter examines the gender-kinship logics that made selective reproduction so desirable. Put differently, what was the necessity of the necessary sin? (Its sinfulness is discussed in Chapter 5.) In what follows, I outline the Mahesana region's moral economy of gender-kinship—a system that subjected male and female bodies to over-determining affective dichotomies: necessity-dispensability, desire-aversion, possession-alienation, hope-fear, security-danger, continuity-rupture, self-other, and reciprocated care versus unreciprocated care.

In qualitative research on sex selection in India, the phenomenon's familial and community-level causes may be its most thoroughly analyzed. For instance, Mary John and colleagues have offered a practice theory analysis of continuities, changes, and contradictions in the gender-kinship practices driving sex selection across northwestern India, ultimately concluding:

> Unintended consequences of contemporary social processes, when combined with parental fears of the unattached sexuality of adult daughters in a context of a highly competitive and differentiated marriage market, are compounding the sense of burden represented by the birth of a daughter. She now requires many more years at home with higher

> investments in nutrition, health and education. Parental responsibility continues to rest on ensuring a 'good' marriage, which takes her away from them, even though this does not necessarily represent the end of their responsibilities. Sons, on the other hand, embody a range of ritual and economic roles. If the current climate of economic volatility and masculine anomie makes them often fall short of expectations, nonetheless, at least one is essential for the future of the family.[2]

"It is this conjuncture," they conclude, "that is producing a falling child sex ratio."[3]

Among other studies, Sunil Khanna has connected sex-selective family planning to changing political economy in periurban Delhi,[4] while Navtej Purewal has discursively deconstructed Punjabi ideologies of son preference.[5] Mattias Larsen has identified two distinct pathways to skewed sex ratios (SRs) amid rapid economic transformation in Himachal Pradesh: changes in intergenerational authority structures, or dowry in the absence of women's empowerment.[6] Numerous essays have also situated sex selection vis-a-vis some combination of patrilineal ideology, marriage practice, domestic hierarchy, and economic change.[7]

This body of research meticulously excavates the gender-kinship norms and practices underlying sex selection, often contextualizing them within broader economic changes. Moreover, it dovetails with vast ethnographic literatures on valorization of sons over daughters in Hindu patrilineal settings[8] and on more general gender inequality in such settings.[9] The purpose of this chapter is not to retread the existing work on causes of sex selection, or on Indian gender inequality more generally. Instead, I aim to show how such causes manifested in the concrete experiences of people pursuing, practicing, and evaluating selective reproduction.

In discussing the reasons for sex selection, people around Mahesana often oscillated—as Gita-masi, Viral-ben, and their neighbors did—between a *first-person* voice that expressed direct experience and a *third-person* voice that situated such experience within a universalized gender-kinship rationality.[10] The movement between the two indexed how sex-selective acts partook of broader moral-economic logics, whose regularities lay far outside the control of individual or familial choices. In this sense,

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[2] John et al. 2008: 86.
[3] John et al. 2008: 86. For the full analysis, see John et al. 2008: 68-79.
[4] Khanna 2009: 15-74, 97-99, 107-108.
[5] Purewal 2010: 9-66, 93-116.
[6] M. Larsen 2012.
[7] E.g., T. Patel 2007c; Puri et al. 2011; Unnithan-Kumar 2011.
[8] E.g., Brunson 2016; Dube 1988; P. Jeffery and Jeffery 1996: 38-52; P. Jeffery et al. 1989: 182-187; Minturn 1993: 273-280; Vlassoff 2013: 93-112. For discussion of the Indian material within a wider Asian context, see Croll 2000.
[9] E.g., CSWI 1974; Dube and Palriwala 1990; Jacobson and Wadley 1977; P. Jeffery and Jeffery 1996; P. Jeffery et al. 1989: 23-36; Mandelbaum 1988: 1-75; Minturn 1993; Papanek and Minault 1982; U. Sharma 1978, 1984; Wadley 1994.
[10] Cf. Cohen 1998: 33-34.

families' imaginings of children-to-be relied on the "historically constructed and historically defined standards of judgment" that congealed as cultural "common sense."[11]

Importantly, the common sense in question was hardly a timeless "tradition," as many facile commentaries and Beti Bachāvo interventions would have it. As in many other situations, "the gender dimensions of reproductive values" emerged "not as contemporary manifestations of traditional culture but as something newly constructed out of the residues of the past and the exigencies of contemporary life."[12] As in the conversations at Gita-masi's house, people repeatedly articulated the undesirable daughter as a distinctly modern problem, situated within a particular historical *jamāno* [era].

In the chapter's first section, I outline the principles of marriage and descent that structured son necessity and daughter dispensability, analyzing the local moral economy as a system of reproductive labor and material ontology. The second section examines how falling fertility squeezed parents toward selective reproduction, sharpening the son pursuit and daughter avoidance latent in kinship principles; it also considers SD's routinization as an everyday practice and the consequent split between high-fertility and low-fertility pathways of son pursuit. In the third section, I move from structural considerations (kinship principles and fertility regimes) toward people's subjective contemplations of gendered fetal potentiality, focusing on ontology and old age care as themes in son necessity and cost and care as intertwined factors in daughter aversion. The final section examines ambivalence, uncertainty and alternatives regarding rigid gender determinism and how it might be expressed or repressed.

Descent, Marriage, and Alienation

> *How much do we pierce a girl? Her ears, her nose—and then by her hands and feet, we pierce her into the community.*
>
> — A Mahesana-area *bhuvā*

"Ek Chhokaro to Joie"

The afternoon of the Dhuleti festival, the fourth SD at Chetna Clinic was for a Soni [traditional goldsmith] family from a village just outside Patan. When Dr. Ranjit rang the bell, a grim-looking woman—Kinjal-ben—entered. The man accompanying her bore a pink powder streak on his right cheek. The infant girl he carried had a matching purple streak across her left cheek. "Hap-py Holi!" he said festively. Then, growing serious, he explained that they were returning for a "final check" and abortion.

After a quick scan, the doctor confirmed: the fetus was female. The couple nodded softly. Dr. Ranjit instructed them to step out with a nurse, who would initiate the abortion process.

An hour later, I found the couple on adjoining cots in a general ward. When I asked, Kinjal-ben said her pain was "okay." She cringed. They invited me to sit next to the husband, Gaurav-bhai.

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[11] Geertz 1983:76.
[12] Greenhalgh and Li 1995: 606.

Kinjal-ben and Gaurav-bhai were in their early thirties. He worked as a mid-level manager in insurance sales. She was an aspiring commerce professor, with consistently distinguished results in her graduate studies. But childbearing had sidetracked her career. Along with the infant, they had two older daughters, five and seven.

As I explained my research, Gaurav-bhai interjected:

> We ended up having to do this because we had no alternative! We have three girls. And our family *is* educated—everyone, minimum college. But this problem—like I said, we had no alternative. Otherwise, we're all educated. We know all this shouldn't happen. There're advertisements on radio, TV, everything. But then, sometimes, there comes a time when you have to become weak.
>
> And really, if you look at it—this shouldn't be done in the first pregnancy. Girls are also necessary! Girls and boys—only if the population ratio is even will this world continue. Otherwise, there'll be lots of problems. If there're fewer ladies, and more gents, then many issues—this, that, the other thing, there can be a lot of problems in society... If you look at it, the number of both should be the same.

Husband and wife began animatedly discussing the problem of men not finding brides due to "shortage of girls"

After a silence, Kinjal-ben explained, "We never got it looked at before. In all three deliveries, we had hope: 'God'll give a boy.' But this time, we took the decision—'Let's get it looked it.'" Much like Viral-ben and her husband, they had faced an unplanned pregnancy and intended on summary abortion, given the infant's still-young age. But like Gita-masi, their relatives had persuaded them to wait some months and "get it checked": what if it was a boy? Although generally reluctant to facilitate SD, their Patan obstetrician had provided the names of three doctors, all in Mahesana District, because of the couple's "genuine problem—three daughters."

Gaurav-bhai sighed. "You have to have one son [*ek chhokaro to joie*]!" he said. "That way, everything from our forefathers continues forward; he can take it up." Quite scholastically, he noted how sonless women might face taunts from conjugal relatives and neighbors. Before I could ask, he and his wife quickly clarified: with everyone in their family being "educated," this was not something *they* had experienced. Kinjal-ben reassured me everyone in the family knew that "it's not on the woman anyway," but rather "in the man," since "eggs are all the same."

Gaurav-bhai mused, "Before, if a girl was born, they made her *dudh-piti*—killed her off. No one liked girls. Now, the proportion of that's much lower. Compared to before, people have started understanding girls, accepting girls. But there's a limitation—they still prefer boys."

Leaning forward, Kinjal-ben explained, "Whatever else is true, a girl'll go away to her *sāsri* [conjugal household]. And then her father's name won't come after hers; her husband's will. And kids—the wife's name isn't going to be the one after theirs, right? It's always the father's. His lineage [*vansh-velo*] keeps going." Smiling, she continued:

> Even with so much education, nobody changes this! A son remains with his parents for life. A daughter doesn't; she'll inevitably go to her *sāsri*. And only the son can care for his parents. A girl can't come running from *sāsri* to *piyar* [natal household]. Many sons don't care for parents! But still, parents say, 'He'll take care of us.' Everyone feels, 'He'll take care of us in our old age. So everyone prefers a boy.

She concluded emphatically, "*One son is necessary* [*ek chhokaro to joie ja*]." Like her husband, Kinjal-ben offered third-person explanations for their son pursuit, implicitly locating herself amid a widely shared kinship rationality.

Gently placing a hand on my shoulder, Gaurav-bhai provided a further explanation through narrative:

> Let me tell you a story from our village. There's a family with only daughters—four, all with *sāsris* in the U.S.A. The old man and old lady did everything as long as they could—did housework, hired a maid, all that. Plenty of money! But what if they'd had a son instead? Someone would have been there, right?
>
> Now, the old man died—the father whose four daughters were in America. For three days, they had to keep the corpse in cold storage. When his daughters came from the U.S.A., only then could they hold his funeral.
>
> Then, the daughters asked his brother's sons to live with the old lady, because she was alone. She went on like that for a year. Then she died, too. She felt it in her heart—being alone, with the nephews. She died, leaving the property to them.

Gaurav-bhai concluded, "So when other people—like us, or others—see this, it poses a scenario, an example: what'll happen to us at a time like this? Their lineage ended abruptly, right? Now, the old man's name is finished. Since they had just daughters, their family's ended, right?"

Kissing her baby girl, Kinjal-ben added, "No matter how educated people are, how good their job, how good their income, they'll still say, 'It'd be good to have one son.' And I feel that way too. The desire for one son is there [*ek chhokaro to joie*]."

Daughters and Sons: Alienation and Retention

Anthropological research on Hindu India has extensively documented the patrilineal, patrivirilocal gender-kinship system that Kinjal-ben and Gaurav-bhai repeatedly invoked to explain sex selection.[13] Mahesana-area households generally centered on lineal male relatives, with many spanning three or more generations. Sons

[13] "Patrilineality" refers to the principle of tracing descent primarily or exclusively through men. "Patrivirilocality" refers to the principle of a married woman normatively relocating to live with her husband and his parents.

normatively remained with parents until the latter's death. Daughters, meanwhile, married out, relocating their residence, labor, and identity to what people called their "real" families— *sāsris*.[14] As Kinjal-ben described, the father's name became a newborn child's middle name; a son retained it forever, but for a daughter, it was replaced by the husband's first name post-maritally. The naming and residence conventions were parts of a moral-economy of gender-kinship that established continuity through sons and required separation of daughters. For parents, the structure attached the two core kinship principles to two kinds of filial bodies: boys became figures of descent, girls figures of marriage.

In formalistic terms, the moral economy was partly a system of daughter exchange.[15] Different caste and class groupings exhibited variation around the general principle. Chaudharys and the poorer strata of other communities typically practiced direct exchange marriage. Others, like Rabaris and Patels, gave daughters into a community of nominal equals, although there was a strong tendency toward *de facto* socioeconomic hypergamy. And still others—most notably Thakors and Rajputs—married daughters "up" according to formalized marriage hierarchies.

Regardless of the specific form, people consistently articulated a sense of releasing daughters into a social order that would reliably return daughters-in-law, whether directly or indirectly. Scholarship on *kanyādān* [the "gift of a virgin"] has often portrayed it as given without expectation of return.[16] In discussing sex selection, families around Mahesana consistently undercut the ideology of non-reciprocal gifting, emphasizing the powerful and obvious expectation that out-marriage of daughters guaranteed in-marriage of wives.

The moral economy was fundamentally a *material* economy organizing the distribution of gendered bodies across households.[17] The gender-kinship system structured alienation and appropriation of parents' reproductive labor, as embodied in daughters. The social order demanded the violent uprooting of bodies for its smooth functioning, and women and their parents bore the burdens. Principles of matrimonial mobility and filiation represented the operation of a political enterprise—a system of power that regulated social reproduction in a manner that overlapped with broader political economy.[18] The moral-economic order connected appropriation of reproductive labor with landholding, inheritance, dowry, gifting, gendered divisions of labor, and other

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[14] Although many people consider "*sāsru*" the standard Gujarati term for a conjugal household, I exclusively encountered "*sāsri*" during my fieldwork around Mahesana.

[15] Lévi-Strauss 1969.

[16] E.g., Fruzzetti 1982: 1-60; Parry 1986: 454, 461-462; Raheja 1995.

[17] In developing my account of the moral economy as a material economy, I am heavily indebted to two theoretical influences from the 1970s. One is Gayle Rubin's manifesto for empirical study of "sex-gender systems," or the kinship and psychological machinery for transforming different bodies into different kinds of gendered persons with different positions in relations of domination and subordination (2011). The other is the structural Marxian school of anthropology, whose fusion of structuralism and historical materialism illuminated how dominant conceptualizations of social organization (ideologically) mystified underlying relations of inequality in social production and reproduction (e.g., Bloch 1975; Godelier 1977; see also Ortner 1984: 139-141).

[18] Cf. Meillassoux 1981: especially 12, 22, 23, 44-46, 61-66, 72.

aspects of "son-centered accumulation."[19] In redistributing bodies, labor, and capital, the system organized reproduction of not just households, but entire sub-caste communities, the broader society, and the nation-state.

The material arrangements of the moral economy functioned efficiently because of their dialectical interrelations with gender-kinship ideologies that legitimated or euphemized the violent processes of alienation and appropriation.[20] Such mystification reconfigured exploitation as gifting—or more cynically, one part of a nebulously conceptualized and ultimately "right" indirect exchange. Violent processes became valorized—and their violence officially repressed—through reconceptualization as "tradition." Separation of daughters remained within the realm of *doxa*—the unspoken and unquestionable assumptions people shared simply by existing within a community; though its various downstream consequences might become enter a gender orthodoxy-heterodoxy debate whose poles were themselves always shifting, the inevitability of a girl's alienation was a simple fact of life.[21] The domination of wife-givers over wife-takers became hegemonic, organizing the entire lived process of reproduction.[22]

Notably, the economy of gender-kinship did not contain a subordinated class *per se*. Instead, most people acted as both exploiter and exploited by virtue of their roles as parents to both sons and daughters. Families aspired to improve their position by obtaining sons, but such "mobility" hardly removed them from simultaneously occupying the disadvantaged position engendered by having girls. Nor did it transform the conditions of exploitation; to the contrary, it reinforced them by vesting appropriative interests in still more social actors. Son possession and daughter alienation remained the common framework within which people maneuvered to improve household prospects.

Selective reproduction emerged as a tactical manipulation within the shared framework of the moral economy.[23] Confronting the objectivized, violent structures of marriage and descent, parents could avoid further disadvantages by recognizing and rejecting potential girls prenatally. As I discuss below, such manipulation proved especially appealing when low levels of fertility and high reproductive investment in individual children heightened the dangers of imbalance between contributions to and extractions from the system. Devaluation of girls among families pursuing sex selection emerged not from individual discriminatory "mentalities," as many held, but from what moral-economic arrangements forced them and their parents to be.

Families pursuing sex selection constantly invoked the imagined daughter's inevitable separation. Understood as always-already to-be-given-away, she nonetheless demanded care and expenditure, leading to ongoing emotional liabilities and

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[19] Sangari 2012: 41.

[20] For foundational discussions of such ideological legitimation or euphemization in the realm of kinship, see Bourdieu 1976: 171-197; Godelier 1977.

[21] My uses of "*doxa*," "orthodoxy," and "heterodoxy" is based on Bourdieu 1976: 169-171.

[22] I am conceiving of "hegemony" as the process of dominant values and conceptions coming to structure lived experience itself, forming the common framework or field within which contention may then take place (Roseberry 1994: 360-364; Williams 1977: 108-110). In my specific usage, the concept is identical to Bourdieusian *doxa*.

[23] In presenting sex selection as a "tactic" within the gender-kinship system, I am using the term as discussed by de Certeau (1984: 29-30).

uncompensated economic losses. Referring to girls as the *dhan* [property] of a *pārku* [alien] household, clients like Kinjal-ben repeatedly invoked their unavoidable relocation after marriage. Parents engaging in acts of care and indulgence for an accompanying daughter—purchasing a new toy, wiping away food, giving kisses—wistfully observed that such acts of love were "just for now, since there's nothing after she goes away." They observed, too, how the ontological rupture of marriage left a woman perpetually in exile, never quite belonging in *sāsri* or *piyar*. And such rupture left parents feeling the pain of separation, particularly when in-laws maltreated their hostage.[24] As suggested by the epigraph to this section, yielding a daughter to the community—her hand in her husband's, her feet on the path to her *sāsri*—entailed piercing pain for both her and her parents.

By contrast, prevailing moral-economic arrangements made the son a permanent possession—a figure of continuity, support, and recognition. The first patient I ever accompanied with Uma-masi explained during the ride to Chetna:

> A son's a necessary thing. A daughter belongs to a *pārku* household. She won't remain with us. Her father's name is erased, and her husband's name added. But a son's *ours*. He perpetuates the father's name. If there's a boy, the door to your home remains open. Without a son, everything's finished. You need an heir! And when we get old, a son and daughter-in-law care for us.

Concluding, the woman nodded and declared, "*Ek chhokaro to joie!"*

The patient's statement encapsulated the rationales I heard again and again for son necessity. The moral-economic expectation of the son and in-marrying daughter-in-law as guarantors of old age care pervaded social life.[25] But the significance of a boy-to-be extended well beyond the narrowly economic. Patrilineal social ontology also made boys key nodes of social recognition.[26] Couples like Kinjal-ben and Gaurav-bhai pervasively noted the importance of continuing the parents' name or lineage through the son. Others explained a son's indispensability by emphasizing how he kept open one's *ghar* [home, house, household], *gharnu bārnu* [door to the home], or *gharno umbaro* [threshold to the home], or kept lit a familial *divo* [lamp]. With their connotations of replication, continuity, extinction, and social interfacing, such metaphors underlined boys as the *sine qua non* for establishing a lasting, meaningful existence within society. In an inversion of literal reproduction, male offspring produced their parents as fully actualized persons,

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[24] Many anthropological works on Hindu patrilineal kinship highlight notions of the daughter as *pārki* (*parāyi* in Hindi), the pain of her post-marital separation, and the predicament of being stuck between a loving but inaccessible natal home and a hostile conjugal reality, with some also emphasizing how women might negotiate or subvert the latter predicament (e.g., Bennett 1983: 165-172; Dube 1988; P. Jeffery and Jeffery 1996: 69-97, 187-200; Minturn 1993: 53-59; Raheja 1995; Raheja and Gold 1994: 88-102; Säävälä 2001: 104-119, 139-155; U. Sharma 1978).

[25] For a succinct ethnographic perspective on the moral ordering of elder care in Hindu North India, see Lamb 2000: 42-69. Also see P. Jeffery et al. 1989: 182-183; Säävälä 2001: 175-182; Vlassoff 2013.

[26] Cf. King and Stone 2010; Sangren 2013.

mediating recognition across the threshold separating the household and its surrounding milieu.[27]

In discussions around selective reproduction, son necessity came into relief against the figure of the household disparagingly described as "*nakhodiyu*"—sonless, with connotations of barrenness, emptiness, and uselessness. Cautionary narratives like the one recounted by Gaurav-bhai highlighted the misfortune of sonlessness: inheritance and last rites gone awry became metonyms for a sad social existence in which name, lineage, and household all ceased to exist, leaving people "alone, with the nephews." Even if one succeeded in marrying daughters into prosperous *sāsris*—the U.S. being the epitome—they could not provide support, care, and companionship as a son would. The desire to obtain the necessary son without having too many daughters was what drove people to sex selection.

Practicing Inequality

Despite what governance initiatives, widespread slogans, and some scholarly works might suggest, the gender-differentiated valuation of filial bodies could not be corrected through a simple shift in "mentality," given moral-economic imperatives. Marriage and descent principles meant daughters and sons *were* manifestly unequal.

The pervasive reality of gender inequality undermined anti-sex selection messages from government institutions, NGOs, and the media. Centered on exhortations to "treat boys and girls as equal" or "giv them the same welcome," such messages rang false for families situated within a gender-kinship system that made male and female bodies structurally unequal. Even if parents treated sons and daughters equally (to a point) when providing love, care, and material resources, the two necessarily diverged in their socially permissible roles and their resultant relations to parents. Public calls for heroic individual resistance to systemic inequality merely forced an acknowledgement from couples like Kinjal-ben and Gaurav-bhai ("we know... this shouldn't happen") before they could articulate the common sense of reproductive striving ("there comes a time when you have to become weak").[28]

This pattern became clear one afternoon in the Nandini Clinic consultory, as I chatted with a couple experiencing their first pregnancy. When I asked if they had considered "getting it looked at," the husband shook his head—"No, no, nothing like that!" Smiling, the wife assured me, "For us, boy-girl are equal! Come visit us, and we'll show you. Everyone in our family has one girl, one boy." I pressed a bit further, asking what they would do if they had a firstborn daughter. Both laughed sheepishly and shrugged. The husband started a sentence—"Well, in that case..."—and his wife finished it: "Of course, we'd have to think about it."

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[27] Sangren (2013) delineates this inversion (with sons producing their fathers) in the realm of Chinese ancestor worship rituals. I wish to highlight that this inverted or ironic dynamic is widely prevalent in the myriad everyday interactions, whether formally ritualistic or not, that constitute social recogntion.

[28] For a comparative perspective on this dynamic, based on China's "Care for Girls" campaign, see Eklund 2011a. Also see Milwertz (1997: 140-145), who discusses the disjuncture between socially desirable statements of gender equality and deeply seated desires for a son in talk around childbearing in China.

I repeatedly encountered this juxtaposition of idealized gender equality and pragmatic willingness to consider SD. Dr. Dilip captured it when he told me, "Now, there's no difference to people if it's boy or girl! But yes, there's a mentality that there should be at least one boy. In this era, boys and girls are the same. But *ek chhokaro to joie!* There may well be no girls, lots of girls, however many girls. But at least one boy—*ek chhokaro to joie ja*."

One evening, I sat in a Nandini inpatient room with a family I knew well. After undergoing selective abortions in two prior pregnancies, the patient—a teacher's wife—had just birthed a daughter. The woman, her husband, and both their mothers fawned over the newborn girl, but a hint of disappointment tinged their words. The patient's mother sighed as she explained:

> We were hoping for a boy. If this was a boy, full-stop! No need to have any more. Now that she's arrived, we'll have to think about it, down the road... Who knows? Maybe after twenty years, girls'll exceed boys! It could be a girls' *jamāno*. For us, sons and daughters are equal. We don't feel like you have to have a boy. But that's not the way it works in society. So we have to keep hoping for one boy. Not more, but you have to have one boy [*ek chhokaro joie*].

I pondered the woman's words, wondering at the complex merging of individual orientation and structural compulsion

The patient's mother used the same phrase as Dr. Dilip, Kinjal-ben, Gaurav-bhai, and countless others to explain the need for sex selection: *ek chhokaro joie*. The predicate, *joie*, brings together notions of desire, need, and normativity.[29] Consequently, the basic phrase *chhokaro joie* covered the semantic range of "want a son," "need a son," and "should have a son." When prefixed, the number *ek* [one] emphasized the sufficiency of a single boy for completing a family. And when infixed or suffixed, the emphatic particles *to* and *ja* highlighted the intensity and inescapability of desire, requirement, and normativity: *chhokaro to joie, chhokaro joie ja, ek chhokaro to joie ja*. Finally, *joie* permitted optional qualification with a pronoun indicating the subject of desire or obligation; the pronoun's facultative character captures how son necessity, son desire, and son expectation blurred boundaries between third-person and first-person—between a general system and particular individuals or households.

Outside of conversations with government officials, activists, and reformed obstetricians extolling the virtues of daughter acceptance, I heard *joie* in conjunction with "girl" quite infrequently, and always in three specific configurations. First, families pursuing SD or selective abortion often joined *chhokaro joie* with a doubly negative denial of misogyny: "It's not that a girl is *not* wanted/needed." They might simultaneously gesture, metaphorically or literally, to already-existing offspring as evidence for their embrace of daughters.

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[29] *Joie* exists only in a third-person, number-invariant form.

Second, some women and relatives used *chhokari joie* as a pivot into advocating for household "balance"—a "one boy, one girl" ideal. Again, they gestured toward existing daughters before reiterating the need for a son.

Finally, some families described daughters as necessary in the context of the marriage system. One Nandini patient, having undergone four selective abortions after the birth of her daughter, said to me, "*Chhokari to joie*! Girls are necessary in society. If we take someone else's daughter we have to give in exchange, right?" Juxtaposed with her history, the woman's statement illuminated the hard reality underlying sex selection. While making potential sons and daughters-in-law necessary for household reproduction, the moral economy of gender-kinship rendered potential daughters an embodied reproductive externality—valuable to the community, but dispensable to parents.[30]

A Modern Reproductive Regime

> *I have two girls and a boy. We got it looked at with the last one—the boy. We got it looked at with the second girl, too, but kept it. I said, 'We can't sin like that. If God's giving it, we have to take it.'*
>
> *But now, my daughters would have to do it. In today's* jamāno*, you have to do it. There's no choice. With one girl, you can't bring home another.*
>
> — A Nandini patient's mother

"What Was the Point of Bringing Home Another Kid?"

"There was one before this—" the woman began.

Her husband finished the sentence: "—and we got an abortion done. 'Female' result, so we got it taken out. This time, we got it looked at again, and Saheb said it was a boy."

I was sitting across from Esha-ben and Sagar-bhai in an unoccupied Nandini room. Uma-masi had suggested they meet with me while waiting for an antenatal visit. Esha-ben, a short, jolly woman in a salvaar-kameez, was visibly pregnant, though not yet near term—around six months, by my guess. Sagar-bhai, dressed in a crisp checked shirt and jeans, appeared quiet and contemplative.

They were Patels. Sagar-bhai's family hailed from Gita-masi's village. Esha-ben had grown up near Unjha, one of five children—four sisters and a youngest brother. Sagar-bhai owned a medical supply distributorship in Mahesana, where his father had previously run a small hardware store.

In the couple's previous pregnancy, two years earlier, Dr. Dilip had provided the names of three colleagues who still performed SD. The couple had chosen Dr. Narendra, whom they knew personally through Sagar-bhai's business. After SD had revealed a daughter-to-be, Esha-ben had undergone abortion.

Sagar-bhai recalled:

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[30] Cf. R. Kaur 2008: 155-157; Säävälä 2001.

> We had one girl. We were sure we definitely didn't want more than two children. What's the point of gathering together so many? It becomes hard to take care of them. That was our thinking. So then what?
>
> Once he told us it was definitely a girl, we came home. Mammi said, 'What's the problem? So many people in the world get it done. What's the big deal?' Since this was the first time, Esha was bound to feel afraid, right? But we agreed: what was the point of bringing home another kid?

Nodding emphatically, he sat back in his chair.

Esha-ben continued the story: "So then, with this one, it was a relief. Naturally, we were worried about the result—'What'll it be? Good or bad?' If it was another girl, we would've had to get another abortion."

Her husband picked up the thread:

> She was really worried when we got it looked at—if the doctor had said the same thing again, it would've been another abortion. But two-three abortions like that can really damage a woman's body.
>
> We have a neighbor who had it done four-five times. There ended up being a huge gap—they married off their daughter, and their son's just now in ninth grade! Seeing things like that made us worry—'What'll we do if that happens to us?'
>
> We ended up calling that lady to come provide some comfort after the abortion two years ago. She said, 'What's the problem? This happened to you for the first time! I had it happen four-five times. And your daughter's still young. Don't worry.' So that made Esha feel a bit better.

As Sagar-bhai spoke, his wife smiled softly, nodding and shaking her head by turns.

Tracking back to the previous SD, I asked whether they had decided beforehand to pursue selective abortion with a "female" result. Esha-ben chuckled, perhaps at my apparent naiveté. "Of course!" she said. "How else would it be? We already had one daughter. What would we do with another?"

Sagar-bhai interjected with a popular family planning slogan: "'A Small Family Is a Happy Family!'"

"Two children is appropriate," his wife elaborated. "In this *jamāno* of *monghvāri* [high costs], you can't keep too many."

"You see how it is in India." Sagar-bhai scoffed and pointed at me with an upturned hand. "If I was an American citizen, I would gather together five girls, no problem! But here, the *jamāno* is such—"

"So much *monghvāri*! If you bring home two daughters, then raising them, feeding them, clothing them, educating them, paying their school fees—"

"We have to remain in comparison with everyone else. We have to move in accordance with that. If my daughter is in a Gujarati-medium school, she'll say, 'Get me tuition, put me in English-medium.' Then how can we say no?"

"In the end," Esha-ben opined, "we have to remain within our means, right? Based on the *jamāno*, two children is appropriate—one girl, one boy. That's the way it should be."

"As the times change," Sagar-bhai concluded, "we have to change with them, no?"

I continued to see the couple over the ensuing months, congratulating them on the birth of their son and occasionally chatting with Sagar-bhai at the tea stall near Nandini. One day, as he and I sat sipping *cha*, he noted:

> It's good that one-two sahebs are still doing this, or it'd be difficult. In fact, this keeps the population in control. If this weren't happening, the population would increase too much! So there's that, too.
>
> And one boy, one girl—that kind of balance is good. In today's day and age, who can afford more than two kids? My daughter's five years old, and still, she wants everything to be fancy! And with a kid, you get them medical care, get them this and that—with today's kids, any old thing won't do. Now you educate them, give them fancy food—my daughter won't eat old-fashioned *pāpad* at home! Every day, she wants a bag of chips! She won't take simple snacks to school. She needs everything *fancy*. So in this *monghvāri*, no one can afford more than two little ones. And within that, *ek chhokaro to joie*. So people get this done.

The Squeeze of Falling Fertility

Esha-ben and Sagar-bhai's comments illustrate how more than just marriage and descent principles ordered the gender-kinship system that gave rise to sex selection. The moral economy also encompassed a specific modern reproductive regime. Selective abortion emerged from the convergence of son necessity and daughter dispensability with rationalities and practices of limited childbearing.[31]

Shortly after our initial meeting, Sagar-bhai neatly summarized this convergence:

> My feeling is, families now accept girls more—educating them, bringing them up, all that. It's not that they don't accept. But within limits. Take our family—there ends up being a limitation. In today's *jamāno*, people's feeling is—well, like the government says: "We Two and Our Two!" Now who fits into "two"? It should be either two boys, or girl-boy; no one feels it should be two girls!

In providing an on-the-ground interpretation of the famous government family planning slogan, Sagar-bhai highlighted how the needs of fertility limitation and son production—one focused on *number* of children, the other on *type* of children—often pulled in opposite directions. Repeated childbearing in pursuit of a boy could drive up family size,

[31] For other discussions of family size preferences in qualitative studies of sex selection in India, see John et al. 2008: 43-44, 47-50; Khanna 2009: 65-67; M. Larsen 2012.

while limiting the number of children could jeopardize the ability to attain the necessary son. Into the gap between the two ideals entered sex selection.

Demographer Christophe Guilmoto has recently proposed the notion of a "sex ratio transition" driven by families being "ready" (willing and motivated), "able" (possessing access to technology), and "squeezed" (compelled to keep families small).[32] Guilmoto's model resonates with earlier Indian scholarship that established an association between fertility decline and skewed SRs by showing how decreases in family size worsened prospects for girls at any given birth order.[33] The model also captures the dynamics of sex selection's emergence in Mahesana. Motivation and access derived from the abovementioned kinship principles and the market outlined in Chapter 1; low fertility preference provided the "squeeze."

In invoking "fertility preferences," I am not suggesting that couples always operated with a fixed, rationalistic plan for number and type of offspring.[34] Factors as diverse as pressure from elders, difficult pregnancy experiences, and the gender of the most recent born child could heavily influence preferences, and people often operated in a space of ambiguity, uncertainty, and ambivalence. Nonetheless, couples seeking sex selection services had more often than not decided that they did not wish for any more than one child. For them, one son was sufficient as the *end*—both goal and completion—of reproduction; any daughter was superfluous. As Mary John has put it, "families [were] actually 'planning' to have at least one son and at most one daughter."[35]

Women had to become pregnant—often repeatedly—in order to pursue a son. Explaining her trepidation regarding the bodily wear of an imminent Caesarean delivery, a first-time mother at Nandini said, "If this is a boy, then it's okay. But if it's a girl, then according to society's rules, I have to get pregnant again for a boy, right?" Obstetricians and clients often invoked or indexed "society's rules," treating as obvious the idea that that sonless couples would pursue further pregnancies. When doctors asked patients whether they wanted to conceive, or to keep an unplanned pregnancy, they could simply answer, "We only have a girl, so..." Families pervasively referred to a recent or anticipated newborn's maleness in conjunction with words like "enough," "complete," "finished," and "full-stop"; for instance, when I visited Gita-masi after her grandson's birth she thrust him into my arms and exclaimed gleefully, "Now our family's complete!"

The focus on *son* production, rather than gender-neutral reproduction, meant sonless couples often desired fertility only contingently. Clients often informed doctors they had conceived "with the calculus of a boy" or "in order to have a boy," indexing a high likelihood of eventually seeking sex selection. In cases like Viral-ben's or Kinjal-ben's, couples might continue unplanned pregnancies with the intention of allowing SD to dictate whether the children-to-be were truly wanted or not.

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[32] Guilmoto 2009.

[33] A. Basu 1992, 1999; Das Gupta and Bhat 1997. For further empirical support of this position, see Sudha and Rajan 1999, 2003.

[34] For nuanced discussion of how anthropological inquiry can "situate" demography with regard to "fertility preferences" or "fertility behavior," see Greenhalgh 1995; Säävälä 2001: 1-8.

[35] John 2014: 36. See also John et al. 2008: 53.

The gender contingency of pregnancies exemplified son pursuit within a modern, low-fertility reproductive regime. There were, in fact, two paths—high-fertility and low-fertility—to the necessary son. Neither challenged the cultural common sense of a boy as the end of reproduction. But each suggested a distinctive modality for reaching the goal: repeated pregnancies and repeated births, or repeated pregnancies and selective abortions.[36]

Fertility has fallen drastically in Mahesana, Gujarat, and India as a whole since the advent of sex selection, part of a broader trend dating back to the 1970s. Since 1981, India and Gujarat's child SRs and total fertility rates (TFRs) fell in parallel (Figure 2).[37] By the 2011 Census, Gujarat's (TFR) stood at a near-replacement level of 2.4—a major drop from 4.3 in 1981. Having declined more rapidly over the previous decade, Mahesana's TFR in 2011 was even lower: 2.0.[38] Low fertility was even more apparent among the affluent. A mid-2000s survey, for instance, found that while TFRs for Gujarati women without education or in lower wealth quintiles were over 3.0, those for women in the top wealth quintile and with ten-plus years of education were below 2.0.[39]

In my observation, couples pursuing sex selection cited various reasons for their desire to limit childbearing. Most prominent among these were questions of cost and care. Sagar-bhai explained:

> See, the thing is, if you look at our country before, everyone had five-six children. At that time, education was not so important. Now that I'm educated, I'll wish for my child to be well-settled, well-nourished, school-going. Before, when there were six-seven kids, one would go to work at a tea stall, and so on—now, it shouldn't be that way. I'll want my son to be well-settled—to become an engineer, a doctor. I won't make him live the life I'm living—something better instead. We have everything now, but his should be better than ours. If there are too many children, then we can't plan properly. If there are fewer—one-two—we can give them time, spend money on them.

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[36] The "high-fertility" or "non-selective" pathway of son pursuit corresponds to a demographic pattern of *differential stopping behavior* (the tendency to cease or slow childbearing only after attainment of one or more sons). For demonstrations of differential stopping behavior in the Indian context, see Arnold et al. 1996; S. Clark 2000; Das Gupta and Visaria 1996; Mutharayappa et al. 1997. Comparative material from Bangladesh—particularly Chowdhury et al. (1993) and Bairagi (2001)—evinces a similar pattern. For discussions of differential stopping behavior in South Korea, see U. Larsen et al. 1998; Park and Cho 1995.

[37] TFR is an abstract synthetic measure widely used in demography. It measures the average number of children born to a hypothetical woman if she were to survive to the end of her reproductive life and bear children according to the age-specific fertility rates currently prevailing in the population. It does not correspond to the actual fertility of any real cohort of women, but provides a useful estimate of fertility in a population.

[38] Guilmoto and Rajan 2013: A3.

[39] IIPS 2008: 6. More locally, whereas a recent study found TFRs above 4.0 in samples of ninety women each from a Mahesana slum and a relatively poor nearby village (Ranjan nd), middle- and upper-class patients at Nandini rarely bore more than two children (and almost never more than three).

Like Sagar-bhai, many couples noted the financial, emotional, and time costs of raising a child "in this *jamāno*."[40] Discourses of aspiration, struggle, and fertility control united upwardly mobile sex selection clients like Sagar-bhai with those experiencing grinding poverty, downward mobility, or stagnation. All agreed that "children are best within limits," given the difficulty of birthing, clothing, feeding, educating, indulging, marrying, and otherwise caring for them.[41]

That people like Sagar-bhai invoked population control rationales and time-honored family planning slogans to justify sex selection reflects how reproductive governance shaped the low-fertility regime. Since independence, the Indian government's construction of state, society, development, and modernity itself has rested largely on aggressively promoting population control, proliferating public and private family planning services, and circulating messages extolling the virtues of small families for household and national economic wellbeing.[42] The recirculation of family planning messages in places like Chetna reflects the extent to which the superfluous daughter was a distinctly modern problem, and how sex selection, though illegal, was very much in line with certain state rationalities of reproduction. (I return to the tension between family planning and anti-sex selection efforts in Chapter 7.)

The modernity of sex selection is also evident in the association between fertility squeeze and economic change. Families' invocations of *monghvāri* and the present *jamāno* point to broader political-economic shifts encompassing the Green Revolution, land reorganization, market liberalization, and the growing importance (and costs) of education and other investments in children. At the time of my fieldwork, Gujarat had experienced several decades of capital-intensive growth—with attracting one-fifth of the country's private industrial investments between 1991 and 2011—that produced rising costs alongside agricultural stagnation, land alienation, limited job creation, state withdrawal of food and other subsidies, uneven poverty reduction, and rising malnutrition.[43] In this context, fertility limitation became a hinge articulating broader political economy with the moral economy of gender-kinship.

At the confluence of liberal political economy, population governance, biomedicalized reproduction, and familial aspirations, low fertility became an imperative hallmark of responsible household economy and virtuous modern subjectivity.[44] Discourse among sex selection practitioners and clients often located the high-fertility path of son pursuit in the past, temporally bracketing those who "don't go for SD" as "backward" or "uneducated holdovers from a premodern era. Drawing contrasts between "this *jamāno*" and "back then," they gestured to the inconceivability and imprudence of having larger families in the contemporary moment.

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[40] Cf. P. Jeffery et al. 1989: 184-187; R. Jeffery and Jeffery 1997: 107-112.

[41] Given the rampancy of profitable but medically unnecessary Caesarean deliveries in Mahesana's private obstetric market, families also cited the wear of repeated operative deliveries as an iatrogenic limitation on family size.)

[42] Chatterjee and Riley 2001; Ram 2001. For overviews of the Indian state's family planning programs, see Guilmoto and Kulkarni 2004; M. Rao 2004.

[43] Dixit 2010; Sud 2012: 47-116. For the figure on private industrial investment, see Sud 2012: 2.

[44] Cf. Chatterjee and Riley 2001: 831-840; Ram 2001: 85-94; Simon-Kumar 2006: 134-162.

In fact, the non-selective and selective tactics of son pursuit coexisted in time. One obstetrician observed:

> The basic mentality is this, that one boy should be there in the family. Every Indian will say this. Even if they don't get SD done, everyone will say this. Patients with five-six females will want to keep pregnancy again at age thirty-five or forty years to have a male child. They don't go for family planning, but they also don't go for SD and female foeticide. If they have a first girl, second girl, they'll keep trying. And then those who have reached enough will get SD.

The doctor's comment highlights the lack of fixity in what I have described as high-fertility and low-fertility "pathways"; rather than formalized tactics, the two were actually temporary orientations to action, meaningful as guiding principles but nonetheless subject to change over time. Families often switched from the former to the latter when they "reached enough"; more rarely, they switched in the opposite direction upon growing frustrated with sex-selective abortions.

I also observed a general sense that falling fertility was pushing more and more families into sex selection. As Dr. Dilip put it:

> Even those who were having four-five-six children before, they are going for two-three—they also think it is difficult to raise a child, economically… Even in the poorer sections, some patients are now requesting SD, because they want to reduce family size. That was not the case fifteen years ago, because people were not so worried about family size—poor, rich, everyone... I can say each and every community is now resorting for fewer children than fifteen years before. Those who were going for five-six now go for two-three. Those who were going for two-three now go for two—one if first is male.

Numerous colleagues echoed Dr. Dilip's observation, with many specifically noting a rise in SD among less affluent families and a shift in the normative timing for SD from the third pregnancy to the second.

Demographic data corroborate the trends and patterns described above. Analyses from late-1990s data clearly demonstrated the coexistence of high-fertility and low-fertility son pursuit in several states, including Gujarat: SRs at birth (SRBs) nadired at second parity, suggesting resort to sex selection in second pregnancies among some women alongside repeated childbearing for a boy among others.[45] But overall trends also suggest the increasing currency of the selective route with time. The decline in TFR since

[45] The clearest elaboration of this analysis comes from Arnold et al. (2002: 780-782), but their empirical demonstration is somewhat indirect, focusing on the SR of children ever born to women with different numbers of children (with the SR being highest among women with two children). Retherford and Roy (2003: 40) offer a more direct empirical demonstration of the pattern through their presentation of parity-wise SRBs (with the highest SRB at second parity).

the 1980s advent of SD technology correlated with markedly lower SRs in Gujarat and Mahesana District. Falling fertility selectively squeezed out girls, as each additional daughter in pursuit of the inevitable son became dispensable.

Selective Reproduction as Routine Practice

Within the low-fertility regime that predominated in Mahesana, people calibrated family composition in one of two ways, depending on the sex of the firstborn child.[46]

Many couples with a firstborn son simply avoided further pregnancy.[47] I heard a common refrain from many obstetricians, often in needling reproaches to couples seeking contraception: "If the first child is male, no one's quick to have another!" Dr. Dilip sometimes playfully scolded single-son couples in a similar vein when they sought abortion of an unplanned pregnancy: "Keep it! If all you people with boys don't have any more kids, how will your sons get married?" While sometimes acknowledging the grave SR skewing, patients and relatives invariably laughed off doctors' jesting opposition to their fertility control requests. Their son could not marry his imagined sister; no one in the family had encountered difficulty marrying; there was no real need for a daughter; and at any rate, what if the second child was also a boy? Single-son couples further retorted that they would be better able to care for and invest in a son if he was an only child. Many specifically voiced wanting to maximize educational investments and avoid fragmentation of patrimony, with the latter concern becoming particularly acute among urban families that had invested considerable wealth in impartible houses (rather than the gold, land, and other inheritables of agrarian village life).[48] Ultimately, couples' diverse stated reasons boiled down to one fundamental principle: an additional child of either gender was unnecessary and would impose unnecessary costs on the family. In a pattern seen across time and region in India, "the number of sons desired was by no means unlimited."[49] One boy was necessary and sufficient. As many sex selection clients said, "*ek ja joie*"—"you only need one."

Nevertheless, the primary contributor to Mahesana's skewed SRs was not the "first son, only child" phenomenon, but its gender-opposed counterpart: pursuit of SD and selective abortion after a firstborn (or higher-order) daughter. Routinized sex selection rested on and reinforced a sense of girls beyond the first as superfluous.

Whenever I asked Uma-masi about the Beti Bachāvo program, she frowned and shouted, "It's wrong! In this *jamāno*, who'll gather together three or four girls?" The predicate she used to describe what parents would do with girls if they did not undertake

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[46] R. Jeffery and Jeffery 1997: 112.

[47] The "first son, only child" phenomenon is an extreme example of differential stopping behavior, with the "stopping rule" being one of single-son sufficiency. Cf. John et al. 2008: 53, 56, 64.

[48] My neighbor, for instance, had two sons roughly my age, with the older having a boy in grade school and the younger having a toddler girl. One day, as I played with the girl, the grandmother explained that she and her husband had reached an understanding with the younger son and his wife that they would not have any more children; the one boy would become responsible for the joint family—his aunt and uncle as well as his parents—and, in turn, the family would not have to worry about splitting the house that they had recently renovated at a cost of 3.2 million rupees.

[49] R. Kaur 2008: 109. See also P. Jeffery et al. 1989: 183-184; R. Jeffery and Jeffery 1997: 109; John et al. 2008: 56-58.

sex selection—*bhegi karvi*—denoted gathering, collecting, or piling up, often with connotations of excess. I heard the construction countless times from couples like Esha-ben and Sagar-bhai: "It's not reasonable to gather that many girls. You see how it is in our society." "Who'll gather six girls to have a boy, in this day and age?" "What's the point of gathering five-six? Four, we already have." "If you gather too many girls, it becomes tough to care for them." "In this *monghvāri*, what's the point of gathering them, over and over gain, to have a son?" These statements, along with countless others like them, were commentaries about collecting excess costs and liabilities, about bringing home someone that had to be given away, about gathering subjects whose care exposed one to the violence of alienation. Looking at the life course over-determined for girls and their parents, many couples decided it was better to eliminate potential daughters prenatally than to bear them, care for them, support them, love them, and ultimately lose them—especially when having an additional daughter would do nothing to obviate the still-pressing need for a son.

Entering the gap between low fertility preference and son necessity, sex selection allowed identification and elimination of dispensable daughters prenatally, before their entry into the world as more fully-fledged persons. Though universally lamented as physically, emotionally, and morally troubling (as I discuss in subsequent chapters), selective abortion permitted families to reject potential daughters at a stage when such rejection was still thinkable. People experienced the practice as an act of tragic pragmatism, chosen despite profound love for existing daughters—and with considerable ambivalence toward the rejected daughter-to-be. One man explained his and his wife's choice for a second consecutive selective abortion by noting:

> It's not like we don't love daughters! We have our daughter, and she's *so* dear to us. Once she's out, living, then a relationship binds you to her [*sambandh bandhāy*]. But if you don't even have her, there's not the same issue. If we feed her, play with her, then we develop affection for her. But that's a different matter. There's not that kind of relationship before having her.

Centering on a phrase literally denoting the processual tying of a durable bond between people, this statement pithily condenses the moral and pragmatic grounds for proceeding with selective abortions. Countless families similarly endorsed the need to "consider these things before another girl is standing in front of you." Birth brought daughters out of liminal personhood, making it legally homicidal and morally unthinkable to kill them or withhold the care incumbent on parents. Once in the world, a daughter bound parents to love her, care for her, and endure the eventual agony of separation.

The avoidance of superfluous daughters through SD was a commonsensical feature of life for many people around Mahesana. One evening, during a break in a neighborhood function, the six-year-old from next door and her eight-year-old cousin approached me and my wife, eagerly sat us down on the bench in front of our house, and began asking questions about life in America. As we reciprocated by asking about their

lives, the older girl explained their relationship and noted that they each had younger brother. She continued, "And once our aunt has a boy—"

The other girl finished her statement: "Yes, once Bucky's mom has a boy, we'll be three girls and three boys."

Intrigued by their certainty, I asked, "Three and three?"

The younger girl continued excitedly, "Me, her, and Bucky; and then her brother, my brother, and the new brother! She's pregnant right now."

"Right now?" I asked innocently. "So they must not know, boy-girl."

Furrowing her brow, the older girl raising an open palm to signal the triviality of the explanation she was about to deliver: "She had the test done!" She smiled and shook her head, as if in disbelief at my ignorance. Our conversation quickly moved on to discussion of smartphone games, but I was left with a new appreciation of my research topic. SD was so routine, even grade-schoolers treated it as common sense.

In the clinic, doctors and clients generally operated on a shared understanding of SD as an obvious choice for those with at least one girl. When Dr. Dilip asked couples whether he should fill the mandatory Form F for an early-gestation ultrasound (and thereby render the pregnancy visible to the government), they would often reply by simply saying, "We only have this one girl, so..." The remainder of the sentence usually remained implicit but apparent. Similarly, I heard countless Nandini and Chetna patients recite obstetric histories that included the line, "That time, we were told it was a girl, so..." Again, the implication was generally unspoken but clear. Families spoke frequently and matter-of-factly about how they would pursue SD after conceiving. And Uma-masi's expressed a common sentiment when she told me one night of her fervent hope for a firstborn son—not because she would not love a girl, but because "a boy is a relief, and if you have a girl, you have to get it checked in the second one and do all that."

The routinization of selective reproduction also colored people's interpretations of observed reproductive outcomes. Sitting on my balcony one evening, I overheard a neighbor deliver a dry response to a relative's telephone inquiry about his daughter's recent delivery: "It's a boy. For those with a previous girl, it's *always* a boy." (On learning of my research topic some months earlier, his wife had intimated in whispers that their daughter had undergone SD and been promised a male.) Whenever a Nandini patient delivered a second girl, one nurse—herself the oldest of three sisters with a youngest brother—always asked incredulously, "A second girl? Didn't they get it looked at?" In a similar vein, couples with a large gap between daughter and son attracted a particular hermeneutics of suspicion in gossip: yes, the gap *might* have resulted from infertility or intentional spacing, but what was the more likely explanation?

Especially among women, sex selection practices had become the subject of a considerable body of everyday knowledge. In the comfort of kitchens, patios, and family gatherings, people spoke in great detail about the logistics and experiences of sex selection: who did it and who had stopped, prevailing charges, different experts' reliability, reasons for error, the fact that "the sahebs can't see until after three months," the utility of a full bladder, and the "bodily ruination" of second-trimester abortion. There was also the ever-present matter of who had gotten it done. On the afternoon of the event at which my neighbor's niece schooled me in the banality of sex selection, another

neighbor, Megha-ben, had visited Chetna with Uma-masi. During the function, the neighborhood women, lounging on tarpaulins in the common plot, whispered and nodded over toward where Megha-ben sat in a plastic chair, smiling quietly: "Yes!... Megha... She got the sonography done!... It happened... She had the sonography done, she did."

Patterning Selective Reproduction

While I saw families from every caste, affluence level, and family size seeking sex selection, my observation and obstetricians' impressions suggested certain definite tendencies with regard to background characteristics. Couples seeking sex selection services tended to hail from the middle, upper, and upwardly mobile classes. In terms of caste, Patels, Chaudharys, and affluent families from the Rabari, Rajput, and artisanal castes were frequent clients; Thakors and scheduled castes were underrepresented, though still common due to their numerical preponderance, while Brahmins and Vaniyas were represented at levels disproportionate to their population numbers. Almost no one pursued SD in a first pregnancy, or with an existing son; instead, as per the discussion above, selective reproduction emerged as a pragmatic tactic among families with daughters—one or two in the vast majority of cases—who wished to avoid any more.[50]

This impressionistic profile of sex selection seekers in Mahesana aligns with the broader demographic research. Nationwide studies have decisively correlated skewed SRBs to family composition and affluence. While prenatal sex selection is rare in first pregnancies, or with living sons, it becomes increasingly common as daughters accumulate.[51] For instance, in 2005, the countrywide SRB was 836 for births after a firstborn girl, compared to well over 950 for firstborns and births after a firstborn boy.[52] In stark contrast to the widespread discourses portraying sex selection as practiced by

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[50] Clinicians and families agreed that while first-time parents might use Ayurvedic or other non-biomedical treatments to promote the conception of a boy, couples would almost never pursue sonographic SD in a first pregnancy. No one would think to undertake a selective abortion, and the black market situation engendered by prohibition had driven the price of satisfying innocent curiosity too high. Obstetricians occasionally mentioned unusual circumstances that might drive couples to seek biomedical sex selection within a woman's first pregnancy: the husband already having a daughter from a previous marriage, for instance, or a jointly living extended family with multiple girls who already burdened the household economy to a point where even one more was unacceptable. Such cases were extremely rare. In general, people made do with "whatever comes" or "whatever God gives" in the first pregnancy and only pursued sex selection after the birth of one or more girls. (But see Visaria's finding of an SRB of 867 in even first-order births in her study of Mahesana-area villages [2007b: 148].)

Similarly, I never saw or heard of a case of sex selection by a couple with one living son and no other offspring, though some doctors suggested it was not inconceivable that a "crazy" couple might seek it out. On three occasions, I encountered couples with one son and one daughter who wished to have another child, but only a son; in each of these cases, the couple was pursuing a third pregnancy somewhat reluctantly, compelled by pressure from the husband's parents, who inevitably declared, "*Be* [two] *chhokara joie*. Can you see with one eye?" (cf. John et al. 2008: 57; L. Visaria 2007b: 156). Obstetricians agreed that families almost never pursued female-selective abortion when already possessing one son.

[51] Arnold et al. 2002; Jha et al. 2011; Retherford and Roy 2003. Analyzing data for Tamil Nadu, Srinivasan and Bedi (2008) found "daughter deficit"—due to both prenatal sex selection and female infanticide—rising with birth order. See also Diamond-Smith et al. (2008), who found female infanticide concentrated in higher-order births and among families with daughters.

[52] Jha et al. 2011: 1922.

poor, uneducated, "unaware," or "backward" people, there is also a "prosperity effect,"[53] with lower SRBs corresponding to urban residence, maternal education, wealth, landholding, expenditure, standard of living, and upper-caste status; moreover, prosperity and family composition may interact, leading to particularly skewed SRBs among affluent families with only daughters.[54] In other words, sex selection in India is most likely among couples like Esha-ben and Sagar-bhai, or Asha-ben and Jiten-bhai: at least-middle class, with one or two daughters.

Leela Visaria's research has specifically demonstrated these tendencies for the Mahesana region (Table 4).[55] Her early-2000s field study of 3,708 births among women in six villages near Unjha and Vijapur found that SRB decreased with each increment in birth order. Overall and at any given parity, SRBs were almost always lowest among women and families with higher caste status, land ownership, and higher education. For instance, SRB at second birth was 659 for women with secondary education, versus 993 for women classed as illiterate. It was 778 for women from landholding families, against 956 among landless counterparts. And it was 654 for upper-caste women, compared to 952 for those from the "other backward caste" (OBC) classification. But even women from landless, OBC, and limited-education backgrounds exhibited drastic drops in SRBs by fourth and higher parities, suggesting a limitation on the willingness to undergo indefinitely prolonged childbearing for a boy; at some point, most families had "reached enough." And the SRB at last birth was 479 overall, 353 among women thirty-five or older (who were most likely to have completed childbearing), and below 600 for virtually every demographic subcategory. A son was, indeed, the end of reproduction.

Envisioning Fetal Futures

Horizoning Work within the Moral Economy

Selective reproduction emerged as a logical choice at the confluence of particular gender-kinship principles and a particular low-fertility reproductive regime. But families pursuing sex selection were not automata, merely acting out large-scale demographic patterns or norms of marriage and descent. They behaved as constrained but nonetheless active subjects, constructing and contending with imagined fetal futures.

In moving back and forth between present reproduction and future kinship, families engaged in what Adriana Petryna has called "horizoning work."[56] Through

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[53] Agnihotri 2000.

[54] Arokiasamy and Goli 2012; Guilmoto 2008; Jha et al. 2011; Jha et al. 2006; Retherford and Roy 2003. While Agnihotri's initial work dealt primarily with EFM, he subsequently demonstrated that SR skewing due to prenatal sex selection also displayed a class stratification: high-expenditure (i.e., prosperous) households exhibited the lowest CSRs (Agnihotri 2003; Siddhanta et al. 2003). The data lend support to the notion of a monotonic decrease in SRB with rising affluence (Guilmoto and Ren 2011). Although this conclusion at the countrywide level may mask more complex regional patterns, the analysis in Siddhanta et al. (2003) suggests a similar pattern of monotonic decrease for many states, including Gujarat.

[55] L. Visaria 2007b: 147-149. For confirmations of the parity effect in field studies of sex selection, see Ganatra et al. 2001: 113-114; George and Dahiya 1998: 2193-2194; John et al. 2008: 53-54; Khanna 2009: 107-108.

[56] Petryna 2013, 2015, 2016, 2017 forthcoming-a, 2017 forthcoming-b, book ms.

detailed ethnographic engagement with the praxis of scientists, emergency planners, and other actors doing "risk management" around twenty-first century ecological transformations, Petryna has demonstrated how the retrieval of future horizons—"fleeting if somewhat arbitrary endpoints, where vision literally disappears"—permits present speculation and intervention amidst uncertainty.[57] By "retool[ing]... complexity and make[ing] it temporarily usable within a particular human or technical frame,"[58] such labor marks out a present space for "modeling, managing, and facing a complex future that is seemingly right at hand."[59]

Horizoning bears affinities with "anticipatory modes," in which "the future is inhabited in the present."[60] Anticipation always involves movements across past, present, and future that render the experienced and the unknown as the "unavoidable template" for writing "histories of the future."[61] Where "anticipation" refers to affect-laden modes of orientation toward to the future, "horizoning" captures the multi-layered labor that takes place within and concretizes those modes.

In this dissertation, I use Petryna's concept of "horizoning" to analyze the process by which the sonographic image became a touchstone for prospective relatives' reckonings with gendered potentiality. Despite the unpredictability of actual futures, the compelling dichotomy emerging from SD permitted "coordinations of human action amidst... physical and moral worlds... on edge."[62] Drawing on personal experiences and understandings of the gender-kinship built up from the past and present, families interpellated the gendered fetal subject as a particular kind of child, spouse, and community member; inhabited potential marriage and descent trajectories in imagined form; and accepted some persons and trajectories while rejecting others.

The core question for understanding familial "horizoning" within the moral economy of gender-kinship becomes: who was the desired son, and who was the daughter eliminated in his pursuit? In many prenatal diagnosis contexts, the combination of informational ambiguity and disjunctures between medical and everyday knowledge produces a situation in which parents must undertake considerable labor to imagine a child's future life; by contrast, the dichotomous gender classification emerging from SD lent itself to ready application of over-determined stereotypes.[63] Discussing sex selection's "phantasmatic future imaginaries," Kumkum Sangari has argued:

> The foetus... already has more than a biological sex. It is given a corporeity, a gendered 'fate,' and a future that needs to be curtailed... It is this positionality and... embodiment of gender, read as perennial

[57] Petryna 2015: 163.
[58] Petryna 2015: 155-156.
[59] Petryna 2013.
[60] Adams et al. 2009: 249.
[61] Adams et al. 2009: 249, 251. In commenting on Casper (1998), Adams et al. have specifically noted that "anticipatory modes reach before birth to fetal management," allowing "tactical interventions to prevent and/or enable imagined futures" (2009: 251).
[62] Petryna 2016.
[63] Cf. Ginsburg and Rapp 1999; Rapp 1999: 265-304; Wahlberg 2009. But also see Gammeltoft on the ubiquity of disability knowledge in Vietnamese women's everyday worlds (2014a: 164-193).

> disadvantage, that is sought to be eliminated. The unborn foetus comes to be personified and feared: as the daughter to be brought up, educated and 'given' away, i.e., a unilateral expense or an investment without returns; a claimant to property; a gendered reproductive body that has to be guarded and policed...; the dowry-carrying bride; the insecure daughter-in-law subject to ill-treatment or dowry harassment;... the 'temporary' member of a family becoming a permanent conduit for marriage demands; and the producer of expensive granddaughters and nieces.[64]

In my ethnographic observation, sonographically materialized fetal bodies did, indeed, elicit these forceful constructions of daughter aversion, as well as obverse constructions of son necessity. In what follows, I discuss how prospective relatives utilized such socially given templates for seeing fetal images.

That templates were socially given does not mean they expressed a timeless "tradition" of gender bias. Pervasive references to the *jamāno* reflect just how much people understood their "horizoning" as situated within a particular historical present. The imagined daughter of SD represented a distinctly modern problem—not just in fertility-limitation terms, but in her very potentiality.

Families pursuing sex selection described "horizoning" around three themes: the indispensability of a son, the cost of a daughter, and the care and emotional liability attached to a daughter. Like the models of ecologists and emergency planners in Petryna's analysis, this tripartite model organized "work that reconfigure[d] pathways of social inquiry, show[ed] the costs of inaction, and inform[ed] prospective thinking about.. [how to] reckon with complex futures."[65] Although people themselves often framed their reasoning around the three broad themes according to neat divisions between instrumental and affective motivations, all three categories thoroughly destabilized such a distinction, braiding together ontological, economic, and emotional concerns.[66] Moreover, the categories often blended into one another, as in the following fragmentary glimpses of "horizoning."

Five Glimpses of the Future

Early in my fieldwork, I discussed SD with a Rabari woman who had just given birth to her first child—a girl—at Nandini. The woman explained why her sister-in-law had unsuccessfully sought SD a few months earlier:

> She figured, what's the point of gathering a lot? Don't the costs build up—to educate them, feed them, clothe them? She felt it would be easier to take care of just two. And what kind of *jamāno* is this? Aren't there incidents of girls eloping, getting kidnapped? That's why she felt it's more possible to care for two.

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[64] Sangari 2012: 39, 41.
[65] Petryna 2016.
[66] Cf. Palriwala 2015: 27-28.

> And even if you have to spend money to marry a son in our community, he remains with us, right? A daughter goes to a *pārku* home after marrying. But a son brings in a daughter-in-law, and they'll care for us, right? We need someone when we get old, no?

Describing third-person rationales that might become hers in the next pregnancy, the woman highlighted a son's indispensability for ontological continuity and elder care, the costs of raising girls, and the dangers of protecting young women in modern times.

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I learned more about configurations of continuity and care in the same Nandini room several months later, from Esha-ben. When I spoke to her and Sagar-bhai together, or to him alone, the emphasis tended to fall on the costs associated with too many girls, and the hindrance they posed to aspiration toward a "better life." When Sagar-bhai stepped out to pick up medications, however, Esha-ben foregrounded different factors. Explaining her prior selective abortion and recent SD, she said:

> *Ek chhokaro to joie*, to perpetuate the lineage. With only girls, no boy, our lineage would end, right? Our girls would be left alone. Because you exist, Utpal-bhai, your sister can think to go to her brother's house. In good times and bad, a brother can support a sister.
>
> And if we bring home too many girls, it becomes hard to take care of them in this *jamāno*. This *jamāno* isn't right—that's why it's unappealing to have a girl. Otherwise, having her, raising her, all those costs are not too much. But you have to take great care of her. Otherwise, people kidnap her from her own home! So you're constantly in tension...
>
> Boys are easy. Girls—I mean, they're still *ours*. Girls are no difficulty. But taking care of them is difficult in this era. And we already have one girl. So what's the point of bringing home a lot? Once it gets to one boy and one girl, that's plenty for us.

Shaking her head, Esha-ben sounded weary as she ended: "Even keeping the one before, we definitely would've had another, no?"

Complementing Sagar-bhai's individual explanations, which emphasized cost, Esha-ben emphasized the desirability of a boy to his parents and sisters, along with the undesirability and dispensability of an additional daughter. Precisely because a daughter was loved as one's own and yet also always-already alienated, caring for her became a constant threat—especially amid the danger of a "not right" *jamāno*.

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Shortly thereafter, I sat in a Chetna general ward with a Patel woman from a village near Patan, keeping her company while her husband placed calls informing relatives of the impending abortion. Hugging her knees, she sobbed, "Right now, the *jamāno*'s no good for taking care of girls—don't you have to look at that? If it's like this now, how'll it be in twenty years? And right now, how many costs are attached to girls? All the costs—to educate her, all that. To get her taken out, the cost's 20,000. And if you

look at a girl, the cost's 1,000,000!" While invoking the vague dangers of a "no good" *jamāno*, the woman also explicitly expressed the cost weighing that remained implicit but strongly present in so many cases. Her "horizoning" provided a "re-entry into the present and a way toward the difficult necessity of making the future less remote"[67] by bringing the care and costs of the future daughter into the present—when the potential daughter could still be eliminated.

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Sometimes, cost and care appeared in a different form. The day after my encounter with the sobbing Patel patient, I sat in the same ward with a family of six Rajput women from near Gandhinagar. Two of them—wives of two brothers—were simultaneously undergoing selective abortions of their second pregnancies.

The women sat on the cots of squatted on the ground, the younger ones pulling their saris over their heads. A mournful quiet pervaded the room. Eventually, the patients' aunt-in-law [*kākiji*] arched her eyebrows and broke the silence, turning to speak directly to me: "You know how it is for us Rajputs. Girls mean death! You have to give so much: lots of gold, lots of money! Then what's left for your own son?"

The patients' mother-in-law scoffed, "There's no limit to the giving! At the very least, twenty *tolā*[68] gold—all at once! Then furniture, and this, and—"

A third woman chimed in, "Then it's all good if our daughters end up happy. But if the men don't turn out the way you expected—all trouble! Then, the girl has to make do wherever we've married her."

"We don't have even 100,00 for my daughter," the first woman explained, "and we can't get her married! What can we do if we can't buy even five-six *tolā* gold? We just don't have the means."

Now, all three women spoke animatedly, often overlapping.

"And in other castes, if it's bad, you can get a divorce—if the in-laws are bad, the girl won't stay!"

"Hm! And among us Rajputs, you can't get a divorce."

"That's the problem, isn't it?"

"So much trouble."

"You have to look very carefully—is the boy good or not?"

"You have to look for a good family."

Embedded in a social world of lavish dowry and pervasive dowry demands, the Rajput women emphasized marriage-related costs, rather than costs of upbringing, as a chief danger of too many girls. And unlike the Patan-area patient, Esha-ben, or the Rabari woman, they invoked care and its ensuing emotional liabilities with a different focus: the possibility of choosing the wrong *sāsri* for one's daughter and subsequently being forced to witness her enduring unhappiness.

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Around the same time, I gained further perspective on the problem of care in the present *jamāno* while sipping *cha* with Chandrika-ben's husband Hemu-bhai. Leaning

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[67] Petryna 2016.

[68] Twenty *tolā* of gold would be roughly 230 grams.

back in a plastic lounge chair set against the counter of his modest shop, he explained the couple's reasoning in choosing selective abortion during their prior pregnancy, just a year after tragically losing a newborn boy due to Dr. Dilip's insistence on premature Caesarean.

"It's not reasonable to gather too many girls," he began. "On social occasions, you have to spend money for her. And there are so many costs associated with feeding and educating them. Then she becomes *pārki*. If you educate a son, prepare him, the benefit accrues to you, right? You can educate a girl, but she's destined to go to a *pārku* household." It was a familiar refrain: the daughter and her labor as inevitably expropriated, leaving the parents with nothing except past expenditures and future liabilities.

But then, Hemu-bhai pivoted to explicit "horizoning"[69] regarding dangerous female sexuality:

> And in the current *jamāno* there's a lot of risk if you gather three-four girls. To take care of so many—it's very difficult. In these bad times, it's tough to tend to them. You know how many incidents [*kissā*] of rape there are in today's era! Men get desperate and start that funny business! And then some girls run away with boys from inferior castes. If a girl's in school, you have to keep constant vigilance on her. A father has no peace—where she is, who she's with, whether she could get raped, all this. If she goes anywhere without asking or elopes outside the caste, our honor's gone, right? And if she jumps into it blindly, if they aren't prosperous, then she'll be unhappy.

As a father of two teenage girls, Hemu-bhai had already begun living the future he was horizoning, keeping a close watch on the dangerous daughters. For parents, rape, conjugal infelicity, romantic dalliances, and elopment—all drastically different experiences from a woman's first-person perspective—occupied the same space of anxiety, which was shaped by marriage practices, community prestige norms, and the menacing *jamāno*.

The Indispensable Son

The elimination of a daughter-to-be always rested on the impossibility of her fulfilling a son's social roles—even if only implicitly, as in the comments from Hemu-bhai, the Rajput women, and the Patan-area patient.[70] People contrasted the potential girl—always-already *pārki*—with the potential boy, who would support his parents to their deaths and secure enduring social recognition.

Popular and scholarly analyses of "son preference" and sex selection often emphasize the ritual-symbolic importance of male offspring, with "carrying on the name," "lighting the funeral pyre," "inheriting property," and the like construed as quasi-autonomous determinative forces. Some accounts tie such factors to a discriminatory

[69] Petryna 2015, 2016, book ms.
[70] Cf. M. Larsen 2012.

"mindset" or "mentality," while others leave the connection tacit. Either way, the ritual and symbolic significance of a son becomes an arbitrary cultural feature, rooted in mental dispositions that value lineage propagation, material inheritance, and fulfillment of ritual obligations.

Such accounts of gender bias miss how isolable "cultural" practices reflect a much larger economy for distribution of ontological significance and social security according to offspring sex. For every family that imagined a future son performing last rights, inheriting property, or soliciting and updating a genealogy with the local Barot, I encountered dozens who scoffed at such notions. Several couples literally burst out laughing when I asked about funerary rites as motivations, with at least one spouse always asking the same incredulous question: "Who looks at all that after we're dead?" For most people, a boy's symbolic roles indexed his centrality in social recognition and material support. Given the out-marriage of daughters, a sonless household would disappear upon the parents' death. Sonlessness subjected parents not only to pity, but to an existence in which their future erasure from the community was already palpably present. When people like Esha-ben invoked notions like "lineage" or "heir," they generally spoke not about genealogy or property *per se*, but about establishing enduring forms of belonging—avoiding oblivion both before and after death.

In "horizoning"[71] around a son-to-be, the chief economic consideration was not inheritance, but the flow of support from children to aged parents. Tightly cinching together ontology, economics, and affectivity, normative residential patterns made the son and daughter-in-law's domestic and extra-domestic labor the assumed bases of social security. One of the verbs used to describe old age care—*sāchavvu*—was the same one used to describe care, policing, and protection of unmarried daughters, pointing to a transitivity within the moral-economy of gender-kinship; vectors of care ran from parents to girls, from women to their husband's parents, and from the husband's parents to *their* girls, with care of a daughter (unlike that of a son) never directly reciprocated, but always paid forward as an externality.[72] Because the economy allocated women's human capital and labor to the *sāsri*, it left even highly educated, working women feeling helpless. Teachers, lawyers, bureaucrats, and other professional women explained their avid desire for a boy by pointing to how separation prevented them from financially supporting or physically caring for their parents. The dependability of the system, which normatively ensured support to any couple with at least one son, rested on the requirement that

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[71] Petryna 2015, 2016, book ms.

[72] Once, during a conversation with two Rabari women, I mentioned that my mother's parents alternated staying with their two daughters and two sons, and that my sister and I might share future responsibilities toward our parents. They both swiftly rebuked me.

"But it is your duty!" the older sister-in-law chided. "You have to keep them."

"Your sister can't keep them," the younger one clarified. "Let me explain it to you—"

"The responsibility is the son's, to keep his mother-father."

"Not the sister's. Even if your wife says no, you have to say something—'No, you have to take care of Mammi-Pappa.'"

"The responsibility's always the boy's."

"Your sister'll have her in-laws in her *sāsri*, right?"

daughters invariably serve her in-laws, regardless of how much parents invested in them. A son thus guaranteed parents the ability to appropriate others' reproductive labor.

Couples pursuing a son envisioned a profoundly uncertain future if their quest failed. Some—usually Thakors, Rabaris, and Chaudharys—said they would fall back on bequeathing property to agnatic nephews in exchange for support in old age. But most dismissed the possibility as undesirable, citing either the undependability of nephews' wives or the rising tendency to leave inheritance to daughters and sons-in-law with the weakening of joint householding.

Some suggested that property could entice a son-in-law to move into his *sāsri*, which would allow him and the daughter to provide care. But as in many Indian settings, the uxorilocally residing man—the *ghar-jamāi*—was a man out-of-place, a figure of derision and untrustworthiness.[73] One Chetna patient, relieved at a "male" SD result after a decade of arduous fertility treatment, told me, "All this will change only when the marriage system changes. My daughter may want to care for me, but I won't find a son-in-law like that. And even if I do, society won't accept it. Why would my daughter's in-laws let her stay with me? Why would they want their son to go to his *sāsri*?" Hemu-bhai was even more blunt, suggesting that only the "bad"—greedy, poor, men of questionable character—would consider leaving "their own home" to become *ghar-jamāis*; only parents who had married their girls unforgivably badly, into desperation and downward mobility, could turn to daughters and sons-in-law. Future material support from a daughter and son-in-law was considered structurally implausible, morally shameful, and ultimately impossible to predict with certainty. Consequently, depending on daughters in lieu of a son became difficult to imagine, especially when undertaking mere "increments of action" in the face of "multidimensional uncertainties"[74] regarding how personal and social circumstances might change.

A third alternative haunted the imagination of sonless couples. I perceived a widespread moral panic centered on the specter of the *ghardā-ghar*, or "old age home." Although none of the sex selection clients I encountered could name any acquaintances in *ghardā-ghars*, many highlighted them as concrete symbols of son necessity.[75] They pointed to the figure of the abandoned, isolated elder as a warning regarding the importance of a boy for securing material support and social belonging.

Prospective parents' meditations on son necessity also reached beyond their own deaths, to existing daughters' later lives. Many told me, "We want a boy not for ourselves, but for these girls." They echoed Esha-ben in emphasizing the importance of a brother for sisters. Sonless households "closed" after a couple's passing, leaving daughters without a tangible natal source of emotional and material support. Released

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[73] On the suspiciousness and stigma of the *ghar-jamāi*, see P. Jeffery and Jeffery 1996: 114-126; P. Jeffery et al. 1989: 36-38, 182; T. Patel 1994: 30-31.

[74] Petryna 2015: 156.

[75] My visit to a Mahesana-area elder home loosely corroborated some of the fears voiced by sonless couples. Fifteen of the thirty-three residents had no children, and an additional nine had only daughters; in conversation, many explicitly cited sonlessness and the social difficulty of living with daughters as factors that had contributed to their institutional residence. Of course, nine lived in the home despite having sons, and despite the absence of definitive statistics, I am certain the number of sonless elders living among kin in the Mahesana area outnumbered those in institutional settings by several orders of magnitude.

into society, brotherless women eventually lost their tangible point of attachment in the *piyar*, leaving them adrift as perpetual outsiders in the *sāsri*. The notion that existing girls necessitated production of a boy uniquely highlights not only son compulsion, but also the extent to which daughters appeared as burdens of cost and care.

The Burdensome Daughter

Against the son as a necessary anchor of social security and social recognition, couples pursuing SD usually spoke of the additional daughter as representing an unnecessary burden of intertwined cost and care. Like the tearful Patan-area patient, people often weighed the cost of sex selection against the tremendous financial costs and taxing care entailed by a lifelong relationship with another potential daughter.

The acts of care involved in raising a daughter—birthing, clothing, feeding, providing constant supervision, indulging, and educating—were also acts of economic expenditure. Ishwar-bhai, whose lamentation regarding the costs of sex selection I presented in Chapter 1, commented to me as we stepped out from Chetna to buy apples for his hungry younger daughter:

> For middle-class people like us without too much financial capacity—maybe just laboring, or even if salaried—imagine they end up with three girls before having a boy, like if we had kept this one. So it's four kids? And the man himself, and his wife, so six people? Now the amount needed to support them will be more than his daily income... So he'll go into debt. Girls prove burdensome because of this.
>
> And no matter how much I educate my daughter, I won't have any expectation of her earning till she reaches maturity. Once she starts earning, it'll all go to her *sāsri*! So this is why another girl was burdensome to us.

Ishwar-bhai went on to explain how he was losing considerable money because of failed investments and ongoing family medical debt. He and his wife Nayna-ben had interpreted their scan result in light of ongoing financial difficulties; the necessary son might override such difficulties, but yet another daughter could only exacerbate them. Whereas investments in a boy brought direct benefits because of his retention within the patrilineage and household, expenditures on a girl represented lost labor; her income and domestic labor would generally benefit her *sāsri*. Because the reproductive economy required alienation of daughters, each additional girl detracted from investment in or endowment for the inevitable son.

In discussing costs, people like Ishwar-bhai often tied together *monghvāri*, *jamāno*, rising education, and the problem of "gathering" too many girls, thereby situating daughter aversion within a particular economic moment. Cost-of-living increases, consumption aspirations, delayed marriage, and rising educational expenses

made daughters seem particularly threatening to household flourishing.[76] More than ever before, investment in girls represented a unidirectional drain from the *piyar* to the *sāsri*.

Just as educational fees recurred as the most prominent pre-marital cost of imagined girls, marriage expenditures and associated gifting also weighed heavily on prospective parents. Gaurav-bhai, the father of three daughters, explained:

> In this *jamāno*, the *monghvāri*'s really increased. Not just cost of schooling; in a middle-class family, it's hard to manage wedding costs for three-four girls. You look at any well-off community, and marrying one girl in good fashion requires a minimum of 800,000. With community expectations, you have to give a certain amount of gold—you have to stay according to your status, right?

Though wedding costs varied considerably by caste and class, sex selection clients from diverse backgrounds shared a sense that they outstripped familial capacity to spend. Poor laboring families might spend as little as 50,000 rupees on a simple ceremony and communal meal at home—still more than a year's income, and almost triple what Dr. Ranjit charged for SD and selective abortion. I also knew of weddings for which Mahesana-area families spent over 10,000,000 meeting and exceeding "community expectations." Between these two poles, most Chetna clients saw peer families spending between 500,000 and 1,000,000 rupees. Like education, wedding expenditure garnered a daughter's parents some social recognition, but always at tremendous cost.

As indicated by Gaurav-bhai's comment, prospective parents "horizoned"[77] wedding costs from a present of already-rampant *monghvāri*. The wedding-commercial complex's efflorescence in North Gujarat and elsewhere was embedded in post-1990 market liberalization. The generation pursuing sex selection in the mid-2010s was old enough to recall the rise of full-blown consumer culture—including rapidly escalating wedding-related ostentation—and to incorporate that history into anxiety regarding the future.[78]

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[76] Cf. John et al. 2008: 74-76.

[77] Petryna 2015, 2016, book ms.

[78] Since the 1990s, numerous sub-caste organizations have attempted to stem ruinous wedding outlays by organizing and promoting joint weddings, in which multiple couples marry at the same time with sponsorship from community donations. Activists and community leaders have heralded joint weddings as mitigators of pressures for selective reproduction, often celebrating them as direct responses to the problem.[78] In fact, a number of couples pursuing sex selection assured me, "Just watch—*bhrunhatyā* will decrease because of joint weddings." While I admire the undertaking, three reasons make me skeptical of its specific impact on SD and sex-selective abortion. First, the rise of joint weddings in the 1990s, *before* sex selection's ascendance to crisis-status in the public imaginary, reveals them as pressure-release valves created to help lower-middle-class and downwardly mobile families cope with sudden post-liberalization rises in prices and extravagance; as such, they were generally already be "priced-in" to families' horizoning around future wedding costs. Second, joint weddings have succeeded unevenly, with a certain degree of normative participation in some communities juxtaposed with an ongoing sense of their connoting economic weakness and inferiority. Finally, and most importantly, the discrete joint wedding intervention may have limited impact on selective reproduction because of the practice's over-determination within the local moral economy. Numerous couples lauded joint weddings while still pursuing SD, citing the costs and

Furthermore, prospective parents did not worry only about wedding costs *per se*, but also about the obligation to give ritual gifts at marriage and throughout the daughter's lifetime. Rajputs such as the above-cited women emphasized "how much we have to give," along with the possibility of explicit demands from a daughter's *sāsri*, to a unique extent. Though not granting the factor primacy, sex selection clients from other caste groups also mentioned the normative expectation that parents would give daughters substantial endowments of gold, jewelry, and other goods upon marriage. No one (even among Rajputs) referred to such endowments as *dahej* ["dowry"], since they knew the term connoted backwardness and illegality. Instead, marital and post-marital gifting consistently fell under the euphemism *vahevār*—"social intercourse," with a distinctly transactional flavor. Whenever I let slip the term *dahej*, families corrected me, substituting the term that linguistically figured gifts as materializations of social relations—between parents and daughters, between parents and parents-in-law, and between parents and the community that granted them status and recognition. Families pursuing sex selection often portrayed *vahevār* as an act of love and care for a daughter, noting that people gave according to their "capacity" or "will"; the compatibility implied by people's frequent invocation of ability and desire in the same statement undercut the fact that the latter almost always outstripped the former. Because marriage gifting offered a unique opportunity for reinforcing and enhancing social prestige, prospective parents embraced it as an institution and thereby rejected its specific embodiment in yet another girl.

In "horizoning"[79] around daughters-to-be, families recognized marriage as not the end of *vahevār*, but merely its beginning. Observing that gifts would have to continue "as long as she lives," couples listed off the various "social occasions" to which Hemu-bhai alluded: childbirth, every parental visit to the *sāsri*, every daughterly visit to the *piyar*, children's marriages, and even the daughter's own funeral, for which her *piyar* provided the shroud. The *māmeru*, or gifting on the occasion of a daughter's children's marriages, figured especially prominently, since its costs could approach those of marrying one's own child—between 100,000 and 1,000,000 rupees for a middle-class family. People noted how such costs could weigh down the eventual son, who would retain less for "our own" household (including, of course, the aged parents). In other words, the burden of too many daughters echoed intergenerationally. Patients sometimes gestured toward sisters or sisters-in-law in explaining their pursuit of sex selection, tying first-hand experience within a multi-daughter *piyar* or *sāsri* to horizoning regarding how one's own daughters might hamper a son's economic stability and upward mobility. "The brother with many sisters," several told me, "can never rise up." Some referenced the widely accepted fact that men with multiple sisters often encountered greater difficulties in finding "good" in-laws and often had to settle for wives from poorer, lower-status families with limited capacity to enrich him with extensive *vahevār*.

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care of girls alongside son necessity; this suggests the extent to which adjusting a specific element of imagined kinship futures might exert little effect on overall horizoning.

[79] Petryna 2015, 2016, book ms.

The danger potential daughters posed to the inevitable son's prosperity also extended to the ultimate inter-generational transfer: inheritance.[80] While families generally agreed that "in our community, good girls still take what is given and don't ask for their share," they also acknowledged that "nobody can say in today's *jamāno*." In the views of sex selection clients, patrilineal property bequeathal remained largely untouched by legal provisions for female inheritance, but each additional daughter still represented a threat to the patrimony, especially since scheming conjugal relatives could harass her into making claims. Even if a daughter forsook inheritance, however, her mere existence—and the normative *vahevār* it entailed—represented real encroachments on household endowments.

Families viewed *vahevār* not only as a parental status-enhancer, but also as an act of care. Some noted that money, gold, or jewelry from marriage gifts provided security against a bad husband or financial hardship (though a woman's ability to leverage such security depended on whether she retained control over the assets). Many more observed that substantial gifts secured the daughter respect within a *pārku* household. Bhanu-bhai, whose wife had undergone three selective abortions, explained:

> If we give our girl stuff, she'll receive a warm welcome. In her *sāsri*, they'll feel, 'Okay, her father's given this much.' If we give her less, then there's going to be bickering. If two plates remain side by side, they're bound to clang, right? Her mother-in-law can say things, taunt her—'What did you bring from your *piyar*?!'

A glance at vernacular newspapers corroborated Bhanu-bhai's account, revealing how conjugal dissatisfaction with level of *vahevār* could lead to a daughter's separation, divorce, or even suicide.

Vahevār's role in securing conjugal felicity pointed to a broader dynamic that overlapped with cost as a driver of sex selection: the burden of care and lifelong emotional liability. Far from being mere objects of exchange, daughters were intimately related human beings that required care. Caring *for* girls, in turn, led to caring *about* them, which produced feelings of helplessness and anxiety within a system mandating their alienation. Until marriage, parents cared for girls and policed their bodies; afterward, they dealt with the fallout of radical rupture, including the ever-present possibility of having to witness suffering without the ability to intervene.

Like the Rajput family, many clients justified sex selection by reference to the *unpredictability* of a daughter's conjugal future. "Who knows how her husband, her *sāsri*, will turn out?" they asked. "It's a matter of luck. But if she's unhappy, we'll have to keep seeing it forever." Unspoken but widely understood in most families' "horizoning"[81] was the fact that marriage involved a degree of *normative* suffering for women, forced to uproot themselves from the *piyar* and enter an alien and often-hostile

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[80] For discussions of gender, property (especially land), and inheritance—and the implication of the nexus in North Indian moral and material economies—see B. Agarwal 1994; S. Basu 1999; N. Rao 2008; U. Sharma 1980.

[81] Petryna 2015, 2016, book ms.

sāsri. Even without spectacular incidents of harassment or other violence, a daughter-in-law's position was one of subjugation, and the ordinary tension of "two plates clanging together," as people called conflict with the mother-in-law, pulled disproportionately on younger women and their parents. As an old Gujarati saying went, fathers of daughters had to always remain bowed.

Moreover, in a *jamāno* supposedly full of "bad boys" and indulgence in vice—alcoholism, gambling, sexual dalliances—one could hardly guarantee that daughters' suffering would be limited to the socially normative. People cited numerous *kissā* [cases, incidents] from everyday experience and media accounts to underscore their fears regarding the future emotional liability wrapped up in a female fetus's potentiality: the acquaintance who immolated herself after her husband wagered *her* when gambling; the cousin "sent back" from *sāsri* to *piyar*, with stigma attached to both woman and parents; or the neighbor who barely supported her two children with hard labor after her husband absconded and the in-laws cast her out. References to such incidents highlighted the disadvantages imposed on women and their parents by arrangements that centered both social recognition and household economy on husbands and fathers.

In addition to instances of conjugal misery, people also included in *kissā* the various misfortunes that might befall parents before their daughters' marriages. In this context, "taking care of" daughters largely meant monitoring, protecting, and controlling their nascent sexuality. As Esha-ben and Hemu-bhai indicated, pre-marital *kissā* included kidnapping, rape, and other violence done unto the girl; families' reference to this danger often invoked the 2012 Nirbhaya gang rape in Delhi and other similar instances to underscore the sense of a "bad *jamāno*." But as Hemu-bhai and the Rabari patient's juxtaposition of violence and elopement suggests, the dangers of care also encompassed instances of daughters, as independently willing persons, pursuing their own wishes to the detriment of familial status.[82] Whereas sons' dalliances rarely attracted opprobrium, daughters' affairs or elopements could prove catastrophic for parents, sometimes driving them to shift residence or withdraw from the community in order to avoid stigma. People also cited the changing *jamāno* in this respect, noting that later marriage and increasing women's education—worthy developments in themselves—made school- and college-going girls weightier burdens on their parents. Given that many girls aspired to and crafted new middle-class femininities through consumption and romantic involvement, public spaces became threats to female chastity, in turn making girls threats to familial status.[83] Additional girls multiplied parents' anxieties around "taking care of so many" in order to "make sure they don't do bad things."

Two threads ran through people's reflections on care: an anxiety regarding loss of control and a sense of contemporary boys (and perhaps girls) as particularly untrustworthy. A line I heard frequently from sex selection—"The boys in this *jamāno* are no good, so no one wants to have girls"—pithily captured the structurally and symbolically violent dynamics that made caring for and about daughters such a burden. By making parents caretakers of an inevitably to-be-alienated daughter, the exchange

[82] For discussions of premarital sexuality, elopement, and familial tensions in North India, see Chowdhry 2007; Mody 2008.
[83] Lukose 2009. Also see John et al. 2008: 74.

system subjected them to the violence of expropriation. A dynamic of euphemization and displacement resulted, with *kissā* synecdochically standing in for the larger fears of parents facing uncertainty about a daughter's premarital behavior and post-marital suffering. Marriage principles themselves generally lay outside the domain of explicit interrogation and challenge, with people upholding them as "our tradition," "our Indian culture"; consequently the normative, barely-submerged violence of the structure became displaced onto some of its downstream manifestations. The liabilities imposed by patrilineality, patrivirilocality, and "today's boys" became inscribed upon women's bodies. In an exemplary enactment of symbolically violent patriarchy, the future effects of masculine domination drove parents to reject potential girls in the present. The socially threatened future daughter became the familially threatening future daughter—and hence, through the work of "horizoning,"[84] a clinically threatened female fetus.

In the act of sex-selective abortion, families rejected the valorized (and subordinated) role of conservatorship, taking full possession of otherwise *pārki* daughters-to-be by preventing them from coming into existence.[85] Such appropriation appeared to many as the only solution, given the expropriation to which the moral-economic structure otherwise subjected their reproductive labor as congealed in daughters. Families thus became the intimate administrators of a gendered violence with community- and society-wide roots, one that was visited upon female bodies before they even came into full being. While rarely calling into question the marriage and descent principles that organized the system, prospective parents often spoke in anguished tones about feeling "forced" or "without any other choice" in their undertaking of sex selection.[86] It was, as many reiterated, a necessary sin.

The Chaudhary Paradox

During my fieldwork, several sociologists familiar with the Mahesana region asked me the some question: "But why do the *Chaudharys* have a skewed sex ratio?" As they pointed out, the community presented a seeming paradox. Chaudharys practiced direct exchange marriage between kin groups, making daughters necessary to secure daughters-in-law for one's own patriline. Inverting the formal or *de facto* dowry practices prevailing in many other communities, Chaudharys required payment of up to 1,000,000 rupees in brideprice by wife-takers who could not offer a bride in exchange. And, as one scholar put it, "the father of a daughter is a *respected* position within that community."

My observations among Mahesana-area families corroborated these elements of the apparent paradox. Reciprocal exchange made Chaudhary affines equals, eliminating the need for a wife-giver to "keep his head bowed." Juxtaposing their own *vahevār* against the brideprice bustom, Rajputs and Patels often sardonically observed that Chaudharys "don't do like us, because girls are blank checks for them!" Community members themselves highlighted the same contrast in a positive light, often noting, "Girls

[84] Petryna 2015, 2016, book ms.
[85] Sangari 2012: 40
[86] Cf. Whittaker, who has discussed Thai women's anthromorphization of poverty as a force compelling them to undergo abortion (2004: 135-139).

are welcome in our community!... We don't have dowry, like the others... So girls are no burden to us."

Yet the fact was that Chaudharys also pursued female-selective abortion with great frequency. Observations at Chetna, conversations with clinicians and families, and caste statistics confirmed the pattern as evident. Many families enacted the paradox rather literally, professing greater acceptance of girls even in the midst of undergoing SD or aborting daughters-to-be. What, then, should we make of the Chaudhary paradox—of a community understood by itself and others to more readily accept girls that nonetheless rejected them with regularity?

The puzzle highlights the over-determination of gendered futures that I have attempted to convey throughout this chapter. Selective reproduction emerged from the conjunction of daughter alienation, son retention, affinal power dynamics, social recognition norms, social security expectations, diverse childrearing costs, perceived burdens of care, and falling fertility. Removal of dowry and affinal inequality from the range of considerations did not alter the fundamental patrilineal, patrivirilocal kinship parameters or most of their downstream manifestations. These features, shared by Chaudharys and other local communities, still made one boy indispensable and more than one girl burdensome. In positing greater "acceptance," Chaudharys and non-Chaudharys recirculated discourses that monocausally ascribed sex selection to the "backward" or "traditional" practices of dowry and hypergamy. But parents of *every* caste community normatively relied on sons for elder care and social recognition. Regardless of the specific form of marriage exchange or the net flow of associated gifts, daughters always posed threats to a family's integrity, reputation, and material wellbeing through their separation, sexuality, and ongoing costs (including post-marital *vahevār*).

Chaudhary resort to female-selective abortion revealed the shared substrate of kinship norms and practices that structured gender inequality. Even the construction of a woman's *father* as a respected figure indexes this inequality. Chaudhary fathers remained unbowed because reciprocal marriage exchanges created a *mutual* hostage situation, with in-laws wielding equal power over one another's daughters. Though wife-givers avoided inferiority by simultaneously becoming wife-takers, wives themselves continued to occupy subordinate positions within households.

Modern social transformations had significantly eroded the mutual hostage-taking dynamic and other potential mitigators of daughter-associated liabilities within the Chaudhary community. In a process of Sanskritization, many prospective parents aspired to give their daughters in marriage without accepting brideprice or a daughter-in-law in exchange—as a "true" gift.[87] Among families that continued to imagine direct exchange marriages for their children, the social breadth of such exchanges had narrowed from all the children of an extended family or even village to much smaller groups—first cousins, or even just siblings; in conjunction with falling fertility, this contracture reduced the value of additional girls, who were superfluous for the purpose of marrying the inevitable (and usually sole) son. More generally, Chaudharys partook of the same fertility trends as

[87] Couples expressed the notion of a "true" gift by stating either that a daughter "should be given as *dān* [a gift, with distinctive religious connotations]" or that they wished to give away their daughters as *kankuni kanyā* (a bride given without direct material return).

other groups, with each child requiring higher investment and each girl beyond the first hampering the son's (and hence the household's) prospects for advancement.

To be sure, Chaudharys' distinctive marriage practices did produce a partially distinctive pattern of selective reproduction. Much as in other communities, families with firstborn daughters typically practiced female-selective abortion if a second or third pregnancy was recognized as "female." But in a stark divergence from other castes, families with two sons sometimes pursued *male*-selective abortion.[88] Chaudhary couples with multiple sons used the otherwise-rare practice as part of a fertility strategy aimed at producing a daughter who could secure daughters-in-law—especially when poverty made payment of brideprice a non-possibility. One woman I knew underwent four consecutive male-selective abortions in the ultimately fruitless pursuit of a sister for her two sons.

But such cases were exceptions set against the shared backdrop of female-selective abortion. Clinicians and community members agreed that even among Chaudharys, a vast majority of selective reproduction was aimed at producing a boy. Although the group's brideprice and direct exchange practices mildly attenuated the pressure for daughter avoidance and even generated son avoidance pressures in exceptional circumstances, the general tendency remained one of son necessity and daughter aversion. Far from being paradoxical, female-selective abortion among Chaudharys vividly illustrated the over-determination of son necessity and daughter by moral-economic structures common to all local caste communities.

Ambivalence, Uncertainty, and the Imposition of Gender

While over-determined, gender-kinship futures hardly formed a seamless whole. In a psychoanalytic examination of sex selection in Vietnam,[89] Tine Gammeltoft has argued for seeing the phenomenon as an expression of personal and social ambivalence toward daughters. In her view, positive attitudes and experiences in relation to daughters stand in tension with the fantasy of patriliny—an "instituted fantasy" that orders reality, repressing other possibilities for familial attachment and thereby encouraging selective reproduction.[90] In this concluding section, I examine ambivalences, uncertainties, and alternative possibilities—both expressed and submerged—within Mahesana's moral economy of gender-kinship. I consider what they reveal about not only the kinship structure, but also the fragility of gender itself.

In Petryna's analysis of ecological "horizoning," the "superimposition of imprecise forecasting on actual events suggests that there are limits of actuarial performances of risk."[91] Similarly, examination of familial horizoning around gendered potentiality reveals how they could ultimately access "only *imagined* futures," full of "paradoxes and contradictions."[92] Unpredictability and equivocality constantly troubled

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[88] As a point of comparison, Retherford and Roy (2003) found evidence of some situation-specific male-selective abortion—SRBs above 1100 in third-order births to women with two sons—in Punjab, Haryana, and Delhi. By contrast, Khanna (2009: 102-103) found absolutely no ethnographic evidence of the practice, albeit in a community (Jats in periurban Delhi) without direct marriage exchange.

[89] Gammeltoft forthcoming.

[90] Gammeltoft's notion of kinship as "instituted fantasy" is drawn and elaborated from Sangren (2013).

[91] Petryna 2015: 152.

[92] Sangari 2012: 41, 39, emphasis added.

horizoning work. For instance, people often said, "This is the *jamāno* now, but who knows what it'll be like in twenty years?" Some ventured that it might be a "girl's *jamāno*," while others insisted that it would be "so much worse for women." People shared a sense of fast-paced and unpredictable transformations in gender-kinship regularities, including maturation of a small-family model, declines in joint family living, weakening of marriages, higher education for young women, work participation by women in unprecedented numbers, shifts in elders' authority vis-a-vis younger generations, and increasing uncertainty regarding the dependability of sons for support in old age. Yet the sense of uncertainty could entrench or feed sentiments of son necessity and daughter aversion just as easily as it could undermine them.

Couples seeking to avoid daughters expressed many positive feelings toward girls—both their own and in general. Some cited classic gendered tropes of symbolic valorization, claiming that "Lakshmis" brought household prosperity, guaranteed good fortune, or embodied *sanskār* [manners, good culture]. Others emphasized how "warm" daughters cared about parents more than "cold" sons—even if separation prevented them from always acting on their affection. More specifically, couples' love and admiration for existing daughters manifested concretely in their behavior on trips to Chetna for SD and selective abortion. They bragged about girls' school results and intelligence; called home repeatedly to check on them; hugged, kissed, held, squeezed, and otherwise demonstrated embodied affection toward them; and rushed home despite discomfort to reunite with them. For many families, young girls remained the center of attention, activity, and cheer during the otherwise-grim proceedings of rejecting a future girl.

In discussing their "horizoning work,"[93] couples also acknowledged unpredictability regarding daughters-to-be, given the rapidly changing *jamāno*. As noted, many said, "Who knows how it'll be in twenty years? Perhaps it'll be a girls' *jamāno*!" They characterized young women as smart, advancing, and capable of attaining tremendous personal and professional success.

Against the possible success of the imagined daughter, prospective parents contrasted "the bad sons and daughters-in-law of today."[94] In a splitting of ambivalent feelings across two differently related bodies, couples characterized daughters-in-law as necessary but uncaring, and daughters as loving but socially restricted from providing care. The women's education and advancement that made the future so promising for daughters took on a negative valence, with highly educated, spoiled daughters-in-law behaving "boldly," "arrogantly," and without regard for their prescribed obligations. "You can't trust sons and daughters-in-law in this *jamāno*," people told me. "They put their parents in *ghardā-ghars*!" Even short of institutionalization, many warned, daughters-in-law might insist on separating from in-laws and providing them only minimal care. The very transformations that made parents more hopeful regarding daughters' prospects for autonomy made them fearful of abandonment and suffering.

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[93] Petryna 2015, 2016, book ms.

[94] The analyses in P. Jeffery and Jeffery (1996: 155-170), Cohen (1998: 87-110), and Lamb (2000: 70-114) suggest that while anxieties about "the daughter-in-law's *jamāno*" and *ghardā-ghars* were configured as distinctly "modern" or contemporary, they were hardly *new*.

In such reflections, sons sometimes appeared alongside daughters-in-law as duty-shirkers, willing to go along with anything due to "wife-craziness." Some people also commented on the possibility of a son poisoning his ontological role, bringing shame—negative recognition—to his parents and patriline through vicious behavior.

Enunciations of alternate futures—the powerful daughter, the wastrel son, the faithless daughter-in-law—in fact expressed ambivalences built into gender-kinship structure. Although couples recognized the inherent tensions at play, they could not resolve such tensions by choosing to have more daughters, or by foregoing the necessary son. The system's dominant parameters remained unchanged, and outside their personal control.

To be sure, some Mahesana-area couples did voluntarily cease childbearing with just one or two daughters. Although statistical evidence on this is difficult to procure, my observation and others' opinions are in agreement that such couples largely came from affluent backgrounds, often with cosmopolitan professional and social networks. Although these characteristics were neither necessary nor sufficient for satisfaction with only daughters, they widened the scope for imagining a future in which social recognition and social security did not depend on a son. Many community leaders admitted they had to disproportionately rely on such families when organizing Beti Bachāvo-related functions centered on felicitating families with only girls, leading to a situation in which, as one put it, "the audience people receive an *example*, though they may not see their own situation in it." Government functions also included public honoring of (generally poor) women who had undergone tubal ligation with only daughters; after one such program, an official intimated to me, "We can always find one-two like that in the district—maybe those whose bodies can't handle having more kids. But it's hard, especially because people don't want to have it declared in public, 'Oh, this woman will never have a son.'"

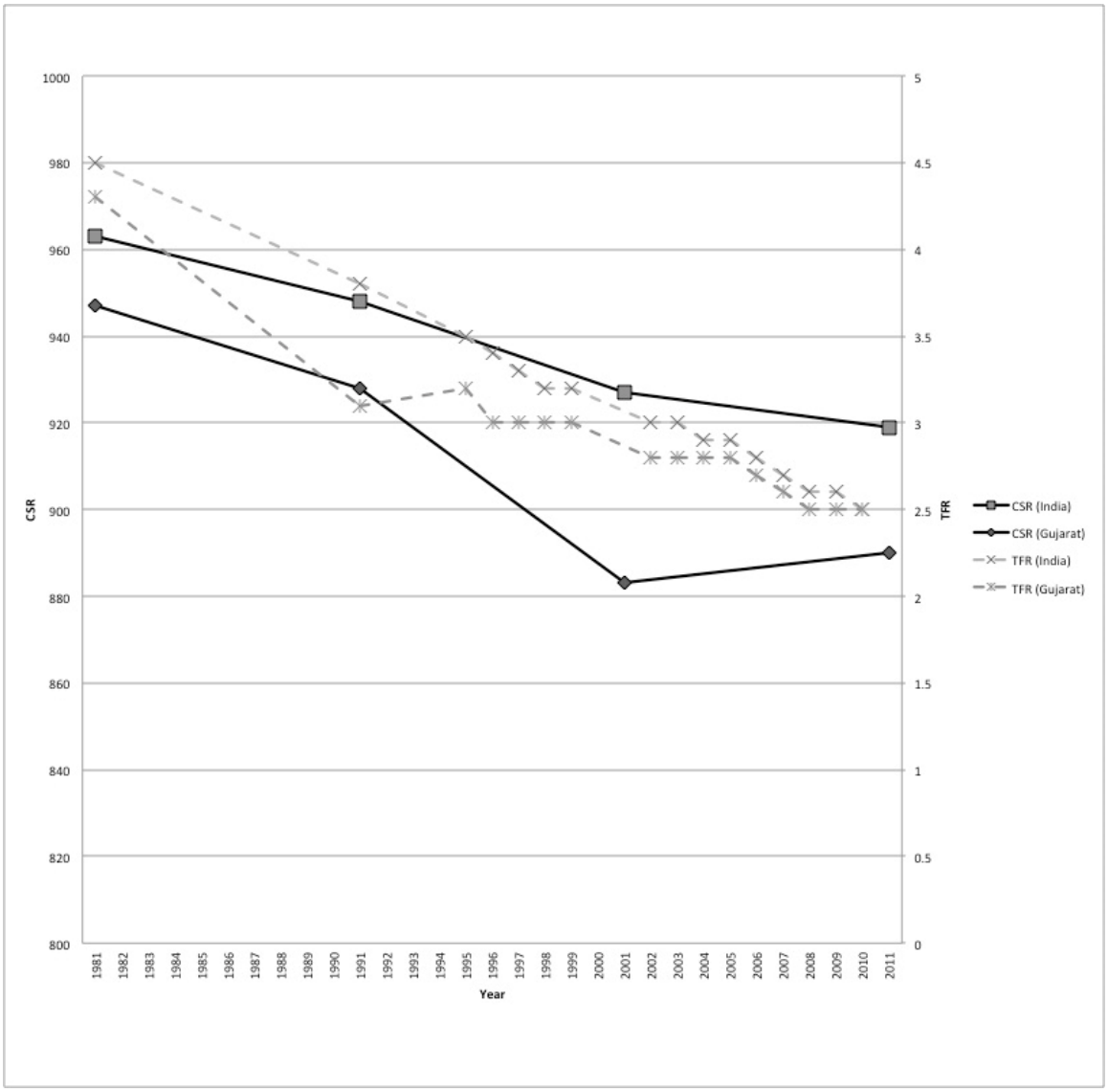
As the government officer's comment might suggest, people more often than not resolved ambivalence regarding children-to-be by reimposing the instituted fantasy of kinship on the future and continuing son pursuit. Even in times of unpredictability, the fantasy interpellated daughters as lost labor, and sons as normative continuity and support. "You can't say for sure," many sex selection clients told me, "but with a boy, at least you can hope, no? You can't keep any expectations of daughters and sons-in-law."

In a pair of studies, Mattias Larsen and colleagues have highlighted a parental tendency to paradoxically "fall back" on normative arrangements (and hence select for and heavily invest in sons) amid the uncertainties of economic liberalization and rapidly changing gender norms.[95] Applying Gammeltoft's insight, one could interpret such "falling back" as an act of repressing ambivalences and submerged alternatives in favor of the perhaps illusory certainties of normative kinship arrangements. Where Gammeltoft has emphasized community-level "reproductive intimidation" as a regulatory mechanism for ironing out ambivalences, I propose that we may also find repression in the very personal acts of reasoning around sex selection. Families intimately enacted the instituted fantasy of kinship through their selective reproduction practices, pushing aside uncertainties in favor of the default pathway. In doing so, they materialized the

[95] M. Larsen 2012; M. Larsen et al. 2006.

patriarchy's ideological reality, imposing son-associated social recognition and social security as structuring principles atop the irreducible fragility of human existence.

Figure 2 - Child Sex Ratio and Total Fertility Rate, 1981-2011



Source: CSR from Census of India; TFR from Sample Registration System

Table 4 – Sex Ratio of Births in Three Mahesana-Area Villages (Early-2000s Survey)

Characteristics	Sex ratio of all live births	Sex ratio of 1st live birth	Sex ratio of 2nd live birth	Sex ratio of 3rd live birth	Sex ratio of 4th and higher order births	Sex ratio of the last birth	Total no. of live births
All	844	867	853	849	780	479	3,708
Age of women							
15–24	927	882	916	1,098*	1,072	732	527
25–34	860	983	841	722	824	460	1,704
35 +	799	716	839	973	730	353	1,477
Women's education							
Illiterate	900	892	993	947	783	557	2,128
Primary level	824	698	838	1,143*	788	611	405
Upper primary level	767	887	707	562	944	366	721
Above upper primary level	742	893	659	618	286	360	454
Women's activity							
Cultivation-cum-animal husbandry	747	769	822	769	539	421	1,101
Agriculture/manual labour	931	891	926	949	972	598	1,481
Other misc. economic activity*	967	1,053	1,000	1,100	714	360	118
Housework	820	928	787	772	667	431	1,008
Caste composition							
Upper castes	727	838	654	978	588	358	1,065
Other backward castes	886	883	952	935	773	565	2,306
SCs + STs	971	889	1,143	769	1,138	524	337
Landownership							
Yes	800	874	778	824	642	409	1,898
No	893	857	956	881	887	578	1,890
No. of births	3,708	1,274	1,074	696	664		

Note: * The number of women with these characteristics was very few in the total universe and therefore the estimated sex ratios based on a few cases cannot be accepted as stable.

Source: L. Visaria 2007b: 148-149

Chapter 3: The Clinical Practice of Sex Selection

Seeing Inside the Black Box

I woke up to twittering sparrows and warm light in the window—the same window through which we had stared during the interminable wait for Asha-ben's abortion.

A bang on the door. I sat up groggily on the cot where Asha-ben had lay a week earlier. The "night halt" Dr. Ranjit had stipulated as a condition of further engagement was complete.

Now, in the daylight, I could see drops of dried blood on the ground. I shuffled into the bathroom, which smelled heavily of feces and urine, and splashed water on my face. The drainage from the sink fell straight onto the floor. Throwing on a fresh shirt, I stepped out to the hallway.

A nurse greeted me with a smile. We walked to the procedure room, where a patient was waiting for Dr. Ranjit. Two or three mice scurried across the floor, passing under the table where the woman lay. The nurse pointed them out for my benefit and chuckled. The woman glanced from side to side, sighing heavily and inspiring sharply. She was waiting for Dr. Ranjit. The previous evening, he had given her the dreaded news: "It's a girl."

Turning around, I took in the waiting room. A dozen young women and their accompanying relatives were already sitting on the benches or spilling out onto the patio. At least five girls, ranging from toddlers to elementary schoolers, fidgeted in their parents' laps, or ran around the waiting room and patio yelling boisterously. I did not see a single boy.

Dr. Ranjit arrived at the clinic. A nurse injected a sedative and short-acting anesthetic into a vein in the patient's left arm. Donning an apron and gloves, the doctor took his seat on a stool in the procedure room. As he performed the abortion—a matter of a few minutes—his face twitched, sometimes hardening into a scowl. The patient did not stir or let out a sound.

I found myself looking back and forth from the patient's face to Dr. Ranjit, from the emerging bodily matter to the nurses holding down the patient's limp arms and legs. As with Asha-ben's abortion, I felt a tightness in my throat and chest, but also a puzzlement at my sense of discomfort. The procedure itself was no different from what I had observed on scores of occasions during medical training and fieldwork. And yet, knowledge of the intention behind it threw me into moral equivocation.

I silently stewed over questions I would revisit again and again over the course of my observation at Chetna Clinic: How, materially, had this particular fetus become an eliminable daughter-to-be? What clinical uncertainties and risks were the patient and Dr. Ranjit navigating in that procedure room, and in that everyday procedure? And what alternatives might have been possible, if only...?

*

Clinical action subjected fetal matter to the moral economy of gender-kinship described in Chapter 2. Gender-kinship norms impelled families to solicit sex determination (SD) scans, in which ultrasound technology and expert sight interacted to visualize the fetal body. Alchemic materialization transformed the image into a body, a genital region, a sex, a gender, and an imagined kinship future. Sonographic recognition of the fetus's gendered potentiality both presumed and enabled further biomedical intervention on the inchoate subject: selective abortion of daughters-to-be, selective nurturance of sons-to-be. Within the governance-shaped black market outlined in Chapter 1, specific biomedical practices revealed, concealed, and disappeared the gendered fetal subject.

Sonography made visible a threshold person—recognizable, but still eliminable. Ethnographers have highlighted ultrasound technology's double-edged character: it personifies incipient life through concretizing specification, but the fetal particulars thereby produced always have the potential to imperil the emerging person's continued existence.[1] This paradox—heightened personhood, heightened contingency—obtains because the ultrasound fetus is "available for public viewing and commentary at a much earlier stage than [otherwise]."[2] Through biomedical visualization and familial interpellation, the potential child becomes "a social actor with a distinctive identity—'the baby'—enmeshed in a social network of kin."[3]

Qualitative clinical research across the world has generated what we might call "technology-near" accounts of experiences with ultrasound SD.[4] It has highlighted clients' curiosity around fetal sex, the gendered meanings attached to SD results, and sonographers' occasional ambivalence—including reluctance to provide the desired information when perceiving the requests as driven by "frivolous" or sex-selective intent.[5] Conversely, fieldwork on SD in India, being based in communities rather than clinics, has tended to produce "technology-distant" accounts; these focus less on the scanning event itself and more on contextual factors such as care-seeking, patterns of use,

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[1] Gammeltoft 2014a: 95-100; L. Mitchell 2001: 118; Rapp 1999: 123-127; Taylor 2008: 53, 65, 76. See Rothman (1986: 86-115, 177-216) for a parallel analysis of amniocentesis as producing a "tentative" pregnancy.

[2] Rapp 1999: 119.

[3] L. Mitchell 2001: 136.

[4] Observers of ultrasound have commented on SD and familial curiosity around fetal sex in the U.S. (Rapp 1999: 121-123; Taylor 2008: 29, 39, 42, 122-123, 125-126), Canada (L. Mitchell 2001: 127-130), Greece (Georges 1996: 162), Ecuador (Morgan 1994: 12, cited in L. Mitchell 2001: 189), the Philippines (L. Mitchell 2001: 190), Botswana (Tautz et al. 2000: 694, 696), Vietnam (Gammeltoft 2007b: 143-144), Iran (Ranji and Dykes 2012), and Syria (Bashour et al. 2005: 150-151, 152). The Syrian study noted the importance of a son in "local culture" but did not mention any evidence of sex-selective abortion. Rothman (1986: 116-154) devotes an entire chapter to SD by amniocentesis and the (hypothetical) possibility of sex selection in the U.S.

[5] For examples of sonographer reluctance in the face of "frivolous" requests and the class-stratification of perceptions of frivolousness, see Tautz et al. (2000: 694), L. Mitchell (2001: 135), and Taylor (2008: 138-140). For examples of concern about women—especially Asian immigrant women—wanting to know sex with the purpose of undergoing selective abortion, see Rapp (1999: 94-95, 324-325en319) on amniocentesis in the U.S. and L. Mitchell (2001: 138) on ultrasound in Canada.

and consequent abortion.[6] Notably, neither body of research has detailed precisely *how* shadowy images materialize fetal bodies in all their gendered futurity.

In this chapter, I peer inside the black box of clinical sex selection, describing how gender was made visible and acted on through biomedical practices that subjected fetal matter to the gender-kinship system. Building on the insight that ultrasound is never a "neutral and passive... 'window,'"[7] I examine how scans "did" gender, subjecting the fetus to systems of power. [8] Analysis of sonographic SD vividly illustrates the broader point that it takes active bioscientific and bioclinical work to produce, maintain, and naturalize genital anatomy as a site of embodied sex-gender dichotomies.[9]

Janelle Taylor has argued that "to inquire into the ordering of materializing practices is to ask how, in the same movement that bodies are enacted, relations of power are forged"; consequently, "at stake... in how even a humble technology like ultrasound gets incorporated into social life, is nothing less than what sort of bodies and what sort of social world get created."[10] At Chetna, the gendered fetal subject materialized through a process that forcibly reiterated specific corporeal and kinship forms as culturally intelligible, producing those forms as effects of biomedical and patriarchal power.[11] Ultrasound mediated the interpellation of potential sons and potential daughters at the very limits of sociality. Sexed fetal bodies became the surfaces of social boundaries. Demarcation of sex-gender-kinship proceeded through "[imposition of] system on an inherently untidy experience"[12] of ambiguous images. If society could be seen as "a series of forms contrasted with surrounding non-form," there lay "a power in the forms and other power in the inarticulate area, margins, confused lines, and beyond the external boundaries."[13] The process of visualization materialized a gendered body from the nebulous, ephemeral shapes on the ultrasound screen and incorporated it into systems of medical and patriarchal power.

As a consequence of its classification through the concerted activity of families, clinicians, and ultrasound machines, the fetus took on a fetishistic character,[14] seemingly acquiring the power to authorize and mediate subsequent intervention. Such intervention most visibly took the form of sex-selective abortion—a biomedical inscription of gender-kinship norms on female bodies, fetal and maternal.[15] Selective abortion extended and enacted the moral economy of gender-kinship prenatally; at the same time, it incrementally reconfigured the distribution of bodies that formed the moral economy's material substrate.

Because sonographic SD always presumed selective abortion as its "barely hidden

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[6] Ganatra et al. 2001: 116-121; John et al. 2008: 55-57, 61-62; Khanna 1997, 2009: 88-92, 99-106; T. Patel 2007b: 253-258.
[7] L. Mitchell 2001: 5.
[8] Butler 1999; West and Zimmerman 1987.
[9] Fausto-Sterling 2000; L. Moore and Clarke 1995.
[10] Taylor 2008: 16. See also Barad 1998.
[11] Cf. Butler 2011: x, xviii-xix; Mills 2014: 99.
[12] Douglas 1984: 4.
[13] Douglas 1984: 99.
[14] Cf. Taylor 2008: 17-18.
[15] Cf. Balsamo 1996: 11-12, 62-79; Casper and Moore 1992.

interlocutor,"[16] the scan was always a watershed moment. The image of a topographic ridge separating water basins is apt. Through visualization, (metaphorically) fluid fetal matter condensed in a moment and at a place that imbued it with potential energy. From that location in space-time, the gendered potentiality of the inchoate person might be driven in either direction: toward dissolution and disappearance, or toward elaboration and manifestation. Once recognized, the limit subject could be rejected or nurtured, with the moment's bivalent possibility resting precisely on the incipient person's liminality.

As a method of protecting familial positioning within the moral economy of gender-kinship, sex-selective abortion could be seen as a form of risk management. But the practice also raised new configurations of risk and risk management around bodily and legal harm. So, too, exposure of the fetal subject's gender, far from merely disambiguating, simultaneously produced new uncertainties and anxieties. In addition to creating new possibilities of care, sonographic revelation could also compel new forms of concealment—from the state, from routine clinicians, even from the pregnant woman herself. And the narrowly clinical practices of selective reproduction inevitably became bound up in contention between women and their families (Chapter 4) and between families and reproductive destiny (Chapter 5).

This chapter's account of SD and its consequences draws from observation in which I employed a hybrid biomedical-ethnographic gaze, oscillating between (and sometimes struggling to hold together together) my identities as anthropologist and clinician-in-training. Beginning with a glimpse from the day after my overnight stay at Chetna, the first section tackles the dynamics of "seeing sex"—the process by which biomedical expertise, ultrasound technology, and kinship norms came together to visually materialize a gendered fetal subject. The second glimpse leads into a discussion of clinicians' and clients' awareness and anxieties around the possibility of error: what if a fetal subject was misclassified? The third glimpse frames an exploration of selective abortion as a risk management technique that itself created new risks amid the prevailing environment of reproductive governance. The fourth section moves away from Chetna, returning to Dr. Dilip's Nandini Clinic in order to examine the inverse of selective elimination—selective nurturance—and how it entailed an elaborate interplay of concealment and revelation around previous SD. In the concluding section, I examine the cutting edge of SD, reviewing possible but improbable methods for rendering gender visible prenatally. In what follows, I discuss the enigmatic images, pervasive uncertainties, and shifting risks that lie hidden in the black box of clinical sex selection.

Learning to See Fetal Sex

After settling in at his desk, Dr. Ranjit told the nurse to summon the day's first SD clients, a Sindhi Muslim couple from Surat. In came Asif-bhai—a tall man, square-jawed and stubbly. He was followed by Rajni-ben, somewhat shorter but stout. Both smiled broadly.

Dr. Ranjit directed them behind the curtain, to the small examining area. He and I followed. He sat on the stool in front of the machine, I on the stool in the back corner.

[16] Rapp 1999: 129.

Rajni-ben lay down on the examining table along the far wall, and Asif-bhai stood to my right, just behind the doctor.

After squeezing ultrasound jelly onto the transducer, Dr. Ranjit applied it to the Rajni-ben's belly. He adjusted his elbow and wrist, shifting position and angle. An oscillating image appeared on the screen: bright white and darker gray areas, interconnected and set against a black background. The doctor pushed a button to zoom in on part of the picture, simultaneously manipulating the transducer to obtain a clearer view of the fetal genitals. By this point in my experience, I could recognize what the drifting white shapes on the screen represented: feet, shins, thighs

While scanning, the doctor asked a few questions. The couple had one daughter, delivered four years ago by Caesarean. They had travelled hundreds of kilometers to Mahesana District after failing to locate anyone willing to "look" in Surat.

A few minutes in, I saw a clear view of the area between the splayed fetal legs. Dr. Ranjit clicked a button to freeze the image. Looking straight ahead at the screen, he pursed his lips and mumbled, "It's a girl."

Rajni-ben did not stir, but Asif-bhai leaned forward and furrowed his brow questioningly. The doctor frowned: "It's a negative report. Female." Now, Rajni-ben looked up at a corner of the ceiling. Her eyes, wide open in anticipation a moment earlier, drooped shut.

Asif-bhai asked, "Is it sure, Saheb? Because if it's sure then"—a flipping gesture of the hand—"it's to be taken out."

"It's sure, it's sure. 110%."

"No, because if you say it, then it's definitely to be taken out. But maybe check one more time? Tell us the final answer."

"Well, it's already final," Dr. Ranjit replied. "But we can check once from below." He instructed the patient to step out and urinate so that could confirm the result with a transvaginal scan.

After the couple left, Dr. Ranjit turned to me and shook his head: "Actually, it's final. Look at this." He pointed to the screen, where the image from a moment earlier remained frozen. The central shapes almost resembled an arch—two gray projections extending downward at thirty-degree angles to vertical, connected across the top by a gray curve with a small white V at the apex. The triangular space between the projections was black. Tracing the shapes with his finger, the doctor explained, "This is one thigh. This is the other thigh." Now, the arch across the top. "Here we are seeing the perineal region." And the triangular area? "In between, there is nothing—only space. If this were male, we would see scrotal shadow and penile shadow on top of it." He drew my attention to the apical white V. "See, in female, there are only these white lines—labia. In male, we would have scrotal shadow coming from here, and just below it, penile shadow." He concluded, "It's actually final. But we'll do it again so that the patient is satisfied."

The couple soon returned. Within seconds of starting the confirmatory scan, Dr. Ranjit zoomed in again. He froze the view, producing another image with the legs splayed. Tracing the fetal parts, he delivered an explanation nearly identical to the one he had given me. Asif-bhai, who was leaning toward the machine and squinting, turned one

side of his mouth down. "So space—blank space," he muttered. "So it's a girl, final." With a sigh, he continued, "Well, then, we have to do the removal. Whatever the process is—let's get it started." Rajni-ben sat up and dangled her legs off the table. She looked at the screen, then at me for a moment, and then down. Without saying a word, she shook her head and closed her eyes.

Asif-bhai leaned toward me and scowled: "Bad luck." I pursed my lips, unsure of what to say, and he repeated the words. I wondered what his wife was thinking in her silence.

The doctor exited to the consultory. Asif-bhai frowned, sighed, and walked out. I was left in the examination area with Rajni-ben. I turned and looked. Her head still hung down. I shuffled out through the curtain, half exiting and half lingering, not sure whether to make her feel like she was not alone, or to leave her alone. She followed a moment later.

Images: Elicitation and Containment

Dr. Ranjit's scan of Rajni-ben encapsulates the alchemy by which sonographic SD and activity around it serially converted echoes into images, bodies, sex, gender, and kinship futures. In the scan and its interpretation, the expert clinician not only secured an often-elusive image, but also transformed the image—opaque or inscrutable for families—into actionable knowledge. Through the interpretive acts of clinician and clients, fetal genitals came to stand in for a host of future events, interpellating the gendered fetal subject as one whose life course was already apprehended.

Far from a straightforward case of "nature unveiling before science,"[17] the visualization of the gendered fetal subject was a process in which meanings were elicited as much as matter was revealed. In discussing the significance of "thinking and feeling in images," Roy Wagner has argued:

> An image has the power of synthesis: it condenses whole realms of possible ideas and interpretations and allows complex relationships to be perceived and grasped in an instant... It has the power of eliciting (causing to perceive) all sorts of meanings in those who use and hear it, as well as the power of containing all the possible meanings that may be so elicited; for the image itself, and only the image itself, is equal to all of them.[18]

Crucial here are the notions of elicitation and containment, which refigure the revelation-concealment dichotomy by placing the object—the image—at the center of action. As an elicitory process, Dr. Ranjit's SD drew out and condensed kinship meanings around visual materializations of fetal relatives-to-be. In turn, such meanings at least briefly *animated* an inchoate person—with animation understood as "the elicitation of life process within... the other."[19]

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[17] Jordanova 1989: 87-110. It bears noting that Jordanova's deft analysis problematizes any notion of a "straightforward" unveiling.
[18] Wagner 2012: 535.
[19] Wagner 2012: 538.

Wagner's fellow Melanesianist Marilyn Strathern has complemented his perspective by emphasizing how "the visible body is observed in terms of a two-way flow."[20] On one hand, "observation is elicited, an audience is asked to see."[21] On the other, "getting objects to appear requires work from the spectator"—"that objects are produced for people to see means that people wishing to see elicit these objects."[22] Consequently, aspects of the bodily surface have "simultaneously (1) been brought forth from inside and (2) come from elsewhere."[23] Of note, Strathern has directly applied her visual approach to ultrasound (in Euro-America), observing:

> Sight is a means of access and supplier of raw material... Interpreting an ultrasound "image" is notoriously difficult unless you already have some sense of what it is that you are going to "see." And when Euro-Americans interpret or depict what is seen, their comprehension becomes a means of organizing this piece of information about the world... Artifacts produced for display... become a particular medium for conveying knowledge.[24]

In SD at Chetna, the visual artifact and kinship understandings mutually elicited and contained one another. Sociality materialized in a two-way process of spectatorship that made potential persons manifest. The gendered fetus became recognizable because its bodily surface became the observational interface of internal and external, personified and inert, elicited and contained.

Locating Sex Determination

My observation of sonographic observation took place in the Chetna consultory's examining area, a curtained-off space that measured hardly eight feet to a side. A wooden examining table—paint chipping, old cotton-filled cushions still surprisingly soft—sat opposite the curtain, under the one tiny window. The positioning of women like Rajni-ben on the table—bellies central to the unfolding action, heads literally blocked from engagement with the scan or anyone else—epitomized how they were too often physically and interactionally marginalized amid a process that operated on their bodies.[25]

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[20] Strathern 2013: 76.
[21] Strathern 2013: 76, 81.
[22] Strathern 2013: 94.
[23] Strathern 2013: 81.
[24] Strathern 2013: 151.
[25] The pattern of women lacking visual access to the screen during the scan is one documented in ethnographies of ultrasound from numerous settings, including Ecuador (Morgan 1994, cited in L. Mitchell 2001: 189), Greece (Georges 1996: 162), and Rajasthan (Unnithan-Kumar 2004a: 66-67). By contrast, ethnographers in the U.S. (Taylor 2008: 65-67), Canada (L. Mitchell 2001: 116-143), Australia (Harris et al. 2004: 38-40), and the U.K. (Draper 2002) have all documented a pattern of sonographers readily rotating the screen to "show the baby" to pregnant women. The timing of fieldwork for these studies, along with the detailed descriptions within them, makes it unlikely that the divergence was solely a matter of technological restriction.

In the examining area, I observed scans for 170 different families—a tutelage in seeing the sex of potential persons. Dr. Ranjit adopted a Socratic pedagogy, pushing me to guess at the sex of the fetus or to identify what factors were impeding its apprehension. He asked what I saw, explained sonographic nuances, and chuckled at my confused interpretive attempts. Sometimes, he shared preliminary thoughts in whispered or medically coded asides, bringing me into a biomedical backstage that excluded clients. When he spoke to patients or their relatives, it was generally to obtain a reproductive history or to confirm their awareness of the expected payments for the scan and "if anything else is to be done."

Early on, I saw little more than the generalities of a bright fetus, a black amniotic cavity, and a gray background field—the patient's uterine wall and abdomen. Objects flickered, oscillated, wobbled, shifted back and forth. At points, the developing child seemed to shapeshift phantasmagorically: a frog, a plucked turkey, a sack of fruit, a cascade of ruffles. Without Dr. Ranjit's interpretation, I hardly knew what to elicit from the image.[26]

I gradually learned to discern fetal body parts, but this was just a precursor to seeing sex. In contrast to routine antenatal scans, which involved quickly glancing at a few "major structures," and extended anomaly scans, which entailed painstakingly examining every body part, SD consisted of a single-minded quest for what Dr. Ranjit called the "perfect vision": a view of the fetus's genital area, exposed by spread legs. Uma-masi once explained that "checking" required "separating out everything else out, so you can see *this* thing." The expert operator had to impose a proper aesthetic form on the ultrasound image, drawing out the desired marker of personhood. Visualizing gender became a matter of marking limits, of separating the locus of fetal sex from the surroundings.

Watching Dr. Ranjit perform scans, I received lessons in how he cast sound in search of an ideal view. By subtly altering the transducer's position and angle, he altered the trajectories along which the machine sent ultrasonic waves and detected their echoes. The fetus's intrauterine localization and a variety of positional factors—the umbilical cord, crossed legs, stray arms, a lateral view—could obscure the view or create an "artifact" masquerading as male genitals. Conversely, SD proved easiest when the fetal legs moved into "space" (the uterus's wide upper portion), drifted forward, and offered a perpendicular presentation to the direction of the ultrasonic beam.[27] If the genitals came into view quickly, Dr. Ranjit would macabrely remark that a particular fetus was "cooperating" or "favorable to us"; [28] if the fetus did not cooperate in its own classification, he shook the transducer against the patient's abdomen in the hope of

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[26] Cf. Mitchell's account of similar perplexity during early fieldwork in a Canadian sonography suite (2001: 60).

[27] In some cases—with the placenta blocking the view, or the fetal legs pressed into the back of the uterus—Dr. Ranjit switched to utilizing the transvaginal transducer, which transmitted and detected sound waves across the cervix, thereby providing better views of the posterior uterine wall. Being more corporeally invasive, transvaginal scans often posed considerable discomfort for pregnant women.

[28] Dr. Ranjit's macabre imputation of fetal subjectivity stands in stark contrast to the more light-hearted (but nonetheless socially significant) examples from Euro-American studies (Harris et al. 2004: 39-40; L. Mitchell 2001: 125-127, 130-131; Taylor 2008: 137-138).

eliciting fetal movement to a different position. The amount of urine in the patient's bladder could also condition sonographic sight, and as in Rajni-ben's second scan, Dr. Ranjit sometimes repeated scans after having patients pass urine or wait for it to accumulate.[29]

More generally, rescans were the norm, rather than the exception. If the doctor could not clearly visualize the genitals after about ten minutes, he asked patients to sit outside in the hope that fetal movement or accumulation of urine would permit a definitive scan. Some women endured more than half a dozen scans—including uncomfortable transvaginal ones—in a single visit. A few still had to wait until a subsequent visit to receive any result. SD sometimes spread out into hours or even days of indeterminacy.

Repeated scans and deferred results heightened an acute anticipation among clients, turning the clinical experience into one of anxiety, tedium, and frustration. When told to sit and wait for yet another scan, patients often turned to me and complained, "This is torture!" The affective charges of desire and aversion, hope and fear described in Chapter 2 suffused scanning trajectories. This was particularly so for pregnant women themselves, who nonetheless could follow the ongoing scans only indirectly, by reading the faces of Dr. Ranjit and family members.[30] In waiting for the doctor to obtain a favorable image, women and their families were waited for nothing less than the knowledge that would determine a pregnancy's wantedness.

Classification at the Limits

Even with an unobscured view, SD required a further expert skill: the ability to classify developing genitals. In Uma-masi's telling, the method was obvious. "Once it's in a position, you get a sense," she explained, splaying her right index and middle fingers in an inverted V. "If it's a girl, it's like this." Then, she pushed her left index finger into the crook of the V. "And if it's a boy, like this. Then this part is erect—it's visible. From that, you can know. If it's a girl, that part isn't there." Uma-masi's digital representation figured the self-evident anatomy that was to be elicited from the digital representation on the sonographic screen.

In explaining their own past or present SD techniques, various obstetricians provided substantially similar explanations. They said they would look for a "penile shadow" and a "scrotal shadow" between the fetal legs. Some also noted that vulvar tissue—"hard," "dense," "echogenic"—strongly reflected sound waves and hence appeared brightly white. Most considered the appearance of fetal genitals and fetal sex so obvious as to hardly merit explanation.

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[29] Sonographers found transabdominal scans easier when the patient had a full bladder, which pushed the intestines out of the way and created a clear "sonic window" to the uterus and fetus. By contrast, transvaginal scans generally proved easier with an empty bladder, which relieved compression of the fetus against the uterine wall, allowing it to better move in "space." Many clients knew the importance of calibrating the mother's urine for optimal SD, and patients sometimes endured considerable discomfort during long journeys to arrive at Chetna with full bladders.

[30] Cf. Georges 1996: 162; L. Mitchell 2001: 144-145; Morgan 1994, cited in L. Mitchell 2001: 189.

Grounded in a taken-for-granted correlation between sonographic images and human anatomy, assumptions of obviousness belay the complexities and ambiguities of "reading" an early second-trimester fetus. In the fourth gestational month, the fetal tissue was just beginning to form sonographically distinctive genitals. (The temporal limitation had percolated extensively into everyday knowledge: "The sahebs can't tell boy-girl until you've let a few days go past three full months."[31]) It required minimal expert effort to identify genitals later in pregnancy, once penile and scrotal shadows became more prominent, but commercial SD had to occur as early as possible to facilitate easier, less risky abortions. Consequently, sonographers like Dr. Ranjit were always eliciting something only barely formed—at the limits of its material existence.

Coupled with the idiosyncrasies of individual fetal development, the inchoate character of fetal genitals made SD a process rife with ambiguities. Several obstetricians noted that they could rule *in* a "male" result early in the fourth month, but felt reluctant to rule it *out* until several weeks had passed: what if the penis was late-developing? Dr. Ranjit frequently called patients back if they were "early", citing the need to confirm a result after further development. Such ambiguities contributed immensely to the errors and doubts discussed in the next section. But how did practitioners discern barely-existing genital structures at all?

Much of my tutelage with Dr. Ranjit focused on the second step of SD. Observing scans, I learned to focus on the space between the fetal thighs—often not a space in real-time, but a potential space, one that would open up with movement—and to search for whether gray shadows occupied what would otherwise be "black". The transition between locating and reading was instantaneous, unpredictable, and fleeting. The classifying gaze might have to spring into action at any moment to detect a vulva, or a penis and a scrotum. Dr. Ranjit and I stared at the fetus interminably, constantly anticipating views of an emergent presence.

It remains difficult to articulate that process of learning to see. I came to associate shadowy, phallic presences with maleness, and black triangles and white Vs with femaleness (Figure 3).[32] But I also absorbed the uncertainties. Was I really seeing "that

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[31] Cf. Khanna 2009: 102-104.

[32] Again, compare Mitchell on learning to see in a Canadian ultrasound suite:

> Before long, I was able to recognize the fetal head, femur, and spine on my own. Yet I was also aware that I was learning to see from a particular standpoint: To read the grey echoes as landmarks for measurements and as signs of abnormality, and to do this in relation to normalized growth charts. Thus, I found myself learning to read ultrasound images while trying NOT to become habituated to the conventions of a sonographic gaze. My field notes record my impressions of other possibilities of seeing... (2001: 60).

Mitchell goes on to cite a variety of heterodox views from her fieldnotes: giggles at adults praising a gray blur, a sense of all sonographic fetuses appearing alike, a feeling of voyeurism, shock at "creepy" eyes and puppet-like movements, and discomfort at the local biomedical idiom of sonography as "cutting." In some ways, my biomedical positionality made it even harder to not become "habituated to the conventions of a sonographic gaze"—to preserve the capacity for "other possibilities of seeing" that Mitchell so beautifully illustrates. Nonetheless, I believe the scope of my fieldwork—like Mitchell's, based in deep engagement

thing," as doctor and clients alike often called it? Was I really seeing "nothing"? Because Dr. Ranjit generally confirmed results from multiple angles before disclosing them, a typical day of scanning entailed hundreds of moments of searching and judging. It was exhausting to train my eyes on the screen for hours on end in a single-minded search. But my cumulative exhaustion resulted not only from searching for a clear view, but also from repeated disappointment on seeing female genitals. That disappointment—a feeling I disdained, in its abstract form, at the outset of my fieldwork—gradually insinuated itself deeper into my mind as I acquired a more situated view of what "female" results usually meant for women: tragic choices, and the bodily suffering of selective abortion.

Dr. Ranjit also anticipated the misfortune of selective abortion in his scanning, albeit in a more technical manner. His measurement of the fetal skull's biparietal diameter—a quantity the machine automatically translated into an estimated gestational age—almost always pointed to an imminent "female" result. Through head size, the doctor gauged the size of the fetus, and hence the difficulty of a potential selective abortion.

Interpreting Images

In sharp contrast to journalistic accounts and circulating rumors that posited elaborate systems for indirect communication of fetal sex, Dr. Ranjit generally conveyed his results quite directly. He would say, "It's male," "a good report," "positive," "a boy," "okay." Or he would say, "It's female," "not good," "negative," "a girl." Given that he used the terms in a given set conjointly and interchangeably, his repertoire for reporting already tied together sex, gender, kinship, and positive or negative valence.

Like Rajni-ben, many pregnant women came to know the result after their relatives. Dr. Ranjit frequently disclosed his findings in a low voice before the patient even sat up, or outside in the consultory before she emerged. Women sometimes emerged to find others already engaged in downstream discussions about abortion planning. They had to ask, "What is it, Saheb?... What did Saheb say?" and wait for a lull in conversation to learn the results.

Unlike some clinicians, Dr. Ranjit regularly "showed" families the genitals, constructing and construing fetal anatomy. In fact, with "female" results, he typically began demonstrating immediately after disclosure, before clients even asked. As with Rajni-ben and Asif-bhai, he usually started by pointing to the screen and tracing the leg landmarks—hips, thighs, knees—in order to orient clients' vision. He then indicated the space between the thighs and narrated "female" results in terms of *lack*[33]—the presence of empty space, and the absence of a phallic shadow: "You can see that there is nothing. It's just black. It's blank space... Because it's a flat space, it's a girl. If *that* were present, it would be here... If it were male, there would be three structures: two little pellets and a phallus." Occasionally, he placed two fists and an index finger on the screen to illustrate how the much-desired male anatomy would appear. When the image included a view of the small white V at the apex of the arch, Dr. Ranjit identified it as the *yoni* [vagina] or

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with clients outside of the scanning context—allowed me to resist sonographic sights full colonization of my mental possibilities for seeing.

[33] Cf. Jordanova 1989; Laqueur 1990; L. Moore and Clarke 1995: 276, 300en265, and passim.

yoninā pad [labia]. But the white lines to which he pointed were tiny, and sometimes only subtly present or intermingled with shadows; I frequently had trouble discerning them, and clients universally admitted to not really *seeing* them. Sometimes, when families with "male" results expressed doubts, Dr. Ranjit demonstrated for them as well, using the English words "penis" and "scrotum." Occasionally, he used the frozen fetal image to illustrate barriers—folded legs, an intruding cord, a lateral view—that prevented him from visualizing definitive absences and presences.[34]

Dr. Ranjit sometimes repeated demonstrations several times in a sort of ritual for creating certainty. For instance, I sometimes saw mothers-in-law, nearly blind because of advancing cataracts or missing glasses, nonetheless ushered into the examining area to "see"—more accurately, hear—the explanation. In such encounters, Dr. Ranjit's interpretive authority condensed through iterative performance. Clients could not straightforwardly check the doctor's expertise against the enigmatic image, but they also did not have to accept a simple verbal declaration. The doctor *performed* his certainty, eliciting knowledge from an evidentiary image—inscrutable to lay eyes, but containing the promise of technically mediated correlation with developing fetal matter, and hence long-term life destinies. Nonetheless, as I discuss below, doubts and anxieties about error remained pervasive, largely due to the sonogram's opacity for clients.

Scholars have widely noted that biotechnical images, far from providing direct views of material reality, always emerge as evidence in intertwinement with biomedical expertise. "Images unto themselves" cannot provide information or proof; they require "particular rituals of registration and display—especially the complex of practices known as 'reading'" in order to make authoritative knowledge. Far from being "self-evident," "icons of professional knowledge... require interpretation during which health professionals not only reveal some of their arcane wisdom but also shape the perceptions of the client."[35] Despite its enmeshment within conventions of visual realism that make "seeing the baby" a seemingly straightforward proposition,[36] ultrasound is no different. Lisa Mitchell has observed:

> To most untrained viewers, ultrasound images are confusing. Women and their partners depend heavily on sonographers' accounts of the image in order to see their baby amidst the swirling grey mass of echoes.... Sonographers endeavour to help parents to 'see'... by offering advice on how to read the image... While these hints about the technology of ultrasound help some parents see the ultrasound fetus, and provide

[34] Dr. Ranjit's demonstrations were a specific instance of the broader pattern Nishizaka (2011) has described for obstetric sonography, in which interaction around vision, touch, and talk produces a fetus in real time by exhibiting and integrating orientations to the spatially separated operational fields of maternal abdomen ultrasound screen. In particular, they exemplified a "differentiation sequence," beginning as they do with Dr. Ranjit's "invitation to differentiation" and ending with client affirmation of the anatomic identification (cf. Nishizaka 2011: 314-322).

[35] Rapp 1999: 66.

[36] Draper 2002; Georges 1996; Harris et al. 2004.

> reassurance, they also constrain that vision in particular ways. The fetus emerges as the product of expert intervention...
>
> "'Seeing' was, for [the women in my study], inseparable from the sonographer's explanation of what was visible on screen. And even with the sonographer's instructions about how to see... and the descriptive labels of what to see..., several women made distinctions along the lines of 'I could see what she was pointing at, but I couldn't tell what it was.'... While the image itself may make little sense, the comments made by sonographers do....[37]

Consequently, one might expect SD at Chetna to follow the pattern Mitchell observed, in which "the sonographer rather than the ultrasound machine was often the... 'window onto the fetus.'"[38]

Sonographic images did, indeed, prove largely opaque to Dr. Ranjit's clients. Before, during, and after demonstrations, families insisted they could not read the images without the doctor's acts of interpretation: "What could we see? Whatever you show us, Saheb. We don't know." "It will only be understandable if you tell us, finally." "Only an experienced man can know—someone who is an expert." "He showed us, but you can hardly see at three months... You have to take him as God for this... The child is just a little round blob." Clients who reported seeing the genitals invariably clarified that they could only pick out the shapes as such with the doctor's guidance. The penile and scrotal shadows, or "blank space" and the labial V, were not self-evident, iconic representations of the genitals. Rather, they materialized as *indices*—residues and proofs—of the doctor's knowledge-making process.

The fetal image's opacity was what viabilized the standard excuse Dr. Dilip and various others proffered in deflecting SD requests: "I don't have the software." And it was the reason several relatives, peering over Dr. Ranjit's shoulders, asked whether "XX" or "XY" would be "written on the screen." In some sense, of course, the image contained these chromosomal meanings, and many others—but only for the expert observer that could elicit them, translating among shapes, structures, and sex. For lay people, SD's visual products were strange symbols, requiring explanation from someone privy to the code.

Fetal Formations, Fetal Futures

Well before the doctor delivered results—indeed, in the very contemplation and pursuit of SD—clients were already mobilizing their own interpretations based on the vague but overdetermined futures described in Chapter 2. By subjected newly materialized fetal bodies to particular social roles, such interpretations made the scan a watershed moment. SD revealed whether continuing a pregnancy would make a couple parents of an avidly desired son or yet another daughter. Suddenly, families could recognize gendered potentiality and initiate decisions about whether to affirm or sever relations with the emergent fetal person.

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[37] L. Mitchell 2001: 120-121, 141-142.
[38] L. Mitchell 2001: 143.

Before and during scans, families anticipated a "male" result with one eye on the past—individual and family histories—and one on an indeterminate future. Particular reproductive histories—"too many daughters," multiple prior selective abortions, years of difficult fertility treatment—folded into the wait for a result. Patients and relatives explained their responses to results—instantly opting for selective abortion, collapsing in relief at the word "good," keeping a twin gestation with one boy and one girl—with phrases like "all this effort was for a boy."

Immediate reactions revealed the heavy affective load of both anticipation and outcome. The exultant cries, broad smiles, relieved sighs, and prayers to the divine in the aftermath of a "male" result contrasted with dejected murmurs, clenched jaws, crumpled features, hung heads, twitching faces, and slumped bodies after the opposite. Both outcomes elicited profuse tears and convulsive sobs as patients saw long quests for a son meet fruition or disappointment. Results drew out emotional reactions that clients would never display elsewhere; Dr. Ranjit chucklingly recalled how one overjoyed SD patient had hugged and kissed her husband in full view of his parents—a behavior otherwise unimaginable.

Clients' reactions offered small glimpses of the broader reproductive meanings contained in the ultrasound image. With "male" results, families quickly transformed the pregnancy into a collective project.[39] Many began asking Dr. Ranjit about the fetus's well being—heartbeats, growth and development, absence of disabilities, and so on. The pregnancy immediately became "precious" (a term used by both doctors and families), eliciting greater familial and medical care for the pregnant woman and her male cargo. Little illustrated the gendered preciousness as vividly as the phenomenon of mothers-in-law complaining about how they found themselves compelled—and willing—to invert typical domestic hierarchies by "doing too much service" for daughters-in-law carrying future grandsons.

With "female" results, by contrast, some families retreated to obtain second opinions or discuss the new information. But many, like Asif-bhai and Rajni-ben, summarily chose selective abortion. In numerous cases, including Rajni-ben's, relatives spoke for the women, leaving them as silent bystanders in the clinical decision. (I examine this pattern, and familial decision-making more generally, in Chapter 4.) Relatives—and women, when they spoke—frequently made explicit their reasoning around the obviousness of elimination: "Well, how can you have daughters in today's society? Getting an abortion is best." "A girl—so what other decision is there to make?" "We'll have to get it taken out, right?"

In SD, expert and everyday interpretation collaborated to produce recognition of gendered fetal subjects. Based on this initial recognition, the threshold person could become the subject of selective elimination or selective nurturance, both of which I discuss below.

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[39] See the discussion of "parental projects" in Boltanski (2013). Due to a narrow ethnographic scope and a lack of engagement with prenatal diagnostics, Boltanski's grand account misses how such projects may be contingent on not only extrinsic or life history factors, but also factors intrinsic to the pregnancy itself.

But for all its weightiness, the interpellating knowledge of SD scans was also mired in ambiguities, uncertainties, and anxieties. How, then, did clinicians and families navigate around the pervasive possibility of error—of a misclassified fetal subject?

"1,000%": Error and Uncertainty

The second couple of the day—a tall, mop-topped man with a thick gold chain and a short woman in a turquoise salvaar-kameez—came from Ahmedabad. Dr. Ranjit interrogated the husband for several minutes before feeling satisfied that he had, in fact, examined the wife before. From the conversation, I gradually realized that they had originally visited Chetna through Uma-masi. I would come to know them as Anjali-ben and Bipin-bhai.

Dr. Ranjit sat down to scan. "Rarely do we get a view as clear as with the previous patient," he said of Rajni-ben's quick result. "Usually, it is somewhat harder." Sure enough, despite fifteen minutes of shifting the transducer's position and angle on Anjali-ben's belly, he could not find a clear genital view. Eventually, he instructed Anjali-ben to go outside, drink water, and let urine accumulate.

During the next scan, Dr. Ranjit pressed a button, and red and blue blotches appeared on the screen. He explained, "We check the Doppler for blood flow. Because sometimes, if the cord is between the legs, it may look like a penis!" After about ten minutes, he declared, "It's a good report." Only I seemed to hear, for both patient and husband craned forward. Already walking out, the doctor repeated himself nonchalantly. After settling the payment out in the consultory, the patient asked whether the result was "sure." Dr. Ranjit nodded: "It's good. It's a boy."

In the day's fourth SD scan, the doctor again approached the fetal thighs from various angles. At one point, he murmured, "Appears echogenic in perineum," informing me in biomedical code of an apparent presence between the legs. But he must not have been certain, for he kept scanning. Eventually, the legs appeared in the bottom left of the screen, flickering in and out of visualization. Pointing to one, he said, "See, this baby is having legs crossed—like a yoga pose." I perceived an upward-folded foot, but I would not have perceived it just by looking; like clients, I required expert guidance to see. Freezing the image, the doctor told me, "What we initially thought was the penis—it was actually the foot." Shaking his head, he declared, "It's a negative report. Looks female." He provided a standard demonstration on the screen. Both patient and husband nodded slowly. When the husband asked if the result was "certain," the doctor suggested, "Come back in two days. We'll look once more."

Like Anjali-ben, the fifth patient of the day was told, after some initial scanning, to sit outside, drink water, and wait. A few minutes into the next SD, Dr. Ranjit asked me, "What's *your* finding?" Frankly unsure, I ventured that there was perhaps a "shadow" between the thighs. The doctor shook his head: "We have no prominence. Look." He zoomed in, and I realized that the white matter between the fetal legs appeared similar to that in "female" scans. Before I could ask, he confirmed, "Vulva, vulva."

Now, it was Anjali-ben's turn again. Dr. Ranjit re-scanned her and confirmed the result from the previous visit—"male". I stepped out and chatted with Anjali-ben and Bipin-bhai while the doctor took a phone call.

Then, just before leaving for lunch, Dr. Ranjit performed five scans in quick succession—all "positive" results. All five families queried his certainty. He reassured them, "110%, confirmed... No need to waste money anywhere else... Final, final... No need to go anywhere else... No need to come back, but I'll check again in a few days if you want."

Sources of Failure, Ethics of Accuracy

Anthropologists have detailed how profound diagnostic ambiguity pervades medical practices around conditions such as genetic disease and radiation-related sickness.[40] In such practices, "overwhelming uncertainty and unknowability"[41] prevails because the material aspects of bodily phenomena—onset, duration, severity, unfolding, symptomology—vary unpredictably, as do their situated social meanings. By contrast, Mahesana-area SD presumed a simple dichotomy—male or female—with overdetermined meanings. But as selective reproductive technologies often do,[42] it, too, produced new uncertainties and anxieties.

Concerns regarding SD centered on possible classificatory errors. While research on sex selection has seldom problematized SD's reliability,[43] people around Mahesana fully acknowledged the possibility of misgendering. Awareness of errors suffused clients' everyday worlds, shaping orientations to doubt and worry. Families almost always probed Dr. Ranjit's confidence after scans: "Sure?" "Final?" "100%?" "Decided?" "Confirmed?" "1,000% sure?" "Perfect?" "Any chance of doubt?" "Any chance of it being different?" People subjected expert classification to intense doubt because of its high stakes. Misclassification could lead to erroneous acceptance of an undesired daughter or erroneous elimination of a much-desired son. Because the inchoate gendered subject remained visible only through sonography, the choice to embrace or reject nascent relations with it always entailed an act of profound, if sometimes grudging, faith in obstetricians' technologically mediated vision.

Obstetricians acknowledged three ways their expertise could fail. In general, they quickly dismissed the first possibility—fetal bodies that could not be forced into a rigid male-female binary—by noting that cases of "intersex" or "ambiguous genitals" were "extremely rare."[44]

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[40] Featherstone et al. 2005; Finkler 2000; Lock and Nguyen 2010: 303-347; Petryna 2002; Rapp 1999: 66-73, 90-96, 107-115, 210-213.

[41] Petryna 2002: 4.

[42] Gammeltoft and Wahlberg 2014: 207-208.

[43] But see Khanna 2009: 101-102; Lock and Nguyen 2010: 141.

[44] Only one doctor—a radiologist often consulted for specialty scanning—said he had seen more than one or two cases of "ambiguous genitals." He explained, "Utpal-bhai, I have also done sonography *after* birth, male or female! The pediatrician had sent them along, asking, are there ovaries inside, or a prostate? There was nothing on the outside, or he would have diagnosed it. I've done five or six sonographies like that. It can go both ways—undescended testes and prostate, or uterus and ovaries. That is a natural congenital anomaly! So in cases like this, if you set out to tell with certainty antenatally, you'll be put into confusion!" Even this doctor emphasized that such cases represented a miniscule proportion of errors in sonographic SD.

Ultrasound technology was a second, more frequently cited source of inaccuracy. Doctors identified screen size, grayscale definition, and pixel count as factors influencing visual clarity, and many disparaged colleagues who performed SD on portables and other small machines. Connectors like Uma-masi also invoked machine size to promote partnering clinicians and discredit competitors; according to them, a "small TV" posed considerable risk of incorrect gendering.

The third source of error lay in sonographers' choices and interpretations—in other words, human expertise. Clinicians could fail, for instance, through haste: if they scanned around the thirteen-week threshold of genital legibility, the likelihood of misreading inchoate structures was higher.[45] Even with a sufficiently "mature" fetus, intrusion of extraneous parts might lead to mistaken inference of a penile shadow. Doctors could mitigate the risk of such "interference" by using different angles, activating Doppler, and rescanning after some time, but not all did. Numerous subtle factors—maternal bladder fullness, amniotic fluid levels, idiosyncrasies of fetal development, and so on—also required careful navigation and interpretation. Such factors opened up considerable variation in interpretive practices and corresponding reputations. For example, several clients endorsed Dr. Narendra's accuracy by noting, "His machine is tiny, but his method of looking is good."

Invoking reputation, moral obligation, and possible extortion by clients following errors, many past and present SD practitioners emphasized the importance of confirmation. Dr. Ranjit maintained a particularly firm ethic of accuracy, consistently allowing and even encouraging families to return to Chetna for confirmation. Once, after reciting errors emanating from his colleagues' carelessness, he explained:

> Most doctors aren't as careful as us. Only one visit—haphazard! We are sensitive. Patient is spending a huge amount! We should also be responsible for accuracy. And this is an illegal activity, so patient satisfaction is very important.
>
> See, I'm verifying the result. Whenever I see there is female, I will cross-check in different views, different angles, different positions. We

[45] Most Mahesana-area obstetricians declared thirteen weeks of gestational age the threshold for sonographic SD. This aligns with the findings of a study that measured accuracy using sonography machines and SD techniques similar to those prevailing in the Mahesana area at the time of my fieldwork; the study found that the rate of "correctly identifying fetal gender" rose from 71.9% at eleven weeks to 92% at twelve weeks, and 98.3% at thirteen weeks (Hsiao et al. 2008).

In discussing the timing of SD, Lock and Nguyen observe, "Sunita Puri notes that there is agreement among her medical informants that the sex of a fetus cannot be determined by ultrasound with unfailing accuracy in the early states of gestation... Ultrasound specialists with whom we have spoken in Montreal concur that only from about 17 weeks can the sex be determined with reasonable confidence..." (2010: 141). I have encountered similar thresholds in my biomedical training, with instructors informing me that fetal sex cannot be definitively determined through sonography before sixteen weeks. Without disputing the local validity of these thresholds, I would propose a "local technologies" interpretation of the divergence. It is possible that the higher stakes of Mahesana-area SD—in terms of both accuracy and abortion timing—have more acutely driven obstetricians toward accurate classification at the earlier limits identified by the study referenced above.

> take action only after becoming very precise. But till now, I've only had to change the result in three-four cases—very rarely.

Dr. Ranjit voiced confidence and pride in his accuracy, and in his conviction regarding its commercial and moral importance. Uma-masi also trumpeted his infallibility to clients, using phrases like "1,000%," "it's perfect," and "don't waste your money anywhere else."

Both Dr. Ranjit and Uma-Masi maintained he had committed very few SD errors during his career. Two surfaced during my fieldwork. When a Nandini patient delivered a girl, Uma-masi frowned and muttered, "They got it looked at with Saheb, but it came out wrong." She distanced herself from the error: "But this wasn't our patient. Our work's totally perfect! I'd never let a mistake happen." A few months later, however, she confessed that routine ultrasound suggested another Nandini patient, who had continued a pregnancy despite a "female" result at Chetna, actually appeared to be carrying a boy. She said ruefully, "I didn't say anything to her. What's there to say, since we went together?" After a pause, she waved her hand and added, "But Saheb's the one who was wrong! He looked too early, at exactly three months, and didn't call them back. So isn't that Saheb's mistake?"

False "Males" and the Risk of Unexpected Daughters

While not privy to the technical ambiguities of sonographic interpretation, clients also acted with error in mind. In accounting for potentially inaccurate gendering, families drew on everyday awareness of reproductive misfortunes resulting from SD failures: the neighbor who paid 50,000 rupees for a "good" scan and birthed a girl six months later, or the cousin who received "male" and "*maybe* female" reports from the same doctor one week apart, without any further guidance. Uma-masi's older daughter-in-law often recounted with glee how Dr. Ganpat had guaranteed her parents she would be a boy. The Nandini staff frequently recalled the woeful case of a fortysomething woman who endured burdensome fertility treatment, gestational diabetes, and gestational hypertension in pursuit of a boy; upon seeing her newborn girl, she had screamed—"How can that be?!"— and confessed that Dr. Narendra had assured her of a son months earlier. In short, people were acutely aware that SD could fail, with stories of error encouraging rescans and second opinions because of the profound implications of "male" and "female" results.

With initial "male" declarations, families sought confirmation to ensure that reproductive labor—not merely during the pregnancy and birth, but for years to come—was being committed to a son. Cautionary tales about the catastrophic births of unexpected daughters indexed more than the narrow loss of a misspent SD fee; they also pointed to wasted reproductive effort and endurance, and the tragic lack of closure resulting from not having reached the (male) end of reproduction.

Families expended considerable energy and money to attain certainty around sons-to-be. After receiving a "positive" result at Chetna, my neighbor Megha- sought opinions at three other clinics, ultimately spending nearly 100,000 rupees; even then, she suffered through "constant tension" until she saw her newborn boy. Although few

patients sought out four independent scans, my neighbor's quest reflected the doubts that plagued women expecting sons. Many reported feeling anxious, uncertain, or worried until the baby actually "arrived." Esha-ben, whose selective abortion and subsequent "male" result I described in Chapter 2, once told me, "I was in doubt all the way to nine months, all the way to the end! After the child came, I finally felt satisfied—'Okay, good.' My cousin had it happen: a gynec in Banaskantha told her it was a boy; then the delivery happened, and it was a girl! This was a fresh example. Since we'd seen this, we were both worried..."

Esha-ben's comment indexes a key factor impelling the quest for conformation: whereas a female fetus could be eliminated *in utero*, a newborn daughter exerted an immediate claim on her parents' love and care—what one obstetrician called "moral bondage." When I spoke to Anjali-ben about her and Bipin-bhai's visit to Chetna, she corroborated this dynamic: "Saheb has declared it. But when it comes, when God gives it to us, that's when it's real! At that point, it's not like we can do anything. Then, whatever it is, we have to accept happily." Dr. Ranjit also observed that parents quickly developed emotional ties to unwanted and even unexpected daughters; though the girls might suffer differential treatment or subtle neglect, they could not be rejected, as a newly gendered fetus could.

People often discussed the stakes of specious "male" results in the language of "risk." After years of fertility treatment, Gauri-devi and Dhruv-ji conceived and subsequently arranged a visit to Chetna through Uma-masi.[46] Upon returning to Nandini, Dhruv-ji repeatedly asked Uma-masi if the result was "100%," even though the doctor had expressed full confidence. As he explained his apprehension, words tumbled forth in an impassioned cascade:

> It's not doubt, nothing like that. But it's a matter of risk. Because now we can't take a risk. We're both about to be forty. There are so many responsibilities to raising a daughter: How will she grow up? What will her in-laws be like? What will happen to her? What about her education? All that. And with a boy, there's nothing like that. A boy'll grow up all on his own! So for us—our capacity will start decreasing soon. We can't take that big a responsibility. So it's a matter of risk; we can't take any risk.

The shadowy possibility of a misclassified girl represented a risk with low probability but high potential harm.

Dr. Ranjit and Uma-masi also invoked tropes of risk in their reassurances to clients. In one instance, a couple returned for confirmation two months after initial SD. The husband complained that his wife was "keeping tension on her mind, staying up at night and not letting me sleep." The patient admitted sheepishly to worrying because older relatives interpreted the similarity in *hend* [embodied experience][47] between her current and previous pregnancies as a sign of another impending daughter. After scanning

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[46] I describe my experiences accompanying Gauri-devi and Dhruv-ji in Chapter 5.

[47] *Hend* denoted the overall bodily experience of a particular pregnancy, including patterns of nausea, pain, craving, and so on.

and demonstrating the fetus's now-prominent penile and scrotal shadows, Dr. Ranjit smiled wryly and said, "Let's make a bet! How much will you put up? 500,000? If you have a girl, I'll give you 500,000!" The couple chuckled, but he continued, "Come here for delivery, alright? If you have a girl, I'll give you 500,000. If it's a boy, you give me 500,000! Give it to me for your satisfaction."

Unlike the proposed wager, Dr. Ranjit's suggestion of delivery at Chetna was more than a rhetorical device. Many women returned to give birth at the clinics where they underwent SD, even if they received routine prenatal care elsewhere. Such returns indexed the sense of obligation that bound practitioners and clients: families would inevitably seek redress upon exposure of catastrophic error, and the mere possibility pushed some obstetricians toward greater care in sonographic interpretation.

All the same, unexpected daughters did appear with some frequency. Obtaining compensation for misclassification depended on clients' willingness to enter uneven extortive terrain. Some families voiced a feeling of helplessness, noting their implication in illegal activity and the lack of concrete records. Others, by contrast, effectively leveraged doctors' interest in keeping their illegal activity invisible. By threatening to expose practitioners—often with the knowledge that prosecution under the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act had never targeted clients in Gujarat—families could extract considerable sums. In one case, a facilitator helped a family recover a 10,000-rupee fee and squeeze another 60,000 rupees from a Patan doctor who had mistakenly declared an eventual daughter "male"; multiple sources confirmed that the obstetrician stopped providing commercial SD thereafter.

False "Females" and the Specter of Mistaken Elimination

Viewed against birth of an unexpected daughter, abortion of a potential son represented a different kind of catastrophe. Mistakenly eliminating a male fetus would amount to discarding the desired object of reproduction. Families grasped for confirmation after a "female" result to avoid losing a precious son-to-be due to erroneous interpretation.

People also pursued confirmation because of the embodied suffering and moral transgression entailed by sex-selective abortion. Women and their relatives cited fear of "ruining the body" and "enduring all that" as a motivation when seeking rescans or second opinions. They similarly expressed a need for certainty before initiating "wrong deeds" or "sin."

Finally, quests for certainty were a way of grappling with the existential misfortune of a female fetus. A "negative" result derailed the teleological narrative of son pursuit, redirecting it from hope into despair. Recognizing a daughter-to-be placed families in a dilemma: embrace sentiments for and against particular types of children and reject the pregnancy, or accept the pregnancy and suppress avidly held desires. In struggling with the existential dilemma of an unwanted result, families might search for alternative certainties. (In fact, as I detail in Chapter 5, they might even attempt to *open up* uncertainties in seemingly airtight knowledge.)

As with birth of an expected son, final proof of an accurate "female" result lay in examining anatomy *ex utero*. Families often requested to see fetal genitals after abortion,

and many clinicians complied.[48] Paradoxically, familial inspection still relied on expert interpretation to make fetal fragments intelligible as markers of a specific kind of rejected potential person. Even after placing the fetal pelvis in a bedpan and showing it directly to relatives, Dr. Ranjit or the nurses generally had to point to the remains and declare, "It's definitely a girl." Despite anatomic inspection's dependence on biomedical mediation, clients valued it as a means of confirming accuracy. Uma-masi recounted an instance in which she had had to arrange a 50,000-rupee settlement after a family threatened to expose Dr. Harnish following selective abortion—not for an error, but for disposing of the fetal remains without showing them.

The paradoxical probatory status of fetal anatomy—significant, but largely inscrutable—made it a common site for forging new certainties and uncertainties. Numerous doctors admitted quietly discarding obviously male fetuses and subsequently telling clients the procedure had mangled the genitals. In such cases, the claim of mutilation-induced ambiguity masked the actual certainty of error, allowing clinicians to perpetuate the fiction of an accurate result. One doctor recounted this tactic in conjunction with even more overt deception:

> It happened that we said female, and it came out male. It happened rarely, but it happened—especially in the beginning, when we first started looking in the '90s. You can't show that patient the male child. If the perineal part's broken up, how's the patient going to know anyway?
>
> Once, I had to cut off the penile portion—this was a temporary measure, the only option I had left. I told the staff to cut it off with scissors...

"You have to protect yourself," the doctor concluded. "You have to do this, or the patient may come against you."

Perhaps due to post-abortion fetal anatomy's relative illegibility—and perhaps due to obstetricians' elimination of evidence undermining their infallibility—cautionary tales of mistakenly aborted male fetuses did not circulate in everyday discourse as widely as tales of unexpected daughters. Instead, stories about misgendered potential sons tended to center on narrowly averted disaster. They highlighted cases where some intervening event—doubt, second opinion, aversion to abortion—enabled birth of an unexpected son.

Through ongoing engagement with Anjali-ben and Bipin-bhai, I learned that theirs was one such case. Bipin-bhai's voice rose in indignation as he recounted:

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[48] Ganatra et al. (2001: 119-120) found that the fetus was shown to most of the women who underwent sex-selective abortion in their rural Maharashtrian sample (185 of 252), with five reporting that the fetus turned out male. Also see Gammeltoft (2014a: 209-223) on confronting and grieving fetal remains after disability-selective abortions in Vietnam, and Rapp (1999: 242-244) and L. Mitchell (2014) on parental interaction with fetal remains after similar abortions in North America. In contrast to the latter three cases, in which handling of fetal remains often combined anatomic appraisal with acts of fondness and remembrance, display of female fetuses after selective abortion around Mahesana tended to focus solely on evaluation of genitals. Women would sometimes speculate about "the girl" represented by the body, but such meanings were not foregrounded in the moment of inspection.

> First, we had it done in Ahmedabad. He told me the opposite report—a girl. Well, I had full doubt.... I'm not the kind of man who just trusts someone else's word. I didn't see it, did I? How would I know?...
>
> He was just interested in his money! He figured that if he told us it was a girl, he would get his full 25,000. Understand? That maybe if he said it was a boy, we might have paid 10,000 and left. So for his money, he was prepared to wreck us!

The couple had found Uma-masi through Anjali-ben's cousin—a previous client—and arranged a visit to Dr. Ranjit, who declared the fetus male. They were returning to Chetna for a confirmatory scan the day we met.

A month later, the couple obtained a 3D sonography in Mahesana and purchased the images on CD. Bipin-bhai took the CD to the first obstetrician and threw it on his desk, thundering, "Just check this on your computer—the photo speaks for itself! Give me back my money, or I'll hit you with a case!" Confronted with the iconic evidence of mid-second-trimester 3D images—more amenable to lay scrutinization than the fuzzy shapes of earlier 2D scans—the doctor immediately returned the payment.

Bipin-bhai and Anjali-ben's cautionary tale demonstrates how doubt could lead to further care-seeking, reclassification, and an altered reproductive trajectory. The story also gives firm voice to an accusation that many families and even obstetricians whispered, though rarely with concrete evidence. Expert knowledge, the rumor went, could be tainted by greed; when unsure, doctors erred toward "female" results to collect extra fees for selective abortion.[49]

Revelation of inaccuracy allowed Anjali-ben to avoid selective abortion. But many women were not so fortunate. I turn now to their experiences.

Sex-Selective Abortion and Risk

Returning from lunch, I learned Dr. Ranjit had already completed Rajni-ben's abortion. He performed another selective abortion; the patient had obtained SD the previous day.

When the doctor returned to the consultory, a couple was already waiting for him. He evidently recognized them, for he scolded, "You are very late!" The husband said they had encountered difficulty in taking time off to return for confirmation, since both worked as agricultural day laborers. Appearing exasperated, the doctor showed them into the examining area.

As he scanned, Dr. Ranjit confirmed the patient's obstetric history: one daughter by Caesarean, a second by vaginal birth, and a third by Caesarean just six months ago. At one point, he sighed heavily and whispered to me, "Gestational age is quite advanced—nineteen weeks. Now it is quite large. In this, you cannot do dilation and evacuation. We will have to initiate labor."

Out in the consultory, Dr. Ranjit informed the couple that while he might have risked a "curetting" two weeks earlier, the fetus's subsequent growth and the history of

[49] For some suggestive evidence of commercially motivated bias in SD results elsewhere in India, see Khanna (1997: 178) and Aravamudan (2007: 100-101).

two Caesarean deliveries now necessitated a "*kāchi* delivery." The process would last more than twelve hours, reaching completion early the next morning. The couple assented, and Dr. Ranjit instructed the staff to take the patient out for catheter placement.

A bit later, when I stepped out for a moment, the husband pulled me into the ward where he and his wife were sitting. He asked if the abortion could be sped up at all: "See, we've left our three little girlies at home. And the little one just can't bear to be without Mummy at night." They had travelled nearly 100 kilometers by bus, from a village in a neighboring district, and were anxious to return home quickly. I explained that rushing the abortion could pose significant risks. The man shook his head and sighed. "What choice do we have?" he asked. "Saheb said it's a girl. And we already have three. Our only work is piecemeal labor. What else could we do?" The couple nodded toward me, which I took as a sign to leave.

Dr. Ranjit performed the day's fifteenth SD on a patient accompanied by two men. "This is XX, clear-cut!" he murmured to me. "There is nothing there." Sonographic measurement of the fetal skull suggested a gestational age of sixteen weeks.

Outside, the doctor collected the payment—10,000 rupees—and chatted with the group about mutual acquaintances. After some minutes, during a lull in the conversation, one of the men hesitantly asked the result. Very softly, Dr. Ranjit replied, "It's a girl." Both men frowned. "If you don't want to keep it, then you'd have to have a *kāchi* delivery done. It's not possible by normal method any more." Turning to me, he explained, "This patient has two C/S. Because it's sixteen weeks, we cannot do it except by induction." He turned back to the men. "There would be risk in taking it out. If you want to get it done elsewhere, get it done, but don't take my name."

As the group rose to leave, the woman looked at the men with furrowed brow and asked, "What did Saheb say?" Amid the low murmuring, she still had not heard the result. Turning toward the door, one of the men mumbled a one-word reply—"female"—and motioned her out.

During the afternoon, I saw Dr. Ranjit encourage several other couples to "get it taken out" elsewhere. His rationale for doing so became clear during an interlude between patients, as we discussed the legal risks of his practice. When I hazarded that the legal prohibition seemed to make SD more risky than selective abortion, he smirked skeptically and said, "No, no! In termination, the risk is there. There may be more risks! Medical complications are there: perforation of the uterus, bleeding. Then we have to give explanation. And then the patient will not keep quiet... Patient may become hostile. And SD patients stay for a few minutes; termination patients stay for a few hours."

I thought of the day's abortion patients. For them, the medical risks Dr. Ranjit cited were bodily risks. Rajni-ben, the women from the neighboring district, several the others—because they sought procedures that almost no one was willing to perform, they found themselves forced to accept whatever the conditions at Chetna might be.

"Ruining the Body"

Most families receiving a "female" result ultimately opted for abortion, whether at Chetna or elsewhere. That Uma-masi referred to selective abortions as "cancel" vividly captures how the procedures eliminated potential children the watershed SD event had

made undesired. Knowledge of fetal sex, interpreted through gender-kinship norms as overdetermined life prospects for future child and parents, prompted severance of inchoate relations with the female fetal subject. At the same time, selective abortions were not a monolithic category: differences in maternal or fetal bodies influenced the procedure's risks and the doctor's willingness to assume them. Bodily and legal risks sometimes interacted in ways that forced women to stage medical emergencies as means to eliminate daughters-to-be.

Sex-selective abortion imposed marked suffering on pregnant women. Emotionally, many experienced ambivalence, sorrow, and anxiety around the "chosen loss" and the procedure that enacted it.[50] Such reactions were elicited by "not abortion in general..., but selective abortion in all its specificity."[51] Women spoke of sex selection as "killing a girl"—an ethical anxiety I return to in Chapter 5. And as I discuss in Chapter 4, many experience profound grief at being forced by in-laws to give up daughters-to-be.

Physically, selective abortion—a risk management technique for families—entailed significant suffering and risk for women. Patients undergo selective abortion at Chetna experienced intense (and sometimes avoidable) physical discomfort, inadequately palliated pain, frequently secondary infection, and incomplete abortions and consequent ongoing bleeding; I knew of cases in which hasty obstetricians perforated the uterus, leading to a catastrophic bleeding and a surgical emergency. Whereas scholarship and policy discourse on abortion in India have frequently highlighted the harm from unqualified practitioners and self-medication, the physical toll of Mahesana-area sex-selective abortion—a middle-class practice mediated by trained clinicians—owed much to the procedure's medical characteristics and legal context. Second-trimester timing elevated the risk of complications relative to typical first-trimester abortions, and the specter of government surveillance drove doctors to rush selective abortions, raising the possibility of greater recklessness and negligence.

Women almost universally agreed that sex-selective abortions "ruin the body." Shortly after Nayna-ben's husband complained the high financial costs of sex selection to me, her sister nodded toward the unconscious woman and explained the corporeal costs:

> Look: her body's energy is so low! This ruins the body so much. If you take it out unripe, of course it's going sap your energy, right? This is a lot worse than a delivery. A delivery is a thing God started. But abortion, *kāchi* delivery—these are things we've started. Unnatural. So there's a difference. She never felt so much torture in the deliveries. But when we do this kind of *bhrunhatyā*, the energy goes down, the body is ruined more, and everything gets messed up inside.

As "unnatural" events disrupting an advanced pregnancy, selective abortions produced pain, weakness, and damage to the maternal body.

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[50] Cf. Margerete Sandelowski and Jones (1996), Rapp (1999: 225-234), Margerete Sandelowski and Barroso (2005), and Gammeltoft (2014a: 194-224) for discussions of the ambivalence and sorrow associated with "chosen losses" after prenatal diagnosis of fetal disability.
[51] Rapp 1999: 131.

Through conversations with women, I came to understand the trope of bodily ruination as standing in for the broader set of embodied sufferings—repeated pregnancies, dashed hopes, ongoing uncertainties, profound disappointment and grief—that women assumed for their conjugal families in the collective pursuit of a son. Sex selection was a bodily inscription of an incomplete reproductive trajectory, one that might contain many more pregnancies and many more chosen losses. Experiences and memories of it always carried a nagging sense of indeterminacy and open-endedness, which came to be contained by the synecdoche of bodily ruination. Moreover, amid the pervasive normalization of sex-selective abortion and the concomitant absence of a cultural language for recognizing the tragedy of specific instances,[52] "ruining the body" became the idiom for grieving the loss of pregnancy, possibility, and potential children.

Women visiting Chetna for selective abortions pervasively discussed fears of the procedures and their attendant pain. Such discussion drew on others' stories as well as their own prior experiences.[53] Dr. Ranjit had little patience for expressions of fear and often chided patients, "Then let it be!" He was often joined by husbands and mothers-in-law who admonished women to "toughen up" and "stop worrying."

The procedures that women dreaded typically took place during the fourth month of gestation. Nurses began by administering hormonal tablets and injections to initiate uterine contractions and cervical softening.[54] As the drugs took effect over several hours, pain, discomfort, and nausea mounted. Families typically bided the time in one of the clinic's private rooms or general wards, often complaining about the uncleanliness. They also complained of boredom and found themselves at pains to occupy young daughters, who often alternated between caressing their ailing mothers and throwing tantrums. For some groups, the ennui of waiting was punctuated only by phone calls to arrange for others to milk buffalo, tend shops, feed daughters left at home, convey apologies for missed social functions, and provide transport home from the clinic.

When the procedure was imminent, many women echoed Asha-ben by asking me to remain present after they were sedated. I read such requests as attempts to secure a biomedically informed check on the doctor's care. The requests also ensured women of at least one familiar, responsive person amid a flurry of often-indifferent clinicians.

The procedure room was dark and grimy, dotted with fresh and dried blood. It was home to several rodents and occasional flies. In preparing patients, nurses undertook frenzied activity around their bodies while almost never responding to their desperate questions about impending pain and sedation. The nurses spoke to the women only to provide stern instructions: "Lie down!" "Take off your underwear!" "Spread your legs!" "Give me your hand!" "Move down!" "Stay still!"

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[52] Cf. Layne (2002: 69) on the "cultural denial" of pregnancy loss in the U.S. and the corresponding need to invent spaces and practices for grieving such loss.

[53] Like Asha-ben and her mother-in-law, many women based their understandings of sex-selective abortion in part on horror stories from the 1980s and 1990s, when women of current patients' mothers' generation had undergone abortions without the mitigating effects of anesthesia or prostaglandins.

[54] While either a tablet or an injection would typically suffice for hormone administration, the Chetna staff employed the two combination in order to facilitate quicker cervical dilation and a shorter time-to-procedure.

Just before the procedure began, a nurse injected a sedative-anesthetic preparation, often without any warning except "Make a fist!"[55] The patient's body usually slumped, and her words petered out. Some women remained somewhat conscious, often moaning or crying out in pain. Dr. Ranjit would shrug and explain, "Response is variable—some are very sensitive." I strongly suspected that his practices also played a role: his staff tended to administer low anesthetic and sedative doses in order to conserve stock amid high patient volume, and he himself often progressed rapidly from injection to physical instrumentation. Like the dirty conditions of the clinic and the procedure room itself, the possibility of pain was an inconvenience patients found themselves compelled to accept, given the scarcity of sex selection services.

After the procedure, staff hurriedly moved patients onto a metal stretcher and wheeled them back out to their families. A nurse handed over a bag of post-procedural pills for the ensuing days: two antibiotics to prevent infection, a vitamin, two drugs to calm gastrointestinal distress, a pain medication, and a lactation suppressant. (Dr. Ranjit explained that his staff dispensed the medications directly, rather than instruction families to procure them at an outside pharmacy, because "otherwise it becomes evidence.") Patients slowly emerged into consciousness, gradually becoming aware of nausea and pain. As with Asha-ben, their first intelligible utterances were often queries about the comfort of existing daughters.

Bodily Risk, Legal Risk, and Staged Emergencies

Dr. Ranjit employed alternative abortion techniques in the presence of three risk factors: more advanced gestation, which correlated to a larger fetus; multiple previous Caesareans, which correlated to more uterine scar tissue; and recent Caesarean, which correlated to immature scarring. All of these significantly raised the risk of uterine perforation, massive blood loss, and downstream complications in a standard dilation-and-evacuation abortion. In such cases, the doctor induced *kāchi* delivery, using an extraamniotic catheter to mechanically irritate the uterus and initiate a labor process that lasted up to twenty-four hours and ended with the expulsion of a whole fetus. As in the early cases recounted by Asha-ben's mother-in-law, *kāchi* delivery generally proved harrowing for women and their accompanying relatives.

Induction of *kāchi* delivery in riskier cases fit into a strategy of risk management. Many obstetricians agreed with Dr. Ranjit's view that selective abortion could prove more dangerous than SD. Explaining why he refused to perform selective abortions despite providing SD, Dr. Tapan said, "There are more complications in termination, right? Where does exposure happen? Where do things come out? With complications!" Referencing the recent scandalous death of a selective abortion patient, he continued, "What happened in that Ahmedabad case, with that woman's death? If she hadn't died, they wouldn't have been caught." He went on to talk about an obstetrician he knew who had become embroiled in a patient's divorce proceedings after she claimed that her

[55] The pre-procedural injection usually consisted of a preparation containing three of the following four drugs: ketamine (a dissociative anesthetic), pentazocine (a narcotic sedative), diazepam (a barbiturate sedative), and atropine (a heart rate-controlling drug).

family had forced her to undergo two selective abortions at his hands. He concluded, "So the whole car flips over. When there are complications, you have problems."

While disclosure of sex was difficult to catch, an abortion mishap like uterine rupture could easily expose a practitioner, with emergency treatment and family outcry bringing down unwanted attention. State policy thus transformed women's bodily risks intro legal risks for clinicians. Though patients sometimes decided to keep pregnancies when faced with the riskiness of a potential abortion, those proceeding entered a terrain shaped by the confluence of three agendas: their own, which focused on eliminating a known daughter-to-be while balancing safety and speed; the doctor's, which focused on generating profits while avoiding medical and hence legal complications; and the state's, which focused on protecting the threatened female fetus, but without regard for pregnant women's safety.

Mahesana-area obstetricians responded to laminated medical and legal risks by assuming positions within a division of labor. Some, like Dr. Tapan, performed SD but left ensuing abortions to colleagues like Dr. Ranjit, thereby profiting from sex selection while avoiding its more dangerous component. Meanwhile, Dr. Ranjit performed selective abortions but left the most difficult ones to "bold" colleagues. Clinicians' divergent roles within the divison of labor depended on differences in their degree of risk aversion, but also differences in their perceptions of risk due to expertise level; many colleagues agreed that Dr. Ranjit could perform dilation-and-evacuation abortions on patients for whom they would attempt only *kāchi* delivery, and the former maintained that Dr. Ganpat could perform quick abortions on patients for whom *he* would insist on induction.

Faced with risky cases, Dr. Ranjit did not refuse categorically. Instead, he did so in ways that left open the possibility of his relenting. He frequently carried on protracted negotiations with families, refusing while avoiding full foreclosure. Within the small openings that remained, insistent clients could convince him, overcoming his medico-legal (and sometimes religious) ambivalence with pleas of desperation and promises of profit.

That the outcomes of such negotiations did not always favor women's safety became clear when I met Falguni-ben and her husband. They came to Chetna from Ahmedabad, toting a six-year-old and an infant, for confirmation of a "female" result declared two days earlier. As soon as the doctor holstered the transducer, Falguni-ben sat up and asked, "The same?" At his silence, she frowned.

"This is when we need to be sure," Dr. Ranjit said to me. "She has two previous C/S. So generally, we don't perform termination. There is scarring, so there is a risk of perforation."

Falguni-ben's eyes widened in alarm: "Saheb, is there risk in this?"

"Ben, with two previous C/S, there's definitely risk. If we do anything, and something happens, then we might have to take out the whole uterus." Dr. Ranjit asked the infant's age and scowled at the reply—eight months.

"Now that there's a problem," Falguni-ben pressed, "can't you do something to solve it?"

"Get it done somewhere else."

"But no one'll do it in Ahmedabad."

"Sister, if it comes to it, I might even have to do a hysterectomy!"

"Meaning?"

"Meaning, we would have to remove the uterus. With no Caesar, it's possible to take a chance, but not here." The couple slumped in place for a long while.

Stepping out to the consultory, Dr. Ranjit encouraged them to "think it over." Falguni-ben retorted, "We don't want to! Since it's negative, what else is there? I'm ready to make the decision."

We sat silently for two minutes—the longest silence I ever observed at Chetna. Falguni-ben's jaw clenched, and her eyes filled with tears that eventually cascaded out in soft sobs. Eventually, Dr. Ranjit said, "Lately, there's been a lot of raids. And the thing is, sister, healing takes time. After a C/S, you have to keep a gap of at least twelve months!" The doctor harangued the couple at length for not utilizing contraception.

Then sounding more conciliatory, he continued, "With a Caesarean, it's safe if we do it by delivery. Or I can talk to Ganpat-bhai. If he does it for you, well and good."

Falguni-ben and her husband shot each other glances. She pleaded, "Saheb, can't you try?"

"Sister, I say no in such cases. When we have such risky cases—say, people with three Caesareans—we always refer to Ganpat-bhai. He can do it with five scars, too!"

Falguni-ben asked about the induction abortion procedure. After explaining it, the doctor cautioned, "But if the child coming down disturbs the stitches, and the scar rips, and a hole forms through it—then you have to take out the whole uterus! Then it's a major problem! Instead, why not keep this one?... Because if your uterus goes, it's all over for you. If the abortion works, it's fine. If not, you're in trouble."

"But we don't want it!" Falguni-ben's tone was indignant. "Since it's a daughter, there's no way we can keep it, no? We already have two."

"If you keep this, then there are chances of a male in the fourth—"

"We don't want to take any such risk! I don't want to keep it. Let's make a decision right now."

"Well, let me try calling Dr. Ganpat." The patient protested, but Dr. Ranjit had already dialed. "Yes, there's a patient... Two previous C/S, but last C/S just nine months ago... Should I send her?... Very well." Hanging up, he relayed that Dr. Ganpat would see them.

Doctor and patient went back and forth for several minutes. Falguni-ben pushed for Dr. Ranjit to perform the abortion—but quickly. The doctor, in turn, insisted she would have to either go to Dr. Ganpat or accept a slow induction.

Eventually, Falguni-ben ventured, "Could I take abortion pills, to start bleeding? Then we could get it done in Ahmedabad."

To my astonishment, Dr. Ranjit acknowledged the tactic—a dangerous one—as possible: "Then you could get it done with your regular doctor."

"Exactly. See, it's possible to stay overnight there." She pointed to the infant: "This one's very little, that's why."

Dr. Ranjit instructed the husband to step outside and ask a nurse for the pills. Alarmed, I asked, "So you're giving them abortifacient pills to induce miscarriage?"

He smiled: “Heavy bleeding is an extremely clear-cut indication! Nobody can deny.” I asked pointedly whether the plan didn’t carry risk of grave complications. He admitted, “Yes. Contractions are always there with prostaglandins.” I waited for further elaboration, but he shuffled papers on his desk.

After a bit, Dr. Ranjit asked where Falguni-ben would obtain the “emergency” abortion in Ahmedabad. She named her regular obstetrician, noting, “We went there yesterday, after you gave us the result. We asked her, but she said, ‘There’s no reason.’ So then we didn’t push it.” Now, the couple would have a reason.

Once the husband returned from the dispensary, Falguni-ben began asking about the effects on her uterus, and whether the pain would be “tolerable.” Sounding impatient, Dr. Ranjit explained, “It will be tolerable. But the process of pain and bleeding can break the stitches. But, don’t go too early either! What if you go early, and she gives medication, and the pain and bleeding stops? What’ll you do if she says you can keep it?”

Now, it was Dr. Ranjit’s turn to sigh. “Instead of all this,” he said, “it’s better if Ganpat-bhai does it. It’ll be over in three-four hours. He’s done a lot of these. The other way, you could get stuck with problems—bleeding, pain, an infection. And the doctor might refuse.”

“Well, this whole problem exists because you won’t do it, right, Saheb?”

“I’d do it slowly, by delivery. You’d have to spend the night.”

“How would Ganpat-bhai do it?”

“It’s nothing big for him. He used to do forty in a day—forty!”

“Saheb, I have no problem going to him. But I don’t want my body to be ruined! I don’t want anything to happen to me.”

The husband, silent till then, interjected emphatically: “Yes, nothing should happen to her!”

Worried about Falguni-ben’s safety if she staged a miscarriage, I proposed, “If you don’t want anything to happen to you, getting admitted here would be best.” She reiterated her concern regarding safety, and the doctor reassured her nothing would happen if she remained at Chetna.

Falguni-ben asked, “What do you say, Saheb? If you say, I’ll stay. I’ll make do.”

Dr. Ranjit pursed his lips. “It’s up to you.”

“I’ll go by your advice. If you tell me there won’t be a problem, I’ll do it.” Beginning to sob and gasp, Falguni-ben continued, “If I do it here, and you’re around, then there’s safety. If I go home and take the pills, and something happens in the middle of the night, where would I go? If you’re around, there’s safety for me—you can take immediate decisions.”

After another silence, the doctor asked, “What do you want to do?”

“Whatever you say.”

“If you want it done in three-four hours, Ganpat-bhai does it. It won’t be a problem.”

A vigorous head-shake. “I don’t want to go there. Why does he do it so quickly?”

“He’s prepared to take risk! He’s done a lot. He has experience. Doctors like us wouldn’t even think of doing what he does.”

“We’ll do whatever you say.”

"*You're* the ones in a rush!" Dr. Ranjit was shouting. "If you weren't, you wouldn't even have to consider it, right? If we tried doing it that fast, the complications would increase."

"So what do you say? I'll stay here and get it done.

"Talk it over with your husband—"

Falguni-ben laughed: "I don't have to ask him! He'll tell you to ask me. What else would he say?"

They discussed induction abortion logistics further, and Falguni-ben asked Dr. Ranjit to try for completion before daybreak. Smirking, he said, "For us, it's best if you leave by the morning! It's safety for us!" He instructed the couple to go outside and wait for induction. After they left, he turned to me and exclaimed, "How much the patient is insisting! 'You do it, you do it, you do it.' But they're not prepared to spend the night!"

Dr. Ranjit stepped out briefly. I went to the patio, where Falguni-ben and her family were sitting. A nurse came out to report that Dr. Ranjit wanted to see the husband. While he went in, Falguni-ben and I occupied the girls with hand games. At one point, she shook her head and muttered, "In this era, it's already so expensive with two daughters. With marriage—and after marriage, so many problems! If you find a good household, no problem. Otherwise, it's all problems."

After ten minutes, the husband returned. Sighing, he reported Dr. Ranjit's words: "'It'll take three-four hours for the pain to start. And I have to step out, so I won't be back for five-six hours. And after that, another five-six hours. Instead, it's better if you get it done in Ahmedabad. Give her the pills at night. It'll happen by morning." Dr. Ranjit had used the meeting with the husband to subvert Falguni-ben's own wishes for her care.

I had to say something directive. Looking at wife and husband by turn, I warned, "In my view, this is very risky. If you have limited bleeding, it's fine. But if you have a lot, there's a lot of risk. Here, he'll handle any complication. But if you do it at home, too much bleeding won't do, nor will too little." The husband was nodding along, repeating some of my words. "The middle road isn't an easy thing. With no doctor, how'll you know how many hours to wait?"

The husband nodded and said, "Saheb said he'll do it, if we tell him."

We entered into a flurry of discussion. They asked me about different abortion procedures. After I answered their questions, they began speaking in hushed tones. The decision was now theirs.

When a nurse came out to the patio, the husband turned to her and declared, "We're going to go back to Ahmedabad and do it there." The nurse went in to retrieve the medication.

Feeling a lump in my throat, I asked, in a last-ditch attempt, why they did not trust Dr. Ganpat. Frowning, Falguni-ben explained, "A friend went from Ahmedabad, and the place was sketchy—sketchy treatment, sketchy nurses, sketchy doctor. And he's been caught once. You have to look at the man, too, don't you?"

The husband, already clutching the younger daughter, patted the older one on the head and said, "It's because of these two girls that we're not staying. If the two of us were alone, it'd be no issue. But with these two girls, it's a problem."

The nurse brought out the pills and reiterated instructions. The couple gathered up the girls and left.

Some days later, I called them to ask after Falguni-ben's health. Her husband sighed, "Forget about it. It was torture. It's taken care of, but it was torture."[56]

I subsequently learned that staging emergency—intentionally making a woman's bodily state so precarious that any reasonable obstetrician would remove the fetus—was not just Falguni-ben's *ad hoc* tactic. Dr. Ranjit routinely used the technique with families that did not wish to remain admitted for *kāchi* delivery. Such staged miscarriages carried their own grave risks. In one case, a patient returned to Chetna at twenty-two weeks—more than a month after initial SD. Given the advanced gestational age, Dr. Ranjit gave her pills to take at home and instructed her to go to a clinic the once bleeding began. I was present at 5:00 AM the next day when two men carried in the woman, now unable to stand. The staff rushed to treat her, and I stayed out of the way. Later, a nurse explained:

> It came out at home, the whole child... But the cord broke! There can be lots of bleeding in cases where it comes out at home. With the placenta stuck inside, that's bound to happen, right?... The bleeding finally stopped only when we removed the placenta, removed the clots, and gave Methergine.[57] Thank God, her blood pressure was not too low. But with so much bleeding, she was so weak.

"There's no problem if God gives you what you want," the nurse mused. "But people run into such difficulties!

While creating the possibility that a patient might experience severe complications, the staged emergency balanced the competing demands of patients, doctors, and the state. Families were generally reluctant to remain at Chetna for long periods; doing so entailed lost time and disruptions to routine tasks like childcare, housework, farming, and business, as well as considerable discomfort, given the clinic's dirty conditions. While Dr. Ranjit generally expressed willingness to admit patients for induction, he felt ambivalent; doing so carried a small but nontrivial risk of heightened government suspicion if an inspection happened to occur during the patient's admission. He admitted that in precipitating miscarriage, he was wagering that the benefits of avoiding a lengthy, risky abortion at Chetna outweighed the unpredictability of an induced emergency that would unfold between the patient's home and another clinic. The PCPNDT Act formed the ground from which both doctor and client orientations arose: because the prohibition on sex selection had made most doctors even more reluctant than Dr. Ranjit to take on late abortions, patients felt compelled to place themselves in such precariousness that no obstetrician could refuse to end the pregnancy.

Put differently, while failing to prevent the elimination of female fetuses, the PCPNDT Act made second-trimester abortions scarcer in a way that perversely

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[56] Falguni-ben, her husband, and I spoke on several other occasions, but never about the abortion experience. Whenever it came up, I sensed that neither of them wanted to revisit it, and left it at that.

[57] Often given after births and procedures, Methergine (methylergonovine maleate) promotes uterine shrinkage and stanches bleeding.

endangered women with "risky" fetuses or "risky" wombs. Where reproductive governance generated unintended negative effects, those effects—just like the effects of the patriarchal order the governance clumsily sought to combat—were visited most starkly on the bodies and psyches of women.

Late-Term Sex Tracking and Selective Perinatal Care

The Nandini Code and Bifurcated Care

Only after two years did I discover that Dr. Dilip still performed SD on each and every obstetric patient at Nandini. He did not disclose the resulting information to families. Instead, he utilized it in other, tremendously consequential ways.

From observing Dr. Dilip's dictation to his assistant, I knew that when he derived the estimated date of delivery (EDD) from sonographic measurements, he might yell "EDD" or "ED." I had long assumed the variation to be a matter of haste or indifference. But one day, I heard him ask the assistant, "What's written on the chart: ED or EDD?"

Confused, I asked the difference. Dr. Dilip socratically turned the question back to me: "What does 'EDD' mean?" I gave the only reply I knew—"estimated date of delivery." Smiling mischievously, the doctor continued, "And 'ED'?" I had to admit I thought it was the same. Dr. Dilip broke into a full grin and chuckled, "Yes! But this has a meaning for PCPNDT." Scrawling the two abbreviations on a chit, he said, "Think about it!" As I pondered the letters, he returned to seeing patients.

After a few minutes, Dr. Dilip briefly stepped out. His assistant waved me over and grabbed the chit. Below the second 'D' in "EDD," she continued writing: "...A-U-G-H-T-E-R." My eyes widened.

Smiling, the assistant explained, "This is a code. Saheb, Uma-Masi, and me—only the three of us know it. Sometimes, we have to actually say the date too, so the patient doesn't figure it out! If the patient's uneducated, it's not a problem. But if they're educated, we have to say the date, too. We used to have a different code—'S' and 'D'—but we got rid of it."

Then, she elaborated, "See, if it's male, they'll immediately agree to Caesarean. It's not like we won't try, but if we try to do a normal delivery at all costs, and something happens, then the patient will get more worked up."

Returning to the consultory, Dr. Dilip turned to me and asked, "Did you figure it out?" When I nodded, he shouted in mock anger, "Someone must have snitched!" Chortling, he further clarified the code's function:

> See, this is useful to us in the management of delivery. In the end time, if at all anything happens to a male child, the family will not forgive. They will be very angry. If something happens to a female child, they will not be as much angry. And so with both, we take care. But with "ED," with even the mildest indication for C/S, we will not hesitate to take C/S. Whereas with "EDD," we can stretch it a little.
>
> If we need to take the C/S and the child is a male child, then afterward, the patient will not object; looking retrospectively, the patient

> will be happy that you have taken this decision and will gladly pay for the operation. But with a female child, they may not be so happy. We don't want any child to expire; we take care in every pregnancy. But this is a well-known fact: if a male child should die perinatally, the family will become very angry. They may become violent, may ruin the doctor's reputation. They may form a mob, as in that Chandrika-ben's case.

"With a female child," he concluded, "they will be sad, but they will be quicker to accept the loss; they will not feel that they have lost so much."

I asked the doctor when he determined whether a patient had an "ED" or an "EDD." He replied:

> Any time after five-six months. Any time I am a little bit free, I will look, and we will note it down, because it can help us in the management. Because with male child, we will not take any risk of normal delivery—we will do C/S for even the mildest indication. Whereas with a female child, if there is some indication for C/S, say fifty-fifty chance of delivery by normal labor, then we will do a longer trial of labor. If there is something like oligohydramnios or cephalopelvic disproportion, we will not even take any chance with a male child, whereas with a female child, we may try normal delivery.

With that, he returned to examining patients, leaving me in thought. I marveled at how the code allowed Dr. Dilip to continue incorporating knowledge of fetal sex into his care decisions—which were, of course, also business decisions.

From then on, I began noticing the Nandini code in every late-term prenatal visit. Sometimes, Dr. Dilip shouted "ED" or "EDD" to his assistant from behind the curtain. On other occasions, he asked her to specify one or the other and then made decisions about care based on the information.[58]

I also noticed a drastic bifurcation in perinatal care at Nandini, precisely as per the clinicians' explanations. Whereas mild to moderate concerns regarding fetal wellbeing often led to watchful waiting in "EDD" cases, Dr. Dilip often recommended immediate Caesarean delivery in otherwise similar "ED" cases. In other words, he intervened more aggressively to deliver sons from the womb. The doctor did not divulge fetal sex, but he frequently pushed families with "ED" pregnancies toward Caesarean delivery, listing out

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[58] I gradually realized that Uma-masi, despite rarely looking at the charts, also seemed to know the sex of regular patients' fetuses. When I inquired about it, she laughed and said:

> I started being able to tell after the raid. So then, when it was time for a C/S, Saheb would call me: 'Uma, do you remember what it is?' I could tell him in my sleep—Saheb, it's this, go ahead and do it. He always asked me; he never wrote it down. Saheb and me—just the two of us knew. It was my job to remember, and when the patient came in, I'd tell him, it's this, or it's this. Now we write a code number on the file. They do it by writing, and I do it with my brain!

a litany of fetal complications if the child was "left in too long." In numerous cases, he preemptively delivered male fetuses in the early ninth or even eighth month—a stage considered "premature" by biomedical standards.

The divergent care enabled by the Nandini code reflected the differential valuation of sons and daughters within the moral economy of gender-kinship. This differential valuation corresponded not only to intensity of familial anger if something befell the fetus, but also to the profitability of male and female newborns as products of obstetricians' work. When doctors gave families what both parties sometimes called "something *good*," the latter made minimal attempts to bargain down the fees for Caesareans, which easily quadrupled those for vaginal deliveries. By contrast, families receiving a daughter often insisted on a lower price; if the delivery had been Caesarean, they might also portray the obstetrician as over-inclined toward operative delivery, damaging his reputation among prospective clients. Surreptitious detection and tracking allowed clinicians to capitalize on fetal sex, performing Caesareans when they were most profitable and avoiding them when they might harm business.

Bifurcated perinatal care, which flatly contradicted the doctor's insistence that "we take care in every pregnancy," had palpable consequences. During my fieldwork, several Nandini patients near full term experienced the heartbreaking stillbirth of a daughter. Uma-Masi, other Nandini staff, and I concurred in our assessment of these cases: Dr. Dilip had not intervened at the earliest signs of danger, when the babies might still have been saved by Caesarean delivery, because the charts had not borne "ED" designations. The assistant doctor's comments after such incidents were always some variation on the same theme: *At least since it's a female, they're a little less shocked. If it had been a male child—imagine what they would be like!* Everyone agreed that stillbirth of a male fetus would carry the potential for what Dr. Dilip called the "atom bomb"—the sort of mob violence that had descended after the death of Chandrika-ben's newborn son.

Ironically, Chandrika-ben's loss had resulted from precisely the type of aggressive intervention that it was eventually used to *justify* (at least for "ED" cases): the child had died after Dr. Dilip, preparing to leave for an out-of-state trip, performed a premature Caesarean. While guaranteeing more biomedically management of transition into the world, early Caesareans also created new threats to emerging sons' survival. In some cases, male newborns, having exhibited no signs of "fetal distress," experienced extensive complications—likely attributable to premature delivery—and had to remain under inpatient pediatric monitoring for a week or more. Although the doctor took some steps to mitigate the risk of complications, the alternative to the son "left in too long" was not a straightforward passage to safety.[59]

Selective perinatal care at Nandini exhibited the same tendencies Claire Wendland has identified in biomedical discourse around Caesarean delivery: it obscured the woman as all but a container, marketed "fetal safety" as a paramount concern, and advocated aggressive intervention to overcome unpredictability.[60] Wombs became

[59] Before delivering sons by premature Caesarean, Dr. Dilip sonographically checked to ensure an adequate fetal weight and administered two maternal corticosteroid injections, which would speed fetal lung maturation.

[60] Wendland 2007.

"dangerous sites from which fetuses must be rescued," and tales of tragedy were mobilized to justify aggressive action.[61] These tendencies reflected reproductive medicine's broader interventionist model, which often transforms maternal and fetal bodies into objects of invasive technocratic management.[62] The fetus's emergent personhood and the specter of perinatal mortality augmented one another, producing an "unborn patient" that merited intervention.[63] In this, the Nandini pattern also paralleled Amrita Pande's recent observations at a Gujarati transnational surrogacy center, where Caesarean delivery became almost inevitable as a means of ensuring safe extraction of "precious" babies attained at great cost and effort.[64]

What distinguished Dr. Dilip's Caesarean interventionism amid these broader patterns was its selectivity. Only some babies appeared precious enough to merit aggressive action. The Nandini code and its clinical deployment produced a gendered classification of emergent lives and a corresponding bifurcation of care. Surreptitious SD, coded tracking, and Caesarean delivery allowed Dr. Dilip to control the delivery of male life into the world and extract profit from it. By increasing the risk of iatrogenic complications, such intervention paradoxically endangered the much-desired son. Nonetheless, because preemptive delivery substituted apparent biomedical control for "natural" unpredictability, aggressive Caesarean became the hallmark of a diligent doctor.

The obverse of this overly interventionist approach was a laissez-faire treatment of female fetuses. By late term, biomedical action was no longer actively eliminating potential daughters. Instead, it was simply leaving emerging girls to weather the vicissitudes of late gestation and delivery, "marked as unpredictable, uncontrolled, and therefore dangerous."[65]

In speaking with Dr. Dilip's obstetric colleagues, I learned that many similarly determined and tracked fetal sex without disclosing it to families.[66] Once obtained, knowledge of fetal sex functioned in various local clinics much as it did at Nandini. In discussing his routine antenatal care practices, Dr. Tapan said, "See, what we do is, we find out, and we just remember, or note down somehow in chart. Then, at the time of delivery, this can be helpful to manage properly. Because this is a fact, that a male child will have more complications. Scientifically, male child will have much more difficulty

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[61] Wendland 2007: 227, 224.

[62] Cf. Davis-Floyd 2004; Jordan 1993; Martin 1987; Oakley 1984.

[63] Cf. Casper 1998; Weir 2006.

[64] A. Pande 2014: 116-120. By contrast, Deomampo interprets high Caesarean rates among commercial surrogates in Mumbai as a function of a racialized view of their bodies as always-already risky (2016: 171-193). The two emphases—the preciousness of the emerging baby for Pande, the riskiness of the intrauterine environment for Deomampo—complement one another in highlighting the importance of aggressively extracting valued children from the womb.

[65] Wendland 2007: 224.

[66] Perhaps wary of the legal risks or moral connotations of admitting to SD, some obstetricians denied deliberately searching for the genitals, instead insisting that the third-trimester penile and scrotal shadows were so prominent that one could not help but notice them. While knowledge of sex may have imposed itself in a pseudo-self-evident manner during sonography, the use of the information for care decisions obviously required a degree of active calculation from doctors.

in same delivery than female child."

Like Dr. Tapan, many clinicians justified the need for greater vigilance around male fetuses on the basis of perceived differences in the hardiness of male and female infants, invoking both personal experience and scientific literature. Research does, indeed, support the notion that greater susceptibility to difficult labor, birth injuries, and maternal disease or accident leads to greater mortality among male fetuses and neonates than among their female counterparts, with the rate of demise perhaps 20% to 40% higher for the former.[67] But in the context of obstetric practice in Mahesana, the documented difference became exaggerated and mobilized to naturalize unequal treatment. For instance, in clarifying his use of the Nandini code, Dr. Dilip ventured:

> One thing you see, that if you have five boys with an alarming situation, then of those five, perhaps three will have difficulty—difficulty breathing, postnatal problem, need to be kept admitted as a neonate, like that. But if you have five girls in the same situation, only one will have that difficulty. Nature has given females this strength, that they are better able to endure a difficult situation perinatally. Males' bodies are less able to handle.

The lower valuation of girls made it easy to speciously contend that nature, left to its own course, accorded them much better survival prospects than their precious male counterparts; the same lower valuation also made their demise less commercially damaging when nature took an unfavorable course. As integral parts of doctors' mental dispositions for fetal monitoring and evaluation, presumptions of female hardiness and male weakness pathologized identical bodily situations as different threats according to sonographic sexing. Naturalization of divergent care for male and female fetuses reflected and reinforced the broader social and market situation, in which families more keenly desired, demanded, and remunerated safe passage into the world for sons.

Family Knowledge and Precious Pregnancies

Of course, clinicians did not simply pull unwitting patients into a regime of bifurcated perinatal care. Six months after I first learned the Nandini code, I entered the clinic from a driving rain to see Sheela-ben and her husband, whose early prenatal visit had been the occasion for my first observation of the "software excuse." Now, after having received a "positive" declaration at Chetna, they were entering the ninth month of pregnancy.

During their visit with Dr. Dilip, the husband said sternly, "There shouldn't be any problems!" The doctor assured him there were none, but the husband retorted, "What if something happens to the child in the belly in the next ten-fifteen days?" Dr. Dilip explained that there was little likelihood of any difficulty, and that to "get it out before the months are complete" could generate its own problems. He dictated his ultrasonography findings—all normal—to his assistant and told her to prescribe the

[67] This assertion is based on neonatal mortality data from India during the 1990s and 2000s (C. Kumar et al. 2013: 125; Million Death Study Collaborators 2010: 1855) and third-trimester fetal demise data from several Western countries across the twentieth century (reviewed in Waldron 1983: 323-324).

patient two corticosteroid injections, as he typically did near term to ensure fetal lung maturation. The husband interjected, "Make it three!" The husband was almost certainly unfamiliar with the biomedical evidence regarding dosing and efficacy of prenatal corticosteroids; in fact, when we discussed the encounter, he admitted he did not really know what the injections *did*. But his insistence indexed an embrace of intensive biomedical intervention to protect a known male fetus.

At the end of the visit, Sheela-ben asked, "What if we draw it out and something happens? You have to do a C/S, Saheb! We have to have a C/S!" They eventually agreed that Dr. Dilip would do a Caesarean delivery in a few days, once the corticosteroids had taken effect.

Doctors widely reported that recognition of a son-to-be drove clients like Sheela-ben and her husband to actively push for more intensive perinatal care. The assistant doctor at Nandini observed:

> Patients who've gotten SD—they worry more. They worry about everything and come in for checkups every ten days. 'It's a boy! What if something happens to him?' It becomes a very precious pregnancy. Then, at the end, they don't want a normal delivery—they only want a C/S. 90% of normal deliveries won't face any problem, but if it's a boy, they won't take any risk. We recently had a patient like that—very wealthy. They had a boy, and they insisted on us doing a C/S. Saheb refused. But they insisted. They said, 'Saheb, what if something happens to our boy? Patients won't do this for a girl. But if it's a boy, they want a C/S.

An anesthesiologist who attended many Caesarean deliveries similarly observed that many patients felt a need to "get it out" quickly when they had "gotten it checked."[68] Such statements underscore the intense impulse toward active extraction of male lives from the womb, where a son-to-be could become endangered at any moment. Based on doctors' pre-delivery warnings and various circulating stories, families generally knew the potential for neonatal complications after premature Caesarean. Yet they demanded preemptive intervention all the same. Early extraction at least rendered the fetus physically accessible, enabling further direct monitoring and intervention; for prospective parents, as for doctors, the iatrogenic risks of such extraction seemed preferable to the unpredictability of intrauterine existence and "natural" passage out of the mother's body.

By contrast, families expecting a daughter often insisted on leaving the fetus to survive the late-term womb and normal delivery without interference. Dr. Tapan observed, "If they find out it's a girl, then no matter what, the patient'll say, 'Just do a normal delivery, Saheb.' That patient won't get a C/S done. Even if there's a natural complication, they won't be ready... If they know it's male, then they'll be overjoyed and do whatever it takes. If it's a female, they won't be too concerned." Given a daughter's lower value to the family, her safe extraction was less imperative. Families explained that

[68] Cf. Margerete Sandelowski (1993: 151-154) on parents' desires to "get it out" via Caesarean after enduring exntensive fertility treatment to conceive.

foregoing Caesareans allowed them to avoid higher medical costs, as well as to spare women's bodies the wear that would decrease short-term contribution to domestic work and long-term ability to safely bear the inevitable son. In an echo of doctor's biological rationalizations, many clients also justified differential care by positing that girls were "naturally" stronger and so could weather greater perinatal difficulties.

I observed dozens of cases substantiating the notion that prior SD heavily influenced client preferences around late-term care. Sometimes, families explicitly declared their knowledge of a son-to-be and demanded safe extraction at all costs. Sometimes, they dropped heavy-handed hints: "This time, it's *good*, so do whatever you need to—do a Caesar if it's necessary." Sometimes, they stopped short of revealing their knowledge but raised concern after concern to nudge the doctor toward or away from intervention. And sometimes, they insisted on non-operative delivery despite warnings of imminent danger to the fetus, mumbling among themselves, "Why do a Caesar for *this*?"

Within the regime of secrecy, partial sharing, and incomplete communication created by PCPNDT enforcement, families and routine antenatal care providers seldom disclosed fetal sex to one another explicitly. But each party incorporated the possibility of the other's knowledge into thinking around late-term decisions. Obstetricians and their staff could often infer, even before examining a fetus sonographically, that families insisting on a Caesarean must be expecting a son. Conversely, patients and relatives sometimes assumed that clinician recommendations for Caesarean delivery indexed the maleness of the fetus, with several offering me asides like "Saheb is saying to definitely do an operation. He knows our situation. Would he keep pushing us toward a Caesar if it wasn't good? So we can infer from that." Occasionally, families expressed acute disappointment when Dr. Dilip or his colleagues delivered a daughter by Caesarean, noting that the doctor's insistence on the necessity of intervention had led them to presume a son.

In sum, doctors' and families' awareness of fetal sex, even when not communicated directly, contributed in largely congruent ways to shaping a regime of bifurcated perinatal care. SD made male fetuses precious to families, prompting them to advocate for greater intervention. And sonographic gendering by the routine care provider identified future sons as prioritizable (and profitable), again leading to greater intervention. Conversely, recognition of femaleness left daughters-to-be less deserving of fully vigilant care. This bifurcation of fetuses and their perinatal care into extremely precious and relatively dispensable, overly aggressive and overly passive, had life-and-death consequences for all emerging babies.

The Cutting Edge of Biomedical Sex Determination

For most doctors and families in the Mahesana region, the only realistic method of sex selection was standard sonographic SD followed by selective abortion. But a range of more exotic technologies—advanced sonography, sperm sorting, pre-implantation genetic diagnosis (PGD), and cell-free fetal DNA (cffDNA) tests—lay near or just

beyond the edges of the local biomedical imaginary.[69] Though inaccessible or infeasible for most clients, they became the topic of animated discussion among practitioners.

One advanced SD technology was simply a further development of the familiar 2D ultrasound machine. Already the standard equipment at many high-end clinics in the Mahesana region, 3D machines could produce more lifelike renderings of the fetal body. Given the material limits of genital development, 3D scanning could not shift the thirteen-week threshold for detecting sex. But many patients and doctors expressed a common-sense view that by displaying three-dimensional images on larger, higher-resolution screens, the more advanced equipment must enable more accurate SD. For instance, Dr. Ranjit said, "With 3D, it is much easier, obviously! Even an intelligent family member can tell!" As indicated by Bipin-bhai's use of a 3D image CD to demand repayment of charges for incorrect SD, the 3D picture could perhaps "speak for itself," representing the genitals in an iconic form that even lay people could understand.

In fact, many experienced practitioners disagreed. High-risk pregnancy experts—those who most frequently used 3D scanning—scornfully said that "anyone can do SD, with even a cheap machine!" Some SD practitioners suggested 2D technology might even prove more accurate than its advanced counterpart. Dr. Tapan explained:

> See, in 3D, *that* part actually isn't so clearly visible. That's what I've heard. Because 3D is a high-intensity modality, you see everything in three dimensions. But *this* gets a bit obscured. Because sometimes, there's only a one-millimeter difference between penis and vagina-vulva. What if that gets blurred in the shape? That, you can see more clearly in a 2D machine.

By asserting the superiority of 2D scans for SD, Dr. Tapan located the key classifying faculty in his and other sonographers' vision, rather than machines themselves.

Disagreements over accuracy notwithstanding, 3D equipment enabled at least one novel method for skirting PCPNDT regulations, though I rarely heard of it being used. Once, while attending a state-level obstetricians' conference, I met a doctor from Anand, in central Gujarat. Upon learning of my topic, he took a long sip of *cha* and sighed:

> What a mess! You know what some of my patients have started to get done lately? They go to a 3D specialist, and they get a CD with the video or images made. That doctor doesn't tell them the sex! But he gives them the CD. And then they go to someone else, who puts the CD in the computer, and tells them. I don't do it, of course. But this is a thing that happens. So the scanner is one man, and the revealer is another.

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[69] Allahbadia (2002) and van Balen and Inhorn (2003) reviewed the use of sperm sorting and PGD for sex selection. Though biomedical research has refined understandings and practices around these technologies, their basic functioning and efficacy remains similar. Since the late 1990s, cffDNA testing has been developed and refined as a method of SD, with very high accuracy now possible even in the first trimester (Devaney et al. 2011; Wright et al. 2012).

I was stunned. The iconism of the 3D picture—and the visual overload of a 3D scan CD, in which a momentary glimpse of the genitals might be buried amid countless other images—allowed even further disaggregation of sex selection services. In addition to separating SD and abortion, clients and practitioners could now subdivide SD itself into two stages. In a way, the practice echoed the sampling-and-interpretation collaboration between obstetricians and pathologists in the bygone era of amniocentesis and CVB.

Other biomedical possibilities, visible more to clinicians than clients, promised to *determine* sex in the sense not of ascertaining it, but of actually causing it.[70] Doctors often reference the possibility of subjecting a sperm sample to centrifugation or flow cytometry in order to separate sperm bearing X and Y chromosomes. The resultant Y-enriched subsample—"semen highly qualified for producing a male child," as one doctor put it—could then be used for intrauterine insemination or *in vitro* fertilization (IVF). One doctor went so far as to warn, "Watch—it won't matter any more if there's female foeticide. The patient will say, just give me a male to start!"

But most obstetricians seemed skeptical that sperm sorting would emerge as a local modality of selective reproduction. The early-2000s amendments to the PCPNDT Act had outlawed pre-conception methods like sperm sorting; one obstetrician with past training in Mumbai recalled her seniors offering wealthy patients sorting services in the 1990s but ceasing it after 2003. Now, acquisition of the clinical equipment, expertise, and market profile necessary to offer commercial sex selection by sperm sorting would likely attract intense government scrutiny.

PGD was a related technique for shaping, rather than ascertaining and reacting to, fetal sex. Performed on embryos prior after IVF, the method allowed for selective implantation of male embryos. Again, local obstetricians expressed skepticism around the feasibility of an underground PGD operation. They cited specialized equipment, need for coordination with a pathologic lab, high cost, and PCPNDT surveillance as barriers to the rise of the practice in Gujarat.

Several clinicians did, however, report cases of patients with means traveling to Southeast Asia or the Persian Gulf to undergo IVF in conjunction with PGD. One fertility expert said of his elite clientele:

> The people who want to get PGD done and have the money, they go to Thailand. Or they go get IVF in Dubai... So they get pre-implantation analysis before embryo transfer. And in Thailand-Dubai, selective transfer is perfectly legal. People can get it done easily there, with no PCPNDT restriction. Couples go, get IVF, get pre-diagnosis and selective transfer, and they come back home with a designer pregnancy.

Gujarat's ever-increasing global linkages, including daily flights from Ahmedabad to Thailand and the U.A.E., permitted affluent families to skirt the PCPNDT Act altogether by shifting key elements of selective reproduction outside Indian jurisdiction. Patients and relatives became "reproductive outlaws," "literally navigating outside the law to

[70] Cf. Rothman 1986: 138.

secure the prohibited reproductive procedures that they [felt] they need[ed]."[71] Journalistic and ethnographic reports from the past decade corroborate the picture of Indian citizens travelling transnationally to "level out the family and get a boy" by PGD.[72]

At the time of my fieldwork, Mahesana-area obstetricians seemed most captivated by the possibility the prospect of cffDNA testing. Based on isolation and analysis of fetal DNA circulating in the maternal bloodstream, the assay yielded SD results with 95% accuracy between seven and twelve gestational weeks. It could thus extended SD back to the first-trimester timeframe previously achieved only by chorionic villus biopsy—and without the latter procedure's invasiveness or medical complications. Doctors returned from various state- and national-level scientific conferences fascinated by the prospect of cffDNA testing: what, they asked, would the government do to restrict an SD technique based on something as banal as a maternal blood draw? Indeed, the state was already to calibrate PCPNDT enforcement to cover cffDNA amid reports of families shipping maternal blood samples to laboratories outside India.[73]

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Despite the proliferation of sex selection technologies within Indian biomedical markets and imaginaries, selective reproduction in Mahesana remained resolutely centered on sonography. One IVF practitioner told me, "Even most people who get IVF are doing SD by sonography at three months, because it's cheaper. Why would they travel and spend for PGD, when this is available for 20,000?" I observed that pre-conception and pre-implantation methods could help avert the "mental and bodily torture" of selective abortion, but he shook his head: "In our country, the economic difficulty is greater. They'll endure mental and bodily difficulty if it means saving money and getting a boy." Cost was, of course, a household consideration; mental and bodily difficulties primarily affected individual women. The overwhelming reliance on ultrasound for SD in the Mahesana region was, no doubt, a function of access to biomedical technology. But local access was also a function of the burdens that could acceptably be imposed on women's bodies in the reproduction of patriarchy.

One can certainly approach this imposition on women through a lens first proposed by influential writings from the 1980s and subsequently carried forward into present-day discourses. The lens in question brings into clear focus how sex selection enacts "femicide" on passivized female bodies, ultimately producing a patriarchal dystopia.[74] Reflecting on the wrenching scenes of SD, selective abortion, and selective perinatal care at Chetna and Nandini, I cannot but see the utility of such a lens. It is sometimes difficult to find in sex-selective acts anything *except* the violent reproduction of patriarchy through biomedical action on women and their fetuses.

But like all lenses, the one in question brings some things into focus and distorts others. While sex selection in Mahesana pervasively objectified maternal and fetal

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[71] Inhorn 2015: 175.
[72] Houton 2013; Inhorn 2015: 94-97; Strausl 2010. The phrase, quoted by Houton, is from a Phuket doctor explaining his provision of PGD to Indian couples.
[73] Andhale and Pal 2014; Isalkari 2013; Mascarenhas 2014.
[74] E.g., Corea et al. 1987; Warren 1985.

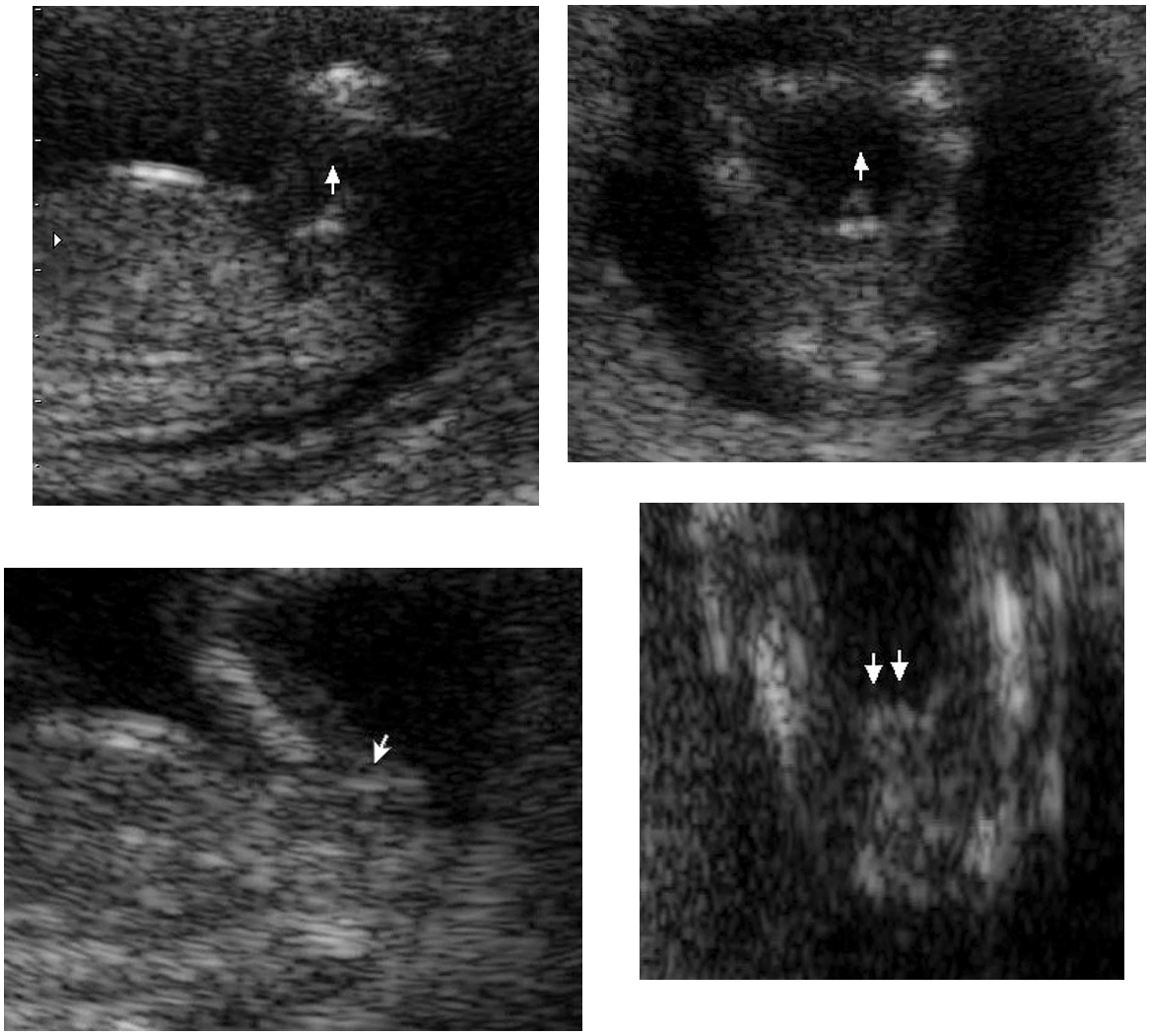
bodies, pregnant women did not simply endure the process passively. Just as often, "patients [could] manifest agency... through their objectification."[75] Many women embraced the biomedical control enacted through SD and selective abortion—sometimes even in the face of familial objections. Though patriarchal, selective reproduction was also a space of women's agency.

Both lenses are ultimately partial. Sex selection involved neither total imposition of masculinist order on women's bodies nor exercise of unfettered agency. Instead, instances of selective reproduction presented a vivid examples of constrained agency—of women navigating an unequal social structure by resisting, acquiescing, coping, and collaborating.

With the need to balance both lenses in mind, I turn now to women's experiences of agency and constraint in decision-making around sex selection.

[75] Thompson 2005: 179.

Figure 3 – Ultrasound Images of Fetal Genitalia, 12 Weeks



Top left: Side view of male genital tubercle. Top right: Head-on ("legs spread") view of male genital tubercle. Bottom left: Side view of female genital tubercle. Bottom right: Head-on ("legs spread") view of female genital tubercle.

Source: Hsiao et al. 2008

Chapter 4: Family Decision-Making and Women's Agency

Situating Reproductive Decisions

Kavita-ben and Rohit-bhai

One day at Chetna Clinic, immediately after lunch, Dr. Ranjit performed yet another selective abortion. The patient, a curly-haired woman named Kavita-ben, had received a "female" result the previous day.

An hour later, on rounds, Kavita-ben lay on a bed, awake. A slender man with bloodshot eyes slouched next to her. A toddler girl in a heavy sweatshirt jumped on the bed, a balloon clutched in her right hand. The doctor asked how the patient felt—a quiet "good" in response. He asked whether the couple had had a Form F filled out or registered the pregnancy with the village community health worker; husband and wife shook their heads in unison, with Kavita-ben explaining that their local worker was "understanding." The doctor nodded in satisfaction that the potential daughter was invisible to surveillance.

A bit later, stepping out, I found the haggard-looking husband—Rohit-bhai—on his way to the street corner to purchase crackers for his daughter. I walked with him. He explained that they were Prajapatis from a village south of Mahesana. He worked in a government mechanical workshop, on a monthly salary of 4,500 rupees. Shaking his head, he muttered, "So my wife said, how many girls are we going to bring home on that much? Otherwise, I didn't want to get this done." The husband claiming reluctance for himself and shifting the responsibility for sex selection onto his wife—it was a pattern I had observed in many families. Over time, my acquaintance with Kavita-ben and Rohit-bhai couple would illuminate the complex dynamics that could lie beneath such initial representations.

Back on the clinic's patio, Rohit-bhai unwrapped the crackers. Clutching her snack with one hand, his daughter began playing in the dirt. Suddenly, Rohit-bhai frowned and said with conviction:

> I'm against this! I said, "Let's not do this." But my wife insisted that she wanted to have it looked at. Her feeling is, how many girls are we going to gather in this era? And on a limited salary, too. We discussed it with everyone—Mummy-Pappa, my sister-in-law and brother. Their thinking was the same as mine—against this. They said their piece but left the decision to us. Well, my missus insisted. She's the one who pulled me here.
>
> Otherwise, my feeling is, aren't we falling into *pāp* [sin], doing this? At three months, the child's development starts, so it's killing a living life, isn't it? Before that, it's not *pāp*, because the development starts at three months. But at three months, if we look, we can tell if it's a

> boy or a girl. It's developing, so the life is in it. If we take it out after that, it's *pāp*—it's *bhrunhatyā*. Don't we accrue *pāp* if we kill that? I told my wife, if it's a girl and we get it taken out, and we get pregnant again, we get it looked at, it's a girl—then what will we do? She said, we'll address that then... But is this a thing you can get done again and again? And what's the effect on the body—long-term damage, right?

Rohit-bhai's monologue presented an assortment of troubles that initially overwhelmed my ability to make sense of them: economic precarity, familial disagreements, ethical misgivings, conjugal blame shifting, and the real possibility—palpable in that immediate post-abortion moment—of long-term bodily and psychic wounds from sex selection. Dizzied by the range of concerns bundled up in the situation, I wondered what Kavita-ben could possibly be feeling and thinking.

A while later, we moved back inside. Kavita-ben was now sitting up. We sat down across from her cot. She said she felt nauseous but otherwise "okay."

After we chatted a bit about our backgrounds, Rohit-bhai started bringing up their decision-making again. Kavita-ben cut in to highlight the world of risk that having a new daughter represented for her: "With a girl, we'll always remain worried. What'll her in-laws be like? What'll her conjugal household be like?" She pointed to her daughter, who was jumping on the cot again. "Now with this one—we'll always worry about what her life will be like! If she encounters sorrow, we'll have to hear about it for the rest of our lives." The futurity of daughters-to-be weighed heavily on her.

"She thinks like this!" Rohit-bhai cut in impatiently. "This girl is two years old, and she thinks, in-laws this, and conjugal household that, and all that. How can we think about all this right now?"

"You have to think about it now!" his wife retorted sharply. She was now leaning forward, toward us. "How can you think about all this later? How to bear the costs of her upbringing, how to educate her, all of this!"

Rohit-bhai grabbed my arm and intoned, "But I say, I'm here, aren't I? Their father?"

Ignoring her husband's pleading claim to successful breadwinner status, Kavita-ben frowned: "It's difficult to run a household on a government salary." Rohit-bhai snorted audibly. Was he taking affront at her diminishment of his earning? Or scoffing blithely at her domestic anxieties?

Kavita-ben continued, "And we think, why should we give another a life like this, like the one we have?" She straightened the hood on her daughter's sweatshirt, caressed her shoulder, and turned back to me. "Why should we subject others to what we have suffered through?" A soft coda, trailing off into silence: "What we know, being a woman..." The rest remained unspoken.

We sat quietly, save for the girl's jumps on the cot, until a nurse came in to discharge Kavita-ben. We left together to catch a bus back to Mahesana, whence they would take a rickshaw back to their village. Just outside the clinic, Rohit-bhai told us to pause on the dusty curb so he could run to pick out a kite for the upcoming Uttarayan festival from a nearby vendor's pushcart. As we waited, the toddler wrapped herself

around her mother's legs and swung from side to side, peeking out at me and giggling. Following Rohit-bhai with her eyes, Kavita-ben mumbled, "People can say whatever they want—be as educated as you please—but *ek chhokaro joie*. That's the way it is." She shook her head and looked down.

Seeing beyond Stock Narratives

In mass mediatized anti-sex selection messages, there was copious discourse about family decision-making—in other words, about how different family members oriented to and acted around visualizing, accepting, and eliminating female fetal subjects. Such discourse often centered on two ethical figures, both feminine: pregnant women and their mothers-in-law. The latter usually appeared as cruel, backward, and coercive, forcing their daughters-in-law into sex selection through physical, verbal, and emotional abuse. Conversely, pregnant women themselves typically appeared as victims, devoid of voice or agency. More rarely, they might emerge as heroes, defying a patriarchal family and society to love and birth a daughter. In such cases, they functioned as the opposite of victims: rather than being totally engulfed by the social structure, they stood outside it**,** rejecting the conjugal and communal bonds of Indian women's sociality in order to realize the modern ideal of gender equality. When pregnant women appeared helpless, the villain-victim-hero trichotomy also allowed for interpellation of the masculinist state as savior.[1]

In examining journalistic narratives of infanticide in Venezuela—depictions of "monstrous mothers and fathers" that "transfixed" readers, "generating steady streams of conversation and public outrage"—Charles Briggs has identified several strikingly consistent characteristics.[2] These instantiations of stock stories feature an emplotment of tragedy devoid of redeeming figures; a generic or familiar quality that produced a sense of the violent act as "familiar, knowable, and contained within the stories"; and provocation of fear or rage from a stable narrative trajectory.[3] The "communicable cartographies" of infanticide in Venezuela enact symbolic domination by "projecting a small set of shared and predictable circuits, creating subject positions, arranging them in spatial, moral, and legal terms, and making only a very limited range of responses thinkable."[4] Most notably, stock narratives sequester violent acts from modernity and state projects, leaving them simultaneously "individualized as products of pathological subjectivities and defective domesticities, and made to represent entire populations,

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[1] My characterization of characters in the stock narratives finds affinities in Ortner's analysis of the "narrative politics" of gendered agency in Grimm's fairy tales: female protagonists are frequently victim-heroes, the only consistently active female characters are all evil, and passive women ultimately require saving through active masculine intervention (2006: 139-142).

[2] C. Briggs 2007: 317. I note at the outset that my purpose here is very different from Briggs's. He is interested in examining "how stories construct themselves as epistemological objects through projections of their own making, dissemination, and reception" (C. Briggs 2007: 325). By contrast, I am drawing from a specific portion of his contribution: namely, the analysis of how the form of stock narratives imposes restrictive subject positions on perpetrators, other participants, and the public audience, and how these have the effect of obscuring power relations and agentic action.

[3] C. Briggs 2007: 325-330.

[4] C. Briggs 2007: 338.

thereby naturalizing representations of class, gender, space, state, and nation" that force certain bodies into the slot of backward or traditional and push others toward the subject positions of "moral, legal, and rational citizens."[5] Ultimately, such archetypal stories matter because they profoundly shape how a social problem becomes publicly visible. In fact, they may become the problem's chief public face.

In Mahesana, there abounded representations that pitted the oppression of traditional culture—embodied in the domineering mother-in-law—against rational, modern gender equality—embodied in official discourses and aimed at reaching the powerless or valiantly resistant daughter-in-law.[6] A television advertisement by the Beti Bachāvo program depicted a snarling old woman pointing menacingly and shouting, "Get it knocked out!" upon learning of a "female" result. In seminars for village women, local Health Department officials often lectured at length about how "females become females' enemies" and how "you are the ones forcing your sons' wives to do this." A popular Hindi soap opera portrayed, over many weeks, a woman's struggle to evade in-law pressure for sex-selective abortion by falsely claiming a "male" result after a scan. One of Bollywood's biggest stars, Aamir Khan, dedicated the much-hyped inaugural episode of his social issues-themed talk show, *Satyamev Jayate*, to the stories of three Rajasthani women who resisted and escaped from families that demanded they undergo sex selection. Magazine essays, plays staged by religious organizations, youth speeches that became viral WhatsApp videos—all these, along with many other representations, perpetuated and amplified the morality tale of the insistent mother-in-law and the victimized or transcendently powerful pregnant woman, often with little pretense of specificity or empirical grounding beyond received common sense. Even the PCPNDT Act encoded the presumption that women had been compelled to undergo sex selection, such that they could not generally be prosecuted for requesting sex determination (SD), as their kin could.

Apart from the PCPNDT Act's bracketing of women's agency, which has always served an important social function, most of the widely circulating narratives about household decision-making functioned largely to reproduce dichotomies between backward tradition and enlightened modernity. Chapter 6 examines the broader representational context within which such stories emerged and circulated. In this chapter, I focus on what was *elided* in straightforward morality tales of coercion, passivity, and resistance: the complexity of reproductive agency[7] around sex-selective reproduction.

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[5] C. Briggs 2007: 331, 336.

[6] Cf. Saharso (2005) and Ticktin (2005), who have observed that Dutch public debates on sex selection reinscribed dichotomies between the complex of culture-tradition-oppression-foreignness and the complex of modernity-rationality-liberalization-West. In my case, the narratives in question are less overtly transnational, instead posing the problem of traditional Indian patriarchy as a problem to be overcome in crafting an Indian modernity (cf. Chatterjee and Riley 2001).

[7] Unnithan-Kumar defines "reproductive agency," as "ideas, actions, thinking and planning in the domain of human reproduction by women and men who engage in reproductive activities and seek healthcare services, as well as in terms of the strategies, compulsions and motivations which inform the actions of medical, clinical and health personnel" (2004b: 6). My analysis in this chapter focuses on what is described in the first half of her definition.

Previous research has described sex selection as a familial choice, frequently hinting at considerable variation in decision-making dynamics.[8] I build on this work by considering *how* women experienced agency in the process of sex selection. Close engagement with women's voices reveals complex power dynamics, in which different family members pursued action around the gendered fetus in accordance with their own subject positions within the moral economy of gender-kinship. Such an analysis challenges stock narratives of coercion and resistance, making visible other agentic dynamics: household consensus, women's pragmatic coping, or active defiance of conjugal prohibitions on sex selection.

While adopting the heuristic of "agency," I am mindful of the need to avoid romanticizing and fetishizing the capacity for action, lest I reproduce the victim-heroes of stock narratives.[9] In attempting to "engage simultaneously women's systematic

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[8] In an early study from rural Maharashtra, Ganatra et al. (2001: 114-116) reported women's considerable decision-making power around sex selection, albeit in a context of joint family consultation, implicit pressure for sons, and occasional explicit demands from conjugal relatives. By contrast, in her study of Mahesana-area villages, L. Visaria (2007b: 159-160) reported not only intense familial pressure, but also "virtually no decision-making power" among pregnant women," who "simply went along with the decision made for them by others" by "[accepting] whatever their conjugal families, including husbands, wanted"—albeit with a certain amount of caste stratification, according to which upper-caste women had to inform or consult their in-laws, and lower-caste women only their husbands. Studies of peri-urban Delhi (Khanna 2009: 102-103, 108-110) and the Punjabi-American diaspora (Puri et al. 2011: 1172-1173) have also mentioned considerable influence from husbands and in-laws, along with some evidence of resistance in the Delhi case (Khanna 2009: 110-112). Noting that "agency in the elimination of girl children or female foetuses is multiple," John et al. have written:

> Even though a woman may on her own take the initiative to visit a doctor for contraceptives and/or take the decision to undergo a sex determination test, and subsequently may even contemplate abortion, most often it has been seen that the ultimate right to decide on matters pertaining to family size, sex distribution, and fertility control lies with the man, or in some cases the extended family. The couple, the mother-in-law, the father-in-law, and the woman's parents are all actors in a system that systematically devalues the girl child and the mother without sons (2008: 63).

They have cited a number of pressure tactics from in-laws, as well as cases in which women pursued sex selection without affines' knowledge or even in defiance of the latters' wishes (2008: 64-65). Finally, while her analysis does not foreground the process of familial decision-making, Unnithan-Kumar (2011: 162-163) has noted the importance of viewing sex-selective abortion as an exercise of pragmatic agency within domestic and social constraints—neither full autonomy nor the full imposition of patriarchal control on women's bodies. Also see A. Agarwal (2003: 12-27) and D. Singh (2007: 27-28), who discuss family decision-making dynamics in ways that are empirically and theoretically more limited.

[9] Two decades on, the introduction to Jeffery and Jeffery's *Don't Marry Me to a Plowman* continues to offer a valuable manifesto regarding the middle path to be charted in examining women's agency in patriarchal North Indian contexts:

> It is important neither to exaggerate the potential of women's everyday resistance to alter the terms under which they lived nor to render invisible the ways women were co-opted by the protective and maybe comforting certainties of the structures in which they were embedded... We want to avoid either stereotyping women as the virtuous victims of oppressive structures or romanticizing their capacity to resist. Their lives were far more complex than that. Women did not speak with a single voice. If they sometimes talked about themselves as victims, they also portrayed themselves in ways that suggested either critique or acceptance. Often, their resistance coexisted with a subservience that took

subordination and the ways in which they negotiated oppressive, even determining, social conditions,"[10] the most useful approach is one that foregrounds *constrained agency*. In this view, agency—an intentionality or orientation toward pursuit of particular projects according to local logics of the good—is always culturally shaped and bears an immanent relation to power: the agency of projects hinges on the agency of power, such that action always partially reproduces public and private structures but also holds the potential to challenge them.[11] Given that the "conditions within which we exercise agency certainly matter—some circumstances are more empowering while others are more constraining"—it becomes imperative to think about agency and oppression as simultaneous, rather than oppositional.[12] Situations of high-stakes choice do not activate an agent that pre-exists outside of or even embedded within social relations; they constitute that agent through complex dynamics of subjection and subjectification.[13] Analyzing women's reproductive agency around sex selection therefore entails uncovering the processes through which pregnant women become agents,[14] enunciating and acting on complex dispositions toward action and reaction, acquiescence and resistance, defiance and cooperation.

Much of the analysis below surfaces the importance of sex selection as a *pragmatic* tactic adopted by women who, while never passive, always acted amid the constraints of patriarchal power relations.[15] Women like Kavita-ben were neither "passive vessels, simply acting in culturally determined ways with little possibility for reflection on their own condition" (a different sort of victim), nor "inherently suspicious of and resistant to technological interventions" (a different sort of hero), and their "dominant mode of response" to SD and selective abortion was frequently "ambivalence coupeld with pragmatism."[16] Tactical use of sex selection technology often subverted or diverted the patriarchal system without leaving it, evincing its nature as "too vast to be able to fix [agents] in one place, but too constraining for them ever to be able to escape from it."[17]

The pervasiveness of pragmatic coping in the stories below highlights that the analytic role of "agency" is not to reveal and celebrated unfettered free action, but to situate various actions vis-a-vis systems of power.[18] Understanding women's agency in

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> account of both the balance of power and the balance of long-term benefits... Certainly, women's agency by no means always took the form of resistance. Women also had many stakes in the system. Their agency might entail endurance as well as acquiescence. It might also entail coercing other women. In brief, women's agency was rather more complex and rather less rosy-tinted than it is sometimes portrayed (1996: 16, 19-20).

Also see Abu-Lughod (1990) and Mahmood (2005: 10, 15).

[10] Mani 1998: 10.

[11] Ortner 2006: 134-139, 142-147, 148-149, 152-153.

[12] Madhok et al. 2013: 2-3.

[13] Das 2007: 77; Madhok 2004: 235; Ticktin 2005: 269. Gammeltoft makes this point pithily: "Subjectivities emerge situationally" (2007a: 160; also see 2014a: 19-21, 225-226, 228-231).

[14] Cf. Ortner 1995: 187.

[15] Cf. Lock and Kaufert 1998a: 11-12.

[16] Lock and Kaufert 1998a: 2.

[17] de Certeau 1984: 40, also 32, 34, 36-37.

[18] Abu-Lughod 1990: 47; Kandiyoti 1988: 275, 1998: 142; Ortner 1995: 190.

sex selection experiences entails simultaneously understanding the operation of patriarchal hegemony. Women struck "patriarchal bargains," consciously making sacrifices in the present for future benefits within a masculinist social order.[19] Such bargains certainly articulated and reinforced feminine subordination. But unpacking both the bargains and the subordination, through examination of how specific pregnant women contended with others within the moral economy of gender-kinship—husbands, conjugal relatives, potential daughters and sons—reveals complexities that challenge oversimplifying accounts of familial and social reproduction.

Moving beyond the monolithic gender-kinship imaginary of Chapter 2 and the zoomed-in clinical glimpses of Chapter 3, this chapter explores how action around a gendered fetal subject—seeking it, embracing it, rejecting it—played out in people's lives. Through the stories of Kavita-ben and four other women, I consider how different family members imagined relations with and action toward potential children, and how women negotiated the resultant household dynamics. Traversing the moral economy of gender-kinship, these five stories reveal the complex and variegated internal power relationships that could condition specific instances of selective reproduction. They exemplify patterns that frequently surfaced in other families, albeit less through extended glimpses of women's trajectories and more through oblique comments, heavy sighs, and third-party rumors. An empirically grounded analysis of women's experiences challenges stock narratives of sex selection, rendering visible nuances that multiply the archetypes for reproductive agency beyond the stereotypes of villain, victim, and hero.

Contentious Decisions, Collective Decisions

Clinicians tended to echo stock narratives of sex selection, often highlighting "pressure," "harassment," and "torture" from conjugal relatives as crucial drivers. Many reinforced the view that mothers-in-law, rather than husbands or other men, played the key coercive role. Dr. Tapan, for instance, said of the families that came to him for sex selection:

> The poor husbands don't say anything. Generally, male is not against female. But the mother-in-law! Generally, the mother-in-law is against the female child. The government should stick mothers-in-law in jail in every district, and then see how the ratio improves!... The poor men don't care about male-female. Gents don't prefer this. But the mother-in-law and other relatives create such a home environment that the patient has to get it done... Woman is woman's worst enemy! No male will pressurize. You do the research: in over 90%, the mother-in-law will be the main figure... And she won't say anything herself here in the clinic—she'll make the poor woman say everything!

Many obstetricians echoed Dr. Tapan, maintaining that "the mother-in-law wants it more" and that "the poor husbands don't say anything." The mother-in-law appeared as

[19] Kandiyoti 1988

the chief decision-making figure, a misogynistic woman who imposed her will—and concomitant suffering—on a hapless daughter-in-law. Husbands and other male relatives remained hidden. Again, this juxtaposition of a blameworthy older woman with a passive and hence supposedly innocent man prevailed not only in doctors' accounts, but also in widely circulating public representations. It posited a straightforward, woman-centered mechanism for the enactment and propagation of patriarchy, absolving men of responsibility and eliding the complex ways in which selective reproduction reproduced gender subordination.

In commenting on the perceived dynamics of family deliberation, past and present sex selection providers like Dr. Tapan insisted that they had always performed SD and selective abortion only after receiving a direct "request" from the patient or her family: "If there was any dispute, we wouldn't do anything. We would only do something if the woman herself was ready." "We never got in the middle of their discussion; we always told them to go outside, or go home, and come back after deciding." "They would come to us with a decision already made."

But as most doctors were prepared to acknowledge, prevailing decision-making dynamics meant that senior relatives' wishes often won out over those of patients.[20] As such, restricting the ethical basis of action to just the clinical request—which might well come from a patient under duress, or from a domineering relative who had successfully silenced the patient's own wishes—frequently meant complicity with in-laws imposing their favored reproductive vision. In our conversations around families' choices, Uma-masi readily recognized this fact:

> Oh, I've seen cases! Many women are not willing to get it taken out. They will cry. Then the mother-in-law and father-in-law force her to get it done. The in-laws say, we don't want a girl... I never get in the middle in those cases. Whatever they decide among themselves is right. There's nothing for us to say—no point in getting involved in their affairs. If they need us, they'll call... Of course, in those cases, in the end, they always get it taken out. What the daughter-in-law wants doesn't matter. The in-laws won't allow it, right? She has to get it done. So then she'll come to us.

Similarly, a Mahesana obstetrician speculated regarding his previous sex selection practice that while he "wouldn't have any idea of what was going on in the home," it was very likely that "when a patient came to me, she had already been beaten and bullied into submission." In a generally patriarchal reproductive context, clinicians' provision of a

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[20] Studies of sex selection report considerable in-law control—through overt demands and more subtle pressures, verbal abuse and neglect, threats of insecurity and withholding of help—across a variety of contexts (Ganatra et al. 2001: 114-116; John et al. 2008: 64-67; Puri et al. 2011: 1172-1173). More generally, an extensive literature on decision-making around fertility and contraception in Hindu patrilineal families shows the tremendous influence that conjugal relatives—and especially mother-in-laws—wield over young daughters-in-law and couples (Char et al. 2010: 157; P. Jeffery et al. 1989: 195-198; R. Jeffery and Jeffery 1997: 117-164; T. Patel 1994: 167-171, 202-208; Säävälä 2001: 148-155, 157-163; H. Singh 2016).

service "on request" ultimately favored whatever party was best positioned to make its request heard within the consultory.

So what were the actual processes by which different family members struggled to actualize their visions regarding gendered fetal subjects? Frequently, SD appeared as an obvious choice to everyone, with little interpersonal conflict. When it did not, most families engaged in multiple conversations about pursuing the test, and what to do with a female fetus, before reaching the clinic. Similarly, after a "negative" result, many couples placed phone calls or returned home to recruit the entire household—and sometimes other conjugal relatives or the woman's parents—into deciding how to reproduce the family. In "discussing it with everyone," as Rohit-bhai and Kavita-ben had done, couples frequently collectivized difficult and impactful decisions around selective reproduction.[21] Although women were always subject to the will of others—and sometimes in overtly violent ways—decision-making dynamics varied greatly, in counterpoint to the unidirectional compulsion portrayed in clinician, media, and government representations.

Ethnographic encounters with women revealed a complex process of collective negotiation with respect to selective reproduction. Conjugal relatives' influence on sex selection varied considerably, not only in degree but also in type. Across different ethnographic cases, husbands and in-laws appeared in the foreground and background; as opponents and advocates of SD and selective abortion; and as subjects of obedience, resistance, and agreement. Better understanding understand kin group contention around selective reproduction requires exploration of complex questions around women's experiences and agency: What were women's childbearing projects, and how did they interact with the projects advanced by relatives? And how did patterns of coercion, coping consensus, and insistence drive sex selection?

Some stories did, in fact, conform closely to the archetype of in-laws compelling an unwilling woman to undergo sex-selective abortion. But even in such cases, close engagement with women's speech illuminates the gender-kinship dynamics that undergirded coercion, as well as the agentic experiences—however constrained—that emerged from it.[22]

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[21] Unnithan-Kumar has proposed the idea of "collective ownership" over pregnancies in Rajasthan (2004a: 61-69, 2004b: 5). Gupta has echoed this in her discussion of collective decisions around prenatal testing in India (2010a). Similarly, Gammeltoft has emphasized how Vietnamese women facing disability-selective abortion turned unbearable decisions into matters of kinship, sociality, belonging, and shared responsibility by recruiting relatives and thereby collectivizing "choice" (2007a).

[22] In analyzing Preeti-ben's experience of coercion through the lens of agency, I am drawing on Sumi Madhok's suggestion that recognizing agency within conditions of oppression (and hence avoiding equation of subordination with passivity or victimization) requires rejection of an "action bias" in favor of a focus on speech acts (2004: 223-227, 234-237, 2013: 1, 5-7, 36-68). In Madhok's view, agency-through-speech-acts lies not so much in resistance or even action *per se* as in the articulation of relations to selves and others, and in the realization of a reflexive capacity for formulating and enunciating ones own preferences for projects. I believe that this framework must be applied carefully, for its indiscriminate use risks reproducing old fetishizations of agency. But in cases like Preeti-ben's, it helps the heuristic of "agency" do important work by demonstrating how alternative projects are imagined—even if not realized—even in events and conditions of profound domination.

Coercion: Preeti-ben

In my youth, I first learned about sex-selective abortion through my mother and grandmother's hushed conversations about how Preeti-ben—a relative distant in reckoning, but close in relationship—had been forced to undergo the procedure. During my preliminary fieldwork trips, Preeti-ben inquired about my research on several occasions. She did not offer any hint of her own experience, and I did not press further. But one day, she called and said, "This study of yours, for Beti Bachāvo? Well, I've had an experience like that happen to me. So I want to talk to you."[23]

Some days later, we met at her sister Sonal-ben's house. The three of us sat on adjoining couches, the afternoon light casting shadows on our faces. For over an hour, Preeti-ben narrated her experience. She largely alternated between looking at me and staring into the distance, occasionally furrowing an eyebrow or shaking her head. Sonal-ben played the role of sympathetic listener, nodding, grunting, and occasionally interjecting to express the shared anger that her sister did not.

Some facts remained implicit, for I knew them from our longstanding association: Preeti-ben belonged to a Patel *gol* of the Mahesana area. In the early 1980s, she had been married to Nitin-bhai, an Ahmedabad real estate developer who was the only son of a wealthy family; from the beginning, she had had a fraught relationship with her in-laws, who lived apart from the couple in Mahesana. After the births of two daughters in 1985 and 1988, and two miscarriages, she became pregnant again in 1991.

At that point, her in-laws began pushing for SD. "Once we had two girls," she explained, "the old lady was unhappy. She kept saying, 'Next time, get a sonography!' But they couldn't force me to do anything until three months."

Preeti-ben acquiesced to undergoing a scan on the reasoning that "if it was a boy, it would be fine." She and Nitin-bhai went to Ahmedabad's Dr. Chandresh—an "early expert in diagnosing at three months," in many colleagues' recollections. Preeti-ben recalled, "He was very clever in this—he's famous! He was Number 1 in all of India for this task. He would look with squinted eyes and tell you, boy or girl. He was never wrong, not even once!"

Later in my fieldwork, I heard Dr. Chandresh's name repeatedly in connection with prestigious conferences and high-class referrals. He had entered a second career act, reinventing himself as an infertility and advanced sonography specialist. Upper-class clients flocked to him. Twenty-five years after the test that initiated Preeti-ben's trauma, the man who had performed it remained casually present—and praiseworthy—in her

[23] I believe that our conversation, and the knowledge that its contents might be more widely disseminated, allowed Preeti-ben to claim some small measure of agency over her experience. She repeatedly emphasized the importance of "you writing all this down," expressed a desire to fill in any missing facts and make the story "complete", and on several occasions explicitly framed our conversation as an act of defiance against her husband, mother-in-law, and now-deceased father-in-law. When I explained my confidentiality protocol, Sonal-ben interjected—perhaps expressing a sentiment that her mild-mannered sister would not—that I should "write it with the names," so that "the scoundrel would really know how much suffering it's been!" As we wrapped up our conversation, Preeti-ben said, "It's like this in speech, in writing. But you imagine what it must have been like then."

social circle's quotidian conversations. "Go meet that scoundrel," Sonal-ben suggested scornfully, "that dog! We call him The Dog. So many lives, he's ruined."

Dr. Chandresh's scan revealed a female fetus. With recognition of a potential daughter, Preeti-ben's in-laws began insisting on selective abortion. She recounted:

> Every morning at 6:30 or 7:00, there was a phone call from them: 'What did you do?' Meaning, did you get rid of it, or not? Imagine! 'We don't want that at all!' It's the two of them who got together and made this mischief happen. Nitin didn't say anything. They felt that since it was a girl, we should get rid of it...
>
> What scoundrels! Imagine it. I certainly wanted to keep it. Two already—what's wrong with a third? Were we going to end up with an army? I opposed it hard. And my family—Sonal, my brother—everyone was with me. But then these people's *najar* got me—I became helpless.

In Preeti-ben's memory, the neutralization of her resistance began with the in-laws' *najar* [evil eye] alighting on her pregnant body.[24]

Early in the second trimester, she experienced heavy bleeding—a threatened miscarriage. She recalled:

> I was admitted, and my two poor girls at home. What did they do then? My mother-in-law was at home during the day, manage the household, care for the girls. When she came in the mornings to see me, she came empty-handed. She brought nothing—no milk, *bhakhri*, crackers—nothing! She wouldn't give me food—imagine! She came alone to the clinic to see me, so normally she should bring food, right? But she didn't bring anything. I was hungry and thirsty, so I would ask for milk. Well, she would say, 'No, I forgot'—forgot! Every day, she said that! Is it possible to forget something like that every day? She would grab my hand and ask, 'So what did you decide?' But she wouldn't give me food. Eventually, Nitin would bring something when he came to see me. But she did this to apply pressure.
>
> They also told the doctor, we don't want a girl, just do an abortion. That doctor—she herself had just two girls—said, 'Preeti-ben is my patient. If she doesn't want it, I can't do it.' But they did a lot of forcing in that way. No physical abuse, but all this stuff.

Preeti-ben was discharged after a few days, but her situation remained precarious. She remembered:

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[24] Numerous scholars have characterized pregnancy in Hindu India as a state of heightened vulnerability to harmful glances (P. Jeffery et al. 1989: 90; Pinto 2008: 160-161; Säävälä 2001: 74-76). In addition, David Pocock has analyzed how accusations of *najar* among Gujarati Patels are enmeshed in relations of strain with intimate others, appearing as both cause and consequence of interpersonal strife (1981).

> I had to be on strict bedrest. Who would give me food? She kept me hungry. Who would look after the household? And my two girls were so little then! Who would care for them? There was just the old lady! Two or three weeks went by. The old man called every day: 'What did you do? Have you gotten rid of it?' My mother-in-law was at my place, handling all my household affairs, so I had become totally helpless. Your husband doesn't look out for you, no one looks out for you; these people are the only ones to look out for you, and they are not even giving food! You imagine it. Your *piyar* relatives could come and meet you in the clinic or at home, but then they would go away. They forced me so hard, forced me so hard!
>
> I was stubborn. I told Nitin, 'Boy or girl, I definitely want to keep it.' A mother doesn't kill her own child. Would anyone do that? I always opposed it. But then I became helpless. In a way, it was coercion. What else could I do? That person is the one feeding you; that person is the one caring for your children. What could I do? Who could I turn to? Nothing of my own, so what could I do? If I was self-reliant, if I was working a job, then it would be a different matter—I could have somehow eked out enough for myself and my daughters. But having no support, being dependent on these people, what could I do? I could go to my *piyar*. But how long can you stay in your *piyar*?
>
> What choice is there, then? I had to go. So then at last I said, fine, let's get rid of it.

Through constant pressure, Preeti-ben's in-laws had manufactured an unwilling willingness that was just barely sufficient to appear clinically as "consent"—or more accurately, lack of objection.

Once Preeti-ben acquiesced, Nitin-bhai and his parents took her to another doctor in Ahmedabad. (Sonal-ben would later express satisfaction that "*that* scoundrel is now dead!") The doctor rechecked the sonography to confirm that he was eliminating a daughter-to-be; his assistant explained patiently that could happen that "the whole case is ruined—we see a girl, and then a boy comes out!" Preeti-ben recalled bitterly, "Once he said it was a girl, my father-in-law said, 'Get rid of it! I don't want a girl!' And my mother-in-law, too. Nitin didn't say anything."

The doctor initiated a *kāchi* delivery. Preeti-ben would later recall, softly but matter-of-factly:

> The doctor gave an injection—he let the medication go in, for the child to suffocate. The child started turning this way and that, jumping. Because it was suffocating on the inside, it turned a lot! I definitely felt that something was happening. Oh, the pain in my lower back!
>
> And no one was with me. The old man sat outside, all quiet. He said, 'What do you need me inside for? You go ahead and get rid of it.' The old lady came in, but then she didn't stay with me. She walked

> around, through all the rooms. People said to her, 'You look so young, so good! We would not believe that you are the mother of five children.' So she enjoyed it. Here I was going through *this*, and there, she was smiling and walking around happily.
>
> And Nitin wasn't even there. They had been smart and kept him at home, to care for the girls. They said, 'What need is there for you at the clinic? We'll call you there later.' He did come later. But he wasn't with me when all this was happening. A husband would feel something if he saw his wife suffering in this way, wouldn't he? Those people didn't want that.
>
> So I was alone. Only Sonal was with me. And that girl flipped this way and that, jumping. She must have been suffocating. I was in so much pain! I screamed out so much, so much. Then, the girl must have passed away inside. After that I was able to lie down. The girl was gone.

"Delivery" of the expired fetus occurred twelve hours after the initial injection. According to Sonal-ben's recollection, the father-in-law asked the doctor to trash the fetal body—"so fair-skinned and nice-looking, a slender girl!"—but found himself responsible for burying it under a bridge, in the Sabarmati riverbed.

After leaving the clinic**,** Preeti-ben went to her *piyar*, where her brother's wife nursed her back to health. Nitin-bhai and her in-laws did not answer phone calls, even though the prescription for post-abortion medications had ended up with them. After a few days, Preeti-ben called her neighbors and asked them to contact her husband. "After that," she recounted, "Nitin finally called back: 'Don't bother coming back. We have no need for you here.' So he threw me out. My father-in-law called a month later and said, 'I don't want to ever bring her back.'" According to Preeti-ben, her in-laws had "decided to divorce me" and begun proclaiming their intention widely. In her view, their determination resulted from her being "so stubborn during this pregnancy": "They thought to themselves, 'Let's get a good one, one who will listen to everything we say, not be stubborn. Let's get one who will take five abortions if we make her get them.'"

Preeti-ben's expulsion from her conjugal household hit a snag after six months, when Nitin-bhai's sister returned home for her first childbirth. Needing someone to do domestic work, the in-laws finally summoned Preeti-ben. She remembered of the period, "The milkman told me, 'You're back? Your mother-in-law was saying they were going to divorce you!' Imagine! Then, the scoundrels—there was a family function, and there was going to be a photo. Everyone else was posed, and I was still sitting on the side. My mother-in-law said, 'Oh, you can be in the photo! It's not like we're going to divorce you any more.'"

Preeti-ben conceived again in 1995, after Nitin-bhai had completed an Ayurvedic regimen for increasing the proportion of Y chromosome-bearing sperm. Recalling the pregnancy, Preeti-ben said:

> When we got it looked at by sonography, I was so scared! I was praying, 'O God, let it be a boy. Otherwise they will grab me and drag me to a

> clinic to get another abortion.' Because they tortured me so much the first time, I thought it would be good if it wasn't a girl. I just didn't have any courage left to fight back. I wouldn't have been able to resolve that I wanted to keep it, like the previous time. Would anyone, after being tortured so much? But that time, it was a boy.

The in-law's previous actions around a potential daughter—pressure for SD, coercion to bring about a selective abortion, temporary expulsion from the only feasible and normatively acceptable position within the gender-kinship system—had disciplined or dissipated Preeti-ben's resistance, channeling her desire toward a potential son as the best possible outcome.

She recalled bitterly of her son's birth:

> My in-laws were sitting outside waiting. They were anticipating: *when will the boy be born*? They didn't care about me. When the nurse came out, they immediately asked her, 'Is it a boy? Is it a boy?' She said, at least ask about your daughter-in-law! I had had lost a lot of blood—bad enough to need a transfusion. But these people didn't care. They just immediately asked the person who delivered me: 'Boy or girl?' They were finally satisfied when she said it was a boy.

The linear narrative ended there, and Preeti-ben, Sonal-ben, and I shifted to a meandering discussion of Preeti-ben's relationship with her in-laws.

In that discussion, it became clear how only blurry boundaries separated the sex selection event from tensions in everyday family life. The violence of the forced abortion was of a piece with more banal indignities and injustices, with which it oscillated back and forth in narration.[25] Preeti-ben repeatedly referred to her in-laws as "like Hitler" and talked about how they routinely subjected her to harsh words, heavy work, and strict restrictions. "They cannot recognize a human being," she said. "They cannot recognize their own daughter-in-law. And they would get so angry with me! My father-in-law, really—when he spoke, it was poison. Once, he said in front of me, 'A dead daughter-in-law is gone. So what? You just get another.'" The experience of reproductive coercion intertwined with myriad gender-kinship experiences, large and small, both shaping them and being shaped by them to produce an overall sense of devaluation, oppression, and restricted agency.

The fact that Preeti-ben's in-laws themselves had four daughters featured prominently in her criticism of their attitudes and behavior. She noted:

> He's a father of four girls himself, my father-in-law! He doesn't think, 'If I had thought this, my daughters would not exist.' He thinks this only for

[25] In this regard, Preeti-ben's connections to her in-laws—through the forced abortion and through ongoing kinship relations—reflect Veena Das's conception of the relationship between traumatic events and the ordinary, in which "the event attaches itself with its tentacles into everyday life and folds itself into the recesses of the ordinary" (2007: 1).

> others... They have four girls themselves, but they say you shouldn't have girls. 'It was different for us'—they said that openly. 'Ours was a different era, and this is a different era.' The thing is, in their era, there was no looking. The difficulty arrived when these sonography machines arrived.

Preeti-ben's comment illustrates a certain historical element to in-law pressure: with the transition from a reproductive regime characterized by high fertility and ungendered fetuses to one characterized by lower fertility and visualizability of fetal sex, selective reproduction became a possibility, desideratum, and object of familial negotiation for her generation of women in a way it had not been for their predecessors.

But the generational difference in reproduction was embedded within more fundamental dynamics that tied familial contention back to the moral economy of gender-kinship. On the one hand, according to Preeti-ben, her in-laws devalued and rejected her potential daughter on typical grounds: "she would go off to her conjugal family"; "she would be a wasted cost"; "she could not be an heir"; "the costs would increase so much—including the cost of marrying her"; "there always remains the question of whether you find a good match for her, and how difficult her in-laws make things for her"; "daughter's sons belong to someone else's family—they aren't ours"; and so on. But on the other hand, the in-laws exhibited great love for their own daughters, lavishing them with gifts, showing them affection in countless verbal and physical forms, and often saddling Nitin-bhai and Preeti-ben with various burdens in order to make his four sisters more comfortable. The in-laws' violent rejection of a granddaughter-to-be, and their concomitant ravaging of the daughter-in-law's body, were not expressions of simple, undifferentiated misogyny, as stock narratives might have it. Even in this case of blatant coercion, something nuanced was driving action around the gendered fetal subject.

Crucial here are the distinctions between daughters and daughters-in-law, and between actual daughters and potential daughters, within the prevailing moral economy. Preeti-ben hinted at these distinctions when she commented on her mother-in-law's "discrimination":

> When the old lady went to see her daughters, she would take all this good fruit with her. But that's because it was her daughters—that's why she'd take the good stuff. Nothing like that for me. When she took care of her daughters during their pregnancies, she would take apples, cashews, raisins, all kinds of good stuff like that. And nothing for me—she wouldn't even give me food! You can see: what a difference between daughters and daughters-in-law! To those people, only their own daughters are dear—not their son's daughters.

One might build on Preeti-ben's statement by adding that in all likelihood, only *actual* daughters—not potential ones—would be dear to her in-laws. The reference to feeding is revealing: Nitin-bhai's parents cared *about* their four daughters because they had cared *for* them, building and being drawn into an affective bond over decades of parenting. (Preeti-ben also invoked the trope of nourishment to concretize her inchoate emotional

investment in the lost daughter, "I've cried a lot—a lot. I have two daughters, and then this one—the one that was killed. I feel so much grief for her! You imagine it—at the time of my pregnancy with that girl, I drank good milk every day. Every day, I ate fruit. To keep things good. And then, to kill her off?") Post-marital alienation only sharpened Preeti-ben's in-laws' sentimental connection to their daughters, imbuing it with the poignancy of nostalgia. The in-laws affectionately cared for their daughters as conjugal relatives almost certainly would not—as they themselves would not for Preeti-ben. The apparent paradox of forcing sex-selective abortion while showering love upon daughters illustrates the precise structural dynamic that made daughters a liability and marked the daughter-to-be for elimination. For Preeti-ben's in-laws, there was likely no incongruity in devaluing the daughter-in-law (and the potential daughter in her womb) relative to actually existing adult daughters. The temporal positioning of different actual and potential daughters within lived gender-kinship experiences played a key role in shaping orientations toward them. We might ask: if family sizes had been smaller, and SD available, would Nitin-bhai's parents have accepted the four girls they subsequently came to adore? I suspect not.

Preeti-ben's story also illustrates how women's ability to resist coercion was compromised by their positioning within the very moral economy that sex selection reproduced. Having been alienated from the support, protection, and security of her *piyar* when given to a household that viewed her as an outsider, Preeti-ben found herself in a precarious position the moment she chose to resist her in-laws. Her reflections on being completely economically dependent—on feeling at-a-loss with regard to the job market despite having a college degree—point to how gender-kinship and political economy intertwined with one another, tying the woman to her husband and in-laws by material bonds of domination and subordination. Moral, domestic, and market economies articulated in a fashion that exacerbated even highly educated women's vulnerability to kin group pressure. Moreover, resistance could jeopardize a woman's own future, as well as the reputation and wellbeing of her natal kin. In light of prevailing norms, divorce, expulsion, and other forms of domestic abandonment would prove more disadvantageous to defiant women than to their conjugal kin, who could usually procure a more compliant daughter-in-law. Resistance also jeopardized the reputations of women's *piyars*, which would suffer from the stigma of a permanently returned daughter. The helplessness of the woman and her natal kin in the face of violence and suffering—a pervasive element of the futures people imagined for daughters prenatally—pervaded Sonal-ben's witnessing, which stood in for the reactions of a whole group of relatives who were outraged but powerless against the alienated woman's oppression.

Regarding her husband, Preeti-ben observed, "Nitin didn't have any say. He didn't say anything. He would just do whatever they said. He just wouldn't consider me. 'Whatever my Pappa says goes,' like that... And he has never said sorry. He has never taken responsibility." She described in detail how "my in-laws have always kept him down... always treated him badly." At different points in the story, Nitin-bhai appeared as a hapless co-victim, silent bystander, or even co-perpetrator. He was, in fact, all of these, with the latter two roles conditioned by the first one. While stock narratives often left husbands hidden, they could actually take on multiple and often conflicting roles within

the moral economy of gender-kinship, with significant ramifications for the fates of daughters-to-be.

Ultimately, the power dynamics within Preeti-ben's conjugal household subjected her to an immense pain whose violence bled into the everyday, suffusing ongoing relationships among kin. Multiple aspects of suffering—the physical torment from the unwanted abortion, the embodied loss of a desired child, the anguish of disempowerment with respect to one's own body, and the misery of isolation and abandonment—overlapped to form a tragic whole. One might synecdochically read the whole into Preeti-ben's recurrent references to isolation and abandonment: being left, by her husband's inaction or complicity, to her in-law's wishes; being abandoned by her husband at the abortion clinic; being left alone during the abortion, in favor of more pleasant pursuits, by both parents-in-law; being barred from her normative place in the conjugal home; being exposed to the indignity of ongoing residues of rejection, such as the milkman's comments, even after return; and being ignored in favor of the newly birthed son despite grave medical complications. In all of these, there was a palpable disregard for—or willful sacrifice of—the woman's body and person in the headlong pursuit of a son.

Pressure, Prohibition, and Coping: Pushpa-ben

Preeti-ben's story illustrates the lived experience of the real women reduced to stereotypical victims in many representations of sex selection. It therefore represents one extreme within a range of decision-making possibilities. In other cases, pressure from in-laws was less direct, and selective reproduction emerged as a tactical exercise of agency by women placed in impossibly difficult positions.

I met Pushpa-ben at the home of a mutual acquaintance—an older woman for whom she performed basic housework. We reclined across from each other—I on a sofa, she on a rattan wicker chair—limbs splaying across the arms of our seats. She laughed, smiled sadly, and cocked her head from side to side as she narrated her experience of sex selection.

A Rajput by caste, Pushpa-ben had grown up in a town of Mahesana District. Some years after marrying young—she could not say at precisely what age—she moved to her conjugal household in Ahmedabad. Pushpa-ben's husband was a college graduate, but he had difficulty procuring a job, and they remained dependent on her father-in-law's government salary. She had a daughter in 1983, another in 1985, and a third in 1986.

According to Pushpa-ben's recollection, that was when the trouble really began. She explained:

> Whenever I was pregnant, my mother-in-law kept wondering, boy or girl? In the second, she felt it a bit more. And with the third, a lot more... No one else in the family, but my mother-in-law kept saying, 'My boy doesn't have a boy! *Chhokaro to joie ja*!' Where was I going to go get one, if it wasn't in my destiny?... But she kept saying, 'The house has been filled up with girls!'

Pushpa-ben recounted with a chuckle that following the third birth, her mother-in-law conspicuously rejected the newborn baby by refusing to take the girl from the obstetrician's hands.

Pushpa-ben subsequently faced a dilemma. On the one hand, her mother-in-law disapproved of sex-selective abortion. Pushpa-ben explained:

> My mother-in-law didn't want another girl, but if she found out I did anything like *that*, she would've made a big fuss—definitely a big uproar. "You went and did what shouldn't be done!" My in-laws definitely wouldn't have let me get rid of a girl. They would've said, "If it's a girl, then let her be born." They wouldn't have let me get it out.

The mother-in-law had made it clear that she viewed sex selection as sinful and would not permit it.

On the other hand, the mother-in-law continued to repeatedly and forcefully express a perceived need for a grandson. Pushpa-ben recalled:

> My mother-in-law kept worrying—"My son doesn't have even one boy, and what if he has a fourth girl? How will he make ends meet, without a job? Feeding, marrying off—we have to spend so much money when we send a girl to her family!"
>
> There was some dispute every day: "Just girls, just girls, just girls! The house is full of girls! They won't let my son advance." My feeling was, the girls are still ours. Were we going to go throwing them away? And well-educated daughters could raise their fathers, too! But she felt, "For my son, *chhokaro to joie ja*! These girls are outsiders—will they remain with us? *Chhokaro to joie...*" Because she kept saying, saying, saying it, I thought, what is this life? "No boy, no boy, no boy." I had to hear that every day.

While opposed to biomedical sex selection, the mother-in-law continued to harbor a strong desire for a son for her son, and she used her familial power to constantly express that desire to the woman responsible for bearing the boy.

The mother-in-law's contradictory attitudes—disapproval of sex selection, disapproval of repeated daughters—placed Pushpa-ben in an untenable position. With domestic friction taking a toll, she eventually resolved the dilemma by secretly pursuing SD. She explained:

> I just didn't have the strength any more. I said, what if I have a fourth girl? This third one was barely accepted. But with a fourth, there's no question of acceptance. So I asked lots of people, gathered lots of information. People told me, if you request it, they will look and tell you, boy or girl; and if it's a girl and you don't want to keep it, they will take it out for you. So I started to get the picture that I should do this thing. So I did it. I had

> already decided: if it's a girl, I don't want to keep it; it will be the end of me if I bring a fourth Mataji into my home!

While the son desire and daughter aversion driving sex selection came largely from the mother-in-law, the movement toward clinical SD appeared as a coping tactic— a "weapon of the weak"[26]—initiated by the pregnant woman in the face of harassment and potential domestic insecurity.

Pushpa-ben's agency in seeking sex selection emerged gradually over the course of our conversation. Early on, she stated, "My *faiji* [father-in-law's sister] said, hey, since it's like this, let's go get it looked at and decide whether to get it out based on if it's a boy or a girl." A few minutes later, passing over the events again, she said, "I said I wanted to go to the doctor because it was like this, and my *faiji* said she would come with me." Toward the end, she explained more fully, "After my third girl, I would talk to people wherever I went to do housework—what to do in a situation like this. People would talk, and I got a sense. They taught me—'Oh, a doctor can do so-and-so...' So I got the information and asked my *faiji* where we could go for something like this." As we talked, Pushpa-ben's active role in pursuing sex selection unfolded palimpsestically, revealing itself in parallel with narration of the household conditions that had compelled it. The emergent narrative defied facile characterization of its protagonist as straightforward hero, victim, or villain. Pushpa-ben was a pragmatic woman, choosing a course of action that was simultaneously suboptimal, overdetermined, and empowering.

Pushpa-ben and her *faiji* went to a female obstetrician in Ahmedabad. After explaining the situation, Pushpa-ben began crying. She "had just three hundred rupees, gathered together from the five rupees, ten rupees, whatever my brother gave me when he came to visit," and knew that she could not afford both SD and an abortion. The doctor "held my hand, calmed me down, talked very nicely to me." "'Don't cry,'" Pushpa-ben recalled the clinician saying. "Don't be afraid. I'll do it for you for free.'" The doctor "put in a needle and pulled some water from the belly," and then sent the patient on her way.

Three days later, the obstetrician summoned the two women. The pathologist's report was back: female. Pushpa-ben broke down sobbing, worried both about how the doctor would possibly perform an abortion without payment, and how to hide the procedure from her disapproving in-laws. The doctor again reassured her, saying that she would perform the abortion as an "act of charity," and in such a way that no one in the family would find out. She asked the pair to return the next day.

Thinking back to the day of the procedure, Pushpa-ben remembered, "I felt like it was no good to get the girl taken out, and no good to keep her. If I kept her, there would be a furor at home. And if I got her out, then I would be sad. I am a girl, after all—I myself am! But then I resolved in my mind, and I went." Having reviewed the constraints of her aporia once more, Pushpa-ben stole out to the clinic with the excuse of buying vegetables. The doctor completed the procedure in an hour, and Pushpa-ben was back home within two.

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[26] J. Scott 1987.

In contrast to Preeti-ben's disdain for "The Dog" who scanned her and "that scoundrel" who aborted her pregnancy, Pushpa-ben expressed only positive evaluations of her sex selection provider's actions, which had helped her resolve an intractable kinship dilemma. This was typical of a broader pattern among women who pragmatically sought out sex selection. Unlike those subjected to overt coercion, who sometimes described complicit practitioners in the most disparaging terms, women seeking sex selection on their own initiative (however constrained) tended to praise their biomedical patrons as understanding and helpful; complaints among the latter category of patients tended to focus on specific issues, such as exorbitant prices, without telescoping them into broader critiques of the doctors as moral actors. Different relationships between familial pressure and selective reproduction produced very different attitudes toward the biomedical practitioners who made sex selection possible.[27]

Throughout the sex selection process, Pushpa-ben's husband remained uninvolved. She recounted with what I heard as a rueful chuckle:

> He would never say anything—neither to me, nor to my mother-in-law. It made no difference to him if we had a boy or a girl. But he never spoke up. I asked him, "Why don't you say anything, when your relatives say so much? When she keeps telling me, telling me, why don't you say, 'It's not just her fault, it's mine, too?' Why don't you say something?" But he wouldn't speak up. So then I had to be strong myself.

The husband's role as a silent bystander was part of what drove Pushpa-ben to pursue sex selection as her own solution to the familial conflict. Other alternatives might have been possible if he, too, had taken an active role in plotting the couple's reproductive future.

In 1989, upon becoming pregnant again, Pushpa-ben reasoned that "I had to check, boy-girl; if I had a girl, I would be in trouble all over." With her *faiji*'s help, she went to the same doctor. This time, the result was "male." When Pushpa-ben announced the good news at home, her mother-in-law scolded her for obtaining SD without informing the family. To calm the older woman's anger, the *faiji* had to insist, "*I* took her"—again hiding Pushpa-ben's agency.

Pushpa-ben's experience provides a point of comparison for understanding the extremeness of Preeti-ben's story and, by extension, circulating stock narratives of selective reproduction. It illustrates heavy in-law pressure without permitting a flattening of complex agentic dynamics into simple "coercion." Placed under myriad and frequently overwhelming constraints, women might turn to sex selection as a pragmatic response, taking decisive action that ultimately had dual effects: making a patriarchal domestic situation slightly more bearable on a personal level while reinforcing patriarchy on a structural level. For Pushpa-ben, SD and selective abortion comprised a path out of an aporia, one that expressed simultaneous compliance with and defiance of in-laws' wishes,

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[27] Cf. Unnithan-Kumar, who found that while Rajasthani women readily acknowledged the profit motive underlying provision of sex selection, they nonetheless viewed providers (rather than the state) as serving their best interests (2011: 161-162).

as well as strategic maneuvering within and enactment of a violent gender-kinship system.

Pushpa-ben's story undermines simplifying attempts to categorize those forbidding sex selection as heroes, those desiring it as villains, and those undergoing it as passive victims. Like Pushpa-ben, women could and did pursue the elimination of future women as a matter of situated agency; they did not thereby relinquish a claim to careful, sympathetic consideration as something more than "sinners" and "cruel mothers." Similarly, like Pushpa-ben's mother-in-law, family members could reject sex selection without feminist motives, and in ways that actually exacerbated the suffering of women beneath them in the domestic hierarchy. Wading into the complexity of Pushpa-ben's experience, it becomes impossible to project a straightforward morality play onto the process of sex selection.

Shifting In-Laws, Shifting Agency

It is no accident that the two rich accounts of family decision-making patterns presented above come from women who underwent sex selection several decades ago, in a city at some remove from Mahesana. Because my fieldwork was heavily anchored to clinics and to home visits with entire families, I often could not have the extended individual conversations that close acquaintance facilitated with Preeti-ben and Pushpa-ben.[28] But many contemporaneous cases from my research exemplify, nuance, and complement the two patterns that emerge from Preeti-ben and Pushpa-ben's stories.

Following the Preeti-ben archetype, I saw several instances in which in-laws played a disturbingly forceful role in pressuring reluctant or resistive women toward selective abortion. For example, during one visit at Chetna Clinic, an older woman began dismissing her daughter-in-law's concerns and objections before even exiting the examining area: "So we have to get it taken out. We don't want to keep it, right?.. No, no, get rid of it, get rid of it! You can't go keeping this... What is there to be afraid of?" In such cases of intense in-law pressure, women could and did resist—with or without the support of their husbands—by insisting on keeping a pregnancy or lying about results to kin who had not been present for the scan.

Similarly, I saw a familial dynamic like Pushpa-ben's in some Chetna cases. This was especially true among Rajput women, many of whom were accompanied by natal relatives lamenting the same dilemma: the conjugal family prohibited the patient from seeking SD while threatening her with abandonment, divorce, or a second marriage for the husband if she did not produce the elusive son. [29] By forbidding selective

[28] Analytically, the temporal remoteness of Preeti-ben and Pushpa-ben's sex-selective abortions is both strength and weakness. The passage of time allows for analysis, clarification, and schematization of dynamics that may not be articulable initially. But by removing the possibility of correlative observation, past-ness also raises the issue of selective narration, selective elision, and exaggeration or minimization of certain actors' agency. Ultimately, even if they selectively add, omit, or modify information—as all narratives inevitably do—Preeti-ben and Pushpa-ben's stories illustrate key aspects of two reasonably prevalent family decision-making patterns.

[29] In facilitating sonless women's access to sex selection services, relatives from the *piyar* engaged in a specific form of the "stigma management" that Marcia Inhorn found among infertile Egyptian women's natal kin, who sometimes acted in direct response to conjugal relatives' attempts to tear up a childless

reproduction while posing catastrophic consequences for the birth of an unwanted daughter, in-laws expressed a burdensome hope, one whose disappointment would radically disadvantage a woman within the gender-kinship system. In such cases, furtive sex selection appeared as an escape hatch, amalgamating compliance and defiance in a pragmatic coping tactic.

There were many other configurations in which in-laws appeared as obstacles to selective reproduction. In them, women's agency became largely a matter of overcoming, skirting, or obeying relatives' wishes against sex selection.[30] Kavita-ben's was a case in which a woman overcame relatives' objections through sheer insistence. By contrast, my neighbor Megha-ben and her husband—they of the four separate opinions—had completely hidden their pursuit of SD from his parents, who viewed sex selection as sinful. Uma-masi commented:

> A lot of cases that come with me are like Megha's. They keep it secret; they don't let the parents know... From the moment there's a pregnancy, they don't let anyone know. They hide it. The families don't know—just the husband and wife. They get the work done quietly, secretly. If it's good, they keep it. Many in-laws don't allow it, right?

Unlike Kavita-ben, many pregnant women were not in a position to successfully mount explicitly challenges to senior relatives' prohibitions on sex selection—at least without precipitating marked familial discord or jeopardizing their sometimes-tenuous positions within the household. Many such women (and often their husbands) went to practitioners like Uma-masi to "get the work done quietly."

The pattern described by Uma-masi provides a foil against which to understand the experience of Shilpa-ben and her husband Dhruv-bhai. After three months of antenatal care at Nandini, they went to Chetna with Uma-masi; Dr. Ranjit declared the fetus female. On returning home to their village, they voiced a shared preference for ending the pregnancy. But Dhruv-bhai's father forbade it. "I'm sure," he said, "that it will be a boy. I'm sure that I have a grandson coming!" He emphasized how Dhruv-bhai's mother and most women of her generation had borne three or more children "without any problem." The collective decision-making process ended there.

Six months later, Shilpa-ben gave birth to a second daughter. The Nandini pharmacist, per her usual custom, expressed bewilderment directly to Dhruv-bhai: "A *second* girl? Didn't you get it looked at?" Following an awkward silence, she smiled and reassured him, "Oh well, it's no problem! God'll give you a boy next time."

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marriage (1996: 165-199). See John et al. (2008: 64, 65-66) for further examples of women accessing SD and selective abortion through natal kin.

[30] The analysis here echoes Madhok's examination of three different women's experiences of contraception—two of them involving sterilization in defiance of conjugal opposition, and sterilization thwarted by conjugal opposition—to emphasize that agency lies "not in the abilities of these women to undertake free action but rather in their reflexive capacities to actively formulate and articulate their preferences" (2004: 226-227).

After momentarily hanging his head and sighing deeply, Dhruv-bhai suddenly stood up erect and reframed the unchosen state of affairs, firmly declaring, "God gives girls to families that are strong enough to care for them!" Uma-masi told me afterward that despite putting on a brave face, both he and Shilpa-ben had felt despondent throughout the pregnancy, ultimately approaching the birth in a spirit of resignation.

Shilpa-ben's story, with its divergences from those of Megha-ben and Kavita-ben, illustrates how different members of a household could channel son desire into different reproductive pathways. Rohit-bhai and his family, Megha-ben's in-laws, Dhruv-bhai's father—all of them insisted, like Pushpa-ben's mother-in-law, on a high-fertility pathway to the necessary son, advocating for repeated pregnancies over selective reproduction. In each case, the pregnant woman herself oriented to and sought SD as a method for minimizing the number of children needed to reach a boy. The disagreements within each family—resolved in favor of Kavita-ben in her case, in favor of senior relatives in Shilpa-ben's, and entirely evaded in Megha-ben's—indexed a generational divide in the acceptability of multiple pregnancies and selective abortion.

Furthermore, many women and providers said that in the era of open sex selection, "strict" in-laws, concerned about sin and "more understanding of right and wrong than people today," had forbidden SD and selective abortion more frequently and vehemently than in the 2010s.[31] Observers proposed three interrelated causes for the perceived decline in the prevalence and strength of in-law prohibitions, which forced women to carry unwanted pregnancies or surreptitiously seek sex selection. First, people felt that the force of senior relatives' dicta had diminished due to family nuclearization and "women's empowerment," including increased education and paid employment.[32] Second, with the transition to a low-fertility regime, even older relatives frequently agreed on the importance of limiting family size.[33] Third, there was supposedly an increased flexibility in attitudes toward sin, divine will, and the morality of sex-selective abortion—in other words, a difference in how people were "understanding of right and wrong."[34]

The trend of decreasing familial restrictions raises a dissonance when juxtaposed with stock narratives about the coercive role of mothers-in-law, and with experiences such as Preeti-ben's, which doubtless continued to occur. Governance institutions, mass media, clinicians, and even sex selection clients trafficked in a cacophony of contradictory explanations, in which conjugal relatives, pregnant women, and the desirability of sex selection seemed to shift trickily with respect to one another: *In-laws drive sex selection... No, they prohibit it, though now the prohibitions have become softer... Women will stop going for sex-selective abortion once education, earning, and collapse of the joint family empower them to make their own choices... But when*

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[31] Cf. John et al. 2008: 58-59; Khanna 2009: 102-103.

[32] Cf. the studies (and assumptions) reviewed in Madhok (2004), which largely deal with the association between women's domestic "autonomy" and declining fertility.

[33] Cf. L. Visaria 2007b: 157-158.

[34] I examine the last factor—a profoundly important one for understanding deliberation around sex selection—in Chapter 5.

permitted to have the final say in reproductive decisions, women generally opt for sex selection...

The various explanatory discourses around intra-household struggles usually fell short because they flattened agentic dynamics that must be understood in their complexity. What happened when women acted on what they perceived as their own reasons for sex selection, with familial impulsion relatively attenuated? How might sex selection be situated, but in dynamics not of conjugal coercion or pressure, but of consensus, or even pregnant women's own open, defiant initiative?

Consensus, Divergence, and Women's Reasons

Quite often, the first-approximation paradigm in family decision-making around selective reproduction was one of consensus rather than conflict.[35] Of course, even cases of consensus showed the traces of invisibly and pervasively violent gender-kinship processes. And then there were many cases, such as Kavita-ben's, in which pregnant women drove the process, often over the objections of husbands and other relatives. Instances in which women themselves initiated pursuit of sex selection services must be understood both as exercises of reproductive agency and as reflections or enactments of the household power dynamics and social structures within which those women were embedded.

Consensus: Deepa-ben

In many households, such as Gita-masi's, Kinjal-ben's, and Esha-ben's in Chapter 2, a broad consensus favoring sex selection united different family members. Early in my fieldwork, I rode along with Deepa-ben—a "VIP patient" from an affluent, Patel family of Mahesana—for a visit to Chetna. When I got into the car at the landmark where we had agreed to meet, I was surprised to see only Uma-masi and the patient inside. The subsequent trip was the only time, in hundreds of car rides around the Mahesana region, that I rode in a car driven by a woman. As we started off on the road to Chetna, Deepa-ben introduced herself and explained that her in-laws were "very good," "very forward-thinking"—they had permitted her to pursue a master's degree even after her marriage, and they had allowed her to learn driving and given her a car to take her daughter to and from school.

A few minutes into the ride, Deepa-ben reflected on families in which girls "piled up" without a brother:

> What is the sad state of those girls? On the inside, they feel, 'Oh, I don't have a brother'—especially on Rakshabandhan and other occasions. See, in my *piyar*, we are three sisters, and just one brother—the youngest. When I finished my master's, he was still in elementary school! So

[35] In calling this pattern "consensus," I do not mean to imply a harmonious whole free of contradictions or ambivalences. I am, instead, attaching a provisional label to a prevalent domestic pattern that must be understood as complex. Rather than demonstrating the absence of inequality, consensus in fact demonstrates the "paradoxical logic of masculine domination and feminine submissiveness, which can, without contradiction, be described as both spontaneous and extorted" (Bourdieu 2004: 240).

> growing up, I didn't have a brother. On occasions like this, we sisters cried. Especially on Rakshabandhan—'Why don't I have a brother, like everyone else, to tie a *rākhdi* on? When will my brother come?' And really, on any social occasion, I felt the lack of a brother.

Deepa-ben understood, from experience, the anguish that local moral-economic arrangements imposed on girls without a brother.

I asked how many daughters Deepa-ben had—just one—and she began gushing : the five-year-old girl was "very smart," always "bringing home top marks," and she participated in speech competitions and sporting events "with confidence." Then, to my surprise, Deepa-ben added, "Actually, we weren't planning for another child after our daughter. But my husband's grandfather, on his deathbed, said that God would give us a boy. So then my husband's grandmother said, won't you fulfill Dada's wish? That's where this all came from. Otherwise, we had no plans." Like the unplanned pregnancies in Kinjal-ben's and Gita-masi's families, Deepa-ben's belatedly planned pregnancy was desired only contingently, as a means to a son.

When I inquired generally about other relatives' attitudes, Deepa-ben preemptively dismissed the question of coercion: "My in-laws are all very good, the poor dears! No forcing or anything. My mother-in-law doesn't even say anything." From there, she began intimating the family's shared desire for a son: "Yes, my husband's grandmother feels that way. She won't say anything, and she doesn't harass me. But of course I get a sense that she is hoping. That's everyone's hope. And she will say things to other relatives—not directly to me, but you can figure it out, no?" Coming to the stereotypical figure of pressure, Deepa-ben continued, "And my mother-in-law must also feel that way inside. She doesn't say anything to me, but she must feel it." Then, she added, "Everyone feels that it would be good if the household gets a boy. Because our Indian culture's system is that the girl marries and goes to a *pārku* household, but the son remains with us." This sex selection trip was driven, it seemed, by a broad consensus in which the desires of others slowly bled into Deepa-ben's own orientation.

Reflecting further on her in-laws' desires, Deepa-ben said, "After this, I'll go home, and we'll decide. I'll tell them whatever it is." I asked whether she would consider keeping the result from her kin, as some women who went with Uma-masi did. Her reply was swift and vehement: "No! I could never lie like that. It's all well and good now, but once they found out afterward, they would feel for the rest of their lives, oh, Deepa deceived me. They wouldn't trust me anymore. And I couldn't face them." Her statement was an expression of disciplining within a particular gender-kinship position, but it was also much more. It tied *reproductive transparency* to familial mutuality and affection.[36] To honestly reveal knowledge of the gendered fetal subject, with the myriad relations it implied, was an act of domestic belonging.

A few moments later, Deepa-ben elaborated:

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[36] Cf. Gammeltoft's discussion how Vietnamese women inhabited mutuality and belonging through consultation about sonographic diagnosis of fetal disability with kin and neighbors (2007a: 159-161, 2014a: 231-234).

> It wouldn't even be a problem to have a second girl! The entire family is supportive. But see, I had very high blood pressure in the last pregnancy—impossible to control, even with every medication. That's why we had to do an emergency Caesarean—oh yes, there's that, too: there's one Caesarean already! But so my mother-in-law and grandmother-in-law say, 'Why endure all of that over and over? How much will you have to suffer?' If I have high blood pressure this time, and it's a girl, then what will the sad state of my body be?

I thought to myself that there was an unspoken but palpable sense of the additional question: *And what about the inevitable pregnancy for a boy after* that*?* I was still reflecting when Deepa-ben rounded out the picture: "My father-in-law, my husband, they say it's okay. But my mother-in-law says, 'Boys don't understand what women have to endure.'" Unlike Preeti-ben, who saw blatant disregard for her body in her mother-in-law's behavior, Deepa-ben found solidarity and maternal concern in conjugal women's advocacy of selective abortion.

As in so many cases, Deepa-ben's husband remained on the margins of the sex selection pursuit. She chuckled as she told us, "He said, get done whatever you want to get done. But don't do anything wrong. See, abortion, all that kind of stuff—he can't bear to see it. He has a soft personality. That's why he's not here. He said that he couldn't bear to see it if the doctor said it was a girl and then there was an abortion or something." Like other men, Deepa-ben's husband had the privilege to remain "soft"—and aloof—in the process of selective reproduction. Because his body did not tether him as tightly to the reproduction of his own patriline, he could avoid direct involvement.

After arriving at Chetna, we had to wait outside for almost an hour. (Dr. Ranjit was scanning a police sub-inspector's wife and wanted to preserve the impression that he provided sex selection services only in "select cases," to "special people.") Sitting in the car, Deepa-ben compulsively rubbed her forehead and bit her fingernails. Eventually, we went inside, and the doctor completed the scan quickly. As Deepa-ben sat up and wiped the gel from her belly, Uma-masi leaned in and whispered, "It's good!" Deepa-ben smiled.

Subsequent conversation confirmed my sense that Deepa-ben's sex selection experience, like her affinal relationships more generally, was less riven with explicit conflict than those of Preeti-ben, Pushpa-ben, and others. She seemed to feel for her in-laws the deep-seated, subtle ambivalence that I generally found to be the best-case scenario for adaptation to the pervasive and normalized violence of being alienated from one's own home and thrust into another. She described her in-laws as *jabara*—a difficult-to-translate word carrying shades of power, strength, willfullness, and even imperiousness. While relatively permissive by the standards of North Gujarat, they stopped well short of the most liberal behavior locally imaginable. They maintained exacting expectations regarding childcare. Partly as a consequence, they had imposed search criteria so onerous as to make paid work virtually impossible despite Deepa-ben's high level of education and the fact that all of her natal relatives—including her sister—worked outside the home; several times, she described her own desire for a job and then

concluded with statements of the form "They say that all this education shouldn't go unused, but..." At the same time, Deepa-ben frequently expressed what seemed like deeply felt affection and admiration for her in-laws, describing incidents and patterns of harmony, cooperation, and mutual respect, and occasionally even chuckling about how one or another relative was "afraid of me."

I believe that this well-adjusted ambivalence in the realm of the everyday bears an elective affinity with uneasy consensus around sex selection. The coexistence of the two was a highly common pattern among the families I observed. In contrast to cases of coercion or prohibition, in which in-laws staked out positions opposed to those of pregnant women themselves, Deepa-ben's experience involved a collective initiation of selective reproduction. Like all situated agents, Deepa-ben participated in the collective initiation under heavy influence from her own embodied history—a brother-less girl's sorrow, a trying pregnancy—as well as the desires and statements of other kin, including the dying grandfather-in-law, the eager grandmother-in-law, and the silent but palpably hopeful mother-in-law. Deepa-ben's SD trip was a manifestation of personal desire that had merged with and taken on those of familial others.

Divergence: Ami-ben

In other cases, such as Kavita-ben's, women seemed to drive the pursuit of sex selection over the objections of other relatives—not as an adaptation to direct familial pressure for a son, as in Pushpa-ben's case, but for other reasons. Just two days before I met Deepa-ben, I accompanied Ami-ben and her family on a Chetna visit facilitated by Uma-masi. Ami-ben sat in the passenger seat of the family's beat-up car, holding a small, round-faced two-year-old bundled up in a bonnet and a red fleece sweater. Her husband drove. I squeezed into the back with Uma-masi and the "close friend" who had connected her to the couple—the husband's sister. They were Patels, from a village between Mahesana and Patan—he a farmer and *bhuva* by trade, the two women housewives.

As we pulled away from Mahesana, Ami-ben recalled with a slight frown, "Last time, we went in that bhai's rickshaw." Uma-masi smiled and nodded. Ami-ben looked over her shoulder and explained to me, "It was a girl then, so we got her taken out." The previous visit had occurred just five months earlier. I was startled by the small gap between the abortion and the current pregnancy. The sister-in-law mentioned that Uma-masi had taken *her* for SD when she was pregnant with her son, who was now five.

Her brother shook his head and muttered, "I told my sister no! She kept a *bādhā* with me, so I said they should not do this sin." The sister-in-law smiled, shook her head, and looked at Uma-masi, arching her eyebrows—"But are we women ever satisfied without getting it looked at?" As Uma-masi grinned and grunted supportively, the brother cocked his head toward his wife and daughter, mumbling, "I'm having to suffer for that sin now, with girl after girl! Karma—that is the most powerful thing in this world." The husband elaborated on his work as a *bhuva* to Shikotar Mata, listing off the various cities where he had connections with clients and fellow *bhuvas*. Then, shaking his head, he said, "I release other people from their sorrow. It's ours that won't let go!"

Uma-masi and I explained my research a bit further. Ami-ben's sister-in-law nodded and said, "See, the main thing is the feeling that if there's one boy, then the door

to the home will remain open." Pointing to her niece, she added, "This one will go to a *pārku* household after marrying."

Suddenly, the husband shouted: "I never wanted to get it looked at! I said, let whatever it is come. Whatever comes is fine—whatever God gives us! After we got it taken out last time, I said, oh God, I will marry a second girl, give her away in *kanyā-dān*, but release me from this sin!" Again, reluctance, disavowal, and blame of the wife: like Deepa-ben's husband and Rohit-bhai, Ami-ben's husband distanced himself from responsibility for the actions he and his wife had undertaken in the pursuit of a son. Ami-ben stared silently into the fields passing by on the other side of the road.

When we reached the clinic, Ami-ben sat silently on a bench in the waiting room, her jaw clenched, her gaze flitting from one point to another every few seconds. The toddler's right arm draped over the mother's right hand, which held the toddler's left arm, which in turn lay across the mother's left arm; they were intertwined like vines.

Eventually, the nurse told the husband and sister-in-law to stay in the waiting room with the little girl and took the rest of us to the back corridor to await Dr. Ranjit's call. Uma-masi asked Ami-ben how she felt. She began, "The *hend* is the same as last time. People say the *hend* should be different! And I don't have a brother myself—we are just three sisters..." Sobs interrupted her speech. She wiped her mouth with the edge of her sari and wrung her wrists, looking down. Tears filled her eyes, and her lips and jaw trembled. Before any of us could say more, the nurse summoned us into the consultory.

The doctor scanned for quite a while. Ami-ben's gaze remained focused on his face, with occasional glances around the room. Her hands were joined, and she seemed to be mouthing a prayer the entire time. After more than fifteen minutes, Dr. Ranjit instructed Ami-ben to step outside and pass urine, explaining that he would need to scan again. She shook her head as she stepped down from the examining table.

Out in the general ward where Uma-masi shepherded us, there was a pair of women whom I recognized from Nandini. Uma-masi began conversing with them. It soon became apparent that though they had come from Mahesana in a separate vehicle, they were also her clients. Uma-masi asked "what excuse you made," given that "the family was saying no." One of the women said, "Oh, they were definitely saying no! But we said we were just going for an outing in the car." Uma-masi turned to Ami-ben and me and explained that the woman had snuck out with her husband and sister-in-law to obtain SD secretly, since her in-laws objected to the practice. Ami-ben nodded and mumbled some words of general sympathy—"Oh, that's the way it has to be, isn't it?"

A few minutes later, the nurse called us all out into the corridor. Ami-ben turned to the other patient and said, "I'm getting this done a second time. I had it done once before, but it was a girl." Her eyes filled with tears, and the corners of her mouth twitched. "Now, this is the second time. But the *hend* feels the same!" She began weeping. The other women vaguely reassured her that a male child did not always correspond to a different bodily experience of pregnancy. The nurse called us in, and Ami-ben quickly wiped her tears away.

Following another long scan, Dr. Ranjit mumbled something to Uma-masi, who quickly ushered us out of the examining area, out of the consultory, and into the back corridor. Ami-ben opened her mouth, but before she could say anything, Uma-masi

declared, "It's a good report! Nothing to worry about!" Ami-ben's whole body slumped, and she buried her face into Uma-masi's shoulder, leaning on her as we walked away. We exited to the waiting room, where Uma-masi informed the husband and sister-in-law of the result. We rode back to Mahesana, sitting in silence save for the devotional hymns the husband blasted on the stereo: "Oh this world, this world is full of sinners..."

Later interactions confirmed the impressions I gained from that initial trip. With support from the sister-in-law, Ami-ben had previously insisted on pursuing SD and then selective abortion. The husband had vehemently objected to both steps but ultimately conceded to his wife's wishes. Like the other client we encountered at Chetna, Ami-ben had been the major advocate of sex selection within the family, in ways poignantly inflected by her own experiential understanding of what being sonless and brother-less entailed. Where her husband voiced concerns grounded in karma and sin, she focused on pragmatic factors such as the inevitable alienation of daughters, the "sorrow" of girls without a brother, and the exhaustion of repeatedly bearing and caring for "whatever God gives." Of course, as the tears in the back corridor suggested, it also fell to Ami-ben to deal most directly with the physical and emotional consequences of a female result—consequences that she found painful despite their chosenness.

Women's Reasons

Deepa-ben and Ami-ben's narratives differ in the degree of familial consensus around sex selection. But they stand united, and in contradistinction to Preeti-ben and Pushpa-ben's stories, by the degree to which the women protagonists were empowered to adopt somewhat active, rather than reactive, approaches to reproductive choice. Pushing aside stock narratives of coercive in-laws, victimized daughters-in-law, and women resisting sex selection against all odds, these stories illustrate how women might agree with and even drive the process of selective reproduction.

Sex selection clients, obstetricians, and connectors often emphasized that women generally seemed more invested in having sons than did their husbands. Couples seeking SD or conceiving yet again in hope of a son frequently joked about the pattern: wives self-deprecatingly admitted that "he doesn't care, it's all me," while many husbands, echoing Ami-ben's, muttered that "whatever comes is fine" or that "I didn't even want to get all of this done."

Families and practitioners usually ascribed greater maternal avidity to "talk in the community," "neighborhood gossip," or "how women always chatter when they get together." In this account, women's son desire could be explained by the amount and content of talk about children, which fetishized a son as a token that bestowed greater social recognition. (Here, too, men remained largely hidden in the analysis of patriarchal dynamics.) Women wanted sons because they were the ones to "hear about it" from relatives, neighbors, and caste-mates when they did not have them. Taunts, expressions of pity, and other negative social commentary about a couple's sonless condition—and the converse once a son was born—differentially affected women, whose access to other avenues of social recognition was often more circumscribed.[37] Whereas Deepa-ben's

[37] For the specific role of sons in enhancing mothers' social recognition and status in patrilineal Indian families, see P. Jeffery et al. (1989: 144-145), John et al. (2008: 66), and Puri et al. (2011: 1171). Das has

husband garnered respect as a successful entrepreneur, and Ami-ben's as a sacrally powerful *bhuva*, their wives' social renown depended largely on becoming mothers to sons.

But it would be mistaken to overdetermine sex selection as *merely* a function of social talk in women's everyday worlds. Such talk fit within a much broader moral-economic apparatus that channeled the desires of particularly positioned persons toward the reenactment of patriarchal structures—an apparatus that allowed considerable latitude of desire and action, even as it imposed heavy constraints. An account of women's reasons for actively pursuing sex selection must consider how such action could rest on pregnant women's experientially situated understandings of potential girls' lives, as well as their own direct stakes in reproduction.[38]

If women frequently exhibited greater apparent desire for sex selection than relatives—particularly husbands—it was partly because they possessed situated understandings of the difficulties of feminine lives. The phrase I heard from Kavita-ben without further elaboration—"Being a woman..."—surfaced countless times as a prelude to women explaining why they did not wish to bring more female life into the world. After trying and failing to access SD, one Nandini patient lamented, "Oh, I'm so worried! A woman's *avatar*—well, a man's *avatar* is better. Worrying about the kids, worrying about everything—women have all the difficulties." The reference to *avatar*, with its evocation of physical form and consequent social destiny, aligns with the way many women talked about the implications of SD: a gendered body implied a gendered fate.

Shaking her head, the same Nandini patient later elaborated, "There's no worth to a girl in our community! I see what the situation for women is every day—abuse, disrespect—in my home, in my community. After seeing all that sorrow, a boy is better. What is the sad state of a girl? How can someone live like this?" Such statements about the sad imagined life of a potential daughter make sense as experientially informed statements about the helplessness of the woman—the wife, the daughter-in-law—within a social structure predicated on expropriation, devaluation, and subjugation of women. Women like Kavita-ben, Deepa-ben, and Ami-ben deeply loved and took pride in their existing daughters, as was evident in boasts about intelligence, hopeful plans for future

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discussed how feminine personhood can be caught up in "dominant norms that would allow a woman life only as a mother of sons" (2007: 189). Writing of Chinese patriliny, Sangren has noted that the "instituted fantasy" of kinship inverts the producer-produced relationship of biological and social reproduction by making the son the agent of the father's actualization through ancestor worship rituals (2009, 2013); moving away from the ritual realm and toward everyday interaction, it is perhaps apparent that the son of Hindu patriliny can perform a similar function for his mother, completing her actualization within the community and creating the illusion of producing her as a person. There is a parallel here to Inhorn's work on infertility in Egypt, which examines experiences of "missing motherhood" that are partly articulated through social ostracism (1996: 51-85, 200-221).

[38] Mookherjee echoes this dual characterization in discussing sex-selective abortion as a form of patriarchal bargain:

> A woman's option for SSA may constitute the most rational and even most empowering decision that she could possibly make. By choosing to abort a female foetus she addresses the problem of gender inequality directly, not only by protecting herself from a loss of social status within her community, but also by saving her unborn child from a life of sexual subordination (2005: 277).

education, and innumerable quotidian acts of embodied care and affection. If their pursuit of sex selection rested on not only son desire and generic preference for fewer children, but also specific daughter aversion, it was partly because they knew from experience the pain of separation—of becoming *pārki* to one's own kin, and hence an outsider everywhere. As Deepa-ben and Ami-ben's impassioned statements suggest, pursuit of a son was frequently informed by an exquisite understanding of the anguish visited upon girls who lacked a brother to make their homes whole within the patrilineal moral economy.

The gender-specific understanding that frequently led women to drive sex selection also encompassed conscious, practical deliberation regarding the implications of childbearing for their own futures.[39] Having gone through at least one pregnancy and having at least one daughter, women seeking sex selection appreciated, in embodied fashion, the work involved in gestating, bearing, nursing, and raising for offspring. with each new child occasioning years of feeding, bathing, cleaning, tutoring, and other unremunerated childcare. As seen in Deepa-ben's narration of family deliberations around the possibility of multiple pregnancies, women possessed unique insight on what they had to endure in the absence of selective reproduction, in a way that "boys don't understand." As seen in Ami-ben's tears, women also possessed unique insight on what they had to suffer when they chose sex-selective abortion as the least bad of all options. And women understood that their own domestic and social ascendancy, from middle age to old age, depended on establishing a patrilineal foothold through a son.[40]

In light of the above factors, the seeming disappearance of men in explanatory discourses and actual decision-making patterns around sex selection becomes more comprehensible. From a systemic perspective, there was doubtless a patriarchal bargaining dynamic at play, with adult men remaining on the margins, disclaiming responsibility, and even disavowing their wives' actions while allowing the women of the household to drive forward son-seeking practices that presumed and re-enacted masculine domination.[41] The aloofness of Preeti-ben and Pushpa-ben's husbands in the face of

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[39] This deliberation is part of what Jeffery et al. have referred to as "counting the cost of motherhood" in terms of pregnancy, childrearing, and healthcare and evaluating "the costs of children" in terms of food, clothing, education, medicine, and other forms of care—calculations that feature more prominently in women's minds than in their husbands' (1989: 167-175, 184-187).

[40] This is one of the central dynamics in Kandiyoti's original conceptualization of the patriarchal bargain: making some tradeoff in the present for enhanced security, status, and power as a senior woman of the household in the future, with the result being "women's active collusion in their own subordination" (1988: 279-280). For a discussion of women's life cycles in patrilineal India and the importance of motherhood in progression through them, see Kakar (1983: 52-102), T. Patel (1994: 74-79), P. Jeffery and Jeffery (1996), Säävälä (2001: 104-119, 134-135, 139-148), and Brunson (2016: 93-112). Cross-culturally, one of the most lucid discussions of this phenomenon remains Wolf's examination of the "uterine family" in patrilineal Taiwan (1972: 32-41).

[41] My use of the term "masculine domination" is intended to evoke Bourdieu's insights on gender inequality (2001, 2004: 340; Bourdieu and Wacquant 1992: 170-172), which displaces a coercion-consent dichotomy in favor of examination of the processes by which "male sociodicy" is rendered self-evident and inculcated into the subjectivities of men and women alike. But in contrast to a simplistic reading of the Bourdieusian perspective, which might treat gender hegemony as an irresistible force that automatically acts through docile subjects, I have attempted to demonstrate throughout this chapter how the hegemonic

verbal harassment and frank coercion amply demonstrates how men's inaction could be a key form of complicity.[42]

But there was also something more intimate—a difference in the quality or channeling of desire—in men's tendency to frequently play less active roles in pursuing sons. Men could afford to waffle, plead "softness," excuse themselves from the process of selective reproduction, or even express objections because their social positioning, experiences, and future prospects did not make childbearing consequential for them as it did for their wives. They did not bear the difficulties of repeated pregnancies or the pain of selective abortions. To a great extent, they did not have to feed girls, bathe them, drive them to school, or engage in the countless other acts of care that constituted everyday parenting. The social patterning of interaction and recognition offered them multiple avenues for self-actualization that partly offset the incompleteness of a sonless state—an escape generally less available to their wives. And whereas social talk usually subjected women with multiple daughters to only scorn or pity, a father of multiple daughters could earn respect for successfully discharging paternal duties by financially supporting and successfully marrying "so many girls"; perversely, his contribution to the alienated reproductive labor congealed in a daughter was often more valorized than his wife's.

The challenge that multiple daughters posed to traditional breadwinning masculinity[43] often activated bold posturing, which usually ended in impotent objections (as in Rohit-bhai's case) or, more rarely, a successful barring of sex selection. Hitesh-bhai, a Mahesana-area government official responsible for promoting both family planning (i.e., fertility reduction) and Beti Bachāvo, once told me proudly:

> I have four daughters—and only then, my son! After three girls were born, in the fourth pregnancy, various doctors and friends supported us to get a sonography done. We found someone in Unjha, and he said it was female. My mother and wife were in agreement: we don't want to keep it. But I said no, we should keep her! I didn't let my wife go to the clinic. She tried to take an abortion pill, but it didn't work—see, it happened as it was meant to happen. I said, 'I'm standing here, aren't I? Hitesh-bhai, the girls' father? Let her be born!'

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ideals of son necessity and daughter aversion may be taken up and enacted (or not) by different actors in different ways.

[42] Ganatra et al. (2001: 115-116) and Puri et al. (2011: 1172-1173) have identified men's silence as a form of complicity in sex selection. John et al. have characterized men as "backstage" actors who often remained out of sight in the clinical process of sex selection itself while still dictating action and controlling material resources (2008: 65).

[43] This is a somewhat different relationship between sex selection and paternal masculinity than the one found by John et al., who have observed:

> In the case of large agrarian castes (both high and low), such as Thakurs, Gujjars, and Jatavs, in Morena and Dholpur, it was found that men have a much stronger voice in deciding matters related to childbearing. Women are subjected to repeated childbearing and are not allowed to restrict their fertility. Fertility is seen as a symbol of masculinity, and women who wish to abort a foetus are accused of infidelity, implying that the child they wish to get rid of has been fathered by another man (2008: 66).

A girl had been saved, in a manner of speaking. But what of the woman forced to unwillingly bear her?

Constrained Agency, Impossible Choices: Kavita-ben, Again

Just a few days after my initial meeting with Kavita-ben and Rohit-bhai, I saw them again. They had invited me to their village for Uttarayan celebrations, and I had gladly accepted.

When I got off the shared rickshaw shuttle, I found Rohit-bhai waiting for me on the side of the highway. He was seated on his moped, clutching his daughter, who was bundled up in a faux-fur sweatshirt.

As we rode toward the village, Rohit-bhai asked, "Do you take drinks?" Catching a faint whiff of alcohol on his breath, I suddenly felt apprehensive about sitting on the back of his speeding scooter. I answered meekly that I sometimes did, and the matter ended there.

We dismounted in front of Rohit-bhai's house, a modest but well-constructed affair. He introduced me to the entire family. His brother, a comfortably positioned State Transport official, and his sister-in-law, a government schoolteacher, lived in Mahesana. His father had just recently retired after thirty years of service as a schoolteacher in a village near Unjha. I learned that Kavita-ben had completed a bachelor's degree in education—a surprise, given her husband's manual labor job and presumably limited schooling. As we settled in on the floor of the house's main room, Kavita-ben's sister-in-law goaded her to take the teaching certification exam again; the latter chuckled and waved off the prodding with some mumbled words that I could not make out. I noticed that she shot a quick glance at Rohit-bhai.

After lunch, we moved to the roof, where Rohit-bhai and his younger cousins had installed an impressive stereo system. We lounged for a bit on plastic patio chairs, soaking in the mild warmth of the winter sun. Then, Rohit-bhai brought up alcohol again: "You must take drinks, being from America!" I repeated that I did so, but only occasionally. I asked if anyone else in the family drank, and his eyes widened: "No! No one!" His tone was vehement. "Don't say a word of it, or I'll be in for it!" Noticing a stronger odor on his breath and a distinct slurring of his speech, I suddenly thought back to his several momentary disappearances in the hour since our arrival.

Worried that we were moving toward drinking moonshine, I asked where he obtained his alcohol. With a casual wave, he reassured me, "You can get as much as you want here!" Widening his eyes earnestly, he quickly added "But since you were going to come in, I got some imported stuff, especially for you, from Patan." He abruptly stood up, tottering onto his feet, and waved me downstairs: "Come, I'll show you the house!"

Rohit-bhai led me on a brief tour that quickly ended in a little-used storeroom. He squatted and slid open a cabinet, hissing at his nephew, who had accompanied us, to bring water and then stand guard outside the door. He pulled out the bottle—Hennessy—which was by now about half full. His eyes kept darting toward the door. He poured a bit out into a plastic cup, filled the rest with water, and thrust it to me. Feeling panicked, I downed the drink in three big gulps. He made himself the same mix and took it down in

one. From outside, the nephew whispered urgently, "Hurry up, hurry up!" Rohit-bhai shook the cup out, flipped it onto the bottle, and slid the cabinet shut. As we stepped into the daylight, I looked at the boy and wondered what he was thinking.

Back on the roof, Rohit-bhai quickly fell asleep in his chair. His father then gave me his own tour of the house, detailing how he had built it up by saving his schoolteacher's salary over many years. It was a very different perspective on the shared domestic space. We discussed the price of land, the cost of construction, and government salaries. At one point, commenting on the difference between Rohit-bhai and his brother, the father mumbled, "Well, our Rohit didn't really apply himself in his studies. We had high hopes for him. But he got into some trouble in high school, and then he had to go to vocational school." That confirmed it: Kavita-ben had attained a considerably higher education than her husband; if working outside the home, she would likely earn significantly more than him. I found myself wondering about their pairing: had it, like so many of the marriages I saw, been fixed in mid-adolescence, when a daughter's development into womanhood compelled her parents to "throw" her into another household, despite a paucity of information about the partner being chosen for her?

The father continued, "Everyone in the family is very well educated—our son, both daughters-in-law. I'm a teacher myself. It's only our Rohit who fell behind, in all of this..." His voice trailed off. He stared into the distance for a moment before resuming an explanation of rising land prices in the village.

After Rohit-bhai woke up, we flew kites with his younger cousins and nephew for an hour or so. He then suggested that we make a "round" through the village. Mounting the moped, he stumbled a bit; he had to ask his nephew to kick-start the vehicle. We rode to a small shop. The shopkeeper asked with a smile whether Rohit-bhai needed a plastic cup, but he shook his head—"Not right now." Another man came up and asked for a cup and three pouches of water. The shopkeeper smiled: "Everyone's doing the same thing today, since the morning!" I looked at Rohit-bhai's bloodshot, slightly discolored eyes. They had appeared identical when I saw him at Chetna.

When we returned to the house, Rohit-bhai hunched toward me and put his extended thumb to his mouth quickly in the standard gesture for "Drink?" I shook my head and asked for some water. He looked disappointed. Shortly thereafter, I took my leave of the family, and he dropped me off on the highway.

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Kavita-ben's experience illustrates, in heartbreaking fashion, how elimination of female fetal subjects—rejection of potential daughters—might prove the most reasonable step for women who found themselves with no good choices. While the dynamics of action in her story differ markedly from those in Pushpa-ben's, both women were united in how structural and domestic factors combined to make them feel that sex selection was inevitable.

In seeking selective abortion, Kavita-ben was certainly acting on the futurity of the gendered fetal image, moving back and forth between the reproductive present and various points in a potential daughter's future—childhood, marriage, and so on. Another daughter would be a lifelong emotional liability because of kinship norms that demanded her separation and propelled her into a potentially harsh conjugal environment. And an

additional girl would also stretch the household economy, making sustenance on a meager government mechanic's salary tenuous not only for herself, but also for her parents, her older sister, and her inevitable younger brother.

But Kavita-ben's story shows how the motivations for sex selection not only fused together care and cost, but also moved beyond their sole attachment to the gendered fetal subject itself: how could the prospect of caring for, paying for, and losing another girl be separated from Kavita-ben's own sense of struggle, feminine suffering, and loss within her conjugal household? Social norms and practices of marriage had funneled her into a household environment in which Rohit-bhai's drinking, educational underachievement, and meager income combined to create a situation of precarity and downward mobility. Despite considerable schooling, Kavita-ben could not improve her and her children's lot through market labor. By avoiding a second daughter, then, she protected herself and her family from further immiseration.

There was a gendered chasm in experience underlying Kavita-ben and Rohit-bhai's divergence on the question of sex selection. He insisted that he was against it and faulted his wife for "pulling" him into wrongdoing. While sharing her husband's sense of sex-selective abortion as *pāp*, Kavita-ben—like Gita-masi—insisted on the necessity of the sin. Like so many men, Rohit-bhai saw the prospect of another girl as a challenge to his breadwinning masculinity, a challenge that had to be met head-on by accepting and supporting the daughter-to-be. But it was Kavita-ben who had to directly reckon with the pragmatic effects of bearing yet another daughter on the path to the inevitable son: carrying the pregnancy to term, birthing the child, nursing, providing years of unremunerated childcare atop domestic labor, and squeezing yet another hungry mouth into the tight household budget. Where her husband emphasized relatively abstract concerns—the sinfulness of selective abortion, his inflated confidence in his own ability as a provider—Kavita-ben's insistence found justification in the lived experience of the domestic. For her, sex selection was an exercise of circumscribed agency in the face of a moral economy of gender-kinship, a stressful domestic life, and a trajectory of downward mobility that left her with only difficult choices.

Chapter 5: The Local Ecology of Son Production

Struggling with Sonlessness

Gauri-Devi and Dhruv-ji

When Uma-masi pulled me into the Nandini Clinic room and introduced me to the couple—"these are the people going today"—I realized I already knew them. Gauri-devi and her husband Dhruv-ji had been traveling from Rajasthan for months to receive fertility and pregnancy treatment from Dr. Dilip. Now, after countless pills and hormonal injections, one round of intrauterine insemination, and fourteen weeks of meticulous supportive care, they were going to Chetna for the all-important test.

Gauri-devi and Dhruv-ji were in their late thirties. They belonged to the Jat caste, a landholding agricultural community. Gauri-devi worked as a government schoolteacher in their home city, several hundred kilometers away. She was tall, with long, black hair that betrayed the first hints of graying, and wide glasses that made her eyes appear distant. As usual, she was dressed in a colorful salvaar-kameez. Dhruv-ji, a bank clerk, was even taller than his wife, with thin-rimmed glasses and oiled hair. He was dressed in gray jeans, a black ribbed sweater, and white sneakers.

Speaking in an *ad hoc* mixture of Gujarati and Hindi, Uma-masi quickly gave the couple instructions regarding discretion: "Don't name names, don't tell anyone, because these government people are now trailing patients!" She then relayed the payment plan: 15,000 rupees for the scan, and another 10,000 "if the other thing is to be done." Smiling, she joined her hands and said, "Keep faith in Sai Baba for a good result! Pray!" Scurrying into a corner, she took a phone call from the rickshaw driver; he had arrived to escort the couple. Downstairs, Gauri-devi, Dhruv-ji, and I got into the rickshaw; Uma-masi had to remain at Nandini, but she had already arranged everything with Dr. Ranjit.

Once the rickshaw was puttering along, Gauri-devi and Dhruv-ji recounted the exhausting work involved in their ten-year-long pursuit of a son, detailing frustrating and frustrated efforts in the realms of biomedicine, Ayurvedic treatment, and religion. I listened and interjected questions occasionally, reviving my shaky Hindi.

At one point, the rickshaw flew roughly over a bump. Dhruv-ji frowned and squeezed the driver's shoulder. "Careful, Bhai!" he said sharply. And then again, gently: "Careful." The still-ungendered fetus, achieved after a decade of longing and several years of tiresome treatment, was too precious to endanger.

The preciousness rested on the potential for a son. The impending sex determination (SD) could still dislodge the pregnancy as a successful endpoint to the couple's arduous reproductive trajectory. Gauri-devi said they had asked Dr. Dilip to "check," but he had demurred, voicing some excuse about "software." Overhearing, Uma-masi had informed them that she "knew a saheb," paving the way for the current ride.

Shifting into the third person, Dhruv-ji opined, "Everybody will want one boy.

That's our social structure. There is the law, there is checking, but still, people get this done. Every man will feel, *ek ladkā to chāhie*,[1] so this happens everywhere. Nothing will change by just the law, because this is our social custom."

Gautam-bhai left us at Chetna after introducing the couple to the waiting room nurse as "Uma-masi's patients." We sat on the benches to wait. Dhruv-ji noticed a photograph of Sai Baba—a nineteenth-century spiritual master whom he held in great esteem— hanging on the wall. He joined his hands, closed his eyes, bowed, and began mouthing a silent prayer. Gauri-devi leaned back against the wall and sighing.

Following a long wait, Dr. Ranjit summoned Gauri-devi. After a few minutes of scanning, he said he would have to repeat the test after more urine collected in Gauri-devi's bladder.

We waited, moving back and forth between the patio and the waiting room. Gauri-devi occasionally grimaced, citing the discomfort of a full bladder. The anticipation of a son, full of hope and fear, stretched out for another hour.

During the second scan, Dhruv-ji remained in the consultory, gazing at a photograph of Sai Baba on his phone. Inside the examining area, Gauri-devi's face was tense, her jaw clenched. She threw her *dupatta* back over her face. Underneath, her breath ebbed and flowed rapidly.

After ten minutes, Dr. Ranjit grunted, holstered the ultrasound transducer, and stepped out. He took a seat behind his desk, and Gauri-devi emerged to sit next to her husband. I watched, with bated breath, from the sofa along the side wall. The two men haggled about pricing for a few moments, with Gauri-devi sometimes whispering in her husband's ear. Eventually, they settled on 13,000 rupees. Dhruv-ji pulled out a wad of cash and extended it toward Dr. Ranjit. Seeing it, the doctor nodded gently.

"It's all set. Male."

Dhruv-ji mouthed the last word as if in disbelief. Dr. Ranjit repeated it twice. Dhruv-ji's face brightened, and he shouted, "*Are*, what news! If you want, I'll pay the full 15,000!" He practically slapped the doctor's outstretched hand. Both Gauri-devi and Dhruv-ji began shouting in Marwadi, their mother tongue. Dr. Ranjit smiled mildly and looked on.

After the couple's shouts had died down, the doctor chuckled and said quietly, "Well, if you want, you can pay the full 15,000." Dhruv-ji's hyperkinetic motion slowed just a bit, and his grin mellowed to a smile. He began asking about the certainty of the result—"Sure? Hundred percent confirm? Definitely male?" The doctor nodded; it was "100%." Dhruv-ji loudly professed full faith in Dr. Ranjit and Dr. Dilip's work "because you both have photographs of Sai Baba—you are true devotees." He promised that he and Gauri-devi would forever keep the doctor in their prayers "for this very good thing you have done for us."

I turned toward Gauri-devi. Streams of tears were suddenly pouring down her cheeks, with her entire face and torso convulsing spasmodically. She wiped her face with her *dupatta* and continued crying for several minutes. We three men stood there in silence. Several times, Dhruv-ji whispered us a reassurance—"Tears of joy." At one

[1] *Ek ladkā to chāhie* is the Hindi equivalent of *ek chhokaro to joie*.

point, Dr. Ranjit leaned over to me and mumbled, with wonder, "See the patient's emotion!"

As we left the clinic some moments later, Gauri-devi shook her head and said to me matter-of-factly, "I feel so sad. So much sorrow. We are just two sisters—no father, no brother. My father was murdered when I was very young. And I have always felt it—that I have no father, no brother, no son. So I always felt that if I got a boy in my home, I would feel..." She trailed off and shook her head. For her, the report of a son-to-be was the culmination of not a decade-long, but a lifelong quest.

We walked to the tea stall near Chetna. As we sipped *cha* and ate biscuits, Dhruv-ji was the picture of confidence. Nodding toward his wife, he smirked, "I had told her from the beginning! Checking—I mean, we get it done for our satisfaction. But I knew that's what it would be—meaning, a positive result! So for satisfaction, fine, we get it done. With technology increased so much, no one can wait that long."

I turned to Gauri-devi and asked if she had felt as certain. She held a wry smile for a few seconds before shaking her head: "*Nothing* like that."

At one point on the rickshaw ride back to Mahesana, I returned to the issue. "Had you made a decision already?" I asked. "If—"

Dhruv-ji did not let me finish the question. Shaking his head vigorously, he interjected, "We did not even think about it! From the beginning, we trusted in Sai Baba. That if it was happening after such a long time..." He trailed off and stared into the landscape speeding past, leaving the implication hanging: divine justice required a boy after such a long ordeal. No other outcome had even been conceivable.

I interpreted Dhruv-ji's confidence as a *post hoc* reframing of an uncertainty-filled reproductive trajectory, one whose animating hope might just as easily have met disappointment as fulfillment. I had witnessed too many cases of shattered expectations to think otherwise.

Dhruv-ji's words and actions lent some credence to my cynical interpretation. Upon returning to Nandini, he repeatedly asked Uma-masi and Dr. Dilip "what that saheb's result is like"—whether "it is 100%." When the couple returned for routine prenatal care a fortnight later, he had Uma-masi arrange another visit—"for confirmation"— to Chetna, "We're not worried," he insisted on the rickshaw ride there. "We've already gotten it looked at once. But this time—a guarantee." Throughout the ride, he peppered Uma-masi's appointed driver with questions about Dr. Ranjit's expertise and the quality of his machine. His persistent anxieties indexed just how high the stakes of an accurate result were.

At Chetna, Dr. Ranjit quickly confirmed the "male" result. Turning to Gauri-devi, he said with a smile, "Go ahead and cry now, if you want to."

She smiled back and said quietly, "No, no. That was an emotional outburst. But we know now, right? It's *pakka* [certain, ripe, fixed]—it's a boy."

The Coin Toss of Son Pursuit

Like all the couples I observed pursuing sex selection, Gauri-devi and Dhruv-ji

were flipping a coin,[2] contending with the unpredictable vagaries of bodily processes, divine will, and chance in order to obtain a boy. Experiences like theirs reveal how reproductive uncertainty and misfortune breached the taken-for-granted character of son production, pushing people to the limits of their analytic capacities, endurance, and moral insight.[3]

Ethnographic scholarship shows that, far from simply constraining, uncertainty and misfortune may expand therapeutic endeavors, precipitating resort to different healers and healing modalities—particularly so when causality lies not just within an individually bounded body, but in interactions and extra-corporeal personalistic forces.[4] In this chapter, I focus on such therapeutic expansion. I examine biomedical, herbal, and religious techniques that operated alongside or instead of the sonography and selective abortion described in Chapter 2. Such techniques offered couples different sorts of agency around a process that Mahesana-area obstetricians treated as essentially random: sex *determination*, in the sense of "causing" rather than "ascertaining."[5]

In contrast to the exploration of familial "choice" in Chapter 4, here "agency" refers to the capacity for intervention on the "fleshiness and fragility of life"[6]—for proactively channeling inchoate vital processes toward the end of *son production*. It is a matter for changing, or attempting to change, fate or chance in line with deeply held desires that define the self.[7] The coin toss is, indeed, a "serious game"—one in which people's pursuit of "the good" (a son) unfolds amid a field of bodily, divine, and chance forces.[8]

For couples like Gauri-devi and Dhruv-ji, *son pursuit* entailed recruitment of various modalities into a "reproductive quest" [9] aimed exclusively at producing a boy. Couples acted not on generic "child desire,"[10] but on *son desires* of the sort described in Chapter 2. The movement toward leaving a state of *sonlessness*[11] was animated by an emplotment of hope that narratively constructed lived time, emplacing various failures and successes within a larger, culturally shaped teleological plot.[12] Hope undergirded the pathways that son desire might follow once put into motion—pathways that empirically ended in disappointment as well as satisfaction.

Scholarship on sex selection has amply documented a dizzying array of technologies that operate alongside conventional biomedical methods. These include

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[2] My use of the "coin toss" metaphor—one appreciated on the ground in Mahesana—echoes the notion of "demographic roulette" (Attwood 1995, cited in Bossen 2007: 211).
[3] Gammeltoft 2014a: 133-135, following Geertz 1973: 100-108.
[4] Reynolds-Whyte 1997.
[5] The distinction is drawn from Rothman (1986: 138).
[6] Mol 2008: 11.
[7] Cf. Sangren 2012.
[8] Cf. Ortner 2006.
[9] Inhorn 1994.
[10] van Balen and Inhorn 2002: 8.
[11] van Balen and Inhorn make a useful decision between "infertility" as the *process* of being unable to have children and "childlessness" as the resultant *state* (2002: 11). Given the lack of established terminology around "sonlessness," and a desire to avoid multiplying jargon, I use the one term to refer to both process and state throughout this chapter.
[12] Mattingly 2010.

herbal medications for "reversing" fetal sex, Ayurvedic pills for shaping a boy, ingestion of particular foods, torso bandaging, amulets, blessings, tantric rites for moving up a boy's birth order, pilgrimages to shrines, calendric methods for properly timing conception, and various techniques for reading the sex of the unborn from the pregnant woman's body.[13]

In this chapter, I focus on a few such technologies, describing how they operated in people's lives and offered control in the face of unpredictability. I situate biomedical, herbal, and religious methods with respect to one another in a *local ecology of son production*.[14] In bringing together "biogynecology" and "ethnogynecology,"[15] my account builds on anthropology's longstanding attention to "medical pluralism" in India.[16]

But the goal is not to uncover the logic of pragmatic "choices" amidst a variety of healing modalities. Nor is it to patronizingly counterpose modern, rational science—anchored by "knowledge"—to "traditions" of magic, religion, and "folk healing" rooted in "belief."[17] Instead, I am to seriously confront diverse, overlapping, and often-contradictory ontologies of reproduction, avoiding disengagement from the "uncanny metaphysics" and various other explanatory models invoked in pursuing sons.[18]

The task at hand appears most clearly in an encounter repeated many times during my fieldwork. When couples expressed frustration at repeatedly conceiving girls, I sometimes asked (as a diligent, bio-centric ethnomedical researcher) what they understood as the cause of their misfortune. Pregnant women and their husbands usually gave some version of a common answer, one that strongly pointed to the operation of various causal forces: *Of course, it's because of the X and the Y. But who can say* why—*why* that *sperm and* that *egg got together? That's the question!*[19]

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[13] Dagar 2002: 37-46; John et al. 2008: 60-62; Khanna 2009: 95-97.
[14] Cf. Das and Das 2006, 2007.
[15] Inhorn 1994.
[16] Alter 2005; Beals 1976; Kakar 1982; Khare 1996; Leslie 1976.
[17] Good 1994: 1-24; Tambiah 1990.
[18] Cf. Goslinga 2013.
[19] The question contains obvious echoes of Evans-Pritchards's question about people injured by a collapsing granary:

> Now why should these particular people have been sitting under this particular granary at the particular moment when it collapsed? That it should collapse is easily intelligible, but why should it have collapsed at the particular moment when these particular people were sitting beneath it?... We say that the granary collapsed because its supports were eaten away by termites; that is the cause that explains the collapse of the granary. We also say that people were sitting under it at the time because it was in the heat of the day and they thought that it would be a comfortable place to talk and work. This is the cause of people being under the granary at the time it collapsed. To our minds the only relationship between these two independently caused facts is their coincidence in time and space. We have no explanation of why the two chains of causation intersected at a certain time and in a certain place, for there is no interdependence between them. Zande philosophy can supply the missing link (1976: 22-23).

Evans-Pritchards's discussion of the granary scenario clearly positions "Zande philosophy" as an excess or superfluity beyond the bounds of an implicitly superior rational, empiricist thought. By contrast, I consider

The pervasive question, which invoked different planes of causality, highlights why analysis of North Gujarat's son production ecology is much more than an application of bland cultural relativism. It is a fundamental exploration of biomedicine's powerlessness and the contrasting avenues of action for proactively—rather than reactively—creating a male fetal subject. Insofar as secular, modern bioscience emerges in the enunciation of opposition to religious, superstitious traditions that are repressed, rather than completely dominated,[20] understanding son pursuit is a matter of tracing "the haunting of modernity by the magic it represses"[21]—seeing "the myth in the natural and the real in magic."[22] Sonless couples' stories surface situations in which bioscience obviously lacked a "grip" on the key substances and causal processes of reproduction.[23] With biomedicine incapable of resolving even those problems it could nominally identify,[24] raw but locally legitimate treatments could prove more important.[25] Non-biomedical models, explanations, and therapies not only permitted coping, but also enunciated the limitations of biomedical science and its practitioners.[26] Given obstetricians' inability to shift the odds in the coin toss of son pursuit, a complex syncretization took place. Biomedicine, indigenous medicine, and religion appeared as "overlapping projects of world-making"[27]—interrelated spaces of politically significant material action. The question became what "quacks" and "quackery" even were,[28] as obstetricians, other medical practitioners, religious ritualists, and individual devotees engaged in complex practices around the scientific cipher of son production. Ultimately, all the forms of work aimed at producing a boy—sonography and abortion, fertility treatment, herbal treatment, formalized *bādhās*, personalistic bargains with God—were suffused with trial and error, hope and failure, and the recognition that the phenomenon of selective reproduction, as well as the desires associated with it, far exceeded the available technology.

In the first three sections of this chapter, I examine the different technologies that families employed in grasping for reproductive control. The first section traces the larger biomedical pathways that couples like Gauri-devi and Dhruv-ji traversed in seeking the elusive son. The second section considers herbal treatment regimens that attempted to proactively intervene on bodily development instead of passively awaiting visualization

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the question of *why*—one that allows a diversity of answers—as a critical gesture toward the limits of bioscience and the agency it affords.

[20] Prakash 2003; Whitmarsh and Roberts 2016.

[21] Pels 2003: 30.

[22] M. Taussig 1987: 10.

[23] Cf. Unnithan-Kumar 2010: 322.

[24] Cf. Pinto (2015) on the recurrent paradigm of western biomedicine as capable of diagnosing hysteria but incapable of curing it, while indigenous healing methods could effect a cure.

[25] Cf. Pinto (2008: 106-140) on *kaccha* legitimacy, *pakka* power, and women's resort to different healers for treatment.

[26] Cf. Bharadwaj (2006) on metaphysical explanations for the success and failure of assisted reproduction in India as coping mechanisms, critiques of Western science, and admission of biomedical practitioners' personal and systemic limitations.

[27] Wiener 2004: 10.

[28] Cf. Langford (1999) on practitioners of "folk medicine" and their participation in mimesis and counter-mimesis around professionalism and legitimacy.

of already-determined fetal sex. The third section considers religious ritual and prayer as means of exercising agency with respect to the cosmic forces—luck, fate, God—that shaped the sex of children-to-be. The chapter's final section—a coda of sorts—returns to the question of a "necessary sin." I examine moral deliberations around the meaning of selective reproductive agency: How did people understand the act of visualizing and acting on a gendered fetal subject—of playing God?

Biomedical Techniques: Reproductive Exhaustion

During our first ride to Chetna, Gauri-devi and Dhruv-ji recounted their laborious quest for a son. They had begun trying to conceive shortly after the birth of their fifteen-year-old daughter. After "waiting, waiting for almost ten years, thinking, 'Oh, it will happen, it will happen,'" they had sought fertility treatment locally in Rajasthan. Four years later, they had decided to seek out a doctor in Gujarat, since "people say the technology's a little bit better here." They had settled on Dr. Dilip "after seeing he was a great devotee of Sai Baba." Once a fortnight for eight months—through summer heat, monsoon downpours, and winter chill—they had boarded a bus at 9:30 PM, arrived in Mahesana at 5:30 AM, spent the day at Nandini for a five-minute visit, and then returned home on another overnight bus.

Reflecting on this time period, Gauri-devi said, "We've had a lot of trouble! But this is our luck. Who's bigger than luck? We kept thinking, 'It'll happen within three or four years.' It ended up being fifteen!"

Dhruv-ji added, "For us, just the pregnancy is a big deal. To me, it's a miracle that it happened naturally! I thought we'd have to go for a test-tube baby. That's the ultimate stage, and there's still no guarantee of success."

Dr. Dilip's treatment had included pills, hormonal injections, and even an exploratory laparoscopy.[29] Using many different methods, the doctor and his patients had somehow succeeded in producing a pregnancy.

During the ride back from Chetna, Gauri-devi recalled hearing that Dr. Narendra provided sex-selective abortion on a large scale, and that some unfortunate women even underwent two or three in a row with him. She shook her head: "Three girls! What happens to the body after three abortions? Finished, right? They take it out by doing all that rasping inside the uterus. So much damage! What kind of bad condition does it end up in? That can lead to uterine cancer." She expanded upon the damage she imagined from multiple sex-selective abortions, repeatedly invoking the trope of bodily "ruination."

After a momentary silence, Dhruv-ji ventured, "But really, you have to understand that as your penance. So many people have seven-eight—imagine how troubled those people feel. But this is all your penance. And penance brings a result.

[29] Laparoscopy is a less-invasive abdominal surgery procedure in which a visualizing scope and instruments are inserted through small incisions in the belly. While the laparoscopy had not revealed endometriosis, fibroids, or other conditions that might have contributed to difficulty in conceiving or carrying a pregnancy, Dr. Dilip insisted, as did many other doctors, that the procedure itself tended to promote fertility in a way that was scientifically inexplicable but nonetheless empirically observable in practice.

Whatever happens in the middle, that's all well and good."

Dhruv-ji's words stood in sharp contrast to his wife's. They exemplified a triumphalist narrative of reproduction, in which the inevitable end—a son—justified any suffering "in the middle." But as Gauri-devi's reflection suggested, the suffering—endless fertility treatments, miscarriages, selective abortions, repeated births of unwanted daughters—was not merely epiphenomenal to the eventual boy. And unlike Gauri-devi and Dhruv-ji, many couples's reproductive trajectories never led to the desired endpoint.

Navigating Reproductive Pathways

Biomedicine was part of the local son production ecology. Like Gauri-devi and Dhruv-ji, couples pursuing a son often underwent expensive, tiresome treatments just to conceive and carry a pregnancy to the point of SD. But the vicissitudes of human reproduction, and the limitations of biomedical techniques, meant the clinical process was always one of trial and error. Bodily phenomena exceeded the biotechnical capacity to control them, imposing a burden of hope and exhaustion on families—particularly women.

One could sketch a general schema for the low-fertility (selective) pathway to a son, passing from conception and early gestation, through SD, toward the eventual birth of a boy. But in reality, the linear pathway often stalled, derailed, or folded back on itself, with the "reproductive disruptions" of infertility, pregnancy loss, and selective abortion alternating in a complex cycle of frustration.[30]

I met Vinita-ben and her husband, an impoverished blacksmith, during a Nandini prenatal care visit. When Dr. Dilip asked if he ought to fill a Form F, the husband shook his head: "We have no choice but to get the test done." In our subsequent conversation, both patient and husband repeated the phrase again and again: "We have no choice."

The couple had two daughters, four and seven, and had already endured an exhausting, tortuous reproductive trajectory. Two years earlier, following twelve months of fertility treatment with a village doctor and another twelve with Dr. Dilip, they had nearly "given up—said, forget about it"; then, "by God's grace," Vinita-ben had become pregnant. At three months, however, a scan had revealed "yet another girl," and they had ended the pregnancy. Two subsequent pregnancies—both scanned as "male"—had ended in miscarriage at four months. Now, in light of weak finances, advancing age, and concern regarding "how many pregnancies the body can endure," Vinita-ben and her husband were "praying to God that *chhokaro joie*." As they left that first day, they reiterated, "We will have to get the test done; we have no choice but to get the test done."

Vinita-ben's experience highlights the challenges of son production. Beginning from a state of sonlessness, the first step was to conceive and carry forward a pregnancy: without a potential child, there could be no potential son. Many couples, finding their son pursuits stalled or derailed at this stage, endured and embraced extensive fertility treatment. Doctors underscored patients' relentlessness in seeking a boy by citing their efforts to conceive at an "advanced age" like Vinita-ben's—late thirties or early forties—and by highlighting cases of women becoming pregnant simultaneously with their grown

[30] Cf. Inhorn 2007; van Balen and Inhorn 2002: 4.

daughters.[31] Son pursuit was hard work,[32] and it imposed often-drastic physical, psychological, and economic burdens on sonless women.[33] Like Gauri-devi, many lamented their exhaustion after treatment with pills, powerful hormonal injections, intrauterine insemination, and even *in vitro* fertilization (IVF), often over many years. Focusing more on cost, a barber's wife once said to me, "We had to get treatment for four years! Do you know how many shaves it takes to gather 80,000 rupees? After all that, to have a girl? Of course we were disappointed."

The comment illustrates another feature present in Vinita-ben's experience: the contingency of the desire that drove fertility and early-pregnancy treatments. Despite great bodily, emotional, and monetary investment, many quests for a son were derailed at the second step: SD. Couples explained that they had ended long-awaited pregnancies, amid tremendous disappointment and pain, because "all the effort was for a boy." In cases like Vinita-ben's, fertility treatments and supportive care became a matter of creating and sustaining vital substance until the developing person could be recognized as a desired or undesired future relative, and nurtured or rejected accordingly. I knew of women enduring up to eight selective abortions due to the recurrent "woe" of "female" results. As with infertility and miscarriage, the work of bodily "fate" often operated at cross-purposes to couples' reproductive labor.

I saw Vinita-ben and her husband again three months after our initial meeting. My heart sank when I learned they had come in for excessive bleeding following an abortion. After their departure, Dr. Dilip turned to me and said, "They will almost certainly be trying again within a short period."

Indeed, the couple returned to Nandini four months later for a prenatal visit. At one point, as we sat in the waiting room together, the husband smiled softly and whispered:

> You know, we were all set last time! It was a boy. But when we went to get it looked at, with Uma-ben, the doctor said that it was a boy, but that there was a cyst in the child's belly. We rushed here, and the child had died inside. So it was a miscarriage... Now, with this pregnancy, we're praying to God. If it comes this time, that's fine. Otherwise, forget it. You can't keep going like this, stretching like this. We're exhausted.

He placed his hand atop his four-year-old daughter, who spun around and smiled into his palm. He sighed, "If it comes this time, that's fine. Otherwise, these two girls are enough."

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[31] For discussion of the general social opprobrium directed toward "pregnant grandmothers" and even women who conceived after their children's marriages, see Mandelbaum (1974:29-33, cited in P. Jeffery et al. 1989: 268en210) and T. Patel (1994: 165-167).

[32] It is possible to see son pursuit, and reproductive work more generally, as "kin work," distinct from both domestic and market labor (cf. di Leonardo 1987). Both Paxson (2006) and A. Pande (2014: 143-165) fruitfully employ the "kin work" or "kin labor" concept in analyzing biomedicalized reproduction.

[33] Bharadwaj (2016) describes the emotional and financial costs of failed encounters with assisted conception in India.

The husband's statement illustrates the role of volitional as well as bodily factors in prolonging or ending couples' traversal of convoluted reproductive pathways. Despite avid desire for a son, grew frustrated with repeated attempts and exited at the first (conceptive) step. Others skipped the second (selective) step, extending uncertainty to childbirth; this might occur due to religious reservations, in-law prohibitions of the sort discussed in Chapter 4, or aversion to the abortion procedure and its bodily effects.

Two months after my last encounter with Vinita-ben and her husband, Uma-masi and I were lounging in the waiting room when she received a phone call. Upon hanging up, she informed me that Vinita-ben had been admitted to Chetna. The couple had been reluctant, she said, but "they gave me the money yesterday, and went for the cancel today."

Vinita-ben's long, draining, and ultimately futile quest vividly illustrates the reproductive exhaustion I saw in so many cases. Hope, even a sense of inevitability, persisted despite difficulty conceiving, repeated pregnancy losses, and sex-selective abortion—despite the physical and emotional toll of son pursuit.[34] Couples tried again and again, until they could try no more. Not every process of work, waiting, and penance produced a son before its animators gave up.

Cruel Certainties

In biomedicalized son pursuit, the gendering scan revealed the outcome of the coin toss, sorting contingently desired (ungendered) pregnancies into definitively desired and undesired ones. A "positive" result allowed some seeking SD for the first time, like Dhruv-ji, to seamlessly continue an optimistic narrative of inevitability. "From the very beginning," people would say afterward, "I had a *feeling*"—a certainty of impending male-ness. The scan merely confirmed an ostensibly prefigured success.

By contrast, many families expressing *ex ante* confidence found their expectations shattered. SD became a moment of crisis that rerouted hope into disappointment, bringing about a previously unthinkable and unspeakable state of affairs. Although pregnancies conceived at great financial and human cost were precious, their value remained bound up in the potential or actual presence of a male fetus. The moment sonography revealed female sex, the child-to-be became unwanted. But contending with such reproductive misfortune frequently took time.

This became clear when I observed Dr. Ranjit scan Stuti-ben, a patient from Mahesana. Dressed in a stately orange-and-black sari, with a shock of white hair, she was in her early forties. The accompanying facilitator explained that she had conceived twins by IVF—at a cost of 40,000 rupees—after nearly a decade of fertility treatments.

A couple of minutes into the sonography, Dr. Ranjit said, "If you've gotten pregnant after twelve years, what is there to look at? Keep it, no?"

"But we already have a girl, right?"

"But if you've gotten pregnant after twelve years, you should keep it."

"So is it female?"

Without responding, Dr. Ranjit continued scanning. Eventually, he holstered the

[34] For discussions of the commodification of hope and the construction of conception as inevitable in fertility treatments, see Becker (2000: 116-133) and Bonaccorso (2004).

transducer, sighed, and declared, "Both are female."

Out in the waiting room, Stuti-ben informed her husband, Nimesh-bhai, a short, stocky man with an orange tilak that immediately identified him as Jain. He shook his head stiffly. Turning to me, he said, "We want boys, or a boy and a girl. *Ek chhokaro to joie ja*. We came here to get the boy-girl thing done, but I'm sure I have two boys!" Thumping his chest with an open palm, he repeated: "Inside, I myself am sure I have boys! Maybe he can't see it exactly."

Upon Dr. Ranjit's return from lunch, Nimesh-bhai marched into the consultory and insisted on a rescan: "She says you said it was female. That's not possible—I'm sure it's male. So I wanted to ask you to look again. I feel I have two boys. I'm sure I have males!"

The doctor grudgingly agreed to repeat the SD. When he froze an image of one fetus, Nimesh-bhai exclaimed, "I'm certain that it's a boy! We already have a girl. We got pregnant after so many years, so it must be a boy." I recalled Dhruv-ji's confidence. Pointing to the screen, Nimesh-bhai continued, "We must have two boys—look at it!"

Dr. Ranjit again suggested the couple keep the pregnancy, given the twelve-year delay and heavy cost. Stuti-ben interjected, frowning and shaking her head: "But if it's girls, what's the point?"

The doctor scanned in silence once again. After freezing an image on the screen, he attempted to provide his standard demonstration of female sonographic anatomy, but Nimesh-bhai interrupted: "I, Saheb, have a boy! 100%, I don't have a girl." Pointing at Stuti-ben, he bellowed:

> It won't do to put her into confusion! They asked if we wanted to keep it. I said yes. And they didn't say, oh, you have two girls! And now she's in a lot of tension—so much tension that she doesn't even talk at home. So what I'm saying, Saheb, is that you have to tell her, or she'll be left with tension. Whatever it is—even if it's one boy and one girl—I want to keep it.

Smiling uncomfortably, Dr. Ranjit suggested that Nimesh-bhai "think of it that way—with that certainty—'It's one boy and one girl, that the doctor is wrong and we are right.'" The husband repeated—"Okay, one boy and one girl"—before returning to his point of insistence: "Why don't you say it once? For no other reason, but that way, my wife is satisfied. *I'm* certain. But if you say it once—'It's a boy and a girl'—then she'll be satisfied that that's what we'll get. So say it once, Saheb, that it *is* a boy."

Dr. Ranjit blandly offered to repeat the scan in a week. After a brief silence, Nimesh-bhai told Stuti-ben, "Now you don't take any tension. It is *that*. Don't take tension—'Oh, it's a girl.' Now, the tension—it's over! We'll come back, sure, but get rid of the tension that it's two girls." Turning back to the doctor, he implored, "Tell her, won't you?" Dr. Ranjit simply repeated his promise to recheck. Stuti-ben frowned. Her husband was huffing in agitation. With some muttered parting words, the couple left.

A week later, they inadvertently returned to Chetna with a connector who promised them a second opinion but failed to divulge the clinic's name until arrival. Dr.

Ranjit rescanned and confirmed the previous result. After they left, he smiled sardonically and recalled, "On that first day, he wanted to force me into saying it—'You say it, that it's a boy!' Sometimes, people do that, if they're emotional: 'Tell me it's a boy... I don't have the strength to hear it... I want it to be good.' I tell them, you want it to be *true*—not good, but true." The harsh reality, of course, was that only half of clients could count on the result being both "good" and true.

A few months later, Dr. Ranjit casually mentioned, "Oh, you remember that Jain couple? The one with twins? They came back recently. They finally got a termination here—at four months!"

Unlike Gauri-devi's quest, Stuti-ben's had ended in disappointment. She and Nimesh-bhai had attained the long-elusive pregnancy, but had not—presentiments notwithstanding—won the coin toss. The husband's defiant exclamations, the search for a second opinion, and the one-month SD-abortion delay indexed a reproductive labor on the couple's part: letting go of years of striving, the product emerging from it, and the hope underlying it.

An Opportunity Foreclosed

A week before Stuti-ben's initial visit, I observed an unusual encounter that illustrated how people might attempt to use SD to actually shift the odds of the game, rather than merely reveal its outcome.

The couple hailed from a distant town in Kutch, and spoke the melodic, lilting Gujarati of that region. They had with them a toddler girl—one of three daughters. their obstetrician had referred them to Dr. Ganpat, who had referred them on to Chetna. The husband furnished the couple's clinical file from Kutch—a highly unusual move for an SD visit, and one whose significance would soon become clear.

Showing the couple into the examining area, Dr. Ranjit explained that the charge would be higher that usual. "Ten might be okay for twins," he said. "But with triplets..." His voice trailed off. The husband mumbled willingness to pay a high fee, as long as Dr. Ranjit provided "some suggestions," since they had to go for "remove." The unusual purpose of this particular SD became clear to me: because a triplet pregnancy was unlikely to safely continue for nine months, the obstetrician in Kutch had recommended "selective reduction," or *in utero* abortion of one fetus. Given the rare chance to intervene on unpredictable reproductive processes, the couple wanted guidance on how to proceed.

As Dr. Ranjit scanned, the husband said they were planning to obtain the selective reduction with Dr. Chandresh—the Ahmedabad clinician who had rebranded himself as a high-risk pregnancy specialist after shelving the SD enterprise for which Preeti-ben still called him "The Dog." The husband explained that the triplets had resulted from extensive fertility treatment, including hormonal injections that had spurred his wife's ovaries to release eggs at an artificially high rate.

After the better part of ten minutes, Dr. Ranjit declared, "You have two females, and one male." The husband nodded slowly. "But when you do the reduction today, you can't say that you want a female reduced." The doctor was complicating the couple's plan. "Most likely, they'll do a female, because they go for the one that's most accessible, and the one in front is female. The male's a bit downward. But if, accidentally, they inject

that one, and the male gets finished off, then everything will be ruined! So you'll have to come back afterward for confirmation. You can't say anything to them!" Concerned regarding his own visibility as an SD practitioner, Dr. Ranjit was enjoining the couple from acting on his identification of the son-to-be.

Squinting, the husband asked, "Can't we make a suggestion to them? Or could *you* tell them?" He was trying desperately to render the crucial knowledge actionable.

The doctor shook his head. "No. I can't say that either, can I?"

Scowling, the husband began, "Okay, so if the male gets reduced—"

"Then it will be a big problem!" Dr. Ranjit said. "Then you would have to get rid of the whole thing, right?" The couple looked down and nodded slowly. The doctor added hastily, "For the most part, that won't happen. They'll do the one in front."

The husband persisted: "So would it be possible for us to meet with him—ask him—and then, maybe if we don't do it—would that be okay? He'll tell us which one he's going to remove, right?"

"Bhai, you can't ask! He's just going to say, whichever one comes first—"

"And that one's female."

"Yes, that one's female. This is just—by chance, if something happens—you'll have to come back once. No charge at that time."

Then, Dr. Ranjit asked for his 20,000 rupees. While counting out the notes, the husband made one last-ditch plea: "And suppose maybe we say, that the front one—"

"But you can't give that kind of suggestion!"

"No, I'll just *ask*: which one are you going to do? Then we can say no, right? That we don't want to do it?"

"Most likely, they'll just do the front one. But you can't tell them to do whichever one is good. You can't ask directly, is it this one or that one or that one? And you also can't say that you've had it checked."

"Okay." The man handed over the money, and the doctor thrust it into his jeans pocket. The couple bowed and left.

Some weeks later, I asked Dr. Ranjit what had happened with the Kutchi couple. He shook his head, smiled weakly, and sighed:

> What happened was—the doctor tried, but he couldn't get the front one. So then he tried another, and that was the male! And the two females were left. This is called luck, eh? Hard luck. The one that was all the way in the back, that's the one that expired! After getting it done, they came here, to get it confirmed: 'The male one is still there, right?' Then I had to tell them the truth.

"After that," he concluded, "they had it done in Kutch. They already had three females, after all. What would they do with two more? But all their effort ended up wasted, didn't it?"

Of course, the "hard luck" could have been averted. The doctor's restriction on the couple's use of the knowledge emerging from SD—a restriction they respected—left them powerless as another practitioner, acting without regard to fetal sex, eliminated the

very object for which they had endured the travails of intensive fertility treatment. The treatment, motivated by son desire, had produced more fetuses than could safely be gestated; SD had identified which of them was the object of desire; and then a procedure to address the precarity of the pregnancy, performed in ignorance of the key knowledge, had rendered the entire gestation unwanted. The post-procedural sonography could only confirm the wasted effort, as it did in half of typical cases. Despite the unusual opportunity for proactive intervention to shape sex prenatally, Dr. Ranjit's injunction had reduced ultrasound back to its usual function: viewing coin toss results and facilitating reactive acceptance or rejection.

The Kutchi couple's experience highlights a key question regarding son pursuit: If sonography could only identify an already-formed male fetus, what techniques allowed people to channel inchoate vital substance down a male development pathway? How could families actively shift the odds of son production, *determining* fetal sex in the stronger sense of the term?

Herbal Techniques: Proactive Son Production

On the ride back from Chetna after Gauri-devi's second SD visit, Dhruv-ji surprised me by bringing up something the couple had not previously mentioned: non-biomedical treatments for producing a son. He explained:

> See, there are Ayurvedic treatments that make it so the child ends up male—a boy—for sure. We got an injection in Udaipur, and a medication in Ahmedabad. The second one's very strict! After finding out about the pregnancy, you have to start within ten days—if you don't, there's no point. And you have to take it for a month, two-three times a day: a powder, a tablet, a liquid, to be taken with cow's milk. You can't miss a single dose or it will be unsuccessful. We had this treatment done.

The regimen, which cost 3,000 rupees, came from a doctor in Ahmedabad. Dhruv-ji elaborated, "The embryo's sex gets decided after three months. Within the first three months, it can still be affected—it can be changed, so that it definitely becomes male. But you have to start on time."

I asked what the medication was like. Dhruv-ji continued:

> It's five-six tablets, different ones! You have to do them all, and on time—it has to be perfect. And all for the woman. Nothing for the man. Because the embryo is affected by whatever goes into the woman's body. That's why there's that injection in Udaipur. It has some effect on the hormones—on the developing embryo—so that its development is only toward the male sex.

The treatment regimen for son production was exacting in administration and mysterious in content. Its known and unknown burdens—punctilious compliance, blame in case of failure, potential bodily complications—all fell on the pregnant woman.

Knowing Dhruv-ji's passion for science, I asked how the Ayurvedic treatment worked if embryonic sex was fixed at conception, as held in standard biological knowledge. He shook his head:

> They say that, but I don't find that science so sure [*pakka*]. Because there are so many cases with this medication, and they're all male! How are there so many, if the sex is decided? Some effect or modification must be possible. Because the embryo's sex is determined after three months. There can be some effect in the early months. That's how this medication works. How does science know it's this or that in the beginning? And there's nothing developed in science that allows you to separate X and Y, so that you can get just one or the other. Science doesn't know that. I don't think the science on that is so complete.
>
> So this is another method. It's hard to say what the success rate is. It's not like the doctor can follow up with everyone!... So if you do it and you get a result, it's true.

I wondered how deeply Dhruv-ji's explanation for the medication's mechanism was intertwined with the three-month threshold for sonographic SD. How might the medication and its justification differ in a world of pervasive first-trimester chorionic villus biopsies or pre-conception sperm sorting? More generally, I wondered at the verificatory impossibility that Dhruv-ji posited. How did the lack of bioscientific studies into the method, along with the isolated, idiosyncratic nature of individual cases, actually help to boost its credibility?

Turning to Gauri-devi, I found her already chiming in: "Yes, I completed the whole course! I didn't miss even one dose—no, no, no! I finished the full course as she instructed. That's how you have to do it." As she nodded enthusiastically, I wondered what it would have meant for her to admit to missing a dose, given the high stakes, the husband's emphasis on compliance, and the disproportionate burden on her to make a son through her actions.

The revelation that the couple had pursued Ayurvedic treatment in parallel with biomedical fertility treatment and SD fit with a pattern I saw in countless cases. Ultrasound and abortion allowed recognition and rejection of a daughter-to-be. But the pursuit of a son often pushed couples toward medical treatments offering proactive intervention material shaping of gendered fetal subjects.

Weighting the Coin

I observed people use various herbal treatments to avoid a fifty-fifty coin toss—to proactively produce a boy. As Dhruv-ji articulated, such treatments presumed that the fetus acquired form, sex, and life between three and five months of pregnancy.[35]

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[35] Cf. P. Jeffery et al. 1989: 76. This is, of course, just one possible ethnoembryology of fetal bodily formation and sex determination. O'Neil and Kaufert (1995) described how Inuit fetal sex remained malleable until the moment of birth, with the process of labor itself capable of altering the fetal genitalia.

Given the ethnoembryology of fluid vital substance, there have long existed a variety of *desi* [folk] and Ayurvedic techniques for shaping bodily matter toward a male destiny. Ethnographies of childbearing in North India have described a variety of herbal preparations that could "flip" or fix the sex of the unborn if administered to women in early pregnancy.[36] Similarly, scriptural scholarship attests to Ayurvedic techniques of son production, mostly notably the *pumsvana* sacrament. Typically performed in the third or fourth month of pregnancy, before quickening signals fixity in formation of the unborn, *pumsvana* typically involves husbands offering a comestible or herbal substance that wives ingested orally or nasally to masculinize the fetus.[37]

Recent research in North India has demonstrated families' utilization of such Ayurvedic and *desi* treatments in simultaneity with biomedical sex selection.[38] One study examining son production drugs noted their widespread availability at pharmacies, their imputed concretization of *pumsvana* principles, their promotion by public and private biomedical practitioners, and the rigid dosing requirements they imposed on women like Gauri-devi.[39]

In fact, a *pumsvana*-based pill called "Select" was one of the first targets of anti-sex selection campaigning in Gujarat. In 1991, before the advent of the Pre-Natal Diagnostic Techniques (PNDT) Act, activists successfully employed a consumer safety argument to secure a state government ban on the drug.[40] Numerous pre-natal and pre-conception herbal, dietetic, and other "natural" methods later came under greater scrutiny nationwide; the most prominent example was a kit advertised by the U.S.-based company Gen-Select, which touted higher rates of son conception through the use of nutriceuticals, dietary modifications, meticulously timed intercourse, external douches to alter the acidity of the female reproductive tract.[41] Early-2000s amendments to the PNDT Act explicitly banned advertisement and administration of son production treatments, but they have continued to flourish just below the state gaze.

Though often dismissed by obstetricians and other skeptics as "quackery", herbal treatments stood in rather complex relation to biomedicine. Their providers variously described them as resting on, complementing, or superseding bioscientific knowledge and practice. Ultimately, such treatments offered women and their relatives something conventional biomedical sex selection could not: a means of contending with and intervening on reproductive unpredictability by actively making a boy.

Acting through the Mother-to-Be: Shastri-ji

Ayurvedic and *desi* treatments aimed at producing a male fetus could be divided into two categories based on whether they acted through the maternal or paternal body.

Morgan (1997: 340-341) described the intrauterine formation of the unborn in the Ecuadorean Andes, in which male and female fetuses developed at different rates.

[36] P. Jeffery et al. 1989: 191-193; R. Jeffery et al. 1984: 1210.

[37] Stork 1992: 92-93.

[38] Dagar 2002: 23, 37-38, 44; John et al. 2008: 60, 61-62.

[39] Bandyopadhyay and Singh 2007.

[40] Unnikrishnan 1993.

[41] See P. Menon and Choudhury (2003) and Aravamudan (2007: 81-82) for discussions of the Gen-Select controversy.

Maternally focused treatments—the kind utilized by Gauri-devi and Dhruv-ji—were exemplified by the practice of the astrologer, priest, and uncredentialed Ayurvedic healer Shastri-ji, whom most people called Shastri-ji.

I first met Shastri-ji at a shop in Mahesana. He had come from his home-cum-dispensary near Vijapur to purchase specialized supplies and see local patients. He was a fifty-something man, with hair that ended posteriorly in the long, slender tuft characteristic of Brahmins.

When the shopkeeper introduced me and my research, Shastri-ji arched his eyebrows. "I've helped 4,000 families get boys!" he declared. The causative verb he used—*apāvvu*—is difficult to translate. Literally meaning something like "to cause to be given," it describes actions such as purchasing an object for another or successfully requesting (or forcing) a third party to give something to someone else. People frequently used it to describe the action of obstetricians, other healers, and *bhuvas* in producing a son, with the implication that the practitioner had successfully secured a bestowal from nature, God, fate, or some other cosmic entity.

"4,000!" Shastri-ji repeated. "And among them, a thousand must have been in their forties already. I can show you the names, addresses, telephone numbers. Name the country, and I'll show you. You must know Chicago. Then New Jersey. Mozambique. Africa. Australia. U.K. Name any district of Gujarat, and I'll show you!"

I asked Shastri-ji how he helped people obtain sons. Smiling broadly, he said, "At one and a half months, I prescribe a course of seven packets. If they take those seven, 100%, it'll be a boy!" He preempted me before I could probe the explanatory model. "Of course, the doctors claim that it's decided from the beginning, when the two seeds meet—that it can't be changed after that. I'm looking to challenge that! It *can* be changed." I expressed my interest in learning about the work people undertook to shape fetal sex, and Shastri-ji invited me to visit him.

Some day later, I was settling onto a charpoy in the dimly lit back room of Shastri-ji's house. He reached into a drawer and produced a yellowed diary, which he opened to reveal an extensive list of names and addresses. He thrust it toward me. "This is just the latest!" he exclaimed. "I have so many filled up like this—all boys!"

Until recently, Shastri-ji had facilitated son production by administering *pumsavana*. Once a month, "thirty-forty-fifty women would line up" at his house. He would grind several plant essences into cow's milk and administer the paste nasally via syringe. Based on this, "it was guaranteed—definitely a boy!" In performing *pumsavana* for countless expectant woman, Shastri-ji had acted as the *uber*-husband, providing the virile substance that would actively shape developing children toward masculinity.

Of late, however, the key herb in Shastri-ji's *pumsavana* formulation had become difficult to procure in fresh form. He had begun putting the dried plant into an herbal powder, which he offered to clients at a price of 1,100 rupees. His description of the treatment model strikingly echoed Dhruv-ji's words:

> It's a seven-day regimen. But it has to be taken *within* three months, while the fetus is still fluid in form. I give them a powder and tell them to take it with cow's milk—or with water, washed down by milk from a cow that

> has had a male calf. The cow's milk facilitates the process, blocking any problems and ensuring the treatment is successful. And the powder actually changes the fetus on the inside: the girl essence in it gets turned into masculine essence. It's the X and Y—it increases Y. See, the doctors say the proportion is decided from the beginning. That's why I want to do research, to show how these plants increase Y. The masculine essence in the cells increases—just in the fetus, not in the woman! Only the woman has to take it, not the man, because the effect must be exerted in the uterus, and the uterus is the woman's... Honestly, you would get a result from just one day of treatment! But I give a week's course in case people forget one day, or if the female seed is more developed... If people keep having girls, it means the female seed is greater. This medication increases the male seed, so then it can't be anything but a boy.

He further assured me that the process never ended "incomplete" or produced a "neuter gender" child—a healthy boy was the only result.

I asked Shastri-ji what made the plants masculinizing, and he said, "That's what I want to research! Right now, we're just accepting the result; we don't know *why* it's happening. It's all based on faith, or trust. But it's written in the scriptures—written by our sages." He added that the need for the treatment had increased lately because various poisonous substances—tobacco, alcohol, spicy and fried food, processed food, South Indian food—had led to "a decrease in masculine essence in the body"—"sperm counts of zero." Consequently, many men were "impotent," and Shastri-ji's treatment of their wives helped to promote conception and increase the likelihood of a boy.

According to Shastri-ji, his patients enjoyed nearly complete success. Girls *were* born "once in a while", but there was always a reason: treatment initiation after the fetus became *paripakva* [mature, ripe] at three months, ingestion of fried food within fifteen days of therapy, poor compliance with dosing requirements.[42] Citing cases of insufficiently virile husbands, with "zero sperm," he acknowledged the impossibility of "making something out of nothing."

Like the model Dhruv-ji posited for Gauri-devi's treatment, the model underlying Shastri-ji's method rested on a complex amalgam of Ayurvedic, biomedical, and lay knowledge about sex and intrauterine development. The maleness of the fetus depended on a high ratio of Y to X chromosomes—of masculine to feminine essence. Because unhealthy substances had rendered men impotent and decreased their sperm counts, external intervention was needed to produce male fetal subjects. Shastri-ji provided that compensatory intervention in the form of herbal medicine. Critically, the intervention had to take place during the first three months of pregnancy, when the developing child's matter was still "fluid"; after that, the fetus's form and sex became "ripe." With its emphasis on male virility as a determining factor in reproductive outcomes, Shastri-ji's model harkened back to seed-and-soil ideologies long enshrined in Hindu scripture,

[42] Bandyopadhyay and Singh's study of sex selection drugs (2007) found similarly fastidious requirements regarding early initiation, dietary abstemiousness, and exact compliance with dosing and administration requirements.

ritual, and lay discourse;[43] the woman was sometimes a mere vessel for the developing child, and sometimes a "threatening" field, whose femininity could overwhelm weakened sperm.[44] Consequently, in prescribing his packets, Shastri-ji was not merely acting on the developing fetal body. He was also treating individual and collective anxieties about impotence and reproduction, to which I return in Chapter 6.

Shastri-ji contrasted his treatment to the work of biomedical doctors, who could not *change* fetal sex—and might even misidentify it—and *bhuvas*, who were "all false." He explained:

> The *bhuvas* tell patients not to go for sonography. That way, their business continues for nine months—no problem till then, right? I have no such restriction. I actually tell them that they *should* go get it checked! Sometimes, people come back and say it's a girl, but that's only if they started after three months, or ate spicy and fried food, so that the medication can't take effect... But if people don't get sonography done, that's fine too. The result will be there! I'm sure... I've had cases where I give my treatment and say it'll be a boy, and the doctor looks and say's it'll be a girl, and then it comes out a boy!

The relationship between Shastri-ji's practice and sonographic SD remained at the forefront of my mind long after I left his house shortly thereafter.fd How did the biomedical practice's uncertainties combine with its complete first-trimester ignorance to create a space for complementary action, even among those who would eventually pursue a scan?

Acting through the Father-to-Be: Dr. Rajen

As stated on the card Asha-ben received following her abortion, Dr. Rajen also offered treatment for "obtaining a son." In contrast to Shastri-ji's, his approach focused on action through the paternal body.

Once, as we lounged in the Chetna waiting room, Dr. Rajen mumbled through a wad of tobacco that the best treatment for son production was a six-month medication course, to be completed by the husband prior to conception. "In this," Dr. Rajen explained, "there are two counts—X and Y. If the proportion of X is higher, then it will be a girl pregnancy. For a boy, you need Y." He listed off the herbal contents of the powders he prescribed, explaining that they all increased "the Y count—the quantity we need for a boy." Wives need not take anything, though certain herbs could help support a male pregnancy. Dr. Rajen's treatment, like Shastri-ji's, mitigated the negative impact of insufficient masculine substance on son production. But instead of acting on fetal matter *in utero*, this treatment aimed to increase Y-chromosomes in the partner's sperm before conception.

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[43] Dube 1986; cf. Delaney 1991. In reviewing these ideologies, Dube has proposed their elective affinity with women's subordination within patrilineal, patrivirilocal relations of production, including land ownership, expropriation of labor, and reproduction.

[44] Cf. Martin 1991.

Within his 30,000-rupee treatment regimen, Dr. Rajen often prescribed industrially manufactured Ayurvedic pills. With brand names like Y-Spur, Y-Grow, and Alto-M, these tablets and capsules publicly promised to address low libido, erectile dysfunction, low sperm count, and "seminal debility" while "ensuring deep penetration" and "facilitating impregnation." Conspicuously absent from their public marketing materials—but readily implied for many practitioners and patients—was an all-important purpose of such "male enhancement": an increase in Y chromosome proportion and the likelihood of conceiving a boy. The possibility of son production did not have to be inscribed in the biomedical imaginary through written information, which PCPNDT surveillance might scrutinize; they readily emerged and travelled in the untraceable discussions, promises, and hopes of people like Dr. Rajen and Dhruv-ji. Multiplied across hundreds of practitioners in North Gujarat, thousands in the state, and hundreds of thousands in all India, the "male enhancement" pills that Dr. Rajen sold at an astronomical markup represented a massive, oft-ignored part of the son production economy.

The doctor readily admitted that his method was probabilistic rather than deterministic: "You get sixty-seventy percent success. It increases the chances in our favor. Even those who keep having girls, many have no idea there's a treatment for this! They just keep getting pregnant, checking it at three months, and getting it taken out with a negative report. So for them, we're increasing the chances." The treatment did not promise a successful coin toss; instead, it offered a subtle improvement in odds.

When Dr. Rajen's patients conceived and reached three months, he personally took them to Chetna for sonographic SD. He explained, "I always have them check! That way, we can be confident. And I make it clear to them at the time of treatment that there's no 100% guarantee. I tell some patients to pay me after they get the report. If they have a negative report, I give them back their money—I count it as a loss. All we can do is give them a chance." I later learned from Dr. Ranjit that Dr. Rajen could forego a considerable proportion of payments because he obtained his herbal substances very cheaply, such that the 30,000-rupee cost of a full course represented a hundred-fold markup. And, of course, regardless of the result, patients always had to pay him for facilitating sonographies and selective abortions.

Like Shastri-ji, Dr. Rajen took pains to set himself apart from other practitioners within the local ecology:

> I don't believe in all that *bhuva* stuff. That's all false. If fifty people go to a *bhuva*, then at least fifteen are going to have a son. That's a matter of nature! Then those fifteen each tell another ten, so you have 150 customers! But it's all blind faith. It's all false. Many patients come to me having kept *bādhās*, and they get it checked, and its a girl. But they trust the *bhuva*, and then a girl is born!

Dr. Rajen's words about *bhuvas* echoed Dr. Ranjit's words about him: "He is trained as an Ayurvedic doctor, but he is doing only this kind of practice!... He is interested in being a quack only! And in the end, in the patients he brings, I see more females, actually." The

landscape of son production was one rife with skepticism, in which others' failures were noteworthy, while their successes were ascribable to the work of nature.

Quackery, Superiority, and the Quest for Control

Within North Gujarat's son production ecology, the herbal treatments offered by Shastri-ji, Dr. Rajen, and countless other practitioners could integrate seamlessly with conventional biomedical sex selection methods. Patients took medication to actively shape a son and then sought out sonography to ascertain whether they had succeeded. Like Shastri-ji, many providers encouraged their patients to obtain biomedical SD; like Dr. Rajen, many facilitated visits for it. A variety of "escapes," as skeptical obstetricians called them—from Shastri-ji's stringent requirements, to Dr. Rajen's probabilistic hedges, to the ultimate fallback argument about female pregnancies resulting from inadequate virility in the potential father—meant that individual "female" results did not challenge overall models. In fact, "negative" results frequently *reinforced* models, providing cautionary tales for couples about how their behaviors or flaws could vitiate the medication's transformative effects.

More broadly, *desi* herbalists, Ayurvedic practitioners, and obstetricians engaged in complex circuits of mimesis, counter-mimesis, and condemnation,[45] selectively critiquing and appropriating[46] each other's explanations and techniques to an extent that blurred the boundaries between different medical models and practices. "Quackery," "blind faith," and falseness became shifting signifiers that circulated in diverse condemnations and contentions. Within this circulation, biomedicine was hardly immune to critique. Who, many asked, was truly "false"? The practitioner whose treatments were merely unproven? Or the one whose treatments were nonexistent, whose models professed ignorance regarding the first few months of pregnancy, and whose "results" were famously unreliable?

To be sure, many biomedical practitioners smirked at a pluralistic approach to SD. Paralleling Shastri-ji and Dr. Rajen's disparagement of *bhuvas*, they often dismissed complementary treatments as "quackery" or "unproven." In a striking echo of Dr. Ranjit's comments on Dr. Rajen, one Mahesana obstetrician lamented, "We're a country of snake-charmers! Some people take vitamin tablets, put them in a different wrapper, and guarantee a male. For that, they take 30,000. Since 50% will have a male, they get their profit. They give the other fifty their money back—just a ten-rupee loss!" Some doctors also cited the potential harm accruing from the unregulated and often unknown contents of herbal son production formulations.[47]

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[45] Cf. Langord's discussion of an Ayurvedic pulse-reader's mimicry of other practitioners and even of publicly circulatings image of figures like him (1999).

[46] Cf. Unnithan-Kumar's discussion of how midwives and other non-biomedical healers in Rajasthan selectively appropriated biotechnologies of reproduction in order to enhance their own legitimacy within local networks (2004a).

[47] There is some emerging biomedical research on the contents and safety of son production drugs. One study (Neogi et al. 2015a) found hormonal content in some preparations but did not specify how the level of hormones related to typical levels in medicinal herbs or to thresholds for harm. Another study by the same group (Neogi et al. 2015b) found that women whose children displayed congenital abnormalities reported use of sex selection drugs at much higher rates than women in a control group; unfortunately, the

The skepticism was hardly restricted to obstetricians. Dr. Rajen dismissed post-conception treatments like Shastri-ji's on the grounds that sex was fixed at fertilization and thus had "nothing to do with the woman"; Shastri-ji, meanwhile, disparaged credentialed Ayurvedic practitioners like Dr. Rajen for relying on unreliable mass-produced drugs.

The prevalence of desperation certainly created scope for blatant hucksterism within the son production ecology. One humid monsoon day, I stood at a Mahesana traffic circle, listening to Uma-masi chat with an Ayurvedic doctor who was referring her a patient for SD. At some point, the man chuckled and said, "You should tell people, oh, get this 5,000-rupee packet from Saheb, and your work will be done!" Guffawing, he said he would put some inert substances in the packets, while Uma-masi would guarantee patients a "100% result." Practically cackling, he said, "If we get two males with a treatment like that, we're in business!" Uma-masi joined him in laughing and slapped his outstretched hand in a gesture of conspiratorial satisfaction. Though she did not follow up with that doctor, she later said she knew of several practitioners who ran such schemes. The practice was supposedly quite widespread: Dr. Ranjit alleged that the region's best-known *desi* son production specialist charged patients several thousand rupees for "only vitamins—B-complex, A, C, nothing else!"

But it would be mistaken to see son production regimens as a marginal phenomenon driven by fraudsters and counterfeiters. Herbal medications for shaping a boy pervaded the local reproductive landscape, overlaying on sonography and selective abortion, because they offered a type of otherwise-elusive agency. Despite decrying "quackery," obstetricians frequently *prescribed* Ayurvedic son production medications. Families grappling with the medical and emotional aftermaths of selective abortion at Chetna often asked Dr. Ranjit to recommend medications "for next time, "so that this doesn't happen again," prompting him to prescribe a pre-conception regimen of the same pills Dr. Rajen used. Even for skeptical biomedical practitioners, son production treatments held appeal as the only possible mechanism for altering biological processes in the way clients desired.

Just as biomedical clinicians turned to complementary treatments to preserve legitimacy with patients, providers of complementary treatments frequently invoked biomedical knowledge to explain the efficacy of their interventions. Pre-conception regimens like Dr. Rajen's purportedly worked by increasing the proportion of "Y sperm". While post-conception treatments like Shastri-ji's diverged from standard biology in positing the first-trimester fetus's sex as mutable, they nonetheless relied on a bank of biosceintific concepts, emphasizing the ties among Y-chromosomes, male essence, and embryonic development. Son production treatments proved appealing to highly educated clients like Dhruv-ji and Gauri-devi because they permitted intervention on bodily substance in a way that was simultaneously comprehensible through biomedical knowledge and impossible in biomedical practice.

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study's case-control design leaves open the possibility of recall bias within the case group, and the authors do not address the issue.

Of course, there *did* exist biomedical techniques for actively shaping a male pregnancy, such as sperm sorting, pre-conception gamete testing, and pre-implantation genetic diagnosis. (Indeed, Dr. Rajen once told me he had overheard some obstetricians discussing a "new allopathic method, in metro cities like Ahmedabad and Bombay," in which "the X is taken out of the semen, and only the Y is kept.") But these techniques were geographically remote, prohibitively expensive, banned by PCPNDT, and barely visible in the local biomedical imaginary. Lack of access to them made Ayurvedic and *desi* treatments the exclusive methods for materially promoting son production. Such regimens were a way for families to contend proactively—rather than reactively—with reproductive unpredictability.

But what if the key to son production lay outside the control of any medical practitioner, in forces divine or cosmic?

Religious Techniques: Fate, Divine Will, and Bargains with God

Riding back from Chetna after Gauri-devi's second SD, Dhruv-ji brought up the matter of divine will and *pāp* [sin] without prompting. Nodding toward Gauri-devi, he said:

> I told her this! 'God will not even give you the chance to commit *pāp*.' We didn't think about abortion at all. What need was there? God was bound to do good. God wouldn't do that to us, would he? God didn't even give us the occasion to think about all this: Keep it, or not? How to care for a daughter at the age of forty? Get an abortion, or not? God knew that it was like this, that it was already quite late for us. So he didn't even put this in front of us—whether to keep it or not.
>
> God's work is always like this. He only does good. He won't let bad things befall a person. I had faith from the very beginning—why would God have us go through such a long process, just to have it taken out? God's the biggest. God's the one who does everything. I said, we've spent fifteen years like this; well, God isn't so cruel that he'd give us a negative result after that. Fifteen years, we tried, tried, tried without a result. That's a punishment! Well, God wouldn't give us another punishment after that. She had doubts, but I always said it. Somehow, from the beginning of the pregnancy, I kept feeling it'd be a boy, a son. Because God can't do such a great injustice, piling another injustice on top of fifteen years of injustice. God wouldn't do that to good people.

Told from the retrospective vantage point of a hope fulfilled, Dhruv-ji's account explicitly construed the long delay, the eventual pregnancy, and the fetus's male sex as reflecting divine will. The ordeal of infertility had been a karmic punishment—a "penance," in his earlier words; the developing son was a cosmic reward. Dhruv-ji's prayers to God and Sai Baba had borne fruit: a child-to-be whose sex obviated any need to contemplate the *pāp* of selective abortion. As "good people" and reliable devotees, the couple had earned a tipping of the odds in their favor.

Building on Dhruv-ji's impassioned monologue, this section considers fate, destiny, God, and other cosmic forces with the capacity to shape the gendered fetal subject. I ask:
What religious techniques did people employ in son pursuit, and how did they experience the failures and successes of variously configured bargains with the universe?

The Powers of Cosmic Forces

For people around Mahesana, divine will and other cosmic forces could decisively control the sex of potential children. I approach families' talk and actions around such forces from the perspective of a "nonsecular medical anthropology," which insists on the ontological co-presence of reproductive bioscience and cosmic intervention.[48] I treat deities as "cohabitants with the living," sovereign figures who engaged with ordinary people through diverse relations of force and contract.[49] Seriously accounting for deities, fate, and chance reveals the "clinical theodicies" that exceeded biomedicine's limits in explaining reproductive success, misfortune, and struggle.[50] At the same time, by drawing attention to the complexities of divine-human transactions, engagement with cosmic ontologies highlights deities' specific materializing agencies, provocatively suggesting shrines, religious rituals, and personal relationships with God as sites of assisted reproduction.[51] The gendered fetus was subject not only to kinship, medicine, and governance, but to cosmic power systems as well.

Mahesana-area families and clinicians pervasively talked about how cosmic agencies could over-determine the coin toss of son pursuit. Some, like Asha-ben's family during the hopeful ride to Chetna, invoked karma as the key causative agent. Others cited *nasib* [luck, fortune], *kismat*, *kudrat* [nature, the universe], God, various deities, or "what is written," often tying the diverse factors together as ultimately one. Many described sons as the fruit of prayer, faith, or trust in God. When faced with anger over refusal to perform SD or disappointment at repeated daughters, obstetricians often told clients to interrogate fate, luck, or God, since "it's not in our hands." And on more than one occasion, I heard families reflect the same clinical theodicy back to clinicians: "We'll accept whatever God gives. You may be a doctor, but you're not bigger than God, right?" The scope and tendencies of the cosmic forces shaping fetal sex could extend far beyond the knowledge or control of any medical practitioner.

People's statements often indexed the assumption that God understood the social structure and could provide household balance. Hope and disappointment became configured in the language of divine providence: "After this girl, God will definitely give us a boy!" "God isn't seeing that it's our turn—he just keeps giving girls." Occasionally, women and relatives even responded to discussions of the sex ratio (SR) and Beti Bachāvo by suggesting that God actively worked to preserve balance at the population

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[48] Roberts 2016; see also Roberts 2012a. This approach bears affinities to ontological models that treat phenomena as emergent products of material-semiotic relations among diverse assemblages of human and non-human bodies (e.g., Barad 2003; Latour 2005).
[49] B. Singh 2012.
[50] Bharadwaj 2006.
[51] Goslinga 2011.

level, making a disproportionate number of firstborns female. "Since there started being less girls," Gita-masi once told me, "God's made a rule that the first child in every family should be a girl." Statistical evidence of roughly equal first-parity SRs notwithstanding, perspectives like Gita-masi's portrayed the divine father as paralleling the state in working to preserve community-level balance.

Statements and stories regarding divine reproductive planning frequently centered on notions of karma and moral deservingness. Echoing Dhruv-ji's reflections on penance, people sometimes treated infertility, repeated "female" pregnancies, and the excruciating anticipation of SD as God-given challenges; this configuration concretized tensions between piety and reproductive endurance while also allowing the further emplotment of son pursuit on the basis of faith in the ultimate inevitability of a boy.[52] The invocation of karma—a personal but ultimately incomprehensible form of responsibility—functioned to deepen or absolve blame on particular people, depending on the circumstances.[53]

Some examples were spectacular. Gita-masi told the tale of a drunken father-to-be insulting a Mataji [mother goddess] and dismissing any need for her, given that sonography had twice confirmed his future child as male; four months later, the man's wife had given birth to a girl, for "Mata-ji switched the child, even after it was fixed as a boy." Much like Shastri-ji's challenges to bioscientific embryology and clinical SD, Gita-masi's story indicated the importance of recognizing that other forces—here, divine action based on moral deservingness—could override biomedical revelation of the coin toss results.

Most instances of imputed divine planning, such as Gauri-devi and Dhruv-ji's, were more ordinary, though no less powerful. Many men treated sons as a focus of moral improvement, pledging to give up a long-held vice—tobacco, alcohol, gambling—if a particular deity granted a boy. Sagar-bhai, the medical supplies distributor whose wife had undergone sex-selective abortion with Dr. Narendra before having a son, invoked notions of moral deservingness in reflecting on the counterfactual scenario of yet another female fetus: "It would've been tough—'What have we done?' We still would've had to try again—for a boy—but our heart wouldn't be in it. We would keep feeling, 'What did we do to deserve a third straight girl? What's the flaw in us?'" One *bhuva* explained that God gave more daughters to "the man who doesn't fear anything, doesn't give in to anything," "the man whom no one else can touch," so that "he can realize how you have to constantly follow daughters in this day and age, in fear"—"so that his progeny can touch him, and he must bow instead of walking around with his head held high."

Consequently, clinical sex selection intersected with two son production techniques that attempted to recruit divine intervention: *bādhās*, and personalistic bargains with God.[54]

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[52] Cf. Ivry et al. 2011; Teman et al. 2011.

[53] Cf. Gammeltoft 2014a: 131-163; Unnithan-Kumar 2010: 322-323.

[54] Research on sex selection has described numerous other religious or spiritual techniques, including amulets, pilgrimages, and blessings from holy men (Dagar 2002: 36, 39-42; John et al. 2008: 61). More generally, the ethnographic literature on Hindu India abounds with descriptions of such procedures. While I knew of Mahesana-area families employing a number of other techniques, *bādhās* and personal prayer were the two that recurred most often, and I have chosen to focus on them here.

Of Bādhās and Bhuvas: Damini-ben and Govind-bhai

The religious ritualists known as *bhuvas* were just as much a part of the local son production ecology as obstetricians, Ayurvedic practitioners, and *desi* herbalists. Like the latter two groups, they offered interventions—*bādhās*—that could alter reproductive trajectories in ways that conventional biomedical sex selection could not. One prominent Mahesana-area *bhuva* once told me, "I use the *bhuva*'s technology! The doctor's technology—sonography and all that—is one thing, and that's what you've studied. But the *bhuva*'s technology is a different thing." Because religious techniques operated on a different plane of causation, they offered a different mode of action: accessing and modifying fate, divine will, or chance where biomedical control could promise no better than fifty-fifty odds.

The *bādhā*[55] was a religious agreement—usually with a Mataji—based on solemnly promising an offering in exchange for the desired object. While sometimes undertaken with just a personal vow, *bādhās* were often mediated by Mataji-specific *bhuvas*. The *bhuva* led the woman, couple, or family in performing rites to initiate communication with the deity. He used his expertise to transmit supplicants' requests to the Mataji, who then transmitted them to the "writer of fates," or the ultimate divinity. The latter then decided whether to change written fates, making the *bādhā* effective or ineffective. If the former, supplicants completed certain offerings through the *bhuva* within an appointed period. A *bādhā* for a son could be initiated before or after conception, and was considered fulfilled with the birth of a boy or—more rarely—a "positive" SD result.

As a senior *bhuva* noted, "there is no young woman who does not have a son in her fate," but black arts, negative karma, or a protracted reproductive destiny could trap her in a sonless state. Acting against conditions, a *bādhā* could expedite son production by altering written fates. Another *bhuva* explained:

> In such cases, all the work's done by the one up there. We're just the proximate cause! We help heal people's sorrow by trying to change the written fate. We explain to people that they are making a request—not with us! With Mataji, and with Him. Not here—up there! It all depends on your faith, your trust. God is with you. We're just the gateways. What does a lawyer do? We make a request to him, and then he passes the request forward. So just as the lawyer becomes a proximate cause, we become a proximate cause.

Ultimately, then, the *bādhā*'s success depended on the strength of the supplicant's faith, the damaging or supporting effect of the supplicant's karma, and an agency whose operation was beyond the comprehension of both supplicant and mediator.

A *bādhā* was often a matter of kin-oriented action. Elders forced their sons and daughters-in-law to pursue ritual requests—often to the exclusion of biomedical sex

[55] The etymology of *bādhā* suggests connection with conditions of tying, yoking, or restriction, as a vow might produce.

selection—even when the youngsters thought them ludicrous. Conversely, women sometimes convinced in-laws to accept *bādhās* as a substitute when multiple selective abortions led to reproductive exhaustion. Supportive relatives might also undertake *bādhās* on behalf of long-suffering women. I knew a prominent anti-sex selection activist who, while fighting tirelessly for recognition of daughters as equal, undertook two separate *bādhās* pledging barefoot 100-kilometer treks to secure boys for kinswomen whose sonlessness had brought down harassment from hostile in-laws.

Gita-masi's grandson was the product of a *bādhā*. After the birth of her second granddaughter, her son had sunk deeper into alcoholism. Gita-masi and her daughter-in-law had initiated a *bādhā* pledging the son's sobriety in exchange for a boy.

Some months later, the daughter-in-law became pregnant. Citing the *bādhā*, Gita-masi forbade her from taking an abortion pill. She compromised by saying the couple could pursue an abortion if sonography revealed another potential daughter.

The Mata-ji and her *bhuva* gave permission for SD. This was in contrast to many cases, where SD was prohibited as a sign of "false faith"; in some cases, *bhuvas* warned that pursuit of sonography would so disappoint the Mata-ji that she might turn a male fetus female at the moment of the test.

The family's scan revealed a son-to-be. A few weeks after the boy's birth, the family rented a jeep at considerable expense to take him to the Mata-ji's chief pilgrimage site and offer coconuts, cash, *penda*, and various other sacrifices. Though I could not verify the precise costs associated with the *bādhā*, my sense was that it reached around 10,000 rupees, or over a month's income for Gita-masi's son.[56]

Instead of simultaneity, *bādhās* and SD could also stand in sequential relation to one another. In this regard, Gita-masi's family's story contrasted with that of their neighbor's daughter, Hetal-ben. Frustrated with three previous selective abortions that had left her feeling "finished," Hetal-ben and her in-laws decided to pursue a *bādhā* as an alternative. In their case, the *bhuva* prohibited biomedical SD, saying it would betray insufficient faith. When I last saw Hetal-ben, she was eight months pregnant, fervently hoping the impending birth would end her long reproductive journey.

For other couples, such as Damini-ben and Govind-bhai, the frustration-based switch between biomedical SD and *bādhā* could operate in the opposite direction. I met the thirty-something couple one day in the Nandini consultory. She was quiet; he, louder, with a booming laugh and heavy gold chains around his neck and wrists. He was a prosperous moneylender and land broker with a monthly income of several hundred thousand. He carried an infant in his arms, and two girls—five and three—trailed close behind.

The couple requested placement of an intrauterine device. Govind-bhai explained, "We'll have to have a five-year gap." Dr. Dilip asked if they wanted another child after that. Govind-bhai chuckled, held up the baby and nodded to each side: "Since we have these three Lakshmis, we'll have to try for a boy in the future, right?"

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[56] Unlike with medical practitioners, I was generally unable to verify precise costs in speaking with *bhuvas* and their clients.

A few days later, I ducked into Govind-bhai's office, set amid a modest retail complex. Removing his overshirt after a busy morning and propping his feet up on his desk, Govind-bhai motioned me to the sofa across from him. The aroma of smoldering *desi* tobacco from his *bidi* filled the room.

He narrated his and Damini-ben's reproductive history. In six years of marriage, she had born three girls by Caesarean delivery. "Now," he explained, "we've decided on a five-year break. Even if nature said right now, 'I want to give you a boy,' I would say no. I have to think about my wife—about her body. Since all three are operations, it's important to look out for her, right?" Then he added, "If they had been normal deliveries, then it would be no problem. But all three are operations! My sense is, the doctors say you should only get three. This is my fortune."

I asked whether they had ever obtained SD. Govind-bhai replied, "Never! We left it to nature. See, we didn't want to commit *pāp*." Looking at a corner of the cieling, he mused, "After the first girl, we thought we would definitely have a boy. Watch, in most cases, that's the way it is—if the first child is a girl, then nature gives a boy." In their case, however, the cosmic balancing had not come to pass. He continued, "Even though we are good, nature visited bad on our home. Even though we do good in our community, and never wrong anyone, nature still gave us girls." Holding up an open palm in a gesture of helplessness, he added, "That's a matter of luck. Many don't have *any* children!"

Elaborating on the matter of SD, he said, "In the second trial, the whole family said it would be good to get it looked at—my missus, too. But I held back. The third time, too, people said, 'Get it looked at, get it looked at.' But I thought, okay, *now* it will come. And again, I held back. We had a *bādhā* with the *bhuva-ji*, so we thought, this time it'll be a boy." He smiled ruefully as he continued, "The *bhuvaj-i* is obviously going to say, 'Yes, keep a *bādhā*!' He's going to get his. So we called the *bhuva-ji*, we kept a *bādhā*, everything. We contacted him afterward; he just said, 'Oh, it's a matter of your luck.' If it was a boy, he would say he made it happen! Honestly, both *dava* and *dua* provide their own benefits." Govind-bhai's regrets echoed the common refrain that son pursuit ought to combine *dava* and *dua*—pills and prayer, or medicine and religion more broadly. Such complementary use, he felt, might have aided him and Damini-ben in expediently reaching the end of reproduction.

Upon asking about the prospective fourth pregnancy, I was taken aback to hear Govind-bhai emphatically declare:

> Then, it's final, we have to get it looked at! It's necessary to get it looked at. Once there's a fourth Caesarean, you definitely can't have another. At this point, it's all for a boy. We're like a critical patient—you can say we're 'on oxygen!' If there's a fourth girl, we won't be able to try for a fifth pregnancy. This is the last round: if I don't kill the enemy with my last bullet, the enemy will kill me. So we're going to get it checked, final. At that point, we'll go to the ends of the earth if we need to. Friends who got it done previously told us to get it done, but we didn't. That was our biggest mistake.

> We have no alternative. We're on oxygen. If they were normal deliveries, maybe we'd make do. But even with three *normal* deliveries, we'd have to think about it. Look at the era! To have a girl, take care of her, let her go out at night—we have to move according to the era. It's not a question of money, but of what she will find: what kind of conjugal family, what kind of mother in-law, what kind of sorrow?

The imperative of son production meant Damini-ben would have to endure further reproductive wear. But with her body's reproductive capacity reaching certain limits, and a son the only purpose of procreation, there appeared no choice but to pursue biomedical sex selection, however sinful. Another full-term coin toss would not do.

When I asked Govind-bhai if they would consider a fifth pregnancy after a hypothetical selective abortion, he rolled his head in acknowledgment, saying, "Of course, another try is necessary." He waved his hand over his head, toward the walls of the office. "All this effort I'm making, what is it for? Who is it for?"

Toward the end of our conversation, I thought back to the moment at Nandini when Dr. Dilip and Damini-ben had gone behind the curtain for the contraceptive placement. Govind-bhai had slid his finger sideways into their baby's mouth, allowing her to bite down and gnaw as a relief from teething pain. Once she had tired of the activity, he had squeezed her into a ball, kissed her, and tickled her, laughing all the while. Over the course of our acquaintance, I would see Govind-bhai care for his three daughters in various forms readily recognized as embodied devotion: embraces, more teething, games with the older girls, walks with all three in tow, proud sharing of their photographs, and weekly trips to track the infant's weight gain on a corner grocer's scale. These were all acts of affection and care—precisely the affection and care that, coupled with compulsory alienation, made the futurity of daughters so bittersweet.

That afternoon in Govind-bhai's office, thinking just of the scene at Nandini, I asked whether he really felt it had been his "biggest mistake" to not obtain SD on the fetus that became the teething girl. He practically shouted the response: "Of course, *yār*! The thought is bound to occur to me, that I have too many girls—in this era, already having three, right? Definitely, I feel that way sometimes—that if we hadn't had this third girl, if we'd had a boy instead of a girl, it would've been good." There was a long pause. Then, he grinned and added, "But now, if she cries, it burns my heart! Now, I can never let her go. The point is, we *did* keep her."

Govind-bhai's views reiterate the lesson that sex selection was not the expression of a crude, totally devaluing misogyny, but a complex manifestation of gender-kinship inequality in which the evaluation of daughters as "bad" was compatible with deep affection and care toward them. Govind-bhai's words also reveal how, despite considering biomedical sex selection morally abhorrent and preferring religious alternatives, people might feel compelled to pursue the former when confronting the simultaneous constraints of a rigid kinship structure and reproductive exhaustion. In Govind-bhai's perception, son pursuit had reached the stage of last chances. His vivid metaphors of shootouts and oxygen, his pledge to travel the ends of the earth, his

resoluteness on the whole matter—these indicate the extent to which he felt the end of reproduction to be near. If that end was to be a boy, definitive action was necessary.

Govind-bhai's statements evinced serious struggles with luck, nature, and God. If his behavior had been good, why had the universe done him wrong by giving so many girls? Why had the good—a son—been withheld? If nature generally bestowed boys after girls, why had the couple received three consecutive daughters? And if sex selection was *pāp*, did its necessity now make it acceptable? Damini-ben and Govind-bhai's failed *bādhās* and the prospect of future SD raised more questions than they answered. Given the inscrutability of the substrate for divine agency around reproduction—karma, written fates, the balance of *pāp* and *punya*—how could one make sense of a wheel whose turns kept yielding unfavorable results?

"We Petitioned the Universe Every Day": Mina-ben and Gajendra-bhai

Alongisde *bādhās*, people People also bargained with God in more personalized ways. In such cases, the *pāp* of past sex selection often became a starting point for negotiating a path toward a future son.

I first learned about personalistic bargains with God from Mina-ben and Gajendra-bhai. We met when I accompanied them and Uma-masi on an SD visit to Chetna. When Uma-masi's son stopped the car at the rendezvous point, I saw four figures: a lanky man; a short, stocky woman; a fashionably dressed preteen girl; and, in the woman's arms, a grinning infant.

As we crammed into the car, Mina-ben thrust the baby toward Uma-masi with a smile. Smiling back, Uma-masi pinched the girl's cheeks and asked, "Is this the one you kept?" Husband and wife grunted and nodded. Mina-ben told me that after obtaining SD through Uma-masi in the previous pregnancy, they had ultimately decided to keep the daughter.

When we reached Dr. Ranjit's town, Uma-masi, Mina-ben, and the two girls stole away to Chetna. Gajendra-bhai and I wandered, chatting about his Patel *gol*, his farming, cost of living, and prohibition on sex selection. "Uma-ben is a great person," he said. "Only one in a hundred people would do as much as she has done for us." I did not learn the full extent of her assistance until weeks later.

Eventually, the women emerged from the clinic and found us at the nearby tea stall. After we piled into the car, Mina-ben smiled and declared a "good report." Gajendra-bhai returned the smile, and both parents clutched their daughters tightly. The older girl looked back and forth between the parents, nodding happily.

On the ride back, Uma-masi said, "What did I tell you? With her, I told you, 'Keep it. You don't want to do *pāp*. If it's in her destiny, she'll bring a brother.' And she brought one! This is great news for these sisters." The couple hurriedly agreed, squeezing the girls.

A few weeks later, Gajendra-bhai and Mina-ben invited me to their village, just outside Mahesana. For two hours, we sat on charpoys, playing with the infant and discussing their experience.

The couple recounted a difficult reproductive history. In 2003, two years after their marriage, a son had been born with cleft palate; despite extensive medical care, he

had expired after five months. "God made it like that," Mina-ben said, shaking her head. "We argued a lot with God in our grief! But it was written in our karma, in our fortune." The older girl was born in 2004. Then, a "five-six year span when every pregnancy ended in miscarriage," per "whatever was written in our karma." The second daughter had been born in 2013, after SD at Chetna. And now, the anticipated son.

The couple explained that obtaining the desired son rested on a karmic balance of *pāp* and *punya* [meritorious action]. They mused, "If we are true, if we only act truly, the universe will eventually look toward us, no? We have to assume that we committed *pāp* at some point, and that it got in the way. Who knows when God is satisfied with you?" The male SD result signaled the sufficiency of their penance—waiting, enduring difficulties, and accepting a girl.

More specifically, the couple characterized the son-to-be as the result of a bargain struck with God after the previous SD:

- Mina-ben: Eighteen months ago, we didn't get it done. We put our hope in God! We told Him to look out: 'We'll bring her home, raise her. But then you look out for us!' Uma-ben suggested it, and it was our will, too. We kept thinking, what if it's in her fate to have a brother? If we bring home another girl—if we don't do *bhrunhatyā*—maybe God will give us a boy.
- Gajendra-bhai: Honestly, when the doctor told us, we weren't thinking of keeping it. But then we came home and decided to welcome whatever it was—to not do wrong. We thought, let's not kill it. Because it's *bhrunhatyā*. Four months—that's when the life is put in. It develops, it's given a form, and it's given life. So then it's *bhrunhatyā*. Imagine how the life is offed as they scramble it up inside!
- M: We thought, if we get this taken out, no good will come to us. Because the *pāp* doesn't accrue to the doctor; it accrues to us.
- G: Of course! He only does it because you pay him—because you go. Does he come to your home? *We're* the ones who made the inquiries to find *him*. So we thought, this is nature, and you can't change nature; if we do *bhrunhatyā* and get pregnant after six months, it will be the same thing.
- M: If we'd gotten it done, God wouldn't have favored us. The *pāp* would've gotten in our way... We would keep getting girls, again and again, because we didn't accept our fate. But we accepted it! We accepted her, and it was in her fortune!
- G: We believed that, as far as possible, the universe wouldn't do us wrong.
- M: We figured God would give us a son. We petitioned the universe every day: 'Look out for us, now that you've given two already!'

Mina-ben and Gajendra-bhai described an agreement, established through prayer, with God, fate, and the universe: the couple would welcome a second daughter-to-be in

exchange for the reward of a son. Notably, the bargain took on its full meaning through the act of SD, which facilitated recognition of the potential daughter as such; sexing the pregnancy made its acceptance a more meritorious act. The couple's stances on *bhrunhatyā*, killing, and *pāp* echoed Rohit-bhai's anguished meditation on Kavita-ben's abortion, conveying the sense that life and form, moral standing and fetal development, emerged in parallel, so that the gendered (and hence selectively eliminable) fetus was also one whose rejection carried the taint of *pāp*.

Mina-ben and Gajendra-bhai's bargain presumed that God understood the patrilineally, patrivirilocally structured moral economy and would act in accordance with common-sense understandings of girls as burdensome and boys as necessary.[57] At the same time, the opaque workings of karma left the couple predestined to have two daughters before reaching a son, as suggested by the hypothetical of interminably repeated female pregnancies following a selective abortion. While mandating a second daughter, "nature"— the universe, divine will, karmic balance, fate, a cosmic plan—would reward compliance by bestowing a son. Moreover, girls' compulsory alienation meant fate and fortune applied intergenerationally: a boy embodied good luck for both parents and sisters.

Despite the sense that "the universe wouldn't do us wrong"—a feeling akin to Dhruv-ji's confidence—Mina-ben and Gajendra-bhai had experienced considerable anxiety at the time of their most recent SD. "Uma-ben told me the result when we got outside," Mina-ben recalled. "Till then, my heart was like, 'Boom, boom, boom!' Like there was nothing else in life. When she told me, it was a relief." I was intrigued as she continued, "Honestly, this was the work of the universe—of God. Otherwise, if it was a girl, what would we have done?" She arched her eyebrow. "Cancel. Definitely. No doubt. That's it." A shrug. "What else could we do? We have two already!" If SD had revealed that the universe had not fulfilled its side of the bargain, the couple would have had no choice but to turn to *pāp*.

Upon returning to Mahesana, I went to Uma-masi's house. Before I had even opened the gate to the compound, she shouted from the patio swing: "They just called to say they told you about all this! I told them it was no problem. They called before you went, too—'This is how it is, can we talk freely?' I told them, no tension! They trust me a lot."

Then, her words took me aback: "And of course they trust me! I've done so much for them—saved them a lot of money. I took them to Dr. Tapan four times for MTP. I got it looked at for less, and finished off for less." Four times. A different picture was coming into focus in my mind.

"We went to Dr. Tapan," Uma-masi reiterated. "They got it taken out four times! Then, with this girl, I told them to keep it. And now, this boy!"

Uma-masi's revelation cast the bargain with God in a new light. The repeated "miscarriages" during the gap between the two girls had been deliberate sex-selective abortions. Mina-ben's scenario—fate indefinitely sending female pregnancies to force a

[57] In this ontological configuration, God shared in his devotees' "historically constructed and historically defined standards of judgment" (Geertz 1983: 76). The historicity and cultural contingency of God's knowledge did not, of course, make it any less *real*.

second daughter—was no hypothetical. It was the lived reality from which their bargain offered an escape.

Subsequent meetings allowed Mina-ben and Gajendra-bhai to slowly reveal the physical and emotional tribulations of repeatedly hoping, conceiving, and aborting. Identifying their problem as lying in the realm of *pāp* and karma, they had ultimately decided that the solution would be religious, rather than biomedical. The acceptance of a known daughter-to-be ended the chain of female pregnancies and its associated killing, paving the way for producing a son.

"Are We Bigger than God?": Nayna-ben and Ishwar-bhai

I also witnessed the aftermaths of bargains that ended poorly. Toward the end of a twelve-hour *kāchi* delivery at Chetna, Nayna-ben asked me and her husband Ishwar-bhai to go purchase a black salvaar, so that she might limp out of the clinic without worrying about the inevitable bloodstains. As we walked through the twilight and into a narrow alley of shops, Ishwar-bhai lamented the family's precarious financial condition.

He then surprised me by revealing that the couple's acceptance of their three-year-old daughter—then snoozing on her mother's cot—had not been sex-agnostic:

> See, hers was the second pregnancy, so we got it checked. But we decided not to get it out. Everyone pressured us, but we said no. We said, 'Boy or girl, no problem. Let's keep it.' I said, 'I'm here, aren't I? Their father?' We were firm. And we made a request to God, that he listen to our prayer—that he understand our situation and give us something good next time. All parents hope this way, that God do something good for them.
>
> But then some fault of ours must 've gotten in the way. We're not going to fault God, right? Are we bigger than God? So it must be something in our karma. Otherwise, we'd expect God to do us good. But there must be some reason—some past wrong deed. See, we don't like doing this thing—we're against it, since it's *pāp*. But we're put in a position of weakness. How many girls can we gather? It would have been good if she had brought a brother in her fortune, but she didn't.

Like Mina-ben and Gajendra-bhai, Nayna-ben and Ishwar-bhai had bargained with God, offering acceptance of a daughter-to-be in exchange for divine provision of the "good"—a son. Their decision had been shaped by a shared notion of *pāp*, and by Ishwar-bhai's insistence that he could handle the challenge of another economic dependent. The bargain had ended unfulfilled, leaving them to blame themselves, their karma, and—less speakably—God himself.

After taking the salvaar to Chetna, Ishwar-bhai and I stepped out. As we walked through the light winter breeze, he shook his head and said, "All this—it's *pāp*, isn't it? Killing a life? Because the life's in the child from fertilization. Once the two seeds come together, the life's in it. That's what causes it to develop, no? If we plant a seed and water it, the whole process starts from there. Any seed—animal, man, tree, anything—it's alive from the time it's fertilized." Unlike Gajendra-bhai or Rohit-bhai, who felt life entered

the fetus at three months, Ishwar-bhai saw the developing child as living—and hence killable—from the moment of conception. The end result, however, was the same: selective abortion added *pāp* to the karmic balance.

Staring at the crescent moon, Ishwar-bhai sighed, "If only in the third—! We were always fine with keeping two girls. If we'd gotten a boy in this third, we would've been all set. But this is our fortune, that it didn't come." Fate had forced them into a difficult choice: accept the burden of a third daughter amid dire financial straits, or commit *pāp*.

On the ride back to Mahesana, Nayna-ben and Ishwar-bhai made several phone calls. I could hear them mumbling: "No, no... Well, what's the point of gathering together lots of girls?... No, we were never going to keep a girl... This is called luck... It's a matter of our luck." They were narrating a failed reproductive coin toss, identified through sonography, enacted through abortion, and ordained by a seemingly hostile universe.

"We Left It to God": Veena-ben and Bhanu-bhai

In still other cases, religious conviction prompted a complete turn away from SD, toward a high-fertility pathway of son production. In such cases, the success or failure of the bargain with God emerged over a longer time course, and reproductive destinies could remain indeterminate for many years.

I was sitting in the Nandini consultory when Veena-ben and Bhanu-bhai entered for a prenatal visit. Veena-ben was in her thirties, friendly and outspoken, with numerous gold ornaments. Her husband appeared about a decade older.

A bit later, we sat down to converse in an empty patient room. At first, Veena-ben and I were alone, as Bhanu-bhai was purchasing medications. She explained that she had given birth to four girls and one boy. The oldest girl, twenty, had recently eloped, much to the detriment of the family's reputation within its Patel *gol*. The next, two years younger, had died in a childhood accident. The sole son had died within a month of birth due to congenital heart problems. After that, she had had several miscarriages, two girls (aged nine and seven), and several more miscarriaged. She was now finding it "difficult to keep a pregnancy without lots of medication."

I asked Veena-ben if she hoped for a boy after such a long reproductive journey. "We've left it up to God," she replied, joining her hands and looking upward. "Of course we're hoping, since we don't have a boy. But this time, boy or girl, we'll get the family planning operation done. Everyone at home agrees. Better that than to keep ruining the body."

Bhanu-bhai entered, and we continued discussing their experience. At one point, I asked whether they had considered pursuing SD in this final pregnancy. Both shook their heads vigorously:

- Bhanu-bhai: We've just trusted God! Whatever comes, comes.
- Veena-ben: We can't commit the *pāp* of killing a daughter. It would be killing a living life.
- B: If we looked, the doctor said it was a girl, we got it knocked out—then it'd be killing a living life! The life enters the child at three

months. After that, if you get it looked at and kill it, then you'll accrue *pāp*.

- V: And if we were getting it looked at, would we have so many girls?

Given selective abortion's sinfulness, the couple was relying on God to grant a favorable result in their final pregnancy.

Two weeks later, Bhanu-bhai met me in his village's central plaza. We went to a small corner shop, where he told the shopkeeper preparing his tobacco: "This bhai's looking to understand why people don't let daughters be born."

Reaching Bhanu-bhai's neighborhood, we stepped into the first house's courtyard, where his late cousin's widow greeted us. The woman offered me a seat and prepared some fresh lemonade. After Bhanu-bhai explained my project, she gestured toward him and said, "Just ask him! He has a lot of experience." Stunned, I glanced sideways. Bhanu-bhai was looking down, avoiding eye contact. The woman continued, "You didn't kow?" Before I could answer, she smiled: "Of course you wouldn't. I know because we're family, right?" As with Uma-masi's divulgence regarding Mina-ben and Gajendra-bhai, an intimate's betrayal had revealed a previously hidden history of sex selection.

We soon retired to Bhanu-bhai's house. Lounging on the patio, we chatted with Veena-ben as she prepared lunch. Unsure of how to handle the sensitive disclosure, I let our conversation meander around general gender-kinship matters.

We had been talking for an hour when Bhanu-bhai sighed and said, "Let me tell you our history." He explained:

> We had two girls, then the boy. But he and one girl died. Then, another pregnancy. They were doing sonography back then. It was a girl, so we got a curetting done. We had three-four done like that!
>
> But eventually, we said, you can't keep killing like this. If there's a girl, and you kill that life—they can tell boy-girl by sonography at three-and-a-half months, once it's been given form and the life is put in. So we both decided that it was a child, and that we were killing it. So we left it to God—on faith. Then, these two girls. And then, the miscarriages: there was too much heat in her body, so she needs cooling medication to keep pregnancy.

Both husband and wife likened their situation to the norm in an earlier era, when people "just kept going," having "five-five, six-six girls for a boy." While giving up on the selective path, they had continued pursuing a son through repeated childbearing.

In explaining the decision to stop pursuing sex selection, Bhanu-bhai emphasized moral considerations:

> I decided this was killing—a great *pāp*. Back then, there were ads on the government buses for Beti Bachāvo: 'Mother, let me be born! What's my fault, that you're killing me?' Imagine the damn feeling, seeing that! I thought, 'Really, what *is* her fault, that we're killing her? That poor girl

> hasn't done anything—hasn't harmed us, hasn't posed any obstacles. Then why do we kill her? We feel hurt if someone gives our daughter a slap—just a slap! Then what of killing her from the roots?' So then we decided this wasn't right. 'Whatever's in our *kismat*.' I decided we wouldn't do this any more. 'If a boy's in our *kismat*, all well and good.' I kept thinking maybe the reason we were facing such sorrow—such hardship, girl after girl—was this killing.

Inspired by Beti Bachāvo programming and frustrated with repeated female pregnancies, Bhanu-bhai had decided, much like Mina-ben and Gajendra-bhai, to give up the *pāp* of sex selection.

Veena-ben—now scrubbing pots and pans—offered her perspective on how Bhanu-bhai's stance had become fixed as household policy. Her and her husband's accounts clashed, suggesting a fraught decision-making process around sex selection and *pāp*:

- Veena-ben: So then he decided that.
- Utpal: And in terms of agreement—
- Bhanu-bhai: No, no! Whatever I said, she agreed with.
- V *[arching one eyebrow]*: He and my mother-in-law—the two of them. Whatever he and the old lady said, I did. *She* was the one who said no.
- B: My mother said no. She said, 'If God gives us more, we'll give them less, but let them come. We don't want to do this *pāp* anymore.'
- V *[shaking her head, frowning]*: With the first of the two youngsters, things weren't so strict, so the two of us asked, and Dilip-saheb told us it was a girl. But then my mother-in-law said, 'We don't want to kill. Whatever's in our fortune, let it come.' So that's why we didn't get it done. They said we'd keep it. 'We don't want to kill,' they said!

Veena-ben's words added further complexity to the seemingly straightforward bargain with God. They cast doubt on Bhanu-bhai's account of his publicity-mediated conversion: had he even been the ultimate decision-maker?

I met Veena-ben's mother-in-law shortly after Bhanu-bhai and I sat down to lunch inside the cool house. She barged in carrying a load of hay from the fields. Waving her hands in my face, she shouted, "Will it be a boy or a girl?!" Her son muttered that I wouldn't know, but she looked me in the eye and asked, "Can't you see it in the TV? Can't the doctor tell?" Again, Bhanu-bhai mumbled a soft deflection. The old lady grunted and walked off in a huff. I marveled at how the mother-in-law, supposedly against sex selection, was nonetheless eager to know the fetus's sex.

After lunch, Bhanu-bhai and I lay down on the patio charpoys. He was soon snoring, but I could not fall asleep. Washing the dishes, Veena-ben mumbled to me, "Oh, the treatment with Dilip-saheb is so expensive! With each of these girls, it cost us 30,000. And still, no happiness." After staring into space for a long while, she shook her head,

started scrubbing again and said, "Girl after girl—with God giving girls even after so much cost, a soul is bound to feel it, no?"

A bit later, once Bhanu-bhai awoke, we talked of the cumulative toll of son pursuit. Veena-ben, now reclining against the wall with a book, frowned and said, "When we get abortions done, it ruins the body." In a somewhat different vein, her husband maintained that "if we knew we'd have a boy after seven girls" it would be "no problem, no worry"—"we'd let eight be born!" Veena-ben scowled and mouthed the words, "Oh, easy for you..." Then, as Bhanu-bhai turned toward her, she softened her face and stated blandly, "Pregnancy ruins the body, too. I mean, how many girls can you have—gather together—for a son? Anyway, after this pregnancy—whatever it is—it's all over."

Veena-ben's stance underscored the gendered distribution of burdens from bargaining (or not) with God. Repeated abortions and repeated childbearing—the hallmarks of low-fertility and high-fertility son pursuit—were both visited upon women's bodies. Making a pact with God might free a household from the *pāp* of *bhrunhatyā*, but it did not liberate women from the toll of son pursuit.

Her attitude, as obvious from the unspoken as from the spoken, made clear the distribution of the burden from bargaining (or not) with God: repeated abortions and repeated full-term pregnancies, the hallmarks of playing the lottery via the low-fertility and high-fertility pathways, both imposed themselves on women's bodies. Striking a deal with God might free a household from the *pāp* of *bhrunhatyā*, but it did not free women from bearing the physical and emotional toll of son pursuit.

As Bhanu-bhai walked me to the bus stop, he expressed hope that Mata-ji would show his family mercy. In this pregnancy, he and Veena-ben had established a *bādhā* with Meldi Mata. His mother, meanwhile, had fixed *bādhās* with both Meldi Mata and Randal Mata, promising to donate silver crowns to local temples and hold feasts for the entire village. Bhanu-bhai invited me to return "when we hold a procession for Mata-ji." *When*—the verbal embodiment of a relentless hope.

Five months later, I returned to the village. I found my way to the house, where Bhanu-bhai's daughters reported he was out in his fields. Veena-ben greeted me with a smile. She showed me into the sitting room, where she was rocking a cradle. I sat down to admire the baby more closely.

Veena-ben had just stepped away when her mother-in-law walked in. Standing over me in the doorway, she shook her head and repeated what Bhanu-bhai had already reported on the phone: "It's a girl." Not knowing what to say, I nodded and turned back toward the child. As if to make her point clear, the old woman frowned and thrust her hand between me and the cradle: "What's the use of this?"

I ventured clumsily—perhaps a bit disingenously—that the girl would encounter tremendous opportunity if she obtained a good education. The grandmother waved dismissively. Searching for an entrypoint to dialogue, I fell back on the platitudinous characterization of girls as "an avatar of Lakshmi." Squatting down to my level, the old woman widened her eyes: "You have to have something to give Lakshmi, right?" She tood up and walked away, shaking her head the entire time.

I spent the next three hours picking cotton with Bhanu-bhai and his daughters. The girls, their nimble fingers accustomed to the task, moved quickly down the rows of

plants, while I bumbled my way along. Periodically, when we met at the end of a row, Bhanu-bhai would mumble something about "broken hope" or the impending "operation."

Back at the house, Bhanu-bhai and I lay down to nap under the mild winter sun. He closed his eyes and murmured, "It's exhausted us—waiting-waiting-waiting. We're tired of it." In contrast to Mina-ben and Gajendra-bhai's successful bargain, or Nayna-ben and Ishwar-bhai's ongoing quest, Veena-ben and Bhanu-bhai's pursuit of a son had come to an end.

Coda: "A Necessary Sin," Again

Talking about *Pāp*

Stories about contention with God or the universe open up deep questions about the ethics of sex selection. If a sex-specific fetus was a cosmically given living entity, its elimination constituted an interference—a killing—that might prove gravely sinful. Some people, like Veena-ben and Bhanu-bhai, eschewed SD or bore sonographically recognized daughters-to-be in order to avoid *pāp*. Others, like Mina-ben and Gajendra-bhai or Nayna-ben and Ishwar-bhai, contemplated and pursued selective abortion while simultaneously agonizing over its sinfulness. Either way, the religious idiom of *pāp* and karma became the chief medium for evaluating the ethicality of selective reproduction.

To be sure, people sometimes invoked other ethical standards. Like Kinjal-ben and her husband in Chapter 2, some cited the plummeting SR to explain why "this should not be done." Some echoed Dhruv-ji, who highlighted the legal and social stigma associated with the practice: "Every man gets this done, it's routine, but no one considers it good—ethically. It's illegal, and society doesn't consider it good, either." But even these speakers usually pivoted, as Dhruv-ji quickly did, from other social rationales back to religious reflections on life, killing, and *pāp*.

The notion of sex selection as *pāp* appeared ubiquitously in my fieldwork with families, facilitators, and obstetricians obstetricians, facilitators, and families: in Gita-masi's articulation of a "necessary sin," and her neighbor's desperate switch from repeated abortions to *bādhā*; in bargains with God, both successful and failed, around the avoidance of *pāp*; in Rohit-bhai's futile stand against Kavita-ben's insistence; in Dhruv-ji's construction of a teleological narrative in which God would never trouble good people with the dilemma of a "female" result; and in the reflections of countless other women, relatives, and biomedical practitioners. I took care to almost never mention *pāp* myself, lest I bias people's comments. Talk about it therefore emerged contextually, from the fabric of ongoing conversation.

People considered sex-selective abortion sinful, and yet they participated in the practice all the same. Scholarship on selective and non-selective abortion in India and Buddhist-influenced Asia has shown how people manage this apparent contradiction under a variety of circumstances. An early study on sex selection in Haryana found that 95% of surveyed women favored the practice even though 72% considered it "a sin as it

is a murder and a rejection of God's will."[58] Research from Southeast Asia has demonstrated how abortion may appear as simultaneously "necessary" and "highly morally problematic."[59] As one scholar has suggested for Japan, it may be helpful to approach people's navigation of the abortion paradox—a difficult choice made amid liberal abortion laws and reverence for unborn life—as a form of "moral bricolage," with the tools for coping with ethics tensions arising from within the very social constraints that produce the tension in the first place.[60]

Moral bricolage around sex selection in the Mahesana area traced the social limits at which the gendered fetal subject appeared. The female fetus was an incipient person—an incipient human life—such that its elimination entailed killing. At the same time, its inchoateness, situated within a processual view of life's emergence, meant such killing entailed involved less *pāp* than infanticide or other forms of *ex utero* murder; the precise degree of *pāp* was the subject of the most anguished moral deliberations I have ever witnessed. Gendered family planning rationales heightened the fetal subject's personhood and the perceived degree of sinfulness, but they also bolstered the act's seeming necessity. And different people managed guilt and responsibility differently: doctors and connectors dodged, dissipated, compensated for, or inverted the *pāp*; families accepted it, but justified it through a discourse of familial need.

These themes readily emerged, in microcosm, during my conversations with Dr. Ranjit. One day, during a lull in patient flow, he leaned back in his chair and said, "Now we want to stop this. We don't feel good when we do this. We feel guilty. While doing an MTP after SD, we feel guilty. We feel we're committing a crime—and a sin."

A few weeks later, during a selective abortion, I raised the comparison some families drew between prenatal sex selection and the female infanticide of yore. After thinking for a moment, Dr. Ranjit nodded: "It's basically the same. In previous centuries, they did *dudh-piti*. That's direct murder. Now, parents are allowing indirect murder." He gestured forward, toward his own hands. "This is indirect murder."

After a few minutes of silence, he chuckled, "If the gynecologist is responsible for this, all gynecologists are murderers—number one murderers!" I observed that such a judgment would require not only holding doctors responsible, but also treating fetuses as entities whose elimination constituted killing. Squinting at me, he declared with a tone almost flippant in its implication of obviousness, "*This is a living thing!* This pregnancy is life! Six weeks, seven weeks—viable pregnancy is viable, right? If you don't do MTP, it'll continue... So almost all gynecologists are criminals, all over. *If* you consider us responsible."

A month later, during another selective abortion, the doctor caught me off guard: "I can't decide who's guilty—whether I'm guilty, or whether parents are guilty. Who is responsible? Agents, of course, are also responsible. But it is the consent of the parents.

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[58] M. Kaur 1993; see also A. Agarwal 2003: 13-14, 16, 19-20, 40, 64-65. Chu (2001: 274-275) found a high prevalence of sex selection in rural central China despite 92% of women calling the practice "not right" and 93% deeming it an unfair treatment of girls, with many deeming it to be "destroying lives."

[59] This is Gammeltoft's encapsulation of the paradox of abortion in Vietnam (2002: 321-322). See Whittaker (2004: 132-139) for a similar dynamic in Thailand.

[60] Lafleur 1992: 10-14.

On what basis should we decide?" I noted that the law held doctors, relatives, and facilitators all responsible. With a fierce look in his eyes, he bellowed, "But I'm talking in God's eyes!" Following a brief silence, he said, "I'm feeling, sometimes, very guilty—during the MTP."

He curetted silently for some minutes. Then he continued, softly:

> When the mother is thinking bad—when mother is ready for termination—who should be called responsible? Mother is the epitome of sacrifice, the epitome of love. When she is prepared, for her own kid, how much must she be compromising? That is the only way of consolation for me. When mother gets ready for termination—

He trailed off. Then, a whisper: "When that epitome of sacrifice, that epitome of love, is prepared—if she is determined for termination, she will go anywhere."

For Dr. Ranjit, life and personhood inhered in the fetus's potentiality, and became more palpable with gendering. Sex-selective abortion was *pāp*—the killing of a living thing. But responsibility for the act lay primarily in the household, with women's needs overriding moral objections and thereby absolving the obstetrician of culpability.

Marking Limits: Life, Personhood, Killability

Sex-selective abortion represented an experiment at the limits of gendered sociality, personhood, and life itself.[61] It raised two questions regarding *killability*. First, there was the question recently posed by anthropologists Bhrigupati Singh and Naisargi Dave: what was the social permissibility of ending particular lives, and what were the associated modalities of killing?[62] But it also raised a further question: what sort of human personhood made it possible to see the elimination of female fetuses as a form of killing, anyway?[63] Killability became "a matter of life itself"[64]— a materialization of social life's boundaries.

Families, connectors, and clinicians uniformly considered sex selection a sinful form of killing contrary to divine will. In a pattern well attested in research on selective and non-selective abortions in India,[65] people considered many abortions—and certainly all selective ones—violent acts that destroyed "what God has given." They described what took place during abortions as *māri nākhavu* [killing] or *hatyā* [killing, murder, slaughter, or massacre, with distinctly dharmic overtones]. The killing targeted a person: a "child," "girl," "soul," or *jivto jiv* [living life]. Adopting the denunciatory discourses

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[61] Cf. Gammeltoft 2014a: 207-223.
[62] B. Singh and Dave 2015; cf. Agamben 1998.
[63] Singh and Dave note that their analysis likely would not extend to humans killing other humans, rather than animals (2015: 245).
[64] Cf. B. Singh and Dave 2015: 244.
[65] P. Jeffery et al. 1989: 200, 207; John et al. 2008: 58-59; Khanna 2009: 102-103, 110-112; T. Patel 1994: 147-148, 182-183; L. Visaria 2007b: 159.

promulgated by governance institutions, many families described their own actions as *stribhrunhatyā* [female foeticide] or simply *bhrunhatyā* [foeticide].[66]

And yet, as sex selection's pervasiveness might suggest, gendered fetal subjects did not attain an all-or-nothing status as persons. Fetal personhood was a processual phenomenon, with emerging fetal bodies exhibiting different kinds, qualities, and degrees of life and moral standing.[67] The unborn's gendered potentiality became actualized incrementally, and the process could be halted with incurrence of significant-but-manageable *pāp*. As Hemu-bhai once told me regarding his wife's selective abortion, "it's a small killing: not like killing a person, but still not good—like crushing a bird." Of course, most people insisted that the "small killing" was *not* equivalent to killing an animal, because the eliminated fetus embodied *human* potentiality.

The incremental development of human personhood that both permitted and problematized selective abortion may be traced through a series of landmarks. The MTP Act imposed a twenty-week limit on abortion, in accordance with the onset of quickening, but this limit aligned only loosely with citizens' complex moral and religious views. More commonly, clinicians, connectors, and families cited three biomedically-inflected milestones as key moments in an ongoing process of development.[68] Like Dr. Ranjit and Ishwar-bhai, some insisted that *all* abortions entailed some killing, since life was present from "fertilization"; if undisrupted, the conceptus's intrinsic potentiality would inevitably manifest as full-fledged personhood.[69]Others maintained that intrauterine matter "becomes living" with the onset of sonographically visible heartbeats in the second month of pregnancy.[70] Finally, many people, such as Rohit-bhai, Gajendra-bhai, and Bhanu-bhai, invoked the cross-culturally significant trope of "form," insisting that life was "put in" at three months of gestation, when the fetus acquired a human shape that could be recognized through sonographic visualization.[71] Those who endorsed the

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[66] I never heard *bhrunhatyā* in any usage except as an abbreviation for *stribhrunhatyā*—that is, with specific reference to sex-selective abortions. This restricted use highlights how the gendering act itself played a key role in making the elimination of the daughter-to-be wrong—a point to which I return below.

[67] Cf. Morgan 1996a: 60. Also see Morgan 1996b: 25-26, 28-30, 32.

[68] The three key landmarks—conception, fetal cardiac activity, and "formation" at three months—were essentially the only ones people invoked. Only one husband cited quickening as the start of life; he also insisted that the removal of the nonliving "earth" present before that nonetheless constituted a form of killing.

[69] Compare the arguments of Catholic moral philosophers around abortion, as discussed in Morgan (2013). Also see Gammeltoft (2002: 325) for Vietnamese couples' deliberations over whether the soul entered the child-to-be at conception or later, with the acquisition of a recognizable human form.

[70] Pollock (2015: 14-16) and Howes-Mischel (2016) discuss the importance of intrauterine heartbeats in concretizing fetal personhood in the U.S. and Mexico, respectively.

[71] Scholars examining a variety of contexts have noted the importance of "form" or "formation" for establishing fetal personhood. P. Jeffery et al. (1989: 76, 200) have described a pre-sonographic North Indian ethnoembryology in which the unborn acquired bodily form, sex, and life at three months. Lafleur (1992: 14-29) has connected the permissive attitude toward abortion in Buddhist japan with a view of fetal life as liquid or fluid, according to which "something just in the process of taking on 'form,' can rather quickly revert to a relatively formless state." Morgan (1997: 341-342) has pinpointed *formación*, or assumption of human form, as the most important marker of intrauterine development in the Ecuadorean Andes; imputations of *formación* could decisively shift the morality of abortion, even in the absence of ultrasound. Whittaker (2004: 132-133) has highlighted the key role of formation in establishing

first two landmarks as starting points for life also pointed to the importance of the three-month landmark, generally describing it as a marker of increasing personhood and moral standing.

Within this punctuated processual approach to life and personhood, sex-selective abortion inevitably entailed killing, *for a gendered fetus was always an inchoate person*. Because sonographic SD remained impossible until the second trimester, the unfolding of fetal potentiality squeezed potential parents into an ethical dilemma. The emergence of a human "shape"—including genital definition—enabled fetal gendering while simultaneously rendering subsequent abortions more sinful. This dilemma was apparent in families' and clinicians' countless anguished reflections on the nexus of "form," "development," "life," *bhrunhatyā*, and *pāp*. Development, visual recognizability, and heightened human potentiality came together to generate an image of a person-in-formation—killable, but not without moral transgression.

The importance of recognizability and potentiality came out in a comment from Dr. Tapan, who performed SD but avoided selective abortion: "After SD, after twelve weeks, once there's viability, then it's definitely *pāp*. See, at two months, viability is short. But here, there's a whole child—a shape! It can't live independently, but if we didn't do anything, then the fetus was going to be born. It was going to live." Like Dr. Ranjit, Dr. Tapan used "viability" at variance with common biomedical parlance, in which the term referred to the possibility of extrauterine survival; the doctors' usage focused more on human recognizability and potentiality than on immediate survival prospects, but ultimately performed work similar to the standard deployment by establishing the fetus's clinical personhood.[72]

In drawing contrasts between fetal discourses in Euro-America and elsewhere, anthropologists have noted that the emergence of the unborn into personhood may rest, to different degrees, on two different processes: interpellation into life, and interpellation into kinship and other social relations.[73] In people's ethical deliberations around Mahesana-area sex selection, the two processes reinforced one another, as sonographic gendering and kinning proceeded in parallel with a heightened perception of life. Moreover, the processual the two intertwined components of emergent personhood became situated vis-a-vis killability through a relativistic Hindu ethic; in this ethic, actors constantly accrued both *pāp* and *punya* [merit], and karmic status depended on the balance of the two, rather than on absolute adherence to particular moral precepts. Doctors and their clients found themselves forced to weight the potential *pāp* of abortion against the intention behind it and the consequences emanating from it. In a pattern well

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personhood, moral status, and the sinfulness of abortion amid a broadly processual view of emergent life in Thailand. Gammeltoft (2002: 323) has noted the specific importance of sonographically visualized human form in establishing fetal personhood and the sinfulness of abortion.

[72] Cf. Christoffersen-Deb 2012. Outside of discussing sex selection, Mahesana-area obstetricians also used "viability" in the sense described by Christoffersen-Deb, to describe the capacity to survive outside the uterine environment. In this usage, viability could be said to emerge in the late second or early third trimester, depending on the availability of neonatal services.

[73] Conklin and Morgan 1996; Roberts 2007; Strathern 1992b.

documented for Buddhist contexts, sex selection could be interpreted as "a sin, but only a small sin."[74]

Of course, the religious sentiments were influenced by circulating political discourses. As some observers have noted, in normalizing abortion, Indian population policy may have played a role in attenuating perceptions of the practice as sinful.[75] At the same time, as the widespread invocation of *stribhrunhatyā* suggests, perceptions of sex selection's sinfulness cannot be understood apart from mass mediatized promulgation of a fetocentric discourse hinging on gruesome imagery.[76] Ubiquitous references to *pāp* and killing in public representations of selective reproduction helped to attach sinfulness to abortion in general, as well as its sex-specific variant.

Given the gradual emergence of intrauterine personhood, the relativistic calculus of *pāp* and *punya*, and the circulating discourse of *stribhrunhatyā*, sex-selective intention emerged as a key factor in understanding of ethical transgression. Explaining his longstanding avoidance of selective abortion, one Mahesana obstetrician said:

> When I did it, I was comparing myself to a butcher. I don't feel that routine MTP is a sin. This is part of our regular process. But if someone tells me to eliminate a sex-determined fetus—*that* I feel as a sin. I'm killing *someone*! There's no biological difference, but intention is different... I get a sin feeling—that I'm killing something that's alive.

Many obstetricians echoed this sentiment, locating the wrongness of sex selection in its performance "for a particular gender bias" or "*intentionally*, because it is a girl." Some contrasted routine and selective abortions by referring to the latter as "genocide" or "gendercide." Such views prevailed among facilitators and families as well. The intent behind selective reproductive practices factored heavily into evaluations of its sinfulness.

The moral segregation of sex-selective abortions from "regular MTP" reflects, again, the liminality of prenatal life, which could be purposefully eliminated, but only for "good reasons." One obstetrician invoked the Bhagvad Gita to clarify the importance of intention in distinguishing sinful abortions from meritorious ones:

> If you test the fetus and then take out a girl, it's *pāp*. If you don't need it, and you take it out, that's not *pāp*—that's MTP... See, Arjun says, how can I kill my brothers? Krishna says, you are a warrior, so *pāp* and *punya* don't apply here. Your overall intention is to do something good. If the

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[74] Whittaker 2004: 109; see also Gammeltoft 2002: 325; Whittaker 2004: 133-134. While I have emphasized the Asian Buddhist parallels due to the shared notion of karma, cognate patterns may be found in many other contexts; see, for instance, Paxson's discussion of Greek Orthodoxy's notion of *ikonomia*, which "recognizes that it is ethical to commit a smaller sin in the interests of avoiding a larger sin" (2006: 499-500).

[75] E.g., V. Mazumdar 1994.

[76] Cf. Lafleur (1992: 160-197) and Hardacre (1997: 77-91) on the discursive contexts promoting fetal-appeasement rituals among Japanese women having undergone abortion.

> girl's unmarried, if she's young—then she has a need, so there's no *pāp*. It all depends on what your intention is—good or bad.

As the Gita parallel suggests, the moral calculus around abortions became a matter of deciding not whether termination of pregnancy was violent or not, but rather what the acceptable *uses* of violence were.[77]

Obstetricians generally identified three legitimate grounds for abortion: gender-neutral family planning, fetal disability, and pregnancy out of wedlock.[78] They pervasively opposed these "good reasons" to sex-selective motives:

- "If you have an unneeded pregnancy, and you get it taken out..., that's not killing. But suppose you do it *for this purpose*—to have a boy—then it's definitely killing, definitely wrong."
- "Suppose parents have completed their family, and a third pregnancy comes—that's family planning! If we don't do MTP, the child that is born will not have proper justice in terms of nutrition, all that. So it's not killing—you're doing a justice to that family. But if you base it on seeing a female, of course that's killing."
- "Suppose the child is defective... Then it's not genocide. Then it's for the better future of the baby and the mother, so it's justified—there's a good reason."
- "I just did MTP for a seventeen-year-old-girl. Think how many lives were saved: the girl's parents and relatives, and now she'll be able to get married in a good place. Otherwise... imagine how much people would say to the girl! If the girl is unmarried, the surrounding village, the whole community—everyone will taunt her."

Reproductive rights, financial precarity, the burdens of raising a disabled child, and the scandalousness of "unmarried pregnancy" were invoked to justify abortions aimed at avoiding unwanted fertility, disability, and unwed motherhood.

But similar arguments could be made to justify sex-selective abortion, in a way that made sense within the local moral economy of gender-kinship—not merely to providers, seekers, and facilitators of sex selection services, but also to sympathetic bystanders in communities, clinics, and government institutions. The necessity of sex selection could negate or override the killing it entailed. The three "good reasons" rested on rationales—limiting family size, securing prosperity, avoiding long-term suffering, preserving social belonging—that could and did apply to sex-selective abortion. Avoiding the birth of another daughter allowed families to achieve all this, and

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[77] In contrast to Benjamin's analysis of violent means and their ends in a Judeo-Christian vein (1986), I am referring more to efforts to grapple with the inevitability of violence—and thus the need to "compromise" with violence—in the Hindu tradition (cited in B. Singh and Dave 2015: 241).

[78] Some doctors also mentioned, in passing, pregnancy due to rape, but I did not learn enough about their perspectives on the matter to responsibly discuss it.

sometimes more. The question then became who bore responsibility for joining the moral-economic need with its sinful fulfillment.

Clinicians and Connectors: Dodging, Offsetting, Compensating, Inverting

Participation in sex selection—profitable, needed, perhaps even meritorious, but sinful all the same—engendered deep ambivalence among obstetricians and connectors, as evidenced by Dr. Ranjit's equivocal reflections. Those providing and facilitating sex-selective abortion might dodge *pāp* by shifting blame onto women and their families, as the doctor did. But they could also mitigate *pāp* by dissipating, offsetting, or inverting it.

All four of these strategies came to the fore in Uma-masi's constant waffling on her work, its return, and its sinfulness. The first time she mentioned *pāp* in relation to sex selection, she remarked, "It's definitely *pāp*. To kill a life—it gets distributed to everyone. Half goes to the family—the ones who have the life taken out. And if the doctor has taken out the life, then he's going to accrue *pāp*. Both get it, doctor and family. I also get it."

Then, she smiled and reevaluated:

> But really, why me? The patient takes out the money, and I hand it over—that's it! Why would I accrue *pāp*? I just stay in the middle. You can't really call it anything—no real *pāp* for me. I've gone to do something good for a living being [*jiv*], right? If you ask me to do it, it's good for you, right? And if the doctor does it, what's there left to say to me?

She was dodging blame as Dr. Ranjit did, by invoking the overriding culpability of others.

Then, further revising her own revision, Uma-masi continued, "Anyway, I always push the money ahead. I use it up! Why would I keep money from *pāp*? I mean, I don't really consider it *pāp* for me, but I use up what I earn." Diffusion of ill-gotten gains dissipated the karmic harm from the act.

A few weeks later, commenting on her earnings from a day with several SDs and selective abortions, Uma-masi declared, "However much I earn in *pāp*, I give in *punya*." She listed out gifts she had purchased for family members from the one-day earnings—20,000 rupees. She clarified, "Once I give it away, I no longer accrue *pāp*, since I've done good work. If you earn money through *pāp*, you have to use it up."

Yet, some time later, while reflecting on how an SD result had forced a family into "wrong work," she paused and stated, "But I don't accrue any *pāp*! Why would I? I came to know of them because they lifted a finger. Whoever lifts a finger is the first to get *pāp*. I'm trying to do good, right? Why would I get *pāp*? It's the doctor, and the client... And really, more the patient. The doctor does it, but only when you ask for it." Here, the dodge returned, but now with a subtle inversion of Uma-masi's own actions as "good."

Such complex, ambivalent perspectives, which Uma-masi expressed with regularity, underline they key dynamic of connectors and doctors' moral reasoning around selective abortion: the act was sinful, but they could dodge, dissipate, offset, or

invert the *pāp* by shifting responsibility, exhausting profits, performing redressive good deeds, or reframing their participation itself as meritorious.

In most accounts, the responsibility for sex selection was differentially distributed across multiple "partners in *pāp*." Like Dr. Ranjit and Uma-Masi, most people—including clients—suggested a hierarchy in which patients were at least as responsible as doctors, and connectors perhaps less so. Moreover, Dr. Ranjit and Uma-masi repeatedly emphasized that they never recommended sex-selective abortion and often actively discouraged it, as in Mina-ben's case. But if families desired the service, they maintained, there was ultimately little they could do but provide it.

Obstetricians and connectors could also mitigate *pāp* by using up profits, and by atoning through acts of prayer or *punya*. Uma-Masi and other facilitators claimed to summarily spend or gift the earnings from sex selection. Similarly, Uma-Masi and I suspected that Dr. Ranjit's sponsorship of local temples and religious events—often with tens of thousands of rupees—was a way of "using sin's earnings to wash away sin," as she put it. By allowing *pāp* to be carried away through gifts or exchanges and offsetting it by making merit, clinicians and facilitators avoided karmic harm.[79]

The possibility of offsetting *pāp* with *punya* facilitated the ethical inversion of service provision: because clients perceived sex selection as their desperate need, to enable it was a good deed. Doctors and facilitators referred to their work around SD and selective abortions as "help," "good work," or *seva* [meritorious service], all of which carried the karmic implication of augmenting *punya*. When Uma-masi reflected on the distribution of *pāp* within the sex selection process, she invariably concluded by underscoring that she was ultimately performing a good deed. Other connectors corroborated this view, with one observing:

> In a sense, this thing is *pāp*, definitely—to ruin a life while it's still inside! But at the same time, it's also the work of *punya*. If people have four-five girls, it'll naturally occur to them to want a boy, to keep the door of the house open. So if you look at it that way, it's also *punya*. So from one perspective, *pāp*, and from another, *punya*!

Dr. Ranjit, frequently referred to selective abortion as "social service," albeit sheepishly, and only in passing. But clients corroborated the stance: after receiving "male" results, many said they would pray for God to reward the doctor, and even in the midst of painful and disappointing abortions, some praised his "good work," declaring him "like God" for having removed them from the bing of bearing an undesired daughter. Thus for providers and facilitators of sex selection, there remained a way to renegotiate guilt by reimagining the very character of participation. Because *pāp* was necessary for families, helping to accomplish it was a meritorious act.

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[79] Claims of dissipating *pāp* through financial outlays echoed notions of letting sin or inauspiciousness be carried away through gifts (Parry 1994: 119-150; Raheja 1988: 37-188), particularly when facilitators described the outlays as either gifts *per se* or altruistic expenditures. The notion of making merit to minimize the negative consequences of abortion is one that is attested both for Hindu North India (T. Patel 1994: 182-183) and Buddhist Southeast Asia (Whittaker 2004: 134-135).

"A Necessary Sin"

For their part, families usually admitted that most of the *pāp* of sex selection accrued primarily to them. Echoing Mina-ben and Gajendra-bhai, many accepted the brunt of moral responsibility by pointing out that facilitators and doctors acted only at their behest—"The doctor didn't come looking for us!"

At the same time, when initiating selective abortion, many clients lamented being trapped in a situation where they felt like "we have to do wrong deeds" or "we have to commit *pāp*." Such statements indexed the rueful recognition of sex selection as a tragic tactic for negotiating a moral economy of gender-kinship that bestowed burdens through daughters, benefits through sons.[80] Although shameful and wrong, sex-selective abortion sometimes felt inevitable when a hopeful narrative collapsed in disappointment, leaving pragmatism to trump karmic considerations.

In thinking about sex selection as an imperfect solution to the dilemma that female fetal subjects presented, I have often returned to Damini-ben and Govind-bhai's case. That hot, dusty afternoon in Govind-bhai's office, as he recounted unsuccessful *bādhās* and declared an intention to pursue SD in the next pregnancy, it was clear he considered sex-selective abortion profoundly wrong. Leaning over her desk, he told me gravely:

> See, in the previous pregnancies, if we got it checked, and it came out a girl, we would've felt like getting it taken out. That's a life—a thing nature has given. If you get it taken out, that's *pāp*! Killing a human—that's the *greatest* killing. If we do that, the universe will surely get after us.
>
> Before, people used to make girls *dudh-piti*. Once a girl was born, they would kill her on the spot, at home. Now, there's no issue of doing *dudh-piti*: at three months, you go to the doctor, give him money, and he looks for you and does the work. Before, people did that because the technology wasn't there. But this is also committing *pāp*: it's *bhrunhatyā*.

In concluding his reflection on selective abortion's immorality, Govind-bhai pivoted to the indeterminate future: "But we've thought it out. We've reached the position where *pāp* seems right—if we have to do it, we'll feel like we have to do it. It's a sin, but it's a necessary sin."

Govind-bhai's reflections on the "necessary sin" echo Gita-masi's from the beginning of Chapter 2. While seeing sex selection as a heinous misdeed, both had already made their peace with pursuing it as a last-ditch option. The moral stricture against killing was strong, but not as strong as the compulsion of a moral economy that necessitated separation of daughters and made sons the only mechanism of social continuity.

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[80] Cf. Whittaker (2004: 135-139) on the rhetorical personification of poverty as a force coercing Thai women into abortions.

Govind-bhai and Damini-ben felt they would have to pursue the sinful killing of a potential daughter because it was the clearest path to the production of the necessary son. Repeated *bādhās* and consistent faith had failed to yield a son, leaving them facing the bodily limits of reproduction itself. For them, as for so many families, the *pāp* of sex selection offered coping mechanism when the conditions of social reproduction—son necessity and daughter alienation—imposed themselves atop the hard constraints of procreative chance.

Chapter 6: Anti-Sex Selection Discourse

Ever since the 2001 Supreme Court rulings mandating "awareness campaigns against the practice of prenatal determination," government institutions, non-governmental organizations (NGOs), and sundry others have poured countless time and resources into efforts to reduce demand for sex selection in India. Considerable applied research has also tackled the questions of how best to effect "communication," "education," "awareness," or "exposure" around skewed SRs and threatened daughters.[1]

In Gujarat, the Beti Bachāvo campaign and related programming have long deployed a wide variety of techniques. As early as 2005, an NGO "communication campaign" in the Mahesana region was utilizing "house-to-house contacts, neighbourhood meetings, street plays, Bhavai (traditional forms of plays with music), rallies, road shows, essay competitions, open dialogues, CD shows, social audit, fairs, [Youth Fair], and public meetings," as well as "exhibitions... on strategic pathways of pilgrims during popular religious events, malls and other public places."[2] To this sampling, one could add the resort, over the past decade, to radio and television advertisements, art exhibitions, murals, essay and speech contests, pamphlets, books, poems, posters, and the ubiquitous Information-Education-Communication (IEC) events held by local branches of the Health and Family Welfare Department (HFWD).

Rather than attempting an exhaustive survey of these materials and strategies, which have publicly proliferated far beyond anyone's capacity to fully catalog them, I attempt in this chapter to examine some of the ideologies embedded in discourses of the threatened daughter. I draw primarily on HFWD materials such as Beti Bachāvo posters and pamphlets; privately printed books and artwork; observation of IEC events; and conversations with government officials, activists, and target families.

Efforts to "save the daughter" interpellated female fetal subjects as "fetal citizens" in need of protection by the (masculinist) state.[3] As attempts to incite reproductive subjects to self-regulate in accordance with state rationalities of population management (most notably "balance"), activities around the threatened daughter were quintessential instances of biopolitical intervention.[4] Postcolonial governance in India exhibits a long history of such intervention, with the regulatory fusion of household-level family planning and collective population control serving as a key channel for production of a distinctly Indian modernity.[5] I discussed in Chapter 2 how the "modern," officially valorized trend of fertility decline played a key role in the rise of sex selection. Here, it

[1] E.g., Jejeebhoy et al. 2015: 34-48; Joseph and CYDA 2007: 79-85; MacPherson 2007.
[2] Vakharia 2009: 32.
[3] On fetal citizenship and state protection, see Berlant 1994; Casper and Morgan 2004; Holc 2004; Mason 2000. On the masculinism in the state and the dangers of appealing to the state for redress of gender violations, see Brown 1995: 166-196.
[4] Foucault 1990: 139-157.
[5] Chatterjee and Riley 2001; Ram 2001; M. Rao 2004; Simon-Kumar 2006: 129-167; Van Hollen 2003.

bears noting that state regulation of Indian women's reproductive capacities also ties to colonial and postcolonial histories of women's bodies as key sites for the elaboration of national identity.[6]

The last point highlights just one way reproductive governance may link to the affective realm in which much of the modern state's institutional power operates.[7] Fetal imaginings may bind state and citizen through shared sentiments of anxiety, fear, hope, and aspiration.[8] But correspondence of sentiments is by no means guaranteed. The pedagogy associated with states' modernizing projects may fail to produce the desired subjectivities.[9] Even while patiently nodding along to public discourses, citizens may practice a "politics of duplicity" in private reproduction.[10]

In general, I did not see Beti Bachāvo and related programming addressing families' deepest concerns—at least not in ways that would effectively divert them from the pursuit of sex selection. Nevertheless, even such instances of failure can reveal much about the state, its ideologies, and its functioning.[11] In this chapter, I examine how the state performed itself, and how citizens experienced it, through an examination of the public representations and everyday practices that made reproductive governance palpable.[12]

In many ways, my analysis echoes Rajeshwari Sunder Rajan's appraisal of anti-female infanticide initiatives in Tamil Nadu, which concludes that unwanted girls became "children of the state."[13] Considering three different framings of female infanticide—crime, demographic imbalance, and gendered violence—Sunder Rajan has highlighted how state interventions constructed the problem as one of deeply entrenched tradition and social backwardness, thereby making its eradication a civilizing mission while prefiguring the difficulty of fulfilling that mission. Similarly, in evaluating the Chinese state's responses to the conjoined problems of "missing girls" and "excess males," Susan Greenhalgh has emphasized the importance of dissecting population discourses (such as the stigmatization of poor rural men) and constantly considering alternatives.[14] Her work pushes us to consider the work biopolitical framings do, and to imagine how things might be otherwise.

Building on Sunder Rajan and Greenhalgh's approaches, I analyze governance discourses about sex selection as organized around three core ethical figures: the backward family, the imbalanced population, and the threatened daughter. By both presuming and acting on these figures, governmental and non-governmental pedagogic practices sought to modernize traditional mindsets, optimize the distribution of citizen bodies, and protect future women. In examining how governance activities missed their

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[6] Das 2007: 18-37; R. Menon and Bhasin 1998: 31-130; cf. Mayer 2000; Yuval-Davis 1997. Also see Kahn 2000; Kanaaneh 2002.
[7] Aretxaga 2003; Stoler 2010.
[8] Gammeltoft 2008, 2014b.
[9] Kipnis 2011.
[10] Kligman 1998.
[11] Nugent 2010.
[12] Cf. A. Gupta 2012; A. Sharma and Gupta 2006.
[13] Sunder Rajan 2003: 177-211.
[14] Greenhalgh 2001, 2012.

marks, I consider what such failure reveals about not only the state and its associated discourses, but also the familial experience of selective reproduction.

The Backward Family

"There's a Need to Increase Awareness"

One afternoon, I visited a Block Health Office responsible for administering Health and Family Welfare programs in a Mahesana subdistrict. The Information Technology (IT) officer—a young man, sprightly, in glasses and a short-sleeve collared shirt—met me as I entered from the muggy heat. He gave a brief tour of the facility, pausing patiently at the storage go-down so I could photograph some spare Beti Bachāvo posters.

Back at his computer, the IT officer pulled up photographs of local IEC activities. First was a recent Beti Bachāvo program. The Block Health Officer (BHO) and several other dignitaries sat atop a dais, microphones on the table in front of them. A hundred women in saris—community health workers—sat on the ground. The IT officer explained:

> Here, we've gathered all the Anganwadi and ASHA [Accredited Social Health Activist] workers. Saheb gives a presentation—that the sex ratio is low, and this and that—to bring awareness. There's a need to increase awareness. That way, a mindset gets formed, and they can go to people in their villages and make them understand. Every pregnant woman should hear this: 'If it's a girl, don't kill her; we need both in society. And if anyone pressures you, tell us." That way, even if they go get it looked at, this is in their minds—they have a sense.

The BHO, he said, folded "a bit of everything else"—malaria, tuberculosis, malnutrition—into the event, using the gathering to deliver other programming messages to the assembled workers.

Since the IT officer had apparently snapped the pictures himself, I eagerly asked "what the audience response was." Squinting, he shook his head: "There's no response in this. It's a presentation from Saheb." He explained that the office held many such presentations, addressing not only community health workers but also the "public" in the subdistrict's villages. Then, he shrugged: "What else can they do to change people's mindset? Nothing more can be done."

The IT officer then showed photographs from seminars and rallies the office had organized during the ongoing World Population Stabilization Fortnight. In one, schoolgirls marched behind a banner bearing the slogan "The Small Family: A Pillar of Welfare"; the third girl in line held a sign declaring, "Boys and Girls Are Equal." In others, clusters of women sat in front of lecturing officials backed by banners with well-known family planning slogans. At several points, the IT officer paused, straightened his shoulders, and formally enunciated the phrases. He emphasized the difficulty and importance of encouraging the "local public" to "keep the population in control."

Eventually, when we exhausted the images, the IT officer cocked his head to one side. Deploying an anti-sex selection slogan as a metonym for the practice itself, he mused:

> Of course, if 'Beti Vadhāvo' stuff happens, it's ultimately because people want to reduce the population. They think, 'How many can we afford?' So they have a selected two-three—really, more like one-two. And that's where the selection issue arises.
>
> Before, with three-four, there'd be two and two. Before, six-seven kids was nothing. Infant mortality was higher. The mortality rate decreased with increasing medical services, so we got the system of two-three children. Now, they understand *monghvāri*'s increased and it'll be hard to sustain so many girls. And the daughter goes to her *sāsri* after marrying but still remains a lifelong burden.
>
> Of course, in the long term, there'll be benefit! If the population's controlled, basic needs'll be met.

"Then," he concluded, "the people who consider this now will reconsider: 'Boy-girl doesn't matter.'"

Pushing back against the facile narrative of progress, I asked whether people with one girl would not still feel that "*chhokaro joie.*" The IT officer nodded knowingly: "Absolutely. That's why families become so large! People feel someone has to do the final rites, and only a son can do that. Then there's keeping the home open. And then dowry... There's such a difference between daughters-in-law and daughters!" With that, he shrugged and offered to introduce me to the IEC officer.

The IEC officer—tall and rail-thin, with a pencil mustache and a velvety voice—recapitulated the format of "awareness" events. Coming to my specific topic, he intoned gravely, "This is a huge social problem! And it'll have very bad consequences." After elaborating at length about the rising rate of intercaste marriages because of "shortage of girls," he suggested that PCPNDT-related stings, surveillance, and fear had decreased sex selection—or at least driven it underground.

Then, the IEC officer admitted, "Things remain difficult. The whole family will want a boy. And the woman herself will also desire a son." With rising *monghvāri*, he said, people were "choosing small families—so if they have two girls, there will definitely be an expectation in the third."

I asked how IEC activities impacted the situation, and the officer assured me, "The events are full of women. I give them the example of some colleagues—doctors—who have only girls. I say, 'If you have an income, even if it's from hard labor, why not welcome a girl."

Then, he frowned. "But in the third pregnancy, almost everyone goes for a check. It's hard." He shook his head. "Our male-dominant society, that's the thing hindering us. Men have all the power."

His face brightened. "But the women never say, 'No, what you're saying is wrong.' They know it's true." Reflecting on his presentations, he said:

> Right now, we're more focused on World Population Fortnight. We just sprinkle in some talk about Beti Vadhāvo. But when we talk about Beti Vadhāvo specifically, we emphasize that daughter-son should be considered equal: 'Don't keep any bias. Accept all.' We talk about the disadvantages to a woman of going through six-seven pregnancies. This, too: the burden on a son of having the responsibility of six-seven sisters.

"It goes down pretty smoothly," he assured me. "We don't have to shove it down their throats."

I asked whether women in the village events ever asked questions. The IEC officer shook his head:

> Not really. When we give information about breastfeeding or something like that, they do. With Beti Vadhāvo, they don't go deep into it. They accept. But then again, no matter how good a message we deliver, those with two girls will feel—for the third—'*Chhokaro joie*.' Obviously, *they* won't ask any questions. And the problem is our Indian society; the decision-making power is with the man and the mother-in-law, not the daughter-in-law.

He listed off the various "customs" that drove families to continue seeking sex selection: the daughter's inevitable departure to her *sāsri*, the lifelong burden of *vahevār*, the son's role in inheriting property and keeping the home open, and the normative expectation of old age care from the son and daughter-in-law.

Stretching and yawning, the IEC officer concluded by assuring me, "But now, there's not so much of a *bhrunhatyā* scenario. Only in very small-town type places."

"Knowledge, Attitudes, Behavior"

My conversations at the block health office exemplify how governance interventions around sex selection located the practice within families and "mindsets" constructed as backward. Despite ample everyday evidence to the contrary—evidence the IT officer and IEC officer readily acknowledged—both official discourses and individual statements treated the problem as fundamentally one of poverty, ignorance, or anti-modern intransigence. This treatment corresponded to a particular pedagogic model for discouraging sex selection. It also highlighted tensions with the modernities and rationalities of family planning and population control.

Speeches, pamphlets, books, and essays pervasively associated sex selection's underlying "gender bias," "sex discrimination," and "boy-craziness" with "customs," "inclinations," or "beliefs" disparaged as "old" or "uncivilized." In a pattern paralleling the discourse around female infanticide in Tamil Nadu, government officials, activists, obstetricians, and other citizens often steadfastly asserted, as the IEC officer did, that the

problem belonged disproportionately to the rural or poor, despite strong statistical evidence to the contrary.[15]

The imputation of backwardness bore distinctive gender-kinship inflections. Both explicitly (in the content of discourses) and implicitly (in the targeting of discourses), governance interventions constructed women's minds as those that required changing. Moreover, as discussed in Chapter 4, the offending women included not only the "cruel mother," as many poems and pamphlets called her, but also the domineering mother-in-law. The approach stigmatized women in particular as "bad" or "backward."[16] At the same time, it made individual feminine subjects responsible for fixing structural problems through virtuous, empowered action.[17]

The construction of sex selection as backward practice fit into a neat historical genealogy. Often laid out in sweeping terms, the timeline moved from an ancient period of supposed gender equality or harmony into a pre-modern era of increasing female subordination and devaluation, with Muslim and British incursions often cited as the reasons for the transition.[18] The pre-modern nineteenth century became the site of rampant gender evils, ostensibly corrected through the civilizing efforts of British and native reformers but now resurging in the form of selective reproduction. Despite the historical and local specificities of sati, female infanticide, and dowry, the three practices became rhetorical crops with which to flog those pursuing sex selection. Rajput widow immolation in colonial Rajasthan, Leua Patel infanticide in nineteenth-century central Gujarat, and Jat dowry in present-day Punjab were loosely invoked (usually without such specification) to condemn all families seeking SD or selective abortion. Furthermore, reformists like Ram Mohan Roy, Shahajanand Swami, and various British administrators—highly complex figures with ambiguous relationships to gender issues—appeared as exemplars of the efforts needed to combat sex selection.

The backwardness model implied that progress depended on families and individuals embracing girls and thereby emerging from a hidebound tradition into a progressive modernity. Consequently, saving daughters required a biopolitical approach centered on enlightenment and responsibilization of reproductive subjects. Even while drawing on notions of backward social mores, Beti Bachāvo programming and related efforts individualized and psychologized the problem of daughter aversion, largely bracketing off the collective morality and materiality of gender-kinship practices.

The enlightenment or awareness paradigm found its formal expression in the standards that structured government education activities and heavily influenced other efforts. National Health Mission materials from the Gujarat HFWD listed Beti Vadhāvo as a chief IEC domain (along with antenatal care, safe delivery, family planning, and support for various national programs).[19] The definition of the approach reflected its focus on transforming minds:

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[15] Cf. Srinivasan and Bedi 2009a: 11-12; Sunder Rajan 2003: 196.
[16] Van Hollen 2003: 193-194.
[17] Cf. Madhok et al. 2013: 4-5; K. Wilson 2013.
[18] For a brief overview of this paradigm of historical myth-making, see Chakravarti 2008.
[19] National Health Mission 2015.

> [IEC] is used for generating awareness. It means process of working with individuals, communities & societies to develop communication strategies to promote positive behaviour that are appropriate to their settings... Strategic IEC... programs use a systematic process to understand people's behaviour and influences. A successful IEC... plan would help in refuting myths and misunderstandings prevalent in the society... thus bringing about a behavioural change among individuals and the community at large. [20]

The National Health Mission website further schematized IEC's roles as a series of concentric circles, from "encouraging/motivating" on the outside through "shaping opinions/attitudes," "persuading," and "informing" to "advocacy" in the smallest circle.[21]

Bipin-bhai, the director of a Mahesana-area NGO actively involved in several anti-sex selection campaigns, further substantiated the paradigm when he explained to me:

> We intervene with newly married couples—because they're going to become parents—around the question of boy-girl, to change the mentality of *chhokaro ja joie*. We do it on the basis of 'Knowledge, Attitudes, Behavior.' This is a standard approach: if you give knowledge, attitudes change, and that changes behavior. So if I have a conversation with them, give them information, then they will change their thinking, and perhaps put that into action. If your relatives say, 'Let's get it looked at, boy-girl'—we've given counseling to give you the idea to not get it done.
>
> Now, knowledge includes information, like the 0-6 sex ratio. It also includes matters that touch the heart. So the other person gets sensitized... We give the whole history: Vedic, Muslim, British. Then what was the custom of sati, how did they make girls *dudh-piti*. So that pinches the heart. Then we say, 'Today, the fetus is being killed.' We describe that whole process, so that sensitizes people to what they are doing. Knowledge makes the individual so empowered that he can solve his own problem...

Within the standard public health behavior change paradigm (Knowledge-Attitudes-Behavior), sex selection became a matter of misguided behavior resulting from insufficient information and improperly oriented attitudes. Governance interventions could protect female fetal subjects from their backward families by imparting enlightening, affectively compelling knowledge. As my block health office conversations indicate, such knowledge delivery was often a distinctly unidirectional affair, with limited effort to "understand people's behaviour and influences"—or to apply moral-

[20] National Health Mission 2015.
[21] National Health Mission 2015.

economic understandings most officers already possessed by virtue of everyday social interaction.

Anti-sex selection functions, writings, and artistic productions often operated on the model of pedagogic revelation. Presentation of some previously unheeded thing—sex ratio statistics, female fetuses' tender voices, gruesome images of *stribhrunhatyā*, sweeping generalizations regarding gender inequality—would increase "awareness," ensuring that "a mindset gets formed," as the IT officer explained.

Among caste organizations and other NGOs, such pedagogy often worked toward overtly conservative ends. Many Patel *gols*, for instance, folded discussions of sex selection into "anti-vice" functions that also covered alcoholism, tobacco use, premarital sex, and elopement. In such instances, cerebral information delivery and emotional exhortations functioned less to dissolve backwardness and more to control social reproduction. Such control frequently bore little relation to gender justice, as evidenced by numerous printed materials, speeches, and conversations in which sex selection was grouped with divorce, elopement, and voluntarily single women—all "calamities laying siege to marriage arrangements," as one pamphlet put it.

Within government institutions, the pedagogy of enlightenment ran into somewhat different problems. First, bureaucrats rarely descended into dialogue around sex selection with village women, leaving community health workers to "go to people in their villages and make them understand," in the IT officer's words. But the social embeddedness that positioned Anganwadi and ASHA Workers to best converse frankly with "beneficiaries" made it exceedingly unlikely that they could or would parrot official IEC discourses about selective reproduction. As many told me, they understood how people felt—commonsensically, given the shared moral economy of gender-kinship—and would hardly presume to lecture people with supposedly transformative but practically out-of-touch declarations. The absence of Beti Bachāvo exchanges between community health workers and their neighbors reveals how constructions of backward mentality crumbled in the face of shared recognition that "backwardness," if it could be called that, pervaded the moral world. When officers from the block health office came to speak, women listened quietly, with social distance and deferential silence preserving the fragile illusion of an enlightening encounter. The bureaucrats could fulfill official duties, temporarily suspending their own intimate knowledge of the kinship and fertility pressures that drove families to SD and selective abortion.

Second, efforts to "enlighten" people into accepting girls conflicted with the state's own family planning and population control rationalities. Contrary to what the backwardness model might suggest, families pursuing sex selection were *already* acting as modern reproductive subjects.[22] There existed a tension between the general promotion of gender-neutral antinatalism and Beti Bachāvo's promotion of gender-specific pronatalism.

As indicated by the IT officer and IEC officer's references to *monghvāri*, fertility decline, and population control, government functionaries could readily recognize sex selection as a family planning mechanism. But the state could not acknowledge as much

[22] Cf. John et al. 2008; T. Patel 2007a.

without undermining one of its projects. Official discourse resolved the contradiction by endorsing each project independently of the other: daughter acceptance without reference to number of children, family planning without reference to gender. For instance, public messaging on the fence around the Mahesana Block Health Office juxtaposed two potentially contradictory slogans: "Small Family, Full Progress: Two Children Is Enough" and "Stop *Stribhrunhatyā*, Celebrate Daughters." Discourses, incentive programs, service offerings, and legal provisions (such as exclusion of people with more than two children from certain public positions) aggressively promoted a two-child norm, while anti-sex selection programming discouraged families from taking steps to ensure they reached the (male) end of reproduction within two births. The failure to address the crucial and obvious tension-producing factor—son necessity—was part of what led so many families to characterize Beti Bachāvo as a program out of touch with gender-kinship realities.

Unbound by the same constraints as the state, citizens often refashioned discourses around sex selection and population control to portray the former as a support to the latter. While denouncing the selective abortion of potential girls, some obstetricians bluntly stated that it did decrease the future number of "factories for generating children." Like Jiten-bhai and Sagar-bhai, many sex selection clients explicitly constructed the practice as a method of "control" that ensured people "don't just keep popping out kids."

Characterization of both high fertility and sex selection as insufficiently modern behaviors filtered into everyday life as part of broader contradictory discourses around the backwardness of certain classes, communities, or regions. Early in my fieldwork, a middle-aged neighbor asked why I had come from the U.S. to Gujarat. After I provided a brief summary of my research aims, he nodded and said, "Let me explain it to you. The issue here is education. The people who do *bhrunhatyā* are uneducated. They can't extract their minds from social orthodoxy."

Perhaps seeing from my face that I was about to challenge his account, he preemptively raised a hand and clarified, "So these people are either uneducated, or they're educated people who *make* themselves uneducated! Get it?" A he went on his way, I thought of his daughter and son-in-law—both holders of master's degrees—whose SD from several months earlier his wife had quietly disclosed to me.

Almost a year later, the same neighbor and I sat lounging on a pair of plastic chairs in our neighborhood's common plot, relishing the occasional wisps of post-sunset breeze. After asking about my research progress, he waited for only a sentence of response before interjecting with a five-minute disquisition on how last rites and property inheritance made people desire a son. He then continued:

> This is most so among people who are ignorant, uneducated. See, I live in the city, I'm educated, so I'll believe that if I have a daughter, my son and daughter are equal—just as Narendra Modi says. But in the village, where people are ignorant, where there's zero awareness—there, it'll take the government a long time to bring awareness. In some parts of Bihar or U.P., there's not even the most basic educational infrastructure. How can the government bring awareness to even a 90% level? See, what happens

> is that people don't have any schooling, so then they believe, '*Chhokaro* joie'—as an heir, to perform the rites, to keep the house open. So then they do *this*.

He arched his eyebrows, apparently seeking my acknowledgement.

I began saying that the population statistics widely circulating in public media located the highest levels of sex selection in the most educated states; that urban areas exhibited higher levels than rural areas; and that the practice's prevalence rose rather than falling with education. Before I could complete my explanation, he nodded and interrupted:

> Yes, yes! There's a reason for that. The educated class has awareness: 'I should have just two kids. If I bring home more than two, then many difficulties will arise—clothing, feeding, raising them. And if it's a daughter, at least 1,000,000 in cost, inevitably.' If I have one daughter, I'll plan to give everything else to my son after marrying her off. But if I have two-three daughters, then the costs'll increase accordingly...
>
> Whereas in the village, the totally ignorant, totally uneducated—they'll think it's no problem: 'The child'll bring its own fortune.' It's no problem to them even if they have four-five-six-seven kids. So people like that don't do this. They don't get sex testing done, and they don't even know it exists. And they don't get abortion done. While among people like us, if you already have one girl, a state of fear arises as soon as there's a second pregnancy: 'Boy or girl?' So among educated people, the proportion's higher for this reason!

"See," he concluded, "city thinking and village thinking are different things altogether."

Like many people I encountered, my neighbor constructed a "geography of blame" for sex selection. Sex selection became a shifting signifier, differently connoting ignorant tradition and rational modernity based on where it was located. Like most, my neighbor began by locating the problem *elsewhere*, in a place or class ostensibly beset by backwardness: Bihar and U.P., which were so poor; Rajasthan, which historically displayed such "male-dominance"; Punjab, Haryana, and central Gujarat, which had such high dowries; Kutch and Saurashtra, which had unpredictable agriculture and social "orthodoxy"; the Thakors and Scheduled Castes, who put their children to work; the Chaudharys and Rabaris, who paid brideprice and so "don't really appreciate girls"; the Rajputs, who stuck stubbornly to their old martial ways; the uneducated, who simply did not know better. If evidence revealed a lower prevalence of selective reproduction in the designated community, the backward-modern evaluations could remain the same, with simple inversion of the signifier: the others were so ignorant that they did *not* practice sex selection, failing to act as responsible reproductive subjects within the national project of population control.

But if high fertility represented one threat to local, state-level, and countrywide biopolitical management, what of sex selection? How did the gender-selective family planning represent a threat to populations?

The Imbalanced Population

"Because We Didn't Let Daughters Be Born"

"In 2014, thirty-nine boys and seventeen girls!"

Seated behind a long table, backed by a large banner, Hitesh-bhai thundered down at the young and middle-aged women assembled before him. He apparently intended to take a fire-and-brimstone approach to the "IEC function" in a village just south of Mahesana.

"In your village, only seventeen girls against thirty-nine boys. Think hard about it!" With this preface, the Hitesh-bhai launched into a fifteen-minute lecture about the causes of *bhrunhatyā*, periodically pausing to remind the women, "This is why you make your daughters-in-law go for the sonography! This is why you ask the doctor to take it out!"

Shifting from causes to consequences, Hitesh-bhai softened his voice. "Now," he said, "let me give you an feample from my own village." He drew out the ensuing words: "*In my village, seventeen men couldn't find wives in their own communities*! Listen up!"

He continued:

> Seventeen men couldn't find brides of their own caste. They tried-tried-tried everywhere, but they couldn't. Then they thought, let's try somewhere outside of Mahesana. They took a jeep and went around all of North Gujarat, but they couldn't find anyone to give them a wife.
>
> So then they thought, let's go somewhere *outside*. One man went to Baroda and brought back an Adivasi woman. One man went to Khedbhrama and brought back an Adivasi woman. Men from two families went to Bharuch and brought back from there. Got it? Now all seventeen men are married, and all the wives are from outside communities.
>
> Sisters, now think of the situation that arises! What did these outside wives do after arriving? You know how a daughter-in-law should behave—can't talk back to elders, must cover her head before elders. What did these women do? They started wearing *dresses*! What do they care? They started walking around the whole village in *dresses*! So then what happens? If they're my neighbors, then my daughter-in-law will also think, 'If the next-door lady wears a dress, why shouldn't I?'
>
> Beware! Our *sanskār* [culture, manners] are changing! Now, daughters-in-law remain sitting on chairs and make their fathers-in-law sit on the ground. Now, if you can't even criticize your daughter-in-law anymore, what can you do? Just sit there, right? Why did the neighborhood's *sanskār* go bad? Because they brought girls from outside.

> And why did they have to bring from outside? Because they couldn't find anyone in the community. And why couldn't they find in the community? Because we didn't let daughters be born! Remember this. We all did this—wished only for boys.
>
> I can show you a village in Unjha subdistrict where there are three women from the same family—from over there, the *outside*. One married a Patel, one a barber, and the third a Thakor. Now imagine you are the Patel family. If the barber's wife comes to your house—they are sisters, after all!—then you have to feed her, right? Now what kind of condition is that, if you have to feed her? Think about it, sisters! What kind of situation arises! There were all kinds of disputes—it'd look bad if they visited each other, and bad if they didn't (being sisters). Eventually, those families had to leave the village!
>
> So look. What's the main reason for our social problems like this? That we don't let daughters be born. I say, as far as possible, welcome whatever is born in your families. If it's a girl, celebrate. And if it's a boy, join your hands and pray. Because tomorrow, people will be bidding on girls. If you want to marry your sons, sisters, you will have to pay money!
>
> The other thing is that if boys don't find girls, then they'll kidnap our daughters when they're out in public. You must know that cases like that have begun, too. In the future, if there are fewer girls than boys, rape and crime and all that'll increase a lot.

"So," Hitesh-bhai intoned gravely, "realize that it's necessary for us to think this way—'We won't do this anymore.'"

"Let's Fulfill Our Social Responsibility"

Alongside the personified female fetus herself, the imbalanced population was a key figure for rendering visible the existential threat to daughters in the Mahesana area. Statistical and impressionistic renderings of "shortage" manifested sex selection as a collective crisis with grave consequences for community, society, and nation. But representations of skewed SRs frequently missed the mark by proposing population balancing as a household desideratum, and they sometimes even reinforced the daughter aversion they sought to rectify.

In an echo of colonial infanticide responses, government institutions, journalists, activists, and common citizens constantly recirculated Census or Health Department SR figures in attempts to capture the magnitude of the sex selection problem (much as I have in this dissertation).[23] Government posters, NGO pamphlets, newspaper articles, and television news segments overflowed with numbers, graphs, and tables that emphasized the drastic shortfall of girls. Political speeches, "awareness" events, and everyday conversations abounded with references to population imbalance. As suggested by Hitesh-bhai's citation of a single village's birth ratio during one year, such references did

[23] For a deconstruction of the SR as a disciplinary technology, see Purewal 2014: 467-473. For a discussion of numbers as "technologies of truth" for measuring gendered violence, see Merry and Coutin 2014.

not always invoke India, Gujarat, or even Mahesana District as the relevant collective. In targeted IEC efforts, government officials and NGO activists frequently presented highly localized figures. Similarly, sub-caste organization leaders and publications frequently used the results of community censuses to highlight the "missing girls" within their own communities—an enterprise impossible for the state, given the lack of caste-specific enumeration for all but a few groups since independence.[24]

Colonially and post-colonially, Indian governance has historically relied on harnessing statistical knowledge to manage populations.[25] In anti-sex selection efforts, however, numbers did not merely support administrative interventions. Their recirculation was aimed at enlightening an ignorant populace, eliciting affective responses that would tie responsible subjects into the shared project of saving girls.

Quantitative demonstrations of the collective need to restore balance highlighted how sex selection threatened social reproduction. Many printed materials juxtaposed images of threatened daughters—for instance, an *in utero* infant being strangled by a noose—with phrases like "Can you imagine a society without girls?" (See, for instance, the advocacy book panel in Figure 4.) Local obstetricians widely displayed a pharmaceutical company-provided "Glorifying Womanhood" leaflet (Figure 5), which warned, "Woman Gives Birth to a Civilization: Save the Girl Child. Those Killing Girls in the Womb—Wake Up!" Many posters and essays caution that *stribhrunhatyā* would "destroy lineage, community, village, country, and nation!" In an echo of the fact that India's social contract was always premised on a domestic sexual contract, representations of population imbalance concretized threats to social continuity at various levels, from the household through the caste community and all the way to the national polity.

Warnings regarding "shortage of girls" and its consequences often veered in a decidedly masculinist direction by focusing on "all the men who can't find wives." In fact, the marriage crisis was perhaps the single most frequently cited negative consequence of population imbalance.[26] Essays and poems with titles like "The Anguish of the Unmarried" excoriated "those committing *stribhrunhatyā*" for reducing the supply of future brides. Printed materials and IEC events like the abovementioned routinely depicted marriage prospects as the chief reason to correct skewed SRs. Daughters became valuable primarily for their circulation as daughters-in-law.

Whether implicitly or explicitly, invocations of marriage crisis always tapped into anxieties about caste and class mixing. In instances like Hitesh-bhai's IEC lecture, the incitation to alarm appeared quite explicitly. Explaining his own use of the same tactic, activist Bipin-bhai said:

> When I go to the village level, I emphasize how we have to pay attention to certain grave social consequences that are emerging because the sex ratio is decreasing. For instance, the social mixing taking place. What will

[24] For the post-1931 invisibility of caste (outside of specific scheduled groups) in population data, see Guilmoto 2011: 31.
[25] Appadurai 1996: 114-138; B. Cohn 1987: 224-254; Cohn 1996.
[26] For an extended discussion of the marriage squeeze and responses to it, see Sandesara ms.

> its outcome be after fifty years? There was recently a report on the BBC—you may have seen it, too—that the arrival and mixing of people from many different communities has led to changes in the DNA of the local people in DNA. So I highlight that kind of thing: how the situation is very bad, with Gujarati Patel men having to bring in Surati women—*Adivasis*—and how illiterate and college graduate are marrying one another.
>
> For example, if I go to a Navratri function at the village level, the Adivasi brides—fifteen, twenty-five, however many—will always be dancing *garbā* together. And you immediately know, okay, this village has this many girls from outside. Their clothes and accessories are nice, like ours, but from their dance style, you immediately know they're outsiders. So I highlight this, too: how is your community changing because of these tribal women, and what will this cause after fifty years?[27]

Bipin-bhai added that he also informed villagers about how skewed SRs were driving local bachelors to frequent commercial sex workers and consequently raising rates of HIV infection. In this, too, saving girls became largely about benefitting men who would otherwise find themselves "with no choice"—as many government officials and activists put it—but to violate sexual boundaries.

In keeping with the state's broader silence around many issues of community reproduction, caste- and class-based rationalities never appeared explicitly in printed materials decrying skewed SRs. But as should be apparent from Bipin-bhai's approach, or from Hitesh-bhai's parable of the three sisters, anxieties regarding social miscegenation lurked just below the surface of official discourses, often bursting forth in the everyday practices that made governance palpable. Even without allegorical illustrations like Hitesh-bhai's, citizens readily understood the subtext in bland official lines like "Many men are now unable to find brides in their own communities."

When governance discourses focused on SR balancing for the sake of women themselves, the argument often rested on alarming visions of a future filled with violent

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[27] Journalist Gita Aravamudan described a very similar approach in her journalistic account of anti-sex selection activism around Mahesana in the 2000s:

> In Anandpur, during our session with the women, Dhrupad Joshi had said, 'The original Patels are getting destroyed. If you continue to kill off your girl children, you will have no women left. And when you want to get your sons married you will have to search for a Patel girl with a pair of binoculars! As it is many of you are going to tribal areas and buying girls for your sons. Soon the original Patel features would have disappeared. All your children will have adivasi features. Is it not ironic that you destroy your own daughters and go and buy daughters-in-law from somewhere else?'
>
> It was a shocking and disturbing speech.
>
> 'You were shocked?' Joshi asked in a satisfied tone. 'Then I am pleased. My objective has been achieved. I want to shock these people so that they will stop doing what they are doing. All our goody-goody speeches have not worked. Ife have to really shock them into action now.' But I was shocked not by the fact that Patel children would have adivasi features. But by the fact that caste purity was being used as a strategy to curb female foeticide (2007: 139-140).

bachelors. Like Hitesh-bhai in the village, many government functionaries warned that gender imbalance portended rampant rape, kidnapping, and sexual harassment. Such warnings often exerted frankly counterproductive effects. Many couples seeking SD and selective abortion justified the practices with reference to governmental and non-governmental representations of dystopian futures. With the *jamāno* becoming ever-worse due to the shortage of girls, they argued, it would be grow even more difficult to protect young daughters from sexual violence; better, then, to not gather more than one.

This paradox—the *reinforcement* of sex selection motivations through arguments ostensibly targeted at eroding them—reflected a fundamental contradiction at the heart of governance institutions' balance-centered arguments. In presenting aggregate SRs as motivations and targets for combating sex selection, the state and NGOs asked families to subordinate household balancing to population balancing. The biopolitical imperative became one of reproductive sacrifice—of heroically enduring the experience of parenting multiple girls for the sake of abstract population-level numbers. Beti Bachāvo materials and performances frequently voiced calls for parents to accept a social responsibility to produce daughters. As in Hitesh-bhai's IEC session, skewed SRs became the grounds for exhorting women to "let girls be born." A banner hanging on the wall during the District Health Office's Daughter Day celebration made the demand explicit: "Let's Stop *Stribhrunhatyā*. Let's Fulfill Our Social Responsibility." Numerous pamphlets and other printed materials placed images of scales alongside lines like "Bid farewell to your boy-craziness! A girl is an inalienable, necessary part of society" (Figure 6).

But population-level rationales ultimately gained very limited traction with couples desperate to obtain the necessary son while limiting fertility. The problem lay in a fundamental feature of the moral economy of gender-kinship. The daughter's inevitable alienation made her an externality for her *piyar*—the reproductive labor of birthing and raising her eventually benefitted another household (and society at large), but not the parents themselves.[28] A government nurse at one of the local public health facilities explained of her attempts to prevail upon people with "balance" arguments:

> People understand: my son is not going to get married by my having a daughter! A little while back, a beneficiary came to me and said she wanted to 'get a check.' Now, she was uneducated, so I couldn't directly talk about ratio. Instead, I said, 'Sister, if we don't keep girls, boys will be left unmarried in the future.
>
> Well, she said, 'Ben, how is my son going to marry by my having a daughter? My daughter will let someone else's son marry! Why should I keep birthing-birthing-birthing girls for someone else?'
>
> So honestly, we don't get too involved in the hassle of trying to make them understand. We can explain the ratio thing—that the government's created this law to preserve balance in society. But each and every person will say the same thing: 'No more girls at my house. To preserve balance, let them be born at my neighbor's!'

[28] This is the tension implicit in the formulation of balanced SRs as a "public good" (Miller 2001: 1091).

> And people have their answers ready: in the community, so-and-so's girl was raped, and so-and-so's daughter's getting beaten, and so-and-so's in-laws threw her out of the house. What's a daughter's life like? What's the point of having a girl?
>
> So in the end, *we* end up getting an earful. And before, there were rapes even though there were lots of girls. Now that there are fewer girls, the incidents will increase. And people think, 'If this is happening, let's not have girls. So it increases even more!'

The nurse's comments reveal how SR-based appeals fell flat. They failed to acknowledge the disjuncture between household-level and community-level balance, as well as a gender-kinship system that made daughters always-already to-be-alienated from the moment of their recognition. There prevailed a collective action problem not unlike the Prisoner's Dilemma. Families could control only their own reproductive behavior; the social environment into which children entered remained largely exogenous. With additional daughters doing little to enhance a son's marriage prospects within a gender-skewed population—and perhaps embodying a particularly challenging burden of care within that population—families saw little reason to go along with the imperative to balance out SRs.

The Threatened Daughter

"The Anguish of an Unborn Daughter"

During a two-month stretch of fieldwork, a great many neighbors, friends, and patient families—some of whom had pursued sex selection, some of whom had not—showed me a clip that had gone viral among Mahesana-area users of Whatsapp and Facebook. Dozens of times, I watched the same impressively steady video of third-grader delivering a fiery speech at a large family reunion. Her red-gloved hands gripped the microphone as she began, "My topic today is *stribhrunhatyā*. Today, I will tell you the anguish of an unborn daughter—a letter from an unborn daughter to her mother." Then, her hands began gesticulating as she declaimed with feeling:

> I am happy, and I pray to God that you all remain happy, too. I am writing this letter because I have heard some astounding news that's left me trembling from head to toe. Oh, Ma, you must remember me, right? Of course. Because since you rejected me, you must be the one remembering me the most, moment to moment.
>
> Oh, Ma! In ancient times, a daughter was considered auspicious. Today, you have considered me inauspicious. But hear me out. Oh, Ma! You pushed me away before I could even enter this world. Didn't you even think about the fact that this was supposed to be my one chance for incarnation after passing through 84,000 *avatārs*? You took that away from me in just one second. Oh, Ma! I wanted to come see the beautiful

world, to know it. But you, for your own happiness, shattered all my hopes.

What, is a boy everything? Isn't a daughter a bed of *tulsi*? Oh, for all you people, a girl is just a snake-like burden. But remember, Ma: a home without a daughter is like a body without a soul!

Oh, Ma. I am a girl. You must have found out, and that's why you are stopping my innocent self from taking birth. Hearing this, I have no faith left. Oh, my tenderhearted Ma—how can you do this to me? How can you bear to have butchered the delicate body of the dear little daughter growing in your womb?

Ma, just say once that everything I have heard is wrong. I am terrified. My hands are so delicate that I can't even tug your sari hard as you go toward the doctor's clinic. My shoulders are so thin and weak that I can't even embrace you. The medicine you want to take to kill me will impose so much suffering on my tiny body! Dear Ma, it will cause me so much pain. You will not even be able to watch how cruelly this medicine will kill me in your womb—how cruelly the doctor's hammer will break my skull into pieces—how his scissors will cut up my fragile arms and legs. Ma, if you had seen this image, you would never have thought of doing this—never even thought of it!

Ma, save me! Have mercy—save me. This medicine will make me slip out of your body like a bar of soap from wet hands.

Ma, I am writing this letter because I do not even have a voice yet. Who would I tell, and how? I really want to be born, Ma. I want to dance on your doorstep, play in your loving lap. Do not worry—I will not increase your costs. Do not buy me an anklet; I will wear the old anklets too small for my elder sister. I will cover my body with old clothes too small for my brother.

But Ma, just once, give me the chance to come out of your belly and live life under the star-filled sky. Let me see the pleasures of God's creation. I am your dear little daughter, your princess. Let me into your home.

Ma, if I were a son, you would accept me. So what is my flaw? Is it because of dowry that you don't love me? No, no—do not fear dowry. This is all a maze. You make an effort, I will make an effort; after growing up, I will support myself, and dowry will not be a big deal. Watch, Ma—I will have *mehndi* on my hands, and wedding music playing, and I will be like a bird of your garden and fly away. Don't make me fly away prematurely.

Ma, I want your love. Is it appropriate to sacrifice an innocent daughter for a son? The sin will accrue to only you and that son of yours! Don't ever let it happen, Ma. Oh Ma—beloved Ma—please just let me be born. Don't kill me. Let me blossom like a rose in your garden. Don't make me wither.

> Yet who knows why?! Today, in this male-dominant society, in the face of gender rules and mentalities, women who have accepted defeat and set aside their weapons. Or perhaps in the scramble to for maleness—in *bhrunhatyā*—they have donned the armor of derangement. What, have you lost faith in your own *shakti* [power]? Do you not have confidence in your own beloved daughter? Fie on women's power, fie on the mother doing *stribhrunhatyā*, and fie on her motherhood! For as far I know, no man or doctor would dare to touch a woman's belly without her permission or will.
>
> A daughter is Lakshmi! A thousand splendid suns pale before the brightness of a daughter. This beloved role *is* daughter. A mother is a stream of parental love, a father is a stream of love—but a daughter is an *ocean* of love! A daughter ties everyone—grandparents, parents, brothers—with a bond of love, and that's why when she goes to her *sāsri*, everyone weeps. A daughter is a father's world, a mother's support, a brother's love. The one who embodies this triad is a daughter... A son is a father's hand, but a daughter is his heart. A daughter is society's wealth, and life without a daughter is incomplete.
>
> Preserve respect for a daughter in society! Never get diagnosis done to know gender!

From the final crescendo, the red-gloved girl segued into a brief song expressing many of the same sentiments, which she dramatized by vocally and physically miming tears.

The speech captured imaginations. Couples uninvolved in sex selection used it to demonstrate how people "should" feel. Government officials pointed to it as a sign of how widely people "accepted" the message of Beti Bachāvo. Obstetricians highlighted it as a sign that "people's mentalities are changing." And families pursuing sex selection sometimes invoked it simply to acknowledge that they knew what they were doing to be wrong.

"The Right to Be Born": Personifying Gendered Fetal Citizens

The red-gloved girl's speech exemplifies attempts to make visible the threatened daughter herself. Perhaps more than any other component of sex selection governance, such attempts originated not only from formal state and non-governmental institutions, but also from nodes scattered throughout society. Representations by essayists, visual artists, schoolchildren, poets, journalists, dramatists, and others joined government and NGO messages in constructing the female fetus as a full-fledged person with vibrant subjectivity, thick kinship ties, and moral standing. Appeals for recognition, often ventriloquized through the potential daughter herself, aimed to harness affects of love and guilt toward acceptance of girls. But as in the virally circulating video, the valorization of girls often reinscribed them within the very system of gender-kinship regularities that made parents find them burdensome. Representations of the threatened daughter ultimately remained out-of-touch with their targets' subjectivities, invoking affective elements of the moral economy while ignoring the realities of reproductive decision-

making within that moral economy. Ironically, apart from making parents feel guilty about an action they would nonetheless undertake, the biggest impact of personifying the threatened daughter may have been to inadvertently generate and publicize anti-abortion messages that jeopardized already-tenuous respect for women's reproductive rights.

Beti Bachāvo posters frequently combined images of young girls with emotional appeals to prospective parents. One typical poster hanging in the Mahesana Block Health Office (Figure 7)—variations of which cropped up ubiquitously—juxtaposed a smiling, preciously posed girl with the lines:

> *Stop and think!* Isn't innocent laughter on your doorstep dear to you? *Stribhrunhatyā*—in the end, it's the destruction of lineage, community, village, country, and all creation! What if our mother had also been *killed in the belly*? Stop *stribhrunhatyā,* celebrate daughters..."

Many other posters simularly used the trope of "innocent laughter" to personify and sentimentalize the imagined daughter. A floor-to-ceiling English-language poster in the HFWD's main Gandhinagar office (Figure 8) made the appeal even more explicit, captioning a girl's face with the words "Do these eyes full of feelings and the innocent face discourage you from committing female feticide? Prevent female feticide and save daughters."

These posters highlight the extent to which public representations personified the female fetus. Personification often extended to creating for the daughter-to-be a full-fledged subjectivity and a will to live. Anti-sex selection poems often echoed the red-gloved girl by giving voice to the imagined daughter, allowing her to directly express feelings to potential parents (or more often, the pregnant woman alone): *I want to see the world*. *I want to bring my relatives happiness*. *I want to play with you*. *I won't burden you*. *I am part of you. Let me live*. Official Beti Bachāvo posters emphasized the same themes. One (Figure 9) superimposed an image of a frolicking mother-daughter pair with a verse expressing hope and requesting hope: "Small and delicate is my mind/ A few dreams, a few hopes/ Ma, I just want your support/ Then I will take wing and fly on my own." Personification collapsed future and present, discursively actualizing the female fetal subject's potentiality by rendering her as a fully formed person with a clear voice, firm desires, and a recognizable body. The accompanying images of infants and girls, like the red-gloved girl's excruciating references to bodily weakness, corporealized the potential girl as a recognizable human being, essentially fast-forwarding her development. Governance messaging thus attempted to pull the fetal person out of liminality and into full existence.

In some cases, the discourse of personification reached the point of explicitly granting the potential girl a right to life. One HFWD pamphlet, whose contents the Indian Medical Association's Mahesana branch repackaged as a sign for display in obstetric clinics, bore the title "A Daughter Also Has the Right to Be Born: Do Not Stop a Daughter from Taking Birth by Committing the Sin of *Stribhrunhatyā*." Similarly, a page from an anti-sex selection book featured an image of an infant and mother, sandwiched by a quote: "Don't kill me in the womb... I have a right to be born." Assertions of a right

to be born represented a logical extension of a broader discourse that transformed potential daughters into rights-bearing fetal citizens, subject to state recognition and protection.

As has been observed for campaigns in several Indian settings, the heavy-handed personification of female fetuses ultimately led to "mixed messages" about abortion, with anti-sex selection messages often becoming anti-abortion messages.[29] The public reception of the profligately used terms *stribhrunhatyā* and "female foeticide" obscured distinctions between sex-selective abortion and killing, reciprocally reinforcing the notions of sin discussed in Chapter 5. Government and NGO posters, IEC lectures, pamphlets, popular writing, and everyday talk positioned sex selection as *pāp* or *mahāpāp*—a "great sin." Murals, drawings, and other artwork condemned the practice through grisly images of death and murder: fetal silhouettes juxtaposed with tiny skeletons (Figure 10), nooses around the necks of *in utero* infants (Figure 4), giant fists gruesomely crushing fetuses, and knives stabbing a globe full of girls' faces, with hands reaching up from below (Figure 11). Written materials referred to parents "killing" their future daughters, frequently dramatizing the point by providing embryological descriptions of "life before birth" or narrating "the unborn girl's screams" during abortion. Many informational pamphlets and books from NGOs unequivocally declared abortion murder and listed out (often exaggerated) dangers to women during and after the procedure. As in the seminal 2005 function at Unjha (discussed in Chapter 1), anti-sex selection events and texts continued to make ample use of explicitly anti-abortion media such as Bernard Nathanson's film *Silent Scream*; Chief Minister Anandi-ben Patel, in an earlier speech to the Gujarat Legislative Assembly, even referenced the *Silent Scream* at length in order to graphically portray abortion as a gruesome and brutal practice. Though nominally restricted to the denunciation of sex-selective reproduction, recirculations of (largely American) anti-choice literature leaked pervasively, leading people to frame all abortions in its terms. Just as *stribhrunhatyā* became simply *bhrunhatyā*, condemnation of sex selection slipped into condemnation of all pregnancy termination. Given the always-tenuous legal and social recognition for women's right to access abortion, anti-abortion discourse—which helped create the context for the serious refusals detailed in Chapter 1—represented an instance of "violations by the state in the very act of combating sex selection."[30]

In a related instance, representations of the threatened daughter's impending murder disproportionately assigned pregnant women the burden of guilt for sex selection. As typified by the red-gloved girl's speech—structured around twenty direct addresses to "Ma" and culminating in excoriation of pregnant women as uniquely culpable for *stribhrunhatyā*—pleas voiced through or on behalf of personified female fetuses specifically aimed to elicit feelings of love and anticipatory remorse in prospective mothers. Ideally, knowledge of the unborn girl's subjectivity would provoke protective attitudes in "Mother," who would then heroically parlay those affective orientations into behavior that saved the future daughter. Posters, poems, and performances frequently

[29] Cf. Ganatra 2008; Joseph and CYDA 2007: 83-84; Nidadavolu and Bracken 2006.
[30] John 2014: 42.

took the form of direct appeals to pregnant women, with titles and tag-lines like "Unborn Dream," "Let Me See the Light of the World," "Letter from a Daughter in Heaven," "Cry to My Pregnant Mother," and "Tell Me Why, Ma." They sometimes literally demonized mothers who sought SD and selective abortion, describing them as "merciless," "ferocious," or "worse than monsters." The singling out of pregnant women found its justification in orthodox norms of maternality, with letters from unborn daughters and other representations emphasizing a mother's role as "the epitome of love and sacrifice," "the incarnation of parental affection," or "a household's heart" (versus the father, who was its "head").[31] After personifying threatened daughters, anti-sex selection messages assigned pregnant women the primary responsibility for heroically enforcing a female fetus's right to birth—despite the fact that selective reproduction was a familially and socially embedded practice, as other programming readily acknowledged. Again, women became responsible for heroically overcoming structural inequalities through the sheer force of their own wills.

"Celebrate Daughters": Negating Unequal Destinies

Public representations personifying the female fetus frequently missed their mark because of a failure to acknowledge what gendered personhood meant within the local moral economy of gender-kinship. Some posters, pamphlets, articles, and IEC sessions highlighted that potential daughters might bring their parents renown by becoming exceptional heroes. The three most commonly cited examples were Indira Gandhi, Mother Theresa, and the American astronaut Sunita Williams, whose father hailed from a village in Mahesana District. In fact, Williams and her father even appeared at a 2012 Beti Bachāvo event in Kadi. The latter beseeched the gathered women to "imagine what would have happened if we had aborted the foetus knowing that it was a girl, like so many people do here." The astronaut herself told the audience, "When I sit in a helicopter, the helicopter does not know whether I am a woman or a man. The spacesuit I wear does not know whether I am a girl or a boy. Why should you allow the society to limit you by the virtue of your sex? Limitations are only in your mind." She later told the *Times of India,* "It is hard for me to fathom that people can do such a thing... I just can't understand this skewed thinking. It is so unfortunate but, as an American, it is hard for me to relate to this problem." The commentary from Williams and her father exemplified state and NGO efforts to ride backward women, families, and communities of their narrow mentalities, which were configured as the only barriers to true gender equality.

Unfortunately, with their focus on the exceptional, such efforts often failed to resonate with the everyday. To be sure, representations of alternative destinies incrementally refashioned local gender imaginaries, and couples content with only girls cited them in explaining a personal indifference to son necessity. But an activist summarized the majority of reactions I heard when he wearily said:

> People don't look at the fact that Indira Gandhi was prime minister, or that the head of the ruling party is a woman. They look at what's going on

[31] For the embedding of orthodox, essentializing conceptions of maternality in the everyday discourses and practices of reproductive health programming in India, see Simon-Kumar 2006: 175-181.

> next-door to them. No one thinks, 'Let me make my daughter an Indira, or a Mother Theresa, or a Sunita.' They think, so-and-so's daughter is being harassed, and so-and-so's was thrown out, and so-and-so's was killed. Those are the main thoughts.

While providing alternative imaginative possibilities, representations of exceptional women often failed to modify anxious "horizoning"[32] rooted in everyday experiences of the gender-kinship system.

The same dynamic undermined the imperative to "Celebrate Daughters." The incorporation of the "Beti Vadhāvo" mandate into Beti Bachāvo efforts since 2008 meant the rise of various forms of felicitation for parents of daughters. Government and NGO functions included public recognition of families who had ceased childbearing with only daughters. Caste organizations publicized the births of girls—especially second girls—among their members and bestowed gifts on behalf of the community. A rapidly proliferating genre of poems and folksongs condensed and expanded the shared language for celebrating newborn daughters. And various institutions delivered letters, cards, or plaques to felicitate parents of infant girls for "welcoming" them.

While well intentioned, such efforts sometimes diverged from the affective experiences of the parents actually receiving more daughters. A government nurse said of one initiative:

> The district's come out with cards. We're supposed to go give congratulations to all the households who have had girls in the past year. Now, what congratulations can we possibly give to those who have five-six girls? It's like throwing ghee on the fire! Even with two. Another daughter is born, and we go tell them it's a matter of *joy*—seriously?! We got the cards to the people who were supposed to get them, but what congratulations are there to give?

The mandatory celebrations often conflicted with families' everyday understandings of what an additional daughter meant.

The dissonance between institutional glorification and household despondency reflected a broader disjuncture inherent to the array of celebratory gestures, slogans, oaths, and other public performances of the threatened daughter's value. In Orwellian fashion, posters and billboards insisted on negating moral-economic realities through straightforward statements to the contrary: "A Daughter Is Not a Lifelong Burden, but an Avatar of Lakshmi." "Sons and Daughters Are Equal." Various public functions, from *gol* gatherings to IEC seminars to medical association meetings, featured full-throated recitation of anti-sex selection oaths from gathered citizens: Today, I vow that I will stop *stribhrunhatyā* from happening in my household, family, community, village, or city!" "Beti Bachāvo, Beti Vadhāvo, Beti Padhāvo!" State and NGO speakers often instructed groups of women to raise their hands and declare that "women's power" was "unlimited,"

[32] Petryna 2015, 2016, book ms.

and that "no one can stop it"—such that pregnant women, if they wished, could singlehandedly end sex selection. In striving to manifest (and thereby materialize) the threatened female fetus's value through pure enunciation, such affective performances perpetuated a head-in-the-sand approach to the disconnect between governance discourses and lived experiences of gender-kinship.

"Erroneous Son-Daughter Notions": Reinscribing Fetal Subjects in the Moral Economy

At the same time, the governance of affect treaded also proved problematic when it hewed to the prevailing moral-economic order in situating potential daughters. In valorizing threatened daughters with reference to the same social structure that made them threatening to families, public discourses inadvertently but powerfully reiterated the hegemony of son necessity and daughter aversion.[33] Put differently, they directly and indirectly reinforced the very "tradition" from which backward families were supposed to emerge in becoming modern, daughter-loving subjects.

Like the red-gloved girl's speech, many messages emphasized affective constructions of girls—"an ocean of love," "the father's heart," "the embodiment of good culture"—that emphasized their contradistinction to boys. Popular writings condemning sex selection often presented extensive binary listings that symbolically reiterated the moral-economic inequalities undergirding daughter dispensability, with "son:daughter" becoming roofbeam:threshold, support:subservience, medicine:prayer, narrative:poetry, hand:heart, lineage:part, word:melody, and so on; in each case, a girl represented something pleasant but ultimately less essential or instrumentally useful than her brother. Anti-sex selection discourses thus isolated superficially positive valuations from the gender-kinship order while ignoring or reinforcing the inequalities associated with such valuations.

In some cases, affective appeals actually emphasized the eventual alienation that made additional daughters unwanted. IEC officers, caste leaders, and writers cited the Gujarati adage "A daughter brightens two households," reinscribing girls as inevitably separated even while ostensibly valorizing them. Religious sermons, popular essays, and fanciful poems attempted to underscore a daughter's value by describing the sorrow parents, families, and entire communities felt on bidding them farewell after marriage—ignoring how the argument, though applicable to *existing* daughters with whom bonds of love had already formed, only underlined the pain associated with *imagined* daughters. Echoing discourses around backward families and population imbalance, some messages situated sex selection within a field of misogynistic practices such as dowry, in-law harassment, sexual teasing, and widespread rape, thereby reminding parents of the dangers of bringing girls into a threatening environment.

In other cases, public representations of the threatened daughter advocated for saving her on the basis of her value to men and a male-dominated social order.[34] One

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[33] Cf. Greenhalgh 2001: 139-141.

[34] For the presence of this trend from the early days of anti-sex selection campaigning, see Joseph and CYDA 2007: 211. For the broader construction of women as instrumental to state objectives in Indian reproductive health programming, see Simon-Kumar 2006: 181-185.

exemplary poem—"Where Will You Get Them?"—emphasized future women's importance vis-a-vis men: bearers of joy for fathers, fulfillers of ritual obligations for brothers, dutiful spouses for husbands, producers of grandchildren for lineages, and bringers of good fortune and character for households. Again, the valorizations highlighted roles that were pleasant-but-dispensable or else useful for *others*, subordinating women to masculinist imperatives while glossing over how they represented lost labor and value for natal households. Other messages extended the instrumentalization of threatened daughters even further, focusing primarily on their identity as future childbearers. As in Figure 5, many pedantically pointed out that women gave birth to "civilization," "society," or "all of creation." Some imposed an even more masculinist inflection on the configuration of threatened daughters as valuable wombs, stating how "great men" also came from women; for example, one Beti Bachāvo poster (Figure 14) paired a young woman's partly concealed face with the warning: "I could be the mother of a future Gandhi, Sardar, Tagore, or Bhagat Singh waiting in the womb. The arch supporting life's relations: son-daughter are equal. Do not participate in the sin of *stribhrunhatyā*." Here, the female fetus's value lay not in her potential to become an exemplary woman in her own right, but in her capacity to bear an inevitably masculine national hero.

One might say that representations valorizing potential girls according to standard moral-economic tropes missed their mark precisely because the target audience already *had* daughters. On the one hand, sex selection clients found exhortations to love girls unnecessary, for they very much loved their existing ones. On the other, they found little in such exhortations to change their reasoning around the pragmatic exigencies of family planning—alienation, possession, fertility limitation, cost, care, support, and recognition—that made one son imperative and rendered additional girls undesirable. Families pursuing sex selection passionately quoted poems, folksongs, sermons, government messages, and other texts extolling the virtues of daughters. In a particularly poignant example, several couples who had opted for selective abortion recited or played a recording of the same passage from a speech by the religious leader Morari Bapu:

> In my view, mother-father are the epitome of affection. But daughter is the epitome of compassion. She leaves behind affection and goes to her husband's home. The site of her affection changes, but her compassion remains intact. And in my experience, her compassion for her father, especially, is very great.
>
> A daughter endures all of life's incidents by her own politeness and the virtues her parents have inculcated. She suffers them. But if anything happens to her father, it's always intolerable for her. If someone tells her, 'Your father's in poor health'—well, only the daughter knows her sad condition.
>
> My understanding is that... the son is his father's hand, but the daughter is his heart. Indeed, that's why, when a father gives a daughter's hand in the son-in-law's hand during *kanyādān*, in terms of *affection*, he

> is giving away his heart itself. This is why our great folk poet Dadu-bhai has said of the experience, 'A piece of my heart slipped out of my hand.'
>
> Upon sending a daughter away, a father ages several years; that's the experience, and people observe it, too. But when that same daughter comes from her *sāsri* to meet the father, he again looks the age he is. And he runs throughout the town—'My child is here!'...
>
> A young daughter becomes a mother to her elderly father. Just as a mother feeds her children, cares for them, et cetera—the daughter bears the same sentiments toward her father. Therefore, the father of a daughter is never bowed.

The same passage circulated widely in Beti Bachāvo-associated programming. And when parents read or showed it to me, it frequently brought tears to their eyes. But where anti-sex selection advocates framed the message as a statement on why girls were valuable and should not be "killed in the womb," families often framed it as an encapsulation of how girls were precious but nonetheless—or *therefore*—had to be rejected. Where governance discourses ultimately foregrounded Morari Bapu's affective emphasis on love and value, parents foregrounded the practical realities he indexed: the pain of compulsory separation, suffering in the *sāsri*, and the rarity and fleetingness of opportunities for a daughter to actually care for her parents. Everyday experience suggested that the parents of daughters—and especially those of *only* daughters—were all-too-often bowed. Where anti-sex selection messaging performed a bait-and-switch by reinscribing female fetuses within a patriarchal system and then enjoining parents to "Reject Erroneous Son-Daughter Notions [and] Let Daughters Be Born" (Figure 15), parents routinely circled back to how material arrangements made the reasoning behind prenatal discrimination far from "erroneous."

"Women's Empowerment" and Beyond

The discursive tendencies described in this chapter echo far beyond Mahesana. In an analysis of China's Care for Girls campaign, Lisa Eklund has observed many of the same patterns: heavy reliance on performative slogans, valorization tactics that reinscribe women into patriarchal structures, marked stigmatization of son desire as backward, assignment of blame for sex selection to the rural and the traditional, and a disjuncture between hopeful talk and gender-kinship realities.[35] I suspect critical studies elsewhere in India, or in other contexts of anti-sex selection activism, would likely replicate these findings.

As many government officials and activists told me, "Beti Bachāvo can only do so much." For some of them, anti-sex selection discourse fulfilled its purpose if it people were "aware" and felt guilty about pursuing SD and selective abortion. Issue-specific campaigns could "create an atmosphere" (many pointed to the "selfie-with-daughter" trend Narendra Modi encouraged), but diminishment of sex selection would ultimately rest on "social change."

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[35] Eklund 2011a.

The definition of social change varied considerably. Reproducing families, noting news reports of financial incentive schemes cropping up in other states, often expressed the hope that Gujarat's government would start assuming some of the financial responsibility for the daughters it constantly encouraged its citizens to bear. The husband of a Nandini patient who had twice undergone selective abortion remarked to me as we played with his five-year-old daughter:

> Look, there's only one opinion to be had in all of this. If there is one daughter, and with a second, the government assumes her costs—with a third, the government assumes her costs—then, if you don't get it looked at, it's fine. But if we're the ones who have to spend the money, then it's a different matter. The root cause of people getting a test, getting it looked at, is this—so much spending behind a girl! And not just money: taking care of her, educating her, thinking about what kind of *sāsri* she'll find, what'll happen—all of this worrying about the future. So if I have one girl, and I have a second, and the government assumes her cost; I have a third, and the government assumes her cost; then, my fourth is a boy, and I assume all his costs, but the middle two girls are covered by the government; then, it's alright.

The comment made me think back to a line I heard repeatedly from one of the women in Gita-masi's neighborhood: "Okay, Narendra Modi keeps saying, 'Beti Bachāvo, Beti Bachāvo'—that's all well and good. But is he going to help pay for our daughters? Is the government going to handle their costs? Then we can talk!"

At the time of my fieldwork, several states already ran substantial financial incentive schemes to encourage (or offset, some might say cynically) production of socially necessary but familially expendable girls. Such programs varied considerably, from conditional cash transfers to defray educational costs to government bonds that would mature when a girl reached "marriageable age." Many critics condemned the programs for reinforcing differential valuation of girls by "bribing" parents or indirectly legitimating the notion of dowry. Moreover, evaluations of such programs (largely focused on Haryana) have not demonstrated immediate definitive impacts on SRs, and have suggested the funneling of much of the incentive money into marriage expenditures and dowry.[36]

Ultimately, many people told me, the solution would be women's empowerment. A catchphrase in public policy, mass media, and everyday conversation, "women's empowerment" meant different things to different people, but usually included some sense of education, work for pay, and "strength"—the last element often psychologized as a "will" or "capacity" to "fight" for one's due in society. In my experience, empowerment talk rarely included discussion of marriage transformation at a *gol-* or society-wide level, or other forms of collective reform. Trapped in the interwoven fabric

[36] Anukriti 2014; Jejeebhoy et al. 2015: 61-72; C. Mazumdar 2012; Sekher 2010; Sinha and Yoong 2009.

of patriarchy and atomizing liberalism, individual empowerment is unlikely to have much more effect than the head-in-the-sand calls to simply welcome daughters against all odds.

Two decades ago, Manoranjan Mohanty warned against the empowerment discourse arising in parallel with economic liberalization, explicitly denouncing the concept as a disabling one.[37] A decade ago, Rainuka Dagar noted the importance of "rethinking female foeticide" by shifting from birth rights to more general rights, from isolated practices to broader norms, from narrow resource control to transformation of hierarchy, and from "women's empowerment" to gender justice.[38] Today, both these perspectives remain highly relevant. The attenuation of sex selection, like true gender justice, requires not a shift in mentality or a narrow form of capacitation, but persistent, creative, and ultimately unorthodox striving for a different vision of gender justice.

[37] M. Mohanty 1995.
[38] Dagar 2007: 121-123.

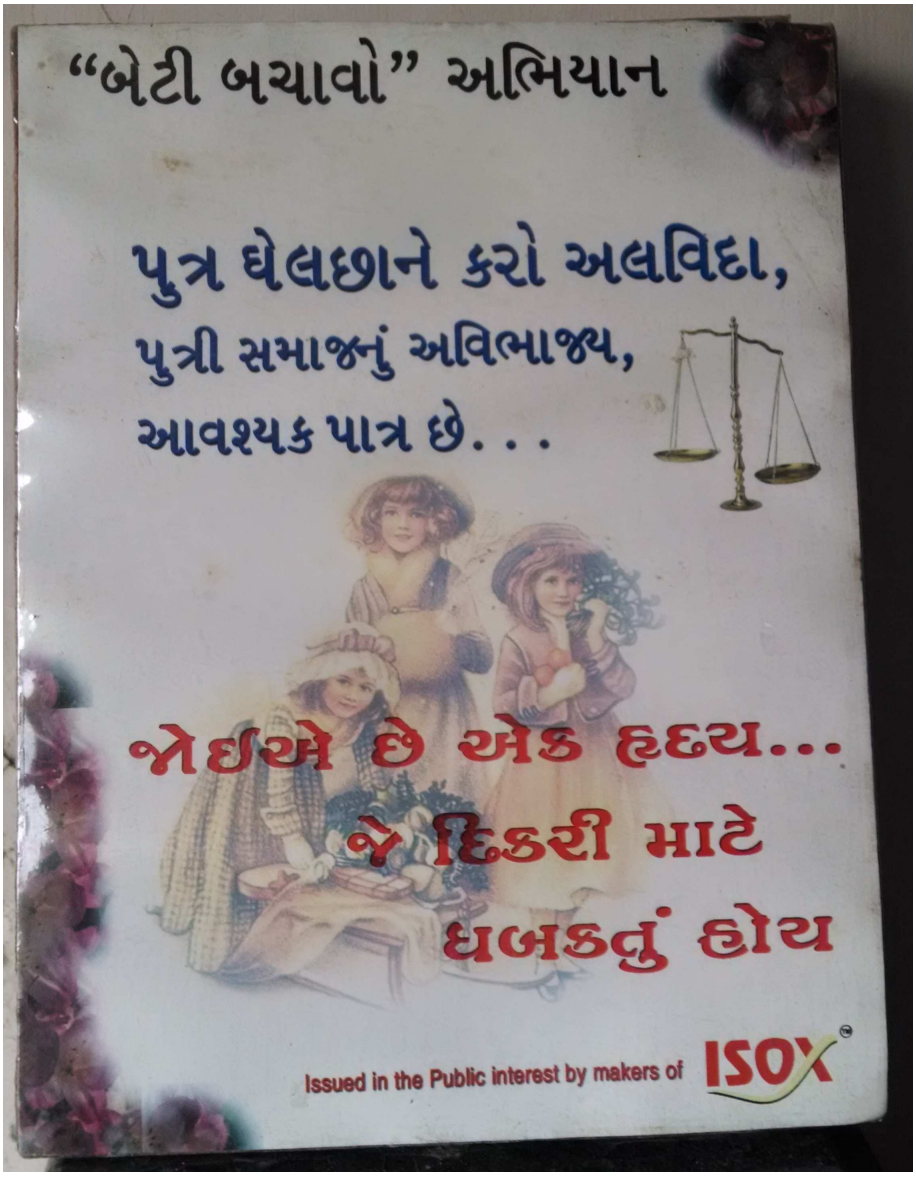
Figure 4 – "Can You Imagine a World Without Girls?"

Source: Gujarat Department of Health and Family Welfare IEC materials

Figure 5 – "Those Killing Girls in the Womb—Wake Up!"

Source: Dahlia Pharmaceuticals marketing materials

Figure 6 – "A girl is an inalienable, necessary part of society"



Source: Mefro Pharmaceuticals marketing materials

Figure 7 – "Isn't innocent laughter on your doorstep dear to you?"

Source: Mahesana Taluka Health Office IEC materials

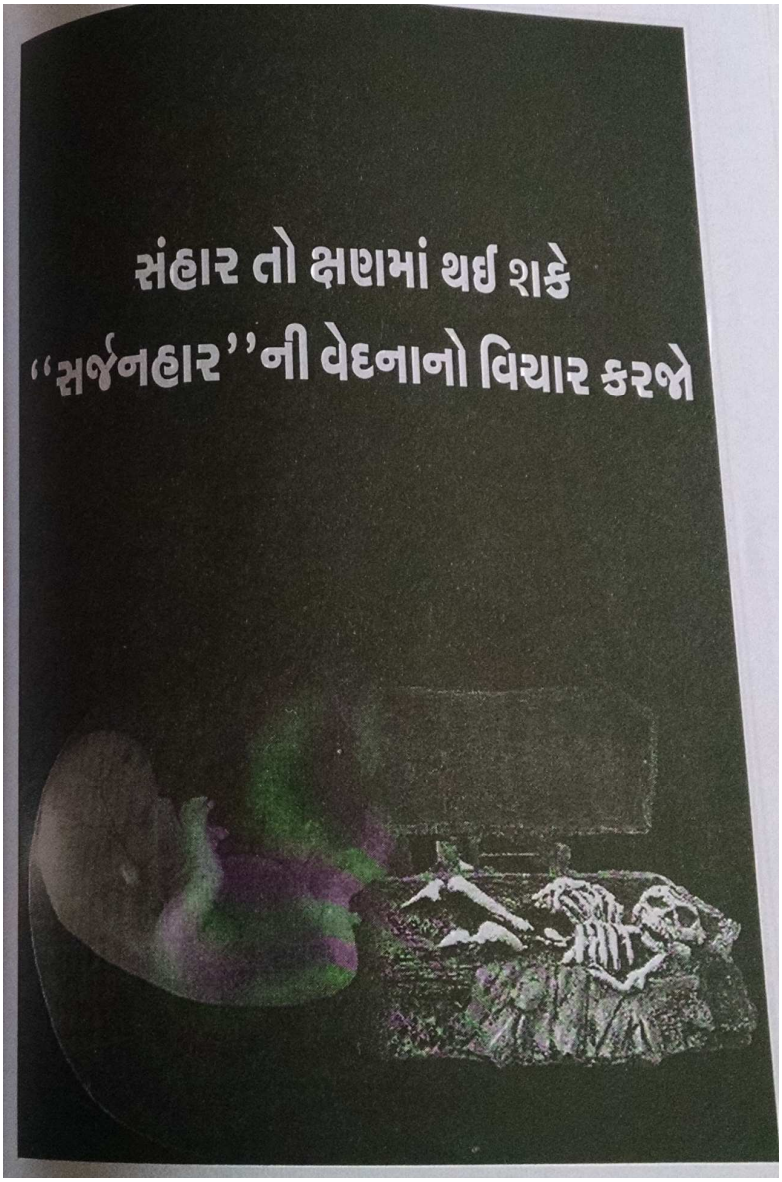
Figure 8 – "These eyes full of feelings and the innocent face"

Source: Gujarat Department of Health and Family Welfare IEC materials

Figure 9 – "A few dreams, a few hopes"

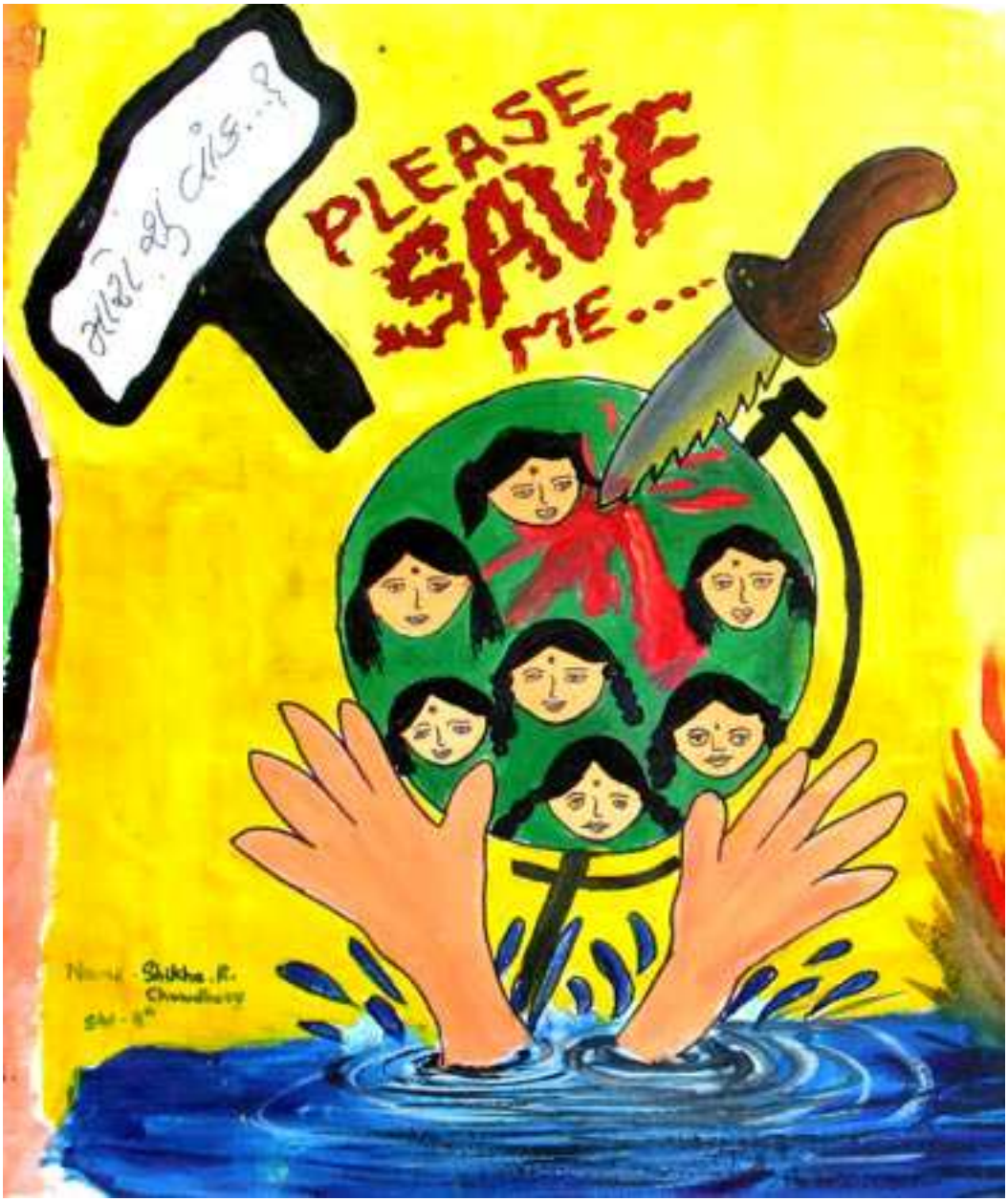
Source: Gujarat Department of Health and Family Welfare IEC materials

Figure 10 – Silhouette and Skeleton



Source: Hada 2010

Figure 11 – "What Is My Flaw?"



Source: Hada 2010

Conclusion

In this dissertation, I have argued for understanding the unborn subject of sonographic sex determination as a kind of threshold person, one defined more by its potentiality than its actuality. The gendered fetal subject is a boundary object, situated at the edges of families, clinical practices, the state, and sociality itself. It proves the point that limits, far from standing in a relationship of exteriority with their fields, actually define those fields.

The gendered fetal subject does not possess a conscious subjectivity; it has not undergone subjectivation. And yet its subjection to systems of power—gender-kinship, biomedicine, and governance—seems to grant it a sort of fetishistic power. The existence of a gendered fetus, or the mere possibility of such existence, authorizes and mobilizes a whole assemblage of imaginings and actions.

In the foregoing pages, I have traced the gendered fetal subject of north Gujarat through various aspects of its social life. Chapter 1 discussed the market within which clinical gendering took place, as well as state attempts to repress that market in the name of unborn daughters. Chapter 2 covered the moral economy of gender-kinship within which familial gendering took place, including the sorts of futures that prospective parents envisioned for gendered fetuses. Chapter 3 examined the collaboration of biomedical experts, technologies, and families in recognizing and reacting to potential sons and daughters. Chapter 4 explored different patterns of household decision-making around sex determination and selective abortion, going beyond popular narratives of one-dimensional victims or heroes to understand the complexities of women's agency with respect to prenatal gender. Chapter 5 considered techniques that operated alongside or instead of conventional biomedical sex selection to determine fetal sex in attempts to produce a son; it also systematically addressed a topic that appeared, in more subdued forms, throughout Chapters 2, 3, 4, and 5—namely, the matter of ethics and sin. Finally, Chapter 6 examined the public representations and everyday engagements that made the female fetal subject a public problem worthy of intervention from state and society.

Throughout the dissertation, I have aimed to situated the gendered fetal subject vis-a-vis a moral economy of gender-kinship—a system of emotional and material regularities that, in the ultimate analysis, governed the distribution of differently gendered bodies in society. One of my chief arguments has been that understanding the gendered fetus within its moral economy allows for a firmer and more nuanced grasp on the affects and actions associated with son necessity and daughter aversion. With such an approach, "patriarchy," "gender bias," or "discrimination" cease to be static, generalized explanations for selective reproduction and become, instead, lived processes whose contours may be accessed by tracing engagements with the gendered fetal subject.

Another major argument—more implicit than explicit in most of the text—has been that a rigorous, ethnographically grounded conceptualization of liminal personhood

can help to elucidate how sex-selective abortion is and is not violent. Examining how sonographic materializations and visualizations make a threshold person allows for appreciation of how the process of selective reproduction tacks back and forth along the person-nonperson axis for fetal being—and how recognition of this very ambiguity can provide a more solid basis for condemning the gendered violence inherent to sex selection. Such an ethnographically grounded perspective achieves at least two things. First, it traces the process by which violent logics become embodied as differential existence, following violence along the entire continuum from the structural to the intimate. Second, it stakes out a middle path between the moral outrage that ignores sex selection's complexities and the moral relativism that normalizes it as a form of family planning.

*

In concluding, three modest recommendations. The first concerns research. Throughout this dissertation, I have often referred to my central figure as unitary: *the* gendered fetal subject. But of course, gendered fetuses are always plural—even within contexts, and certainly across them. With sex selection a burning social issue across so many different settings inside and outside of India, there remains a need for close dialogue with people in the active process of imagining, engaging, and acting on the gendered potentiality of unborn beings. For instance, how does the black market for sex selection services appear different in Indian states with different regulatory approaches, and what strategies do clinicians use to finesse the resulting configurations of risk? How did the One-Child Policy shape specific imaginings of fetal futurity within Chinese moral economies, and how is the policy's recent relaxation changing this? How do prospective parents in different settings understand the stakes of erroneous gendering, and how (if at all) does surreptitious selective interventionism make appearances? How do family decision-making patterns (and perhaps even the stock narratives about them) shift with different domestic arrangements? If bodily ruination and sin represented two of the greatest downsides of a recognized daughter-to-be for couples around Mahesana, what are the corresponding anxieties, fears, or disappointments elsewhere? What other techniques do people use in order to actively shape male fetuses, and what can they tell us about local ontologies, local anxieties, and local experiences of reproductive agency? Are the backward family, the imbalanced population, and the threatened daughter the inevitable representational pillars of anti-sex selection discourse, or have other ethical configurations emerged and flourished?

These are just some of the questions one might ask in examining gendered fetal subjects across contexts. Moreover, while the investigative project is doubtless imperative in settings of highly prevalent sex selection, our understandings will best be enhanced through examination of a variety of cases. How, for example, do parents navigate moral economies in places where selective reproduction is unexpectedly rare? Or how might gender inequality seep perniciously into the prenatal in settings, such as the U.S., where many are not accustomed to expect it?

My second recommendation concerns the multifarious attempts to save the threatened female fetus through "awareness." As I hope to have demonstrated throughout this dissertation, and in Chapter 6 in particular, anti-sex selection discourses miss their

marks because they fail to account for the complexity, over-determination, and crushingly high stakes of moral-economic imperatives to have sons and avoid daughters. Moreover, they reiterate harmful ideologies of backwardness and gender orthodoxy, assign pregnant women disproportionate burdens of culpability, and encroach on the already-tenuous acceptance of Indian women's right to access abortion. More fundamentally, they naively (or cynically) assume a need for "education" and "sensitization" when even a cursory glance at social conditions suggests the need for material shifts in the possibilities for gender justice. I propose that state bodies, non-governmental organizations, journalists, and other agents of reproductive governance might do well to scale back anti-sex selection efforts as currently constituted and redirect attention to more modest but efficacious modes of intervention. The allure of righteously saving daughters (or at least trumpeting the ideal) is strong, and it is admittedly difficult for any institution to pull back from an aggressively meliorist line when its legitimacy is at stake. But I propose that rather than trumpeting the same slogans and well-worn explanations, those seeking to combat sex selection might do well to engage carefully with their "audiences," better understand the factors behind the practice, and seek out grassroots possibilities for shifting some small part of the moral economy of gender kinship.

And therein lies my final recommendation. Truly stemming the gendered violence of sex-selective reproduction will require addressing not just mentalities, but the moral-economic structures underlying them. In a way that neither "awareness" alone nor narrow "empowerment" can achieve, it is necessary to open up different futures—to destabilize the over-determination of potentiality that hung over every sex determination scan at Chetna. This is no easy task. It requires nothing less than the prying open of alternative arrangements of social security, social recognition, and post-marital residence. If prospective parents are to treat male and female fetuses as equal, there must be some prospect that sons and daughters *will* be equal in the future. I believe that caste organizations can play a particularly important role in the necessary transformations. Historically, *gol* associations and other caste-affiliated groups have often played the role of reinforcing orthodoxy. But even if they have typically wielded their control toward conservative or reactionary ends, I hope they may see the disproportionate influence they could exert by advocating for and facilitating meaningful shifts in marriage and descent practices—in the material arrangements undergirding social existence itself. If a *gol* association developed and firmly committed to a program for ensuring social belonging and wellbeing for parents with only daughters, it would have a better chance of effectively realizing change than almost any other institution. Such change might prove partial, incremental, still fraught with contradictions and ambivalences. But if designed properly, it would mark a true step toward broader gender justice.

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