Bioethical Inquiry (2007) 4:181–192
DOI 10.1007/s11673-007-9060-7

The Ethics of Birth and Death: Gender Infanticide in India

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Received: 28 June 2007 / Accepted: 5 October 2007 / Published online: 13 November 2007

Abstract This paper discusses the persistent devaluation of the girl child in India and the link between the entrenched perception of female valuelessness and the actual practice of infanticide of girl babies or foetuses. It seeks to place female infanticide, or 'gendercide,' within the context of Western-derived conceptions of ethics, justice and rights. To date, current ethical theories and internationally purveyed moral frameworks, as well as legal and political declarations, have fallen short of an adequate moral appraisal of infanticide. This paper seeks to rethink the issue.

Keywords Infanticide · India · Women's rights · Reproductive rights · Bioethics

Introduction

The elaborate rituals surrounding the event of birth in the human lifecycle signify different realities and value systems for men and women across various cultures and times. This paper discusses this sensibility in the Indian context, and it raises some worrisome ethical issues surrounding Indian attitudes and practices, for which current theories fall short of an adequate moral appraisal. The socio-historical construction of the goods that a culture valorises are symbolically transmitted across generations, towards the establishment of enduring cultural values. Whilst the benefits and the traditions of intimacy between mother and child are evident in the ritual performatives surrounding the birth of a boy, statistics on gendercide, or female infanticide, suggest that the bearing and birthing of a girl is an event fraught with moral conflicts.

In the first section of this paper I attempt to locate the occurrence of female infanticide within a broader framework by analyzing some of the socio-historical, political and religious factors that underpin this unfortunate ethical state of affairs. My central argument here is that the empowerment of women towards greater levels of choice, autonomy and worth can be continued only through an analysis of the prevalence of gendercide in India today.

The second section of this paper looks specifically at the causal factors behind the culturally entrenched view in Indian society that female children are of less value than their male counterparts. In particular, this section examines the success of the pragmatic efforts made by local healthcare centers to alter community perceptions of female value at a grassroots level. I argue that whilst healthcare centers, non-governmental organizations and activists have made minor gains in terms of challenging existing attitudes, structural factors such as economic impoverishment, women's property rights, the role of dowry and the inequality of

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resource distribution in the home remain considerable obstacles to the promotion of the intrinsic value of female children. Given that the generational transmission of female infanticide is a systemic problem, I suggest that only a holistic approach that tackles both the cultural and economic dimensions of this dire ethical dilemma will produce viable and appropriate solutions.

In the final section I attempt a programmatic dialogue between various non-western feminist ethical frameworks in order to shed light on a possible emergent ethical framework that might begin to examine the *unthought* issues surrounding this menacing problem.

Socio-historical, Political and Religious Roots of Gendercide

Birthing

In most societies, a mother's care and the rearing of her children is frequently experienced with ambivalence. But paradoxically, birthing, that most primal of functions, is often surrounded by elaborate customs, traditions and institutionalized religious rites. If Freud's early essay, *Totem and Taboo* is to be invoked then this process is accompanied by strong group and familial urges of love, hate and other affective arousal [1]. As Freudian theory suggests, the rite of passage embodied in an infant's entry into the world is a signifier not only of immense consequence for the immediate individuals, but it is also revelatory of ambivalently held attitudes of place, space, time, society and culture.

The birth of a human child occurs within a context both immediate and familial, but also in a socio-historical environment that will effect, and affect, the emerging natural instincts of the infant. The immediate social milieu plays a profound role in shaping the budding individual through the ministrations of the mother or guardian. Thus it is important that during the period of parturition and afterbirth, parents, especially mothers, are adequately supported as their prime task is the provision of a stable environment for the child. How a culture views this perennially recurring nativity through myths, legends, songs, popular literature and so on, is revealing of culturally enshrined values related to mothering, birth and infancy.

In relation to the nation-state of India the signifier of birth is indeed a poignant one. It may be identified with the birth of the nation-state or infused with numerous other images, such as the birth and antics of the revered child Krishna supported by his guardian Yasoda. For a woman, childbirth may signify the accomplishment of one of her main tasks in life; it may mark a pivotal point in the passage towards maturity, and it may encourage acceptance by her in-laws. In many parts of India the concept of planned childlessness is foreign. And a 'barren' woman is subject to various degrees of discrimination if not outright abuse.

The process of birth and accompanying birth rituals reflect a syncretic mix of folk, indigenous and regional traditions as well as being derived from Brahmanic texts. Subsequently, the child is viewed as redeemer of the parents from future misfortune and child birth is celebrated along with a genuinely appreciated joy of birth as a 'blessing from above.' But whilst this sentimental ethos surrounds birth, the event itself can, depending upon the sex of the infant, be a rather bleak affair.

Historical Considerations

Matrilineal structures have, by and large, flourished in societies where a women's right to choose and practice health in ways conducive to self-control and agency are valued over all areas of health. The discovery of the pre-Aryan agrarian settlements of Mohenjodaro and Harappa around 1925 highlights the presence of an indigenous people whose practices mingled with the traditions of the Aryan invaders. The Lokayata texts (texts prevalent among the Harappan people) speak of an agrarian culture where social ease was enjoyed by women.

In contrast, the classical Sanskrit texts tend at the best of times to be misogynistic in relation to issues pertaining to women's health and sexuality. A close reading of women's writing in Sanskrit sees issues emerge concerning concubinage, property and maintenance rights of mistresses on a par with legal wives, *niyoga* (roughly: sanction for a widow to beget a son by ritual union with her husband's brother), prayers for the welfare of illegitimate children and the disposition towards secret lovers (*jara*).

As these various religions intermingled, so too did traditional ideas and self-conceptions. Notably, a

number of the agrarian feminine concepts and icons were incorporated into the hitherto predominantly male pantheon of the Sanskrit tradition. These tropes continue today, more broadly in the *bhakti* or devotional traditions and popular resistance movements such as *satyagraha*, as Devi/Goddess inspired movements and in images of Mother India.

But perhaps most importantly, pre-Aryan understandings of women's issues and needs have been continued and maintained in the personage of the lay healer. The village *vaid* (naturopath), *siddhic* (shamanic healer) and *dai* (village midwife) have acted as the repository for a number of folk traditions The services of such a person may be called upon regardless of caste, class and religion and their skills may indeed be renowned. In contrast to a more monastic, written Sanskritic tradition, lay healing practices have survived based on apprenticeships and the verbal transmission of skills within different regional dialects.

The decline of the Hindu Aryan era during the first to fourth centuries C.E. led into the period of Mughal rule. Women in this time had access to the land as peasants and although they continued the *bhakti* traditions, they were also involved in courtly intellectual scholarship. This, together with the emergence of the Buddhist tradition, allowed women entry into the more 'monastic' Sanskrit and Pali traditions of incantation based healing and the practice of nursing allied to medicine.

Zysk argues that in contrast to the earlier Sanskrit traditions of healing by incantation of texts and *slokas* (stanzas), Buddhist medical practices were more empirically based [2, 3]. The practice of dissection under water enabled a more comprehensive knowledge of anatomy and physiology to evolve, which in turn provided a system of medical practice different to that practiced by the Brahmanic priests. Furthermore, the Buddhist concept of *karuna* (compassion) and the philosophy of the Middle Way were distinctly anti-Brahmanic in caste orientation. Thus hospices began to embody a more egalitarian ethos and their care of the sick and dying also began to cater for the needs and illnesses of women. Buddhist nuns schooled in these intellectual traditions were sanctioned to manage dispensaries and this perhaps provided the beginnings of institutional nursing and health management.

The nineteenth and twentieth centuries were largely preoccupied with colonial rule and the formation of freedom movements that would lead India towards self-rule as an independent nation-state. The welfare of women and the role played by women in this movement is well documented elsewhere [4: 23–38, 149–161, 291–317, 393–426; 5]. By the mid 1970s, India's women's movement had regrouped. Its focus now was upon post-independence activities, such as an increased involvement in the trade union movement.

But as 1975 was being proclaimed "International Women's Year," the Declaration of Emergency Rule was pronounced and it facilitated 2 years of despotic government under Mrs. Indira Gandhi. During this time, sensitivity and awareness of issues relating to women's health and fertility reached an all-time low. Programs of forced sterilization of both men and women were implemented with military zeal, with total disregard for the wishes of the people involved. The nuclear family was advocated at all costs and incentives were offered in billboard and radio announcements supporting the practice. Population control became the catch-cry. It muted all attempts to promote informed consent in the context of educational programs about contraception and health more generally. Subsequently, self-agency and access to a more informed decision-making process became a privilege relegated to minority elite groups capable of purchasing healthcare and education.

India's contemporary situation fares little better. Ironically, in spite of progressive reforms of the penal code in relation to dowry, child marriage, *sati* and widow remarriage provisions, healthcare remains the purview of largely unpaid work by Non-Government Organization (NGO) networks. Even NGOs have struggled to make progress with respect to healthcare, constrained as they are by financial limitations and off put by conditions that they are not prepared for or that their workers have never before encountered.

Narayan Desai, a Gandhian activist in South Gujarat who, with his family of volunteers, promulgated a sort of non-violent economic revolution from his base in Vedchhi, an Adivasi (tribal-aboriginal) village near Surat [6: 50–51], recounts how he was shaken by an incident shortly after they started a school in the region. A brilliant young girl fell ill and then died within hours. She succumbed to sunstroke after working in the paddy fields with her parents all day. Drinking cold water on top of the heat-stroke without an adequate intake of food was fatal to her lean constitution.

Desai recalls many of the young women in that village falling victim either to death or to premature old age immediately after their first natal delivery. He surmised: 'It was bad economic conditions that prevented them from taking any nutritious food. Quite a lot of our students we realized, probably one-third or so, were night blind. Just a cup of milk a day could cure this… Later on I found out during my tour of Bhoodan that conditions in other parts of the country were even worse than this [6: 50].'

Towards a Two Tiered Healthcare System?

Following the compilation of a report on India's *Eighth Five-Year Plan* [7], Indian activists declared the 1990s the decade for the welfare of the girl child. Efforts were made to establish community health centers, to foster community links with village *panchayats* (assembly of elders) and to encourage the inclusion of the *dai* (midwife) as part of the health team. These stratagems and various other measures were responses to the growing concerns over the interlinked but separate issues of population control and the health and welfare of women.

The construction of a community-based healthcare system, it was hoped, would enable women to make informed decisions about fertility control. The aim of such a system was to link in with the village *panchayat* (assembly of elders), and to provide the *dais* (village midwife) with delivery and cord kits whilst educating them in matters of high risk delivery, aseptic technique, immunization and delivery support.

Ideally, the community health center was to function in a way that assisted traditional healers whilst also allowing for the establishment of a local birth registry and for the creation of epidemiological profiles, used to develop future preventive programs. The aspiration was to educate women in matters pertaining to birth control options, information on sexually related diseases and their prevention, and the termination of pregnancies in appropriate ways. In short, the community system was an endeavor designed to prioritize women's health issues and help meet women's health needs.

Of course these aims and a regionally organized healthcare system as such, are not dissimilar to Western models of health and service delivery. Indeed, it can be argued that moves such as the introduction of payment following the registration of births at local health centers exemplifies a shift towards a dual healthcare system.

That said one must keep in mind that the aims and methods of health and population control experts have not always been motivated by a desire to improve conditions for women. Population control efforts can often be tinged with benevolent 'Western aid philosophies' or are simply draconian and not particularly cognizant of ethical issues related to informed consent, experimentation ethics or of the politics of pity.

At the very least it is clear that in accepting Western-instigated aid, nations often tacitly accept the incumbent ideologies of reproduction and birth control [8]. Such ideology when imported into economically disparate, and often desperate, environments can spawn some unsavory practices. The use of women in preliminary trials of depot medications is a well documented, but ongoing phenomenon [9]. Further, the covert *in vivo* trial testing of contraceptives on women in 'undeveloped' countries is an enterprise that involves multinational drug companies and other agencies in complex ways.

In moving away from the passive acceptance of aid, national government agencies at the present time seem to have recognized the different guiding goals between population control and informed healthcare for women [10: 361]. Nonetheless, vigilance has to be maintained against the collapse of categories of knowledge, each with different ethical considerations, as it has had dire consequences in the past.

Indeed, at least this much has been repeatedly expected of the State in numerous reports, and human rights and law commission inquiries. In his report on the recommendations towards reworking the Indian Constitution, the former Chief Justice of the Supreme Court of India, the Hon. S. N. Venkatachaliah strongly underscores the constitutional responsibility of the State in these dark areas of recent Indian history [11: 72–73]. His following recommendation is poignant:

> As of today, free medical treatment in government hospitals is totally inadequate. Nor is it available always in close neighborhoods. It is not possible to deal extensively with the pathetic conditions of medical care provided by government hospitals in our country. It is a fact of life that the poorer and weaker sections of society are unable to afford the extraordinary expense

> involved in the medical care provided by private hospitals. There is, therefore, an urgent need to see that, progressively, the State allocates adequate funds in this area. (Section 3.28.2)

Contemporary Challenges to Culturally Entrenched Views

Desire for the Male Child

Due to culturally entrenched worldviews, the delivery of a male child in the context of a large family serves as a metaphor that operates on multiple levels. Most importantly, it is seen as a financial provision against old age and a way to meet the strictures of inheritance rights. Statistics show maternal and neonatal morbidity and mortality rates increase with early marriage and subsequent multiple, poorly spaced pregnancies. Despite this, it is commonly presumed that due to high infant mortality rates, numerous pregnancies are a sound way of investing in the future. Education programs in rural areas have had little success in changing this accepted cultural view.

Healthcare centers have attempted to challenge entrenched attitudes emphasizing the benefits of child rearing during a woman's twenties rather than in her early teens. They advocate the spacing of children with attention to the health of each child and stress that child welfare and immunization programs are most effective when targeted at small families. Basic measures such as nutritional supplementation following common gastric ailments can often prevent infant mortality. School programs are also vital for the wide scale monitoring of development within normal parameters. With the laws brought in by Rajiv Gandhi ensuring free education for girl children, it was hoped that girls not registered at birth who has fallen through the net of the community health centre system may be brought to the attention of school medical authorities.

As the findings of the National Commission on Population [12: 45–78, 13: 1–11] demonstrate, however, health care centers have had relatively little success with respect to these objectives. The committee found that although community centers were being increasingly used for immunization and family welfare, approximately 70% of births still took place at home. Further, it noted a stark disparity between the expectations of the community and the capacities of health centers. Limitations of personnel training, large regional service numbers, limited programs with interpersonal discussion in all areas of women's health, plus co-ordination difficulties between agencies, all speak of the limited resources that community groups must labor under.

Furthermore, differences in community culture and service providers' intentions were shown to create tensions between service delivery personnel and slum or rural dwellers resulting in the deterioration of services, morale and communication. And in spite of the best intentions, often powerfully competing religious and economic ideologies lead to the exclusion of certain class, caste or religious groups from the ambit of service delivery. It is clear that the special needs of minority groups such as tribal women (*adivasis*), Muslim women and women in the sex trade require special attention; and sanguine programs are being developed by activist consultations. For the success of the community healthcare movement, however, these factors will need to be kept in mind, well into the twenty-first century.

The Population Report also demonstrates the difficulties of altering deeply felt community attitudes towards a family without a son. It illustrates that optimum family size is a contentious issue. In squatter families the preference is for two sons and one daughter, but these figures are malleable if this ideal is not immediately achieved. This conflicts with town planners' expectations of one son and one daughter. In the absence of fixed wages, social security and old age pensions, advocating the equal status of female and male children is, at best, a difficult pursuit.

One lesson to be learnt from the findings of the Population Report and other recent studies [14: Part 4] is that the promotion of the virtues of the 'girl child' must be more complex and sensitive than simplistic population control-minded strategies. The empowerment of women can be achieved only through the examination and implementation of schemes aimed at female education, the acquisition of vocational skills, economic development and an increasing awareness by lobby groups of the constitutional rights of the girl child. The broader issue of children being seen as the future service providers in the absence of social security and pensions indicates minimal anticipated change, in spite of massive government and NGO programs.

Sex-Selection, Gendercide and Contemporary Changes in Law

The practice of gendercide has its origins in a diverse and complex range of antecedents, both cultural and economic. De Mause suggests that death wishes and thoughts of infanticide are a fairly frequent phenomenon following birth [15]. Post-partum depression and the internalization of hostility arising from the perception of having failed at the task of reproduction is a phenomenon that occurs in many societies. In India however, this is specifically linked to the birth of a girl child. Of course the fantasy of infanticide, although not uncommon, is not acted upon unless extreme maternal illness is present. However, when it occurs with certain regularity the aetiology remains complex and difficult to deconstruct.

According to De Mause the infanticidal mode is the enactment of fantasy sanctioned by cultural mores. The non-containment of parental anxieties about the care of girl children by killing them affects the family and perpetrates certain myths within the culture. Cultures evolve differing ways of handling these anxieties. Certain other modes identified by De Mause are abandonment (i.e., to governesses as in the Victorian era), ambivalence and neglect, intrusion, socialization and the helping mode. These latter modes have an underlying ethos of the child as a *tabula rasa* object to be molded, controlled (punished), educated and in more enlightened societal structures, to be helped towards developing competence.

In Parsons' descriptions of socialization, he places the infant's plasticity, sensitivity and dependence as the 'fulcrum' on which is balanced future socialization of the child [16]. The mutuality of infant–mother dyad is well documented in contemporary psychoanalytic literature. Affect attunement between mother and child is also the beginnings of the capacity for concern, moral, social and cognitive development trajectories, which continue throughout life based on early experiences of competent caring. The transmission of cultural concepts through affective and conceptual development is well explored in the works of Piaget, Mead, Wilfred Bion, Winnicott, Kohlberg and numerous others.

What remains fundamentally problematic is the generational transmission of female infanticide. The very act sanctions further acts and becomes part of the fabric of culture transmitted, along with a complex range of gender expectations and roles pertaining to sexual identity. This familial experience of worth the infant experiences determines the expectations that that woman will eventually have of her own fertility and reproductive health. Chodorow's examination of the 'reproduction of mothering' in Western societies has much relevance to India, in that Indian women often identify with the tasks related to becoming wives and mothers, whereas men predominantly identify with the skills required to become a worker [17]. Thus a woman's attitudes to both her maternal role and to her daughter's value are essentially important in shaping projected patterns of mothering and the general perception of the worth of women.

Let's consider the problem from another perspective. A human rights approach to infanticide not only recognizes a foetus' or neonates' rights to inheritance but also to 'life.' The case for medical termination of pregnancy is usually followed through after a consideration of factors in relation to maternal and child health as well as maternal rights. Presently, legislature that addresses a review of the extensive evidence of the presence of foeticide and infanticide has led to a review of the relevant penal code(s). The Infanticide Acts introduced in Maharashtra, Delhi and Karnataka mark only a beginning towards legal reform [18].[1] Enforcement of this act has already proved difficult in many states, where blatant advertisements by medical fraternities advocating infanticide still exist.

The contemporary anti-infanticide movement appears to be fueled by a number of factors, including a growing urban middle-class consciousness that cuts across the previous distinctions based on male Brahmanical casteism. Women's ability to gain employment outside the parameters of traditional occupations, together with the urban drift of rural women, further adds to this. So too does increasing levels of literacy among women, which ensures economic independence and some breakdown of traditional sex stereotypes.The process of population control is beginning to address the issues of women's empowerment and old traditions are being challenged by new economic and social realism which place women in a different light with respect to inheritance, education, equal opportunity, and economic viability and independence.

[1] The first Infanticide Act was enacted by the British; modern Indian states began enacting new Acts from 1988.

Statistical Trends over a Century of Reform and Legislature

In an extensive study, George examines some of the historical and social aspects of female infanticide [18]. The first documented account is placed in 1789 in eastern Uttar Pradesh. Accurate statistics are not possible given the nature of the act and its illegality, hence female infanticide remains an essentially a hidden epidemic. However, one can see evidence of the phenomenon in sex statistics that highlight the disparity in the female to male birth ratio.

In most parts of the world, birth ratios generally show a slightly higher proportion of female births. However, in India this is consistently and historically not the case. Census figures in 1901 placed the ratio as 972 females to every 1,000 males. In 1961 this figure was 941 females to 1,000 males. In 1981 it dropped again to 934:1,000. A decade later it was lower still, 927:1,000. More recent statistics compiled in *The National Human Development Report* (2002) show a marginal increase of 933 female births to every 1,000 male [14]. However, despite this small reversal in a continuously decreasing trend, the number of female births in India remains considerably below world averages. (The world figure is 990 female to 1,000 males but in Africa the ratios are 1,015 female to 1,000 males, in the USA 1,054:1,000.)

The general trend of decreasing female births as a proportion of overall births has regional variations, the highest drops in female numbers occurring in the northwestern states of Punjab, Rajasthan, Gujarat and Bihar with lower figures recorded in the southern states, especially Kerala. In terms of the overall picture, it is best surmised by Chatterjee who places the death ratio for girls as being greater by a third of a million per year with every sixth death causally linked with gender discrimination [19].

Panigrahi and Bullimer document some of the anecdotal evidence of the means of death by poisons allegedly administered by midwives, mothers and in-laws as well as hired mercenaries [20: 18–21, 21: 43–48]. But female infant mortality also stems from deliberate neglect in caretaking, malnutrition, induced gastroenteritis, premature weaning by guardians and the absence of provisions and of a secure familial environment for the child. All of these factors and actions can be seen as an enactment of infanticidal wishes.

While infanticide is not strictly a class- or caste-based phenomenon, demographic factors, kinship systems, and spiritual orientation are factors which do have some bearing. The use of amniocentesis to determine gender and the practice of foeticide is offered at a commercial cost by a number of obstetrics practitioners. For those who can afford it, such technology has become widely accessible across the length and breadth of the subcontinent. Amniocentesis and chorionic villus sampling were developed for the detection of birth abnormalities in selected patients such as women with a family history of birth defects or other medical complications, but it has become a technique that has rapidly taken the place of infanticide in certain classes.

Between the mid 1970s and the early 1980s, 78,000 abortions of female fetuses were performed after *in vivo* sex determination by medical practitioners [21]. This wholesale misuse of medical technology has ethical undercurrents. In a survey of obstetricians, Wertz and Fletcher found that 84% carried out sex selection practices giving reasons such as population limitation, prevention of infanticide and prevention from maternal abuse as the stated aims [22]. In passing laws against sex selection the tendency towards devaluation of the girl child is not eradicated, reasons for which are deeply embedded in both traditional and secular hegemonic trajectories.

For those who cannot afford access to such technology, the depression, mourning and hostility at the failure of reproduction marked by the birth of a girl child is most usually suppressed. Repression of this failure is countered with preparations for the birth of a male child, hence the tendency towards frequent pregnancies during the early child bearing years of a woman's life. The aforementioned benefits derived from the birth of a male child (inheritance, continuation of a line, economic prospects and support of parents) are coupled with the disadvantages of having a girl, for whom parent's will have to provide a dowry and perhaps even part with *stridhana*.[2]

Thus a combination of factors ranging from economic impoverishment, women's property rights, the role of dowry, to the inequality of resource

[2] An inheritance of woman's own property that is usually given at the time of marriage but 'without consideration in marriage,' unlike dowry – which is in consideration of marriage.

distribution in the home, creates anti-female bias which impacts on fertility and mortality. The studies I have referred to point unequivocally to this rather sad state of affairs. However, the solution to these problems does not lie in a simple statistical increase of women to men. This alone will not lead to feminine empowerment. Empowerment is a complex issue, but before it can even be considered, the low female ratio has to be addressed as a menace in its own right; and it is here that infanticide plays a contributory role.

Thinking the *Unthought*: Theoretical Perspectives on the Emotions, Justice and a 'Micro-ethics of Empathy'

Toward a Possible Non-Western, Feminist Ethics

In recent years there has been a growing body of literature on ethics within feminist frameworks, with a move toward micro-ethical formulations rather than faith in grand narratives [23].These emerging frameworks are the subject of debate among feminists and are becoming central to a number of disciplines. In current times awareness of the impact of globalization has affected most areas of discourse, just as narrative theory, postmodernism and post colonialism did in the later half of the previous century.

So far, I have taken a fairly straightforward historical and sociological view of the problem of infanticide. Yet now, imaginatively, I wish to take the emotions aroused by this practice to orientate myself ethically anew to this profoundly subjective discussion on violence, subjugation, dominance and the rights of the unborn girl-child. What then of the feelings of disgust, pity, rage that this practice induces in one sensitive to its ramifications? Perhaps what lurks here is the fear that I may not have existed given different circumstances, an immolation before birth, a pre-birth *sati* phenomenon of sort [24].

How then to make a coherent sense out of emotions, in theory and in the psyche or subjectivity for the young women of Indian descent that I teach, mentor and counsel towards self esteem, productive careers and fulfilling lives? This is a burning issue. Here the project of making sense of a culture, of negotiating the spaces between tradition and modernity, must be seen as an applied praxis of living confronted with gender violence both individually and collectively.

In approaching the unspeakable I take inspiration from two main sources, firstly as a psychiatrist practicing within refugee and immigrant groups and secondly, from involvement with subaltern feminist theory within the subcontinent. The network of 90 or so South Asian women with whom I examined activist theory and praxis and with whom I discussed a number of field work studies, shared one conclusion: that conventional approaches to identity, health, religion, nationality and culture fail to meet the bill towards the construction of core self concepts and an orientative and imaginative ethic of deconstruction and action [25].

The history of emotions within western philosophy takes inspiration from the works of Plato, Aristotle, Hume and the Stoics. Later discussions on virtue ethics, identity theory, the mind-body problem and God continue a non-engagement with non-western cultural contributions to ethics. Emotions such as *amae* (attachment in Japanese); filial piety, *dana, karuna,* speak of the ethical systems of the Other, other than self. One exception here is Edith Stein, a close early collaborator of Husserl's who worked on the ethics of care and the problem of empathy. Stein observes that existence, transcendence and inter-subjectivity could give rise in one's life to a lived phenomenology of action and ethics of care [26, 27].

The Dalai Lama in his Kardinia Park talk, in Geelong in 2002 [28], spoke of a circular ethics of engagement. Emotions such as love, compassion and altruistic intention override the subject/object boundary. The enlightened disciple having had a glimpse of nothingness, by various practices of the middle way works for the betterment of all sentient beings. Not unlike Western conceptions of empathy [26], the Buddhist conception of altruistic intention is based on a transcendental experience of nothingness and the attendant condition of dependent origination, the understanding of which is ideally within the grasp of all beings. Thus cyclical ethical emotions such as altruistic intention and compassion can be the basis for an examination of the problems of human life.

What then is the locus of thinking in relation to the practice of infanticide? A disembodied feminine that is not birthed, lives in the timeless ethical unconscious of self and other. Given our global world what structures of thinking can we bring to bear on this

unethical practice? What of poverty and global debt? How are these factors located? Is there justice for the unborn girl child? What are her rights, legacies, if any [29]? Here I am positing the idea that ethical cyclical concepts such as compassion give rise to altruistic intention and perhaps to further analysis of the contents of the ethical unconscious which hopefully will lead to more positive action.

As stated earlier, Indian feminists declared the 1990s to be the decade of the girl child. The Vienna Declaration re-issued this message [30, 31]. Its long-term aim is the incorporation of the *Convention on the Rights of the Child* in national action plans world-wide. This breaks down to: reducing infant mortality, malnutrition and female illiteracy rates and improving access to safe drinking water and also to education. The declaration highlights the need for protection against infanticidal practices, child labour, prostitution, pornography and sexual abuse, as well as modification of cultural practices that cause harm and violate the rights of the girl child. These statements of intent were amplified at the Cairo Conference on Population and Development which surmised a three pronged action plan: the reduction of loss of girls at, or prior to birth; strengthening the status of the girl child; and improving child welfare, especially in the areas of 'health, nutrition and education' [32].

Of course the pragmatic statements of feminist action plans and manifestos are liberating in the moment of production and they are the focus of much aid work that produces a global euphoria on the moral good achieved by aid organizations. But as Kabeer points out in her astute work on 'Reversed Reality' much of the 'power-speak' of development agencies falls short of a more reflexive praxis real to the lives of grassroots NGOs involved [33]. The imagined reality of subordination, from a white middle class perspective, misses the complexity of the factors that lead to a phenomenon such as infanticide. One must ask: from which perspective are we speaking about infanticide and from which place are we acting to prohibit it?

Non-Western, Feminist Theory of Justice

In reviewing the literature on a Feminist Theory of justice, it becomes apparent that a non-western feminist perspective on justice is possible.

Okin argues that Rawls' theory of justice as fairness is improbable in light of the complexity of issues facing women, virtually anywhere [34, 35]. Sen considers Rawls' theory of justice to be more applicable to democratic pluralistic societies than to the varieties of regime that exist in the third and developing world [36]. Mouffe doubts the use of the generous qualifier, 'pluralistic' here: by ruling out marginal voices, adversary, and disconsensus on the interpretation of the principals that win consensus in the original position, Rawls' well-ordered society negates conditions for pluralism [37]. Reflective equilibrium that attempts to balance the disadvantages of minority communities, as in affirmative action, is like an after-thought; it is not inscribed in the original deliberations where lived history begins or ought to, or in as many of these recurring revisions.

A universal concept of justice, then, has to take into account micro-ethical systems within which individuals are historically rooted and culturally and spatially located. Categories of the nation-state and citizenship conceptualize notions of justice as much as do categories of gender and marginal status. But an 'effective equilibrium' would weigh towards the latter categories. The voices of those like Spivak are now claiming authentic space in the articulation of non-western theory of justice *without* throwing out the gains won by universal theories of humanism and fair society with common laws and regulations [10].

Sen's shift from an index of social primary goods to an index of capabilities, thus taking into account minority needs, is to be highly commended [38, 39]. An account of capabilities or basic needs in the context of the historical and social realities is far more prudent and judicious than some universal code or notion of justice that does not adequately allow for a micro-ethical formulation given the local culture, climate and customary laws. An 'interactive universalism' allows for the articulation of a hierarchy of difference in theory at least, and at best to a more reflexive theory of justice.

What then is a theory of justice most suited to an articulation of difference given that liberal and communal systems have demonstrated in-built limitations on ethnicity and gender justice? I will not answer that question directly, but relativize it to the specific issues that concern us in this paper.

It may be observed that distinctly feminist conceptions of care, mothering, altruism, and aligned moral

ideals of child rearing lie outside perceived notions of justice. As Hoagland rightly points out [40] if an ethics of caring is going to supplant an ethics based on principle and duty, especially in the context of oppression, the concerns of the marginal *other* would have to be central to a system of justice. In a feminist epistemology of justice obviously emotion plays a key role. Jaggar argues that Western philosophy of emotion had downplayed the epistemological and ethical significance of emotion [41]. Emotions activate action and moral thinking; hence, emotional work is part of constructing an ethical life. The attention to hitherto emotional areas of life previously barely covered under the rubric of 'family law' is now being significantly enlarged by the work of gender activists.

One example is the recently formulated Rome Statute, which entered into force on 1 July 2002 [42]. The ratification of The Rome Statute in the International Criminal Court codified crimes of sexual and gender violence that historically had not been addressed in humanitarian law. Although brokered by communal transnationals such as the UN, UNDP, this is nevertheless a document with the potential to take crime prevention and abuse reduction against women a step closer to actualization.

The mainstreaming of gender into humanitarian law means that rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization and sexual violence were included in the Rome Statute as war crimes and crimes against humanity. Prior codifications of humanitarian law, such as the Geneva and Hague Conventions, had failed to fully address this range of crimes against humanity or to recognize them as among the most grave of violations. In addition, trafficking and gender-based persecution were included for the first time as crimes against humanity.

But the existence of the fledgling International Criminal Court (ICC), along with the Rome Statute, face a rocky future with the USA threatening to 'unsign,' as the ICC will not be dependent on the UN Security Council and the USA was not successful in achieving exemptions for its nationals.

Conclusion

For well over a century, public reform campaigns have failed to alleviate the ingrained prejudice of valuelessness surrounding the birth of a female infant. A number of factors have contributed to the resilience of this prejudice and have helped impede reform and inhibit change. Modern technology, in the forms of amniocentesis and pre-natal sex diagnoses, has been used to bolster traditionally enshrined gender values. The resurgence of religious fundamentalist movements has tended to reinstate traditional religious proscriptive value systems with respect to birth and mothering. Further, enforced population control strategies have laid the burden of guilt for the regulation of reproduction upon women, while downplaying the need for welfare, education and informed choices towards self-care.

The adaptation of modern technology for the fulfilment of infanticidal desires highlights the persistence and maintenance of value systems that denigrate the value of the girl child. Structural analysis of the process and of the socioeconomic concomitants of the subjugation of women will take wide reaching concerted analysis. The value of the girl child will need to be seen in a broader context than towards a future geared only in the interest of mothering and child rearing. The examination of gender stereotypes often buttressed by religion and mythology will need to be interpreted in the context of the special needs of the girl child, and adolescents. Other contentious issues such as consent to marriage, minimum age at marriage with the provision of viable alternatives such as employment and educational opportunities remains a challenge for the twenty-first century.

In this essay I have attempted to argue for an outline of the kind of 'micro-ethics of empathy' that I believe is necessary to be articulated, albeit with much greater refinement than I have been able to here. I hope to have pointed to the conceptual, textual or discursive resources for such an applied philosophical ethics which will hopefully emerge in the decades ahead.

Acknowledgements This paper is a posthumous adaptation of an unpublished paper by Renuka Sharma entitled *Gender/Infanticide: Ethics of Death in the Shadow of Motherhood and Childbirth in India.* It was adapted and edited by Sara Jayne Kerr with assistance from Professor Purushottama Bilimoria. A previous version was presented at the Doshi Lecture Series, Loyola Marymount University, Los Angeles, in 1995 and printed in the Souvenir of *The First International Conference on Dowry and Bride-Burning in India*, September 30, October 1–2, 1995, Harvard Law School, Edited by H. Thakur and M. Witzel, Cambridge, Massachusetts, 1996, pp. 1–23. Sally Percival Wood provided current updates. Renuka Sharma was

formerly associated with the University of Melbourne and the Monash Asia Institute. She was a medical and psychotherapeutic practitioner, feminist philosopher, and social activist in India and Australia.

References

1. Freud, S. (1950). *Totem and taboo*. London: Ark.
2. Zysk, K. G. (1950). *Asceticism and healing in ancient India: Medicine in the buddhist*. Monastery. Delhi: Motilal Banarsidass.
3. Zysk, K. G. (1985). *Religious healing in the veda*. Philadelphia: Transactions of the American Philosophical Society 75 (part 7).
4. Sharma R (Ed.). (1996). *Representations of gender, democracy and identity politics in relation to South Asia. Naari series in gender studies*. Delhi: Sri Satguru Publications of Indian Book Centre.
5. Agnes, F. (2002). Transgressing boundaries of gender and identity. *Economic and Political Weekly, 7*, 3695–3699, September.
6. Narayan, D. (1997). A non-violent revolution story of a gandhian educator. In A. P. Hare (Ed.) *Lewiston*. N Y: The Edwin Mellen Press.
7. India Planning Commission (1992). *The eighth five year plan, 1992–97*. New Delhi: Government of India.
8. Tankard Reist, M. (1994). Whose consensus is it? The feminist challenge to Cairo. In M. Cook (Ed.) *The new imperialism: World population and the Cairo conference* (pp. 89–106). Crows Nest, NSW: Little Hills Press.
9. Dumble, L. (1996). Denying blame and claiming credit for women's fertility: the political scapegoat for global poverty, environmental degradation, and declining public health. In R. Sharma (Ed.) *Representations of gender, democracy and identity politics in relation to South Asia. Naari series in gender studies* (pp. 329–335). Delhi: Indian Book Centre Satguru Publications.
10. Spivak, G. A. (1999). *Critique of postcolonial reason: Toward a history of the vanishing present*. Cambridge: Harvard University Press.
11. National Commission to Review the Working of the Constitution. (2002). Delhi: Universal Law Publications.
12. Working Group on Registration of Births, Deaths and Marriages. (2004). National Commission on Population. Population and Human Social Facts, Part I. Government of India.
13. Velkoff, V. A., Adlakha A. (1998). Women of the world women's health in India. International Programs Center, Government of India, December.
14. The National *Human Development Report* (HDR) of the Planning Commission of India generated from the 2001 census. New Delhi: Oxford University Press, for Planning Commission of India; March 2002.
15. De Mause, L. (1984). The evolution of childhood. In: C. Jenks (Ed.). *The sociology of childhood: Essential readings* (pp. 48–62). Basford Academic and Educational.
16. Parsons T. (1984). The socialization of the child and the internalization of social value-orientations. In C. Jenks (Ed.). *The sociology of childhood: Essential readings* (pp. 139–150). Batsford Academic and Educational.
17. Chodorow, N. (1978). *The reproduction of mothering, psychoanalysis and the sociology of gender*. Berkeley: University of California Press.
18. George, M. (1978). Female infanticide. In R. Sharma (Ed.) *The other revolution: NGO and feminist perspectives from South Asia* (pp. 271–282). Delhi: Sri Satguru Publications of Indian Books Centre.
19. Chatterjee, P. (1989). The nationalist resolution of the women's question. In K. Sangari, & S. Vaid (Eds.) *Recasting women essays in colonial history* (pp. 233–253). Delhi: Kali for Women.
20. Panigrahi, L. (1972). *British social policy and female infanticide in India*. New Delhi: Munshiram Manoharlal.
21. Bullimer, E. (1990). *May you be the mother of a hundred sons: A journey among the women of India*. New York: Random House.
22. Wertz, D. C., & Fletcher, J. C. (1993). Prenatal diagnosis and sex selection in 19 nations. *Social Science & Medicine, 37*(11), 1359–1366.
23. Sharma R. (1998). Gender, ethnicity and psychiatry: The too hard basket. In: P. Komesaroff (Ed.), Proceedings of the conference on crosscultural aspects of health. Melbourne: Australasian Bioethics Association, Eleanor Shaw Centre for Medicine, Law and Society, Baker Research Institute.
24. Sharma, R., & Bilimoria, P. (2000). Where silence burns: sati (suttee) in India, Mary Daly's gynocritique, and resistant spirituality. In Feminist Interpretations of Mary Daly (Ed.) *Rewriting the canon series* (pp. 322–348). Philadelphia: The Pennsylvania State University Press.
25. Sharma, R. (2000). Feminism: South Asia. In C. Kramarae, & D. Spender (Eds.) *Routledge International Encyclopedia of women global women's issues and knowledge, Vol II* (pp. 833–837). New York/London: Francis & Taylor.
26. Sharma, R. (1992). A brief hermeneutic of empathy. In J. Fook, & C. Rana (Eds.) *Crosscultural communication in the 1990s: Application, methods, practice. Proceedings of the fifth conference of the network for intercultural communication* (pp. 128–135). Bundoora: La Trobe University.
27. Sharma, R. (1993). *Understanding the concept of empathy and its foundations in psychoanalysis*. Lewiston, N.Y: Edwin Mellon Press.
28. City plans welcome for Dalai Lama (press release). Available online: http://www.geelongaustralia.com.au/Media_Releases/September_2006/City_plans_welcome_for_Dalai_Lama/. Accessed 12.10.2007.
29. Sharma R. (2001). Women worshipping; worshipping women: Immanence and transcendence. Journal of Dharma. Special Issue on Women: Perspectives from World Religions, XXVI (2); April–June 2001: 235–251.
30. United Nations Vienna Delaration and Program of Action. Available online: http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En. Accessed 12.10.2007.
31. Five year implementation review of the Vienna Declaration and Programme of Action. Submission by the Government of India for the Report of the Secretary General. Available online: http://www.indianembassy.org/policy/Human_Rights/vdpa_india.html. Accessed 12.10.2007.
32. United Nations International Conference on Population and Development (Cairo Conference). Website: http://www.iisd.ca/Cairo.html. Accessed 12.10.2007.

33. Kabeer, N. (1993). *Reversed realities: Gender hierarchies in development thought*. New Delhi: Kali for Women.
34. Okin, S. A. (1989). *Justice gender and the family*. New York: Basic Books.
35. Okin, S. A. (1995). Inequalities between the sexes in different cultural contexts. In M. Nussbaum, & J. Glover (Eds.) *Women, culture and development* (pp. 274–297). Oxford: Clarendon Press.
36. Putnam, R. A. (1995). Why not a feminist theory of justice? In M. Nussbaum, & J. Glover (Eds.). *Women, culture and development* (pp. 298–331).
37. Mouffe, C. (1997). Democratic identity and pluralist politics. In R. Bontekoe, & M. Stephaniants (Eds.) *Justice and democracy cross-cultural perspectives* (pp. 381–394). Honolulu: University of Hawaii Press.
38. Sen, A. (1993). *The quality of life*. Oxford: Clarendon Press.
39. Sen, A. Mortality as an Indicator of Economic Success and Failure. Discussion Paper, DEP No 66, Development Economic Research Programme, STICERD, London: London School of Economics.
40. Hoagland, S. L. (1999). Engaged moral agency. *Ethics and the Environment, 4*, 91–100.
41. Jaggar, A., & Rothenberg, P. (Eds.) (1984). *Feminist frameworks: Alternative accounts of the relations between men and women*. New York: McGraw-Hill Book Company.
42. International Women's Tribune Centre Newsletter, Women's GlobalNet (2002): No. 192. Available online: http://www.iwtc.org/192.html. Accessed 12.10.2007.