

The Forsaken Daughters of a Developing World Femicide, Development and Women's Health in India

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Abstract: *Development processes have had an adverse impact on Indian women in correlation with increasing instances of femicide. The term, femicide, refers to all three cases of female feticide, infanticide, and the death of a girl child based on neglect. Various areas of India were historically infamous for committing female infanticide, but this had begun to decrease over time. Nonetheless, several forms of development have ensured that sex-selection technologies are accessible to a larger proportion of the population, which has led to a gender imbalance. These technologies have also produced mixed results for women's health. The birth ratio of males heavily outnumbers that of females in many regions of India. On the other hand, several development initiatives have increased female literacy and independence, yet this "progress" appears to be increasing the abortion of female fetuses. Thus, we argue that femicide remains a problem in India because development processes and medical advancements have failed to alter social perceptions about women and overlooked the social, economic, and legal context that continues to marginalize women. This paper will first examine the socio-economic factors that have historically subordinated women and demonstrate how they continue to have an influence today. Second, it will describe how development has diversely affected Indian women and their health based on class. Finally, this paper will explain why legal policies discouraging femicide have failed. Overall, it provides an analysis of the implications that efforts to control women's bodies and reproduction have had on women's health in India.*

Keywords: development, women's health, femicide, infanticide, feticide, new reproductive technologies

1. Introduction

"Her courage and her zest for life will always serve as an inspiration to us. We should all pay tribute to her by resolving that we will not let the loss of her life go in vain and will work together to enhance the safety and security of women in our country." - Dr. Manmohan Singh

In this speech, the former Prime Minister of India is referring to the 23-year-old victim of a Gang Rape that occurred on December 16, 2012 in Delhi ("Delhi Gang Rape", 2013). The victim was returning home on a bus with her friend when she was brutally raped by a number of men using a metal rod. The victim's death precipitated an international outcry advocating for policy reforms and justice ("Amanat's body brought back to Delhi" 2012). Delhi is a well-developed area where media outlets are widely available, and a significant group of women's rights activists reside (Roychowdhury 2013). Previous cases in Haryana, Andhra Pradesh, and West Bengal, which are also developed areas made the headlines, but they failed to produce a similar reaction (Fernandes 2012; Press trust of India 2012). Interestingly, Delhi and Haryana are regions with an unequal sex ratio where the birth of males heavily outnumbers that of females. An unequivocal preference for male children exists worldwide but its perpetuation in certain regions of India has had grave consequences and some have attributed a greater number of cases of rape to this in equal sex ratio; although the claim's validity is debateable (Ahmad 2010; Diamond-Smith and Rudolph 2018). Historically, various groups were known to neglect female children and practise infanticide in India. Infanticide denotes the killing of a child after it is born, and feticide refers to the abortion of a fetus for being female. However, today, this situation has worsened as the birth ratio of males has proliferated over the past three

decades. Scientific technologies that allow the fetus' sex to be determined have had negative implications for unborn daughters. ¹A vast amount of literature written by scholars such as Rai, Rao, Sagar, R. Pande (2007), and Dagar (2007) determines that development has had an adverse impact on Indian women, which has indirectly affected their health and well-being. Hence, if development processes have marginalized women, then there may be a correlation between development and escalating rates of femicide. The term, femicide, refers to all three instances of female feticide, infanticide, and the death of a girl child based on neglect (V. Patel 2007). Nonetheless, sex selection technologies may have also assisted with reducing health risks that women previously faced by giving birth to a female fetus such as intimate partner violence, death, conducting covert abortions, or participating in other forms of health jeopardizing activities to determine the sex of the fetus. In this regard, legal actions to contain femicide may have had negative implications for women's health; although due to the hidden nature of these activities, the extent is difficult to assess. On the other hand, in the 1990s, many scholars argued that sex detection technologies had harmful effects on women's health (Khanna 1999). Moreover, several development initiatives have increased female literacy and independence, which many Indians believed would minimize the preference for sons;

¹Sex-selection technologies have become a flourishing business in India. The most popular methods of sex detection include ultrasound machines, amniocentesis, and chronic villus sampling. Ultrasound machines are not always effective because they involve the doctor's speculation and cannot confirm the child's sex. Amniocentesis was introduced to examine the defects that a baby may have but it is more popularly used for sex-selection. Women's groups have also been concerned about the impact of these methods on the mother's health (Ahmad 2010; Bose, 2007; V. Patel, 2007).

nevertheless, it appears to be increasing the abortion of female fetuses (Mazumdar 2012). Thus, this paper finds that development processes and medical advancements have had problematic implications for women's health because they have failed to alter social perceptions about women, particularly overlooking the social, economic, and legal context, which has propagated instances of femicide within many regions of India. The analysis will first discuss the socio-economic factors that have historically subordinated women and demonstrate how they remain relevant. Second, this paper will describe how development has affected Indian women diversely based on class.² Finally, it will explain why legal policies discouraging femicide have failed. Overall, any efforts at securing the safety of women that Manmohan Singh mentioned in his speech, must alter social perceptions about women to improve the standards of their health and status in society as a whole.

2. Our Positionality

Rishma Johal—I am a second-generation Indo-Canadian woman and a feminist. As a member of the Indo-Canadian community, I have seen that son preference is quite largely embedded within Indian culture, so I do not believe that access to sex-selection within the Indian context formulates a 'free-choice' for women. However, my positionality lies outside the purview of 'third-world' feminists because I have been raised in Canada, but I agree with most of their views, which is evident in this paper. Moreover, women must be allowed to safely obtain abortions and have control over their bodies, despite all these factors. Women's lack of control over decisions concerning their bodies is associated with the growing rates of femicide, and the overall subordination of women. Hence, development projects that have, thus far, increased the use of sex-selection technologies must aim to alter social perceptions about women, which will also change how this society regards the conception of daughters.

Amit Johal—I am a second-generation Indo-Canadian male and I believe it is imperative to examine the case of femicide from a women's health perspective. A considerable amount of literature on the subject focuses on cultural implications and the effects on what has been termed by Sen as 'missing women'; however, it is vital to consider the impact on the health of women that would be giving birth to these fetuses. In addition, these discussions must consider that new reproductive technologies and abortion of female fetuses was reducing cases of malnutrition, neglect, mortality, and infanticide among female children, although much of this may have been attributed to avoiding their births (Sahni et al. 2008). Nonetheless, this fact alone does not justify the introduction of NRTs in India where the social context has undoubtedly induced a skewed sex ratio. Legal actions to contain femicide must consider how they will protect young girls and ensure their good health as well as their mothers. The case of femicide in India conveys that medical advancements, innovations, and development also need to

bear a gender focus and consider the implications of specific contexts that may impact the general outcome.

Indian Women's Socio-Economic Position through History

Many of the social customs and practices that Indians currently espouse have evolved from cultural beliefs associated with Hinduism, although the nation is home to people of numerous faiths. Manu, the ancient law giver in Hinduism, established a patriarchal society. His laws instituted the caste system and diversified the experiences of women based on social group. In this society, when an upper caste daughter was married, her family paid a dowry to the groom's family, signifying acceptance of the woman's burden as she would not contribute to the family income (V. Patel 2007). However, lower caste women worked outside of the home and this custom was not prevalent among them (V. Patel 2007; T. Patel 2007). Hypergamy, which stipulated that daughters marry into a caste above their own or remain unmarried, intensified female infanticide among those of higher castes. This was impossible for the highest castes, so some chose to murder their daughters when they were born, instead of 'facing shame' in the future (Kalantry 2017). Manu also ordained that one could only attain *moksha* if a son lit the funeral pyre of his parents, which was integral for a group that believed in reincarnation (Ahmad 2010).³ Based on the latter belief, many individuals that belonged to other castes also desired at least one son, and if they had too many daughters that they could not afford to raise, then female infanticide was a viable option. Likewise, instances of infanticide have been noted among some Sikhs who paid a bride price for their daughter's marriage and Muslims with a strong son preference (Sagar 2007). Bose (2007) terms this socially constructed preference for male children as the 'son complex'. This 'son complex' is rooted in India's history and it affects the way that many Indians regard daughters, and more generally, women today.⁴

The culture is changing, and women's socioeconomic position has improved in some instances, but these changes have been unable to alter people's perceptions about women. One, the practise of dowry has extended to most of the upper class, middle class, and a substantial proportion of the lower class (Ahmad 2010; Gaur and Anand 2015). It is also a status symbol for women to remain at home as housewives, despite higher levels of education (Sagar 2007; Sudha and Rajan 1999). Moreover, T. Patel explains, "A woman in patrilineal society gains status and position through motherhood, especially through producing sons for the family and lineage" (2007:142). Patel's words explain that most women have internalized the 'son complex' based on the eminence of a male bias within the culture, which is closely connected to their personal status. This has led to the

³*Moksha* means release and refers to liberation from the cycle of birth and death. Several other customs in Hinduism have subordinated women such as the *Artha Shastra*, which decreed that a male could remarry if his wife was unable to provide a male heir (Sagar, 2007).

⁴It is important to note that India is a heterogeneous nation and there are many forms of womanhood that are celebrated. A woman's power is sometimes regarded as a form of divine power that ascends from goddesses like Lakshmi, Durga, and Kali, even though their status in society remains subordinate.

²In this paper, I am using a sociological class framework and referring to three main class structures: the upper class, middle class, and working class.

belief that a male child is a necessity, which has induced the 'normalisation' of aborting female fetuses (Bose 2007). Additionally, if women refrain from aborting a female fetus, they may face pressure from their in-laws, husbands, or relatives, which could have serious ramifications (Hegde 1999). Many women experience psychological stress and mental health problems associated with giving birth to a female child, and in some cases, this has negatively affected their ability to breastfeed (Garg and Nath 2008; Tandon and Sharma 2006). The latter aspect also has an impact on the health of female children who may suffer from malnutrition. Fledderjohann et al. convey that if a gender gap of 0.45 months in breastfeeding was eliminated, then it could significantly enhance the life expectancy of young girls as each month of breastfeeding enhanced life expectancy by 24% (2014). Some of the pressure or mental strain that women experience stems from coercion that may include violent means to abort the fetus or commit infanticide. Additionally, obtaining an abortion after the safe period of 12 weeks is more than a health concern for women that may endanger their life, yet it may be regarded by them and their families as a necessity (Tandon and Sharma 2006). Therefore, the societal structure not only subordinates women, it also places an onus on their health and lures them into an unending cycle of violence against women.

Female children often bear the brunt of being born the "wrong" sex through what scholars have termed neglect. This may significantly affect the health of female children and their ability to survive, which is more prevalent among families suffering from poverty. Parents are less likely to seek medical attention or provide good medications for a daughter if she is sick to avoid the expense (Garg and Nath 2008). Female children do not always receive immunization on time and their health is considered a secondary concern in comparison to male children (Kishor 1995; Pande 2003). They are less likely to be fed than their male counterparts from breastfeeding onwards to childhood. Some academics argue that the rates of malnutrition and stunting are also higher among female children, although this varies depending on the region with male children faring worse in some cases (Garg and Nath 2008; World Bank 2013). Nevertheless, in comparison to other nations with severe cases of malnutrition, female children were more likely to survive there than in India, even though female children are scientifically known to have a better survival rate. In 2012, India's data for children with malnutrition under 5 conveyed that there were 108.5 female deaths for every 100 male deaths (Fledderjohann et al. 2014). These stats are concerning and suggest that female children face greater health risks associated with neglect in India, particularly malnutrition, despite better odds of survival globally.

3. The Correlation between Development and Femicide

A regional discrepancy among states in India demonstrates that development is heightening rates of feticide. A dichotomy has emerged between undeveloped regions where infanticide persists and developed areas where female feticide is augmenting (Sagar 2007). Dagar (2007) argues that femicide is now only a concern in developed areas because rates of infanticide have decreased. However, this is an oversimplification because development in rural areas

means that they are gaining access to sex-detection technologies as well. For instance, Bose (2007) outlines three preconditions for the spread of female feticide in correlation with a 'son complex': 1) easy access to medical facilities, 2) ability to pay the doctor and abortionist, and 3) a good network of roads. The latter condition has made it plausible for medical professionals to transport ultrasound machines from village to village for sex detection (Ahmad 2010; Bose 2007; V. Patel 2007). Furthermore, clinics have been built specifically to detect the fetus' sex in areas without basic amenities such as drinking water (Sudha and Rajan 1999; Patel 2011). Development is occurring all over India, which is increasing access to sex-selection technologies but producing serious repercussions for unborn daughters.

Subsequently, access to sex-selection technologies has decreased the birth ratio of female children even though supporters of New Reproductive Technologies (NRTs) often argue that this development is about allowing women a choice. Technology may be neutral, but it has gendered implications in this society (V. Patel 2007). Chronic villus sampling, ultrasonography, fetoscopy, needling, ultrasound, and amniocenteses have made it simpler for Indians to obtain male children.⁵ These technologies have minimized the moral compunction that infanticide entailed and allowed female feticide to become an acceptable social practise (Ahmad 2010). Although supporters of NRTs sometimes use the same arguments as feminists about allowing women a choice, many academics argue that in a society where the preference for male children is deeply entrenched, NRTs cannot be regarded as providing a 'free choice' (John 2008; Sagar 2007). India's 2011 Census data illustrates that for every 1000 boys only 940 girl children are conceived. In fact, it conveys that for a population of 1, 210, 193, 422, there are only 587, 584, 719 women in total with an increase in the disparity among sex ratios of children between 0 and 6 from 108 males per 100 females in 2001 to 109 in 2011 (Carl Haub and O. P. Sharma 2011). Gaur and Anand (2015) suggest that this low sex ratio is related to a greater amount of affluence and modernised urban living. Consequently, access to sex-selective technologies has strengthened the 'son complex,' while other forms of development have also continued to marginalize women.

4. Development and the Marginalization of Indian Women

Post-colonial development projects forced poor women into precarious situations and overlooked their economic position. Rai (2002) argues that women remained central to the construction of nationalist discourses during independence, but quickly became excluded from development. Likewise, various international and nongovernmental institutions that established development projects in India overlooked the gendered impact of their initiatives. They negatively affected the tribal communities

⁵ Pre-implantation diagnoses are also a part of New Reproductive Technologies that allow prospective parents who cannot have babies in the traditional sense to select the sex of the fetus (V. Patel, 2007).

and Scheduled castes. Tribal women traditionally shared the workload with men and played a vital role in decision-making (Bose 2007). However, development endeavours that displaced these populations, altered gender relations among them by redistributing land to the men (Pande 2007). For example, resettlement policies instituted by the Narmada Valley Dam project for displaced populations allotted land rights exclusively to men (Silliman 2001). Moreover, India's Green Revolution, which sought to create jobs in the agrarian sector, accomplished this goal by replacing female labourers from the Scheduled castes (Sudha and Rajan 1999). Although, the project did not aim to exclude women, this revolution introduced new farm methods and technologies, which many farmers believed men were more apt to utilize. Consequently, the project failed to determine how social perceptions and changes in this sector would affect women.⁶ These women had to move to the cities and work in the informal sector for up to 15 hours a day, with low pay, and no job security (Pande 2007). Moreover, the World Bank's structural adjustment policies required the Indian government to make cuts in welfare programs to pay back their loans (Rao 2005; Pande 2007). Therefore, most of the poor women who lived in the cities lost the social safety net that was once there. In addition, the situation of women in areas based on an agrarian economy continued to deteriorate with the introduction of patents. Women in this sector held significant knowledge about seed production but patents eliminated their control over agriculture (Pande 2007; Rai 2002). Thus, post-colonial development has inimically affected poor women, primarily Scheduled caste and tribal women who contributed more equitably to the family income.

These women's exacerbating economic circumstances determine why some individuals believe that forsaking their daughters is better than raising them into poverty. Many women who take the lives of their girl children believe that they are 'freeing' them from a life of drudgery (Hegde 1999). Bose affirms that some women abort female fetuses because they are concerned about "...the fate of girls subjected to eve-teasing, molestation, sexual harassment, and after marriage, exposed to the risk of bride burning and dowry death" (2007:87). Sagar quotes a woman stating, "It is good if one has no daughter. At least she won't suffer" (2007:187). Scholars have also speculated that if a mother's health is suffering, particularly due to malnutrition, then this may be the reason that some female fetuses are aborted (Kalantry 2017). According to data collected by the World Bank, many new mothers are adolescents and 75 percent are anemic during pregnancy, passing on the cycle of malnutrition to their baby (2013). In this case, women's health becomes a concern before the fetus is conceived based on social circumstances that once again subordinate women to the point that they are married as child brides and face pregnancy in conditions of extreme poverty. In addition, many working-class individuals or those living in

poverty believe that the sex-selection tests and obtaining an abortion are more affordable than bearing the expense of raising a daughter (V. Patel 2007). For instance, a survey that was conducted in the slums of Mumbai determined that many women there had taken a sex-detection test, and if the fetus was a female, then they had obtained an abortion (V. Patel, 2007). In fact, early advertisements of sex-determination tests openly read, "It is better to pay 500 Rupees now, than 500, 000 Rupees in dowry later" (Sagar 2007:195). Escalating poverty among working class women and their families has enhanced instances of femicide because many believe that finding ways to avoid giving birth to a girl child is better for their families and their unborn daughters.

On the other hand, feticide is more predominant among the middle and upper classes that do not have the same economic compulsions as the poor. This can be somewhat ascribed to the continuation of historical practises among upper caste groups as well as a strong preference for male children and easy access to sex-selection technologies (Dagar 2007; Sagar 2007; V. Patel 2007). The upper and middle classes continue to believe that having a greater number of sons augments one's status (Bose 2007). Social practices such as keeping women in the home and passing property to sons remain dominant (Hegde 1999). More importantly, despite the success of development initiatives such as rising female literacy, enhancing life expectancy, and better health facilities, feticide has intensified. Thus, contrary to popular beliefs, development has failed to alter the social perceptions of educated individuals with good incomes and the ability to access good healthcare (Dagar 2007; V. Patel 2007). In fact, Bose asks, "With higher levels of economic growth, better income levels and better transportation networks, will all states in India follow the footsteps of states like Punjab and Haryana?" (2007:86). Punjab and Haryana have heavily masculinized sex ratios, but they are two notably developed regions. Rates of feticide are aggravating in areas where development is increasing, so Bose's question may be answered affirmatively. For example, the government established greater development initiatives in the peri-urban areas of Kanpur and its sex ratio declined from 869 females per 100 males in 2001, to 558 females in 2009 (Ghosh and Sharma 2012).⁷ Overall, a 'son complex' persists and has likely strengthened among upper and middle class individuals, so development has failed to change social attitudes and projects have overlooked how they negatively affect the unequal birth ratio.

5. The Legal Context, Development, and Health

The Indian government's introduction of family planning discourses also increased female feticide because they failed to take the socio-economic context of most Indian regions into consideration. The Family Planning Programme (FPP) was introduced in 1951 to control population growth because the Indian government believed that these policies were imperative for India to become a developed nation (V. Patel 2007). This policy overlooked the fact that many

⁶ The Green Revolution was the period in the 1970s when India began introducing high-yielding varieties of seeds and enhanced the use of fertilizers and irrigation. The main goal of this revolution was increasing the food supply to make India self-sufficient and it was expected to simultaneously expand the number of jobs available.

⁷ Peri-urban areas are those that link developed and underdeveloped regions.

Indians believe they should be allowed to abort female fetuses if they have to control the number of children they conceive (Bose 2007; Sagar 2007). Most consider having at least one son a must; many accept the first child if it is a girl but opt to abort subsequent female children (Mazumdar 2012; Kalantry 2017). Moreover, educational institutions have advocated for family planning, yet failed to change the preference for sons. This has created a situation in which educated individuals are more likely to plan their families and undergo sex-selection (V. Patel 2007). Ghosh and Sharma affirm, "Literate women belonging to General Caste, and in better economic condition with respect to possession of land, poverty level, and socioeconomic score indicated significantly higher sex determination than uneducated Scheduled Caste and Tribal women" (2012:1029). Although, education and development often aim to change attitudes about women, the social context determines how these initiatives will be received (Mazumdar 2012). National development endeavours must consider the impact that they will have on gender and how previously held social norms will affect the results of new legal policies.

In addition, family planning policies further marginalized poor women. In 2002, the National Human Rights Commission designated family planning policies as a violation of human rights and stipulated that these were heightening female feticide (Rao 2005). Yet, states such as Haryana, Andhra Pradesh, Madhya Pradesh, Rajasthan, Himachal Pradesh, Uttar Pradesh, Orissa, and Chhattisgarh have continued to advocate for family planning. These policies countered the effects of the 73rd Amendment to the constitution, which saved seats in the *Panchayat Raj* institutions (local political bodies) exclusively for the Scheduled Castes and women (Rai 2002; Rao 2005). This policy had led to a slight improvement in women's condition. The above states have limited women's ability to remain a part of the *panchayats* by restricting the participation of anyone with more than two children (John 2008; Rao 2005). This has further excluded marginalized women from governance, especially in areas with poor conditions where women must bear an average of 6.2 children for 1 to survive (V. Patel 2007). Hence, family planning policies in association with development reinforced the marginalization of women in poverty.

Many legal policies, at the national and state level, have aimed to control femicide, yet they have been unsuccessful and overlooked how they may affect women's health. The Prenatal Diagnostic Techniques Act of 1994 prohibited sex determination tests in India, but this simply shifted the practise from the public to the private health sector (Visaria 2007). The PNMT Act sought to limit the use of technologies such as amniocenteses and ultrasound for the detection of genetic or metabolic disorders and chromosomal abnormalities in the fetus. It banned the advertisement of sex determination tests and criminalized both clients and practitioners who used these technologies. Nevertheless, the act embedded many loopholes for practitioners to escape punishment but not for clients. This component of the policy ensured that women bore the brunt of criminalization, while doctors and medical personnel could walk free (V. Patel 2007). Furthermore, criminalizing

feticide has reduced women who believe that having a son is necessary to find other means of acquiring a baby of the "right" sex, risking their personal health. This has opened the market for illicit drugs, covert abortions, and check-ups from unreliable personnel. Women may also risk their and their baby's health to give birth to a son by engaging in various rituals and taking drugs that are quietly marketed as changing the sex of the fetus (Cousins 2017). There is an unregulated market of drugs from claiming to successfully abort fetuses to ensuring that the fetus will be a male that may pose extensive health risks. When doctors initially opposed the PNMT, they warned that this would only drive the practise of feticide underground, which has certainly been the result and continued to risk women's health (Ahmad 2010). The act was amended in 2003 to gain control over sex-selection technologies, yet the criminalization of women continued, and this illegitimate market remains a health concern. The policy required the registration of ultrasound machines to counteract their illicit use for sex determination, but once again, it failed (Ghosh and Sharma 2012; V. Patel 2007). Although, feminists and activists have advocated for control over sex selection technologies, they have failed to address concerns regarding the impact of these new policies on women's health in a "black" market.

In contrast, northern states such as Rajasthan attempted to end femicide by providing cash incentives to women that were willing to be sterilized after conceiving one or two female children (John 2008). This policy was also problematic because it targeted women's bodies and failed to provide them with adequate information about their health or birth control.⁸ Moreover, it caused sterilization overdrive in Rajasthan (Mazumdar 2012). Similarly, in 1992, Tamil Nadu introduced the 'cradle baby scheme' to halt infanticide in its Salem district and allowed women to drop unwanted daughters at an adoption centre (Hegde 1999; Sudha and Rajan 1999). This policy became an ongoing program to eradicate female infanticide and save female children (India Development Gateway 2011). However, the main problem with this initiative was that the program became a substitute for infanticide and it was unable to alter the preference for male children. Consequently, legal policies that do not challenge the devaluation of females but validate previously held social perceptions only provide temporary solutions that will inevitably fail; moreover, they must aim to improve women's health.

Nevertheless, some recent policies provide hope for shifting the gender imbalance. In 2005, Haryana established the *Ladli* Scheme, which offered cash incentives to anyone who conceived a second daughter. *Ladli*, means loved or pampered female. Mazumdar states that this policy has moderately improved Haryana's sex ratio as has Delhi's *Ladli* Scheme (2012). On the other hand, these are relatively new measures, so it is difficult to determine their long-term effects, but some scholars have indicated that they remain problematic for women because they do not necessarily alter their social status (Gaur and Anand 2015). On the other

⁸ This policy led to the sterilization of numerous women. Many accused it of being coercive because it did not provide a real choice since women were not educated about other methods of birth control.

hand, according to a study by Krishnan et. al, the ratios have continued to decline in Haryana, despite the implementation of this scheme from 862 per 1000 boys between 1995 and 1998 to 826 between 2005 and 2010 (Krishnan et al.2014). The ratios have not dramatically declined, but the scheme has not necessarily succeeded at eliminating the gap. The issue may be that few people have knowledge about these schemes, and they lack understanding of how they work, which may explicate the discrepancy in the scheme's impact (Gaur and Anand 2015; Krishnan et al.2014). However, they have portrayed a certain amount of success from beneficiaries in terms of immunizing more young girls and delaying their marriages until 18 years of age. The latter may have the effect of decreasing rates of maternal mortality as well. Mazumdar (2012) suggests that the amount of money given to families should be increased for this policy to have a greater impact; whereas, some of the participants in another study argued that they should receive money for each daughter and/or receive components of the full amount in intervals (Gaur and Anand 2015). Overall, the Indian government must continue to act and formulate policies that account for India's socio-economic context, women's health, and alter the preference for male children.

6. Conclusion: Saving the Girl Child and Daughters

In conclusion, both federal and state authorities must formulate policies to counter femicide and enhance women's status, while finding ways to improve their health. This paper has demonstrated how factors all the way from development, health, and law to socio-cultural practises have intersected in the case of femicide. Moreover, development initiatives have further marginalized poor women and strengthened the preference for sons. Increasing cases of rape appear to be related to this gender imbalance as well (Ahmad 2010). In fact, instances of both rape and femicide determine that women are still viewed as subordinates in this society, despite their higher levels of education. Development has also provided a way to conceive sons for those among the upper and middle classes who adhere to family planning and favour male children. In fact, by increasing access to sex-selection technologies, development has proliferated female feticide among all three class groups. This has also driven the practise of sex selection underground, leaving women susceptible to unreliable medical alternatives, although many doctors secretly provide services like sex detection. Consequently, future development endeavours must encompass a three-fold initiative that alleviates women out of poverty, while changing attitudes about women, and improving their health. Solely, educating women or encouraging their entry into the workforce will not change the preference for sons, rather the content that educational institutions produce must alter negative social perceptions of women. Similarly, legal policies have to limit the accessibility of sex-selection technologies through effective means and they must be sensitive to women's health and socio-economic position. More importantly, new efforts to control femicide must avoid the failures of previous development initiatives, making considerations for how the social, economic, and legal context affects women and their health.

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