CHAPTER-IV

A. NEW REPRODUCTIVE TECHNOLOGIES (NRTs) AND SMALL FAMILY NORM

INTRODUCTION

An important area of the present research, which requires rigorous and micro level investigation, is the causes for the declining child sex ratio (CSR). By and large, studies on the declining CSR focus on the possible causes of this problem. Apart from the misuse of new reproductive technologies (NRTs) these studies argue that the prevailing norms of son-preference in Indian society have been exacerbated by the current population control policies and changing economy (Mazumdar, 1994; Mutharayappa et al, 1997; Mallik, 2003, Visaria, L.2007; Patel T. 2007; Ravindra, 2007; Bora and Tygai, 2008; Larsen, Hatti and Gooch, 2008; Samaiyar, 2008).

Studies indicate that the misuse of NRTs (including ultrasound sonography (USG), chronic villi biopsy (CVB) and others) are apparent since the early 1980s in India—a point debated by medical fraternity, social scientists and civil society organisations (Ravindra, 1986; Bhandari, 1991; Kishwar, 1999; Saheli, 2006, Patel, T. 2007a; Zavier and Bhat, 2007). Similarly, small family norm is also seen as one of the important reasons, as the norm, that exist within the patriarchal framework where having at least one son is inevitable for an ideal sex composition of the family (Mallik, R, 2003: 1-2). “Contemporary developments like the availability of diagnostic technologies for sex selection coupled with the desire for smaller families (as a result of population policies that enforce a two-child norm) have served to create new dynamism in family building strategies” (Mallik, R, 2003: 2). The deadly combination of small family norm and advent of NRTs in late 1970s or early 1980s resulted in increase in SSA followed by a rapid decline in CSR. This chapter looks at this combination and its manifested influence on the survival of girl child in India in general and in the state of Gujarat in particular. It is further divided in to two sub sections, where in section-A discusses the impact of small family norm and misuse of NRT on the declining CSR and the Act (PCPNDT) which is formulated to control the misuse is discussed in section-B.
4 A.1 SMALL FAMILY NORM AND POPULATION POLICY

Around six decades back, India became the first country in the developing world to initiate a state-sponsored family planning program with the goal of lowering fertility and slowing the population growth rate. Since its inception in 1951, the National Family Planning Program has been dominated by demographic goals. The government introduced method-specific family planning targets in the mid-1960s. Population control programmes were coercive, especially towards the poor and woman. During the emergency of 1975-77 the government carried out compulsory mass sterilisation of men in slums. The strong reaction to this policy forced the government to gradually shift its focus on women as the object of family planning (Menon, 2004: 71). Since they were more or less target oriented programmes aiming at better population figures, the reproductive health of the women remained poor. In the larger context of family planning, small family became the norm.

Small family norm is sought to be imposed even where factors like high infant mortality rates and insecurity of incomes make it rational to have larger families (Menon, 2004: 72). Small family norm often ignored the reproductive rights of the women. Women remain one of the most underserved segments of the Indian population. The almost singular focus of the Indian Family Welfare Program on female sterilization resulted in the neglect of many areas of women's reproductive health (Visaria, Jeejebhoy and Merrick, 1999: 44). Small family norm was implemented within the social structure which imposed inevitability of having a male child in the family. Around this time, introduction of NRTs opened a new avenue in the reproductive sector.

It is important to note that during the past two decades the average family size has been declining. This has been a result of voluntary acceptance by couples of smaller families, in response to a number of economic and social changes and partly due to the government’s efforts to hasten the transition through the family planning program (Mallik, 2002: 189). “Small family norm is a product of the ‘development package’. The development has brought with it modern technology and qualified persons capable of harnessing it. It has also resulted in the emergence of consumerist culture, and has contributed significantly to the acceptance of the small family norm” (Ravindra, 2007: 124).

Earlier the small family norm was largely an urban phenomenon but now it has started trickling down to the villages. Son-preference plays an important role in planning a family
size and sex composition. In past, families continued to give birth to children till they had desired number of sons (at least two). However, with small family norm and target approach of family planning by the government, the number of children per family shrunk to two with the strong preference for at least one son. It is pointed out by several scholars that the desire for fewer children is not necessarily accompanied by a preference for less number of sons. This combination of small family and desire for at least one son has been fatal to girl child (John et al, 2008: 49-50).

Son-preference continues to be a significant determinant in family building strategies. The National Family Health Survey (NFHS-II, 1998-99) collected information on the role that son-preference plays an important role in determining family planning practices. At the all-India level 83 per cent of every married woman in the age group 15-49 with two sons and 76 per cent with one son said they did not want any more children. On the other hand significantly fewer women, 47 percent, with two daughters said they did not want more children (Retherford and Roy, 2003: 65). The same report of NFHS-II elucidates that “two child norm as well as voluntary desire for smaller families can potentially serve to exacerbate SD and SSA” (NFHS-II, 2000: 119).

With small family norm, one daughter is accepted if not always welcome among all the castes and class categories. In two child norm generally the first child’s sex is secondary because the first child is a symbol of couple’s fertility. A woman is required to bear children to prove her womanhood and a man his virility (Patel, T., 2007a : 250-251). It’s only at the time of second child that the desire to have at least one son becomes stronger. The desire to have small family leads to the efforts to have not more than one daughter.

When large family size is the norm and access to contraception is limited, son-preference has little influence on sex ratio because couples continue bearing children, largely irrespective of the gender of the children. Female infanticide, abandonment of newborn girls, and neglect of daughters have been used in such societies to increase the male-to-female ratio in families, especially in situations where poverty has limited the number of desired children. “When the family size norm is moderate and only contraceptive methods are available, couples may consider the sex distribution of their existing children and decide whether or not to use family planning, weighing the need for a son against their desired family size” (Hesketh and Xing, 2006: 13272).
Further, Retherford and Roy (2003) use NFHS-2 data to point out that this trend currently appears to be strongest in families that already have two children. This they attribute to the fact that the current total fertility rate (TFR) for India is about three and as a large proportion of women wish to stop childbearing after having three children, a strong sex preference, mainly for sons, clearly determines the third birth order. It is also worth highlighting that son-preference and abortion can be linked in two distinct ways. “First, through the specific use of SD and SSA to identify and eliminate female foetuses and the second is abortion. These decisions purportedly appear to be for family planning but the sex of living children constitutes an important basis for the decision” (Arnold, Kishor and Roy: 2003, 769).

Not just the secondary data like NFHS reports, a number of ethnographic reports confirms the connection of small family norm and son-preference. “Couples hope to have smaller families of between two to four children and at least one or two sons. The actual number of children which a couple proceeds to have is still very much dependent on the early arrival of sons and the number born and surviving” (Croll, 2000: 92). The use of coercive measures in implementing population policies particularly undue emphasis on the use of terminal methods can easily lead to an intensifying trend towards SD and SSA (Mallik, 2002: 190). “Family planning is dependent on the number and sex of the children survived. Women who had to undergo sterilization, accepted only if they had sons and rejected if they had only daughters” (Croll, op cit: 100).

As discussed by Das Gupta (1987) “the subset of daughters born to families that already have one or more surviving daughters seems to be subjected to increasing concentrations of excess mortality relative to other children, if their mothers are younger and, even more, if they are educated” (Das Gupta, 1987: 95). Thus among young educated women, these girls experience 2.36 times higher child mortality than their siblings. This is probably because these mothers have experienced the maximum decline in both fertility and mortality. They are reducing their completed family size to fewer than three living children, and still want to have one to two sons, so they are under increased pressure to have fewer surviving daughters. Through a better ability to manipulate their fertility and their children's mortality, educated women are better equipped than others to achieve the family size and sex composition that they desire. This pattern contradicts the common assumption that increasing female education necessarily improves the quality of care given to children, regardless of
their sex. That excess mortality among later birth order daughters increases with the education of the mother, and “through a better ability to manipulate both their fertility and their children's mortality, educated women are better equipped than others to achieve the family size and sex composition that they desire” (Das Gupta, ibid).

Several ethnographic studies highlight the ideal family size for couples as discussed in their field study. As covered by Oldenburg (1992) in her study, “the ideal family in Thane district consists of two sons and 1.3 daughters (with women's and men's views virtually the same)” (Jeejeebhoy and Kulkarni, 1989: 109). Khan and Rao (1989) reports: “Irrespective of economic class a minimum of two sons still seems to be the prevailing norm of rural Bihar [their emphasis] with a 'two sons one daughter' family, the modal preference” (Khan and Rao, 1989: 147). Even in south India (in this case in Karnataka): “Most families want a minimum of two sons, largely because of the danger of losing one, but also because two are believed to be the minimum size of a male team within the family” (Caldwell, Reddy and Caldwell, 1988: 77). According to Srinivasan and Kanitkar (1989) “The second all India survey on family planning practices in India conducted in 1980-81 indicates that for a large percentage of couples the best combination of children was two sons and one daughter” (Srinivasan and Kanitkar, 1989: 39) (All as cited in Oldenburg, P., 1992: 2660). Thus, from all these regional studies, it is clear that all over India, the need for having at least two sons exist. However, the number of daughters generally does not exceed more than one.

4A.2 SMALL FAMILY NORM AND SEX COMPOSITION OF THE FAMILY IN GUJARAT

In the post family planning era, the average size of the family is shrinking in all the north-western states and Gujarat is no exception. The average family size of Gujarat from 3 children in NFHS-I (1993-94) has now come down to 2.4 NFHS-III (2005-06). In urban areas it is still lower at 1.9 children per family. Fertility in Gujarat is lower than the national average, but is higher than the fertility in 14 other states, including Maharashtra and Goa. “For almost 72% of the couples in Gujarat the ideal size of the family is two children or less” (NFHS-III, 2005-06: 5).

As discussed in the previous section son-preference is very strong in most parts of Gujarat even NFHS reports confirm the same. According to NFHS-II data percentage of couples who want more sons was 33%, whereas the percentage of couples who want more
daughters was sheer 1.8% (Bora and Tyagi, 2008: 53). NFHS-III also reflects the similar attitude. One in five or more women and men want more sons than daughters, but only 2 percent want more daughters than sons. The desire for more children is strongly affected by number of sons surviving in the family. For example, among women with two children, 95 percent of women with two sons and 90 percent of women with one son want no more children, compared with only 49 percent of women with two daughters. Notably, however, the proportion of currently married women with two children who want no more children is higher in NFHS-3 than it was in NFHS-2, irrespective of women’s number of sons (86%, compared with 76%). (NFHS-III, 2005-06: 7). Even the use of contraception is influenced by number of sons a woman has. Consistent with son-preference, women in Gujarat are more likely to use contraception if they already have a son. For example, among women with two children, 88 percent of women with two sons and 76 percent with one son and one daughter use a method of family planning, compared with 50 percent of women with no sons (NFHS-III, 2005-06: 9). All these factors clearly indicate the impact of small family norm and son-preference on declining CSR in Gujarat.

Since no data is available of district wise household on attitude towards the ideal family size and sex composition of these families, it is difficult to assess the impact of small family norm on declining sex ratio for Vadodara from secondary sources. However, the data collected from the field work conducted by Sahiyar (2002) in Vadodara evidently suggest that the two-child norm guides the upper middle class and middle class family in deciding the size of the family. Also the same study revealed that most of the families want at least one son and 45 percent of women with only daughters were ready to undergo SD and SSA in desire for a son (Shah, Ghelani and Choksi, 2002: 15-16). The present study will further try to co-relate the small family norm, size and sex composition of the family and its impact on CSR.

4A.3 USE AND ABUSE OF NEW REPRODUCTIVE TECHNOLOGY: A BACKGROUND

The introduction of new reproductive technologies in 1975 has generated a great deal of interests and arguments in favour and against amongst academicians from pure and applied sciences, social scientists, health professionals etc. It’s wide acceptance, use, abuse and misuse has had far reaching and complex implications not just on women’s reproductive health but also on several demographic and ethnographic indicators of a nation.
The new reproductive technologies entered India in mid 1970s, to be precise in 1975. The All India Institute of Medical sciences (AIIMS), New Delhi had initiated experiments using amniocentesis (the technique is discussed in detail further in the chapter) for detecting foetal abnormalities. The technique was used widely at AIIMS, New Delhi, the Institute of Research on Reproduction and Harkisondas Hospital, Mumbai. Foetal SD was an off-shoot or a by-product of this method. (Ravindra, 1986; and Bhandari, 1991) Knowing the sex of the foetus through amniocentesis became a popular tool for parents with a strong son-preference and was often followed by abortion to make easy way to eliminate girl child.

The right to bodily integrity, defined as the inalienable right of women to have control and autonomy over their bodies, has been central to arguments made by reproductive health advocates. It focuses on the demand for women’s access to reproductive technologies (RTs) including abortion. Access to reproductive and genetic technologies have indeed provided women with expanded choice as well as numerous benefits with regard to reproductive decision-making (Mallik, 2003 and Menon, 2004). At the same time, unregulated provision and use of RTs have served to create new challenges and ethical dilemmas. The one that is of utmost concern is the manner in which the language of choice is being misappropriated by various actors - doctors, manufacturers, families to rationalise the non-medical use of RTs which in turn serve to exacerbate gender based inequities. “The widespread misuse of prenatal diagnostic technologies for SD and SSA of female foetuses in India is one such example of the misuse of technologies to obtain a *negative choice* - the birth of sons” (Mallik, 2003: 1).

It is important to examine scientific, social, juridical, ethical, economic and health consequences of the NRTs. NRTs have made women’s bodies a site for scientific experimentations. They(NRTs), in the neo-colonial context of the third world economies and the unequal division of labour between the first and the third world economies, have created a bizarre scenario and cut throat competition among body chasers, clone chasers, intellect chasers and supporters of femicide. “There are mainly three aspects to NRT -assisted reproduction, genetic or pre-natal diagnosis and prevention of conception and birth. It is important to understand the interaction among NRT developers, providers, users, non-users, potential users, policy makers, and representatives of international organisations” (Patel, V., 2003: 4).
Along with amniocentesis, in later years other methods of SD were also introduced in the reproductive health sector. The three most popular diagnostic technologies that are used for SD are amniocentesis, chorionic villous sampling (CVS) and obstetric ultrasound. Amniocentesis and CVS are intrusive trans-abdominal procedures that involve removal of fluid from the intra-uterine environment at different stages of foetus development. “Amniocentesis (amnion: membrane and kentesis: pricking) refers to removal of about amniotic sac fluid through a long needle inserted into the abdomen. The foetal cells are then separated from the fluid for further observation followed by foetal SD” (Ravindra, 1986: 4). It is normally performed after 15-17 weeks of pregnancy. “CVS refers to the removal of elongated cells (called villi) of the chorion, the tissue surrounding the foetus, through the cervix. The tissue cells are tested to determine the sex of the foetus. It enables SD between 6-13 weeks of pregnancy. In both these methods there are risks of miscarriages, haemorrhage or limb defect to the foetus” (Patel, T. 2007: 246).

Obstetric ultrasound on the other hand is a non-intrusive method and considered a safe procedure. The current equipments that are used for ultrasound are called real-time scanners that provide a continuous picture of the moving foetus. However, in the case of ultrasound as is the case with the two other tests, detection of the sex of the foetus is possible after 16 weeks of gestation and 95-100 per cent accuracy rates have been reported when the test is conducted after 20 weeks. Ultrasound does not carry with it some of the hazards that amniocentesis and CVS entail, but the chances of the diagnosis being inaccurate are fairly high. This is because accurate SD is affected by various factors including foetal position; potential over diagnosis as a result of inadequately trained staff and the use of poor equipment.

The latest technology in this area has gone a step further where instead of pre-natal diagnosis of the sex of the foetus, there are pre-conception methods used for sex selection to have a desired child. The most popular technique here is Ericsson Method which was perfected by Dr.Ericsson in the US. “Where in the X and Y chromosomes are separated by filtration and the faster moving Y chromosome (responsible for male child) is let fertilised with the egg (which has XX chromosomes by default) to have a gender pre selection” (Patel, T., 2007: 247). In this method using a laboratory process, the sperm is passed through a sticky protein liquid, the assumption being that the slower moving X sperm would get stuck while the Y sperm would whiz through. The process is repeated till a concentrate of Y
bearing sperm is collected this concentrate is used to inseminate the eggs in the mother’s uterus. “This process was promoted by a US company called gen-select in the year 2001” (Aravamudan, 2007: 80-81). Another pre conception process undertaken for sex selection is Pre-implantation Genetic diagnosis (PGD). It involves chromosomal analysis of few cells taken from a test tube embryo to determine the sex (Patel, T., 2007). The original purpose of this techniques was to sort out human embryos with hereditary defect, had been adapted to select and eliminate female embryos (Aravamudan, 2007: 83).

Ultrasound in India is considered to be the most widely used and reliable method for SD. Often known as sonography test (colloquially jaanch/tapaas) it has spread in India like a wild fire. Medically introduced to detect the foetal abnormalities, the test since its introduction is often (mis)used to detect the sex of the foetus. Its misuse has been seen by activists, intellectuals and women’s groups as a major factor leading to depletion of CSR in India. Discussing his DELTA analysis of declining CSR, Ravindra (2007) states that “since the 1980s and 90s increased the T factor-technology availability several times through growing privatization, replacement of amniocentesis by sonography, lower cost, earlier sex prediction (and hence earlier abortion), information availability and better access through nearby or ‘at your door step mobile’ clinic (Ravindra, 2007: 124).

4A.4 WIDE SPREAD USE OF ULTRASOUND SONOGRAPHY (USGs)

As discussed earlier, immediately after its introduction, NRTs and SD techniques spread like a wild fire in India. Clinics had proliferated in most parts of the country by mid eighties. At AIIMS doctors noted that “most of the 11,000 couples who volunteered for the tests wanted to know the sex of the child and were not interested in the possibility of genetic abnormalities” (Mahabal, 2004: 28). One study conducted in 1986 estimated that there were 248 clinics and laboratories, and approximately 16,000 tests were performed in Mumbai metropolitan region annually (Mallik, 2003). Bumiller’s (1991) study in 1980s in Mumbai showed that 84 percent of Mumbai’s (then Bombay) private gynaecologists conducted ‘sex tests’ solely to determine the sex of the child, and in 80 percent of the cases after knowing that the unborn child is a female, women were hell bent on abortion. “Between the year 1978 and 1982, an estimate put the number of abortions of female foetuses after the ‘sex test’ at 78,000” (Bumiller, 1991: 113).
According to one of the records retrieved and preserved by Avabai Wadia archives (AWA) at the Research Centre for Women Studies (RCWS), SNDT Women’s University, Mumbai, “In 1985, Sir Harkisondas hospital in Mumbai alone recorded 2767 cases of SD. In 1982 there were just 10 centers in Mumbai where SD was performed. In 1988 this number raised up to 1000. By then it had already become a profit making industry” (Bhatt, 1988: 9-10). A similar record revealed by a leading newspaper states that out of total abortion carried out in state government hospitals in Maharashtra were 8000 out of which 7999 were of that of female foetuses (TOI, 1988: 3). It was during this time that the notorious and heinous advertisement of ‘better 500 now than 50,000’ later at Dr. Bhadari’s clinic at Amritsar, Punjab drew attention and created uproar. It indicated that it is better to spend Rs.500 now to undergo SSA to eliminate female foetus rather than spending 50,000 as a dowry amount at her wedding (Bhandari, R., 1991:5).

As the society became aware of rampant misuse of the technology, it caught the attention of women’s organisations and other activist groups, and in 1982 recommendations were sent to government asking for limiting the use of amniocentesis, stringent punishments to medical professionals indulging in unethical practises of SD and SSA. Circulars were sent to state governments and concerned medical departments regarding banning the use of technology for abortion and making it a penal offense. However, this was only pertaining to government offices and it further led to privatisation and commercialisation of reproductive technologies (Mazumdar, V., 1994: 3-4). “The ban on the use of this technology in government institution led to its privatisation and commercialisation. SD clinics mushroomed all over the country. Districts which lack basic amenities like potable water and electricity have pre-natal SD clinics. Rural health centres with no facilities for the testing of sputum for TB send samples for amniotic fluid in ice-packs to the nearest towns for SD tests” (Menon, 2004: 75).

Increased privatisation of health care has been encouraged by the government in line with policies of liberalisation. More and more private players are entering in to producing or importing the medical equipments. In case of ultrasound sonography, doctors in urban India advise routine ultrasound sonography checkups at least thrice during the pregnancy. Local production of these machines has made the tests affordable across classes. As per the presentation made by Saheli, “the manufacturing of ultrasound sonography machines in India since 1988 to 2003 has increased 33 times” (Saheli, 2006: 3). In 2002-03, The Indian
Radiology and Imaging Association have 4000 registered members. (Malik, 2003: 6). Since 2001 to March 2006, 28,422 facilities offering ultrasound tests have been registered across the country as per information received. “384 cases are currently filed for various violations under the Act, including the communication of the sex of the foetus, non-maintenance of records and non-registration” (PCPNDT Handbook, 2007: 20). By end of the year 2005, “ultrasound scanning for sex detection had become Rs.500 crore industry and it was totally illegal” (Aravamudan, G. 2007: 69).

As a result of sex-determination and sex-pre-selection tests leading to selective abortions of female foetuses, sixty lakh female infants and girls are ‘missing’ due to abuse of amniocentesis, chorion villi biopsy, sonography, ultrasound and imaging techniques. Sex pre-selection techniques prevent arrival of female baby at a pre-conception state. Even anti-abortionists use this method to get baby boys, as it does not involve ‘blood-bath’ (Patel, V. 2003). UNFPA estimates, “during 2001-07 for the country as a whole, on an average nearly 5 percent of female births did not occur because of prenatal sex selection” (UNFPA, 2010: 6).

Arnold, et al.(2002) uses NFHS-II data to provide direct information on the pattern of use of the two principal tests. They contend that in North India, the three states where sex-selective abortions are thought to be most common have much higher levels of ultrasound use (19-23 per cent) than any other state except Delhi. These results they argue “provide evidence that ultrasound is widely available and is often used by women during pregnancy, with the attendant possibility of misuse of the test for the purpose of SD of the foetus and SSA” (Arnold, Kishor and Roy, 2002: 774). NFHS-II data also shows that women who do not have sons are more likely than other women to undergo ultrasound tests. The authors also point out that “a consistent pattern of differences in the use of these procedures by the sex of living children demonstrates the use of these procedures for the purpose of SD” (Arnold, et al, 2002: 774).

4A.5 MYTHS AND FACTS REGARDING SD (SD) AND SSA (SSA)

Drawing from the sources of data discussing the arguments in favour and against the use and misuse of NRTs, following are some of the myths that prevail and the facts presented by scholars and civil society organizations working in the field.
Myth: SD and SSA are indicators of ‘pro-choice’ components of women’s reproductive health-: It has been stated that women welcome these tests out of their free will. It provides them a better freedom of choice and control over their own body.

Fact: No choice exercised by women is in vacuum or free from their own social context. Like any other reproductive right, including that of abortion, is a product of several socio-cultural dominations imposed on women. She is never viewed as a free agent. Her ‘choices’ or ‘decisions’ are mediated through socialization process by which she has internalized the subordination to all these dominations.

Myth: SD and SSA are means to control population. It helps aid family planning--: Doctors and certain demographers argue that by eliminating unwanted daughters and helping the couple to have a ‘balanced family’ will result in couples having smaller families and that too with an ideal sex composition. So it is alright to kill daughters if a couple already has one and by doing so doctors are actually doing a social work by contributing to control of population growth.

Fact: These arguments are not just illogical, irrational but also fatalist. The notion of balance family itself is faulty. Because the balance family include only two children and of which there has to be at least one son. This ignores the basic human right of a girl child to be born and survive especially in the second order birth. A balance family without a balanced society cannot be a priority. In the name of social work doctors are trying to address their own vested interest of profit making.

Myth: Adverse sex ratio improves the status of women-: Some economists and scholars apply the demand and supply rule to human population and argue that just as an object’s supply in the market decreases its demand increases and the value (price) of the product will go high. Similarly women, once less in supply as a result of adverse sex ratio, will have an advanced status in society.

Fact: Human population can neither be reduced to just numbers nor can be transformed to consumer product in the market. Commodification of society is neither possible nor desirable. The status of women in case of masculinisation of sex ratio has further declined as SSA is a result of devaluation of daughters. States where the ratio is declining there are evidence of
increase in violence against women, trafficking and forced prostitution. This by no means enhances her status in society.

**4A.6 NEW REPRODUCTIVE TECHNOLOGIES (NRTs) IN VADODARA AND GUJARAT**

After its introduction in India, new reproductive technologies became a boom in the state of Gujarat. Owing to its development in health sector on one side and strong son-preference on the other, new reproductive technologies like amniocentesis and ultrasound sonography became popular methods of SD and SSA. “By 1982, Gujarat had topped the list of SD clinics amongst the major states in India” (Mazumdar, 1994: 4). In an early report from *Free Press Journal* in 1991, there were 25,000 legal abortions registered in Gujarat wherein from every 1000 abortions, 995 were cases of female foeticide (Trivedi, 1991: 2). In 1988 after FASDSP was formed in Mumbai, its counterparts in Gujarat stated that, “after 20,000 SD tests, at least 10,000 female foetuses are destroyed every year in Ahmadabad alone. The majority of the SD seekers were from Patel, Darbaar, Sindhi and Marwari communities (These communities have perennially been daughter deficit communities due to their strong son-preference and high amount of dowries). These tests used to cost between Rs.700-Rs.1500 depending on the test” (Momin, S., 1988). Even after the implementation of PNDT act in 1994, the state continues to be prospering in SD business.

According to a study, conducted by Population Research Centre, M.S. University Baroda in 2004 on centres using ultrasound machines in the state of Gujarat, there are about 1,735 registered centres/clinics using ultrasound machines in the state of Gujarat. Of these, 95% are owned by private sector. Further amongst these centres, less than half of them had qualified persons (gynaecologists/radiologists) operating the ultrasound machines. Vadodara city has the second highest number of scanning centres after Ahmadabad. It was 155 in 2004 and increased to 235 in 2007-08 (Das, Desai and Shah, 2004: 3; PNDT, 2007).

The PNDT report by the government of Gujarat very clearly notes the co-relation between the number of sonography machines and the sex ratio at birth in that district. “Ironically, progress in science and technology and the easy availability of new machines that are able to identify the sex of the foetus, has spawned another form of violence – female feticide, killing the girl child in the womb. For several parents, there is no - or less - moral guilt attached to elimination of a fetus, as compared to killing the girl child after she is born.
These sex-selective abortions are preceded by sex indemnification, which is done by amniocentesis, chorion villous biopsy and, the most popular technique: ultra Sonography. Interestingly, all these techniques and machines are not new. Some of them have been in use in India since 1975 – but primarily for the determination of Genetic abnormalities, which is what they were created for. However, in the past few decades, they are being misused to determine the sex of the fetus. If it is a female, an abortion inevitably follows.” (PNDT report, 2007: 11).

The modus operandi used in Vadodara and other parts of Gujarat for conducting SD test undercover is brought into light by newspapers and other media sources time and again. There are middle men who operate between the patient (pregnant mother and her family who wants to know the sex of the foetus) and radiologists. A portable sonography machine is used to conduct the tests at an unidentified location (not at the clinic). “The results are also not communicated directly as it is prohibited by the law, but code words are used to communicate the same. ‘Jai shri krishna’ and ‘Jai mataji’ are the most common codes used for boy and girl respectively. Other code words are ‘babo kem chhe tamaaro’ (hows your baby boy doing?) or baby no taav utri gayo? (Has you daughter’s fever come down). The cost of such USG tests generally, are around Rs.500, but knowing the sex of the foetus with the help of middle men costs Rs.5,000 per test” (Kaushik, H. 2009: 3).

4A.7 POWER-RELATIONS AND NRTS

The new reproductive technologies are often advocated in the name of ‘choice’ bestowed to women and enabling better control over their reproductive health. On the other hand, abortion after being legalised under Medical Termination of Pregnancy act (MTP) 1971, was also propagated as a pro-choice feminist landmark right of women. But neither of them can be really perceived as empowering apparatus for women as an independent right to ‘choose’. Both are as Menon (2004) argues, “to be seen and administered within the context of economic and cultural constraints that limits women’s possibilities of choice” (Menon, 2004: 67). Right to abortion originated more from the population control imperative than from feminist movements. NRTs promoted as access to technology for better control of one’s own body also needs to be checked in the patriarchal social structure. A woman rarely has a ‘free will’ in decisions regarding reproduction including abortion.
The NRTs, originally developed to administer foetal health have been misused to a great extent to have a designed, pre-planned (male) child. They are just sophisticated tools to reinforce the age-old traditional son-preferences. “Search for ‘perfect’ baby through genetic screening, antenatal SD tests, pre-implantation diagnosis, commercialisation of sperm and/or egg donation, commercialisation of motherhood and hormonal contraceptives raise many socio-legal and ethical questions” (Patel, V., 2003: 6). It is important to examine scientific, social, judicial, ethical, economic and health consequences of the NRTs. NRTs have made women’s bodies’ site for scientific experimentation.

It is important to understand that reproduction has an individual and a social dimension. While examining birth control practices, an individual is a unit of analysis. While examining the population control policies we have to analyse pros & cons of NRTs. NRT as a choice for some women (educated career women) can become coercion for others (powerless and less articulate women). Hence it is important to be vigilant about power relations determined by race, age, class and gender while examining implications of NRT on different stake groups. “NRT will serve the interest of patriarchy, medical mafia, pharmaceutical industries, scientists, techno-docs at the cost of vulnerable human beings especially woman as raw material” (Patel, V., 2003: 7).

A major landmark in the movement against new reproductive technology was the formation of the Forum against SD and Sex Pre-Selection (FASDSP) in Mumbai in 1985. The members in this forum were feminists, health and human rights activists and academicians involved in people’s movement. Later the PNDT bill passed in Maharashtra and then the Act passed in 1994 (more details discussed in the second section of this chapter) was major setback to amniocentesis, however ultrasound sonography as a technology continued as a determination technique in the pretext of detecting genetic abnormalities as its main and sole purpose. An interesting contradiction worth noting is the fact that even as better enforcement of the PNDT Act limits the scope to use ultrasound on pregnant women the tests themselves have gained widespread acceptance as an important component of prenatal care particularly in urban centres. The medical associations too continue to emphasise the importance and universal use of ultrasound as much as possible to confirm and evaluate all pregnancies. As rightly put by Patel (2007) with NRTs, “family obtains desirable sex composition of children, government health staff posted locally fulfils their targets and
private medical practitioner make money, while the female foetus disappears” (Patel, T., 2007: 259).

In such a situation, the NRTs barely prove to be ‘pro-choice’ for women. Being a lucrative business, SD and SSA, in spite of being regularized and prohibited, continue to flourish. As on one hand it is the family who benefit by having a desired and designed family and on the other it enables doctors to earn hefty profits. The close nexus between these two stake holders (the family and doctors) make it very difficult to legally curb the menace. Hence, it is essential to look at this nexus at a more micro level (Vadodara for this study) to establish the co-relation between the misuse of NRTs and declining CSR.

INTRODUCTION

As discussed in the earlier section, the introduction of new reproductive technologies (NRTs) and the rampant misuse of the same in the form of sex determination techniques (SD) and sex selective abortion (SSA) have had an adverse impact on the child sex ratio (CSR) of India. As a response to this, social scientists, activists and academicians set off a nationwide campaign to check the misuse of the technology and subsequently improve the CSR of the country. The campaign was successful in creating pressure on the legal machinery to formulate a law prohibiting the sex selection. This section of the chapter discusses the process of formulation of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, (1994 and amended in 2003), the role of various stakeholders under the Act, its success and loopholes as discussed by experts in the field. The Act and its implementation is one of the important factors influencing the declining CSR.

The campaign against SSA has been carried on in India since 1980s. As the rampant misuse of the technology came in to light from media and other research reports, it caught the attention of women’s organisations and other activist groups. In 1982 recommendations were sent to government asking for limiting the use of amniocentesis and stringent punishments to medical professionals indulging in unethical practices of SD and SSA. “Circulars were sent to state governments and concerned medical departments regarding banning the use of technology for abortion and making it a penal offense” (Mazumdar, 1994: 3). However, this was only pertaining to government hospitals and clinics and it further led to “privatisation and commercialisation of reproductive technologies” (Mazumdar, op cit: 4).

A major landmark in the movement against NRTs was the formation of the Forum against Sex Determination and Sex Pre-Selection (FASDSP) in Mumbai in 1986 (though the campaign started earlier in 1980s the formal organisation was established in 1986). The FASDSP initiated its campaign in Mumbai to raise awareness on SD and SSA and secure an effective ban in 1986. The Forum membership ranged from varied backgrounds and interests
ranging from feminists, public health advocates to activists from the people’s science movement. The major activities of the forum were conducting public awareness drives, identifying doctors who performed these tests, exposing them, collecting evidence, writing articles in popular press, meeting people at the government level especially the health ministry to create pressure to formulate stringent law against SD. *Eve’s Weekly* reports (1986) on the first of its kind rally by FASDSP in December 1986 “the youngest member in the rally was two year old with her mother (Academician and activist Dr. Vibhuti Patel and her daughter Lara). With placards reading ‘daughters are not meant for slaughter’, doctors, artists (Play Wright Vijay Tendulkar with his daughters), journalists, lawyers, woman Activists from Young Women’s Christian Association, Committee for Protection and Democratic Rights, Stree Mukti Sangathana, Forum Against Oppression of Women, Mahila Daxata Samiti, People’s Science Movement had all rallied to protests the misuse of new tests in Mumbai” (Patel, 1986: 8-9). During the same time several doctors in Mumbai who opposed the misuse of NRTs also formed a group ‘Doctor’s against Sex-Determination and Sex Pre-Selection Techniques’.

Later the PNDT Bill (then known as The Maharashtra Prohibition of Amniocentesis and other SD Medical Tests Act, 1986) was introduced and passed in 1988 in Maharashtra Legislative assembly (Patel, V., 2011: 8). It took another 5 years to pass the Bill at the Centre and form an Act in 1994. In 1988, the state of Maharashtra became the first in the country to ban pre-natal SD through the enactment of the Maharashtra Regulation of Pre-natal Diagnostics Techniques Act. The state of Gujarat and Karnataka had followed the suit subsequently. At the national level the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act) was enacted on September 20, 1994 (PCPNDT handbook, 2007: 18).

**4B.1 PRE-NATAL DIAGNOSTIC TECHNIQUES ACT, 1994**

The Pre–natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994, as amended in 2003 to The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PC & PNDT Act), is a legislation to curb the abhorrent practice of SD and sex selection. The PNDT Act is a unique piece of legislation that not only guided the appropriate use of diagnostic technologies but also opened up space for articulating the need to regulate other types of reproductive and genetic technologies that were beginning to enter the Indian market. “The objective of the Act is to provide for the
regulation of the use of pre-natal diagnostic techniques for the purpose of detecting genetic or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex linked disorders and for the prevention of the misuse of such techniques for the purpose of prenatal SD leading to female foeticide” (Warke and Chauhan, 2006: 467). (for more details on the Act see APPENDIX - III).

4B.2 LOOPHOLES IN PNDT ACT, 1994

After it came into effect since 1996, PNDT was seen as a major deterrent to SD and SSA by Activists. However, till the year 2000 there was no conviction under the Act due to its loopholes. The major loopholes were that it criminalised the family and the women as a seeker of SD or SSA and did not question the doctors involved in the Act. It made the victim culprit who could be imprisoned for three years. Doctors, centres and laboratories were excluded from the provision of the test being a ‘non-cognisable, non-bail able and non-compoundable’ offence. The doctors who were influential and rich could easily get away as according to the Act, the court had the power to decide for a lesser punishment if it desires to do so (Patel, V., 2011: 8-9). The involvement of government bodies such as medical officer as an ‘Appropriate Authority’ made a mockery of people’s participation. The authorities often misused their power for their nasty, corrupt interests.

Campaign, originally thought to be protecting women’s reproductive rights often thought of being anti-abortionist. Activists were also labelled as anti-women, anti-development as they were questioning ‘women’s choice’. “Use of the word female foeticide by the campaigners instead of SSA, images used in the posters and other ICT material were all giving a wrong message of abortion being illegal and not SSA. There was also a fear of the whole abortion industry going undercover posing more threat to women’s health” (Gupte, 2003: 4).

In adopting the route of registration of clinics and equipment the law ends up sanctioning the private industry that has sprung up around provision of SD under the guise of pregnancy screening. Registration could well serve to legitimize these clinics as having a stamp of approval but it might not be effective in monitoring misuse or misconduct. Law has taken with regard to NRTs limiting it to include ultrasound, CVS and amniocentesis, all technologies for SD. However, even as this law was being debated new pre-implantation (PGD) and preconception technologies were being introduced in the country by doctors.
trained abroad as well as manufacturers who considered India to be a good market to promote these technologies and harvest profits (Mallik, 2003: 11).

**4B.3 SECOND PHASE: FROM PNDT TO PCPNDT**

In late 1990s and early 2000 evidence with regard to the widespread use of SD continued to surface both in the media as well as through smaller pilot projects. This served to create awareness on the on-going prevalence of SD as well as the neglect of this issue by both the national and state governments. This information proved to be substantial enough to file Public Interest Litigation (PIL) in the Supreme Court of India. Dr Sabu George, Centre for Enquiry into Health and Allied Themes, Mumbai (CEHAT) and the Mahila Sarvangeen Utkarsh Mandal (MASUM) filed the PIL on SD in the Supreme Court of India in February 2000. The original petition provided evidence to validate claims that the PNDT Act, 1994, had failed to achieve its goals. “The PIL also urged the Court to allow for an amendment to the Act that would allow the inclusion of new techniques such as pre-implantation genetic diagnosis (PGD) and other pre-conception techniques” (Mallik, 2003: 12).

The Pre-Conception and Pre- Natal Diagnostic Techniques (Prohibition of Sex Selection) Rules 1996, amended in 2003, came into force with effect from February 14, 2003. The change in nomenclature denotes a shift in emphasis from ‘regulation’ of techniques to ‘prohibition’ of sex selection (PCPNDT handbook, 2007: 4). The Act provides “for the prohibition of sex selection, before or after conception, for regulation of pre-natal diagnostic techniques for the purpose of detecting genetic abnormalities or metabolic disorders or sex linked disorders and for the prevention of their misuse for SD leading to female foeticide and for matters connected therewith or incidental thereto”. (Patel, V. 2011: 9).

The PIL has played an important role in creating widespread awareness of the criminality of SD and SSA. The role of law and in particular the response of the Supreme Court demonstrates that an important role can indeed be played by laws, in particular where the executive lacks the will to Act against powerful lobbies such as medical associations and doctors.
4B.4 THE PRE-CONCEPTION AND PRE-NATAL SEX SELECTION/DETERMINATION (PROHIBITION AND REGULATION) ACT, 2003:

4B.4.1 KEY CHANGES

- One of the key changes in the Act is the inclusion of technologies that allow sex selection to be undertaken during the preconception and pre-implantation stage previously not included within the purview of the Act.
- Another important addition is the requirement on the part of clinics and doctors, who provide ultrasound, to maintain written records (form ‘F’) that detail the specific reason why an ultrasound or amniocentesis test had been recommended to a pregnant woman.
- Under the Act, the person who seeks help for sex selection, with the exception of the pregnant women can face, the first conviction, imprisonment for 3-year period and can be required to pay a fine of Rs. 50,000.
- All sonography centres are required to register themselves with the appropriate authority-the medical officer of the particular ward.
- The registration certificate and the message that under no circumstances, sex of the foetus will be disclosed are mandatory to be displayed.

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 has since been amended with effect from 14.2.2003. Amendments to the Act mainly cover to:

- Bring the technique of pre-conception sex selection within the ambit of this Act so as to prevent the use of such technologies which significantly contribute to the declining sex ratio.
- Bring the use of ultrasound machines within the purview of this Act more explicitly so as to curb their misuse for detection and disclosure of sex of the foetus lest it should lead to female foeticide.
- Further empower the Central Supervisory Board for monitoring the implementation of the Act.
- Introduce State level Supervisory Board for monitoring and reviewing the implementation of the Act in States/UTs
- Constitute a multi member State Appropriate Authority for better implementation and monitoring of the Act in the States
- Make punishments prescribed under the Act more stringent so as to serve as a deterrent for minimizing violations of the Act
Empower the Appropriate Authorities with the powers of Civil Court for search, seizure and sealing the machines, equipments and records of the violators of law including sealing of premises and commissioning of witnesses

Making mandatory the maintenance of proper records in respect of the use of ultrasound machines and other equipments capable of detection of sex of foetus and also in respect of tests and procedures leading to pre-conception selection of sex.

Regulate the sale of ultrasound machines only to the bodies registered under the Act. (PCPNDT Handbook, 2007: 19)

Based on the amendments made to the Act, the Rules framed there under have also been amended under the amended Rules

A provision for appeal has been made: Any person having grievance against the sub district level Appropriate Authority can make an appeal to the district level Appropriate Authority and similarly for grievance against the district level Appropriate Authority an appeal can be made to the state/UT level Appropriate Authority.

23 indications, prescribed by Indian Council for Medical Research (ICMR), have been included in the PNDT Rules for which ultrasound scanning can be conducted during pregnancy for the well being of the pregnant woman and her foetus.

Forms have been simplified. Consent is required only in case of invasive techniques. (PCPNDT Handbook, 2007: 19).

4B.5 SHORTCOMINGS OF PCPNDT ACT, 2003

While the PCPNDT Act is a progressive legislation that, in spirit, has taken a stand against a discriminatory practice, it cannot ensure that sex selection does not occur.

Within the boundaries of a doctor-patient relationship, it is impossible to ensure that sex of the foetus is not revealed to the expectant parents. “Apart from decoy operations or installations of spy cameras, that have ethical issues associated with them, there is almost no way of doctor being ‘caught in the Act’” (Contractor, S., 2011: 15).

It is very difficult to prove the Act of sex selection when “disclosure of sex of the foetus is done by different means such as making gestures, abortion and sonography being performed at two different places showing no connection between the two, difficulty in monitoring the In Vitro Fertilization (IVF) centres” (Khanna, 2011: 9)
Also as discussed in the earlier section, monitoring abortion as an outcome of sex selection often mislead to anti-abortion message and possibility of unregulated and unsafe abortion procedure under cover.

Regulating medical technology is very difficult as our whole health sector itself is not strictly regulated. Especially the private sector does not fall within the purview of regulated health sector giving enough scope for sex selection.

There are technical difficulties too. Using the terms genetic clinics and laboratories interchangeable with ultrasound clinic and imaging centre is faulty. “Similarly the qualification for operating and conducting ultrasound sonography suggests either two years of experience in medical genetics or a degree certificate and diploma in medical genetics. According to experts these two cannot be equated” (Patel, V., 2011: 10).

Giving absolute and supreme power to Appropriate Authority (AA) as a whole and sole person to whom the complaint can be register gives absolute power to him/her to misuse his office for cancelling/sealing of USG machines as per his/her whims and fancies. The possibility of personal grudges/equations being settled in the name of implementation of the law cannot be denied.

Very often convictions are done for incomplete forms or lack of proper documentation, which of course are punishable, but in this small process the real bigger picture of penalising clinics actually conducting SD and SSA are missed out. Those who maintain all the records and have their documentation in place, get scot free.

The elite and highly educated class go out of the way to get a ‘balanced’ family or a designed baby from a foreign country (particularly west), where SD is legal and is beyond the confines of PCPNDT.

Rampant and sometimes haphazard sealing of sonography machines by AAs have created a stir amongst medical fraternity for whom, it serves like “a stethoscope and in absence of which detecting genetic abnormalities is almost impossible” (Aravamudan, 2007: 97).

4B.6 THE DEBATE BETWEEN RIGHT TO ABORTION (MTP) AND PROHIBITION OF SSA (PCPNDT)

In India, abortion has been legalised since 1971 and implemented in 1972. However, unlike west, it was never seen as a result of a trajectory of feminist struggle. Independent of women’s struggle it has always been a population control issue. In 1965, UN mission
evaluating India’s population policy recommended legalising abortion. In 1966, Shantilal Shah Committee submitted its report, recommending that access to abortion be liberalised in order to put an end to the large number of unsafe and illegal abortions. “The objectives of the Act were laid down as a) humanitarian: to help the ‘unfortunate’ women who are victims of ‘forcible sexual Acts’ b) health: sympathy toward women who become pregnant because of failure of contraception and c) Eugenic: to reduce the risk of ‘crippled’ children” (Menon, 2004: 72-73).

A women can get her pregnancy legally terminated under the conditions laid down by the law such as “if the pregnancy is a risk to mother’s physical or mental health or in case continuation of pregnancy may result in grave physical or mental injury, if the foetus is physically or mentally abnormal or disabled, if the pregnancy is result of rape or in case of unwanted pregnancy due to contraception failure. Recording of abortion with the written consent of the pregnant mother is mandatory by the law” (Aravamudan, 2007: 99).

The NRTs are often advocated in the name of ‘choice’ bestowed to women and enabling better control over their reproductive health. On the other hand, abortion after being legalised under Medical Termination of Pregnancy Act (MTP) 1971 was also propagated as a pro-choice feminist landmark right of women. But neither of them can be really perceived as empowering apparatus for women as an independent right to ‘choose’. “Both are to be seen and administered within the context of economic and cultural constraints that limits women’s possibilities of choice” (Menon, 2004: 67). The MTP Act is however often seen contrary to the PCPNDT Act, which denies the freedom of abortion to some extent.

As a result of the contradiction between the two Acts there is a state of confusion created in woman’s mind. And she is often unable to distinguish between what is ‘legal’ and what is not. There is also a thin line between what is abnormal but not illegal. In the sense aborting a female foetus is not legal based on the reason that it is ‘female’ but it is legal to abort a female foetus if it is ‘abnormal’. “According to sociologists and demographer Leela Visaria, in parent’s mind ‘medically abnormal foetus’ is given a same status as that of ‘female’ foetus because both are socially ‘undesirable’ because both are less productive and a liability” (Aravamudan, 2007: 100). This has often resulted in selfish and untrained medical practitioner to thrive on this confusion. In spite of the MTP Act, only 10% of total induced abortions are performed through licensed safe medical services (Bang, R. and Bang, A., 1992
Lack of information on legality of abortion leading to unsafe abortions has been a major cause for high Maternal Mortality Rate (MMR) in India.

Another argument made by FASDSP was that the permissible clause of ‘mental health’ of the women in danger needs to be revised in MTP. “While interpreting ‘mental health’ doctors include trauma that the women would be subjected to if she had a female child, and on this basis have conducted abortions up to twenty weeks. This existing provision of the MTP Act can legally permit selective abortion of female foetus” (Menon, 2004: 79).

Under the pressure to implement PCPNDT all the second trimester abortions done legally are looked upon with suspicion. Under the environment where access to safe abortions is already a problem, this kind of suspicion makes the access even more difficult. In situations where certain physical abnormalities are detected only in the second trimester, putting every abortion under scanner proves to be an impediment for right to abort an unhealthy or disabled child.

There is a very thin line between using NRTs for SD and detection of abnormalities. The very USG machine used for detecting the foetal growth and abnormalities can also reveal the sex of the foetus as a by-product. And hence, banning SD tests completely or sealing sonography machine for minor reason like insufficient documentation under PCPNDT can also result in lack of detection of foetal growth or abnormalities and violates one of the important clauses of MTP. There are larger dilemmas arising out of the contradiction between the two ‘if women has right to abort’ and has ‘control over body’ how can one deny the right to abortion based on sex of the foetus? Of course it is sexist to undergo SSA and also right to abortion cannot be seen as an absolute right, it does create a conflict between morality, legality and feminism.

CONCLUSION

Hence, the package of family planning programme with small family norm and use of NRTs has brought a unity of purpose of controlling the population and having a desired family. This purpose is achieved within the larger structure of patriarchy and son-preference resulting in disappearance of daughters. The two child norm, as depicted in all the primary and secondary data, is followed by the population along with a strong need for at least one son. This leads to misuse of widely and easily available SD for systematic elimination of girl child. There is substantial data to prove this for Gujarat in general and Vadodara in particular.
The campaign initiated by FASDSP and then carried forward by activists, social scientists and civil society organisations has been, to a great extent, successful. As right put forward by George (2002), one of the three petitioners of the PIL, points out that “a law and effective use of the judiciary can bring pressure on the executive branch of government to do a better job of monitoring use of these technologies, guide medical ethics that till date have been seriously lacking with regard to SD and SSA, and at the same time serve as a catalyst to address deep-rooted patriarchal norms within Indian society” (George, 2002 as cited in Mallik, 2003: 6). However, there still exist loopholes in the formulation and particularly in the implementation of the PCPNDT Act. Giving absolute power to the AA has been a major pitfall. Also it is difficult to break into the close nexus of doctors/gynaecologists-radiologists and patients involved in the misuse of the NRTs. Ethical questions on the *modus operandi* used by the PCPNDT committee to catch hold of doctors ‘in the act’ have also been raised.

Furthermore, in the zeal to check the problem of sex selection and ‘save the unborn child’ “the campaign has often encroached upon the right to abortion, both inadvertently and intentionally” (Contractor, S., 2011: 14). The focus of the campaign, which was to be on SD, has been on SSA entirely. Although it is absolutely necessary for the campaign to continue to pressurize the government to implement PCPNDT Act, it requires a rethinking from the gender justice and feminist perspectives.

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