CHAPTER IV
FEMALE INFANTICIDE AND FOETICIDE- DISTORTED 
DIMENSIONS OF MALE PREFERENCE

Though indispensable for the survival of society, ‘women’ have been looked down upon and have been at the receiving end in every sphere in our society. The obvious result has been more explicitly pronounced in the Census of India 2001. The 2001 census is the sixth decennial population census in independent India and the 14th since the first census was conducted in British India in 1871. A special effort has also been made in 2001 census process to sensitise senior functionaries, trainers and the enumerators to gender issues.1 India’s population, as on the midnight of February 28 – March 1, 2001, stood at 1,027,015,247, that is 102.70 crores. This makes India the second most populous country in the world, following China with 127.76 crores on February 1 and way ahead of the next most populous country, the United States of America i.e. 28.14 crores in April, 2000.2 About one-sixth population of the world is living in India.3

The population in India increased from 238 million to 846 million between 1901 and 1991; the population of males increased from 117 million to 407 millions in the same period. While we have added 318.2 million males to the population of India in 90 years, we have only added 290 million females to the population in the same period.4

However, the growth rate of population has come down in India during 1991-2001 (21.34%) as compared to 1981-1991 (23.86%) in

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1 Venkatesh Athreya, “Some progress, some concern” at http://www.frontlineonnet.com
2 Ibid.
practically all major states. The decadal growth rate between 1991-2001 is in fact the lowest inter-census growth rate during the period 1951-2001.\textsuperscript{5}

A. \textbf{Census of India 2001 – An Eye Opener}

The overall sex-ratio of India as revealed by Census of India, 2001 stands 933 females per 1,000 males. The sex-ratio of India has consistently been unfavourable to females and has shown a long term declining trend barring a few exceptions.

<table>
<thead>
<tr>
<th>Census Year</th>
<th>Sex Ratio (females per 1,000 males)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>972</td>
</tr>
<tr>
<td>1911</td>
<td>964</td>
</tr>
<tr>
<td>1921</td>
<td>955</td>
</tr>
<tr>
<td>1931</td>
<td>950</td>
</tr>
<tr>
<td>1941</td>
<td>945</td>
</tr>
<tr>
<td>1951</td>
<td>946</td>
</tr>
<tr>
<td>1961</td>
<td>941</td>
</tr>
<tr>
<td>1971</td>
<td>930</td>
</tr>
<tr>
<td>1981</td>
<td>934</td>
</tr>
<tr>
<td>1991</td>
<td>927</td>
</tr>
<tr>
<td>2001</td>
<td>933</td>
</tr>
</tbody>
</table>

\textbf{Source:} Provisional Population Totals, Sex Composition of the Population at 2, Chapter 6, Census of India, 2001 Series, India, Paper 1 of 2001

The estimated sex-ratio of the world around the year 2000 was 986 females against 1000 males. Thus, the imbalance of sexes can be evidenced in different populations around the world. Except Indonesia and

\textsuperscript{5} \textit{Supra} note 1.
Japan, the other Asian countries show low sex-ratios. Table-II presents the global sex ratio and that of the ten most populous countries in the world as estimated for the year 2000.

### Table-II

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Country</th>
<th>Sex Ratio (females per 1,000 males)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>World</td>
<td>986</td>
</tr>
<tr>
<td>1</td>
<td>China</td>
<td>944</td>
</tr>
<tr>
<td>2</td>
<td>India</td>
<td>933</td>
</tr>
<tr>
<td>3</td>
<td>U.S.A.</td>
<td>1,029</td>
</tr>
<tr>
<td>4</td>
<td>Indonesia</td>
<td>1,004</td>
</tr>
<tr>
<td>5</td>
<td>Brazil</td>
<td>1,025</td>
</tr>
<tr>
<td>6</td>
<td>Pakistan</td>
<td>938</td>
</tr>
<tr>
<td>7</td>
<td>Russian Fed.</td>
<td>1,140</td>
</tr>
<tr>
<td>8</td>
<td>Bangladesh</td>
<td>953</td>
</tr>
<tr>
<td>9</td>
<td>Japan</td>
<td>1,041</td>
</tr>
<tr>
<td>10</td>
<td>Nigeria</td>
<td>1,016</td>
</tr>
</tbody>
</table>

**Source:** World Population Prospects (mid year estimates) 1998 Revision, Volume 2, Sex and Age, United Nations.

A study conducted by the United Nations Statistical Office and population division points out that the declining sex ratio in India suggests that it is an exception to the global rule of girls surviving better than boys owing to their biological stronger constitution. In most countries, the sex ratio tends to be in favour of women with an average of about 1050 women for every 1000 men.

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Chapter-IV

This deficit of women in India's population has been documented ever since the first decennial enumeration of people was conducted in the late 19th century. At the Census of India, 2001, the sex ratio among the major states ranged from 861 in Haryana to 1058 in Kerala. In 1991 also, Haryana with a sex ratio of 865 was at the bottom with Kerala 1036 at the top. The major states contributing largely for the decline in the overall sex ratio in India are Uttar Pradesh, Bihar, Jharkhand, Orissa, Chhattisgarh, Madhya Pradesh, Gujarat, Maharashtra and Tamil Nadu. Albeit the sex ratio in Punjab has been consistently low, it has shown long-term upward trend and has not contributed to the overall deterioration in the sex ratio of the country. The sex ratio in Rajasthan always remained in a low level. Haryana, Andhra Pradesh and Karnataka are the states where the sex ratio has remained more or less stagnant. The most disturbing alert for gender inequality is the sharp decline in the child sex ratio in the 0-6 age group. It was for the first time in 1991 census, the separate child sex ratios for the age group 0-6 and 7 and above were tabulated. The imbalance in the number of males and females begins in the beginning itself. As a well-established law of nature, it is believed that generally 943-952 female births take place for every 1000 male births, which results in deficiency of about 50 females per 1000 males in every birth cohort.

The Child Sex Ratio (CSR) in India has been indicative of a negative trend towards girl children for decades now.

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9 Supra note 6 at 5.
Table-III Sex Ratio of Total Population and Child Population in the age
group 0-6: 1961-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Sex Ratio in age group 0-6 (Females per 1000 Males)</th>
<th>Overall sex ratio (Females per 1000 Males)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>976</td>
<td>941</td>
</tr>
<tr>
<td>1971</td>
<td>964</td>
<td>930</td>
</tr>
<tr>
<td>1981</td>
<td>962</td>
<td>934</td>
</tr>
<tr>
<td>1991</td>
<td>945</td>
<td>927</td>
</tr>
<tr>
<td>2001</td>
<td>927</td>
<td>933</td>
</tr>
</tbody>
</table>

**Source:** Provisional Population Totals, Sex Composition of the Population at 2, Chapter 6, Census of India, 2001 Series, India, Paper 1 of 2001

The sex ratio in the age group 0-6 has decreased at a much faster pace than the overall sex ratio of the country after 1981. At the national level, there is sharp decline in CSR from 962 in 1981 to 945 in 1991. The 2001 census shows a further decline of 18 points from 945 in 1991 to 927 in 2001. Such drastic decline in the CSR seems to have cascading effect on the population in the long run leading to diminishing sex ratio in the country. The decline is even sharper in several states. This decline can be evidenced in all the states and union territories except Kerala (5 points increase), Sikkim (21 points increase), Tripura (8 points increase) and Mizoram (2 points increase). This conspicuous decline in CSR is assuming an alarming proportion in certain districts of Punjab (CSR declined by 82 points – 875 to 793), Haryana (by 59 points – 879 to 820), Himachal Pradesh (by 54 points – 951 to 897), Chandigarh (by 54 points – 869 to 845), Gujarat (by 50 points – 928 to 878), Uttaranchal (by 42 points – 948 to 906), Maharashtra (by 29 points – 946 to 917) and Delhi (by 50 points). In fact, the CSR has declined in every state with a population exceeding 20 million in 2001, with the solitary exception of Kerala.

10 Id. at 4, 8 and 9.
11 Supra note 1.
<table>
<thead>
<tr>
<th>No.</th>
<th>State</th>
<th>0-6</th>
<th>7-14</th>
<th>15-29</th>
<th>30-69</th>
<th>70+</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Sikkim</td>
<td>878</td>
<td>875</td>
<td>965</td>
<td>986</td>
<td>860</td>
</tr>
<tr>
<td>12</td>
<td>Arunachal Pradesh</td>
<td>859</td>
<td>901</td>
<td>982</td>
<td>961</td>
<td>829</td>
</tr>
<tr>
<td>13</td>
<td>Nagaland</td>
<td>886</td>
<td>909</td>
<td>993</td>
<td>975</td>
<td>865</td>
</tr>
<tr>
<td>14</td>
<td>Manipur</td>
<td>958</td>
<td>978</td>
<td>974</td>
<td>961</td>
<td>955</td>
</tr>
<tr>
<td>15</td>
<td>Mizoram</td>
<td>921</td>
<td>938</td>
<td>969</td>
<td>971</td>
<td>911</td>
</tr>
<tr>
<td>16</td>
<td>Tripura</td>
<td>945</td>
<td>950</td>
<td>967</td>
<td>975</td>
<td>940</td>
</tr>
<tr>
<td>17</td>
<td>Meghalaya</td>
<td>955</td>
<td>975</td>
<td>986</td>
<td>975</td>
<td>947</td>
</tr>
<tr>
<td>18</td>
<td>Assam</td>
<td>923</td>
<td>932</td>
<td>975</td>
<td>964</td>
<td>910</td>
</tr>
<tr>
<td>19</td>
<td>West Bengal</td>
<td>917</td>
<td>934</td>
<td>967</td>
<td>963</td>
<td>907</td>
</tr>
<tr>
<td>20</td>
<td>Jharkhand</td>
<td>922</td>
<td>941</td>
<td>979</td>
<td>966</td>
<td>908</td>
</tr>
<tr>
<td>21</td>
<td>Orissa</td>
<td>971</td>
<td>972</td>
<td>967</td>
<td>950</td>
<td>972</td>
</tr>
<tr>
<td>22</td>
<td>Chhattisgarh</td>
<td>985</td>
<td>990</td>
<td>984</td>
<td>975</td>
<td>986</td>
</tr>
<tr>
<td>23</td>
<td>Madhya Pradesh</td>
<td>912</td>
<td>920</td>
<td>941</td>
<td>929</td>
<td>905</td>
</tr>
<tr>
<td>24</td>
<td>Gujarat</td>
<td>934</td>
<td>971</td>
<td>928</td>
<td>878</td>
<td>936</td>
</tr>
<tr>
<td>25</td>
<td>Daman &amp; Diu*</td>
<td>969</td>
<td>709</td>
<td>958</td>
<td>925</td>
<td>971</td>
</tr>
<tr>
<td>26</td>
<td>Dadra &amp; Nagar Haveli*</td>
<td>952</td>
<td>811</td>
<td>1,013</td>
<td>973</td>
<td>937</td>
</tr>
<tr>
<td>27</td>
<td>Maharashtra</td>
<td>934</td>
<td>922</td>
<td>946</td>
<td>917</td>
<td>931</td>
</tr>
<tr>
<td>28</td>
<td>Andhra Pradesh</td>
<td>972</td>
<td>978</td>
<td>975</td>
<td>964</td>
<td>972</td>
</tr>
<tr>
<td>29</td>
<td>Karnataka</td>
<td>960</td>
<td>964</td>
<td>960</td>
<td>949</td>
<td>960</td>
</tr>
<tr>
<td>30</td>
<td>Goa</td>
<td>967</td>
<td>960</td>
<td>964</td>
<td>933</td>
<td>967</td>
</tr>
<tr>
<td>31</td>
<td>Lakshadweep*</td>
<td>943</td>
<td>947</td>
<td>941</td>
<td>974</td>
<td>943</td>
</tr>
<tr>
<td>32</td>
<td>Kerala</td>
<td>1,036</td>
<td>1,058</td>
<td>958</td>
<td>963</td>
<td>1,049</td>
</tr>
<tr>
<td>33</td>
<td>Tamil Nadu</td>
<td>974</td>
<td>986</td>
<td>948</td>
<td>939</td>
<td>978</td>
</tr>
<tr>
<td>34</td>
<td>Pondicherry*</td>
<td>979</td>
<td>1,001</td>
<td>963</td>
<td>958</td>
<td>982</td>
</tr>
<tr>
<td>35</td>
<td>Andaman &amp; Nicobar Islands*</td>
<td>818</td>
<td>846</td>
<td>973</td>
<td>965</td>
<td>790</td>
</tr>
</tbody>
</table>

**Source:** Provisional Population Totals, Sex Composition of the Population at 2, Chapter 6, Census of India, 2001 Series, India, Paper 1 of 2001
It may be noted that the number of states and union territories with sex ratio of below national average has increased from seventeen in 1991 to eighteen in 2001. It may further be seen that the sex-ratio of the total population have shown improvements in as many as twenty three states and union territories. However, during the corresponding period the sex ratio of the child population in the age group 0-6 has increased in only four states and one union territory.¹⁵

Table V - Bottom Ten Districts by Child Sex Ratio in Age Group 0-6 in Rural Areas-India: 2001

<table>
<thead>
<tr>
<th>DISTRICTS</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sonipat (Haryana)</td>
<td>788</td>
</tr>
<tr>
<td>2. Rupnagar (Punjab)</td>
<td>787</td>
</tr>
<tr>
<td>3. Mansa (Punjab)</td>
<td>780</td>
</tr>
<tr>
<td>4. Sangrur (Punjab)</td>
<td>779</td>
</tr>
<tr>
<td>5. Kapurthala (Punjab)</td>
<td>773</td>
</tr>
<tr>
<td>6. Ambala (Haryana)</td>
<td>772</td>
</tr>
<tr>
<td>7. Kurukshetra (Haryana)</td>
<td>772</td>
</tr>
<tr>
<td>8. Patiala (Punjab)</td>
<td>764</td>
</tr>
<tr>
<td>9. Salem (Tamil Nadu)</td>
<td>763</td>
</tr>
<tr>
<td>10. Fatehgarh Sahib (Punjab)</td>
<td>747</td>
</tr>
</tbody>
</table>

Source: eCENSUS India Issue 15 : 2003

¹⁵ Id. at 7.
rapid decline in male mortality with the decline in the mortality rates, whereas, many states known for their gender bias show evidence of the 'substitution effect', *i.e.* more rapid decline in female infant and child mortality rates in the wake of increasing incidence of pre-natal sex selection. This post-natal discrimination against the girl children has been substituted by the pre-natal selection.  

Table VII: Distribution of districts by child sex ratio in the age group 0-6 for urban areas – India: 1991-2001

<table>
<thead>
<tr>
<th>Ranges of sex ratio</th>
<th>1991</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of districts</td>
<td>Share of population</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Absolute</td>
</tr>
<tr>
<td>Total</td>
<td>565</td>
<td>215,383,755</td>
</tr>
<tr>
<td>Less than 800</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>800-849</td>
<td>5</td>
<td>1,126,912</td>
</tr>
<tr>
<td>850-899</td>
<td>68</td>
<td>23,129,902</td>
</tr>
<tr>
<td>900-949</td>
<td>261</td>
<td>110,785,366</td>
</tr>
<tr>
<td>950-999</td>
<td>216</td>
<td>78,588,567</td>
</tr>
<tr>
<td>1000-1049</td>
<td>12</td>
<td>1,733,359</td>
</tr>
<tr>
<td>1050 and above</td>
<td>3</td>
<td>19,649</td>
</tr>
</tbody>
</table>

Note: Excludes fourteen districts of Jammu & Kashmir where Census was not held in 1991, nine totally urban districts and Kachchh and Kinnaur districts of Gujarat and Himachal Pradesh where 2001 Census has not been held so far.

Source: eCENSUS India Issue 15: 2003

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Some of the important reasons explaining consistent low levels of sex ratio and their further decline in the country have been enumerated as–

- Neglect of girl child resulting in their higher mortality at younger ages.
- High maternal mortality
- Sex selective female abortions
- Female infanticide
- Change in sex ratio at birth.\(^{18}\)

Sex ratio at birth is one of the ‘initial conditions’, which determines the sex ratio of the overall population. It is nearly constant within a range of 104-107 male live births per 100 female live births in the absence of any sex-selective human intervention. Various biological, environmental and socio-economic factors affect sex ratio at birth. Primary sex ratio (sex ratio at conception) is believed to be much higher than the sex ratio at birth or the ‘secondary’ sex ratio.\(^{19}\)

Sex differentials in mortality have been identified as the main cause of low female/male ratio by the analysis in the last quarter century. This was traced to discrimination against women. The discrimination resulted in an unequal access for women to life sustaining inputs like food, nutrition and health care, leading to higher female over male mortality. This is conspicuously evident in the mortality of female children in the juvenile age group.\(^{20}\) Such discrimination has been termed as ‘subtle killing’.\(^{21}\)

As shown in Table VIII, Infant Mortality Rate (IMR) has come down significantly in India compared to 1951 from 142/1000 live births to 72/1000 in 1998.

\(^{18}\) Supra note 6 at 4.
\(^{19}\) Supra note 4 at 40.
\(^{20}\) Id. at 41.
\(^{21}\) Quoted in Kumkum Chadha, “Women’s worst enemy” The Hindustan Times, at 10 (May 16, 2003).
14,000 and a sex-ratio among minors (born after the 1857 mutiny) of 310 girls per 1000 boys.\(^{36}\)

In history, female infanticide was common among certain castes and tribes such as the Rajputs, Jats, Gujjars, Ahirs and Sikhs. It was a custom widely accepted among these warrior tribes, where sons were needed to defend the honour and more importantly, the territories of the tribe. Among other cardinal social factors were the mutual rivalries and a strict hierarchy as between different clans restricted the number of clans to which women could be given in marriage.

In the north-western parts of India, the horrid practice of sacrificing female children as soon as born has been known from time immemorial. The Hindus ascribe this custom to a prophecy delivered by a Brahman to a Rajpoot King that his race would lose the sovereignty through one of his female posterity.\(^{37}\) Others hold the view that from the effect of malediction pronounced, no good ensues from their preservation; in so much that if any daughters of this tribe get married into other houses, the grain in such houses becomes less plentiful; nor do such women produce sons, but are the occasion of feuds in the families into which they are thus transplanted. To quote Colonel Walker, “The Hindoos, with a facility proportionate to their credulity, generally ascribe their peculiar institutions to a divine origin: and, by connecting their observance with religious duties, they have passed inviolate through many ages. When the customs or rites of any people are harmless, whatever form they assume and from whatever source they may be derived, they are entitled to toleration and protection;
but they ought to be punished or amended when their evident tendency is
to diminish population and to alienate the natural affections of mankind".38

Pained with the prevalence of this gruesome custom, for the sake of
humanity and philanthropy the earliest efforts of the Britishers to abolish
the same are commendable.

- In 1808, Alexander Walker, Chief President of Baroda, encouraged
  the Chiefs of different clans to enter into deeds to renounce this evil
  practice of killing female infants. Penalty was imposed on the
  violators.
- An infanticide fund was also set-up to defray marriage expenses;
- He also extended cash awards to parents of girls.
- In Punjab, it was diagnosed that the intense factional rivalry was the
  cause of female infanticide. So the state established marriage
  bureaus.
- Johan Strachey enacted a special Act of 1870, applicable to North
  West Province, which suggested an enlarged police force, increased
  surveillance, regular and thorough census and restriction on
  marriage expenses. It was also declared in 1872 that those clans
  which had a proportion of girls less than 40 per cent of the total
  population were declared very guilty of crime of female infanticide.
  Thus, the entire community was deemed to be responsible for every
  criminal act of exterminating female infants.39

By 1905, the government of the United Provinces, Agra and Oudh
(formerly the North West Province) was of the opinion that the Special Act
of 1870 was no longer required as the punitive provisions had been quite
effective in practice. The Act was finally withdrawn in 1906.

38 Id. at 134, 135.
39 Referred in "Report of Public Hearing on Female Infanticide & Foeticide", Tamil Nadu State
Commission For Women at 61 (10th July 2002).
Assistant Resident Willoughby set up an elaborate network of informers and used to levy punitive fines and incarcerate practitioners of female infanticide.

Easkive, on the other hand, sought to end surveillance and used education to end the menace.

Finally due to the persistent recurrence of the problem of killing of baby daughters, the British were forced to declare female infanticide a criminal offence.40

A UNICEF Report establishes the rampant prevalence of the custom of infanticide throughout India, particularly, in Tamil Nadu, Uttar Pradesh, Rajasthan, Haryana and Bihar. In certain communities in Bihar and Rajasthan, the sex ratio has plummeted to 600.41

A noted economist and a social activist for the prevention of female infanticide in Tamil Nadu, Dr. Venkatesh Athreya also acknowledges and affirms that female infanticide is seen across several regions in rural India and its incidence is on the rise. According to him, the practice is no longer confined to its original territory of northern provinces, but has emerged in south as well. He concedes that practically all-agrarian castes practice female infanticide. According to him fight against female infanticide is a fight against the dominant culture of patriarchy.42

Female infanticide in Tamil Nadu has recently received widespread attention. The practice of female infanticide was first highlighted in the national media in 1985 by the leading newsmagazine India Today. For bringing female infanticide to mainstream attention in India, the credit goes to Andal Radhakrishnan, Shahrulk Alam and Diya Kapoor, in "Female Infanticide And Foeticide - Legal Issues", Family Medicine India, Vol. 3-No. 4, 28-30 at 28 (1999).

See Geeta Athreya, "Right to Life : Need for Social Movement Against Foeticide and Gender Bias" in National Workshop on Gender Bias : Female Foeticide and Infanticide, New Delhi, organized by Indian Medical Association and UNICEF at 10 (7-8 Aug. 1999).

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to Sabu George. According to him, prejudices against the girl child are not just prevalent across the country but are growing.43 Despite the ban on the practice of this heinous custom, the practice continued, more clandestinely in the northwestern plains. A recent report in The Times Of India, Mumbai, September 17, 1999, on a village called Devra in Rajasthan said that a girl child not only survived through a series of accidental circumstances but also brought a ‘barat’ i.e. a groom’s marriage party to the village for the first time after 110 years.44

Among the Punjabi Community in Canada, occasional cases of female infanticide are reported every few years.45

A comprehensive study46 of Juvenile Sex Ratio (JSR) brings out linkage between female infanticide and female foeticide by saying that the pre-natal selection has accorded legitimacy to the elimination of a child on the basis of sex and where money and facility are available, it is resorted to by the social super-stratum. Those who do not have access to this facility look for ‘affordable’ alternatives i.e., infanticide. As the incidence of infanticide spreads, those who practice prenatal selection occupy a ‘holier pedestal’ since they are not indulging in the ‘barbaric’ or the ‘cruel’ practice of killing a newborn infant.

While another view is that infanticide is not a cost-effective method of sex-selection. The psychological and moral costs are so high that

44 See D. Bandyopadhyay, “Gender and Governance in India” Economic And Political Weekly, 2696 to 2699 at 2696, July 29, 2000.
45 Jeeva, K; Gandhimathi and Phavolam : Female Infanticide : Philosophy, Perspective and Concern of SIRD – Search Bulletin at 9-17 at http://www.hsph.harvard.edu/organisations/healthnet
people are unlikely to take such a step except under extreme circumstances. With the advent of sophisticated technology for sex determination, female foeticide has emerged as yet another form of denying the right to be born, though extenuating the sin of killing baby girl after birth.

C. Female Foeticide – Hi-Tech Sexism

Foetal diagnostics is contributing to the trend in social development towards what might be called ‘social-brutalisation’ in which people are sorted out in worthy and inferior, desirable and undesirable categories. Bio-evolution has a way of adapting itself to changing lifestyles and environments. Creating artificial life, a single-gender or even a genderless world is not as fantastic as it seems. Hi-tech Sexism with the advent of the sophisticated technology of sex-determination in India in 1974 (All India Institute of Medical Sciences, New Delhi introduced amniocentesis to detect foetal abnormalities) has reverberated the patriarchal values. It has proved to be another killer of human civilization making it possible to determine the sex of the foetus and getting it aborted if not of the desired sex.

Desire to know the sex of the child before birth and efforts at sex-selection can be dated back to the 5th century BC when the sex of the child was linked to the day of conception. In the days of Aristotle it was said that the North wind favoured a male child and a South wind a female.
The ancient Greeks had strange ways of determining the sex of the unborn child. Philosopher (520 BC) believed both men and women produced semen and the sex of the child depended on which side of the testicle and uterus the semen came from. Empedocles (450 BC) thought sex was determined by the location of conception in the womb.51

In the 18th century one of the myths prevalent was that if the left testicle was squeezed during intercourse it helped to produce a male child. Dupuy in 1888 devised a mathematical law to pre-select the sex of the child. In 1989, Cleisz suggested that if an elderly man mated a young poor woman and the conception took place between April and June; the resultant child would be a boy. Seasonal differences have been related to the sex of the child. The Chinese calendar claims that according to the year of birth, conception in the suggested month will lead to birth of a child of the desired sex.52 Throughout history women have tried to influence the gender of their child but instead of quaint fertility rituals hi-tech methods get better results. Parents have been seeking ways to do it for centuries, trying everything from sampling the contents of witches’ cauldrons to performing bizarre fertility rituals.53 It was an enigma a couple of years back to know the sex of the unborn child. Tremendous technological advancement in biochemical sciences including molecular biology techniques and analysis; genetic and medical sciences have made it possible not only to determine but to pre-select the sex of the unborn child. However, the main aim of prenatal diagnosis is to detect the mental or physical abnormality in the child to be born. These technologies have

52 Supra note 50 at 6.
fitted into our patriarchal cultural patterns which are evidently prejudiced against female sex. However, social consciousness is unable to keep pace with advances made in science and technology.

Prejudice against female is particularly stark in certain contexts where socio-cultural devaluation of the female life would lead to individual, familial perceptions of female children being a liability and takes the form of “pre-victimisation”54 through sex selective abortion. Families with the help of advanced sex determination technologies and sex selective abortion of female foetuses can ‘technically’ control the natural course of procreation, reinforcing with greater efficacy culturally demarcated sex preference norms.55

The most common methods of sex determination of a foetus are:

1. Chorion Villus Biopsy
2. Amniocentesis
3. Ultrasonography

1. **Chorion Villus Biopsy:**

   A vertical explosion of biotechnological advancement resulting as chorion villous biopsy two decades ago was another miracle of science. This technique made it possible to diagnose hereditary diseases and congenital defects in an unborn foetus as early as seven weeks after conception. But in today’s scenario, the technique is largely used to know the sex of an unborn child. It is performed in the first 7-11 weeks of pregnancy under strict aseptic conditions. A plastic canula is passed through cervix up to amniotic sac (water bag in which foetus floats) and a few chorionic cells which occur at the site of future placenta, surrounding

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the sac are aspirated (removed by suction) under ultrasound vision. These cells are cultured in a specific solution. Examination of these cultured cells gives information about growing foetus, besides revealing sex\textsuperscript{56}. It has been reported that 98\% of chorion villous biopsy done in our country is for sex determination only.\textsuperscript{57}

The risk\textsuperscript{58} of such procedure is:-

i) There is 4 – 12\% chance of precipitating spontaneous abortion.
ii) Genetic diagnosis may be wrong in 4-6\% of cases.
iii) There are chances of introducing infection.
iv) This may produce limb defects in the foetus.
v) Bleeding at site of biopsy may lead to growth retardation of the foetus.\textsuperscript{59}

2. Amniocentesis:

Amniocentesis was first advocated for diagnosis purpose in 1930. In 1951, Rosa and Fanaed described a method of foetal sex determination by amniotic fluid cytology. In 1965, this technique was used for antenatal diagnosis of hereditary diseases. Since 1980s, the amniocentesis in India has become synonymous with sex determination test. Amniocentesis is very expensive in other countries and is under strict government control.

\textsuperscript{57} Dr. J.B. Sharma, "Female Foeticide : A Great Danger To Indian Society", Family Medicine India, Vol. 5, No. 1, 34-35 at 34 (January 2001).
\textsuperscript{58} A personal experience of a gynaecologist as narrated by her says, "About 8 years back, a Medical Practitioner’s wife had undergone chorion villous biopsy at 9 weeks of pregnancy, to know the sex of the foetus, at Loomba Clinic in New Delhi. After this test, she complained of bleeding per vaginum and subsequent ultrasonography revealed a big blood clot inside the womb (amniotic sac) which hampered the growth of the foetus. At birth the baby was grossly under weight and had to be revived with great difficulty. Compounded with the above problems, the boy is now mentally retarded. Quoted by Dr. Neelam Singh in Family Medicine India, Vol. 5 No. 1, at 39 (January 2001).
\textsuperscript{59} National Workshop on Gender Bias : Female Foeticide and Infanticide organised by Indian Medical Association and UNICEF, New Delhi at 25 (August 7-8, 1999).
Amniocentesis is a procedure in which 15 - 20 ml. of amniotic fluid (liquid in baby's water bag) is taken out. This liquid is examined and tested to know various diseases and congenital defects in the unborn child. Sex determination is essential only in cases of genetic diseases that are sex linked such as hemophilia, which cannot be diagnosed by any other means. The test is routinely used for women after 40 years of age when the risk of giving birth to deformed babies increases. ‘Revelation of sex’, caught attention of the doctors in India as they foresaw its enormous potential for the son besotted Indian society.

Amniocentesis has nearly 1% risk as –

i) It may induce abortion or induce premature delivery.

ii) Introduction of infection.

iii) Bleeding

iv) Hip dislocation

v) Respiratory complications

vi) Needle puncture mark on baby.

vii) Accuracy rate is 95 – 97%\(^{60}\)

Amniocentesis is usually done at between 14 – 16 weeks of pregnancy. For accurate determination of sex, cell culture for 3 weeks is required. In practice generally these cells are not cultured in India as the report is required promptly to determine the sex. This method is now totally obsolete for sex determination.

3. **Ultrasound Scan:**

In today’s scenario, ultrasonography is the most widely used method of sex determination. Ultrasonography is being used in obstetrics and gynaecology for nearly three decades but its use for determining the sex of

the foetus is only a couple of years old. The technique is non-invasive. It is done at about 14-16 weeks of pregnancy. It has gained immense popularity as a pre-natal sex-determination technique. This has led to the mushrooming of ultrasound centres exclusively for sex determination, even in smaller towns. In some small towns and villages of Haryana, sex-determination tests are conducted in mobile vans. These vans are doing brisk business by preying on the psychology of people. If the foetus is female, a mid-trimester abortion is carried out either by a doctor or by a dai (in remote areas) depending upon the financial status of the family. Charges vary from Rs. 750/- to Rs. 10,000/- for abortion in the second trimester.61

Ultrasonologists opine that at the stage of 13-14 weeks of pregnancy, the chance of correct prediction is 95-96% depending upon the expertise of the ultrasonologist. As pregnancy increases the chances of accuracy also increases.62

Researchers all over the world are working on new ways to detect the sex of the foetus prior to birth. According to researchers at the Prenatal Genetic Diagnosis Unit at Tel Aviv Medical Centre in Israel, a hormone in the blood during the first 2-3 weeks of pregnancy could suggest whether a boy or girl is on the way. The researchers found that only 16 days after conception, there were clear differences in the levels of the hormone – called HCG – between women carrying male and female foetuses. Girl foetuses have on an average 20% higher level of hormone.63

Besides sex determination methods, technologies have now gone far ahead to ensure that the female foetus is not only conceived.

61 Supra note 59 at 25.
62 Ibid.
63 “A New Sex Determination Method” Women’s Era at 26 (January 2003)
a) **Ericsson Method**

In the recent years, a more scientific approach to the problem of doing away with the unwanted sex of the child has resulted in the emergence of various techniques for the separation of sperms bearing X & Y chromosomes in an attempt to establish a pregnancy with a child of the desired sex. Ericsson’s technique involves sperm washing and treating sperms to enhance its ability to produce a boy and implanting them in the woman by intrauterine insemination. This technique involves the identification and discarding of the female embryo; XX (female) and XY (male) chromosomes are separated and only XY sperms are implanted in the woman’s womb and are used for artificial insemination. The success rate of this method is 65-70%. Cost of X-Y separation varies between Rs. 15,000 to Rs. 20,000/-. 

b) **The Pre-Implantation Genetic Diagnosis (PGD)**:

In this technique, one or two cells are removed from an 8-10 celled embryo and tested. The ‘healthy’ embryo is then re-implanted into the uterus. Pre-implantation diagnosis should only be used for couples with a high risk of having children with very severe hereditary disorders. Pre-implantation diagnosis has the advantage that it takes place before there is pregnancy, and with ‘selective’ transfer of ‘healthy’ embryos, termination of the pregnancy at a later stage can be avoided. In PGD, the pre-embryos are sexed for the selective destruction of the female pre-embryo, which can be called ‘female embryocide’.  

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65 Supra note 59 at 26.
66 Ibid.
67 Sabu M. George & Ranbir Dahia, “Female Foeticide in Rural Haryana”, *Economic and Political Weekly*, 2191-2198 at 2192 and 2193 (August 8, 1998)
Scientists who have developed the technique at the genetic and IVF Institute of Fairfax, Virginia, claim that it is 90% effective for couples wanting a girl and 72% for boys. It is, of course, the hi-tech nature of the latest “sperm sorting” procedure, along with objections that it is unethical to select the sex of babies for social reasons that have caused the most opposition to it.  

With tacit support of the society, this two step process i.e. sex determination and if the foetus turns out to be of female sex then consequent abortion, has emerged as yet another form of denying the right to be born though extenuating the sin of killing a baby girl after birth.

Dr. Ashish Bose rightly calls it “unholy alliance between technology and tradition to perpetuate gender bias”. Such a trend is leading towards a ‘systematic decimation’ of the female sex. Ms. Vibha Parthasarthi, former Chairperson, National Commission for Women condemns that the glorious heritage and legacy of India, is neck deep in the inhuman and cruel crime of selective female foeticide.  

A survey in Mumbai reported that out of 8,000 foetuses aborted, 7944 were girls. According to one estimate, every year 10% of all Indian women undergo sex pre-selection tests and 50,000 female foetuses are aborted. According to a Medical College Study, in Jaipur, pre-natal sex determination tests result in an estimated 3500 abortions of female foetuses annually. According to a noted gynaecologist, Dr. Sharda Jain, "atleast 50 lakh female foeticide operations are conducted every year in

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68 Supra note 53.
69 Supra note 59 at 16.
70 Id. at 15.
71 Ibid.
73 Case Study : Female Infanticide in www.gendercide.org
Progressive liberalization has moved abortion laws from a focus on punishment toward concern with women’s health and welfare and with their human rights. The most recent development places abortion within a spectrum of services to which women should have safe access as a matter of human rights and social justice.106

The MTP Act was contemplated with the following three objectives: -

1. Health grounds, that is, when there is danger to life or risk to the physical and mental health of a woman; or
2. Humanitarian grounds largely when pregnancy is caused as a result of sex crime or intercourse with a lunatic woman; or
3. Eugenic grounds when there is a substantial risk that the child, after abortion, would suffer from deformities and diseases.107

Besides checking the incidence of illegal induced abortions by improving the accessibility and availability of scientifically approved services for induced abortion in properly screened cases, the latent object of the Act seems to be to empower the woman to take decisions concerning her body, that is, the right to space, limit or reject pregnancy. Another important feature of the Act is that it encourages a check in the rate of population growth by permitting termination of an unwanted pregnancy of a married woman on the ground of ‘contraceptive failure’.

The MTP Act permits the termination of pregnancy provided following conditions are satisfied: -

1. The person conducting the termination of pregnancy is a registered medical practitioner.

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106 http://www.findarticles.com/plarticles/mi_m2872/is_2_26/ai_62140798/pg_2
3. In case of pregnancy not exceeding 12 weeks, one medical practitioner is required to examine and in case of pregnancy exceeding 12 weeks, but not exceeding 20 weeks, two medical practitioners are required to examine and to form an opinion whether the continuation of pregnancy would involve risk to the pregnant woman, grave injury to her physical and mental health or substantial risk that if child was born would be seriously handicapped.

Section 5 is an exception to sub-section (2), Section 3 and provides that where the pregnancy exceeds 20 weeks, it cannot be terminated except in cases when it is immediately necessary to save the life of the pregnant woman.

The term “grave injury to her mental health” includes:

a) anguish caused by any pregnancy alleged by the pregnant woman to have been caused by rape and

b) anguish caused by pregnancy resulting from failure of any device or methods used by any married woman or her husband for the purpose of limiting the number of children. In effect this reason legalised abortion on demand. Contraceptive failure is not a ground for abortion for unmarried women but only for married women.

The opinion has to be formed in “good faith” which means applying “due care and caution”. Pregnancy of any woman who is less than 18 years or who is a mentally ill person can be terminated only, with the consent of her guardian in writing.\textsuperscript{108} The Act also provided that the termination of pregnancy should be undertaken either in a government

\textsuperscript{108} Section 3 sub-section (4); “mentally ill person” has been substituted for “lunatic” by Act 64 of 2002 (w.e.f. 18.06.2003).
hospital or a place approved by the government or district level committee constituted by that government.\textsuperscript{109}

With a view to reduce the unsafe abortions by making legal abortions more widely accessible, Section 5 of the MTP Act, 1971 has been amended. The amended section provides for rigorous imprisonment for up to seven years in case the pregnancy is terminated by an unauthorised person or in an unauthorised place and the owner or the administrative head of such place would also be liable for the same punishment.\textsuperscript{110}

The most ambiguous yet safest ground in terms of evading law for seeking abortion is ‘failure of contraceptive device’, which often features as the standard excuse put forth for legalizing abortion.

However, the fact that abortion services are being provided on demand by an increased number of unregistered service providers, non-allopathic practitioners, paramedics and others and the estimates state that nearly six million abortions are performed every year outside the ambit of the Act.\textsuperscript{111}

The Shah Committee (1966) had estimated an annual incidence of 6.5 million abortions indicating three-fifths or 3.9 million to be induced and two-fifths or 2.6 million to be spontaneous. The assumption was that for every 73 live births, there are two stillbirths and 25 abortions.\textsuperscript{112}

According to another study\textsuperscript{113}, over 11 million abortions took place in India in the year 1992 out of which only 0.6 million were registered MTP

\textsuperscript{109} Section 4, ibid.; substituted by Act 64 of 2002 (w.e.f. 18.06.2003).
\textsuperscript{110} Substituted by Act 64 of 2002 (w.e.f. 18.06.2003).
\textsuperscript{111} Preface, Sex Selective Abortions and Fertility Decline: The Case of Haryana and Punjab, UNFPA, New Delhi, India (September 2001).
\textsuperscript{112} Id. at 9.
\textsuperscript{113} Research Study by Rami Chhabra and Nuna Sheel (1994) quoted in Sharda Jain, “Doctoring the Number of Abortions And Sex Selective Abortions In India”, Family Medicine India, Vol. 5, No. 1 at 2-4 at 2 (January 2001).
cases despite legalization of abortions for two decades. Bangalore Society of Obstetrics and Gynaecology claims that an estimated 6.7 million abortions take place in India every year, mostly by unauthorized medical practitioners.\textsuperscript{114}

Roughly 5 million abortions today are performed under the modern health services network and almost equal numbers are performed illegally, according to World Bank, 1996.\textsuperscript{115} According to various estimates, the number of abortions performed outside approved facilities varies between 2 million and 6 million per annum. However, according to government data, only about 1 million abortions were performed annually under these laws.\textsuperscript{116}

According to a study commissioned by UNFPA in the States of Punjab and Haryana, the annual number of induced abortions in the former was about 137,000 and in the latter was 101,000 in 1990-92. According to same analysis, the number of induced abortions in 1996-98 in Haryana is estimated at 77,000 and that in Punjab at about 194,000.\textsuperscript{117}

The availability of technology for sex-detection of the unborn child and the motivation of couples to have sons under patriarchal traditions within small-family norm, appears to have affected substantially the incidence of sex-selective abortions in Haryana & Punjab and throughout India at large. As per the analysis, sex-selective induced abortions in Haryana in 1990-92 stood at 69,000 and that in Punjab at 57,000. These constitute 68 per cent and 42 per cent of all induced abortions respectively. In a study commissioned by UNFPA, the estimated number of sex-

\textsuperscript{114} Kamalnain Bindra, "They 'Wash' And Suffer Silently" in Documentation on Women, Children And Human Rights Library And Documentation Centre, All India Association For Christian Higher Education, New Delhi at 7(7uly – September, 2001).

\textsuperscript{115} Quoted in Sharda Jain, "Doctoring The Number Of Abortions And Sex Selective Abortions In India," Family Medicine India, Vol. 5, No. 1, 2-4 at 3 (January 2001).

\textsuperscript{116} Supra note 81 at 58.

\textsuperscript{117} Referred in supra note 111 at 9.
selective abortions in 1996-98 in Haryana and Punjab was 62,000 (81 per cent of total abortions) and 51,000 (26 per cent of total abortions). During the period 1990-92 and 1996-98, rural areas of each state registered a decline in the number of sex-selective abortions. By contrast, the urban areas registered the opposite; the increase in case of Haryana was almost five times compared to an increase of only 18 per cent in Punjab i.e. from about 6,000 in 1990-92 to about 28,000 in 1996-98.\(^\text{118}\)

According to one estimate, between 1978-82 nearly 78,000 foetuses were aborted in the country after sex-determination. Between 1986-87, 30,000 to 50,000 female foetuses are apprehended to have been aborted. Between 1982-92 the number of clinics for sex-determination grew manifold\(^\text{119}\).

Whereas sex-selective abortion is discouraged legally, the total abortion is accepted and legally permitted. The use of induced abortions, to limit family size under certain conditions including contraceptive failure, as a backup to quality Family Welfare Programme is legally allowed in India. By contrast, the practice of sex-selective induced abortion following a prenatal sex determination is illegal.

The National Family Health Survey-II (NFHS) conducted in 1998-99 also reaffirms a very strong and pervasive preference for sons affecting the attitudes and behaviour with respect to children. In Haryana, ninety percent of women want at least one son among their children and a slightly smaller percentage (81 per cent) want at least one daughter.\(^\text{120}\)

The most important fact brought out by one study is that a substantial proportion of the decline in fertility between the two National

\(^{118}\) Id. at 9, 10 and 26.

\(^{119}\) Supra note 7.

\(^{120}\) National Family Health Survey (NFHS-II), India, International Institute For Population Sciences at 78 and 79 (1998-99).
Family Health Surveys was due to recourse to sex-selective abortion. Mounting pressure of "small family norm" along with liberal abortion policies have added hay to the fire. A study using data from NFHS for nine major states, (Andhra Pradesh, Bihar, Gujarat, Haryana, Madhya Pradesh, Punjab, Rajasthan, Tamil Nadu & Uttar Pradesh) noted that the declines in fertility in Haryana & Punjab, for the age group 15-29 years was the highest among the nine states considered.


The deluge of scientific advancements to determine genetic abnormalities which could also indicate the sex of the foetus, as well as liberalized law of abortion, resulted in unleashed misuse of the technique for selective extermination of the female foetus. These pre-natal diagnostic techniques have been promiscuously exploited for the purpose of sex-determination leading to rampant illegal female foeticide in the country. Generally, if the foetus is pronounced as female, this prompts termination of the pregnancy and brings to an end an unborn child.

Sex-selective abortion is a two-step process involving an initial determination of the sex of the foetus followed by abortion if it is not of the desired sex. The Indian government opposes sex-selective abortion but it took a long time to pass legislation to combat it. In 1976, the government banned sex-determination tests in government facilities but not in private facilities. In 1984, a broad-based coalition of women’s groups, civil liberties groups and health organisations established the Forum Against Sex Determination and Sex-Pre-Selection headquarters in Mumbai. This organization monitored the growing use of sex-determination tests for the

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121 Supra note 111 at 11.
122 Study by Mari Bhat, 2000 quoted in Id. at 14.
purpose of sex-selective abortions and agitated to outlaw the use of the tests for this purpose. As a result of these and other efforts, the state government of Maharashtra passed the Regulation of the use of Prenatal Diagnostic Techniques Act in 1988. The states of Punjab, Gujarat and Haryana subsequently followed. In 1994, although some clinics offered sex selection from the late 1970s onwards, it was only in the 1980s that these services received widespread publicity and formed the subject of Parliamentary debate, after a senior official’s wife underwent an abortion of a male foetus that was mistakenly diagnosed as female.

Shaken out of its slumber by the consistently deteriorating situation, as revealed by the social scientists and demographers, the Central Government in Delhi enacted the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 and it came into force from January 1, 1996, covering all India.

This piece of legislation aimed at regulating numerous medical centres, which had sprung up for pre-natal diagnostic tests, resulting in sex-determination and female foeticide. Such abuse of technique is discriminatory against female sex and affects the dignity and status of women.

The public interest litigation brought into focus the apathy of the government in non-implementation of the Act and its ineffectiveness even after five years of coming into force. Two NGOs – Centre for Enquiry into Health and Allied Themes (CEHAT) which is a research centre of Anusandhan Trust based in Pune and Mumbai and Mahila Sarvangeen Utkarsh Mandal (MASUM) based in Pune and Maharashtra and Dr. Sabu M. George who has technical knowledge and experience in the field, filed a

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123 Robert D. Retherford and T.K. Roy in Factors Affecting Abortion in India and 17 major states, National Family Health Survey Reports, Number 21 at 14 (January 2003).
124 Id. at 16.
public interest litigation in the Hon’ble Supreme Court in the case Centre for Enquiry into Health and Allied Themes v. Union of India.\textsuperscript{125}

In response to this writ petition, the Hon’ble Supreme Court of India gave directions in its order dated 4.5.2001 to the Central Government and State Governments for effective implementation of the Act by appointing Appropriate Authorities at district and sub-district levels in all the states and union territories.

In this case, the petitioners highlighted a “diabolic link” between sex selection technologies, female foeticide and India’s plummeting sex ratio. The petition also noted another pre-conception sex-selection technique called “Pre-Natal Diagnosis” which did not come within the ambit of the Act.

The Supreme Court directed on 4.5.2001:
- To take prompt action against any person or body who issues or causes to be issued any advertisement in violation of Section 22 of the Act.
- To take prompt action against all Genetic Counselling Centres, genetic laboratories and genetic clinics as also against persons who are operating without a valid certificate of registration under the Act.
- To furnish quarterly returns to the Central Supervisory Board giving a report on the implementation and working of the Act.
- The quarterly returns should inter-alia contain specified information about:
  1. Survey and Registration of Genetic Counselling Centres, Genetic Laboratories and Genetic Clinics including bodies using ultrasound machines.

\textsuperscript{125} (2001) 5 SCC 577.
2. Action taken against non-registered bodies operating in violation of Section 3 of the Act, inclusive of search and seizure of records.

3. Complaint received by the Appropriate Authorities under the Act and action taken pursuant thereto.

4. Number and nature of awareness campaigns conducted and results following thereupon.

- To examine the necessity to amend the Act keeping in mind emerging technologies and difficulties encountered in implementation of the Act and to make recommendations to the Central Government.

- Among other things, directions include wide publicity both at national and state levels for generating awareness about the Act and against pre-natal determination of sex and female foeticide through appropriate releases/programmes in electronic media.

- To implement with all vigour and zeal the PNDT Act and the Rules framed in 1996.  

Pursuant thereto, the government machinery and the Central Supervisory Board have been galvanized. Government of India proposed amendments in PNDT Act dated 31.08.2001 giving effect to the inclusion of the pre-conception sex-selection techniques which were not covered under the then Act and also ensuring effective implementation of the Act at all levels.  

The Hon'ble Supreme Court in its order-dated 19.09.2001 had directed all the state governments/union territories to implement the Act and submit a compliance report as directed in its order-dated 4.5.2001.  

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126 Id. at 578, 579, 580
The Supreme Court in its order dated 7.11.2001, directed that the central government should take immediate steps for the implementation of the Act and suggested to set up a National Inspection and Monitoring Committee for the implementation of the Act.¹²⁹

Another landmark in the course of the PIL was the hearing held on December 11, 2001.¹³⁰ The Supreme Court called upon the Chief Health Secretaries of Punjab, Delhi, Bihar, Rajasthan, Gujarat, Haryana, Uttar Pradesh, Maharashtra and West Bengal to remain present before the Court on January 29, 2002 for non-compliance of orders passed by the same. Stressing on the strict implementation of the Act by the Union Government, State Governments & Union Territories, the petition has finally been disposed of in September, 2003.¹³¹

Keeping in view the directions of Hon’ble Supreme Court’s order dated 4th May, 2001, the need was felt to amend the Act in order to incorporate therein certain emerging technologies like selection of sex prior to conception as well as those in current use which are being misused for pre-natal determination of sex of the foetus.

By Section 3 of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002 (14 of 2003) (PNDT Act) the nomenclature of the Act has been amended and now it stands as The Pre-Conception And Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (57 of 1994) (PC and PNDT Act). This amended Act came into force with effect from February 14, 2003.

The Act as stands today provides for the prohibition of sex selection, before or after conception¹³² and for regulation of pre-natal diagnostic

techniques to be conducted only for the purposes of detecting chromosomal/genetic abnormalities or metabolic disorders or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith and incidental thereto.

Section 3A provides

No person, including a specialist or a team of specialists in the field of infertility, shall conduct or cause to be conducted or aid in conducting by himself or by any other person, sex selection on a woman or a man or on both or on any tissue, embryo, conceptus, fluid or gametes derived from either or both of them.

"Sex-Selection" as defined under the Act includes any procedure, technique, test or administration or prescription or provision of anything for the purpose of ensuring or increasing the probability that an embryo will be of a particular sex.

Prior to the amendments, a US-based company had started offering pre-conceptual gender-selection with a success rate of 96 per cent. The promoters Jill and Scott Sweazzy conveniently claimed ethicality and exemption from the PNDT Act, on the premise that the procedure was pre-conception and not pre-natal.

The Act provides for various regulatory provisions such as:

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133 Section 4(2), ibid.
134 Ibid. Section 2(ba) "Conceptus" means any product of conception at any stage of development from fertilisation until birth including extra embryonic membranes as well as the embryo or foetus; (bb) "embryo" means a developing human organism after fertilization till the end of eight weeks (fifty-six days); (bc) "foetus" means a human organism during the period of its development beginning on the fifty-seventh day following fertilization or creation (excluding any time in which its development has been suspended) and ending at the birth;
135 Section 2(o) inserted by Act 14 of 2003, Section 4.
136 The Indian Express at 4 (November 21, 2001).
137 Supra note 7.
• No diagnostic techniques shall be used or conducted unless the person qualified to do so is satisfied that the pregnant woman is either above 35 years; has undergone two or more spontaneous abortions or has been exposed to drugs, radiation, injection or a chemical, or the pregnant woman or her spouse has a family history of mental retardation or physical deformities.\textsuperscript{138}

• No person, relative or husband of the pregnant woman shall seek or encourage the conduct of any pre-natal diagnostic techniques on her except for the purposes as specified in S.4(2).\textsuperscript{139}

• No person shall conduct any such procedure unless all the
  \begin{enumerate}
  \item known side effects are explained to the pregnant woman and a
  \item written consent is obtained.\textsuperscript{140}
  \end{enumerate}

• Communication of sex of the foetus by words, signs or any other manner to the concerned pregnant woman or any other person is prohibited.\textsuperscript{141}

• Provision has been made to ensure that an unqualified person should not be employed by the genetic counselling centre, laboratory or clinic whether on honorary or payment basis by amending section 3 sub-section (2).

• By inserting section 3B\textsuperscript{142}, sale of any ultrasound machine or imaging machine or scanner or any other equipment capable of detecting sex of foetus to any genetic counselling centre, genetic laboratory, genetic clinic or any other person not registered under the Act is prohibited.

\textsuperscript{138} Section 4(3), \textit{The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994}.

\textsuperscript{139} Section 4(4),\textit{ibid}.

\textsuperscript{140} Section 5(1) \textit{ibid}.

\textsuperscript{141} Section 5(2) \textit{ibid}.

\textsuperscript{142} Ins. by Act 14 of 2003, Section 6.
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- No such centre, clinic or laboratory including clinic, laboratory or centre having ultrasound or imaging machine or scanner or any other technology capable of undertaking determination of sex of foetus and sex selection, can be opened by any person unless it is duly registered under the Act. Every offence under this Act shall be cognisable, non-bailable and non-compoundable.

- The Act prohibits publication or issuance of advertisement regarding sex-determination of the foetus and sex-selection before conception in any form including advertisement thereof on Internet. Contravention is punishable with imprisonment up to three years and with fine up to ten thousand rupees.

- Any medical geneticist, gynaecologist, registered medical practitioner or any person who owns a Genetic Counselling Centre, a Genetic Laboratory or a Genetic Clinic or is employed therein and renders his professional or technical services there, whether on an honorary basis or other wise and who contravenes any of the provisions of the Act or rules made there under shall be punishable with imprisonment up to three years and with fine up to ten thousand rupees and on any subsequent conviction, with imprisonment up to five years and with fine up to fifty thousand rupees.

- A convicted doctor may be banned from practising for five years initially. On second conviction, the doctor’s registration may be cancelled permanently.

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144 Section 27, The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.
145 Section 22 (1), substituted by Act 14 of 2003, Section 18, for Section 22.
146 Section 22(3), The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.
147 Section 23(1), ibid.
148 Section 23(2), ibid.
The PC and PNDT Act provides for three main instruments for implementation of its provisions viz:-

a) The Central Supervisory Board\textsuperscript{149} at the Central government level and

b) The Appropriate Authorities\textsuperscript{150} assisted by Advisory Committees in states and union territories for whole or parts thereof.

\textsuperscript{149} Section 7(2). Ibid., The Board shall consist of –

(a) The Minister in charge of the Ministry or Department of Family Welfare, who shall be the Chairman, \textit{ex officio};

(b) The Secretary to the Government of India in charge of the Department of Family Welfare, who shall be the Vice-Chairman, \textit{ex officio};

(c) Three members to be appointed by the Central Government to represent the Ministries of Central Government in charge of Women and Child Development, Department of Legal Affairs or Legislative Department in the Ministry of Law and Justice, and Indian System of Medicine and Homoeopathy, \textit{ex officio};

(d) The Director General of Health Services of the Central Government, \textit{ex-officio};

(e) Ten members to be appointed by the Central Government, two each from amongst –

(i) Eminent medical geneticists;

(ii) Eminent gynaecologist and obstetrician or expert of \textit{stri-roga} or \textit{prasuti-tantra};

(iii) Eminent paediatricians;

(iv) Eminent social scientists; and

(v) Representatives of women welfare organizations;

(f) Three women Members of Parliament, of whom two shall be elected by the House of the People and one by the Council of States;

(g) Four members to be appointed by the Central Government by rotation to represent the States and the Union territories, two in the alphabetical order and two in the reverse alphabetical order: Provided that no appointment under this clause shall be made except on the recommendation of the State Government or, as the case may be, the Union territory;

(h) an officer, not below the rank of a Joint Secretary or equivalent of the Central Welfare, in charge of Family Welfare, who shall be the Member-Secretary, \textit{ex officio}.

\textsuperscript{150} Section 17(3), ibid., The officers appointed as Appropriate Authorities under sub-section (1) or sub-section (2) shall be, --when appointed for the whole of the State or the Union territory, consisting of the following three members:-

(i) an officer of or above the rank of the Joint Director of Health and Family Welfare – Chairperson;

(ii) an eminent woman representing women’s organization; and

(iii) an officer of Law Department of the State or the Union territory concerned: Provided that it shall be the duty of the State or the Union territory concerned to constitute multi-member State or Union territory level Appropriate Authority within three months of the coming into force of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002: Provided further that any vacancy occurring therein shall be filled within three months of the occurrence;
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c) The State Supervisory Board\textsuperscript{151} and Union Territory Supervisory Board\textsuperscript{152}

The main functions\textsuperscript{153} of the CSB are to advise the government on policy matters relating to use of pre-natal diagnostic techniques and sex selection techniques, to review and monitor implementation of the Act and Rules, recommend changes therein to create public awareness against the practice of pre-natal determination of sex, lay down code of conduct for persons working at Genetic counselling centres, Genetic laboratories and genetic clinics and to oversee performance of various bodies constituted under the Act to ensure proper and effective implementation.

The main functions of the State Supervisory Board\textsuperscript{154} are to create public awareness against the practice of sex determination and sex selection leading to female foeticide, to review the activities of the Appropriate Authorities and recommend appropriate action against them, to monitor the implementation of provisions of Act and the rules and make suitable recommendations thereto and send consolidated reports in respect of various activities undertaken in the State to the Board and Central Government.

The functions of the Appropriate Authority\textsuperscript{155} are to grant, suspend or cancel registration of a genetic counselling centre, laboratory or clinic and to enforce standards prescribed for them, to investigate complaints of breach of provisions of this Act or the rules and take immediate action. Besides these, some more functions are to take appropriate legal action

\textsuperscript{151} Section 16A, \textit{ibid.}, Constitution of State Supervisory Board and Union territory Supervisory Board. –(1) Each State and Union territory having Legislature shall constitute a Board to be known as the State Supervisory Board or the Union territory Supervisory Board.

\textsuperscript{152} Section 16A inserted by Act 14 of 2003.

\textsuperscript{153} Section 16, subs. By Act 14 of 2003, for Section 16.

\textsuperscript{154} Section 16 A, \textit{The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.}

\textsuperscript{155} Section 17 (4), \textit{ibid.}. 
against the use of any sex selection technique, by any person at any place, *suo motu* or brought to its notice and also to initiate independent investigations in such matter, to create public awareness, to supervise the implementation of the provisions of Act and Rules, to recommend to the Board and State Boards modifications in the rules in accordance with changes in technology or social conditions and to take action on recommendations of the Advisory Committee made after investigation of complaint for suspension or cancellation of registration.

In order to enable the Appropriate Authorities to discharge their functions effectively, they have the powers to summon any person possessing any information relating to violation of the provisions of this Act or the rules, to issue search warrant for any place suspected to be indulging in sex-selection techniques or pre-natal sex determination.

It has been observed by NFHS-II, that the importance of sex-selective abortions has grown in the post-1995 period despite passage in 1994 of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, which prohibits the use of pre-natal diagnostic techniques for the purpose of ante-natal sex determination. Monitoring of legal and illegal abortions is a very sensitive area. Indian society stigmatises the woman concerned and the family. In Haryana most of the private institutions conducting MTPs are either not reporting or are under/irregularly reporting. On enquiry some private institutions disclosed that though they are conducting illegal MTPs (for unmarried girls or after sex determination test etc.), but the written consent in all cases is being taken along with the undertaking that no sex determination test has been got done. Scrutiny reveals that about 30% to 40% MTPs conducted in the private sector are illegal.\(^\text{157}\)

\(^{156}\) *Supra* note 3 at 16.  
In order to keep a check of the misuse of the ultrasound machines, the following steps have been/are being taken in the State of Haryana:\footnote{Quarterly Report on Implementation And Working Of The Pre-Conception And Pre-Natal Diagnostic Techniques (Prohibition Of Sex Selection) Act, 1994, State Appropriate Authority-cum- Director General, Health Services, Haryana, Panchkula (for and on behalf of State Government), (Report for the quarter ending 31.03.2006).}

1. A survey of all bodies/persons using ultrasound machines has been completed and continuing. 875 Ultrasound Clinics/Genetic Clinics and 66 Genetic Counselling centres under the PNDT Act have so far been registered with the various District Appropriate Authorities.

2. 45 ultrasound machines have been registered in the Government Sector.

3. 3636 inspections of various ultrasound clinics have been conducted till date.

4. Registration of 118-ultrasound centres has been suspended/cancelled for violation of various provisions of the PNDT Act.

5. 64 ultrasound machines have been seized and sealed by respective District Appropriate Authorities on account of being unregistered/unserviceable/for violations of the various provisions of PNDT Act 1994/Rules 1996\footnote{Refer to Annexure VI}.

All the District Appropriate Authorities have been directed to take personal interest and play a pro-active role in conducting raids in the clinics operating and violating various provisions of the PNDT Act by deploying decoy customers and as a result of this, 25 prosecution complaints (6 each in Faridabad & Gurgaon, 3 in Rewari, 2 each in Ambala & Rohtak and 1 each in Bhiwani, Fatehabad, Jhajjar, Kurukshetra, Panipat and Yamuna Nagar) and 1 FIR lodged (in Hisar) against the violators of various provisions of PNDT Act 1994 & Rules 1996 have been filed in the
respective courts. Out of these 24 cases, 13 cases have been filed for Sex Determination, 5 cases for issuing of prohibited advertisement, 4 cases for Non-maintenance of Records and 2 cases being un-registered. First 3 court cases under this Act were launched in Haryana (District Faridabad), which were first of its kind in the whole country and thus became a trendsetter.

In one case “State v. Anil Sabhani,”160 Palwal, Faridabad under the PNDT Act, the court has ordered against Dr. Anil Sabhani and Mr. Kartar Singh, Technician to undergo simple imprisonment for a period of two years and to pay a fine of Rs. 5,000/- each. The case has been already been sent to Medical Council of India for suspension of registration of the said doctor.

In another case “State v. Dr. Surinder Yadav, Gurgaon”, the charges have been framed against the accused in the Court of the Chief Judicial Magistrate, Gurgaon. In another case a team of six senior health officials raided Bhargava Nursing Home, Rewari on 11.04.2006. A decoy customer, who was a four-month pregnant, was sent to Bhargava Nursing Home with numbered currency notes. Dr. (Mrs.) Vijay Bhargava conducted the sex determination test and disclosed the sex of the foetus. Dr. Ashok Bhargava (husband of Dr. Vijay Bhargava) was caught red handed in this raid while taking Rs. 2350/- from the patient for conducting the test. The health officers raided the clinic and recovered the currency notes. The ultrasound machine has been seized & sealed at the spot and a show cause notice was served. The case has been launched in the Hon’ble court of Sh. Ajay Tewatia, Chief Judicial Magistrate, Rewari and the next date of hearing in this case is 06.06.2006. Decision rendered by the court of Sh. N.P. Dewett, Addl. Session Judge, Gurgaon in a case “State v. Rajni and Others”, under the MTP Act on 02.03.2006, Dr. Rajni

has been convicted to undergo vigorous imprisonment for a period of one year and to pay a fine of Rs. 1000/- under Section 15(2) and 15(3) of the Indian Medical Council Act, 1956 and in default of payment of fine the convict Dr. Rajni shall undergo simple imprisonment for a period of one month more. The convict Neera (patient undergoing the MTP) has also been sentenced to undergo vigorous imprisonment for a period of 2 years for commission of offence under Section 315 IPC. She is also sentenced to undergo vigorous imprisonment for a period of 2 years for offence under Section 317 IPC. Both the sentences awarded to convict Neera shall run concurrently. The court has also ordered that the period of custody of the convict Neera during investigation and trial of this case will be deducted from the period of sentence awarded. The convicts have been sent to district jail Gurgaon for execution of the sentence awarded.\(^{161}\)

A participant in the Seventh Meeting of the Central Supervisory Board held on April 2, 2002 remarked that it would be wrong to paint the medical community as innocent sufferer. Ideally, no law would have been needed if doctors had not misused the PNDT Act unscrupulously and on a very large scale. The need for the Act and the subsequent PIL arose specifically due to the attitude of the medical community to disregard law and ethics and by their associations to ignore such acts by its members. Whereas, Dr. Mira Shiva, Director, Voluntary Health Association of India stressed on the rational use of medical technologies and also on preventing their abuse and unnecessary use of profit hungry practitioners. She said that misuse of ultrasound machines cannot be legitimised.\(^{162}\)

Nevertheless, the IMA, the MCI and the FOGSI have taken a number of steps to counter sex-selective abortions. The Medical Council

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\(^{161}\) As quoted in Implementation of PNDT Act – 1994 in Haryana, Health Department, Haryana.

\(^{162}\) Minutes of the Seventh Meeting of Central Supervisory Board constituted under the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 held on 02.04.2002 at 6.
of India itself has come forward with some shocking revelation regarding unethical practices relating to female foeticide:

a) In several cases, sex of the foetus being terminated may not be clear as doctors are doing ultrasonography at 9 to 11 weeks of gestation. At this stage, it is not possible to make out the sex of foetus. The earliest doctors can make out the sex of the child is at 13 weeks.

b) At some centres, women are asked to go through repeated ultrasonographies.

c) The charges at these centres vary from Rs. 250 to Rs. 5,000 depending on the area in which it is located.163

Another observation brought forth by Dr. Ashish Bose regarding field situation is that the Chief Medical Officers who are supposed to prosecute the guilty doctors are normally not motivated to go against a fellow doctor. At the district level, the fraternity of doctors is very strong. He suggested that the law should provide for an independent body comprising public-minded persons who will be asked to give verdict on such medical malpractices. The Indian Medical Association, despite good intentions, has not been effective in bringing to book guilty doctors.164

There is a fallacy of a doctor as god. The medical community is largely unquestioned, unregulated and unaccountable, yet it remains the most culpable as far as the crime of female foeticide is concerned. Unless the erring doctors are put in the dock for their malpractices today, they could play midwife to a future without daughters.165

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164 Ashish Bose, "Fighting Female Foeticide, growing greed and shrinking child sex ratio," Economic and Political Weekly, Vol. 8 XXXVI No. 36, 3427 to 3429 at 3429 (September 8, 2001).

165 Pamela Philipose, "The beti-maru mindset", The Indian Express, Chandigarh at 4 (September 15, 2004).
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Dr. Ashish Bose points out that our doctors are cleverer than our policemen, our law demands evidence. He has forwarded a suggestion to the government to hire private detectives who should collect incriminating information against doctors who flout the PNDT Act; to create a stir to get people working and rethinking. Female foeticide is the result of an unholy alliance between the traditional preference for sons and modern medical technology, the increasing greed of doctors, the rising demand for dowry that makes daughters financial burdens, the ineffectiveness of the PNDT Act and the liberal Medical Termination of Pregnancy Act and lack of any serious involvement of society in fighting this menace.\(^{166}\)

Despite the widespread campaigning, awareness and activism, state and central laws, and intervention by the Supreme Court and National Human Rights Commission, we still continue to indulge in mass massacre of female sex. This highlights three fatal fallacies that mark our approach to the issue. The first is the tendency to address the population policy and the female foeticide issue as two distinct phenomena, when, in fact, they are intimately related for example, two-child norm is itself adverse to the female sex. Even the Supreme Court is not immune to this binary approach. While it directs the government to stop sex-selective abortions, it also upholds the soundness of a coercive two-child policy. The second is our tendency to sever the adverse sex ratio from other factors that disempower women. Female foeticide is linked with other acts of violence against women from rape and domestic violence to homicides. The devaluation process begins within the family and is intrinsically bound with property rights and dowry inheritance practices. The third fallacy is to equate doctors with god.\(^{167}\)

\(^{166}\) Supra note 12.

\(^{167}\) Supra note 165.
To deal with the menace of sex-selective abortions pragmatically, both the legislations *i.e.* the PC and PNDT Act and the MTP Act have to be read together and understood together and in consonance to give meaningful interpretation to the intention of the legislature. While the MTP Act permits medical termination of pregnancy on certain grounds, the provisions of the PC and PNDT Act cannot be by-passed. Sex-selective abortions are preceded by resorting to sex-determination tests, covered under PC and PNDT Act.

Both these Acts are complimentary and supplementary to each other, since sex-selective abortion is a two step process – determination of sex and subsequent abortion of foetus not of desired sex. Nowhere both these steps are to be correlated or linked, making it easy to flout the law and difficult to detect the same. Much of the activity to violate the law is clandestine and not many people are interested in exposing it.

Under the MTP Act, no abortion can be conducted beyond 20 weeks and is illegal. Thus Amniocentesis is itself an offence under the MTP Act as it is generally carried out in the 16\(^{th}\) week of pregnancy. Thereafter, the entire process, that is, culture and tests normally takes another 6 to 8 weeks, based on which the decision to abort if it is a female is made. It, thereby violates the MTP Act which stipulates that abortions have to be carried out within 20 weeks.

Viewing the intensity of this malpractice and to give real effect to both these legislations, certain steps need to be taken:-
1. Enact special legislation to register, regulate and monitor the functioning of private health institutions.
2. Sex ratio at birth must be included as an official indicator of a population's health. Because sex ratio at birth is a direct indicator of the incidence of female foeticide, it is imperative that it be
documented. Goals also should be formulated to improve the sex ratio at birth, with appropriate budget allocations.

3. Require registration and monitoring of all pregnancies from the 12th week, to deter selective elimination of female foetuses and to improve the health status of pregnant mothers.

4. Require registration of all births and deaths.

5. Monthly monitoring of sex-ratio, specially in the states with already adverse sex-ratio.¹⁶⁸

6. Require documentation of foetal sex for all second-trimester abortions with sufficient proof.

7. The biological fact that it is the chromosomes of the man, not the woman, that determines the sex of the baby should be widely publicised to stop mothers being blamed for girl babies.

8. Remove ‘contraception failure’ as a ground for MTP as this is the mostly abused ground.

9. Ban all the pre-diagnostic tests as by promoting eugenics, as are promoting the discrimination of a particular race i.e. disabled person.

At this stage where we stand today, we have to accept the fact that technology, in itself is neither good nor bad. It is the way it is used or abused. For a population with deep-rooted gender bias, lack of technology is no bar to exhibit son preference. Sex-selective abortion is only a symptom of the problems; the real malady lies in the obsession for son.

Rapid advances in the field of new reproductive technologies has “created a situation where there has been a break down of the moral consensus” with respect to medical ethics and gender justice. Technodocs refuse to see larger contexts, future implications and gender

implications.\textsuperscript{169} In words of Member Secretary of Maharashtra State Commission for Women, "the attempt at legitimising the vetoing of female life even before it appears, is worse than the earlier abortion related violence in the womb, precisely because it is so sanitized and relies on seemingly same arguments against the policing of 'human rights' in a democracy in the intensely personal matter of procreation. This needs to be resisted at all cost.\textsuperscript{170}

The New Reproductive Technology is serving the interest of patriarchy as well as the professional allies being benefited in the whole process at the cost of vulnerable human beings as raw material. Reproduction has not only individual but a social dimension as well.

All reproductive technologies have been basically market-oriented, highly capitalistic and patriarchal enterprises ostensibly in the service of women and out rightly exploiting them.\textsuperscript{171}

Besides the inherent weakness in law and its ineffective implementation, there is neither the political will nor the social commitment to implement it. The present situation is the result of continued apathy of the government to implement its laws properly by providing the necessary infrastructure in a scenario where females have been reduced to an instrument for procreating 'sons'.

Progressive legislation is not a substitute for cultural changes and inner awakening. The nature of this malaise is such that law alone cannot deal with it single handedly. The solution lies in soul searching and self-regulation. PC and PNDT Act can, however, be an enabling tool for achieving social transformation. Thus, the Act can be used as an

\textsuperscript{170} Quoted in ibid.
\textsuperscript{171} Supra note 7.
educational tool to build up awareness among the populace. By imposing stringent penalties on the wrongdoers shall serve as an eye-opener and a deterrent for others.