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Law, Liberty and Life: A discursive analysis of PCPNDT ACT

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"WHILE SOME PROGRESS HAS BEEN MADE BY OUR COUNTRIES TOWARDS THE ACHIEVEMENT OF THE GOALS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CHALLENGES REMAIN TO PUT CONCRETE MEASURES IN PLACE TO FULLY IMPLEMENT THE AGENDA".

Istanbul Statement of Commitment, Fifth International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action, Istanbul, Turkey, 2012

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Abstrat: The gender discrimination though is an universal and usual phenomenon practices across time and space with fewer exceptions, it takes a deep and pervasive from in India as it starts not just with birth of the girl child but even before that. To put it succinctly the practice of 'sex selection' and sex selective abortions India has not only adversely affected an already skewed child sex ratio but has disastrous consequences for the future. The tradition of 'son-preference syndrome' coupled with the modern medical technology that has enabled early detection of sex of the foetus has spelled doom for the defenceless female foetus. Surprisingly, this practice is more among the rich, urbane and educated families than the rural, poor and less educated couples. The centuries of psychological conditioning in the case of women, their vulnerability and helpless conjoined with prejudice towards girl child has turned the protectors into perpetrators of a heinous crime. It is in this context the Govt. of India enacted a specific legislation titled 'Pre-Conception and Pre-natal Diagnostic Techniques (Prohibition of Selection of Sex) Act-1994', in short PCPNDT Act to curb this menace. However, the chasm between the law in theory and law in practice at least in this case seems a bit far due to various socio-economic and cultural factors. In this article an attempt has been made to systematically analyze the issue from the perspective of sociology of law.

Keywords: Gender discrimination; Sex selection; PCPNDT Act; Tradition; Modernity and social transformation.

1. INTRODUCTION

Sociological imagination as Mills explains to us is 'a quality of mind' that allows an individual to locate himself in the prevalent social milieu. The ability to inter-relate the biography and history and locate the self in society provides a perspective but the capacity to transcend the intersection in creating a niche either

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individually or in a group in an essentially hierarchical and competitive social system then is an emancipatory project. If sociological imagination liberates the individual from the immediate conditionalities to look beyond the 'private trouble' then it requires serious social interrogation to understand the plethora of discrimination that women across the world beyond space and time. Indeed, social stratification based on gender has attracted serious attention from scholars cutting across the boundary of nationalities and as a result there have been a sizable documentation and literature on the subject. Both as a project of modernity and subject of globalization, the discourse on gender have formed the core of contemporary academic and literary endeavours. These literatures duly prove that women as a social category face and continue to face serious and severe discrimination right from birth till their death but it is matter of grave concern that even before their birth daggers knives not just sour their dreams but to altogether do away with their life. An attempt has been made in this paper to look into the newest form of gender discrimination and examine the legal procedures set to deal with them and its limits. The new form of danger is defined as the process of sex selection and by extension sex selective abortion. However, before we enter into critical engagement with the issue of sex selection it would be pertinent to highlight some of the core issues associated with women, rights and legal realms.

2. WOMEN AND RIGHTS: A CONCEPTUAL UNDERSTANDING

In the era of high mass consumption (Rostow, 1968) the discourse on the parity of sexes and efforts to achieve' gender neutral doctrine of development' acquaints one with the contours of modernity. But with the rise of 'third wave of feminism' and the advent of 'postmodern condition' (Lyotard 1984), the debate has taken a decisive and definite turn. Questioning the doctrine of homogeneity and parallelism the postmodern thinking has focused on plurality of traditions and diversity of identities. According to this world view the question of gender is not merely about the status of women but a question of ethics, morality, rights and of responsibilities, the fundamental cannons of living in a civil society, and principles of jurisprudence.

However, the question of women in general and gender in particular need not be addressed separately and in isolation. Rather it will run counter to a sensitive and actual portrayal of the reality. The best illustration of dualism and callousness can be viewed from the fact that the capacity to bear children is in many senses the most creative of all human potentialities. It is also a social necessity. Yet far from being valued, women's unique reproductive function has generally been used as a pretext for stigma and exclusion from public life. The reason for this lies deep in the history of women's subordination to men. As we have seen, throughout history, women have been portrayed as naturally and all-pervasively reproductive creatures, a convenient justification for imprisoning women in domestic life. This essentially male perspective on the role of the childbirth has been a major factor contributing to the perpetuation of women's subordination' (O' Brien 1988).

Over the last decade or so, the phrase 'women's rights as human rights' has been used to explore, assert and redress the gap between the stated international commitment to equality for women and the actual experience of women (Bell 1999). But very little has been done in the face of wider disparities that exist among various women groups culturally and socially. Consequently, one can perceive vast differences in the cognitive, connotative and consumption pattern of women residing in different spheres of social and economic layers. In a world divided in terms resources, opportunities and consumption pattern reflecting in the growing chasm between the poor and the rich, the victims of exploitation and oppression have largely been the women of third world countries in general and the lower section among them in particular.

The current theme of the paper i.e. about the sex selection test and subsequent abortions are unique to some countries especially to India. Interestingly this particular form of gender violence is prevalent among all sections of society despite the hierarchical nature of Indian society (Dumont 1958; Galanter 1998). In this paper emphasis has been laid on looking the problem of sex selection through the prism of gender, human rights and law.

3. CULTURAL DIMENSIONS: CONVERGENCE OF SPIRIT AND DIVERGENCE OF PRACTICE

In recent times the issue of gender rights has converged with the question of human rights although an undercurrent of tension is still visible at the surface as well as in the core. But they have jelled well to fight the common enemy and have incorporated points of dynamic confluence from theory of civil society and democratic ethos towards their own advantages. In fact, one can easily discern the points of convergence between the human rights and gender rights groups. The commonness of strategy implies that women must start their fight against discrimination and exploitation and the paradigm of human rights has provided them with necessary wherewithal and moral support to renew their battle.

Human rights are defined in terms of fulfillment of basic human needs and rights those come naturally to him by virtue of being born as human. The UN has envisaged human rights as the natural rights of man and has elaborated them in the context of civil~ political and social rights. In the words of UN, 'we the people of the United Nations ...reaffirm faith in fundamental human rights in dignity and worth of the human person in the equal rights of men and women. ..and promote social progress and better standards of life in larger freedom[2]'. Though such a conceptualization of human rights provides an emancipatory and expressive ambience for the fulfillment of human potential it has received severe mauling at the hands various obscurantist, fanatical and regressive forces. Before we proceed further it will be apt to mention some of the principles of United Nations Declaration on Human Rights (UDHR 1948), the cornerstone of human rights platform.

- All human beings are born free and equal in dignity and rights. Everyone has the right to life, liberty and security of person. **(Principle 1)**
- Advancing gender equality and equity and the empowerment of women, and eliminating all forms of violence against women, are cornerstones of population and development-related programmes. **(Principle 4)**
- Everyone has the right to enjoy the highest attainable standard of physical and mental health. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. **(Principle 8)**
- Everyone has the right to education. Education should be designed to strengthen respect for human rights and fundamental freedoms. **(Principle 10)**
- Every child has the right to an adequate standard of living, health and education and to be free from neglect, exploitation and abuse. **(Principle 11)**

[2] See generally Universal Declaration of Human Rights, Article-1, (' All human beings are born free and equal in dignity and rights. ..to define and protect the rights and freedoms of every individual regardless of race, sex, language or relation '); Article 2 (equal protection of the law and against discrimination). UNGA: 1948.

Describing the impact of religious fundamentalism on human rights Howland writes that, fundamentalists are particularly concerned with women's sexuality-as a danger and as a threat to society-and thus are keen to regulate and control women's sexuality and reproduction through a variety of measures. Controlling women's sexuality fits neatly into the religious fundamentalist's promotion of the patriarchal family and the 'proper' role for women as being in the home. A feature that fundamentalisms share is an emphasis on women's role being confined to that of wife and mother and the restriction of their role in the public world (Howland 1999). In fact, this has stooped lower enough to deprive women from giving birth to girl child and go for abortion despite their unwillingness.

The prevalence of 'son preference syndrome' in India is one example where couples look forward to the birth of a son notably in north India and are dismayed with the birth of a girl child (Cain 1984; ORG 1990). The inability of a couple in producing a male child and hence not leaving an 'heir' to the family in considered a curse and looked down upon. In cases where the couple remains barren the woman has to bear the brunt of the social ostracization, ridicule, maltreatment, and numerous other hardships though male impotency is a recognizable factor. This is a result of a deep malaise of the society and has been internalized in the psyche of both the men and women. As a result polygamy, feticide, female infanticide, dowry, sexual discrimination and subsequent maladies become wanton and pervasive. This has also a lot to do with the social system and it's functioning, these acutely patriarchal societies practice repressive and discriminatory system and maintain it through various cultural fronts like rituals, educational system, symbolism etc. Earlier these sexual discrimination start at the birth and institutionalized through formal and informal agencies of socialization and carried forward throughout the life but in case of sex selection it has gone beyond the stage of conception.

4. UNITED NATIONS, WOMEN AND HUMAN RIGHTS: CHALLENGES AND RESPONSES

The right to self-determination has also been linked to that of democratic entitlement, (Frank 1992) but the formal processes of western democracy assumed to be part of democratic entitlement typically deliver less freedom to women than to men.[3] It is important to know that women's status in society-socially, politically, legally, economically-has been fundamentally the same across history for a majority of the world's population. Except for surface differences in manner and style, the basic arrangements for division of labour and power between men and women have been the same across the world. A woman's right over major decisions about her children's future, place of residence, marriage, inheritance, employment, and the like have been severely curtailed in most of the world during most of human history (Huddard and Freindly 1985). The international community now recognizes that women's rights are human rights and human rights are women rights. These positions are recorded in several international documents, and are encapsulated by the mission statement to the platform for Action of the United Nation's Fourth World Conference on Women held in Beijing, 1995. The Platform for Action is an agenda for women's empowerment. One UN document states that "advancing gender equality and equity and the empowerment of women, and the elimination of all forms of violence against women, are… cornerstones of population and development-related programmes" (Principle 4, United Nations Population Division, Programme of Action, 1994).

Human rights instruments drafted by men are silent on the issue of sexuality and reproductive rights. Feminist legal scholars have attempted to read these rights so that a woman's physical integrity is respected

[3] For a discussion of the under representation of women in a Government despite democratization in most countries, see Beijing Declaration and Platform for Action adopted by Fourth World Conference on Women, adopted September, 15th, 1995.

with regard to her reproductive organs (Cook 1995). Here the term "reproductive health paradigm" refer to a view of reproductive and sexual health and rights that found its fullest -even if still imperfect[4]-official, public expression in the declaration and programmes that emerged from the ICPD[5] and the Fourth World Conference on Women held in Beijing in 1995[6]. The ICPD programme, in particular, can be seen as the culmination of more than a decade of work by women's movements throughout the world, coming from different perspectives and situations, and building on many years of local activism on women's health and right issues[7].

It is easy to perceive in the context the surreal dialectics of difference between the development of self (women) and the development of society (world) or in a more philosophical planes the duality of self and society .The grand theory of philosophy does not recognize women as 'separate being' that excludes the body and within the boundary of rectitude and the elevated consciousness. Rather it brings the body-mind dichotomy into discourse and uses sacred-profane, nature-culture and purity-pollution to differentiate between male and female. Ontologically speaking gender dichotomy is not an unconscious act of social development conceptualized on the lines of division of labour but a conscious attempt of a power game to subordinate and suppress a potential rival. The symbolism and semantics of philosophy barring exceptions succinctly exposes the inherent bias of an essentially masculine discourse. Women are rarely treated with reverence and regency but often characterized in terms of beauty, body and banalities.

There are four key elements envisaged in ICPD: First, health must be viewed holistically with reproductive issues planted firmly within the wider context of a women's overall physical and emotional health and well-being over the course of the life span; Second, reproductive health is premised on a woman's right to make decisions about childbearing and to have the means to implement such decisions, and to express and enjoy her sexuality free from coercion, violence and discrimination. Third, Women's reproductive health and reproductive rights are grounded in the enjoyment of a wider set of human rights, including economic, social and cultural rights, which are also key to their societies' broader health and social development and finally, because of this vision of reproductive health and rights, such policies and programmes need to be dramatically reoriented to incorporate women and women's perspectives in the planning and implementation.

Adherence to reproductive rights was also called for in the UN convention on the Elimination of all forms of Discrimination against Women (CEDAW), which was adopted by the United Nations in 1979. For the first time CEDAW document declared that reproductive rights should be exerted on the basis of equality between men and women' (UN: 1979). Specifically, it recommends that: 'State parties. ...shall ensure, on the basis of equality of men and women..... the same rights to decide freely and responsibly on the number and spacing their children and to have access to the information, education and means to enable them to exercise these rights (CEDAW: 1979). The 1984 World Population Plan for Action further clarified this responsibility: 'Any recognition of rights also implies that couples and individuals should exercise this right, taking into consideration their own situation, as well as the implication of their decisions for

[4] See Rosalind Pollack Petchesky , From Population Control to Reproductive Rights: Feminist Fault Lines, 6 REPROD. HELATH MATTERS 152, 152(1995); Rhonda Copelon and Rosalind Patchesky, Toward an Independent Approach to Reproductive and Sexual Rights: Reflection on ICPD and Beyond, in From Basic Needs to Basic Rights: Women's Claim to Basic Rights343, 353-56(Margaret A. Schuler, ed. Washington. DC: Institute for Women, Law and Development, 1995).

[5] See Programme of Action of the International Conference on Population and Development adopted Sept.13, 1994, UN DOC. A/CONF. 171/13 (preliminary version), 1994.

[6] See Beijing Declaration and Platform for Action adopted by Fourth World Conference on Women, adopted Sept.15, 1995, UN DOC A/CONF. 177/20 (preliminary version), 35, I.L.M. 401 (1996).

[7] See T .K. Sundari Ravindran, Women's Health Policies: Organizing for Change, 6 **REPROD. HEALTH MATTERS** 7, 7-8,1995.

the balanced development of their children, and of the community and society in which they live (UN: 1984). Women's equality, their ability to make their own decisions freely and without coercion, is central to any effective population and development policy. More than 18 years since the world's governments adopted a landmark Programme of Action on population and development, it is clearer than ever that the autonomy of women and girls – to decide, free of coercion and violence, whether, when and with whom to be sexually active; whether and when to become pregnant and have children; and whether or not to marry – is fundamental to any effective progress.

The notions of social and individual rights are not difficult themselves as far as their comprehension and understanding is concerned but they create wider problem in terms of their applicability and drawing a line of distinction between the two. It often happen that individual and social rights are often juxtaposed and treated as mutually exclusive categories. In the context of sociology of health and reproductive behaviour social and individual have supposed to create a gulf between the individual's right to choose the number and spacing of their children while the moral responsibility to look at the balance of country's population. In fact the United Nations clearly states that Parents have a basic human right to determine freely and responsibly on the number and spacing of their children and right to adequate education and information in this respect' (UNGA: 1969).

ICPD and Beijing Conference have played significant role within the ambit of UN in defining and setting an agenda for women in general and reproductive right in particular. "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the rights to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents"(ICPD Programme of Action, paragraph 7.3). "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (Beijing Platform for Action, paragraph 96).

5. LAW, GENDER AND REPRODUCTION: A CROSS CULTURAL APPROACH

It may sounds rhetorical but looked from a functionalist perspective the relationship between law and society is extremely close. They are interrelated, interdependent and interpenetrated. Law is not only an agency of social control but is also instrument of social change (social reform). In the democratic society mere representation of people in government does not automatically democratize the society but it requires the presence of rule of law.

In the context of law and gender it can be said that gender discrimination continues to haunt women in every sphere of their life but of late, it has affected the very domain of womanhood especially before its conception. To state the Indian women not only face discrimination after birth but the process begin much before pre-natal stage and the very conception of the girl child is done away with by using advance sex selection techniques. The fast decreasing child sex ratio in India in general and in the state of Madhya Pradesh in an indicator of state of affairs- an index of our apathy, callousness and calibrate effort to extinguish

the life an unborn girl child. In this section we will look into this aspect from a perspective of legal impact analysis by critically examining the PNPNDT Act-1994 and putting the Act in a perspective.

6. THE GENESIS OF THE ACT

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002, is endeavors to penetrate the social, legal, ethical and medical veil of indifference towards the "Missing Girl Child". This Act was passed in 1994 and came into force from 1st January, 1996. It was further amended in 2003. This Act has been divided into 8 chapters. It provides for the regulation of genetic counseling centers, genetic laboratories and genetic clinics, regulation of pre-natal diagnostic techniques, central supervisory boards, appropriate authority and advisory committee, registration of genetic counseling centers, genetic laboratories and genetic clinics, offences and penalties. The intervention of the Hon'ble Supreme Court in CEHAT, MAUSAM & Dr. Sabu Geroge v. Union of India & Ors (AIR 2003 SC 3309) has elaborated the ambit of the law. Unfortunately, this comprehensive and well thought over laws in the country has not been very effective in combating the menace of the declining female child sex ratio in Madhya Pradesh.

Prior to the PCPNDT Act, the Medical Termination of Pregnancy (MTP) Act was enacted. The act was implemented in the major states of India except Sikkim. Under the act, abortion is legal if the pregnancy that it terminates endangers the life of the woman or causes grave injury to her physical or mental health or is likely to result in the birth of a baby with physical or mental abnormalities or is a result of rape or contraceptive failure. The act further states that abortions could only take place in government approved health facilities specifically approved for conducting abortions and by registered medical practitioners.

Sex determination technologies arrived in India in 1975 for determination of genetic abnormalities after the enactment of the MTP Act. However, these techniques came to be widely used for determining the sex of the foetus and subsequent abortions if the foetus is female. In view of the widespread misuse this technique; the Maharashtra government enacted the Maharashtra regulation of the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 by the government of India.

The 1994 Act provided for the "regulation of the use of prenatal diagnostic techniques for the purpose of detecting genetic or metabolic disorders, chromosomal abnormalities or certain congenital malformations or sex linked disorders and for the prevention of the misuse of such techniques for the purpose of sex determination leading to female foeticide and for matters connected therewith or incidental thereto." Except under certain specific conditions, no individual or genetic counseling center or genetic laboratory or genetic clinic shall conduct or allow the conduct in its facility of, pre-natal diagnostic techniques including ultra-sonograpgy for the purpose of determining the sex of the fetus; and "no person conducting prenatal diagnostic procedures shall communicate to the pregnant women concerned or her relative the sex of the foetus by words, signs or in any other manner." The Act provides for the constitution of the Central Supervisory Board (CSB) whose function is mainly advisory and for the appointment of an Appropriate Authority (AAs) in States and Union Territories to enforce the law and penalize defaulters and Advisory Committee/s (ACs) to aid and advise the AAs.

The law was amended in 2003 following a Public Interest Litigation field in 2000 to improve regulation of technology capable of sex selection and to arrest the startling decline in the child sex ratio as revealed by the Census 2001. The amended Act now called "The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act" not only prohibits determination and disclosure of the sex

of the foetus but also bans advertisements related to preconception and pre-natal determination of sex. All the technologies of sex determination, including the new chromosome separation techniques have come under the ambit of the Act. The Act has alos made mandatory in all unltrasonography units, the prominent display of a signboard that clearly indicates that detection/revelation of the sex of the foetus is illegal. Further, all ultrasound scanning machines have to be registered and the manufacturers are required to furnish information about the clinic and practitioners to whom the ultrasound machined have been sold.

Prior to the disposal of the PIL, among other things, the Supreme Court in its order dated December 11m 2001 directed 9 companies to supply the information of the machines sold to various clinics in the last 5 years. Details of about 11,200 machines form all these companies were fed into a common database. Addresses received from the manufactures were also send to concerned States and UTs to launch prosecution against those bodies using ultrasound machines who had failed to get themselves registered under the Act. The Court in its order dated January 9, 2002 directed that ultrasound machines/ scanners be sealed and seized if they were being used without registration. Three associations viz. the Indian Medical Association (IMA), Indian Radiologist Association (IRA) and the Federation of Obstetricians and Gynecologists Societies of India (FOGSI) were asked to furnish details of members using these machines,

Since the Supreme Court directives of 2001 to March 2006, 28,422 facilities offering ultrasound tests have been registered across the country as per information received. 384 cases are currently field for various violations under the Act, including the communication of the sex of the foetus, non-maintenance of records and non-registration.

The PNDT Act, 1994 was enacted to be a weapon to combat the decline in the child sex ratio by arresting the misuse of technology. This Act restricts the medical practitioners from testing and determining the sex of the foetus. It further empowers the Government to take appropriate action in light of any violation of the Act. Initially due to lack of awareness and institutional indifference the Act failed to realize its objective to the fullest. The PNDT Act, 1994 was amended in the year 2002. After amendment, this Act is called the pre-conception and pre-natal diagnostic techniques (prohibition of sex selection) Act, 1994. Timely intervention by the Courts, Civil Society and Government has given an impetus to the implementation of the Act in letter and spirit.

With the passage of time various gaps have been identified in the Act. These are both at the interpretation as well as at the level of implementation. Different stakeholders are actively contributing to plug these gaps and make add to the effectiveness of the Act. These legislative intents are a reflection of the provisions of the Constitutions which embodies various provisions guarding the interests of the women and children. Directive Principles of State Policies spearheads the cause of women and child welfare. Art. 39(a) provides, all citizens, irrespective of sex, equally have the right to an adequate means of livelihood. It has been observed that in a civilized society, the importance of child welfare cannot be over-emphasized because the welfare of the entire nation depends on the well-being of its children.

7. THE CASE OF MADHYA PRADESH

Gender discrimination continues to haunt women in every sphere of their life but of late, it has affected the very domain of womanhood especially before its conception. Indian women not only face discrimination after birth but the processes of discrimination instigate much before pre-natal stage and the very conception of the girl child is done away with by using advance sex selection techniques. The fast

decreasing child sex ratio in India in general and in the state of Madhya Pradesh in particular is an indicator of state of affairs- an index of our apathy, callousness and calibrates effort to extinguish the life of an unborn girl child.

Child Sex Ratio (CSR) of India has reached at an all time low of 914 in 2011 which was 976 in 1961, similarly, in Madhya Pradesh it has gone down to 912 in 2011 from 967 in 1961. The sharpest decline has been witnessed during the last three decades. Child Sex Ratio is the number of girls per 1000 boys in the age group 0-6 years. The decline in child sex ratio is worrisome, as it points to the increased incidence of sex selection. CSR is an important indicator to measures extent of prevailing inequity between males and females. It is also a sensitive indicator of social development.

Misuse of medical technologies has played a central role in the problem of declining child sex ratio in India and its states. It has reinforced negative patriarchal systems that demand male heirs. In fact, developments in sex selection techniques have a direct relation to the declining child sex ratio in our country. Techniques like Amniocentesis and pre-implantation genetic diagnostics, X-Y separation methods, assisted reproductive technologies like IVF, IUI, Ultrasonography and many other are readily available and employable to meet the demands of a society widely suffering from Son Preference Syndrome. In fact, it can be said that unholy alliances of tradition and modernity, i.e. modernization of tradition and traditionalization of modernity have wreaked havoc in the life of girl child.

In the year 1901, the sex ratio of Madhya Pradesh was same as that of India and nearly maintained a comparatively similar trend till 1951. PCPNDT Act was passed in 1994 and came into effect from 1st of January, 1996. An impact assessment of the "Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of sex selection) Act, 2003, in the state of Madhya Pradesh will sufficiently gauge its efficacy in combating the menace of declining female child sex ratio. The Impact assessment will involve identification of the loopholes in the Act which is inhibiting it from achieving its objectives. It will further analyze the roadblocks in the implementation of the Act in light of the contemporary socio-cultural matrix of Madhya Pradesh.

Madhya Pradesh's apathy towards its girl child is blatantly reflected in the Census of India Reports. Unfortunately, undertone of systemic and rampant indifference towards girl child is increasingly the undertone in Madhya Pradesh. The Census Commissioner of Gwalior State Wrote: 'Female infanticide does not now exist anywhere in this State and must be ignored as a factor causing deficiency of female sex. But is very striking that Tonwarghar (presently known as Morena district), the habitat of Tonwar Thakur, should show, 19001 and 1911, the lowest proportion of female to males. Tonwar Thakurs, of all castes and races, show the smallest ratio of 526 females in the whole state. In their own districts they return the very low proportions of 438 per mile, i.e., less than one female to two males' (Gwalior Census Report 1921:47[8]. The decline in the number female in Bhind and Tonwarghar was attributed to the rampantly prevalent female feticide in the Rajput and Brahman faction of the society. In the 1931 Census, the Commissioner observed that 'at one end of the scale is the Sondhia, Balai, Sahariya, Bhil and Bhilala with an almost even proportion of the sexes; at the other end is the Rajput, Brahman, Bania and Maratha, all showing a startling excess of males.'[9] Sub-castes namely Bhaduria and Tonwar Rajputs in the northern part of the state are adopted suspicious modes to disappear or eliminate girl child. Evidently, Rajputs enjoins a lot of pride and fanfare

[8] Gwalior Census Report 1921 (1922). Census of India, 1921, Volume XX, Gwalior, Part-I – Report. The Alijah Darbar Press, Gwalior.
[9] Gwalior Census Report 1921 (1933). Census of India, 1931, Volume XXII, Gwalior, Part-I-Report. The Alijah Darbar Press, Gwalior.

to the birth of a male child in the family. Tables in the annexure show details and graphic representation of scenario of sex ratio in Madhya Pradesh.

8. THE LEGAL LOOPHOLE AND LOST LAUREL

An indepth analysis of the case reflects that, though the PNDT Act 1994 was amended and the amendment Act came into force in January 2003, no significant impact of the Act was felt at the grassroots level because of the difficulties associated with the implementation of the Act. There is an avid ignorance about the Act among different stakeholders.

a. The Appropriate authorities and the Advisory Committees throughout the State should be made aware of the provisions of the Act as well as the Rules. A copy of the relevant judgment from different districts of Madhya Pradesh should also be provided to them. A comparative approach will enable them to properly implement the provisions of the Act. The Appropriate Authority has been empowered to grant, suspend or cancel registration of a Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic. In addition to they can enforce the standards prescribed for a Genetic Counseling Centre, Genetic Laboratory and Genetic clinic. Evidently, sufficient powers have been given to the Appropriate Authorities. A look at the cases *sub-judice* or decided in the Madhya Pradesh reflects some drawbacks in taking of cognizance by the concerned Appropriate Authorities.

b. In the State of Madhya Pradesh a award scheme has been introduced to encourage people to inform the Appropriate Authorities regarding any practice which is in contravention to some provisions of this Act. This award scheme has proved to be of not much use due to the delay in framing of charges.

c. In most of the cases the quantum of punishment is negligible as compared to the benefits reaped by the accused. The punishment given is too less and it nowhere acts as a deterrent. Bearing this in mind the provisions of the Act should be strengthened. The practice of sex-selection should be a high risk offence. The probability of conviction and punishment will prove effective in arresting the spread in the sex determination practices in Madhya Pradesh.

d. There have been numerous cases when the ultrasound machine has been seized by the Appropriate Authority. As per the provisions of the PCPNDT Act, if the Appropriate Authority seizes any ultrasound machine or other equipment of detecting sex of foetus, which is used by an organization not registered under the Act, the machine of the organization is released only on payment of penalty equal to 5 times the registration fee and on such organization giving and undertaking that it will not indulge in the detection of sex of foetus or selection of sex before or after conception. This provision takes away the fear or deterrence out of the Act. It simply conveys that on payment of a minimum amount and on writing of an undertaking the individual may continue with his work. This Rule should either be deleted or amended in order to stop encouraging the perpetrators of this crime to violate the provisions of this Act.

e. In most the cases during search and seizure the Appropriate Authorities found loopholes in the filling of the Form F. These forms are preliminary documentary evidence in order to ascertain the identity of the patients. Due to improper documentation it becomes difficult to trace the women and ascertain whether sex selective abortion was conducted after the ultrasonography. Improper maintenance of records is an offence under the PCPNDT Act. The Courts have shown dealt with these contraventions of this provision very leniently. This in turn has encouraged the owners of

these ultrasonography centers to flout the rules. The mandatory submission of From F by all clinics to the Appropriate Authorities as per rule 9(8) will act as a check and will allow a periodic assessment of the Clinics. In case these records are not maintained immediate legal proceedings should be initiated against these Clinics. It should be borne in mind that the mismanagement of Form F is minor problem pertaining to documentation. It may reflect the nefarious practice of sex selective elimination of daughters through the active participation of the ultrasound clinic owners.

f. As a matter of fact for any law to act as a deterrent it is important that there is a good rate of conviction. During the legal analysis it was observed that the rate of conviction has been very low in Madhya Pradesh. There are different ancillary reasons for the same. Most importantly, there seems to be an inability to appreciate the gravity of the problem on part of the Judicial Officials, Prosecution Officers and the Appropriate Authorities.

Preliminary investigation and study of the cases establishes the lackadaisical approach of the stakeholders namely, Appropriate Authority and Prosecution Officers. The Appropriate Authority has been assigned the primary task of taking action against the errant doctors or medical practitioners. It can grant, suspend or cancel registration of a Genetic Counseling Centre, Genetic Laboratory or Genetic Clinic. It further can grants, suspend or cancel registration of a Genetic Counseling Centre, Genetic Laboratory and Genetic Clinic. Most importantly, it is powered under the Act to investigate complaints of breach of the provisions of this Act and to take immediate action. This action involves *suo moto* action in case of complains brought to its notice and also to initiate independent investigations in the particular matter. In most of the above stated cases fundamental loopholes where found in the filing of the complaint. ***Section 22*** prohibits advertisement relating to the pre-conception and pre-natal determination of sex and punishment for contravention. The term of punishment under this Section is imprisonment for a term which may extend to three years and with fine which may extend to ten thousand rupees. On the other hand under ***Section 25*** punishment extends to three months or with fine, which may extend to one thousand rupees or with both in the case of continuing contravention with an additional fine which may extend to five hundred rupees for every day. Contraventions under ***Section 22*** are deliberately registered under Section 25 in order to save the medical practitioners from more trouble. Reportedly, a nexus works behind the curtains to prevent the filing of the complaint under ***Section 25***. Paying the meager amount of one thousand rupees has proved to be an escape route for money minting doctors. The impact of the Act is further compromised due to the role assigned to the Chief Health and Medical Officer. The Chief Health and Medical Officer share a professional proximity to the accused doctor. This proximity curbs his efficiency in adequately playing his role.

PCPNDT Act provides for the maintenance of records in respect of pregnant woman by genetic clinic/ultrasound clinic/imaging centers. This Form requires the recording of the patient's name. Collaboration between the doctor and the patient results in recording of distorted information in the Form F. Resultantly it makes it impossible to trace the pregnant woman and establish the course of action adopted by her. The writer is as a member of the State Advisory Committee regarding the implementation of PCPNDT Act of the Govt. of Madhya Pradesh as well as a member of the District Monitoring Committee has access to date generated by government. In fact, as a member of Monitoring Committee he has the experience of visiting more than 100 Hospitals, Infertility Centres, Genetic Counseling and USG Centres etc. where there instruments to detect the sex of the foetus are placed over a period of two years. A preliminary observation and analysis of his experience are discussed below. :

9. SOME OF THE COMMON LOOPHOLES IN THE F FORMS ARE ILLUSTRATED BELOW:

1. The F Form had wrong registration number written on it at one of the Centers.
2. Addresses were incomplete.
3. Name of the Doctor by whom the patient has been referred is written but the address is missing.
4. Referral slips were missing at few of the centers.
5. All clients being self referred at few centers.
6. Indication of prenatal diagnosis has been mentioned in all the forms as fetal well being in some centers and completely missing a few.
7. The result of sonography is not mentioned as normal/abnormal, only the weeks of gestation are written in places of results.
8. At few centers the results of USG was completely missing.
9. At one of the centers, results of the sonography were written as 'no' on all of the F Forms.
10. Results of the USG informed to whom and when was no filled in. on any of the F Forms at few of the centers.
11. Few of the centers did not have Name & Registration No. of the Radiologist/Gynecologist/RMP, who performed ultrasound and few did not have Name, Registration no. and signature of the Gynecologists/Radiologist. Director of the clinic on F Forms.
12. Declaration by the doctor performing the USG was not there on F Forms of the September month at one of the centers.
13. Declaration by the doctor performing the USG has not been typed on F Forms, the seal has been put and then it is signed at few centers.
14. MTP Records were not properly maintained at the centers performing the procedure. The indication for the MTP is not stated and the number of sex of the issues is not mentioned in any case.

The Monitoring Committees in Bhopal, the capital city of Madhya Pradesh made the following observations:

1. The common finding at 5 branches of one of the biggest centers of Bhopal was that there were 7 USG machines gone missing which were entered on the PCPNDT Registration Certificate. On asking, it was told that they have been disposed off to Kawadi (waste collectors) as they were out of order. There were no documents of disposal and no information was given to the Appropriate Authority.
2. Doctor's certificates of qualification and the state medical council registration certificates were not displayed at many centers. They were kept in the file/drawer etc. Some places it was not available at the centers.
3. At few Centers it was noted that OBG postgraduate doctors are doing the USG's was 1 to 3 training.
4. It was noted that even IVF centers are not doing invasive procedures.
5. Display boards stating 'detection of sec of the fetus is not done here and it is a legal offence, was displayed at prominent place in Hindi only at most of the centers.

6. Many centers did not have a copy of the PCPNDT Act.
7. MTP Registration Certificates not displayed/not available on the centers performing the procedures.
8. Some centers did not maintain separate ANC Registers.
9. Review of the reports and records of the last three months shows that there was delayed submission of the monthly reports to the District Appropriate Authority at few centers, with proper acknowledgements available.

10. CONCLUSION

The tables and figures used in the paper highlight the declining sex ratio in Madhya Pradesh from 1961 and also depict the worst affected districts of Madhya Pradesh. It is also interesting to note the districts with higher tribal population and lower economic growth have a better sex ration than their counter parts. This often lead to assume that knowledge, availability of technology and necessary economic capacity is responsible for higher sex selective abortions rather than mere the presence of traditional son-preference syndrome. The unholy alliance between tradition and modernity that provided access technological access to reinforce a traditional mindset, there has been the failure of law in eradicating the menace of sex selection. This has put the nation and society in quagmire and if we fail to get out of hole then future certainly looks bleak. However, it is believed that the if we can change the mindset of all the stakeholders by informing, communicating and educating them about the bleak future and their potential role in halting this madness then certainly there is light at the end of the tunnel.

Figure 1

Declining CSR in India

Census	Total	Rural	Urban
1981	962	963	931
1991	945	948	935
2001	927	934	906
2011	914	919	902

Source: Census of India

Figure 2

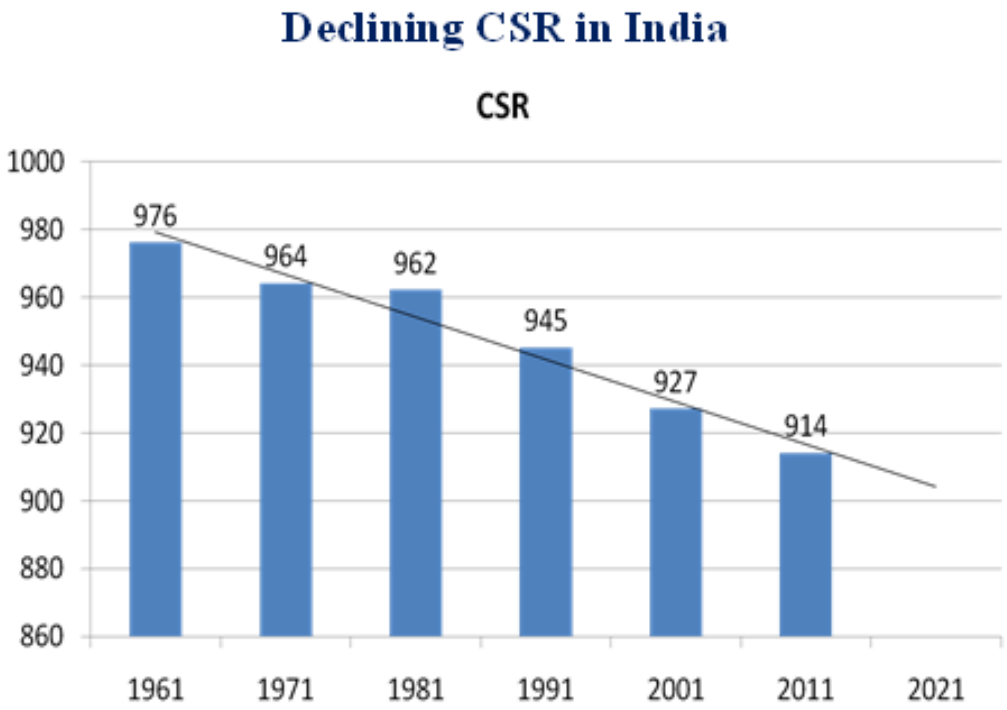
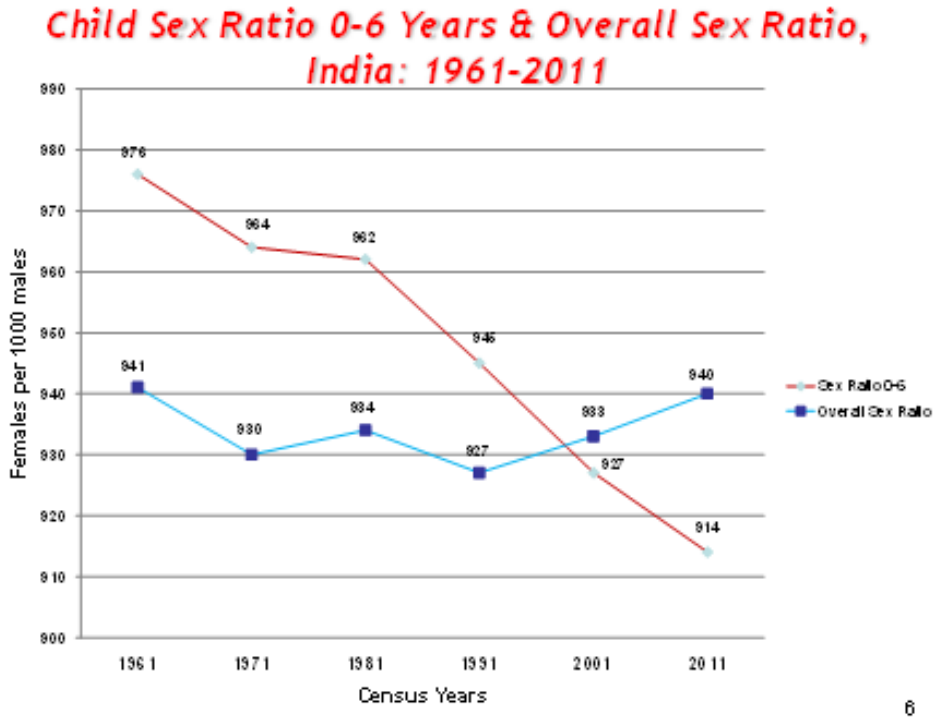
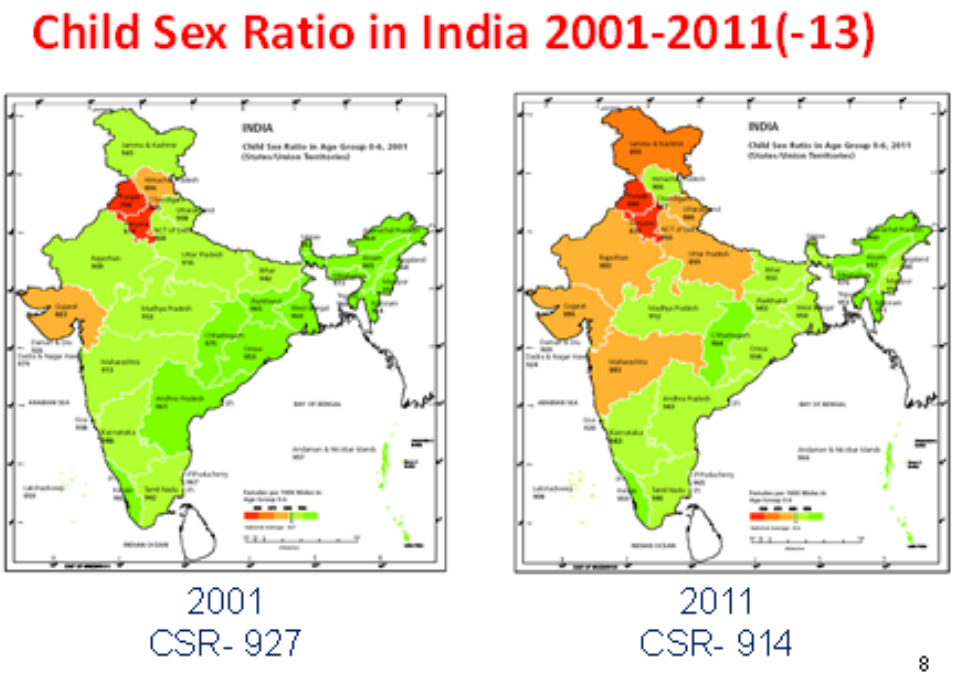


Figure 3



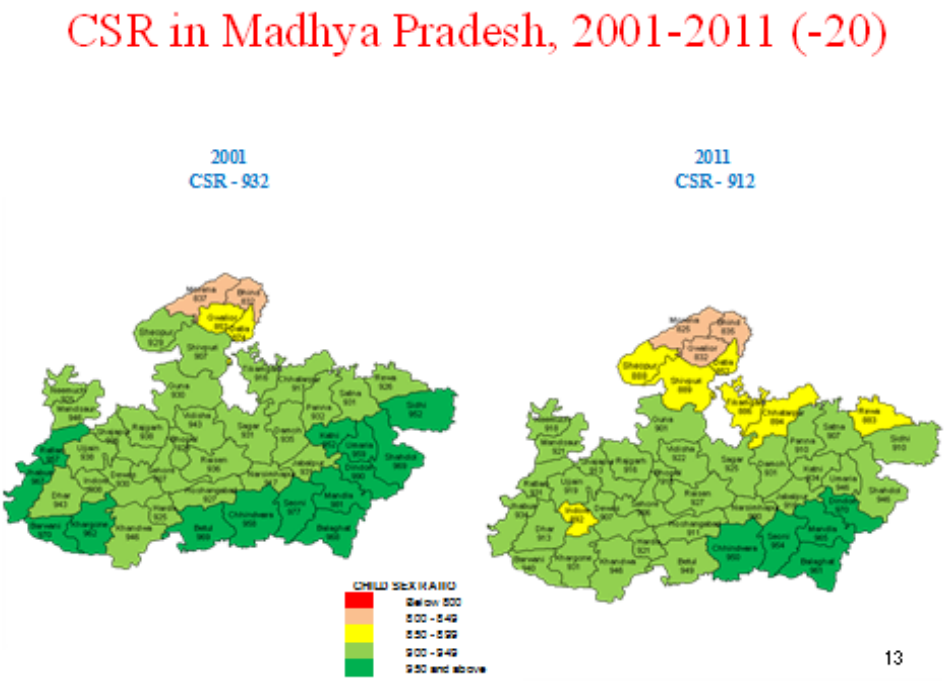
Source: Census of India

Figure 4



Source: Census of India

Figure 5



Source: Census of India

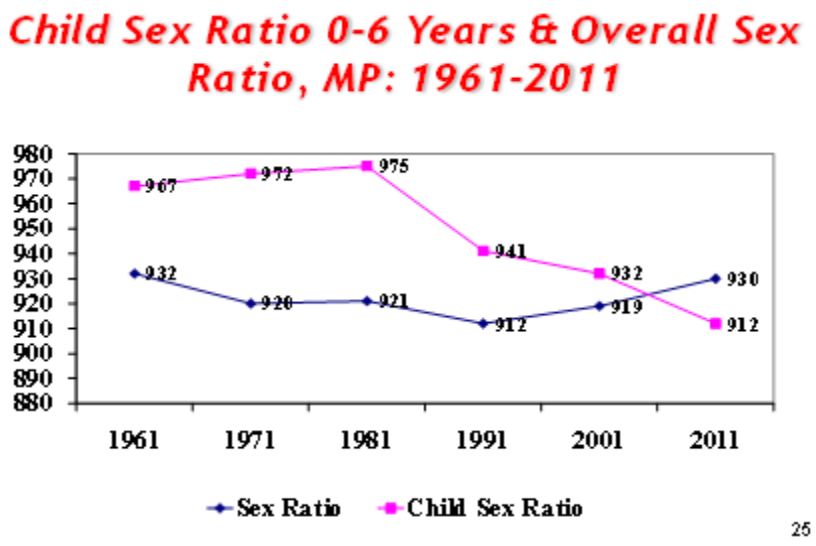
Figure 6

Estimates of Missing Girls due to Pre-natal Sex Selection 2001-07, India and Selected States (computed from SRS data)

State	Estimated number of female births that did not occur each year due to prenatal sex selection	% of missing female births (out of the total female births)
Punjab	35,833	16.2
Haryana	33,588	12.9
Jammu & Kashmir	9,987	10.5
Delhi	11,033	8.9
Rajasthan	71,931	8.7
Gujarat	47,503	7.9
Uttar Pradesh	1,95,899	7.6
Himachal Pradesh	4,468	7.6
Bihar	76,160	6.0
Maharashtra	55,053	5.9
Jharkhand	12,718	3.4
Madhya Pradesh	17,261	1.9
Kerala	3,697	1.5
Andhra Pradesh	8,621	1.1
Assam	3,832	1.1
Karnataka	1,942	0.3
India	6,01,468	4.8

(Source: UNFPA, India 2010) 23

Figure 7



Source: Census of India

Figure 8

No. of Districts based on CSR:
Madhya Pradesh 2001 & 2011

CSR	No. of Districts 2001	No. of Districts 2011
986 & Above	1	0
951-985	16	5
916-950	27	24
881-915	2	17
880 & Below	4	4

[2]

Figure 9

CSR : Census – 2011
MP: Top 5 & Worst 5 districts

Top 5 Districts		Worst 5 Districts	
District	CSR	District	CSR
Alirajpur	971	Morena	825
Dindori	970	Gwalior	832
Mandla	965	Bhind	835
Balaghat	961	Datia	852
Seoni	954	Rewa	883

Source: Census of India

Figure 10

Decline in CSR between 2001 & 2011: Districts of M.P.

S.No.	District	CSR		Change Between 2001 & 2011 (In Points)
		2001	2011	
1	Rewa	926	883	-43
2	Sidhi	952	910	-42
3	Sheopur	929	888	-41
4	Singrouli	955	921	-34
5	Anuppur	977	943	-34
6	Jhabua	967	934	-33
7	Khargone	962	931	-31
8	Tikamgarh	916	886	-30
9	Dhar	943	913	-30
10	Badwani	970	940	-30
11	Guna	930	901	-29
12	Ratlam	957	931	-26

Figure 11

Decline in CSR between 2001 & 2011: Districts of M.P.

S. No.	District	CSR		Change Between 2001 & 2011 (In Points)
		2001	2011	
13	Mandsaur	946	921	-25
14	Satna	931	907	-24
15	Chattarpur	917	894	-23
16	Shahdol	969	946	-23
17	Shajapur	936	913	-23
18	Dewas	930	907	-23
19	Seoni	977	954	-23
20	Datia	874	852	-22
21	Panna	932	910	-22
22	Rajgarh	938	916	-22
23	Gwalior	853	832	-21
24	Vidisha	943	922	-21
25	Sehore	927	906	-21
26	Dindori	990	970	-20

Figure 12

Decline in CSR between 2001 & 2011: Districts of M.P.

S.No.	District	CSR		Change Between 2001 & 2011 (In Points)
		2001	2011	
27	Betul	969	949	-20
28	Ujjain	938	919	-19
29	Shivpuri	907	889	-18
30	Ashoknagar	932	914	-18
31	Katni	952	934	-18
32	Narsingpur	917	900	-17
33	Indore	908	892	-16
34	Hoshangabad	927	911	-16
35	Mandla	981	965	-16
36	Khandwa	946	931	-15
37	Jabalpur	931	916	-15
38	Umaria	959	946	-13
39	Neemuch	931	918	-13
40	Burhanpur	934	921	-13

Figure 13

Decline in CSR between 2001 & 2011: Districts of M.P.

S.No.	District	CSR		Change Between 2001 & 2011 (In Points)
		2001	2011	
41	Morena	837	825	-12
42	Alirajpur	982	971	-11
43	Bhopal	925	916	-9
44	Raisen	936	927	-9
45	Chhindwara	958	950	-8
46	Balaghat	968	961	-7
47	Sagar	931	925	-6
48	Damoh	935	931	-4
49	Harda	925	921	-4
50	Bhind	832	835	3
	Madhya Pradesh	932	912	-20

Source: Census of India

Status of Cases under PC & PNDT Act in Madhya Pradesh

Sr. No	Name of the District	Name of Parties	Status as on 29.03.2011
1	Bhopal	1. Dr. Nirmal Jaisawal, Nirmal Nursing Home, Bhopal (Case No. 1370/4/10-33-04). Act punishable under Section 22 of PCPNDT Act, 1994. 2. M/s Laxmi Ausadhi Bhandar, Roshanpura, Bhopal (Case. No. RT9139/07). Act punishable under Section 22 of PCPNDT Act.	Court ordered imprisonment and Rs. 2000 fine on 27.01.2011. Name removed from the State Medical Council Regsiter for 5 years, dated 2.04.2011. Appeal in District Court Case under consideration in District Court. Charges Framed. Evidence being collected
2.	Shivpuri	1. Dr. Bhagwat Bansal, Director Kalpana X-Ray and Ultrasound Centre, Arya Samaj Road, Shivpuri (MCRC 948/07/6.02.2008 and MCRC 949/07. 2. Dr. Anita Verma, Gynecologists, Verma Nursing Home (MCRC 950/07 & MCRC 948/07/6.02.2008). 3. Against verdict of Honorable Court again appeal was done in District Session Court, Shivpuri. Case No. MCRC/129/07, against Dr. Dinesh Kasual, Dr. Bhagwat Bansal, Dr. Anita Verma.	1. Case was rejected by CJM Court on 24.01.2009. 2. Appeal in High Court 3. Case is pending in the Court.
3.	Bhind	1. Gwalior Ultrasound Centre. Dr. Lane, Bhind, Case No. 696/2007 against **Mrs. Kusum Jain, Director. Violation of Rule 13 and 3A of the PCPNDT Act alleged.**	1. Acquitted, no conviction on (22.09.2010).

4.	Indore	1. Chhabra Diagnostic Centre, D-33, HIG, AV Road, Indore (22.06.2007, Case No. 19564/07, Appeal No. 30/08) 2. Mittal Sonography and X-Ray, 108, Chanakya Complex, 1st Floor, Malva Mill Chouraha, Indore (Case No. 18498/07) The Center didn't maintain records of "F" firms as prescribed under Section 29 of the PCPNDT Act. As per the material seized violation of Section 23 and 25 was alleged. 3. Gill Diagnostic Lithotripsy Center, 304, Jawahar Marg, Indore (Case No. 29036/07). **The Center didn't maintain records of "F" firms as prescribed under Section 29 of the PCPNDT Act. As per the material seized violation of Section 23 and 25 was alleged.** 4. Dr. Premlata Bansal,Gori Devi Nursing Home, 113, Jawahar Marg, Indore (Case No. 21982/07). **Non maintenance of Form "F" as prescribed Under Section 29 of PCPNDT Act. As per the material seized violation of Section 23 and 25 was alleged.** 5. Dr. Girish Mehta, Dr. Vivek Sahu (Case No. 1126/03) 6. Dr. Vikas Vagera (Case No. 21301/06) 7. Dr. Manvinder Singh Gill (Case No. 1839, dated 2.02.2011)	1. Case in JMFC Court. Evidence being collected. Cross examination of the witness on 8/08/2011. 2. Stay order has been granted against Honorable High Court on the proceedings of the case. Next hearing on 8/11/2011. 3. Case in JMFC court. Cross-examination in progress. Next hearing on 8/08/2011. 4. Decision on 26.07.2007- Rs. 1000/- fine non compliance 1 month imprisonment. Appealed case no. 1239/2008 in High Court Judgment given that under Section 265 of CPC case cannot be considered again. Center has been closed. 5. Evidence being collected in JMFC Court. Next hearing on 16/08/201. 6. Evidence before charges being collected in JMFC Court. Next eharing on 26/08/2011. 7. Case in CJM Court. Accused has been summoned to be present in the Court. Next hearing on 4/11/2011

5.	Gwalior	1. Dr. Sushma Trivedi, Trivedi Nursing Home, Nai Sadak, Gwalior (Case No. 5622/09) 2. Dr. S.K. Srivastava, Suresh Memorial Clinic, Huravarli Road, Baradari, Muraar, Gwalior (Case. No. 5623/09) 3. Dr. Sandhya Tiwari, Sandhya Nursing Home, M-888, Darpan Colony, Gwalior (Case No. 5621/09) 4. Dr. Pradeep Saxena, Gyneacologist, Civil Hospital, Dabra, Tapaswari Complex, Near Central Bank, Fort Road, Gwalior(Case No. 5659/09)	1. Case in CJM Court. Stay on proceedings by Hon'ble High Court. Next hearing on 24/08/2011 2. Case in CJM Court. CD is to be produced by the CMHO. 3. Evidence before charge is being collected. Cross-examination underway. Next hearing on 2/09/2011. 4. Stay on the proceedings from Hon'ble High Court. Case in CJM Court. Next hearing on 29/09/2011.
6.	Ujjain	1. Dr. Anil Palod, Sonography Centre, Tarana, Ujjain, Writ Petition No 6648/2010.	1. Case is pending. Hearing scheduled on 29.11.2010.
7.	Anuppur	1. Dr. Pradeep Tiwari, Sonography Centre	Charges framed.

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