Media Sensitization Workshop On Sex Determination

Jan 30-31, 2003
New Delhi

(A Report)

Organised by:
Centre for Advocacy and Research
in collaboration with The Centre for Women Development Studies (CWDS)

Supported by:
WHO , UNIFEM, UNICEF, CMAI

Introduction

The Indian Census 2001 figures show that the demographic situation of women and girls continues to deteriorate. The net deficit of females in India which was 3.2 million in 1901 has now widened to over 35 million at the Census of India, 2001. In respect to the child sex ratio in the age-group 0-6 years, the situation is even worse, with the decline being from 945 girls per 1000 boys in 1991 to only 927 girls per 1000 boys in 2001 Census. According to Mr. J.K. Banthia, the Registrar General, India, the decrease "has been at a much faster pace than the overall sex ratio of the country after 1981". This "decreasing sex ratio in this child population" he stated would have a "cascading effect on the population over a period of time leading to diminishing sex ratio in the country".

A Media Sensitisation Workshop on Sex Determination organised by the **Centre for Advocacy and Research (CFAR) and the Centre for Women's Development Studies (CWDS)** in New Delhi, brought together more than 35 journalists from all over the country. Organised on 30-31 January 2003, the aim of the workshop was to motivate journalists to help eliminate the practice of female feticide through sensitive reporting.

The workshop was held against the background of the recent pressure from the Supreme Court on the government to start implementing the original PNDT Act, 1994 and the subsequent passage of the PNDT Amendment Bill in parliament.

The 2001 Census provides evidence that millions of unborn girls have gone missing over the last decade. Today the foetal stage has become the most dangerous for females due to the practice of sex determination tests and the elimination of the female foetuses. Sex determination tests are becoming increasingly popular throughout the country. Distortion of child sex ratios is the immediate outcome, with the likelihood of engendering increased violence against surviving women in the coming decades.

SESSION I: INAUGURATION

In his opening remarks, Public Health Administrator, WHO, India Office, Dr. Tej Walia, said that gender-based inequality permeates every aspect of the Indian woman's life, with discriminatory practices starting even before the child is conceived. As economist Amartya Sen put it in a 1990 essay, "many faces of gender inequality" the practice of pre-natal sex determination has led to 100 million fewer women than there should have been given normal population growth, with India alone accounting for 32 million of these missing women.

The main culprit here is sex selective abortion, misusing technology for sex determination of the unborn child.

Violence against the female, he emphasised, is first and foremost a question of inequalities and, by extension, a denial of human rights. Violence against women, moreover, undermines the basis for sustainable human development.

Participants agreed that gender-based violence requires urgent action as a major public health issue. Since it involves, changing the behaviour of individuals, this is a complex and challenging task. Ultimately, all social change depends on the changed beliefs and behaviours of certain groups and individuals, who, in this case are :

- Policy-makers and decision-makers;
- Civil society organisations;
- Service providers; and
- Service seekers / users.

The media-print, audio-visual and the Internet-has a critical role to play in highlighting the issue and its implications on a regular and sustained basis. Furthermore, it could challenge public opinion by investigation and reportage. This would keep the issue alive in the minds of all stakeholders and policy-makers and thus underline the social concern regarding this practice.

Media practitioners including management should be sensitive to the fact that irresponsible action on their part, such as allowing advertising on media for sex selective abortion, can have very profound and negative social implications.

The Government of India has enhanced efforts for enforcement of the PNDT Act. The coalition efforts of all stakeholders-UN agencies UNICEF, UNIFEM and UNFPA, along with WHO and the Government of India (GoI)-hold the key to addressing this complex issue.

SESSION II: KEYNOTE ADDRESS on GoI COMMITMENT

Delivering the Keynote Address, Secretary, Department of Family Welfare, Mr J V R Prasada Rao said that the principal focus of the workshop was to understand the nuances of reporting on such a sensitive issue. Already much publicised in the media, gaining in exposure very quietly, the Census figures of 2001 have more forcefully brought the issue to everyone's notice.

Given the accepted understanding that any society with a male-female ratio of 1:1 or slightly higher on the woman's side is indicative of development, India presents a grim reality.

The country has seen an increasing decline in the male-female ratio, at no point of time more pronounced than in the last decade. Within the national average, moreover, there is a wide variation in the ratio from state to state. From Kerala to Punjab, state to state, the variation is very noticeable. Especially in the Western States of Punjab, Haryana, Delhi, Rajasthan, Gujarat and Maharashtra, the ratio has worsened significantly. Eastern India, generally regarded economically backward, seems comparatively less socially regressive, and shows a better sex ratio than the western part of the country.

Evidently, economic advancement and the advent of technology has, rather than help people achieve improved socio-cultural standards, contributed to a decline.

If unchecked, female feticide and the increasingly unequal sex ratio is certain to cause severe social problems, including:

- Reversal of social gains. The economic and social gains made over the last five decades are at stake if there are fewer women in the society.
- Increasing violence again women. Insecurity for females would increase and, consequently, so would violence against women, various economic and social injustices.
- Increasing insecurity. Economic insecurities would include less employment for women and also a fall in girls' education. In parts of Rajasthan, women are already compelled to be partners to more than one brother in her marital family; this practice may spread to other parts of the country.

Female feticide is a social problem, requiring a change in the mindset of people. While all possible efforts need to be made at every level, the law can be used as one effective tool to penalise and to create fear in the minds of those offering or resorting to pre-natal sex determination tests. But law alone cannot solve the problem. In a social problem of this sort, the government is just one part of the entire machinery that is required to resolve it.

Legal initiatives by the government include -

- Provisions in the Indian Penal Code, 1860, such as punishment for wilfully causing miscarriage and other such offences. But none of these provisions have ever been effectively utilised.
- The Maharashtara Regulation of Pre Natal Diagnostic Act, 1988, the first law intended to combat the rise in use of pre-natal investigative techniques (for sex-determination). Although a remarkable initiative, the Act had little impact. It gave rise to an intense public debate and out of that emerged the Pre Natal Diagnostic Techniques (Regulations and Provisions of Misuse) Act, 1994
- This Act, enacted on 20 September 1994, actually came into effect in 1996. But even after 1996, several of the provisions virtually remained on paper for nearly four years.
- The Public Interest Litigation (PIL) suit in Feb 2000 brought the issue to the fore, following which the Supreme Court gave strong directions regarding action to be taken by the state governments and the Government of India. Subsequent to intense public debate, the Supreme Court issued very clear guidelines to the governments.

Strong reactions from civil society organisations, NGOs, the media, etc., played a significant role in prompting the government to amend the 1994 Act. The amended law extended the purview of the Act to include the pre-conceptions techniques. The amendment also covers the loopholes that existed in the 1994 legislation and makes the Act more comprehensive, with the potential for more effective implementation.

With the advent of technology, two things have happened:

- Pre-natal sex determination tests can be more easily conducted. The ultrasound technology earlier used for sex determination was an invasive procedure. Some samples had to be taken from the woman's body for the purpose, and only qualified doctors could do that. In the mid-'90s, non-invasive procedures were introduced, and mere scanning is required to determine sex.

- Technicians too started using the machine. Because of the simple, non-invasive procedure, even technicians who can run the ultrasound machine have started conducting the tests.

Ultrasound technology is a boon to medical science, but it is abusing or misusing the technology to bring it to the service of pre-natal sex determination testing. Such misuse always comes in when technology advances and one has to prevent that, which is the object of the government legislation.

Due to the advances in pre-conception techniques, the sex of the child can be determined even before conception. Genetic clinics are increasingly using these sophisticated techniques.

In a practice like this (sex determination and female feticide), the two parties involved are the doctor and the family.

The family comprises the mother-to-be, her husband, in-laws, sometimes the natal family and friends and others, so that sensitisation of all-the society-is important. The other party to the contract, the doctor, also has certain responsibilities towards the society.

Every doctor is on oath, taken on registration as a practitioner, to refrain from resorting to any unethical practices. The Medical Council of India (MCI) regulations, which guide medical practitioners, also reiterates the principle. Pre-natal sex determination is an obvious area with enormous scope to bring such regulations to bear upon medical practitioners and for the strongest possible punishment to offenders.

For a doctor, there is no stronger punishment than having the right to practise revoked, and de-recognition from the MCI. The threat of de-recognition should be real and effective. Following the government's amendments in the MCI regulations, female feticide and pre-natal sex-determination tests are now regarded unethical practices. Violation of the law can lead to -

- Cancellation or de-recognition of the degree, or
- De-recognition of the registration with the MCI (a doctor cannot practise unless s/he is registered with the MCI).

Apart from the MCI regulations, altogether there are three legal provisions regarding female feticide:

(1) The Pre Natal Diagnostic Techniques (Regulations and Provisions of Misuse) Act, 1994;
(2) The Pre-Natal Diagnostic Techniques (Regulations and Provisions of Misuse) Amendment Act, 2002
(3) The Amendment to the Rules of 1996

These have together created a good legal environment for effective enforcement. But a good strong Act is not enough. The will to implement has to come from the Union government, which has enacted the legislation, and the administrations in the states and the districts, where the actual implementation takes place.

The Chief Medical Officers at the district and sub-divisional levels have been designated as constituting the appropriate authority for the enforcement of this Act. In some districts and states there are appropriate authorities with a tremendous sense of mission, and these areas have done better. But in other states and districts, where the issue is taken in a casual fashion, the person put in charge of implementation needs to be sensitised that it is not just a question of enforcement of law but a huge social problem. The official needs to be more proactive than a normal government official.

Sensitising appropriate authority has been under way. Briefly, this has involved -

- State-wise sensitisation of the appropriate authorities at the district and state levels has already been undertaken and six to seven states have been covered, most in the western belt.
- This has brought into focus many operational issues, which have been addressed in a handbook (an Act or rule does not spell out everything, and some things are left to administrative discretion).
- These sensitisation workshops must be conducted regularly because the appropriate authorities / officials are frequently transferred, and the average tour of duty of a chief medical officer in a district is usually around 18 months. With every transfer a new official needs to undergo sensitisation to the issues.

The other important issue is about how to sensitise the civil society. It is clear that in order to sensitise civil society we need to build partnerships and effective strategies. While NGOs are doing good work in their own areas, to bring the issue of female feticide and the declining sex ratio into focus in a large country like India, the media is the most effective instrument.

Given the publication of a number of excellent reports, the focus needs increasingly to be on the issue, not merely on examples or case studies.

The media should highlight female feticide as a social issue and discuss its causes and remedies.

In the discussion that followed, participants raised questions on:

- How effective is the enforcement of the Act in various states
- Whether the enforcement stops at the registration of machines or goes beyond.
- The availability of data for educationally advanced states
- What is the orientation of the policy.
- Whether there is any thinking on using the untapped resource of self-help groups (SHGs).
- Whether the rise in female feticide has resulted in a decline in female infanticide.
- The availability of people for the advisory committees.

In response to the above questions, Rao said that:

- On the implementation and enforcement of the Act in various States, he stated that:
- The Act is administered at the state level very actively;
  - There is very intensive monitoring of the implementation of the law by the government as well as the Supreme Court;

- The Supreme Court has asked the state governments to file affidavits on the work done;
- The amended law does not punish women who have undergone the pre-natal sex determination test; and
- The amended law has designated medical doctors as the appropriate authority, allowing police personnel to step in only when there is a law and order problem.

- On the enforcement of the law going beyond registration of machines he stated that the Ministry of Health and Family Welfare finds out from the concerned authorities on:
  - How many cases have been registered;
  - How many offenders arrested;
  - How many machines have been sealed during the particular period under investigation; and
  - What is the sensitisation work undertaken.

- **On the data for the educationally advanced states, he stated that -**
  - In Kerala there is a decline of sex ratio, but not as pronounced as in Punjab or Haryana or Delhi. But there has been a decline even in educationally advanced states.
  - States like Jharkhand, Chhatisgarh, or the North Eastern States are definitely better in the sex ratio than some of the so-called economically advanced states (which has more access to advanced technology)

- **On the orientation of the policy, that-**
  - It has, so far, been focusing on rural areas, and is increasingly targeting coverage of urban centres;
  - It seeks to ensure that the benefits of the technology are protected, while abuse of the technology-such as using it for pre-natal sex determination tests-are curtailed; and
  - Since an ultrasound machine is socially neutral, and its use dependent entirely on the orientation of the user, there is an increased social sensitisation to the issues involved.

- **In addition, he observed that -**
  - Civil society organisations like self-help groups (SHGs), especially those involving women, have to play an active role in sensitising communities and also play the role of watchdog. The government has not attempted this sufficiently yet and have to be sensitised to do so.
  - Female feticide has not resulted in a decline in female infanticide. A reduction in IMR (infant mortality rate) has nothing to do with female feticide. Mostly a healthcare issue, IMR will be reduced only when there are better facilities in the hospitals.
  - Not many people are available for appointments on the advisory committees. Even at the sub-divisional level, mainly NGO and local doctors are available.

SESSION III: SITUATION OF THE INDIAN GIRL CHILD

Chairing the session, Deputy Director, UNICEF, Ms Erma Manoncourt emphasised that UNICEF views the issue of female feticide from the human rights perspective. Through international conventions for children and for women governments commit to citizens to address issues such as that of pre-birth elimination of females within a human rights framework.

In India, there is a wealth of data and there is no problem in generating data. The problem is in analysing it to be clear about what the patterns, the trends, the graphs mean. The workshop, she said, is about trying to find out what are the facts, and even more importantly, how to interpret these.

Ms Kamla Bhasin, Gender and Development Expert, speaking on 'The Girl Child: Assessing the Rhetoric of the Last 20 Years', said that any country where 36-40 million girls are either not allowed to be born or are allowed to die, could hardly be called a great country. Female feticide is the death of not only a girl child, but of morality and conscience, a symptom of a society so self-centred and short-sighted that it does not see where this will lead. Notwithstanding the fact that India is a signatory to the Convention for the Elimination of Discrimination against Women (CEDAW)**,** in place of eliminating all forms of discrimination against women, there is elimination of women themselves.

The rhetoric of the issues regarding the girl child has been changing over the past two decades, because there has been changes in the -

- Problems;
- Factors responsible for the problems; and
- Understanding of the problems.

In the early and mid 1980s, the effort was to tell the society about the situation of girls and to look after them better. For example there were songs and posters to empower girls. But the rhetoric is different now.

Female feticide is not the problem, it is a symptom of a much deeper malaise. Parents are forced to kill daughters due to a patriarchal social system and ideology that holds that men are superior to women. This also results in a preference for sons, a symptom evident in religious and traditional practices such as allowing only boys to perform the last rites of Hindu parents, inherit family properties, and carry the family name.

The main problem today is that a profit- and greed-oriented economic system is marginalising and disempowering women. Earlier, women used to be at the centre of production systems, but in the last 50-60 years they have been pushed to the periphery and made dispensable, as -

- Development planning of the last 50 years, considering principally the economic criteria, pushed women to the margins;
- Capital intensive technology pushed women to the margins; and

- Patriarchal societies allow women less mobility, less education and less skills, restricting their ability (along with the Dalits and the Adivasis) to compete in markets.

This combination of patriarchy and a greed-oriented economic system has proved 'deadly' for girls and women.

In the 1970s, among the poor working class communities and castes, women paid no dowry but commanded a bride price instead because she was valuable in her own family and she would be valuable to the family into which she entered upon marriage. There was, however, dowry among the wealthier sections, where she was less valued. Even today, said Bhasin, the so-called scheduled castes and scheduled tribes do not kill their daughters in the way educated, urban, lower middle classes, and middle classes do.

Bhasin suggested that much deeper analyses are needed to see how greed and consumerism have affected values and morality. This paradigm of development is deadly not only for women, it is deadly also for Adivasis, Dalits and the Third World. This paradigm is increasing disparities and inequalities and, consequently, producing conflict.

Speaking on 'Declining Child Sex Ratios and the prosperity efect', Dr Satish Agnihotri, Consultant, UNICEF Kolkata, said that the problem of the elimination of girl children is a sub-set of a bigger problem where one segment of population is considered dispensable on the basis of gender. Given the iniquitous developmental pattern that we have adopted other groups may face similar fate tomorrow based on the colour of their skin, the shape of their nose, the caste they belong to and so on. He reminded the audience that none of these criterion are hypothetical.

By means of maps and diagrams based on the census 2001 and the NSSO data for 55th round, Agnihotri showed that -

- Urban centres show a greater decline in female sex ratios than the overall average for the country. The epicentres of girl child 'deficit', as evident in the Census 2001 reports, are in the urban areas;
- Within the urban areas, the disturbing pattern is that the 'deficit' is higher in the prosperous segments of the population;
- At the all-India level too, the female to male sex ratio declines as prosperity increases both in urban and rural areas, for the adult as well for the child population, and
- A similar trend is observed in the state level data although there are some fluctuating trends because the NSSO survey sample is smaller, but the over all trend is fairly clear.

Given these trends there was a necessity to guard against what he called the 'prosperity optimism'. The Trickle Down theory of the 1960s, was legimitised by an assertion that as a nation becomes prosperous, inequality first increases, then a 'turning point' comes and it starts decreasing. Similar logic is being offered in the context of the household without verifying whether such a turning point comes in the household level prosperity or how severe is the inequality at this 'turning point'. Even as a society is becoming prosperous, where kinds of inequalities can coexist. Inequality in food consumption may reduce, but inequality in healthcare could continue. In India, for example, when it comes to taking the children to hospital, the male child gets preference over the girl child. A combination of

these inequalities has a bearing on the survival chances of the girl child and that is what appears to be happening.

Dr. Agnihotri reminded the audience that all other things being equal, the female foetus and the female infant is biologically stronger than its male counterpart. So wherever there is no unnatural intervention, more male children die during infancy than female children. Nature has a way of bringing parity in the sex ratios because at birth, usually there are 950-970 girl children and 1000 male children. The surplus 30 odd male children do not make it to their fifth birthday, therefore it results in a rough parity. Hypothetically, where no child dies in the first five years, the f/m sex ratio will be around 960.

However -

- In South Asia, up to 1981, the social trend was to cause excess female child mortality through neglect, inequality in access to food, nutrition, medical care, and so on;
- The decade of 1981-91 was a period when technology crept in, so did a new level of discrimination during infancy;
- Up to 1981 there was excess mortality among female children, not in the first year, but in the next four years of life. But after 1981, people have started eliminating them at birth or even before by using ultrasound technology for sex determination. The profit motive of the medical practitioners reigned supreme. The nature of elimination of female children thus changed -elimination through technology has been first accessed by the urban and the prosperous, then by the less prosperous in urban areas, and eventually by the rural prosperous.

The decline (from 1991 to 2001) in the rural female sex ratio in response to the urban decline can be compared to the phenomenon of 'sympathetic resonance' in physics illustrated through the example of two cloth strings next to each other. If one string is oscillated up and down continuously, the other rope does not respond first, then starts swinging slowly and then in tandem. Similarly -

– Some rural areas are not yet responding to the urban swing;
– Others are responding slowly;
– Still others, are responding strongly; while
– A few rural areas are overtaking the urban areas in disposing of its daughters.

All these four kinds of situations are seen in the country today.

Referring to the view that discrimination against girl children is neither new nor unique to India Agnihotri observed that such discrimination in many other countries did not generally impinge on their very survival under the age of five as it does in India. We appear to 'deduct at source' the girl children. This is an extremely important distinction in the type of discrimination.

Giving data on the sex ratio at birth based on the 1981 and the 1991 census data, he indicated that the pattern of female deficit observed in 2001 census data could have been anticipated in a number of districts. It is important therefore that we estimate the sex ratio at birth based on the 2001 census data on an urgent basis and not wait till 2011 to find out the severity of the problem.

Speaking on 'Census 2001 Findings on Child Sex Ratios', Registrar General & Census Commissioner of India, Dr J K Banthia, an expert in historical demography, said that this is not the first time in the last 150 years when science and technology has been misused against the girl child. Around 1870, when the British were conducting their first census, they found some extraordinary results and thought their counting had gone seriously wrong. This so-called invisibility of the women in the census was intensely debated.

In the earlier part of the 19th century, when the British introduced the vaccine to fight the scourge of smallpox, parents tended to ensure that male children were vaccinated and either neglect or exclude female children, resulting in an artificially created lower female sex ratio.

To deal with such problems, the Census of India 2001 could be used to identify imbalances in the composition of the population, its distribution, etc.

Sex ratios for various states vary, so that -

- From Jammu & Kashmir to Himachal Pradesh, Punjab, Haryana, Delhi and Rajasthan, the decline is very clear.
- Uttaranchal shows a smaller decline.
- In the southern and eastern states, the imbalance is significantly less.
- In the west, in Gujarat and Maharashtra, the sex ratio is notably adverse to females.
- The 10 most developed districts of India have a female sex ratio higher than 945. The higher the ratio of female children, the less the bias, and evidently also better amenities and access to health infrastructure.
- Technology has not reached remote areas in Sikkim, Arunachal Pradesh, Jammu & Kashmir (Kupwara), Chhatisgarh, Arunachal Pradesh, Manipur and Nagaland, places that show the highest female sex ratios in the country.
- Among the ten states with the lowest female sex ratios, Punjab, at 754, reports the worst ratio. The best of these 10 has reported 784:1000.
- The lowest sex ratio in the country is well below 793 in Punjab. There is disappearance of almost 240-250 girls for every 1000 boys.
- In 1991, the district, tehsil and the community development block maps for Punjab showed the overall average female sex ratio at 875:1000.
- Female sex ratio is found to fluctuate significantly in the border regions. This could be due to-
  - The presence of army personnel, which artificially increases the male population figures; and
  - Migration of the local male population in search of employment.

Subsequently, various population segments in Punjab have stepped in to address the issue, including -

- The media: In coverage.
- The Sikh clergy: Immediately following the census result, in a pioneering move, the clergy in India met and issued a *fatwa* that Sikhism does not support any discrimination against the girl child.
- International pressure groups: The Sikh community outside India also issued a similar statement.

- The government: The Punjab government is faced with the question of sex ratio and the status of the girl child before the Planning Commission and the Union government, the issue being linked to release of funds for development.
- Politicians: Some leaders, like the chief minister of the neighbouring state of Haryana, which shares Chandigarh as its capital with Punjab, have begun emphasising the need to sensitise communities and educate politicians on the issues.

In Himachal Pradesh, meanwhile -

- Various committees have been monitoring sex ratios district-wise and have reported a significant difference in sex ratios between the plains districts (Kangra and Hamidpur) and the hilly areas. The plains have started following the Punjab trend very closely (HP is neighbour to Punjab).
- Subsequently, the HP government has been alerted and efforts have begun to highlight the problem by disseminating information, the emphasis also being on the need for social and community pressure to dissuade parents from pre-natal sex determination tests.

Historical demography, analysed on a North-South geographical axis, north and south of the Aravalis, shows -

- The status of women is poorer to the north of Aravali than to the south of the range.
- However, in 1991, Salem district in Tamil Nadu, south of the Aravalis, reported a female sex ratio for the younger population well below 850.
- While in 1991 only one in a total of 577 districts reported female sex ratios below 850, in 2001, a total of 48 districts did so.

This imbalance has larger social, economic and cultural implications.

A UN report suggests that till 2100, almost for the next 200 years, India's population will not stabilise. At all points of time, there will be an excess of births over deaths.

In the discussion that followed, participants suggested that -

- Maintain monthly records: All states must maintain and produce monthly records of births and work out the simple sex ratios.
- Improve data collection and analyses: Reputed institutions like the Christian Medical Association of India, which runs several hospitals, could not only provide data but also analyse health issues in terms of the sex ratio. The United Nations inter-agency working on gender and development could also help and support such an initiative. Following the 1991 Census, several studies have been commissioned by UNIFEM and UNICEF to study the implications of the changing sex ratios.
- Focus on sex ratios of scheduled tribe and scheduled caste communities: Compilation of data by scheduled castes or scheduled tribes takes longer than overall aggregates. But, even after this is done, there is some indifference in examining it, which should be changed. Sex ratios by scheduled castes has been examined (and found to be adverse to females) in Haryana, Western UP, parts of Rajasthan and northern Madhya Pradesh. Bereman, an anthropologist who worked in Himachal Pradesh, had earlier catalogued the regressive practices adopted by socially upwardly moving castes.

Studies of sex ratios within the population, by religious communities, show that -

- The sex ratio for the Christian community across the country is close to the normal biological sex ratios at birth (which is about 105 male for every 100 female children). It is about 103-104 males to 100 females. The sex ratio for the Muslim community across the country is also close to the normal biological sex ratios at birth at about 105 males
- The sex ratio for the Hindu community across the country is about 106-108 male which indicates an increased male
- The sex ratio for the Sikh community across the country is about 110 male which also indicates a higher presence of the male child

SESSION IV: IMPLEMENTATION OF THE LAW

Speaking on a case study of 'Faridabad': Proactive Regulation of the Law', Appropriate Authority, Haryana State, Dr B S Dahiya referred to a [June 2001] newspaper report that that sex-determination was at a premium in Faridabad, in Haryana. Following this, a team of medical professionals, that included him, was asked to investigate. In two weeks, the taskforce concluded that a Medical Officer was behind the story and a criminal case/complaint filed in the court under the PNDT Act for taking recourse to sex determination.

However, initially it was difficult to find sufficient grounds to book the culprits and prepare a criminal report. The task was challenging, and awareness among the masses was generated through various IEC activities. Meetings and seminars were organised to make it a people's movement.

Simultaneously, efforts were made to book the guilty through constant surveillance and vigilance of genetic clinics, genetic laboratories and ultrasound centres for illegal determination of sex. There were special meetings and strategies to nab specific nursing homes supposedly doing sex determination. Following this, suits were filed against doctors and clinics where such illegal testing was taking place, the first district in India where this has happened under the PNDT Act. Faridabad is today cited as a success story of exposing mafia groups indulging in illegal activities of sex determination and female feticide.

All over the country, there are 300 cases registered under the PNDT Act.

Speaking on a case in 'Gurgaon: Commitment to Respect Law', Dr Vishesh Kumar said that in Saman *taluq* in Haryana, ultrasound technicians are operating pre-natal sex determination centres. Kumar pointed out that more medical graduates are opting for radiology as a subject for post-graduate specialisation because it has become more remunerative. Both radiologists and gynaecologists are involved in pre-natal sex determination tests. Even many government doctors are guilty of this misconduct, he added, referring patients to private doctors from whom they get commission.

He added that proof for court scrutiny is difficult to come by as those who have undergone such tests refuse to testify and the operators are unlikely to do so either. However, if a

pregnant woman is examined by ultrasound after the foetus is 18 weeks old, it should be proof that the radiologist has violated Section 6 of the PNDT Act, Kumar said.

According to Section 5 of the PNDT Act, information about the sex of the foetus is prohibited and according to Section 6, determination of sex is prohibited. Ultrasound is a very advanced technology, and it can detect stones, abnormalities in the foetus early but the sex can be determined only after 16 weeks.

Section 4 of the Act is being totally misread by the medical and judicial communities, commented Kumar. The section specifies that ultrasound testing is allowed where the woman -

- Is more than 35 years old;
- Has had two or more spontaneous abortions previously;
- Has a history of taking harmful drugs; and
- Has a history of mental retardation in previous babies.

In the discussion that followed, participants raised questions about -

- Political interference in implementing the law. Political interference may be localised in small areas, but does not happen at the state level.
- The need to sensitise doctors. This is a difficult task but imperative if the practice of pre-natal sex determination is to stop.
- The situation regarding sex ratio in Haryana. Some districts, such as Rohtak, Sonepat and Kurukshetra have female sex ratios of 800:1000. Economic and social factors, such as increasing competition, imitating others, expenditure in weddings, and social biases have contributed to this.

SESSION V: REFLECTIONS BY DOCTORS

Speaking on 'Sex Determination in Delhi', Foetal Medicine Specialist, Apollo Hospital, Dr Puneet Bedi said that things that happen in Delhi reflect what is happening in the rest of the country. He stated that, it is true that many doctors take extremely unethical positions, with a head of department in a teaching hospital actually saying that doing amniocenteses and pre-natal sex determination tests would do immense good to India's population problem.

Obviously, not all radiologists conduct pre-natal sex determination tests, but very few would actually speak out against it in public because of loyalty towards co-professionals. Doctors, Bedi commented, indulge in crime purely for greed.

Medical bodies like the IMA are elected bodies, which function like a trade union association and cannot be expected to take a stand against member-doctors, he added. In association meetings, people who are supposed to be watchdogs of society sit and listen but don't act. They take oaths, call religious leaders, but no amount of moral oath taking has helped. Whenever any regulation on the profession is proposed, doctors unite against it. For instance if the Consumer Protection Act is imposed on radiologists, the Radiology Association President would threaten action against it.

There is no case for conducting 'routine ultrasound' in pregnancy, and there are no instances anywhere in the world where professional bodies / associations have prescribed 'routine ultrasound' during pregnancy. But in Delhi this is common.

The 1991 Census had clearly indicated declining sex ratios in places like Amritsar, but nothing much has been done even till 2001. The PNDT Act was enacted in 1994, but in private practice in Delhi, it is still not difficult to have a pre-natal sex determination test and subsequent abortion.

The fear of law is extremely important, and although there are flaws in the 1994 Act, it can be made effective. To track the errant doctor one can audit the number of ultrasounds s/he has conducted, an obvious indication of pre-natal sex determination testing. Moreover, punishing a few will prevent thousands of others from doing such testing.

The desire for a son is as old as marriage or patriarchy. It is provider-specific, where the radiologist, the gynaecologist, and many others are involved. It is Rs 5-billion a year industry, and should not be taken lightly.

Speaking on 'Changing Expectations of Patients', Obstetrician, Vatsalya, Lucknow, Dr Neelam Singh said that ultrasound testing became popular and sex-determination tests started in Lucknow in 1991-92. She said that one measure of dealing with this was to sensitise doctors as to the implications of female feticide and another was to counsel young women. But the roots of patriarchal thinking go very deep, and several women return during later pregnancies to terminate female foetuses.

Speaking on 'Role of medical practitioners in stopping sex determination', Obstetrician, Dr Hema Divakar from Bangalore said this involves both demand and supply—demand from the patients (or family) for pre-natal sex determination, and supply of services from the doctors.

She emphasised that both demand and supply have to be reduced.

No single method would be uniformly effective through the country, because it is so diverse, and the infrastructures are different. She suggested that -

- There has to be a merger of science and philosophy, because the technology is really like a nuclear weapon, with dual use for good and bad. The ultrasound machine is a boon to medical practice, and appropriate usage would always be for good. But a few practitioners are misusing it.
- The righteous or ethical practice, involving a change in the mindset of doctors and technicians, has to be brought about. Imbibing ethics is always a slow process.
- Protest against pre-natal sex determination by medical professionals would have a tremendous impact both on others in the profession, thereby affecting supply from the profession, as well as demand from people.
- However, specific attention is needed to reduce the demand (with doctors playing a role in changing the thinking of the patient and her family), requiring the doctor to spend time with the patient to sensitise her on the issues, appealing to -

In the discussion that followed, participants said that -
A number of gynaecologists and other medical practitioners are not even aware of the law. Once they know [about the law], they will stop doing pre-natal sex determination testing and abortions of female foetuses.
Many medical practitioners have an intellectual arrogance that comes from mystifying professional knowledge.

SESSION VI: Human Rights And Population Policy

Introducing the topic, Executive Director, Population Foundation of India, Mr. A R Nanda said that while population stabilisation programs are under way in the various states, the very term 'population policy' brings to mind the bogey of population control and coercion. However, many believe that -

- An explosion in population lies at the root of many social problems. This is held by policy-makers, political leaders and activists, journalists…most of the middle class.
- Coercive measures, even if these involve violation of human rights, at the command of the state may be used.
- Female feticide may solve the population problem, because people have more children in seeking a 'balanced' family. The National Family Health Survey of 1998-99 reveals very clearly the working of this mindset.

Nanda further elaborated that the desire for a smaller, 'balanced' family is further aggravated because of state policies. A number of state governments, including Maharastra, Uttar Pradesh, Madhya Pradesh, Rajasthan and Andhra Pradesh, have instituted coercive policies by introducing disincentives and incentives depending on size of family. These are extremely counter-productive, he said, both from the standpoint of gender issues and in the fight against female feticide. On the other hand, such measures are not likely to fulfil the limited purpose of controlling the population.

Speaking on 'Causes why people adopt sex selection tests: the gender in a two-child norm', Member, NHRC, Ms Nirmala Buch said that India decided long ago that its policy on population would be based on choice. In practice, the policy doesn't work that way because -

- There is one national policy and there are various state policies, which differ in approach. Differences arising from state-specific needs are justifiable, but the approach should not be different.
- A number of measures in the state government policies are based on coercion and compulsion, though the main direction of the state policies is also to respect choice and avoid coercion in the form of targets [for sterilisation, etc].

The norm says that if a person has more than two children, s/he will not -

- Be eligible to contest elections to panchayats, municipalities, co-operatives and all other elective bodies except the state legislatures and Union parliament; and
- Get any benefits of government programmes, loans, subsidies, etc.

This type of policy leads to practices such as sex selection, commented Buch. It especially impacts people in the younger reproductive age-group.

This norm has not been introduced in all the states. Four states introduced it in the 1990s when they changed their panchayat laws, two states in 2000, and one in 2002.

In 1994, when Haryana and Rajasthan introduced the two-child norm, the women's movement had forecast that -

- Women would be the worst sufferers under this, facing more marital abuse, including desertions; and
- Medical malpractice would increase, with increase in abortions and female feticide.

These apprehensions were found to have come true in the course of exploratory studies carried out in five states-Andhra Pradesh, Haryana, Rajasthan, Orissa and Madhya Pradesh. Though quantitative data was not forthcoming, it was found -

- In one instance, that a woman (according to her own testimony) had aborted a female foetus for fear of losing her panchayat position, but carried a male child to full term, though she was then disqualified from the panchayat. Many others said they would risk losing their positions if the third child was male, but would not do so for a female child.
- There were cases of men, under threat of being disqualified from the panchayat, insisting their wives abort the foetus at a very advanced stage despite the danger to life.

Evidently, such instrumentalist policy measures do not help in population stabilisation. Instead, these make women more vulnerable to abuse. Such measures are fraught with danger.

This law and its implementation affects people's human rights and reproductive rights, women's empowerment and democratic rights. Marginalised sections of the people are worst affected.

Speaking about 'Human rights and population control', Coordinator, Jagori, Ms Kalpana Vishwanath said that in the 20th century, dramatic changes have taken place in demography. In order to understand, which, factor has had an impact on sex ratio one needs to examine the factors that influence the approach to so-called population policies.

A 'population policy' necessarily means looking at people as numbers that need to be controlled. But in reality, having children is an extremely personal individual decision. People have fewer children only when they felt the benefit of this, when -

- Circumstances change, society changes, life choices change; and
- Economic development, medical advances lower infant and maternal mortality.

Population policy and the individual choice of family size are inherently two different processes. If the aim is to regulate an extremely personal individual decision by means of a policy, it cannot be done except through coercion and violence.

India has had a population policy from 1952, started and funded by the Ford Foundation. It was an urban clinic-based approach. Briefly -

- In the early 1960s, it had a more rural focus and looked at community development programmes. But by the late '60s it had become a very strong target-oriented approach. Each health worker / ANM (auxiliary nurse midwife) had a certain target s/he had to fulfil within a time period on specified numbers of terminal and spacing methods within their area.
- The target-driven approach became more aggressive in the 1970s, becoming most coercive during the 'Emergency' years. Alongside, though supervised by a single ministry, health policy and 'population policy' began to be seen as two separate things.
- The large-scale human rights violation in the name of 'population policy' during the 'Emergency' years especially targeted males. The focus subsequently has completely shifted to women, introducing both terminal and spacing methods.
- In the 1990s, the M S Swaminathan Committee formulated a draft population policy, which was not implemented. In 1994, following the ICPD (International Conference on Population and Development) organised by the UN, terminology-and the approach-changed / shifted from family welfare / family planning to reproductive and child health.
- This led to India adopting the target-free approach of the National Population Policy 2000 and moving towards a more comprehensive reproductive and child health policy, with three main objectives-
  - The immediate objective is to meet unmet needs for contraception.
  - The medium term need is to bring down the total fertility rate to replacement levels by 2010.
  - The long-term need objective is to achieve a stable population by 2045.

The different stakeholders involved in the population discourse are -

- The political class;
- The medical community;
- International and donor agencies, who play an extremely important role in determining policy;
- Women's groups and NGOs, which play a significant role in setting some of the terms of a discourse on these issues; and
- Women in low-income groups who bear the brunt of the proposed methodologies, experiments and policies.

SESSION VII: MEDICAL ETHICS

In his introductory remarks, Transplant Surgeon, Jaslok Hospital, Mumbai, Dr Sanjay Nagral said that the Forum for Medical Ethics, which took shape around 1993, takes a stand on various issues, including the controversy about the medical profession being brought back under the purview of the Consumer Protection Act. The Forum also publishes *Issues in Medical Ethics*, interacts closely with NGOs, and has various collaborative health activities in Mumbai and elsewhere. He said that there is a great deal of confusion in the medical profession about what are medico-legal issues and medico-legal commitments and what is ethics. People tend to equate ethics and legality. Ethics is much more than medico-legal principles and covers issues beyond legality or the medico-legal requirements of practice of medicine. Ethics involves social and moral

understanding-what is a good way to practice medicine, what are the values that one should give importance to in the practice. The focus of the profession should be on ethics, he commented, on how to practice medicine as a profession, what should be the values. Finally, he said that unless a section of the medical profession openly or publicly refuses to connive with illegal practices (like feticide, illegal organ transplantation, etc.) it would be very difficult to break the whole cycle of unethical (and often illegal) activities.

Speaking on **'**History of the first PNDT Act – Maharashtra, 1988', KEM Hospital, Mumbai, Prof. Kamakshi Bhate recalled that during 1985-86, women's groups had protested against posters that said: "Pay 500 now to save 50,000 later". The small posters made obvious references to dowry. Plastered all over the local trains in Mumbai, these advertised a very prominent and popular abortion centre in Mumbai.

In the discussion that followed, participants suggested that vigilance committees be set up for the implementation of the PNDT Act, 1994. They said that this would help people know where they may register complaints, who they can approach and inform of violations.

Speaking on 'Evidence based practice of obstetric ultrasound', Dr Puneet Bedi said that advances in obstetric care was made with the introduction of blood transfusion services and the use of antibiotics, making haemorrhage and infections controllable, and most cases of maternal mortality manageable.

Few medical investigation procedures have been as universally accepted as ultrasound technology, which has been in use for about 25 years. Questions about its safety and efficacy have been raised only recently. In selected cases, use of ultrasound is excellent. The issue in question is whether ultrasound has improved neonatal outcome.

The Cochrane database clearly shows it has not improved neo-natal outcome as of today. Routine ultrasound for the whole population has not improved pre-natal mortality, morbidity or outcome. In the best centres in the world, Bedi said, 60 per cent of the major abnormalities are missed in scans conducted at 16 to 18 weeks. Published studies report that 64 per cent of all major abnormalities were missed.

Narrating government initiatives, Director PNDT Cell, Ms Madhu Bala said that the government has set up appropriate authorities at the state and the district levels, but not at the sub-district level in some states. These have been instituted mainly to grant, suspend, cancel registration of genetic counselling centres after the advice of an advisory committee, which comprise medical and legal experts, as well as social workers.

The PNDT Act has about 34 Sections, the violation of which is considered an offence. Violations include -

- Non-registration of an ultrasound centre;
- Determination of the sex of a foetus;
- Communication of the sex of the foetus to parents;
- Advertisement of the services provided at the centre; and
- Not maintaining records.

From time to time the Supreme Court gives directions to the Centre, the states and the appropriate authorities, which are to be implemented.

The amendments to the PNDT Act in 1994 include -

- Extending the purview of the Act to pre-conception sex selection techniques earlier not covered;
- More explicit ban on the use of the ultrasound machine for sex determination. The ICMR has listed 23 indications for use of ultrasound technology, and the doctor has to specify for what purpose it has been used;
- Requiring mandatory registration by all places where ultrasound machines or imaging machines for diagnostic tests;
- Different categories of ultrasound clinics, imaging centres have been included for the purpose of registration, including mobile ultrasound machines;
- Barring manufacturers from selling machines to centres that are not registered; and
- Mandating that all ultrasound centres send a monthly report to the appropriate authority, so they can be monitored.

In addition, for better implementation -

- The Act provides for appeals;
- The appropriate authorities have been made multi-member bodies, with representatives from NGOs as well as the medical and legal professions, in addition to government representatives;
- State supervisory boards have been set up, in addition to the Central Supervisory Board at the state level, which include ministers to head the Board. The Board is to meet once every quarter to review the functioning of appropriate authorities and related issues; and
- Punishment has been made more stringent, allowing also for cancellation or suspension of a doctor's registration.

In the discussion that followed, participants raised questions, discussed and made suggestions about -

- Identifying clinics that are registered and not registered. It was suggested that there should be an action plan to visit clinics regularly and see whether records are being properly maintained. Manufacturers should be asked to send quarterly reports about how many machines have been sold and to which clinic, allowing for cross checking.
- The conviction rate and the nature of cases registered under the PNDT Act. As per the quarterly reports from the state governments, it varies between 250-300

SESSION VIII: MEDIA PARTICIPANTS FORUM

Chaired by Ex Member, NCW, Ms Saeeda Hamid, the panellists included the following: Senior City Correspondent Times of India, Pune, Manjiri Damle, NDTV Correspondent, Guwahati, Bano Haralu, News Editor, Mathrubhumi, Kerala, P S Nirmala, Correspondent Times of India, Bangalore Seethalakshmi and Assistant Editor Saptahik Sakal, Pune, Sandhya Taksale

The panellists stated that:

- While depicting women in the media (in serials, etc) liberties should not be taken to depict them in a regressive way, because serials can have very widespread impact;
- Although Kerala has a sex ratio favourable to women, it has problems such as dowry, and even educated women don't have rights equal to men;
- Urban India suffers from erosion of spiritual values and there is a spiritual vacuum. The mystery in the birth of a child-whether a boy or a girl-should not be interfered with;
- Doctors are to be blamed for everything that is happening in respect of pre-natal sex determination testing. If the supply stops, then there would be no demand at all. It is easier to convince a doctor not to do the tests than to convince a woman come to consult the doctor;
- The media should consistently try to expose doctors conducting sex determination and female feticide; and
- Readers have to be made aware about both the demand and supply aspects of this issue.

Chairperson Hameed commented that consumerism encourages the phenomenon of pre-natal sex-determination. The basic issue, she said, is to raise awareness among people, because self-regulation, self-censorship and a spiritual understanding of the dignity of human beings is much more important and effective than all the regulations imposed by government.

In the discussion that followed, participants said -

- On media's responsibility in reporting the issue: Investigative journalism still takes a partisan position. There should be accountability. Whether it is social initiative or the supplies side, the role of the media is precisely to create that measure of accountability.
- On reduction in supply and demand: While supply can be reduced through better enforcement, demand can be reduced through better education. These have to go in tandem.

SESSION IX: VIOLENCE

Chairing the session, Health Advisor, Plan India, Dr Nalini Abraham commented that the PNDT Act and its implementation, the judiciary and the professional bodies cannot do as much as the media in changing people's outlook. Misuse of ultrasound technology is not about sex selection alone, but the whole issue of gender equity.

Speaking on 'Violence and health, global view', NPO, WHO, Dr Arvind Mathur said-

- The World Health Organisation has recognised violence as one of the major public health problems;
- More men should be involved in fighting female feticide and should be informed about the supply and demand issues;
- Systems issues have to be considered, including how gender issues can be introduced in the concerns of bodies like the MCA and how changes can be introduced in the medical science curriculum to include medical ethics; and

- Data on violence in India should be made more widely available.

Speaking on 'Feminist perspective', feminist activist, Member, Saheli, Laxmi Murthy said that -

- Sex determination and feticide is a crime without a tangible victim. At the individual level there is no victim, but at the social level, there is the huge problem of sex ratios.
- The right to abortion should not be confused with the illegal activity of pre-natal sex determination testing and of feticide.
- In discussing the issue of rights, we should be clear about whose rights are under discussion: The doctor's, the woman's, or the foetus'. The issue also extends to whether the foetus has a right. Many male foetuses are also being aborted. We need to look at the complexities of the issue.
- This also raises the issue of the rights of foetuses with disabilities -whether they have a right to take birth.
- The terminology of feticide revolves around whether abortion is morally and ethically wrong, whether the woman's right to abortion or to have control over her body is morally and ethically correct or wrong. The practice of feticide is similar to homicide or genocide. So the endeavour has been to promote the use of terminology like 'sex selective abortion' rather than 'feticide'.
- Opposing feticide does not mean opposing the right to abortion. People against female feticide are not necessarily against abortion.
- At the policy level, there has been some tokenism. There has not been real change.
- There have been no policy level changes in the dowry system-one of the major reasons for preference for male children-nor land or property rights for women, rights to participate in religious rituals like death rites.

SESSION X: ACTIONS AGAINST SEX DETERMINATION

Introducing the session, Country Representative, UNFPA, Chairperson Mr Francois Farah commented that the role of the media is absolutely critical, not only to share information, but also to provide analysis and to shape a mindset.

Speaking on 'The situation in the Supreme Court', CWDS, Dr Sabu George said that-

- There have been a number of directions from the Courts, but these have not been implemented at the grassroots.
- The principal obstacle has been that doctors and medical associations have been petitioning the courts to protect their vested interests, sometimes asking for nothing more than ensuring procedural delays.
- The media has been helpful in highlighting the issue, which needs to be kept in the limelight.

Speaking on 'Maharashtra State Commission for Women', Chairperson, MSCW, Ms Nirmala Samant Prabhawalkar said that -

- Media is often used to perpetuate customs and traditions that uphold discrimination against women.

- Msany people think that what has been shown on television is true. Glorification or depiction of practices like sati, which is an offence, can have a significant impact.
- There are difficulties in implementation of the PNDT Act, but the Maharashtra state government has formed committees right from the taluka to the state level to check the practice. Sometimes decoy patients are sent to doctors.
- There is increasing awareness of the issues among medical practitioners in Maharashtra.
- Awareness drives have been conducted to make people aware about X and Y chromosomes, ensure that there is greater understanding that the birth of a girl is dependent on the Y chromosome of the father, so that women are not victimised for giving birth to a daughter.
- Zilla parishads have been active in mobilising political and other elected representatives, NGOs and women from a cross-section of people to improve understanding of the PNDT Act and various related issues.

Speaking on the Delhi students and teachers campaign against female feticide, Senior Lecturer, Miranda House, Ms Bijaylaxmi Nanda said it was inspired by the urgency to pressurise for the passage of the PNDT Amendment Bill and the dismal child sex ratio in Delhi as shown in the 2001 Census. Similar such campaigns have been launched in different parts of the country, some of the important ones being CASSA (Campaign Against Sex Selective Abortion) in Tamil Nadu, the FASDSP (Forum Against Sex Determination and Sex Pre-selection) in Maharashtra.

The Delhi campaign was initiated with an orientation meeting of teachers, followed by discussion and debate among various societies within colleges like the WDC and the NSS. A 'March to the Parliament' was mobilised in July 2002 and again in November 2002, urging immediate passage of the PNDT Amendment Bill. In the beginning, the students' response was mixed. But after sustained efforts of dialoguing through various methods like screening the film *Atmaja*, street plays, presentation of the census data and case studies, etc, their response became more positive and enthusiastic. Student participation involves about 100 volunteers spread over 19 colleges. Street plays, debates, papers are common methods of disseminating information and awareness, not only among colleges but also students' homes and the overall community. A core group of volunteers have even given names of various clinics where their relatives have had sex selective abortions.

Ms Devyani gave a short account of the NFI's activities on the issue, and the NFI media fellowships.

The workshop ended with Senior Fellow, CWDS, Dr Smita Tiwari Jassal reading a few sections from the draft of the 'Social Charter for India' prepared by the Centre for Women's Development Studies, which takes into account the Declaration of 2001-2010 on the SAARC decade of the rights of the child.