Missing Girls: Political Economy of Sex-Determination

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Discrimination against the girl child and women is an old tradition in India, as it has been all over the world. Forms of discrimination have undergone changes over time and in many parts of the world open and obvious forms of discrimination have disappeared. However, in India and a few other countries around it the open forms of discrimination not only continue but also are getting exacerbated through use of new technologies and with the connivance of professionals, especially medical professionals. Here we will not go into the entire gamut of discrimination against the female of the species but restrict ourselves to sex-determination and sex-selective abortions which have caused havoc over the last two decades and are clearly manifested in rapidly declining juvenile sex-ratios.

A Peek into History

The PNDT Act came into force on 1st Jan. 1996. This was after a long and protracted struggle by women's groups and health groups from Maharashtra, and later Delhi, Gujarat, Tamil Nadu and Punjab. The history of use of modern medical technology for sex-selection goes back to the mid-seventies when in 1974 AIIMS was experimenting with amniocentesis to detect foetal abnormalities. By 1975 it had become clear that doctors were using this test rampantly for sex-determination leading to abortion of female foetuses. As early as May 1975 an article in Indian Paediatrics pointed out that 7 out of 8 persons who did the test were doing it for sex-determination. As knowledge of the use of this test spread doctors in the private sector saw this as an opportunity for making money. From Delhi it quickly spread to Punjab, Haryana, Maharashtra, Gujarat and other states. By 1979 Amritsar had become the headquarters of sex-determination with the setting up of Bhandari's Antenatal Sex-determination Clinic.

In 1982 there were some protests against the use of genetic tests for sex-determination which even got the then Union Health Minister to make a statement at the annual Health Ministers Conference where he exhorted his counterpart in the states to take appropriate preventive action against this "highly unethical, unjust and immoral practice." The Govt. of India even issued circulars making the use of these tests for sex-determination and abortion a penal offence and ordered the concerned departments in the centre and states to monitor this.

But it was only in the mid-eighties that this became a major campaign issue by women's and health groups in Mumbai. A concerted campaign in Mumbai under the banner of Forum Against Sex Determination and Sex-Pre-selection, supported by groups in other states, led to the formation of an investigation committee and later the formulation of an Act in 1988 in Maharashtra. This had a snowball effect and subsequently Punjab, Gujarat and Goa also saw

struggles by women's and health groups that led to formulation of Bills in these states on the lines of Maharashtra's Act. In the meantime advocacy initiatives and pressure from women's and health groups, as well as the Health Secretary D T Joseph from Maharashtra got the Union Ministry of Health to hold a national Consultation on Sex-determination and the process was set for formulation of a national legislation, which was passed in 1994 as the Pre-Natal Diagnostics Techniques (Regulation and Prevention of Misuse) Act.

Failure to Implement

While the Act was brought in as a secular initiative of health and women's activists and the governments, there was no effort in pushing for implementation of the Act. It suffered the same fate as that of other social legislation like those against dowry, child marriage, Sati etc. The machinery required to enforce this Act at the state and the district levels was not put into place, the required allocation of resources needed were not provided and there was general disinterest on the part of various governance bodies to take this Act seriously.

Further, the family planning program's insistence on the small family norm (2 children or even one child now) coupled with the son preference bias in India added pressure on families to look at sex-selection as a via media for their desired family composition. And now with many states talking about disincentives in their "Population Policies" for those who do not follow the norm, there would be added pressure to seek access to technologies that help sex-determination. Also the medical profession and its associations like IMA and FOGSI remained silent over such malpractice by their members. So the State's complacency coupled with socio-cultural "demands", the disincentive pressures of population policies and the unconcern of the medical profession led to the failure of enforcement of the Act.

Given this situation and a growing evidence of the practice of femicide (this includes, *sex-selection of embryos, sex-selective abortions and female infanticide and all other methods of averting the natural formation of a female foetus),* especially reflected in the fast declining sex ratios, it became necessary to intervene and bring back this issue on the national agenda. Thus Sabu George (individual activist), CEHAT (Centre for Enquiry into Health and Allied Themes) from Mumbai and Pune, and MASUM (Mahila Sarvangeen Utkarsh Mandal) from Pune decided to file Public Interest Litigation and approached the Supreme Court. The decision to file the petition was primarily a result of the commitment of the petitioners to women's health and rights issues, ethical medical practice, and upholding human rights.

Back to Struggle

The PIL was filed in Feb. 2000 with two goals. First, to activate the central and state governments for rigorous implementation of the central legislation, and second, to interpret the legislation and/or to demand amendment to ensure that the techniques which use pre-conception or during-conception sex

selection like, for instance, the Ericsson method (X and Y chromosome separation) and Pre-implantation Genetic Diagnosis (PGD), or any other technology existing or from the future which prevents the natural assignment of gender, are also brought under the purview of the Act.

The petition draws attention to the gross misuse of reproductive technology in a society characterized by a strong bias against the female child. Even as female infanticide is yet to be eradicated, techniques like PGD are widening the gap in the already skewed sex ratio. Sex-selective abortion needs of society finds its roots in the patriarchal social norms and the low status accorded to women. The new reproductive technologies - unregulated and abused - are now further perpetuating these practices which are discriminatory and unethical from the standpoint of medicine, as well as violative of human rights of women. That a link exists, between elimination of female foetuses during pre or intra conception or post-conception or infanticide and the widening gap in the juvenile sex ratio, is now being accepted by demographers. Thus a sophisticated technique like PGD helps couples with genetically determined conditions, but this does not out-weigh the damage caused by its misuse by unscrupulous practitioners.

The evidence is clear from the sex-ratio data of the census. Rapid declines from 1981 onwards in the juvenile sex-ratio clearly points a finger at sex-determination tests. The 2001 Census results are indeed shocking (see Annexure 1). Similarly, data compiled recently from Jalandhar city birth records is also very revealing - in year 2000 month-wise data for boys and girls born is as follows:

Jalandhar City Births for Year 2000

Sex	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Boys	780	805	636	-	629	629	811	1145	936
Girls	608	583	598	-	537	513	622	840	874
Sexratio	**779**	**724**	**940**	**-**	**854**	**815**	**767**	**734**	**934**

Source: Indian Express, December 12, 2000

The Supreme Court passed an order on 4th May 2001, which aims at ensuring the implementation of the Act, plugging the various loopholes and launching a wide scale media campaign on the issue. As regards this order, the second goal of filing the PIL, that is amendment of the Act to include pre and during conception techniques, like X and Y chromosome separation, PGD, certain ayurved/herbal methods etc has not been considered - there is no specific order on that. The order largely concerns only the implementation of the Act and putting the required infrastructure in place. However, the order entrusts the responsibility to the Central Supervisory Board of examining the necessity to amend the Act keeping in mind emerging technologies and difficulties encountered in implementation of the Act and to make recommendations to the Central Government. The SC order also does not make any directives for the medical professionals and their associations to make them accountable given the fact that it is the medical professional who has been critical to the failure of

implementation of this Act.

As mentioned earlier, social legislations like dowry, child marriage, sati etc have failed and there is no reason why this will not fail if the approach remains similar to how those issues have been tackled. The court judgement in this case is only the starting point; it is a means to bring the issue back on the national agenda. The real struggle has to begin now. We have to bring together all stake holders, like the government who has to implement the provisions of the Act, the medical profession which has to fight unethical practices and malpractice within their profession, and the women and health groups, NGOs and the media which have to campaign and build awareness within civil society. Only such an approach can deal with a problem that is essentially social. The one difference sex-selection has in comparison to issues like dowry and child marriage is that the process is not confined to within a closed community interaction. The interface for sex selection is a secular process between social norms (son preference in this case) and the medical profession. The fact that law prohibits sex-selection is a strong deterrent (if implemented in right earnest) for the medical professional, and it should not be difficult to convince a large proportion of the profession on just ethical and moral grounds (in relation to its illegality) to stop such practices. The easiest way, if professional bodies do not respond to take action against their erring members, is to convict afew doctors and the others will fall in line. Activists supported by women and health groups can easily precipitate such action.

The government on its own is going to find it difficult to implement the provisions of the Act. They should pass the onus on to medical bodies like the Medical Council of India, IMA, FOGSI, Indian Radiology and Imaging Association etc by bringing in an amendment that holds these associations responsible and accountable. The government should also involve on a large-scale women and health groups and other civil society organisations to be partners in the implementation and monitoring process. And for this there is a national platform available in the Peoples' Health Assembly (PHA) initiative, which is a global initiative and is very active in India through over 1200 peoples' organisations, NGOs etc. in 18 different states. The PHA has taken a decision to take up sex-selection and femicide as a major campaign issue this year and it has launched this campaign after a national meeting on this issue held in Rohtak, Haryana in April 2001. The PHA also has state level and district level branches and hence is in a position to make a sustainable impact. Ofcourse, the ultimate responsibility will have to remain with the government, that is the authorities created by the PNDT Act. And ofcourse major amendments in the Act to include pre-conception and intra conception technologies need to be undertaken immediately.

The Political Economy

The medical profession is central to the political economy of sex-determination. Similar to other modern technologies, which are mass-based, it has provided an opportunity to the traditional patriarchal preference for sons to transit from a traditional and cruder form of sex discrimination, which is today considered criminal by modern law to a form of sex discrimination that is subtle and

secular. New medical technology has helped (sic) discrimination based on gender transit from the old political economy based on socio-cultural determinants of patriarchy to a new political economy based on technological determinants of patriarchy. This is not very different from caste-based discrimination where the modern form of discrimination is not based on physical distance but on professional assignment. This transition by no means implies that traditional forms have ceased to exist. Infact, unlike most other countries, India and perhaps afew neighbours, can claim credit for preserving older/feudal forms of discrimination as well as devising or adopting newer forms. This despite the fact that there is a ban on such practices by an Act of Parliament.

As mentioned earlier, the main missing link in the failure of the Act is the complacency of the associations of the medical profession. They have failed to check any form of malpractice in the profession. With these issues coming into the arena of public debate some associations are voicing concern but have not been able to put this concern into positive action. The malaise is so deep set that the average medical professional does not view this issue from the ethical or moral standpoint. For them it is a business opportunity and if one talks to them many feel that they are doing a social service; many even go to the extent and say that they are helping control the population of the country through sex-determination. This understanding is part of the overall process of complete commodification of medicine and what really matters to the professional is only money. Hence, medical associations have got a lot of work on their hands since sex-selection is illegal. They have to be proactive in educating their members on the implications of such malpractice and to set an example they would have to take harsh decisions to drive home the point.

This should not be difficult given the fact that the technology used for sex-determination is available in cities and larger towns, though it is expanding at a fast rate to smaller towns. This is an opportune moment when there is pressure from the state to implement the Act, that the medical associations provide support to the state authorities by doing their own vigilance and restoring ethical practice by its members. If they fail to do this then actions like that taken by Indian Express by sending a decoy and trapping two doctors in Delhi and Faridabad will become the only means of driving home the message.

The sexratio declines in themselves suggest the wide scale of practice of sex-determination. Infact it is the better off districts where this practice seems to be more common as revealed by the sex ratio data. The volume of these tests being done is difficult to obtain because of the poor registration system in India – let alone amniocentesis laboratories and ultrasonography centres, we do not have firm data on number of medical clinics and hospitals. However, some indirect estimates have been made. In 1975 the May issue of Indian Paediatrics found that 7 out of 8 women using amniocentesis test did it for sex selection. This means that a test mainly to be used for identifying genetic abnormalities was being used almost entirely for sex determination. In 1984 a survey done for the Public Health Department of Maharashtra by Dr. Sanjeev Kulkarni, himself a

gynaecologist, found that 42 out of 50 gynaecologists he interviewed consented that they were using genetic tests like amniocentesis and chorionic villi biopsy for sex determination and most of them believed that they were doing a social service by saving the women the repeated trauma of female births and thus also contributing towards population control! In 1985 a survey of a major abortion centre in Mumbai revealed that nearly all of the 15,914 abortions done in that centre were post-sex-determination tests. And in Nov. 1999 a UNICEF/IMA workshop pointed out that in India each year over 50 lakh female foeticides were being done. This is the kind of sporadic evidence that is available. Also one can safely estimate that it is the developed states like Punjab, Haryana, Maharashtra, Gujarat, Tamil Nadu and within them the developed districts which have a large infrastructure of amniocentesis laboratories and ultrasound centres. And it is no coincidence that such states and within them developed districts also have the lowest and rapidly declining sex ratios in the country. The tables below reveal the declining sex ratios in these "worst" states, and districts of Maharashtra :

Sex-ratio for population aged below age 1 – females per 1000 males

YEAR	Tamil Nadu	Punjab	Haryana	Gujarat	Maharashtra
1961	1013	968	-	970	975
1971	1012	952	960	973	970
1981	988	946	929	971	951
1991	968	854	871	919	935

Source : Census of India, respective years

Sex-ratio 0-6 age group – selected districts of Maharashtra

Year	Ahmed-nagar	Auran-gabad	Jalgaon	Kolha-pur	Pune	Sangli	Satara	Solapur
1991	949	933	925	931	943	924	941	935
2001	890	884	867	859	906	850	884	897
Decli-ne	59	49	58	72	37	74	57	38

Source: Census of India – Maharashtra, respective years

The favourable judgement of the Supreme Court of May 4, 2001 is a positive step forward. Unless it is backed by stringent implementation by the state and complemented by people based advocacy, it would only be another women-centred judgement that would remain on paper without having any impact at the ground level.

As a result of this court case the IMA at the national level seems to have made a turn around and has issued a warning to its members. The FOGSI too has shown some concern through its newsletter. In Punjab the Akal Thakt in Amritsar (where it all started!) after an inter-religious meeting issued a hukumnamma warning all concerned to refrain from using sex-determination

and resorting to femicide. The government too, that is the Dept. of Family Welfare, has got energised thanks to Minister Dr. CP Thakur and Secretary Mr. Nanda and they have issued an advertisement in national dailies saying that it is a crime to carry out sex selection and have also activated the Central Supervisory Board by calling a meeting. This is a step forward and we hope that all stakeholders, the State, the medical profession, NGOs, activists, women and health groups, journalists and media etc come together to see that the provisions of the PNDT Act are implemented to its fullest extent.

In Maharashtra the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Maharashtra State Commission for Women (MSCW) are bringing various stakeholders together on a common platform. CEHAT, alongwith other organisations who have been part of this campaign, is actively supporting the implementation of the Act in Maharashtra through the Jan Arogya Abhiyan (People's Health Assembly) initiative and continues active advocacy on this issue at the national, state and grassroots levels, including policy makers, peoples' organisations , medical profession bodies and the media. The MSCW has taken on an active role to pressurize the state government from within to set up the appropriate machinery for implementation of the Act as well as to build awareness on this issue. The MSCW has constituted a vigilance committee, which has been authorized by the government to monitor and investigate laboratories and clinics to see if there is any evidence of malpractice.

Thus, in order to change the political economy of sex-determination the medical professional, who thrives on it, has to be targeted by his/her own associations who have to become proactive to re-establish professional ethics and to punish those who indulge in malpractice, that is if they want self-regulation. If they continue to be unconcerned with the filth within their profession then they have no right to protest when their members are taken to task. They have an opportunity to redeem themselves by taking the lead in identifying those who indulge in malpractice and take away their membership and registration to practice. They could begin with the two doctors indulging in sex-determination exposed by the Indian Express reporter.

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ANNEXURE 1: SEX-RATIOS ACROSS STATES – females per 1000 males

STATE/UNION TERRITORY	TOTAL POPULATION			0-6 YEARS AGE GROUP		
	2001	1991	1981*	2001	1991	1981#
India	933	927	934	927	945	979
Jammu& Kashmir	900	NA	892	937	NA	
Himachal Pradesh	970	976	973	897	951	970
Punjab	874	882	879	793	875	925
Chandigarh	773	790	769	845	899	914
Uttaranchal	964	936		906	948	
Haryana	861	865	870	820	879	921
Delhi	821	827	808	865	915	943
Rajasthan	922	910	919	909	916	979
Uttar Pradesh	898	876	885	916	927	965
Bihar	921	907	946	938	953	1004
Sikkim	875	878	835	986	965	978
Arunachal Pradesh	901	859	862	961	982	984
Nagaland	909	886	863	975	993	991
Manipur	978	958	971	961	974	991
Mizoram	938	921	919	971	969	994
Tripura	950	945	946	975	967	983
Meghalaya	975	955	954	975	986	995
Assam	932	923	910	964	975	
West Bengal	934	917	911	963	967	991
Jharkhand	941	922		966	979	
Orissa	972	971	879	950	967	1003
Chhatisgarh	990	985		975	984	
Madhya Pradesh	920	912	941	929	941	989
Gujarat	921	934	942	878	928	962
Daman&Diu	709	969	1062	925	958	
Dadra&Nagar Haveli	811	952	974	973	1013	1000
Maharashtra	922	934	937	917	946	961
Andhra Pradesh	978	972	975	964	975	1000
Karnataka	964	960	963	949	960	981
Goa	960	967	975	933	964	965
Lakshadweep	947	943	975	974	941	972
Kerala	1058	1036	1032	963	958	
Tamil Nadu	986	974	977	939	948	974
Pondicherry	1001	979	989	958	963	986
Andaman&Nicobar	846	818	760	965	973	985

Highlighted figures and states are cause for concern

Source : Census of India 2001 – Provisional Totals

[#] Census of India 1991 - Working Children in India (this data is for 0-4 years population)

*Census of India 1991 - State Profile of India