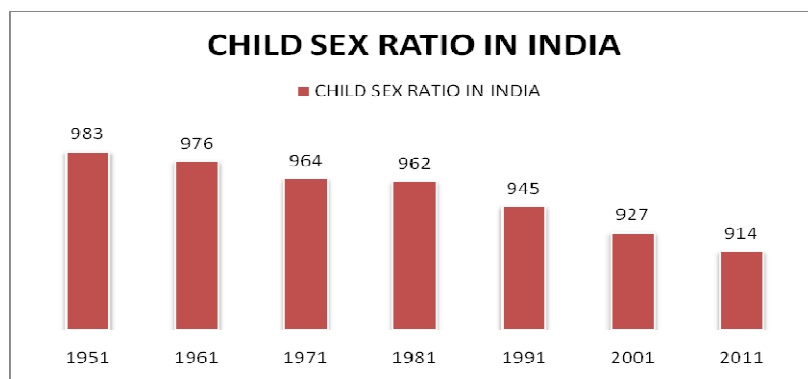


## FACTS ON SEX SELECTION

India's history of strong patriarchal influence in all spheres of life has translated into an obsessive preference for sons and discrimination against the girl child and women. It has spawned practices of sex determination and sex selection as well as neglect of girl child in terms of nutrition, education, health care and her overall development. Thus, the 'elimination' of girls and women is not entirely new to India's socio-cultural fabric. The obvious result is a sex ratio increasingly adverse to women.

Following facts highlight the scenario of sex selection across the globe and India;

- ✚ *Sex selection* is any act of determination / identifying the sex of the foetus and elimination of the foetus if it is of the undesired sex by using any method, scientific or unscientific. The undesired sex in most cases being a female. Sex selection refers to elimination before conception, during pregnancy or after birth.
- ✚ Worldwide, the natural "sex ratio at birth" is 105. This means that at birth, there are 105 males born for every 100 females. The sex ratio at birth is usually expressed as the number of boys born alive per 100 girls born alive. Nature provides that the number of boys born is slightly more than the number of girls, owing to greater biological vulnerability of the male child.
- ✚ *Sex Ratio at Birth:* China – 118, India – 109, Pakistan – 106, Bangladesh – 104.9, Singapore – 107, South Korea – 106, Vietnam – 111, Azerbaijan – 116.5, Armenia – 114.9, Georgia -113.6, Albania – 111.7, Montenegro – 109.8. These figures point at the proportion of deficit in female births, indicating that prenatal sex selection has become increasingly global phenomenon. (Source: *Sex-ratio imbalance in Asia: Trends, consequences and policy responses*, Christophe Z Guilmoto, UNFPA)
- ✚ Across the globe, UNFPA estimates a total gender gap of 117 million women missing in 2010, most of them from China and India.
- ✚ In India, the 2011 census found about 7.1 million fewer girls than boys under the age of 6, as against a deficit of 6 million girls in 2001.
- ✚ UNFPA estimates that, 30 per cent women in India resort to sex selection for their last birth in absence of a previous male child.
- ✚ As per Census 2011, the all India child sex ratio (0-6 age group) is 914:1000, an all time low in last 50 years!!



- ✚ As per Census 2011, barring the States of Punjab, Himachal Pradesh, Haryana, Gujarat, Tamil Nadu, Mizoram and Andaman & Nicobar Islands, all the remaining states show a declining trend of child sex ratio. Maharashtra has child sex ratio as low as 883:1000 in 2011 as compared to 956 in 1981
- ✚ In 2011, the bottom ten districts with worst child sex ratios were in states of Haryana, J&K, Maharashtra and Uttaranchal.
- ✚ As against common misconception, the child sex ratio is found to be lower in the urban areas as compared to the rural parts of India. Thus, indicating that sex selection is not caused by poverty and illiteracy.

STATE	CENSUS 2001			CENSUS 2011		
	TOTAL	RURAL	URBAN	TOTAL	RURAL	URBAN
<b>INDIA</b>	927	934	906	914	919	902

- ✚ In India, as per Census 2011 the child mortality rate (per 1000 children) in the age group of 0-6 years is 69.7 for boys and 79.2 for girls, indicating discrimination against girls in age group 0-6 years. If the sex determination and elimination is not done, then the chances of girl child surviving are 10% more than the male children. As a result, the child mortality rate would be 89.2 for girls meaning increase in almost 20 points.

### **THE REPUBLIC OF KOREA – A SUCCESS STORY**

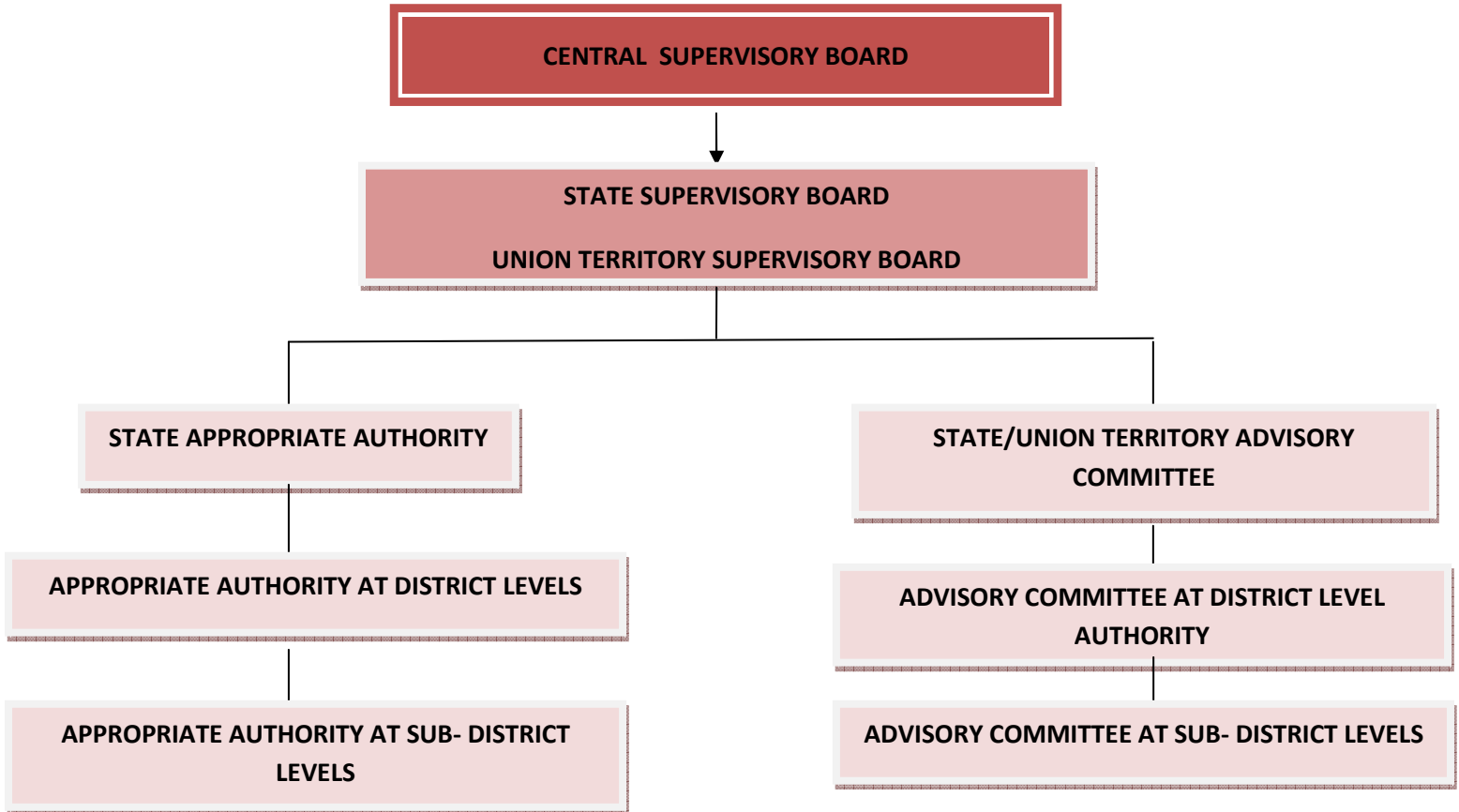
In the 1980s and 1990s, the Republic of Korea had a highly imbalanced sex ratio at birth that reached almost 116 (KNSO, 2004). By 2007, the ratio had returned to 107. It appears that a combination of factors contributed to this shift. Two decades of exceptional economic growth led to fundamental changes in Korean society with a shift away from a farm-based economy, increasing desire for small families, increasing urbanization, greater participation of women in the workforce with better employment opportunities, and parents having retirement savings for old age (Guilmoto, 2007b; Ganatra 2008). All of these factors contributed to an increase in the status and value of women and their greater autonomy (Chung & Das Gupta, 2007). Several laws – such as allowing women rights and responsibilities within their natal family even after marriage, and recognizing women-headed households – were seen to be beneficial, as was a *Love Your Daughter media campaign*. In addition, the highly organized and controlled health system in the Republic of Korea was able to regulate sex determination tests more effectively than is the case in China or India (Kim, 2004). In a recent decision, the Constitutional Court ruled that parents have the right to know the sex of the fetus, indicating a level of confidence in the current situation where girls and boys are equally desired (Asia Pacific News, 2008)

*Source: Preventing gender-biased sex selection: an interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO. , 2011*

## LEGAL PROVISIONS IN INDIA:

1. The State of Maharashtra was the first in the country to ban pre-natal sex determination in 1988 through the enactment of *Maharashtra Regulation of Prenatal Diagnostics Techniques Act*.
2. At the national level the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act) was enacted on September 20, 1994.
3. The PCPNDT Act was amended in 2003. It is now called the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act and covers the in-vitro fertilization (IVF) techniques used to ensure a male child.
4. The Act provides for the prohibition of sex determination, before or after conception, and for regulation of pre-natal diagnostic techniques for the purpose of detecting genetic malformations or sex linked disorders. The Act also prevents misuse of pre-natal diagnostic techniques for sex determination.
5. A written consent of pregnant woman undergoing pre-natal diagnostic procedures is mandatory as per the PCPNDT Act.
6. An offence under this law is cognizable, non-bailable and non compoundable. The punishment for a medical practitioner can range from an imprisonment up to three years and with a fine up to Rs 10,000. on any subsequent conviction, he/she may get an imprisonment up to 5 years and fine up to Rs. 50,000/-.
7. For a first offence, the name of defaulting medical practitioner can be removed from register of the State Medical Council for a period of five years and permanently for subsequent offence.
8. Any person, who seeks to determination for sex selection purposes for a pregnant woman, is punishable with imprisonment for a term which may extend to three years and with fine which may extend to Rs. 50,000/- for the first offence. For any subsequent offence the imprisonment may extend to five years, with fine which may extend to one lakh rupees.
9. The implementing machinery of this Act comprises of;
  - a) Central Supervisory Board
  - b) State Supervisory Board and Union Territory Board
  - c) State Advisory Committee and Union Territory Advisory Committee
  - d) State Appropriate Authority for the whole or a part of the State/Union Territory
  - e) District Appropriate Authority for the whole or a part of the district
  - f) Advisory Committees for designated areas attached to each Appropriate Authority.

10. The Structure of Implementing Machinery:



11. The Key Functions and powers of Implementing Machinery;

- The **Appropriate Authority** (AA) is responsible for the implementation of the Act.
  - a) it can grant, suspend or cancel registration of Genetic clinics, Counseling Centers or Laboratories
  - b) In the case of breach of provisions of the Act, it is meant to investigate complaints and take immediate action.
  - c) It has the powers to search premises, examine any record, register, document etc.
  - d) It also has powers to seize any of the above that may furnish as evidence of the commission of the offence.
- The **Advisory Committee** comprising of eight members is responsible for providing advice and guidance on matters of implementation to aid the AA to discharge its functions.

- The **Central Supervisory Board** has to meet at least once in six months and functions include;
  - a) advising the Central Govt on policy matters relating to use of pre-natal diagnostic techniques
  - b) reviewing implementation of the Act and the Rules, as well as suggesting changes in the Act
  - c) creating public awareness against the practice of sex selection
  - d) Laying down the code of conduct to be observed by persons working at Genetic Clinics, Counseling centers or Laboratories and Ultrasound or Imaging Centers.
- The functions of **State Supervisory Board** are;
  - a) reviewing activities of AAs and recommending appropriate actions against them if they are found not functioning as per the Act, to the CSB
  - b) monitoring the implementation of the Act
  - c) sending consolidated reports to the CSB regarding various activities undertaken in their State
  - d) creating public awareness against practice of sex selection

12. The Ultrasound Scan centers should comply with the following under the PCPNDT Act;

- **Display:** Registration certificate, PNDT board and pamphlets
- **Records:** Mandatory records
  - a) Register showering in serial order
  - b) Name & Addresses of men or women given genetic counseling and/or subjected to prenatal diagnostic procedure or test
  - c) Names of their spouses or fathers
  - d) Date on which they first reported for such counseling
  - e) Form D/E/F under the Rules: The scan centre shall send consolidated report on Form F statutorily by 5th for the previous month to the Appropriate Authority.
  - f) Case Records
  - g) Forms of Consent
  - h) Laboratory results
  - i) Microscopic pictures

j) Sonographic plates or slides

The referrals of the doctor recommending scan and a declaration from the pregnant mother regarding her non interest in knowing the sex of the foetus is a must for every case.

13. Filing a complaint:

- A complainant can approach the designated Appropriate Authority (AA) of the State or district or sub-district. The AA at the State level is a high ranking health department official above the rank of Joint Director of Health and Family Welfare. But there are also officials at local level in rural and urban areas who can be approached – the civil surgeon or the chief medical officer at the district level; the chief health officer or a ward health officer in a city; and the medical superintendent of rural hospital in rural areas.
- A written complaint has to be made to AA which to acknowledge the receipt. AA has to take action within 15 days of lodging the complaint.
- The AA will initiate the investigation and a case would then be filed once the offence has been proved. The guilty would be punished as per the provisions of the Act.

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