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## ELEMENTS RESPONSIBLE AND OUTCOMES OF FEMALE FOETICIDE

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### ABSTRACT

Female foeticide remains a persistent issue in India, reflecting deeply ingrained gender biases and social inequities. This abstract explores the multifaceted elements responsible for the prevalence of female foeticide in the country. At its core lies India's patriarchal social structure, which prioritizes male offspring and perpetuates cultural norms valuing sons over daughters. These entrenched beliefs are reinforced by religious and societal customs that celebrate the birth of a son while marginalizing the arrival of a daughter. Socio-economic factors exacerbate the gender imbalance, as poverty and dowry obligations contribute to the perceived burden of raising a daughter. The availability of prenatal sex determination technologies further enables sex-selective abortion, despite legislative efforts to regulate their use. The culmination of these cultural, socio-economic, and systemic factors underscores the complexity of the issue. Addressing female foeticide requires a holistic approach that challenges patriarchal norms, promotes gender equality, and empowers women and girls. Strengthening enforcement mechanisms, improving access to healthcare and education, and fostering economic opportunities for women are essential steps towards combating female foeticide in India. By confronting the root causes and investing in sustainable solutions, India can strive towards a future where every child, regardless of gender, is valued and afforded equal opportunities for a fulfilling life.

### INTRODUCTION

Female foeticide, the deliberate termination of female fetuses, remains a distressing reality in contemporary India despite progressive strides in various spheres. This deeply entrenched practice reflects the stark gender disparities and social biases prevalent in Indian society. The roots of female foeticide run deep, intertwined with a complex web of cultural, socio-economic, and systemic factors that perpetuate its existence. Understanding these elements is paramount to addressing the underlying issues and fostering meaningful change.

At the heart of the issue lies India's patriarchal social structure, which has historically favored male offspring over females. Deeply ingrained cultural beliefs and norms dictate the value placed on sons, often at the expense of daughters. The preference for male heirs is rooted in notions of lineage, inheritance, and the perpetuation of family names—a legacy passed down through generations. Sons are viewed as providers, protectors, and bearers of the family's honor, while daughters are often seen as burdens due to dowry obligations and concerns about their safety and security in a patriarchal society.

This preference for sons is further reinforced by religious and societal customs, which often celebrate the birth of a male child while mourning the arrival of a daughter. Rituals, festivities, and social gatherings marking the birth of a son contrast sharply with the subdued response to the birth of a daughter, highlighting the differential treatment accorded to children based on their gender. These cultural attitudes not only perpetuate gender biases but also contribute to the normalization of practices such as female foeticide as a means of fulfilling societal expectations.

Socio-economic factors also play a significant role in driving the practice of female foeticide, exacerbating the gender imbalance in Indian society. Poverty, inadequate access to resources, and economic instability contribute to the perceived burden of raising a daughter. The practice of dowry, although illegal, continues to prevail in many parts of the country, placing financial strain on families and perpetuating the devaluation of female children. In regions where patriarchal norms are deeply entrenched, the economic implications of dowry can incentivize families to resort to drastic measures such as sex-selective abortion to avoid the perceived financial burden associated with raising daughters.

Moreover, India's healthcare system, while making significant advancements in recent years, remains plagued by disparities in access and quality, particularly in rural and marginalized communities. The availability of technologies such as ultrasound scans for prenatal sex determination has made sex-selective abortion more accessible, further exacerbating the issue of female foeticide. Despite legislative efforts to regulate the use of such technologies and prohibit sex-selective abortions through laws such as the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, enforcement remains a challenge, allowing clandestine practices to persist.

The interplay of these cultural, socio-economic, and systemic factors underscores the complexity of the issue of female foeticide in India. Addressing this pervasive problem requires a comprehensive approach that tackles the root causes while simultaneously addressing the immediate challenges. Efforts to promote gender equality, challenge patriarchal norms, and empower women and girls are essential to shifting societal attitudes and dismantling the structures that perpetuate discrimination. Strengthening enforcement mechanisms, improving access to healthcare and education, and fostering economic opportunities for women are critical steps towards creating a more equitable and inclusive society.

## 1.1 WHAT IS FEMALE FOETICIDE ?

Female foeticide in India is the abortion of a female foetus outside the legal methods . The frequency of female foeticide in India is increasing day by day .Prior to analysing the issues and challenges faced, it is imperative to understand the current landscape of the medical termination of pregnancy in India as well as

the backdrop in which the law governing such scenarios came into existence, i.e., to grasp the normative reality we need to analyse the socio-political milieu in which the law was passed.

### The Legislative process

In the past, abortion has been viewed as an immoral act, striking at the sanctity of life. At the same, nearly 4.4 million abortions were taking place during the late 1960's itself. This clearly showed the gap between the socially proclaimed values and the social realities.<sup>1</sup>

Prior to the existence of the MTP Act, 1971, the abortion landscape in India was governed by the Indian Penal Code (IPC). Section 312 of the IPC criminalized abortion except in cases where it was performed in good faith for the purpose of saving the life of the mother.<sup>2</sup> Section 313 levies a punishment of up to life in prison for whoever committed the offence under section 312 without the woman's consent. Section 314 provides for a scenario where death of the woman occurs as a result of causing miscarriage and prescribes a punishment of up to 10 years which may be up to life in case where such death occurs as a result of an induced miscarriage, without the woman's consent. Section 315 further says that whoever, before the birth of a child, does any act with the intention of preventing that child to be born alive or die upon birth, except to save the life of the mother, and if such event actually transpires, would be liable to be punished for a period of up to 10 years. Section 316 covers a situation where an act is done by a person that would qualify as culpable homicide, if death occurs, causes a quick unborn child to die.

Thus, we see that the IPC considered artificially terminated pregnancies, with or without the consent of the pregnant woman, an offence, except in situations to save the life of the pregnant woman. In the latter case, such a termination of pregnancy would not be an offence.

In India, the legislation governing medical termination of pregnancy is the MTP Act, 1971. As early as in 1957 the Mudaliar Committee reported on the problems of illegal abortions in India. In 1964, the Parliamentary and Scientific Committee, under the chairmanship of Lal Bahadur Shastri, proposed that abortion be permitted as a remedy for the failure of contraceptives. A report was prepared by the Shantilal Shah Committee which was sent to all states in 1967 for their comments. After weighing the pros and cons, the Committee recommended that the law on abortion in India needs to be liberalized and that the existing law contained in section 312 of the Indian Penal Code, was outdated. The Committee also suggested that termination of pregnancy should not only be allowed to save the life of the pregnant woman but also to avoid grave injury to her physical and mental health. As a result of joint consultations between the Ministry of Health and Family Planning and the Ministry of Law, the Draft Bill titled 'Medical Termination of Pregnancy Bill, 1969' was finalized, incorporating the suggestions of the State Governments.

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<sup>1</sup>*Shantilal Shah Committee Report*, Ministry of Health, Government of India, p.19 cited in Savithri Chattopadhyay, "Medical Termination of Pregnancy Act, 1971: A Study of the Legislative Process" 16 *JILI* 549-550 (1974).

<sup>2</sup> 312. Causing miscarriage -

Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Explanation- A woman who causes herself to miscarry, is within the meaning of this section.

On Nov. 17<sup>th</sup> 1969, the draft MTP Bill was introduced in the Rajya Sabha by Dr. S. Chandrasekhar, the then Minister of Health. He sought support for it on the grounds that it was primarily a health measure. He was of the view that the health aspect was important as it would reduce mortality and morbidity resulting from illegal, unsanitary and botched-up abortions.<sup>3</sup> Dr. Chandrasekhar believed that the problem surrounding abortions should be looked at from three angles. First, from the point of view of the autonomy of women over their own bodies. Per his assertion in his book, he believed that a woman in India, at any time, should have the right to obtain a legal abortion, from a public or private hospital, without giving any reason and that they should not be considered as human incubators. Second, from the point of view of the unborn child. A child who may be physically deformed, mentally retarded, unloved and uncared for becomes a delinquent child. Third, from the point of view of the State and society. The unwanted child who is not supported by his family might end up on the street, destitute and disgruntled. There are limits to the welfare that the State can provide and India, with a developing economy (then underdeveloped) was ill-equipped to handle such situations.<sup>4</sup>

The split in the Congress Party in 1969 led to a rapid decline in the strength of the party in the Lok Sabha with speculations of dissolution of the Lok Sabha itself. This political uncertainty led the government to introduce the Bill, not in Lok Sabha, but in Rajya Sabha. Rajya Sabha recommended that it be referred to a Joint Committee of both the Houses and on Dec. 24<sup>th</sup> 1969, Chandrasekhar moved that the Lok Sabha concur with the recommendations of the Rajya Sabha, on the Bill. The motion was adopted by the Lok Sabha. On the same day, the Bill was referred to a Joint Committee, however, no action was taken on it. When the Congress Party returned with a majority under the leadership of Indira Gandhi, in 1971, D.P. Chattopadhyaya, the then Deputy Minister for Health, reintroduce the Bill in Lok Sabha on Aug. 2<sup>nd</sup> 1971. This time the Bill was promptly passed in both the Houses, and thus it became law.<sup>5</sup>

Termination of pregnancy is possible in different ways. Medically three distinct terms, viz., abortion, miscarriage and premature labour are used to denote the expulsion of foetus at different stages of gestation. The term 'abortion', is used only when an ovum is expelled within the first 3 months of pregnancy before the placenta is formed. The term 'miscarriage' is used when a foetus is expelled from 4 to 7 month of gestation, before it is viable. Premature labour is the delivery of a viable child, possibly capable of being reared, before it has become fully mature.

Pre-natal sex determination techniques were introduced in the early seventies as aid for early detection and reduction of following abnormalities :

- Chromosomal abnormalities
- Genetic metabolic disease
- Haemoglobinopathies
- Sex linked genetic diseases
- Congenital anomalies.

<sup>3</sup> S. Chandrasekhar, *Abortion in a Crowded World*, 88 (George Allen & Unwin Ltd, 1974).

<sup>4</sup> *Id* at 89.

<sup>5</sup> Savithri Chattopadhyay, "Medical Termination of Pregnancy Act, 1971: A Study of the Legislative Process" 16 *JILI* 549-550 (1974).

By liberalizing the law on abortion, the Medical Termination of Pregnancy Act, 1973, allowed abortions on selective basis through amniocentesis test. Scientific advancement was soon put to use for sex determination purely with the intention of aborting the female foetus. The earliest foetal sex determination methods employed were genetic tests like amniocentesis and chronic Villus Biopsy. Ultrasound machines appeared in India by early eighties.

## **AFTER PERFORMING SEX DETERMINATION TESTS VARIOUS METHODS ARE EMPLOYED FOR PERFORMING INDUCED ABORTIONS:**

**Menstrual Extraction (endometrial or vacuum aspiration)** : This method is used for most abortions performed during the first trimester. It is done by suctioning out the lining of the uterus (endometrium) through a thin opening of the undiluted cervix. It is a method used after a woman has just missed a period, or anytime up to about the eighth week of pregnancy. It can be performed safely in the doctor's office and has a very low rate of mortality.

- **Dilation and Evacuation (D&E) (also called vacuum suction or suction curettage) and Dilation and Curettage (D&C)** : This method is commonly used for late first trimester or early second trimester abortions. In this method suction is used to remove the foetus and placenta. The cervix is first dilated under local anesthesia using a suction tuber that is firm, and a stronger suction is used than in menstrual extraction. Another way of dilating the cervix is the use of a type of dried seaweed, called laminaria, which expands as it absorbs moisture. Some doctors use a hollow, spoon-shaped knife, or curette, to ensure that all the placental tissues are removed by scraping the uterine walls.

If curettes are used throughout the procedure instead of suction, the method is called dilation and curettage (D&C). Before the twelfth week of pregnancy, D&E is preferred over D&C because it does not require general anaesthesia, causes less discomfort and is less costly. D&C can be used up to the twelfth week of pregnancy. The mortality rate for both D&E and D&C is approximately 3 per 100,000 abortions.

- **Prostaglandin<sup>6</sup> or Saline Administration**: This method is done by injecting prostaglandins or saline solution through the uterine wall and into the amniotic sac holding the foetus to induce labour and delivery of a nonviable foetus. This procedure is commonly used for second trimester abortions. Prostaglandins may cause nausea, elevated temperatures, and vomiting but are<sup>7</sup>
- safer than the saline solution. Mortality rate for second trimester abortions performed by this method is approximately 20 per 100,000 abortions.
- **Hysterectomy** : This method is similar to caesarean section, the uterus is opened through a methods have failed repeatedly, it is performed under general anaesthesia. It is used between small abdominal incision and the foetus is removed. Hysterectomy is usually performed only when other the twelfth and the twenty fourth week of pregnancy. This method has the greatest risk of

<sup>6</sup> The life and death matters – the challenge of abortion by bill muelenberg

<sup>7</sup> The Dublin Journal Of Medical Science by John William Aloore , 1887



complications out of all the abortion procedures, maternal mortality rate is approximately 200 per 100,000 abortions.

## 1.2 ASPECTS RESPONSIBLE FOR FEMALE FOETICIDE

Prabhuji mein tori binti karoon	Oh, God, I beg of you,
Paiyan Paroon bar bar	I touch your feet time and again,
Agle Janam Mohe Bitiya Na Dije	Next birth don't give me a daughter,
Narak Dije Chahe Dar...	Give me Hell instead...

- Folk Song from Uttar Pradesh

Subordination of women to men is prevalent in large parts of the world. We come across experiences where women are not only treated as subordinate to men but are also subject to discriminations, humiliations, exploitations, oppressions, control and violence. Women experience discrimination and unequal treatment in terms of basic right to food, health care, education, employment, control over productive resources, decision -making and livelihood not because of their biological differences or sex, which is natural but because of their gender differences which is a social construct.

Prior to the passage of the MTP Act, an abortion could not be conducted in India (except to prevent danger to life of a woman) without penal sanctions under the IPC, 1860.<sup>8</sup>The MTP Act, 1971 diluted the stringent nature of the erstwhile law. The MTP Act, provides for certain criteria under which abortion is permitted.

They are as follows:<sup>9</sup>

- Medical termination of pregnancy can be performed only where:
  - the length of the pregnancy does not exceed twelve weeks;<sup>10</sup> or

<sup>8</sup> Ss. 312-316.

<sup>9</sup> S.3. It reads:

### 3. When pregnancies may be terminated by registered medical practitioners-

(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner, -

(a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is,

or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are.

Of opinion, formed in good faith, that, -

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1.-Where any, pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.-Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in C1.(a), no pregnancy shall be terminated except with the consent of the pregnant woman.

<sup>10</sup> S.3(2)(a).

- the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks: in this case the opinion of two RMPs (registered medical practitioners), in favour of the termination, is essential.<sup>11</sup>
- Where the continuance of pregnancy would involve a risk of grave injury to the physical or mental health of the pregnant woman;<sup>12</sup> or
- If there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities.<sup>13</sup> Such termination is contingent upon the gestational age of the foetus. It should not be beyond 20 weeks.

Another provision in which an abortion can be conducted regardless of the gestation period is when it is immediately necessary to save the life of the woman, as in the opinion, formed in good faith, of an RMP.<sup>14</sup>

*Upper limit of medical termination of pregnancy- Section 3(2):*

There is a Bill pending in Parliament since 2014 catering to, among others, the requirement of raising the upper limit of medical termination of pregnancy in certain scenarios.<sup>15</sup> This Bill, if passed, will bring about a much-needed change, in the archaic MTP Act. All the while the number of cases coming before the High Courts and the Supreme Court for medical termination of pregnancies beyond 20 weeks, are on the rise. Concerned parents, with foetuses suffering from physical or mental handicaps, that are discovered beyond the upper limit of 20 weeks, knock the doors of these courts for relief, when they are shunned away by hospitals who are constrained by the limits of the black letter law.<sup>16</sup> Sometimes, the courts allow the termination of pregnancy by relying on the ground of immediate threat to life of the pregnant woman<sup>17</sup> while other times when this requirement is not so easy to prove, even on the advice of medical experts, the courts are compelled to deny relief to such parents.<sup>18</sup>

The MTP (Amendment) Bill, 2014, allows termination of pregnancy between 20-24 weeks, if there is a substantial risk that the child if born would suffer from serious physical or mental abnormalities. But since this Bill is yet to pass, the law of the land remains that beyond 20 weeks, it does not matter if the foetus is capable of extra-uterine existence or not, it cannot be aborted.

Shrimati Purabi Mukhopadhyay, the then Member of Rajya Sabha, suggested that the upper limit of 20 weeks in clause (b) of section 3, should be done away with from the draft Bill of 1969, if the object was to save the life of the mother. This was affected in the Act by a separate section, i.e., section 5 which says that section 3 won't apply if the two RMPs are of the opinion that it is necessary to conduct an abortion to

<sup>11</sup> S.3(2)(b).

<sup>12</sup> S.3(2)(i).

<sup>13</sup> S.3(2)(ii).

<sup>14</sup> S.5. It reads:

**Sections 3 and 4 when not to apply -**

(1) The provisions of Sec.4 and so much of the provisions of sub-section 2 of Sec. 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by the registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

<sup>15</sup>The Medical Termination of Pregnancy (Amendment) Bill, 2014.

<sup>16</sup>*Dr. Nikhil D. Dattar, Mr. X and Mrs. Y v. Union of India and State of Maharashtra* 2008 (110) BOMLR 3293.

<sup>17</sup>*Miss X v. Union of India*, AIR 2016 SC 3525.

<sup>18</sup>*Supra* note 14.

prevent an immediate threat to the life of the pregnant woman. Beyond this there was no discussion on the upper limit of termination of pregnancy or the conditions associated with it.<sup>19</sup>

This upper limit of 20 weeks was challenged by the petitioners in *Suchita Srivastava v. Chandigarh Administration*,<sup>20</sup> (*Suchita Srivastava case*). Relying upon *Roe v. Wade*,<sup>21</sup> (*Roe case*) the court held that there is a cogent reason for this upper limit as there is a clear consensus in the medical community that termination of pregnancy beyond this limit can cause harm to the physical health of the woman.

In a writ petition of 2014 filed by HRLN, *Mrs. X and Mrs. Y v. Union of India*,<sup>22</sup> (*HRLN petition*) the constitutional validity of this ceiling of 20 weeks has been challenged. It has been averred that this ceiling may have been appropriate when the MTP Act was passed, back in 1971, however, with the advancement of medical technology, it is perfectly safe for a woman undergo a medical termination of pregnancy up to 26<sup>th</sup> week and even thereafter. The petitioners also averred that the determination of foetal abnormalities in many cases is possible only after 20 weeks and forcing a woman to deliver a child with serious abnormalities after suffering excruciating pain is unreasonable. This ceiling has thus been claimed by the petitioners to be arbitrary, unreasonable and thus in violation of articles 14 and 21 of the Constitution of India. In their support of making this claim, the petitioners quoted the statement of FOGSI that:<sup>23</sup>

[the] risk to the mother in case of termination of pregnancy at 25 weeks is not significantly higher than the risk at 20 weeks. [I]n case of foetal abnormality which has been detected late and which leads to an extremely serious handicap at birth, such foetus should be allowed to be terminated, even after 20 weeks.

It is submitted that it is time to revisit this issue as mere reliance on *Roe* case appears unreasonable considering that *Roe* case itself was a 1973 decision. If qualified medical doctors believe that a medical termination of pregnancy can be successfully conducted even during the 26<sup>th</sup> week and thereafter, then the legislature and the judiciary should not make conservative assumptions.

*The issue of Explanation 2 to Section 3(2):*

Read in entirety, this explanation states that if the pregnancy does not exceed 20 weeks, and two RMPs are, of opinion, formed in good faith, that the pregnancy has occurred as a result of a failure of any device or method used by any married woman or her husband for the purpose of limiting children, the RMPs can consider it (of-course after their opinion is formed in good faith) a grave injury to the mental health of the pregnant woman, and thus the termination of pregnancy can be conducted.

Now, there are two issues with it:

1. The married couple has to convince the RMPs that the pregnancy resulted as a failure of a contraceptive device or method used to limit the number of children. This means that they cannot, as a matter of right, go for an abortion if they have not used any such device or method. What if the RMPs ask for some proof? Shri AD Mani, the then Member of Rajya Sabha pointed out that this has to be on the basis of

<sup>19</sup> Rajya Sabha Debate held on 27.05.1971 at 142

Available at:

[http://rsdebate.nic.in/bitstream/123456789/481543/1/PD\\_76\\_27051971\\_4\\_p135\\_p175\\_9.pdf#search=medical termination of pregnancy](http://rsdebate.nic.in/bitstream/123456789/481543/1/PD_76_27051971_4_p135_p175_9.pdf#search=medical%20termination%20of%20pregnancy) (last visited on 03.05.2024)

<sup>20</sup> (2009) 9 SCC 1.

<sup>21</sup> 410 U.S. 113 (1973).

<sup>22</sup> W.P.(C) NO. 308/2014.

<sup>23</sup> FOGSI - The Federation of Obstetric and the Gynecological Societies of India. Statement quoted from the *HRLN petition* available at <http://www.hrln.org/hrln/images/stories/pdf/xandy-petition-8-3-14.pdf>. (last visited on 29.04.2024).



trust, as photographic evidence of the failure of a contraceptive is not possible and would make the Act a laughing stock.<sup>24</sup> Shri Bipinpal Das, another member, said that the question of morality is a very serious one. He said that a married couple should not be allowed to take advantage of the license given to them by the society, and practice their sex life without restraint. The husband should not be permitted to practice sex recklessly and make the wife suffer unwanted pregnancies.<sup>25</sup>

2. The other issue is that this explanation restricts the already restricted benefit only to married couples and does not take into account unmarried women who might become pregnant with their live-in partners or through casual sexual encounters. Members such as Shri A.D. Mani and Shri G.A. Appan were against this restriction and thought of it as a regressive step, making unmarried women vulnerable in many ways.<sup>26</sup> But still this explanation clause was adopted as such. The MTP Bill of 2014 addresses this issue and provides this benefit to unmarried women. But even this Bill, limits itself to circumstances where a method or device for limiting the number of children was used, but such method or device failed. Are the legislators supposed to impose their conception of sexual morality on a couple, married or otherwise? Such a distinction can also be challenged on the anvil of arbitrariness and/or reasonable classification under article 14 of the Constitution. The MTP Act was brought with an object of population control as well as preventing illegal abortions causing a significant number of maternal deaths.<sup>27</sup> It was estimated that before its enactment as many as five million induced abortions were carried out in India every year, of which more than three million were illegal.<sup>28</sup> With such an object in mind, how can the classification between married and unmarried couples be reasonable. Moreover, this distinction between married and unmarried couples that this explanation makes, can be said to be arbitrary because it is certain that even unmarried couples enter into sexual unions, some even underage. Such women who become pregnant out of wedlock face more social stigma than anyone else in such a position, are more vulnerable because if the partner refuses to do anything with the child such women are left to their own wits and might choose to end their life along with the child. Denying the benefit of this legislation to such women appears not only arbitrary but also unreasonable. This explanation clause has not been challenged before the Supreme Court till date and hence still survives.

The MTP Act does not leave the decision to abort with the woman. The satisfaction of the medical practitioner(s) that the grounds mentioned in the Act are satisfied, is a pre-requisite under the statute. Instead, the Act grants the veto power to a third person, the medical practitioner. Thus, abortion laws in India reflect that policy makers consider abortion a tool for controlling population growth, rather than as an expression of a woman's right to autonomy over her body.<sup>29</sup>

In recent times, the Indian judiciary has taken a much more progressive stance on the issue of abortion. In the case of *Suchita Srivastava* case,<sup>30</sup> a Three-Judge Bench of the Supreme Court while dealing with the

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<sup>24</sup>*Supra* note 17.

<sup>25</sup>*Id* at 150.

<sup>26</sup>*Id.*

<sup>27</sup> K.D. Gaur, "Abortion and the Law in India" 28 *JILI* 356 (1986).

<sup>28</sup> N.R. Madhava Menon, "Population Policy, Law Enforcement and the Liberalisation of Abortion: A Socio-legal Inquiry into the Implementation of the Abortion Law in India" 16 *JILI* 626 at 632-33 (1974).

<sup>29</sup>S.3(2) of MTP Act.

<sup>30</sup>*Supra* note 18.

importance of the consent of the pregnant woman as an essential requirement for proceeding with the termination of pregnancy, observed that:

There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood Under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods.

In the very recent case of *Meera Santosh Pal v. Union of India*,<sup>31</sup> (*Meera Santosh case*), on medical termination of pregnancy in the 24<sup>th</sup> week, a Division Bench of the Supreme Court, allowing the termination, observed that though, the pregnancy is into the 24<sup>th</sup> week, having regard to the danger to the life and the certain inability of the foetus to survive extra uterine life, they considered it appropriate to permit the petitioner to terminate the pregnancy.

In another recent case of *Miss X v. Union of India*,<sup>32</sup> (*Miss X case*), a Division Bench of the Supreme Court comprising of J.S. Kehar and Arun Mishra, JJ., allowed the medical termination of pregnancy in 24<sup>th</sup> week, citing the medical report which showed that the foetus was incapable of an extra-uterine existence and that the condition of the foetus could also prove to be dangerous to the life of the pregnant mother. This order, though benevolent in the outcome, can be criticized on the ground that it cites no precedents, no deliberation on the report of the medical panel, and appears on the face of it that to allow the termination of the pregnancy owing to the foetal abnormalities, the Court clubbed it with danger to the life of the woman, ostensibly, so as to circumvent the limit of 20 weeks provided by section 3(2) of the MTP Act.

However, the petitioners were not so fortunate in the famous case of *Dr. Nikhil D. Dattar, Mr. X and Mrs. Y v. Union of India and State of Maharashtra*,<sup>33</sup> (popularly known as *Nikita Mehta case*). The facts of this case were that the petitioner was in her 26<sup>th</sup> week of pregnancy. During 24<sup>th</sup> week of pregnancy the petitioner learnt that the foetus in her womb was diagnosed to have congenital complete heart block. The petitioners, husband and wife, chose to go for termination of pregnancy, but were shunned away by the hospitals as they had crossed the upper limit provided by the MTP Act.

When the matter was brought before the High Court of Bombay, it was contended by the petitioners that preamble of the MTP Act clearly provides that this legislation has been brought into place to prevent dangers to the life, health (physical and mental both) associated with the termination of pregnancy and also on humanitarian grounds such as rape, mental retardation etc. Additionally, it also provides relief where there is substantial risk that the child, if born, would suffer from abnormalities. Taking into consideration the contingencies under which the pregnancy can be terminated in terms of Section 3, the same should be read in section 5 also. It was further argued that, there was a lapse on the part of the legislators in not including such eventualities under section 5 of the said Act and relying upon the decision of the Supreme

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<sup>31</sup>(2017) 3 SCC 462.

<sup>32</sup>*Supra* note 15.

<sup>33</sup>*Supra* note 14.

Court in the matter of *Union of India v. Association for Democratic Reforms*,<sup>34</sup> it was submitted that the said lacuna is required to be filled in by reading down section 5 to include such eventualities. However, these contentions were rejected on the ground that doing so would virtually mean legislating upon section 5 of MTP Act and that under the guise of reading down a statute the Courts are not empowered to legislate upon it. Hence the petition was rejected. This case gave rise to the whole debate of raising the upper limit of abortion from 20 weeks to 24 weeks.

In the *HRLN* petition mentioned earlier in the assignment, it has been argued that MTP Act, violates several of India's international obligations under ICCPR, ICESCR, and CEDAW. It has also been challenged on the ground of violation of fundamental rights under articles 14 and 21 of the Constitution. Violation under article 14 due to arbitrary nature of the upper limit of 20 weeks, while violation of article 21 due to encroachment upon the right to life, health,<sup>35</sup> dignity<sup>36</sup> and privacy<sup>37</sup> of the pregnant woman. But this petition is pending before the Supreme Court and has had seven hearings since 2014. Only interlocutory orders have been passed till date and on Bench has been allocated to this matter.<sup>38</sup>

In the very recent case of *Savita Sachin Patil v. Union of India*,<sup>39</sup> decided by a Division Bench of the Supreme Court comprising of Bobde and Nageshwar Rao JJ, a woman asking for permission to terminate her foetus in the 26<sup>th</sup> week of pregnancy as the medical tests revealed that the foetus would be born with Down Syndrome, was denied permission to do so by the Court. The Court observed:

[E]verybody knows that children with Down Syndrome are undoubtedly less intelligent, but they are fine people. [W]e don't think we are going to allow the termination of pregnancy. We have a life in our hands. This echoes the sentiments of disability rights activists<sup>40</sup> that there should not be any "screening out" of the disabled regardless of the nature of the disability, that this diversity should be celebrated<sup>41</sup> and that it is the responsibility of the society to take of such children. On the other hand, it is believed that foetuses with acute disabilities which will make their existence a curse rather than a boon should be aborted or "screened out". Such a selection for the purposes of abortion is permitted within the ambit of the PCPNDT Act, as well.<sup>42</sup>

### 1.1.1 PATRIARCHAL SOCIETY

Patriarchy literally means rule of the father in a male-dominated family. It is a social and ideological construct which considers men (who are the patriarchs) as superior to women. Patriarchy is based on a system of power relations which are hierarchical and unequal where men control women's production,

<sup>34</sup> (2002) 5 SCC 294. In this case, the Supreme Court was dealing with the issue pertaining to the power of Election Commission in the matter of conduct of election and the scope of the word "elections". It was held that mere absence of any provision in relation to the procedure to be followed for exercise of the powers would not render the Election Commission helpless to formulate the regulations as required by the circumstances.

<sup>35</sup> *Consumer Education and Research Centre v. Union of India* 1995 SCC (3) 43.

<sup>36</sup> *Francis Coralie Mullin v. Union Territory of Delhi* 1981 SCR (2) 6.

<sup>37</sup> *PUCCL v. Union of India*(1997) 1 SCC 301.

<sup>38</sup> Available at: [http://courtnic.nic.in/supremecourt/casestatus\\_new/caseno\\_new\\_alt.asp](http://courtnic.nic.in/supremecourt/casestatus_new/caseno_new_alt.asp) (last visited on 29.04.2024).

<sup>39</sup> Writ Petition (Civil) No.121/2017.

<sup>40</sup> Views of Tom Shakespeare in Stephen Wilkinson's, "Prenatal Screening, Reproductive Choice, and Public Health" available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4315897/> (last visited on 05.05.2024).

<sup>41</sup> Sentiment shared by Committee on the Rights of Child (CRC). See CRC/C/66, Annex V, 16th Session, 6 October 1997 available at: <http://www.ohchr.org/EN/HRBodies/CRC/Documents/Recommandations/disabled.pdf> (last visited on 05.05.2024).

<sup>42</sup> S.4(2).

reproduction and sexuality. It imposes masculinity and femininity character stereotypes in society which strengthen the iniquitous power relations between men and women. Patriarchy is not a constant and gender relations which are dynamic and complex have changed over the periods of history. The nature of control and subjugation of women varies from one society to the other as it differs due to the differences in class, caste, religion, region, ethnicity and the socio-cultural practices. While subordination of women may differ in terms of its nature, certain characteristics such as control over women's sexuality and her reproductive power cuts across class, caste, ethnicity, religions and regions and is common to all patriarchies.

In the ancient Indian text, the Atharva Veda, mantras are written to change the sex of foetus from girl to a boy. A son's birth is likened to a "sunrise in the abode of Gods" and to have a son is as essential as taking food at least once a day. A daughter's birth is a cause for great sadness and disappointment.

Mind set of the Indian parents to have a male child is on account of the following reasons:

- i) Sons carry on the family name.
- ii) Sons confer the benefit upon the souls of dead ancestors by offering 'pinda' and 'water' to them on the occasion of 'Shradha'. They also conduct funeral rites.
- iii) Sons are entrusted with the task of supporting their parents in old age.
- iv) Sons bring dowry at the time of marriage thereby compensating for expenses incurred on their upbringing.
- v) Investing on sons, say on education or business, the wealth remains within the family itself.

The son mania can be seen from a case reported in the Indian express wherein an old couple defied age to have a male child in order to have an heir, though after the birth, the mother is in critical condition.

### 1.1.2 DAUGHTER AS A BURDEN

i) One of the most publicised reasons for female foeticide is the dowry system prevailing in the society. The practice of Dowry which was mostly confined to the rich and bride's father unilaterally according to his capacity as a symbol of parents love and affection gave 'varadakshina'; with passage of time became an instrument of subordination of women and an instrument in the hands of groom's parents to extract money or gifts from bride's parents. The magnitude of the problem can be adjudged by the fact that on an average one Indian woman commits suicide every four hours over a dowry dispute. According to data compiled by National Crime Record Bureau a total of 2,276 female suicides due to dowry disputes were reported in 2006, i.e. 6 a day in average; while the figure was 2,305 in 2005 and 2,585 in 2004.

Dowry as a social evil has become the root cause for the daughters being treated unequally and treated as a liability. This has resulted in people resorting to female foeticide, infanticide and female abandonment *etc.* Commercialization of institution of marriage, marriage customs and cultural practices has led to large scale devaluation of girls, making girl child an unwanted burden. People agree with statements like 'better to spend Rs.1000 on prenatal diagnostic tests and to save Rs.10 lakhs later'.

ii) Society believes that daughters in India are at an economic disadvantage due to their relatively low earning potential. Long hours spent in cooking, cleaning and caring for the children are viewed as "sitting

at home all day". Even the time spent in the fields is also not considered significant. Parents start calculating the cost that will be incurred in raising their daughters i.e. expenses related to child bearing, education, health and at the time of marriage. It is not a custom in our culture for parents to take any money from their daughter even if she starts earning. This means that the money spent on the girl child's upbringing will not yield any monetary benefit later. In many areas women are still not encouraged to gain financial independence.

iii) Women became collaborators in the ghastly crime, perhaps because they know from personal experience that the life ahead for the unwanted new born girl will be sub human existence during which she will die bit by bit every day. They have travelled through this hell themselves and do not want their offspring to face the same fate. Despite the legal safeguards provided for women, violence against women continues unabated in our country both inside and outside home. As per the reports of the National Crime Records Bureau, namely Crime in India, 2005, everyday

- 50 women are raped
- 22 women are murdered due to dowry
- 168 women face domestic violence by their husband and his relatives.
- 120 women were molested
- 426 cases of crimes against women were reported.

Generally, the parents are frightened by incidents of crime and are unable to protect the girls from untoward happenings. Since they are doubtful about their duty to protect their girl child, they find escape route by not bringing her into this world. Society is filled with crime against women and parents are afraid of their daughter's future. To get rid of all of their tension, they avoid the birth of a girl child, so that they do not have to face the problems like rape, dowry or bride burning *etc.* A girl child is believed to be a burden to parents as she is vulnerable to exploitations.

### **1.2.3 MISUSE OF MODERN MEDICAL TECHNOLOGY AND POOR ENFORCEMENT OF LAWS**

While preference for male child has always been a part of the society, non-invasive and instant sex determination through modern medical technology has made the elimination of girls in the pre conception and early stages of conception easier. Coupled with the greed and unethical practices of medical community have facilitated the increase in rate of female foeticide.

Apart from the Constitutional guarantees of gender equality and women empowerment under Articles 14, 15 and 21 read with Articles 39 and 42, there are specific legislations prohibiting female foeticides.

The provisions from Sections 312 to 316 of the Indian Penal Code, 1860 declare the intentional causing of miscarriage as an offence and prescribe punishment extending to imprisonment for life. Though provisions exist in the law pertaining to the Medical Termination of Pregnancy Act, 1973, regarding abortion of a female during pregnancy in case of risk to a female's life, this Act does not cover a situation where the gender of the unborn is a matter of choice. The Pre-Natal Diagnostic Techniques (Regulation & Prevention of Misuse) Act, 1994 amended in 2003 was passed to regulate the use and to provide deterrent punishment



to stop the misuse of sex determinative techniques. In spite of existing laws, umpteen incidents of female foeticide are taking place. The enforcement of laws against female foeticide is poor, including the medical practitioners and extremely poor conviction rate.

### **Hurdles In Stringent Implementing Of The Act**

The implementation of the Act has been mired by a wide range of factors, such as lack of awareness among stakeholders and concerned individuals, challenges faced by authorities, including lack of legal training, a casual attitude among many of the implementers, and failure on part of authorities and owners of diagnostic centres to maintain records properly in accordance with the Act. Numerous studies and media reports over the years have focused on understanding these hurdles and suggesting ways forward. The Lawyers' Collective undertook an intensive and a landmark study in an attempt to collate the opinions of main actors involved: providers (medical professionals associated with or engaged in performing pre-natal diagnostic techniques) and users (women who underwent pre-natal diagnostic techniques). The study found that 78% of the women were aware of the law against identifying the sex of the foetus. Most of them believed that the act of sex determination followed by abortion was punishable under the law. This may indicate that the respondents are not aware finding out the sex of the foetus itself is punishable under the law. 20 An all-India study by the Abortion Assessment Project<sup>24</sup> found that women and service providers were aware of the details of the Act; interestingly, they had a greater degree of awareness regarding this Act as compared to the MTP Act. The study concluded that almost all women are aware that they are indulging in an illegal act when they undergo sex selective abortions. However, studies also reveal high levels of ignorance among the general population as regards provisions of the Act. This ignorance seems to be prevalent even among groups which are working on the issue.

While implementing bodies are generally aware that offences under the Act are criminal, most are unaware of their powers under the Act. A study undertaken by Prayatn in the state of Rajasthan highlighted that almost half of the AAs had not received training about the provisions of the Act and over one-third of the AC members expressed lack of power as a loophole.<sup>28</sup> This study also states that there is a lack of awareness among lawyers and judges, in addition to some of the frontline implementers and enablers. This study also called for political commitment, accountability and monitoring in order to make the implementation of the Act a success. A study by Ekatra, IFES and USAID on the extent of implementation of the Act highlighted the importance of training, workshops and sensitization of implementing authorities, judges and advocates.<sup>29</sup> Incidents such as the one in Nayagarh,<sup>30</sup> where female foetuses were discovered in a well, and similar instances in Gurgaon, Ratlam, Buldhana (Maharashtra) or Pattran (Punjab) speak of the poor implementation of the Act across the country.

District health officials in Hyderabad detected several irregularities in corporate hospitals and diagnostic centres. No hospital had properly maintained the medical records regarding the use of scanning machines, which is a violation of Section 27 of the Act.<sup>35</sup> Prayatn, an NGO based in Rajasthan, conducted medical audit at the pre-natal care facilities in Rajasthan. When they tried to trace the contact details of pregnant women who had undergone ultrasonography, the details were found to be fake. The investigators traced

some women with the help of the district administration who had reported that their previous children were females. It was found that they were no longer pregnant and had not even delivered a baby. On further questioning the women revealed the names of the facilities/centres where they had undergone sex selection tests. The Lawyer's Collective study showed that a small segment (37%) of all radiologists surveyed preserved ultrasound reports, and those who did preserve them for less than the period stipulated under the Rules of the Act. The study also found that owners and practitioners are not clear about the kinds of forms to be maintained, especially about filling Form D.

### 1.3 CONCLUSION

The causes of female foeticide are embedded deep in the edifice of society. It is necessary to change the mind set of people and enable them to throw off the yoke of unhealthy and inhuman traditions. Here, they are required to liberate themselves from ruthless and detrimental traditional bonds and develop humane qualities in the true sense. This chapter dealt with the various factors which are responsible for the female foeticide and its consequences. It delineated that if this malpractice is not checked it will have far-reaching consequences in the future.

