

## **Socio-Legal Impact of the Pre-Conception and Prenatal Diagnostic Techniques Act in India**

**Sushil Purohit**  
*Research Scholar*  
*School of Legal University*  
*Jigyasa University*  
*Dehradun, Uttarakhand*  
*Email: sushilpurohit1@gmail.com*

**Dr. Bhupnesh Kumar**  
*Assistant Professor*  
*School of Legal University*  
*Jigyasa University*  
*Dehradun, Uttarakhand*

### **Abstract**

*The issues that arise from the role of the judiciary and directly affect how the Act is applied include those concerning judges' and lawyers' familiarity with this particular Act, the judicial processes involved, and the entire process of addressing a private complaint. It is the responsibility of all healthcare providers who conduct prenatal diagnostic procedures to adhere to the Act's and the Rules' guidelines. According to research by the Lawyers' Collective, every gynecologist surveyed in Delhi knew that the Act prohibited sex determination and sex-selective abortions. Although 60% of respondents felt that such a rule was appropriate, they also believed that there were better options, such as banning dowries, protecting retirees, promoting women's education, and social measures to improve women's status. The political clout of medical professionals frequently makes it impossible to successfully comply with the Act. Despite knowing that the acts covered by the Act are criminal in character, the majority of implementing bodies are unaware of their legislative authorities. The paper identifies a lack of understanding among judges, lawyers, and certain frontline implementers and enablers. This study also emphasized the importance of openness, oversight, and political participation in ensuring the Act's successful implementation.*

### **Key Word**

*Women, Socio-legal impact, sex selection, PNDT etc.*

Reference to this paper should be made as follows:

**Received: 30.08.2024**

**Approved: 29.12.2024**

**Sushil Purohit**  
**Dr. Bhupnesh Kumar**

Socio-Legal Impact of the  
Pre-Conception and  
Prenatal Diagnostic  
Techniques Act in India

*RJPSSs 2024, Vol. L, No. 2,*  
*pp. 242-250*  
*Article No. 030*

Similarity Check: 12%

**Online available at:**

[https://anubooks.com/  
journal-volume/rjpss-vol-  
l-no2-dec-2024](https://anubooks.com/journal-volume/rjpss-vol-l-no2-dec-2024)

**DOI:** [https://doi.org/  
10.31995/  
rjpss.2024v50i02.30](https://doi.org/10.31995/rjpss.2024v50i02.30)

## **Introduction**

According to the 2011 Indian national census, which revealed that there were only 914 women aged 0–6 for every 1000 men, female feticide is a highly frequent practice in India. Female feticide agents, a form of systemic violence against women, have a complicated and multiple underlying causes. The “Ministry of Health and Family Welfare”<sup>2</sup> stated in its 2006 annual report that “India’s social, cultural, and religious fabric is primarily patriarchal and contributes comprehensively to women’s secondary status.” This secondary status is reflected in the high incidence of female feticide.

According to recent data, sex selection is still widely practiced in India, especially among the well-educated and rich. To stop sex selection and to regulate prenatal diagnostic procedures in order to prevent the complete eradication of female feticides, the Indian government passed the “1994 Pre-natal Diagnostic Techniques (PNDT) Act”. To do this, the government set up a bureaucracy to oversee the sale and control of ultrasound equipment, a crucial diagnostic tool for sex-selective abortions. The “2003 Pre-conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act” was adopted in response to the first PNDT deployment.

With every national census since the PNDT Act’s introduction, the sex ratio has continued to fall, raising doubts about its efficacy. According to the census data collected, the sex ratio decreased from 945 females per 1000 males in the 0–6 age group in 1991 to 927 females per 1000 males in 2001 and 914 females per 1000 boys in 2014. A well-meaning piece of legislation founded on the deterrence principle, the PCPNDT Act is also poorly applied. According to data up until 2006, India had not recorded a single violation of the PCPNDT Act since its inception, according to the Public Health Foundation of India’s 2010 review of the Act.

It is challenging to determine if the inability to drastically lower the frequency of female homicides in Indian nations was caused by inefficiency or improper handling of instances involving pregnant women. Additionally, the Act requires all ultrasound professionals to register, regardless of whether they utilize ultrasound for “ultrasound” to place central vascular access. Outside of radiology, the approach has resulted in time-consuming and expensive registration processes that deter medical providers from using ultrasound. As a diagnostic and procedural tool, peripheral nerve block programs that address identity error and central vascular access have become standard practice in anesthesiology. (Public Health Foundation of India,2010) Apart from operating rooms, “pulmonary ultrasonography, transthoracic echocardiography, and trans oesophageal echocardiography are also common” in intensive care units and operating rooms. The Weill Cornell Medical

College's Department of Anaesthesiology carried out and provided funding for this as part of its Global Health Initiative. In order to avoid the possible legal repercussions of ultrasound that did not adhere to PCPNDT laws, participants need anonymity. (Government of India, (Regulation and Prevention of Misuse) Act, 1994)

It is troubling that the great majority of analysts at these centers lacked access to ultrasounds, and that one-third of those who did have an ultrasound did not follow PCPNDT guidelines. All of the anaesthesiologists who responded to the poll were frustrated by this inaccessibility, which reflected their belief that this crucial tool might be used to deliver better treatment. Due to the PCPNDT registration process, an anaesthesiologist has reported an ultrasound delay of over two years.

By placing moral and legal obligations on physicians, the PCPNDT Act oversimplifies a complicated subject. In October 2014, Harsh Vardhan, the former Indian Health Minister, stated rather aptly: "It is evident that twenty years have not gone by since focusing on sex-selection providers. The 'Save the Girl Child, educate the Girl Child' campaign and Punjab's free public schooling for girls are positive steps. By providing Indian doctors with legal options to fulfill their responsibilities, the PCPNDT Act is a well-meaning piece of social legislation that enhances medical ethics practice. The serious social problem of feticide and its unexpected effects on women are successfully recognized and brought to light by the PCPNDT act.

### **Female Feticide and the PNDT Act: Issues and Challenges**

Over the years, women have endured the disparaging conditions of patriarchal society. This is true in other parts of the world as well as in India. Not only is gender bias pervasive at the communal level, but it also has deep roots in the family, which is a society's basic unit. The dangers of injustice are apparent at every stage of a woman's life, beginning with the difficulties she faces at birth as a woman and continuing through every stage of her life.<sup>6</sup>

The killing of a female fetus inside a mother's womb is known as female feticide. The complicated issue of sexual determination has an impact on culture, morals, sociopolitical situations, and sexual policy (Sex Selection Prohibition Act, 1994; Pre-conception of prenatal research methodologies). In India, sex-selective abortion made the issue worse. Female feticide cannot be outlawed on its own because abortion is permitted prior to 24 weeks of pregnancy. Therefore, it was believed that a new law was required to prevent the MTP Act from being abused for sexual abortions. This took effect on January 1st, 1996. The 1994 PNDT Law (as amended in 2002)<sup>7</sup>.

To address the aforementioned situations, the Indian government passed the Prenatal Diagnostic Techniques Act of 1994 (PNDT Act). It became operative on January 1st, 1996. In order to prevent women from being sexually exploited, the

PNDT Act of 1994 (as revised in 2002) prohibits sex discrimination before or after birth and controls prenatal testing practices. Chromosome disorders, abnormality disorders, hemoglobinopathy, sex-related genetic flaws, congenital malformations, or any other anomalies or defects are among the prenatal diagnoses that are offered by the Act.

Any unit owners or medical professionals who breach any of the Act's provisions face a maximum punishment of "three years and a fine extending up to Rs 10,000." Subsequent offenses carry a five-year prison sentence and a fine of Rs. 50,000. For the following conditions, the relevant authorities must submit the registered medical practitioner's name to the State Medical Council:

- a) The cancellation of enrolment while the court considers the charges and until the matter is settled;
- b) His name will be removed from the Council Register for a period of five years due to the first violation and the discharge of his own name. Those who request sex tests or sex selection may face a maximum term of three years in prison and a Rs 50,000 fine.

Each successive offense carries a maximum penalty of Rs. one lakh and a maximum penalty of five years. The status of female feticide in India has not changed since the PNDT Act was passed, according to critical evaluations of the law's implementation. The increasing abuse of reproductive technologies has increased the gap between the already warped sexual relations, even though the Act's inability to be enforced may not be considered the primary source of the issue. According to "United Nations Children's Fund reports (UNICEF)," institutional discrimination against the sexes has caused up to 50 million females to be absent from India since 1991.

Thus, the disposal of a female kid simplifies medical and scientific procedures (Centre for Enquiry into Health and Allied Themes) CEHAT vs. Union of India, 2001)7. Ninety percent of the 15 million illegal abortions performed worldwide in 1997 were performed in India with the goal of killing the girl child. The gender-based decimation is not limited to urban areas; it has also extended to smaller cities.

Since it went into effect in January 1996, the law that forbids such actions has not been effectively enforced, which is disheartening. In 1998, an NGO filed a written petition in accordance with "Article 32 of the Indian Constitution" after obtaining new information on the subject from the Apex courts. The exploitation of cutting-edge medical technology to abort a child before birth, while being aware that this is unethical, immoral, and illegal, was brought to light by the NGO case at the "Centre for Enquiry into Health and Allied Themes (CEHAT)".

Furthermore, the general population is not significantly impacted by the awareness campaign in this manner, with the exception of urban areas. The central

and state governments initiated an awareness campaign using traditional and electronic media due to the low level of knowledge regarding the Act and the rights of girls. (S.L. Tandon and R.S. Das, 2006).

**The issues and challenges are:**

The main problem with enforcement is that, in the majority of cases, both service providers and service seekers choose to disregard the law's application. Because it is challenging for district health authorities to disclose cases against other physicians, fraternity problems have been observed in the administration of this act. The district officers and employees are inconsistent, and it is also clear that the authorities are unable to prosecute criminals on a regular basis. Since there are no standardized procedures, the program's implementation necessitates metrics to evaluate how well the Act is working.

There aren't any regular meetings of the Advisory Board. Since no more employees are assigned to this task in the districts, the data used to monitor the law's implementation puts more strain on the health service. Both the individual's social pressures and the involvement of financially driven practitioners contribute to the crime. It can be quite challenging to gather evidence for a court case, and circumstantial evidence may not be used very often.

The quality of the evidence found in clinical records is inadequate. The limited "The Medical Termination of Pregnancy Act (MTP)", which permits abortions for emotional illness and hence still penalizes sexual decisions, is the reason the bill fails. Doctors find it challenging to verify the verbal results of sex testing. Some medical specialists in the sex selection industry have demonstrated little interest in this issue. Justifying the abortion of a fetus in relation to its gender identity is more difficult. Because they were permitted, "amniocentesis, chorionic biopsy, MRI, etc." could not be avoided when looking for genetic flaws in the fetus. (S. Phadke, 1971).

Abortion of a woman's fetus has become a separate industry and forced the establishment of major companies. The home test kits are available online and are freely promoted. In order to successfully address criminal offenses related to female feticides, the PNDT Act's implementation needs to be given careful consideration. As a result, strict measures must be taken to eradicate the very societal ill that fundamentally threatens mankind and the existence of the human race.

A comprehensive law on reproductive rights founded on the principles of gender equality is also said to be a step in the right way. Furthermore, a system of women's empowerment must balance reproductive rights in a patriarchal society like India; otherwise, it may be detrimental to the nation's social and cognitive well-being. Eliminating this tradition is a significant task in Indian society. It is

important to provide careful thought to actions that will empower women and improve their rights by opposing practices, making sure that existing laws are strictly followed, and promoting high standards for medical personnel.

In addition, the Medical Council (Medical Association), doctors, volunteers, media outlets, responsible organizations, religious and social leaders, and law enforcement should all work together. The only way to eradicate the long-standing customs of female feticides from society is to combine monitoring, awareness campaigns, and effective law enforcement.

### **Pre-Conception and Pre-Natal Diagnostic Test Work and Their Implications**

The ultrasound sonography test (USG) has been a useful tool in obstetrics and diagnostic radiology for a number of years. The field of anesthetics, which deals with critical treatment and pain relief, has been developed to incorporate this technology into clinical practice and to improve and broaden patient care. In India, the “Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT) Act of 1994 and 2003” has been in place to regulate the long-standing social problem of female feticide. (M. Dhar, Y.S. Krishna, 2018)

### **USG and An Aesthesia**

The use of USG is essential to modern anesthesia. In its absence, it would be “secure,” but only moderately “unsafe.” As usual, anatomical and benchmark practices are the main sources of the experience. The application of USG methods is supported by their level of protection and precision. Numerous works of literature describe the various approaches and techniques of assessment that it includes. The technology is still in use today and is being improved upon in conjunction with medical disciplines, particularly anesthesia.

India has a long history of regressive and sexually humiliating norms, including as the dowry, underage marriage, female fetuses, and the sati system. Following deliberate and systematic efforts in the fields of law and society, some were eliminated completely or nearly completely. Given the beginnings of our early social history, where women play a role that differs from that of men, it is crucial to keep in mind that such habits were difficult to abolish. The aspect of society that has shown the most resistance, endured, and fell into this modern era is female feticide. Over the years, our nation has seen a steady increase in sexual ratios despite countless attempts by the government and social groups. The “*PNDT Act of 1994, amended in 2003 by the PCPNDT Act, was one of the acts to address this threat.*”

In an effort to prevent female feticide, the PNDT Act of 1994 restricted and outlawed prenatal procedures such as chorionic Villus cells and amniotic fluid. The Act was amended in 2003 to include USG clinics within its purview due to the

statute's blatant inefficiency. According to this rule, every facility that possesses any equipment (including USG) that might be able to determine the sex of prenatal or preconceptionally fetuses must register with the relevant authorities and face consequences for their involvement in sex determination. Families of expectant mothers who ask for sex determination run the risk of facing reprisals.

Failure to abide by the provisions of this Act may result in incarceration. Additionally, each physician using the USG machine needs to be registered and competent to conduct sonography properly. This law targets obstetricians and radiologists/sonologists who frequently do prenatal or pre-design exams. The credentials needed for sonography and training are also hotly debated. "A doctor with a degree or diploma and six months or a year of experience in USG or imaging scanning is defined as a 'sinologist or imaging specialist' under the act." "Anesthesiologists, surgeons, cardiologists, intensive care practitioners, trauma practitioners, and other specialists in this law are ambiguous and constantly debating and changing legislation," according to the position and role in this environment.

Doctors and institutions that own or operate a USG machine are listed in the Delhi High Court's 2016 rule in the event that undertakings or declarations state that a machine "is not intended for prenatal diagnosis and is not intended to be used or permitted to be used in prenatal diagnostic procedures." This must to be prominently displayed outside of any location where USG is utilized. The PCPNDT Act unintentionally placed onerous constraints on medical professionals who wanted to utilize USG for purposes other than prenatal diagnosis, even though its main goal was to regulate and prohibit sex determination and illegal abortion.

### **Conclusion**

The supporters of the movement against sex pre-selection and predetermination have praised both the Act and the subsequent revision. Nonetheless, it is nonetheless true that Maharashtra's legal system and Act implementation have both fallen short. The study's main goal was to collect evidence about problems pertaining to the PC-PNDT Act's non-implementation. It raises two significant problems. On a larger scale, it presents basic questions regarding how the Act should be applied to an area that isn't otherwise controlled. Second, it also brings up particular concerns regarding the practical aspects of the Act's real implementation.

To elaborate on the first point, attempts are being undertaken to monitor and regulate the operations of the large private medical sector, which is now unregulated and immune to all forms of governmental supervision, in order to implement this Act.

Therefore, attempts to regulate or control the private medical sector's operations through a single piece of legislation might not be the best course of action. The other problem that comes up is that the State needs to be more involved in order to implement this Act, and passing legislation is just the first step in that direction. A more important role must be played by the state apparatus, in this case the health department, which is sometimes overlooked as a fundamental health function. ((Prohibition of Sex Selection) Act, 2006, PNNT).

The pertinent problems with the application of other social laws should be examined in addition to the Act's execution. Research has demonstrated that the majority of social laws have extremely unfavorable implementation records. The legislation itself is another significant topic that affects any discussion regarding the Act's implementation, even though it is outside the scope of this study. Lawyers and organizations striving for the Act's successful implementation have expressed concerns about changing a few of its sections. The judiciary is crucial to the Act's application in this issue, just like in any other legal matter.

The concerns pertaining to judges' and attorneys' knowledge of this specific Act, the judicial procedures involved, and the full process of handling a private complaint are those that stem from the judiciary's function and have a direct impact on how the Act is implemented.

All medical professionals who perform prenatal diagnostic procedures are accountable for following the Act's and the Rules' regulations. All of the gynecologists surveyed in Delhi were aware that the Act forbade sex determination and sex-selective abortions, per a report by the Lawyers' Collective. Despite their belief that such a law was suitable, 60% of respondents thought there were better alternatives, including dowry prohibition, retirement protection, social initiatives to elevate women's positions, and education for women. (Centre for Youth Development and Activities (CYDA), 2007).

Medical practitioners' political influence frequently prevents the Act from being successfully complied with. Most implementing bodies are not aware of their statutory powers, even though they are aware that the crimes under the Act are criminal in nature. A Prayatn research in the state of Rajasthan found that over a third of AC members saw a lack of power as a weakness, and that almost half of AAs had not received training on the Act's requirements. According to the report, certain frontline implementers and enablers, as well as judges and attorneys, lack comprehension. This study also underlined how crucial political participation, openness, and supervision are to guaranteeing the Act's successful execution.



## References

1. Census of India. "Gender composition", 2011.
2. PNDT Division, Ministry of Health and Family Welfare, "Government of India. Annual report 2006. Implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act. 2007".
3. Government of India, "The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994", New Delhi 7 Gazette of India, 1996. Accessed on July 20, 2020
4. Public Health Foundation of India, "The National Human Rights Commission, New Delhi & UNFPA. Implementation of the PCPNDT Act in India Perspectives and Challenges", 2010.
5. S.L. Tandon and R.S. Das, "Female Foeticide and Infanticide in India: An Analysis of Crimes against Girl Children", *International Journal of Criminal Justice Sciences*. 2006, Vol. 1 Issue 1.
6. Government of India, "The Pre-Conception and Pre-Natal Sex Selection/ Determination (Prohibition and Regulation) Act", 2002. New Delhi Gazette of India.
7. A. Chawla, "Female Foeticide in Punjab". *M.D.U. Law Journal*, Vol XII, Part II, at 189.
8. S. Phadke, "Pro-choice or population control: a study of the Medical Termination of Pregnancy Act, Government of India, 1971.
9. M. Dhar, Y.S. Krishna, "The Pre-Conception and Pre-Natal Diagnostic Techniques Act and its implication on the advancement of ultrasound in anaesthesiology; time to change mindsets rather than laws", *Indian Journal*. 2018;62(12):930-933. Doi: 10.4103/ija.IJA\_518\_18
10. S. Mani, "Guidelines for ultrasound owners and owners of clinics, diagnostic centers, nursing homes and hospitals", *The Indian Journal of radiology & imaging*, 22(2), 125–128.
11. Jaising, Sathya Mala and Basu. 'From the Abnormal to the Normal- Preventing Sex-Selective Abortions Through the Law', Lawyers Collective, India, 2007
12. Annual report on implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 2006, PNDT division, Ministry of Health and Family Welfare, Government of India.
13. Reflections on The Campaign Against Sex Selection and Exploring Ways Forward. Report by Centre for Youth Development and Activities (CYDA), Feb 2007.