ABORTION, SEX DETERMINATION AND GENDER BIASED SEX SELECTION

ANSWERS TO CRITICAL QUESTIONS

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FREQUENTLY ASKED QUESTIONS ON
ABORTION AND SEX DETERMINATION & SELECTION

ABORTION

1. WHAT IS ABORTION?

An abortion refers to the termination of pregnancy by removal or expulsion of a foetus/embryo from the uterus. An abortion may be spontaneous or induced, most commonly referring to the latter. When an abortion occurs spontaneously it is usually called a 'miscarriage'. An abortion may also be induced, medically, with the intention of expelling the foetus. Such an abortion is referred to as 'Medical Termination of Pregnancy'.

2. WHAT ARE THE VARIOUS METHODS OF ABORTION IN USE TODAY?

There are several methods to induce abortion available today. The stage of gestation when a woman accesses abortion services determines the appropriate type of procedure to be used as well as the associated risk. The following are the methods of abortion legal in India in the first and second trimesters (MoHFW, GoI, 2010):

First trimester:

Vacuum Aspiration[1]-

Vacuum aspiration is a method by which contents of the uterus are evacuated through a plastic or metal cannula that is attached to a vacuum source. The term vacuum aspiration includes both Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA).

Gestation limit: up to 12 weeks of gestation.

Medical abortion-

Medical method of abortion (MA) is a non-surgical termination of early pregnancy using a combination of Mifepristone or RU-486 and Misoprostol.

Gestation limit: up to 63 days[2] (i.e. nine weeks) of Last Menstrual Period (LMP).

Second Trimester:

Medical method[3]: Ethacridine Lactate – Extra Amniotic Instillation:

Ethacridine Lactate is instilled extra-amniotically, leading to uterine contractions. The volume to be instilled is calculated as per period of gestation of the pregnancy (10 ml/week of gestation).

[1] Dilatation and Curettage (D&C) has been the commonly used technique for abortion in the past. However, the rates of major complications such as excessive bleeding, vaginal and cervical injury, perforation, post-abortion bleeding, etc are 2 to 3 times higher in D&C than in VA. Hence, a joint declaration by WHO and International Federation of Gynaecology and Obstetrics (FIGO) recommends properly equipped hospitals to abandon D&C and use either manual or electric aspiration. (Source: MoHFW, GoI, 2010).

[2] Mifepristone + Misoprostol (1 tab of Mifepristone 200mg and 4 tab of Misoprostol 200mcg) combipack has been approved by the Central Drugs Standard Control Organization, Directorate General of Health Services for medical termination of pregnancy up to 63 days of gestation in December, 2008. (Source: MoHFW, GoI, 2010)

[3] Use of Mifepristone and Misoprostol is presently not an approved method of second trimester abortion in India. However, evidence from other countries shows that it is a safe and effective method for termination of second trimester pregnancies. For further information on the suggested protocol of the technology as practiced in other countries, please refer to: Ministry of Health and Family Welfare, Government of India, (2010), *Comprehensive Abortion Care: Training and Service Delivery Guidelines*, New Delhi (Annexure 7.1 on page 66)

Gestation limit: between 15-20 weeks of gestation.

Surgical Method: Dilation and Evacuation (D&E): The D&E method involves preparing the cervix and evacuating the uterus with a combination of suction and forceps. D&E is not a commonly used method in India and requires special training.

Gestational Limit- between 13-16 weeks of gestation.

3. WHAT IS THE LAW REGULATING ABORTIONS IN INDIA?

Abortion in India is regulated by the Medical Termination of Pregnancy Act, 1971. The MTP act was legislated to counter the problem of illegal and unsafe abortions in India and the resulting maternal mortality. The Act, with its Rules and Regulations, provides the legal and medical framework for the circumstances in which women can terminate their pregnancy in certified facilities by registered physicians. The following sections are based on guidelines for comprehensive abortion care published by the Government of India (MoHFW, GoI, 2010).

Who can legally provide abortions?

The MTP Act of 1971 (amended in 2002) states that abortions can be provided by a medical practitioner who possesses a recognized medical qualification as per the Indian Medical Council Act, 1956, (102 of 1956), whose name has been entered in a State Medical Register and who has experience or training in Gynaecology and Obstetrics as prescribed by rules made under the MTP Act. For performing first trimester abortions, the MTP Rules 2003 allow any registered medical practitioner who has received special training in MTP and performed 25 cases in a training institute approved by the government. Second trimester abortions on the other hand, can only be performed by persons with a PG diploma or degree in Obstetrics and Gynaecology, in addition to the above requirements.

Under what conditions can a woman seek abortion as per the law?

The MTP Act 1971 with its amendments in 2002 allows an unwanted pregnancy to be terminated by a registered medical practitioner under the following conditions:

- The continuation of the pregnancy involves risk to the life of the pregnant woman or of grave injury to her physical or mental health
- There is substantial risk of that if the child were born s/he would suffer from physical or mental abnormalities as to be seriously handicapped.
- Rape or incest
- Failure of any contraceptive device or method used by a married woman or her husband for the purpose of limiting the number of children.

For termination of a pregnancy that exceeds 12 weeks but is up to 20 weeks of gestation, the opinion of two registered medical practitioners is required.

Where can abortions be provided?

The MTP Act by implication recognizes all public sector health institutions as potential abortion facilities. This means that it is the state's responsibility to ensure that every public health institution is capable of providing abortion care.

In case of private institutions, these institutions must be approved by the District-level Committee constituted by the government with the Chief Medical Health Officer as Chairperson, upon the fulfilment of detailed criteria.

As per the Act, abortion can be provided only in the following places:

- A hospital established or maintained by the Government
- A place approved by Government or a District Level Committee constituted by that Government with the Chief Medical Officer or District Health Officer as Chairperson of the Committee.

The act also lists facilities and equipment required for approval of a site providing abortion. These requirements are different for first trimester and second trimester abortions.

Who will approve and monitor these facilities?

The approval process follows the below steps:

i) The place seeking approval must fill out Form A of MTP Rules, 2003

ii) Application in Form A is to be addressed to the Chief Medical Health Officer by the health facility seeking approval

iii) CMHO verifies or inspects the place to satisfy that termination can be done under safe & hygienic conditions

iv) CMHO recommends approval to the committee

v) The Committee considers application & recommendation and approves and issue certificate of approval in Form B of MTP Rules, 2003.

During the approval process, the site seeking approval/ place is to be inspected within 2 months of receiving application. The Certificate (Form B) is to be issued within 2 months of inspection. If a deficiency is found, the certificate will be issued within 2 months of the deficiency having been rectified. The CMHO is to inspect the facility to ensure safe & hygienic conditions for conduction of abortions.

What are the punishments for non-compliance with the law?

If an abortion is conducted by a person who is not a registered medical practitioner, or is conducted at a place which is not approved for that purpose under the Act, then such a person as well as the owner of the place where abortion is conducted, will be served rigorous imprisonment for minimum two years which may extend up to seven years.

If a clinic which has been approved for providing abortions is found upon inspection to be lacking in necessary facilities and there is non-maintenance of records, the certificate of approval (Form B) issued under Sec 5 of MTP Rules 2003 will be suspended or cancelled and the owner will have to apply for a certificate again after meeting all the requirements.

4. WHY DO WOMEN SEEK ABORTIONS?

i. Women are often coerced to have sex both within and outside marriage. They have little to no voice in taking decisions about when to have or not have sex. This could lead to an unwanted pregnancy, causing them to seek an abortion.

ii. Women may not be able to negotiate the use of contraception with their partner. Even when contraception is available, it may not be foolproof and women may have risks associated with it. (Visaria, et al, 2003) Lack of awareness and access to contraception is even more acute among unmarried women. (Jejeebhoy, et al, 2009)

iii. Women are forced to bear the burden of responsibility for contraception and childbearing as well as rearing of children. Female sterilization is the most commonly used form of contraception but it is often resorted to only after the desired number of children are born. This leaves women at risk of unwanted pregnancy prior to sterilization making them turn to abortion as a method of contraception. (Visaria, et al 2003).

iv. Medical issues relating to the health of the woman or a threat to her life caused by serious complications during pregnancy, as well as deformities or life threatening conditions of the foetus are among the reasons why women seek abortion.

v. Even though women bear the risk of childbearing alone, they hardly ever have exclusive or any right over the children who are born.

vi. Thus, access to abortion acts as a substitute for the rights denied to women otherwise by society such as the right to have or not have sex, right to ask a partner to use birth control or to look after the child.

Hence, women must have access to abortion without restriction. The voices of women below highlight the above issues which push women to seek abortion.

My husband is a drunkard and does not bring home any money. He just loves to sleep with me. After I conceived he ignores me or physically abuses me. He will pretend to be concentrating on some work. When the child is born he will deny paternity to the child by saying that he is not the 'real' father of the child. Since I have experienced all this twice, I decided to go for an abortion. There is no other way I could have handled the situation. In any case when children are born, I have to provide them with food while he goes around disclaiming his fatherhood.

35-year old married woman, Tamil Nadu
Anandhi 2007
Women, work and abortion: A case study from Tamil Nadu
EPW March 24: 1054-1059

When I express reluctance for sex saying that I am worried about getting pregnant, he says, "I will take care of if it happens." If I object strongly he shouts: "Are you sleeping with someone else?" After my first childbirth, he called me for sex within a month. When I objected, he beat me. This is a regular happening in my life.

Younger woman, ever-user of abortion, Tamil Nadu

He alone is responsible for the abortion, because first he prevented me from having the operation and then be beat me when I was reluctant to have sex. So again it led to an unwanted pregnancy and abortion.

Older woman, ever-user of abortion, Tamil Nadu
Ravindran & Balasubramanian 2004
"Yes" to abortion but "No" to sexual rights:
The paradoxical reality of married women in rural Tamil Nadu, India
RHM 12 (23): 88-99

"If I'm a widow, then abortion can help me save face. Within marriage you have the choice to keep it or drop [abort] it"

"It should be available at least in difficult moments. The law shouldn't make things difficult…"

"When husbands refuse [women] sterilisations, it is good to have abortion as a right for women."

"Even if she marries the same boy, she should first drop the thing. Her in-laws might start wondering about the child's paternity."

Gupte et al. 1997
Abortion needs of women in India: A case study of rural Maharashtra
RHM 5(9): 77-86

5. WHAT IS THE STATUS OF ABORTION PROVISION IN INDIA?

The MTP Act envisages institutions in the public health sector as potential sites for provision of abortion. This is to ensure that abortion which is a basic and important procedure remains affordable, safe and accessible. In practice however, majority of abortions conducted in the country do not happen in the public health sector. The Abortion Assessment Project – a study conducted in 2003, across six states in India, estimated that there are 6.4 million abortions that occur in the country annually. Of these, 1.6 million or approximately one fourth are provided by traditional, non-medical providers often employing unsafe and invasive methods. Of the remaining, only a third were provided by the public sector. The private health sector is therefore the largest provider of abortions in the country. It is important to bear in mind however, that accessing abortions in the private sector is expensive – the cost is almost 7 times that of the public sector, thus making access difficult for a large section of the population. Yet it is the private sector that is being sought more than the public health sector by abortion seekers. The Abortion Assessment Project finds that women report better quality of services in the private sector and they feel their confidentiality is better maintained there (Bart Johnston, 2002).
Paradoxically, women have also reported high cost of services in the public sector – even though abortion is supposed to be available free of cost in the public sector – as a factor for preferring the private sector. (Barge, et al, 1997 in Bart-Johnston, 2002).

5. WHAT ARE SOME OF THE BARRIERS FACED BY WOMEN IN SEEKING ABORTION?

(a) Household level

Women have no decision making power with regard to sexual relations regarding when to have sex or not have sex, when to bear or how many children to bear. They lack support at the household level, are financial dependent on other family members and face restrictions on mobility. These are some of the barriers women face at the household level in accessing abortion.

(b) Societal / community level

Social Stigma

Social stigma surrounding abortion means that confidentiality becomes a critical concern for women seeking abortion and plays a major role in deciding the location of availing such services. For unmarried women, due to greater stigma associated with sex outside of marriage the difficulty in accessing abortion is greater and leads not only to delay in seeking abortion but also pushes women to go to unqualified providers.

Lack of information

There is a dearth of information among women and communities on when abortion is legal, under what conditions, and where safe, legal abortions can be accessed. (Bart Johnston, 2002) The understanding of what is legal and the ambiguity surrounding the law form major obstacles to accessing safe services. Further, women are often unaware of their menstrual cycles and it may take up to three months for them to even realize that they are pregnant. Abortion is permissible only up till 20 weeks and it would be too late by the time they made a decision and reached a health facility.

(c) At the level of the provider

Though abortion is legal in India, its provision is entirely provider-controlled. Doctors make the final decision about whether or not a woman can get an abortion. They use coercive measures such as making abortion conditional to getting a Copper-T insertion or sterilization done after the procedure. (Bart Johnston, 2002) The law does not require any such procedure to be performed in

addition to abortion unless the woman herself wishes it.[4] Providers also ask for the husband's/family members' consent before an abortion though this is not required by law. These measures serve to discourage women and further hinder their access to safe and legal abortion.

6. WHY DO WOMEN DELAY SEEKING ABORTION?

Usually it is a combination of the above mentioned factors that results in delay in seeking abortion. . The greater the barriers faced by women, the later they will reach a health facility. Women, who have the least knowledge, the least access to resources, and are the most isolated geographically, or have been facing abuse, are the ones who face the greatest barriers. In other words, women who reach the health facility later in their pregnancy are more vulnerable.

The following case study illustrates some of the conditions of vulnerability under which women operate in seeking abortion; thus leading to delay: (Citation: Common Ground Module)

***Anjana**, an 18 year old woman was working as a housemaid for the past year at a place far from her house, came to the hospital seeking an abortion.*
Three months after starting work as a housemaid, the unmarried boy in the house, who was 28, (he and his mother stayed in the house), asked Anjana to have sex. She refused. He approached her again with reassurances and she consented and they had regular sexual contact for nine months. He used condoms for initially but then discontinued and instead bought three packets of oral contraceptive pills for Anjana. She refused because she did not know how to use the pills and also thought they might harm her uterus.
Anjana developed itching and vaginal discharge after a month of sexual contact. She was not able to approach any health care provider and took no treatment. When she did not get her next period, she assumed it was delayed. She suspected pregnancy only at about eight weeks of amenorrhoea and told her sexual partner. He said he would not marry her because nobody would agree to such a match. He gave her Rs. 800 and asked her to go home and go to a hospital.
Anjana informed her mother and grandmother about this. Her mother advised her to go to a local hospital. The pregnancy was confirmed and the local hospital referred her to the tertiary care centre. Because her mother was sick, Anjana could not come to the clinic for another three weeks. When she finally reached the hospital, she was told that she would require 1200 rupees to undergo an abortion. She went back and took two weeks to make arrangements for the additional money. By this time, she was in the second trimester.

The above case study illustrates how in the absence of adequate information about reproductive and sexual health, women may take several weeks to suspect pregnancy and still further time to ascertain it. This causes delay right at the outset in seeking abortion. This case study also illustrates intimate partner violence in the form of the man's refusal to use condoms as well as in deceiving the woman with false promises. The need for seeking an abortion arose directly due to these factors. These difficulties are exacerbated by poverty and lack of availability of affordable abortion services, which combine to cause delay in seeking abortion.

7. BOX: DEBUNKING MYTHS ABOUT ABORTION

Myth: Consent of the husband/mother-in-law/father-in-law is required in order to get an abortion

[4] This is reiterated by the Comprehensive Abortion Care: Training and Service Delivery Guidelines (MoHFW, GoI, 2010). The guidelines state that "MTP should not be denied irrespective of the woman's decision to refuse concurrent contraception."

Fact: *The law does not require consent/signature of the woman's spouse to be taken for an abortion. According to Section 3(4) (b) of the MTP Act, 1971 only the consent of the pregnant woman is an essential requirement for proceeding with the termination of pregnancy. Only in case of a girl below 18 years of age, or for a woman who is mentally challenged, the guardian's consent is required.*

Myth: Abortion is only legal until the first three months of gestation

Fact: *As per the MTP Act 1971, abortion can be carried out until 20 weeks (5 months) gestation. However, MTP between 12 and 20 weeks (3 to 5 months) can be only be carried out with the additional and independent confirmatory opinion of a second registered medical practitioner.*

Myth: It is mandatory to get a tubal ligation or IUD otherwise abortion cannot be provided

Fact: *The doctor cannot enforce a concurrent contraceptive procedure such as Tubal Ligation (sterilization) or insertion of an Intrauterine Device along with an abortion. The law does not require any such method of temporary or permanent contraception to be performed in addition to abortion unless the woman herself wishes it.*

Myth: Medical abortion is unsafe/ Medical abortion results in more loss of blood than other procedures

Fact: *Medical abortion is one of the safest abortion techniques when carried out under the guidance of a qualified medical practitioner (MoHFW, GoI, 2010). It is convenient, as abortion occurs after the administration of the dosage within the privacy of one's home. This procedure does not require extended hospital stay unless the woman chooses it. There is a misconception that medical abortion causes excessive bleeding, but this also is not true. Some bleeding after the procedure is complete is normal and is also the case for other abortion techniques such as D&C.*

Myth: Emergency Contraception is the same as Abortion

Fact*: No, emergency contraception is used within 72 hours of unprotected sex in order to prevent conception from taking place. Hence, it is not the same as abortion.*

Myth: Abortion is murder

Fact: *Abortion is not murder as it is legal when conducted within prescribed limit of gestation by a qualified registered medical practitioner, in a place approved for that purpose. An illegal abortion is punishable under the law but the charge brought down is not that of murder.*

SEX DETERMINATION AND SEX SELECTION

1. WHAT ARE SEX DETERMINATION AND SEX SELECTION?

Sex determination: The use of pre-natal diagnostic techniques, which are meant for detecting genetic abnormalities, metabolic disorders, chromosomal abnormalities, certain congenital malformations or sex-linked disorders, to determine sex of the foetus is termed as sex-determination.

The Preconception and Prenatal Diagnostic Techniques Act, 2003 includes in this ambit procedures such as ultra-sonography, foetoscopy, taking or removing samples of amniotic fluid, chorionic villi, embryo, for conducting pre-natal diagnostic tests to determine sex of the fetus.

Sex-selection: As per the PCPNDT Act, sex selection includes "any procedure, technique, test or administration or prescription or provision of anything for the purpose of ensuring or increasing the probability that an embryo will be of a particular sex."

This includes procedures which may be performed pre-fertilization, and post-fertilization. Pre-fertilization procedures include flow cytometry (separation of X-bearing and Y-bearing spermatozoa). Pre-implantation procedures include biopsy of one or more cells from a developing embryo and discarding those embryos of the undesired sex.

Note:

The PCPNDT Act does not mention abortion as a method of sex-selection, but other documents such as the ACOG statement on sex selection as well as the UN Interagency statement both take into account the use of abortion as a method of sex selection. It is important to remember that the PCPNDT Act does not outlaw abortion (see Q. 6) but only criminalizes sex determination, irrespective of whether it is followed by an abortion. For instance, if after sex determination the foetus is found to be male and the pregnancy is carried to term, this action is still criminal under the PCPNDT Act.

In this document, we will use the terms sex determination and sex selection in the sense that they have been used in the PCPNDT Act.

2. WHY IS SEX DETERMINATION AND PRE CONCEPTION SEX SELECTION AN ISSUE?

Sex Determination and preconception sex selection is the overlapping effect of three factors:

- Deeply entrenched son-preference and discrimination against women in society
- A highly commercialized and unregulated private health sector
- Easily available and undetectable technology for sex determination and sex selection.

The practice of son-preference is said to be driven by both religious/cultural and economic factors. In Indian society, it is the son who bears the family name and provides for the parents throughout their lives. The practice of dowry further adds economic incentive for wanting to have sons. Despite the fact that dowry is outlawed, the practice has not only survived, but has in fact taken on even greater proportions in recent years. Getting a good dowry can therefore enhance the economic status of the groom's family and therefore having a son is clearly a 'good investment'. Women, on the other hand, need to be provided for and do not yield any benefits to their natal family. They are therefore seen as a 'bad investment'. Apart from these economic factors, there are strong religious beliefs which perpetuate the need for producing a

male child. Among Hindus for instance, certain funeral rites can only be performed by sons, without whom salvation cannot be achieved. (Macklin 1995)

In a society where there is no son-preference, the mere availability of technology does not warrant its misuse for sex determination and sex selection. If there was greater regulation of the health sector, doctors could not have connived in the misuse of technology and caused widespread popularization of sex determination and selection.

A study by Mary John, et al, (2009) argues that misuse of medical technology to eliminate the birth of girls has brought to fore the phenomenon of 'daughter-aversion' which goes alongside the age old son-preference in our society. This study depicts how and why families are making the transition from wanting to have sons to actively planning to not have daughters, aided by medical technology.

The coming together of these three factors was exacerbated by the small family norm pushed for by the population policy. Family planning strategies have translated into planning to not have daughters. Sex determination and sex selection are seen by doctors and families alike as a means of controlling the population by ensuring the desired family size and composition.

The use of medical techniques for conducting sex determination and sex selection constitutes a form of discrimination against women. One of the reasons why it is increasingly being considered a concern is because of the falling sex ratios associated with our country. However, falling sex ratios are symptomatic of the environment in which women exist, and a reflection of devaluation of women in our society. A society that devalues women will also display discrimination and violence against women throughout their lifespan.

As discussed earlier, the practice of this particular form of discrimination has been enabled by connivance of doctors and could not have become so widespread otherwise. Hence the Preconception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act, 2003, was passed in order to put the onus of responsibility of preventing this form of discrimination on doctors.

3. WHAT IS THE PCPNDT ACT? WHAT ARE ITS MAIN FEATURES?

The Pre-Conception and Pre-Natal Diagnostic (Prohibition of Sex Selection) Act, 1994 (Amended in 2003) is a legislation enacted to prohibit the use of sex determination and sex selection techniques both before and after conception. The Act when passed in 1994 only prohibited prenatal sex determination techniques, but was amended in 2003 to include preconception techniques as well. The amendment was made taking into consideration the advancement in medical technology wherein it became possible to manipulate the process of fertilization due to advanced Assisted Reproductive Techniques.

- ***Regulation of prenatal diagnostic techniques:***

The Act regulates the use of pre-natal diagnostic techniques by categorically enumerating the purposes for which these techniques might be undertaken such as for detection of chromosomal abnormalities, genetic metabolic diseases, haemoglobinopathies, sex-linked genetic diseases and congenital anomalies. In all the above cases, the medical practitioner should record in writing the reasons for use of prenatal diagnostic techniques.

- ***An absolute prohibition of the use of sex selection techniques:***

The Act provides a broad definition of sex selection so as to include any procedure, technique, test or administration or prescription or provision of anything for the purpose of ensuring or increasing the probability that an embryo will be of a particular sex

- ***The Act also specifies the medical personnel who may conduct tests and other pre-natal diagnostic processes***

- ***Registration of facilities:***

The Act requires registration of all hospitals, nursing homes clinics or centres which provide pre-natal diagnostic techniques or services of genetic counseling. Failure to register is a punishable offence under the Act. The Act categorically states that even a vehicle which has an ultra sound machine and an imaging machine or any other equipment which may be used for sex determination also needs to be registered. The registration is meant to be obtained through an 'appropriate authority' assigned under the Act.

- ***Record keeping:***

The Act requires facilities to keep records of every ultrasound performed along with details of the client. Failure to maintain appropriate records is also punishable under the law.

- ***Offences and punishments:***

Offences under this Act are cognizable, non-bailable and non-compoundable.

This Act makes it an offence for any person or organization to advertise or communicate in any form, the availability of facilities for sex determination or selection at any genetic counselling centre, clinic, laboratory, or any place having an ultrasound machine or any technology capable of prenatal sex determination or sex selection. The punishment for this offence is imprisonment up to three years and fine up to Rs. 10,000/-.

Any medical geneticist, gynaecologist, registered medical practitioner or person owning or employed in any clinic, laboratory or centre where these facilities are advertised or made available is culpable under the law. The punishment is the same as above at first conviction. Upon subsequent conviction, the punishment is imprisonment up to five years and fine up to Rs. 50,000/-. Additionally, the name of the registered medical practitioner will be reported to the state medical register for necessary action. This includes suspension of registration while the case is being conducted. If convicted, the practitioner's name can be removed from the register for a period of five years at first offence and permanently upon subsequent convictions.

Any person who seeks the aid of any medical geneticist, sinologist, gynaecologist, registered medical practitioner or any other person or clinic, laboratory, counselling centre or any other such place for the purpose of conducting sex selection or sex determination, is liable to three years imprisonment and a fine up to Rs. 10,000/-. Upon subsequent conviction, the punishment is imprisonment up to five years and fine up to Rs. 1,00,000/-.

Unless otherwise proved, the court shall presume that the woman who undergoes sex determination or selection was compelled to do so by her husband or any other relative, and such a person will be held liable for abetment of the offence and the given punishments will apply.

The Act also provides that whoever contravenes any other provision of the Act or rules made under it, for which no punishment has been provided elsewhere, to be liable for imprisonment up to three years and fine up to Rs. 10,000/- or both, and in case of continuing contravention, an additional fine of Rs. 500/- for every day after the first contravention is convicted.

The Act recognizes the liability of companies in contravention of its provisions and provides for punishment in accordance with the offence.

4. DO THE MTP ACT AND THE PCPNDT ACT CONTRADICT EACH OTHER?

No, the two laws do not contradict each other and in fact regulate completely different procedures.

The MTP Act specifies the conditions in which abortion is legal, where, by whom and with whose consent abortion can be performed. The PCPNDT Act, on the other hand regulates the use of pre-natal and preconception diagnostic techniques. The law criminalizes the use of preconception methods to select foetal sex and the conducting of tests to determine the sex of the foetus.

It is important to note that the PCPNDT Act does not criminalize abortion. In fact, it does not even mention abortion. It only talks about techniques to identify or select sex of the fetus. The attempt of a person to identify the sex of the foetus irrespective of whether it is undertaken for the purpose of abortion is a punishable offence under the Act.

5. DOES THE LAW PUNISH WOMEN WHO RESORT TO SEX DETERMINATION OR SEX SELECTION?

The woman resorting to sex determination or sex selection is not held guilty under Act. Women are invariably under family pressure to bear a son. Taking this into account, the Act does not criminalize women who resort to sex determination or selection.

Instead, the Act puts the onus of responsibility on doctors and persons who run facilities that provide prenatal and preconception diagnostic techniques in their role in perpetuating this discriminatory practice. The Act specifies that husbands or relatives who either encourage or seek to conduct pre-natal diagnostic techniques to identify the sex of the foetus are punishable under the Act.

6. ARE SEX DETERMINATION AND SEX SELECTION A PROBLEM INDEPENDENT OF THEIR IMPACT ON SEX RATIOS?

Yes, sex determination and sex selection are a problem because these practices are used to perpetuate discrimination against girls which is deep-rooted in our society. Whether or not they have a significant impact on sex ratios of the country, these practices continue to be problematic.

While sex ratios are among the indicators of gender equity in society, it should be remembered that sex ratio, i.e., number of women per thousand men in the population is calculated for different age groups and that each sex ratio is affected by different factors. Of these, the sex ratio at birth is the only one that can be influenced by sex determination and sex selection techniques. (Ravindran 2012) There are, however, other factors which affect sex ratio on the whole. This is evident in the fact that the sex ratio declined sharply between 1901 and 1971 when there were no sex determination tests available. But between 1971 and 1991, after the advent of sex determination tests, the sex ratio fell only by one point ie from 930 to 929 females per 1000 males. This means that there were several other factors affecting sex ratios even before the advent of medical technology to assist this phenomenon. (Macklin 1995)

7. IS IT ENOUGH TO FOCUS ON DECLINING SEX RATIO?

As discussed above, it is discrimination that is at the heart of the problem. Therefore, measures taken to address this situation must focus on eliminating gender discrimination. Equalizing the sex ratio does not automatically translate into a more gender-just society. Discrimination against women and girls always existed in our society even when sex ratios were higher than they are at present.

If the issue is seen in isolation, the measures taken will only focus on ensuring that a ‘sufficient’ number of baby girls are born. This will inevitably involve approaches that are intrusive (more on this in the next section) of women’s reproductive choices and will impinge on their access to abortion. However, such

measures will neither ensure that girls are more valued in society, nor will they counter the discrimination and violence that girls and women face throughout their lives.

ISSUES OF CONCERN

In recent times, especially in India, there has been a growing concern regarding falling sex-ratios. Governments and civil society organizations alike have, in good faith, tried to curtail the problem of sex-determination through restricting abortions. There is tremendous confusion between the MTP Act and the PCPNDT Act among service providers, policy makers, activists and people at large. As discussed earlier, a woman may seek an abortion for a host of other issues around preserving her health other than sex-selection. The argument that that restricting access to abortion will lead to an improvement in the sex ratio, has no merit. This section looks at precisely these areas of intersection and confusion between abortion and sex selection.

1. WHAT ARE SOME OF THE REASONS WHY PEOPLE CONFUSE ABORTION WITH SEX DETERMINATION AND SELECTION?

There are several reasons why this confusion occurs. The entire issue of sex-selection has been constructed as an issue of the 'rights of the unborn child' or 'saving the girl child', rather than from the perspective of eliminating discrimination against women. This discourse leads people to believe that it is the act of abortion that is wrong and not the daughter aversion. This is reflected in the language and imagery in the IEC material, which is the source of misinformation.

i. Lack of information on legality of abortion vis-à-vis sex determination and sex selection:

There is little or no information among lay people about the fact that abortion is legal in India. The aggressive campaigning against sex selection and the ambiguity regarding legality of abortions often foster an understanding that all abortion is conducted with the purpose of sex selection and is therefore illegal.

ii. Use of anti- abortion language:

Language plays an important role in disseminating information. Terms such as 'foeticide' are used to describe sex-selection which translates to 'killing the foetus', thereby casting abortion itself in a negative light. Terms like '*paap'* (vice) which are moralistic are also employed. The use of pejorative terms like *'kanyabrunhatya'* (female foeticide), '*garbhasthya shishu ki hatya'* (killing the child in the womb) in local dialects has also limited the understanding of abortion to only include sex selective abortion. The use of terms like 'infant, child, *shishu*,' convey personhood, and the implication that abortion is equal to the act of killing a child. (Nidadavolu V., 2006)

iii. Personification of and violence against the fetus:

The IEC material provided by various agencies including the State, NGOs, Civil Society organizations, etc tends to confuse the issues of sex selection and abortion, by personifying the fetus and depicting violence against it. Many of these posters and pamphlets depict images of a foetus being squeezed by a fist, or knives stabbing the foetus, with the foetus depicted as crying out "*garbh mein mujh bachchi ko mat maro" (*don't kill me, the girl child, in the womb). Such images give personhood to the foetus and then imply that abortion equates murder. Also these do not speak of the conditions under which is abortion is legal. The literature denouncing sex selection is intended to induce fear and is hence unclear in terms of legalities. However, core issues of gender discrimination which make sex selection a problem are not conveyed.

2. WHAT ARE SOME OF THE WAYS IN WHICH THE GOVERNMENT HAS TRIED TO RESTRICT ABORTION IN THE BID TO CONTROL SEX SELECTION?

With the increasing concern about falling sex ratios, there have been several knee jerk reactions that the government has resorted to in the bid to control sex-selection. Some of these measures are:

- Making it mandatory to take permission of the state before performing an abortion: In Nagpur and Latur in Maharashtra, the municipal corporation issued an order that expected abortion clinics to take permission from the corporation prior to performing an abortion (Times of India, 13th July 2011).

- Equating abortion with murder: After female foetuses were found abandoned in June 2012, a court has responded by charging 16 persons, including the doctors responsible for carrying out sex selective elimination, along with the women and their families, with murder (Times of India, June, 2013). This step takes away focus from sex-selection, which is the problem, and will only serve to criminalize abortion by equating it with murder.

- Proposal to restrict gestational limit for abortion: There has also been news that the time-frame for abortion will be reduced to 10 weeks, ostensibly to check sex-selective abortions. Such measures will only impede women's access to safe and legal abortion. Secondly, there are several other sex-determination (including pre-conception) techniques available which make sex-determination possible even sooner than 10 weeks and hence reducing the time frame of abortion is redundant.

- Proposal to increase documentation: For instance, in the case of second trimester abortions it has been proposed that pictures of "abortus" that indicate the sex of the fetus should be preserved by doctors.[5]

- Restricting access to medical abortion pills: There has been a crackdown on chemists, who have stopped stocking the pills due to increased burden of documentation and fear of inspections. An eight-city study by IPAS found that over half the chemists surveyed have stopped stocking on the pills and in Mumbai, not a single chemist could be found selling it. (Times of India, April, 2013).

The lines between access to abortion and prevention of sex-selection seem to have blurred. Such moves are more likely to exclude the most vulnerable women – ones who were unaware of their pregnancy status or were unable to reach services – from the purview of access to safe abortion.

3. HOW HAS THIS AFFECTED THE AVAILABILITY OF ABORTION SERVICES?

The pressure to curb sex selection has had repercussions on the availability of abortion services. The crackdown on chemists for instance, has had an impact on availability of medical abortion drugs. In Maharashtra, an eight-city study found that over half the chemists surveyed have stopped stocking on the pills and in Mumbai, not a single chemist could be found selling it. (Times of India, April, 2013). There is also a lack of drugs like Ethacridine Lactate which are used in conducting second trimester abortions.

The medical fraternity too, under pressure to curb sex-selection, has further restricted access to abortion. Individual providers are reluctant to perform second-trimester abortions. In a study conducted by CEHAT in Maharashtra, District Level Committee members spoke of second trimester abortions not being provided even in public hospitals, as it is difficult to ascertain whether they are for the purpose of sex-selective elimination or not. Individual private providers too are reluctant to carry out second trimester abortions because of the legal hassles involved. Particularly when the woman already has daughters, there is a fear that the abortion being requested may have followed a sex determination test and the doctor would be held liable.

[5] These recommendations were made by the Oak Committee in September 2011, which was formed by the Govt. of Maharashtra, in order to address the problem of sex-selection and illegal abortions.

"I don't mind helping a genuine case. She had two daughters already and wanted an abortion at 16 weeks. How do I know if she had an ultrasound done elsewhere? I may get caught. If my name gets into the newspaper, my reputation will be gone. After 15 years of good practice, why take such a risk just for some money?" (Gynaecologist, private practice, quoted in Dalvie, 2008)

Hence, they prefer to not do these abortions at all. The ultimate impact of this is borne by women who seek late abortions and as it has already been discussed above, these women are often the most vulnerable.

4. WILL RESTRICTING SECOND TRIMESTER ABORTIONS PREVENT SEX SELECTIVE ABORTIONS?

Merely outlawing second trimester abortions or implementing other restrictive measures will not eliminate the deep-rooted bias and discrimination against women in our society, of which sex determination and selection is only a symptom. Hence it cannot have any impact on dwindling sex ratios or on this discriminatory misuse of medical technology.

community based studies in West India have estimated that among married women, the proportion of sex-selective abortions to abortions for other non-medical reasons is between 2.5% and 17% (WHO, 2011). This goes to show that there are a whole range of other factors affecting women's decisions to undergo abortions and sex selective abortions are not the major chunk of them.

Further, there are tests to determine sex of the foetus earlier in the gestation period, such as Chorion Villus Sampling which makes it possible to detect the sex of the foetus within the first trimester as well. Therefore targeting second trimester abortions is not likely to have any effect in terms of preventing sex selective abortions.

Lastly, sex selection can also be conducted prenatally, as discussed earlier. Restricting second trimester abortions can have no impact on this.

5. WHAT CAN BE THE IMPACT OF MEASURES THAT RESTRICT ACCESS TO ABORTION?

Such measures will only serve to put women at risk and lead to flourishing of illegal/unsafe providers. If women are forced to seek unsafe abortions, they will be at risk for increased morbidity and/or mortality. It may lead to a situation similar to that before the MTP Act of 1971 was enacted, when abortion was a criminal offence and as a result, women resorted to unsafe methods, leading to high maternal morbidity and mortality. In fact, as of now, unsafe abortions are said to be the third most common reason for maternal deaths and contribute to 8% of maternal mortality. If access to abortion is further restricted, the numbers are likely to increase. The recent Interagency Working Group Statement of the UN bodies (WHO, 2011) draws attention to this problem very succinctly: *"Restricting access to technologies and services without addressing the social norms and structures that determine their use is therefore likely to result in a greater demand for clandestine procedures which fall outside regulations, protocols and monitoring. Discouraging health-care providers from conducting safe abortions for fear of prosecution thus potentially places women in greater danger than they would otherwise face. It is clear that, while intending to effect a common good, restrictive laws and policies implemented in isolation from efforts to change social norms and structures can have unintended harsh consequences, and may violate the human rights of women."*

6. WHY IS TRACKING PREGNANT WOMEN NOT AN APPROPRIATE APPROACH?

Tracking pregnant women is an infringement upon their right to make their own reproductive choices and control their own fertility, and also a breach of privacy and confidentiality of information.[6] Given the difficulties that women face in accessing abortion, such an approach will amount to a breach of confidentiality and create yet another barrier to safe and legal abortion services. For most women, privacy remains the foremost priority in choosing an abortion facility, due to the stigma that society attaches to it. In fact, women often access abortion facilities in neighbouring towns and villages for the sake of maintaining confidentiality. They incur great costs and prefer going to private providers for the same reason. (Gupte et. al, 1999) In the case of unmarried young women this need is even more pronounced due to the additional stigma associated with premarital sex (Jejeebhoy, et al, 2010). If the tracking of pregnant women is implemented, many abortion-seekers will be pushed to unsafe and unqualified providers. This will not only endanger women's lives but also make the approach counterproductive.

7. WHAT IS THE WAY TO ADDRESS SEX DETERMINATION AND SEX SELECTION WITHOUT COMPROMISING ACCESS TO SAFE AND LEGAL ABORTION?

The problem of sex determination and selection brings to fore the rigidly entrenched patriarchal structures in society. It cannot be tackled without addressing societal norms that discriminate against and dis-empower women. The only way to address this issue is to challenge son preference and the resultant daughter aversion by striving to improve the position of women in society. In order to eliminate daughter aversion, it is essential that the social worth of women be increased. While doing so it is imperative to remember that preserving the access to abortion and curbing sex selection are actually not antithetical to each other, but are part of the same endeavour to strengthen women's rights and control over their lives and bodies. The Inter Agency Working Group statement on preventing gender biased sex selection (WHO 2011) emphasizes the need to look beyond legal prohibitory measures. It states: "*Prohibitive legal responses should be seen as a demonstrable attempt on the part of government to redress sex-ratio imbalances, based on the hypothesis that combating the use of technology for non-medical reasons will lead to a rapid halt in sex selection. Yet there is wide agreement that the causes of biased sex selection lie in gender-based discrimination, and that combating such discrimination requires changing social norms and empowering girls and women. These long-term processes will require sustained effort and political commitment."* Indeed, the prohibition of sex-determination in India is a positive step, but it will not, in itself, address the root cause of gender-based discrimination against women and girls. Legislation has its limitation, and what is required is a more concerted affect at various levels of society to change the paradigm of son preference and daughter aversion.

Following are some of the measures that can be taken at various levels:

(I) At the level of community:

1. Creating awareness on the difference between abortion, and sex determination and selection:

There is a need to create IEC material that clearly mentions the legality of abortion and illegality of sex determination and selection. It is important that the two issues be depicted as separate ones. The fact that abortion is legal until 20 weeks of gestation, and places where services can be availed must be publicised, so as to increase information among women. There should be no use of moralistic tones in the material. The narrow view of abortion that depicts all abortions to be sex selective abortions should also be challenged. Along with this it is critical that information about contraception is provided so that future unwanted pregnancies can be prevented.

[6] It is important to make a distinction between tracking women with the purpose of providing entitlements (such as antenatal care) and shadowing them in order to ascertain whether they resort to abortion or not. The former is a way to ensure access to services where women have the right to opt in or opt out of the services, while the latter is an infringement on a person's reproductive choices.

2. Education on sexual and reproductive health and sexuality:

Measures should be taken to break the social taboo on topics of sexual and reproductive health and sexuality by educating young people, especially women, about their own bodies and about safe sex practices. Information about planning pregnancies and use of contraception can prevent unwanted pregnancies and are an integral part of reproductive health education.

3. Ending discriminatory practices that devalue women in society:

Measures taken to strengthen women's worth in society should not stop at increasing their access to education and resources. Till such time as daughters are seen as a burden on their natal families because of practices such as dowry, the social compulsion of getting a daughter married and the high cost of marriage of a daughter, daughter aversion will continue in society. There is need for such practices to be challenged at the level of the community so that bringing up a daughter is no longer seen by parents as a "bad investment." There must be greater awareness about the fact that daughters too have a right to property based on the reformed law. There must be joint ownership of property between the husband and wife.[7] Communities must be encouraged to report those who take/demand dowry, as it is a crime as per the Dowry Prohibition Act. The Protection of Women from Domestic Violence Act clearly states that pushing a woman to have a male child constitutes domestic violence. Communities must be made aware of this and must be encouraged to take action when women are pressurized to undergo sex-determination tests.

(II) At the level of policy-making:

1. Steer clear of initiatives that restrict abortion:

Policies to curb misuse of medical technology should be wary of any move that could adversely impact access to abortion. As we have seen earlier, women face significant barriers in accessing legal and safe abortion services, which could be compounded by attempts to restrict abortion services in a bid to control sex determination.

2. Enforce laws that strengthen women's rights:

While there should be more stringent implementation of existing laws for regulation of medical technology, it is not enough to only take regulatory measures. Since sex determination and selection is linked to discrimination against girls and women and the resultant daughter aversion, policy measures should simultaneously focus on protecting women's rights by enforcing laws such as prohibition of dowry, bringing in legislation for women's right to inheritance and laws to prevent and tackle violence against women in both domestic and public spheres. Daughter aversion will decline only by strengthening women's position in society; hence the need for policy measures to address the issue of gender discrimination.

(III) At the level of campaigning:

1. Never use anti-abortion language:

Campaigns for prevention of sex determination and selection should not make use of terminology such as "*bhrunahatya*" (killing of the foetus), "female genocide", "female feticide", "elimination of

[7] In November 2003, a Government Resolution was passed in Maharashtra which instructed all panchayats to register residential property jointly in the names of husband and wife. Through the initiative of MASUM, more than 80 per cent of houses in Purandar taluka in Maharashtra are registered jointly in the names of couples. *Ref: V.Radhika, "Yeh tera ghar ye mera ghar". Hindu Businessline, September 23, 2005. http://www.thehindubusinessline.com/todays-paper/tp-life/yeh-tera-ghar-yeh-mera-ghar/article2205102.ece*

female foetuses", "missing girls" etc., because this approach leads to personification of the foetus and casts the issue in the light of violence against the foetus. While such an approach has emotional resonance with people, it is ultimately counterproductive because such language equates abortion itself with murder and leads to confusion between the two issues.

2. Address the issue as one of discrimination against girls and women: campaigns should recast the issue of sex determination and selection within the larger framework of discrimination against women and girls, rights and start a wider discussion on the link between misuse of medical technology and the violence that girls and women face in various spheres throughout their lives. For instance, a campaign can highlight that in a patriarchal society, sexual violence against women and the subsequent perception of loss of family honour are seen as reason enough to avoid having daughters.

3. Do not reinforce gender roles:

Campaigns should also avoid use of messages which glorify the traditional roles of women in society as a justification for having daughters; as also fear mongering that if girls are not allowed to be born in the present, there will not be enough brides for young men in future. This approach is deeply problematic because it counts women's worth only in terms of their utility as wives and mothers and not as human beings with rights.

4. Address other issues of women's rights, including abortion:

It is urgent that the campaigning against sex determination and selection should ally with other campaigns for women's rights, particularly abortion, which is not currently a right in our country. Given that access to abortion is conditional and can be easily hampered by knee-jerk reactions in the name of preventing sex selective abortions, campaigns against sex determination and selection should take an explicit position on the issue that protecting the rights of women in one sphere should not lead to curtailment of their rights in another.

(IV) At the level of health system:

1. Impacting medical education:

There is a need for building perspective within medical education on social issues such as gender discrimination, value clarification on abortion and the role of medical practitioners in preventing sex determination and sex selection.

2. Regulation of private sector:

Regulation of the large private health care sector is an important step that needs to be taken in order to curb the widespread abuse of prenatal diagnostic technologies for sex determination as well as flourishing of preconception sex selective technologies.

3. Increasing provision of abortion in public sector:

Simultaneously, there is need for increasing the capacity of the public health sector to provide safe abortions in accordance with the provisions of the MTP Act. This will ensure that abortion remains accessible to large sections of the population.

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