ABORTION IN INDIA

A SOCIOLOGICAL STUDY

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CERTIFICATE

This is to certify that the dissertation titled "**ABORTION IN INDIA**" – *A **SOCIOLOGICAL STUDY***" has been submitted by ***Prarthi Sharma*** in partial fulfillment of the requirement for the award of the degree, Master of Philosophy. This dissertation has not been submitted for any other degree to any other university and is her own work.

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Dedicated

to

My Mummy

the Pillar of Strength

in My Life

whose Love, Affection and Trust for Me

keep Me on the Right Track

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Date 25.July '05

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INTRODUCTION

THE PROBLEM

Since the late 1960s, the issue of abortion has shifted position from an illicit, clandestine activity to one, which is legal and open. It has moved from being a verbal taboo to being a frequent topic of conversation. It has become visible, no longer hidden. While this transition has been uneven across the various segments of the society and has emerged out of bitter and emotional controversy, it has been indeed dramatic. Moreover, despite this, the fact remains that abortion continues to evoke controversies. The issue of abortion is one of the most debatable issues these days because of various reasons. The arguments against and in favour of abortion commonly originate from theological sources on the one hand, and scientific sources on the other. Part of the reason for the position of this controversy, among others, in the general public consciousness is that it has implications affecting the moral value of the human life, the source of that value, and the question over when human life begins at conception, at birth or at some point in between. There are arguments over the difference between living beings in general and persons, what constitutes personhood as an entitlement to rights, and so on. Taking a look at the issue from global perspective, it becomes apparent that the ways in which these debates develop are fundamentally shaped by the cultural context in which they are held.[1]

In India the issues related to abortion are shaped by the socio-historical and cultural context. As we know India is a large country with cultural diversities. Abortion for Indian society is not only a moral and ethical question but also a question of women's health and rights. In the Indian context, this issue has to be understood on five grounds, viz. the socio-historical context, as a women's health issue, as a women's rights issue, and as family planning method.

[1] D. Reidel (1984).

Apart from this, another issue, which is recently emerged, is the issue of sex selective abortion. Sex selection is not a new phenomenon for Indian society; it has a vast history, which needs to be explored.

In India the state has never understood abortion as a question of rights, but rather as an issue of women's health. This standpoint of the state derives from the condition of women in the Indian context. The conception of western feminism about abortion could inform Indian feminism, but in reality it cannot be applied in the same way because of the position of Indian women is different from that of their western counterparts. Given the fact that in India itself the conditions of Indian women varies from community to community, we can define the key structural variables determining women's conditions and their decision making power as family, caste, class community, region, and spatial considerations like rural and urban backgrounds.

In India abortion is legalized by Indian Constitution through the Medical Termination of Pregnancy Act 1971 (M T P Act). It has been over three decades back that India officially de-criminalized abortion. Before that abortion was a crime or sin for which the mother as well as the abortionist could be punished in all cases except where the abortion had to be induced in order to save the life of the mother.[2] This legislation can therefore be seen as a gender progressive legislation, by which Indian women are enabled to rid themselves of the liability of unwanted pregnancies in spite of poor health.

It needs to be understood however that the MTP Act, though a beginning in the direction of giving opportunities to women to terminate unwanted pregnancies, is not adequate in the way it is defined. The restrictive definitions of the MTP Act, specifying what provider in which facility is recognized as a legitimate provider of abortion services, the undue focus on public sector providers, never particularly known for either efficiency or sensitivity; the plethora of regulations governing private sector providers, itself with an indifferent record; and turning a blind eye to informal service providers – be they traditional healers or otherwise qualified personnel without

[2]Chandrashekher. S (1974).

a medical degree – implied that most women continued to rely on the services of those outside the pale of the legal framework.

For years, it was insufficiently realized that a vast majority, well over ninety percent, of abortions continued to take place outside the legal framework. Whatever the ethical and moral feeling professed by society as a whole on the question of induced abortion, it is an incontrovertible fact that a large number of women in India are prepared to risk their lives in an illegal abortion rather than carry that particular child to term.[3] Consequently, we have little idea about either the quality/safety of these services or information on what is happening to the women. Evidently, there is little concern as long as family planning targets were being met.[4]

In India the perception of the issue of abortion, and its legislation, reflects a general insensitivity about women, including their reproductive health. Hardly any effort was made which centered on the liberalized regimen defined by the MTP Act, and not enough attention was paid to whether the techniques are risky, and the conditions under which women underwent abortion.[5]

The availability of new medical technologies to detect abnormalities in the fetus dramatically changed both the situation and public concern, more so once it was realized that these tests (amniocentesis, ultrasound) also helped discover the sex of the fetus. Suspicion deepened that, in the guise of testing the health of the fetus, the girl child was being eliminated in the womb. A combination of easy access to abortion facilities, and the availability of new medical technologies arguably helped contribute to an alarming increase in sex selective abortions.[6]

India, like the rest of South Asia and China, has long been marked by a son preference, more correctly, a deep-seated bias against women. It comes as no surprise that unlike much of the developed, western world, the sex ratio in the country is dangerously tilted against women. While the sex ratio at birth is nominally in favour

[3] Ibid p. 11-14.
[4] Coyaji,Banoo J (1994).
[5] Saha,Shelley (2000).
[6] Devendra, Kiran (1993)

of boys, i.e., more boys are born as compared to girls worldwide, in the first year after birth; the girl child has a greater natural propensity to survive. Thus, in situations of gender parity, women should in due course equal or slightly outnumber men.[7]

To understand the issue of abortion in Indian context, we need to understand the women's reproductive health issue with gender power dynamics in the patriarchal social structure of Indian society.

THEORETICAL CONSIDERATION

Abortion is a sensitive issue impacting crucial aspect of women's reproductive health and rights. As it is a reproductive freedom has been a major demand of the women's liberation movement for most of its existence, as well as one of its most controversial issues. Although reproductive rights include an entire gamut of the issues, such as sex education, access to contraception and an end to forced sterilization of the poor and minority women, at its core is the question of abortion.[8] Controversy over abortion preceded the women's movement by many years, and feminists did not initiate its resurgence as a contemporary issue. The American Civil Liberties Union was the first National Organization to support it publicly, in 1965, and the ACLU has sponsored the key court case since then. National organization to repeal abortion laws have developed independently of the feminist issue movement, but the issue has nonetheless become thoroughly identified as a feminist issue. Consequently, an argument that was originally expressed in term of the right to privacy and medical safety is now primarily debated in term of a women's right to control over own body.[9]

Reproductive health encompass a range of health concerns, as indicating in the consensus definition emerging from the 1994, International Conference in Population and Development (ICPD) at Cairo.

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[7] Amniocentesis or Female Foeticide. (1987).
[8] Nadean, Bishope (1984).
[9] Ibid. pp. 39-53

Specifically, Reproductive Health is defined as:

"a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process" (U N 19994).[10]

According to the WHO definition:

"reproductive health is the ability to have a safe, responsible and fulfilling sex life, the freedom to decide if, when and how often to have children and to avoid to become ill or die due to reproductive cause"[11]

Reproductive health is based on the right of women and men to know about and obtain safe, effective, affordable and acceptable methods of family planning and the right of the women to have access to appropriate and good quality health services to enable them to have a safe pregnancy and birth. Still today, these rights are not respected worldwide due to ideological and political obstacles and also accessibility problem due to lack of health services or of poor quality due to economic restrictions. Reproductive health is severally jeopardized in poor country like India and women and their children lives are affected. [12]

Although the reproductive health problems, per se are rooted in the biomedical sphere, there origin often lie in human behavior that is embedded in socially and culturally constructed patterns of gender relations. These are, in tern, influenced by economic and political factors. It is theses behaviors- the practices in which individuals are engaged, the choice they make, their awareness of healthy practices, and their perceptions of what constitute acceptable behavior for men and women – that determine the extent to which women and men can attain 'state of complete physical, mental and social well-being'.[13]

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[10] Ganatra, Bela (2000).
[11] ibid. p.186-235.
[12] Mabel Bianc (2002).
[13] Ramasubban ,Radika, Shireen J.Jejeebhoy (2000).

From a gender perspective it is confirm that facts as coverage of reproductive health's needs varied between men and women. Gender is a socially constructed difference between men and women. The difference between sex and gender is that, gender is social and cultural in nature rather than biological. In most societies, gender predetermines different expectations about the appearance, qualities, behavior, and work appropriate for male or female. The social relations of gender are not determined by biological differences, however biological differences play role in social relation of gender.[14]

The three concepts of gender inequality are inequality in prestige, power, and access to control resources.[15] The concept of gender enables us to explain why women's health has received so little attention. Women traditionally have held a lower socioeconomic status and been seen dependent upon men.[16]In India, within the given socio-cultural matrix women get low access to health care. Women's lower status influences their health in many ways. Because of reduced access to education and information, they are often poorly informed about their health. This results in failure to recognize early symptoms of infection and disease, leading to chronic health problems. "Women's lower status in the family, where decisions regarding mobility and expenditures for health care are in the hands of men, it is not so easy for them to seek health care. It has also been widely recognized that women are treated in an inferior way by health care providers, and that they are therefore hesitant to seek treatment."[17]The biological aspects to women's health are influenced by the socio-economic and cultural context. There are various different ways in which the health risks faced by women are influenced by gender - by the socio-economic and cultural aspects of being female.

[14] Busfield J. (1996).
[15] Okojie CEE (1994).
[16] Vlassoff(1994).
[17] Ibid. 1249-59.

A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes, and indigenous and ethnic groups.[18]

The society of India is patriarchal; traditionally the men are superior to the women. The patriarchal structure of the societies in the third world countries prescribes an inferior or subordinate status for women in the society. Various institutions -religious, economic, political, social and legal - all of which emphasize women's inferior position in the society reinforce it. [19]Thus women are expected to be subordinate to men within and outside the household. Women's accesses to material resources were restricted, leaving them dependent on male relatives. All these have implications for women's health status and health behavior in the event of illness. [20] Women in India suffer extensive discrimination, being generally regarded as useful only for sex, reproduction, and housework. Although the constitution provides equal right for both sexes, the existing social norms and practices do not allow them to utilize it properly.[21]. In matters of marriage, divorce, maintenance and inheritance, women are deprived of equal rights. Violence against women within the family is not considered as a violation of women's basic dignity and human rights.[22] Women are frequently deprived of their human right to self-determination In India, both Hindu (80% of total population) and Muslim (20%) religions restricted the autonomy of women in different ways. Muslim women are subjected to the rules of Purdah (seclusion), which limits their mobility and education. Hindu women enjoy comparatively greater mobility, but they too are subject to prejudice and restriction.[23]

Women as social category cut across the boundary of caste and community, race, estate, etc social grouping. It should be keep it in the mind that in India women do not form a homogenous category. They belonged to diversify socio-economic groups and

[18] United Nations (1995),
[19] Okojie(1994)
[20] ibid, p. 1237-47.
[21] Kuntal Agarwal(1993).
[22] Ibid. p. 145-156.
[23] Visaria, L. (2000).

also divided in tem of spatial consideration like rural and urban.[24] The social and cultural factors which have vast influence on women in their health status and access to health care services include:[25]

- Socio-economic status of women
- Son preference
- Utilization of health facilities
- Barriers in decision making ,reaching and receiving treatment

Women's vulnerability rise from the physical environment where they live, their employment status and numbers of other factors. In the majority, origins of women's vulnerability are well established in factors related to gender. One of the most important factors which affect the maternal mortality in India is low social status of women. Their needs of health, education and employment are given the lowest priority. Women are married at a young age and undergo the trails of constant motherhood, besides the drudgery of household chores. [26]

The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health. Educational opportunities for girl and women powerfully affect their status and the control they have over their own lives, their health and fertility. The empowerment of women is therefore an essential element for health.[27]

The literature on excess gender discrimination has shown that son preference discriminated the family allocation of food and the access to health care services for girls in India. "Reasons given for families preferring sons to daughters include:[28]

- son maintain and extend the lineage
- sons inherit family property

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[24] Chanda, S.K (1996).
[25] Ramasubban ,Radika, Shireen J.Jejeebhoy(2000).
26. W.H.O (1996)
[27] Ibid
[28] Bhalla, Manisha ,(2004).

- they act as a hedge against financial disaster
- they provide support for parents in old age
- they farm the family land

Daughters on the other hand are considered as a liability for the family, because:

- They marry early and outside the family, any investment in them is lost to the family
- They contribute little to household expenses
- They require large dowries and expensive weddings
- They provide no support to the family of origin after marriage
- For these reasons, families preferred to have sons and to maintain them in good health since sons are considered as an asset for the family.

Women's access to health care is also influenced by restrictions on mobility and seclusion of women in the household. Costs and distance considerations are also inter-related with gender inequality. Furthermore, gender inequality in access to health care is reflected in women's unwillingness to go to hospital to deliver because it will disrupt household organization, there may be none to take care of older children or their husbands"[29]

Barriers in decision-making, reaching and receiving health care maternal deaths can be avoided significantly if women have access to emergency obstetric care. To obtain obstetric care, women with obstetric complications face a variety of barriers. Some of these barriers are cultural e.g. the low value places on women's lives. Some of the barriers are geographic e.g. long distance and poor communication, some are economic-e. g. lack of money to pay for transport and there are some socio-cultural barriers which causes these delays. The problem is not solely medical. Gender inequality affects women's timely use of health services. The subordinate status of women in society limits their autonomy in decision-making; it

[29] Okojie CEE (1994).

limits their access to transportation, and leads to discrimination in health care utilization. [30]

Gender differences in health in developing countries have, until recently, received little attention from researchers, health programmers and international development efforts. Even in the industrialized world, women's issues were not part of the overall health care agenda prior to the 1980s.[31]Women's health and maternal mortality is a particularly sensitive indicator of inequity, it display the status of women, their access to health care system in responding to their needs. Levels of maternal mortality in industrialized and low-income countries show a greater disparity than any other public health indicator.[32]

Among the indicators of the health of community - mortality, morbidity, and malnutrition – mortality is the most commonly employed. [33]

In India, maternal mortality ratio due to unsafe abortion is very high and is a major public health problem, not only due to the large number of such deaths, but, also due to the traumatic aftereffect of such an event on the family in particular and society in general.

Maternal mortality should not be viewed as a chance event so much as a chronic disease developing over a long period, for the outcome of a pregnancy is profoundly influenced by the lower status and circumstances of a woman's life.[34] Inadequate access to nutrition and health care in childhood, illiteracy and heavy burdens of domestic work all have damaging effects on women's general health, and therefore on their potential for healthy childbearing. Cultural and economic pressures towards early marriage and pregnancy compound these lifelong disadvantages.[35]

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[30] Ibid. 1237-47.
[31] ibid. 1249-59.
[32] AbouZahr et. al (1996).
[33]Hirve, Siddhi (2003).
[34] WHO (1989).
[35]Doyal L (1995).

As the women do not have autonomy and economic power, they do not have any influence on their families to make a decision in favor of her. Studies show that, though their situations are critical and they need emergency obstetric care, several women were refused to be referred to hospitals with such facilities because their husband was absent or the husband did not give permission for referral.[36] Most women realize the life danger for themselves or for the child, but the family members did not perceive such danger. It was indicate that reproductive health and rights in India accounted by social structural factor. [37]

To explore the question of abortion in Indian society the present study analyses the issue from four angles: in the context women' health issue; as an issue of women's rights or feminist discourse; from the point of view of son preference; and from the point of view of enforcement of small family norms through population policy.

OBJECTIVES OF THE STUDY

- To explore the socio-historical context of abortion.
- To examine to current situation and patterns of abortion in India.
- To analyze abortion with feminist perspective.
- The evaluation of Medical Termination of Pregnancy Act by feminist perspective.

METHOD OF THE STUDY

The methodology, for this study, broadly focused on approximating the various objectives by taking into consideration secondary sources. The modus operandi of undertaking his research, keeping in the mind absence of fieldwork and other limitations such as includes discussions with several academicians, lawyers, NGOs and other activists. The study has been bereft of any empirical investigation and has, therefore, relied essentially on secondary sources - Government of India releases, Institutional and annual reports of several NGOs, doctoral thesis and dissertation work

[36] Ibid, p, 1237-47.
[37] Pillai Vijayan K & Guang- Zhen Wang,(1999).

of research students from leading universities. An exhaustive literature survey has been undertaken by means of reading books, articles, newspaper reports, magazines and journals working on the aforesaid theme. As mentioned before, there is little theoretical work on the said issue; therefore an attempt was made at theorizing it by using the theoretical consideration revolving around the issue (e.g. gender perspective of reproductive health, patriarchy, women's health, women's autonomy and population control policy).

LIMITATIONS OF THE STUDY

The study being devoid of any primary data collection can put as the first constraint. In other words, the study is based on mainly on secondary sources. The second limitation is that the area of study has been restricted to India. Lastly, the study avoids premising itself on any single framework. In fact, combinations of concepts from wide ranging philosophical framework have been employed to approximate the issue.

ORGANIZATION OF THE STUDY

The study is divided into four parts that deals with abortion with sociological gender perspective.

The next chapter i.e. Chapter first deals with the socio-historical context of abortion, deals socio-historical background of the country, and religious views about abortion It also includes the history of sex selection and the socio-cultural context of abortions. The chapter concludes with changing perception and practice of abortion in the society.

Chapter second talks about the feminist perspective on abortion, and how feminists views on abortion is different from Indian counterpart. In India, how abortion is becomes a dilemma for Indian feminism because of growing practice of sex selective abortions.

Chapter third analysis, the current data on abortion from gender perspectiv how gender plays and important role in decision making and accessi services after the legalization of abortion services in India.

The fourth chapter deals with the medical termination of pregnancy w perspectives, and discusses how the population policy affects women's r autonomy. This chapter also deals with social implications of the medical of pregnancy.

CHAPTER- I

SOCIO-HISTORICAL CONTEXT OF ABORTION

Abortion appears to be as old as civilization itself, anthropological studies suggest that it is a universal feature of all societies. having held an important role in the limitation of births for all groups.[1] In preliterate societies, it was the chief preventive method. Early documentation of this claim is sparse but evidence does exist.[2] However, although abortion was and is widely practiced, nearly all cultures and societies have tried to control and regulate it, whether through social mores, moral conventions religious taboos or government law and regulations. The code some of the earliest civilization that arose in the western and south Asia-centuries before the Christian era –dealt with it and reflect the concern of the community with the problem, which is as old as attempts contraception, if not considerable older.

The *Sumerian Code* of 2000 B C, the Assyrian *Code* of 1500 b c, the *Hammurabic* code of 1300 b c, the *Hindu Code* of 1200 b c and *Persian Code* of 600 b c –all dealt with the problem of induced abortion. They prohibit and punish such acts as striking an expectant mother or indulging in any act that leads to the loss of an unborn infant. The law of the day tried not only to protect the pregnant woman but also to compensate her for the loss of her unborn child. In other words, the foetus can be sacrificed to save the life of mother, and this stand is more rational than that of exodus.[3]

There are references in *Hindu Upanishad* (ceria 1500 b c) to certain method of controlling conception. The *Brihadyogatarangini* contain several contraceptive recipes including a method for the occlusion of the cervix. There is another earliest reference to an abortion about seventh century AD certain *Chinese* medical texts (as in *sun ssu mo's* book of *chin fang*) offer several contraceptive

[1]Zimmerman, Mary. K. (1977).
[2] Deverex. (1955.)
[3] Chandrasekher, S., (1974)

methods. Old Testament Jews were evidently familiar with abortion, as it mentioned in their writings. Mention is also found in the law of ancient *Mesopotamia*.[4]

The frequency of occurrence is difficult to estimate for early societies, but most writers conclude that abortion was relatively common. There is sound evidence in ancient *Greece* and *Roman*. In *Greece*, abortions were institutionalized to the extent that a group of midwives performed them as explicit part of their duties. While there were some ancient *Greek* who wanted abortion prohibited, other including *Plato* and *Aristotle* encouraged it as a method of maintaining desired family size. *Plato* (c.427-348 BC) in his republic examines everything under the sun including modern problem as communism, democracy women's liberation, birth control, abortion, and eugenics. To *Plato*, a child's education should bring birth', meaning he must be born of select and healthy ancestry. Therefore only healthy man woman should have children and the need of health certificate for every bride and groom. Men may reproduced only when they are over thirty and under forty-five; women only when they are over twenty and under forty; offspring born of unlicensed mating, or deformed, are to be exposed and left to die. Before and after the age specified for procreation, mating is to be free, on the condition that the pregnancy is aborted.

Aristotle (384-322 BC) was equally permissive. According to him, if it should happen among married people that a woman, who already had the prescribed number of children, becomes pregnant, then before she felt life, the child should be driven from her.' He was the view that any woman who conceived after her forties years should have an abortion.

As Durant mention on his book '' the story of philosophy'':

Thc state should determine the minimum and the maximum ages of marriage for each sex, the best season of the conception, and the rate of increase in the

[4]Zimmerman, Mary. K., (1977)

population. If the natural rate of increase is too high, the cruel practice of infanticide may be replaced by the abortion and 'let abortion be procured before sense and life have begun'.... There are an ideal number of populations for every state, varying with its position and resource.[5]

Devereux, who has carefully examined 350 primitive ancient and pre-industrial societies, asserts'' that there is every indication that abortion is an absolutely universal phenomenon, and that it is possible even to construct an imaginary social system in which no women would ever feel at least impelled to abort.[6]

Perhaps the earliest recorded contraceptive prescription are those found in early *Egyptian Kahun Papyrus* dating back to about 1850B C. the *Ebers papyrus* of 1550 B C ,considered 'the most ancient book in the world', contains what is believed to be the first reference in writing to a prescription to prevent conception as for abortion ,(that is induced abortion ,meaning human interference with and termination of an unwanted pregnancy within a particular period),it has been resorted to by almost all societies, at different period of history, for a variety of reasons these have been case of incest , rape ,pregnancy in a unmarried girls, pregnancy in girl below the age of consent, and pregnancy in a sick or emotionally disturbed woman. Abortion has been also carried out to insure the physical health or survival of a woman. Besides these considerations, an abortion has been carried out when a pregnancy showed of lack of spacing, when it has occurred during the lactation period, or eugenic reasons. [7]

The Jewish people described in the Old Testament (ceria 600 b c) knew of various birth control methods. The withdrawal method –coitus interrupts or onanism was certainly known, though it is difficult to estimate how widespread the practice was. As for abortion, the Old Testament refers briefly to accidental miscarriage, and does not specifically touch on the induced abortion, for

[5] ibid. p.14-18.
[6] Deverex. (1955.)
[7] http://www.finsa.org/fall98#top

possibly it was not a serious problem among the Jews then. The relevant passage in exodus reads: [8]

If when men come to below, they hurt a woman who is pregnant and she suffer a miscarriage, though she does not die for it ,the man responsible must pay the compensation demanded of him by the woman' master: he shall hand it over arbitration . But should she die, you shall give life for life, eye for eye tooth for tooth, hand for hand foot for foot, burn for burn, wound for wound, and strike for stroke.

The Talmud, on other hand, which contains only one reference to abortion, appears to be more humane and lenient on the question [9]

If the woman is in hard travail [and her life cannot otherwise be saved], one cut up the child within her womb, and extracts it member by member, because her life comes before that of (the child). But if the great part [or the head] was delivered, one may not touch it, for one may not set aside one person's life for the sake of another. [10]

In other words, the foetus can be sacrificed to save the life of mother, and this stand is more rational than that of exodus.[11]

Man' attitudes towards abortion have ranged over a wide spectrum, from approval, bordering on encouragement, to total prohibitions and condemnation; all the way from early civilization to present day.

CONCEPTUAL UNDERSTANDING OF TERM ABORTION

Abortion is a ubiquitous and important medical, demographical, and sociological event.[12] The term 'abortion' in both legal and obstetric parlance is generally applied to the premature expulsion of the product of conception that is

[8] ibid.
[9] ibid
[10] Chandrasekhar S.(1974)
[11] Deverex. (1955)
[12] Potts Malcolm,Diggory Peter,Peel John(,1977),

before twenty-eight weeks of pregnancy (the period after which the foetus is considered viable). An expulsion of the foetus at and after twenty-eight weeks and before the end of gestation is termed a premature birth.[13] By another definition abortion may be defined as loss of a pregnancy before the foetus or foetus is potentially capable of life independent of mother. In most mammals this period extends over the first two- third of the pregnancy.[14]

The 'abortion' has acquired in popular parlance a pejorative connotation. According to the dictionary, to 'abort' is to bring forth premature offspring' or to 'give birth prematurely; but an abortionist' is 'a producer of illegal abortion'.[15] Obviously one cannot call a surgeon who performs a legal abortion an abortionist. In the clinical sense, abortion means the physiological process of evacuating a pregnant uterus, but in the legal sense, it normally refers to induce abortion.[16] The only internationally agreed definitions concern the term foetal death. In 1950s the WHO committee in the health statistic, recommended definition of foetal death was adopted by the organization, namely 'death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy'. The same committee also recommended dividing foetal death into three categories: early, up to 19 weeks gestation; intermediate, 20-28 weeks; late, over 28 weeks. The last category would be synonymous with the 'stillbirth' and the early and transitional with the term 'abortion'. However, not all countries agree to the definition abortion as loss of the products of conception prior to 28 weeks. Some use a definition of the foetal weight (usually 1000g) rather than age. The intention has usually been to define an abortion as loss of the foetus prior to viability i. e it is capable of surviving outside the uterus. [17]

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[13]. Ibid p. 23-26.
[14]Chandrashekher S. (1974)
[15] ibid p.p.2-3
[16] Potts Malcolm,Diggory Peter,Peel John,(1977).
[17]Chandrasekhar. S.(1974).

In Britain and the USA, there is a legal definition of abortion as loss before the twenty-eighth week of menstrual age. Before this date of the conception, when delivered, is disposed of by incineration or any other convenient method, where as once this date has passed a stillbirth certificate must be issued, and disposal by burial or cremation must follow the same registration and certification procedure as for adult deaths. [18]

The abortion may be either spontaneous or induced. Moreover, induced abortions are divided into legal and illegal. A spontaneous fact abortion is one that occurs naturally as result of certain pathology condition often beyond the control of the pregnant woman and the physician. In fact, a certain amount of pregnancy wastage occurs even before a woman is aware that conception has taken place, so that it is difficult to establish the incidence of spontaneous abortion. According one estimate, there is about one spontaneous abortion for every five full term deliveries. [19]

An induced abortion is the deliberate interruption of the pregnancy by artificial inducing the loss of the foetus. The legality of an induced abortion depends upon the particular law in force in a country. In some country only a therapeutic abortion, carried out to save the life of mother is legal. In some other countries, an induced abortion may be permitted only to safeguard the mother's physical and mental health but also on humanitarian, demographic eugenic and social grounds. Of late, abortion laws, which were rigid and strict in many countries during the first half this century, have been gradually liberalized. In some countries, the picture is rapidly changing. Man, through the age from primitive, non –literate societies to advanced industrialized and sophisticated societies, has attempted to control conception by the variety of the largely crude and rule of thumb methods. When he failed to prevent conception he tried to interrupt

[18] Potts Malcolm,Diggory Peter,Peel John(,1977)
[19] http://www.un.org/esa/population/publications/abortion/doc/india.doc

pregnancy. When this did not succeed certain societies even resorted to infanticide.[20]

To add to the confusion even the spelling of the foetus is in dispute. The English and American spelling of 'foetus and foetus 'differs. Etymologists and anatomists are agreed that foetus in the current usage as the word derived from the Latin feto—I bear. However, English clinicians continue to use foetus. The word 'abortion comes from the Latin word ''aborri''—to fail to be born. In it the foetus dies while yet within the generative organs of the mother, or it is ejected or extracted from them before it is viable; that is, before it is sufficiently developed to continue its life by itself. The term abortion is also applied, though less properly, to cases in which the child is become viable, but does not survive the delivery.[21]

The word miscarriage is taken in the same wide sense. Yet medical writers often use these words in special meanings, restricting abortion to the time when the embryo has not yet assumed specific features, that is, in the human embryo, before the third month of gestation; miscarriage occurs later, but before viability; while the birth of a viable child before the completed term of nine months is styled premature birth. Viability may exist in the seventh month of gestation, but it cannot safely be presumed before the eighth month. If the child survives its premature birth, there is no abortion -- for this word always denotes the loss of foetus. [22]

It was long debated among the learned at what period of gestation the human embryo begins to be animated by the rational, spiritual soul, which elevates man above all other species of the animal creation and survives the body to live forever. The keenest mind among the ancient philosopher Aristotle conjectured that the future child was endowed at conception with a principle of only vegetative life, which was exchanged after a few days for an animal soul, and

[20] http://www.un.org/esa/population/publications/abortion/doc/india.doc
[21] Potts Malcolm,Diggory Peter,Peel John (1977)
[22] ibid.p.26-28.

was not succeeded by a rational soul till later; his followers said on the fortieth day for a male, and the eightieth for a female, child. The authority of his great name and the want of definite knowledge to the contrary caused this theory to be generally accepted up to recent times.[23] Yet, as early as the fourth century of the Christian era, St. Gregory of Nyssa had advocated the view which modern science has confirmed almost to a certainty, namely, that the same life principle quickens the organism from the first moment of its individual existence until its death (Eschbach, Disp. Phys., Disp., iii). Now it is at the very time of conception, or fecundation, that the embryo begins to live a distinct individual life. For life does not result from an organism when it has been built up, but the vital principle builds up the organism of its own body. In virtue of the one eternal act of the Will of the Creator, Who is of course ever present at every portion of His creation, the soul of every new human being begins to exist when the cell which generation has provided is ready to receive it as its principle of life. In the normal course of nature, the living embryo carries on its work of, self-evolution within the maternal womb, deriving its nourishment from the placenta through the vital cord, till, on reaching maturity, it is by the contraction of the uterus issued to lead its separate life. [24]

THE RELIGIOUS VIEWS ABOUT ABORTION

Religious views about abortion are given below:

THE HINDU VIEW

The first reference to the abortion is found in the Atharva–veda. As for the induced abortion, the Hindu, scripture from the Vedic age down to the Smritis (100 BC-AD 100) called it bhruna hatya (foetus murder)or garbha hatya(pregnancy destruction), and condemned it as a serious sin. According to

[23] http://www.religiousconsultion.org
[24] ibid.

Vishnu smiriti (c. 100BC –AD 100), the destruction of an embryo is tantamount to killing a holy or learned person'. [25]

The deliberate termination of pregnancy, from the earliest times, Hindu tradition and scriptures condemn the practice, except when the mother's life is in danger. It is considered an act against Rita and Ahimsa. Hindu mysticism teaches that the fetus is a living, conscious person, needing and deserving protection (a Rig Vedic hymn [7.36.9, RvP, 2469] begs for protection of fetuses). The Kaushitaki Upanishad (3.1 UpR, 774) describes abortion as equivalent to killing one's parents. The Atharva Veda (6.113.2 HE, 43) lists the fetus slayer, brunaghni, among the greatest of sinners (6.113.2). The Gautama Dharma Shastra (3.3.9 HD, 214) considers such participants to have lost caste. The Sushruta Samhita, a medical treatise (ca 100), stipulates what is to be done in case of serious problems during delivery (Chikitsasthana Chapter, Mudhagarbha), describing first the various steps to be taken to attempt to save both mother and child. "If the fetus is alive, one should attempt to remove it from the womb of the mother alive..." (Sutra 5). If it is dead, it may be removed. In case the fetus is alive but cannot be safely delivered, surgical removal is forbidden for "one would harm both mother and offspring. In an irredeemable situation, it is best to cause the miscarriage of the fetus, for no means must be neglected which can prevent the loss of the mother" (sutras 10-11)."[26]

Hindus object to artificial life support, organ transplants, and cloning. They believe that unless the body is completely at rest, the soul is not allowed to be released, and will be confined to that body until it dies. By interfering with the natural cycle of the releasing the soul, they interfere with the timing and cycle of that soul's travel to another life, which will set the soul off course in its spiritual

[25]Chandrasekhar, S. 1974)
[26] S.Chandrasekhar (1977)

evolution. Though many will accept a transplant to save a life, they do not support the practice in principle. [27]

THE ISLAMIC VIEWS

Islamic leader currently set a rather conservative gloss on a liberal theology. However, some are beginning to look anew at the ancient problem of abortion.

What is the Islamic view of family planning and abortion? Though there is no centralized Muslim spiritual hierarchy comparable to the pope among the Catholic, the Muslim are required to find the answer to their problem firstly from the Holy Koran, secondly from the Hadith, (traditions from the prophet Mohammed), and thirdly from the interpretation and opinions of Islamic ecclesiastical head such as the Muftis and the Ulamas.[28]

It is known that coitus interruption (Azl or al-azh) was practiced widely by the Arabs for preventing unwanted pregnancies. It is believe that the Prophet allowed this practice. There is evidence that the Hanafy School of Law, the Grand Muftis issued a fatwa dated 12th Dhi al Quada 1335 (25 January 1937). It runs: 'It is permissible for either husband or wife by mutual consent to take any measure.... In order to prevent conception (He refer to both natural and artificial methods). He continues: 'Later scholars of the Hanafy School consider that such consent is not even necessary if either husband or wife has an excuse as those mentioned or any similar ones'. [29]

There is strict prohibition like other religion but there are positive statements also from such leading Ulamas of Islam as Al-Ghazali and Ibn-Tainmiya, in favour of birth control. 6[30]

[27] Hindu Ethics on the Moral Question of Abortion (2004).
[28] s.chandrashekher (1974)
[29] ibid. p. 7-12

CHRISTIANITY

In the Christianity, abortion is deeply immoral. The Christian attitude held that once a woman is pregnant it is by the will of God, and nothing should be done to interfere, regardless of the circumstances. It may well be, as some have suggested, that the desire to increase Christian populations was behind this view.[31] Whatever the source, it constituted a marked departure from previous definition of abortion. It is true that early Jewish teaching had discouraged abortion except in cases of danger to the mother' health, but the Christian view was much more intense in its prohibition. [32]

The attitude of the early Christian church towards sex, marriage, family was largely derived from Judaism, which viewed as women as inferior person but as the important source of children. Apart from that Jews believed that the continuance of the family and racial line and the preservation of the Jews way of life, that of a 'chosen people', were of paramount consideration. Hence, the importance of the need for large number.[33]

The Christian concern with abortion also involved the issues surrounding the point at which life begins. The conclusion they reached in this matter was that the foetus possesses a soul from the moment of conception, and hence constitutes ''life '' in the fullest sense. With this belief, the notion of abortion as crime was established.

Protestant denominations have a diversity of opinion regarding when life begins and whether abortion should allow. Thus, the protestant church unlike the Catholic Church has in response to man's changing needs and the threat of overpopulation approved not only contraception but abortion as well.

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[31] Chandrasheker S (1974)
[32] http://www.religiousconsultion.org
[33] http://www.religiousconsultion.org

THE SOCIO HISTORICAL CONTEXT OF SEX SELECTION

Biologists, sociologists, and anthropologists have long assumed that scarcity, whether natural or man-made, is chief catalyst for both social competition and social conflict. Scarcity may involve tangible items of value, such as cattle or water, or less tangible goods, such as societal status or group identification.[34]

There is probably no society in the world in which women do not experience some from of gender inequality- that is, the subordinate status or inferior treatment of females in political, legal, social, or economic matters. Gender inequality exists when females, compared with the male counterparts, are less educated and less well nourished; and have fewer political, legal, social, and economic rights and freedoms.[35] However not all societies, practice exaggerated gender inequality, we define exaggerated gender inequality as existing when, because of gender, one infant allowed to live while another is actively or passively killed. Offspring sex selection, which almost universally favours males, is found in societies where the lives of females hold significantly less value than those of males, or indeed, when they have no value at all. Offspring sex selection denotes violence against females simply because they are female. There can be no greater evidence of exaggerated gender inequality in a society than prevalent offspring sex selection.

The masculinization of Asia's sex ratios is one of the overlooked ''mega trends'' of our time, a phenomenon that may very likely influence the course of national and perhaps even international politics in the twenty –first century. Historical data suggests that there is a historical origin of offspring sex selection.[36]

The historical literature on offspring sex selection contains a variety of hypothesis and explanation concerning the origins and continuation of this

[34] Hudson Valerie M. and Andrea M. Boer (2004)
[35] ibid. p. 121-156.
[36] ibid. p. 121-156.

practice. Literature surveys suggest that there are two main environmental stresses- military invasion and chronically fragile subsistence system that are constantly linked to the emergence of prevalent offspring sex selection.[37] By prevalent mean an act practiced by a nontrivial percentage of families at nearly every level of socio-economic status that continues over time and typically goes unpunished even when such behaviour is illegal.[38] These two factors only initiate the social move from occasional, idiosyncratic offspring sex selection to prevalent, typical offspring sex selection.

(1). Military Invasion

Military invasion traditionally threaten its victims in two fundamental ways: through physical extermination and social extermination. The threat of physical extermination of a targeted group is initially felt most acutely through the loss of men –especially young men – who, acting as warriors, risk death to protect the group. Following victory, invaders would often single out surviving warriors and other males of fighting age for execution.

The social extermination of group, on the other hand, is felt most acutely when the invaders seize women for concubinage, marriage, or slavery. Without women to provide and socialized children, the targeted group is doomed to social extinction within a generation or so. Preventing the physical loss of men and the social loss of women is therefore vital to group survival. The distinction between physical and social loss is important to understand because the social loss of women is sometimes viewed as best achieved through their physical loss. There can be three dynamics linked to military invasion seems to encourage the practice of offspring sex selection. The first is the need to stanch the physical loss of men, which in tern puts a greater premium on the birth of male infants. A group suffering such a loss may therefore consider the investment of time and energy required to ensure the survival of baby as wasted on a female infant

[37] ibid. 121-156.
[38] ibid.121-156.

when the real need is to replace lost males. Sex selective infanticide increase the like hood that the mother can deliver another child within a year, rather than within two and a half years.

Second, the birth of female infant can increase the vulnerability of the target group and thus threaten its identity. The need to protect the honour of the girls and their social capture through sexual union with members of the invading army open the group to further physical loss of men. The more females, the greater the vulnerability. The social loss of these females (and the consequential physical loss of males attempting to protect men attempting to protect them) may seem more costly than the physical loss of these women through offspring sex selection.

Third, girls eventually required suitable marriage partners. To prevent their social loss, the group must find them husbands from within the group or from other acceptable groups. Invaders, on other hand, seek out women from the target group as sexual partner, usually by force, to weaken its morale and sense of identity. Even if the targeted group is able to keep the social capture of its women to a minimum – for example, by secluding them in locations and protected by men from the group, the likely loss of these men in this endeavour decrease the number of prospective husbands.

(2). Chronically Fragile Subsistence System

Historically, survival was as a day-to–day struggle. With the agricultural all but impossible, hunting and fishing remain the primary means of providing sustenance for the group. Over the time natural sexual division of labour developed: Men focused on hunting and fishing, while women cared for children, rendered the meat into usable food, and cured hides for clothing and shelter. Hunting and fishing are supposed to be treacherous, and men are often killed or disabled in the process. Given the lack of alternative food sources, the strict division of labour along gender lines, and men's physical advantage in

procuring food, male became more important to the group. The birth of male babies meant a steady supply of new hunters and fisherman, so that even if some were killed or disabled, other could take their place. This ability to feed the entire groups required the maintenance of a delicate balance between the number of hunters and non-hunters. An excess of non-hunters means that everyone in the group would experience hunger and perhaps starvation. The practice of female infanticide reduced the number of infants who would never become hunters; it also lowered the number of potential mothers. In many societies, the type of food procurement system plays a role in determining the prevalence of female infanticide. Hunting, large animal husbandry, and agriculture involving heavy plowing render sons more valuable than daughters. Male cantered food production systems go hand in hand with patrilocality, wherein a wife not only joins her husband's family upon marriage but also severs daily contact with her natal family. Females are usually not allowed to inherit real property, because when they marry, it would fall into the hand of their husband's family. Even before marriage, girls are viewed not as family members but as houseguest. Investment in their care by their natal families is therefore considered a complete loss's common proverb in patrilocal culture is ''Raising a daughter is like watering a plant in another man's garden''. ''Son, who stays with their families to care and provide for them, is thus considering more valuable.

The combination of male centred food production systems and patrilocality virtually guarantees not only women's lowly place but also the hefty dowries necessary to marry them off. The dowry system further erodes any natural affection parents might have for their daughters, and for their birth may consign their families to financial ruin.

The history of sex selection in India is bound up with the history of the country, its religions, and the evolution of its social structure and the changing role of women. The position of the women within the family and the society has not been uniform throughout history or throughout the country; a woman's status

varies according to religion, position within the social hierarchy, region, economy, and even within each family, according to birth order.

SEX SELECTION IN THE INDIAN CONTEXT

Understanding the current discriminatory practices against women, including female infanticide, sex selective abortion, and differential morality requires an examination of India's unique history, religion, and social structure.

Historical setting

India comes from the Sanskrit word *sindu,* which was used to describe the Indus River by the Aryan- speaking migrant who travelled from their homeland between the Caspian and Black Sea and eventually settled in Indian subcontinent. Their arrival in 1500 B.C. disrupted the lives of the existing inhabitants. Hindu society became organized around the principle of *Verna-ashram –dharma*—class, stage of life (which determine the status, goal, duties and obligations), and righteousness and sacred law- as outlined in Hindu scripture and tradition. In addition to intertribal wars that followed the Ayaran invasion, other invaders attempted to encroach on Indian Territory. During that period, several other dynasties attempted to gain status Muslim invaders who, having begun their attack on India in A.D. 997, gained control over a large portion of the subcontinent in 1175. In mid nineteen century British took over rule of the Indian subcontinent. India would not become independent of British rule until 1947.[39] India has long history of invasion and invaders. The theory of military invasion can be applied on this situation. The picture becomes clear that how historical settings of India initiate the practice of offspring sex selection.

[39] Wolpert , stanely(1993), A new history of India'' 4th ed. (New York: oxford university press, 1993), pp.106-109.;

Religion

Hinduism is dominant religion in India, fallowed by 82% of the populace. Hinduism is vast socio-religious system that encourages the acceptance of diverse beliefs and custom; unlike the monolithic religion of Christianity and Islam, it has no unifying creed, and it's recognized innumerable Gods. Hindus accept the notion of an order of the universe and the fulfilment of obligation based on one's sex, and status within the social system. Islam is the second largest religion in India. Muslim make up 12% of the population, and Christianity, Sikhism, Buddhism, Jainism, and other religions make up the remaining 6%.[40]

Most of the religion in the world condemn or prohibit the practice of offspring sex selection but unfortunately this practice is still prevalent in most of the societies. Hindu religious text (the Veda) appears to hold all human life sacred. Indeed, in pre-Vedic and even Vedic periods, women were more highly valued by society and religious thought than they are today. Women could be warrior, even generals, and they had a say in government and their choice of husbands. Marriage involving bride-price was common. Some early Hindu text appears to proscribe infanticide. For example Vasistha warned that only three act could make a woman impure: becoming an outcaste, murdering her husband or the killing her unborn or newborn child (Vas.Xxviii.7). According to Gautama, aborting a foetus was just cause for an outcaste (G.xxi 9).

Following the end of the Vedic period and subsequent Mughal invasion, new religious texts and interpretations began to emerge. Among the most influential was the Manusamhita or Code of Manu. Herein was developed the idea that the primary reason for a man to marry was to produce a son who could perform certain rituals for the father's soul after death. Without a son to perform these rituals, the father soul would be consigned to hell. In addition, Hinduism began to assume that children were not living soul until approximately two years of

[40] http://www.censusindia.net/cendate/datatable23.html

age, and death of a child before that age was not death of completing death of human being. As in Hindu culture, daughter in Islamic culture have the same position. However there is no written text. There is one evidence suggest that this practice once common among the pre Islamic nomadic tribes of the Arabian Peninsula, was essentially condemned when Prophet Mohammed asked his followers to imagine themselves before God on the day of the judgement, then added: And when the girl-child that was buried alive is asked for what sin was she has slain,....then every soul will know what it hath produced. Without that sanction, practitioners of female infanticide were deemed to be beyond the moral order of Muslim society.

Social system

Hinduism provides the religious rationale and sanction for the caste system, the basis of India's social system. The caste system in India is extremely complex. Social status, occupation, and opportunities for marriage within Indian hierarchical social system are determined by one's jati and Verna – both jatis and Verna are hierarchal, with Brahmans atop of the hierarchy and those outside the caste system – the untouchable – at the bottom. Although other religions of India do not participate in the caste system, even members of these religion communities find themselves involved in it because of their proximity to the large Hindu population. To maintain jati purity, all contact with those less pure (of a lower caste) whether through marriage, eating, or drinking- is controlled. [41]

Marriage is the most public statement of jati status. Most marriage takes place within one's jati, the only exception being the possibility of a woman marrying a man of higher status. The system of marriage in India is hypergynous; women must marry within or above their position in the social hierarchy. The birth of a daughter in some societies perceived as threat of loss of social boundaries. Social boundaries create division among people: division of identity, wealth,

[41] David G. Mandelbaum (1968), "Family, Jati, Village " in Milton Singer and Bernard S. Cohn, / eds . Structure and Change in Indian Society., Aldine De Gruyter, p.41.

power, privilege, risk, vulnerability, and security. Boundaries allow the family or group to exclude other from sharing its resource. Families, however defined are unit around which foundational social boundaries are erected. A family's accumulation of wealth, power, security, and so on can be perpetuate only through inheritance. Without a next generation to maintain the family's social boundaries, and thus the accumulation of wealth is wasted, as are the resources accumulated. For centuries eunuchs fought for the right to adopt uncastrated sons who could give them families and to whom the eunuchs could bequeath their riches.

The need to exchange marriage partner outside of the family create a dilemma. New generation must be produced for social boundaries and resource exclusively to be maintained, yet the marriage required for such reproduction may compromise those same social boundaries. And imperil resources exclusivity. In this light, marriage both extremely and important and exclusively perilous. For minimize the threat to social boundaries and resources exclusively, Hudson and Boer in their study illustrate three conditions. [42](1) Family-based accumulation of resources or resource access of persistence value, (2) The desire to maintain social boundaries that make possible accumulation and resources exclusively, and (3) the need for exogamous marriage for biological reasons. From these assumptions Hudson and Boer derive several propositions. [43]

First, in most traditional economies, families do not leave marriage to chance: rather, they strictly control the choice of mates for their children. In these economies, the family seeks to keep sons within its social boundaries, foe at least three reasons: (1) sons are better able to provide physical defence of resources accumulation and exclusively; (2) sons are likely to be the primary creator of additional accumulation;(3) sons are capable of producing more children than daughter.

[42] Valerie M. Hudson and Andrea M. Boer (2004)
[43] ibid. 121-156.

Second, daughters given in marriage to another family are denied access to the natal family's accumulating wealth so that the social boundaries and resource of the natal family can remain intact. Daughters are not allowed to inherit family accumulation to any significant degree, especially not land.

Third, to minimize penetration of their social boundaries, families choose their daughter's husband from families of higher social status (hypergyny). Mildred Dickemann explains: ''the pyramidal nature of hierarchical societies meant that the higher the status of the sub caste, the fewer options for its daughters: the operation of hypergyny in a pyramidal structure guarantees competition for a resources which is always scarce in relation to demand. In such systems, as in Indian society woman must bring a dowry with her to the marriage –a form of economic benefit to the groom's family from the bride's family; the higher the sub caste, the greater the dowry that must be given upon marriage.

Fourth, when marriage of daughters would be too costly or socially threatening, families pull them out of the marriage market either by engaging in female infanticide.

THE SOCIO-CULTURAL CONTEXT OF ABORTION IN INDIA

The practice of sex-selection within the cultural and material context of India is not a recent phenomenon in India. This practice is only the latest manifestation of a long history of gender bias, evident in the historically low and declining population ratio of women to men. In order to combat the practice of using technology to abort female fetuses, one need to look at the wider social and historical context of gender bias on the population.

The Context sex selective abortion is a fairly recent phenomenon, its roots can be traced to the age old practice of female infanticide was initially documented by British officials in the late eighteenth century who recorded it in their diaries during their travels. One British official, James Thomason, while speaking to a group of landowners in Uttar Pradesh in 1835 referred to one of them as a son-

in-law of another. His remark "raised a sarcastic laugh among them and a bystander briefly explained that he could not be a son-in-law since there were no daughters in the village.[44] Thomason was told that the birth of a daughter was considered a most serious calamity and she was seldom allowed to live."[45] Realization of the occurrence of this practice prompted the British to pass the Infanticide Act in 1870, making it illegal. It was not until 1871, however, in the setting of India's first census survey, that the scope of the problem of infanticide became evident.[46] At that time it was noted that there was a significantly abnormal sex ratio of 940 women to 1000 men.[47] Since this ratio was the inverse of what had been observed in England and other countries where women outnumber men, the paucity of women in India invited much speculation. Theories ranged from an Indian genetic predisposition towards having sons to a purposeful under-reporting of women from families who distrusted the British motives. One commissioner even stated, "male births increase in proportion to the warmth of the climate" (British government, 1870, as quoted in Miller, 1981). Others realized that the abnormal ratio was secondary to the fact that Indian women had a higher mortality rate than men from both natural causes such as childbirth, as well as unnatural causes such as infanticide and sati (the practice of a widow throwing herself on her husband's funeral pyre). Subsequent census reports showed no improvement in the abnormal sex ratio despite attempts to ensure that all women were reported. Some Sikh villages had ratios as low as 31 women to 100 men.[48] Regionally the practice of female infanticide was confined mainly to the northern part of India, although some areas in the south were also known to practice it. The Infanticide Act was difficult to enforce in a country where most births took place in the home and where vital registration was not commonly done. Autopsies were not performed on corpses except in the unusual circumstance in which the police were notified. Given the high infant mortality rate due to natural causes in India a female infant could

[44] Patel, Rita. Fall (1996).
[45] ibid.
[46] George, Sabu M. (1997).
[47] Ibid. 124-132
[48] Miller B. (1981).

easily be suffocated, poisoned, or starved without arousing the suspicions of others. Moreover, because of the seemingly widespread acceptance of the practice, it is unclear whether anyone would feel morally compelled to report a suspicious incident. Aware of the limitations of legislation, the British made other attempts to curtail the incidence of infanticide. They established a government dowry fund to aid destitute families who felt that they could not afford another daughter. They held conferences with the princely families. They threatened with imprisonment and fines. Their efforts may have curtailed the incidence of outright infanticide, but many felt that it was supplanted by more subtle neglect:

Even if there is no deliberate design of hastening a girl's death, there is no doubt that, as a rule, she receives less attention than would by bestow upon a son. She is less warmly clad, and less carefully rubbed with mustard oil as a prophylactic against the colds and chills to which the greater part of the mortality amongst children in India is due; she is probably not so well fed as a boy would be, and when ill, her parents are not likely to make the same strenuous efforts to ensure her recovery (1901 Indian Census, as quoted in Miller, 1981)[49] The other effect of the British policies was that the act of female infanticide became secretive for fear of legal retribution. As a result, much of the evidence as to the prevalence of infanticide had to be extrapolated from the census data rather than direct surveys. The sex ratio continued to decline until 1981 at which time a small improvement was noted from 930 to 934 women per 1000 men. This improvement was attributed to the rising status of women as evidenced by the birth of several feminist groups. It was also felt to be the result of better health care and decreasing maternal mortality during a period of economic growth. Projections were optimistically made for a ratio of 944 women to 1000 men by the year 2001.[50] It was therefore a great shock to many when the 1991 census

[49] Ibid, p. 23-29.
[50] Kanitkar T. (1993)

instead showed a decrease in the ratio to an all-time low of 929 women to 1000 men.[51]

To understand the social context in which the practice of sex selective abortion exists and, in fact, flourishes, one must first examine the cultural basis of son preference in India The reasons behind what has been called "son mania" are both multifaceted and deeply imbedded in Indian culture.[52] They are also unfortunately inextricably entwined with a corresponding discrimination against daughters. In the ancient Indian text, the Atharva Veda, mantras are written to change the sex of the foetus from a 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", whereas a daughter's birth is a cause for great sadness and disappointment.[53] Indian society is patrilineal, patriarchal, and patrilocal. Sons carry on the family name. They are also charged with the task of supporting their parents in old age. Parents live as extended families with their sons, daughter-in-laws, and grandchildren. Daughters, on the other hand, become part of their husband's family after marriage and do not make any further contributions to their birth parents. Indian sayings such as, "Bringing up a girl is like watering a neighbor's plant," and "The girl who has married is like the spittle which has been spat out, and no longer belongs to the parents," exemplify the feeling of wasted expenditure on raising a daughter[54] Indian men are also responsible for the funeral rites of their parents and are the only ones who can light the funeral pyre. Some feel that they will only be able to achieve *moksha* (transcending the circle of reincarnation via the performance of good deeds) through their sons. Thus the importance of having sons continues beyond even this life in Indian culture.[55] A very important factor contributing to son preference is that of economics. Daughters, for several reasons, are an economic liability to families whereas sons are a great asset. One of the most publicized

[51] http://www.censusindia.net/cendate/datatable23.html
[52] Patel, Rita. Fall (1996).
[53] ibid.
[54] Jeffery R, Jeffery P. (1984).
[55] Ibid-p. 1207-12.

reasons for this disparity is the dowry system.[56] In many parts of India, particularly in the North, the parents of the bride must give money and gifts to the groom's family as part of the marriage agreement. Formerly, dowries were only expected in high caste marriages where the bride would not be expected to work in the fields and was thus presumed to be an economic burden on her husband. The bride's family, therefore, compensated the groom's family with a dowry. Presumably in an attempt to emulate higher castes, the custom of dowry giving has, over the past several decades, spread throughout the social structure in India Lower castes, viewing dowry as a status symbol, have adopted the custom with even more zeal than the upper castes: "the Brahmanical form of marriage with dowry is often considered more prestigious and when castes attempt to upgrade themselves they frequently assume this form of marriage payment".[57] The dowries, in present times, frequently cost the bride's family two to three times their yearly income. Refusal to offer a dowry seals a girl's fate as a spinster and shames the family name. Failure to deliver the offered dowry or honour further requests may result in a so-called "dowry death" or "bride burning" in which the groom's family kills the bride to allow the groom to remarry and bring in a more substantial dowry. Furthermore, in some groups, the gift-giving continues after the marriage.[58] Another economic disadvantage of daughters in India is their relatively low earning potential. As in many other countries, although the women work as hard as or harder than their male counterparts, they make very little money. The long hours spent cooking, cleaning, and caring for the children are viewed as "sitting at home all day". Even the time spent in the fields is not considered significant since the men do much of the heavy lifting. Frequently illiterate, due to lack of schooling women in India are generally unable to obtain high-paying work and are therefore financially dependent on the men in the family. As a result, it is felt to be to a family's economic advantage to minimize the number of daughters. Since many of the reasons behind son preference are economically based, it is ironic that the

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Patel, Rita. Fall (1996).
Miller (1981)
Kanitkar T. (1993)

most extreme sex ratios are seen in the higher castes that tend to have most of the wealth.[59] The reason for discrimination against daughters in these groups seems to be related more to issues of family pride than to concern over money. Indian culture requires that a girl marry into a family with a caste equivalent to or, preferably, higher than her own. She then adopts that caste as her own and is thus "elevated". Boys, conversely, are encouraged to marry below their castes to maximize dowry potential. As a result, it is frequently difficult to find an appropriate husband for a daughter of an upper class family, which has the potential for putting great shame on the household. In addition, some of the higher castes, such as the Rajputs, are Kshatriyas which translates as warriors. These groups take great pride in their fierceness. Daughters do not fit well into their culture and are potentially a source of vulnerability in the family. Sons, on the other hand, are a source of pride and strength: "the role of sons in exerting control over farm resources, in protecting the community against dacoits, and in the army of the state...may have been factors militating for the generalized preference for sons".[60] The Rajputs and the other warrior castes are cited throughout the literature for their liberal use of infanticide prior to the advent of sex determination techniques. The need for men as protectors may also partially explain the geographic differences in the practices of infanticide and sex selective abortion.[61] The history of northern India, where son preference is the strongest, is characterized by numerous foreign invasions requiring the men to fight. Women did not contribute to the defense and were thus a source of weakness in the community. The relatively unscathed south, on the other hand, did not have a similar need to protect itself against foreign invaders and has a correspondingly low incidence of infanticide and sex selective abortion another reason given for the prevalence of sex selective abortion is India s attempt to control its population. Although the government has not adopted coercive methods since the "Emergency" in the 1970's under Indira Gandhi's rule, it has become increasingly unfashionable to have a large family in India. The ideal

[59] Miller (1981)
[60] Machlachlan MD. (1982).
[61] ibid. p. 879-85

family size, particularly among the high socioeconomic classes, is two children. Given that at least one son is necessary, families with two daughters become increasingly anxious about the sex of their expected child. Studies have supported this theory, demonstrating that sex selective abortion occurs most frequently in families with two or more daughters'.[62] Multiple surveys have been undertaken to determine the general population's view towards the practice of sex selective abortion. In one study of middle class Indians in Punjab, 63% of women and 54% of men felt that amniocentesis should be undertaken if the couple has no son and more than two daughters. If that test shows that the foetus is female, 73% of women and 60% of men felt that it should be aborted. The top three reasons cited for aborting a female foetus include "a male dominated society" (23%), "social stigma attached to having a daughter" (19%), and "difficult to afford a dowry" (17%).[63] Several interesting conclusions can be drawn from this study. First of all is the startling finding that women are more likely than men in this middle class, fairly well-educated population to support sex selective abortion. This finding may be secondary to the fact that these women can better empathize with both the ostracized, guilt-ridden mother with no sons as well as the unwanted daughter who may be made to suffer by virtue of her sex. Another result of interest is that dowries were only the third most cited reason for aborting a female foetus.[64] This has important implications for policy-making, since legislation to eliminate the dowry system, according to these data, would likely have only a moderate impact on the demand for sex selective abortion.

Attitudes towards sex selective abortion in a highly educated sample from cosmopolitan Delhi were examined in another study by Shah and Taneja[65]. In this population, 59% of women and 63% of men held highly negative opinions towards sex selective abortion, 36% of women and 37% of men had somewhat negative opinions, and 5% of women and 0% of men had positive opinions.

Ramanamma A, Bambawale U. (1980).
singh G, Jain S. (1993).
Ibid. 13-19.
Shah A, Taneja, S. (1992).

Again, women tended to support sex selective abortion more than men; however, the population overall seemed not to agree with the practice. When asked what steps might be taken to prevent its occurrence, the vast majority stated that the key component for change was education of individual women, as well as the general public. Physicians in India have been strong supporters of sex selective abortions since their inception. Their arguments include that it is the family's right to make this personal decision, that the mother will suffer if she has too many daughters, and that the daughter will have a very difficult life. One Bombay gynecologist states, "How can you deny her [the mother] the right to have a son instead of a third or fourth daughter? You can't wish away centuries of thinking by saying that boys and girls are equals . . . it is better to get rid of an unwanted child than to make it suffer all its life" They also argue that it is unreasonable to make abortion of female fetuses illegal if abortion of male fetuses is not. Furthermore, doctors raise the concern that "barring of these tests could lead to mushrooming of private clinics headed by quacks where sex-detection tests and abortions will be carried out clandestinely and prove to be extremely hazardous to the mother and foetus alike".[66]. Equally worrisome is the possibility that it might lead to a resurgence of the still utilized female infanticide.[67] . Although gynecologists certainly have a financial interest in the practice, their views generally reflect those of much of the rest of the country.[68] Another frequent argument used by supporters of sex selective abortion is that the decline in the sex ratio as a result of this practice will result in an elevation of the status of women and reform of the dowry system. Feminists have responded to this disturbing contention by saying that a decreased ratio does not improve the status of women; it simply reflects it. Moreover, there are no indications that the declining ratio over the past century has elevated the position of women or eliminated dowries. In fact, despite the lowest sex ratio in the past century, the status of women in India arguably has never been lower, as

[66] Kusum. (1993)
[67] Jayaraman KS. (1994)
[68] Ibid. p, 370: 320.

demonstrated by the recent increased incidence of bride burning and dowry deaths.

CHANGING CLIMATE OF ABORTION IN INDIA

A little more than a century ago abortion was made a crime for which the mother as well as the abortionist could be punished in all cases except where the abortion had to be induced in order to save the life of the mother. Since late 1960s, abortion has been shifting from this predominantly illegitimate status toward a more legitimate one. The seeds of the transition began to germinate in the early 1960s. Long before that, however, in the 1920s and 1930s, the issue of fertility control was a very important one in the United States. It is interesting that while there was a significant birth control movement during that time abortion was generally opposed. Later, during the 1940s and 1950s through the vehicle of several conferences, healthcare professional began to voice concern about the prevalence of illegal abortion. Finally, in the 1962, a dramatic event succeeded in bringing the abortion issue to the attention of the public.

Looking back over the history of the abortion in society, two features appear with some regularity. The first is the vagueness and lack of consensus in the culture standards defining the place of abortion. No society has been entirely successful in establishing abortion both unequivocally right and unequivocally wrong. In most cases, the appropriateness of abortion has remained vague.

A second relatively persistent feature has been the substantial numbers of abortions have been performed. Rather than reflecting ''the moral decay of the society '', as is so often suggested, substantial numbers of abortions probably have characterized most societies throughout history. Technology and organizational patterns have changed, but women have always had the desired to

restrict births.[69] The persistent frequency of abortion is testimony to the inability of any society to successfully stop them

Whatever the ethical and moral feelings professed by society as a whole on the question of abortion, it is uncontroversial fact that a large number of mothers are prepared to risk their lives in an illegal abortion rather than carry that particular child to term. Further more, a great majority of these pregnant women are married, and have not particular need to conceal their pregnancy. In recent years, as health services have expanded and hospital facilities have been used to the fullest extent by all the classes of the society, doctors have been confronted all too often with gravely ill or dying pregnant women who have tampered with their uterus with a view to causing an abortion and, while not fully succeeding in their purpose, have suffered miserable and severe consequence. With the instrumentality of law the abortion situation can be change. Therefore the question of how far permitted abortions can serve the wider purpose of family and society can bear dispassionate examination. A law that rigidly prohibits something that nevertheless continues as a fairly widespread practice in the community is one that requires a re-examination. Law is a vehicle of society and family as a unit of a society has always been safeguarded and even hedged in by customs and conventions, rules and regulations based on ethical, moral, and religious values. Beside society is not static but a changing and evolving entity, and the family patterns change within it.

The India of today bears witness to change, which is unconventional and even radical. The whole process of economic development, involving rapid and large-scale industrialization and technological change, is rapidly ushering in a new way of life affecting not only the economic, and political but also the social sphere of life. The traditional pattern of family organization and life has been changing by the utilization of modern science and technology for the economic betterment of people. The remarkable changed position of women and children in the new society that is being built up is a very relevant factor, for these

[69] chandrashekher , S (1974).

vulnerable groups cannot be regarded any longer or in any manner as subordinate with the lesser rights. The quality of the sexes is enshrined in India's constitution and is being built into the foundation of modern society.

In another ways, Mary k. Zimmerman[70] explains societal changes in present context of abortion by the using the concept of legitimation. Legitimation refers to a process of justification (acceptance)-a process whereby an act becomes institutionalized and established as a regular and proper part of the social order. To analyze the particular case of abortion, legitimation can be differentiated in terms of three types, or level: symbolic legitimacy, institutional legitimacy, and moral legitimacy.

She explains the concept of symbolic legitimacy, which somewhat similar to what Gusfield (1967) refers to as instrumental legitimacy. Symbolic legitimacy occurs with the public pronouncement by the agents of legal-government authority that an action or event is acceptable. This process began to occur in 1967 and culminated in the United States supreme court of 1973, which nullified those restrictive laws still in existence. The court's decisions removed the ability of sates to restrict abortion during the first trimester of pregnancy, leaving the abortion decision to the pregnant women and her physician. The court further determined that the state could regulate the abortion procedure in the second trimester expect only in ways reasonably related to maternal health. Finally, right to restrict abortion in the final trimester except when it might be necessary to preserve the life or health of the mother.

Institutional legitimacy comes about when the action is incorporated openly into the mainstream of the established institutional structure of the society. Institutional legitimacy began in the mid 1960s, and, is still far from complete. In the early stage, abortion reform groups had to work within a strictly illegal framework. The first step taken was to provide counseling and referral services. While they could not provide women with legitimate, professional care, they

[70] Mary K. Zimmerman, (1977).

could attempt to channel women to the safest, most economical abortion available. They could also attempt to avoid as much as possible approximating the stereotype abortion situation, which horrified most women. As soon as the first states began to reform old laws, reform group were able to expand and improve their services, referring thousands of women to areas of the country where legal, high-quality medical facilities were available. Institutional legitimation has been only partially achieved. When one considers the percentage of abortions now performed in established medical setting, legitimation appears considerable. When, on the other hand, one consider the resistance of many hospitals and the uneven availability of abortion services, then the incompleteness of the legitimation process is much clearer.

Moral legitimacy exists to the degree that societal member's attitudes confirm the propriety and acceptability of the action in question. Public attitudes do not necessarily follow changes in the social structure of a society – at least not directly nor immediately. She finds that social change such as is involved in the legalization of abortion, followed by the provision of the institutional setting where abortion are routinely obtainable –although not uniformly available- has not accompanied by parallel change in the moral definition of abortion. Among many, abortion continues to be viewed as immoral act. The author indicate that the guilt feeling which result from the discrepancy between what is legally permissible and moral belief is the price which they must pay. [71]

Thus, the normative, ambivalence and vagueness along with a relatively high frequency of occurrence, have characterized abortion historically, creating cultural ambiguity. In one sense, abortion is not yet fully legitimized. Specifically, while abortion is legal, and legitimate medical activity, but, from the standpoints of societal members abortion is not a moral act. The ambiguity between abortion and society throughout the past is still present today.

[71] Ibid. p, 32-36.

CHAPTER II

FEMINIST PERSPECTIVES ON ABORTION

.... that all the while the fetus is forming .....Even to the Moment that the soul is infused, so long it is absolutely not in her power only, but in her right, to kill or keep alive, save or destroy, the Thing she goes with the, she won't call it child; and that therefore till then she resolve to use all manner of Art, to help of drug and physician, whether Astringent Diuretic, Emetics, or of whatever kind, nay even to Purgation, Potion, Poisons, or any thing that Apothecaries or Druggists can supply...

DANIEL DEFOE [1]

Behind Defoe's scathing condemnation of female malice in the act of abortion lies the presence of not only'' right to life'' antecedent in seventeenth-century England but the idea among women that abortion is a woman's right'. Women have demanded abortion but their access to services has been restricted by a number of social and legal hurdles. Far from being static, the norms governing the ethic of abortion have been modified from time to time and from one social context to the other. However, it is noteworthy that regardless of their (restrictive or permissive) orientation, abortion norms and laws has been directed, almost invariable, towards the fulfillments of extreme social needs. Women and their right to determine their sexuality, fertility and reproduction are considerations that have seldom, if ever, been taken into account. [2]

Abortion always has been the important subject of feminist's discussion. They claim that abortion is right. The feminist views on abortion have been always the centre of debates. They do not consider themselves as pro abortion but demand that abortion should be a woman's right, as part of the right of women to control their bodies. For feminists abortion means women's right to choose or reject motherhood and they should have control over their bodies and decision in regarding reproductive life.[3] In this

[1] Petchesky,Pollack Rosalind(1985).
[2] Jesani Amar and Iyer Aditi,(1993).
[3] Cannold, Leslie,Rene,Denfield,(2000).

chapter I would analyze the feminist views on abortion by using the three models viz. social, medical, and legal.

SOCIAL & MORAL MODEL

The task of feminist ethics on the topic on abortion is to begin with a look at the role of abortion in women's lives. In this model they claim that the social situation of women justifies the view that individual women must be the only persons to determine whether their pregnancies should end or continue. They claim that every women has right to have control over her body, her sexuality, reproductive life, and the freedom to decide how many and when to have them. "Abortion is the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood, and young women's sexuality are contested.[4]' The feminist claim to reproductive freedom thus provokes powerful opposition from those who adhere to the traditional view of women's sole function as mother and wife.

Historically, opposition to women's reproductive choice centered not on a concern with fetal life, but on the desire to keep women in their biologically defined and subordinate place, and on a moralistic condemnation of all non-procreative sexual activity. Today, these goals are no longer constitutionally or culturally legitimate and a professed concern with protecting fetal life dominates the debate. While some anti-choice activists sincerely believe in the personhood of the fetus, the movement's systematic hostility to the welfare of born children strongly suggests that something else is at work. Protection of unborn life has become a surrogate for other social objectives.

Nevertheless, abortion opponents persistently invoke the image of the fetus, and the image now permeates contemporary abortion discourse, due partly to the development of medical diagnostic imaging technology. Fetal imagery, even when accurate, distorts human pregnancy by wrenching it out of its biological, historical and social context. Barbara Katz Rothman observes that "the fetus in uteri has become a metaphor for 'man' in space, floating free, attached only by the umbilical cord to the spaceship", while the

[4] . Petchesky,Pollack Rosalind(1985).

pregnant woman "has become empty space." The fetal image thus serves a political function. It becomes the most potent symbol of helplessness demanding paternal protection. In its loss is condensed the multiple losses of family, economic security, national strength, motherhood that, patriarchal power under the likes of Reagan or Bush promise to revive again. "Saying the fetus" and "Saving America" go together, and they both require a strong male leader. [5]

Linda Gordan lays the ground for a feminist theory of reproductive freedom, she argues that through out the history women have practiced form of birth control and abortion; recurrent moral and legal prohibition against such practice merely' forced underground in their search for reproductive control''. [6]

The universality in birth control practices helps us to understand that reproductive freedom for women is not simply a matter of developing techniques that are more sophisticated. While the ascent from ''purgations, potion, and poison'' to vacuum aspiration doubtless represent a gain foe women political, not technological agenda which feminists find necessary to mobilize over and over again.[7]

Susan Sherwin[8] a feminist, her argument on abortion seems to rest on two claims:

(1) the social situation of women justifies the view that individual women must be the only persons to determine whether their pregnancies should end or continue, and

(2) The personhood of a foetus is a function of the social relation that exists (or does not exist) between woman and her foetus.

The Feminists views society as patriarchal or in other words man centred, or man dominant. Through the years of history, these patriarchies and other clamour to control reproduction and worked feverishly to recast the womb according to the need and dominant ideologies of the days. Fascists, socialists, Dictators, Monarch, Theocrats, and

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[5] Rachae,N . Pine and Sylvia,Law. (1993)..
[6] Linda Gordan (1977).
[7] Petchesky,Pollack Rosalind(1985).
[8] Sherwin,Susan (2004).

even the Democrats have all harnessed women's reproductive functions to state policies in the past, and continue to do so now. This strong bag of muscle in a women's body called the uterus or the womb has been subject to a variety of role-plays, cast, uncast, and recast by patriarchies. [9]

Feminists feel that the ethics we now use to evaluate such topics as abortion are based on principles generated out of male interests and are unable to recognize female needs and experiences. Since the dawn of our culture, women have been dominated by men and have never been able to exist solely outside this arena. Accordingly, the feminist approach towards abortion can be summarized as a focus on the consequences of pregnancy for women in all areas of their lives.[10] Denying women the right to abortion makes women bears all the hardship and blame for unwanted pregnancies, ignoring the fact that men bear responsibility too, and that many unwanted pregnancies result from unwanted intercourse. For many women; and especially young, an unwanted pregnancy can alter irrevocably the course of their lives, closing off the options forcing them into marriage they do not want, or making them raise a child without social and material support. No women want an abortion if she can help it, but sometime it is the only way out. [11]

Sherwin writes, "Feminists analysis regards the effects of unwanted pregnancies on the lives of women individually and collectively as the central element of the moral examination of abortion; it is considered self-evident that the pregnant woman is the subject of principal concern in abortion decisions."[12] Feminists hold that an ethical issue must be re-assessed because of the social context that subordinates women, such as our patriarchal society. Sherwin argues that there are many instances where men dominate women to subordinate them to a certain social role. Our society builds a patriarchal context in which women must remain dependent upon men for their needs, especially when they are pregnant because it is much more difficult to provide for one. Sherwin argues that women must have the freedom to choose abortions because in

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[9]. Bhargavi Nagarajan,(1988).
[10] Shrage,Laurie (1994).
[11]Bishop,Nadean(1984).
[12] Susan Sherwin,(2004)

many cases women are unable to control their own sexuality. This she attributes to women's subordinate status. [13]Furthermore, if women are unable to receive abortions on demand this subordination is likely to increase because of the responsibility of caring for a child, and the increased finical need, and the decreased economic opportunities associated with childcare. Sherwin continues to argue that this dependence will imply a sexual loyalty on her part, restricting her sexuality, and further perpetuating the cycle of oppression. Feminists believe that the decision to abort is best left up to pregnant, woman for the only she truly knows what is best in her situation. According to Sherwin, feminist analysis of abortion differs from most other perspectives because feminist analysis focuses on how the woman got pregnant. She points out that the pro-life movements have argued that women can avoid unwanted pregnancies by simply avoiding sexual intercourse. Sherwin believes that currently and historically women have little control over their sex lives, and therefore have little control over the decision to become pregnant. She adds that women are often subject to rape by strangers and those known to them. She says sexual coercion is a common practice, and often isn't even realized by the woman. The way we are socialized determines whether we will participate in sexual intercourse. Sexual intercourse is rarely desired, but is instead the result of force, compliance, or accommodation. Sherwin goes even further to argue that birth control alone cannot be expected to prevent pregnancy. Further, because of the awareness of this dependency pregnant women are culturally forced to use unhealthy means of avoiding pregnancy. These means of avoidance can often be expensive and unsafe for the female user. She argues that there is no form of birth control available that is both safe and reliable. The most effective means available, namely the birth control pill or the IUD, are known to involve health hazards for women, and therefore she cannot be expected to spend her reproductive years on these medications. As for the safer methods, being diaphragms and condoms combined with spermicidal foam or jellies are inaccurate, awkward, and expensive. This, she argues leaves only one safe and fully effective form of birth control, the use of a barrier method with the back up option of abortion. These types of implications necessitate that abortion be accessible for women to remedy the condition they are placed in by the patriarchal society.

[13] Ibid.

Further, need to understand that pregnancy occurs within the female and has intense consequences upon their lives. Specifically, women undergo the desire of abortion and thus the laws and moral codes solely affect women. Thus, the issue of abortion should be tackled by the perspective of women because it involves their lives.[14]

Further, feminists would argue that the feelings of a woman considering an abortion should be relevant to her moral decision. Considering the issue of abortion in more detail the feminist would maintain that abortion services are essential. Sherwin's moral defense of abortion rests on two claims. The first of these two claims is that the social situation of women justifies the view that individual women must be the only persons to determine whether their pregnancies should end or continue. [15]

Feminists stress that women must be acknowledged as full moral agents, responsible for making moral decisions about their own pregnancies. Women may sometimes make mistakes in their moral judgments, but no one else can be assumed to have the authority to evaluate overrule their judgments.

Feminists insist that women ought to be recognized as moral agents with the capacity of autonomy and self-determination over their own bodies. Although women may mistakes in judgments, this does not remove their capacity of self-determination, or as autonomous individuals. Feminists maintain that women are the only ones with the capacity and experience to make an accurate decision. Women contemplating the issue of abortion are the only one's capable of determining the consequence because they are the only ones who can fully know the situation and implications of the decision.

Sherwin (2004) argues that there are many implications on women's autonomy and sexuality within the issue of abortion and this must be considered carefully. From a feminist perspective, women in our society must stay with a man for support during the pregnancy. Pregnancy brings the woman under a disadvantaged condition in which she must rely on the support of a man to provide the necessities of life. To support her first claim that the social situation of women justifies the view that individual women must

[14] Ibid.
[15] ibid.

be the only persons to determine whether their pregnancies should end or continue, Sherwin argues:

No one other than the pregnant woman in question can do anything to support or harm a fetus without doing something to the woman who nurtures it. Because of this exorable biological reality, the responsibility and privilege of determining a foetus's special social status and value must rest with the woman carrying it.

This claim is fallacious because it disregards men's inherent responsibility to the foetus. The interpretations of her argument as Women are responsible for the foetus. The responsible person is the only one able to make a moral choice. Therefore, the woman ought to make the moral choice about the foetus. This argument flows from the Western feminism has traditionally taken the position that the right to abortion is a fundamental and non-negotiable demand, a right to self-determination to which all women entitled.

THE FEMINISTS VIEWS ON FOETUS

The second section of this chapter discusses the feminist view of the foetus. As the debate currently stands, a competition has been established between the rights of the women and the value of the foetus. Sherwin (2004) argues however, that there are other accounts of foetal value that are more plausible and less oppressive to the lives of women. The feminist perspective examines foetal development in the context in which it occurs in women's bodies. In the feminist perspective, the value of the foetus is relational rather than absolute. The feminist perspective argues that what is valued about persons is not existence, but instead personality. Therefore, foetuses must not be viewed as morally significant because they have not developed sufficiently in a social relationship. Sherwin concludes this section by saying that because of the status of the foetus, within and dependent on a woman, the responsibility and privilege of determining its social status and value lies within the women. [16]

[16] Ibid.

ABORTION AS REPRODUCTIVE RIGHT

Gender forms a basis in all societies for the division of labour, and the social allocation of rights and responsibilities. Hierarchies of age, race, ethnicity, religion, caste, and class, among other distinctions, inequalities based on gender pervade every aspect of social life and affect girls' and women's chances for survival and security in fundamental ways.[17] Historically for women, it has been a never-ending saga of pain and violence, of subordination and oppression, of economic deprivation, of gender inequality, of suppression and oppression of struggle against the onslaught of multiple patriarchies in the family, in the individual relationship and in wider society. The gain of the women's movement, so bitterly fought and precariously won, are still threatened by structure, system, and institutions in the society wherein the dominant male ordered ideology dictates the assumed legitimacy of handing over the control of women's minds and bodies to men the family and the states.[18]

The emergence of women as a self-conscious interest group that claimed abortion as a right marked a new and fundamentally different stage in the abortion debate.

The women's movement, beginning with the first wave of feminism particularly fought for women's right. By the 1960s, the right to abortion had come to be seen as essential to women's right to equality as ''individuals''.[19] Reproductive right has been a major demand of the women liberation movement. Perhaps one of the most publicized political and social issues of this decade is the issue of the reproductive rights. A number of social and political phenomenons have played a catalytic role in the emergence and current visibility of women's reproductive rights. Since the establishment of the U N commission on the status of women (cws) in 1946, the international community has adopted treatise and recommendation to promote women's rights in political, economic, civil, and social field. It was not until the recent decades that the right to make reproductive decision was recognized as a fundamental human right. The population control movement in some developing countries have contributed

[17] Dixon-Mueller,(1993,).
[18] Bhargavi Nagarajan,(1988).
[19] Luker,Kristian,(1984).

to the current visibility of the women's reproductive right as a social issue. Reproductive rights include the rights such as right to decides on the starting, spacing, and stopping of the fertility. The basic right to decide on the spacing and number of children may not be taken for granted universally even today.[20]

Although reproductive rights include an entire gamut of the issues, such as sex education, access to contraception and an end to forced sterilization of the poor and minority women, at its core is the question of abortion. Controversy over abortion preceded the women's movement by many years, and feminists did not initiate its resurgence as a contemporary issue. The American civil liberties union was the first national organization to support it publicly, in 1965, and the ACLU has sponsored the key court case since then. National organization to repeal abortion laws have developed independently of the feminist issue movement, but the issue has nonetheless become thoroughly identified as a feminist issue. Consequently, an argument that was originally expressed in term of the right to privacy and medical safety is now primarily debated in term of a women's right to control over own body.[21]

DEFINING REPRODUCTIVE RIGHTS

Reproductive rights are a section of women's rights and as such, they cannot be considered apart from the exercise of other basic human rights. The philosophical basis for the rights remains a matter of disagreement. For some, reproductive are natural rights. For other, reproductive rights are socially determined entitlement that requires state intervention to address social inequalities.[22]

A simple definition of the reproductive rights is stated in the report of the ''women's global network on reproductive rights'' on its conference in Madras (MAY 1993). ''Reproductive rights are about self-determination in matter of procreation and

[20]Vijayan K.Pillai.,and Zhen ,Wang Guang,(1999).
[21] Nadean,Bishop (1984)
[22] Vijayan K. Pillai,and Zhen Wang Guang (1999)

sexuality. Reproductive rights are about us being in charge of our bodies/ourselves, our freedom to express ourselves, sexuality, and to be free from abuse.[23]

According to Petchesky[24] and Correa (1994) '' four basic ethical principles lie at the heart of reproductive and sexual rights bodily integrity, personhood, equality, and diversity. Each of these principles can be violated through act of violation and abuse-by government official, clinicians, and other providers, male partner, family members etc, or through acts of omission neglect or discrimination by public authority (national, or international).

Bodily integrity

The right to bodily integrity means the right to security in and control over one's body, and it lies at the core of reproductive right. The right of women to ''control over' or ownership of their bodies does not imply that women's bodies are mere thing separate from themselves and isolated from societies and communities. Rather, it sees the body as an integral part of one's self whose health and well-being are the very basis for participation in society. Hence, bodily integrity is not just an individual but also a social right. Yet, the principle of bodily integrity also means that in its specific applications, reproductive rights through necessarily social are also irreducible personal. While they cannot be fulfilled without economic development, political empowerment and culture diversity, their site ultimately is individual women's body.

Bodily integrity, firstly includes ''a women's right not to be alienated from her sexual and reproductive capacity (e.g. through coerced sex or marriage, genital mutilation, denial of access to birth control sterilization without informed consent etc). It also implies her right to be free from sexual violence from unsafe contraceptives method, from unwanted pregnancies or coerced childbearing and from unwanted medical interventions. Such negative abuse soccue at various levels in relation to sexual partners, kins, clinicians, state, and or military campaigns (example coercive fertility reduction programme or rape of women as a tool of ethnic cleansing).

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[23] ibid. p.19-28.
[24] Petchesky, Rosalind and Correa Sonia (1994). p.107-120.

Bodily integrity also implies affirmative rights to enjoy the full potentional of one's body for health, procreation and sexuality. The term integrity in relation to health implies ''wholeness'' as against treating the body and its present needs and fragments.

The right to procreation

The right to procreate is highly complicated because patriarchal kinship system throughout the history used such claims to confine and subordinate women. Procreative rights, nevertheless is integral to reproductive rights. It implies participation in the basic human practice of raising and nurturing children, to give birth under safe and decent conditions, good health etc. it also implies transformation in the prevailing gender division of labor. The principle of bodily integrity also stands for the right of sexual pleasure and freedom. The expression of this, however, becomes complicated in the context of raising prevalence of HIV/STDs infection. However, this does not diminish the right of all people to responsible sexual pleasure in a supportive social and cultural environment. This requires sex education, re-socialization of male and females. This gives bodily integrity a significant social right dimension, which has become very relevant now.

Personhood

Personhood in this context refers to women's right to be treated as principle actors and decision makers in matter of reproduction and sexuality, i.e. they should be treated as subject, not object of medical, social and family planning policies.

Equality

This principle implies in two areas, one in the areas of gender division between men and women. The second is in the area of relation among women i.e. that condition like age, class, nationality, and ethnicity, which divided women as group. In the area of gender division reproductive rights is one strategy within a much larger agenda, which seek to do away with the social biases against women that lie in their lack of control over their body and reproduction.

The principle of equality, brings to the fore the debate on equality versus ''difference on the surface this seems to pit the equality principle against the principle of personhood. It may seem that the agenda that privilege women's control in reproduction reinforced a gendered division of labor, which confines women to the domain of reproduction. However, a more serious study of the problem shows that the emphasis on personhood and the need of take responsibility for fertility control is rooted in other kinds of gendered power imbalance which work against a ''gender equality'' approach to reproduction health policies. Therefore, there is a need to address lager issues. This includes the social system where no educational or economic incentives are provides and the need to encourage malt participation and involvement in childcare etc.

Coming to the application of the principle of equality in the second area i.e. inequalities among women, the example of certain contraceptive method, such as Norplant (which carry risks but whose long-term effect are not known) such methods are tested targeted or promoted among poor women. On the other hand, beneficial methods such as condoms, low dose hormonal pills or hygienic abortion facilities may be available to women with financial resources. Therefore, equality among women requires that government and international organization which promote reproduction and sexual right, should address such differences. Freedom to ''choose'' whatever method is therefore linked to geographic access, financing, high quality services and supplies etc. Thus as pointed by Gita Sen, R. Petchesky, S.Correa, the question on human rights, development and reproductive rights becomes inseparable because the economic and political change needed to create the necessary condition is not just a matter of development, but of social rights.

Diversity

The diversity principal requires respecting the different values, needs, and priorities among women based on culture, ethnicity, religion, sexual orientation, and nationality, but as women, not as a male kin politician or religious leaders define those values, needs, and priorities. Different religion and cultural values shape women's attitudes towards children bearing, towards medical technologies. While defending the universal

applicability of sexual and reproductive rights, there is a need to acknowledge that rights do have different meaning, different points of priority in different social and culture context.

Reproductive rights also implies as:(1) the freedom to decide how many children to have and when to have them; (2) the right to have the information and means to regulate one's fertility; and (3) the right to "control one's own body".[25] As a concept, reproductive right was originally formulated by women activists, or better says, women's groups involved with health issues such as reproductive health and it contains a radical critique of patriarchal society and the dominant development model.[26] The attention has been drawn to the ways in which women's roles and status are fundamentally linked with the reduction of women through social and political process.[27]

Reproductive right also stands for (1)the right to liberty and security, (2)the right to decide whether and when to found a family (3)the right to decide with whom to found a family,(4)the right to choose when and how to space births,(5)right to informed consent in all aspects of reproduction and sexual life. Protection of bodily integrity is an essential aspect. Other rights include the right to health, right of access to reproductive health care including family planning, right to appropriate counseling and quality care.

Male-gendered institutions of government, religion and the health professions have justified intervention in women's reproductive self-determination by invoking their own principles of public order, morality, and public health. There are still laws against contraception and abortion in many countries; women lack control over their sexual and reproductive lives and the overall quality of reproductive health care is poor. In addition, the statistics show the interconnection between poverty, lack of reproductive rights, and women's mortality.[28]

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[25] Dixon-Mueller, (1993)
[26] Vuola, (1998,).
[27] Ibid.
[28] Idib.

REPRODUCTIVE RIGHTS: INDIVIDUALISTIC OR SOCIAL

There are two essential ideas underlie a feminist view of reproductive freedom. The first is derived from the biological connection between women bodies, sexuality and reproduction. It is an extension of the general principle of ''bodily integrity'', ''bodily self- determination'', to the notion that women must be able to control their bodies and procreative capacities. The second is a moral and historical argument, based on the social position of women and the needs that such a position generates. It states that, insofar as women, under the existing division of labor between the sexes, are the ones most affected by pregnancy, since they are the ones responsible for the care and rearing of children, it is women who must decide about contraception, abortion, and childbearing.[29]

Reproductive right is characterized by two dimensions. The first emphasizes the individual dimensions of reproduction, the second the social dimensions. The first appeals to a ''fixed'' level of the biological person, while the other implies a set of social arrangements, a sexual division of labor. Finally, one is rooted in the conceptual framework of '' natural rights'', while the other invokes the legitimating principle of ''socially determined needs''. [30]

Rosalind Petchesky argument is that reproductive freedom –indeed, the very nature of reproduction – is social and individual at the same time; it operates ''at the core of the social life'' as well as within and upon women's individual bodies.

The individual dimension

The principle of bodily self-determination has three distinct but related basis-liberalism, Neo-Marxism, and biological contingency. Its liberal roots may be traced to the Puritan revolution in seventeen-century England. In that period, the levelers idea of a ''property in one's person'' was linked explicitly to nature paralleled the idea of the ''nature right ''to property in goods: ''to every individual in a nature is given an

[29] Petechesky. (1985)
[30] Petchesky (1985)

individual property by nature, not to be invaded or usurped by any. A person, to be a person, must have control over himself or herself, in body as well as mind. Control over one's body is an essential part of being an individual with need and rights. The direct connection between ''control over one's body'' and feminist claim regarding women's control over reproduction seemed obvious to early birth advocates. Ezra Heywood, an anarchist birth controller in the 1870s, asserted ''women's nature right to ownership of and control over her body self – a right inseparable from women's intelligent existence. This connection is real today. Because pregnancies occur in women's bodies, the continued possibility of an ''unwanted pregnancy affect women in a very specific sense, not only as potential bearer of fetuses, but also in their capacity to enjoy sexuality and maintain their health. A women's right to decide on abortion when her health and her sexual self-determination are at stake is ''nearly allied to her right to be''. Reproduction effect women as women; it transcend class division and penetrates everything –work, political and community involvements, sexuality creativity, dreams. This idea has a radical edge, which rejected the commoditization of the body.

The Neo Marxist linage of reproduction rights may be traced to the writings of Herbert Marcuse, in his essay on Hedonism. Marcus analyzed the contemporary forms of domination and suppression, which result in the alienation of the individual from the sense of connectedness with his or her body and with the physical and social world. Marcus arrived at hedonism as containing a libratory element that element is a sense of ''complete immediacy of sexuality'' which Marcus suggest is a necessary pre condition for the development of personality and the participation of the individual in the social life. This link between eroticism and politics is a receptivity that is open and that open itself (to experience)control over one's own body is a fundamental aspect of this sense of immediacy, this receptivity a requirement of being a person and engaging in conscious activity.

The third aspect is biological contingency. It is important, however, to keep in mind that women's reproductive situation is never the result of the biology alone, but of biology mediated by social and cultural organization. That is, it is not inevitable that women, and not men should bear the main consequence of unintended pregnancy and thus that

their sexual expression be inhibited by it. Rather, it is the result of the socially ascribed primacy of motherhood in the women's lives. Yet biology as it is socially mediated by male dominant institutions affects all women. Yet reminds us that bodily integrity '' principle has an undeniable biological component. As long as women bodies remain the medium for pregnancies, the connection between women's reproductive freedom and control over their bodies represent not only a moral and political claim but also, on some level, a material necessity.

The social dimension

The idea that biological reproduction is a social activity is essentially Marxist in aspiration. Marx defines that three aspect of social activity: social relationship, according to Marx comprise of the production of material life'', production of new needs and human procreation – reproduction within the family. It has been attested in recent writing as in Michael Foucault that sexual meaning and practices like the meaning and practices of motherhood, vary greatly through history across cultures and within the same culture. This reinforces, like that natural human experiences, like reproduction are constantly mediated by social praxis and design. It has been argued by feminist like the one Linda Gordon that contraception, abortion and child-rearing practices throughout civilization has been transformation by conscious human intervention. The existing birth control methods and technology and access to them class division and the distribution /financing of health care, nutrition, employment, the state economy in general, provides the definite material conditions, which sets the limit of reproduction process. The social relations and social arrangement within which women give birth involves herself her sexual partner(s), children, kins, neighbor ,doctors ,family planners, employers, church, and the state etc. thus such a view pays central attention to social rather than the biological basis of reproduction. This view defines reproduction rights in terms of the principle of social determined needs. In other words, reproduction right is the moral imperative, which grows out of the historical and culturally defined position which women find them in through motherhood.

The emphasis on the social dimension brings to the force the issue of women's autonomy and empowerment. This implies that women must have the capacity to manipulate their social environment without which ''right to choose becomes meaningless. Hence, the social dimension of the reproductive rights stress the need to create a broad range of social, economic, and cultural conditions. These are broadly referred to as the enabling condition. Thus reproductive rights become claim on behalf of collectivities for social justice that the static and mediating institutions must implant defined pose a direct challenge from basic health care policies (e.g. structural adjustment programme).

The social dimension of reproductive right also does away with the artificial created public and private sphere. According to dualistic vision of society (classical liberal rights discourse), rights exist in a private domain where individual are to be left alone. Feminists have criticized such a public – private division. They point out that both domains in most societies tend to be dominated by men and male dominance in one sphere reinforces it in the other. The social dimension of reproductive rights by rejecting the dualistic vision allows the states and the international agencies to legitimately intervene in the traditionally defined ''family matters''.

However, reproductive rights as social rights must not be treated in absolute terms. The limitation of such an approach is disturbingly suggested in Alison Jagger's defense of abortion. If the whole community assume the responsibility for the welfare of mother and children, the community as a whole should now have a share in judging whether or not a particular abortion should be performed. Such a notion evokes absolute communitarians, which can be a conceptual trap. Authoritarianism after underlines the ideal of the community, which quite often appropriates them towards their own end.

Thus to view reproductive rights as purely individualistic or as exclusively social would not only be insufficient but also dangerous. Hence, despite the tensions and contradictions between two aspects of reproductive rights, they have to be linked together. Reproduction itself is irreducibly social and individual at the same time e.g., it operates at the core of social life as well as within and upon women's individual bodies.

Therefore, strict compartmentalization of reproductive rights as individualistic or as social rights would render reproductive rights meaningless.

However, it is important that strategies for establishing reproductive rights must lay more emphasis on one dimension over the other in accordance with different historical and political, context. (This is not suggest that other aspects should be ignored)

Reproductive rights must be defined in terms of power and recourse: power to make informed and decision about one's own fertility, childbearing, child rearing gynecologic heath and sexual heath and resources to carry out such decision safely and effectively. It is a dynamic concept, which is linked to the idea of social change necessary to eliminate poverty and to empower women. Hence, it dissolves the boundary between sexuality, human right and development.

MEDICAL & LEGAL MODEL

Petechesky[31] examine the contradictory implications from a feminist perspective, of regarding abortion as ''health issue'' for women. She argue that neither a ''medical model (supported by political liberals, family planners, and clinicians) nor a moral model (supported by pro-lifer but also by many pro choice), advocates of freedom of conscience adequately represent a feminist position on abortion. For feminists access to safe abortion is an unmistakable condition of women's reproductive health, but also their sexual freedom and their moral autonomy. A viable feminist politics of abortion for the 1980s has to encompass all these dimensions as well as the tension between abortion as an individual right and as a social need.

The moralization and sexualization of abortion issue by the new right must be understood as a reactionary response to feminist ideas, and particularly the idea that safe legal abortion is necessary (though not sufficient) condition of women's autonomy as moral and social beings and their sexual self expression. But this refocusing of the politically debate around abortion has simultaneously meant that the health dimensions

[31] Petchesky,Rosalind Pollack (1985).

of abortion – which family planners and clinician in the past tended to emphasis almost to the exclusion of moral and sexual issue have nearly gotten lost. Feminists since the days of illegality have opposed the idea that abortion to be justified, has to be based on therapeutic criteria, medical necessity, or any reason other than a women's own judgment about whether or not she wished or was able to bear a child. Abortion has always been for feminists and for most women a decidedly moral and sexual question and not only a matter of health.

She analyzed the contradiction inherent for feminist politics in the views and policies, which define abortion rights in medical terms. First, she goes through the history of the medical model of abortion in the period prior to legalization and examines how that model became integrated in thinking of policy makers and the courts as the dominant justification for the abortion. In this part of the analysis, her emphasis will be on how that model has been used to assure medical control over abortion services and in practice to exclude all but selectwomen from access to them. This experience helps to explain feminist skepticism towards the ''medical necessity'' standard as one that confines women's reproductive control within narrow limits and vitiates the idea of reproductive freedom of any moral control.

The second point is that why a feminist view of abortion must also take into account that the question of abortion is intimately connected to women's health.

In the face of this reality, she argued that ''health model of abortion right, rather than a ''medical model''; one which posits the legitimacy of abortion not only in terms of women' need to control their bodies and sexual experience but also in terms of the basic need for decent health care made equally available to all people, regardless of class, race, gender or age and she attempt to distinguish this plumiple front one whose main end is professional autonomy for doctors. From a feminist perspective, there cannot and should not be a dichotomy between health and morality.

Abortion on demeaned and women's right to control over her body were never ideas that carried much weight in family planning medical association and policies. They

emphasis only on the legitimacy of ''therapeutic abortion''. This concept that the condition justifying abortion are those that involve a women's health, though this may be broadly defined to include a women's mental or emotional health as well as fetal health. Those exclusively qualified to determine when such conditions or ''medical indications exist and to administer the procedures are certified physicians.

From a feminist perspective, the concept of ''medical necessity'' or' therapeutic'' abortion implies that all non-medical abortion are elective meaning they are somehow frivolous, merely ''personally necessary''. This bifurcated view distorts reality, denying that familial, economic, and sexual condition as well as physical health creates genuine, pressing needs that justify abortion. It also reduces the meaning of health ignoring the extent to which medical problem them are related to social, economic, family, and sexual condition. On the other hand, it contains the old eugenic idea of child bearing as a scientific undertaking for which only certain women are fit. Thus, it can allow abortion in some cases because in those case women are seen as too poor, too young, or too physical and mentally incompetent to bear children; or some foetus as too defective to be born. Abortion and contraception become, in this framework not a right of women to self-determination, but a duty to the nation, the race, the family, or even the self. In this ways, therapeutic eugenic discourse about fertility control including abortion, allows the liberal states to accommodate without at the same time legitimating feminist demands.

Feminists have long raised vocal opposition to the distinction between therapeutic (necessary) and elective (unnecessary) abortion: radical and socialist feminist, working consciously and rejected both the medical model of reproductive health and (though not always) population's goals as the basis of birth control. In contrast to family planners and public health practioners, feminists put towards a libertarian view of abortion on demands as to control their bodies and pregnancies.

All the excellent supporting reason – improved health, lower birth and death rates, freer medical practice, the separation of church and the state, happier families, sexual privacy, lower welfare expenditure are only embroidery on the fabric: woman's right to

limit her own reproduction. It is this rationale that the new women's movement has done so much to bring to the fore. Those who caution us to play down the women' rights argument are only trying to put off the inevitable day when the society must face and eradicate the misogynistic roots of the present situation. And anyone who has spoken publicly about abortion from the feminist point of view knows all too well that it is feminism –not abortion- that is the really disturbing idea[32]. (cisler 1970:276)

Feminists adamantly opposed ''reform '', which they contrasted to the more radical demand for repeal. They argued that any other position was steeped in medical and other conditions that denied women's capacity and right to make their own reproductive decision. Medical and legalistic models of abortion, they pointed out, focused on ''hardship'' situations- rubella, rape, and mental illness and thus ''always pictured as women as victims... never as possible shapers of their own destinies''. In addition, these models implicitly suggested that women were incompetent to act as moral agents on their own behalf. Repeal, on the other hand, would simply abolish any restrictive, discriminatory conditions impeding abortion, so that medical authorities could no longer be used as moral great keepers. Legal abortion had always been possible in some states to save a woman's life or spare her serious ''health problem. But to obtain an abortion even under these requirements involving going through hospital committees and private network that were penetrable only to privileged women. These restrictions effectively excluded poor women who lacked the personal connection to private doctors and the funds necessary to obtain a safe hospital abortion.

During the late 1960s, radical feminists made clear the difference between their approaches, which emphasis concrete access to abortion for all women. Feminist consistently opposed legislative proposal that restricted legal abortion to ''licensed physicians and therapeutic criteria, insisting on the importance of Para-medicals and non-hierarchical form of reproductive health care if all women were to have access to services. This is a practical way to criticize the elitism of the medical care system and the abstract idea of abortion as a ''private matter'' between a woman and her doctor''. For the majority of the women do not have access to a cosy, and confidential

[32] Petchesky .(1985)

relationship with the doctors, traditionally the ticket to a safe abortion. Thus, the feminist position implicitly called for substantive change in the quality and condition of reproductive health care.

ABORTION AS A DILEMMA FOR INDIAN FEMINISM

In a global context where induced abortion is restricted by law and even criminalised in several countries India enjoy the dubious distinction of being a country where abortion is legal but largely unsafe and unavailable. In 1972, with the implementation of the Medical Termination of Pregnancy (M.T.P.) Act of 1971 India joined 25 other countries, which had enacted a legislation decriminalizing abortion and making it legally available. The M.T.P. Act of 1971 permitted abortions to be performed not only on therapeutic and eugenic grounds, but also for humanitarian reasons such as pregnancy resulting from rape, for pregnancy resulting from contraceptive failure, and for 'social' reasons: 'where actual or reasonably foreseeable environment (social/economic) would lead to risk of injury to the health of the mother.[33] Assessments of India's abortion scenario in the 1990s raised an alarm bell. The legalization of abortion had not solved the problem of morbidity and mortality related to septic abortion. A larger number of women were found to be seeking abortion services outside the approved facilities in the 1990s than was the case in the 1960s when concern on this score brought about the MTP legislation. Mortality from septic abortions was estimated to range from 11% to 20% of all maternal deaths in the late 1990s morbidity amongst the mothers.' [34]

Unlike in many countries of the world where liberalization of abortion was and is a central demand of the women's movement, in India abortion was never framed as a women's reproductive rights issue, affecting women's ability to control their sexuality and fertility.

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[33] Karkal,Malini(1991).
[34] Ibid. p. 223-230

The debate about the reproductive freedom and women's choice has the taken a new ominous turn in India, because of subordinate position of women in India society as well as the growing practices of selective abortion of female fetuses after sex determination test during the pregnancy. The liberalizing abortion in patriarchal country like India where women have little say in the most matter even on there is no strong health education programme and where abortion is seen as a family planning measure .it cannot be seen as promoting women's right but aggravating hazard to women's lives, these reproductive rights are difficult to translate operationally in a society where the reproductive unit is still in the family hold where practice of marriage and birth are family oriented and where women lives are deeply embedded within families and communities. In more educated circle, the practice of selective abortion is increasing.[35]

The liberalization of abortion services in India took place in 1972 in relative isolation from the women's movement. Until then, the efforts of the movement were concentrated on subverting criminal law without politically articulating specific demands. This may partly (but not wholly) be attributed to the absence of a strong feminist current within the movement during the 1960s and early 1970s (for despite the growing strength of feminism during the last decade, abortion continues to be an issue receiving low priority). Secondly, anti-abortion votaries in India are not as belligerent or as strident as their counterparts elsewhere; as a result, feminists have not been driven to adopt abortion as a programmatic issue. Thirdly, the low priority may be engendered by the unawareness of the fact that legalization has not actually been buttressed by safe and humane abortion services.[36]

In India, the issue of abortion has entered the lexicon of feminist struggle through a very different trajectory from that followed in the west.[37] Here the right to abortion has never been at the centre of much debate since it is seen as measure to control population. Since poverty is understood to be result overpopulation, abortion has long been accepted as a measure of 'family planning'. Far from having to struggle for the right to

[35] Gupta, Krishana (2001).
[36] Jesani and Iyer (1993).
[37] Menon (Nivedita 1993)

abortion, feminist finds that in India government sponsored programme as well as private clinics like Marie Stopes explicitly advocate the use of abortion as a method of controlling population.[38]

Clearly then, the issue of abortion appears to feminist of west quite differently than it does to the feminist of the India. Feminist of India, while recognizing that access to abortion must be retained, do not see it as under threat in their societies. To them, abortion appears as a more tool with which the reproductive autonomy of women may be controlled. As Malini Karkal points out, in India the right to abortion is often little more than a measure forced on women by husbands who refuse to use contraceptives. [39]

It is therefore for quite a different reason that abortion has become an issue for Indian feminism. For over a decade now, amniocentesis has been used to determine the sex of the fetuses in order to abort female fetuses. The vocal public on this practice, including feminist responses, nightlight issues located precisely at the points of tension in the feminist discourse on abortion.[40] First, the legislation curbs on sex determination tests demands by feminist are not easily separable from possible restriction on the access to abortion itself. Second, there is a profound philosophical incoherence involved in arguing for abortion in term of right of women to control their bodies, and at the same time demanding that women be restricted by law from choosing specifically to abort female fetuses. The another criticism about abortion as a right from feminist perspective is that how they can claim that abortion is right of a woman and she is the only sole decision maker about whether she should or should not continue her pregnancy, in spite of that how they claim after the delivery of child for share responsibility and where is the stand for paternity claim?

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[38] Chhachhi,Amrita,and C. Satyamala.(1983).
[39]Menon., Nivedita(1993)
[40] ibid p. 370-392.

CHAPTER- III

CURRENT SITUATION OF ABORTION IN INDIA

A number of studies exist on abortion rates and ratios, demographical profile of women, contraceptive behavior and morbidity and mortality. Much less has been written about the socio economic and gender power context underlying a women's exposure to the risk of an unwanted pregnancy, the decision making and seeking abortion services and having a safe abortion. In this chapter I will examine the studies carried out on abortion in India during 1990-2003 through gender lens. My intention is to synthesis from the body of research available, the way in which gender in conjunction with structural variables influences women's abortion experiences.

Abortion law in India, governed by the Indian Penal Code, 1862, and, the Code of Criminal Procedure, 1862 till 1971, the 1960s and 1970s saw the liberalization of abortion laws across Europe and the America which extended to many other parts of the world through the 1980s,[1] the Shantilal Shah Committee, based on a comprehensive review of abortion from various socio cultural, legal and medical aspects, recommended legalization abortion to prevent maternal morbidity or mortality on compassionate and medical grounds[2].

Abortion is possibly the most divisive women's health issues the health risk of abortion multiplies manifold if a woman has to resort to it repeatedly. Given the fact that women in India have little control over their own fertility and also have poor health, the chances are very high that they may not only experience abortion, which includes both spontaneous and induced abortion, once but perhaps more than once. [3]

Though some states looked upon the proposed legislation as a potential strategy for population control, the Shah Committee specifically denies legalization of abortion for the purpose of population control.[4] On the contrary, it stresses that to legalize abortion for

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[1] Hirve ,Siddihi (2003)
[2] Berer ,M. (2000).
[3] Phanindra Babu, Dr. N.; Dr. Nidhi; Verma, Dr. Ravi K (1998).
[4] Phadke . S. (1998),

demographic goals may be counter-productive to the constructive and positive practice of family planning through contraception[5].

The MTP Act enacted by Parliament in 1971 in 22 states and nine Union Territories (subsequently amended in 2002) seeks to liberalize abortion in India. The act was enforced in the states of Jammu and Kashmir, Mizoram, and Sikkim only in 1980 while the Union Territory of Lakshwadeep still has restrictive abortion laws.[6]

The annual estimates of abortion vary from 3.9 to 6 million, with some projections claiming upwards of 12 million. Even a conservative 3.9 million annual abortions resulted in about 70 million abortions in the initial 18 years since 1971 compared to official reported figures of 6.3 million abortions (GOI 1990) – a gross underestimate – suggesting that a majority of abortions are either not reported or take place illegally. The abortion ratio (number of induced abortions per 100 pregnancies or per 100 live births) has varied from 1.3 in large scale national surveys (IIPS 1995, ICMR 1989, IIPS 2000), to 2.1 based on government statistical sources (Chhabra 1996, GOI 1996, Henshaw 1999), to about 9 to 14 in micro-studies (Nair 1985, Kumar 1995, Ganatra 2000, Ganatra 2000a), to about 18 to 20 based on projections (Chhabra 1994, Singh 1996).[7]

In India, after the introduction of Medical Termination of Pregnancy (MTP) Act in 1972 legalizing abortion, reported MTP cases have been on increase.[8] According to available statistics, the number of approved institutions providing MTP facilities has increased from 1.877 in 1976 to 7.121 in 1991. Similarly, the number of M T P cases from a mere 25 reported in the year 1972-73, has gone up to in 632.526 in 1991-92. However, these figures are only the tip of an iceberg as it is estimated that in India, every year approximately, an additional 5-6 million abortions are conducted by private practitioners. Majority of these cases are done in rural areas having inadequate facilities and hence done in an unhygienic and unscientific way. All such abortions conducted in unrecognized clinics are considered as illegal and hence not reported in any statistics.

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[5] Government Of India (1966)
[6] Hirve ,Siddhi (2003)
[7] ibid.p. 14-19.
[8] Radika Ramasubban, Shireen J.Jejeebhoy(2000)

These illegal abortions carried out by untrained village practitioners are a major determinant of continued high levels of maternal morbidity and mortality in India. In India around 15000-20000 abortions related deaths are reported in year. The ICMR study (1989) attributed 12 per cent of the maternal deaths septic abortions due to unsafe abortions.[9] While another study puts this figure around 20 per cent. [10]

It is surprising that even after thirty years of legalization of MTP, its availability, particularly in rural area, is very limited. Recently, however, there is a growing realization towards an urge need to increase safe MTP facilities both in rural and urban areas, so that a woman could have access to safe and hygienic abortion facilities, if she desires to terminate her pregnancy. Necessity for such facilities is crucial not only from family planning perspective, but more importantly as a measure to ensure safe motherhood. [11]

Despite a liberal abortion policy, there has been no significant increase in the number of legal abortions in India, implying an overall increase in illegal abortions. Legalization has not translated into improved access to safe abortion care, access to which remains inequitably distributed. Awareness of the legality of abortion and/or misconceptions about the law among women and providers is low. [12]

LEVEL OF INDUCED ABORTION IN INDIA

Induced abortion is defined as deliberate wastage of fetus before 28 weeks of gestation and is being used for long period as an effective method of getting rid of unwanted pregnancy. If not performed in time and by professional medical person, induced abortion poses greatest threat to the reproductive health of a woman. Bongaarts et al. (1983), in their proximate determinant of fertility framework have identified induced abortion among the four most important proximate determinants of fertility.[13]

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[9] ibid. p. 139-156.
[10] Khan, M.E.; Barge, Sandhya; Philip, George(1996):
[11] ibid 208-225
[12] Bela Ganatra (2000).
[13] The Level of Induced Abortion (2004) on http://www.iussp.org/Brazil2001/s20/S21_01_Acharya.pdf.

Inadequate registration system as well as women's reluctance to admit to having had an abortion in survey setting makes the estimation of abortion level imprecise at best. While examining the issue of legalizing abortion in the mid 1960s, Shah Committee (GOI,1966) postulated, based on a study of 100 pregnancies, 73 end in live births, 2 in still births, 15 in induced abortions and 10 in spontaneous abortions. This assumption was an illustrative example to estimate the number of abortions taking place in the country and the annual expenditure incurred on them. Surprisingly, thirty years later these assumptions are still the basis for most available estimate of the actual number and the level of induced abortion regionally and nationally.[14]

Data on abortions occurring outside the legal framework is rare and unreliable. The estimates for non-legal/unsafe abortions are largely speculative and range from 2 to 5 (ICMR 1989, Karkal 1991) to 10 to 11 illegal abortions (Chhabra 1994) for every legal abortion. The '80s and '90s have shown marginal increases (about 4.5%) in the number of approved abortion facilities and in fact a relative fall (about 1%) in abortions reported by these approved facilities (GOI 1998). Access to safe abortion care is further hampered by regional as well as urban/rural inequity in availability of abortion facilities (CORT 1997). A review of public sector abortion facilities reveals that in most states less than 20% of PHCs provide abortion services (ICMR 1991, Khan 2001).[15]

While there is no reliable estimate of the magnitude of abortions that take place, a few sporadic studies tend to suggest that the proportion of women resorting to abortion could be alarming. Very few studies have tried to present some kind of valid estimates about the incidence of abortion both at the national and global level. This huge data gap in the area of abortion is to some extent due to the fact that safe and legal abortion services are far and few between with the result that a large number of women receive abortion services from illegal sources and these are never reported. [16]Further, the lack of awareness about abortion services and its legal status, and more significantly, the socio-cultural contexts of abortion also confound the reliability of abortion data. Abortion is an

[14] Bela Ganatra (2000) .
[15] Hirve , Siddhi (2003)
[16]. Chhabra Rami(1996)

extremely sensitive topic and it is perhaps unreasonable to expect reliable figures for abortion in a country like India where even vital registration - the mere recording of births, deaths and marriages - is far from being accurate, complete or reliable.

In this context, the National Family Health Survey [17] data on abortion deserves a closer examination for the simple reason that for the first time large-scale community based data on abortion has been collected. Moreover, the number of women reporting to have experienced abortion in the survey is considerably large.

State -Wise Variations in Induced and Spontaneous Abortions

Presents state-wise information on the abortion rate measured in terms of the induced abortion rate or the number of abortions per 100 pregnancies, the proportion of women who reported to have experienced abortion, and the average number of abortions experienced by a woman. Of all the pregnancies reported by the women interviewed in the survey, a little over one per cent was reported as induced abortions and five per cent as spontaneous abortions.

The induced abortion rate was the highest in Delhi (4.6 induced abortion per 100 pregnancies) followed by Tamil Nadu (4.3). The other states in descending order were Assam (2.8), Goa (2.6), Manipur (2.4) and Tripura (2.2). These states were closely followed by Punjab (1.7), West Bengal (1.7), Kerala (1.6) and Haryana (1.58). While Mizoram reported no incidence of induced abortions, the rate was very low in Bihar, Madhya Pradesh and Uttar Pradesh (the most populous north Indian states). The incidence of spontaneous abortions was also found to be very high in Delhi (7.94 per 100 pregnancies) closely followed by Tamil Nadu (7.04). Goa (6.74), Kerala (6.44), Haryana (6.54) also reported a very high incidence of spontaneous abortions, and so did Uttar Pradesh, Karnataka and the Jammu region.

Not only were the induced and spontaneous abortion rates high in Delhi, even the number of women reporting to have experienced abortions wag high: 27 per cent of all women

[17] International Institute for Population Sciences(1995)

who reported to have had an abortion belonged to Delhi followed by those in Tamil Nadu (24.4 per cent), Goa (20.5 per cent), Haryana (20.5 per cent) and Assam (20.5 per cent). The proportion of women who reported having had an abortion experience was lowest in Rajasthan, Andhra Pradesh and Madhya Pradesh (less than 10 per cent), including some of the states in the North eastern region where it was less than even five per cent.

The findings seem to suggest that Delhi, Tamil Nadu and Goa are in the lead as far as the incidence of abortion, both spontaneous and induced, is concerned. It must be noted that all the three states have very high female literacy rates and the accessibility of abortion facilities is also likely to be high. Consequently, the reporting of abortion may have also been better in these states as compared to many other states. If it is assumed that most of the abortions relate to recent pregnancies, then the higher abortion rates in Delhi and Tamil Nadu could also be a reflection of higher usage of the modern sex-selection test leading to the abortion. Very high abortion rates in Delhi, Tamil Nadu and Goa have also been estimated by Chhabra and Nuna.[18]

As mentioned earlier, given the very poor health and nutritional status of Indian women, and the little control that they have over their bodies, a large number undergo abortion not once but more than once during their reproductive lives. Woman in the NFHS sample had experienced on an average, 1.43 abortions irrespective of the type of abortion. Almost all the states in the Northern region, except Haryana reported higher figures than the national average. An average woman in Uttar Pradesh, Madhya Pradesh, Rajasthan and Delhi was found to undergo more abortions during her lifetime than an average woman from any other part of the country. The only exception was the woman from the North-eastern states particularly Arunachal Pradesh and Nagaland where the average number of abortions per woman was almost two. It may be recalled that in these states the incidence of induced abortion was low and the incidence of spontaneous abortion was high. Obviously, repeat abortions in these states are indicative of the higher incidence of spontaneous abortions. The data on women reporting repeat abortions indicates that 31 per cent had experienced more than one abortion.

[18] Chhabra Rami and Nuna S.C (1993).

The findings do not show much of a difference between the average number of abortions experienced by rural and urban women, although older urban women reported a slightly higher mean number of abortions. Overall, it appears that women with a low level of literacy, women from other caste groups and Muslim women experienced a higher number of abortions than their counterparts. Very few studies have provided information relating caste and religion with experience of abortion. These two variables were considered here for their cultural connotations and, by and large, the relationship was exploratory. [19]

In a nationally representative sample of 89,777 ever-married women interviewed, the NFHS 1992-93 found an abortion rate of about six per 1000 pregnancies. About 30 per cent of all the women who had experienced abortions reported to experience it more than once in their lifetime. The present paper presents a state level variation in the rate of induced and spontaneous abortions and also examines the background characteristics of those women who had experienced repeat abortions - both induced and spontaneous. The level of abortion reporting was found to be the highest among women from the North-Eastern region of the country. Women who had had consanguineous marriages had reportedly experienced more abortions than those who had not married a blood relative. [20]

Large-scale surveys like the NFHS have always been criticized for their inadequacy to capture correct estimates of sensitive issues like abortion. The NFHS estimates however correspond very closely to the ICMR multi-centric five-state study, which had also indicated an overall abortion rate of six per 100 pregnancies.[21] The NFHS also revealed the occurrence of repeat abortions. It is surely a matter of concern that a substantial proportion of women continued to experience repeat abortions particularly those from the Northern and Central regions where fertility is high, literacy is low and contraception is heavily terminal-method oriented. Obviously, women in these regions have little control over their own fertility and/or scant access to health facilities to regulate it. Since most of the women came from rural areas where traditional practitioners provide abortions by

[19] Hirve Siddhi (2003)
[20] International Institute for Population Sciences (1995).
[21] Yadava KNS, Saxena HC, Dube S and Marwah SM:(1979)

massage, insertion of objects into the uterus and other folk methods, the women may not reveal their experiences of abortion and suffer silently its complications and health hazards. The health needs of these women in general and abortion/family planning needs in particular should be addressed urgently.

The enormous gap between estimated abortions and reported MTP cases suggests that only less than ten percent of the abortions are carried out in government recognized institutions. Safe abortion is not available to desiring women, particularly in rural areas, after thirty years of legislation of MTP.

ABORTION SERVICES

Legally, only a certified allopathic doctor at an authorized health centre can provide abortion services. The act allows abortion to be conducted only by a registered medical practitioners ''who has such experience or training in gynecology and obstetrics'' at a place which is approved by the concerned authority for the purpose, or in the hospital established or maintained by Government. From a concern for the morbidity and mortality that could affect women undergoing abortion, one cannot dispute the need to make available properly-trained personnel and well equipped centers.[22] Unfortunately, the ground realities are different in India where basic health care services, leave alone abortion services are inaccessible and unavailable for many.

In the Indian health care system, the public sector provides health services through a three-tier network of health facilities consisting of the primary health centre (one for 30,000 populations), community health centre (one for about 100,000 populations), district hospital (one for two million populations) and a teaching/tertiary hospital. With this vast network, government facilities are the most accessible source of health care to the rural communities.[23] Under the M T P Act, 1971 a hospital established or maintained by government is recognized by default as an authorized place to provide M T P services. In contrast, private hospitals and clinics need government approval and authorization (certification) to provide M T P services. The private clinics receive their certification

[22] Radhika Ramasubban and Shireen J.Jejeebhoy (2000)
[23] Sandhay Barge et. al (2003)

only if the government is satisfied that 'termination of pregnancies may be done under safe and hygienic conditions,' and the clinic has the requisite infrastructure and instruments in place. Despite the existence of a well-integrated network in the rural areas and their authorization by default to provide M T P services, the number of government health facilities providing these services is low.[24]

Though certification of the health facility is a requirement under the law for facilities in the private sector, in reality not all private clinics adhere to the law. Among the 306 private clinics currently providing M T P services, only three out of every ten facilities are certified. The rest are providing M T P without certification and, therefore, the abortions performed at these clinics are illegal. Some of the common reasons stated by the non-certified private facilities for not getting themselves registered were: 'no need for registration', 'have trained provider', 'no particular reason/never thought about it', 'no knowledge about it'. This underscores the need for creating awareness among providers about the requirement of place and provider certification under the law.[25]

Distribution of both government and private M T P facilities across the various study states is unequal for which there is no rationale. For instance, in Orissa only 7% of the total facilities are government, while the number is 38% in Rajasthan. In Mizoram, which is a relatively smaller state, MTP services were provided predominantly (84%) by government facilities. In the case of certified private facilities, their distribution across the states varies from a high of 57% in Rajasthan, followed by 36% in Kerala, 27% in Madhya Pradesh, 19% in Haryana, to as low as 4% in Orissa. In Mizoram only two out of the four private clinics covered were certified.

In terms of physical accessibility and infrastructure, nine out of ten private facilities were strategically located, on the road, whereas 83% of government facilities were so placed. Private certified clinics had relatively better logistics – seating arrangement for clients, sheltered waiting area, auditory and visual privacy during consultation and visual privacy

[24] Ibid. p, 36-40.
[25] Ibid. p, 36-40

in the recovery room – than government and non-certified private facilities. The availability of supportive equipment was better in the private certified facilities.

However over the years, the number of such approved M T P centers has risen considerably from 1,877 at the time of legislation to 9,467 in 1997(Khan et. al., 1999). However, there are vast regional disparities in the distribution of these services. For instance, only 16% of all approved M T P centers lie in the four large northern states (Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh), although together they account for over 40 %of the country population. . Distribution of approved M T P facilities in the major states of India shows large variation across the States. A comparison of these percentages with the proportion of total country population contributed by those States shows than often the M T P centers are disproportionately concentrated in few better performing and progressive States. For instance, Maharashtra has about 23 per cent of total M T P approved clinics in the country while it contributes only 9.4 per cent country's population. Similarly, while about 10 per cent of the M T P centers are located in Gujarat, the State contributes only 4.9 per cent of the total population. In contrast, Uttar Pradesh which contributes 16.6 per cent of the country's population has only about 6 per cent of the M T P centers. Situation of Bihar is still worse which has 10.3 per cent of country's population and has a share of only 1.6 per cent of the M T P facilities in the country. This shows wide disparity in allocation of M T P facilities across the country. Thus, the problem is not only lack of inadequate availability of M T P facilities, but also wide disparity across the States.[26]

Apart from regional imbalance, there is a marked inequity in rural-urban distribution. Even in the Maharasthra, Mumbai alone accounts for more than half the reported legal M T Ps. Only 176 of the 1,646 functioning primary health centers in the state are approved M T P centers (Chabra And Nuna 1994).

[26] Ibid. p, 36-40

TRAINED MANPOWER AND TRAINING FACILITIES[27]

After the three decade of introduction of M T P Act, the facilities for M T P services are extremely limited. The same pattern is observed in establishing training institutions for generating adequate number of trained manpower. According the available information, at national level there are altogether 162 designated M T P training centers providing training in M T P to doctors. These institutions are classified as a type Post Partum (PP) centers generally attached with some medical college or district hospital. In India, altogether there are 554 post partum centers, out of which 230 are in a type category. There is no detailed documentary evidence regarding actual supply or stock of trained physicians and their distribution according to their residence (i.e. rural and urban) in the country. However, according to one estimate (Chhabra et al. 1994) only around 3000 doctors trained in M T P were available in 1992 as against requirements of about 21.000 in the rural area itself (for P H Cs). Further, it could be assumed that majority of these trained doctors are located in urban area. This vast gap of demand and supply of trained manpower is largely because of lack of proper planning and allocation of resources. For instance, all the 230 A type Post Partum centers which have adequate case could have been designated M T P training centers, but the fact that only 162 have actually been made training centers shows that on serious thinking have been given to these aspects. It may not be out of place to mention that to designate an A type PP Center as M T P training center not much resources are required. A MTP training center gets a maximum of Rs. 2,000/- per year (@ Rs. 100 - per trainee) for training a maximum of 20 doctors. Similarly like M T P service facilities, allocations of these training centers in different States are also very disproportionate to their size.

During situation analysis of M T P facilities in Gujarat, Tamil Nadu and Uttar Pradesh, C O R T also conducted a quick assessment of the training facilities in these three States and quality of training provided. The curriculum development Government of India (G O I) for M T P training is fairly comprehensive and covers both theoretical and practical aspects. There are two different training courses, one for the general practitioners having

[27] Current Situation Of Abortion In India on http://www.hsph.harvard.edu/Organiztions/healthnet/S.Asia.

no specialized training or less than 3 years of work experience in Ob/Gyn. The second for those who have received post graduate diploma or degree in Ob/Gyn or doctor with at least 3 years experience of Working in Ob/Gyn (Ministry of Health and Family Welfare, 1986). The duration of course is one month. During this period, apart from the theoretical course, performing 25 M T P cases independently is an essential requirement. Recently, however, duration of training has been reduced to 15 working days provided the doctor has conducted 25 M T P cases and the trainers are satisfied that they are sufficiently trained to carry out M T P. In Gujarat there are eight M T P training centers, in Tamil Nadu 15 and Uttar Pradesh 17 centers. Some of these training centers are attached to teaching medical colleges, while others are attached to non-teaching hospitals. During the present study, all these M T P training centers were visited and either the in charge of the training center or some other senior faculty member was contacted and interviewed.

Subsequently, 6 to 8 doctors in each State who were recently trained were also contacted to assess their views on the training they received. Data on number of doctors trained in M T P for all the institutions during the last five years revealed the performance of M T P training centers Uttar Pradesh and Gujarat is quite poor and they could not train even half of the expected number in a year. In contrast, the performance of training centers in Tamil Nadu is much better. A discussion with a senior official of the Tamil Nadu revealed that the performance has improved a lot during the last two years as the Govt. of Tamil Nadu has made it compulsory for each government doctor to go through MTP training and hence there is a pressure on each training centre for taking maximum load.

PROFILE OF THE ABORTION SEEKERS

Arguably, the best-studies aspect of Indian abortion seeker is their demographic profile. There is general conception in India that abortion is something related to unmarried women and its attached lots of stigma. But the data shows another story, studies uniformly suggest that the majority are married and multiparous, with at least two living children. Most of the abortions involved women between the age of 20 and 30. This appears consistent, as fertility in this age group is the highest. However, a few urban

studies show a larger proportion of younger women of lower parity. (Dhall and Havey, 1984; Iyenger and Gupta, 1991).[28]

A small but significant minority of abortion seekers do not fit into the 'typical mould'. Adolescents account for anywhere from 1-10% abortion seekers, although occasional studies have reported that nearly a third of their MTP clients were adolescents (Chhabra et.al., 1998; Mondal, 1991; Solapurakar And Sangam, 1985). Most adolescent abortion are unmarried girls but NFHS data suggest that even the amongst married women, induced abortion ratios for teenagers were higher (1.7) than those among women as whole (1.3), the difference being more marked in urban areas (IIPS, 1995). [29]

Overall, studies report anywhere from 2-30% of abortion client as being unmarried (chhabra et. al., 1998) women who are separated, divorced or widowed are also a significant minority. Studies shows that the proportion of illiterate women among abortion seekers to be low (chhabra et.al 1998). Moreover, knowledge of available services and accessibility is greater among educated women so that unwanted pregnancies among educated women may be terminated whilst illiterate women may simply accept the undesired pregnancy[30]

REASON FOR TERMINATING PREGNANCY

The MTP Act does not allow abortion on request. The act has certain specified condition on which a woman can abort her fetus, thus abortion is legalized with certain conditions. Apart from that abortion supposed to be a punishable crime in Indian Penal Code. The act provides termination of pregnancy when a pregnant woman's life is at risk, or if there is a risk of abnormalities in the fetus, or if the woman has been raped or contraception failed to prevent pregnancy in a married woman. Since on record reason are necessarily tailored to fit these provision, it is not surprising that government figures and MTP case records invariably list failure of contraceptive or risk to the mother's health as the most common

[28] Bela Ganatra (2000)
[29] Ibid. p, 139-156.
[30] ibid. p, 139-156.

reason for terminating a pregnancy.[31] Data suggests[32] that majority of abortion seekers desire to limit family size and to space the next pregnancy- a telling indicator of the unmet need for contraception (Ganatra et. al 2000). In some case women considered too old to have children. Abortion may become a stop-gap method of family planning in cases where a woman may not a tubectomy till the survival of youngest child, especially if it is boy, is assured, although pregnancies may be mistimed for variety of other reason, ranging from employment and education related problem to economic difficulties.

WHO DECIDES?

Decision-making is far more complex issue in the case of abortion. Abortion is the issue, which attached lots of stigma with it. Studies show[33] that amongst married women, the first person to be consulted about unwanted pregnancy is often the husband. Even when a friend or a female friend relative is consulted first, most women report that the final decision is usually taken jointly with the husband.

The democratic nature of this decision, however, is the open to question. Although dialogue and discussion between the couple does take place, the women's role as decision makers is often not so much about making choices as accepting the alternative that has social and societal sanction. While women may be pressured into having an abortion, some women who wish to terminate a pregnancy may face opposition from the family on religious and moral grounds. [34]

By and large society approves of the family's right to decide whether the pregnancy is wanted or not and whether an abortion is justified. Justified, incidentally, has little to do with the legal circumstances under which abortion is permitted.[35]

So for example, the family planning programme has succeeded in instilling a small family norm and in many contexts abortion has become completely de-stigmatized and

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[31] Nair. Pavan (2004)
[32] Bela Ganatra (2000)
[33] idib p,139-156
[34] Ibid,p.139-156..
[35] Ibid, p.139-156.

perceived to be an essential tool with which to achieve this – whether in terms of family size (Tamil Nadu is the most telling example) or sex composition (witness the increasing use of sex detection tests). However, moral and religious feelings about abortion do surface occasionally and may play a role in deciding a course of action. Several studies have also noted inter-generational differences on these issues (Ganatra et al. 2000, Mohrankar 2003, Anandhi 2003).[36]

The woman is expected to make choices that are in keeping with her family's circumstances, needs and wishes. The woman's own wishes play a role to a greater or lesser extent – depending on her own status within the family at the time. Thus, older women who have proved their fertility and women with more economic means and mobility have a greater role in deciding (Ganatra, Hirve 2002). Alternatively, women with independent support systems and economic means may short circuit the family decision-making process and terminate a pregnancy before the family comes to know about it.

In this context, a woman may be pressured overtly or covertly into ending a pregnancy that she would rather not have. Several studies report that husbands often coerce their wives, not with physical violence but the implication that her fidelity is at stake or that her digression from his wishes will lead him to a second marriage (Gupte et al. 1997, Ganatra 2000). Equally important, women may have to continue a pregnancy that they personally feel they are not in a position to continue with. It is hard to know how often this happens or what the consequences are, as studies on abortion seekers entirely miss this group and surveys that ask whether a particular pregnancy was wanted or not merely scratch the surface of the issue.

When sexually activity takes place in less than socially acceptable situations, the focus is on ensuring that the symbol of the sexual activity, i.e. pregnancy, is not known to anyone. Abortion is one 'solution', but as several studies are finding, so is suicide (Ganatra, Hirve 2002, Johnston et al. 2001, Mohrankar 2003). Studies in Bangladesh and Nepal also report that other alternatives may include banishing the women from the community,

[36] ibid. p.139-156

allowing her to deliver a child in secrecy and then resorting to infanticide or abandoning the child (Fauveau and Blanchet 1989, CREHPA 1998).[37]

What options are actually open to the woman depends again on what is at stake for the family if her pregnancy becomes public, who the concerned man is (caste, class, power and authority issues), and the financial and practical involvement or otherwise of the male partner, and the support and sympathy she can garner from her immediate family. The degree to which secrecy becomes important may depend on how much the sexual activity is perceived to be the girl's fault and how much she is perceived to be a victim. For example, unmarried young girls may find some sympathy, seen as having been lured into sexual activity by older men under the pretext of marriage.

While in some communities and areas within the country, viz. Mizoram, such pregnancies or even a child born out of them may indeed not be a stigma and thus puts a different face on decision-making (Indranee Datta; personal communication), we really do not know much about whether the increasing acceptance of premarital sexual activity even in urban areas has actually led to lower stigmatization if and when pregnancy does occur. Practical difficulties and ethical dilemmas often prevent studies from reaching out to unmarried abortions seekers and our information base remains sparse and largely anecdotal.

Ironically, for those pregnant in socially illegitimate settings where the pregnancy needs to be got rid of fast, are precisely situations where the recognition of pregnancy often takes the longest. Denial, lack of knowledge of physiology, irregular menstruation in the early years after menarche, often lead to waiting until the pregnancy becomes physically evident. For some women the very act of approaching a provider for a way to being on a delayed period is an admission of pregnancy or at the very least a cause for suspicion. Some studies have reported that women may ask their male partners, other male members, friends or older women in the family to act as a go-between and procure these medicines for them (Maitra 1998, Johnston et al. 2001). Even for married women in some settings, the shame of being examined by a male doctor may lead them to use their

[37] this data carried out from www.seminar532_december2003

husbands as intermediaries in order to obtain medication from providers and chemists (Johnston et al. 2001).

In a situation where the concept of treating a delayed period is an essential first step in the abortion seeking process, what are the potential implications of the newer technologies of medical abortion (i.e. tablets that can be used to abort a pregnancy in the first seven weeks or so following the last menstrual period)? Would an abortion-inducing tablet meet the women's needs, especially vulnerable women's needs for confidentiality and secrecy? Will women perceive this technology as an abortifacient or as one more medicine available to bring on a delayed period?

By and large, awareness of legality of abortion remains a well-guarded secret and studies in different settings show that women (even those who themselves have had an abortion) either think it is illegal or simply do not know (Malhotra et al. 2003; Ganatra and Hirve 2002). Legality and social acceptability are equated, which further constrains the choices women have in terms of going to a safe provider. The publicity around the PNDT Act in recent years has in fact translated to awareness about the illegality of sex detection. Unfortunately, however, most women (and men) have assumed (wrongly) that the law is actually about a ban on abortions and that the government has now banned all abortions (Barge 2003, Radkar 2003), whether sex-selective or not – a dangerous trend that will likely have a backlash on accessing safe services for any woman in need of abortion services.

PROVIDER CHOICE

The current situation in our country, although still unacceptable as abortions continue to be unsafe and illegal, is a vast improvement over the earlier days. Certainly, as envisaged, the MTP Act has contributed significantly to save the pregnant woman's health, strength and often life. However, even today, of the estimated 6.7 million induced abortions in the country, only about six lakh reported legal abortions take place, a figure that has stagnated over several years now (despite an enlarged base of reproductive age population), except for two years when it crossed seven lakh. It is worth noting that of

this figure, Parivar Seva alone, through its Parivar Seva/Marie Stopes clinics in selected locations, accounts for about 13% of all reported cases in the country.[38]

Available data suggests that about 2.6 million abortions are possibly performed by providers who though not legally recognized, have some basic knowledge regarding pregnancy and the abortion procedure. This leaves a balance of 3.5 million abortions that are performed by totally untrained personnel or the woman herself – at great risk to the lives of women.[39]

This pathetic situation results from a lack of knowledge regarding the legal status of abortion as well as insufficient access to safe, quality, legal and affordable abortion services and because of lack of availability of recognized service delivery centres and competent service providers ensuring confidentiality and compassion. The most to suffer are unmarried young girls and widows. Despite a liberal law, they face social discrimination and are exploited by the providers who charge exorbitantly for abortion services.[40]

Parivar Seva, through its 38 full-fledged reproductive health clinics, provides over 78,000 abortions annually. As a result, it has gained valuable insight and experience in this sensitive area of reproductive health care.[41] In addition, several baseline and research studies[42] have been carried out by Parivar Seva, both by its own research department as well as by engaging the services of other professional agencies and lessons fed into the system to further improve services. It is, therefore, no surprise that our client base is constantly increasing and referrals to our clinics from satisfied clients forms the major basis of our clients. It is satisfying to note that although Parivar Seva/Marie Stopes clinics are located in cities and smaller towns, we cater to a large percentage of rural clients who travel long distances to avail of quality service.

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[38] Tiwari ,Sudha (2003)
[39] ibid.p,61-64.
[40]. Bela gantra (2000)
[41] Tiwari Sudha (2003)
[42] ibid p,61-64.

Our typical client is a married woman with one child who has not used a contraceptive method earlier because of the myths associated with it. Economically and health-wise, she is not in a situation to go through another pregnancy. Above all, she and her family are concerned about the consequences of another full pregnancy and child birth on the health and well-being of the current small child who first needs nurturing for proper growth and whose survival is often at stake. Most of our clients, on counseling, which is our unique service, easily accept a suitable family planning method, thereby ensuring proper spacing until the next child and safeguarding the health of both the mother and child for a reasonable period. [43]

THE ABORTION EXPERIENCE

A number of methods are used to terminate pregnancies. Methods of abortion vary depending on the stage of pregnancy.[44] Methods used to terminate pregnancies of the first trimester (up to 12 weeks of gestation) are relatively simple and require less supportive equipment as compared to the methods used to terminate second trimester pregnancies (13-20 weeks of gestation). A majority of the facilities (67% government and 76% private) provide MTP services only for first trimester pregnancies. MTP services for the second trimester, which require relatively more supportive equipment, were provided by only one-third of the government facilities and 24% private facilities. Among private facilities, 65% of the private certified facilities were providing first trimester services, while the figure was as high as 81% among the private non-certified facilities. This indicates that private non-certified facilities do not want to risk performing second trimester abortions either due to inadequate equipment or because their providers lack the necessary skills.[45]

Among the first trimester methods like manual vacuum aspiration (MVA), electric vacuum aspiration (EVA), dilatation and curettage (D&C), D&C continues to be the most commonly used method, though the WHO (2003) strongly recommends that all possible effort be made to replace sharp curettage with vacuum aspiration. The recommended

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[43] ibid. p,61-64.
[44] Bela Ganatra (2000)
[45] Ibid. p,139-156.

surgical method of abortion for the first trimester is either manual or electric vacuum aspiration. D&C, which has a higher risk of complications, blood loss and longer recovery time, should be used only in the absence of other safer methods.[46]

Each method of abortion requires a basic set of instruments and equipment. In its absence, the provider may compromise the quality and still perform MTP. Information on the availability of complete sets of D&C, MVA and EVA showed that around two-thirds (65%) of the facilities had a complete set of D&C instruments, while 32 and 40% of the facilities had a complete set of MVA and EVA instruments respectively. In this case too, private certified facilities were relatively better equipped than government ones with a complete sets of instruments required to carry out different procedures like MVA (43% private certified vs. 22% government), EVA (51% private certified vs. 25% government), and D&C (78% private certified vs. 63% government).[47]

Further, in order to deal with complications it is important that the facility has instruments for more than one method of abortion. Analysis of the number of methods available with complete set of instruments in the facility shows that 35% of them did not have a complete set of instruments even for one method of abortion, 23% had a complete set available for one method, 12% for two methods and 30% to provide three methods. Clearly, some facilities are performing MTP procedures even in the absence of a minimum set of instruments required for the procedure, compromising the quality of service.[48]

POST ABORTION CARE

In India post abortion care is equated with family planning acceptance. Other aspects of care receive little attention. For instance, data[49] based on exit interviews with MTP client in four states indicates that while most women were told that the procedure was safe, few were informed it has potential risks. Similarly, they need some counseling which is not

[46] Sandhay Barge et. al (2003)
[47] ibid.p,36-41
[48] ibid. p, 36-41.
[49] Bela Ganatra (2000)

the part of abortion services. The act does not provide any counseling services. After abortion getting done hospital provides contraceptives counseling which is part of family planning services. Abortion is very traumatic for women; it has physical as well as psychological pressure. In married women even she can get some type of support and counseling but for unmarried and teenager it is very difficult to get any care or counseling.

SEX SELECTIVE ABORTION

No engagement with abortion in India can be undertaken without considering first the issue of sex determination (SD) and sex selective abortion (SSA). SSA underscores the profound complexities that surround the abortion debate in India. Today, more than ever, there is wide-ranging consensus in India that this practice is morally and ethically unacceptable and the urgency to address it has gained tremendous momentum. However, the intersecting 'spaces' occupied by sex selective abortion and women's right and access to safe abortion create a number of thorny overlaps that make the consensus urging a ban on sex determination appear laden with ambivalence and contradictions.[50]

The emergence of this phenomenon, however, should not be viewed as a sudden consequence of the availability of diagnostic technologies. It should be seen as an additive strategy within the existing continuum of discrimination against women and female children that has resulted in excess female mortality and the decline in the sex ratio.[51]

The evidence appears to be plentiful. In 1975 all India institute of medical sciences, a government –run medical research center and hospital, conducted tests to diagnose fetal abnormalities through amniocentesis. Of the fifty women who volunteered for tests, forty-five decided to abort their fetuses after learning that they were female.[52]

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[50] Rupsa Malik (2003)
[51] Goodikind D. (1996).
[52] Parikh, Manju(1990).

protest by women's groups and other activists concerned by the high percentage of women who wished to abort female foetus once their sex was known.[53] Prenatal sex determination tasting was subsequently banned from all government institutions; however, a privatized industry soon emerged to meet the continuing demand foe this services. By the mid-eighties, ten years after the technologies were first introduced in the country; clinics had proliferated in most parts of the country, though mainly restricted to urban centers. For example, one study (1986) estimated that there were 248 clinics and laboratories, and approximately 16,000 tests were performed in Mumbai metropolitan region annually.[54] Another study claim that in between os 1982 and 1987, the number of clinics foe sex determination testing multiplied rapidly- in Mumbai alone, it increased from 10 to 248.[55]The growth in the number of clinics continued throughout the nineties. In a single district of Haryana, 65 ultrasound clinics have been registered.[56] With growth in the number of clinics and easy availability of these tests there has been a corresponding drop in the price of obtaining a test, which fluctuates between Rs 500 to 1500, though some have pointed out that recent effort to ensure effective implementation of the ban on SD has served to double the cost of clandestine SD tests.[57] The costs of sex determination technology have dropped considerably since the 1980s. For example, amniocentesis, which in the 1980s cost 1,500 to 2,000 rupees, now costs from 200 to 500 rupees.[58] Sensational ads stating ''Better Rs. 500 now than 5 lakhs laters'' warn parent of the expense of raising a daughter and one day paying a large dowry instead of small sum to abort her.[59]

Recent efforts by the government to enforce a two-child norm as well as voluntary desire for smaller families can potentially serve to exacerbate SD and SSA. Studies have pointed out that the desire for fewer children is not necessarily accompanied by a preference for a fewer number of sons. Till date, son preference continues to be a

[53] Fourm Against Sex Determination And Sex Pre Selection,(1988)
[54] Lingam (1998),
[55] Arora Dolly(1996)
[56] V.Pushkarna(2002)
[57] Rupsa Malik (2003)
[58] Parikh Manju(1990)
[59] Ghosh Srikant(1989)

significant determinant of family planning strategies, although this is strongest for birth orders two or more.[60]

As India undergoes its fertility transition the conditions exist for intensification in SD and SSA. Retherford and Roy (2003) use NFHS data on the sex ratio at birth as an indirect indicator to assess prevalence and determinants of the practice.[61] They argue that multiple factors influence the levels of SSA confounding the effect of any single variable. Some of the important predictor variables identified by them include a composite variable of the child's birth order and the mother's number of living sons, education levels of women as well as rural-urban residence. The authors also point out that the potential for SSA to increase is greatest in states like UP, Bihar and Rajasthan where there is continued evidence of strong son preference. Currently, these states have low sex ratio at birth but with increased availability of information and technology for SD this can change.

For over two decades there has been a sustained campaign against SD and SSA. A significant focus of activism has centered on the demand for laws that ban sex determination and regulate the medical use of diagnostic technologies. Recently, the focus has simultaneously been on the effective implementation of the law. The history of the activism can be broadly divided into two phases. The first decade of activism was dominated by the campaign by the Forum against Sex Determination and Sex Pre-Selection (FASDSP) and resulted in the formulation of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994.[62]

The second decade of activism has been symbolized by renewed activism on the issue of SD and SSA but most importantly on the implementation of the PNDT Act, 1994 and subsequent Public Interest Litigation (PIL) filed in the Supreme Court of India resulting in improved implementation as well as amendments to make the existing law more

[60]. Balakrishanan R . (1994)
[61] Ruspa Malik (2003)
[62] ibid. p,30-36.

effective. A main feature of the amendment was bringing within its purview new technologies used at the preconception and pre-implantation stage for sex selection.[63]

After analyzing the current data on abortion I conclude that after over thirty years of legalization of abortion, abortion in India is legal but unavailable to women who are still getting unsafe and unhygienic abortion services. Denial of access to abortion services has been an effective mechanism of patriarchal control over women's reproductive health and rights. Apart from that, Government policy and poor implementation of abortion services are making situation more complex.

[63] ibid. p.30-36.

CHAPTER- IV

ABORTION LAWS IN INDIA

HISTORY OF THE CURRENT LIBERAL LEGISLATION

Abortion law in India governed by the Indian Penal Code, 1862 and the code of criminal procedure 1898 till 1971 traces its origins to 19th century British law wherein abortion was a crime punishable for both the mother and the abortionist, except when it was induced to save the life of the woman. The 1960s and 1970s saw the liberalization of abortion laws across Europe and the America, which extended to the other parts of the world through the 1980s.[1]In 1965, a UN mission evaluating India's population policy recommended legalizing abortion. In 1966, the Shantilal Shah Committee submitted its report, recommending that abortion be liberalised in order to put an end to the large number of illegal and unsafe abortions. As a result of joint consultation between the ministry of health and family planning and the ministry of laws, ''The Medical Termination of Pregnancy Bill, 1969 was finalized. This measure received considerable assistance from Mr. Panampalli Govinda Menon, the union Law Minster.

While introducing the Bill the former Member of Parliament and Minster of health and family planning S. Chandrashekher sought support for it on the ground that it was primarily a health measure. While the demographic factor was played down for obvious reason, the health aspect was important in that legal hospital abortions would greatly reduced the mortality and morbidity resulting from illegal, unsanitary, and botched-up abortions.[2]

The writer of the Bill pleaded that the problem of abortion must be examined from three basic points of view in any society, and particularly in an underdeveloped economy like India's.

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[1] Berer (2000).
[2] Chandrashekher. S, (1974)

First there is point of view of women—her physical and mental health and her freedom. Apart from the government's decision to pass this measure, the writer personally believes that any woman in India, at any time, should be able to obtain a legal abortion from public hospital and private clinic without given reason. This may be the radical position for present climate in India but it high time that women became their own masters. In an enlightened world there should be no need for them to suffer from the ageless slavery of unwanted pregnancies. We have come a long way in emancipation our women but their emancipation cannot be complete unless we grant them the right not to have a baby they do not want.

Secondly, we must examine abortion from the point of view of the unborn child who may be physically deformed or mentally retarded, and the unwanted child who became unloved, uncared for, and in time the delinquent child. The problems here are too obvious to need comment, especially in view of daily newspaper evidence of growing incidence of delinquent behavior of children and teenagers.

And lastly, we must examine abortion from the point of view of state and society and the total socio-economic and demographic picture. The unwanted child who cannot be supported by his parents or even the large extended families (which is gradually breaking up) ends up on the pavement with the beggar's bowl, and became starving, disgruntled and anti social citizen, a burden to himself, society and the state. [3]

The MTP Act, Rules and Regulations define when (gestation limits, under what conditions), by whom and where an unwanted pregnancy can be legally terminated. The act offers full protection to the registered medical practitioner against any legal or criminal proceedings for any harm or injury caused to a woman seeking abortion, provided that the abortion has been or intended to be done in good faith under the provision of the M T P Act. The law is so liberal in its scope that it virtually allows an unwanted pregnancy to be terminated under any condition which may be presumed to construe a grave risk to the physical or mental health of the woman in her actual or foreseeable environment – as when pregnancy results from contraceptive failure, or on

[3] Rajaya Shabha Debates (1969).

humanitarian grounds (such as when pregnancy results from a sex crime as in rape or intercourse with a mentally challenged woman), or on eugenic grounds (where there is reason to suspect substantial risk to the child, if born, to suffer from deformity or disease).[4]

The Act allows medical termination of pregnancy up to 20 weeks gestation. In the event of a M T P to save a woman's life, the law makes certain exceptions – the doctor need not have the necessary experience/training criteria stipulated in the M T P Rules but still needs to be a registered allopathic medical practitioner, a second opinion is not necessary for abortions beyond 12 weeks, and the facility may not have prior certification. In such situations the provider is required to report an abortion done to save a woman's life within one working day. The law is unclear about an abortion beyond 20 weeks done to save a woman's life. [5]

The M. T. P act enacted by parliament in 1971 in 21 states and nine Union Territories seeks to liberalize abortion in India. The act was enforced in the states of Jammu and Kashmir, Mizoram, and Sikkim only in 1980 while the Union territory of Lakshwa Deep still restrictive abortion law. [6]

THE MEDICAL TERMINATION OF PREGNANCY ACT 1971 [7]

The Medical Termination of Pregnancy Bill was passed by both the Houses of the Parliament and received the assent of the President of India on 10th August 1971. It came on the Statute Book as the "The MTP Act, 1971". This law guarantees the Right of Women in India to terminate an unintended pregnancy by a registered medical practitioner in a hospital established or maintained by the Government or a place being approved for the purpose of this Act by the Government. Not all pregnancies could be terminated. The declared objects and reasons of the Act state that pregnancy can be terminated:

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[4]. Hirrve Siddhi,(2003).
[5] Ibid.14-15.
[6] Ibid. 14-16.
[7] The Medical Termination of Pregnancy Act 1971 on:
http://www.aims.ac.in\aims\events\Gynaewebite\ma_finalsite\report.html

(1) As a health measure when there is danger to the life or risk to physical or mental health of women

(2) On humanitarian grounds – such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman etc. and

(3) Eugenic grounds – where there is a substantial risk that the child, if born, would suffer from deformities and diseases.

(4) Contraceptive failure

The MTP Act (Act No. 34 of 1971) has been defined in its opening lines as ''An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto''. Passed by Parliament on August 10, 1971, this is a Central Act that extends to the whole of India except the state of Jammu and Kashmir, which adopted it in 1980.

The purpose of this act was to define the situations and circumstances in which safe abortion could be legally performed and to empower medical practitioners and institutions delivering this service. All practice of induced abortion medical or surgical has to be conducted against the all-pervading backdrop of the MTP Act.

Even today, voluntarily 'causing miscarriage' to a woman with child – other than in 'good faith for the purpose of saving her life' is a crime under Section 312 of the Indian Penal Code, punishable by simple or rigorous imprisonment and/or fine. Consequent sections (IPC Sections 313 – 316) relating to causing miscarriage without a pregnant woman's consent or causing maternal death due to the procedure are stricter, with punishments ranging from up to 10 years imprisonment, and extending up to life imprisonment.

The MTP Act is an empowering legislation, which if adhered to completely, offers protective umbrella allowing clinicians to offer legal safe abortion services within

well-defined limits. The use of medical methods for early abortion is also completely covered by the MTP Act.

The MTP Act is an Act of Parliament providing a broad overview of the methodology of safe abortion practice and defining and delegating authority to central and state governments to make rules and regulations. The MTP Rules are framed by the Central Government, but must be placed before each House of Parliament. The MTP Regulations are framed by State Governments and relate to issues involving opinions for termination, reporting and maintaining secrecy.

The importance of this distinction is the possible flexibility in introducing or modifying rules and regulations within the ambit of the Act without having to steer amendments through Parliament. The potential for appropriate changes in rules and regulations to encompass medical methods is particularly significant, since this new development is not adequately reflected in the present rules and regulations.

A registered medical practitioner (RMP) is protected under law if a pregnancy is terminated in accordance with Section 3 of the MTP Act, based on opinion formed in good faith.

According to Section 3 (2), pregnancies not exceeding 12 weeks may be terminated based on a single opinion formed in good faith. Since the use of medical methods governed by clear guidelines issued by Drug Controller is presently up to 49 days, the single clinical opinion is necessary and sufficient.

According to Section 3 – Sub section (2) of the MTP Act, a pregnancy may be terminated for the following indications:

1. If the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical and mental health.

2. If there is a substantial risk that if the child was born, it would suffer physical or mental abnormalities as to be seriously handicapped.

Explanations I and II further clarify the following indications Pregnancy alleged by the pregnant woman to have been caused by rape. Pregnancy resulting from a failure of any device used by any married woman or her husband for the purpose for limiting children.

It is important to note that the MTP Act does not permit induced abortions on demand. The responsibility rests with the medical practitioner to opine in good faith regarding the presence of a valid legal indication. These indications are also mandatory with medical method.

Section 2 – Sub section (4) of the MTP Act mandates the presence of a valid legal consent.

1. Termination of pregnancy in minors (under 18 year's age) or lunatics (as defined in Section 3 of Indian Lunacy Act, 1912) only with consent in writing of guardian.

2. Termination of pregnancy in adult women over 18 year's age permissible with their valid consent.

The consent must be informed and recorded in Form C recommended in Rule 8 of MTP Rules. This is also a requirement every time a medical method is used for early abortion. An adult woman requires no other person's consent except her own.

According to Section 4 of the MTP Act, pregnancies may only be terminated in the following settings.

1. A hospital established or maintained by the Government.

2. A place approved for the purpose of the Act by the Government.

For approval Rule 4 of the MTP Rules further elaborates on the Clause 2 mentioned above as follows:

The Government should be satisfied with safety and hygiene.

The following facilities should be provided.

- An OT table and instruments for abdominal and gynaecological surgery.
- Anaesthetic, resuscitation and sterilisation equipment.

- Drugs and parenteral fluids for emergency use.

Any procedure performed in a center which does not have government approval is deemed illegal. Medical methods have difficulty in fulfilling this particular requirement, since the administration of one or both drugs and the actual process of abortion may take place outside a clinic or hospital setting.

The necessary qualifications of a medical practitioner registered in the State Medical Register are broadly defined in Section 2 – Clause (d) of the MTP Rules.

1. Postgraduate degree or diploma in gynecology and obstetrics.
2. Registered before commencement of the Act with over 3 years experience in the practice of obstetrics and gynecology.
3. 3. Registered after commencement of the Act if

- Six months of house surgeon ship in gynaecology and obstetrics.
- Experience in any hospital of over 1 year in the field of gynaecology and obstetrics.
- Assisted in performing 25 MTPs in a government hospital or a recognised training institute.

While medical practitioners with postgraduate training or qualifications in gynecology and obstetrics stand automatically recognized, there is great scope to train registered medical practitioners in safe abortion techniques at recognized training centers. This could dramatically increase the access to and availability of safe abortion nationwide.

The training and registration of a cadre of registered medical practitioners exclusively for medical methods with links to a recognized centre would be the final step in decentralizing safe abortion services.

According to Regulation 5 of the MTP Regulations all approved centers are required to maintain an Admission Register in the format prescribed in Form III. A fresh register is started each calendar year, with new serial numbers generated by mentioning the year against the serial number.

The Admission Register is a secret document and should be kept in safe custody. The Admission Register should be maintained for at least 5 years from the last entry.

The importance of documentation is mandatory with medical methods to underline legality to benefit from protection of the MTP Act. Prompt and sincere reporting is important since it also contributes to databases.

FEMINIST DISCOURSE ON LAW WITH SPECIAL REFERENCE TO M. T. P. ACT

Legal reforms have been at the centre of the agenda for strategizing gender justice in India. This has been so, right from the beginning social movements through the period of national struggles, down to the contemporary women's movement. In more recent times, this reliance on the efficacy of law and legal reform to initiate change in social order toward a gender just egalitarian society gets voiced in what might be termed the first comprehensive document marking the contemporary feminist movement in India, i.e. the report of the committee viewed legislation as on the major instrument for ushering in change in the social order in the India society. Legislation can act directly as norm setter, or indirectly providing institution which accelerate social change by making it mere acceptable. Building a gender just society is perceived as part of the task of nation building, of development and social reconstruction. The role of law in the whole process is perceived as non- ambivalent, well defined and positive.[8]

In a way this ambivalence about law and legal reform of securing gender justice is nothing new in the history of women's movement in India. Back in the nineteenth

[8] Mukhopadhayay,Swapna,(1998).

century, when social reformer Raja Ram Mohan Roy and nationalists like Bal Gangadhar Tilak were concerned with oppressive social practices like 'sati' or 'child marriage', the tension between the indigenous scriptural dicta and the colonial heritage of the British legal system always lurked in the background.[9]

The contemporary women's movements are at the crossroad now. In the light of the experience of the last years, the question that keeps recurring is whether legal reforms are capable of bringing about gender justice in society. However during the last two centuries the traditional life of the Indian women has subjected to various changes due to the enormous efforts of our great social reformers, state policy, and development. But unfortunately still the real status of women in our country has not changed; they still face a formidable amount of discrimination in private and public life. It is generally assumed as Marc Galanter (1984) points out that law should be institutionalized pursuit of justice. But power and unequal dynamics hampered the equal access to justice.[10] Feminist asserted that every aspect of human society is gendered; conferring very specific benefits or disadvantage to either of the social category, men and women. It emphasizes the long roots of patriarchal traditions, which have throughout history been reconstituted and realigned with the change in the mode of production, to keep women in subordination position.[11]

In the context of the contemporary women's movement, the ambivalence that marks feminist engagement with law as an instrument of ensuring gender justice has a somewhat different character. While demand for legal reforms has been one of the major foci for mobilizing popular support and specific cases of atrocities on women have been used to further the aim of the movement, the disenchantment with the potential of law as an instrument of social transformation has been triggered by simultaneous development. On the hand last year's experience of the effect of legal reforms has been perceived to be not altogether positive.

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[9] Ibid. p. 1-13
[10] Galanter, Marc (1984).
[11] ibid. p.32-35

The failure of the law to derived justice in feminist terms is understood to be a result of the interpretation of the law in sexist way, so that the law's capacity to be just would be freed from the biases of individuals.[12]

A powerful and influential critique of the law comes from Catharine Mckinnon who argues that liberalism support state intervention on behalf of women as abstract persons with abstract rights while in reality 'the state is male in the feminist sense' she again argues that world is patriarchal and oppressive. She sees the state as embodying and ensuring male control over female sexuality. [13]

Elizabeth Kingdom (1991) in her article ''legal recognition of a woman's right to choose''[14] advocates that it is a commonplace to make a comparison between classical Marxist theories of law and certain feminist theories of law. For classical Marxism, the economic interests of the bourgeoisie are formed independently of law but find expression in it. Legislation, legal practices in court and tribunals, and the attitudes of legal personnel are according seen as mirror, the representation of economic class interest, and the legal sphere is seen as a major instrument of the bourgeois state's continuing exploitation of the proletariat. Feminists have challenged classical Marxist theories for their failure to identify the specific forms of oppression experienced by women. To remedy this deficiency feminists have develop the concept of patriarchy to explain gender oppression, and this concept has been engaged both to complement that of class and as substitute for it. Michele Barrett has noted that 'just as some socialists have argued that the state would ''wither away'' in the transition to communist society, so some feminists have viewed the state as an instrument of male control that would fall away with the destruction of the patriarchy.[15] In feminists sense the law is seen as the expression of the state interests and as a key mechanism for the reproduction of patriarchal oppression. Feminists argued that the history of women struggles for formal legal rights shows that even where women's legal position has been improved there is no corresponding, and certainly no automatic, improvement in

[12] Menon Nivedita,(1993)
[13] Ibid.p.396-392.
[14] Kingdom Elizabeth,( ).
[15] Ibid .

their social and economic position (cf. Brophy and smart, 1981, p.3; Humphries, 1980, p.390; Caldwell, 1981, p.49). [16]

In order to the change conditions of Indian women, government liberalized abortion in order to end to the large number of illegal and unsafe abortions and related mortality and morbidity (as recommended in the Shantilal Shah Committee Report).[17] However this act passed independently from women's movements. All groups welcomed the liberalization of abortion in India with the little bit opposition from some religious groups.

Abortion has become an issue for Indian feminist for quite a different reason over the eighties, with the growing practice of sex selective abortion of female fetuses after sex determination test during pregnancy. They criticized the act on the ground of several levels. The picture of Indian scenario is quite different from the west. In a article 'Abortion Laws and Abortion Situation in India' (1991), Malini Karkal argues, "introduction of a liberal law in a country where women have little say in most matters and there is no strong health education programme, can only defeat the purpose of defending women's right. And in a country where a national programme encouraging smaller families is in full force, one can only expect a rising number of abortions resulting in hazards to women's life". Through a presumed belief in the accessibility of abortion services (a natural consequence of liberalization), she advances the hypothesis that women have increasingly been pushed into utilizing these services. However, statistics reveal that legalization has not significantly increased the rate of legal - induced abortions. Further, by doing away with legalized abortion services, can a given society reduce abortions and can that automatically improve women's health. [18]

In India the 'right' to abortion has never been at the centre of much debate since it is seen as a measure to control population growth. The dominant ideology in, and about, countries such as India presents poverty as a function of rising population. One

[16] Ibid
[17] Menon ,Nevedita (1993).
[18] Karkal ,Malini (1991).

consequence of this ideology is that family planning has been a central focus of government programme for economic development.

In India, abortions were prohibited (unless medically indicated to save the pregnant women) till the Medical Termination of Pregnancy (MTP) Act was passed. Two shades of opinion were in evidence. At one end were proponents of family planning and population control who favored liberalization with a view to lowering the birth rate. At the other end were those who were concerned about the ill effects of abortions conducted by non-qualified, untrained, and ill-equipped medical practitioners under unhygienic conditions.[19] A quick examination of an annotated bibliography of abortion studies conducted in the 1960s and 1970s [Karkal M, 1970] reveals that the research agenda was geared up towards understanding and calculating incidence patterns in the context of age, socio-economic background, duration of marriage, pregnancy and contraceptive histories.[20] With the growing emphasis on family planning in the health agenda in the 1960s, academicians were prompted to draw a link between the two. In this context, themes such as liberalization vis-à-vis its birth control potential as well as the possible implications of liberalization on the social and cultural fabric began to appear. Thus, the two actors who persuaded policy-makers to liberalize abortions were demographers and doctors both being motivated by their own material interests and ideologies.[21] In the mid-1960s, the government of India appointed a committee under the chairmanship of a medical professional Shantilal Shah. A report was submitted on December 30, 1966, and in 1971, the MTP Act was passed by parliament. The MTP Act, as an opening paragraph states, was designed "to provide for the termination for certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto" (emphasis added). In essence, it liberalizes and regulates medical practices in relation to abortion but does not even begin to provide women with the means to control their reproduction. The act, therefore, allows medical liberalization to supersede medical criminalization.

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[19] Jesani And Iyer (1993).
[20] Ibid., p. 2591-94
[21] Menon, Nivedita(1993).

Secondly, the act confers a monopoly on medical opinion in matters related to the length type of pregnancy. Accordingly, a pregnancy up to 12 weeks necessitates the authorization of one doctor while those between 12 to 20 weeks necessitate the opinions of two doctors. The act enjoins doctors to take ''pregnant women's actual or reasonable foreseeable environment'' into account this would involve risk of injury to health. In this connection, pregnancies following rape (marital rape not included), or failure of contraception (for married women) are specifically mentioned as indicators in two separate explanatory notes. Another clause refers to the possibility of the child suffering from ''physical or mental abnormalities as to be seriously handicapped''.[22]

Clearly, the pregnant woman seeking abortion cannot avoid giving an explanation. To say that pregnancy was wanted at the time of conception, but is unwanted now easily disqualifies her. She is required to furnish explanations that fit into the broad liberal - and yet, restrictive - conditions, listed in the act. This situation keeps the act open to differing interpretations. Ironically, the current preoccupation with population control and the somewhat dubious motivations of the medical profession have engendered a liberal interpretation of the law. However, the danger that this liberal interpretation could become a restrictive one without a single word of the text being altered remains. This could easily happen under different socio-economic and demographic compulsions.[23]

The act creates two major legal restrictions to the accessibility of abortion services. It stipulates that abortion can be legally induced only by a registered medical practitioner "who has such experience or training is gynecology and obstetrics" and that it can be conducted only a place that is sanctioned by the appropriate authority (if the facilities available follow the standards prescribed in the rules of the act).

There is no dispute on the necessity of having properly trained medical personnel and well-equipped centers. With about 73 per cent of India's (mostly indigent) population living in rural areas, the provision of free and accessible health care is more than just

[22] Malini Karkal (1991).
[23] Ibid. p 22-33

an essential prerequisite for the maintenance and improvement in health status of the people (and especially of women who experience morbidity following abortions). However, the ground realities are quite different.[24]

The knowledge that liberalization has neither resulted in a reduction in the magnitude of illegal abortions nor an improvement in women's health and the fact that it is tagged to the population programme, has bred a great deal of scepticism among some academicians.[25]

The dilemma expressed by the sceptic, in fact, highlights the limitations of treating abortions, as a civil right for individual freedom and 'privacy'. Legality provides only a thin cover, a kind of political legitimacy that is necessary but not sufficient to change the material conditions of women's lives. There are two reasons why legalization, as seen as a mere civil right, is not sufficient. Firstly, it makes it possible for ant-abortionists, under a conservative political climate, to juxtapose the civil rights of the unborn child with the civil right of the pregnant woman. This has happened in the U.S. In India, sceptics have been juxtaposing the right of women to health care over their right to safe abortion services and have thus failed to appreciate that legalization per se is not responsible for women's ill-health.[26]

Secondly, a civil right to abortion does not amount to a social right carrying all the necessary enabling conditions that make it concretely realizable and universally available. Further, a really safe abortion is possible only by embedding abortion services in the full range of social services - health care, pre-natal care, child care, safe and reliable contraception, sex education, protection from sexual and sterilization abuse etc. These social services must function, under the organized vigilance of women's groups to ensure that women do really get access to such services.[27] Further, abortion is not merely an issue of political and legal conflict but of social, cultural, and moral conflict as well. Good social services expand the scope of what is

[24] Jesani and Iyer (1993)
[25] ibid. 2591-94
[26] ibid. 2591-94
[27] ibid. 2591-94

meant by 'women's reproductive freedom' and are, therefore, of utmost relevance and urgency. However, this is not the only answer to the issue at hand. One argument avers that, at the most, this could result in a partial or total shift in child rearing responsibilities from women to men and ease the material burden of motherhood (through improved benefits and services).[28] Petchesky (1986:16-17) argues that, "it may also operate to perpetuate the existing sexual division of labour and women's social subordination" and suggests that the realisation of "women's reproductive freedom" will have to be part of the radical transformation in the social relations of reproduction and production [29]

In Hilda Scott's words (1974:190), ... no decisive changes can be brought about by measures aimed at women alone, but, rather, the division of functions between sexes must be changed in such a way that men and women have the same opportunities to be active parents and to be gainfully employed. This makes women's emancipation not merely a women's question but a function of the general drive for greater equality which affects everyone ....the care of children becomes a fact which society has to take into consideration. [30]

A close examination of the M. T. P Act and of judicial pronouncement on abortion reveals that this right is (a) circumscribed by the absolute discretion of medical opinion; and (b) precariously balanced on patriarchal assumptions. Nevedita menon[31] in her paper asserted that the legal discourse on abortion is not concern for women's health or their autonomy, but a punitive sprit which treats abortion as crime unless performed under specific conditions. An abortion which does not meet the conditions set by the M.T.P Act continues to offence under the Indian penal code (IPC) (Section 312 to 316).

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[28] ibid. 2591-94
[29] Petchesky, Rosailind Pollack (1986).
[30] Jesani and Iyer,(1993)
[31] Menon, Nevedita (1993)

Jesani and Iyer[32] in their study of M.T.P. Act point out that the pregnant woman cannot avoid giving an explanation in order to avail of abortion. She cannot simply state that it is an unwanted pregnancy. She is required to furnish explanations that fit into the broad liberal and –yet restrictive condition listed in the Act. She argued that these conditions confer a monopoly on medical opinion which has power to decide whether the woman meets the requirement of the Act. Thus, during the first twelve weeks of pregnancy termination available on the certification of one registered gynecologist or obstetrician. From twelve to twenty weeks, termination required two registered gynecologists or obstetricians to certify either that that pregnancy involves a risk to the life of the woman or would cause grave injury to her physical or mental health, or alternatively, that there is a substantial risk that a seriously handicapped child would be born. After twenty weeks a pregnancy can be terminated only if two registered gynecologists or obstetricians testify that it is immediately necessary to save the life of pregnant woman. The Act does not define 'health', substantial risk seriously handicapped and so on. It is left to the medical practitioner to decide these terms are to be interpreted, although two explanatory notes indicate that pregnancy in the case of rape (excluding martial rape) and contraceptive failure (in the case of married woman) may be treated as causing injury to mental health. In fact, even the word 'abortion', 'miscarriage', and 'termination of pregnancy' has not been defined, either in the Act or in the relevant section of Indian Penal Code, which leaves the medical opinion on these matters sacrosanct.

In a same way Jesani and Iyer pointed out that the liberal provision of the M. T .P. Act could become restrictive without a single word of the text being altered.[33] Indira Jaising[34] (feminist advocate) also pointed out that in one sense, section 312 of the I P C is broader than the M. T P Act, because it allows the termination of pregnancy in order to save the life of the pregnant woman, while the M. T .P Act only allows this if it is immediately necessary to save her life. Nevedita menon[35] in her study of M. T. P. Act emphasizes that the lack of clarity in the definitions of that marks the M. T. P. Act

[32] Jesani and Iyer, (1993)
[33] Jesani,Amar and Aditi Iyer (1995).
[34] Indira Jaising(2004).
[35] Menon,Nevedita.(1993)

and relevant section of the I. P. C. does not indicate the ability of legal discourse to be flexible. Rather, it underscores the move towards fixing meaning that is characteristic of the law. She pointed out that in the case of abortion, this fixing is sought through the supposed 'neutrality' and scientific' of medical discourse which will be determine exactly the period of gestation, the precise degree of risk of a disable foetus, the possibility of mental injury and so on. Such a move towards rigidly codifying and normalizing the ambiguities and ambivalences inherent in decision to abort can only be antithetical to the morality underlying the feminist defence to the abortion right.

In patriarchal society like India gender imbalance is very visible in every aspect of life. In India the women condition is miserable and doubly victimized only 39 percent of women are literate according to latest census (2001), and opportunities for education considerable diminish for women at the higher levels. They are socially and culturally meant to be very submissive to serve the interest of patriarchal values that is only for men. Another important thing is that women in India do not form a homogenous category. The structural factors such caste, class, race, ethnicity, religion and urban and rural are affect their decisions regarding their health and rights and even the decision making power. The complex way in which the position of women is structured makes it impossible for collective women's action to make patriarchies the specific target to attack or reform. [36].

MEDICAL OPINION ON THIS ACT [37]

The MTP Act in Section 8 protects the registered medical practitioner from suits or other legal proceedings for any damage caused or likely to be caused by anything done in good faith under the act. Section 52 of the IPC defines good faith as adequate and due care.

[36] Nair,Janki (1996).
[37] Tiwari,Sudha(2003).

This last section of the MTP Act has far reaching implications as it is the foil protecting a medical practitioner diligently functioning within the boundaries set by the MTP Act, MTP Rules and MTP Regulations, from being prosecuted under the IPC or even potential civil or consumer court action. Of course this protectionist conditional to judicious fulfillments of all the legal and statutory mandates and requirements.

Doctors continued to be blatantly confronted with gravely ill or dying pregnant women whose uterus had been tampered with a view to causing an abortion. The reason being that although an act had come into force, the social realities had not been addressed by policy-makers since abortion continued to be stigmatized and both the providers and abortion seekers remained ignorant of its legalized status. The situation was even grimmer as both officials responsible for provision of services as well as the law enforcing authorities not only continued to remain ignorant of the act, but also often imposed their personal views in a gender discriminatory manner. The women may be suspected of infidelity, treated badly at the health services. It is disturbing to note from the studies that medical officers and also staff health facilities often believed that abortion is not a right thing. The nurse and midwives helped women get abortion in their words, 'only because of the women would also undergo sterilization, helping the nurse and midwives fulfill their target for sterilization. [38]

REPRODUCTIVE AUTONOMY VERSUS POPULATION CONTROL

Since poverty is understood to be the result of overpopulation, abortion has long been accepted as a measure of family planning. The Medical Termination of Pregnancy (MTP) Act was passed in 1971 amidst parliamentary rhetoric of choice and women's rights, but it was clearly intended as a population control measure, as several member of parliament pointed out during the debate (Lok shabha debates, Fifth series, V 7:159-200).[39]

[38] ibid. p. 61-64
[39] (Lok shabha debates, Fifth series, V 7:159-200).

Many MPs, however, pointed out that the real objective is clearly family planning. Savitri shayam, for example, argued that the failure of contraceptive as a ground for abortion can be justified only in the context of family planning. She argued that the government should accept that the family planning programme had not been successful and that this measure is simply an additional tool. J. M. Gowder applauded the Bill as 'we have been spending crores of rupees on family planning programme because of our unwanted hesitancy in legalizing abortion. Nawal Kishore Singh and Vikram Chand Mahajan argued that the bill should simply allow for women who wish to terminate their pregnancies. Only two MPs M.M.Joseph and Muhmmed sheriff opposed the Bill on the ground that abortion is murder.

What the parliament debate on the bill establishes is that there is no serious anti - abortion steam of opinion in India. However, the reason for widespread support for liberalizing abortion arises from impulses quite at variance with feminist concerns about reproductive freedom.

The experience of Indian women in the idea of reproductive right is different from their western counterpart. Choice is not a central component for Indian women. For abortion is available on demeaned for family planning purpose? Western feminism has traditionally taken the position that the right to abortion is a fundamentally and non negotiable demand. In the U SA the feminist discourse on abortion in generally conducted in the language of liberal rights. In developing countries like India abortion is rather a socially mandated consequence of the progressive attitude of Indian states to abortion is dictated by compulsion other than a commitment to women' liberation.[40]

The Medical Termination Act was passed in 1971, which legalized abortion under specific conditions such as danger to the health of mother and /or the child. Section 3 of this act facilitates pregnant women to terminate her pregnancy voluntarily (if she is minor or lunatic written consent of the guardian is necessary.) By a registered medical

[40] Menon,Nevedita (1993)

practionor if the length of pregnancy is b/w 12 and 20 weeks, then the concurring opinion of two medical registered practioners is needed. An abortion certified that the continuing of the pregnancy would endanger of life of the pregnant women or mental health seriously or there is substantial risk of the child being born with physical or mental abnormality or handicapped. The act allows M. T. P facility not only to protect the mental health of the raped victim but also to a woman whose pregnancy is the out come of the failure of contraceptive device. Further a woman can seek an abortion on the ground of her actual or reasonably foreseeable environment, being not conducive to her pregnancy.[41]

In fact there already exists a vocal and influential school of thought, which justifies the sex selective abortion of female fetuses as a form of population control. The argument is, in essence, that if abortion of female fetuses were permitted, couple would not be forced to continue having children until the desired son was produced. (Kala 1991:8) At the seminar in 1984 a government official stated that sex determination tests must be allowed because our population problem calls for desperate measures.(Sadasivam 1986:40). Similarly, the head of obstetrics and gynecology at the government hospital in Bokaro said: our priority is population control by any means. Amniocentesis should be used as method of family planning and should be made available to everyone at a minimum cost or even free' (kulkarni 1986:23).

Moreover, although the government does not openly advocate sex determination tests, the selective abortion of female fetuses seems to be having been built into the population control policies of the sixth and seventh plans. These plans set a target of net reproduction rate (NNR) of one (that is, one women should replace her mother) and it is expected that this goal, together with the objective of limiting births to two to three per woman, will be achieved by 2006-2011. it would appear that one implication of these policies is that 'excess' girls will have to be killed at the foetal stage to minimize the NNR of one(sadasivam 1986:40).[42]

[41] ibid. p. 370-392
[42] Menon,Nevedita (1993)

It becomes obvious that in the whole process of limiting population control exercise, women's reproductive needs were left untouched by public and private initiatives. As the work of Jeffery.P and Jeffery.R to the study population process in Bijnor in 1990 concluded that how the local form of patriarchy, in combination with a Government maternal health programme deformed by its linkage to the population control programme, left women's needs during pregnancy, delivery and the post- partum period very poorly catered for. [43]

Feminist writing on reproductive rights in family planning context in India attempted to recast the population debate in different, some times conflicting ways. Springing from concerns with human rights, some feminists have identified physical reproduction as the defining feature of womanhood, and have sought to release women from outside control, whether by husbands, other kin, or the state. [44] As a women's declaration on population policies expressed it, ''women have the individual right and the social responsibility to decide whether, how and when to have children and how many to have; no women can be compelled to bear a child or be prevented from doing so against her will.[45]

The debate about the reproductive freedom and women's choice has the taken a new ominous turn in India, because of subordinate position of women in India society as well as the growing practices of selective abortion of female fetuses after sex determination test during the pregnancy .The liberalizing abortion in patriarchal country like India where women have little say in the most matter even on there is no strong health education programme and where abortion is seen as a family planning measure . It cannot be seen as promoting women's right but aggravating hazard to women's lives; these reproductive rights are difficult to translate operationally in a society where the reproductive unit is still in the family hold where practice of marriage and birth are family oriented and where women lives are deeply embedded within families and communities. Added to this are the division of caste class and

[43] Jeffery.P and Jeffery .R, (1997).
[44] Ibid. p .39-53
[45] Ibid p .39-53

ethnicity .As Shobha Raghuraman [46]point out the women's movement has directed its attention to the states as the culpable agent for anti women reproductive policies, deflecting attention from societal responsibility for pervasive violation of women's right. Even through nearly half all married couples now use contraceptives services are by no means universally accessible or affordable with the result that nearly one third of pregnancies end in unsafe abortion after performed illegally and under unsafe condition, it is therefore not only a question of coerced family planning.

The medical termination of pregnancy act is not so much concerned about women's health and autonomy performed under specified conditions. Similarly, Pravin Visaria[47] argues that in the name of reproductive rights, policy attention on sterilization, contraception, and abortion while access to health care has been ignored. Abortion when used as method family planning is bound to become a tool in the hands of demographer, and the doctor, politician and administration to control the reproductive autonomy of the women .it was supposed that it would eliminate unwanted or force pregnancies or going to quacks that result in post natal trauma.

Denying women the right to abortion makes women bear all the hardship and blame for unwanted pregnancies ignoring that fact than men bear responsibility too, and that many pregnancy result from unwanted intercourse .in the similar way Malini Karkal [48]points out, in India the right of abortion is often little more a measured forced on women by men who refuse to use contraceptive. Another study also looked into the relationship b/w fertility dimension of patriarchy and development in India that is reproductive behaviors often strongly related to gender inequality.

SOCIAL IMPLICATION OF MEDICAL TERMINATION OF PREGNANCY ACT 1971

Govt. of India has enacted much social legislation since independence. In practice we find that this very good social legislation has remained in the books and the govt. is

[46]Raghuraman, Shobha and Rahaman (1995)
[47] Visaria ,Pravin and Visaria, Leela (1994)
[48] Karkar Malini (1996)

not able to implement these laws. Take for example the anti-dowry bill or the Child marriage bill or the anti-sati bill. Child marriages still takes place. The MTPA is the only social legislation that has found wide acceptance without any resentment. Unwanted pregnancy is a social stress in all societies. Before the MTP act, resorting to illegal abortion, infanticide or deserting the newborn in lonely places managed unwanted pregnancy. Now with the MTP act, the social fears are considerably reduced and the urban and the rural community have taken advantage of the Act.[49] Patters of sexual and reproductive behaviors have changed significantly over the years. Most important change is the increase in the premarital sex in all societies. There is also an increase in the out of wedlock births. There is increasing freedom enjoyed by the teenagers in social life. This often results in increased teenage pregnancy. The tragedy is that physiologically and anatomically there is a trend towards earlier maturation while process of social development is lagging behind. Young boys and girls are exposed to knowledge and information, and values not shared by parents or older members of the family.[50]

The impact of the MTP act should be judged in the context of changing social values and attitudes. The social implications of MTP in unmarried girls and MTP in married woman are different. MTP in married woman is not considered as a social stigma, whereas MTP in unmarried girls is not easily accepted and hence girls are taken to other distant places for MTP, and hence the girl's social future is not destroyed. This social legislation has certainly reduced incidence of suicide in these women because they can seek safe abortion under the law. The health of the woman has also shown improvement because of the MTP facilities. The acceptance of the family planning methods after MTP has also increased. It is paradoxical that though the community is taking the advantage of MTP services, they want to maintain secrecy and not let the neighbor about it.[51]

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[49] Bhatt R.V,(2004).
[50] Tanna,Ketan Narottam (1994).
[51] Radkar Anjali (2003).

Here negative aspects of the MTP Act have also to be considered. Though the MTP services are now available in rural areas, we are not sure of its effectiveness and safety. The high-risk cases are not recognized and MTP is performed in such cases without adequate back-up services. This results in immediate complications and long-term morbidity in term of infertility, menstrual disturbances and pelvic inflammatory disease (PID). These long-term complications may have social implications in form of broken marriages, divorce, and promiscuity. Mehlar, Director General of WHO has said, "because of serious effects of legalized abortion on the health and reproductive capacity of women, upon the stability of family and upon the morality of country specially its youth, it should be carried out only in a hospital and that to by a gynecologist."[52]

How true are the words in context of the present situation in India? The Govt. must see that MTP is done by trained surgeons only and that to in a hospital set-up. Gynecologist must also share some blame for MTP complications. The young girls and women come to the gynecologist at any time for MTP. This is because they do not want to inform the parents or other family members about it. Some deaths on operation table have been reported because of the practice of performing quick MTP without proper checkup. It is necessary that gynecologist do not perform MTP at unearthly hours and without proper facilities to fight complications if they do arise.

It is said that termination of pregnancy is performed on flimsy ground such as 'approaching examination'. 'Marriage in the family', 'going on a tour or vacations', etc. It is said that medical fraternity encourages such unnecessary terminations more often for financial reasons. It is necessary to check this trend of pregnancy termination on flimsy grounds. It is often not realized that to frequent and unnecessary pregnancy termination can result in infertility and PID.

[52] 'Mukherjee GG, Das H.S. (2004).

Though the MTP act was never thought to be used as a method of family planning many women unfortunately use it as an alternative to regular methods of family planning. It is the social responsibility of obstetricians to counsel all patients coming for MTP about the use of some contraception. It should be emphasized that contraception use is much safer than MTP. The use of emergency contraception (EC) by women should be encouraged in time of contraceptive accidents or failures. At present easily available methods for emergency contraception is oral contraceptive, and intrauterine device. The Obstetrician must remember that some woman coming for MTP may be HIV positive if they are used to multiple partners or their husbands/ partner is used to multiple sex partners. There is a risk of STD/HIV transmitted to medical and paramedical staff if precautions are not taken. It is debatable whether HIV testing should precede all MTP procedures. The Govt. of India has banned pre natal sex determination test for selective female feticide and violation of law is punishable with fine and imprisonment. The centres for pre natal test facilities have to be certified by govt. agencies. These laws are enacted to reduce selective female feticide which is a good objective, it is not clear if these laws have reduced MTP procedures for selective female feticide. These social legislations succeed only if there is will nit he part of the community and the medical people. The social purpose of these laws will not be served unless the medical people and the community co-operate in its implementation.[53]

THE CURRENT SITUATION OF MEDICAL TERMINATION OF PREGNANCY ACT 1971

In India the 'liberality' of the M. T. P. Act has rarely been put to the test because of the acceptance of abortion as mode of family planning. A recent nation wide study, Abortion Assessment Project by CEHAT and Health Watch finds that only 15 percent of the abortions are conducted in the defined framework of MTP Act. However, in the few cases regarding abortion which have come to court it become evident that a concern for the autonomy or physical health of women is not motives of judicial discourse. In reality a women's right to abortion is very restrictive and mostly, it turns

[53]Dwivedi Kirti (2005).

out to be a family decision. Under the Act, terminating the pregnancy requires only the consent of woman if she is above 18 year and sane. However the woman cannot be punished for the act itself, a Delhi High Court judgement in 1983 held that abortion without the consent of the husband constitute 'cruelty' within the meaning of Hindu Marriage Act and hence is a ground for divorce. In Staya v. Shriram (AIR 1983 Punjab and Haryana 252) the High Court observed in this sort of the case, the court has to attach due weight to the general principle underlying the Hindu Law Of Marriage and the importance attached by Hindus to the principle of spiritual benefit of having a son who can offer a funeral cake and libation of water to the name of his ancestors. In the word of the judgment, the wife had refuses to 'satisfy a husband's natural and legitimate craving to have a child '.

In Sushil Kumar v. Usha (1987 Delhi 86) the Delhi High Court opined that whether or not an abortion would amount of cruelty would also depend upon whether one of the parties desired a child in the very first pregnancy without the husband's consent would amount of cruelty. Courts have thus chosen to restrict the absolute right given under the statute.

Cases where the permission has been obtained from the court for abortion have been very few. In C. R. Nair and others, a 28-year-old woman from Madras, who was a victim of rape, sought permission from the court to terminate the pregnancy, which was granted subjected to the doctor's opinion. The Court observed, 'the petitioner has been impregnated against her will suffer traumatic and psychological shock'. In V. Krishnan v. G.Gopalan and another, the father of a minor girl sought permission to abort her foetus on the ground that she was kidnapped and was victim of rape. Under the M T PA, the pregnancy of a girl below 18 years or that of a lunatic can be terminated only with the consent in writing of her guardian. The minor girl did not wish to an abortion. The Madras High Court dismissed the application. It observed that an abortion against the will of girl would undoubtedly affect her mental health and possibly her physical health as well. The Court observed that the constitution does not make any distinction between a major and minor in the matter of fundamental rights. The judgment while safeguarding the right of a minor, however, referred in the

process to the various religious texts relating to sanction against abortion, and restricted the right by observing that 'Even during the first trimester, the women cannot abort at her will and pleasure ..... There is no question of abortion on demand. [54]

Another clause of this Act is based on that an abortion can be obtained on the ground of contraceptive failure. This can be considering as the positive aspect of this Act but this relief is restricted to married women only. Unwed pregnant women are forced to mention rape or grave injury to mental or physical health in order to seek abortion. Mostly women are prefer to go private hospital because the government hospital rules are very rigid this may led to unsafe and unhygienic abortion from quacks. Feminist on this point says that there should be need to extend the M T P relief in practice to all women irrespective to marital status.[55]

Beginning with an incorrect understanding of the medical termination of pregnancy act we have travelled a long way down a horrific path and there appears no end in the sight to the carnage of the girl child. The problem was identified in the 90s when the 1991 census showed a marked decline in sex ratio. What is needed now is to re-examine the applicable of the act in the area of contraceptive failure, the failure of contraceptive is legally accepted as a valid reason for the termination of pregnancy, irrespective of the fact that woman is undergoing her first or subsequent pregnancy or whether or she has any surviving children. The consent of the women was required in writing and medical practitioners has to form an opinion in the good faith that pregnancy being terminated is either life heartening or its continuance would cause grave physical or mental injury to the women. In fact, all he has to do is tick an option on a printed form without even recording the clinical reason for doing so. It is as simple as that. Everybody got an impression that abortion has been legalized where act

[54] Menon ,Nevedita (1993)
[55] Ibid. p.370-392.

only specified certain conditions under which a pregnancy could be terminated. Most doctors, lawyers, and social worker are still under that wrong impression today. [56]

Female fetuses are being selectively aborted in very large number on the ground of failure of contraceptive in blatant contravention of the sprite of act. Ultrasonic arrived in 1980s, which explain the sudden, drop thereafter, though the act itself becomes law in 1972. Sex could be determined anytime after 12 weeks and a simple tick or a signature in blue or black ink in an ultrasound clinic could mean a death sentence. The male child syndrome, which has always been prevalent in India, was now realizable, low cost option. Advance in technology legislation gone badly wrong and a disregard for ethics by noble profession together achieved distinction of having one of the lowest sex ratio in the world.

They're no need to under go the entire term of pregnancy as also the process of childbirth before getting to know whether it is girls or boy. It is like a win situation for all the family, the clinic the doctor and the women who for the first time by her or coerced by her family could actually opt for the sex of the child by repeatedly conceiving and aborting. Never mind that her mental and reproductive health is being battered in the process.

We have understood that failure of contraception is very rare and yet can be used as an excused to go on trying to conceive till a male child result. studies conducted by the government as well as a number of N G Os has indicate in the early 90s that almost all pregnancies were terminated on this very ground . This should have indicated those things were going wrong.[57]

THE CAMPAIGN AGAINST SEX DETERMINATION TESTS

No engagement with abortion in India can be undertaken without considering first the issue of sex determination (SD) and sex selective abortion (SSA). SSA underscores the profound complexities that surround the abortion debate in India. Today, more

[56] Nair Pavan(2004)
[57] ibid. web p. 1-4

than ever, there is wide-ranging consensus in India that this practice is morally and ethically unacceptable and the urgency to address it has gained tremendous momentum. However, the intersecting 'spaces' occupied by sex selective abortion and women's right and access to safe abortion create a number of thorny overlaps that make the consensus urging a ban on sex determination appear laden with ambivalence and contradictions.[58]

The forum of against sex determination and sex pre-selection (FASDSP) was formed in 1984, and it has been lobbying for legislation to ban the practice. In 1988, the state of Maharasthra passed an Act banning prenatal diagnostic practices. The FASDSP a broad forum of feminist and human rights groups is disappointed with the Act because it is full of loopholes and has not taken on the various recommendations the Forum had made (FASDSP). FASDSP then continued its campaign in the form of pressing for central legislation, which would be more effective. Parliament passed the Prenatal Diagnostic practices (Regulation and Prevention of Misuse) Act in 1994.[59] According to the law a woman may avail herself of the facility only if she is:

A) Above the age 35
B) If she Has a family history of genetic disease
C) Has had two or more spontaneous abortion
D) Has been exposed to agents that are potentially harmful to the unborn child.

It further states that:

- Determination and communicating of the sex of a foetus is illegal.
- Genetic tests can be carried out only in registered clinics and centers;

Hon'ble Supreme Court of India is regularly monitoring the implementation of PNDT Act 1994. In is last order dated 11th of December 2001, Hon'ble court directed the central government to frame appropriate rules with regards to sale of ultrasound machines to various clinics and to issue directions not to sell the machines to

[58] Malik,Ruspa(2003),
[59]Menon Nevedita (1999).

unregistered clinics. In its earlier order the court had also directed the central government to frame code of conduct to be observed by persons working in genetic counseling centers, genetic laboratories and genetic clinics.

The ban on the use of this technology in government institution led to its privatization and commercialization. Sex determination clinics have mushroomed all over the country. District which lack such basic amenities as potable water and electricity have prenatal sex determination clinics. A study shows that even landless laborers and marginal farmers were willing to take a loan at high rates of interest to avail of these tests. [60]

Women's groups are dissatisfied with this act, and in august 1994 urged the president to send it back for reconsideration to parliament. Some of the point that their memorandum raised are as follows:[61]

- All ultrasound machines and other equipment, which can be used for SD tests, should be registered.
- Future technique for sex determination as well as for sex pre selection should be brought within the ambit of the bill.
- The Act punishes the woman if it can be proved that she was not coerced and that she went in for the test and the abortion of her own will. The memorandum says that punishing the woman is misguiding, even on the presumption that she was coerced unless proved otherwise. This is unjust in a context where a woman rarely takes autonomous decisions. The act in this respect is anti women, and would create condition that would limit its effectiveness.

Thus it is not surprising that the act is full of loopholes. First, the legislation does not ban private genetic laboratories and clinics, which carry out sex determination tests. Second, the act enables the state government to overrule the decision of the highest monitoring body set up by the act with respect to cancellation or suspension of the licence of clinic from the provision of the act. Fourth, the ordinary citizen cannot

[60] FASDSP; (1988).
[61] Saheli newsletter, 1995.

directly move the court but must approach the monitoring bodied. Finally, the monitoring bodies can refuse to make records or information available to the complainant 'in the public interest'.

Contention and controversy have characterized key debates amongst the various constituencies, in particular the activists who urged a ban and the medical community, some of who opposed the ban. Three broad themes underpin these debates and are discussed in some detail[62]. First, the role of RTs and the gendered context in which they find use; second, the usefulness of regulatory frameworks to guide their use; and finally, the dual agenda of promoting the right and access to safe abortion while curbing sex selective abortion.

'FASDSP does not believe in saying a categorical "no" to technology. But certain questions have to be asked: Is there a qualitative difference between the various technologies? If so, how does one identify it and if not, how does one evolve criteria by which a distinction can be made to help determine those technologies that are desirable and appropriate?'[63] (FASDSP 1992: 91).

The reproductive technologies need to be examined through a lens that extends beyond the procedures to include the socio-cultural and economic context in which they find use. The most significant contribution of feminist analysis of RTs has been to demonstrate the gendered context within which these technologies are often used. However, RTs continue to be often seen as scientific progress that helps reduce women's reproductive burden. This shortsighted view of technologies as magic bullets makes little or no effort to address the unequal arrangement and disproportionate burden that women bear with regard to reproduction[64] (Birke et al. 1990). The case of SD and SSA is a stark example of how RTs can result in reinforcing women's oppression.

[62] Ibid. p. 1-2
[63] FASDSP; (1988.).
[64] ibid.p, 1-14.

Feminists advocates remain divided with regard to defining a position on new reproductive technologies. Some in the past (e.g. Feminist International Network of Resistance to Reproductive and Genetic Engineering) have advocated a blanket ban. Others emphasize the ambivalent effects that RTs have on women's lives. As a way out of this deadlock the debate on science and technology can and should be framed around two broad issues – that of political control and of morality and ethical standards (Nelkin 1992: x).[65] For example the FASDSP's demand to regulate diagnostic technologies and ban SD tests is an effective strategy that highlighted the disproportionate control of the medical community over the provision of these technologies and the absence of moral or ethical standards in the use of that power.

[65] D. Nelkin (ed) (1992).

CHAPTER-V

CONCLUSION

The coexistence of opposition to abortion and support for it is centuries old. All religions oppose abortion, emphasizing the right to life rather than the right to choose. The disjuncture between public policy, private morality, and individual behavior, are aspects that make up the background to the current discourse on abortion. On the one hand, the legalization of abortion renders it acceptable and appropriate behavior. On the other hand, public moral sentiment - partly reflecting the years of severe restriction – tends to cast abortion as inappropriate behavior. Hence, the ambiguities of the past are still present today, intensified, rather than diminished by recent changes.

A little over the three decades back, India decriminalized abortion. Unlike in the west, where efforts to liberalize abortion have been subject to intense religious, moral and ethical debate, the Medical Termination of Pregnancy Act 1971 became law in India without much fanfare. This is not because Indians are unconcerned about moral and ethical quandaries on whether a foetus should be equated to a living being or ontological debates over the meaning of life, but more because the Act is pioneered as part of a population limiting exercise with considerable support from the medical establishment.

In India legalization of abortion was never seen as a part women's reproductive right. However, this Act seems to be laid down on liberal grounds, through which women obtained the right to safe, scientific and legal abortion. It can be seen as legalization which confers on women right to privacy and freedom of choice. It would put a stop to illegal and unsafe abortion performed by unqualified and untrained and unequipped medical practices under unhealthy conditions. The Act also has been termed as a milestone in the modernization of Indian society through the instrumentality of law. It would have direct impact on population and in achieving economic and social development and would play a role in the emancipation of women from the age old fear of abortion being a sinful and criminal act.

Historically, women have practiced various forms of birth control methods and also abortion for fertility control. These practices have generated intense moral, and ethical, political, and legal debate since abortion is not merely a medico-technical issue but also a social issue.

Abortion in India is legalized with the aim to reduce the maternal mortality and morbidity as mentioned in Shantilal Shah Committee Report in 1966. Since poverty and underdevelopment is understood to be the result of overpopulation, abortion has long been accepted as a measure of family planning by some states, in spite of that fact that the Shah committee specifically stated that it is not to be treated as a population limiting exercise.

In India, maternal mortality ratio due to unsafe abortion is very high (10-20 percent) and is a major public health problem, not only due to the large number of deaths, but also due to the traumatic affects of such an event on the family in particular and society in general. The health risk of abortion multiplies manifold if a woman has to resort to it repeatedly. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and women in different geographical regions, social classes and indigenous and ethic groups. The socio-economic status of women, son preference, low utilization of health facilities, social barriers in women's decision making, and ineffectiveness in the actual availability of treatment are all factors that make women more vulnerable.

When abortion was not legal, a woman had to face the situation in terms of carrying an unwanted pregnancy in the face of unfavorable conditions such as lack of economic independence and poor health. If she did not wish to carry the pregnancy to term, her only option was to use indigenous- or self-treatment to get rid of the foetus. This situation is still present after the legalization of abortion.

Abortion is a sensitive issue in India. The experiences of abortion for Indian women are totally different from those of their western counterparts. In India, the socio-cultural and historical background shapes the debate on abortion. India is a land of diversities in

terms of cultures and traditions. It has a patriarchal social structure where the position of women is placed in subordination. Their position is understood to be for serving the patriarchal needs. In India women as a social category cut across the boundaries of caste, class, race, estate, etc. In spite of this, it should be kept in mind that women do not form a homogeneous category. They belong to diverse socio-economic groups and are also divided in terms of spatial considerations in term of rural and urban backgrounds. Therefore, though the MTP Act is universally implemented in India, the accessibility of these services is affected by these socio-economic factors. Given the fact that women in India have little control over their own fertility and also have poor health, the chances are very high that they may not only experience abortion once, but perhaps even more than once. In general both woman and her family prefer to remain silent about the matter. Though abortion in married women is now gaining greater acceptance, especially in urban areas, its incidence among 'not married women' is neither accepted nor openly talked about.

Abortion is perhaps the most contentious of all reproductive health needs of women, the subject of acrimonious and emotional debates. Denial of access to abortion has been an effective mechanism of patriarchal control over women's sexuality. Access to safe and legal abortion is thus an issue central to the rights and status of women, unwanted or mistimed pregnancy is in itself to a large extent a reflection either of unwanted and coercive sex within and outside the marriage; to women's lack of control over contraceptive use and men's lack of responsibility to prevent a pregnancy. It is in the context of abortion decisions that one becomes acutely aware of power differentials between men and women in matters related to reproductive health. While both are responsible for pregnancy, it is the woman who has to face the consequences of the pregnancy, either in going through an abortion and all the difficulties it may entail or carrying through the pregnancy and taking responsibility for bearing, nurturing and raising a child in adverse conditions. Apart from this, accessing abortion services is a path strewn with obstacles at many levels ranging from decision-making power to raising the money needed and finding a service provider who will carry out a safe abortion.

The legality of abortion does not mean that abortion services are universally available for every woman. Despite its legal status for over the thirty years, abortion in India largely unavailable, many women still go in for clandestine and unsafe abortions. Women cannot avail of abortion on their own will. There are some specified conditions under which women can abort their foetus. Apart from the social, economic, political, and legal factors which affect her decision making power, abortion services are also still far from the reach of women, thus preventing them from getting safe and hygienic abortion. It is neither the woman nor her family that is solely responsible for the ineffectiveness of available abortion services; rather it is the state that creates this situation through the poor implementation of the MTP Act. After over thirty years of legal status of abortion, under the MTP Act, 1971 a hospital established or maintained by government is recognized by default as an authorized place to provide MTP services. In contrast, private hospitals and clinics need government approval and authorization (certification) to provide MTP services. The private clinics receive their certification only if the government is satisfied that 'termination of pregnancies may be done under safe and hygienic conditions,' and the clinic has the requisite infrastructure and instruments in place. Despite the existence of a well-integrated network in the rural areas and their authorization by default to provide MTP services, the number of government health facilities providing these services is low.

The right to bodily integrity defined as the inalienable right of women to have control and autonomy over their bodies, has been central to the argument made by feminists and reproductive health advocates. For feminists, abortion means women's right to choose or reject motherhood, and their control over their bodies and decisions in regarding reproductive life. They claim that abortion is right but they do not consider themselves as pro abortion but demand that abortion should be a women's right as part of the right of women to control their bodies. They demand that reproductive health technology including abortion services should be accessible to women as per their demand. Although reproductive health and genetic technologies have indeed provided women with expanded choice as well as numerous benefits with regards to reproductive decision making, unregulated implementation of the MTP Act and gender relations in a

patriarchal social structure, especially in the context of India, (where abortion was never seen as a right) has created new challenges and exacerbated gender based inequalities.

In spite of the fact that abortion is seen as a family planning method, has the potential to reduce maternal mortality and morbidity, and also gives women the right over their bodies, the legalization of abortion has given it a new ominous turn in India. This relates to the issue of sex-selective abortion in India, which has originated from the subordinate position of women and son preference in society. No engagement with abortion in India can be undertaken without considering the issue of sex determination and sex selective abortion. Sex selective abortion underscores the profound complexities that surround the abortion debate in India.

In India, a son preference and a deep-seated bias against women are now more visible; however, sex selection is not recent phenomenon for Indian society. Son preference is an integral part of religion in India, so it comes as no surprise that unlike much of the developed, western world, the sex ratio in the country is dangerously tilted against women. Historically India has seen numerous invasions from external invaders as well as wars within various small kingdoms. Men served as a fighting force in these wars while women became easy targets for invaders, who raped and kidnapped their in the kingdoms that they vanquished; thus women were rendered a 'liability' in social terms. Thus son preference and bias against daughters was considered to be justified.

Social roles were also defined so as to consider men as bread earners and women as housekeepers. A son born in the family was considered an asset as he would earn to support his parents; on the other hand a daughter was thought to be a liability since parents would have to save up to pay for her marriage dowry. In this sense son preference also received justification in terms of economic as well as social security.

Most abortions among married women were sought for reasons of spacing between the children and for limiting the family. Abortion of the female foetus emerged as the most common reason for abortion. Since son preference is strong among both men and women, both of them feel that a couple should have at least one son. Therefore, they do

not think it wrong to undergo sex detection tests and abort the female foetus if the couple already has two or more daughters. More than sex selective abortion, this is seen as sex selective birth; a process of 'customizing' the family according to the wishes of the couple as well as the dictates of society. Such abortion thus has social sanction and approval from the family, despite the risk associated with late abortions. Women also undertake such sex-selection, or 'family customizing', expecting an improved status in the family. As highlighted by an educated rural respondent, 'Making the family is a career for rural women and getting a son is an important milestone in the career.'

The availability of new medical technologies to detect abnormalities in the fetus dramatically changed both the situation. It is realized that these tests (amniocentesis, ultrasound) also helped discover the sex of the fetus. These facilities are easily available in urban and small town areas. Suspicion deepened that, in the guise of testing the health of the fetus, the girl child was being eliminated in the womb. A combination of easy access to abortion facilities and the availability of new medical technologies arguably helped contribute to an alarming increase in sex selective abortions.

Dilemmas and conflicts between an individual woman's right to decide freely about her reproductive and sexual health and the state's social responsibility to population control, can not be resolved through policy statements but it needs action. If the status of women is not change then liberalized policy is not sufficient. One needs to alter the social structure which is insensitive towards women and it needs to be backed by creating gender sensitivity, political will and commitment in terms of adequate infrastructure support, accompanied by social inputs with the woman in focus.

We need a concerted effort to address the bias against girls at the source and alter the underlying conditions that promote sex-selective abortions. However, this is an uphill task and every action and every group that can address it will contribute to improving the status of women in our society.

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ABBREVIATIONS

ACLU	American Civil Liberties Union
CCP	Code of Criminal Procedure
CEHAT	Centre for Enquiry into Health and Allied Themes
CHCS	Community Health Centers
CWS	Commission on the Status of Women
D&C	Dilatation And Curettage
DHOs	District Health Officers
EC	Emergency Contraception
EVA	Electric Vacuum Aspiration
FASDSP	Forum against Sex Determination and Sex Pre Selection
FP	Family Planning
GOI	Government of India
I P C	Indian Penal Code
ICMR	Indian Council of Medical Research
ICPD	Conference in Population and Development
IIPS	Indian Institute of Population Studies
MMR	Maternal Mortality Rate
M T P –	Medical Termination of Pregnancy
M T P ACT	Medical Termination of Pregnancy Act
MOs	Medical Officers
MVA	Manual Vacuum Aspiration
N F H S	National Family Health Survey
NGOs	Non Governmental Organizations
NRR	Net Reproduction Rate
OT	Operation Theater
PHCS	Primary Health Centers

PID	Pelvic Inflammatory Disease
PIL	Public Interest Litigation
PNDT ACT	Pre-Natal Diagnostic Techniques (Regulation And Prevention Of Misuse) Act
PP	Post Partum
RMP	Registered Medical Practitioner
RTS	Reproductive Technologies
S D	Sex Determination
SAP	Structural Adjustment Programme
SSA	Sex Selective Abortion.
STD	Sexual Transmitted Disease
U N	United Nation
W H O	World Health Organization