Sex selection and safe abortion: unravelling the Gordian Knot[1]

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Overview

The authors have been involved in the safe abortion rights as well as sex determination issues in India as individuals and through their role and associations with various organizations, movements, campaigns, studies, publications and advocacy efforts, for over two decades.[3] It has been their observation that many civil society groups and individuals working on these issues, as well as those involved in the on- the- ground implementation of related laws and policies and programmes, are often uninformed, mis-informed or confused since the nuanced inter-relation of the issues is usually not

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[1] Wikipedia: The Gordian Knot is a legend of Phrygian Gordium associated with Alexander the Great. It is often used as a metaphor for an intractable problem (untying an impossibly tangled knot) solved easily by finding an approach to the problem that renders the perceived constraints of the problem moot ("cutting the Gordian knot").

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discussed or clarified, thus creating a false sense that the values around these two issues are in conflict, whereas if one goes deep enough into the ideology and perspectives that frame both the movements, it is a different story.

In this article the authors propose to provide a snapshot of the current landscape around both issues in order to unpack the historical perspectives as well as the trajectory of the politics and the influences that have shaped them. This weaves in an academic perspective as well as a view from the trenches.

Background

The Medical Termination of Pregnancy Act (MTP Act) [i] was passed in India in 1971 to ensure women's access to safe and legal abortion under specific circumstances, and to prevent the high number of maternal deaths caused by septic abortion. The Act was drafted as an outcome of a long study carried out by the Shantilal Shah Commission which was set up to review the causes of high maternal mortality. It is often stated that the Act also owes its genesis to the simultaneous concerns about the increasing population but the authors were unable to find any documents to refute or corroborate this position. Finally, and most crucially, the MTP Act needed to be passed because abortion/causing of miscarriage has been criminalized in the Indian Penal Code (drafted in 1860 as the British Penal Code) in sections 312-316.[ii] Thus the provisional and exceptional situations in which abortion may be allowed is made clear in the opening statement of the MTP Act 1971: "Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act."

At the time the MTP Act was passed in 1971, hardly a handful of other countries had a similar law and it was thus seen as a progressive legislation, which in many ways it was, allowing abortions not only for rape or to save the life of the pregnant woman but also a wider range of reasons such as for protecting her mental and physical health and for failure of contraception used by a married woman or her husband. Juxtaposed against the current anti-abortion environment in some parts of the world, the MTP Act could still be considered a relatively liberal law, with the MTP Amendment Bill of 2020 seeking to also expand single women's access to abortion. However, despite these expanded provisions, access to safe abortion is not really a right in India - only a conditional provision, which vests the power of decision-making in the designated provider, rather than the person with the unwanted pregnancy, and it has strong eugenic overtones.

Thus, despite the MTP Act which was hailed as a progressive legal provision in 1971 and which does offer a wide range of conditions for providing an abortion, the ground reality related to awareness about the law and safe abortion access at healthcare facilities across the country is far from satisfactory even five decades later. The notion of an abortion still remains shrouded in stigma originating from patriarchal notions about women's bodies, their reproductive lives and their gendered roles in society as child bearers and mothers within a cis-heteronormative, patriarchal (often endogamous, family-arranged) marriage.

Stigma, silence and fear prevents women from accessing or obtaining accurate information, either from social networks or through formal media. Fear of lack of confidentiality in the clinic setting and the critical desire for secrecy forces women to seek providers who are located at a distance, rather than those who are closer to home[iii] or to seek services from informal providers. In fact, a recent study showed that as many as half of all women they reviewed had originally attempted to induce abortion at home using medication, home-made concoctions or traditional methods.[iv] As a result, pregnant persons (women and transmen) continue to undergo severe stress caused by unwanted pregnancies and the subsequent economic exploitation or social punishment, and are often left with no choice but to undergo an unsafe abortion, with the resultant morbidity and mortality risk.

The second concern flagged in this article is that the provisions and implementation of the PCPNDT Act which prohibits sex-determination during and before conception have been misguidedly and unnecessarily conflated with abortion services. In 1994, as a result of campaigning by the women's rights movement against the practise of foetal sex determination in India, the central government passed the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act. This was later amended to The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act) in 2003.[v] This Act bans the use of any medical technology to determine the sex of the foetus, either before or during pregnancy, except for the diagnosis of certain specific sex- linked conditions. The initial campaigners within the feminist and health rights movements were clear about the separation of abortion access and rights issues and the technology that determined foetal sex, but once this campaign became widespread in the decade of 2000, the populist messages and rhetoric around it have been increasingly articulated in a sensational manner, sounding more anti-abortion rather than anti-sex determination. The Act prohibits sex determination but the phrasing used in these campaigns was 'sex selection' or 'sex selective abortion' thus bringing an unwanted focus on the abortion rather than the reason for the sex determination. This conflation has worsened the moral panic associated with abortion as an issue, making it difficult to

separate the abortion rights discourse from gender discriminatory sex-determination, especially when anti-abortion messages are disseminated across the country in local languages, where awareness about the MTP Act still doesn't exist. This non-nuanced positioning encourages vilification of abortions as the end point and adds credence to the baseless assumption that 'controlling' women's access to abortion would somehow 'fix' the 'skewed' sex ratio.[vi]

The conversation and rhetoric around sex ratio became more visible and mainstreamed in the 1990s. Unfortunately this resulted in making the sex ratio a priority as a number to be 'fixed' and deflected attention from the core issue of gender-based discrimination which is the reason why daughters are unwanted and sons are desired in India. It ignored the centuries of oppression and inequality that has led to girls being seen as a social and economic liability to their natal families. It also encouraged quick fixes which did little to acknowledge or change the skewed power dynamics and injustices done to girls and women within the patriarchal socio-cultural context.

Thus, the scramble to equalise the sex-ratio has not been accompanied by any significant measures to enhance gender equality and women's economic and political empowerment. As a result, women are still shamed and made to feel guilty after giving birth to a girl child, and often subjected to violence and/or abandonment.[vii] Neglect and discrimination of girl children continues as well resulting in a higher death rate for the girl children below six years of age, even as the policy and programme efforts are on to ensure that more of them are being born.

In order to understand the conflation between abortion access and sex determination at the level of policy and practise, it is important to understand the trajectories of both these issues that profoundly impact women's well-being and rights. Based on our personal involvement in the advocacy and campaigning work around safe abortion access as well as preventing discrimination based on sex-determination we attempt to juxtapose them in the context of emerging sociocultural-political changes in the country. We then discuss the possibility of disentangling them from each other in future campaigns, interventions and policy amendments.

A. Abortion Law and safe abortion services

As mentioned above, providing and having an abortion is still a criminal offence in India under Sections 312-316 of the Indian Penal Code[viii]. The MTP Act of 1971 only selectively decriminalizes abortion by exempting both the doctor and the woman seeking abortion under the specific situations outlined in that Act. Though it can be interpreted liberally, the conspicuous absence of the language of rights makes it vulnerable to narrow

and restrictive interpretations, especially if hostility towards abortion increases in society. 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." [ix] The risk is compounded by the fact that the Act allows doctors rather than pregnant persons to act as final decision-makers and gatekeepers for abortion, giving the former the right to deny an abortion, while simultaneously denying pregnant people the right to get an abortion on demand.

At the time of the passing of the MTP Act, the women's health and rights movement in India was still gathering its strength, and thus could not contribute to the formulation of the MTP Act. The process was led mainly by demographers and doctors, resulting in the conspicuous absence of a rights-based or gender-just language in the Act, and more importantly, the missed opportunity for a guarantee of this right under all circumstances through amendments to the Indian Penal Code itself. The MTP Act is seen to uphold access to abortion "through a sanctification of social norms, which are in fact, antithetical to feminism." [x] Further, the eugenic aspects of the MTP Act have also been questioned by groups working to establish the rights of people living with disabilities.[xi]

In the 1970s, the impetus for decreasing the population and reducing maternal deaths created a viable market around abortion needs, encouraging several doctors in private practise to start providing abortion services. As a result of the greater need for privacy and quick services as well as the insensitive behaviour of the public health sector staff and providers, along with the coercion for contraception, most abortion service seekers choose the private sector.[xii]

The Abortion Assessment Project (2004)[xiii] noted the failure of the State in setting up safe abortion services in the public sector, in regulating the costs of abortion services in the private sector and in widely disseminating information about the services under the Act. Lack of awareness of the provisions of the law, coupled with inadequate access to safe abortion services in the public sector results in the fact that three out of five abortions taking place in India are still deemed unsafe. [xiv], [xv]

As the resistance to target-based population control policies grew over the next couple of decades, and starting from the 1990s, there was a significant opposition to the use of women's bodies to fulfil the State's demographic ends. The fever pitch of the family planning programme started scaling back and newer, more lucrative procedures such as endoscopic surgery and IVF became available for gynaecologists in private practise. The late 1990s also saw an increase in misdirected PCPNDT implementation leading to panic among private doctors who were providing abortion services. This, coupled with the

advent of newer medical procedures in the 2000s such as the Medical Abortion Pills, meant that perhaps surgical abortion was no longer as lucrative for doctors in the private sector as it used to be.

Mifepristone and Misoprostol have been registered for sale in India since 2002 and the MTP Act was amended in 2003 to include this procedure as a legal method of termination of a pregnancy. Combipacks have been available through social marketing schemes for as little as 2 USD. A newspaper article reported that the total market for medical abortion pills in India is around Rs. 400 crores.[xvi]

The findings of an abortion incidence study conducted in 2015 estimated that of the possible 15·6 million abortions that occurred in India in 2015, only 3·4 million abortions (22%) were obtained in health facilities, while the vast majority of 11·5 million (73%) abortions were medication abortions done outside of health facilities.[xvii]

One of the changes in the sociocultural-political landscape has been a slow but persistent rise of religious fundamentalisms. The dominance of conservative ideologies bolsters patriarchal norms by adding a moral value to traditional binaried gender roles, compulsorily casting good women as mothers within marriage, and portraying women who want abortions as deviants from the ideal of motherhood and therefore, bad. The direct result is that increasingly one finds doctors and even chemists acting as individual moral agents in a healthcare system that is largely unregulated by the State or by itself.[xviii] Since the MTP Act grants the doctor the authority to take the final decision in every case 'in good faith',[xix] pregnant people are anyway subjected to the vagaries of individual providers. The continued control of the medical profession over access to abortion is dangerous, especially when a recent study conducted among medical students in Maharashtra state showed that "Almost one quarter of the respondents considered abortion to be morally wrong, one fifth did not find abortions for unmarried women acceptable and one quarter falsely believed that a woman needs her partner or spouse's approval to have an abortion."[xx]

The MTP Act can be read or interpreted differently by each doctor, depending largely on their own sense of ethical 'responsibility' towards the abortion seeker, while at the same time balancing financial gain and potential 'risk'. [xxi] It is interesting to note that some informal providers seem to have shifted to using the safer Medical Abortion Pills, [xxii], [xxiii] while on the other hand illegal and/or unsafe abortion 'rackets' (including those after sex-determination) continue to be reported across the country. [xxiv]

In the meanwhile, sex-determination continues to be available and the centres/ providers involved are known to the community and often also have the protection of powerful local political persons. Predictably, as a result of the various crackdowns these services now work under the radar, resulting in escalating costs as well as danger, as was evident in Sangli, Maharashtra.[xxv]

Abortions, especially those between 12-20 weeks of gestation have become exorbitantly expensive because the doctor 'faces the risk' of aborting a female foetus (which would happen in close to 50% of abortions anyway) and thus being charged under the PCPNDT Act for having conducted a 'sex-selective abortion'. Women in the seven- state study conducted by MASUM in 2018 have reported exorbitant payments for abortion and the pilot study conducted in a sub-division of Pune district revealed that first trimester abortions can cost anything between Rs. 8000 - 30,000 in the private sector.

B. Abortion and Patriarchy

Women's status (or lack of thereof) within a patriarchal society depends on their reproductive capacities.[xxvi] Motherhood, involving child bearing as well as child rearing, firmly situates the woman as an ever-loving, ever-ready altruistic individual within the cis-heteronormative family unit. Any demand made for men's participation in her unpaid and often unappreciated household chores is considered as being unrealistic or selfish. Failure to perform sexual or reproductive 'duties' (both biological and social) can result in neglect, violence, exclusion or desertion, because women can be rendered dispensable at any time by their natal or marital families.

The care provided to her within the family and that ensured to her by the State through its policies (such as for safe deliveries, antenatal and postnatal care) concentrate on these limited aspects of her life. The push for 'respectful maternity care' reflects this perspective of emphasizing 'respectful' services during motherhood rather than being made mandatory during all health interventions.[xxvii] The booming infertility industry in India is testament to the prime value placed on biological motherhood within marriage. The inordinate emphasis on having a child of one's own genetic make-up at any cost is also reflected in the fact that "India is fast becoming the hub for IVF and surrogacy as the country's market value is expected to touch INR 14.2 billion"[xxviii]

It can thus be argued that the act of abortion challenges the core gender roles to which women are held, and simultaneously questions the very notion of 'compulsory motherhood' through which cis-heteropatriarchy is perpetuated.

C. Unwanted daughters: An age-old story

The phenomenon of son preference combined with the daughter being unwanted has been documented in many studies. [xxix]

Sex selection through female infanticide has been a long-standing practise in India. The movement against sex selection also has a long history that originates from colonial times, when discriminatory practices against female infants caught the attention of the British civil servants and the Prevention of Female Infanticide Act was passed in 1871.[xxx] However, 150 years later, there are still instances of such practices despite schemes like the 'cradle baby scheme' set up in 1992 in Tamil Nadu where unwanted girl-babies could be left in the cradles at government hospitals and could be then adopted. [xxxi]

Historical and cultural practices compounded each other to create an unequal economic status for the girl child. The practise of providing a trousseau or gifts to the bride in the form of cows, jewellery, clothes and so on has been practised by many cultures, including ancient Indian traditions. However, during colonial rule, the British prohibited women from owning any property, resulting in these gifts being owned by men.[xxxii] This eventually led to the girl child becoming an economic burden, especially among the propertied classes, since she would not contribute robustly and equally to the labour and earnings of the natal household like a son, but would in fact cost the family dearly in terms of dowry. The phrase used to describe daughters is telling; *paraya dhan* translating as the 'wealth of a stranger', namely her future husband / in-law. Even though the Hindu Personal Laws were amended in 1956 to give women the right to inherit ancestral property,[xxxiii] in practice however, women rarely inherit any. Patriarchal attitudes also overrule other gender sensitive laws. Despite the Dowry Prohibition Act being passed in 1961[xxxiv] the practise continues unabated in direct or indirect ways. A recent analysis of the data available in the public domain shows that there was in fact a 74% increase in dowry-related deaths from1995 to 2007, while there was a 31% increase in the reporting of dowry-related suicides.[xxxv]

Factors beyond the 'economic burden' argument, such as fear of losing family 'honour' due to the sexual conduct of a daughter, patrilocality (whereby the daughter leaves her natal home and joins the affinal household after marriage), socio-cultural restrictions on her being allowed to support her parents, and the family's economic dependence on a son in the absence of any State supported pension or social security schemes are also considered reasons for daughter unwantedness.

Even as State sponsored programmes are rolled out to ensure that more girls are being born, there are studies showing systematic neglect of the girls during early childhood with malnutrition, incomplete immunization and active neglect, leading to a higher mortality rate for them compared to boys. There are also the lifelong mental and emotional health issues caused by the knowledge that they are unwanted by their parents, as can be seen by this practise of naming them *Nakusa* (unwanted girl). [xxxvi]

D: Discriminatory sex determination tests and their conflation with abortion.

In the early 1980s, the women's movement focused attention on a newly emerging form of gender discrimination: the use of medical technological advances to determine the sex of the foetus (in order to selectively choose to continue only that of the male sex). Feminist groups, including the Forum Against Sex Determination and Pre selection (FASDSP),[xxxvii] Doctors Against Sex Determination and Pre- Selection (DASDSP) in Mumbai, Saheli in Delhi and other women's groups challenged extant sexist technologies and spoke up for addressing gender discrimination as the root cause for perpetuating discrimination through such medical technologies. As a result of this strong campaign by the feminist movement, Maharashtra State and then the Central Government of India passed the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 (PNDT) which subsequently was amended to include pre-conception techniques and renamed as the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 2003 (PCPNDT). While the original PNDT Act does employ the term 'foeticide' in one specific context[4], it refrains from any discussion on abortion, and focuses only on monitoring the use of medical technology for sex determination. Both these Acts mention 'sex determination leading to female foeticide' with the aim of distinguishing this from sex determination done to diagnose medical anomalies, but they do not mention any regulations or punishments for the act of abortion in any other section, nor invoke sections of the MTP Act.

Parallel discourses based on discrimination and violence against women were dominant within campaigns against sex determination and sex pre-selection.[xxxviii] It was not uncommon for some factions of the campaign to use messages that personified the female

[4] The preamble of the Act reads: An Act to provide for the prohibition of sex selection, before or after conception, and for regulation of prenatal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide; and, for matters connected therewith or incidental thereto.

foetus as a helpless being beseeching its *mother* for the chance to *survive*, and the phrase female 'foeticide' was coined in order to problematize the act of sex determination. [xxxix] Inadvertently, this blurred the lines between the two acts: sex determination and abortion. While many feminists have since then worked to separate the two, there are other campaigners who have relied on such personification to appeal to the masses. Abortion inevitably becomes vilified through such messaging. The corollary of the emphasis on 'protecting' and 'saving' female foetuses was that the act of abortion got projected as the sole means through which sex selection took place. The fact that *not* aborting (and thus, retaining) male foetuses was equally an act of sex selection was lost. The focus on abortion following sex-determination legitimized the surveillance of women having female foetuses, putting them at further risk of discrimination versus women who benefitted within patriarchal marriage after sex determination, namely those who had male foetuses and therefore who did not go / were not taken for an abortion. Monitoring pregnancies, making them public or following up on women with female foetuses became acceptable measures in order to 'protect' the female foetus; all this without any considerations for the privacy, autonomy and personhood of the pregnant woman. A movement that started off as one questioning gender discrimination in the 1980s gradually became a platform for people with underlying or overt anti-abortion views to voice their sentiments and shape public thinking accordingly.[xl]

The rise in religious revivalism and conservatism in the 1990s shaped the discourse on abortion within the expanding campaign against sex selection. Emphasis placed on the traditional gender roles of women resulted in abortion being perceived as immoral, unethical and selfish, even. As the issue of sex selection gained prominence and popularity in the media and was spoken about at public events ranging from school parades to mass gatherings and political party election campaigns, several new stakeholders, inspired by paternalistic views about traditional gender roles of women, highlighted the utilitarian need for women's existence, such as female foetuses being crucial for future generations as wives and mothers. Assumed cis-heteronormativity and marriage for every person in society (in a 1:1 ratio) became the cornerstone of this futuristic imagination.

Figure 1: A wall painting that says 'If you do not have daughters how will you eat the food cooked by their hands?'

Another significant development that has a bearing on the conflation between sex-determination and abortion was the use of total sex ratios in the public discourse to quantitatively assess son preference and daughter unwanted-ness. India has had an

adverse female sex ratio documented since the very first census of 1901 which noted the female to male ratio was 963 females to 1,000 males.[xli] . The sex ratio at birth suggests elimination at the preconception or prenatal stages, and juvenile sex ratio indicates any neglect and direct or indirect violence meted out to female children that could lead to their death. While the juvenile sex ratio (0-6), continues to be low (914 per 1000 births in 2011), somehow the sex ratio at birth has gained importance as a marker of sex determination and the resulting elimination of female foetuses through abortion. The concern about fixing the sex ratio rose to prominence particularly after the 1990s, when Nobel Laureate for Economics, Amartya Sen, used the skewed sex ratio to point out that more than 100 million women were 'missing' from India's population.[xlii] However, a low female sex ratio at birth could also indicate a higher survival rate for male foetuses (usually more fragile than the female foetus), made possible because of the improvement of maternal healthcare, and not always because of deliberate intervention made to selectively eliminate the female foetus. [xliii] The total sex ratio is affected by mortality due to medical, non-medical reasons at any stage of life, migration or lack of recording births of female children; however, the distinction between the other two sex ratios and their nuances have not been well understood in the public discourse around sex selection. There may be many million girls 'missing' but there are also millions of girls born who are unwanted and face starvation, neglect, abandonment that leads to an early death.[xliv]

When sex determination technology was first made available in India in the 1980s it was through the use of amniocentesis and chorionic villi biopsy. Both are invasive tests conducted in the late first trimester, at around 11 weeks of gestation, so they carried some risks but the resultant abortion was a first trimester procedure. With the advent of the ultrasonography (USG) machines, this new non-invasive technique took over, but it could only be used after 13 weeks of gestation, thus needing access to second trimester abortion if required to terminate the pregnancy. However, USG was easier to perform and also was not subjected to as much scrutiny as the earlier invasive procedures which needed a laboratory and surgical set up. As a result of these technology intensive interventions, many campaigns and on-the-ground responses have revolved around the control of such technologies resulting in a high focus on registering, inspecting, sealing of USG machines and radiology clinics, along with 'sting operations'. Radiologists have protested about this and there have been recent demands for amending the PCPNDT Act to ensure graded punishments. [xlv] Despite the law, as always, those who can afford it manage to obtain their ultrasound or other means of sex-determination, even if they have to travel abroad to do it.[xlvi] These attempts at controlling the technology also fail to recognize that it is the desire for the male child that needs to be changed since there may be newer methods emerging in the near future which would be even more difficult to monitor.

Prior to the PCPNDT Act, for almost two decades, sex determination tests had created an unprecedented and lucrative opportunity for several private practitioners to employ medical technology to identify the sex of the foetus as well as to then selectively terminate pregnancies with a female foetus, on request of the family. Many doctors believed that by helping women to terminate an unwanted pregnancy with a female foetus they were helping her avoid further suffering at home due to violence and harassment.[xlvii] Concerned by the weak implementation of the PCPNDT Act in spite of the Supreme Court ruling, UN agencies such as The United Nations Population Fund (UNFPA) increased programmatic support across several states for monitoring of sex determination. Government authorities enthusiastically embraced the ideas of tracking pregnant women, either through ultrasound machine based Silent Tracker or through actual live tracking of women at the village level, impinging upon women's right to a life of dignity and privacy. [xlviii], [xlix] In an over-zealous intervention in 2012, a Minister from the Maharashtra Government had even sent a proposal to the Central Government suggesting that 'sex selective abortion' should be considered murder and made a punishable offence with life imprisonment.[l]

Even though the PCPNDT Act only addresses sex determination, the implementation on the ground has often resulted in targeting the abortion service facilities, and second trimester services in particular, thus creating a false understanding that all second trimester abortions themselves are now somehow illegal or not acceptable. As a result of such rhetoric in public domains and the perceived as well as actual harassment by the local authorities, a study found that many doctors in private practise in Maharashtra would no longer perform second trimester abortions. [li] Since the vast majority of second trimester abortion are for reasons other than sex determination, this puts many women at risk of seeking unsafe abortions. There are also case studies of some private doctors conducting home visits at night and providing the abortions which are not only illegal but can also be unsafe. [lii]

Over the past couple of decades, given the lack of public knowledge about the legality of abortion and the MTP Act, the sudden increase in publicity about the illegality of sex determination (framed as 'selection') created confusion in the minds of the layperson. It is not uncommon to find the terms 'female foeticide' and '*stree bhrunahatya'* (both of which translate as 'killing of the female foetus') being reiterated in the work of several governmental, non-governmental organisations and even educational institutions in an attempt to prevent sex-determination. Several posters, photographs and videos employ grotesque images of the product of conception, and using imagery of a noose around the foetus to draw attention to the vulnerable female foetus, largely because the public can relate better to a discourse around overt violence, as compared to that of gender- based

discrimination. The visual representation of bloodshed and death has escalated negative sentiments around abortion, and greatly increased the already existing stigma and uneasiness around it. Such messages also shift the accountability of the act from the medical profession to appealing to individual pregnant women and by casting women as daughters, mothers, sisters and wives, thereby reinforcing patriarchal gender stereotypes.

Figure 2: Anti sex selection poster

Figure 3: If you kill a daughter, how will you find a bride?

While not all factions of the campaign employ utilitarian language, the increasing popularity of such messages influence even well-intentioned stakeholders to shift to a discourse based on instrumentalism, rather than an intrinsic approach to women's human right to equality, autonomy and non-discrimination.

E. Current legal and policy responses to the sex ratio concerns and abortions

The population census of 2011 revealed that the population ratio in India is 940 females per 1000 of males.[liii] The state with the highest ratio is Kerala and lowest is Haryana. The SRS Report 2018 shows that sex ratio at birth in India, declined marginally from 906 in 2011 to 899 in 2018.[liv] These numbers have bearing on the status of women in Kerala as compared to Haryana and the impact of those conditions reflecting on the skewed sex ratio; yet some stakeholders in the campaign have increased pressure on the government to implement immediate measures to 'save the girl child' by stopping sex selection. Some drastic measures have been undertaken, causing adverse outcomes for women.

In June 2012, when the closure of a clinic in Beed,[lv] Maharashtra brought into limelight the nexus between providers of sex determination services and doctors providing abortions thereafter, this episode increased misgivings about all abortion services in the state, resulting in a policy that also restricted the availability of medical abortion pills. Sex selection also became a prominent theme in the campaign speeches that preceded the 2014 elections. The central government endorsed the language of conflation, oftentimes vilifying abortion in its attempt to highlight sex selection. In his Independence Day Speech on August 15, 2014, the Prime Minister appealed "to doctors not to kill the girl child." Similarly, on January 24, 2015, the National Day of the Girl Child he said, "In our neighbourhood girls are commonly killed in their mothers' wombs, and we don't feel pain." [lvi]

Figure 4: Where would you be if your mother was not allowed to be born?

On January 22, 2014 the Prime Minister launched the "Beti Bachao, Beti Padhao" campaign (Save A Daughter, Educate A Daughter) with a focus on prevention of sex selective elimination and ensuring survival, protection and education and participation of the girl child. A paternalistic and utilitarian approach presents girls as victims, but they also link their survival to the future roles that girls are expected to play as wives and mothers.[lvii] The campaign did not do much to address the secondary status being faced by girls and women in Indian society at present, nor did it work to eliminate the stigma and discrimination faced by the girl child.[lviii]

On January 21, 2015 the Union Women and Child Development Minister announced a Rs.1 crore award for districts in Haryana[5] that can improve their sex ratios and simultaneously launched a scroll that read, "*Beti hai to kal hai*," (We can have tomorrows only if we have daughters) casting women once more into their traditional roles as daughters-in-law and child bearers. [lix]

A new amendment was proposed in October 2014 to the MTP Act in order to increase access to safe abortion.[lx] If passed, this would have allowed women to access abortion services up to 12 weeks without having to give any reason (thus converting abortion into a 'right' at least in the first trimester). The proposed amendment also recognized that single / unmarried women might require abortion services, and extended the gestational limit of abortion from the existing 20 weeks to 24 weeks. Unfortunately, the Bill was rejected by the Indian Medical Association (IMA) and Federation of Obstetric and Gynaecological Societies of India (FOGSI) because of the proposed inclusion of non-allopathic doctors and mid-level providers, and extension of the gestational age with respect to abortion. Thus, a relatively progressive amendment was thwarted by the powerful doctors' lobby in a turf war for protecting their private practise income at the cost of greater access for women.

On 2nd March 2020 another MTP Amendment Bill was tabled in the Lok Sabha (the Lower House of Parliament) where it was passed after deliberations. Civil society groups working on safe abortion advocacy issues were taken unawares and had to step in quickly in order to understand and critique the new amendments being proposed. Some of the concerns expressed by activists and advocates working on this issue have been around the fact that despite minor progress through changes in removing the word 'married' in the

[5] Haryana records the lowest sex ratio in India with 857 females to 1000 males.

failure of contraception clause and proposing extension of gestational age limit to 24 weeks for foetal malformations, there is no real shift in power of decision making or control from the service provider/doctor to the woman or the pregnant person. The proposed State Medical Boards to review cases beyond 24 weeks are in fact a violation of human rights of the women by creating a third party in the decision- making process. The extension of gestation limit to 24 weeks is also only in a selected group of cases including rape and foetal deformity, thus reinforcing the victimhood and the eugenic tenor of the MTP Act.

Despite intense advocacy efforts from civil society groups, the Act was tabled in the Rajya Sabha (Upper House) in September 2020 and then again in March 2021 where it was passed. Once it is signed by the President it will become a law.

Various civil society groups and individual activists have shared critiques of the amended Act. [lxi], [lxii], [lxiii]

F. Nuancing, without dividing

a) While in India the MTP Act was enacted within the discourses on population control and public health, in the global north, abortion has almost always been located within a rights-based framework that prioritizes individual choice. In recent times, anti-choice factions in those countries have employed the issue of sex selection, particularly among immigrants from China and India, to question the ethics of choice. The arguments range from the demand to selectively ban 'late term' abortions, to the pro-choice feminist argument of respecting a woman's right to make unconditional choices, including for the sex of the foetus. While the latter argument of pro-choice feminists is difficult to recognize in India currently where gender discrimination is highly prevalent, the former argument, made by the anti-choice lobby is not very different from the demand being made in India to selectively curb abortion services to prevent sex 'selection' The recent racial profiling of South Asian and Asian communities in the UK by selectively monitoring their access of sex-determination is a troubling feature.[lxiv]

b) It is important to make a distinction between sex selection and sex determination. While the former includes diverse steps to fight the son-preference-daughter-unwanted-ness continuum[lxv], the latter specifically concentrates on medical advancements and their misuse to further patriarchal concerns. Although the campaigns concentrated on sex determination and sex-selection as distinct

categories (during pregnancy and pre-conception), the terms sex-selection and sex-determination have come to be used interchangeably, blurring the distinction between the act of determining the sex of the foetus or embryo, and the act of selecting a foetus or embryo of a certain sex for survival or elimination. Sex 'selection' can also be practised post-birth either through infanticide or pernicious neglect of the girl child. [lxvi]

c) In the decades of the 1980s and 1990s, the campaigns against sex selection focused on the multiple forms of discriminations meted out to women at different stages of their life. In the new millennium however, the focus has shifted dramatically, pitting the woman and the girl child against each other on the one hand and conflating the girl child with the foetus on the other hand. Using the sex ratio as a marker and putting the spotlight on the 'missing' girls has led to a much greater focus within the movement on 'saving' the girl child. Terms such as 'save' and 'child' not only pose a linguistic as well as an ideological problem, painting the picture of a hapless entity or victim who must be 'rescued'; they also infantilise a woman by reducing her existence to being seen as primarily a 'girl 'child' to be saved. It reinforces the paternalistic penchant of appearing to or desiring to 'protect' women, without protecting their right to autonomy; without working towards gender equality as the goal; and, without empowering women to use their own agency and access their human rights at all times.

G. Discussion and Recommendations

Future Campaigns

Gender-biased sex selection and people's access to safe abortion are intrinsically linked to patriarchal gender roles, discrimination and people's human and reproductive rights. Campaigns around these issues have been diverse and often contrary, involving stakeholders who bring in a range of perspectives, insights, experiences and beliefs, ranging from patriarchal to paternalistic to feminist ones, and from reasoned arguments to populist ones. Several civil society groups and organizations across the country are invested in working on issues of sex determination, sex selection and safe abortion along with government programmes, and many of them sometimes knowingly or unknowingly perpetuate the conflations mentioned above in their everyday work. Their perspectives

are rooted in diverse ideologies that range from saving the girl child, to women's roles as mothers, to anti-abortion sentiments, to being feminist and striving for gender equality.

The current populist discourse speaks out against sex selection in order 'save' the female foetus posited as the potential future girl child/ married woman who will run the household and bear children. It personifies the foetus on the one hand and essentializes gendered roles of the girl/ woman on the other hand. The feminist perspective focuses on improved access and right to safe abortion for persons who are already born, who have the right to agency and who are not helpless victims, even though the politics of patriarchy, conditional motherhood, population policies and divisive identity politics are played out on their bodies. The narrative of singling out the 'girl' for one debate and the 'woman' for another needs to be replaced by a realisation of a continuum of human and constitutional rights throughout life. The Human Rights declaration states that all humans are born free and equal, which is interpreted to mean that the rights apply to born humans and not to the foetus.

Interventions

The current instrumentalist approach needs to be replaced with an intrinsic one that protects and promotes people's reproductive and sexual human rights during every stage of their lives. Similarly, access to safe abortion cannot be accomplished without ensuring the reproductive and sexual rights of people and without State obligation to provide comprehensive health care and sexuality education. Working together with health rights campaigns, whether to prevent privatisation of health services or to regulate the private medical and pharmaceutical sectors, and to hold public sector services accountable would be essential too.

Medical technologies have emerged as one of the biggest points of contention, although science and technology do not operate in a socio-political vacuum. As changes in the demand-based market economy make more advanced technologies commercially available, feminist activists are concerned about ensuring equal access for all who may need to use these technologies, while also preventing 'misuse' of these same technologies for patriarchal purposes. While the former is a priority for stakeholders engaging with abortion rights, the latter is a concern for those working on sex determination. Both factions rely on law and policy to ensure their ends. Constant and nuanced dialogue on how these seemingly opposing ends can be served is required, to reduce the rift between the campaigns that work on either of these issues and to recognize the rights of the pregnant individual in the context of systemic discriminations and frameworks of oppression. The attempt to use the law to control or ban diagnostic technology has to take

into account a foreseeable future where the technology for sex determination could be self-administered through a simple blood or saliva test, or through a smartphone operated ultrasound, and which would elude the control of legal enforcement. Our strategies must necessarily focus on gender- based discrimination, and not merely on technologies or access to medical procedures, because in any case structures perpetuating inequality would constantly spew out new methods to serve their vested interests. We also need to recognize the perspective of social justice wherein the rich would always have access to any new technology in a globalised world, thus leaving only the poor and vulnerable being further penalised.

Laws and Policy

The opposition to 'selective' abortions on the basis of gender (and its prohibition through the PCPNDT Act) also leads us to a quandary faced with the growing debate about the discriminatory practise of allowing 'selective' terminations for foetal disability, which is in fact one of the stated reasons for allowing abortion under the MTP Act and emphasized in the newly passed Amendment Bill 2020. If gender is a social construct that facilitates discriminatory practises against women, intersex and trans persons, then so is disability. Absence of sign language, Braille and ramps in public and private domains, and barely any political participation and representation in local and national decision-making bodies are some obvious manifestations of disability-based discrimination, exclusion and stigma. Such contentious issues necessitate debate and dialogue on whether the present MTP Act needs periodic amendments or whether abortion should be decriminalized entirely and whether it should become an unequivocal and inalienable right for people in India by amending the Indian Penal Code instead. In the long run we need to discuss whether we even need any Act to govern people's access to abortion, since no similar specific Acts govern many other potentially irreversible medical or surgical interventions.

Other excluded groups such as sex-workers, whose motherhood is stigmatized, need to become an active part of the campaign for the right to abortion. It is telling that a recent judgement which in fact allowed a sex-worker to access abortion was based on the patriarchal notion of legitimacy: "Treating her mental agony to be equal to that of a victim of rape, the Rajasthan High Court allowed the plea of a forced sex worker to abort her foetus. Moreover, the single judge said "*If the child in the womb is allowed to be born, his / her mental agony will be no less. He/she will always be reminded of the petitioner's past, and the fact that his/her paternity is not known*."[lxvii]

While the woman in question did get access to safe abortion through this judgement, the 'chivalry' of the judge in allowing the abortion strengthens the belief that the birth of a sex-worker's child is a fate worse than being aborted, mainly because of the stigma associated with unknown paternity, and the shame related to the 'past' of the pregnant woman.

Misogyny is the bedrock upon which the sociocultural-political attitude of society towards abortion is constructed - from the gendered expectation that women have to bear and rear children for the cis-heteronormative patriarchal family, to why people fail to recognise and respect the right to access safe abortion, bodily autonomy and people's reproductive and sexual rights. Ultimately the attitude of the State in respecting someone's decision not to continue an unwanted pregnancy has been and still remains a difficult obstacle to tackle from the personal to the political levels. Therefore, we need to reach out to allies within the system too. It is heartening to note that the Bombay High Court divisional bench gave a remarkable judgement[lxviii] stating that:

"[The] MTP Act bestows a very precious right to a pregnant woman to say no to motherhood. It is the right of a woman to be a mother, so also it is the right of a woman not to be a mother and her wish has to be respected. This right emerges from her human right to live with dignity as a human being in the society and is protected as a fundamental right under Article 21 of the Constitution of India with reasonable restrictions as contemplated under the Act.

……Woman owns her body and has a right over it. Abortion is always a difficult and careful decision and woman alone should be the choice-maker. ... unborn foetus cannot be put on a higher pedestal than the right of a living woman."

This was followed by another landmark judgement in Indian history, in August 2017, when the Supreme Court unanimously ruled that the right to privacy is a fundamental right of every Indian citizen. The nine-judge bench constituted by Chief Justice JS Khehar ruled that the right to privacy and dignity is intertwined with the right to life and liberty. Justice Chelameswar stated that "*A woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy*."

Public health sector and access

The public health sector infrastructure and quality needs an overhaul regarding shortages of trained staff, equipment, medication and electricity as well as improving the insensitive approach towards people seeking abortions and coercion for contraception. Within the medical community, the dearth of ethical practice and accountability, especially in the private sector, has significantly influenced provision of sex determination and in becoming gatekeepers in people's access to abortion services. The lack of access in public sector to sensitive confidential abortion services is further compounded by the fact that many doctors who refuse women care in the government hospitals then offer the same services later in the day at their private clinics for high fees. Lack of ethics education or sensitization on gender and rights issues in the current medical curriculum and inadequate regulation of the private sector allows providers to charge exorbitantly for abortion care on the one hand, and to perform sex determination tests on the other hand. The allopathic private sector professional bodies were responsible for blocking the proposed amendments to the MTP Act in 2014 since it included the provision for expanding the service provider base to non- allopathic providers and nurses. These are among the compelling reasons to demand for more effective, sensitive non-coercive services in the public sector through a rights-based approach that includes accountability towards those seeking abortions. The current bio-medical focussed curriculum also needs a radical revision in order to imbue young doctors and nurses with the basics of gender issues and ethical practice, which provide them with an understanding of the social, economic and political framework, within which they can make ethical and people-centred decisions.

Society and gender norms:

The conflation of abortion and sex selection at the level of interpretation and implementation of policy has its roots in social, cultural and political realities that predate modern concepts such as equality and personhood. As more conservative stakeholders enter into campaigns against sex-selection, synergies between the feminist activists who campaign against gender biased sex-determination and those who work on abortion rights are essential for gender discrimination to be addressed from a feminist perspective, and to ensure that the right to access safe abortion is fully recognised and protected. Cross movement collaborations that consciously challenge paternalistic and patriarchal frameworks, and religious / cultural morality-based arguments are essential in order to develop strategies that can be incorporated into the popular discourse by engaging with the media.

While the conflation between sex determination and abortion is largely manifested at the level of interpretation of policy, leading to misguided implementation at the ground level, some documents like the Beti Bachao Beti Padhao directly articulate a conflation despite the discrete nature of both the issues and Acts. It is thus of critical importance that the ways in which both are women's rights issues should be clarified in public discourse and through tailored and specific training for the concerned authorities.

Broader and more entrenched issues of gender discrimination that keep women subordinated and oppressed through unequal access to resources, opportunities and property rights, early and child marriage, dowry, control over women's sexuality and bodies, and valuing women solely on the basis of their reproductive potential in a cis-heteronormative marriage need to be challenged. Only such a broad framework can bring together the different groups working on gender equality. Discriminatory sex-selection and the right to safe abortion should be placed within a feminist, human rights-based framework that acknowledges women's agencies, and sees their lives and experiences in a holistic way. Most importantly, women and gender non-binaried people should be actively included in these dialogues since their bodies are ultimately the site where technologies, patriarchy and law converge.

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