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Highlighting Contradictions around Right to Life and Right to Choice related to Abortions in India

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Abstract

Indian society is a patriarchal society where women are considered as the second sex in comparison to men. Women's rights are often violated in different stages of their life in different ways. Women exercise less reproductive rights or have less decision making power related to the issues of reproduction. They also remain subject to different forms of violence in their life that could also put their reproductive health in jeopardy.

In our society, women's life is perceived as highly undesirable to the extent that a baby girl is killed within the womb. The 2001 Census had reported the child sex ratio in India as 927 that has further reduced to 919 in 2011. The prevalence of the sex selective abortion has not stopped even with spread of education and it is prevalent across the different economic classes. In most of the north Indian states and Maharashtra, the child sex ratio has reduced abysmally even below the national average. The practice of the sex selective abortion not only annihilates the right to life to the girl children but also puts the health of the women at risk. The sex selective abortion is a grim form of violence against female gender which negates the very framework of human rights itself. Furthermore, such a social practice might give rise to the gender imbalance by putting the equilibrium of the society in halt, capable of creating several social maladies. In order to control the sex selective abortions,

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the Indian state has formulated the Pre-Natal Diagnostic Acts in 1994 which was further amended in 2002 and is known as Pre-Conception and Pre-Natal Diagnostic Acts (PC-PNDT) that helps preventing sex selective abortions.

The Indian women have less control over their own body and exercise less rights related to reproductive issues and choices. However, the Indian state under the Medical Termination Prevention Act has legalised abortion (with a few restriction), under which a female has a right to abort a foetus. This law also in essence ensures that abortions of the foetus are not selective of a particular sex. The sex selection abortion deals with two contradictory rights of women i.e., right to life and health and the women's right over their own body. Under the law, although women have right to abortion, they have no right to abort a foetus on the basis of the selection of the sex of the foetus. The paper argues that though there is a seemingly contradiction of these two rights, in fact they are complementary to each other to ensure better protection of rights of female gender. It further argues that though the state has been successful in introducing the law, it has largely failed in implementing the law.

Key Words: Rights, sex selection, abortions, and Laws

Introduction

Right to life is a basic human right of an individual and when the life of the individual is denied purposefully before the birth of the child, particularly because it belongs to female gender, then a woman's utmost right is violated. Discrimination to girl child based on sex selection is one of the major forms of violence against women. The international conventions such as The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) intend to abolish all forms of violence faced by female gender. The CEDAW convention was adopted by the UN General Assembly that defines discrimination against women as "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.". The constitution of India guarantees the right to life under article 21. The constitution of India under the section of Fundamental Rights also ensures equality of treatment before law that states "All citizens irrespective of birth, religion, sex, or race are equal before law". Equality being one of the fundamental rights, discrimination against any particular sex is perceived clearly a denial to fundamental tights. The practice of sex selective abortion in India is highly discriminatory in nature that puts women's basic human rights and fundamental rights in peril.

There are over millions of girl children missing in India in every decade. Killing of the female child or sex selective abortion is not new to a patriarchal state like India. During the mid-1980s, the colonial rule mentioned about the practice of the female infanticide in India and subsequently the Female Infanticide Act of 1871 was passed (John 2014). Historically, as Pandita Ramabai has written in her diary describing her travel in 19th century to the northern part of the country, female babies were being destroyed with the support of the community or clan by several abhorrent methods. She noted that patriarchal communities projected hidden fact of female infanticide under the veil of stealing of girl children by wolves, stealing and murder of girl children by unknown

thieves and so on. Citing the Census report of the 1870s, she discussed a strange fact that 300 girl children were stolen in one year from Amritsar (Chakravarty, 1987). With sarcasm question, why those wolves were fond of only girl children! Long after independence in a few northern Indian states there was the practice of killing of female children ceremoniously. Change if any, during the current age is that the practice of sex selective abortion is clandestine because of the law against it. In addition to the patriarchal values which have been existing since 19th century, it is now the new technology that facilitates this.

Of late, patriarchy has become a pan-Indian phenomenon to the extent that male dominance over female can be reflected even in some of the matriarchal communities of India[i]. Among many manifestations of female subordination, female infanticide and sex selective abortion are odious illustrations. Such incidence of female oppression previously was predominantly confined to north-western Indian society. In the more recent decades it has extended to southern and eastern states of India as well. For long, through various means male gender has been proving their hegemony over females.

The paper in the first section, addresses the severity of the problem of the sex selective abortion in different states of India. It then discusses different reasons including the availability of technology contributing to the phenomenon of the sex selective abortion. The paper then highlights the complementarity of debate between the right to life and reproductive rights and finally it critically analyses the role of the Indian state towards protecting the rights of female.

Sex Selective Abortions in India: Why is it a problem?

The census report 2001 in India shows the occurrence of decreasing child sex ratio from 0-6 years age group of the female children in the country. Population of India according to 2001 Census shows that child sex ratio went down to 927, while creating a deficit of 3.5 corers of women (figure 1). In some of the Indian states, e.g., Punjab, Haryana, Gujarat, Maharashtra, the situation is especially grim. The downward trend in sex ratio had been a phenomenon more associated with the northern and north-western states of India at least prior to 1991. But as 2001 census shows, the problem is spread as an all India phenomenon. The child sex ration in India has further reduced drastically to 919 and many northern states such as Haryana, Punjab, Gujarat, Rajasthan, Chandigarh, Himachal Pradesh, Uttarakhand, and U.P the current child sex has further reduced to the national average.

Figure 1: A Declining Trend of Child Sex Ratio in India from 1901 to 2011

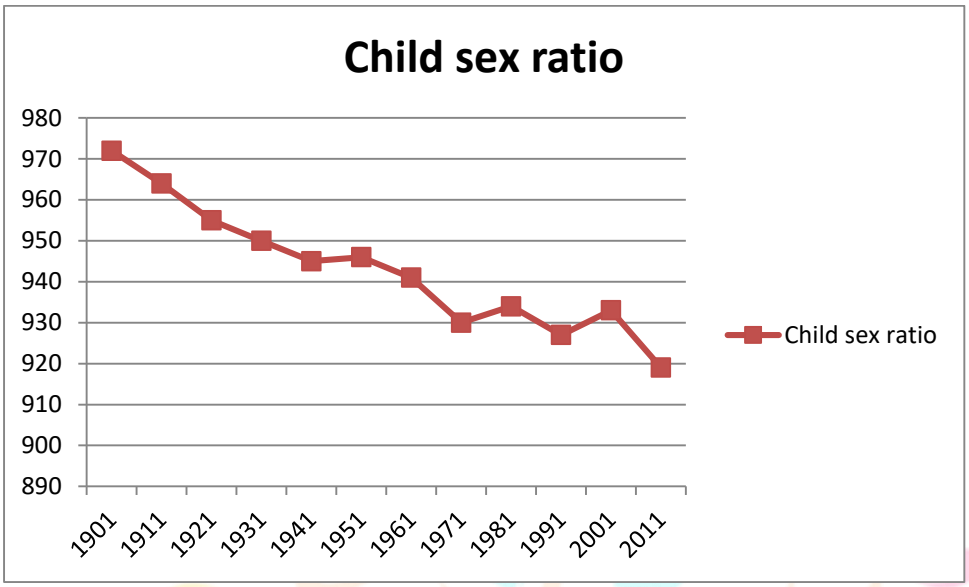

Table 1: A State level Trend Analysis of Child Sex Ratio across Time

States	Child Sex Ratio in 1991	Child Sex Ratio in 2001	Child Sex Ratio in 2011
Kerala	958	960	964
Puducherry	963	967	967
Tamil Nadu	948	942	943
Andhra Pradesh	975	961	939
Chhattisgarh	984	975	969
Meghalaya	986	973	970
Manipur	974	957	930
Orissa	967	953	941
Goa	964	938	942
Karnataka	960	946	948
Himachal Pradesh	951	896	909
Uttarakhand		908	890
Assam	975	965	962
West Bengal	967	960	956
Jharkhand	979	965	948
Lakshadweep	941	959	911
Arunachal Pradesh	982	964	972
Madhya Pradesh	941	932	918
Maharashtra	946	913	894
Rajasthan	916	909	888
Gujarat	928	883	890
Bihar	953	942	935
Uttar Pradesh	927	916	902
Punjab	875	798	846
Sikkim	965	963	957

Jammu and Kashmir		941	862
Haryana	879	819	834
Delhi	915	868	871
Chandigarh	975	845	880

Source: Census

The biological sex ratio is commonly accepted as 105 males per 100 females at birth (Kelly, 1975). Even if 120 to 150 males are conceived to 100 females by the time of birth the number settles at 106 male to 100 female during later part of conception. Apart from this, life expectancy of female at birth is biologically higher than that of the males. Yet again biologically, given the equal chance of treatment after birth, to both the sexes there is the possibility of the higher female survival during infancy than male. In spite of the biological advantage, in many south Asian countries the social systems showing male superiority and drastic decrease of the female sex ratio.

While women's right to life has been hitherto violated from the cradle to grave, with the invention of the new technologies the journey starts even earlier: the state of foetus. The only difference perhaps is that it occurs so silently that the victims are not heard of crying for help. Sex selective abortion is becoming rampant due the advantages of its practice. The process of sex selective abortion acts as a double-edged sword for women's health and rights. A female foetus is destroyed within womb, and denied of basic right to life, merely because it is a female foetus sex selective abortion also threatens to women's health; of mothers who get their foetus aborted during second trimester i.e., after 3rd month of their pregnancy, remain vulnerable to health risks. 'Only two in five of the estimated 6.4 million abortions that take place annually in India are safe' (Sinha, 2009). While abortions are on the basis of gender preference there is a greater chance that the health risk of women are high. This risk may contribute considerably for higher mortality rate of women (Bose, 2003). Women are often accused, since women get the abortion done thus, they themselves are responsible for discriminating against female gender and violating their own rights. The fact is that women hardly have any decision making power in their reproductive rights issues that includes whether to have children, when to have and how many to have and so on (Sen, 2002). The section below focuses on several factors responsible for sex selective abortion.

Sex Selective Abortion: What are the different factors Responsible?

Indian society is patriarchal in nature where male enjoys more power over women in many respects of life[ii]. They are treated as the "second sex" in the society (D Beauvoir, 1972). The society at large through socialisation inculcates certain gender values and norms, fixes gender roles, etc. In the process, women are perceive to be timid and dependent creatures, over generations[iii]. Several agencies such as education, history, media and so on that could act a revolutionary role in questioning patriarchy, indeed have failed in doing so. Here, power relations take different implication for women in different aspects of their life. Thus her freedom of operation, choice and even health in almost all stages of her life is determined by the decision taken by male members. Hardly a few women are empowered enough to take decisions regarding the use of their own body and their reproductive life. The control of reproduction rights in family is at the heart of gender relations, and is central to the denial of equality and self-determination in economic, politic and legal situation to women (Sen, 2002). Therefore, it

happens that in her reproductive life all most all the choices are made by her husband, like what kind of the contraceptive to use, when to have a child and whether to have a boy or a girl. The patriarchal family having preference for a son often decides on behalf of a pregnant woman. In such cases, a woman's decision is influenced by the patriarchal belief system of the family members as she remains subject to the socio-economic and cultural forces. In some other cases women themselves may prefer a boy child to a girl. Led by lower socio-economic status, a majority of women consider their life as vulnerable and insecure in comparison to the male members in the society. It happens due to several reasons; in the society, a married female is considered as a worthy mother if gives birth to a son. In order to gain social prestige a woman may not hesitate to prefer a boy child and abort her female foetus. A woman, being socialised to the patriarchal values, may hardly feel it unethical to abort female foetus. Secondly, women within the society are subject to various forms of violence. Many women also prefer a boy child because of the perception that women are more vulnerable to sexual violence than the boys. Females remain subject to eve teasing, molestation, and sexual harassment, and dowry deaths (Dewan and Khan, 2009). The lower status reproduces the female subordination in a cyclical way.

Patriarchy as an ideology dominates within the Indian society. Thus, as Gramsci visualised the dominant ideological of the dominant class or group tries to exercise the male hegemony through forces like science, literature, history, and media (Harshe, 1997). The projection of a woman in the fields of literature, history, and media facilitates in focusing a subordinate image of a woman.

Some studies carried out on sex selective abortion show that there is a co-relation between less education and sex selective abortion. It is believed that more literacy among women would reduce the sex selection abortion. (Jeorge 2003; Prakasham, 2005), Whereas, in reality it would be difficult to conclude that with the increase of the level of the education of a women, the female feticide would come down. Because, it is a fact that now a days the illiterate and most importantly the educated mass also go for such abortions (Kumari, 2015).

In the society, economic determinants also influence people to opt for a boy child. Women's economic status is usually low in Indian society due to different reasons; the household work or the reproductive work done by a woman is generally regarded as non-work (Stiglitz et al., 2007; Ferrant *et al*, 2014). The work force participation of women is less than men and a majority of them are in the unorganised sector (Nandal, 2006). Even in the informal market the wage a woman gets for any work is generally low in comparison to a male worker. Similarly, a wide spread dowry system has represented a girls child as a burden for the family (Gill, 1998). In a parental family a girl's earning is always considered as 'pseudo earning', as it is believed that a girl's earning is useful for her in-laws After spending money on the girl child's education and upbringing, it is generally believed that the economic return from a daughter would be nil for parental family. These are some of the economic disadvantages associated to the socio-culturally positioned female bearing low economic status than men. Therefore, most of the Indian family either poor or rich analyse the cost effectiveness of having either a boy child or a girl child. Economic determinism has been playing a vital role towards the opting for a girl or a boy child (Patel, 2007).

Even the property rights also play a major role in son preference. The pattern of property right exists is extremely patrilineal where property shifts from father to son (Miller, 1981; Das Gupta, 1987; Kabber, 1996; Croll 2000; Sekhar and Bhatt, 2005). Although legally a daughter has a right of inheritance, in practice a daughter is never appreciated to take share from the parental property especially if she is married.

Several studies argued that poor people, in order to avoid the economic burden of the girl child prefer aborting the female child. However, in contrast, many literatures show that sex selective abortion is a practice confined to more affluent and progressive areas. For example, in the states like Punjab, Haryana, Tamil Nadu, Karnataka, and Himachal Pradesh, etc, (Bose, 2003), which also indicates that well off and rich also abort female children. Moreover, states or districts having fertile land are more likely to have increasing sex selective abortions, as high value of the land makes people to be more attached to their land and thus, do not like to spare it for any cause. For example, in a few districts of Karnataka like Belgaum, Mandya, and Dharwad (these areas are fertile for sugarcane cultivation), sex ratio is very low and the cost of the land in those areas is very high (Sahu, 2010).

Scientific Knowledge and Technology: How far is it Responsible?

Of late, killing of girl child has been easy with the increasing unethical use of the technology. Regime of science may be proved devastating if it is not used properly and as Foucault (1994) states that knowledge in terms of science and technology act as power that can in turn control the society. With the discovery and development of the science and technology could recognise the sex of a foetus and the mis-use of the knowledge of the doctors as well as technicians have made irreversible harm to the female foetuses. 'Amniocentesis' was invented to detect the genetically problems of a foetus, subsequently was used as sex detection machine of the foetus. Following Amniocentesis, ultrasound machines were further used for sex selection of foetus. The invention of developed version of the sex determination technology like ultrasonography, the use of new technology has become easier, non- invasive, less risky and quicker than previous methods like Amniocentesis. Ultrasonography can be more shattering; can detect the sex of a foetus even in an early period. Further, the technology of preconception diagnostic technologies (for instance the technology of test-tube baby) potentially could also be miss utilised. Hence, medical technologies and its use in a particular way have helped in re-establishing the subordinate and defamed status of womanhood (Kramarae, 1998). In the process, medical knowledge establishes the male hegemony over the female gender. As stated by Amartya Sen, "it is a technological revolution of a reactionary kind", that has led to increasing missing women in India. In such case the power of the patriarchal society is exercised through the reproductive technology is being imposed directly or indirectly over the womb of a woman. Therefore, woman's body becomes a field of power exercise and thus the status quo of the patriarchal society is maintained there in.

At times the state policies also may affect the trend of sex selective abortions. For instance, two child norm propagated by the government of India motivates people further towards opting for at least one son out of two children. In such case if the first child of a couple is a daughter then they generally prefer to have a boy during

the second time. In addition, in a few states like Orissa the candidates contesting at the panchayat level election was to follow a limited child norm that in turn determines their suitability of candidature in the election.

The Right to Life Vs. Reproductive Rights: Are they Contradictory or Complimentary?

A pregnant woman in our country has been legally permitted to abort a child. In such case, she has reproductive rights and can exercise her choice whether to have a child or not. The reproductive rights provides agency to women to have control over their own body. The legalisation of the abortion was permitted in the 1970s, due to several reasons, as it was one of the methods to control the increasing population. Abortion also provided some control to couples to avoid unwanted pregnancies and so on. Initially, it was not perceived as a reproductive rights issue even by the state. The reproductive rights issues became popular in the mid 1990s by the state.

The approach of the Indian state towards women health in general and women's reproductive health in particular, has been in a state of flux. For instance, during the early era of the independence, the state had a voluntary and target free perspective towards women's health, and it changed during the middle of 1960s. During the 1960s, it focused more on controlling population and reducing birth rates and in the process, the voluntary approach of the State changed to the target-specific methods (Srinivasan, 2006). This approach indeed continued till the end of 1980s that often targeted the body and health of the woman than the men. Sterilization methods and women specific contraceptive were aggressively pushed by the State. In order to increase the number of sterilizations, incentives were offered and along with that certain targets were fixed for health workers, doctors and other paramedical staff to achieve (Sahu, 2015). In the mid 1990s the maternal and child health programme was changed to Reproductive and Child health in India.

Nivedita Menon (2012) has argued that in India, the MTP ACT of 1971 was initiated in the country not because of the feminist concern or concern for women but purely as a method of the population control. A few feminist were critical of the legitimacy that was provided to abortion than that of the contraception methods especially usage of male condom. Menon's argument strengthens the strand of the debate related to the abortion which believes that it is as exclusively as a practice of the family planning or practiced because of the failure of the contraception rather than exercise of the agency or the choice by the women.

In contrast, S. Anandi back in 2007 argued, based on the primary study done in four villages of Tamil Nadu[iv], abortion is perceived as a necessity to negotiate at the workplace, the decision also led by the different socio-cultural beliefs and practices and not merely because of the failure of the family planning methods. In her study she shows that how many women especially unmarried women in order to continue earning money in a few industries prefer to delay their marriage and motherhood and in the process go for abortion as a choice taken by women. Many selected women also aborted their pregnancy especially because they conceived during *Adi* (July-August, considered to be an unsuspicious time to conceive). A few other women also aborted because they remained subject to domestic violence and thus did not want to have a child. Therefore, she argues that it would be inappropriate to state that women do not exercise their agency at all, especially women while negotiating

work and domestic violence were the ones who had made a choice on their own. Anandi's arguments towards abortion, as decision made, has a broader perspective to reproductive rights issues. As, her arguments also explores how the decision to abort a child by the woman herself is a matter of rights and choice that she exercises.

The Medical Termination of Pregnancy (MTP) Act 1971 and the Medical Termination of Pregnancy Amendment Act 2002, states that 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. The act (a) allows a woman to abort the continuance of the pregnancy if it involve a risk to the life of the pregnant woman or grave injury to her physical or mental health. b) Where any, pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman (c) it consent abortion if a woman become pregnant because of the failure of the contraception, as the anguish may create grave injury to mental health (d) if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. (e) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment. e) Finally, if any pregnant women have any serious medical disease then she is allowed under law to abort her child. Under the Act, 'termination of pregnancy is possible where: the length of the pregnancy does not exceed twelve weeks the length of the pregnancy and whether the pregnancy exceeds twelve weeks but does not exceed twenty weeks': in this case the opinion of three registered medical practitioners in favour of the termination of the pregnancy is essential[v].

Despite legalisation of abortion, numbers of illegal abortions have been more in the state. As per government statistics, an estimation of legal abortion is about 0.6 million annually, whereas the illegal abortions are 8 to 11 times more than legal abortions (Sekhar and Bhatt, 2005). When there is more illegal abortions and unusually large proportion of male births (Census, 2001), it can be somewhat inferred that majority of these illegal abortions were the abortion of the female foetus. There is no reliable statistics available in national level, and an indirect estimation using the data of two rounds of National Family Health Survey indicators shows that more than 100,000 sex selective abortions take place in India in a year (Arnold, *et al.* 2002). Every year, more than 20,000 women die due to abortion related complications (Menon, 2012).

The Indian state formulated the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, as the ethical and legal step to curb sex selective abortion. Subsequently, the amended PNDT act came into force in 2003 and it included a ban on sex selection at the time of 'pre-conception' along with the pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act. "An Act to provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting 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 sex selective abortion and for matters connected therewith or incidental thereto."

The Medical Termination of Pregnancy (MTP) Act 1971 and the medical Termination of Pregnancy Amendment Act 2002 ensures reproductive rights of women. However, the reproductive rights need not violate the right to life specifically followed by the sex selection banned under the PC-PNDT Act (2002). In having a legal deterrence towards detection of the sex of the foetus and helping preventing abortion of the female foetus selectively, the law of the state protects the right to life of the female foetus. In such case these two kinds of rights pertaining to women's life i.e., right to life and reproductive rights are complementary to each other and not contradictory as both the rights ensures gender rights and women's empowerment. Both the acts directly and indirectly ensure these two rights of women.

The State and Sex selective abortion: How far the state Influence the Social malice?

The Indian state has played a paradoxical role towards addressing the reproductive rights of women. At one hand, it has successfully brought the legal measures to ensure different rights pertaining to women's rights. It has legalised abortion and also banned the possibilities of abortions driven by the sex selection.

However, when we analyse implementation of the PC-PNDT Act, it has not been successful in checking the misuse of the sex-selection techniques which remained a major cause for the sex selective abortions in several states of India. As a result, the number of the sex selective abortion has been increasing in an alarm way. The legal discourse could be contradictory, for instance, if PC PNDT act not followed strictly, or if misused, there is possibility ``of violation or abridgement of the MTP Act as well, which will put the rights of women in peril. For example, if the ultrasound centres do not function within the parameters of the law and reveals the sex of the foetus, a couple after knowing the sex of their foetus from one such ultrasound centres, may visit to a hospital and may seek the abortion on the basis of one of the permitted grounds or may get the illegal abortion done. For instance, it may be stated by the pregnant woman that her pregnancy would affect her mental health condition, as she does not desire to have a child', thus, needs to get the foetus aborted, and if it is accepted by the doctor or doctors, she can aptly get her foetus aborted, in a very clandestine way. Despite the legal deterrence, there are some doctors as well who carry sex selective abortions beyond legal parameters. It therefore, becomes necessary for adequate implementation of the MTP Act in such a way that the illegal abortions are prevented and abortion based on the selection of the sex of the foetus needs to be stopped. The district health administrative Officer needs to bring stringent steps in guaranteeing adequate implementation of both MTP and PC- PNDT Acts.

At the implementation level, general maternal health initiative and initiative against sex selective abortion have not integrated effectively. If integrated properly for action, the clandestine sex selective abortion can be prevented. To understand the question, why is there such a tardy and ineffective implementation? Among several explanations offered, one important cause is that behaviour of officials or personnel charged with the responsibility to ensure implementation of PC-PNDT hardly have a mind-set for taking initiatives for adequate implementation of the law. The doctors lobby especially who have private clinics with ultrasound machines is very strong, therefore, it remains a challenge to scrutinise it under the law. Moreover, there is no accountability of the grassroots health worker called ANMs or ASHA towards informing the district health administration

officer relating maintenance of any case of pregnancy, abortion and reason of abortion in their respective areas[vi]. The ANM while working at the grassroots level, can keep a track of all the pregnancies, termination and cause of terminations of pregnancies if any. In fact, ANMs and ASHA can be given awareness to educate people against sex selective abortion.

Despite increasing number of sex selective abortions being taken place, a very few technicians or doctors who run private health centres having ultrasound machines and carrying out sex selective abortions have been arrested. For example, in one of the districts of Karnataka i.e., Mandya following a flash of news in Indian Express[vii] about the involvement of seven doctors' in banned practice of sex selective abortions. In that case, the District Health Officer instead of punishing involved medical personnel, issued show-cause notices to all the accused doctors. However, stringent steps like cancellation of the licences were not found taken for reasons not known. There could be several reasons as in order to maintain the system from any crisis situation; the state governments may not be willing to implement the policy and moreover since the medical lobby is very strong in India there is high possibility that government has to take stringent action against any doctors who are part of the medical community.

Concluding Remarks

Sex selective abortion is one of the social evils and grows with the social attitude of discrimination towards female gender. Out of several manifestations of gender discrimination, sex selective abortion is the most heinous one having severe implications. Such act puts women's health and their right to life at stake. There are several social and cultural factors responsible for the increasing sex selective abortions. Even the economic factors favouring male gender in the society also has directly or indirectly influenced the act. In addition the misuse of technology has been acting as the means for achieving the end of sex selective abortions. Socialisation through several agencies like education, history and media further strengthens the patriarchal ideology in the society, which influences both men and women in favouring and accepting male dominance. It is because of the influence of socialisation that even educated women do not abort their female foetus.

The Medical Termination of Pregnancy (MTP) Act 1971 and the amendment Act 2002 ensures reproductive rights of women. However, there is conditionality attached with the right to abortion, which further enhances women's right. While protecting the right to choice, the state law also ensures that the right to life of a girl child is not violated. Thus, the right to life and reproductive rights or right to choice remain complementary to each other and not contradictory as both the rights ensures gender rights and empowerment of women.

The state as the guardian of the fundamental rights of individual has the responsibility to ensure conditions that could protect individual's rights in general and women's rights in particular. The Indian state has taken a number of legal and policy measures, challenging the patriarchal components of the socio-economic sphere of life in India. As far as sex selective abortion is concerned, at one hand, the state has taken policy measures in terms of PC PNDT Act to curb sex selective detection which could lead sex selective abortions. However, there have been several lacunae associated with the state's approach, as the state has remained unsuccessful in ensuring

adequate implementation of the Acts. The state being the legitimate holder of science and technology has not been adequately successful in controlling the patriarchal contours of the society, and preventing devastating gender consequences.

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[i] A study done by Kerala Sahitya Parisad (2005). has come up with the similar result in the state that shows even among the matriarchal families the practice has taken place. The project report on female feticides in Kerala was presented in the workshop on "Live at Risk: Vulnerable Daughters in a Modernized Society, Sep 28-29, 2005, at ISEC, Bangalore.

[ii] At the micro level, as far as male and female power is concerned, second sex status of women maintained. Starting from the private life to the public affairs women are lagging behind in decision making. For instance, in the community level decision making women' voice are hardly heard or their opinion are not respected. In the family or within micro power structure, women enjoy very minimal power in deciding their home affairs, and even a few women are empowered enough to take decisions regarding use of their own body and their reproductive life in the way they wish.

[iii] With the change of time, Indian image of women altered while taking conglomerated ideas drawn from both modernity and tradition. Even Partha Chaterjee (1999) has mentioned this kind of a paradoxical situation of Indian women, particularly, during the Indian National movement. During this period and afterwards, Indian women were exposed to public sphere much more than they were before. Although, women were exposed to the modern world, and even performed some non-stereotypical work at one level, i.e, in public sphere, they maintained their traditional role at the level of their private life. In doing so, women perhaps were not cautious about their subordination to both the traditional and modernity. They imitated both a traditional and a modern image of an ideal woman (which is constructed by male forces). In the process, they hardly questioned their dual subjugation, they repeatedly emulated the perfect role of a woman in both private and public sphere.

[iv] Tamil Nadu was the place where many women used the contraceptive and so also it was the state with highest number of prevalence of abortion.

[v] Notwithstanding anything contained in the Indian Penal Code, the termination of pregnancy by a person who is not a registered medical practitioner shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years under that Code, and that Code shall, to this extent, stand modified, MTP ACT 1971.

[vi] Although the recent national policy called as Beti Bachao and Beti Padhao Scheme ensures Promote registration of pregnancies in first trimester in Anganwadi Centres (AWCs), does not go beyond of first trimester by keeping a record of the pregnancies.

[vii] The news item flashed in the Indian Express on 21st August 2005, brought to light involvement of seven private doctors in sex selection and female feticide in the district of Belgaum.