Claiming the Right to Safe Abortion: Strategic Partnership in Asia

Partner Report

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CommonHealth- India

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1. Introduction

1.1 Country situation, critical issues and gaps in ensuring right to safe abortion

1.1a Country situation: India is a parliamentary democracy with a federal structure comprising of 29 states and 7 Union Territories. Health is a State subject and they are responsible for organizing and delivering healthcare services to its residents (healthcare, public health, hospitals and sanitation). Along with the central government they are jointly responsible for medical education, national disease control, and family planning programs.

As per the Census of India, 2011, the country's population was 1210 million in 2011 (623 million males and 587 females), which grew at an average annual rate of 1.2 per cent between 2010 and 2019 (State of World Population, 2019). Sixty nine percent of this population lives in rural areas (Census of India 2011). About one fifth (243 million) of the population is in its adolescence and a tenth is above 60 years of age.

The policy and programme environment is conceptually comprehensive. The National Population Policy, 2000 (NPP 2000) of the Government of India highlights voluntary and informed choice and consent of citizens for availing of reproductive health services and provides a framework for meeting the reproductive and child health needs of the people of India while achieving a net replacement levels (TFR) by 2010.The National Health Policy - NHP 2017, envisages "*the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence*" [1]. The policy aims to progressively achieve universal health coverage through free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. The policy focus has however been largely to reduce maternal mortality and therefore the overall approach to sexual and reproductive health (SRH) service delivery since 2005 has come to stand for institutional deliveries, antenatal coverage, immunization and contraception through the public health care system.

India's health system has a significant presence of both the public and private sectors. The public sector has three main divisions, central, state and local (or peripheral). At the central level, the Ministry of Health and Family Welfare is responsible primarily for policymaking, planning, guiding, assisting, evaluating and coordinating the work of the State health ministries. The Directorate General of Health Services (DGHS) in the states is the ultimate authority at state

level; responsible for all the health services within its jurisdiction and locally, the district is the principal unit of administration. Each district is further subdivided into different types of administrative areas, called blocks. A network of primary health centres (PHC), sub-centres, community health centres and rural hospitals provide primary health care at this peripheral level. A wide network of both formal and informal private health care facilities is also spread across all Indian states.

Abortion has been legal in the country since 1971. The Medical Termination of Pregnancy (MTP) Act formulated in 1971 allows termination up to 20 weeks of gestation. The grounds on which abortion is legally permitted are: when it's continuance involves a risk to the life or health of the pregnant woman; it is caused by rape; it is caused in married couples by failure of contraceptive for limiting children; and if there is a substantial risk that that the child born would be handicapped either physically or mentally. Registered medical practitioners (MBBS/allopaths) with experience or training in gynaecology or obstetrics as prescribed by rules are permitted to terminate pregnancy. All government centres above Primary Health Centre level are automatically approved for abortion service provision and in the private sector, it can be terminated at centres equipped with infrastructure as per the rules and established or maintained or approved by a district level committee set up by the government except in case of emergencies. The amendment of the Act in 2002 has given the scope to expand services through increase the number of approved medical facilities by simplifying approval procedures. The Act allows medical abortion till 49 days of gestation while Drug Controller General of India approves the Mifepristone-Misoprostol combipack for use till 63 days of gestation.

1.1b Critical issues at the country level: Indians are living through a period of unprecedented economic inequality in more than a century. In 2017, only one percent of the wealth generated in the country went to the poorest 50 per cent of the population and 224 million people were reportedly living below the poverty line of US$ 1.90 per day [3].

India's population of more than 1.3 billion is beset with stark gender inequalities, economic inequalities and these are reportedly at their highest in the present decade. There are equally significant inequities in health as a result of socio-economic position, gender, and socially constructed vulnerability as in case of Dalits and Adivasis, persons living with physical and mental disabilities; those living with HIV and AIDS; internal migrants; and the elderly, among others [4]. India ranks 108 out of 144 countries on the Global Gender -gap Index 2017. There are significant male-female gaps in health. India is among the few countries of the world with a higher female than male mortality in infancy and childhood. While life expectancy for women exceeds that for men, life expectancy of women in the *dalit*caste is lower than that of *dalit*men by 6 years. Life expectancy of women in the *dalit*caste is lower than that for women from other

castes by as much as 14.6 years [4] Women's health, particularly reproductive health has consistently been a cause for concern and public debate and the health outcomes of women from marginalised communities and poorer quintiles of the population continue to be poor.

Fertility has been steadily falling and was 2.3 in 2016 [2], with wide rural-urban variations and differences across states. The proportion of elderly in the population is rising and the growing proportion of older women and men in the population has brought with it a new generation of SRH concerns (e.g. sexual health issues related to diabetes), which have not even begun to be acknowledged.

In India, States are responsible for health services to its citizens through their public health system. The public health system is poorly resourced and has been weakened by decades of under investment, has failed to fulfil its expected role of protecting the poor and marginalised from inequities induced by the market mechanism. Over the years, dependence on private sector has increased due to limited or lack of availability of government health services for safe abortion, reproductive morbidities and adolescent health as envisaged within the national reproductive health programs [2]. Sexual and reproductive health services except maternal health care are available predominantly from the private health sector, incurring considerable OOPE.

There has been a growth in religious and cultural fundamentalisms, which has had a direct impact on respect for women's liberty and autonomy. Strict control over women's mobility, dress codes and interactions with members of the opposite sex have been accompanied by "kangaroo" - courts, ruling against inter-caste or inter-faith marriages, witch hunting and honour killings. The modest advances towards gender equality made during the previous decades are under threat. Post 2014, there is also an atmosphere that discourages criticism and dissent. Many think tanks partially or fully funded by the government are being under-funded and progressive civil society does not have space to voice its concerns. Human rights activists are often subject to intimidations for defending the rights of others. There are many instances of suspension of the registration that permits receipt of foreign-funding of human-rights organizations and progressive academic and civil-society organizations, a tactic of the government to silence those advocating civil, political, social and economic concerns that contest the government's views.

Abortion: Country situation and critical issues: Abortion is widely prevalent in India. Unsafe abortions reportedly contribute to around 8 per cent of all maternal deaths. However, a hospital-based study over a 15-year period reported the proportion of abortion deaths to be as high as 17 per cent [17]. Abortion-related complications appear to be disproportionately suffered by women from lower castes [10].

A 2015 study documented that as many as 15.6 million abortions were performed in India [6]. A majority of abortions (81%) were carried out using medication obtained either from a health facility or another source. Medical abortion over the counter is not legally allowed in India and is supposed to be available only on prescription. Fourteen per cent of abortions were reportedly performed surgically in health facilities, and the remaining 5 per cent were performed outside of health facilities using other, typically unsafe, methods.

There is limited availability of safe abortion services in public sector although all public facilities above the PHC level are approved MTP centres by law. However, these services do not exist even in well-functioning health systems such as Tamil Nadu (TN). As population control is no longer a concern in many states which have achieved replacement fertility, healthcare providers no longer feel obliged to provide safe abortion services in the larger interest of curtailing India's run-away population growth. Inefficiencies exist in the private institutions too, given the overall lack in trained professionals and cumbersome approval and certification mechanisms that vary in different states.

Lack of awareness and misperceptions are common across stakeholders. An intense public focus on sex-selective abortions has led to widespread misperceptions that all abortions are illegal. Almost all (95%) women in a study in Jharkhand in 2012 were unaware that abortion is legal in India [19, 20]. Misperceptions that the husband's consent is required have created a situation where women were less likely to terminate a pregnancy, according to a study in Rajasthan [12]. A detailed and critical review of abortion studies in India between 2000 and 2014 is available [13].

The close interplay between three factors has shaped the abortion scenario in India.

1. The programmatic focus on and user preference for permanent methods of contraception has a major role to play. A little over 50 percent of women of the reproductive age 15-49 years used modern contraceptive methods in 2015, of which 80 per cent women underwent sterilization [6]. Sterilization is the most desired method of contraception for many women, who have no experience or encounter with most spacing methods. This explains the need for abortion services – women tend to use abortions to space pregnancies. The latest study on abortion conducted in 2015 reports the abortion rates as 47 per 1000 women, and unintended pregnancies at the rate of 70 per 1000 women aged 15-49 in the country [6].

2. Early age at marriage also influences the abortion service use. A little over 36 per cent of women are married before they are 20 years old [6]. More than 50 years of the family planning propaganda has firmly established the small-family norm among a vast majority

of women, and at the same time, modern spacing methods of contraception are neither widely available, nor acceptable even when available. This leads to a large number of unwanted or mistimed pregnancies and the need for abortion. Lack of comprehensive sexuality education and lack of access to acceptable contraception makes abortion the only way to prevent an unwanted pregnancy, for many adolescents and young women.

3. Availability of safe abortion services is under threat because of the decline in the child sex ratio (0-6 years) [7] and the introduction of the POCSO Act. Programmatic emphasis on '*save the daughters campaign'* has impacted the provision of safe abortion services in most Indian states. Sting operations targeting providers of ultra-sound scanning and abortion services and consequent prosecution under the PCPNDT Act has created an atmosphere of fear among the providers to provide any abortion services, especially second trimester abortions. On the other hand, mandatory reporting requirement and possible legal implications have resulted in denial of services to the adolescent girls and young women. Being a woman from poor and/or marginalized communities such as Dalit, Adivasis, or being single, adolescent, HIV positive compound the difficulties that almost all women face.

The situation regarding safe abortion service availability in the country is disconcerting. Over the past five years or so, there appears to be a growing intolerance of induced abortions among healthcare providers. Many anecdotal reports exist, of women being denied abortions and instructed to continue with their pregnancy. There are a growing number of court cases being filed for seeking abortion for child survivors of rape. In many instances medical opinion has not supported abortion over continuance of pregnancy, resulting in children giving birth to children, with traumatic consequences to their lives and wellbeing [8, 9]. There are also cases being filed by pregnant women beyond 20 weeks of gestation in case of foetal abnormalities detected in later gestational stages. While some of them were progressive judgments favouring abortion in the light of women's health [25], others have resorted to the language of the rights of the foetus [10], a deviation from the actual MTP Act, which premises the termination of a pregnancy on women's health.

With the health crisis precipitated by the recent pandemic, women's access to safe and good quality services of the public health system, especially of marginalised and vulnerable women, is a challenge because of supply and service disruptions. With diversion of the public health system resources and case overload, even essential services have been relegated to the backseat. Reproductive health services such as contraception and safe abortion services have been completely neglected.

1.1c Gaps in ensuring the right to safe abortion: In India there are many gaps in our understanding of the barriers to safe abortion services. The data on actual availability of safe abortion services in the public and private sectors is inadequate and unreliable. There is a perception of growing anti-abortion sentiments in the country but information about who have these and why they may be opposing the availability of abortion services is unavailable. While there are studies and reports indicating health providers' opposition to provision of safe abortion, it is not known if it is a blanket opposition or if they would support it under specific conditions. Little is known about how local community leaders, women and men and civil society organisations (CSOs) – even those working on health and gender – perceive abortion and whether they would support abortion as a women's right. A fair understanding of these issues is fundamental to meaningful advocacy for safe abortion as women's right.

In India, in view of the socio-cultural, economic and health system variations, advocacy to promote access to safe and high-quality abortion services has to be based on state-specific strategies. These strategies would be premised on the history of policies and interventions related to safe abortion (or prevention of sex-selective abortion) in the state; availability of and access to health services, specifically safe abortion services in the public and private sector; the needs and experiences of marginalised groups in the state and the cultural sensitivity and norms surrounding abortion practices. It is also important to map key actors and their positions related to promotion of safe abortion services. There is a need to engage with different stakeholders including medical professionals, health administration and networks at the community level. CommonHealth intends to undertake this activity in selected States of India.

CommonHealth members from the field report that frontline workers of the public health system themselves are unable to address women's needs because of lack of PPEs, fear of infection transmission and movement restrictions and lack of transport during the lockdown. Closure of private facilities has added to limiting sources of care for women. Many states have publicly articulated a moratorium on provision of contraceptive services such as IUCD and sterilisation that involve close human interaction. Supplies of pills and condoms are adversely affected in view of the logistic difficulties posed by the stringent lockdown. Under the circumstance, women, who bear the burden of contraception even otherwise, are either forced to use whatever contraceptive is available, face an unwanted pregnancy or opt for unsafe abortion services. There stories are emerging from the field level about an increase in unplanned and unwanted pregnancies and attempts to terminate them by whatever means that are available. The lived in experiences of women with reproductive health needs during this pandemic need to be explored and documented in detail to understand the barriers faced by them and also to identify potential solutions and alternative pathways of meeting their needs.

1.2 Introduction to the Organisation

CommonHealth - Coalition for Maternal-Neonatal Health and Safe Abortion, constituted in 2006, is a multi-state coalition of organizations and individuals working to advocate for better access to sexual and reproductive health and health care, with a specific focus on maternal health and safe abortion. One of its prime objectives is to mentor and build capacity of its members and other advocates to hold the health system accountable for universal access to good quality reproductive health services, including safe abortion services. It brings voices from diverse constituencies to influence discourse at the national level. This is achieved through advocacy efforts in states where CommonHealth members mobilise local communities and partners[1]. It also mobilises a new generation of advocates representing different sectors, both at state and local levels to build synergies that strengthen advocacy within and across states. It was among the first to put forth the agenda for "Creating Common Ground" between activists working to prevent sex-selective abortions and those working to promote access to safe abortion, in order to expand the constituency supporting the demand for safe abortion services. It has partnered with CREA with support from the Safe Abortion Action Fund (SAAF) to build the capacity of a core group of women's rights advocates and abortion service providers. This core group of change-makers, 'the champions' - with support through various actions, were empowered to sustain the right of women to access to safe abortion in five States.

[1] As of August 2020, we have 45 institutional members and 281 individual members from around 20 Indian states.

2. Progress of National Advocacy

2.1 Completed activities

In the following table, document and reflect on progress thus far:

Activity *List key project activities that have been done so far*	**Objective** *What was the purpose of each activity?*	**Achievement** *What are the results*	**Timeline** *What was the initial time line? When was it actually accomplished? Were there delays?*	**Process** *What was the process involved for each activity? Example- meeting, proposal planning etc.*	**Responsibility** *Who was primarily responsible for each activity?*
Bring together of key stakeholders and build of synergies with other networks- Meeting to discuss formation of Think Tank for Abortion rights	To create an expert group, integrate their perspectives and interface with advocacy efforts around safe abortion in the country.	Meeting held on 3rd Nov and 18th November 2020 virtually		Key stakeholders working on the issue were invited and attended the meeting. Summary report of the meeting is attached as ***Annexure 1*** and a note developed on Think Tank is attached as ***Appendix 2***	Abortion theme lead, CommonHealth Co-ordinator
		Recommendations on the Medical Termination of Pregnancy (Amendment) Bill 2020) CSO recommendation for MTP amendment bill 2020 in Hindi	Aug- Oct 2020	A common response has been formulated along with other members of the network and has been sent to the committee – attached as ***Annexure 3.*** Also, a response to newspaper article was formulated and released – attached as ***Annexure 4***	Abortion theme lead, and alliance network members
		Paper published on Medical Termination of Pregnancy (Amendment) Bill 2020)	Jul 2020	The MTP 2020 Amendment Bill: anti-rights subjectivity – attached as ***Annexure 5***	Abortion theme lead, and alliance network members

Evidence building on Access to abortion during the pandemic	To document evidence on the issues of Abortion access during the pandemic situation across regional through engaging with partners on short research study	Documentation of barriers to access safe abortion and reproductive health morbidity, health system response and support systems for access were documented	Aug- Oct 2020	The short term research was approved by SAHAJ IEC and data was collected by 9 partners across 8 states Work in progress for finalizing report and developing regional dissemination flyers. Draft report is attached as ***Annexure 6***	Abortion theme lead, CommonHealth partners & Coordinator,
		Opinion pieces, newspaper articles, papers and social media posts		A blog titled "Blog on "Access to Safe abortion in South Asia during the pandemic: A crisis or an opportunity" was published in wordpress – attached as ***Annexure 7***	
		Consolidated report of Safe abortion activity across states		28th Sep awareness events and news articles published by regional partners. Report of activities attached as ***Annexure 8***	
		Outcomes of 3 part webinar series on abortion decriminalization- Infographics in Hindi and English		Series of online posts on social media on findings from Decriminalisation of abortion webinars in Hindi and English were shared to create awareness on abortion issues and advocacy for same https://www.commonhealth.in/safe-abortion/ https://www.facebook.com/cmnhsaIndia	
Build capacity of CommonHealth members and people working on the issues of abortion provisions and advocacy	CH-CREA capacity building online alumni advocacy institute on Abortion, Gender and Rights	Capacity building of alumni of earlier Institutes about safe abortion access and relevant topics / issues in the emerging context of policy change and pandemic	Aug-Sep 2020	The workshop sessions were planned with expert facilitators and schedule for online sessions was checked with participants, technical aspects were organized and 8 sessions with around 52 participants were conducted. Report of planning and agenda/schedule of the workshop is attached as ***Annexure 9.*** Tool kit developed for these	Abortion theme lead, CREA staff CommonHealth members

				webinars it available as ***Annexure 10.*** Audio-visual versions of the online sessions are being developed for offline launch of similar courses in collaboration with CREA	
	To facilitate members to write critiques and articles from gender and health perspective 10 module abortion tool kit prepared with CREA	Blog posts, articles and papers		Blog on "Access to Safe abortion in South Asia during the pandemic: A crisis or an opportunity" ***Annexure 6*** Based on themes emerging from discussion on 3 part webinars	
Sensitisation of CBOs, CSOs and youth	To provide IEC material with uniform and acceptable vocabulary to be used at community level	IEC material Abortion advocacy toolkit was prepared with CREA and same was shared with CH members/partner along with other IEC material on MTP, PCPNDT and POCSO Acts, Contraception pamphlets	Aug-Sep 2020	IEC material was translated into Hindi and is been translated into other regional languages – Marathi, Tamil, Gujarati and Punjabi for regional dissemination and use by CSOs. ***(Available on request)*** Reviewing advocacy activities proposals by partners, guiding the partners in advocacy strategies, supporting them with relevant resource materials and ethical aspects	Abortion theme lead, CommonHealth members
	To create awareness on issues of abortion rights and access through Social media campaign	Innovative ways of presenting the issues of abortion through graphics and video/online posts to CH members and CBOs/allies	Posts in Hindi and English – ensured wider outreach with members/content used for advocacy efforts by partners	Identifying key themes from the discussion on abortion decriminalisation webinars –working out thematic graphics	CREA and CH-abortion theme lead, CH coordinator

Facilitate, mentor and support awareness campaigns	To provide IEC material with uniform and acceptable vocabulary to be used at community level To provide mentoring support with regard to activities planned for Advocacy to mark Safe abortion Day – 28th Sep 2020	IEC material on MTP, PCPNDT and POCSO Acts in regional languages, Abortion Tool kit modules in Hindi and English- On myth of abortion, Contraception, law and services Consolidated report of advocacy activities carried out in different states by partners ***Attached as annexure 8***	Sep 2020	28th Sep awareness events and news articles published by regional partners. Report of activities attached as ***Annexure 8***	Abortion theme lead, CommonHealth members

On-going Activities

In the following table, document and reflect on on-going activities:

Activity *On-going activities (any that have been initiated but the intended output is not achieved)*	**Objective** *What was the purpose of each activity?*	**Achievement** *Intended achievements of activity – what could be the results*	**Timeline** *What was the initial timeline for each activity to be complete?*	**Process** *What is the intended process involved for each activity?*	**Responsibility** *Who is primarily responsible for each activity?*
Development & printing of knowledge products	To create awareness about myths & misconceptions and frequently asked questions	12 module Abortion tool kit covering topics such as abortion related incidence, myths, gender and sexuality, services, contraception, laws, communication, advocacy, social media etc. has been developed. It is now being translated in regional languages	Mar 2020	Themes emerged from the webinar on decriminalization and previous consultations were listed down and focused different modules were conceptualized. The tool kits was prepared in collaboration with CREA Two pagers were developed on Contraception and Medical abortion pills and were translated in	Abortion theme lead, CommonHealth Co-ordinator, members and CREA team

				regional languages. Attached as ***Annexure 11 and 12***	
Publication of blogs on issues related to safe abortion services	To create awareness about related issues	On existing issues and emerging issues because of COVID19, Act amendments		CH members associated with research /advocacy are being encouraged to share their field experiences related to the issues of Safe abortion access through blog articles	Abortion theme lead, CommonHealth members
Study on access to abortions services during the pandemic	To understand women's lived in realities related to abortion services during the pandemic to come up with advocacy issues	First draft of consolidated report of the study is ready. 8 Flyers / briefs are been prepared in regional language	Dec 2020	8 regional flyers for dissemination are being developed and printed for partners to conduct evidence based local advocacy as well as for dissemination thru the website.	Abortion theme lead, CommonHealth CSO members and Co-ordinator
Bring together key stakeholders and build synergies with other networks	To arrive at and present a common response to government policy initiatives	Building consensus with network members to come up with a common response to the initiatives	December 2020	Government initiatives to increase legal age at marriage, emerging data on sex ratio and legal interpretations of relevant laws all have implications for women's access to safe abortions services. Webinars to deliberate on these and come up with advocacy response is being planned with members. Think tank of experts is expected to guide the response	Abortion theme lead and network members
Planning regional meetings for dissemination of study and workshops on issues of Safe abortion access	To reach out to regional advocacy groups for their capacity building on the issues and learn about the regional issues impeding Safe abortion access		2021	Discussions have been had with CH members to take leads in their regions. They will be provided with all relevant material for the purpose	CH theme lead, CH programme team members/CH coordinator

Build capacity of CommonHealth members and people working on the issues of abortion provisions and advocacy	CH-CREA capacity building online advocacy institute on Abortion, Gender and Rights	Capacity building of CSO, NGO, service provider, frontline worker representatives from Sothern, Eastern and North-eastern States of India about safe abortion access and relevant topics / issues	Aug-Sep 2020	Preliminary discussions have taken place and the online workshop sessions are planned with expert facilitators between June to December 2021. Material used in previous online institutes is being updates and adapted to the regional context. Audio-visual versions of the online sessions are being developed for offline launch of similar courses in collaboration with CREA	Abortion theme lead, CREA staff CommonHealth members

4. Log Frame Reflection

Result 1: Capacity Strengthening and Linking and Learning

Intended Result 1.1. National partner's and target groups understanding has improved in the following aspects

a) Value clarification on abortion and related issues

b) The lack of awareness among women and service providers on right to safe abortion

c) Social stigma and norms amongst the broad range of actors affecting legislation and service and information provision related to abortion

d) The use of conscientious objections to limit and prevent legislation, access to rights-based abortion services and information

e) Poor quality of services as relevant in respective countries.

Indicators for 1.1

I1. Number of national partners and target groups who claim to have an improved understanding on the identified areas of work (MoV 1 and 2)

I2. Level of understanding of national partners and target groups on the identified areas of work has improved (MoV 1-3)

In line with the above indicators, please specify:

- Has the team's understanding on abortion and relations issues improved? If yes, how has it improved and with regards to which issue/issues? If no, why has it not improved? Please detail and provide examples. Reflect on the key issues the project is trying to improve knowledge on, that have been identified as key issues in the focus countries and in the region.

Yes. CommonHealth has been actively engaged in advocacy for safe abortion services in India for many years. One of the core activities of CommonHealth is to conduct capacity building workshops for different stakeholders and campaigning on access to safe abortion at both national as well as sub national level. During this reporting period it conducted online advocacy institute with its alumni on "Abortion gender and rights" in partnership with CREA . This institute, brought back its alumni and some new members from CREA –CH network who are actively working on the issues of Abortion and engaged in 8 enriching sessions using case studies and group work approach to discuss on current landscape, access to services, sex ratio, technical aspects, MTP and recent amendments, issues of decriminalization, abortion and conflicting laws and themes/strategies for advocacy. The interactive sessions enriched their understating on the issues around safe abortion. Pre and Post assessment of participant knowledge indicated a positive change. CH partners were engaged in advocacy on these issues during their routine interaction with stakeholders in the community as well as during the celebration of International Safe Abortion Day on 28th September 2020. Additionally, CH partners were also involved in the study on the access to safe abortion during the pandemic. This helped them get perspectives of women and other key stakeholders in accessing and provisioning of abortion services at the local level during the health crises situation. The research evidence that we are generating and the discussions we have had at national & subnational level with allies has been useful in prioritising CH advocacy activities related to right to safe abortion and decriminalisation of abortion which are evident in the number of advocacy briefs and publications that we are developing in this year.

Key issues identified: *Our members have been familiarised with access issues related to abortion and through our evidence building and training as well as their own field experiences they have realised that there is a lack of awareness on legal status of abortion among women, community leaders as well as service providers. Myths & misconceptions continue to prevail and there are socio- cultural barriers and taboos in access to abortion services. Non-availability and poor quality of abortion services in the public facilities, and the high out of pocket expenditure (OOPE) in the private facilities were major barriers for poor and marginalised women to access the safe abortion services. The legal impediments and lack of focus on women's rights in law making have added to barriers to access.*

- Have there been any achievements so far in relation to understanding of the issues and related to learning objectives of the overall partnership? What are these - list of achievements and reflect on how it has changed.

We have generated evidence on safe abortion, shared it at national as well as sub-national level and have collaborated with a range of stakeholders as well as other networks and movements for advocacy activities. During our participation in meetings and conversations with other allies we prioritized legal as well as socio-cultural issues especially women's lived in reality for advocacy for safe abortion access for

women. We are also in the process of consolidating findings and coming up with dissemination material in local languages. Based on all these we do and will continue to pro-actively take up advocacy for legal and policy revisions and for availability of safe abortion services specifically in public facilities – in alignment with international commitments and service guidelines.

Despite the COVID19 pandemic related restrictions, the online advocacy activities, publication of blogs, and responses to government legal reform initiatives and policy revisions with partners, other stakeholders and network members has been acknowledged as well as has received media coverage.

Besides, CH is also in the process of implementing a series of webinars on Government initiative to increase legal age at marriage, merging data on declining sex ratio with talk about stringent PCPNDT implementation, recent legal interpretations of POCSO and MTP act in various court rulings and implications of these for women's access to safe abortions services to increase the visibility of women's rights, entitlements and advocate for availability of safe and legal abortions

- Reflect on what has led to/contributed to this/these achievement. If none can be identified, reflect on whether there is little or no achievement.

The members of the CommonHealth; particularly the steering committing members have supported the efforts to conduct these activities in respective states. The Safe abortion activities conducted across states by CH partners to mark the International safe abortion day received tremendous visibility in media and has helped build local support groups-linkages for advocacy and services provision. The collaborative efforts for advocacy after due deliberations on each issue existing as well as emerging has created helped in policy makers and media pay due attention to the issue.

Intended Result 1.2. Partners and ARROW capacities are strengthened in the following and has increased knowledge sharing, linking and learning within the partnership

a) Evidence generation on abortion related issues in five countries

b) Planning of evidence-based advocacy, including accountability of duty-bearers at sub-national, national, regional and international levels.

Indicators for 1.2

I1. National partners and ARROW have improved capacities of evidence generation in the identified areas of work (MoV 1 and 2)

I2. Advocacy plans have been developed by national partners and ARROW that are evidence-based, relevant to the contexts and include a focus on accountability (MoV 1 and 2)

I3. Number of women in the intervention areas, including young women, marginali sed women that have been mobilised to claim their right to safe abortion, and hold governments accountable in the intervention areas in the partner countries *(This indicator will be further developed and refined once the country TOCs are developed and will include target numbers for each country)* (MoV 3 and 4)

I4. Level of change in duty bearer's knowledge and awareness on safe abortion in the intervention areas evident in their efforts to improve access to safe abortion services for women in their local areas in the 5 countries. *(This indicator will be further developed and refined once the country TOCs are developed)* (MoV 3 and 4)

In line with the above indicators, please specify:

- Has the partner team's capacities improved/strengthened in evidence generation? If yes, how? If not, why not? How can this be further supported? Reflect on the process thus far with the conceptualisation, engaging in the baseline research proposal, tool development, ethical review process and approval

For the abortion study, the research team members with the support of mentors developed research tools appropriate to their context and helped in regional translations of the tool, informed consent forms and after review by ARROW and SAHAJ's Institutional Ethics Committee members finalised those. During the training the research partners raised all their concerns with regard to conduct of the study and identified alternatives ways of approaching their participants in COVID19 pandemic lockdown situation. Throughout the data collection period they were also actively mentored by the partner teams co-ordinator as well as a point person from CommonHealth Abortion theme leadership.

- Has the partner team's capacities improved strengthened in visioning the evidence-based advocacy focus of this project at the national level? If yes, how? If not, why not? How can this be further supported?

Yes, CH partners, many of whom are working at grassroots also participated in activities related to evidence generation, region specific documentation and advocacy. They have been participating in the online webinars and meeting/consultations to keep themselves updated with the recent developments and contribute their thoughts and experiences at the ground level. The research and deliberations helped partners understand the relationship between field realities and possible solutions and how access barriers can be addressed through various available mechanisms activated through advocacy efforts. Additionally, briefs and two pagers in English as well as regional languages based on the findings have helped partners and CH members understand the evidence base for advocacy. Continuous updates, posts in social media and blogs and articles maintain the momentum of updation on emerging issues and evidence to address or counter those. These improvements are reflected in the activities they have undertaken in their own work constituencies.

- Is advocacy visioning that was done still appropriate given the national context? Please elaborate. Is it informed by evidence and the baseline completed thus far? Please elaborate. How does/can it include accountability? Please elaborate

The advocacy envisioning done was appropriate but somewhat ambitious in view of the CommonHealth members' voluntary profile. The need for evidence continues to inform the advocacy efforts but the plan is more realistic and practical based on partner competence and interests. First year experience of doing advocacy with member organisations also provided the clarity about individual member's capacity and areas of expertise. Implementation of the advocacy plan could thus be tailor made to the members' expertise. The impact of pandemic and the government initiative to amend the Act and review criminal laws in the country have made CH expand the scope of its advocacy content. Along with its allies and other movements and networks it has formed a loosely structured group to conduct this advocacy. Work on advocacy dimensions is shared by partner organisations of this group depending on their expertise. The sharing and peer review of work ensures accountability of work undertaken.

Result 2: Evidence Generation and Creation of Knowledge Products/ Advocacy Tools at Regional and National Levels

Intended Result 2.1. Development of knowledge products/advocacy tools and engaging in evidence-based advocacy at the sub-national, national, regional and international levels

I1. 7 knowledge products are produced consolidating the evidence base from 5 national baseline studies (5 national baseline reports, 1 regional briefing paper on bridging feminist discourse on rights based advocacy for safe abortion with population control discourse for safe abortion, 1 publication under the ARROW advocates guide series focusing on the human rights approaches to safe abortion to assist monitoring right-based access to safe abortion services in the five countries (MoV 2-5. 1. Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion: A Project Brief; 2. Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion in Kancheepuram District, Tamil Nadu, India: A Project Brief; 3. Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion in Nawada District, Bihar, India A Project Brief ; 4. Safe Abortion: Knowledge, Perception and Practices amongst Urban Poor Women in Vadodara, Gujarat: A Study by SAHAJ & CommonHealth; 5. The Medical Termination of Pregnancy Act, India; 6. The Protection of Children from Sexual Offences Act and Provision of Abortion Services to young People: A Brief Note for Service Providers). Additionally, a position paper on decriminalisation, a paper on MTP Act amendment and two blog pieces have been developed.

I2. Knowledge product are used to facilitate discourse and dialogue on the right to safe abortion at national and regional levels, and facilitate linking and learning across the partnership (MoV 2-5)

I3. National baselines in the 5 countries are used to define capacity building, accountability and advocacy trajectories on the right to safe abortion at the national level (MoV 2-5)

Baseline findings, existing laws and Acts, updates in these as well as access issues because of emerging situations and material used in capacity building institutes have been central to development of knowledge products. These have been translated in local language keeping in mind the range of audience and their ability to understand technical language. Knowledge products have also been based on the information in public domain about laws and Acts and the dilemma's about service provider obligations under these. The knowledge products have tried to provide responses to these dilemmas in simple local language. In the coming months we will be developing knowledge products on the legal updates, government initiatives and on findings of our study on access during the pandemic

Result 3: National and Regional Advocacy

Intended Result 3.1. To enable 5 national partner organisations to increase their impact on and influence over the implementation of abortion laws and policies as identified by country partners TOC through concerted advocacy at the national level

Accountability and advocacy at the national level (in the intervention areas on the identified areas of work around right to safe abortion) results in incremental implementation of safe abortion legislation and access to safe abortion services as defined in respective country theory of change*(please note these indicators will be developed further after the country TOCs are developed in year 1 and in line with national advocacy plans)*.

Indicators for 3.1

I1. ARROW and national partners in at least 3 of the 5 countries have developed rights-based recommendations focusing on abortion issues to support advocacy efforts towards implementing country CEDAW committee recommendations/ UPR country recommendations (MoV 1)

I2. Partners in at least 3 of the 5 countries have advocated for the implementation of respective country CEDAW committee recommendations/ UPR country recommendations pertaining to right to abortion and the identified areas to policy makers at national level (MoV 2-3)

I3. ARROW and partners, if reporting to CEDAW/ UPR cycles during the project phase, have developed and/or contributed to and submitted briefing papers, shadow reports or related CSO inputs that highlight the right to safe abortion to UPR/CEDAW committee as relevant (if the reporting is after the project phase, then the evidence will be used for next cycle reporting) (MoV 2-3)

Intended Result 3.2. ARROW and partners influence norms and standards on the right to safe abortion through concerted advocacy at the regional and international advocacy spaces.

Indicators for 3.2

I1. Recommendations are made in submissions focusing on abortion related rights, services and information are reflected in concluding observations and/or in UPR reports (MoV 1)

I2. Regional and international advocacy bodies including at the human rights advocacy spaces have adopted progressive and inclusive norms, standards and policies around the right to safe abortion and promote accountability with at least three mentions of safe abortion in the resolutions, outcome documents across the project phase (MoV 4-5)

- What is the intended theory of change and how has progress been made towards it?

The theory of change has been formulated with the overall goal of creating an environment where women[1] of all ages, especially of marginalised communities can access safe abortion services without stigma, by spreading awareness using a women's rights discourse and increasing availability of safe and legal abortion services in the public sector. We had identified gaps and areas of priority action based on baseline assessment in two States. Knowledge products were developed based on the knowledge gaps identified at baseline. Community level activities for petitioning with State government for making safe abortion services available in mandated public facilities in Tamil Nadu were undertaken in the first phase of the project and continued in this phase till the lockdown. With the pandemic and the consequent lockdown the community level campaigns have been temporarily suspended. In the meantime national level advocacy efforts to influence legal and policy level issues have been undertaken in alliance with networks and movements associated with women's rights, especially health rights. Once the lockdown and the risk of pandemic subsides, community level campaigns will be resumed. Till then some attempts will be made to campaign using social media. With the COVID19 pandemic and associated restrictions and precautions, while the implementation approach for achievement of objectives has changed and has become largely online or in compliance with local government's stipulations the overall objectives and strategies remain same.

- How have CEDAW/UPR recommendations on abortion from previous years been implemented on the ground? How has your advocacy focused on integrating these recommendations at the national level?

CEDAW has categorised violations of women's sexual and reproductive health and rights, such as forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care and forced continuation of pregnancy as forms of gender-based violence. It has recommended that, corrective measures should keep women at the centre and giving primacy to her rights, agency and autonomy; they should be designed and implemented with their active participation. Additionally, efforts should be made to repeal legal provisions that are discriminatory against women. CommonHealth has been articulating its support for these recommendations at various forums. The community level events in the past and those proposed for future engage with women's Self Help Groups, women Panchayati Raj Members and CSOs who work with women in the community. The stress in these events has been on safe abortion as a woman's right. CommonHealth, during the course of its webinar series on decriminalisation of abortion, stressed on the relevance of non-discrimination, substantive equality, and state obligation, the three foundational principles of CEDAW-. As far as repealing the legal provisions is concerned, CommonHealth has joined hands with other networks and initiatives that are pursuing it through advocacy campaigns and legal recourse. Since CommonHealth itself does not have the requisite organisational structure and capacity to undertake legal initiatives but has the expertise to generate evidence to support the efforts, it has proposed to undertake that role. The process is ongoing. It has also formulated a Think Tank to provide response and position to such initiatives

- Has there been any engagement with CEDAW/UPR processes during the project/reporting period? Please give details of this engagement. How have the experienced and findings from the baseline been use in these reviews and related advocacy? How are women's realities and the experienced of marginalised women been highlighted?

There has been no engagement with these processes but the realities and experiences of women have been well documented and disseminated at various forums. The current study undertaken to document women's lived in experiences related to access to abortion services during the COVID19 pandemic would also be disseminated widely. The evidence will be used not only to design strategies to address the barriers but would also be used as a learning based on which strategies that can be used in any health crises situation without waiting for it to happen and then start designing it, thus hit the ground running.

Result 4: Strategic Multi-country Partnerships

Intended Result 4.1 An inclusive and strategic multi-country partnerships is in place and advocate for the right to safe abortion in Asia and at the specific country level.

I1. A regional partnership on the Claiming the Right to Safe Abortion: Strategic partnerships in Asia is established with the 5 national partners and ARROW
I2. The regional partnership includes linking and learning, capacity strengthening on the identified areas around abortion, and engages in evidence based advocacy at national level and at the regional level

In line with the above indicators, please specify:

- Reflect on the creation of the Solidarity Alliance for the Right to Safe Abortion – the process of creation, modalities of engagement and clear identification of activities for engagement.

CommonHealth is a member of Solidarity alliance launched in 2018 with 6 CSOs from the region. CommonHealth and the other CSOs are committed to right to safe abortion for all women through strategic interventions. The alliance is the forum to bring together Global South voices to mobilise and engage into targeted interventions, share knowledge and expertise and build the momentum for tangible change in access to safe abortion in the region. The alliance has already worked on position papers on issues relevant to the topic. These are in the process of finalisation. Additionally, the forum has been used to exchange experiences of members related to access to SRH services during the pandemic in their respective countries. The members are also have come together to plan the activities for Safe abortion day in September 2020. Members from time to time respond to international situations that have impact on access to safe abortions services especially in the Global South

- Reflect on any other aspect of partnership building and engagement and what could be done to strengthen these aspects within the partnership.

Partners need to be part of the planning process. There has to be cross fertilisation of ideas. However, partner's capacity to understand and use the same vocabulary has to be ensured

5. Lessons Learnt

What has been the learning thus far? Please elaborate. Reflect on learning related to:

	Learning consolidation
1. Dissemination of findings and publication of report	While publication of report in English serves the purpose of disseminating the findings and advocacy issues with researchers, donors and other English speaking audience, brief report in local language help familiarise State and local level stakeholders and keep them invested in subsequent advocacy efforts
2. Government engagement	Access to public health data as well as efforts to engage public health system officials is a difficult process because of lack of trust in NGOs as well as the bureaucratic processes. Identification of NGOs / CBOs and members who have worked with / work with the State government and through them engagement of government system right from the beginning is helpful.
3. Partner engagement in advocacy	Partners have specific strengths and rapport with select groups

	in the community. Instead of a fixed, standard advocacy plan, a flexible, capacity based plan yields better dividends in terms of creating awareness and common ground.
4. Network member's strength	Network members come in with range of expertise and strengths. This has to be harnessed without encroaching on their territories and advocacy has to be done in a complimentary manner to communicate a more comprehensive and stronger message to policy makers

6. Challenges –Current and Future

This section documents the obstacles/challenges faced so far and mechanisms used to overcome them. It also reflects on potential challenges to mitigation.

Challenge faced / anticipated	**Was it within your control? Was it not within your control?**	**How did you deal with the challenge?**	**What could have been done better? What should be changed?**
Comprehension & vocabulary of members involved in advocacy	It is within our control	CommonHealth conducted values clarification workshop with engaged members and develop IEC material and knowledge products that use acceptable vocabulary to ensure that everyone is on the same page	Values clarification and common ground workshops should precede full-fledged advocacy at community level.
Conflicting priorities of allies	To a limited extent	Partner with allies who are on the same wavelength and / or work in collaboration only where the ideas and language are compatible.	Selection of partners for advocacy should have been strategic based on their work experiences and local context.
Suspension of in-person meetings and community level activities	Not within our control at all as the lockdown stipulations prevented any such in person interactions	CommonHealth opted for webinars and zoom meetings.	Nothing more can be done currently. As and when the situation is more in control, in person interactions and meetings and advocacy will be resumed

What challenges could arise? How can it be mitigated?

We hope that we will get the government permission to interview government health care providers of medical officer cadre, for the study on access to abortion services during the pandemic. In case we are not able to get the requisite permission, we will use the HMIS data available in the public domain.

7. Risks and Mitigation

Identified risks

Identified risk and review	**Mitigation**
Government will not want to prioritise abortion as a health need and allocate requisite attention & budget to ensure facility preparedness for mandated safe abortion services	Documentation of safe abortion services in government policy, programme commitments, district Project Implementation Plans (PIPs) and available budgets along with field realities, need for, access to and use of services will be shared with officials Alignment of safe abortion service availability in public sector agenda with government programmatic focus on promotion of PAIUCD and reduction of preventable maternal deaths.
All allies will not be equally interested, sensitive and invested in abortion related issues, their interest may not be sustained and "Global gag rule' will impact allies' engagement	Alliance with select partners who are unencumbered by global gag rule, have genuine interest in the issue and who work on SRHR will be aimed at Conduction of common ground workshops and engagement of allies in planning, implementing and monitoring strategies while ensuring that strategies are complementary and not competitive
Increasing anti-abortion sentiment and environment of conservatism, patriarchal values, restrictions on women's autonomy will prevail. Legal reviews will continue to look at abortion related legal stipulations in a piecemeal way, reform select sections.	Documentation of safe abortion services in government policy, programme commitments, along with field realities, need for, access to and use of services will be shared with those opposed to the services. Dissemination of IEC material and knowledge products will be undertaken. Position papers and advocacy for rationale against legal reforms that impede seeker's access to safe abortion services
Census of India figures on sex ratio will link sex determination and abortion and push back the campaign for access to safe abortion services	Delinking of sex selection and safe abortion will be actively undertaken by highlighting that sex selection is a gender issue and safe abortion is women's right issue
Token changes in the laws and third party authorisation for permission to late gestation abortions	We have and will continue to advocate for abortion of constitution of medical boards i.e. third party authorisation for approval of late gestation abortions.

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List of Annexure

Annexure 1: Minutes of meeting on Think Tank for Abortion Rights

Annexure 2: Note on Safe Abortion-Think Tank

Annexure 3 Civil Society Recommendations on MTP Amendment Bill 2020

Annexure 4 Whose Crime is it anyway.pdf

Annexure 5 The MTP 2020 Amendment Bill anti rights subjectivity.pdf

Annexure 6 Draft report - Access to abortion services during COVID19 pandemic

Annexure 7 Blog: Access to Safe Abortion in South Asia during COVID 19.pdf

Annexure 8 International Safe Abortion Day 2020: A Report.pdf

Annexure 9 CREA-CH capacity building webinar outline

Annexure 10: Abortion advocacy tool kit (English)

Annexure 11: Two pager on Contraception

Annexure 12: Two pager on Medical abortion pills

Additionally earlier developed knowledge products such as

Outcomes of 3 part webinar series: Infographics on abortion decriminalization- in Hindi and English

Two pagers developed till date have been translated in Guajarati, Hindi, Marathi, Punjabi and Tamil.