**Claiming the Right to Safe Abortion: Strategic Partnership in Asia**

**Partner Report**

Mid-term Narrative Report: 1st April to 31st October 2019

**CommonHealth- India**

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**List of Acronyms**

AIDS Acquired Immune Deficiency Syndrome

APCRSHR Asia Pacific Conference on Reproductive and Sexual Health and Rights

ARROW Asian-Pacific Resource and Research Centre for Women

CAP Comprehensive Abortion Policy

CBO Community-Based-Organisation

CEDAW Convention on the Elimination of all Forms of Discrimination Against Women

CEmONC Comprehensive Emergency Obstetric and Neonatal Care

CHC Community Health Centre

CoI Census of India

CommonHealth Coalition for Maternal-Neonatal Health and Safe Abortion

CSO Civil Society Organisation

DGHS Directorate General of Health Services

FGD Focus Group Discussion

HMIS Health Management Information System

HIV Human Immunodeficiency Virus

IDF IPAS Development Fund

IEC Information, Education and Communication

MBBS Bachelor of Medicine, Bachelor of Surgery

MoHFW Ministry of Health and Family Welfare

MTP Medical Termination of Pregnancy

MVA Manual Vacuum Aspiration

NGO Non-government Organisation

NHP National Health Policy

NPP National Population Policy

OOPE Out Of Pocket Expenses

PAIUCD Post-Abortion Intra-Uterine Contraceptive Device

PCPNDT Pre-Conception and Prenatal Diagnostic Techniques

PHC Primary Health Centre

PIP Project Implementation Plan

POCSO Protection of Children from Sexual Offences

RH Rural Hospital

RoP Record of Proceedings

RUWSEC Rural Women's Social Education Centre

SAAF Safe Abortion Action Fund

## SAHAJ Society for Health Alternatives

SC Subcentre

SRH Sexual and Reproductive Health

SRHR Sexual Rights and Reproductive Rights

TFR Total Fertility Rate

TN Tamil Nadu

ToC Theory of Change

UNFPA United Nations Population Fund

UPR Universal Periodic Review

1. **Introduction**

**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

***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].

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]

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.

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, Critical Issues and Attempts to Ensure the Right to Safe Abortion**

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 per cent 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 current situation regarding safe abortion service availability in the country is even more 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.

**Abortion: Gaps in Understanding the Issues and Addressing the Issues**

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.

**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]](#footnote-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. **Overview of National Baseline**

**Objectives**

As mentioned above, CommonHealth had perceived a number of gaps in understanding the barriers to safe abortion services such as inadequate data on the availability of services, community and provider views and attitudes towards abortion rights and services and support from Civil Society Organisations (CSOs) and Community-Based-Organisations (CBOs) to abortion as a women’s right. As a part of the first phase of the project, it conducted a baseline assessment to generate evidence on the availability of affordable and safe abortion services in the public and private health sectors, and its consequences for women, get an overall picture on the extent of support for safe abortion from the government and from CSOs and understand the perspectives of different actors on abortion as women’s right.

**Methodology**

The baseline assessment involved primary and secondary data collection. Secondary data was sourced from national surveys and studies and from review of existing literature. Primary data was collected in Nawada district, Bihar and Kancheepuram district, Tamil Nadu. In-depth interviews were conducted with key informants such as frontline workers, community leaders, and health service providers; Focus Group Discussions (FGDs) were conducted with women from marginalised groups and facility surveys were conducted in select government and private facilities.

Trained investigators from Lok Chetna Vikas Kendra, Bihar and Rural Women's Social Education Centre (RUWSEC), Tamil Nadu, both CommonHealth member organisations, undertook the baseline assessment. Semi-structured tools in the local languages (Hindi and Tamil) were developed and used by the field investigation team to collect the primary data.

Data-entry boards, dummy tables for quantitative data from secondary sources, and procedures for coding and collating qualitative information were developed. The research coordinators and the mentor jointly evolved the methods for triangulating information from multiple sources. All original transcripts and data were carefully stored, and all soft copies were backed-up in external hard disks after removing respondent identifiers.

***Ethical approval***

The research proposal and study tools were thoroughly reviewed and approved by the Institutional Ethics Committee of the RUWSEC. The study was approved in July 2018.

**State Context**

Both Bihar and Tamil Nadu are very different in terms of their socio-demographic and health profiles. Bihar is the third most-populous state and is known for its poor economic and socio-demographic indicators and public health infrastructure. There is a significant shortage of gynaecologists and obstetricians in peripheral areas of the State. On the other hand, Tamil Nadu is industrially developed with better socio-demographic and health indicators, and a well-functioning public-health system. Yet, significant gender, rural and urban differentials exist in literacy rate and work participation rates in the State.

Both states had some government initiatives aimed at improving access to safe abortion services, but in neither was abortion a priority health issue. In 2011, the Government of Bihar jointly with IPAS Development Fund (IDF) launched Yukti Yojana, a Public-Private Partnership, to provide low-cost first-trimester abortion services through empanelled private hospitals and involved IDF in the training of providers at the PHC level and equipping facilities to provide first-trimester abortion. The State government also allocated Rs 385.9 lakh in its Project Implementation Plan (PIP) for operationalisation of safe abortion services. In the same year, the Government of Tamil Nadu developed a Comprehensive Abortion Policy (CAP) to increase the availability of safe abortion services and promote spacing methods of contraception at all levels of health care. While a number of doctors and staff nurses in Primary Health Centres and government hospitals in the State were trained in MVA techniques and the Record of Proceedings (ROPs) for 2017-18 allocated funds for training and purchase of medical abortion drug kits for all CEmONC centre, the policy was not adopted in its entirety in the State.

Non-government (NGO) and Civil Society Organisation action in both States was found to be conspicuous by its absence. The local branches of US-funded international NGOs in Bihar being bound by the ‘gag rule' and were prevented from being associated with abortion services of any kind. In the recent past, NGO action to prevent sex-selective abortions in the State has gained some momentum following a UNFPA study on the poor implementation of the Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT) Act. In Tamil Nadu, very few NGOs working on women’s sexual and reproductive health issues existed. Of these, some were found to be against abortions on moral grounds and many exclusively worked on preventing abortions for gender-biased sex-selection.

**Findings**

According to the 2015 Guttmacher study, an estimated 1.25 million abortions were performed in Bihar and 0.7 million in Tamil Nadu. These were both safe and unsafe and in health facilities and other settings. In these States, health department’s Health Management Information System (HMIS) captured less than a fifth of these for the same period.

Further, there was only one abortion facility for 370,000 people in Nawada, Bihar, and one for 70,000 in Kancheepuram, Tamil Nadu, far lower than the recommended norm of one facility per 20,000. More than 60 per cent of the facilities were private, with most of them run by unqualified providers in Nawada and by qualified medical professionals in Kancheepuram. The public facilities providing abortion services were the district hospital in Nawada and the district, taluk and non-taluk hospitals in Kancheepuram. In both districts, qualified abortion service providers were concentrated in the urban centres, leaving vast rural pockets with hardly any abortion facilities.

Even in public facilities the availability of second-trimester abortions was highly restricted. Unmarried women reported services being denied or they being subjected to abusive and disrespectful care. Other women had to make several visits in order to undergo an abortion. These delays often led to women exceeding the legal gestational limit for a MTP, in which case they were denied the service. In both states, married and unmarried women typically needed to be accompanied by their husbands or ‘guardians,’ who had to provide consent for the procedure. Also, abortion services in public facilities were conditional on the acceptance of post-abortion contraception.

On the other hand, the cost of private abortion services by a qualified medical professional was very high and ranged from Rs. 1000 to 40,000. The cost being unaffordable, most women from marginalised groups sought out unqualified providers or relied on self-medication with drugs from pharmacists.

There was a low level of awareness on the legal status of abortion. While opinion was divided on the circumstances in which abortion was justified, the general perception in the community was that women seeking abortions were likely to be humiliated, gossiped about, considered immoral, and unlikely to receive any support from peers and family members.

Providers were generally against providing abortion services to married women with an unplanned or mistimed pregnancy but supported provision in the case of foetal anomalies. Attitudes towards abortions for unmarried girls were mixed, with some willing to provide these services and others not, but the overall attitude was one of disdain for the girls, for not having used contraception. The CSO leaders felt that sex-selective abortion ought to be prevented, but without compromising the availability of safe abortion services. In Tami Nadu, the need for abortion services was considered very important to prevent suicides among unmarried girls.

***Key Issues***

Denial, delays, poor quality of services and negative provider attitudes in government facilities, non-availability of medical abortion at the Primary Health Centre level and the high costs of abortion services in the private hospitals, and low awareness amongst women of the legal status of abortion, appeared to be major barriers to women’s, particularly marginalised women’s access to safe abortion services.

**3. Progress of National Advocacy**

**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?* |
| Copy edit and print the final report | Printing of an error proof, comprehensive national report | Printed report was prepared and soft as well as hard copies of final report were shared with ARROW (*Annexure 1*) | April 2019 | Draft version of consolidated report was shared for review by external expert as well as by ARROW. Report was finalised after incorporating comments and suggestions. It was subsequently copy edited and sent for publication | Research Team, Mentor, Abortion theme lead and CommonHealth Co-ordinator |
| Dissemination of findings of baseline research at the national level | To share findings at the national level, identify issues for advocacy, prioritise them and set the stage for building Common Ground | Presentations highlighting the findings & issues relevant to advocacy were developed & discussed to identify & prioritise advocacy issues.  (*Annexure 2*) | March 2019 | Findings and soft copy of the report were shared with stakeholders from the health system, other government departments, researchers, academicians and CommonHealth members | Research Team, Mentor, Abortion theme lead and CommonHealth Co-ordinator |
| Meeting of CommonHealth Steering Committee | To finalise Theory of Change and Advocacy plan | Revised ToC and advocacy plan  (*Annexure 3*) | June 2019. Delayed by 2 weeks to ensure availability of past & present steering committee members at the meeting | ToC and advocacy plan were shared with members along with findings. Feasibility and process of identified priorities were discussed and ToC and advocacy plan finalised | Abortion theme lead and CommonHealth Co-steering committee members (both past and present) |
| Development and printing of research briefs | To disseminate research findings – voices from the ground | Simple two pager briefs based on national as well as 2 State reports and on another study conducted by SAHAJ were developed in English & local language for wider dissemination to disparate audience and were printed  (*Annexure 4*) | June 2019 | Research teams identified key findings and critical issues. Abortion theme lead developed the briefs and circulated these within CommonHealth steering committee and research team for feedback. Briefs were finalised after incorporating the feedback | Research Team, Mentor, Abortion theme lead and CommonHealth Co-ordinator |
| Submission of abstract for 10th Asia Pacific Conference on Reproductive and Sexual Health and Rights | To share baseline findings highlighting voices from the ground with a larger fraternity working on the issue | A 450 word abstract was developed and submitted  (*Annexure 5*) | Revised deadline October 2019 | Abstract was developed based on the national consolidated report and shared with CommonHealth members. It was finalised after incorporating feedback & suggestions and then submitted | Abortion theme lead and CommonHealth members |
| Participation in meeting with lawyers working on abortion related litigation | To build alliances & bring together key stakeholders to understand the current status of safe abortion access and laws | Participation and sharing of voices from the ground. Exploration of possible areas of engagement. | August 2019 | Abortion theme lead and three other members of CommonHealth were invited for the meeting. Participation was approved by CommonHealth steering committee. Report will be shared by the organisers. | Abortion theme lead and CommonHealth members |
| Gram Sabha meetings in 7 villages of Kancheepuram District, Tamil Nadu | To pass Gram Sabaha resolutions asking State government to ensure availability of safe abortion services at PHCs | Four Gram Sabhas passed the resolution  (Report and Photos in *Annexure 6*) | August 2019 | RUWSEC staff wrote letters to SHG women & youth leaders in 7 villages & had a meeting with them a day prior to the Gram Sabha meeting. Baseline findings and people’s entitlements were shared. These SHG women & youth leaders participated in the Gram Sabha meeting and advocated for availability of services wherein resolution was passed through consensus | CH member RUWSEC, Kancheepuram, Tamil Nadu, CH Abortion theme lead and CH members |
| Development & printing of knowledge products | To create awareness about MTP, PCPNDT & POCSO Acts. | 2 briefs or two pagers in English as well as in local language on MTP Act, POCSO Act for an audience of health service providers, women / community and CSOs & CBOs  (*Annexure 7*) | December 2019 | Briefs have been finalised in consultation with Abortion theme members, translated, printed and disseminated through CH members and at different meetings | CH Abortion theme lead and CH members |
| Celebration of the World Safe Abortion Day | Increase visibility of safe abortion as women’s right | Increase in awareness about women’s health needs, relevant laws & court rulings in recent past  Meeting and issues discussed got wide media coverage.  In Tamil Nadu and UP, demand for safe, good quality abortion and contraceptive services at all recognised government centres submitted by CBO members | 28th September 2019 | Meeting in collaboration with government tertiary care hospital in Nawada for SHG leaders, government frontline workers and PRI members  Participants knowledge tested through a quiz contest at the end of the meeting. (*Annexure 8*: Report). | CH member Lok Chetna Vikas Kendra, Nawada, Bihar, CH Abortion theme lead and CH members |
| 28th September but actually took place on 30th September as 28th was a holiday | Meeting in Nangal, Punjab in collaboration with local tertiary care hospital, government master trainers and representatives of juvenile justice board for 85 government frontline workers and NGO staff.  Short play by NGO staff (*Annexure 9*: Report) | CH member Arpan, CH Abortion theme lead and CH members |
| Meeting in collaboration with district health office of the Uttar Pradesh State government for 56 district level health service providers and CBO leaders (*Annexure 10*: Report). | CH member Gramin Punarnirman Sansthan, Azamgarh, UP, CH Abortion theme lead and CH members |
|  | Meeting in collaboration with SHGs and CBOs for 150 members of these organisations & local government health workers.  Procession with placards on messages related to safe & legal abortion services.  Role plays were performed by village women.  Participants’ knowledge tested through a quiz contest at the end of the meeting. (*Annexure 11*: Report). | CH member RUWSEC, Kancheepuram, Tamil Nadu, CH Abortion theme lead and CH members |
| Launch of blog site for article on issues related to safe abortion | Increase the visibility of issues pertaining to safe abortion services, women’s access issues and CH position on women’s right to safe abortion | Two blogs have been published till date | 1st blog on 28th September | CH members who have been actively working on the issue were invited to write articles based on their experiences (*Annexure 12*: Blog articles) | CH members and CH abortion theme co-ordinator |

**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 | 2 briefs or two pagers in English as well as in local language for an audience of health service providers, women / community and CSOs & CBOs | December 2019 | Briefs are being developed. They will be shared with Abortion theme members and based on the feedback & suggestions, these will be finalised, translated and again reviewed before sending for printing. | Abortion theme lead, CommonHealth members & Co-ordinator |
| Publication of blogs on issues related to safe abortion services | To create awareness about related issues | Blog on “Victims twice over: Pregnancy due to sexual abuse and forced motherhood due to failed justice” (*Yet to be published*) | November 2019 | Next blog by Dr. Sundari Ravindran is in the pipeline and will be published in the 3rd week of November | Abortion theme lead, CommonHealth members & Co-ordinator |
| Meeting to discuss decriminalisation of abortion | To come to a consensus on CH position on the issue and then publicise it. | Position paper is being developed by CH abortion theme lead. | December 2019 | The plans have been finalised, invites have been sent for a meeting on 9th December 2019 in Mumbai | Abortion theme lead, CommonHealth members & Co-ordinator |

**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. This research and advocacy project as well as participation in meeting with potential allies has enriched our understating on the issues around safe abortion. The research evidence that we are generating and the discussions we have had at national & subnational level with potential allies has been useful in prioritising CH advocacy activities.*

***Key issues identified:***

*From our field interviews and group discussions, we found 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 mariginalised women to access the safe abortion services.*

* 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 identified some members/ groups in the two states as partners for advocacy activities. During our participation in meetings and conversations with other potential allies we have been able to prioritise issues for advocacy and areas where we can pro-actively engage in facilitating the advocacy process for safe abortion access for women. We are pro-actively taking up advocacy for safe abortion services in public facilities and have conducted meetings to coincide with International Safe Abortion Day in 5 States. The activities received visibility in media in some States and in other States community representatives submitted resolutions to the State government demanding availability of safe abortion services.*

* 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 research team in identifying CSO/ CBO’s in the respective states. The presence and familiarity of the local NGOs in the state have helped the research team in identifying study participants and establishing contacts with government officials. Similarly, national level dissemination meeting and dissemination of report have provided visibility to CommonHealth initiative and brought in potential allies.*

***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, marginalised 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

*Yes, the draft research proposal that we prepared was first submitted to ARROW. It was reviewed by ARROW team and experts group, then based on the comments we revised and finalised it. Likewise research team members with the support of mentor developed eight types of research tools, informed consent forms and submitted to ARROW and RUWSEC’s Institutional Ethics Committee members, both the teams reviewed and provided insights and suggestions for revision. Then we incorporated these suggestions and finalised them. The final research proposal and tools were submitted to IEC and got approved. Then we started field data collection work.*

* 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. Dissemination meetings at state as well as national level provided the forum for sharing of baseline findings. These findings 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.*

* 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.*

**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)

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 have been central to development of knowledge products based on the gaps identified. These are brief and 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.*

**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 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 have been able to identify gaps and areas of priority action based on baseline assessment in two States. Knowledge products have been developed and the process is ongoing. These are based on the knowledge gaps identified at baseline. Additionally, community level activities for petitioning with State government for making safe abortion services available in mandated public facilities in Tamil Nadu are ongoing. Community level campaigns are scheduled for the month of September and detailed plans and budgets have been approved.*

* 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. As far as repealing the legal provisions is concerned, CommonHealth is in the process of joining 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 currently in process.*

* 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.*

**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.

*During the data collection process CommonHealth has identified CSO’s CBOs working on the issues, interviewed a few groups and some others participated in the community level meetings. Some of these are interested in working on the issues and were involved in the 28th September 2019, World Safe Abortion Day related activities. Similarly, CREA-CommonHealth project alumni have expressed their interest to actively participate in advocacy work on the safe abortion as women’s right and are partnering in the same activities. These partnerships are being further leveraged to create a common ground on decriminalisation of abortion in India. Similarly, CH became one of the signatories for the petition filed in Supreme Court of India to extend gestational age for legal termination of pregnancy from 20 to 26 weeks.*

* 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 |
| 1. 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. |
| 1. 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. |

**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 will have to conduct 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. |

***What challenges could arise? How can it be mitigated?***

We hope we will get the government permission to access the data and interview with health care providers by the end of October. Suppose If we don’t get it, we will use the HMIS data available in the public domain and also try to collect the certain information under Right to information act.

**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. | 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. |
| 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 |

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**Annexure 1**

Final National Baseline Research Report

(Attached as a separate file)

**Annexure 2**

Presentations at the National Dissemination Workshop

(Attached as a separate zip file)

**Annexure 3**

Revised Theory of Change

(Attached as a separate file)

**Annexure 4**

Baseline Research Briefs – Bihar and Tamil Nadu (English)

(Attached as a separate file)

**Annexure 5**

Abstract Submitted to the 10th Asia Pacific Conference on Reproductive and Sexual Health and Rights

**Availability of Safe Abortion Services and the Perspectives of Actors on the Right to Safe Abortion in India**

# Abstract

**Authors:** Dr. Sundari Ravindran, Mr. P. Balasubramanian, Dr. Padma Bhate-Deosthali, Dr. Alka Barua

**Objectives**: CommonHealth, a multi-state coalition of organizations and individuals advocating for better sexual and reproductive health, is part of a five South-Asian country project which aims to strengthen capacities to ensure right to safe abortion services. To develop an appropriate theory of change for guiding advocacy in India, it was necessary to understand the perspectives of all stakeholders. CommonHealth therefore conducted a baseline study to generate evidence on the availability of affordable safe abortion services, the extent of support for these from government and civil society organisations and on the perspectives of different actors on abortion as a women’s rights issue.

**Methods**: The study was conducted in Nawada district in Bihar and Kancheepuram in Tamil Nadu. It was designed as a rapid assessment and used a mixed-method approach based on secondary and primary data. Secondary information sources included published and unpublished studies, media reports, official documents and data sources, and reports from national and district surveys. Primary data was collected from in-depth interviews with key informants among community leaders, healthcare providers and leaders of civil society organisations (CSOs); focus group discussions with women from vulnerable groups; facility surveys in selected government and private facilities; and meetings with community leaders in both districts.

**Results**: Both Bihar and Tamil Nadu had government initiatives to improve access to safe abortion services but it was not a priority issue. Neither was it a priority for CSOs, rather Tamil Nadu had groups advocating for restriction of second-trimester abortions to protect the rights of the ‘unborn child’.

Government services were mostly conditional on husband’s consent and acceptance of contraception. Women reported abuse, denial, delays and poor quality of care at the government facilities. They preferred private facilities but opted for unqualified providers or self-medication due to the prohibitive cost of qualified provider services.

Most women considered abortion illegal but acceptable for foetal anomaly, rape or risk to women’s health. Women had mixed opinions about abortion services to unmarried girls. The CSO leaders felt that prevention of sex-selection should be without compromising the availability of safe abortion services. Providers seemed opposed to abortions for contraceptive failure, unplanned pregnancies and pregnancy from marital rape in married women.

**Conclusions**: Even after five decades of legalising abortion, access to safe abortion remains a major challenge for women, in low-resource settings of Bihar as well as in the relatively privileged setting of Tamil Nadu. Negative and disrespectful attitude of government service providers, the high costs of services in the private hospitals, unawareness amongst women and stigmatisation in the community appeared to be major barriers to women’s access to safe abortion services. The study findings will guide the advocacy agenda towards making affordable safe abortion services available to women in need and towards promoting abortion services as a woman’s reproductive right.

**Annexure 6**

**Gram Sabha Resolutions for safe abortion service provision at PHCs Kancheepuram District, Tamil Nadu**

As a part of our advocacy activity, using the key findings of our research on Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion in Kancheepuram District, Tamil Nadu, conducted by RUWSEC in Collaboration with CommonHealth, we wrote letters to SHG women, and youth leaders in seven villages to demand safe abortion services at PHCs in Tirupporur and Thirukazhukundrum blocks of Kancheepuram District.

The main content of the letter is “*As per the policy statement and advertisements in Popular FM Radios in Tamil Nadu, medical abortion services are available at PHCs in Tamil Nadu. The state government has also spent money for purchasing MA pills and trained medical officers but from the study and our experience the safe abortion services are currently not available at our local PHCs. This is an important services for poor young and marginalised women. Due to non-availability of the services at PHCs, many women are forced to use services of unqualified providers and make heavy out of pocket expenditure. So, we request people in our village to discuss and pass a resolution to demand the services at PHCs”.*

We circulated the letter to seven panchayats through RUWSEC staff and volunteers and they discussed the matter in the SHG meeting in a day before the Gram Sabha meetings. Few representatives from each SHG, youth and RUWSEC staff and volunteers in the village attended the Gram Sabha meetings and requested the villagers to pass the resolution (15th August, 2019). A Copy of the two pager RFSU project summary was also provided to them for reference.

Of the seven panchayats, four villages (Echankarunai, Ammanampakkam, Perumpedu and Acharavakkam) have passed the resolution requesting the authorities to provide the services at PHCs. The meeting was cancelled due some problems with villagers and officials in the reaming three villages. We are planning to present the matter in few more panchayats in the next meeting schedule on 2nd October 2019.

*Echankarunai Panchayat Resolution No 17, dated 15th August 2019 says “We, the villagers strongly believed that safe abortion services are very important for us. If we get the services at our Nerumpur PHC, this would definitely be very useful for poor and marginalised women in our panchayats, so we pass this important resolution requesting the authorities to provide the services” .* Passed with the consent of all members presented in the meeting and signed

**Photos**

**Acharavakkam Village – Tirupporur Block  Ammanampakkam village, Thirukazhukundrum Block**

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**Perumpedu Village, Thirukazhukundrum Echankarunai Village, Thirukazhukundrum Block**

**Annexure 7**

Briefs on MTP Act and MTP Act & POCSO (English)

(Attached as a separate file)

**Annexure 8**

Report of International Safe Abortion Day workshop 28th September 2019

Lok Chetna Vikas Kendra Nawada, Bihar

Supported by: CommonHealth

(Attached as a separate file)

**Annexure 9**

Report of International Safe Abortion Day workshop 28th September 2019

Society For Advancement Of Rural People And Natural Resources (ARPAN), Ropar, Punjab.

Supported by: CommonHealth

(Attached as a separate file)

**Annexure 10**

Report of International Safe Abortion Day workshop 30th September 2019

Gramin Punarnirman Sansthan- Azamgarh, Uttar Pradesh

Supported by: CommonHealth

(Attached as a separate file)

**Annexure 11**

Report of International Safe Abortion Day workshop 30th September 2019

RUWSEC, Kancheepuram, Tamil Nadu

Supported by: CommonHealth

(Attached as a separate file)

**Annexure 12**

CommonHealth Blogs

# Autonomy and Abortion Access

27th September 2019

Dr Suchitra Dalvie MD,MRCOG



We need more girls to be born they say. We need to stop the ‘gendercide’ that is taking place across the world, they say. For social justice. For women’s rights. For human rights.

While this is a compelling argument when taken at face value, if we take a moment to examine it more closely, the true nature of the discourse becomes clear. It sounds as though it is for women’s rights but in reality is it putting restrictions on them, using the excuse of sex determination while doing so.

If we are to recognize safe abortion as a right for women to terminate an unwanted pregnancy, then we cannot sit in judgement of which reason for it being unwanted is acceptable to us or not. This is especially true when people are uncomfortable around what is called a ‘selective’ abortion, whether it is for the sex of the fetus or a disability.

One could say simplistically that every abortion is in fact a selective abortion! That particular pregnancy is being terminated because it is not wanted. It is being ‘selected out’ of the reproduction cycle for some reason.

But of course when we say ‘selective’ we mean selective for a specific reason. Usually nowadays it is understood to mean a pregnancy being terminated because of the sex of the fetus. In India for example this usually means the selecting out of the female fetus and the choosing of the male fetus to continue.

Both parts of this are important to recognize as selective choices but the discourse, politics, debates and publicity usually focusses only on the abortion which selects out the female fetus. It is this unbalanced approach that has led to the continued failure of various ‘rescue’ programmes as well as the increasing utilization of this as ammunition by the anti- choice groups.

By showing up one of the ‘choices’ as inherently immoral/ cruel/ unfair/ discriminatory, they hope to tar all abortions with the same brush. Choice is inherently a bad idea they seem to say because you ‘cannot trust women’ and ‘they will choose it all wrong’.

Translation: Women will choose things that society/ partriachy will not approve.

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It is worth considering if there is ever any true choice? Most “choices” are a direct result of limitations arising from or expectation imposed by a range of conditions such as personal reasons, family reasons, economic reasons (e.g., potential jobs for women, lack of equal pay, lack of maternity benefits, the cost of education) or state policy (e.g., one-child or two-child family norms, military recruitment).

So why do we allow the discussion to focus on macro-level numbers (i.e., country-specific sex ratios) when we should really be addressing individual rights?

Does not the insistence on girl children being born push the burden on individuals while the there is no meaningful intervention taking place to eliminate the gender discrimination that leads individuals to make that choice in the first place?

The reality is that “choice” is not really exercised in a vacuum and the State can (and does) interfere with the reproductive freedom of individuals. If we want to ensure that women and couples do not choose to terminate a female fetus, we need to start addressing the reasons why the girl child is so unwanted.

We need to recognize that, like many other choices, this one is being made for the same economic reasons that drive so many others. A girl child is simply a financial liability in a patriarchal traditional culture that would not give that girl an equal opportunity in education, employment, earning capacity or support that would allow her to work after having children. Under this reality, the son basically operates as the old-age pension, social security and retirement plan rolled into one, and so the selection to have make children isn’t so much a “choice” after all.

Hence, long term strategies to address sex-selective abortion should address the lack of economic parity and gender equality first.

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Ironically we find that the current rhetoric around the issue argues that– if girls are not born, how will the boys find brides?

It is appalling that such slogans have even been endorsed by government campaigns thus making it obvious that no one is making the link between sex determination as an expression of gender discrimination and the abysmal status of women.

Once again it bears repeating that those who find out it is a male fetus and choose to continue are also selectively choosing a reproductive outcome which is never penalized or even recognized as a selective act.

The entire issue of the sex ratio and the ‘imbalance’ is also something that is accepted at face value and never questioned.  There are projections of violence against women, rape, polyandry – as though there is no exploitation and abuse in societies with a ‘good’ sex ratio! The underlying argument is also a bit of a threat – ‘If you don’t have more girl children, don’t blame us for what happens next. We warned you’.

We live in the same country that worships the Mother Goddesses, considers motherhood to be the highest attainable purpose of any woman’s life, where women are still being killed as witches[[i]](https://safeabortiondotblog.wordpress.com/2019/09/27/autonomy-and-abortion-access/#_edn1), where dowry is illegal but still being given in different forms and where a woman can be Defence Minister as well as defenseless all at the same time.

It is worth noting that the British passed the Female Infanticide Prevention Act in 1870[[ii]](https://safeabortiondotblog.wordpress.com/2019/09/27/autonomy-and-abortion-access/#_edn2) in India, a full 100 years before the MTP Act and 110 years before ultrasound machines were being used for sex determination.

All that technology has done is moved the active selection process earlier in the reproductive timeline. It has not created a demand for the male child that did not exist for thousands of years already. It did not create a secondary status for women and make them an economic burden. That was the socio-cultural complex along with the patriarchal constraints which make it difficult for girls to obtain equal education, equal job opportunities, paid maternity leave and equal pay for equal work.

We know that selective abortions are also undertaken when the fetus is diagnosed with a disability. Those are usually considered as acceptable because the recognition that such a child would be a burden to its parents and they should be allowed to choose a better life for themselves.

Surely the same argument is valid for parents of a female child when the sex of the child makes her a liability, economically and socially and culturally due to the existing norms?

So do we work to eliminate the discrimination or ‘save’ the fetus?

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This blogpost is extracted from an article written by the author for Catholics for Choice , Conscience magazine where it was published as ‘A Wolf in Sheep’s Clothing’. It has been slightly updated and modified for this version. <https://consciencemag.org/2018/08/31/a-wolf-in-sheeps-clothing/>

[[i]](https://safeabortiondotblog.wordpress.com/2019/09/27/autonomy-and-abortion-access/#_ednref1) <https://www.thebetterindia.com/175301/witch-hunt-murder-crime-women-india/>

[[ii]](https://safeabortiondotblog.wordpress.com/2019/09/27/autonomy-and-abortion-access/#_ednref2) <https://en.wikipedia.org/wiki/Female_Infanticide_Prevention_Act,_1870>

# Why do Indian Women Need Safe Abortion Services?

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If this reading, kindles a spark in you to know more about women undergoing abortion, then you would decide to hear voices of women seeking abortion…But if you simply decide to blame women and abortion, you are at a loss of understanding reality…

For last five years I have worked on the issues related to safe abortion services for women.  I want to share my experiences of working on the issue and a general story of why women undergo abortion and why many women need abortion, especially respectful, safe abortion services at the public health facilities.

In India, currently the number of doctors, bureaucrats, leaders of civil society organisations (working in health sector) and even researchers who believe in women’s autonomy and their unconditional rights over their body and reproductive choices is small. While, they understand about women’s lived in realities and the importance for health services, there are several amongst them who are ambiguous about supporting induced abortion as a woman’s right. Whenever anyone mentions unconditional abortion rights of women, they argue, “What about sex selective abortions and missing girls?”, “Do women not know they will become pregnant and be responsible?”.

Even doctors, who are not totally against women’s right to abortion, often choose to deny services based on their own judgements and moral view of right and wrong about a woman and her pregnancy. This is precisely what happens when third parties are authorised to make decisions for others. It is important for providers and law-makers to understand why women seek abortion, need safe abortion services and their plight in absence of access to these.

While the prominence given to declining sex ratio is well placed, the role of induced abortion alone in the process has been undeservedly stressed and second trimester abortions have been maligned through media and by political forces. Induced abortion has been deemed as a major threat to the demographic composition of the nation and consequentially often perceived as an illegal, irresponsible act by the woman and her family who seek it and the provider who provides it. I do not deny that sex selective abortions are happening. But in my extensive field experience across these five years especially in Tamil Nadu, these as a proportion of overall induced abortions are few.

The women I interacted with were primarily rural, marginalized, married women. None of them intended to have an abortion when they conceived for the first time. It was not surprising as lot of eminence is placed upon motherhood and it is seen by the society as the epitome of achievement of the woman, her purpose in life. Most women wanted to have abortion, when they conceived soon after childbirth. They wanted to space pregnancies. Others who had attained the desired number of children, ‘irrespective of the sex of the living children’ wanted to have an abortion before they could resort to some permanent contraceptive method.

I looked at these occurrences in the context of people’s arguments, “Didn’t these women know they will become pregnant, before engaging in a sexual relationship?”, “Isn’t something called contraception available?”.Yes, they were definitely aware. But have we forgotten how rules and norms of a patriarchal society work for women? How much autonomy did these women have in controlling their sexual lives? Does the societal norms that govern ‘her’, a woman’s responsibility towards her spouse in a marriage, permit her to deny sexual intimacy or use of contraception against her spouse’s wishes? How much control did she have over her reproductive desires, number of children for instance, or use of contraception? Would the available modern contraceptive method of her choice be acceptable to her spouse? If she chooses to have these controls what are the likely consequences in her daily and future life? Unless and until one is prepared to explore the answers to each of these questions, it is unfair to form an opinion and oppose women’s decisions, choices and services they need.

Government’s aim is to promote use of contraception, especially PPIUCDs and PAIUCDs, sterilization and injections to control ‘population explosion’. Doctors in public sector are known to make services conditional on contraception acceptance. Many young women aged 20-35 years I spoke to never wanted to have more than one or two children or at worst three children, irrespective of their education and economic status. These women were responsible, committed to their children and families but given that they had no decision-making autonomy either at home or at the service provider’s, they were often helpless and had to resort to unsafe, clandestine methods to meet their needs. These are sometimes known to even cost some of them their health and life.

Women find it difficult to share their private experiences and lack of autonomy in sexual life with doctors. As one of them said, “How can I exactly tell the doctor what happens within the four walls of my house when I say ‘NO’ to my husband for sex….all the bad and abusive words he calls me, the hitting and slapping…the doctors want my husband’s permission to do abortion…with my husband standing next to me what do I tell?”.

I came across a number of life stories where intersection of their personal bodily experience, family circumstances, socio-economic conditions, domestic violence defined their lives and institutional norms and might during service seeking defined their choices. There is a need to change the narrative. To begin with there is a need to spread awareness that abortion is conditionally legal and then we need to sensitize providers, lawmakers to the lived in realities of women. Humane, respectful and empathetic services is all that women are seeking.

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1. As of August 2017, we have 29 institutional members and 208 individual members from around 20 Indian states. [↑](#footnote-ref-1)