"Gender, Sex Selection and Safe Abortion: Creating Common Ground"

Short Course organized by CommonHealth at Sarvoday, St. Pius' College Campus, Goregaon, Mumbai
13-16th April 2009

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Gender Sex Selection and Safe Abortion: Creating Common Ground

Why the need for this course?

Close to 15 years after the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Declaration pledged themselves to universal access to comprehensive reproductive health services, maternal mortality in India still remains among some of the highest in the world. Lack of skilled attendance at birth and lack of access to safe abortion services contribute significantly to pregnancy-related deaths.

Medical Termination of Pregnancy was legalized in India close to four decades ago, and yet an estimated 6.7 million abortions per year are still not performed under safe conditions, or by a skilled provider. The reasons are many-fold and increasingly new barriers arise in the form of the anti sex selection debate and an ever increasing groundswell of religious fundamentalism in the country. Women activists find themselves challenged by the dilemma of standing against female sex selection as a reason for abortion while at the same time standing up for safe abortion as a women's right.

Gender issues and their impact on women's lack of autonomy and self determination over their own bodies, their own sexuality and their position in society needs to be understood by those who choose to work for improving access to safe abortion services in our country.

We are at a crucial juncture in the history of women's sexual and reproductive rights in India. Women's access to safe abortion services may be under threat of further deterioration. It is women from vulnerable and marginalized sections of society who will be most affected by this, and will bear a disproportionate burden of morbidity and mortality related to unsafe abortion.

At this point in time, it is important for all concerned with and working in the area of women's sexual and reproductive health and rights to sharpen their understanding of the complex issues surrounding safe abortion in India and develop strategies for promoting access to safe abortion services. The present short course was designed precisely for this purpose.

Objectives

- To develop an in-depth understanding of abortion technology and service delivery issues in India.
- To understand how laws, policies and programme influence access to safe abortion services.
- To build clarity on the way gender and rights issues are an integral part of safe abortion access.
- To obtain a nuanced understanding of the need to prevent sex selection while ensuring continued access to safe abortion services.
- To explore the process of advocacy and creating a framework for focal campaigns for each participant (individual or organizational).

Resource persons

- Suchitra Dalvie – Course Coordinator
- Renu Khanna – Course Coordinator
- Sharad Iyengar (ARTH)
- Leila Varkey
- TKS Sundari Ravindran (CommonHealth, RUWSEC)
- Unisa Sayeed (IIPS)
- Leni Chaudhari

DAY 1

Welcome and Introduction

A total of 25 participants joined the course. One participant left early due to a family emergency and two participants joined the course one day late. There were 10 men and 15 women from both government and private sectors representing 20 NGOs and 5 governments. Very few were CommonHealth members. Participants represented a healthy mix of doctors, administrators, a lawyer and a communications expert to name a few. While some had worked in this field for long, however, for others this was their first exposure to any information on these topics.

The format of the workshop allowed the participants to interact and different perspectives were shared in group assignments.

The participants were welcomed by Sundari and then Suchitra facilitated an interactive round of introductions. Everyone was given half of a magazine article on women's issues. They had to find the person with the other half, pair up and introduce each other. This worked as an ice breaker and soon

everyone knew the other person's name, organization and also what makes them happy and whom they admire.
Renu then started a game on chain of names which reinforced memory of the names and everyone had a good laugh during this session!

Session 1: Gender, Sexual Health, Reproductive Health, Sexual Rights, Reproductive Right and Human Rights – facilitated by Renu Khanna

After tea break, we then moved on to the first formal session, which was facilitated by Renu. The participants were divided into 5 groups and each one had to discuss and then present their definition and understanding of the following terms:

Gender, Sexual Health, Reproductive Health, Sexual Rights, Reproductive Right and Human Rights.

The following are the highlights of the presentations made by the groups:

1. *Gender:* (Presented by Anuradha, Deepti, Rajeev and Jiban)
Socially and artificially created/constructed, affecting behavior and expectations, has an adverse effect on society. It has a stigma attached and varies from place to place and cross cutting. The presentation also included socio-economic and human rights issues.
Sex can be male or female or indeterminate but gender is not biologically defined. Gender identity can be empowering or disempowering, Gender and Health are connected.

2. *Reproductive Health:* (Presented by Manita, Sangeeta, Rajnikant and Swati)
The topics discussed in the presentation were- healthy reproductive period, safe motherhood, reproductive organs, healthy behaviours and reproduction. Who should be aware of reproductive rights? Awareness of our own reproductive health? "Holistic health in the reproductive age group- other than safe abortion and family planning – other than reproductive organs". But we still have our organs? Safe health of women? What about single women?

3. *Sexual Health:* (Presented by Shilpa, Sonvi, Bala and Sangeeta)
The presentation included the topics on Sexual Health like Sexual identities, freedom from diseases, coercion (rape, sexual assault), fear, sexual pleasure and satisfaction and hygiene. The definition of sexual health given by the society. Seclusion of menstruating women. Topics such as Male virility, Power, Sexual health, Contraception and Infertility were also presented.

4. *Human Rights:* (Presented by Deepa, Veena and Laxmidhar)
Human rights are given to an individual once he/she is born. Human rights are needed in order to be treated like a human being (or to have human dignity). There are rights based on Ethics. There are even constitutional rights/justice and many are subsumed in wider human rights.

There is no discrimination on the basis of caste race, class, region language, religion, sex, marital status, ability to seek justice, freedom of speech thought experience, right to life and security, access to health and education opportunity, right to food and shelter.

5. *Sexual Rights:* (Presented by Sunita, Kavita Swamy Satya)
Sexual Rights are the Rights to have sex irrespective of marital status, right to have a sexual partners, right to be bi, homo, hetero or asexual, rights to knowledge on sexual health and safety, rights to sexual pleasure. Older couples are often meant to be asexual – socially older people.

6. *Reproductive Rights:* (Presented by Laxmi, Ritesh, Sanjay)
Reproductive Rights include the right for Safe motherhood, safe abortion, right to access FP, right to information about decisions, choices, right to ask, right to improve quality of reproductive knowledge. The discussion highlighted - Male reproductive rights, rights to have children, not to have, when, and how many?

This session achieved a greater clarity about the differences. It forced us to question ourselves, see the connections, different dimensions to the life-style and changing trends in community. It also helped reflection by individuals in the small groups.

Formal presentation by Renu (PPT on CD)

Gender – how it works as a system and the resulting different access to and control of resources—(leisure, time, rest, preferential control) – this leads to decision making and power and creates differentials in power (inequity).

Gender Analysis – social beliefs, how men and women are supposed to behave, sexual division of labour, activities and tasks, access to and control over resources and decision making and power.

Gender Roles - within society, which are vested with power such as husband, wife, mother-in-law and sister-in-law.

Gender relations - the differences between the gender roles and the power differences.

Inequality - Creating inequality in a very systematic and structural way – a violation of human rights. Gender justice is a subset of social justice – within larger social discrimination.

Power - Our work is equalizing the distribution of power by gender.

International declarations and modern discourse on human rights emerged after the Second World War. UDHR - Universal Declaration of Human Rights. They have universality and an aspirational content. They are all interdependent.

There is a difference between human and constitutional rights. Human Rights are aspirational. Constitutional Rights are given to us by our country's constitution.

Rights begin at birth and not before birth. Convention on Child Rights. More and more groups are demanding articulation of definitive rights.

(State obligations – protect of individuals legal rights, respect rights of individuals, promote facilitate rights)

Principles and underlying values of Human Rights

- Equality
- Nondiscrimination
- Dignity
- Bodily integrity
- Self determination
- Compassion
- Interdependence
- Right to life and development

In the post lunch session, Renu discussed Sexual Rights. She pointed out that Reproductive Rights and Sexual Rights are used interchangeably. However, there is a difference. Sexuality exists without reproduction. Sexual Rights pertain to healthcare, education, information and services, privacy and confidentiality. The right to choose if, when, how and with whom to be sexually active and engage in sexual relations with full consent (illegal below 16 years)

Ritesh Tewari generated a very interesting debate on codification – voting – taking to international law and how countries implement or violate these rights and what is the recourse.

Session 2: Abortion as a Gender, Rights and Reproductive Health Issue - facilitated by Renu Khanna

Five case studies were distributed among the groups and they had to analyse the case study on the dimensions already discussed - gender Issues, sexual rights, reproductive rights, reproductive and/or sexual health issues.

Case study: Anjana

Anjana came to the clinic with her 78-yearold grandmother, who was not able to provide any support other than waiting outside the clinic. She would wait outside the clinic till her granddaughter got things cleared at different stages in the health care system.

The young woman was working as a housemaid for the past year at a place far from her house. She had been recruited through a broker. She said, “I lost my father 10 years ago. Mother, grandmother and my younger brother were at home. I have an elder sister who is married and lives away from home. My mother was not able to go for work for the last few years because she suffers from weakness of hands and limbs. My brother rarely gets some work. Since I have to support the family I opted for the job.”

Three months after starting work as a housemaid, the unmarried boy in the house, who was 28, (he and his mother stayed in the house), asked Anjana to have sex. She refused. He approached her again with reassurances. She consented and they had regular sexual contact for nine months. He used condoms for about two weeks initially but then discontinued, saying using them was painful. He bought three packets of oral contraceptive pills and asked Anjana to use them. She refused because she did not know how to use the pills. She also thought that the pills might harm her uterus. She knew about pills, condoms, as well as IUDs and injectables from the radio, television and books.

Anjana developed itching and vaginal discharge after a month of sexual contact. She was not able to approach any health care provider and took no treatment. She suspected pregnancy at about six weeks of amenorrhoea and told her sexual partner. He said he would not marry her because nobody would agree to such a match. He gave her Rs. 800 and asked her to go home and go to a hospital.

Anjana informed her mother and grandmother but not her brother. Her mother advised her to go to a local hospital. The pregnancy was confirmed and the local hospital referred her to the tertiary care centre. Because her mother was sick, Anjana came to the clinic with her old grandmother.

She came late to the hospital and could not get registered that day. She went back and could return only after three weeks because of financial problems. She had a vaginal infection that was treated symptomatically. Her pregnancy was terminated without any immediate morbidity. Anjana said that abortion was bad in general and it was specifically bad for the uterus because there was a chance that in future she may not be able to have another child.

Gender: Being a woman she has to work in a household (she has less options). Her mother is not getting access to health care system; her sister is not informed about the problem in the house. Even her brother was not informed about pregnancy; hence no male member accompanied her. This shows - Unequal gender power relations.

Human Rights: Mother has no access to health care, brother has no job, there is no social security and delay in getting treatment.

Sexual Rights: Sexual right to have contact, she used her right – she refused, her partner was not willing to bear responsibility of contraception. There is no violation of sexual rights, it is lack of sexual education and negotiation.

Reproductive Rights: She does not have accurate and complete information on contraception. She was not aware of implications of unprotected intercourse.

Sexual Health: She has no pre and post abortion complication; she has the right to have children. She developed an RTI – she never went for the treatment. She had unwanted pregnancy.

Case study: Bindu

She came for abortion care accompanied by her husband's friend, who was responsible for the pregnancy. Bindu had a three-year-old child. Her husband was impotent, and he had given his consent for her to have this one child by somebody else. A neighbour was her sexual partner for the first pregnancy; she did not know this neighbour's whereabouts now.

For the pregnancy that brought her to the clinic, her sexual partner was the friend of her husband, who knew that the husband was impotent. Bindu said she and this person had sexual relations for a long time, but her husband was unaware of this. There was no delay in suspecting pregnancy and Bindu consulted the local hospital for confirmation. She told her partner. He took her for an abortion to a friend who worked in the medical college. The friend wanted her to consult a particular doctor who was on leave. When that doctor returned they consulted him but he was busy. He referred them to the family welfare clinic.

By then Bindu was 14 weeks pregnant and it was recommended that she get admitted to the hospital. She refused because she had to reach home before her husband returned from work. Neither her husband nor his family members knew about this pregnancy. Bindu was also not able to take any support from any of her family members, because all of them knew that her husband was impotent. She was discharged on the day of the abortion because she was very anxious.

She said that in her marriage she had the power to make decisions and had control over the resources. She said she wanted to get sterilised to avoid the possibility of another pregnancy. She did not want another child. Her sexual partner took care of all the expenditure for the abortion. She said she did not know much about this man, not even if he was married.

Gender: This is what we call 'culture of conditional silence'. Husband gives consent because of virility and fatherhood realised. The wife needs to be home when husband returns. This is Power dynamics.

Sexual Rights: Go to a specific doctor – ethical: loyalty in marriage, rights to sexual pleasure, does not know much about sexual partner, Man's sexual health needs.

Human Rights: Divorce.

Reproductive Rights: Her not wanting to have a second child- is this free and independent decision, she wants sterilization? Is it completely independent?

Sexual and Reproductive Health: As she was allowed to go to 14 week pregnancy, this is negligence on part of doctor. Immediate medical help – but partners – denied for a 14 week period. She wanted to be discharged on same day – negative. High risk of STIs- no knowledge of partner. Contraception is not mentioned?

Case study: Anita

She came with her 36-year-old mother to the clinic to terminate her pregnancy. The mother had been working in a far away place for the last two years. The girl was staying with her father and younger brother. The mother would come home once in two months, but she used to talk on the telephone every week with her daughter. The girl attained menarche at the age of 12, and since then had irregular cycles.
She reported frequent (at least twice a week) sexual contact with her father over the past one year. Initially, the father would beat her for refusing to have sex with him. Later, seeing no way out, she continued the relationship. She had no idea that this could lead to pregnancy. "Only now I have started learning about reproduction in school. We have a chapter about this," she said.

The girl missed her periods but never thought of pregnancy. The amenorrhoea was regarded as part of her irregular cycles. She never talked about the amenorrhoea with anyone. She said she was afraid to tell her mother because she was afraid that her mother would scold her. She did not tell her father or any other family members or close friends. "How could I say bad things about my father to others?" she asked.

When her mother came home from her contract work, the girl was taken to a nearby hospital because of pain in the leg. The pregnancy was not diagnosed and she was put on some medication for pain. She was then moved to a hostel for further studies. When she began to feel uneasy, she told the warden about the amenorrhoea. The warden informed the mother. Since then the father has been absconding. There were no further delays in the health system and the girl did not develop any morbidity.

The hospital authorities wanted to register a case against the father, but the mother did not agree. The mother blamed her daughter, saying that the girl should have informed her early about the entire situation. About the abortion, the girl said, "It is good to terminate for my future."

Group Analysis

Child abuses, incest, terminate late pregnancy, no-legal action against father, whose permission needs to be sought to file a case? Is the hospital at fault?

Gender: Girls-women need to keep quiet, (silence in violence). Needing mother, father not protecting, father taking back seat, Father-daughter power imbalance, and mother does not allow. Father absconding.

Human Rights: Incestuous relationship, right to dignity , health and information, children have a right to bodily integrity, guardian – can be kept to adult – a liberal loop hole – in practice it may actually narrow options.

Sexual Rights: Not right to refuse, seeing no way out, sexual violence

Reproductive Rights: Able to terminate pregnancy; get information to unsafe sex, sexual and reproductive right,

Reproductive Health: Issues about having irregular cycles, amenorrhoea, lack of diagnosis of pregnancy, government policy of sex education, timely management.

Case study: Muneja Bibi

Muneja Bibi was a muslim woman, living in a large extended family with 9 brothers and their families. They are not poor, and have many small scale business ventures. They have a two-storied 'pukka' house in an otherwise poor village. She was pregnant for the 4th time. She had 3 daughters but she desperately wanted a son. She went with her husband to a big doctor in the city, where an ultra sound was done and they told her that the baby was another female. It was the 4th month of the pregnancy. She and husband returned to the doctor (an MBBS & DGO) the next day for an abortion. The abortion was done. The doctor told her to come back for check up after 8 days.

When she returned home her in-laws all came to know what they had done, and she faced much abuse from them. They said whatever be the case, she should not have had an abortion. She did not return to the doctor after 8 days for the check up. However the bleeding didn't stop. She bled for 18 days. One day she went to the pond for a bath, and she collapsed. The family took her to a private hospital in the city, where the doctor told them that she had no blood left in her body. Before they could give any blood or start the treatment she died.

This story was told by an old woman of the village. The family of the woman gave a different story. They say that she was bleeding before the abortion was done (missed abortion), and went for a D & C. They do not mention anything about the ultrasound. Her husband, however, remarried after 6 months.

Human Rights Violation: right to life, health, right to information dignity, discrimination, right to abuse by in-laws/discrimination.

Reproductive Rights: PCPNDT, right to choose sex of child (rider?), timely access to RH care.

Sexual Right: Right to remarry.

Reproductive Health: This is a case of PCPNDT right violation, lack of information on contraception, lack of post abortion care, delay in health care, lack of availability of hygiene and privacy.

Case study: Sulochana Devi

Sulochana Devi was a poor woman of the barber caste (SC) in a big village of around 5,000 people. Her husband worked as daily labourer. She was the mother of 3 children and she became pregnant for the 4th time. She did not want the baby, and asked her husband to take her to a hospital for an abortion. But her husband said no, let it be. He said have the baby then go for 'operation' (sterilization) next year. Her in-laws also agreed with the husband, and said let it be. When the whole family opposed her, she became angry with everyone, and refused to speak to anyone in the family.

She knew that the dai gave medicines for abortion, so she went to her and told her of her wish to abort the baby. She said, "I am 4 months pregnant, can you give me medicines to cause the baby to fall from my womb?" The dai said, yes I can cause the opening of the menstruation, and the baby will come out. So the woman said to give her the medicines. Dai gave her 7 days of herbal medicines, to eat morning and evening on empty stomach. The dai takes Rs.150 for this medicine. Many women of the village go to her secretly. Some women don't have any trouble, and some women die too. So she took the medicines secretly, and didn't tell the family.

When her whole body was swollen then they took her to an RMP doctor who lives by the main road. This 'doctor' examined her, and said she has no blood, send her to a big hospital in the city. They took her to the city the next day. She had become yellow by then. They got her admitted, the doctor did a D&C, and blood was given. She was there for 6-7 days. Then she died.

This story was told by a meeting of village women. In the meeting they blamed the woman for this death. She should not have gone and taken this medicine secretly. Her husband has since remarried.

Group Analysis

Gender: Unequal decision-making powers, limited mobility, limited information.

Sexual and Reproductive Health: Did not Dared to talk about her SRH, other women do not understand her problem from a women's perspective, forced to forced pregnancy, husband to remarry.

Human Rights: poverty as a barrier, Caste, right to information, right to access to appropriate services, right to life because of medical services were not provided and security of personhood (not die), right to redressal (where is there a right to redressal).

Sexual Rights: Right to information and right to access to appropriate services.

Reproductive Rights: Right to have or not have children-no use of contraception, Right to information, right to access to appropriate services, right to safe abortion

Sexual Health: Shame and guilt to talk about sexual reproductive health, safe abortion, delay in service provision, unwanted/forced pregnancy, husband made decision of sterilization, inappropriate medical diagnosis, wrong diagnosis by quack, lands up with jaundice - right to access appropriate services.

Issues raised in the case studies: Summarized by Renu

Safe Abortion as a Gender Issue

- Women's lack of control
- Men's abdication of responsibility to prevent pregnancies
- Non-consensual sex within or outside marriage
- Contraception failure
- Stigma and guilt in relation to abortion
- Cost of services and lack of access for women
- Poor quality, exploitative services because of the stigma and guilt
- Limited access of quality
- Discriminatory nature of services – as weeks increase, charges increase - single women, class, caste
- Lack of awareness of legal status of abortion
- Women's perspective of quality – confidentiality, affordable, able to return home on the same day

Safe Abortion as a Rights Issue

- Right to Life,
- Right to Quality for safe abortion within other larger RH services
- Right to affordable, free from discrimination SRH services,
- Right to consensual sex and bodily integrity,
- Right to pleasurable sex free from disease and pregnancy

See also Renu's PPT Presentation on the CD.

Session 3: Update on Contraception Technologies - facilitated by Suchitra Dalvie

This was a technical presentation which covered the anatomy and physiology of the female reproductive system. The concepts of fertilization and implantation were clarified and the mechanism of action of all the methods of contraception were explained.

The various methods explained were natural methods, condoms, IUDs, oral contraceptive pills, sterilization and emergency contraception.

The various methods of safe abortion were also described--surgical (vacuum aspiration) and medical using Mifepristone Misoprostol.

End of Day 1

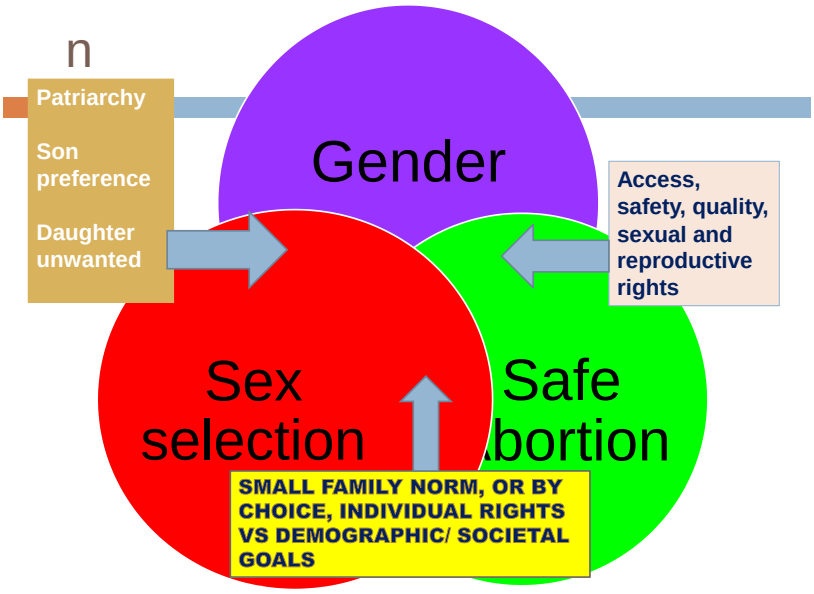
At the end of the day, participants were given reading homework in preparation for the next day's discussion.

Feedback was shared from the participants at the end of the day. They suggested that we need to keep timing, lectures to be made more participatory and useful to our work, as well as the need for a "parking lot" for issues that we will deal with later. The case studies were found to be good and a useful methodology.

Day 2

We started the day with a review by **Deepa and Samita**

Suchitra then presented a diagrammatic representation of creating the 'common ground'. This 'common ground' grew layer by layer each day. The final 'common ground' that emerged on Day 4 is described on page 33 of the report.



Question

Is there an intersect between sex-selection and unsafe abortion - the two laws are clearly different and the place where the problems are (urban – sex selection, rural – unsafe abortion) are different – so why do we need to separate the issue out? (Ritesh) Is the problem more in rural or urban areas? It was suggested that we wait for this question to be answered in a later session when we report on the readings on sex Selection and Safe Abortion.

Session 4: An update on Sex Selection Technologies - facilitated by Suchitra Dalvie

Suchitra then spoke about the technology of sex selection. She discussed about scientific progress and technology being value neutral but being misused. She explained the various methods such as Chorion Villus Sampling (CVS), amniocentesis and ultrasound. She briefly spoke about IVF and pre implantation diagnosis. She then also discussed that one of the problems with the PCPNDT legislation and its implementation is that the technology outruns all these and we now have a blood test which can identify the sex of the fetus and also a technique called MicroSort which is being advertised on American websites for "Family balancing".

The discussion after this raised some of the following issues:

- Why not focus on key technologies used that are leading to exploitation?
- It was useful to see how other technologies work
- First trimester can also be sex selective so it is not practical to think that banning second trimester abortion will solve the problem.
- Medical fraternity is part of society. Medical fraternity is the most responsible.

The discussion reinforced the belief that this is a very complex issue and that just the enactment of the law is not the only answer - we should look beyond laws to other solutions.

Session 5: The PCPNDT Act - facilitated by Leni Chaudhary

She spoke about the original Prenatal Diagnostics Techniques Act: misuse of the techniques (2003) and how 'pre-conception' was added after a PIL filed by CEHAT, Sabu George, MASUM. She pointed out the lacunae in the implementation of this act.

She also spoke about the regulatory framework – in what context, by whom, on whom how and what are the mandatory record making and reporting procedures. (The doctor must not communicate the sex of the fetus. Clinics conducting USG must be registered. All clinics must display that disclosure of sex is not permitted. Cannot advertise sex detection of any kind. Need to register all types of techniques and also registers need to be made for every scan done)

She spoke about at the importance given to form F in the implementation and monitoring. Legally any deficiency of record maintenance is a violation.

Leni explained about the punishment clause and how the monitoring of the Act is facility driven. Inspection, raids, search, seizures are carried out. Punishment is based on the way the charges are framed. She clarified that if a lay person wants to report an incident of sex selection, they must go to the appropriate authority.

She also pointed out that these raids do not always result in conviction. In Maharashtra for example there have been 13 decoy cases and not a single

conviction. It takes years for conviction – 103 cases filed so far and 70% are for non-registration.

Session 6: Understanding the Sex Ratio - facilitated by Sayeed Unisa

Sayeed Unisa's presentation covered the following:

- Definition of sex ratio. While internationally, sex ratio is number of males to 100 females, in India it is, number of females per 100 males.
- Processes of sex ratio data collection and the various inconsistencies that creep in and affect the sex ratio.

She spoke about the different Sex Ratios. First she said that Sex Ratio is defined as the number of males per 100 females which can be expressed as the

Sex Ratio= 100*Number of Males/Females*100 -International Definition

Sex Ratio= 100*Number of females/Males – Indian Definition

Sex Ratio= 1000*Number of females/Males – Indian Definition

The different sex ratios are

- Overall sex Ratio (Total Population)
- Sex ratio of child Population - (Below 15 years, 0-4 years, 5-9)
- Working age sex ratio - (15-59 or 15-64)
- Aged population sex ratio - (Population aged 65+)
- Sex ratio at birth - (Live births)
- Natural sex ratio
- Secondary sex ratio – (Live births)
- Primary sex ratio - (At the time of Conception)
- The overall sex ratios of the populations of the most countries fall within the narrow range of about 95 to 105.
- In general the overall sex ratios of the developing countries are on the higher side. The sex ratio of India, Pakistan, Bangladesh, Iran and China have values which surpassed 105.

She explained that several factors affecting the over-all Sex Ratio. These are

- Sex Ratio at Birth
- Sex Differential in Mortality
- Sex Differential in Migration
- Sex Differential in Enumeration

Going on to explain the factors affecting Sex ratio at birth, she stated that these were as follows:

- Even in the absence of sex selection practices, a range of "normal" sex ratios at birth of between 103 to 107 boys per 100 girls has been observed in different societies, and among different ethnic and racial groups within a given society.
    - Environmental factors
    - Social factors
    - Data sources and data quality issues
- Incomplete or inaccurate reporting or recording of the births or the survival of infants.
- Premature newborns are not counted as live births
- When unusual sex ratios at birth (or any other age) are observed, it is important to examine misreporting, misrecording or under-registration of births or deaths as a possible explanatory factor.

Session 7: Legal aspect of MTP Act - facilitated by Sharad Iyengar

Sharad Iyengar started the session with a quiz (See Annexure 6) which dealt with commonly misunderstood facts about the MTP Act in India.

Group members raised the following questions:

- What are the provisions of the act?
- Does the government institution have the same reporting requirement?
- When does the doctor have to reveal the identity of the women to the police or only if there is a court order?
- Where can we report violations?
- Whose consent is required for unaccompanied minor?

He briefly highlighted the history of the MTP Act and spoke about the Shantilal Shah Report which recommended legalization of abortion because of the large number of women dying from unsafe abortions. The Law is meant to enable an exception to the Indian Penal Code. It aims to improve maternal health by decreasing unsafe abortions; it legalizes abortion, promotes access, de-criminalizes abortion seekers and offers protection to medical practitioners who would otherwise be penalized.
(http://www.mohfw.nic.in/MTP.htm)

Up to 20 week, requirements are:
Consent of the woman, consent of guardian, opinion of RMP (MBBS) formed in good faith under certain circumstances. 12-20 weeks two RMPs.

Indications: Risk to woman, risk to fetus, rape, failure of contraceptive in married couple (remains even in amendment).

The Act provides a lot of space to a practitioner to be liberal in determining risk to injury for health in either the current or the foreseeable environment.

This presentation took the participants through the MTP Act, the MTP Rules and MTP Regulations, Legal abortions in the Act were defined as – termination done by approved medical practitioner, in an approved place, for conditions within the gestation – all as prescribed by the Act. The amendments to the MTP Act in 2002 were also described. The amendments also include the Medical Abortion.

Amendments to MTP Act in 2002

- Decentralizes site registration to a 3-5 member district level committee chaired by the CMO/DHO
- Approval of sites that can perform MTPs under the act can now be done at the district level
- Stricter penalties for MTPs being done in a un-approved site or by a persons not permitted by the act

The implications of the amendments are extremely important for us to understand. The amended act simplifies registration of sites which can be done at district level now. Providers can get their sites approved for providing abortions under the MTP Act for 1st trimester only or up to 20 weeks and thereby come under the protective cover of the MTP Act. Approved providers can provide medical abortions from their clinic, as long as they have access to an approved site. There is a potential to increase number of approved sites, which would enable women to access safe abortion services. Effective implementation will help to bring all abortions within legal frame work.

Sharad also did a comparison of the MTP Act with the CDTP Act of South Africa which is extremely liberal. The session ended with a relook at the quiz.

Session 8: Value Clarification – facilitated by Sundari Ravindran

Sundari divided the participants into two groups to enact two role plays.

Role Play 1

Ahalyabai is pregnant for the fourth time. Because of her extreme poverty, she has been unable to gather the money needed for terminating her pregnancy and go to a government health centre for several months. It is

now just past the 16th week of pregnancy, and Ahalyabai has finally managed to reach a health centre known to provide abortion services. But when she reaches there, the health workers and the doctor abuse her saying that she has come for a sex-selective abortion. Ahalyabai is unable to understand what is going on, she pleads with them to help her, but does not know whether or not they will terminate her pregnancy.

Q: What will be the consequences if the doctor refuses to perform the medical termination of pregnancy?

Q: List different actions that can be taken and the persons who can take them, so that women like Ahalyabai are not denied access to safe abortion services.

Role play 2

Lata lives in a village of this district which has become notorious in recent years for its very low female child sex-ratio. People of this district believe that increasing dowry demands for daughters' weddings are an important reason why couples would like to avoid having female children. This is Lata's second pregnancy. Her first child is a girl. Having found out through ultra-sound scanning that the sex of the foetus in the current pregnancy is female, Lata approaches a health centre for abortion. The doctor, after finding out that Lata's first child is a girl, refuses to provide her abortion. Lata continue with her pregnancy and delivers a female child. She faces serious violence and abuse in the household because of having a second daughter. In vulnerable health and mental state, Lata is traumatised and unable to cope with this situation.

Q: What are the different things a doctor can do in situations such as Lata's? Which of these will be supportive of her, and which, not?

Q: List different actions that can be taken and the persons who can take them, so that sex-selective abortions do not take place in this area.

Participants presented the role plays and a discussion ensued after each.

Role Play 1 Ahalya

Consequences would be a likelihood of her going to a non-legal provider or giving up on the idea of abortion.

Some of the reasons for providers' denial of MTP discussed included

Fear under PCPNDT – providers are obliged to respect the letter of the Act PCPNDT. What could be some indicators on the basis of which a doctor could make reasonable just decisions? E.g. if she disagrees to sterilization I know that she wants another child, so this may be a sex selective abortion. It is her decision, she faces abuse at home. I should help her to get it.

There was a discussion on what can I do to change the situation? We need to work to change gender norms in society. Some measures are required to make it clear through the media and to the medical community that the MTP and PCPNDT must be kept separate and not confused. Implementation of the two acts and performance of all work under the act needs to be emphasized.

We need to address the fears of doctors - understand why there is fear and step by step explain under the provisions of MTP Act. They should be well informed to provide services.

Role Play 2 Lata

The doctor can counsel the mother-in-law and sister-in-law along with Lata. He/She can drop by their house and try to help by sharing information about schemes that support the girl child. He/She can tell them it is OK to have a second girl child. Doctors have the power and can use it constructively to influence social norms in the community. They can associate themselves with local NGOs and lend their voice to give value to the Girl Child.

If no information is provided about the sex of fetus, then would abortion be given?

Can doctors follow the guidance of 'what is the immediate need of the woman? and can I meet it?' The doctors spoke at length about the tension between what the women wants and what we (doctors) think is good for her.

Other responses:
'Some NGOs are involved to improve the situation of the girl child – e.g. so that eventually demand for this will come down.'

'Society takes a long time to change so it is for an active doctor to do the MTP.'

The person who played the doctor said, 'I was confused – to do or not to do? What can I do? Come to me - initially I refused. I did my best to dissuade her about sex determination. I tried to convince her – this is not legal. If I don't do the MTP, her right to have an MTP is denied. An unwanted girl child would be born. I have to think of her as an individual case. But in dealing

with the individual cases, the doctor will get a name for being soft and others will come for sex selective abortions.'

Sharad stated, 'It is in the law that the doctor can find out reasons why the woman wants an abortion. The doctor is meant to make enquiry about what are the circumstances as per current law. After arriving at an opinion, she/he has to act on this opinion. This is the implementation of the law. He remarked that PCPNDT is not about individual rights but about restoring the societal justice for females. Is there a reasonable middle path whereby we don't further encourage sex selection, and also do not deny women abortion.

Another participant stated, 'Doctor should find out who is doing sex determining and report it to appropriate authorities. We should use our influences to stop the malpractice.'

What can be done to tackle the larger issues while we take care of individual women's needs in the immediate time? We need to work with sensitization of community members and providers.

After a prolonged and heated discussion, there appeared to be consensus on

A. When a woman approaches a provider for safe abortion, while not violating any requirement the provider should provide abortion.

B. We cannot close our eyes to sex selection. We need to put our efforts at the point where the sex selection happens. We need to put our efforts to stop misuse of the technology.

C. We need to strengthen the larger efforts, the root of the problem, on the BIG Issues working with entire communities to change mindsets AND also ensure that technology for pre-natal diagnosis of genetic disorders is not used for sex determination.

End of Day 2 feedback was generally positive. The day's contents were informative and useful. The session on Review of technologies under PCPNDT provided holistic information – that it is not technology that is 'bad' but the use to which it is put. Provisions under the PCPNDT Act – 'many of us were not clear about its rules and regulations'. Loopholes in the implementation of the act were discussed. Understanding Sex Ratio - complex factors affect it. It is important not to jump to conclusions about sex selective abortions from a higher sex ratio – it fluctuates normally as well. MTP Act – unlike other acts it facilitates a woman to have abortion.

Role plays were found useful - generated discussion on the issues. Role plays left us thinking from the perspective of the individual's smaller goals and larger goals we need to work on simultaneously.

Leila left us all with a question - Where is our understanding of the root causes and where we are placing ourselves - what we can do to change things from our own place?

Readings were assigned for homework.

The participants were divided into four groups and the following readings were divided amongst them.

Essential Readings (in groups)

1. Hirve SS. Abortion law, policy and services in India: A critical review. Reproductive Health Matters 2004;12(24 Supplement):114-121.
2. Khan ME, Barge S and Kumar N. Availability and access to safe abortion services in India: Myths and realities. Paper presented to IUSSP Conference
3. Understanding induced abortion: Findings from a programme of research in Rajasthan, India. New Delhi, Population Council, September 2004.
4. Barnes L. Abortion options for rural women. Case studies from Bokaro district, Jharkhand. Mumbai, CEHAT, Abortion Assessment Project, India.
5. Duggal R and Barge S. Abortion services in India: Report of a multicentric enquiry. Mumbai, CEHAT, Abortion Assessment Project, India. Chapter VI. Utilisation and accessibility.
6. Kishwar M. Abortion of female fetuses: Is legislation the answer? Reproductive Health Matters 1993;1(2):113-115
7. Nidadavolu V and Bracken H. Abortion and sex determination: Conflicting messages in information materials in a district of Rajasthan, India. Reproductive Health Matters 2006;14(27):160-171
8. Visaria L. Female deficit in India: Role of prevention of sex selective abortion act. CEPED-CICRED-INED Seminar on Female Deficit in Asia: trends and Perspectives. Singapore 5-7 December, 2005.
9. Madhiwalla N. Sex selection: Ethics in the context of development. Indian Journal of Medical Ethics, Oct-Dec 2001, 9(4).
10. Bandewar S. Exploring the ethics of induced abortion. Indian Journal of Medical Ethics, Jan-March 2005, 13(1).
11. Retherford RD and Roy TK. Factors affecting sex-selective abortion in India. NFHS Bulletin no. 17, January 2003.

12. Pande R and Malhotra A. Son preference and daughter neglect in India. What happens to living girls? Washington, International Centre for Research on Women, 2006.

Two groups read papers related to access to safe abortion in India and two groups read papers related to sex-selective abortions. The groups were allotted readings as follows:

Group 1: Paper 1, 2, 3 are about the situation about access to Safe abortion
Group 2: Paper 4, 5

Question for Groups 1 and 2: What is the situation around access to safe abortion in India?

Group 3: 6, 7, 8
Group 4: 9, 10, 13
Group 5: 11, 12

Questions for Groups 3, 4, and 5: What is the situation related to sex selective abortions in India? What has been the role of Legislation or laws and campaigns against it in preventing it?

DAY 3

The first session on the third day still carried the previous evening's discussion forward. Participants had mulled over the confusing and troubling issues and stated:

- We do not believe in denying an abortion to a woman who needs it and is eligible as per law of the country.
- We do not accept sex selection as a valid indication.
- Denying abortion on the basis of merely suspecting sex determination is very wrong.
- Stop misuse of technology.
- Doctors must engage in the larger community.
- Change in the mindset of community is crucial. We need to look at patriarchy.

There was a discussion on how a doctor can get involved in identifying a place for sex-selection without interfering with abortion.

- When we report on misuse of technology, we should report the place and not the woman's name.

- As far as possible we should try to provide services – within the MTP purview.

Another issue discussed was the role of right wing forces and religions in reinforcing patriarchy and limiting women's rights. Participants spoke about the recent attacks on young girls in Bangalore and Mangalore by the right wing Hindutva groups to control their mobility and freedom. Participants were beginning to see the links between Patriarchy, Sex Selection and forces like the right to life campaign that could jeopardize women's access to safe abortion services.

Session 9: Contemporary Challenges in Access to Safe Abortion – facilitated by Sundari Ravindran and Renu Khanna

The objectives for this session were for the participants to

- Grasp of the literature on the challenges to accessing safe abortion services in India
- Understand issues related to sex-selective abortions in the Indian context: extent of the problem, causes, strategies adopted to reverse the trend
- Think through the implications for access to safe abortion of the campaign against sex-selective abortions

Participants had read through the papers assigned to them overnight. Each group met and worked on preparing a presentation of about 7-8 minutes, responding to the following questions: (a-b) for groups reading on access to abortion and (c-d) for groups reading on sex-selective abortions.

a) *What is situation with respect to access to safe abortion services in India today? What are some major barriers to access? Which groups are most affected?*
b) *What are the likely health consequences of lack of access to safe abortion services?*
c) *What are the dimensions of the problem of sex-selective abortion?*
d) *What some of the policies and interventions through which the campaign against sex-selective abortion seeks to prevent the selective abortion of female fetuses?*

The session started with presentations on the scenario: first, issues related to access to abortion, and then, issues related to sex-selective abortions. Each presentation was followed by a brief discussion and unresolved issues were flagged and tabled for further discussion.

The readings and presentations led to an overview understanding of the complex issues and current debates surrounding Access to safe Abortion Services and Sex Selection and Declining Sex Ratio. Within a short span of time, the participants were acquainted with some of the classic articles related to these issues.

Session 10: Safe Abortion <u>within</u> the RCH-2 programme of the NRHM – facilitated by Sharad Iyengar

Sharad Iyengar gave an introduction to the GOI's Family Welfare Programme, which became the RCH-1 Programme following the ICPD. Abortion was included into the RCH-1 Programme. Central Government money has been provided to the states for implementing the RCH Programme. The Guidelines and protocols heave also been coming form the centre. The second phase of the RCH Programme (RCH-2) has further emphasized MTP and provision of Safe Abortion Services.

The NRHM was started with the UPA Govt. in 2005 and is meant to be an umbrella program in rural area, included lowering of maternal and child mortality and control over fertility.

The NRHM has therefore taken under its wing the RCH Programme although the RCH Programme came earlier and has a few donors involved (<15% other from national budget) has a lot of autonomy and independent decision-making.

Sharad showed the participants the States' report of MTP to GOI, 2002-05. Underreporting and misreporting is major feature of these reports. If we look at 'Distribution of MTP Cases by Reasons', we see that failure of contraceptives is a major reason.

He then gave a group exercise to three groups. Look at the PIPs of 3 states. MP, Chhattisgarh and Gujarat. What is the state's commitment to MTP? Look at the Goals/Objectives, Strategies to increase access to safe abortion, Interventions/Activities, Budget.

He asked the participants to use 'find' command with MTP, read through those sections and prepare their reports. Then the National PIP would be examined and finally leach state would be looked at in detail.

The session was insightful – participants learnt that there is such a thing as state PIPs and other state and national level documents that we can study and analyse to see what attention is being given to the agenda of provision of Safe Abortion services.

Session 11: An Overview of Advocacy - facilitated by Suchitra Dalvie

Her presentation covered 'What is Advocacy? Why is it needed? How do you plan for advocacy, who will you reach out to?' She highlighted the steps in Advocacy:

- Identify problem, gather information, make a decision, plan take action and evaluation – then take it back to problem (new information).
- Who are your partners / public health policy makers/your allies?
- Who will you be working against? Your opposition?
- Fence sitters - Who may come on to your side? She cautioned that the opponent is not your target; they are gatekeepers of patriarchal system.
- Focus on the targets – who is actually likely to give you what you want? Professionals, religious leaders? She emphasized that it is strategic to join hands with organizations groups, create a broader coalition – to whom you don't have access to but they do.
- For optimum utilization of resources find some way of evaluating success. Focus energies at the circles you influence.

Sharad and Suchitra then discussed organizations and networks working on Safe Abortion Issues with whom participants can align.

- PSI
- FPAI
- ASAP (www.asap-asia.org)
- Safe Abortion Consortium (donor initiated, includes ARTH, CEHAT, SOMI, FPAI-Tonk, IPAS- Aurangabad, FOGSI, Population Council- OR-MVA and Med abortion).
- Safe Abortion Consortium and CommonHealth – together for Safe Abortion Campaign. CEHAT is the national secretariat.
- Any donor—medical abortion, funders, e.g. SIDA, Packard Foundation, Buffet , DFID, Government, Gynuity Health project- willing to work on medical abortion in collaboration.

End of Day 3 – Feedback from the participants indicated that they wanted consolidation on what is the 'common ground'. They felt that good issues were covered – NRHM, RCH-2, PIPs etc.

DAY 4

In response to the plea for the participants for a discussion on clarification of personal values, Renu and Leila shared their own perspectives on Safe Abortion and Sex Selection. While Renu's was a verbal presentation, Leila's was a graphical display of the root cause analysis (See annexure 7) again the discussion and debate went on for sometime with participants struggling to come to a resolution, both at a personal level and also collectively as a group. The resource persons reiterated that at this stage it is a personal call for each person – for some individuals the thinking and position may evolve and we have to be okay with this.

Session 12: Communication on Sex Selection, PCPNDT Act and Safe Abortion – facilitated by Renu Khanna

ARTH's collection of posters on these topics were divided amongst the participants and they were asked to critique them. The discussion was animated. Participants learnt from each other both critique of the intended messages as well as the visuals and design. The communication and design expert in the group, Lakshmi Murthy raised some very valuable questions and shared insights on design.

Session 13: An exercise on Advocacy – facilitated by Renu Khanna

Participants listed the constituencies to whom they want to advocate. In small groups they had to decide on their advocacy message for the constituency that they considered important, decide on a method and a medium (poster, press conference, TV show, street theatre etc.) and execute the advocacy initiative.

From amongst the rest of the participants a jury panel was nominated to provide feedback on each group's advocacy presentation. This way all participants got an opportunity to critique.

Group1 Constituency selected - Rural Adolescents. They developed and enacted a role play on an adolescents' girl-boy relationship, leading to an unwanted pregnancy, an unsafe abortion and the untimely death of the girl. The feedback was as follows: The play was excellent – it demonstrated ignorance about contraception among the young adolescent couple.

Some suggestions for improvement by the jury members were as follows:

- Be clear about your audience and what specific message you want to communicate. Rural adolescents is okay but we need a clearer profile –

who among them? Unmarried adolescent girls and boys? We need to differentiate the group. What was the purpose? Avoid premarital sex? Have safe sex? Different messages for girls and boys? How to negotiate and assert yourself for girls? And for boys?

- The play can be used in several innovative ways. You can break the play at critical points and invite audience participation through specific questions like 'if you were the girl and this friend is pressuring you to have sex, what would you do?' 'You realize that you are pregnant, what are the options available for you?' 'If you were the boy what would you have done?' 'What can the mother do?' 'What can the health care provider do?'

- Participants in the audience can either be invited to enact out different options or they can be involved in discussion.

Group 2 Constituency selected - Urban Providers.

This group developed a poster on Safe and Legal Abortion to be put up in the health care provider's facility entitled 'Your Duty, Her Right'. The messages were in the form of a pyramid. There was a discussion on 'Why a poster?' It was felt that the same message could be put on a desk calendar.

The jury declared that the poster was very good and it was felt that the Coalition could produce it as one of its own advocacy tools.

Group 3 Selected constituency - Media.

This group of two persons worked on a Press Note to be presented at a Press Conference. The Press Note was on – Declining sex ratio is a problem – it will increase Violence against Women. Girls are still discriminated against – they are deprived of education, dowry continues to be a problem.

The Press Note also talked of unsafe abortions, and that safe abortions are provided for under the MTP Act. There is a need to identify where sex selection and sex determination is done as this is the height of discrimination. We should play our role with responsibility so that women's/girls' dignity is upheld.

The Press Conference was called to speak with journalists about these issues - about gender discrimination, patriarchy, sex selection, safe abortion, and the media's role in responsible reporting, sensitizing them about using the right words (e.g. Do not use foeticide, bruhn hatya')

This group also used some posters produced in Rajasthan with changes in the language based on the morning's critique.

The feedback from the Jury was as follows:

- Please put your long educative press note as a feature article on Sunday. The Press Note should use a current event as a peg.

- You could use the Press Note to comment on the political parties' manifestos in the event of the impending elections. This will enhance the printability.

- Simple language that was used was good for media.

- The jury commented that the posters used to sensitise the media were problematic – they give the pregnancy a Personhood.

- All of them had antiabortion message.

- The message on the poster says let "her" grow and develop… there is a presumption that it is a girl—how do we know, it can also be a boy baby?

- We must do away with this bias in our work on PCPNDT – the fetus is of unknown gender

- Your content covered too many issues for us the press - concentrate on one issue or a few issues - what do we take with us?

Group 4 Selected constituency – District & State Health Officials

The Coalition for Gender Equality have read a press report and are going to do a TV Interview with Director, Family Welfare. The Director does not want to handle the press alone and calls in the PCPNDT Director. The interview cannot proceed forward, there is practically no dialogue. The Coalition puts the government officials on the defensive.

The jury comments:

- Message is confusing – adolescent is beaten up, unsafe abortion, other things also brought in – the message does not come through. The message was "Family Counseling Centre and Adolescent Friendly health services and MTP centers are not available for girls.'

- Confidentiality is being violated. Should not mention the name of the victim.

- You were not doing advocacy. Your head on attack put the government officers on the spot. This is activism and not advocacy, activism ends up making the other side adversaries. We need to differentiate between advocacy and activism.

Group 5 Selected constituency – women's group. Low literacy. Rural area.

Message – Safe Abortion, Prevention of Sex determination and sex selection.

The group created catchy slogans. They showed a poster of a woman signing a paper. The slogans were 'Sarkar ne dee hai 20 hafte ke liye anumati, mahila bhi khud sabal hai zaroorat nahi hai, dastakhat ke liya pati'.

The jury suggested some language changes, eg. Garbh samapan for MTP, Instead of Dastakhat, sahmati may be better

They also pointed out that the slogan excludes unmarried women by using the word pati – we may need another one for unmarried women.

Group 6 Selected constituency - Men

This group created a Radio Jingle for men to urge them to take responsibility – take the wife to the doctor, discuss with doctor that the sex of the next child is of no consequence – I will support my wife no matter what the outcome and be a buffet between her and my mother.

The jury said that there is need to be careful – the message appears to be that women are the ones who want sex selection – and men don't.

Session 14: Developing Advocacy Plans – facilitated by Leila Varkey

After this extremely energising session the participants were asked to develop **Advocacy Plans with** members of their group/organization.

- What is the issue you want to work on?
- What is the expected outcome?
- What are the activities?
- How will you evaluate the outcome?

It was generally agreed upon by all the participants that they need to look at the issue of abortion in a more holistic manner and in fact raised a demand

to have similar workshops across various regions of India and involve a greater variety of stakeholders/ constituencies in future workshops.

CONCLUSION

The course was drawn to a conclusion by summarising the Common Ground as follows:

We all agreed that

1. Gender issues are important
2. Gender discrimination exists
3. The rights based approach is non negotiable
4. Sexual and reproductive rights are integral to the fulfillment of Human Rights
5. We are beginning to understand that sex selection is a complex issue and that the PCPNDT Act may be only one of the ways of tackling it.
6. PCPNDT and MTP Act knowledge is important. We learnt about its implications, its limitations and barriers to its implementation.
7. Knowledge of the technology used for MTP and pre conception pre natal diagnostic techniques is useful and also helps us gain insight into the fact that technology in itself is value neutral and that 'misuse' is interpreted depending on who is looking at it !

We are gaining clarity on

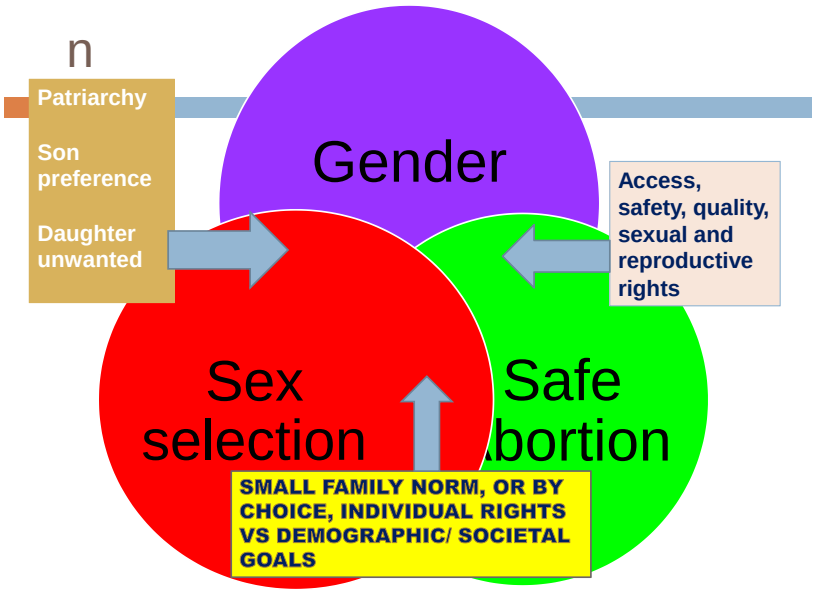
8. What can constitute a rights violation…..tracking pregnant women?? Two child family norm?? Policies of the government with incentives and disincentives which affect only those who are not so well of i.e. social justice issues
9. Doctors are parts of the community so why single them out for accountability and intervention? Short term and long term strategies are needed.
10. Where do individual rights end and who decides that? Can demographic goals and individual rights be in conflict?
11. How do we handle adolescent sexuality and the need for access to safe abortion services?

We touched upon these issues again and realize that these are areas which require much more in depth discussion which involves macroethics and microethics and many other dimensions beyond the scope of this workshop

The role plays left us thinking from the perspective of the individuals involved—women, their families, the doctors and other healthcare providers.

But also made us think about the big picture and suggest strategies to address the issue at both levels.
Finally we agreed that

- We do not believe in denying an abortion to a woman who needs it and is eligible as per the law of the country.
- We do not accept a female fetus identified through sex selection as a valid indication for an abortion by itself.
- We do however understand that denying a woman for fear of consequences just by suspecting her of having done a sex selection is not rational and may lead to a denial of safe services.



The course concluded with an evaluation by the participants and distribution of certificates.

A summary of the evaluation by the Course Coordinators has been presented below:

The Course went off amazingly well, given the challenges and the odds. The participants' diversity was great – the range of perspectives represented were very useful.

Needed a Course Coordinators meeting at least week before the Course- recognize a gap in the structuring of the sessions and how they flow into each other.

Redo the Sex Ratio session – give about 1/3rd time to definitions and concepts. Spend more time on what's happening to demographics, finer nuances e.g. later parity. Give readings before the session. Ask participants to do the analysis as an exercise.

The RCH and NRHM Session - the Group work on PIPs was not necessarily needed. The analysis was needed to check out the PIP to see how this is reflected in State PIPs.

Too much content on Day 3. Also all the methodologies used by the resource persons added value for the proceedings.

Must have ice-breakers ready. Mid workshop social evening event should be planned.

Value clarification: Role play then readings was what was done, Are there other ways of doing it? Could do more with posters (visuals review) for values clarification.

Readings were more like historical documents, although they were classic articles – Participants liked to have something more recent– e.g. NFHS-3.

Logistics was an issue among participants.

Follow-up: Ask to collaborate with the State players, and inform coalition members, the participants and what they are doing

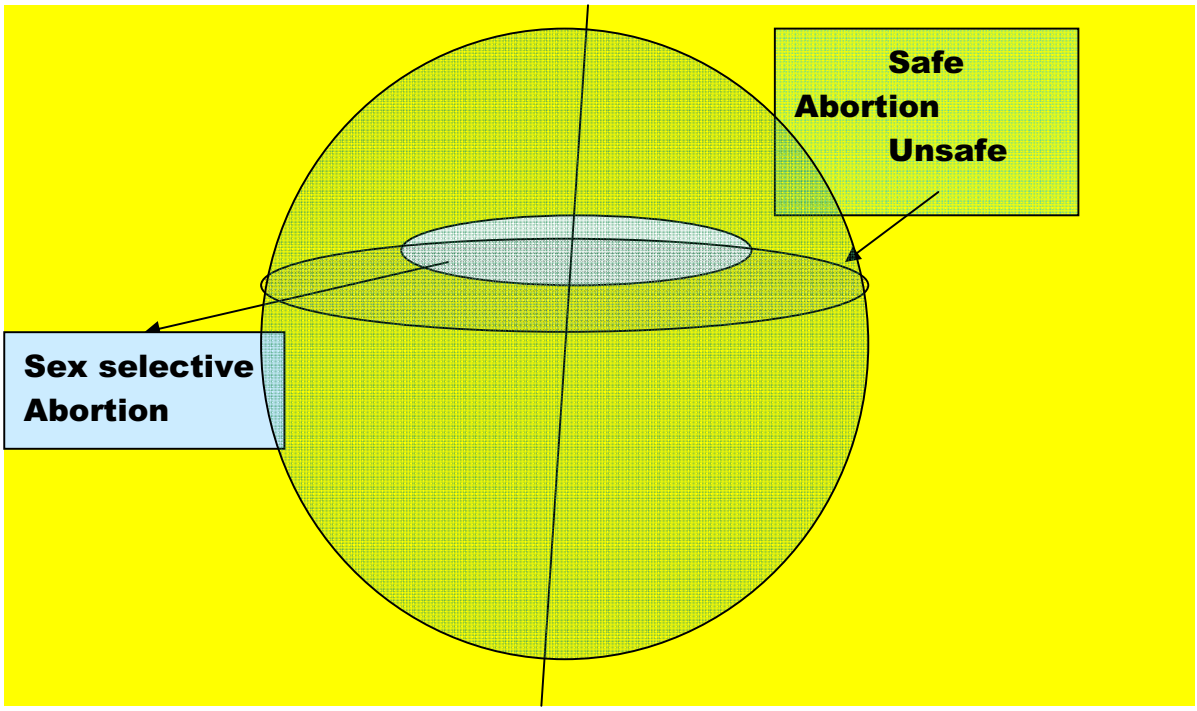
Document the session outlines and design, learnings from the workshop as a resource for future training.

Bring in other resource persons as observers and experts for giving feedback.

Issues divided into 3 categories – Proximal to Distal

Immediate (Proximal)
Methods to comply
Root causes (distal)

Venn diagram of the interrelationships



Annexure 1: List of the participants

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18.	Sangeeta Mecwan	SAHAJ Sishu Milap	13, Krishna Society, Haribhakti Extention Colony, Old padra Road, Vadodara- 390007	Vadodara	sahaj_sm@yahoo.co.in	9898076529 0265-2358307 (O)
19.	Dr. Sanjay Patil	Population Services International	18 Kumjai Cooperative Society, V.P.Road, Khotachi wadi, Girgaum, Mumbai-400004	Mumbai	spatil@psi.org.in	9920036191
20.	Satya	LEPRA Society	Lepra Society, Sakhyam, 94 Khervela Nagar, B.B.S.R, Bhubaneshwar, Orissa	Orissa	sdev_here@yahoo.co.in	9861663352
21.	Dr. Shilpa Shroff	Asia Safe Abortion Partnership (ASAP)	A-1001, Matoshree Towers, P.T. Marg, Mahim, Mumbai-40016	Mumbai	shilpa_desai@yahoo.co.in	9821076210

Sl. No	Name	Organisation	Address	Location	E-mail	Contact
22.	Snehal Velkar	CEHAT	Aram Society Road, Vakota Pipeline, Santacruz, Mumbai	Mumbai	velkar.snehal@gmail.com	9821792728
23.	Sonvi Kapoor	International Centre for Research on Women (ICRW)	C-139, Defence Colony New Delhi-110024	Gurgaon	skapoor@icrw.org	9999790133, 46643333/ 24654216/ 17 (O) 24635141(O)
24.	Sunita Gandhi	Sanwad	At- Mirjoli Tal Post, Chiplun, District Ratnagiri-415605, Maharashtra	Maharashtra	sunitavspindia@yahoo.in	9423278324
25.	Veena Sinha	Department of health, Government of M.P (PCPNDT Cell)	Department of Health and Family Welfare, Government of MP, E-109/11, Shivaji Nagar, Bhopal	Madhya Pradesh	hemant-veena@gmail.com	9425167877

Annexure 2: Course Schedule

Day 1: Monday, 13th April		
Time	**Details**	**Resource Person**
9-9.30 am	Registration	
9.30 – 11.00 am	Welcome, About CMNHSA, Introductions and Objectives Process Diary	TK Sundari Ravindran & Suchitra Dalvie Leila Varkey
11-11.15 am	Tea Break	
11.15-1.00 pm	Gender, Sexual and Reproductive Health and Rights and Abortion	Renu Khanna
1-2 pm	Lunch	
2-3.30 pm	Case studies and film	Renu Khanna
3.30-3.45 pm	Tea Break	
3.45-4.45pm	Case studies and wrap up	Renu Khanna
4.45-5.30 pm	Technical update (Pregnancy test, Emergency Contraception, methods of Abortion, methods of sex selection)	Suchitra Dalvie
	Home Work - reading on sex-selection and safe abortion	TK Sundari Ravindran
Day 2: Tuesday, 14th April		
9-9.15 am	Review and preview	Renu Khanna
9.15-10.15 am	MTP Act	Sharad Iyengar
10.15-10.30 am	Tea break	
10.30 -11.30 am	PCPNDT Act	Leni Chaudhari
11.30-1.00 pm	Understanding the sex ratio Discussion	Sayeed Unissa Renu Khanna
1-2 pm	Lunch	
2.00-5.15 pm with tea break	Current debates : safe abortion and sex selection (Presentation based on readings of the	TK Sundari Ravindran

	previous evening) Values Clarification	
	Home Work—readings	TK Sundari Ravindran
Day 3: Wednesday, 15th April		
9-9.15 am	Review preview	Suchitra Dalvie
9.15-10.45 am	Values clarification continued	TK Sundari Ravindran
10.45- 11.00 am	Tea break	
11.00-12.00 pm	Barriers to access and role of RCH-2 and others	Sharad Iyengar
12.00- 1.00 pm	Overview of other campaigns and initiatives	Sharad Iyengar
1:00 pm-2:00 pm	Lunch	
2.00-3.00 Pm	Overview of advocacy process	Suchitra Dalvie
3.00- 4.00 Pm	Developing Advocacy Messages (A letter to the Editor, press release, etc).	Leila Varkey
4:00-5:30 Pm	Presentations and feedback on Advocacy Messages	Renu Khanna
	Home Work-Group work to develop street plays, slogans, posters & Power Points (Developing 5 key messages for their constituency -Community, media, policymakers, health care providers)	
Day 4: Thursday, 16th April		
9-9.15 am	Review preview	Suchitra Dalvie
9.15 -10.30	Presentation of group work	Renu Khanna
10.30 -10.45 am	Tea break	
10.45-12.15 pm	Developing advocacy action plans	Leila Varkey

12.15 -1.30 pm	Presentation of action plans	Leila Varkey
1:30-2:15 pm	Lunch	
2.15 -3.30 pm	Coalition's plans from Members' meeting about Abortion and sex selection campaigns – reporting and finalizing	Suchitra Dalvie Renu Khanna
3.30- 4 pm	Closing	Suchitra Dalvie & Renu Khanna

Annexure 3: Reading Material

Session: Gender, Sexual and Reproductive Health and Rights and Abortion

1. Religious Fundamentalisms in India: the impact of Hindu fundamentalism on sexual & reproductive health rights. Jashodhara Dasgupta.
2. ''Yes'' to Abortion but ''No'' to Sexual Rights: The Paradoxical Reality of Married Women in Rural Tamil Nadu, India. TK Sundari Ravindran,a P Balasubramanianb
3. Induced Abortions Among Adolescent Women in Rural Maharashtra, India. Bela Ganatra a, Siddhi Hirve
4. Sowmini Report.
5. Abortion needs of women in India: A case study of rural Maharashtra. Manisha Gupte, Sunita Bandewar, Hemlata Pisal
6. Critical Review Papers on Abortion: Sundari.
7. Making Safe Abortion Accessible: A Practical Guide for Advocates. Charlotte E. Hord. IPAS
8. From Rights to Reality: How to Advocate for Women's Reproductive Freedom Worldwide. Centre for Reproductive Rights
9. The Troubled Context of Human Dignity: women's engagements with patriarchy, community and conflict in south Asia. Kalpana Kannabiran
10. Rights Based Approach to Reproductive Health. Outlook Volume 20, Number 4, December 2003.
11. Proposed Amendments to MTP Act, 1971
12. Safe and Legal Abortion is a Woman's Human Right. Briefing Paper.
13. Safe Abortion Policy: A Public Health Imperative. Briefing Paper.
14. Human Rights, Unwanted Pregnancy & Abortion Related Care. Reference information and illustrative cases. IPAS.
15. CESCR, The right to the highest attainable standard of health: 11/08/2000.

Session: Technical update (Pregnancy test, Emergency contraception, methods of Abortion, methods of sex selection)

1. Article: Prenatal Sex Determination Female Foeticide and Infanticide. Tabasum Parvez.
2. Abortion policy and the economics of fertility. Levine PB (Abstract).
3. The Global Gag Rule and maternal deaths due to unsafe abortion Population Action International (Abstract).
4. Consolidated reply Solution exchange: http://www.solutionexchange-un.net.in/health/cr/cr-se-mch-13020901.htm

Session: MTP Act

1. Legal Update, MTP (Amendment) Act and Rules, 2003.
2. MTP (Amendment) Act, 2002
3. Form A
4. Form B
5. Form C
6. Form I
7. Form III
8. Form II
9. Chapter 4 Summary, Legal and Policy Considerations (Safe Abortion: Technical and Policy Guidance for Health Systems).
10. Berer, Marge, Making abortion safe: a matter of good public health policy and practice. Reproductive Health Matters 2002.

Session: PCPNDT Act

1. From the abnormal to normal: Preventing sex selective abortions through the law. Asmita Basu

Session: Understanding the sex ratio

1. Factors influencing the use of prenatal diagnostic techniques and the sex ratio at birth in India. PN Mari Bhatt, AJ Francis Zavier.
2. Improving the child sex ratio: Role of policy and advocacy. Leela Visaria.

Session: Current debates: safe abortion and sex selection

1. Abortion of Female Foetus: Is legalization the answer. Madhu Kishwar.
2. Son Preference and Daughter Neglect In India. Pande R and Malhotra A.
3. Abortion Law, Policy and Services in India: A Critical Review. Hirve SS.
4. Abortion and sex determination: Conflicting messages in information materials in a district of Rajasthan, India. Nidadvolu V and Bracken H.
5. Female deficit in India: Role of prevention of sex selective abortion act. Visaria L.
6. Exploring the ethics of induced abortion. Indian Journal of Medical Ethics. Bandewar S.
7. Sex selection: Ethics in the context of development. Indian Journal of Medical Ethics. Madhiwalla N.
8. Factors affecting sex-selective abortion in India. NFHS Bulletin. Retherford RD and Roy TK.
9. Understanding induced abortion: Findings from a programme of research in Rajasthan, India. New Delhi, Population Council, September 2004.
10. Availability and access to safe abortion services in India: Myths and

realities. Paper presented to IUSSP Conference. Khan ME, Barge S and Kumar N.

11. Case studies from Bokaro district, Jharkhand. Mumbai, CEHAT, Abortion Assessment Project, India. Barnes L.
12. Duggal R and Barge S. Abortion services in India: Report of a multicentric enquiry. Mumbai, CEHAT, Abortion Assessment Project, India. Chapter VI. Utilisation and accessibility.
13. Factors affecting Sex-selective abortion in India & 17 Major States. Robert D. Rethweford & T.K Roy. (Only in the CD).

Session: Barriers to access and role of RCH-2 and others

1. NRHM National Programme Implementation Plan (NPIP) 2007-2008

Session: Advocacy process

1. Advocacy (Handout)
2. Chapter 6 Advocacy Strategy and Planning

Session: Developing Advocacy Messages

1. Media Advocacy Manual, American Public Health Association, Washington.

General Readings

1. MAPEDIR-Maternal and Perinatal Deaths: Enquiry and Response in India.

Annexure 4: List of Power Point Presentation

1. Abortion as a Gender and Rights Issue, Renu Khanna.
2. Contraception Update, Dr. Suchitra Dalvie.
3. Medical Termination of Pregnancy, Dr. Suchitra Dalvie.
4. Medical Termination of Pregnancy (MTP) Act (1971), amended 2002, Sharad D. Iyengar.
5. Pre Conception and Pre Natal Diagnostics Techniques (Prohibition of Sex Selection Act) 1994, Leni Chaudhuri.
6. Prenatal Sex Determination, Dr. Suchitra Dalvie.
7. Understanding the Sex Ratio, Prof. Sayeed Unisa.
8. Safe abortion within the RCH2 Programme of the NRHM, Sharad D. Iyengar.
9. The Universe of Advocacy, Dr. Suchitra Dalvie.
10. Gender, Sex-selection and Safe Abortion: Linkages, Leila Caleb Varkey

PERSPECTIVE BUILDING EXERCISES:

11. National PIP extract: Enhance availability of facilities for institutional deliveries and Emergency Obstetric Care (EmOC).
12. Quiz on legal aspects of abortion.
13. Values clarification: Role plays debriefing.
14. Service delivery System: Abortion Services Programme flowchart.
15. Poster exercise: From the perspective of Gender, sex selection, abortion.

Annexure 5: Evaluation Form

Instructions:
Your feedback will be used to assess the overall effectiveness of the workshop. Please check the appropriate boxes that best represent your rating. Thank you for participating in the CommonHealth workshop.

WORKSHOP TOPICS AND DISCUSSIONS

1. The subjects were chosen well.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

2. The presenters were very knowledgeable.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree
☐ Not Applicable

3. The design of the presentations was most appropriate.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

4. The resource materials were very useful.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

5. Comments: _____

_____

_____

PERSONAL VALUE

6. I gained new knowledge and insights.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

7. The quality of my work will be enhanced as a result of participating in the workshop.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree
☐ Not Applicable

8. I am satisfied with the opportunity I had for participation.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

9. The amount of interaction between the participants and the presenters was ideal.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

10. Informal conversation with other participants and resource persons were beneficial.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

11. Comments: _____

_____

_____

ORGANISATION & COORDINATION

12. The programme was well organised and coordinated.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

13. The length of the programme was appropriate.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

14. The length of the individual sessions was useful.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

☐ Not Applicable

15. Comments: _____

_____

_____

16. The topic most valuable to me was … why?

_____
_____
_____

17. The topic least valuable to me was … why?

_____
_____
_____

18. The future sessions of this workshop, I would like to have the following areas covered:

_____
_____
_____

19. Other suggestions which I feel would improve future workshops are:

_____
_____
_____

Annexure 6: Quiz on the MTP Act

Name **Organization/Place**

Date

1. Which of the following providers can be trained to legally terminate a pregnancy In India?
   a) MBBS
   b) MD, Pediatrics
   c) M.D Gyne
   d) *Dai*/Birth attendant
   e) Ayurvedic Doctor
   f) Village practitioner
   g) ANM
   h) DGO

2. Which of the following places can be authorized under the Act, to carry out pregnancy termination?
   a) District Hospital
   b) *Aanganwadi* Centre
   c) Community Health Centre
   d) Private Hospital
   e) Sub-centre
   f) Provider's Place
   g) PHC

3. List some circumstances/ reasons under which a woman might seek abortion from untrained/ informal provider

   1. _____

   2. _____

   3. _____

4. Under which Act has termination of pregnancy been permitted in India?
   a) Maternity Benefit Act
   b) MTP Act
   c) Protection from Domestic Violence Act
   d) PCPNDT Act

5. The Medical Termination of Pregnancy Act permits the termination up to the following duration of pregnancy:
   a) 2 months
   b) 25 weeks
   c) 20 weeks
   d) 6 months
   e) 1 ½ months

6. Which of the following are legally not permitted to undergo a pregnancy termination?
   a) Woman whose husband is away and she is pregnant
   b) Single or widowed woman
   c) Unmarried or divorced woman
   d) 45 year old married woman
   e) 14 year old girl

7. Pyari a 15 year old girl, was raped by some influential people of the village, while she was working as a labourer on a farm. When after 2 months Pyari showed signs of pregnancy, her sister accompanied her to a doctor at the government health centre for an abortion. Whose consent would be required for termination?
   a) Pyari
   b) Pyari's mother
   c) Pyari's father or guardian
   d) Doctor

8. Tapli was a 16 year old married adolescent of Rajasthan, whose *gauna* had not taken place, and she therefore stayed with her parents. A few weeks ago, her 18 year old husband came over to celebrate a festival. He followed Tapli when she went to fetch water, and they got close. They landed up having sex another 2-3 times until he left after the festival. Tapli became pregnant. Her parents took her to a private doctor for abortion. Whose consent would be required under the Act?
   a) Tapli
   b) Tapli's mother
   c) Tapli's father
   d) Tapli's husband
   e) Her mother-in-law or father-in-law

9. Sapna, a 19 year old girl, had an affair with Suraj. Her family did not know about her relationship and was actually looking for a suitable match for her. Since she was not feeling well for the last few days, Sapna went to the local nurse. After check up the nurse revealed that Sapna was pregnant. As per law what options does Sapna have?
   a) She cannot get an abortion because her relationship is illegal
   b) For safe abortion she can go to the sub centre or private Hospital
   c) She can go to a *Dai* and get the abortion
   d) She can go to the district hospital

10. Where must all pregnancy terminations be registered or reported, as per law? Tick all correct options
   a) Local panchayat or municipality
   b) Hospital
   c) *Aanganwadi* Centre
   d) Sub-centre
   e) Govt primary health centre, CHC or hospital
   f) District Health Office

11. Namrata was 26 years old. While preparing for an all India competitive examination, she got married to a bank officer. Namrata wished to resume preparation for the examinations, but her parents-in-law were conservative and did not want her to study further and work. Her husband argued that she did not need to work as he was earning sufficiently well. This soon led to frequent arguments in the home. When Namrata became pregnant about 8 months after marriage, she decided that she did not want the pregnancy and shared this with her family. Much against the wishes of her husband and parents-in-law, she visited a doctor. The husband and his mother too reached there and informed the doctor that Namrata had been quarrelling frequently of late, was behaving erratically, and was mentally unsound. The husband also threatened to

complain to the police of the doctor carried out an abortion. In this situation what can the doctor do?

a) The doctor should rely on the family's statement and send Namrata back
b) The doctor should ask for a medical certificate indicating that Namrata has a mental illness
c) The doctor listen to Namrata in private, and counsel her based on an assessment of her situation
d) The doctor should agree to carry out an abortion only if the husband also gives consent

12. Sujata, a 25 year old unmarried girl was raped by a colleague at the BPO unit where she worked. On missing a period, she went to a doctor for abortion. As per law whose consent was required?

a) Sujata's b) None c) Father d) Police

13. Under the MTP Act which institutions need to be registered?

a) Private Hospital
b) Charitable hospital run by government recognized NGO
c) Government Hospital
d) No registration required
e) Government sub-centre
f) Government Community Health Centre

14. Which authority can register a hospital for carrying out abortions?

a) *Zila Parishad* b) State Directorate of Health
c) District Committee d) Panchayat
e) District health office

15. Ramesh is a father of 4 daughters, wants a son. He takes his pregnant wife to an ultrasonologist and asks for a sex test. After check up, the doctor tell Ramesh that he can go and celebrate, implying that a boy is on the way. Some months later, another daughter is born. Has there been a violation of the law in this case?

a) Yes b) No

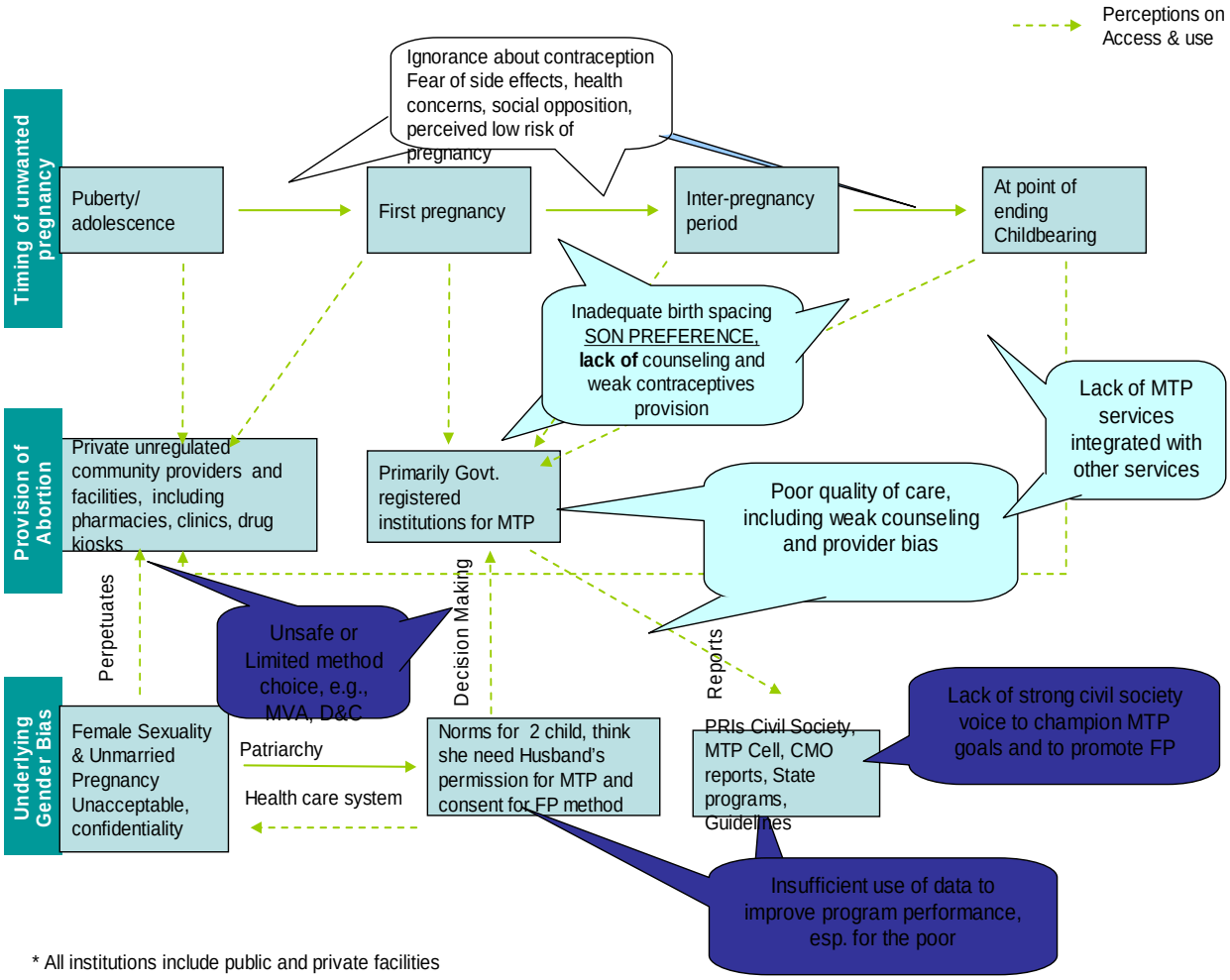
16. In your opinion how has the law been violated?

a) Asking for sex determination b) no violation of law
c) Performance of sex determination

17. MTP reports from licensed institutions is sent to the District Health & Family Welfare office on

a) Form I
b) Form II
c) On the letter head of the institution

Annexure 7: Potential Root Causes to Problem: Safe Abortion



* All institutions include public and private facilities