

Claiming the Right to Safe Abortion: Strategic Partnership in Asia Partner Report

Narrative Report: 1st January to July 2022

CommonHealth- India

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1. Introduction

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

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

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

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

India's health system has a significant presence of both the public and private sectors. The public sector has three main divisions, central, state and local (or peripheral). At the central level, the Ministry of Health and Family Welfare is responsible primarily for policymaking, planning, guiding, assisting, evaluating and coordinating the work of the State health ministries. The Directorate General of Health Services (DGHS) in the states is the ultimate authority at state level; responsible for all the health services within its jurisdiction and locally, the district is the principal unit of administration. Each district is further subdivided into different types of administrative areas, called blocks. A network of primary health centres (PHCs), community health centres (CHCs) and rural hospitals (RHs) 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 (for specific conditions) 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 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 PHC 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.

In 2021, the Medical Termination of Pregnancy (Amendment) Act, 2021 was passed by the parliament. The amendments include enhancing the upper gestation limit from 20 to 24 weeks for special categories of women; stipulating opinion for termination of one provider for gestation up to 20 weeks and of two providers for gestation up to 20-24 weeks; relaxing upper gestation limit in cases of substantial foetal abnormalities diagnosed by a Medical Board; safeguarding identity of a woman whose pregnancy has been terminated except to a person authorised under any law for the time being in force and permitting the ground of contraceptive failure for termination to any woman and her partner. In the recent past several petitions had been received by the Courts seeking permission for aborting pregnancies at a gestational age beyond the present permissible limit on grounds of foetal abnormalities or pregnancies due to sexual violence faced by women. The government expects that amendments will increase the ambit and access of women to safe abortion services and will ensure dignity, autonomy, confidentiality and justice for women who need to terminate pregnancy.

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

India's population of more than 1.3 billion is beset with stark gender inequalities, economic inequalities and these are reportedly at their highest in the present decade. There are equally significant inequities in health as a result of socio-economic position, gender, and socially constructed vulnerability as in case of Dalits and Adivasis, persons living with physical and mental disabilities; those living with HIV and AIDS; internal migrants; and the elderly, among others [4]. India ranks 135 out of 146 in the Global Gender -gap Index for 2022, a steady decline from 108 out of 144 countries in 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 has been lower than that of *dalit* men by 6 years. Life expectancy of women in the *dalit* caste has been lower than that for women from other castes by as much as 14.6 years [4]. Women's health, particularly reproductive health has consistently been a cause for concern and public debate and the health outcomes of women from marginalised communities and poorer quintiles of the population continue to be poor.

Fertility has been steadily falling and was reported to be 2 in National Family Health Survey 5 (NFHS 5, 2019-2021) [12], with wide rural-urban variations and differences across states. The

proportion of elderly in the population is rising and the growing proportion of older women and men in the population has brought with it a new generation of SRH concerns (e.g. sexual health issues related to diabetes), which have not even begun to be acknowledged.

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

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

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

Though NFHS5 [12] reports that only three percent of pregnancies in the five years preceding the survey resulted in an abortion, almost half of the abortions (48%) were to terminate an unplanned pregnancy, 68% were terminated using medical method, only a fifth were in public sector and about 16 percent of these women had complications from the abortion. ^[1]_{SEP} These numbers however appear to be a significant under-estimate. A study documented that as many as 15.6 million abortions were performed in India way back in 2015 [6]. A majority of abortions (81%) were carried out using medication obtained either from a health facility or another source. Medical abortion over the counter is not legally allowed in India and is supposed to be available only on prescription. Fourteen per cent of abortions were reportedly performed surgically in health facilities, and the remaining 5 per cent were performed outside of health facilities using other, typically unsafe, methods.

There is limited availability of safe abortion services in public sector although all public facilities above the PHC level are approved MTP centres by law. However, these services do not exist even in well-functioning health systems such as Tamil Nadu (TN). As population control is no longer a concern in many states which have achieved replacement fertility, healthcare providers

no longer feel obliged to provide safe abortion services in the larger interest of curtailing India's run-away population growth. Inefficiencies exist in the private institutions too, given the overall lack in trained professionals and cumbersome approval and certification mechanisms that vary in different states.

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

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

1. The programmatic focus on and user preference for permanent methods of contraception has a major role to play. A little over 50 percent of women of the reproductive age 15-49 years used modern contraceptive methods in 2015 which increased to 58 percent in 2019-20 [12], of which 80 per cent women underwent sterilization [6]. Sterilization is the most desired method of contraception for many women (62% NFHS5), who have no experience or encounter with most spacing methods. The unmet need for contraception has shown marginal decline from 13 percent in 2015 to 9 percent in 2019-20 [12]. 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].

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]. There has been very little improvement in age at marriage. The median age at first marriage for women age 20-49 slightly increased from 19 in 2015-16 to 19.2 years in 2019-20.

2. More than 50 years of the family planning propaganda has firmly established the small-family norm among a vast majority of women, and at the same time, modern spacing methods of contraception are neither widely available, nor acceptable even when available. This leads to a large number of unwanted or mistimed pregnancies and the need for abortion. Lack of comprehensive sexuality education and lack of access to acceptable contraception makes abortion the only way to prevent an unwanted pregnancy, for many adolescents and young women.
3. Availability of safe abortion services is under threat because of the decline in the child sex ratio (0-6 years) [7] and the introduction of the POCSO Act. Programmatic emphasis on '*save the daughters campaign*' has impacted the provision of safe abortion services in most Indian states. Sting operations targeting providers of ultra-sound scanning and abortion services and consequent prosecution under the PCPNDT Act has created an atmosphere of fear among the providers to provide any abortion services, especially second trimester abortions. On the other hand, mandatory reporting requirement and possible legal implications have resulted in denial of services to the adolescent girls and

young women. Being a woman from poor and/or marginalized communities such as Dalit, Adivasis, or being single, adolescent, HIV positive compound the difficulties that almost all women face.

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

With the health crisis precipitated by the recent pandemic, women's access to safe and good quality services of the public health system, especially of marginalised and vulnerable women, is a challenge because of supply and service disruptions. With diversion of the public health system resources and case overload, even essential services have been relegated to the backseat. Reproductive health services such as contraception and safe abortion services have been completely neglected. A study conducted by Foundation for Reproductive Health Services, India estimated that during the peak of the pandemic in 2020, close to 24.6 million couples did not have access to contraception, resulting in about 1.9 million unintended pregnancies. In their estimate 1.2 million of these were likely to be terminated with more than half (0.6 million) were through unsafe methods resulting in additional 1425 maternal deaths.

The Medical Termination (Amendment) Act of 2021 allows termination to be done on the advice of one doctor up to 20 weeks, and two doctors in the case of certain categories of women between 20 and 24 weeks. It allows termination of pregnancy upto 20 weeks even in unmarried women to also terminate a pregnancy in the case of failure of contraceptive method or device. It recommends setting up of state level Medical Boards with a gynaecologist, paediatrician, radiologist/sonologist, and other members notified by the state government to decide if a pregnancy may be terminated after 24 weeks due to substantial foetal abnormalities. Finally, it stipulates that a registered medical practitioner may only reveal the details of a woman whose pregnancy has been terminated to a person authorised by law.

While the Act has a positive provision of reducing the number of doctors' opinions needed for abortions between 12 to 20 weeks from two to one, recommendations proposed in 2014 amendments to provide abortion services on demand up to 12 weeks have been disregarded and the increase of the gestational age from 20 weeks to 24 weeks remains conditional to women belonging to certain categories only. Replacing the phrase 'married women and her husband' in the clause for providing abortion services in case of contraceptive failure with 'women and her partner' is partially welcome as it encompasses those out of wedlock. But retaining this focus on the partner, excludes single women, especially sex workers. Use of gender specific term 'women' as against 'pregnant persons' excludes trans and gender non-binary persons. Setting up of medical boards remains the biggest concern as it violates service seeker's reproductive rights,

adds an unnecessary layer of third-party authorization, and creates a deterrent to service access owing to inevitable implementation challenges. The overall bill fails to consider abortion access as a right of the pregnant person and rather extends the discourse of service provision under eugenic and compassionate grounds at the discretion of medical professionals. The bill continues to be hetero-patriarchal in nature.

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

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

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

1.3 Introduction to the Organization

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 partners¹. 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.

¹As of August 2022, we have 50 institutional members and 305 individual members from around 22 Indian states.

2. Progress of National Advocacy

2.1 Completed activities

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

Activity <i>List key project activities that have been done so far</i>	Objective <i>What was the purpose of each activity?</i>	Achievement <i>What are the results</i>	Timeline <i>What was the initial time line? When was it actually accomplished? Were there delays?</i>	Process <i>What was the process involved for each activity? Example- meeting, proposal planning etc.</i>	Responsibility <i>Who was primarily responsible for each activity?</i>
Development & printing of knowledge products	To develop publications on emerging issues related to safe abortion services	<ul style="list-style-type: none"> - Two pagers were developed on the MTP (Amendment) Act 2021 Annexure 1 - Updated briefs & “Abort the Stigma toolkit” were translated Annexure 2 - Briefs on abortion access study findings were translated in State specific language - Proposal & tools for access to contraceptive practices study were developed Annexure 3 	Review and printing is going on as per need.	The MTP flyer was revised based on the recent amendments in the law. The CommonHealth members for awareness building and advocacy for Safe abortion rights use these IEC materials especially during the conduct of International Safe abortion day activities throughout the month of September.	Abortion theme lead, CommonHealth members and Co-ordinator
	To develop state specific briefs on findings of study conducted on access to safe abortion services during the pandemic for CommonHealth grassroots partners to carry out local level dissemination and state /district level advocacy	Development of 8 state specific 2 pagers for dissemination of access to abortion during the pandemic Annexure 4	Feb 2022, process was slightly delayed because of consultant’s personal emergencies	The consultant analysed the state specific data in coordination and consultation with the abortion theme lead and produced 2 pagers which were reviewed (by partners) and published and shared with the partners	Abortion theme lead, CommonHealth members, consultant and Co-ordinator
	To develop a user friendly fact sheet on Protection of Children	The final version of factsheet “ The POCSO Act and adolescent’s access to	July 2022. As per schedule	The factsheet was developed in collaboration with partners.	Abortion theme lead with partners (CJLS,

	from Sexual Offences (POCSO) Act and its implications for abortion services access amongst adolescents	abortion in India: Heightened vulnerabilities, health risks, and impact on their human rights” that highlights the legal framework and resultant barriers to sexual and reproductive healthcare, particularly abortion services, for adolescents has gone for printing			Hidden Pockets and CRR)
	To contribute to the development of 'Access to Safe and Legal Abortion: A Handbook on Abortion Laws for Healthcare Service Providers in India'	The Handbook was developed in consultation and feedback from both healthcare service providers, lawyers, scholars and activists working on issues of SRHR. The design and interface of handbook is demystifies the legal provisions, is interactive and accessible and will be a help to providers to navigate the updated legal and policy framework and increase reach of safe and legal abortion services for all pregnant persons. as possible. The handbook is also translated in Hindi.	The handbook was virtually launched on 13th July 2022 from 10:00 a.m. to 11:30 p.m.	The handbook was developed by Centre for Justice, Law & Society (CJLS) of Jindal Global Law School in collaboration with IPAS development foundation. CommonHealth as a network partner reviewed and provided feedback for the manual.	Abortion theme lead
	To contribute to the development of advocacy manual as a significant resource guide for advocacy strategies around abortion laws through an intersectional lens	Final draft of the manual “Access to abortion through an intersectional Lens: Challenges and recommendations: <i>An Advocacy Manual</i> ” is ready for printing. Being the first of its kind the manual looks at issues concerning access to safe abortions on ground from a holistic perspective rather than the singular lens of the MTP.	March 2022. It was completed on time.	The manual was developed in collaboration with partners. It is being translated in Hindi by CommonHealth	Abortion theme lead with partners (CJLS and IPAS)

Building of evidence	To conduct a qualitative study was conducted to explore and document women's reproductive intentions, the pathways they adopt to meet those, their preference for specific contraceptive and determinants of that preference; their use and experiences of contraceptive use including continuation and discontinuation and their reasons and consequences.	CommonHealth members conducted the Study "women's perception and experiences of contraception" in nine States representative of the five administrative regions of the country. Data from the qualitative study in nine States representative of five administrative regions of the country was analysed and report of the study was written. The study findings were disseminated in the recent ARROW partners meeting with SAIGE partners and recently at the CommonHealth General Body Meeting in June 2022. Report of the study is ready	Study completed in March 2022. Report completed July 2022, design and publishing is on going Annexure 5	Concept note was finalized in consultation with experts and Steering Committee members. Protocol was developed and was approved by Institutional Ethical committee of SAHAJ. Eleven partners across 9 states conducted the study in January 2022. A consolidated report was worked on based on the data from 9 states collected by CommonHealth partners/members is being published.	Abortion theme lead, CommonHealth members, consultant & Co-ordinator
Bringing together of key stakeholders and building synergies with other networks	To contribute to a course (Clinic) for law students on reproductive justice	A one-year long clinical course of reproductive justice, gender, and the law for law students in partnership with Jindal Global Law School. There is currently an absence of a curriculum on the subject of sexual and reproductive health and rights and the evolution of the reproductive justice movement. This course is expected to fill that gap.	March 2021 to March 2022	Clinic was conducted in partnership with Centre for Justice, Law & Society (CJLS) of Jindal Global Law School and Centre for Reproductive Rights. Topics were identified in consultation and sessions have been conducted. CommonHealth contributes to sessions on medical framework for abortion, laws affecting access at ground level and reproductive politics and policies- <i>Annexure 15: PPT</i>	Abortion theme lead with CJLS and CRR
	To contribute to symposium on global reproductive politics, reproductive justice and limits of law	Two panel discussions for inclusive deliberations directed at reimagining reproductive justice in India and globally through an intersectional framework of reproductive justice were conducted	May 2022	Topics and experts were identified with network partners to conduct panel discussions on "Reproductive justice: A discourse on centring access" and on "Decriminalising abortion: Towards a rights based approach".	Abortion theme lead and ARROW, CJLS, CRR, Rising flame, Sriti disability rights centre and Transcare
	To contribute to Universal periodic review of abortion status in India	A shadow report on "Decriminalisation of Abortion: A Shadow Report for India's Fourth Cycle Universal Periodic Review" was developed	June 2022	Consultations were conducted with network partners and report was developed and submitted. Annexure 6	Abortion theme lead and CJLS, CRR and Hidden Pockets
	To share evidence generated	Evidence and advocacy efforts shared at	As and when these	Partners and participants from different	Abortion theme lead

	through multi-partner studies in India and advocacy plan for claiming the right to safe abortion along on different platforms	ARROW's South Asia partners meeting and at workshops by Family Planning Association of India, CJILS, SAMA. Also at CommonHealth member general body meeting. Annexure: 7, 8 and 9 (PPTs)	were scheduled	regions / context shared their experiences, action plans for joint learning	with CommonHealth coordinator
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On-going Activities

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

Activity <i>On-going activities (any that have been initiated but the intended output is not achieved)</i>	Objective <i>What was the purpose of each activity?</i>	Achievement <i>Intended achievements of activity – what could be the results</i>	Timeline <i>What was the initial timeline for each activity to be complete?</i>	Process <i>What is the intended process involved for each activity?</i>	Responsibility <i>Who is primarily responsible for each activity?</i>
Development & printing of knowledge products	To develop publications on emerging issues related to safe abortion services	Article on impact of Roe vs. Wade on Indian abortion scenario is being written. Manual for service providers and advocacy manual are being translated in Hindi	Between mid-August to October 2022 – depending on product	CommonHealth members are writing the article in consultation with other members, experts and available literature. Some media personnel have expressed interest in publishing it.	Abortion theme lead, Project consultant, Coordinator
Capacity building of CommonHealth members	To build capacity of CommonHealth members in northern and eastern states to advocate for right and access to safe abortion based on the evidence generated and recent Amendments in MTP Act	The meeting for northern states has been finalised and logistics are being worked out. Proposal for eastern states has been received and is being reviewed.	The activity for northern states is proposed in October 2022 in Chandigarh. The activity for eastern states is planned in December and discussions will be taken up sometime in September 22	Proposal was sent by CommonHealth members from the States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Delhi and Chandigarh. Agenda was finalised in consultation, resource persons identified and now logistics are being finalised	Abortion theme lead, CommonHealth members/ CommonHealth coordinator
	To increase awareness of CommonHealth members about implications of global and national updates related to right to safe abortion and about amended MTP Act and its rules with a view to build capacity to strategise and advocate for right and access to safe abortion	An online session is planned for members/activists, advocates and other network allies	17 th August 2022	A CommonHealth member, an activist lawyer who advocates for right to safe abortion would be conducting the sessions. The project theme lead would anchor the session. The registrations are underway for the session. More than 80 registrations have already been recorded	Abortion theme lead, CommonHealth resource person and co-ordinator
Bringing together of key stakeholders and	To contribute to a course (Clinic) for law students on reproductive justice	Repetition of the one year long clinical course of reproductive justice, gender, and the law for	Dates are yet to be decided. Discussions are going on	Clinic as earlier, will be conducted in partnership with Centre for Justice, Law & Society (CJLS) of Jindal	Abortion theme lead

building synergies with other networks		law students in partnership with Jindal Global Law School.		Global Law School and Centre for Reproductive Rights.	
	To sensitize public health professionals (MBBS, BAMS, BTech/B SC nursing/Masters in social sciences etc) and CommonHealth members and its network members on recent developments with respect to MTP amendments and on the global context of abortion laws	A two-day symposium is scheduled in September 2022. In Panel 1, MTP Act, medical aspects of abortion, socio-cultural context and recent evidence in NFHS5 will be covered. In Panel 2, global aspects of abortion and their implication for access to safe abortion in India will be covered. This will be followed by a participatory workshop with MPH students of AMCHSS	28 and 30 th September 2022	Discussion and collaboration have been with Achuta Menon Centre for Health Science Studies (AMCHSS) of Sree Chitra Tirunal Institute for Medical Sciences & Technology to plan the sessions and engaging the stakeholders	Abortion theme lead, CommonHealth SC members & CommonHealth coordinator
	To increase awareness and build capacity of sex workers to improve their access to their entitlement to safe abortion services	A workshop is scheduled in August 2022 with SAHELI, the sex worker's network	23-24 th August 2022	Discussions have been conducted with SAHELI members, content, agenda and resource persons for the workshop have been finalised.	Abortion Theme Lead, CommonHealth co-ordinator , Resource persons, SAHELI network
Facilitate, mentor and support awareness campaigns	To provide mentoring support with regard to activities planned for Advocacy to mark International Safe abortion Day	Call for action for 28 th September advocacy events was sent out to members. Proposals have been received.	August – October 2022	CommonHealth sought proposals from CH members to conduct advocacy with different stakeholders in their region. These will be reviewed and members would be supported for conducting awareness and advocacy campaigns in their work area.	Abortion theme lead, CommonHealth members

Result 1: Capacity Strengthening and Linking and Learning

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

- a) Value clarification on abortion and related issues
- b) The lack of awareness among women and service providers on right to safe abortion
- c) Social stigma and norms amongst the broad range of actors affecting legislation and service and information provision related to abortion
- d) The use of conscientious objections to limit and prevent legislation, access to rights-based abortion services and information
- e) Poor quality of services as relevant in respective countries.

Indicators for 1.1

- I1. Number of national partners and target groups who claim to have an improved understanding on the identified areas of work (MoV 1 and 2)
- I2. Level of understanding of national partners and target groups on the identified areas of work has improved (MoV 1-3)

In line with the above indicators, please specify:

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

Yes. CommonHealth has been actively engaged in advocacy for safe abortion services in India for many years. One of the core activities of CommonHealth is to conduct capacity building workshops for different stakeholders and campaigning on access to safe abortion at both national as well as sub national level. During this reporting period it conducted online advocacy institute with its alumni on "Abortion gender and rights" in partnership with CREA. This year CommonHealth and CREA conducted a scoping and needs assessment study to understand training needs and also because it was venturing into newer regions. This institute had some members, especially from the North-eastern and Northern states especially Jammu and Kashmir who have till now not been actively working on the issues of abortion but wanted to know more and be active. The institute content and design was revised based on findings of the study and profile of participants who had registered. Given the need expressed by study participants for sessions on sexual and reproductive health and rights, special session was conducted on that. Number of participants in this institute was more and participants were more engaged than before as the design and content was based on their needs. The interactive sessions enriched their understating on the issues around safe abortion. Additionally, CH engaged with its partners on the planning the access to safe abortion study. Participant feedback and evaluation suggests that there was knowledge needs were met with to a large extent. There is better understanding of abortion as a gender issue and need for it to be seen as a service seeker's right as well of the enabling environment, specifically the legal environment (including the amended MTP Act) which has a major impact on service availability and access. Customised training / capacity building sessions are being planned for sex workers network.

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

- 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.

In the past CommonHealth has generated evidence on safe abortion, shared it at national as well as sub-national level and have collaborated with a range of stakeholders as well as other networks and movements for advocacy activities. During our participation in meetings and conversations with other allies we prioritized legal as well as socio-cultural issues for advocacy and areas where we can pro-actively engage in facilitating the advocacy process for safe abortion access for women. We have pro-actively taken up advocacy for legal and policy revisions and for availability of safe abortion services in public facilities with other like-minded organisations and networks.

In eight States CommonHealth has also studied the impact of COVID-19 on service access, especially for marginalized sections of population. Report of the study is ready and will be disseminated in second half of the year. Despite the COVID related restrictions, CH member CSOs and NGOs continue to raise the issues at different forums and conduct advocacy activities across states. The consistent participation of community and other stakeholders and media coverage indicate the presence of NGOs/CBOs in their areas of work and the trust of community and others towards the work, this is one of the great achievements of CH in building such capacities to outreach and extend support even in difficult times. Regional dissemination of this work is planned in Northern and Eastern States this year. Also dissemination of the study on contraception experiences and its consequences will be shared.

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

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

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

a) Evidence generation on abortion related issues in five countries

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

Indicators for 1.2

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

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

I3. Number of women in the intervention areas, including young women, 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

The change was reflected in the way the partners conducted the access to abortion services study during the pandemic. The study was conducted amongst the most marginalized women who were significantly more adversely impacted by the lockdown and inaccessibility of services. Nine partners conducted the study in eight states keeping in mind the restrictions and safe social distancing norms of that specific state. The study had also been reviewed and approved by CH steering committee as well as the IEC of SAHAJ. Similarly, the study on contraception experiences was conducted by eleven members / partners in nine states. Also, the International abortion day celebrations on 28th September since the launch of this project, are focused and stress on awareness of entitlements in the community and advocacy with the government policy and programme staff. CSO members engage community in advocacy and demands for entitlements being met by the local government.

- 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 the fact that CH partners many of who are working at grassroots as support for service provisioning and empowerment of women and communities are also participating in the evidence generation research and advocacy activities and help document the regional contexts of Safe abortion. They have been participating in the online webinars and meeting/consultations to keep themselves updated with the recent developments and contribute their thoughts and experiences at the

ground level. The research and deliberations helped partners understand the relationship between field realities and possible solutions and how access barriers can be addressed through various available mechanisms activated through advocacy efforts. Additionally, briefs and two pagers in English as well as regional languages based on the findings have helped partners and CH members understand the evidence base for advocacy. Continuous updates, posts in social media and blogs and articles (not necessarily of CommonHealth but any relevant ones) maintain the momentum of updation on emerging issues and evidence to address or counter those.

- 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 2021 plan is more realistic and practical based on partner competence and interests. First year experience of doing advocacy with member organisations also provided the clarity about individual member's capacity and areas of expertise. Implementation of the advocacy plan could thus be tailor made to the members' expertise. The impact of pandemic and the government initiative to amend the Act and review criminal laws in the country have made CH expand the scope of its advocacy content. Along with its allies and other movements and networks it has formed a loosely structured group to conduct this advocacy. Work on advocacy dimensions is shared by partner organisations of this group depending on their expertise. The sharing and peer review of work ensures accountability of work undertaken. Additionally, CommonHealth has constituted a Think Tank of eminent experts with varied profile who can contribute to advocacy related to sexual and reproductive rights and entitlements related to abortion.

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

11. 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;^[1] A Project Brief; 3. Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion in Nawada District, Bihar, India;^[2] A Project Brief ; 4. Safe Abortion: Knowledge, Perception and Practices amongst Urban Poor Women in Vadodara, Gujarat: A Study by SAHAJ & CommonHealth; 5. The Medical Termination of Pregnancy Act, India; 6. The Protection of Children from Sexual Offences Act and Provision of Abortion Services to young People: A Brief Note for Service Providers). Additionally, a position paper on decriminalisation, a paper on MTP Act amendment and two blog pieces have been developed.

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

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

Baseline and access to services during pandemic study findings and existing laws and Acts 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 obligations of service providers under these. The knowledge products have tried to provide responses to these dilemmas in simple local language. In the coming months we will be developing knowledge products on the legal updates, government initiatives and on findings of our study on access during the pandemic. In addition, blogs have been published on topical issues such as parliamentary discussions on MTP Act amendment and population control bill introduced in Uttar Pradesh (Annexure 7).

During this phase, CommonHealth has also joined hands with Center for Justice Law & Society (formerly CHLET) and Center for Reproductive Rights (CRR) to offer a one year long clinical course of reproductive justice, gender, and the law. There is currently an absence of a curriculum on the subject of sexual and reproductive health and rights and the evolution of the reproductive justice movement in law schools. The course design has been finalised and first semester sessions have already been conducted. This course will be repeated this year. Discussions are ongoing. It has also contributed to development of advocacy manual by law students, handbook on abortion laws for service providers and to Universal Periodic Review with focus on decriminalisation of abortion

Additionally, CommonHealth partnered with 11 NGOs/CSOs to conduct “Spotlight” webinars to celebrate 50 years of MTP Act in India. The six webinars focussed on a series of key areas related to access to safe abortion services such as history of the Act, field implementation and associated experiences available data etc.

level (MoV 2-5)

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)

- 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?

• What is the intended theory of change and how has progress been made towards it?
 CEDAW has categorised violations of women's sexual and reproductive health and rights, such as forced abortion, forced pregnancy, criminalization of the type of choice, lack of safe abortion and/or restrictive abortion care and forced continuation where women as farmers, gender-based violence, marginalised communities recommended that corrective measures should be taken by spreading the centre and giving primary rights, sexual and consent for, they should be designed safe and implemented with their active participation. Additionally, efforts should be made to repeal laws of privacy that are discriminatory against women. Two CommonHealth continues to articulate its support for these recommendations at various forums. The community level events for the past and those proposed for future engage with women's Self Help Groups as women, Panchayat Raj Mahabharat and Saman Nidhi with women in the community. The steps in phase of events has been on safe abortion as a woman's right. CommonHealth during the course of its activities on decriminalisation of abortion and stressed on the relevance of non-discrimination, substantive equality, and state obligation, the three foundational principles of CEDAW. As far as repealing/revising the legal provisions issues have been CommonHealth in aligned hands with other networks and initiatives that are pursuing it, through and through campaigns and legal advocacy. Since CommonHealth itself does not have the requisite organisational structure and capacity to undertake legal initiatives, it has some attempts to participate in generating evidence supporting the efforts, it has proposed to undertake that role. The process is currently on. It is also contributing to training and capacity building efforts undertaken by other network members.

- 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 as CommonHealth but the realities and experiences of women have been well documented and disseminated at various forums. The studies undertaken to document women's lived in experiences related to access to abortion services during the pandemic would also be disseminated widely. The evidence will be used not only to design strategies to address the barriers but would also be used as a learning based on which strategies for future health crisis situation are in place and are not designed after the crisis has already set it. Also, CommonHealth members do engage with UPR process on individual basis and their efforts are to some extent guided by evidence generation under the aegis of CommonHealth. As mentioned above, Abortion theme lead has contributed to UPR with focus on decriminalization of abortion.

Result 4: Strategic Multi-country Partnerships

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

I1. A regional partnership on the Claiming the Right to Safe Abortion: Strategic partnerships in Asia is established with the 5 national partners and ARROW

I2. The regional partnership includes linking and learning, capacity strengthening on the identified areas around abortion, and engages in evidence based advocacy at national level and at the regional level

In line with the above indicators, please specify:

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

CommonHealth is a member of Solidarity alliance launched in 2018 with 6 CSOs from the region. CommonHealth and the other CSOs are committed to right to safe abortion for all women through strategic interventions. The alliance is the forum to bring together Global South voices to mobilise and engage into targeted interventions, share knowledge and expertise and build the momentum for tangible change in access to safe abortion in the region. The alliance has already worked on position papers on issues relevant to the topic. These have been finalized and are available in public domain. Additionally, the forum has been used to exchange experiences of members related to access to SRH services during the pandemic in their respective countries. The members are also have come together to plan the activities for Safe abortion day and to contribute to advocacy efforts undertaken by other members. Also, members have engaged with partners from the LAC and shared experiences that have been very valuable for their own advocacy efforts.

- 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. It would also like to learn from experiences of partners from other countries about how to anticipate and counter anti-choice sentiments that are gaining ground in the country.

5. Lessons Learnt

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

	Learning consolidation
1. Community level activities during the pandemic	While creation of community level awareness on rights and entitlements related to abortion services and advocacy for the same are the main objective of the project, to ensure community engagement and commitment to meet their needs, means that the activity scope has to be dynamic. It has to include activities that are somewhat tangential to the main objective but are the prevalent community need at a given point. For example, COVID19 and vaccination related knowledge was the primary community need and CommonHealth took upon itself to fulfil this need.
2. 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
3. Alternative mechanisms in times of crises	COVID19 pandemic highlighted the need to revise existing in-person approaches of awareness creation and advocacy. CommonHealth had to adapt to online capacity building and dissemination methodologies and had to take social media approach to reach the community. Also, members had to consistently be mindful of State norms for community level activities before undertaking those. These had implications for budgets as well as timeline and reach in the community.
4. 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.
5. 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. Anticipate and mitigate efforts of anti-choice movements	Anti-choice, pro-life movement is raising its head in the country, though currently in its infancy, there is a need to anticipate their moves and be ready with evidence and risk mitigation strategies to ensure that the gains till date are not negated

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 has conducted values clarification workshop with members and developed IEC material and knowledge products that use acceptable vocabulary to ensure that everyone is on the same page. The efforts are continuous.	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.
Emergence of anti-choice, pro-life movement	To a limited extent	CommonHealth does not lose any opportunity to advocate for highlighting right of individuals for safe abortion. It has written articles / publicised its views	Well thought out strategy that anticipates next moves and counters them through hard data and rational arguments is necessary

What challenges could arise? How can it be mitigated?

We hope that we will be able to engage community as well as national level advocacy networks that represent intersecting issues in campaigns and activities in our endeavour to ensure individuals' right to safe abortion.

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	Alliance with select partners who are unencumbered by global gag rule, have genuine interest in the issue and who work on

related issues, their interest may not be sustained and “Global gag rule’ will impact allies’ engagement	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
Token changes in the laws and third party authorisation for permission to late gestation abortions	We have and will continue to advocate for abortion of constitution of medical boards i.e. third party authorisation for approval of late gestation abortions.

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- Annexure 14: Webinar in the Spotlight Series; titled "MTP Act @50- The more things Change, the more they remain the same...! (PPT attached)
- Annexure 15: Sessions on medical framework for abortion, laws affecting access at ground level and reproductive politics and policies (PPT attached)
- Annexure 16: Findings of CommonHealth's studies with frontline workers of Chhattisgarh for SAMA (PPT attached)
- Annexure 17: Refresher Training on Abortion Gender and Rights (Agenda attached)
- Annexure 18: Abortion Gender and Rights advocacy Institute (Agenda attached)