Expanding the Discourse on Comprehensive Abortion Care in India

A compilation

June 27-28, 2016

Ipas Development Foundation acknowledges the support of
the David and Lucile Packard Foundation,
and cooperation of Human Rights Law Network;
The YP Foundation; International Institute of Population Sciences;
CAC Connect; and civil society partners from Bihar, Madhya Pradesh,
Maharashtra, Jharkhand and Uttar Pradesh.

CAC Conclave is an initiative of the Ipas Development Foundation (IDF) with support from the David and Lucile Packard Foundation.

Working for the cause of increasing access to comprehensive abortion care (CAC) in India for past over a decade, IDF's on-ground experience shows that in recent years, abortion has moved beyond being just a health service. There are many issues that intersect with it and have the potential to impact it. This formed one of the key objectives of CAC Conclave – bringing together subjects that are related to and can impact access to CAC.

At the same time, as we increased our spread across and depth into the country, we came across unique and effective change makers for abortion. And this became our second key objective for the Conclave – making way for a new generation of voices and giving them a platform for meaningful collaborations.

Putting the two objectives together, we identified five themes for the first-ever CAC Conclave that was held in June 2016 in New Delhi. Over the two days, more than 100 academics, NGOs, researchers, lawyers, service providers, donors, and community-based organizations from across 11 states of the country, along with select media persons came together to deliberate on the dynamics of abortion in India, especially its unseen aspects.

We sincerely thank our speakers and participants – this book is a compilation of the diverse initiatives and activities that were presented at the CAC Conclave.

We hope this is the beginning of a journey that will lead to discovery of new paths and companions as we all go towards making safe abortion a reality for women in India.

Speakers

Name	Affiliation
Ms. Aarti Dhar	Journalist
Mr. Ajit Yadav	International Institute of Population Sciences (IIPS)
Dr. Ameya C Purandare	Federation of Obstetric and Gynaecological Societies of India (FOGSI)
Mr. Anand Sinha	The David and Lucile Packard Foundation
Dr. Ashish Raj	CAC Connect, Madhya Pradesh
Ms. Bani Das	Kranti
Dr. Basab Mukherjee	Federation of Obstetric and Gynaecological Societies of India (FOGSI)
Ms. Garima Dutta	International Institute of Population Sciences (IIPS)
Ms. Farah Shaikh	Kranti
Kumari Kamla Mukhi	Center for Social Welfare and Rehabilitation (CSWR)
Ms. Madhulika Masih	Human Rights Law Network (HRLN)
Dr. Neelam Singh	Vatsalya
Dr. Nikhil Ranjan Rajkhowa	CAC Connect, Assam
Dr. Noor Fathima	CAC Connect, Bihar
Dr. Nozer Sheriar	Federation of Obstetric and Gynaecological Societies of India (FOGSI)
Dr. Parag Biniwale	Federation of Obstetric and Gynaecological Societies of India (FOGSI)
Mr. Pradeep Surin	Journalist
Ms. Reena Khatoon	The YP Foundation
Ms. Samishti Solomon	Human Rights Law Network (HRLN)
Dr. Shailesh Jain	CAC Connect, Rajasthan
Ms. Stella Paul	Journalist
Ms. Surabhi Srivastava	CREA
Mr. Vinoj Manning	Ipas Development Foundation (IDF)

Poster presenters

Name	Affiliation
Dr. Amirchand Prasad	CAC Connect, Bihar
Dr. Amrita Sarkar	CAC Connect, West Bengal
Ms. Anubha Singh	CREA
Dr. Anupama Dhananjai	CAC Connect, Chhattisgarh
Mr. Appa Saheb Ugale	Marathwada Gramin Vikas Sanstha (MGVS), Maharashtra
Dr. Archana Mishra	CAC Connect, Madhya Pradesh
Dr. Bharat Kumar Mahale	CAC Connect, Maharashtra
Ms. Caroline James Mehta	Hope Center for Women & Children, Madhya Pradesh
Ms. Meera Sharma	Sumitra Samajik Kalyan Sansthan (SSKS), Uttar Pradesh
Ms. Mili Dutta	International Institute of Population Sciences (IIPS)
Mr. Murari M.Choudhury	Network for Enterprise Enhancement and Development Support (NEEDS), Jharkhand
Ms. Pallavi	Hidden Pockets
Ms. Prakriti Sareen	Human Rights Law Network (HRLN)
Ms. Pritisha Borah	Human Rights Law Network (HRLN)
Mr. Rajinder Singh	Lok Chetna Vikas Kendra (LCVK), Bihar
Mr. Ramu	International Institute of Population Sciences (IIPS)
Mr. Ripudaman	Gram Praudogik Vikas Sansthan (GPVS), Bihar
Dr. Ruchi Bhushan	CAC Connect, Jharkhand
Dr. Runa Bal	CAC Connect, West Bengal
Dr. Sandhyarani Panigrahy	CAC Connect, Odisha
Dr. Sarita Khandelwal	CAC Connect, Madhya Pradesh
Ms. Shailu Shrivastava	ASRA Samajik Lok Kalyan Samiti, Madhya Pradesh
Mr. Suresh Singh Yadav	Jyoti Gramin Kalyan Sansthan (JGKS), Uttar Pradesh
Dr. Susmita Majumdar	CAC Connect, West Bengal

OPENING REMARKS

Mr. Vinoj Manning
Executive Director, Ipas Development Foundation

Dr. Nozer Sheriar
Board Member of the Guttmacher Institute and Ipas, and Member of the Technical Advisory Group, WHO

Mr. Anand Sinha
Country Advisor, The David and Lucile Packard Foundation

In a normal family conversation, we talk nonjudgmentally and openly on all subjects, except abortion. When it comes to abortion, we either don't talk about it, or allude to it as if it is something that happens to families very different from our own.

While the last four decades have looked at abortion solely from a public health perspective, the need is to expand the discourse, advocacy & action from the public health perspective to that of rights and reproductive justice. The CAC Conclave is a starting point in this direction.

Mr. Vinoj Manning

As per a study by the Guttmacher Institute, 56 million abortions take place in the world each year, [so] we have to accept that abortions are something that are extremely important in a woman's life. The study went on to say that while the incidence had dropped a little in the developed world, it is the same in the developing world, [and] the prevalence of abortion was exactly the same whether it was legal or illegal, whether it was available or unavailable in the public health system of the country.

We have to accept that when pregnancies are unwanted, safe abortions are absolutely vital to a woman's health and wellbeing. In fact a safe abortion procedure as a medical procedure is probably one of the safest medical procedure there is.

Dr. Nozer Sheriar

The Packard Foundation's work on population and reproductive health is centered around the belief that every individual must have the ability to make their own reproductive choices. In particular, the Foundation is focused on young people, looking at young people as leaders in the field, young people as being change makers for themselves and for society, and essentially recognizing that if you work with young people, long lasting changes will happen, and that it is not a short term intervention.

Essentially it [seeking an abortion] is an individual choice more than anything else, and as much as we may be talking about it from a public health perspective, the issue is not as much of public health as it is from rights perspective – this is important to keep in mind as we discuss, debate and strategize on how to ensure that women have rights to access the whole range of reproductive health services, including safe abortion.

Mr. Anand Sinha

Theme 1

ABORTION AND LAW

The Medical Termination of Pregnancy (MTP) Act has been in place since 1971, and provides a framework for provision of safe and legal abortion services in the country. Even though women in India do not have the right to abortion on demand, the Act allows termination of pregnancy by a registered practitioner up to 20 weeks of gestation for a broad range of indications. The MTP Act also offers protection to a practitioner, if he/she adheres to and fulfils all the requirements under the MTP Act.

More than 40 years after the legalization of abortion in the country, while significant progress has been made, a lot more needs to be done to ensure effective implementation of the Act.

Ipas Development Foundation expresses gratitude to Human Rights Law Network for their collaboration in the planning and execution of this session.

We especially thank Ms. Ena Singh, United Nations Population Fund (UNFPA) for chairing the session.

Community Perspective in conflation of the MTP Act and the PC&PNDT Act

Dr. Neelam Singh
Vatsalya

The Medical Termination of Pregnancy (MTP) Act, 1971 and the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) (PC&PNDT) Act, 1994 both aim at the empowerment of women and girls through very distinct intents. While the MTP Act aims to ensure access to safe abortion, the PC&PNDT Act aims to prevent misuse of technology. However, lack of information and flawed understanding results in misinterpretation of the laws. This often leads to imposing restrictions on access to abortion services and most significantly, second trimester abortions, as an easy solution to fix the problem of sex selection. The consequences are aggravated in the context of low awareness about the legality of and stigma attached to abortion in the community. It is, therefore, important to ensure that the implementation of each Act is done judiciously without impinging on the objectives of the other.

Communication plays an important role in the context of gender-biased sex selection. The use of terminologies such as foeticide or *bhrun hatya* stigmatise abortion and imply it is not to be provided, endangering women who seek abortion for legal reasons. Similarly, images of foetuses being crushed in the womb or speaking from the womb must be avoided. In fact, any opportunity to communicate on sex selection should also be used to emphasise the legality of abortion and draw attention to the misuse of technology.

Some recommendations for improving implementation of the two laws:

- Capacity building of Appropriate Authorities on both the MTP Act and the PC&PNDT Act
- Sensitization of media on the difference between legal abortion under the MTP Act and sex-selection under the PC&PNDT Act
- Use of right language and right imagery
- Mass public awareness about the MTP Act
- Prioritization of safe abortion within the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) framework

In the context of declining sex ratio in the country, it is important to ensure proper implementation of the PC&PNDT Act. However, at the same time, it is important to ensure that women's access to safe abortion services is safeguarded and women are not forced to seek services from untrained providers posing a risk to their lives, facing lifelong morbidities and even mortality.

Using the Law to Enforce the Right to Abortion

Ms. Samishti Solomon
Human Rights Law Network

Women in the tribal villages of Chhattisgarh face specific barriers in access to safe abortion services. Two specific cases in the High Court of Chhattisgarh highlighted this aspect:

➤ *National Alliance for Maternal Health & Human Rights vs State of Chhattisgarh & Others*

Following amendments to the MTP Act in 2002, the district level committees (DLCs) were authorized to approve private facilities eligible for performing abortion services in a district. A DLC comprises of 3-5 government officials, and is chaired by the district's chief medical officer or district health officer. Despite this, it is seen that a significant proportion of abortions in the state are performed by unskilled providers. This is because most of the districts in the state have not constituted the required DLC, thereby resulting in lack of legally-approved abortion services in the private sector. Further the funds allocated by the central government under the National Health Mission (NHM) for CAC services are largely unutilized, raising concerns about the availability of CAC services in the public sector.

In response to the petitioner's claims, the High Court ordered the state government to ensure setting up of DLCs in all districts, and to submit a compliance report including a timeline for the completion of this task.

➤ *Rape victim vs State of Chhattisgarh and others*

A young girl (not named for confidentiality) was kidnapped and raped for three months. Upon her return to her home district, it was found that she was pregnant. Due to unavailability of adequate services in her home district, she was made to travel to a medical college in Bilaspur. She was denied services as the family was not able to produce the required documents that were beyond the family's control. A petition was filed, and the court immediately ordered the hospital authorities to allow admission and termination of pregnancy. Upon examination, it was revealed that the girl's pregnancy had exceeded 20 weeks, which is beyond the legally permissible limit for abortions in India. However, the High Court applied the "Best Interest Theory" laid down by the Supreme Court in specific cases, and ordered the termination be allowed under the supervision of a medical team of five doctors. The termination was successfully conducted and the girl was safe.

Judicial Colloquium: An Effective Tool for Using the Law for Sexual and Reproductive Health and Rights (SRHR)

Ms. Madhulika Masih
Human Rights Law Network

One of HRLN's strategies to ensure effective implementation of the law is to organize judicial colloquium to update the judiciary on the latest development in human rights and international law, as well as bring forth issues that are faced by people who do not have access to the legal system.

Some issues that HRLN has been focussing on in their colloquiums include the Right to Information, HIV/AIDS, Trafficking, Right to Education, Right to Food, Child Rights and SRHR

One of the recent judicial colloquium in the North East sought to establish an ongoing dialogue on SRHR and the fundamental issues that impact the lives of millions in India. The broad objective of this colloquium was to familiarize the legal community with the legal and human rights associated with SRHR, to create a space for dialogue and sharing of knowledge and lessons learned, as well as to share examples of judicial strategies being positively used for promoting SRHR. The colloquium helped to:

- Promote the role of judges in implementation of SRH services that are client and gender sensitive
- Update the judiciary on the latest developments in human rights and international law, and sensitize judges to issues that are faced by people who often have no access to the legal system
- Develop a consensus on the utilization of human and reproductive rights, discuss strategies for more creative and widespread use of reproductive rights and norms
- Enhance awareness among judges, judicial officers on the barriers faced by women in accessing justice on SRHR issues
- Assess how courts in different legal systems follow human rights treaties to ensure that reproductive rights are guaranteed and that there is equality and non-discrimination

The colloquiums are an important platform to collaborate with judges who draft orders and decisions that have a nation-wide precedent. By improving their knowledge on the finer nuances of key issues, and familiarizing them with ground realities, the colloquiums have great potential in strengthening the judicial system of the country.

Challenges in Making Safe Abortion Services Available in Rural Madhya Pradesh

Dr. Ashish Raj
CAC Connect, Madhya Pradesh

There are multiple questions that a woman is confronted with when she thinks about getting an abortion done – whether abortion is legal or not? Who to approach for safe abortion services? How much will it cost to get an abortion done? What will people think?

Most women in rural parts of Madhya Pradesh (MP) lack awareness about the legality of abortion, and are unsure who an eligible provider is. They frequently get confused between rural practitioners and registered medical practitioners, often ending up in the hands of illegal providers. Moreover, as per one study, only 12% of the community in MP knows that abortion is legal – this is the major issue why women hesitate to access a government facility for abortion.

Confusion among providers arises in the background of other laws which often tend to be linked with the MTP Act. For instance, in case of rape, confusion regarding informing the police and about giving consent for the procedure. For young women, confusion on offering services in the light of the Protection of Children from Sexual Offences Act, 2012 (POCSO). And most importantly, confusion arising due to the mis-linkages with the PCPNDT Act, and every second trimester abortion being looked as a sex-selective abortion.

It is important that the MTP Act provides protection to providers for offering safe and legal abortion services, and not pose challenges in any form. In addition, it is important that offenders of the law and illegal providers are duly punished to ensure strict enforcement of the law. There is strong felt need to increase service provider base and inclusion of mid-level providers to improve the base of trained providers for better services to women.

Theme 2

ABORTION AND TECHNOLOGY

Like any other medical procedure, technology lies at the core of comprehensive abortion care. Technology, if used right, gives power – this is true both for women who receive services and for providers offering services using appropriate technology. Given the technological advancements and the options they have made available, it is important that any deliberation on technology for abortion be centered on women and upholds women's interest as its core function.

We especially thank Dr. Atul Ganatra, FOGSI and Dr. Sangeeta Palsania, CAC Connect, Madhya Pradesh for chairing the session.

Women's Perspectives on Technologies for CAC

Dr. Parag Biniwale
Federation of Obstetric and Gynecological Societies of India

There are various barriers that hinder women from accessing abortion services. Ignorance about legality of abortion is one of the leading causes – which is only worsened if she is an adolescent or a single woman. Some key barriers related to the service provider that make the decision more difficult include judgemental attitude, desire for spousal consent, requirement of multiple authorizations, lack of privacy, respect, confidentiality, dignity and out-of-pocket expenses.

Often women do not know who is a safe or unsafe provider, and where they should go to avail services. Moreover, various myths around abortion including it being dangerous for women, that it indicates women's irresponsible nature along with religious opposition to abortion, further hamper access.

Various studies on abortion have been done to understand women's preference for abortion:

- In most trials that offered participants a choice between surgical and medical abortion, 60-70% women chose the medical method, as it provides greater privacy and autonomy, is less invasive and more natural than surgery
- A study to understand the effectiveness of Behaviour Change Communication interventions in Bihar and Jharkhand concluded that multiple approaches should be used when attempting to improve knowledge and perceptions among women about stigmatized health issues such as abortion

It is important that women seeking abortions be provided suitable information regarding the available method, and information on the latest available technology. It is important that the service provider spends adequate time explaining advantages and disadvantages of each to enable the woman to make an informed choice. Need and choices of contraception to prevent unplanned and unwanted pregnancies should also be emphasized.

Access to Second Trimester Abortion

Dr. Noor Fathima
CAC Connect, Bihar

Both central and state governments have made significant efforts to train doctors at the lowest level health facilities and ensure adequate first trimester abortion services. However, a considerable number of women require abortion in the second trimester. It is important to understand why women go for abortion in the second trimester. Contrary to popular perception, sex-selection is one of the least common reasons. Women, due to varying reasons listed below, are often not able to take the decision about continuing their pregnancy, and inadvertently land into the second trimester. Reasons for delay in decision making include:

- No knowledge of or access to contraceptives, hence high chances of unplanned and unwanted pregnancy
- Late detection of pregnancy
- Cases of rape
- Financial constraints
- Uncertainty about the legality of abortion
- Fetal anomaly detection, which mostly happens after the first trimester
- Detection or worsening of certain medical conditions with increasing gestation
- Delayed referral from prior health worker or facility

Service provider-related barriers also contribute to the delay in accessing services within the first trimester. Some of these are: lack of knowledge about legality of second trimester abortion services amongst health workers and providers, lack of awareness about facilities offering these services, availability of trained providers, patient overload and providers' insensitivity. Another big deterrent for service providers is stigma associated with second trimester abortions, especially being labelled as sex-selective.

To overcome these challenges we need to have a structured approach. Some suggested measures are:

- Training more doctors from public facilities for uninterrupted services
- Orientation of providers and support staff on newer and safer technologies
- Sensitizing providers and nursing staff, focusing on counselling skills
- Upgradation of selected public facilities for provision of second trimester abortions
- Creating awareness among communities regarding availability of CAC services by using IEC material and BCC activities

Using Technology to Optimize Outcomes in Safe Abortion Services

Dr. Ameya C Purandare
Federation of Obstetric and Gynecological Societies of India

For any technology to succeed and have the desired impact, it should be safe, simple and successful. To use technology to improve quality of abortion services, three avenues to focus upon are manual vacuum aspiration (MVA), medical methods of abortion (MMA) and use of ultrasound.

Karman & Wilson introduced the first MVA syringe in the 1980s, but it is now completely replaced by the MVA syringe that can be used by peripheral providers with basic training even at the primary health centre level. MVA is a safe technology for uterine evacuation up to 12 weeks of gestation. Accurate clinical assessment, counselling and informed consent are essential before the procedure. Pain management forms the mainstay of the treatment - ideal pain control during vacuum aspiration is a combination of verbal reassurance, oral analgesic and paracervical block. One important technological advancement in the process of MVA is the use of misoprostol for ease of cervical dilation, thereby reducing risk of perforations and cervical trauma.

The use of MMA began when the use of mifepristone was licensed by the Drug Controller General of India in April 2002. As per the MTP Act, MMA can be provided to women seeking termination of pregnancy up to seven weeks (49 days from last menstrual period with regular cycles) of gestation. It is mandatory to counsel and rule out contraindications before initiating the MMA procedure. It is important to note that all documentation required for surgical abortions is also required for MMA (including Forms C, I, II and III).

The advent of ultrasound is an important technological development that has revolutionized the understanding of normal early pregnancy development and management of early pregnancy failure. Ultrasound is not always necessary for the provision of early abortion (RCOG 2000), but when available, it can aid in the diagnosis of ectopic pregnancies beyond six weeks gestation age. Some providers find the technology helpful before and during abortion procedure at later stages of pregnancy.

It is important for every health care provider to use all abortion-related technologies to their advantage, so as to optimize the service provision to women seeking abortion.

Postabortion Contraception

Dr. Basab Mukherjee
Federation of Obstetric and Gynecological Societies of India

"If the woman we treat for postabortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice"

Verme, 1994

The importance of postabortion contraception cannot be overstated. Studies have shown that unmet need for family planning (FP) is high among postabortion care clients. Women are particularly at risk of pregnancy immediately after an abortion, and hence most receptive to counselling and likely to adopt a method just after an induced abortion. Also, to seek an abortion may be the first time a woman comes in contact with the health care system, and therefore this is an opportunity that should not be missed.

As per USAID's model, there are three core components of postabortion care.

- Emergency treatment, which involves management of immediate complications, including incomplete abortions, haemorrhage and infection.
- Postabortion FP counselling, emphasizing on ill effects of repeated abortions on physical and mental health of the woman, and information on eligible methods - efficacy, side effects with a stress on long acting reversible contraceptives (LARC)
- Family planning options, with thrust on LARCs, with vital information on the timing of initiation

Steps to improve postabortion contraception:

- Provide contraceptive services at the same time and location where a woman receives abortion services
- Provide a service environment that protects the dignity of women seeking post-abortion care
- Ensure equitable access to contraceptive services, regardless of the abortion method
- Consider client costs and motivation
- Offer a wide range of contraceptive methods
- Connect clients to a continuous contraceptive supply and to ongoing support
- Promote provision of these services by mid-level providers
- Address cultural and organisational barriers to FP method use

It is important to remember that postabortion services cannot be complete unless accompanied by contraceptive counseling and service delivery. Provision of universal access to postabortion contraception should be a standard practice for all health care providers.

Theme 3

YOUNG WOMEN

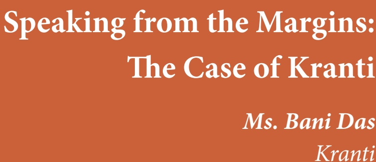
Young women are a particularly vulnerable group; they often lack the means, awareness and social support to seek safe services, especially sexual and reproductive health (SRH) services, including abortion. And young women, particularly those who are unmarried, face incredible amounts of stigma, in addition to other barriers, leaving them in more precarious conditions.

It is unfortunate that SRH interventions are often not designed to deal with the special needs of young women. As a result, they are the ones who are not able to avail or benefit from these interventions. This is one large gap that needs to be addressed.

Understanding issues like these, and the underlying reasons, is critical to truly comprehend the stigma and discrimination that young women face in the context of sexual and reproductive health, including abortion. While providing insights to challenges that women in this age group face, this will facilitate the process of finding solutions suited to meet their special needs.

Ipas Development Foundation expresses gratitude to The YP Foundation for their collaboration in the planning and execution of this session.

We thank Dr. Manju Chhugani, Rufaida College of Nursing; and Ms. Vinita Sahasranaman, The YP Foundation for chairing the session.



Speaking from the Margins: The Case of Kranti

Ms. Bani Das
Kranti

Young girls face discrimination in accessing SRH services, which is further augmented for daughters of sex workers. They are reprimanded and insulted, because they come from the red light area, and are denied services. They are expected to behave in a 'responsible' manner and to adhere to socially acceptable norms. They are kept away from their mothers in the red light area in an effort to mainstream them and integrate with the community at large.

Kranti is a non-governmental organization (NGO) based out of Mumbai that works to empower young girls from Mumbai's red-light area to enable them to become agents for social change. Therapy, education, extra-curricular activities form the main stay of their work, and girls are encouraged to take up courses as per their preference and to travel to explore themselves better. Along with education, they focus on identifying their interest areas and help girls in the realization of their true innate potential.

Kranti homes lay special emphasis on sexuality education as they believe that these girls are 'normal' and have the same feelings and aspirations as other girls of their age group. They are prepared to be better informed, including on sexuality, to prepare them as they venture out for higher educational and other pursuits.

Ms. Farah Sheikh
Resident of Kranti home

Two important components of Kranti homes are therapy and travel. Therapy or counselling is important since most girls have experienced some form of abuse or violence, in addition to the emotional/mental burden of belonging to the 'red-light area'. While time taking, therapy sessions facilitate the process of self-acceptance to develop self-respect. Travelling, on the other hand, provides an opportunity for learning through interactions with other people, knowing their perspectives and experiences, and helps develop confidence by providing an exposure to the world.

Girls in the Kranti homes do not need sympathy because of their background – they instead believe their background is their strength and take pride in it!

Youth-led Evidence: A Mapping Study on Youth-Friendly Services in Lucknow

Ms. Reena Khatoon
The YP Foundation

Young people, between ages 10-24 years, constitute 30% of India's total population, with adolescent girls adding to a total of 11%. Despite these numbers, young women are systemically kept away from access to information, services and discussions around SRH, including any form of decision making.

To further understand the extent of the problem, a study was conducted in the urban areas of Lucknow. The study aimed to establish the quality of available services in the area and young people's experience of accessing these services. Led by 12 youth members, this was done in partnership with the YES Foundation, and covered 29 providers, including indigenous health providers. Various SRH services were analysed, including aspects like counselling, availability of commodities and information, education and communication (IEC) materials.

The study revealed that no information about the availability of adolescent-friendly clinics was available, neither online, nor among the hospital authorities where the clinic was set up. Young, unmarried women have limited access to SRH services; for abortion services, they were denied services if the woman was unmarried and not accompanied by a parent. Young people were encouraged to read about SRH on the internet by the service provider instead of asking them, and were refused contraceptives when they asked for it. No attention was paid to privacy and confidentiality when offered services.

It is important to orient service providers to enable them to develop a more favourable attitude towards young, unmarried people, especially women, and to guarantee at least the minimum standards of privacy and confidentiality when working with this group. Mainstreaming comprehensive sexuality education is the key, as without access to information on their bodies and rights, young people continue to be disempowered and are unable to make healthy and informed decisions.

CAC for Young Women: Challenges and Some Solutions

Dr. Shailesh Jain
CAC Connect, Rajasthan

Every two hours, one woman dies due to an unsafe abortion in India. As per NFHS 2005-06, 41% of all abortions in India are among young women. Young women – especially school or college going, those requiring to be away from home for work or education, and women in live-in relationships – have a greater likelihood of having an unwanted pregnancy. While these women face numerous hurdles in accessing CAC services to terminate a pregnancy, service providers also face challenges in offering services to this special group. Hesitation in confiding in the provider, lack of decision making, lack of knowledge coupled with myths around contraceptives, conflicting laws that are restrictive in nature, in addition to providers' own bias against offering services to young women are just a few.

Comprehensive abortion care, incorporating all its aspects, needs to be at the centre of service provision, especially those meant for young women. There needs to be special emphasis on maintaining confidentiality and counselling when working with this age group. Sex education should be made compulsory in schools, with focus on orienting girls on important SRHR topics before they pass out from school. Parents also have a crucial role in imparting education on sexuality to their children and it is important to maintain a healthy parent-child relation for an open discussion on these topics at home. Wider dialogue and awareness building measures, including orientation of community health intermediaries, and through media – especially radio – need to be focused upon.

C- Confidentiality

O- Options to woman

M- Medical care

P- Proper management

R- Rehabilitation

E- Explaining pros and cons

H- Health issues tackling

E- Emergency conditions

N- New techniques

S- Support mentally

I-Intelligent counselling

V- Vision towards future prospects

E- Explaining laws to woman

Experiences of Providing SRHR Information to Young Women in Jharkhand

Kumari Kamla Mukhi
Centre for Social Welfare & Rehabilitation

The first hindrance that the youth leaders face is from the family members of their target group, especially mothers, who have questions around the need for an SRHR-focused intervention and its benefit. Also, working with unmarried young women on these sensitive issues is difficult, as they are either not interested or very hesitant to take part in such discussions, as they think this is relevant to married women only. The youth leaders patiently explain the importance of such SRH-focused intervention to foster their support during the sessions.

Attitude of *sewika* and *sahiyas* is also unfavourable, as they feel such topics should not be talked about among women of this age group. Moreover, the already limited awareness on contraceptives among young women is further aggravated as the community health intermediaries often do not provide information on them. A thorough orientation of these intermediaries helps in improving their knowledge levels and correcting their notions, and in ensuring their active support.

One of the biggest resistance comes from the menfolk in the community who feel that youth leaders disillusion young women in their villages and mis-lead them into irresponsible sexual practises. Discussion with the *Mundas* and other senior members of the community helps clarify these doubts and gaining their support, in addition to sensitization of men which is important for the overall success of the intervention.

There are numerous challenges of working in such backward areas, but the need is immense, as awareness of even basic menstrual practise is lacking. With continued, small steps, change is possible that will go a long way in improving lives of these tribal young women.

Theme 4

ABORTION AND RESEARCH

Abortion is an area of maternal health that requires significantly more investment in scientific and grounded research than the current standards. This research can help identify gaps in healthcare and has the potential to contribute to improved national policies. The current valid sources of abortion-related data are insufficient to understand the abortion scenario on a macroscopic scale or even to fully comprehend how women make abortion-related decisions. Prioritizing research will result in stronger policies, systems and communities.

Ipas Development Foundation expresses gratitude to International Institute for Population Sciences for their collaboration in the planning and execution of this session.

We especially thank Prof Chander Shekhar, IIPS and Dr. Malini K V, CAC Connect, Karnataka for chairing the session.

An Assessment of Availability of Selected CAC Components in the Public Health System in India

Ms. Garima Dutta
International Institute of Population Sciences

Approximately 8.5 percent of maternal deaths are caused by unsafe abortions in India (Registrar General of India, 2006). These statistics make access to safe abortion a major public health concern that requires attention and in-depth assessment. A study was conducted to examine the availability of selected CAC components across different level of facilities and geographical regions. The data source used was the District Level Household and Facility Survey (DLHS-4), 2012-13. The analysis covers all the states except Jammu and Kashmir and Gujarat.

The sample size for this study included 1,588 District Hospitals/Sub Divisional Hospitals; 4,843 Community Health Center (CHCs) and 8,540 Public Health Centers (PHCs). The five key focus areas were human resource (HR), equipment, services, drugs and training.

The study concluded that there is a dearth of trained providers and it is imperative to make efforts to provide MTP training to more number of medical doctors. Poor infrastructure and lack of essential equipment is widespread – the government needs to emphasize on infrastructure and availability of surgical equipment and drugs for MMA especially at CHCs and PHCs. Special emphasis should be given on postabortion counseling and contraception as these are critical for ensuring comprehensiveness of abortion services.

Challenges of Offering Comprehensive Abortion Care Services to Young Women: Our Experience

Dr. Nikhil Ranjan Rajkhowa
CAC Connect, Assam

Approximately 70,000 young women (10-24 years of age, UNFPA 2009) die every year and an additional two million of them suffer from chronic illness following unsafe abortion. A retrospective study was conducted on women who had undergone MTP in Jorhat Medical College and Hospital, Assam, with the aim of identifying areas of intervention that need improvement for CAC services for young women. Some of the key aspects the study evaluated included women profile, gestation period of MTP, complications of MTP and contraceptive acceptance.

Summary of the key findings of the study:

- Out of 675 cases of MTP conducted over a period of one year, 206 (30.51%) cases were young women
- Majority of these women, 45%, did not complete class 10, while 305 of them were uneducated. Sixty percent women belonged to lower middle class
- About 69% women had one child, while seven percent had three or more children. Less than four percent were primi gravida
- Most of the women (94%) reported contraceptive failure as the indication for seeking abortion services
- Sexually transmitted diseases (STDs) were detected in three percent cases
- 45% women sought services at six weeks gestation, 30% at eight weeks and five percent at 12 or more weeks gestation age
- MVA was used in most cases (90%), while the remainder were done using EVA
- 70% of young women accepted some form of contraceptive measures
- There were no major complications or death. Seven percent women reported minor complications (uterine perforation, excessive haemorrhage, infection, incomplete abortion, Ashermann syndrome)

The study concluded that CAC services provided by trained personnel in appropriate set-up using correct technology in early weeks of gestation is a very safe procedure (per-op complication 0.97%). CAC-related major complications that occur in cases related to late gestational weeks can be minimized by providing abortion in the early gestation. It is important to emphasize on postabortion contraceptive counselling so that repeated MTPs can be prevented.

Gender Bias and Missing Girls Due to Sex Selection in India and Major States

Mr. Ajit Kumar Yadav
International Institute of Population Sciences

The main objective of the study was to assess the role of prenatal and postnatal factors on changing child sex ratio, and estimate number of missing girls in India and selected states in two consecutive census.

A decomposition analysis was carried out using various data from Sample Registration System and Census of India. The analysis revealed some interesting findings on the contribution of prenatal and postnatal factors in changing the child sex ratio in India and in some major states.

- 71% contribution by prenatal and 29% contribution by postnatal factor in changes in child sex ratio at national level
- Odisha had the highest (98%) contribution by prenatal factor and only 2% by postnatal factor in changes in child sex ratio
- Uttar Pradesh (UP) had the lowest prenatal factor (59%) and the highest postnatal factor (41%) among the study states
- Girls' mortality was very high in UP compared to national average and rest of the study states

The study found that in India, on an average, 4.04 lac were missing at birth annually in 2011 as per the Census of India, while in 2001 this figure was estimated to be 2.60 lac. During the period 2001-2011, UP, Bihar, Rajasthan and Maharashtra together contributed more than 65% (2.6 to 4.04 lac) of the girls missing at birth annually. It is worth noting that Punjab and Haryana contributed the highest proportion in 2001 and 2011.

Sex selection is a big challenge in India. It requires serious attention by the government, especially the implementing authorities, to curb this immoral and illegal practise before it gets too late.

Theme 5

ABORTION AND MEDIA

Media plays an important role in creating and shaping public opinion, and this is particularly true for issues of social interest. With technological advancements, and the rise of social media along with print media and broadcasting, communication has become easier and quicker than ever before. It is hence important that we leverage media as an effective tool to take forward the right messages on abortion to the community, and contribute towards reducing abortion-related stigma. We need to strategize ways to retain and redirect media's interest in abortion issues, to leverage its reach and address myths and misconceptions around abortion

Ipas Development Foundation thanks Ms. Sayema Rahman, Radio Mirchi for hosting this session.

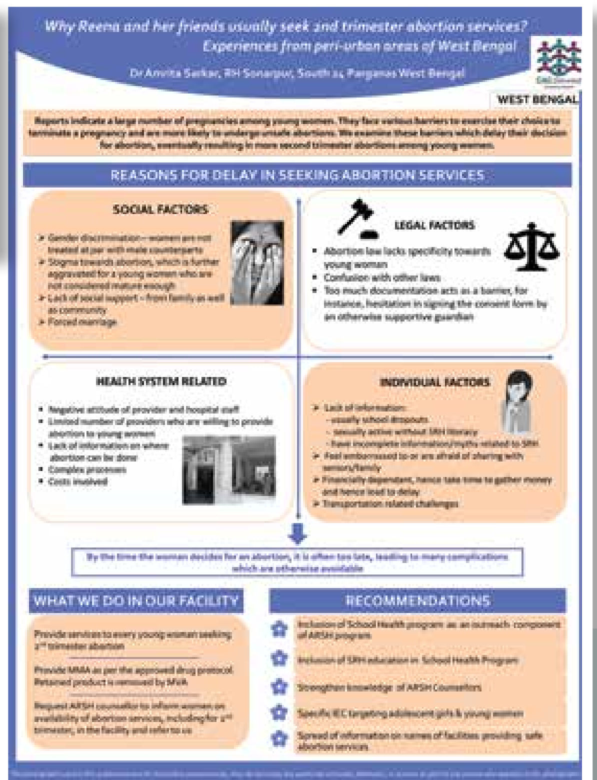
This session was conducted as a talk show with Ms. Aarti Dhar, Ms. Stella Paul, Ms. Surabhi Srivastava and Mr. Pradeep Surin, as guests and facilitation by Ms. Sayema Rahman. Sharing their personal experiences about reporting on abortion, and the specific challenges they face in their respective formats, the guests emphasized the need for on-going education of media persons, journalists as well as editors, and the need for collective action for sustaining discussion on abortion in media.

Some key discussion points are presented below:

- One major challenge an independent writer faces when working with a global news agency, especially of the western media, is the stereotype editors have about the Indian context and their resistance to accept anything that is progressive and contrary to their belief.
- Social media can be a huge asset to talk about issues that are not being addressed on the mainstream, whether by the government or media. It allows one to talk on abortion, and also issues around abortion – like sexuality, patriarchy, bodily integrity or autonomy – to take it beyond just a public health issue to one of women's right to control her own body and sexuality.
- Hindi newspapers have the furthest reach, but any discussion around abortion is often confined to sex-selective abortions or a case of abortion following rape.
- The Hindi language while being a big asset also poses a big challenge, as even subtle alterations can border to vulgarity.
- Abortion is often not recognized as a women's health issue that needs to be discussed and written about. Not only do the journalists, but news editors also need to be educated on the critical nature of abortion as an issue that requires attention.
- Social media can be only one, but not the only strategy, for drawing people's attention to the issue, and must be used in tandem with other formats.
- Efforts must be made by service providers, and administrative officials to orient reporters of their local media on the issue of abortion to help them develop a more accurate understanding of the issue.
- While being helpful as a medium that provides anonymity and hence the freedom to speak one's mind, especially for a sensitive issue like abortion, one criticism that social media faces is on the change that it can really bring about, especially in the mindset of people.

POSTERS

Dr. Amrita Sarkar
CAC Connect

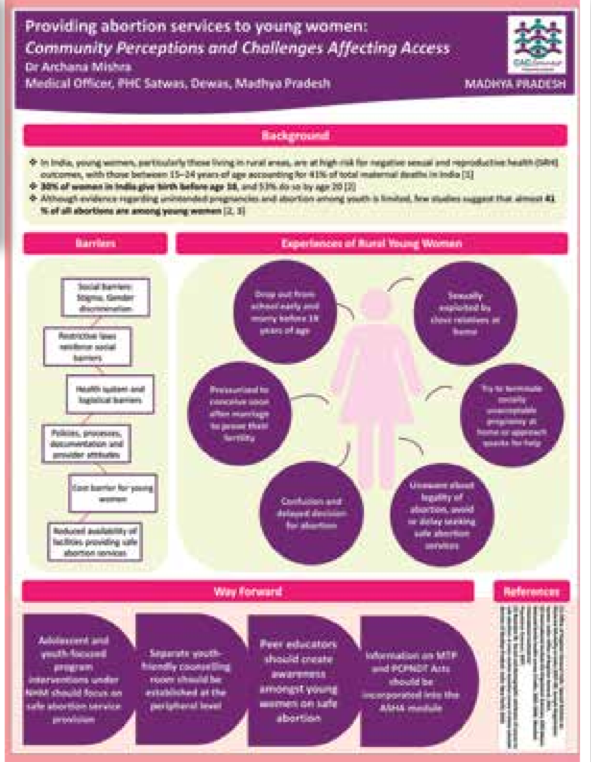


Mr. Appa Saheb Ugale
MGVS

	Aurangabad		Nasik	
Activity	Nos	Population covered	Nos	Population covered
Group meeting	763	23,935	1,484	22,197
Home visit / One to one meeting	58,275	58,275	12,167	16,672
Street plays			66	12,883
Training of ANM/ASHA/ and Anganwadi worker	178	178	258	258
Wall painting	409	76 village covered	91	91 village covered
Total		82,388		52,010

Dr. Archana Mishra

CAC Connect



Ms. Caroline James Mehta

HOPE

Ms. Meera Sharma
SSKS

Mr. Murari M Choudhary
NEEDS

CAC Conclave: Expanding the Discourse on Comprehensive Abortion Care in India
Theme: Field Realities of Increasing Access to CAC

Title: Counting Every Step to Comprehensive Safe Abortion and Care

Why is there a need to speak up for Safe Abortion?

Abortion is not about terminating pregnancy only; it's also about exercising a freedom of choice and to Unite for Body Rights. Abortion practices in India has over the time passed the acid test across religious arguments, academic debates, social discourses as well as the women's body being the site of political juxtaposition in different cultural paradigm.

Recognizing the preventable nature of most maternal mortality and morbidity related to unsafe abortion, the Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971. Unfortunately, these policy and service delivery interventions have not led to a significant reduction in unsafe abortion or related maternal mortality and morbidity in India, including Jharkhand, primarily because of limited access to and utilization of safe abortion services and the lack of awareness of the legality of abortion.

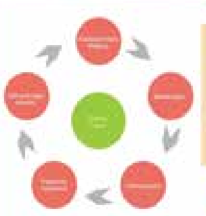
In India, due to unsafe abortion an estimated 8% of maternal deaths take place according to the latest government report on causes of death from 2011 Annual health Survey.
India recorded 6.5 million abortions (of the total 10.5 million abortions in the South and the Central Asia region) in 2008 of which 66% were deemed unsafe – Times of India.
10% of the country's population lives Jharkhand but only 1.2% of all certified abortion facilities are located here. Less than 1% of the state's 2,200 functioning primary health centres currently provide MTP services. 95% of the centres do not have a doctor trained in MTP, and nearly all centres lack necessary equipment or even basic infrastructure like water and electricity (IIPS 2001).

The Theory The Change

The cycle of wellbeing among young woman can be ensured if young woman have knowledge and information about contraceptives, then they would be able to avoid unwanted pregnancy, and if they are provided with complete knowledge about what is safe and legal abortion, they can avoid any form of risk \ related to abortion.

The How & What

NEEDS proposes to initiate an Inter Personal Communication program with women of reproductive age-group with a focus on young generation of 15-24 years for informing and sensitizing them about legality and safety aspects of abortion. One of the effective ways to address the gap between service availability and utilization is through Behaviour Change Communication interventions. BCC interventions have rarely been used to increase awareness of abortion issues in India.
NEEDS took a step forward to select peer leaders from the community itself, known as the Kalyani didi and imparts training on Sexual and reproductive health covering major issues on safe abortion. The program engages adolescent girls and imparts them modular training



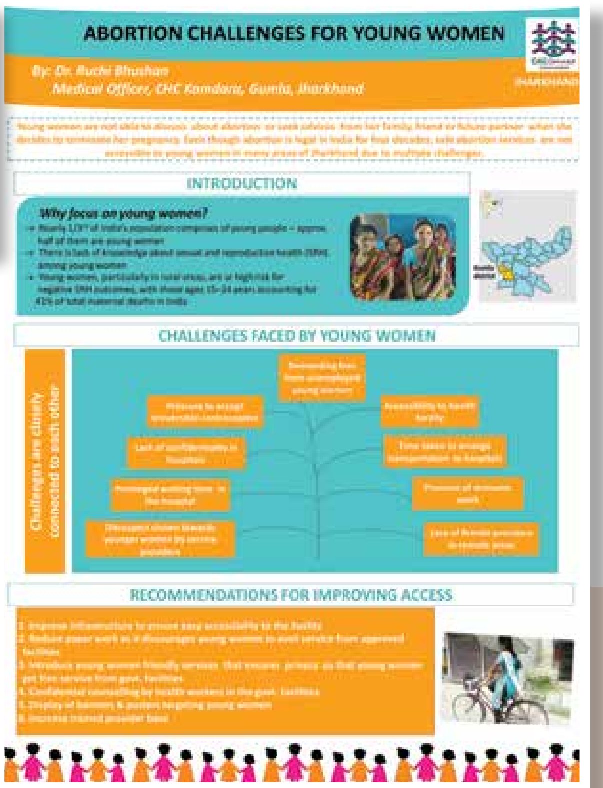
The Vision

To create an enabling environment to increase women's knowledge and access to sustainable comprehensive abortion care services within the broader preview of reproductive health and rights in legal, social and psychological aspects.

Mr. Rajinder Singh
LCVK

Mr. Ripudaman
GPVS

Dr. Ruchi Bhushan
CAC Connect



Dr. Sandhyarani Panigrahy
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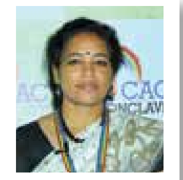
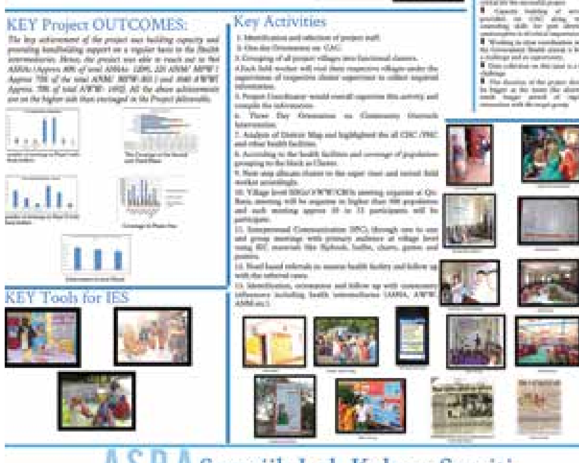


Ms. Shailu Shrivastava
ASRA



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Dr. Amirchand Prasad
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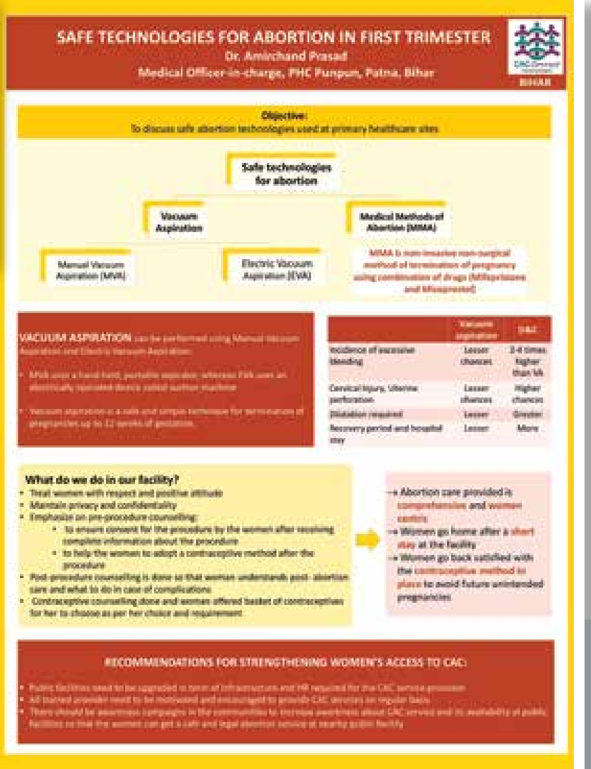

Ms. Anubha Singh
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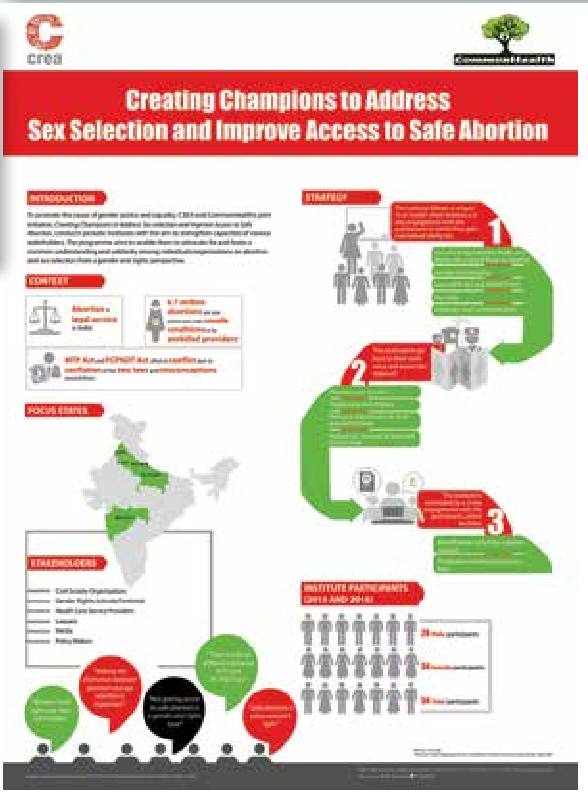

Dr. Anupama Dhananjai
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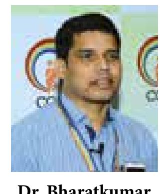

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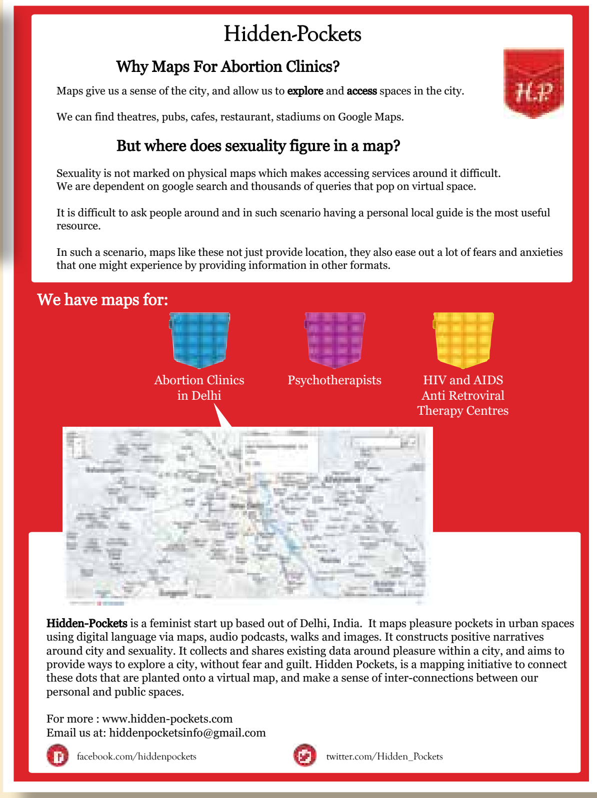
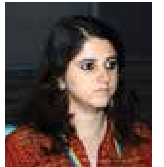
Ms. Mili Dutta

IIPS

Ms. Pallavi

Hidden Pockets





Ms. Prakriti Sareen

HRLN

Limited Access to Medical Abortions in Maharashtra

Introduction and Background

Access to safe abortion for a woman means accessing one's most basic right to life, health, liberty, equality and dignity.

India has the largest number of maternal deaths in the world.10 women die every day due to unsafe abortions in India.

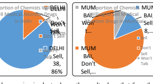
For ensuring and regulating right to abortion for women the government of India passed two major laws: Medical Termination of Pregnancy Act, 1971 (MTP Act) and the Drugs & Cosmetics Act, 1940 (DCA); and later released the Comprehensive Abortion Care Training & Service Delivery Guidelines (Abortion Guidelines, 2010), which enable termination of pregnancies through the simple administration of the drugs Mifepristone and Misoprostol and under the National List of Essential Medicines (NLEM, 2011) mandated the government hospitals to supply these drugs.

In 2012 the State of Maharashtra engaged in a campaign against abortion under which it increased enforcement of all abortion-related regulations, including medical abortion drug regulations under the Drugs and Cosmetics Act (DCA), which has created two major barriers to pregnant women in need of medical termination of pregnancy: limited drug availability and limited privacy.

Research Methodology

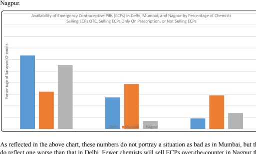
In June 2014, a team of health rights activists and advocates engaged in a fact-finding mission to investigate barriers women face in obtaining medical abortions in the state of Maharashtra. We surveyed hospitals and conducted interviews with gynecologists and chemists in Mumbai and Nagpur as well as in New Delhi, for comparison and referred to various academic literature and reports.

Proportion of Chemists willing to sell the drugs in Delhi, Mumbai and Nagpur: For the fact-finding the team visited 44 chemist shops in Delhi, 69 in Mumbai and 40 in Nagpur. The findings are as follows:



As can be seen in pie charts above, the results show that from the sample interviewed most chemists are willing to sell more and more chemists from Nagpur are willing to sell than in Mumbai.

Proportion of chemists willing to sell Emergency Contraceptives over the counter or on prescription and not selling: We interviewed 33 chemists in Delhi, 31 in Mumbai and 29 in Nagpur.



As reflected in the above chart, these numbers do not portray a situation as bad as in Mumbai, but they do reflect one worse than that in Delhi. Fewer chemists will sell ECPs over-the-counter in Nagpur than in Delhi, but more alarming is that chemists who do not sell ECPs over-the-counter are more likely to not sell them at all than to demand a prescription.

Results from hospitals: In Delhi none of the 6 major public hospitals had Misoprostol, Mifepristone and ECPs in stock. As far has Mumbai is concerned out of the 8 hospitals (7 public and 1 private), among the 7 majority provide medical abortion services by writing prescriptions that women have to fill at chemists shops. Similarly, in Nagpur we met 4 gynecologists (at 1 major public hospital and 3 private clinics) and found the scenario no different. All for gynecologists reported that they do not keep the stock and send the women to chemists with prescriptions.

Overall analysis and recommendations:

Most of the commonly cited reasons by chemists and hospitals for not stocking/selling medical abortion drugs and ECPs:
Believing there was a ban on the drugs
Paperwork involved is too tedious or the risk of error too great
Finding too difficult to obtain drugs from the manufacturers

The team found that:
There is limited and incorrect information among women, chemists, and medical providers regarding medical abortion and ECPs.

State of Maharashtra's claim under FDA that by regulation it is preventing sex-selective abortions; it in fact harms women and deprives them of their fundamental rights to life, health and equality.

Violations	Enforce
State is failing to ensure medical abortion drugs/ECPs are available at public hospitals/chemists.	Clear violation of National List of Essential Medicines, 2011/ Guidelines: Comprehensive Abortion Care Training & Service Delivery/ Administration of ECPs by health providers.
State is failing to protect the confidentiality of pregnant women seeking medical abortion, by demanding that chemists and gynecologists maintain records of the name and address of the women obtaining medical abortion drugs (under state DCA).	Violates guidelines to protect the confidentiality of pregnant women seeking abortion as mandated by the Medical Termination of Pregnancy Act, 1971; Medical Termination of Pregnancy Regulations, 2003; and Medical Termination of Pregnancy Rules, 2003
State is failing to make medical abortion information and drugs available and accessible to women seeking medical abortion services, including at public sector facilities. Women have to search out unacceptable and poor quality services or expensive private sector when faced with unplanned or unwanted pregnancies.	Guarantee women's fundamental right to health (Art. 12) under the International Covenant on Economic, Social and Cultural Rights, (ICESCR). Guarantee the availability, accessibility, acceptability, and quality of medical abortion services as advised by the AAAQ Framework enshrined in Article 12 of the ICESCR.

Conclusion

Women are entitled to ensure access to safe abortion, the State must ensure adequate implementation of the protections guaranteed by the MTP Act, guarantee access to quality contraceptives, and follow the National Health Mission's Abortion Guidelines and ECP Guidelines.

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Ms. Pritisha Borah

HRLN

Using law to ensure and promote safe abortion Human Rights Law Network (HRLN)

Pritisha Borah

Background

•Obtaining accurate data for abortions is challenging, and especially so for unsafe abortion. Because unsafe abortion is often done by untrained individuals or by the pregnant women themselves, much of it goes undocumented.

•According to WHO, every 8 minutes a woman in a developing nation will die of complications arising from an unsafe abortion.

•In India, the second most populous country in the world, abortion has been legal on a broad range of grounds since 1971, however though abortion services is allowed at all public facilities as long as the provider is certified in abortion provision, In India, complications of unsafe abortion account for an estimated 9% of all maternal deaths, according to the latest government report on causes of death from 2010.

•Maternal Mortality rate in Assam as per the SRS in 2010-12 was 328 (per 1000 births) while the national figure was 178. Assam has one of the highest number of abortion related deaths with 92 deaths reported in 2012.

Methods

Undertake fact findings in the unserved and underserved rural areas of Assam to ascertain and document providers who have lack of specific training in abortion procedures, and have been the reason for the increase in maternal deaths.

Abortion Laws

Indian Law:

Medical Termination of Pregnancy Act: The Medical Termination of Pregnancy (MTP) Act regulates abortions in India. Enacted in 1971 with the objective to reduce illegal abortions and consequent maternal mortality and morbidity.

International Conventions

Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)., Universal Declaration of Human Rights , International Covenant on Economic, Social and Cultural Rights (ICESCR)

Case Studies and HRLN intervention

•Aimony a resident of Kamrup Assam, was married when she was 18 in the year 2014. On January 6th, 2015 her mother in law, ASHA worker by profession took her to a dispensary when Aimony was 3 months pregnant to get her an abortion against her will. Without her consent she was aborted. HRLN, Guwahati took up her case and filed a writ petition, for justice to Aimony

•Bijoy Laxmi a 37 year old resident of Assam was physically abused by her husband's family and forcibly pushed into taking abortion pills. This resulted in severe infection, and incomplete abortion. High Court gave maintenance order of Rs. 8000/- pm.

• Karabi Nath, a 32 years old resident of Kamrup, Assam had undergone 4 previous pregnancies. She had under gone three abortions between her first and last pregnancy. Karabi's abortion was done in a Ayurvedic hospital, which did not have the competence to provide comprehensive abortion care, resulting in her tragic death.

Results and Discussion

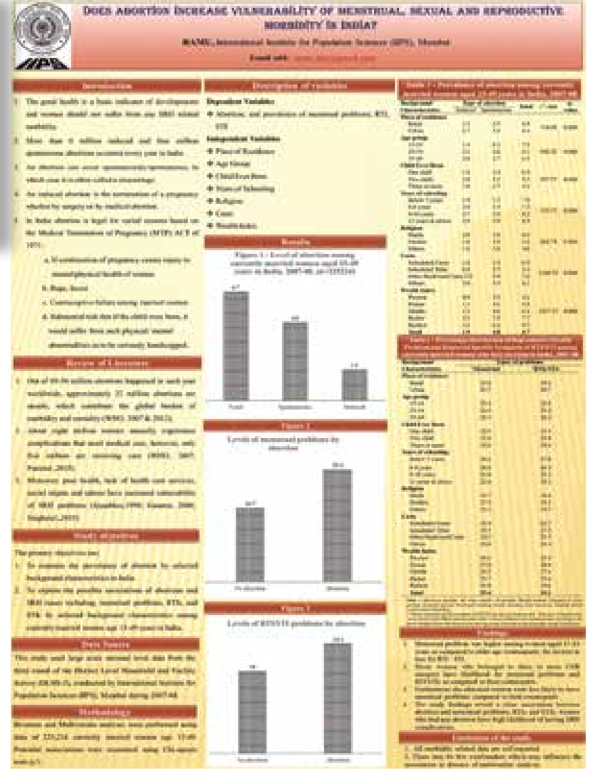
Some of the key results are:

•The number of public-sector health facilities available to serve India's growing population has not kept up with population growth and thus remains largely inadequate.

•Even when safe services are available and women are aware of them, the stigma surrounding abortion services in India affects women's abortion-seeking behavior.

•Karabi Nath opted for services in the Ayurvedic Health Centre as that was cheap and available. There is a huge gap in availability of comprehensive abortion care specially for the rural poor leading to deaths

Mr. Ramu
IIPS



Dr. Runa Bal
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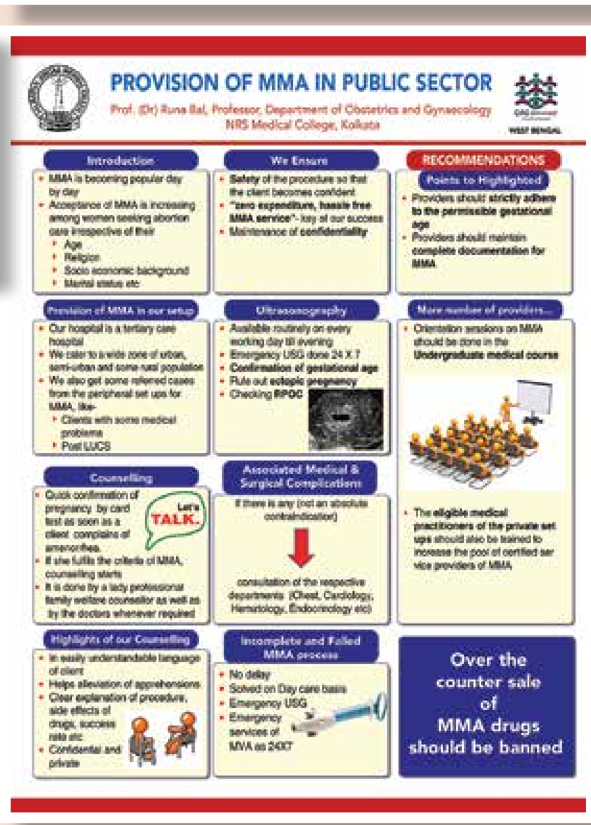

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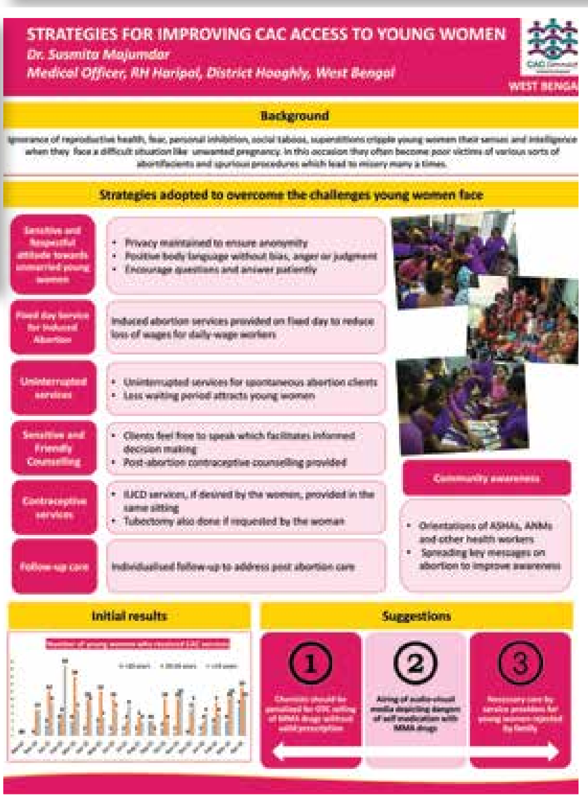

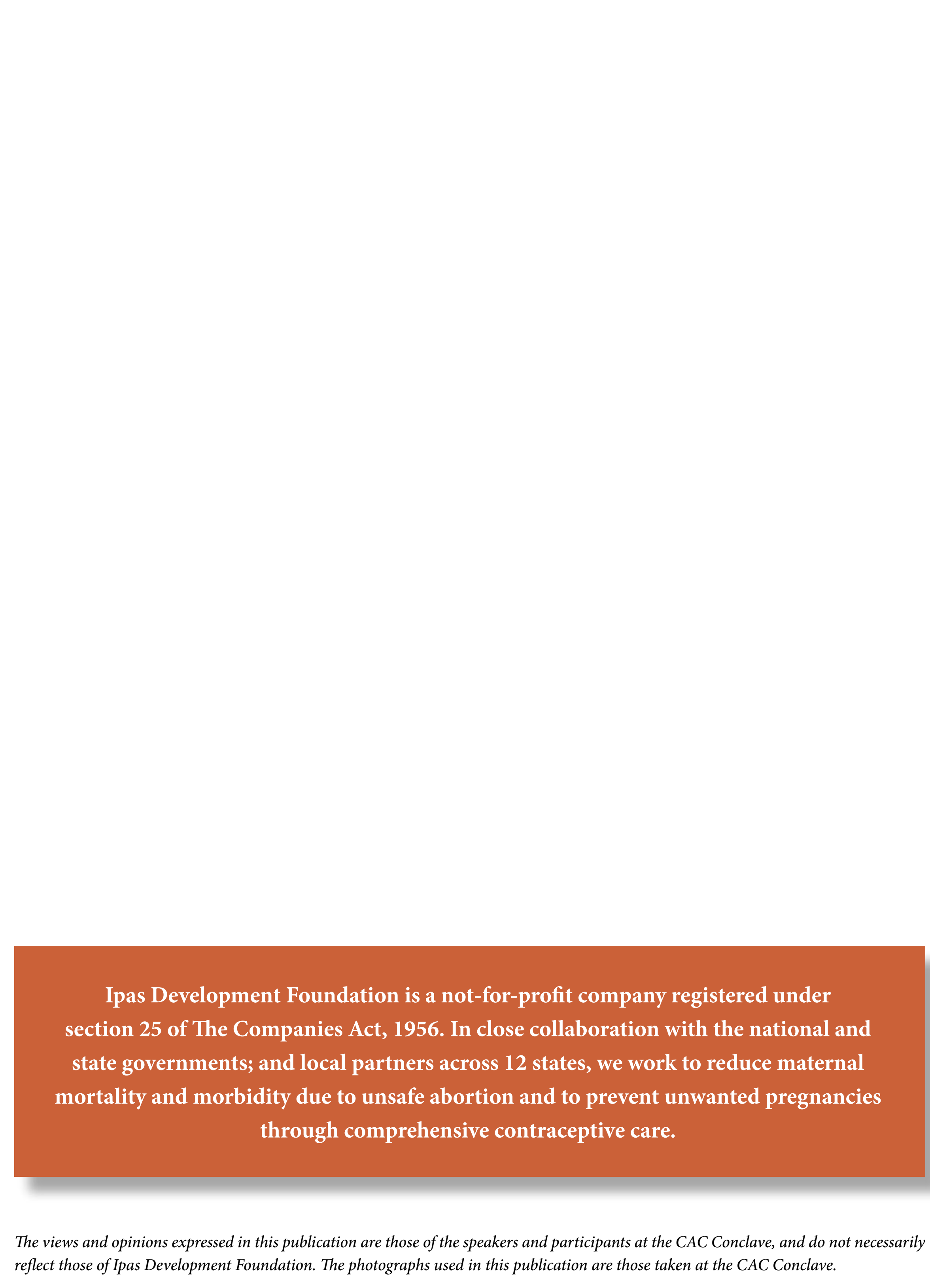

Ipas Development Foundation is a not-for-profit company registered under section 25 of The Companies Act, 1956. In close collaboration with the national and state governments; and local partners across 12 states, we work to reduce maternal mortality and morbidity due to unsafe abortion and to prevent unwanted pregnancies through comprehensive contraceptive care.

The views and opinions expressed in this publication are those of the speakers and participants at the CAC Conclave, and do not necessarily reflect those of Ipas Development Foundation. The photographs used in this publication are those taken at the CAC Conclave.

October 2016

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