



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

A bortion 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

Why Reena and her friends usually seek 2nd trimester abortion services? Experiences from peri-urban areas of West Bengal

Dr Amrita Sarkar, RH Sonarpur, South 24 Parganas West Bengal

WEST BENGAL

Reports indicate a large number of pregnancies among young women. They face various barriers to exercise their choice to terminate a pregnancy and are more likely to undergo unsafe abortions. We examine these barriers which delay their decision for abortion, eventually resulting in more second trimester abortions among young women.

REASONS FOR DELAY IN SEEKING ABORTION SERVICES

SOCIAL FACTORS

- Gender discrimination—women are not treated at par with male counterparts
- Stigma towards abortion, which is further aggravated for a young woman who are not considered mature enough
- Lack of social support - from family as well as community
- Forced marriage

LEGAL FACTORS

- Abortion law lacks specificity towards young women
- Confusion with other laws
- Too much documentation acts as a barrier, for instance, hesitation in signing the consent form by an otherwise supportive guardian

HEALTH SYSTEM RELATED

- Negative attitude of provider and hospital staff
- Limited number of providers who are willing to provide abortion to young women
- Lack of information on where abortion can be done
- Complex processes
- Costs involved

INDIVIDUAL FACTORS

- Lack of information:
 - usually school dropouts
 - sexually active without SRH literacy
 - have incomplete information/myths related to SRH
- Feel embarrassed to or are afraid of sharing with seniors/family
- Financially dependent, hence take time to gather money and hence lead to delay
- Transportation related challenges

By the time the woman decides for an abortion, it is often too late, leading to many complications which are otherwise avoidable

WHAT WE DO IN OUR FACILITY

- Provide services to every young woman seeking 2nd trimester abortion
- Provide MMA as per the approved drug protocol. Retained product is removed by MVA
- Request ARSH counsellor to inform women on availability of abortion services, including for 2nd trimester, in the facility and refer to us

RECOMMENDATIONS

- Inclusion of School Health program as an outreach component of ARSH program
- Inclusion of SRH education in School Health Program
- Strengthen knowledge of ARSH Counsellors
- Specific IEC targeting adolescent girls & young women
- Spread of information on names of facilities providing safe abortion services



Mr. Appa Saheb
Ugale
MGVS

Informing women about safe and legal abortion Two District of Maharashtra

Aurangabad Nasik

Group meet with meo, Group Meetings with women, Wall Painting, Street Play, ANM Training, Project Model, Staff Training, Project Team

Activity	Aurangabad		Nasik	
	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

Marathwada Gramin Vikas Sanstha (MGVS) Aurangabad
www.mgvsabad.org



Dr. Archana Mishra
CAC Connect

Providing abortion services to young women: Community Perceptions and Challenges Affecting Access

Dr Archana Mishra
Medical Officer, PHC Satwas, Dewas, Madhya Pradesh
MADHYA PRADESH

Background

- In India, young women, particularly those living in rural areas, are at high risk for negative sexual and reproductive health (SRH) outcomes, with those between 15-24 years of age accounting for 41% of total maternal deaths in India [1]
- 30% of women in India give birth before age 18, and 53% do so by age 20 [2]
- Although evidence regarding unintended pregnancies and abortion among youth is limited, few studies suggest that almost 41% of all abortions are among young women [2, 3]

Barriers

- Social Barriers: Stigma, Gender discrimination
- Restrictive laws reinforce social barriers
- Health system and logistical barriers
- Polices, processes, documentation and provider attitudes
- Cost barrier for young women
- Reduced availability of facilities providing safe abortion services

Experiences of Rural Young Women

- Drop out from school early and marry before 18 years of age
- Sexually exploited by close relatives at home
- Pressured to conceive soon after marriage to prove their fertility
- Confusion and delayed decision for abortion
- Unaware about legality of abortion, avoid or delay seeking safe abortion services
- Try to terminate secretly, unrecognize pregnancy, or look for approach options for help

Way forward

- Adolescent and youth focused interventions under NMA should focus on safe abortion service provision
- Separate youth-friendly counselling rooms should be established at the peripheral level
- Peer educators should create awareness amongst young women on safe abortion
- Information on MTP and PCNDT Acts should be incorporated into the ASHA module

References

1. WHO. *World Maternal and Perinatal Health Statistics*. Geneva: World Health Organization, 2010.
2. WHO. *World Adolescent Reproductive Health Survey*. Geneva: World Health Organization, 2011.
3. WHO. *World Abortion Incidence and Health Care Coverage*. Geneva: World Health Organization, 2012.



Ms. Caroline James
Mehta
HOPE

Experience implementing CAC Services in Hoshangabad Dist. in M.P.

S.No.	Category	No.	No.
1	Total Villages in 200	713	800
2	Urban Wards	347	
3	Total Population Estimated	13,81,79	
4	Hoshangabad Population (15-24)	4,00,000	
5	Unintended Pregnancies (15-24)	27,000	

Hoshangabad (Madhya Pradesh)

S.No.	Health Intermediaries	No.
1	ASHA	857
2	AWA	1424
3	AJWA	200
4	Other Volunteers (SHGs members, Teachers)	1633
Total		4114

- **Goal:** To prevent maternal deaths from unintended pregnancies in Hoshangabad district of M.P.
- **Objective:** Ensure that marginalized and young women are able to exercise their rights to choose pregnancy prevention and safe abortion, by improving their knowledge on legality and availability of abortion services.
- Create enabling environment for young women to access CAC services from local approved health providers in public and private sectors.
- **Map of Hoshangabad District**
- **Targeted Population**
- **Health Intermediaries**
- **Timeline**
- **Orientation of Intervention** MTP, MSA, NPI, EVA
- **Training & Learning Tools**
- **Dissemination**
- **IEC Material**
- **Mis Training by CAC Providers**
- **Key achievements - Quantitative & Qualitative**

Key achievements - April 2013 to Dec 2015

S.No.	Category	Target	Phase I	Phase II	Phase III
1	ASHA in Ward	857	853	856	850
2	AWA in Ward	1424	1384	1327	1407
3	AJWA in Ward	200	204	204	205
4	Other Health Intermediaries (SHG members, PSC members)	1633	1567	1579	1607
Total		4114	3998	3967	4069



Ms. Meera Sharma
SSKS

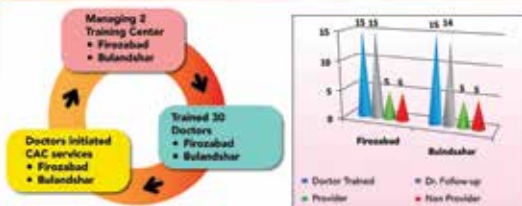
Sumitra Samajik Kalyan Sansthan

(A nonprofit entity registered under Societies Registration Act, India)
Ghaziipur-233001 U.P



Comprehensive Abortion Care Services in Firozbad & Bulandshahr
Supported by: Ipsas Development Foundation (IDF) New Delhi

Achievements:-



Activities:-



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.

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

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 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

LOK CHETNA VIKAS KENDRA Nawada (Bihar)

Comprehensive Abortion Care Program at Nawada, Begusarai & Munger Dist of Bihar
Supported by Ipas Development Foundation, New Delhi

ACTIVITIES

- Strengthening Training Centre: Co-ordination with District, DHO, DHS officials
- Selection & Nomination of Doctors & ANMs for CAC Training
- Facilitating CAC Training
- Post Training Program: support to CAC Trained Doctor & his Site
- Community Mobilization: Activities through Organization of NGOs, Informational JASHAs, ANMs, AWWs, OASAs (Kiosks)

ACHIEVEMENTS

- Training Centre Nawada, Munger & Begusarai
- Liaisoning with District, Sadar Hospital & DHS Officials
- Trained Doctors Nawada 57, Munger 6 & Begusarai 3
- Doctors providing CAC Services Nawada 97, Munger 6 & Begusarai 2

District	Dr. trained	Dr. followed up	Non Provider
Nawada	57	97	0
Munger	6	6	0
Begusarai	3	2	0



Mr. Ripudaman
GPVS

Recognizing the need to increase access to safe abortion services to reduce maternal mortality and morbidity, the state government of Bihar, introduced an innovative mechanism of accrediting private health care facilities. The program, Yukt Yojana, accredits eligible health facilities and supports them in providing abortion-related services free of charge to rural and low-income urban women.

युक्ति Launched 23rd April 2011

- Applying for Yukt Yojana Accreditation
- Programme Support Team
- Signing of MoU between DHS and Private Site
- Orientation of District level Health Officials on Yukt Yojana
- Accessible & Available
- Key Data - 05 May '16: Applications Filed - 257, Sites Accredited - 70, Women Served - 53,331, Induced - 30,733, Incomplete - 26,449, Complicated - 149, Referral - 149, Claims - 433 Lacs (DHS), Reimbursement - 583 Lacs (DHS)
- Respecting Women's Feedback to Improve Quality of Services
- Star Performers

1800-102-9484 (Natio Yukt Helpline II)

1800-415-0475 (Calling IVRS...)



Dr. Ruchi Bhushan
CAC Connect

ABORTION CHALLENGES FOR YOUNG WOMEN

By: Dr. Ruchi Bhushan
Medical Officer, CHC Kamdara, Gumla, Jharkhand

JHARKHAND

Young women are not able to discuss about abortion or seek advice from her family, friend or future partner when she decides to terminate her pregnancy. Even though abortion is legal in India for four districts, safe abortion services are not available to young women in many parts of Jharkhand due to multiple challenges.

INTRODUCTION

Why focus on young women?

- Nearly 1/3rd of India's population comprises of young people - approx. half of them are young women
- There is lack of knowledge about sexual and reproductive health (SRH) among young women
- Young women, particularly in rural areas, are at high risk for negative SRH outcomes, with those aged 15-24 years accounting for 42% of total maternal deaths in India

CHALLENGES FACED BY YOUNG WOMEN

Challenges are closely connected to each other

- Inability to access affordable contraception
- Lack of confidentiality in facilities
- Psychological willing time to the provider
- Disrespect chosen services provided by service providers
- Increasing fear from judgemental young women
- Accessibility to health facilities
- Time taken to arrange transportation to facilities
- Presence of domestic work
- Lack of female providers in remote areas

RECOMMENDATIONS FOR IMPROVING ACCESS

1. Improve infrastructure to ensure easy accessibility to the facilities
2. Reduce paper work so it encourages young women to seek services from approved facilities
3. Increase young women friendly services (Self service provision as per young women's get their services from govt. facilities)
4. Confidential counselling by facility workers in the govt. facilities
5. Display of banners & posters targeting young women
6. Increase trained provider base



Dr. Sandhyarani Panigrahy
CAC Connect

SAFE ABORTION AND GENDER-BIASED SEX SELECTION

SAFE ABORTION

... (text) ...

CAUSES OF FEMALE FETICIDE

- Many girls are considered a financial obligation
- Poorer
- Lack of proper education
- Parental preference - marriage, dowry
- Absence of all traditional practices
- Obsession for son
- Gender discrimination
- Family is considered as greater responsibility than a child, mostly due to societal issues

OBSESSED

... (text) ...

LEGAL INITIATIVES

- The Medical Termination Act (1986)
- The Medical Termination of Pregnancy Act (2002)
- The Sex Ratio (Regulation) Act (2006)
- The Prenatal Diagnostic Techniques (Regulation and Control) Act (1997)

CONSEQUENCES OF FEMALE FETICIDE

- Distortion in birth of population
- Adverse effect on societal health, socially, economically and demographically
- Threats to social, economically, culturally, religiously and morally
- Impact on birth of women

CONCLUSION

- Government should take steps to reduce the sex ratio and to improve the status of women
- There is a need to improve the status of women
- There is a need to improve the status of women
- There is a need to improve the status of women

LEGAL INITIATIVES

- The Medical Termination Act (1986)
- The Medical Termination of Pregnancy Act (2002)
- The Sex Ratio (Regulation) Act (2006)
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- The Prenatal Diagnostic Techniques (Regulation and Control) Act (1997)



Dr. Amirchand Prasad
CAC Connect

SAFE TECHNOLOGIES FOR ABORTION IN FIRST TRIMESTER

Dr. Amirchand Prasad
Medical Officer-in-charge, PHC Puspun, Patna, Bihar

BIHAR

Objective:
To discuss safe abortion technologies used at primary healthcare sites

Safe technologies for abortion

Vacuum Aspiration

Manual Vacuum Aspiration (MVA)

Electric Vacuum Aspiration (EVA)

Medical Methods of Abortion (MMA)

MMA is non-invasive non-surgical method of termination of pregnancy using combination of drugs (Mifepristone and Misoprostol)

	Vacuum Aspiration	MMA
Incidence of excessive bleeding	Lesser	2-4 times higher than MVA
Cervical injury, Uterine perforation	Lesser	Higher chances
Mediation required	Lesser	Greater
Recovery period and hospital stay	Lesser	More

VACUUM ASPIRATION can be performed using Manual Vacuum Aspiration and Electric Vacuum Aspiration.

- MVA uses a hand-held, portable syringe, whereas EVA uses an electrically operated device called suction machine.
- Vacuum aspiration is a safe and simple technique for termination of pregnancies up to 12 weeks of gestation.

What do we do in our facility?

- Treat women with respect and positive attitude
- Maintain privacy and confidentiality
- Emphasize on pre-procedure counselling:
 - To ensure consent for the procedure by the women after receiving complete information about the procedure
 - To help the women to adopt a contraceptive method after the procedure
- Post-procedure counselling is done so that women understands post-abortion care and what to do in case of complications
- Contraceptive counselling done and women offered basket of contraceptives for her to choose as per her choice and requirement.

→ Abortion care provided is comprehensive and women centric
→ Women go home after a short stay at the facility
→ Women go back satisfied with the contraceptive method in place to avoid future unintended pregnancies

RECOMMENDATIONS FOR STRENGTHENING WOMEN'S ACCESS TO CAC

- Public facilities need to be upgraded in term of infrastructure and HR required for the CAC service provision
- All trained providers need to be motivated and encouraged to provide CAC services on regular basis
- There should be awareness campaigns in the communities to increase awareness about CAC services and its availability at public facilities so that the women can get a safe and legal abortion service at nearby public facility



Ms. Anubha Singh
CREA

Creating Champions to Address Sex Selection and Improve Access to Safe Abortion

INTRODUCTION

To combat the issue of gender parity and equality, CREA and CommunitEaTH joint initiative, Creating Champions to Address Sex Selection and Improve Access to Safe Abortion, involves people together with the aim to strengthen capacities of women leadership. The programme aims to enable them to understand and have a common understanding and identify among individuals requirements for decision and sex selection from a gender and rights perspective.

CONTEXT

- Abortion is a legal service in India
- 6.7 million abortions are performed annually, 50% are unsafe procedures
- 80% of unsafe abortions are performed in unhygienic settings

FOCUS STATES

STAFF

1. To create a network of champions to address sex selection and improve access to safe abortion services.
2. To provide training and support to champions to address sex selection and improve access to safe abortion services.
3. To monitor and evaluate the impact of the programme on sex selection and access to safe abortion services.

STAKEHOLDERS

- Constituent Organizations
- Gender Rights Activists/Practitioners
- Health Care Service Providers
- Leaders
- Media
- Policy Makers

INSTITUTE PARTNERS (2013 AND 2016)

- 24 Karnataka
- 24 West Bengal
- 24 Bihar



Dr. Anupama Dhananjai
CAC Connect

MEDICAL METHODS OF ABORTION AND ROLE OF PRIMARY HEALTH CENTER

Chhattisgarh

Dr. Anupama Dhananjai
Medical Officer, PHC Chandkhuri, District Rajpur, Chhattisgarh

BACKGROUND

- Unsafe abortions make a significant contribution to maternal morbidity and mortality – nearly 8% of all maternal deaths in India are abortion-related deaths.
- Shortage of trained providers and lack of infrastructure constitute major barriers to safe abortion services
- Medical Methods of Abortion (MMA) is a safe technology for abortion care
 - Can be offered at all levels of health care, including primary levels
 - Preferred choice of women – maintains privacy and confidentiality, and addresses fear of surgery as there is no anaesthesia and hospitalization

MMA AT THE PHC LEVEL

MMA is a non-surgical, non-invasive method for termination of pregnancy by using a drug or a combination of drugs.

PHCs play an important role in providing CAC services:
 → PHCs are the first point of contact between the rural population and qualified medical doctor
 Access to MMA at PHCs prevents women from going to unsafe hands
 → First day for ABC check-up in every PHC – this provides an opportunity to provide pre-abortion counselling and post-abortion counselling for contraception to women who need it
 → Each PHC caters to a population of 35,000-50,000 and within 30 km periphery of villages – hence providing MMA at PHC is affordable, accessible and sustainable option
 → Offering early abortions using MMA would also be able to avert severe complications due to one-visit abortion

Counselling plays a key role:

Advantages of MMA

- Can be done at an early stage of pregnancy
- The process occurs at home
- Non-invasive method
- No anaesthesia needed
- Can be done in facility with less infrastructure/equipment

Limitations of MMA

- Requires multiple visit to the facility
- Women may experience nausea, dizziness and cramping
- Post procedure bleeding may be longer



Role of ASHA:
Easy availability of drugs without prescription or even the counsellor and incomplete knowledge about drug protocol leads to complications.

Orientation of ASHA to guide women to come to PHC can help in early abortion and reduce complications.

SUGGESTIONS

- Continued availability of CAC trained doctor at PHC
- Sufficient stocks of MMA drugs at PHC
- Provision of required pathology facility (Hb test, HIV test, Pregnancy test)
- Introduction of ASHA incentive for accompanying women to PHC
- Provision of proper transportation facility in case of referral

MMA at PHC makes safe abortion services affordable, accessible and sustainable for women.



Dr. Bharatkumar Mahale
CAC Connect

CHALLENGES OF PROVIDING CAC SERVICES TO YOUNG WOMEN IN TRIBAL AREA

MAHARASHTRA

DR BHARATKUMAR MAHALE M.D.
Obstetrician & Gynaecologist
Patangshah Cottage Hospital Jawhar, Palghar, Maharashtra

CONTEXT

- Geographically remote area
- 447 meters above seashore
- Part of northern Western Ghats
- 95% tribal population
- CBR is >21/1000 population
- 30% teenage pregnancies



Hospital Jawhar, India

In our facility, we provide:

- Emergency CAC services for immediate and missed abortion cases
- First day for MMA and second trimester abortion services
- Counselling services up to the 10th or 12th weeks in the same setting

CHALLENGES

TEENAGE PREGNANCY

Traditionally restricted, this is increasing!
 Early marriage before 18 years
 Lack of reproductive information among women
 Lack of interest about sexual communication etc.
 Pregnancy in school & college going girls

NUTRITIONAL ANAEMIA

Often frequent partner violence
 Anemia after haemoglobin release deficiency
 Not full range blood bank facility leads to delays MMA in multiple trimesters

DELAY IN PREGNANCY DIAGNOSIS

Multiple trimester abortions
 Unplanned pregnancies
 Anemia and poor nutrition
 Inadequate IUD kits etc.
 ASHA
 Pregnancy diagnosed in second trimester

UNSAFE ABORTIONS TRICKS

Unplanned self-medication of abortifacient pills
 Use of herbal abortifacients
 Abortion from untrained etc
 80% from unskilled/untrained ASHA

SPONTANEOUS ABORTION

Presence in despite being from non-haemorrhagic abortion
 Incomplete abortion
 Incomplete abortion need of consultation
 Haemorrhagic shock
 Severe abortion

MEDICO LEGAL COMPLEXITY

Unplanned pregnancy minor girls
 Missed pregnancy girls below 18 years
 Unplanned but unreported pregnant adult girls
 Fear about police & legal prosecution

INACCESSIBILITY OF CAC SERVICES

- Remote villages
- Lack of trained doctors & recognized centers
- No specified role of ASHA & ANM about CAC
- Phobia about MMR procedure
- Fear about disclosure of confidentiality
- Heavy charges in private centers

SUGGESTIONS

ASHA & ANM'S FOR CAC

- Adequate IUD kits supply
- Early pregnancy diagnosis
- Referral linkages to nearby recognized CAC centres
- Special incentives for promotion of safe abortion to ASHA
- Recording & follow up of abortion cases by ANM

EXPANSION OF ASHA PROGRAMME

- Weekly ASHA CLINIC in each PHC
- Dedicated MGR for programme
- Supervision of Medical Officer
- Coverage of school & colleges for counselling
- Outdoor counselling for non-school going girls

PHC AS CAC CENTRE

- Training of PHC doctors
- Development of PHC as CAC centre
- Free availability of ASHA at all PHC
- Free transport for referral of CAC cases



Ms. Mili Dutta
IIPS

Socio-Demographic determinants of second trimester abortion in the selected states of India

Mili Dutta
Project Officer UPAL, IIPS

INTRODUCTION

- Second trimester abortions contribute to 30-35% of all induced abortions worldwide and account for the majority of complications (Brenner, Swartzman & Callaghan, 2009)
- Mitigated Development Goals(MDG) is intended to reduce MMR by three quarter between 2002 to 2015 and can achieved
- According to World Health Organization (WHO), abortion accounts for 1.3% of maternal deaths, majority of second trimester

NEED FOR THE STUDY

- Comprehensive abortion care rate account of 97 aspects of abortion care including providing safe, high quality abortion, increasing number of accessible (physical) and women centers with sexual and reproductive health needs, understanding the determinants of second trimester abortion it will be helpful to reduce the incidence of second trimester abortion
- Presence of safe, high quality abortion care abortion care would save the lives of thousands of women each year

Objective

The objective of the study is to examine socio-demographic determinants of the second trimester abortion in the selected states of India.

Methodology

Data Source
District Level Household Survey (DLHS)4 Conducted in 2012-13 (DLHS-4 survey on 28 states of India which is included for the study)

Methodology
Percentage Distribution
Logistic Regression Analysis

Variables Description
Independent Variable: Second trimester abortion
Independent Variable: Age Group, Place of Residence, Working Status, Education Level, Caste, Religion

RESULTS

Figure 1: Percentage distribution of second trimester abortion

Figure 2: Percentage distribution of abortion by education level

Figure 3: Percentage distribution of abortion by working status

Figure 4: Percentage distribution of abortion by place of residence

Figure 5: Percentage distribution of abortion by caste

Figure 6: Percentage distribution of abortion by religion

Conclusion

- Women's older self-refer problem size of the higher risk of going for second trimester abortion. The prevalence of second trimester abortion is much higher among less educated women
- The higher education (going school) decreases the likelihood of second trimester abortion.
- One fourth of second trimester abortion is prevented by 50% provision in obtaining the women's health.

Cont...

- There is need to focus on the accessibility, affordability and availability of the family planning methods to reduce unintended pregnancies which is a major cause of abortion. Therefore to comprehensive abortion care services family planning should be given priority as this trimester pregnancy can be prevented or avoided to report.
- Promoting education and awareness is necessary to minimize the incidence of second trimester abortion.

Limitations

- Underreporting of abortion incidences in survey.
- Data on EMG status and Assam is not included in DLHS-4



Ms. Pallavi
Hidden Pockets

Hidden Pockets

Why Maps For Abortion Clinics?

Maps give us a sense of the city, and allow us to **explore** and **access** spaces in the city.


We can find theatres, pubs, cafes, restaurant, stadiums on Google Maps.

But where does sexuality figure in a map?


Sexuality is not marked on physical maps which makes accessing services around it difficult. We are dependent on google search and thousands of queries that pop on virtual space.

It is difficult to ask people around and in such scenario having a personal local guide is the most useful resource.


In such a scenario, maps like these not just provide location, they also ease out a lot of fears and anxieties that one might experience by providing information in other formats.




Abortion Clinics in Delhi



Psychotherapists




HIV and AIDS Anti Retroviral Therapy Centres




Hidden-Pockets is a feminist start up based out of Delhi, India. It maps pleasure pockets in urban spaces using digital language via maps, audio podcasts, walks and images. It constructs positive narratives around city and sexuality. It collects and shares existing data around pleasure within a city, and aims to provide ways to explore a city, without fear and guilt. Hidden Pockets, is a mapping initiative to connect these dots that are planted onto a virtual map, and make a sense of inter-connections between our personal and public spaces.

For more : www.hidden-pockets.com
Email us at: hiddenpocketsinfo@gmail.com



facebook.com/hiddenpockets



twitter.com/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 abortion in India.

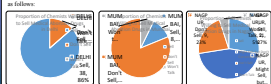
For ensuring and regulating right to abortion for women the government of India passed two major laws: Medical Termination of Pregnancy Act, 1971 (MTP Act) and the Drugs & Cosmetics Act, 1968 (DCA), and later released the Comprehensive Abortion Care Training & Service Delivery Guidelines (Abortion Guidelines, 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 access.

Research Methodology

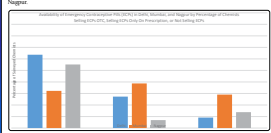
In June 2014, a team of health rights activists and advocates engaged in a fact-finding mission to investigate barriers women face in obtaining medical abortion in the state of Maharashtra. We surveyed hospitals and conducted interviews with gynecologists and chemists in Mumbai and Nagpur as well as 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 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 indicate one more than that in Delhi. Fewer chemists will sell ICPs over-the-counter in Nagpur than in Delhi, but more claiming to be chemists who do not sell ICPs over-the-counter are more likely to not sell than at all than in Mumbai.

Results from hospitals: In Delhi most of the 8 major public hospitals had Mifepristone, Misoprostol and ECPs in stock. As far as Mumbai is concerned out of the 8 hospitals (7 public and 1 private), among the 8 majority private medical abortion services by using prescription for women have to fill at chemist shops. Similarly, in Nagpur we met 4 gynecologists at 1 major public hospital and 7 private clinics and found the scenario is different. All 4 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 in the risk of arrest too great. Finding it difficult to obtain drugs from the manufacturers.

The issues 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 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, 2005.
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 unavailability, acceptability, unacceptance 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 facilities: Women have to search unavailability, acceptability, unacceptance and poor quality services or expensive private sector when faced with unplanned or unwanted pregnancies 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.



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

•Aimoy 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 Aimoy 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 Aimoy.

•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 especially for the rural poor leading to deaths



Mr. Ramu
IPS

DOES ABORTION INCREASE VULNERABILITY OF MENSTRUAL, SEXUAL AND REPRODUCTIVE MORBIDITY IN INDIA?

IAMS, International Institute for Population Science (IIPS), Mumbai
Email: iips@iipsindia.org

Introduction

The great health is a basic indicator of development and most health care index from any SDG related indicator.

More than 10 million induced and less than 10 million spontaneous abortions occur every year in India.

An abortion can occur spontaneously (miscarriage) or induced (involuntary or intentional).

An induced abortion is the termination of a pregnancy whether by surgery or by medication.

In India, abortion is legal for certain reasons based on the Medical Termination of Pregnancy (MTP) Act of 1971.

A combination of pregnancy control helps to ensure physical health of women.

Risks: Inevitable

Contraceptive failure among married women.

A substantial risk due to the MTP was found, it would rather have such physical related abnormalities than to voluntarily terminated.

Scope of the Review

Use of 10-15 million abortions happened in each year worldwide, approximately 27 million abortions are reported, which contribute the global burden of morbidity and mortality (WHO, 2007 & 2012).

India's high abortion rates among sexually reproductive complications that are not medical care. Women with this condition are commonly seen (WHO, 2007; Prasad, 2010).

Abortion poor health, lack of health care services, social stigma and other have increased vulnerability of MTP patients (Healthcare, 1999; Gupta, 2009; Singhani, 2010).

Study objectives

The primary objectives are:

- To provide the prevalence of abortion in selected background (rural/urban) in India.
- To explore the possible correlation of abortion and MTP among various menstrual problems, STIs, and STIs in selected background (rural/urban) among sexually related women age 13-49 years in India.

Study Design

This study used large scale survey from data from the third round of the Indian Family Health and Vitality Survey (FHVS-3), conducted by International Institute for Population Science (IIPS), Mumbai during 2007-08.

Methodology

Primary and Secondary sources were preferred using data of 225,278 sexually related women age 13-49. Provided information were examined using STATA software (v.11).

Descriptions of variables

Dependent Variables

- Abortion and prevalence of menstrual problems, STI, STIs

Independent Variables

- Place of Residence
- Age Group
- Marital Status
- Level of Education
- Religion
- Health Status

Results

Figure 1: Level of abortion among sexually related women aged 13-49 years in India, 2007-08. (n=225278)

Figure 2: Level of menstrual problems by abortion.

Figure 3: Level of STI/STI problems by abortion.

Table 1: Prevalence of abortion among sexually related women aged 13-49 years in India, 2007-08.

Abortion Status	Total	Spontaneous	Induced
Abortion	100	100	100
Spontaneous	100	100	100
Induced	100	100	100

Table 2: Prevalence of menstrual problems by abortion.

Menstrual Problem	No Abortion	Abortion
Menstrual Cycle	100	100
Menstrual Pain	100	100
Menstrual Bleeding	100	100
Menstrual Discomfort	100	100
Menstrual Irregularity	100	100
Menstrual Delay	100	100
Menstrual Excess	100	100
Menstrual Pain	100	100
Menstrual Bleeding	100	100
Menstrual Discomfort	100	100
Menstrual Irregularity	100	100
Menstrual Delay	100	100
Menstrual Excess	100	100

Table 3: Prevalence of STI/STI problems by abortion.

STI/STI Problem	No Abortion	Abortion
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100
STI/STI	100	100



Dr. Runa Bal
CAC Connect

PROVISION OF MMA IN PUBLIC SECTOR

Prof. (Dr) Runa Bal, Professor, Department of Obstetrics and Gynaecology
NRS Medical College, Kolkata

Introduction

- MMA is becoming popular day by day
- Acceptance of MMA is increasing among women seeking abortion
 - Age
 - Religion
 - Socio economic background
 - Mental status etc.

Transition of MMA in our setup

- Our hospital is a tertiary care hospital
- We cater to a wide zone of urban, semi-urban and some rural population
- We also get some referred cases from the peripheral set ups for MMA, like:
 - Clients with some medical problems
 - Post LUCS

Counselling

- Quick confirmation of pregnancy by card test as soon as a client complains of amenorrhoea.
- If she fulfills the criteria of MMA, counselling starts.
- It is done by a lady professional family welfare counsellor as well as by the doctors whenever required.

Highlights of our Counselling

- In easily understandable language of client
- Helps alleviation of apprehensions
- Clear explanation of procedure, side effects of drugs, success rate etc.
- Confidential and private

We Ensure

- Safety of the procedure so that the client becomes confident
- "zero expenditure, hassle free MMA service"- key of our success
- Maintenance of confidentiality

Ultrasonography

- Available routinely on every working day 24 X 7
- Emergency USG done 24 X 7
- Confirmation of gestational age
- Rule out ectopic pregnancy
- Checking BPOC

Associated Medical & Surgical Complications

If there is any (not an absolute contraindication)

↓

consultation of the respective departments (Onced, Cardiology, Hematology, Endocrinology etc)

Incomplete and Failed MMA process

- No delay
- Solved on Day care basis
- Emergency USG
- Emergency services of MMA as 24X7

RECOMMENDATIONS

Points to Highlight

- Providers should strictly adhere to the permissible gestational age
- Providers should maintain complete documentation for MMA

More number of providers...

- Orientation sessions on MMA should be done in the Undergraduate medical course

The eligible medical practitioners of the private set ups should also be trained to increase the pool of certified service providers of MMA.

Over the counter sale of MMA drugs should be banned



Dr. Sarita Khandelwal
CAC Connect

Experiences of providing safe abortion services in the context of PC-PNDT Act

Madhya Pradesh

Dr. Sarita Khandelwal
Principal at J District Hospital Raipur, Madhya Pradesh

BACKGROUND

The Medical Termination of Pregnancy Act (MTP) and Pre-Conception and Pre-Natal Diagnostic Techniques (PC-PNDT) Act are two acts for protecting women's interest.

MTP Act

- Enables women to take an early abortion under certain specific conditions.
- Specifies requirements for safe and legal abortion.
- 100% open but many women still afraid.
- Specify the state when abortion can be provided to women.

PC-PNDT Act

- Enforced to stop female foeticide and control the sex ratio and control the prevention of sex selection. "Under act after conception."
- Prevention of misuse of pre-determination leading to gender based sex selection.

CONTEXT

- Raipur has a sex ratio of 927 females per 1000 males. Major reasons can be attributed to deep-rooted social and cultural issues that value son over a daughter.
- Political scenario is focused more on implementation of PC-PNDT Act rather than giving equal emphasis on implementation of PC-PNDT and MTP Act.
- Due to implementation of "Beti Bachao Beti Padhao", a campaign initiated by the Government of Madhya Pradesh aimed at eradicating the declining sex ratio, state and district officials feel pressured to focus more on implementation of PC-PNDT Act as this campaign is under personal stewardship of the Chief Minister of MP.

CHALLENGES IN IMPLEMENTATION OF MTPACT

- Program focuses more on providing PC-PNDT Act which are strict in enforcement and regulation.
- Common ignorance of local health care providers with respect to implementation of both acts.
- Appropriate effort put in Raipur like a regular campaign in implementing district districts, where the District Magistrate issued a notice that all health care should undergo counselling along with identity record of women.

SUGGESTIONS

- Advocacy with policy makers and relevant officials to sensitize them on the need for equal emphasis on implementation of PC-PNDT Act and MTP Act.
- Facilitation of media on these Acts and guidance on correct terminology (eg. avoid use of words certain "Shon bharj") and appropriate use of graphics and headlines.
- Approved private clinics should display about the availability of abortion services so that women feel less stigmatized and are able to access services.
- Initiate Behavior Change Communication (BCC) for public and private providers for proper counselling and to motivate community to stop sex discrimination.

CONCLUSION

There is a need to clearly understand and explain the true intent of both the Acts so that healthcare providers and officials have a better understanding of what each does with regard to the protection of safe abortion and the prevention of sex selection. This way both the Acts can be implemented effectively without affecting the other.



Dr. Susmita Majumdar
CAC Connect

STRATEGIES FOR IMPROVING CAC ACCESS TO YOUNG WOMEN

WEST BENGAL

Dr. Susmita Majumdar
Medical Officer, RH Naripal, District Hooghly, West Bengal

Background

Ignorance of reproductive health, fear, personal inhibition, social taboos, superstitions cripple young women their senses and intelligence when they face a difficult situation like unwanted pregnancy. In this occasion they often become poor victims of various sorts of abortifacients and spurious procedures which lead to misery many a times.

Strategies adopted to overcome the challenges young women face

Sensitive and respectful attitude towards unmarried young women

- Privacy maintained to ensure anonymity
- Positive body language without bias, anger or judgment
- Encourage questions and answer patiently

Fixed day service for induced abortion

- Induced abortion services provided on fixed day to reduce loss of wages for daily-wage workers

Uninterrupted services

- Uninterrupted services for spontaneous abortion clients
- Less waiting period attracts young women

Sensitive and Friendly Counselling

- Clients feel free to speak which facilitates informed decision making
- Post-abortion contraceptive counselling provided

Contraceptive services

- IUCD services, if desired by the women, provided in the same sitting
- Tubectomy also done if requested by the woman

Follow up care

- Individualised follow-up to address post-abortion care

Initial results

Suggestions

1. Chemical should be provided for free, with a view to reduce the cost perception.
2. Airing of radio-visual media regarding dangers of self-medication with MMA drugs.
3. Necessary steps by service providers, for young women to be supported by family.

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.



E-63, Vasant Marg, Vasant Vihar,
New Delhi - 110 057
E-mail: cac-conclave@ipas.org

