Report of the Dialogue on Gender, Sex-Selection and Safe Abortion

Mumbai, 27 February 2013

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Organized by:

CommonHealth- Coalition for

Maternal-Neonatal Health and Safe Abortion

&

Centre for Enquiry Into Health and Allied Themes (CEHAT)

Introduction

Declining female sex ratio in India since the beginning of the 20th century has been a matter of concern. The female child sex ratio (0-6 yrs) in India fell throughout the last century. Sex determination and sex selection are one the many manifestations of son preference and daughter aversion. However, some of the steps taken by various state governments have contributed to denying women access to safe abortions compels them to seek abortions from unsafe providers causing an increase in maternal mortality and morbidity. The current challenge faced by advocates for sexual and reproductive health and rights is to speak out against sex-selection in favour of the male child on the one hand yet defending the right of a woman to access a safe termination of an unwanted pregnancy. Women's access to safe abortion services is under threat. As always, it is women from vulnerable and marginalised sections of society who are being most affected and bear a disproportionate burden of morbidity and mortality related to unsafe abortion.

CommonHealth- Coalition for Maternal-Neonatal Health and Safe Abortion, and Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai organised on 27 February, 2013, a day-long dialogue aimed at creating common ground between those working to prevent sex-selection and those committed to promote women's access to safe abortion.

The dialogue intended to cover the following areas

- the situation with respect to access to safe abortion services in India today, barriers to safe-abortion access, groups most affected, likely health consequences
- situation with respect to declining sex ratios: extent of the problem, causes, strategies adopted to reverse the trend; policies and interventions through which the campaign against sex-selection seeks to prevent the selective abortion of female foetuses
- Ways in which both groups can work together to promote gender equality, prevent sex-selection and promote access to safe abortion

The Dialogue was attended by 30 participants including seven persons from the host organisations.

The Context

The meeting started with Padma Deosthali outlining the context and rationale for the dialogue.

- Gender discrimination is at the root of sex-selection and is deeprooted within the patriarchal mindset. Unable to check "sex-determination" the government has shifted its focus to controlling "sex-selective" abortions and in the process cracking down on abortion services across the board.
- The Government of Maharashtra has taken a series of actions in response to the 'problem of declining female sex-ratios' (See Box 1). There have been attempts to ban medical abortion pills, reduce the gestation period for medical termination of pregnancy, remove 'failure of contraception' as legitimate reason for abortions and the "Silent-Observer" system to track pregnant woman using ultra-sound scan services for monitoring pregnancy.
- This has led to further stigmatization of women who seek safe abortion services. Many women are forced to utilise risky and hazardous services with serious health implications on women's health.
- Activism and advocacy should therefore focus on addressing the right of women to avail of safe abortion services keeping in mind this environment.

Participants' concerns related to sex-selection and safe abortion

Following the introduction to the Dialogue by Padma, participants introduced themselves and also stated one of their major concerns related to sex-selection and safe abortion.

One of the concerns related to access to safe abortion was a worry that the increase in sex-selection was increasing the stigma surrounding accessing abortion services. Another was service providers' negative and judgemental attitudes towards abortion-seekers, which could sometimes translate into verbal (and even physical) abuse during service delivery. One person noted the preponderance of denial of abortion services and expressed a desire to study the grounds on which women were turned away without an abortion.

Concerns were expressed about the prevalence of sex-selection even among the economically weaker groups such as slum dwellers. One of the participants had been working for the implementation of the PCPNDT Act for several decades and the task was far from accomplished.

Some of the most challenging issues related to the ways in which the two issues got intertwined, often to the detriment of both. The representative from UNFPA said that UNFPA had been working to prevent sex-selection for several years. This has been deliberately and carefully planned. What was worrying was the knee-jerk reaction by

BOX 1

Steps taken by GoM for addressing the issue of 'declining sex ratio"

At the policy level:

Measures to restrict abortion rather than liberalize it further

- Proposed ban on the abortion pill
- Proposal to remove 'Failure of Contraception' a valid reason for providing abortion
- Proposal for reducing gestational limit to 10 weeks
- Aurangabad and Latur – special 'permissions' before conducting abortions
- Proposed efforts to 'track' women to ensure that they do not abort (silent observer)
- Oak Committee formed for "coming up with recommendations for changes in MTP law to address declining sex ratio" –problematic recommendations : increasing documentation for second trimester abortions through pictures of abortus, restricting access to medical abortion
- Involving crime branch officers for implementation of MTP
- Call for declaring abortions murder

Consequences at the facility level:

- In light of the pressure to curb sex-selective abortions, individual providers refuse 2nd trimester abortion as it is difficult to ascertain that it is not sex-selective
- Some facilities have stopped providing medical abortion and sometimes even second trimester surgical abortion for lack of drugs (crackdown on pharmacies)
- As it is, abortions are difficult to access – second trimester even more so – result is that most vulnerable women are denied abortion
- Second trimester abortions – more likely to be unmarried women, result of non-consensual sex, not being able to access a facility in time, delayed recognition of pregnant status

At the community level

IEC material is misleading people

- Use of the term '*bhrunhatya*' or 'killing the foetus'
- Images that personify the foetus
- Images of violence against the foetus
- Barely any awareness about MTP

government whenever a further deterioration in sex ratio was in the news, which created more problems than it solved. It was important to ensure implementation of the PCPNDT Act but at the same time, one needed to work also towards changing the mindset that caused it.

The representative from Ipas said that Ipas had been working with the Central MoH and with state governments for the promotion of safe abortion and governments had been supportive. She wondered why, when both the MTP Act and the PCPNDT Act had existed for a long time the two were being linked in the current time period (when this was not the case earlier).

Another challenge was "How do you communicate about sex-selection without treading on rights to safe abortion"? The founder and chief functionary of Population First said a few words about how they were addressing this challenge through their Laddli programme with media persons.

A lawyer who has been working on reproductive rights violations including poor access to safe abortion services was concerned that the boundaries between the MTP Act and the PCPNDT Act were no longer being kept separate.

Other concerns included the intersection between the right to safe abortion and disability rights and the need for late abortions (beyond 20 weeks of gestation) in some instances.

An overarching concern that affected both the violation of PCPNDT Act and the availability of safe abortion services was raised by one of the participants, viz., the growth of an unregulated and profit-oriented private sector in health. The PCPNDT Act and the MTP Act both represent an anomaly in so far as they are the only legislations laying down standards and restrictions on an otherwise unregulated private sector. The dwindling availability of safe abortion services in the private sector (it s availability in the public sector has always been limited) may not be due to 'moral' concerns about sex-selective abortion of the female foetus as providers seem to claim, but because services such as assisted reproduction have become more lucrative to provide. Government's and public concern over sex-selective abortion may also have given providers the opportunity to project themselves as morally upright, at a time when the medical profession has been receiving a lot of flak for being commercially minded and lacking concern for people's wellbeing.

The sharing of participants' concerns and positions provided a good introduction for the rest of the day's proceedings. The next on the agenda was a presentation by Dr Leela Visaria on Understanding Sex Ratios.

Understanding Sex Ratios

- Globally, sex-ratio is calculated as the number of men to 100 or 1000 women. India still follows the 19th century system of representing sex ratio as the number of

women per 1000 men. The term 'sex-ratio' is often used without specifying the population age group to which it refers. It is worth noting that the sex-ratio at birth naturally favours males, and 105-107 boys are born to every 100 girls. Sex-ratio of the total population is influenced by migration, so in geographic regions where men out-migrate, the population sex-ratio may be favourable to women, while in urban areas and regions where men migrate into, the population sex-ratio may show a deficit of women. Since the 1981 census which presented information on population aged 7 and above (in order to calculate effective literacy rates), it has been possible to calculate the 'juvenile sex-ratio' – or sex-ratio in the 0-6 age group, a sex-ratio that is not likely to be affected by migration.

- The problem of skewed sex ratios in India has existed for over a century. There have been attempts since the first census in Colonial India to explain the gender anomaly. Genetics, age misreporting, fear of women being enumerated and a mortality bias (against girls) were all suggested to make sense of the difference in sex ratio as compared to Europe. Later the inherent "son-preference" leading to the neglect of girls' health and pockets of regions with female infanticide was identified as the cause for this anomaly in the sex-ratio in the country.
- Thus a skewed juvenile sex ratio in India is the product of gender-discrimination and one cannot blame the technological advances alone. There is female excess mortality in infancy and childhood in almost all states of India and this also contributes to a deficit of girls in the 0-6 age group. Technological advances have also enabled women to exercise their choice for a safe abortion. One therefore needs to focus on the root cause of sex-selection followed by abortion instead of portraying all abortions as problematic.
- Estimating changes in sex-ratio is a complex demographic exercise that requires following a large population over a significant period of time. Though there are celebrations over smaller improvements in the sex ratio these are not necessarily significant. For instance small changes in ward level sex-ratios in Mumbai which is calculated based on 1000 or 1500 births are questionable. At least 5000 births would be required to estimate the sex ratio and they would have to be followed at least for a period of 3 years in order to assess changes.
- There is also a tendency towards loosely using data without looking at spatial and temporal differentials coupled with the limitations of information and understanding the underlying contexts. Therefore enforcing a strong reporting system such as the Civil Registration System is crucial to analyse trends in sex ratios especially at birth.
- Furthermore there has been a systematic neglect of the MTP act since it was passed, except in the context of family planning. On the other hand, the PCPNDT Act has received tremendous and this is obvious in the effort of organizations such as the UNFPA.

- The important thing to understand is that sex determination is illegal, abortion is legal in the country and acknowledged the world over as a right of women. We need to separate these two issues. To link sex determination with abortion is the critical confusion that we have created. The lobby to support to support PCPNDT act is very strong now.

- Dr Leela Visaria ended her talk with posing some questions to the group. She challenged them to think through the following:

    - What will happen if we now scrap the PCPNDT act? Will things get worse?
    - Have things got better because of the PCPNDT Act? In what ways?
    - What would have happened if there never had been a PCPNDT Act? How did we manage son-preference and its manifestation before such an Act was promulgated?

  She believed that a genuine discussion around these questions would help us develop a better understanding of the strengths and limitations of the PCPNDT Act and also of how else we may be able to address the many negative consequences of gender discrimination of which sex selection was only one manifestation.

Abortion as a gender and rights issue

Dr Visaria's presentation was followed by a presentation by Dr TK Sundari Ravindran on safe abortion as a gender and rights issue.

- Nearly 15,000-20,000 women die every year in India because of lack of access to safe abortion services and thousands of others suffer ill-health. Every one of these deaths and disabilities in avoidable.
- Abortion is a gender issue – because unwanted pregnancy is in many instances the result of non-consensual sex, lack of information about sexuality and reproduction and unmet need for contraception.
- With only 1/4th of public facilities able to provide abortion services and 4 abortion facilities per 100,000 of the population the huge unmet requirement for such services can be deduced.
- Awareness about the legal status of abortions not only among women but also health-care providers such as ASHA is a major obstacle in enabling women to access abortion services.
- Another key factor is the nature of IEC materials on sex-selection which gorily depict abortion as murder. Therefore there is a need to engage with the groups working against sex-selection to point out how imagery hinders acceptance of abortion as a health right of women.

- Since only women need abortion services, restriction of access to abortion services is discrimination against women, and a rights violation.
- Access to safe abortion services is essential for the protection of women's right to health, and of their right to life.
- Women's right to enjoy the benefits of scientific progress and its applications, enshrined in the Covenant on Economic and Social and Cultural Rights, also implies that women should not only have access to safe abortion, but also to the latest methods, including medical abortion, deemed safe and effective for inducing abortion
- India has been a pioneer in making abortion legal. It is indeed a tragedy that we have not yet succeeded in making it safe for all women.
- It is time to reaffirm women's sexual and reproductive rights including access to safe abortion services – 20 years after ICPD, and also as a part of the quest for achieving MDG 5.

Following the presentation, suggestions were made for developing a pool of acceptable forms of imagery which can freely used by organizations, campaigns and activists without negatively portraying abortion such as the website www.creative-excellence.org.

Basic facts about medical abortion

Dr. Suchitra Dalvie made the next presentation which was on basic facts about medical abortion.

- Medical abortion is a method that causes miscarriage, a natural phenomenon in about 15% of all pregnancies.
- About 22% of all pregnancies are terminated through induced abortions, 15% end in still births or miscarriages and the remaining 63% result in a live birth.
- Medical Abortion is carried out using two drugs: *Mifepristone* and *Misoprostol.* How do they act? Mifepristone (the abortion pill or RU-486) is a medication that was developed and tested specifically as an abortion-inducing agent. It is taken in the form of a pill. It works by blocking the hormone progesterone, which is necessary to sustain pregnancy. Without this hormone, the lining of the uterus breaks down, the cervix (opening of the uterus or womb) softens, and bleeding begins.
- Within a few days after taking either mifepristone, a second drug, misoprostol, is taken. Misoprostol tablets (which may be placed either into the vagina, between cheek and gum, or swallowed) cause the uterus to contract and empty. This ends the pregnancy.
- Mifepristone or RU 486 was invented by Dr. Etienne-Emile Baulieu. Sir Malcolm Macnaughton, former President, Royal College of Obstetricians and Gynaecologists, U.K. called the invention of this drug "…. *an advance in reproductive medicine of the*

same magnitude as the development of the hormonal contraceptive pill **. . .**" The then French Minister of Health, hailed it as " *the* ***moral property of women*** *, not just the property of the drug company*."

- In India, the DCGI approved Mifepristone in April 2002 for pregnancy termination up to 49 days gestation.
- Misoprostol is on the WHO Essential Drug List, and In India it has been approved for use in prevention and management of post partum haemorrhage, cervical ripening and induction of labour.
- In May 2003 Rules and regulations governing the MTP Act were amended to specify that Medical Abortion could be provided by certified providers even in unregistered facilities as long as they had access to a registered facility for backup services.
- The Combipack of Mifepristone and Misoprostol available with social marketing organizations and at chemists is recommended for use upto 63 days.
- The accepted regimen for Medical Abortion is as follows:
  It is to be administered for pregnancies up to 49/63 days gestation. Ectopic pregnancy and blood group Rh type have to be ruled out.
  On *Day 1,* 200 mg of Mifepristone is administered orally (pill)
  On *Day 3,* 400 µg of Misoprostol orally/ under the tongue/ in the cheek
  On *Day 14,* the woman return for a follow-up visit. This is also the visit during which a method of contraception is initiated.
- The following table compares the advantages and disadvantages of medical abortion as compared to surgical methods:

METHOD	ADVANTAGES	DISADVANTAGES
Medical Abortion	Used early during pregnancy Resembles a natural miscarriage Often considered more private Usually avoids intervention Anesthesia not required High success rates	Often requires at least two clinic visits Takes days, sometimes weeks to complete Efficacy decreases at later gestational ages Women may see blood clots and the products of conception
Surgical abortion	High success rate (>99%) May require only one clinic visit Procedure completed within minutes Sedation is available	Involves an invasive procedure May not be available very early in pregnancy Often considered to be "less private" Quality of facilities may vary significantly

- Between 1% and 5% of medical abortion users experience method failure and continuing pregnancy. About 1% experience incomplete abortion that may need aspiration. Only 1%-2% experience haemorrhage that requires aspiration, and a very small proportion (0.1%) experience haemorrhage that needs blood transfusion. Infection and undiagnosed ectopic pregnancy are very rare.
- On rare occasions, uterine bleeding can be extremely heavy or prolonged. Some clinicians treat excessive bleeding with an ergot alkaloid such as methylergonovine maleate (Methergine) before resorting to aspiration. Bleeding significant enough to require transfusion is rare and is most likely to occur 1 to 3 weeks after taking the medications. Approximately 1% of women experience uterine bleeding that requires vacuum aspiration and about 0.1% require transfusion.
- Medical abortion can be taken with little medical supervision, therefore more mid-level health-care providers can administer the drugs. Medical abortion also represents an opportunity to vastly expand access to safe abortion for women: just 1% of PHCs are equipped to carry out surgical abortions, but all PHCs can provide medical abortion.
- There is evidence indicating that medical abortion drugs are being bought by tens of thousands of Indian women. In 2011 around 10 million (100 lakhs) Mifepristone pills are estimated to have been sold in India.
- The figures for sale of Mifepristone also call to question previous estimates of the extent of abortion in India.

Suchitra ended her presentation with the announcement of a new campaign in India. Some groups met in Delhi last month and agreed that we need to launch a campaign which will address both issues—women's empowerment as well as access to safe abortion. This campaign, called the "Campaign for Gender Equality and Safe Abortion Access" will be officially launched within the next few months. It was important for all groups and individuals concerned about women's access to safe abortion and about sex-selection to participate in this campaign.

Discussions

Following the three presentations, there were a number of comments from participants which are presented below:

- The MTP Act and the PNDT Act are the only Acts that set guidelines of how abortion facilities should function and be equipped. There are no regulations on the regular day-to-day functioning of other health-care facilities, nor is the functioning monitored in any way. Tight restrictions on eligibility to become a registered MTP

facility are forcing many of the facilities to operate underground. Therefore activists must challenge such tight regulations to enable better access to services.

- There is also increasing religious ideas that are shaping the discourse on sex-selection and therefore affecting the efforts to make abortion the right of the women.
- Since there is stigma surrounding seeking abortion, often women would be hesitant to report their knowledge about availability of services and their access to such services. It is important to interpret with caution data on women's lack of information about abortion and its legality.
- We need to explore further the shift in the attitude of gynaecologists from 70s where there was support for abortion services to the present times when there is so much resistance for it. Morality is the main reason cited for this shift by the doctors – in the 1970s they were willing to perform abortions because it was a social responsibility to control population growth. However, the fact that providing abortion services is no longer lucrative in the present times also needs to be considered. Anecdotal evidence suggests that since abortions are no longer profitable, doctors have withdrawn their support for medical termination of pregnancies. Medical abortions coming into the market have also undermined doctors' monopoly over abortion services. So they may no longer be interested in supporting it.
- The utilitarian argument that has underlined all population and health policies in India (e.g. safe abortion is needed because population growth has to be controlled; because women are dying from unsafe abortion) needs to be replaced with recognition of health as a right and entitlement. Safe abortion services need to be framed as a right of women and failure to provide women access to safe abortions, as a violation of their human rights. Such a paradigm shift should be the basis of campaigns for access to safe abortions.

Group Work

Post-lunch, participants divided into two groups, and discussed the following question:

What are the steps that we can take to work on preventing sex selection without compromising on women's access to safe abortion services?

The two groups deliberated on this question and reported back to the larger group. Many constructive and substantive suggestions emerged. These are summarised below:

***Suggestions for action from Group 1*:**

- There is need to map all stakeholders for both promotion of access to safe abortion and prevention of sex-selection; and to engage with them in a forum that discusses challenges and works together towards developing strategies to address both issues simultaneously.
- Connect with other civil society groups who work on these issues and reach a common understanding on issues and strategies. For e.g. what is our stand on using decoys and sting operations to identify violators of the PCPNDT Act?
- Identify strategies in campaigns for the prevention of sex-selection that may harm access to safe abortion, and avoid such strategies. (For example, gory portrayal of the destroying of female foetuses that send out an anti-abortion message)
- Put together simple fact sheets on certain issues such as sex ratios, medical abortion, emergency contraception and the PCPNDT Act.
- Create/identify spokespersons among health professionals, media persons and policy makers who can highlight /speak about both issues
- Use case studies such as that of South Korea which have been successful in combating the problem of skewed sex ratios with a female deficit
- Document denials of safe abortion services by doctors and work with medical professionals/ professional groups to improve access to safe abortion
- Create a regular forum for dissemination and sharing of work among those working for preventing sex selection, promoting gender equality and promoting access to safe abortion services. The Forum Against Sex-Selection (FASS) in Mumbai (representatives of which were present in the group) offered to be one such forum where regular exchanges and dialogue could take place.

Suggestions for action from Group 2:

- Better public communication and education materials need to be developed to address sex-selection against females. In particular, falling sex ratios should NOT be the focus of IEC material. Rather, the focus should be on challenging and changing son preference and daughter aversion leading to discriminatory attitudes and behaviours towards the girl child. IEC materials should address gender and patriarchy dimensions of sex-selection, highlight the systematic devaluation of women and girls at various stages of their lives, and also work towards creating a more positive image of the girl child and women.
- Activists, campaigners and educators should ensure that no conversations with any stakeholder happens about PCPNDT Act without also talking about its boundaries and about the MTP Act, and vice-versa – all conversations about the MTP Act should also clarify its relationship (or lack of it) to the PCPNDT Act. This applies to all stakeholders,

including PCPNDT and MTP cells, lower judiciary, health care providers at different levels, political representatives, women activists, and more.

- There can be a tie-up with a newspaper, those in languages, for periodic publication (fortnightly/monthly) of features that clarify the deep-rooted gender discrimination that underlies both sex selection and denial of access to safe abortion.
- Another strategy would be to challenge through litigation any use of the PCPNDT Act beyond its scope. For example, we need to counter violations such "Silent-Trackers" and other moves of the government that go beyond the scope of the PCPNDT Act.
- Use web-based platforms such as the Ushahidi to source real-time information publicly on occurrence and geographical location of incidents of denial to women of safe abortion services. (For an illustration of how Ushahidi is used to map geographically maternal deaths, visit http://liberia.ushahidi.com/reports/view/632. In India, SAHAYOG uses it to document informal fees collected in government health facilities. Visit http://meraswasthyameriaawaz.org/page/index/2).
- There is need to come up with indicators other than sex ratio to track incidence of sex-selection.
- It would be useful to explore progressive trends in religion and religious texts that support abortion and to use this for advocacy purposes.
- There is urgent need to work with medical students to prevent the development of anti-abortion attitudes and to impress upon them the circumstances within which women's need for safe abortion services arises; and also uphold what constitutes ethical treatment of women seeking safe abortion services.

Way Forward:

- The "Anti-Sex-Selection Campaign" and the "Right to Abortion Campaign" are not on opposite sides. Both are deeply concerned about gender discrimination and committed to promoting women's rights. In fact, many individuals and organizations are active in both campaigns. This meeting has been another step forward towards working together to maximise our synergies.
- Each one of the organizations present may disseminate widely the action points from this meeting in any forums, workshops, meetings and trainings that they organize or participate in. Online forums such as the http://fassmumbai.wordpress.com/ need to be more active on the issue.
- There is need to document discussions held during such meetings on abortion in order to disseminate the information to other partners in the campaign.
- CommonHealth's website http://www.commonhealth.in/ provides access to a large number of reports and the latest data on reproductive and sexual health, including data needed for advocacy against sex-selection and safe abortion. Participants may please send CommonHealth resources that they have produced on these topics, to

help build a pool of resources for both advocacy and for developing IEC materials for public education.

- Organizations and activists as they come across public personas and spokespersons of the cause of women's rights and health rights should educate them on the right terminologies to be used – for example, never to use the term 'foeticide' which has the connotation that an abortion is "murder of the foetus" and is therefore anti-abortion language. It is important that a culture of appropriate terminologies and concepts develops within the campaigns for prevention of sex selection and promotion of access to safe abortion.

Annex 1

AGENDA

10.00 -10.30	Registration and tea
10.30-11.00	Introduction and rationale for organising the dialogue
11.00-11.30	Self-introduction by participants and sharing of one major concern related to sex-selection/safe abortion
11.30-13.00	Understanding issues and concepts: Sex Ratios: Professor Leela Visaria; Safe abortion as a women's rights and health issue: TK Sundari Ravindran; Frequently asked questions about medical abortion: Dr Suchitra Dalvie
13.00-13.45	LUNCH
13.45- 15.30	Group work (*Action points for working in Maharashtra on preventing sex selection without compromising women's access to safe abortion services)*
15.30-16.15	Groups report-back, discussion in the large group on the Way Forward

Annex 2

List of participants

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27	Sana Contractor	CEHAT		
28	Siddharth	CEHAT		
29	Himanshu	CEHAT		
30	Premila	CEHAT		