**Report of the National Consultation of Safe Abortion and Sex Determination**
**21st to 22nd April 2008[1]**

## Introduction:

With a welcome to all participants, a brief background to the present consultation was provided. In recent times, the National Abortion Assessment Project coordinated by CEHAT and Healthwatch Trust brought together many researchers and experts in the field of abortion. The project has produced massive evidence on various aspects of access to abortion care for women in India. In 2006, a similar process brought several organisations namely ARTH, CEHAT, FPAI, IPAS, Pop Council and SoMI together to form a consortium for safe abortions in India. The consortium seeks to improve access to comprehensive abortion care for women in the public health system through setting up of intervention sites in two primary health centres in two states. In addition to this it also advocates for expanding the provider base for abortion care and is working in two states towards better implementation of the MTP Act. As part of the conceptualisation of this work, especially on advocacy for implementation of MTP Act, several discussions took place and very early on the concerns related to the impact of the campaign on sex selection was brought into discussion. It was then agreed that CEHAT would hold a consultation to deliberate on abortion rights and sex selection.

Around the same time, there was a meeting called by the MOHFW for discussing amendments to the MTP Act. While some positive and progressive amendments were agreed upon by the group, one contentious issue was related to 2nd trimester abortion. During this meeting and a few events following that, it became evident that a dialogue on the issue was essential. A few civil society groups and the representatives of the PNDT Cell of the GoI strongly recommended further restrictions to 2nd trimester abortion and cited this aspect of the MTP Act as being the biggest barrier in implementing the PCPNDT Act.

The consortium members decided to expand this discussion and invited other groups working on women's health and concerned about the issue so the HealthWatch forum, MASUM, ANS, CMNHSA were invited. While planning for a national consultation, the group strongly felt the need to launch a campaign for safe abortion. In India, there has not been a campaign clearly demanding right to abortion for women. It was felt that this required at least a two year sustained effort that engaged with various stakeholders.

The group decided that a consultation for arriving at better clarity on safe abortion and sex selection was a must. It also identified three core issues that it would focus on:

- Improving access to safe abortion
- Addressing gender discrimination including sex selection
- Affirming women's reproductive rights and right to self determination.

The two days programme had been conceptualised by the working group. Following this, an overview of the planned programme for the next two days was provided. It was reiterated that this was a consultation and an attempt to bring together people working in the field to proactively

[1] *Report Compiled by Aarthi Chandrashekhar and Padma Deosthali*

address the issue. The outcome of the consultation would depend on the manner in which the discussion would evolve.

A round of introduction by the participants followed.

**SESSION I**

**SAFE ABORTION: WOMEN'S PERSPECTIVES**
Presenter: Renu Khanna
Chairperson: Padmini Swaminathan

Padmini expressed her concern about the issue by giving an example of the rising number of unwanted pregnancies among young women in the informal sector in Chengealpattu, Tamil Nadu, where there has been a shift from agrarian sector to the industrial sector.

Renu began by saying that women, even today, view abortion as an illegal act. The stigma is compounded by lack of knowledge that abortion is legal and can be sought. She spoke of a study that they conducted in the Gynaecology OPD of V.N. Desai hospital, Mumbai, where most women came with concerns surrounding MTP. In Surendranagar, Gujarat, women wanted other health services in close proximity but wanted abortion services far off so as to maintain anonymity. Most women were unwilling to seek abortion services from the public health system because of concerns about confidentiality which could override the cost factor.

According to studies by B.Ganatra (2000) and S.Jejeebhoy (1996), most abortion seekers were between the age of 20 and 29 years, married with two or more living children. 2-30% of abortion seekers were unmarried women of which 50% were adolescents. Adolescent and unmarried abortion seekers were more likely to be illiterate and belong to lower socio economic group than other abortion seekers. Reasons behind women seeking abortion (in order of occurrence) included reaching family size, birth spacing, sex-selective abortions, medical reasons, failure of contraception. Abortion, however, is used as a last resort when women have little control over sex in their marriage or use of contraception.

Sex selective abortion seekers "...were significantly more likely to come from joint families and were better off economically (as measured by owning a house with a separate kitchen and irrigated land) than women who had an abortion for other reasons. However, they had less autonomy and mobility, and were less likely to play a major role in family decision-making. They were also less likely to have an independent source of personal income and even when they did earn money, a significantly lower proportion of these women were able to keep or spend their earned income (12.5 versus 38.4 per cent)" Ganatra et al. 2001**,** Sex-selective abortion: Evidence from a community-based study in Western India, Asia Pacific Population Journal 16(2): 109-124**.**

Renu presented testimonies of women that echoed being blackmailed and suspected if they were reluctant to have sex with their partner for fear of an unwanted pregnancy. In one case the woman threatened to commit suicide if she was not provided an abortion.

Abortion seekers chose the private sector over the public sector owing to less time taken, availability of better facilities and assurance of confidentiality and privacy even in sex-selective abortions. Women emphasised the need for confidentiality and respect. Practice of self-induction or using informal providers remained the first choice among unmarried women, adolescents, rural and economically disadvantaged women. Reasons such as lack of knowledge concerning legality of the MTP Act, lack of decision-making power, cost factor also prevented women from seeking safe abortions. In doing so she highlighted various quotes of women seeking abortion services.

She said that the campaign would face a huge challenge because it is centred around the public sector while most women prefer going to the private sector. She said that her presentation was meant to set the tone for the discussion by bringing in women's perspectives. Renu encouraged participants to take the discussion forward in line with reproductive and sexual rights and safe abortion - the issues that need to be taken up in the campaign. This presentation was in the spirit of opening up the discussion.

While opening up the discussion, Padmini said that the voices of males as husbands, boyfriends, fathers-in-law need to be included in order to strengthen the campaign.

**Discussion**

The various issues that came up during the discussion are summarised here.

- Women increasingly see the availability of drugs for medical abortion as a self-medicative process. The easy availability of the drugs in the country is rankling enforcement agencies. Interaction with adolescents indicates that the media has a strong impact on their mindset. The emergency pills that are sold over-the-counter have increased the risk of unsafe abortion.

- Bela clarified that the morning-after pill is essentially a contraception which differs from medical abortion drugs that are at the moment available only on prescription by gynaecologists. These drugs have been available since 2002. There has been fear of misuse and efforts have been made towards controlling these drugs. A study in Bihar on the use and awareness of medical abortion showed that it was not being used widely in the form of self-medication. Other forms of oral drugs – Ayurveda and indigenous medicines were being used as they were much more easily available, at a fraction of the cost.

- A question was raised whether or not to differentiate between access to abortion services in the context of determinants of abortion.

- Concerns around the invisibility of women's perspectives on abortion were expressed. Although abortion is a woman's issue, often her voice is not heard. Little is know about women's perspectives on sex selective abortions and the context in which they became pregnant. The discussion needs to include ways in which their dilemmas will be addressed.

- It was brought out that abortion has never been discussed in the context of rights, but in the context of family planning. There must be a clear understanding about access and women's right. For example, medical abortion could have adverse effect on women's health and may lead to deterioration of her nutritional status. There is increased potential for abuse. Keeping these factors in mind, women's groups have not favoured medical abortion. (this was later clarified during the discussion and also through a presentation on the next day)

- The issue of public hospitals offering abortion on condition of sterilisation (for married women) was brought up. It was also brought out that unmarried, under-aged girls were at greater risk. Most women do not access public hospitals in rural areas; those who go to untrained attendants are at great risk. At the State level, there should be access to information to increase access to abortion.

- An observation was made regarding women negotiating some kind of choice in terms of abortion. The Women's Movement definitely created awareness among women of being wronged, but there are various challenges in articulating choice. In a study with the BBC, it was found that younger women and their young partners were most likely to challenge norms. It is difficult to speak about abortion as a right. The methods of abortion are imposed on women and unless the conceptual framework is recognised, the campaign will not be very successful. To form an understanding of the different ways in which abortion is carried out, the science of abortion also needs to be looked at. This was said with reference to medical abortions.

- There was some reflection regarding the history of the MTP Act as compared to the PCPNDT Act. The MTP Act was made in 1971 following the Shah Committee report that threw up evidence on large number of unsafe abortions. This committee has been set up to enquire into reasons for maternal mortality. The report highlighted the lack of access to contraceptives and several deaths due to unsafe abortions. Abortion was never placed in the context of rights in India. Internationally, India is viewed as being liberal with respect to abortion; but this is not actually so. Abortion has been a moral issue.

- Another issue that was pointed out was the importance of ensuring quality abortion services followed by counselling. Post-abortion counselling, although an important service is not easily available. There are many young and unmarried women who had been thrown out of their homes after they sought abortion services. Many unmarried women therefore, claim to be married. There are neither counselling services available, nor provisions for follow-up. The campaign needed to take this into account. There were also caste/class issues in accessing abortion services.

- Women rarely have any choice when they undergo abortion. There is a dearth of trained abortion providers in the public health services. Quacks are in large numbers and the campaign needs to look into provision of safe abortion services.

- An unsafe abortion is only one of the end points of unwanted pregnancies. Often women are forced to commit suicide or abandon infant after birth. A woman's limited access to

contraception and lack of sexual autonomy results in unwanted pregnancy. All the pathways need to be studies as each has some risk. The safest option for these women needs to be identified.

- It was felt that the campaign should on making abortion a priority for public health services.

- There was a need to retain women's voices in the campaign and also continuously understand women's perspectives.

- The barriers in accessing abortion and limitations of the MTP Act too should be taken up by the campaign as the law continues to provide abortion under certain condition and not as a women's right. It therefore remains a moral issue for women as well as providers.

- There was mention of a study that showed Muslim women as being vulnerable due to the religious opposition to sterilisation. Someone pointed out that there are also sections of the non-poor such as adolescents who were vulnerable. Among tribes in the North-East, there are unwanted pregnancies due to sanctioned premarital sex. Religion too puts women at the receiving end; Catholic gynaecologists refer women with unwanted pregnancies to chemists for medical abortion drugs. The government does not provide abortion facilities. They tell voluntary organisations advocating abortion centres to leave aside the abortion issue saying they are in the process of upgrading facilities.

- The campaign also needs to look into the methods of abortion, wherein D and C continues to be extensively used despite availability of safer methods. One voice asked whether the campaign would only centre around modern technology or address safe traditional methods of abortion too.

- Amongst reasons that push women to seek abortion, a nurse shared that there are a number of student nurses who resort to abortion despite planned pregnancies only because they are not permanent employees and will not be granted maternity leave. This has been the trend in the last five years.

- There was a suggestion that the campaign should build a ground for abortion as a right, keeping consent and autonomy of the woman at the fore. It is not just about safety and access but also about her decision. The current law is not in this spirit. For example, all women with mental illness need a guardian to sign the paper before undergoing abortion as per the law.

Asha summarised the discussion on the basis of themes that emerged:

- The context of women's circumstances – caste, religious and social - needs to be looked at in order to profile them.
- Looking at unwanted pregnancies, how they come about and consequent inaccessibility to safe abortion.
- The risk women face in continuing with the pregnancy.

- The ongoing debate in India is whether the public sector views access to safe abortion as a priority.
- The methods used – D&C being the most unsafe of the methods and its wide use.
- Discussion of stereotypes that exist within individuals in the consultation.
- Revisiting the understanding of risk.
- Promoting entitlements for safe abortion.

- A participant said that if access to second trimester abortion is restricted, it would hit adolescents and unmarried women the most. It is necessary to be conscious of this social profile.
- Padmini spoke of the seven states study on safe abortion. She mentioned that in the study in Gujarat several doctors spoke of the emotional distress they experience after performing abortions. When talking of abortion, it is only seen in terms of the woman's right; what about the doctor's right to refuse to perform abortions owing to the distress caused. Most studies are to do with poor women. Soap operas portray the middle and upper class women getting married and wanting an abortion. But the man talks of his right to the child. The question is how far women's rights can be stretched. These are issues that need to be looked at when chalking out a future plan for the campaign.
- It was also pointed out that amongst providers the notion of the husband's right over the foetus is very high and is reflected in their insistence on getting the paper signed by the woman's husband when she comes for an abortion when as per the MTP Act this is not a criterion.
- The framing of rights needs to be done carefully after adequate consideration to possible opposition and backlash.

**SESSION II**
**DECLINING SEX RATIO & CHALLENGES IN FORESTALLING THE EVIDENCE**
Presenter: Leela Visaria
Chairperson: Subhash

Leela said that the lack of research studies on abortion and related issues prompted her as part of Healthwatch to undertake research in collaboration with CEHAT. She presented the current scenario where deficit of women has progressively increased in India's population from 972 women per 1000 men in 1901 to 933 per 1000 men in 2001. The main causes of declining sex ratio are social and cultural practices. This is starkly indicated in the north where there has been a dramatic decline in the sex ratio.

Decline in sex ratio can also be attributed to new technologies like portable sonogram which have made sex selective abortions possible. Studies showed that in Punjab, Haryana, Himachal Pradesh, Gujarat, deficit of girls among 2nd and 3rd child was greater compared to 1st child and when there was already one daughter. There was also a deficit of girls among educated, landed, high caste women, indicating a preference for certain sex composition of children, while keeping the family small.

The campaign against misuse of prenatal diagnostic techniques in Maharashtra in the 1980s led to a ban on the practice in 1986. The Government of India enacted the PNDT Act in 1994.

Owing to public interest litigations by health activists to make this Act more stringent, its scope was expanded and it came to be known as the PCPNDT Act in 2003.

Measures were taken to bring an end to the prevailing practice of sex selection and sex-selective abortion. The mass media was used extensively to spread messages about the value of girl child and posters were displayed. National advocacy and communication strategies were developed. These measures have helped keep the issue alive whether or not they have succeeded in putting an end to the issue itself. Although the Act increased awareness among people, the practice of sex determination and sex-selective abortion continues. The Act has also created confusion; many interpret it to mean that all abortions are illegal. This has resulted in reduced access to safe, legal and affordable abortion.

She emphasised on various challenges. One of them was with regard to development in medical technology that may make it more difficult to rely on legislative measures to control use of new techniques for sex determination. For example, a simple blood test may be used for determining the sex of the foetus. The distinction between physiologically abnormal foetus for which termination is legal and termination of a foetus that is sociologically undesirable is often confused. When getting into the campaign mode, this needs to be addressed rather than pushed under the carpet. She also spoke of the confusion created by some activities when they demand that records of all women seeking medical termination of pregnancy be made public. This would further reduce women's access to safe and legal abortion.

Statements such as "*the decline in sex ratios has reached grave and alarming proportions"* and *"India is on the brink of a demographic catastrophe"* need to be widely debated for underlying assumptions. There is hue and cry about moving towards a womanless society and being unable to find brides. Leela spoke of a research study about the number of men bringing in brides from other castes. Only about 2% of them did, but even a single such case created uproar.

She emphasised the need to work with members of the Indian Medical Association and Federation of Obstetricians and Gynecologists to abide by the stipulations of the PC/PNDT Act. Ethical considerations should be discussed in the medical curriculum and legislations that directly affect the practice of physicians should be incorporated.

The final aim should be towards changing ingrained attitudes about the value of women.

**Questions and discussion**

- Leela was asked whether as a demographer, she would form a link between the declining sex ratio and sex-selective abortion.

Leela responded that there is enough literature to prove this link. This has been noted as far back as 1901. There are studies that show several factors that have led to the decline in sex ratio such as under-remuneration of girls. In the 60s and 70s, health care of girls was neglected. Between boys and girls, girls were taken to health care providers at a later stage. Girls from the age of 5 years to their reproductive period, experienced greater mortality than their male counterparts. Discrimination has always existed; now there has been a shift towards sex-selective abortion. If

the sex-ratio is calculated by birth order, the number of girls is very low: for the third child, there are 250 girls against 1000 boys.

- Another question was whether she would call this declining sex-ratio a demographic catastrophe. Leela replied that this would depend on the tolerance level of people – how far they would consider the declining ratio as appropriate.

Abhijit added that this was not an issue of discrimination, but of technology. He asked whether she saw this as a problem of discrimination or violence. A third point made by him was implied personhood when speaking of pre-birth elimination of girl children and the girl's right to be born. He stated that he did not consider this a right. He was of the opinion that a short term emotional approach be worked out. He expressed his view of the possibility of positive change just as had occurred by the passing of the Sharda Act that increased the age of consent for marriage to 18 years for girls and 23 years for boys. In twenty years, there was drastic change in accepting this age of marriage. This could be used as an example in strategising without losing focus of the campaign.

- A point was made based on Leela's presentation which seemed to indicate that the rich who are actually a minority in our country are accessing technology to undergo sex determination. How would this minority affect the sex ratio to such a large extent? Leela said that in a study conducted on a small sample in Gujarat and Haryana, the sex ratio was found to be consistently low among the literate and the landed. This was not the case among the scheduled castes. The rich had access to technology which resulted in pressure from families.

- Bela was of the opinion that the sex ratio at birth and juvenile sex ratio were thrown around depending on the data. She also mentioned a study by demographers that claimed male-selected abortions in higher birth order, which meant girls were favoured. She wanted to clarify whether this could be true.

- Leela clarified that she used the terms accepted internationally which measured the number of girls per 100 boys. In India however, sex ratio is measured per 1000 boys. Assuming no discriminatory practice and equal mortality, the sex ratio should be 940-950 girls per 1000 boys. This ratio will remain so till the age of 6. The ratio also indicated 972 in some parts of the country which indicated some error in analysis. Anything below 950 is considered a threat. The life expectancy of women beyond reproductive age is high, hence the overall ratio would differ wherein women may outlive men. Another concern is that most births are not recorded.

- It was shared that in 2007, in Himachal Pradesh 878 births of girls was recorded (with a 90% birth registration). This was calculated over the last five years. Leela replied that this was difficult to accept. In Kerala, the sex ratio was reported as normal and birth registration is high (95%). But they may well visit the hospital for delivery after having undergone sex-selective abortions.

- Lester explained Kaushik Basu's Game Theory which put forth that sex selection for a boy would actually benefit the girl. The desire for fertility would be greater when the first child is a girl. But with advancing technology people do not even wait for the first child and go in for sex-selective abortions. 15-17% of parents who go through prenatal diagnostics would go in for sex-selective abortions. He wanted to know whether this explained the general trend. Leela said that this was true of certain pockets of India. Orissa had recorded a decline in sex ratio from 933 to 932. **Though it is stated as a cause for concern, it is not really so. In her opinion it was not a national issue.** She explained the issue in terms of the probability theory. There was equal probability of the first child being a girl or a boy. The condition remains the same for the second child too. Thus, 25% would have two girls and 50% would have one boy and one girl. This entire issue, in her opinion, has become an issue of concern only because of the hue and cry raised in the international arena. Things would settle even without any interference.

- Leela's use of sober language in place of usual terms like foeticide and gender cleansing was appreciated by all. One participant shared findings of one of the studies that clearly indicated rampant sex determination among the Scheduled Castes. The emerging one-son norm was a result of the agrarian crisis and not just gender-related. She also mentioned other studies by Satish Agnihotri and others which recorded the existence of sex determination. This is similar to discussions in 1985 when concerns over the demonstration effect that had taken place with dowry too whereby dowry had filtered to several areas in the country where this concept had never existed before. Leela agreed that this was also the case in Gujarat where families wish to have one son. Leela said that while there is evidence to show a decline in son preference, there is no study that shows an increase in value of daughters. She said that a 2% fluctuation in sex ratio was normal.

- Mary cited a study from the Lancet which showed the rising number of sex selected abortions among NRIs, Chinese and Koreans. Masculinisation is also maintaining itself. There is a decline in the number of deaths among baby boys. This may be attributed to availability of good health services.

- Issue was raised about whether the campaign could argue for the woman's right to have a son when speaking of rights and self-determination. There needs to be a clear idea of whose rights are being addressed. The whole issue of sex selection seems like another target approach – from the family planning target of reducing the number of children per family, there seems to have been a shift in target to having a certain number of girls.

Leela said that she had a positive approach towards the matter. She reminisced that as a field worker among the OBCs fifteen years ago, a couple did not see each other until they were married. Today, they meet before marriage and the girl is asked whether she would like to go ahead with the marriage. Even though in actuality, the woman may not have the space to decline the offer, there has been a positive shift towards asking the woman about her opinion on the matter. She emphasised the need to appreciate incremental changes such as these rather than expect dramatic changes.

An important concern was raised regarding the way the data is being used and how the problem get framed. Often it depends on who is funding the project. Another matter of focus would be to decide whether it should be viewed from the human rights perspective or the demographic perspective. These complex processes need to be unpacked. There is a tendency to get caught in these dynamics.

When speaking of 2% fluctuation in sex ratio, the tolerance level needs to be identified. Does it mean it is alright for 2% to die in Sati burning or must this be viewed from the social justice perspective where there would be zero tolerance and this kind of fluctuation would be completely unacceptable.

It was suggested that the non-negotiables be listed. The evidence must also be kept in perspective. These will be valuable in beginning the work. The values behind the various arguments presented, need to be listed too. There must be clarity about the funding agencies behind different evidences that are brought out. There is a tendency to buy the rhetoric easily. Alignment can be placed only when there is an awareness of where the difference lies.

There needs to be an understanding about how sex ratio got linked to the campaign and the fall-outs associated with it. In strategising, there is a need to see who the actors are, without being naïve about it. While working with the community, the campaign may have taken the stand of abortion as a right of the woman, but abortion on the basis of discrimination needs to be discussed.

One of the participants (Subhash) said that as a citizen of India, he would abide by the fundamental principles of the country. Hence, he was against abortion on the basis of any form of discrimination.

**SESSION III**
**EXPANDING SAFE ABORTION**
Presenter: Bela Ganatra

Thirty six years after the legislation on sex selection, there is still dearth of information on abortion. Official statistics such as NFHS underreport as much as 8-10 times. Morbidity is not declining; severe life threatening conditions continue to exist. The rural, poor and illiterate remain vulnerable. There are a large number of informal abortion service providers who even use invasive methods.

Another point that was brought up was the issues around technologies and barriers that are not within the law. Discrimination is not equal to decline in sex ratio. There are other aspects of son preference that affect sex ratio. No matter how liberal abortion laws are made, son preference will continue to be practiced in our society. There is no cause and effect relationship between sex ratio and abortion. Not all abortions are carried out owing to sex selection. Failed contraception is a common reason for abortion. Second trimester abortions are held culprit and banning it is considered the solution. But as per the data of recorded MTPs, it is evident that delays occur for a variety of reasons. There is increased morbidity and mortality rather than decline in number of abortions and an increase in unsafe abortions.

Across the world, clamping access to abortion has led to an increase in unsafe pregnancies and abortions. Sex determination if banned, is the same as placing a ban on abortions. Emergency contraceptives were taken off the shelf in Tamil Nadu considering it a method of abortion. Labelling the foetus as male or female amounts to personifying the pregnancy. Different posters carry blatant messages to discourage abortion. Having such posters makes it difficult to counter emotionally targeted information.

A participant articulated the need to personalise women's voices rather than personify the foetus. Attention was brought to the fact that if sex selection was accepted in the campaign, the pros and cons must be well thought out. A likely way of looking at this issue would be by studying other countries that have dealt with this matter.

**Situational Analysis with respect to implementation of PNDT and MTP in Rajasthan and Maharashtra:** Presenter: Leni Chaudhary and Sharad Iyengar

The Maharashtra presentation showed that 83% MTP services were provided by private sector while only 17% were provided by public facilities. There has been an increase in number of registered abortion facilities in the state, the District Level Committees too have been formed. The implementation of the PCPNDT has however been poor. There was no glaring evidence that indicated backlash due to the campaign. The Rajasthan findings showed the poor registration of facilities, lack of abortion facilities in the public health services, poor reporting and data management within the government department. The poor implementation of the MTP Act was evidenced. Through the presentation, Sharad spoke of recent events such as the Sahara Sting Operation on doctors providing illegal abortion services and the practice of female foeticide. A certain sect of the Jain community has created an uproar over the entire issue of female foeticide. A content analysis of messages and posters was also presented. It clearly reflected the prevailing hostility towards safe abortion in Rajasthan. Another point brought out was that medical imagery made it appear as a medical problem rather than a social problem.

**Discussion:**

It was pointed that there was a need to develop a methodology for critiquing the campaign material produced on sex selection. The messages need to be looked into and disputed. The campaign did yield good results in creating awareness amongst women about the location of the womb. A poster with too much information may provide factually correct information but may not serve the purpose.

There was a suggestion that a mass media campaign targeting the urban population needs to be developed.

In Maharashtra, there has been a fairly structured method of implementation especially of the PNDT. Reporting has been quite responsible in Maharashtra – sex selection has largely remained a part of PNDT and not mixed with MTP. There was a general difference in governance in the two states.

When speaking of sex selection, the issue of disability rights also comes in. Even child rights groups are articulating anti-abortion positions.

Posters and material of both states seem to draw a link between sex determination and abortion confusing PCPNDT and MTP. There was a need to work on son preference.

Concerns about the need for the campaign to have conceptual clarity, not target abortion or women. While the campaign against sex selection and demand for implementation of PCPNDT has been active, there is no one accountable for implementation of the act. Hence if there is a decline in sex ratio, no one would be accountable. Social justice and social accountability needs to be looked at. The government has taken different steps in the case of girl children such as depositing Rs.100/- on the birth of the girl child which can be redeemed when she turns 18.

An opinion was that our society is not yet ready to work for abortion as a right. There are several religious sects who will remain opposed to this concept. Another way of looking at the sex selection campaign is to think of ways to improve it, engage with it and develop alternate messages rather than disregard it altogether.

The reproductive health campaign must not function in isolation. Fractures in conceptualising may result in fractures in implementation. Safe abortion is a public health priority that should be looked at as a right to health and right to life rather than directly calling it right to abortion. Unless the MTP Act is implemented well, undercover, sex-selective abortions will continue.

There was a need to understand different views shared by those in the room and a stand taken with regard to the issue. Some participants wanted to know where the PNDT and the MTP Acts overlap. The preamble of the PNDT Act mentions prevention of female foeticide. As for MTP Act, the provider decides the need for abortion under three conditions. An abortion carried out after sex selection is illegal under the act.

**This was followed by a debate on how to frame the issue, what framework/approach should the campaign adopt? Some of the opinions that came up:**

- Unsafe abortions lead to mortality and morbidity. Women also turn to unsafe methods due to poor access and availability of services.
- Available evidence demands that abortion services be made available and accessible within the public health system.
- Would a public health argument work? If the female mortality is low such an argument may not work while arguing for safe abortion. In India, considering the population, the maternal mortality figures may not be useful in garnering support for safe abortion services.
- It was felt that the public health argument would work better as social justice would open up many other issues too. The vulnerability framework presents the view that the poor and uneducated are vulnerable and will access the poorest of services, hence the need for services in the public health system. The social justice argument strengthens the public health argument that looks into the lives affected. The public health argument also presents numbers, which may be useful.

- Considering the large private health sector in abortion services and the increasing privatisation of health services, how far would the public health approach take us?

It was felt that the campaign needs to adopt an approach that will face least resistance.

There was an agreement that there is a need to engage with the messages. An example was cited of a poster that read 'uphold my right to be born' which is there since 2001 and no one protested. There is a need to stop the use of 'daughter language'. The foetus should be seen a part of the self and the focus should be on preventing harm towards the self than towards murdering the foetus. It was recapitulated that at the previous meeting of the Working group of the NCSA had discussed that the campaign would take the public health dimension, issue of lack of access to safe abortion and right to non-discrimination.

It was felt that there is an assumption that abortion is a right but this has not been discussed. The group was asked if they were in agreement on non-personification of foetuses be it girl or disabled. In response, Sabala said that the right to abortion was viewed in terms of right to health. Not wanting to name it as a right was problematic as the Women's Movement had always campaigned for the right to abortion.

There was a discussion in the group whether this could be taken for strategic purpose. There was some disagreement in this regard. The Disability movement too has raised some issues. The right of disabled foetuses does not amount to the right of the foetus to be born. There was a need to arrive at more clarity on this through engaging with this group. It emphasised that if a woman decides to terminate her pregnancy, it is her decision. People view pregnancy in a different way such that it is no more the woman's decision alone. Must her right to decide be taken away from her?

It was decided that a few focused topics be taken up for discussion to get more clarity with regard to the campaign.

**CONCEPTUAL CLARITY ABOUT CORE CONCERNS, KEY ACTORS, NEXT STEPS - DISCUSSION**

- **Improving access to safe abortion**
- **Addressing legal frameworks for MTP & PNDT**
- **Addressing the social determinants of sex-selection**
- **Addressing groups working on sex-selection**

Discussion pertaining to conceptual clarity about core concerns, key actors and next steps was taken up to get more clarity. The initial idea was to break up into groups and discuss four issues, namely, improving access to safe abortion, addressing legal frameworks for MTP & PCPNDT, addressing the social determinants of sex-selection and addressing groups working on sex-selection. However, some participants strongly felt that each issue feeds into the other and in smaller group discussions, the richness would be lost in presenting to the larger group. So the topics were discussed in the larger group. The arguments and thoughts that emerged in the discussion have been documented below.

**Addressing legal frameworks for MTP & PCPNDT**

- Some were of the opinion that abortion need not necessarily be framed as a right.
- Abortion services must also reach across different groups.
- Legally, the boundaries of the MTP & PCPNDT Acts need to be looked at closely.
- Good implementation of the MTP Act must be the focus.
- Response to these could be in the form of government plans and schemes. The issue can raise controversies. Knee-jerk responses must be avoided.

**Access to safe abortion**

There is conflict between making a choice and sharing the patriarchal view if the woman's autonomy is looked at closely. Abortion as a choice in reality will work only when there is true autonomy. A woman is often either faced with direct pressure from others or an invisible pressure from herself. She needs to be empowered to be able to make a choice. There is a gap between having a policy and implementing the policy. There is a poorly regulated private and public sector – these must have some form of accountability such as through RTI.

- Provider skills and attitudes need to be worked on. The provider perspective must also be understood.
- Access to abortion services at PHCs must be improved.
- A referral list must be given to quacks and abortion services by quacks should be discouraged.
- Women must have access to new, safer technologies.
- Provider base must be expanded.
- Quality of services must be ensured; comprehensive care must be provided.
- Consent of minors should be taken.

A question was raised regarding whether a rights perspective would also allow health care providers to deny abortion services because of the distress it caused them. Sharad responded that the health system has obligations to provide services. Individual HCPs who do not want to provide the service can do so as per 'individual provider's conscience'. However, denial of services cannot be arbitrary.

A question was raised about the role of RTI with regard to the MTP. Sharad responded that as long as the name of the patient is not revealed, information can be obtained.

- The campaign could work towards sensitisation of stakeholders such as policy makers and the community.
- There must be universal standards for public and private service providers.
- There must be participation by women in determining quality services from women's perspective. The campaign must also work towards de-stigmatising abortion. There must also be participation by families. Men's participation can be encouraged through promotion of the use of contraceptives.

One member of the group posed the dilemma faced by doctors when a minor is involved as there are legal requirements such as filing a police complaint because of which doctors hesitate to take them on. They cover up for the minor by stating her age as 18 years and write it as a case of 'induced labour' rather than 'MTP'.

**Social Determinants of Sex-selection**

There is a linkage between determinants of lack of access to abortion and sex ratio.

- Sex selection is also associated with gender discrimination.
- The two-child norm is a political determinant of sex-selection.
- The value attached to girls/women is another factor.
- The daughter-language used is another factor and the campaign must see to it that this language is not used.
- Misuse of technology is another determinant.
- Dowry is a strong determinant.
- Religious institutions and son preference – patriarchy that is reflective in inheritance, kinship and death rites.
- Economic drivers for the service providers.
- Patrilocality and village exogamy
- Women's perceived altruism to save daughters – thereby aborting the female foetus before it is born.
- Understanding of political economy and the morals they preach.
- Notions of fertility and son bearing.
- Increased burden of rearing daughters – the social cost incurred – that causes greater aversion towards daughters.
- Insecurity.
- Government implementation of law.
- Agrarian crisis that is encouraging son preference to meet the demands of the crisis.
- Fear of desertion.
- Normativeness of marriage.
- Poor implementation of law.

Wherever there has been economic development without social empowerment, for instance, in Punjab, Haryana, there has been an increase in sex selective abortion. The discussion ended with some consensus on certain issues. The discussion through the day had brought out a large number of issues to think about.

**DAY II**

After a brief recap of the previous day, Bela made a presentation on medical abortion as several participants wanted information regarding the same.

**SAFE ABORTION: TECHNICAL & POLICY GUIDANCE FOR HEALTH SYSTEM - TECHNOLOGY**
Presenter: Bela Ganatra

A table from a WHO publication was presented to indicate appropriate methods for each trimester and the methods were explained.

**Vacuum Aspiration**
This method creates a vacuum and pulls out the products from the uterus. This can be done both manually as well as with an electric suction machine. The manual method is more useful in the Indian setting considering problems with electricity supply. Both these are safe options.

**Dilatation & Curettage**
It scrapes the products from the lining of the uterus and causes immense damage. D&C was used long before the vacuum techniques came in. Most doctors are trained to use this technique since the 70s. This method, though unsafe, is still widely used in India. Manual Vacuum Aspiration is an improvement over the Menstrual Regulation Method.

Training on abortion procedures should be part of the curriculum at the undergraduate level. However, it is taken up only during post-graduation. This is why only Gyneacologists or those with six-month training on abortion techniques are eligible for providing abortion services.

Old providers use a combination of D&C and MVA; they first do an MVA and then check with the curettage method. D&C has become a generic term for abortion. Hence caution must be exercised when speaking of abortion procedures.

A doctor from Bengal added that with D&C, there are chances of infertility if the HCP curettes too much. However, there is no such risk with the newer methods.

Pain management can now vary from giving no anaesthesia at all to general anaesthesia. General anaesthesia is required during a D&C procedure but is not necessary in the MVA method. Anaesthesia brings in its own risk which adds to the unsafe abortion.

A participant added that with general anaesthesia the woman would have to stay in the hospital for eight hours which would be very difficult if she has come in for a discrete abortion. A trial is on in India by the Population Council of conducting abortions by non-doctors along the lines of the trials done by the WHO in South Africa and Vietnam.

Subhash suggested that the choice of technology be added to the patients' rights charter. It was added however, that choice may be limited by the medical condition of the woman. But it was agreed that choice of procedure must not be left to the provider's discretion.

**Medical Abortion**

Medical Abortion is done using two types of pills. The woman is given Mifepristone 7 weeks after the last menstrual period (LMP). According to the WHO manual, however, this must be given 9 weeks after the last menstrual period. Three days later, she either returns or takes home two tablets of Misoprostol.

The process that happens over a few days is similar to that of a spontaneous miscarriage. The actual abortion takes place within a few hours. A follow-up after fifteen days is recommended. This procedure is effective 95-99% of the time. It can be followed up by an MVA. The number of weeks from LMP is different from a missed period. LMP takes place much earlier.

In the second trimester, medical abortion is preferred. However, there is an increased dosage and greater supervision is required. Initially 3 tablets used to be prescribed. Later just 1 was shown to be effective. Some doctors, however, continue to prescribe three pills. Lester added that the continued use of 3 tablets can also be partly attributed to the packaging which comes in threes. There is a need for a new product that packs the required tablets together.

The function of Mifepristone is to separate the foetus. The next tablet causes contraptions and makes the foetus detach itself. An MVA back-up is definitely recommended when going through a medical abortion.

The drugs for medical abortion can be sold only on prescription under supervision. But they are being sold over-the-counter even in other countries like Brazil. Yet, it is still better than unsafe abortions and other unsafe methods available, although this does not in any way suggest that one must undergo a medical abortion without the doctor's advice or as a substitute for safe options.

Change in technology has increased assurance of confidentiality. They even bring their children and take back a tonic to maintain discretion of undergoing an abortion. Proper referral sites should be in place so that women may find it more convenient to access safe abortion.

A question raised was whether everybody would bleed; especially anaemic women. It was clarified that the amount of blood lost is the same as in any other procedure. The difference lies in the fact that the blood lost through medical abortion is visible to the woman while in the others it is not as they are surgical procedures. But the loss of blood during abortion (100ml) is certainly less than the loss during delivery (500ml). It is not as catastrophic as a PPH (post-partum haemorrhage) even if there is heavy bleeding. If the woman's haemoglobin level is 9gms/dL or less, she must be treated. Bleeding after medical abortions is as much as after a spontaneous abortion.

Dr. Padmaja wanted to know how many clinics using MVA were using drugs to curtail blood loss. She was told that there were studies that compared blood loss during delivery to blood loss

during abortion. These studies would have to be looked into. But Dr. Padmaja was of the opinion that such a comparison could not be made.

The issue of contraception was raised – although there is a lot of theoretical training around contraception, HCPs are never trained on communicating this to the user. Current communication is very directive; contraceptives are usually prescribed rather than describing them and leaving the options open for the user.

A question asked was whether giving one tablet and asking the women to return for the next was a cause of poor follow-up. In response, it was said that if the course of medication is not over, the pregnancy is likely to continue. The woman should be given signs to watch out for, so that she can return for care.

Another question was related to procedures followed for conducting follow-ups. Bela replied that sometimes Misoprostol is given and the woman is asked to wait for a few hours till the abortion takes place within. Home visits create problems around confidentiality and are therefore not taken up.

Suchitra added that bleeding usually takes place on the third day after taking the tablet. Most women are aware whether or not the abortion is complete; they are accurate 90% of the time. Follow-up is also done over the phone. Bela said that medical abortion not only cuts down the number of visits to the clinic but also the HCP's discomfort of carrying out a surgical procedure.

Some women do not take the next dosage of pills owing to the cost. However, overall cost of the consequences of not having completed the dosage is much more than that of the pills.

Good counselling increases compliance. Modules on gender sensitivity training for HCPs have had a positive influence. Giving information on contraception is integral to safe abortion. Although it is not known whether repeated abortions are harmful, regular contraception is a much better technique. There is a larger battle with the medical fraternity – patients' rights are often ignored and they are not given complete information.

IPAS has developed a pictorial chart indicating what women will feel when they use the drug. But drug manufacturers are not comfortable inserting it in their packaging. This effort was made keeping in mind the inevitability of over-the-counter usage of these drugs. Talking to women about the discharge will help train counsellors about the kind of questions they can expect from other women; getting women to speak to the counsellors will also sharpen the tools of training.

A question raised was whether the surgical procedures have any advances over medicines. Medical abortion is a recognised method, but specific standards and guidelines need to be followed. Use of either method is also a matter of choice. The MVA for instance, can be used at a much earlier stage.

Sharad informed the group that Arth has done 2500 abortions using the MVA method. Standards have been met even in a small setting. Misoprostol is used before the procedure to dilate the cervix. The patient is spoken to in a soothing manner and analgesic used.

Another question was pertaining to the relative costs. Suchitra said that the cost borne would be that of consultation fees and the cost of medicines, which would roughly amount to a maximum of Rs.1500/- in the first trimester in a place like Mumbai. Sharad said that at Arth, an abortion would cost Rs.500/- be it medical abortion or an invasive method. For an abortion in the second trimester, the woman would certainly need in-patient care which would be more expensive. In Bihar and Jharkhand, the cost is Rs.400/-. With preferential pricing, a further drop in prices is expected.

There is a feeling that they go in for sex-determination and then opt for a medical abortion because of fully-formed foetuses found in Rajasthan. The common notion is that a surgical procedure mutilates the foetus while a medical abortion retains the formation of the foetus. However, both surgical and medical abortions produce the same result. These misconceptions are spread to discourage medical abortion. The social tension in terms of availability of oral contraception and emergency contraception must be recognised. Liberal views on abortion need to be promoted.

**BUILDING A CAMPAIGN FOR SAFE ABORTION - ISSUES FOR CONSIDERATION**
Facilitator: Abhijeet

Abhijeet began by reminding the group that they had assembled because of the prevailing discomfort associated with abortion. Through the discussions of the past one-and-a-half days, dimensions have been explored and policies have been analysed.

**Developing the campaign**

This session was facilitated by Abhijit and there was an open discussion through the session.

Some points are highlighted here:

He stated that using influential people was neither desirable nor effective in such a rights participatory campaign.

There is stigma attached with abortion. The deeper the stigma, the higher the vulnerability to unsafe abortion; adolescents are a highly vulnerable group. It was stated that the lower the class, lesser the stigma.

Abhijit then asked whether everybody was at a level of consensus in general. Padmini responded that the issues discussed till now were too general for people to disagree with. Arguments would come up only if they got into the specifics.

Abhijit said that this would be taken up shortly. He said that they would work within small time horizons on amenable changes that could take place. There would be a campaign working group, campaign partners, broader alliances and stakeholders. They would have to do an actor-factor analysis. The actors would be human facilitators and the factors would be the laws, policies, programmes and social institutions. They would have to move them towards the desirable point

of view. He presented a table with four columns – structures, policies, technology and ideas – which would culminate into the activity plan.

A question was raised whether the activities would be only as an advocacy campaign; some might need only capacity building as in the case of providers' competence. Abhijeet responded that there was a need for a system to bring about that sort of a change, which would be done through advocacy, but training of service providers would not qualify as advocacy. They would have to identify trainers and look for any overlap with the HCP's training curriculum. They would probably become campaign partners. Hence, it is best to call it training and not advocacy.

One of the participants said that this was not the first time that a campaign on safe abortion was being organised. It would be good to see how this would be different from the previous ones, whether there was any impact that was desired earlier but not covered and how the impact would be tested one year down the line. It was mentioned that in the context of the campaign on sex selection, the language used was a setback to the previous campaign of the 70s. The present campaign would therefore, need to strategise accordingly. The language of the people involved in the anti-sex-selective abortion would have to change. They must recognise the difference between sex-selective abortion/sex determination and safe abortion.

A suggestion was to bring out the relation between the sex ratio and abortion before the 2011 census. Thus reiterating the urgency to tackle this issue.

The previous efforts of the Women's Movement with regard to safe abortion were brought to notice, so to say that the issue had been raised before. But this campaign would be unprecedented in the sense of encouraging something rather than discouraging something.

Subhash said that when Saheli and Jagori carried out their campaign and Sutra launched their book '*Bitiya Badi Ho Gayee*', there was a backlash. But today things have changed. Earlier, the conservatives were opponents; today the right wing is the opponent.

It was clarified that there has been no systematic campaign on abortion. The movement of the 80s was by the Women's Movement and abortion was only a part of a larger movement. This was further clarified and stated that the work on safe abortion has not been defined as it has been now. The earlier campaign was around the MTP Act. Plans that were made were not advocated. The National abortion Assessment Project threw up valuable evidence but there was no advocacy. So there were no previous campaigns around this issue and thus, no learnings. But there could be learning from other campaigns.

It was also stated the campaign on sex-selection has looked at the issue with blinkers; complex context within which it is taking place has not been looked into.

A participant expressed the need to set up safe abortion centres while taking it up as a campaign. The existing safe abortion centres can also be a part of the campaign. There is also a need to set up an outcome.

In the context of focusing on issues for the campaign, it was stated that the campaign would have to confront certain issues. How this is done needs discussion, either issues are dealt with as and when they arise or we pre-empt certain problems and plan accordingly. In 2002, during the process of marking amendments to the MTP Act, there was a lot of pressure to restrict abortions esp second trimester abortions. The entire process was stalled so that no damage was done to the existing law. But there is a need to amend the current law and therefore the need to engage with contentious issues.

Abhijit said that the core issue of concern from the previous day was the confusion between sex-selection and safe abortion. He said that collective action should be for a common purpose. If the group had not yet arrived at a common understanding they would need further preparation; they were not yet ready to launch a campaign.

It was sharply brought out that there was an increased threat in the way policy makers were viewing abortion because of sex-selection. The campaign would have to respond to this. He asked whether they could look at the campaign on very narrow lines and work accordingly rather than look at other issues.

Leela was of the opinion that the sex-selection issue must be addressed at the individual level among the group members. Messages cannot be in terms of social justice because their immediate concerns have to be addressed. Sociological abnormality and legal abnormality are different. For instance, if a woman who already has three daughters wants to abort the fourth girl, considering her parameters, it is alright and this needs to be understood.

**Actor-factor analysis**

Abhijit suggested that these issues be taken up individually in a tabular form to obtain clarity.

| Issue for change | Desired change | Opp++ | Opp-- | Neutral | For+ | For++ |
|---|---|---|---|---|---|---|
| Women concerned about daughters – getting husband, health, education, old age security for self. | *'paraya dhan'* attitude Norms | | | | *Sarva Shiksha Abhiyan* | *Mahila Samakhya* |
| Present legal framework is restrictive. | Better draft which is endorsed by alliances (among the present circle & official circles) | | WCD<br>UNFPA<br>PNDT cell<br>UNICEF | ICMR<br>AIDWA<br>Law ministry | Health ministry | Shruti DGHS<br>FOGSI group members<br>Competent lawyers' groups |

**Key:**

Opp++ = strong opponents
Opp-- = opponents
For+ = supporters
For++ = strong supporters

There may be women's organisations working on some of the issues listed who may have nothing to do safe abortion. Efforts should be made to neutralise the opposition and prevent those at the neutral level from becoming opponents and also in moving those in a neutral position to a favourable position.

Earlier campaigns were done instinctively; there is a need to strategise and plan rather than move instinctively.

A doctor providing abortion may not know whether the woman has had a sex-selection test. The issue that came up the previous day was about abortion on demand even if the woman has undergone a sex-selection test. Participants felt that this needed discussion.

The question posed was whether everybody agreed that a woman has a right to sex-selective abortion in which case the individual right is in conflict with social justice. Abhijit reframed this as 'all women should have the right to expel/remove product of conception before onset of natural labour (unless medically contra-indicated)'.

The responses are summarised here:

- ✓ Yes, woman has a right because if one does not agree then it would mean personification of the foetus.

- ✓ This would mean that the group agrees to sex selective abortions.

- ✓ Example was cited of a woman who may face severe violence if she is not provided a sex selective abortion. Many felt that in such a case for her safety, abortion must be provided. Another view point was about looking at alternatives for ensuring her safety as merely providing abortion would not end the abuse in her life. It was also stated that doctors have an ethical responsibility of not carrying out sex-selection. There was a need for state intervention at the family level and support to the woman.

- ✓ It was voiced that as a campaign group, we were okay with sex-selective abortion, it also meant that we were okay with sex-selection.

- ✓ It was felt that merely articulating right to sex selective abortion as a right would not ensure autonomy for women.

- ✓ A clarification was sought on whether supporting sex-selective abortion meant they were looking only at the first trimester and not the second. It was clarified that it included both.(?)

- ✓ One viewpoint strongly articulated was that to proceed or not to proceed with a pregnancy was purely the decision of that individual. No line should be drawn for the abortion issue.

- ✓ A dilemma was presented by a doctor when she/he comes to know that the woman has undergone sex-selection and demands an abortion. As a doctor she is forced to refuse in such a scenario.

- ✓ Another person said that campaign needs to decide on its focus. Whatever may be a woman needs a safe abortion. If the reasons behind the abortion need to be looked into then it should be another campaign altogether.

- ✓ Another person felt that just giving the woman access to abortion is not the only solution. Principally, the woman has the right to abort as well as the right not to abort.

- ✓ One participant said that she had come with a position against sex-selective abortion. But the discussions have shown that such a position keeps the female foetus in mind, rather than the woman. While speaking of right to body and health, there is opposition towards sex-selective abortion. The woman may be facing other forms of violence too. If she is denied safe abortion, she will go elsewhere. Therefore, she felt that for the campaign on safe abortion should include sex-selective abortion as well.

- ✓ It was felt that decision should be well-informed. There is an interface between social and individual priority. The right to abortion in this sense is leading to the right to sex determination.

- ✓ A researcher spoke of a qualitative study on rural women where it was observed that the women did not understand 'rights' but they clearly knew what they wanted. Women do not come alone for sex-selective abortion; they are usually accompanied by someone. She personally felt that there must be some restrictions on this matter.

- ✓ It was also articulated that if sex-selective abortions were stopped, women in desperate situations would have nowhere to go. Hence she was for abortion even if it were to be sex-selected.

- ✓ Another member said that other than on medical grounds, there should be no need to ask the woman for reasons for seeking an abortion. Though he was personally in favour of abortion, as a campaign there was a need to restrict sex-selected abortion.

- ✓ Another strong viewpoint was that the provider had no business to ask for reasons behind seeking abortion. The provider-client interaction should be privileged because the complexities have not been understood nor addressed. He posed a question to the group whether or not they agreed that the provider-client relationship should be left to itself. This invited criticism that such an approach would mean taking a protectionist attitude towards the gynaecologists and creating a hyper-victim image.

- ✓ Again the issue of which approach to be taken came up whether the social justice approach or libertarian approach.

- ✓ At this point, it was pointed out that the discussion seemed to be conveying the message, 'abolish the PCPNDT Act'. The participant strongly felt that work should be carried out within the constitutional framework which meant they would be against any form of discrimination. He felt that if the campaign took the path of safe abortion irrespective of reasons, it would not succeed.

Abhijit then asked the group to take a look at the brochure on the campaign on safe abortion and see whether the there is consensus on the commonality of action. He emphasised on the sentence in the brochure that says, "sex selection must continue….(footnote) 4th page" and asked whether there was agreement on this statement.

It was felt that the statement did not sit well considering the discussion about what is non-negotiable.
It was also suggested that there careful articulation on several fronts is required for the campaign. As a campaign measure, it was urged that data be collected to show that mortality due to sex-determination has had a backlash on abortion. This was true of some parts of the country. Ways of dealing with the issue of sex-determination need to be articulated carefully.

There was a disagreement with having sex selection as a strategy in the core principles. Another person said that as part of the Women's Movement, she was against sex-selection abortion and would not be a part of the campaign, nor would other members of the Movement.

An urge was made to distinguish between sex determination and sex-selected abortion. This campaign should not make the same mistakes of tracking sex selective abortions. While sex determination needs to be opposed strongly, at the time of seeking abortion services no further barriers should be posed on women. There is a need to respect the right of women to seek abortion under any condition.

Abhijit spoke of the Sahara sting operation that showed women getting a sex-selective abortion at 20 weeks of pregnancy. He asked whether the group was alright with this. He pointed out that the onus of proving that the abortion was not sex-selected should not be on the provider as this removes the onus of decision making from the woman. The right of the woman is very important in this sense. There is a complex, competing interest of rights. It competes with the collective right of gender equality.

Learning from past campaigns is to move strategically rather than instinctively.

**Plan for the future:**

Padma said that the agenda was planned keeping in mind the issues that needed deliberation and clarity. The last two days discussion has thrown up the need to think through several issues much more in depth. The invitees for the consultation were decided by the Working Group as it was felt that each one of them would meaningfully contribute to the discussion and in taking the discussion ahead.

At this point, it was felt that rather than seeking feedback on the consultation, participants should mention their commitment towards taking the campaign forward.

Sharad said that some operational statements need to be looked at.

Subhash said that the right to safe abortion needs to be safeguarded.

Koyali felt the need for a follow-up meeting. In the meanwhile there would be some deliberation over the issue.

Sababla said that she would involve the autonomous women's groups as they have been involved with the issue historically. She would share the issues raised here within the group.

Anupama was for a regional dialogue on the matter in different regions where these issues chould be taken up. She said that Jan Arogya Abhiyan would take up the issue and see what could be done.

Anurita from NEN said that she had benefited individually as she gained better understanding of abortion as a right; research in the north-east does not speak of women's issues from the rights perspective. She added that she would see if something could take place in the region because access to safe abortion is important given the political situation.

Supriya felt the need to be reactive in the short term. The long term goal also needs to be visualised.

Lester expressed the need for other representatives in the group. There needs to be decentralisation. People from regions where sex-selective abortion is rampant must be roped into the campaign. Some work on damage control and preventive work needs to begin. There has to be an open dialogue at the national level.

The doctor from Kolkata was also in favour of decentralisation and open dialogue with other organisations. He offered to share the results of a qualitative research underway in Bengal on its completion.

The representative from Bihar emphasised the importance of taking up the issue in Bihar and Jharkhand. He offered to take up responsibility for his region.

Subhasree shared that when the backlash of the sex-selective abortion movement on abortion was explained to a group they were working with, they were willing to change. Such groups that can change must be identified and dialogue should be initiated with them.

The nurse in the group committed to do her bit at the national and state level. She said that the nurses would cooperate in the process of data collection in the event of a study. As a provider she would inform women who approached her about the issue.

Another participant said that bureaucrats and the medical association must also be involved; the media should also be assigned a role.

Usha Rai said that she was willing to provide media support.

Anubha expressed her desire to be part of the working group and find out the legal services available across the country. She would also network with Josheel Colloqium and HRLN.

Suchitra offered to translate in Hindi and Marathi any reading material that required translation.

The representative from Orissa said that she would hold dialogues with the State government.

Leni would work on sex selection and access to abortion with demographers.

Mary said that the presentations could have been worked on in terms of their current position and taking it forward. They would have saved a lot of time that way. She said it would be good to document the discussion.

Abhijit asked whether anyone could look at the project implementation plan of the state and give feedback; he informed the group that the district PIPs were available on the website.

Bela said that action must begin immediately. Conceptual thought on demography must be built. Personally, she offered to be a part of the working group and said that IPAS had always supported the cause.

Shruti committed to take it forward with the expert group.

Subhash said that there was a need for pre and post counselling centres at MTP centres. He asked whether IPAS would train their doctors and whether counselling centres could run on available health providers. He also felt there should be MTP facilities for young single women.

Abhijit felt that the voices of women seeking abortion should be documented.

Asha offered to do her bit in the interest of the campaign. She concluded by saying that several issues had come up at the meeting. They had come a long way from their understanding of abortion by developing a common ground and showing patience and tolerance. The working group would stay in touch to develop future steps for the campaign.

## Annexure I

**National Campaign for Safe Abortion:**
**Working for Women's Health and Self-Determination**

**Venue: The YMCA International, Mumbai Central**
**Agenda for the national consultation,**
**21st April and 22nd April, 2008**

*Objectives of the National Consultation:*

- *Develop conceptual clarity about safe abortion and sex selection*
- *Highlight concerns based on state level situational analysis*
- *Develop campaign strategies that address safe abortion and sex selection issues within frameworks of gender discrimination and reproductive rights*

**Day 1**

| | |
|---|---|
| 9.30 am to 10.00 am | Registration and tea |
| 10.00 am to 11.00 am | Welcome and Introduction: Padma Deosthali |
| 11.00 am to 11.30 noon | **Safe Abortion: Women's Perspectives & Legal Frameworks** |
| | Chairperson: Renu Khanna. |
| 11.30 noon to 12.30 pm | Plenary Discussion |
| 12.30 pm to 1.00 pm | **Declining Sex Ratio & Use of Diagnostics: Evidence** |
| | Chairperson: Subhash Mendapurkar |
| | Presentation: Leela Visaria |
| 1.00pm to 2.00pm | Plenary Discussion |
| | Lunch |
| | **Safe Abortion and Sex Selection** |
| | Chairperson: Suchitra Dalvie |
| 2.30pm to 2.45pm | Presentation I: Overview of evidence: Bela Ganatra |
| 2.45 pm to 3.00 pm | Presentation II: Maharashtra: Leni |
| 3.00 pm to 3.15 pm | Presentation III: Rajasthan: Sharad Iyengar |
| 3.15 pm to 4.15 pm | Discussion |
| 4.15 pm to 4.45 pm | Tea |
| 4.45 pm to 8.00 pm | **Conceptual clarity about core concerns, key actors, next steps** |
| | Open Discussion: Facilitators: Suchitra Dalvie and Asha George |

- *Improving access to safe abortion*
- *Addressing legal frameworks for MTP and PNDT*
- *Addressing the social determinants of sex-selection*
- *Addressing groups working on sex-selection*

## DAY 2

| | |
|---|---|
| 9.30 am to 10.00 am | **Review/reflections:** Asha George |
| 10.00 am to 1.30 pm | **Campaign Structure and open discussion**:<br>Facilitator: Abhijit Das |
| 1.30 pm to 2.30 pm | Concluding and future plan<br>Asha and Padma |