Sex selection and safe abortion rights:

Past trajectories, current impact and future strategies

A meeting

Organized by ASAP and CREA

On Saturday 20th June 2015

At

India Habitat Centre, New Delhi

Agenda

Time and Session	Facilitator
10:30 am Registration and Tea	
10:45 am Welcome and Objectives	Suchitra Dalvie, Coordinator, ASAP Trainer, CREA-CommonHealth Project
11:00 am -12:30 pm Political mapping –Presentation on the findings Discussion moderated by Suchitra Dalvie	 Shweta Krishnan Project Associate Dept. Of Humanities and Social Sciences IIT Madras
12:30 pm-1:15 pm When Doctors Say No Discussion moderated by Anand Pawar	 Pritam Potdar Regional Coordinator, SAMYAK Pune
1:15 pm – 2:00 pm Lunch	
2:00 pm – 3: 00 pm Panel Discussion: Status Update on Safe Abortion Moderator: Priya Nanda, Group Director Social and Economic Development International Center for Research on Women (ICRW) Asia Regional Office, Delhi	 Panelists: Kerry McBroom Director, Reproductive Rights Unit Human Rights Law Network (HRLN) Delhi A.L. Sharda Director Population First Mumbai Advocate Varsha Desphande Sangli Maharashtra

	Vinoj Manning Executive Director Ipas Development Foundation Delhi Anand Tamang Executive Director CREHPA, Nepal Ragini Pant Research Assistant Centre for Social Research Delhi Pratishtha Arora Assistant Trainer Centre for Social Research Delhi
3:00 pm-3:30 pm CREA-CommonHealth Project: Creating Champions to Address Sex Selection and Improve Access to Safe Abortion	Surabhi Srivastava Program Coordinator CREA, Delhi & Kristin Francoeur Fulbright-Nehru Scholar PhD Candidate Indiana University Bloomington, U.S.A
3:30 pm-4:00 pm Next Steps Facilitated by Suchitra Dalvie	Discussants: Sonali Regmi Leela Visaria Dr Gorakh Mandrupkar
Tea	

Welcome and Objectives:

Suchitra Dalvie, Coordinator ASAP, welcomed the audience on behalf of ASAP as well as CREA. She noted that for some years now the issue of sex selection has gotten entangled with the safe abortion access and the understanding of women's right to safe abortion in our country. The conflation had occurred at many levels—policy, programmes, language and implementation.

ASAP had undertaken a study starting in Jan 2014, to look into the origins of the sex selection campaign in India and the history of the girl child in pre- colonial and post- colonial times.

Shweta Krishnan, in her capacity as the **Communication Officer at ASAP**, had conducted in –depth interviews with key stakeholders working on the anti- sex selection campaign as well as those working on issues of the girl child, safe abortion access and women's rights. The conceptualization and analysis of this study owed much to the inputs given by **Prof Sundari Ravindran**[1] and **Dr Manisha Gupte**[2], both of whom were unfortunately unable to attend the meeting.

Shweta shared her findings in a presentation titled **"The Unfortunate Entanglement ".**

The study attempted at unpacking a conflation caused in part by issues with the implementation of laws and a poor understanding of social contexts. She noted that abortion in itself is already a stigmatised issue, even in the absence of the problems with sex selection. Despite a law passed over four decades ago, access to services is still limited. Many reasons have been documented repeatedly and include a lack of public

[1] Prof. Sundari Ravindran, Achutha Menon Center for Health Science Studies, Thiruvananthapuram

[2] **Manisha Gupte**, Ph.D., co-founder of Mahila Sarvangeen Utkarsh Mandal (MASUM)

funding, lack of facilities and trained practitioners in the public sector. There is also a pervasive ignorance about the MTP Act and social stigma attached to abortions.

The law as it exists was once considered a liberal one, but it does not frame safe abortion as a women's right and instead gives complete authority to the doctor. This can lead to a situation where doctors can deny (and are denying) women without a single word of the law being altered (Jesani and Iyer 1993). This is particularly evident in the current scenario where women are being sent away when they seek second trimester abortions. (Potdar, Barua and Dalvie 2015)

The sex ratio at birth or for the age group of 0-6 has become the focus of the work being done around sex selection. It was probably Amartya Sen's comment on the 'million missing girls' which led to this becoming a household word. However, the focus on numbers hides the reality of the gender discrimination being faced by the girls who do survive and the need to locate the issue of sex selection within the women's empowerment agenda.

Looking at issues of gender discrimination in pre-colonial and post-colonial times, she noted that we have inherited the Indian Penal Code drafted over 200 years ago and wherein the Section 312 still criminalizes abortion. The British had noted sex selection happening early on, and wrote about the "cultural aspects which privileged male" and led to female infanticide in certain areas. The Female Infanticide prevention Act was passed in 1871. Dowry has also been a long standing practise but has transformed itself from a security fund for the new bride to being a demand from the groom's family. (Talwar-Oldenburg 2002)

When the Shantilal Shah committee was set up in the late 1960s , they investigated the social, legal, and medical aspects of 'septic abortion' as it was called in those days and recommended legalizing safe abortion MTP on humanitarian grounds as a need and not a right.

Through this study we wanted to map the politics and positions of the various key stakeholders in order to understand the movement as cohesive whole. Non structured interviews were conducted with 11 stakeholders identified through a mapping of the various constituencies involved. We also carried out an in –depth literature review.

Study Title : The Unfortunate Entanglement- A study of safe abortion and sex selection, unpacking a conflation caused by misinterpretation of laws and poor understanding of social realities

OBJECTIVE 1:

Understanding Abortion in India

Tracing the movement against sex selection

Understanding the origins of the conflation

OBJECTIVE 2

Map the positions taken by stakeholders and understand various positions articulated within the movement against sex selection in order to form stronger synergies to address the conflation and separate the two issues

OBJECTIVE 3

Compile data that could lead to further analysis of the possible trajectories that these movements could take and understand how each stand to affect access to safe abortion.

Methodology

Literature Review

Interviews with Key Stakeholders

Non-structured Interviews

Expertise on sex selection or safe abortion or both

Positions and perspectives on both issues

Perspectives on conflation

Perspectives on separation and the future of advocacy in both domains.

Highlights of the study are:

Findings on Abortion:

- Lack of feminist activism on abortion from 1970 onwards has made it very vulnerable and placed in a public health, population control discourse
- Stigma around abortion still exists, information about the MTP Act has not been promoted
- Rise of right wing politics since late 80s – what it meant for women and how we discuss patriarchy and sexuality at large and abortion as an already marginalised issue within it.
- Lack of rights based approach to safe abortion
- Shift to conservatism and a lack of secular feminist ethics teaching to medical students leads to doctors bringing in their own personal views to their practise.
- Lack of public funding on abortion and lack of acceptable services in public sector leads to dependence on private sector

Understanding Sex selection:

- Sex selection, in general, indicates that the child of one biological sex is 'selected' for survival over the other.
- This can happen before or after birth, and the family can select a child of either sex.
- In patriarchal societies, such selection is often the result of a systemic preference shown to a male child, because of economic, social, cultural and political structures that selectively empower male members of the society, rendering a son more valuable than the daughter (Miller 1985).
- Sex selection, resulting from son-preference has been recorded in several Asian countries, including those in South and Southeast Asia and Central Asia (Miller 2001).
- These campaigns take again the very patriarchal view on sex selection but they also create a negative way of looking at abortion. Since sex selection is done in clinics,that lead to a focus on technology which conflated it with all other medical technologies seen to be exploiting women's bodies.

Understanding the sex ratio:

- Correcting the Sex Ratio becomes the focus of several wings of the movement.
- Post birth selection needs to be looked at
    - Direct - infanticide
    - Indirect – female child are neglected leading to death

- Together the ratios reveal a 'double jeopardy': Girls who are born are born into an environment of increasing gender bias against them.
- Calls for attention to discriminatory practices like willful neglect of the female child, malnutrition and lack of medical care, which could contribute to a high mortality rate among young female children.

Conflation

- Policy Level
    - Lack of distinction between sex selection and sex determination; shifts focus from 'determination' to 'selection.'
    - Budget for campaigns on sex selection vs. investment in promoting safe abortion. This will affect the budget allocated for safe abortion services. In the long run, creating barriers for USG services will also have affect antenatal care.
- Linguistic
    - Verbal Language –use of the phrase female feticide, often short-formed to feticide is very anti –abortion, especially when translated into local languages and for community messaging
    - Visual Language uses posters of foetuses and imagery invoking violence.
- Programmatic Work:
    - Barriers to safe abortion access due to a lack of clarity
    - Compromised antenatal care, particularly ultrasound services
- Using patriarchal tools to tackle sex selection and safe abortion
    - The discourse on 'saving' girl children and women
    - Personification of the foetus
    - Essentialization of motherhood
    - Role of the girl child seen as contributing to further patriarchal norms
- Political Economy of abortion and sex determination
    - Abortion services not as lucrative for doctors any more
    - Sex Determination still has great demand
    - Lack of feminist, secular ethics education
- Perspectives on Technology

- Technology surrounded by negativity
- How to deal with it: More laws? More information?

Shweta emphasized that in looking forward it was important to understand the bigger picture and how **globalised campaigns** are also affecting sex selection as well as safe abortion politics in our country as well as region. It is critical for those of us working on this issue to understand the policy and urgently frame a new verbal and visual language.

Using a **feminist approach**, we need to think of how to shift the focus on ideologies that drive this campaign. We need to strategize on strengthening the approach to safe abortion as a right by placing it within the sexual and reproductive rights as well as human rights framework. Unless we start thinking of safe abortion as more than a need or a public health imperative, or a way to control family size, this cannot be achieved.




Key points of the discussions that followed this presentation:

- At present there is no coordinated pro-life group in India
- Safe spaces for such conversations need to be created

- Lack of funding silences the ability to work in this field so although there is no anti-choice lobby, the work around safe abortion rights advocacy has been impacted due to lack of funds.
- As per the current law, services and decisions are provider dependent and we need more conversations among doctors and activists in order to work together

The next session was moderated by Anand Pawar, Executive Director of Samyak, a Pune based NGO a Pune-based, non-government organization that promotes gender equality and advocates for human rights www.samyak.org

During their field work on another project, Samyak team found that doctors are consistently refusing women who are seeking abortions. They decided to study this issue in greater depth. Pritam Potdar, Regional Coordinator at Samyak had undertaken a study in 2014 with the support of ASAP and she made a presentation based on this.

Women's rights movement campaigned in the 1980s on 'Stree bhrunahatya thambava' (Stop female feticide) and eventually the PCPNDT Act was passed. But the reality of how it is being implemented also needs to be understood. Women in the community say to the workers that you do what you have to with all these Acts. We have unwanted pregnancies and we need we just need safe abortion services.

"If a women has even one daughter, I refuse to perform abortion: impact of implementation of the law against sex selection on safe abortion access."

This study was conducted by Samyak and has been accepted for publication in the next volume of Reproductive Health Matters (May 2015 volume). This presentation was made by Pritam Potdar, Regional Coordinator, Samyak.

During the course of their work in rural areas of Western Maharashtra, Samyak found cases of private medical practitioners denying safe abortion services to women, claiming legal concerns. Thus they planned an exploratory study to document the knowledge and perspectives of private practitioners regarding the relevant laws and their interactions and experiences with the PCPNDT regulatory authorities and persons responsible for on the ground implementation. The study, being exploratory, involved a purposive and small sample of service providers in four districts of Western Maharashtra. The four districts were identified on the basis of low or declining child sex ratio in three consecutive Census of India reports. The sex ratio in these districts averaged 933 (range 924-941) in 1991, 865 (range 839-895) in 2001, and 864 (range 845-880) in 2011.

Within each district, the block[3,4] with the lowest sex ratio was selected. In the selected block, one town was selected based on information about use of abortion services (either observed or provided by the municipal councils).

Many studies, including the recent National Family Health Survey (NFHS) III, show that the private medical sector remains the primary source of health care for the majority of households in urban (70%) as well as rural areas (63%).[5]

An exercise was undertaken to map the registered private medical practitioners who are authorized to provide abortion services. About 10% of these medical practitioners, or at least five of them (whichever was more), constituted the sample for in-depth interviews. Informed consent was sought from the selected private medical practitioners, and interviews were conducted with those who agreed to participate in the study.

The study was conducted in four selected blocks of the four identified districts of Western Maharashtra. A total of 19 gynaecologists (about five per block) were interviewed.

Detailed interview notes and audio recordings of interviews were transcribed into Marathi, the local language. The transcripts were then coded and analysed according to the objectives of the study.

During the mapping exercise, we approached 34 private medical practitioners through phone calls; 29 of them agreed to be part of the study. However, during the data collection, ten refused, some even after giving appointments. The reasons given ranged from fear of reprisal from the government authorities, high workload or influence of their colleagues, who advised them to refuse. In themselves, these were signs of something going very wrong. Finally, we were able to interview 19 respondents from four selected towns.

---

[3] Government of Maharashtra. State Welfare Department. *Chhakulya Mukalelya* (Marathi). 2005.
[4] Census of India 2001. http://censusindia.gov.in/Census; You/gendercomposition.aspx.
[5] Rao PH. The private health sector in India: a framework for improving the quality of care. ASCI Journal of Management 2012;41(2):14–39. http://journal.asci.org.in/Vol.41%282011-12%29/41_2_phrao.pdf.

Key findings:

- All the respondents we interviewed spoke of the difficulties and challenges they faced while attempting to follow the guidelines of the PCPNDT Act.
- They expressed their frustration at the pressure of the demands from the local community as well.
- 14 of the 19 said that unmarried girls should have access to abortion services for an unwanted pregnancy because it is a very sensitive issue and could result in lifelong problems for her.
- All of them said they had been trying hard to maintain the paperwork that is required, but said that relatively trivial mistakes were used by the authorities to warn and intimidate them as well as the inevitable exploitation and corrupt practises that have occurred.
- Some of the respondents reported that apprehensions over action by the regulatory authorities was resulting in some of their colleagues exhibiting irrational behaviour
- *"I saw in the cancer hospital a friend was filling in the F form for a male cancer patient. When I asked him why, he told me that it was better than being harassed."*
- Another said *"...Nowadays it is very easy to accuse a gynaecologist of sex determination and sex selective abortions. I am very conscious of this and that is why I have 11 CCTV cameras in my hospital and in the compound also. Because I don't know if someone might put a female fetus in the hospital compound. Then it will create problems for me* (zakzak nako dokyala)*."*
- There are rumours of new rules and regulations which are not found in documents but which pervade the atmosphere in their practices. *"Recently, government have announced that we should not use indication of contraception failure for the second trimester abortions as they can be sex selective abortions. It is a protective step taken by the government. So we do not provide abortion service in the second trimester, even if there is any anomaly in the baby."*
- The study also found that these fears are leading medical professional organizations in some towns to advise their members to avoid providing terminations, especially in the second trimester.

Our study uncovered a scenario in which private medical practitioners were resentful of being harassed for clerical errors; they wanted their dignity as professionals to be respected. On 15 April 2015, thousands of radiologists went on strike in India to protest criminal action being taken against their numbers under the PCPNDT Act 1994. The radiologists said the PCPNDT Act had become "draconian for all practising sonologists and radiologists" instead of serving the purpose of 'saving the girl child'. They alleged that the Act had become "a harassing tool" in the hands of the authorities implementing it. They also echoed the views of many of our respondents and said that "This Act has failed to yield any result for the past two decades.

So the actual reasons for deteriorating sex ratio should be analysed and corrective action taken"[6]

We learned that women's right to confidentiality under the MTP Act was not respected under the PCPNDT Act by the monitoring authorities, thus making the atmosphere hostile.

Pritam also spoke about the next phase of the study wherein 12 women who had been refused an abortion by a legal provider were interviewed. This study has also been submitted for publication.

A total of 12 women (age group 20 to 32 years) participated in the study. 5 were from urban slums and 7 from the villages. 6 of them had completed 10 years of school, while 3 of them were educated beyond that also and 3 were uneducated. Two of them were working on construction sites with their husbands, 2 were running their own small business, 1 was an accredited government outreach worker (ASHA)[7] and the other 7 were not employed or earning members but managed the family and home . The vast majority were economically dependent on their families and the majority were below the poverty line.[8]

All of them were refused abortion services from authorised abortion service providers in the time period of the last 3 years (from 2011 to till the date of interview in 2014).As a result of this, 7 out of the 12 women continued the pregnancy, 3 approached another doctor for an abortion and 2 of them were able to procure 'abortion pills' and terminate the pregnancy.

"I was already having 6 children. Our economic condition is not very good. Me and my husband work as a construction labor. So we don't have capacity to take care of so many children. My husband didn't even know that I am pregnant and when I told him about my pregnancy he said to me, do whatever you want. So, I decided to have an abortion. Then I went to the government hospital (Rural Hospital)

– *A woman from district 1*

All these women approached an authorized and legal provider but six of the respondents said that the doctor denied them an abortion because the pregnancy was in the second trimester. While this could be due to the fear of being caught under the PCPNDT Act and reflects the findings from our earlier study[9], some of the women were told it would risk their lives or future fertility and one of them was clearly told it was a sin.

---

[6] Feature: Sonologists, radiologists and gynaecologists in India on strike, 15 April 2015. International Campaign for Women's Right to Safe Abortion listserve. 24 April 2015.

[7] Accredited Social Health Activist (ASHA)

[8] Below Poverty Line (BPL) as defined by the Government to be per day spending capacity of 37 INR in rural and 42 INR in urban areas. Approximately half to three quarters of 1 USD

[9] We can add the exact citation once published in the May issue

"Doctor told me, you have completed 3 months of pregnancy. Now it is difficult for doing an abortion. We both might have to face many problems due to the abortion. Also it is legally banned now so we cannot do abortion after 3 months. Better you continue the pregnancy and then do a family planning operation after delivery."

– *A woman from district 2*

"That doctor was very rude. She shouted at me and said, "Didn't you realize before? Now we cannot do your abortion. It is banned by law and now there is risk to your life. Who will be responsible if something is happened to you? And don't you feel anything while killing your baby."

– *A woman from district 3*

Of the 7 women who had to continue the pregnancy, 4 women went to a private hospital for the delivery and spent about 20,000 to 30,000 INR[10] for treatment, medication and other expenses. Those who managed to obtain a safe abortion also had to pay very high costs in comparison with their monthly income.

Key points of discussion:

- The districts were not identified to protect the identity of the respondents.
- The women who were denied services were identified through Anganwadi Workers and other community health workers. The women were approached by AWWs and others who knew they had been denied services. When the women agreed to be a part of this study, then the field team reached out to them and obtained a detailed informed consent and maintained complete confidentiality of the data.
- It would be useful to study access to safe abortion in states or areas where the PCPNDT Act is not being implemented so vigorously.
- While in this state the fear of harassment by PCPNDT implementation authorities is causing doctors to refuse services, in a state like Rajasthan the DLC's for MTP centre approvals were not even formed till 2013.
- Authorities themselves are not adequately informed and this leads to unnecessary record keeping and issues with confidentiality of MTP cases.
- What seems to be emerging is the abortion access has always been an issue but sex selection implementation and communications are creating additional barriers
- Need for collaboration and trust building among those working on the issues

[10] Approximately 300-450 USD

We had a panel discussion post lunch which was moderated by Priya Nanda, Group Director, Reproductive Health and Economic Development, ICRW

Kerry McBroom Director, Reproductive Rights Unit, Human Rights Law Network (HRLN) Delhi shared the findings of their study on Access to Medical Abortion.

They had interviewed 44 Chemists in Delhi most of whom were willing to sell Medical Abortion on prescription and also had stock. In Mumbai of the 69 interviewed, only 8 were willing to sell drugs with prescription but even they did not keep a stock. The chemists said that there was a ban on the drugs because of 'female feticide' and kept repeating the term 'misuse' of the drugs.

It is very difficult to obtain the drug even at Government hospitals despite it being on the list of essential drugs.

There are problems with privacy because the MTP Act goes out of its way to protect the woman's privacy but when women need to get MA drugs, they are now being asked for ID proof and so their privacy being compromised. HRLN has prepared a petition and is currently looking for partners.

Dr. A.L. Sharda, Director Population First, Mumbai spoke about promotion of the issue among media and policy makers. She shared that when they started these conversations with the groups, there was no resistance and in fact they were very receptive. It is important to have a conversation with those who can influence policy and opinions.

Advocate Varsha Deshpande Lawyer, High Court Mumbai and PCPNDT Activist, said that there are 42 cases related to PCPNDT pending opposite 70 doctors. Of these 18 have been convicted and 5 in jail. She said that all these districts are showing a positive trend of sex ratio and that after their work there is a 3 times increase in the reporting of MTP, and the government records show a three times increase in sale of drugs.

According to her the MTP Act is gender biased since the marital status is being asked for. We should be careful that we do not expose the MTP Act to further conservative forces given the current political situation. She also told us that women going to legal providers are often routinely blackmailed bout revealing their identity and thus addressing the stigma around women's sexuality is important.

Ragini Pant Research Assistant, CSR Haryana had been a participant at the **CREA –CommonHealth Institute** and shared some images of the anti- sex selection campaign which has a target driven approach and officials have been asked to increase the sex ratio by 10 points in a year. She showed some photos of posters which say 'feticide is a sin and a crime'.

She also spoke of the need to address the issues around women's sexuality and the patriarchal forces that seek to control them. She said that the tracking of pregnant women is very problematic and the image of all women as "Mother India" results in essentializing motherhood.

Pratishtha from CSR also shared her positive experiences of the CREA-CommonHealth Institute

Vinoj Manning, Executive Director Ipas Development Foundation Delhi spoke on future strategies and what civil society can do to improve access. The MTP Act Amendments have been in the making for the last 9 years. This February, the Government finally decided to move it

but were opposed by IMA and FOGSI. He asked why the civil society did not raise its voices and push for the amendments. He shared the guidance developed by the MoHFW which spoke of the sex selection and safe abortion issues. Four regional consultations are going to be held for dissemination.

Anand Tamang Director, CREHPA Kathmandu said that Nepal has the most excellent law. Safe abortion service is not restricted to doctors and even mid- level providers can perform it up to 9 weeks. The current challenge is due to the open availability of drugs and unregistered drugs being sold as well. Services are not free even in public hospitals and they need to work on that. Foreign funded anti-choice groups like 'Voice of the fetus' are gaining ground and we need to be alert about this.

After the panel, one of the questions asked to Adv Varsha Deshpande was to know more about the **'Beti Bacho Beti Padhao'** campaign that has been launched by the Prime Minister. How is it being implemented and what is expected from that ? Is it further likely to impact on women's rights to bodily integrity, autonomy? Is there something to be concerned about?

Varsha responded that there is no mention of the MTP Act in the 'Beti Bacho Beti Padhao ' documents. There are 5 laws which will be brought in by this campaign -POCSO, domestic violence, child marriage, child labour, PCPNDT, but we will have to think and then include MTP in this. The implementation does include the **possibility of tracking of pregnancies.** It has been removed from the Maharashtra state plan, but once the funds are received by other states and pregnancy tracking is initiated then it will a problem. We may have to track the doctor, but pregnancy should not be tracked.

The next presentation was by Surabhi Srivastava, program coordinator CREA and Kristin Francoeur, Phd. Scholar Indiana University. They gave an update on the CREA-CommonHealth Project: Creating Champions to Address Sex Selection and Improve Access to Safe Abortion. The goal of the project is to build capacity of individuals and organisations working on sex selection/declining sex ratio and/or safe abortion in selected states in India (**Punjab, Haryana, Delhi, Uttar Pradesh and Maharashtra**) which will enable them to advocate for and foster a common understanding and solidarity on the issue of sex-selection and safe abortion from a gender and rights perspective, and thereby work towards the larger shared goal of gender justice and equality.

The project comprises of a 2-pronged approach in order to achieve this goal; first, to conduct **a 5-day intensive training** to increase the knowledge and understanding of participants about various aspects and dimensions of the issue of sex selection and safe abortion in India using a gender and rights framework. And **second, to provide relevant support to the participating organisations** to operationalize state-specific action plans put together by the participants at the training to address the issue of declining sex ratio and unsafe abortion in their respective communities at local- and state level.

As part of this initiative a 5 day training was recently concluded which saw an overwhelming response from 20 participants from 5 states (Delhi, Punjab, Haryana, Maharashtra and Uttar Pradesh) participated in the training, representing 12 civil society organizations, one independent media organization, one academic institution, and the Department of Health and Family Welfare, Punjab Government. They also shared overview of some of the key findings of an **intensive mapping exercise** conducted before the training across the 5 selected states, with the objective to understand the socio-political and cultural context around the issue of sex-selection/declining sex ratio and access to safe abortion services at the state-level.

Surabhi and Kristin also shared information about an online campaign they are doing with Youth Ki Awaaz (http://www.youthkiawaaz.com/) which is a mobile platform for the youth to express their opinions on various social issues. This will be an online social media campaign on speaking out about abortion in order to break the stigma and shame attached to the issue. The 3-month campaign, aims to increase awareness about the work being carried out with regard to safe abortion in their respective communities and at the state-level. The campaign will culminate into **a call for action on September 28th, which is celebrated as the Global Day of Action for Access to Safe and Legal Abortion**.

Dr Gorakh Mandrupkar, former Secretary, **FOGSI** from Islampur, Maharashtra, spoke about the fear that providers are facing while providing the abortion in the first term as well. It is very easy for providers to refuse abortions as it is no more a lucrative business and in fact has more hassles. But what we forget to see is that our women are facing problems. The women who need the services are denied and have to go to many practitioners before getting

the service. As a gynaecologist he said that it is not just Maharashtra, but this fear is also spreading to Gujrat and Karnataka.
We need to arrange meetings of CSOs, doctors and Government officials and discuss this. Many authorities do not know that they are not the authorities. The way PCPNDT officials deal with doctors is as if all providers are criminals. He informed us that the authorities have been asking them to take a photo of the foetus after 2nd trimester abortions and send it to the authorities. He has stopped his own MTP centre and set up CCTV surveillance because he does not want to get into any legal hassle.

Prof Leela Visaria from **Gujarat Institute of Development ResearchAhmedabad** then shared her thoughts on what could potentially be next steps:

She noted that she was among the first demographers to have pointed out this drop in the sex ratio many years ago. She pointed out that India has enjoyed the ‘distinction’ of having more men in its society than women in last 70 years.

We do not have a good understanding of which women undergo sex selection and for which pregnancy. We need to look into why women are neglected and why families make these

decisions on behalf of the women. In the future should we focus on the MTP Act and let the PCPNDT Act lie low? For an individual woman, the drop in SRB from 971 to 914 is not of any relevance at all ! Until we address this issue at the family and community level, we may not make much headway.

Sonali Regmi, Regional Manager for Asia, Centre for Reproductive Rights, Kathmandu, Nepal then spoke about how we are all passionate about access to safe abortion as a rights based approach, but we also need to start talking about decriminalising abortion. She said that in Nepal, decriminalization came about because of the gender equality movement. So may be its time for India to remove this from its penal code. That is when we can make a real shift and start including safe abortion within sexual and reproductive rights. We need to link it to all other rights—against torture, against slavery, for right to education, employment, autonomy. We need to move away from the protectionist approach and move from conditional to absolute rights.

It is time to make a paradigm shift on gender discriminatory issues. We need to ensure equal inheritance of property, act against dowry and child marriages and ensure equity in women's participation in all spheres such as political, judiciary, law enforcement and others.

She questioned whether we really need District Level Committees to sit and decide on this? Why can we not leave it to women and trust them to make the right decisions?

Suchitra Dalvie thanked them for these eloquent arguments and guidance for future actions. She then made the closing remarks:

We need to ensure that the amended MTP Act also includes accountability of the government to ensuring safe and acceptable abortion services in the public sector. We cannot expect to regulate only one service within the private sector but we need more comprehensive regulatory mechanisms.

If we are speaking of safe abortion as a choice, it is very limiting since it implies choosing only between existing options. Many women seek an abortion when they have no other choice. We also need to see the context or the environment within which she is making this choice, since no one functions in a vacuum.

We claim to have moved away from numbers and targets since the ICPD but here we are again talking numbers and ratios and not standing up for rights. Where are the individual rights when the state dictates terms on demographic matters?

Feminists and activists always believe in "nothing for us without us" but in such meetings we routinely discuss women who have carried out sex determination and sex selection without bringing any one of them to the table.

If we do not strongly move to recognize safe abortion as a right, today we see it threatened by the issue of sex selection, tomorrow it may be the disability rights, or the sustainable population concerns.

Historical evidence of discrimination against the girl child, the patriarchal mind-set regarding the role of women and girls, poor implementation of other laws such as preventing child marriages and payment of dowry, the role of technology, misdirected campaigns, going for easy targets over making deeper changes, selective regulation of the private medical sector and lack of options within the public sector – all these further reduce spaces for women's health rights and access to services.

Rather than recognize requests for sex determination and abortion of female fetuses as a marker of gender discrimination and the status of women in the country, a misdirected connection is repeatedly made with access to safe abortion services, especially those obtained in the second trimester.

The time has come to move away from quick fixes and rhetoric about "save the girl child" and recognize the need to approach the issue from multiple levels. Positive reforms, interventions and implementation are what will make a difference. While Acts such as the PCPNDT Act should be implemented, so should the MTP Act, as well as laws against dowry, to prevent child marriage, to provide education and employment for girls and women, and ensure equal inheritance, paid maternity leave and so many others to ensure that all factors determining girls' and women's welfare are addressed in a holistic and comprehensive manner.

Asia Safe Abortion Partnership:
Blog: http://asap-asia.org/blog/
Facebook: https://www.facebook.com/AsiaSafeAbortionPartnership
Twitter: https://twitter.com/asapasia
You Tube: http://www.youtube.com/user/ASAPasia

CREA: http://www.creaworld.org

Annexure 1

List of Invitees:

S no	Name	Organisation
1.	Abhijit Das	Centre for Health and Social Justice (CHSJ)
2.	Ajaz	Breakthrough
3.	Akhila Sivadas	Centre for Advocacy and Research (CFAR)
4.	AL Sharda	Population First
5.	Alka Barua	CommonHealth
6.	Amar Ravi Navsharan	International Development Research Centre (IDRC)
7.	Anand Pawar	Samyak
8.	Anand Tamang	Center for Research on Environment Health and Population Activities (CREHPA) Kathmandu
9.	Ankit Gupta	Youth Coalition
10.	Anand Sinha	Packard
11.	Anshul Tiwari	Youth ki Awaaz
12.	Anand Mathur	World Health Organisation
13.	A R Nanda	Former Secretary of Health and Family Welfare, Govt. of India
14.	Bijaylaxmi Nanda	Grassroot Support Foundation
15.	Debjani Khan	Plan India
16.	Deepa Nag Choudhary	MacArthur Foundation
17.	Ena Singh	UNFPA
18.	Garima Shrivastava	Asia Safe Abortion

		Partnership (ASAP)
19.	Geeta Sen	Development Alternatives with Women for a New Era (DAWN)
20.	Gorakh Mandrepurkar	The Federation of Obstetric and Gynaecological Societies of India (FOGSI)
21.	Jasodhara Dasgupta	Sahayog
22.	Kerry Mcbroom	HRLN
23.	Kristin Francoeur	CREA
24.	Neha Rathi	Researcher
25.	Nilangi Sardeshpande	CommonHealth
26.	Prabha	TARSHI
27.	Praneeta S. Kapur	American Jewish World Service (AJWS)
28.	Preet Manjusha	Samyak
29.	Pritha Biswas	MSI
30.	Priya Nanda	International Center for Research on Women (ICRW)
31.	Poonam Muttreja	Population Foundation of India
32.	Ragini Pant	Centre for Social Research (CSR)
33.	Reena	YP foundation
34.	Renu Khanna	CommonHealth
35.	Rizwan	Girls Count
36.	Sharad Iyenger	ARTH
37.	Shilpa Shroff	Asia Safe Abortion Partnership (ASAP)
38.	Shireen Jejeebhoy	Population Council

39.	Shivani	FAT-NET
40.	Shubhra Phillips	Population Services International
41.	Shweta Krishnan	IIT Madras
42.	Sonali Regmi	Centre for Reproductive Rights (Nepal)
43.	Suchitra Dalvie	Asia Safe Abortion Partnership (ASAP)
44.	Surabhi Shrivastava	CREA
45.	Vanita Mukherjee	Ford Foundation
46.	Varsha Deshpande	Advocate, Sangali
47.	Vinoj Manning	Ipas Development Foundation