Asia Safe Abortion Partnership
Youth Advocacy Institute

Report

Dates: 5th & 6th October 2024

Venue: West End Hotel, Mumbai, India

A group picture of all the participants and facilitators

Introduction:

The Youth Advocacy Institute (YAI) – India was organized by the ISAY team with support from Asia Safe Abortion Partnership (ASAP). The institute was held on the 5th and the 6th of October, 2024 at the West End Hotel, Mumbai. There were 20 participants from various medical colleges. They attended the 2 day long institute along with 6 core team members from ISAY Core team members from ISAY included Saraswati Palnitkar, Sara Gattani, Anusha D'Cruz, Vivek Bokka, Nikki Agarwal, Krati Pandey. All of them have contributed to this report.

Objectives of the Institute:

1. To create a community of trained and sensitized **youth champions** who have an understanding of access to health care as a gender, sexual and reproductive rights, as well as a human rights issue.
2. To facilitate the utilization of **social media** and other community-level networking and communication by the youth champions through capacity building and ongoing mentoring.
3. To support the **ongoing engagement** of the youth champions, within and outside their community to ensure implementation of the above strategies in order to advocate effectively for improved access to health care services, including medical abortion.

The alumni will be facilitated to emerge as a community with a strong voice on this discourse at local, national, and regional levels and to engage with the issues on an ongoing basis through the online network as well as through participation in relevant meetings.

DAY 1: Saturday, 5th October 2024

Introduction:

All the participants and facilitators stood in a circle for a round of instructions through a memory game initiated by Dr. Suchitra Dalvie, Coordinator, ASAP . Participants were asked to talk about their expectations from the workshop. Together they also came up with some ground rules to be observed during the two days of the institute.

A still of the participants introducing themselves

Session 1: Understanding Gender and Patriarchy and its Link with Safe Abortion Issues

Facilitator: Nandini Majumdar

The impact of gender based inequality can be seen in almost all spheres of life, beginning from the moment a child is born. When life begins, when a child is born, the first question that is usually asked is *"Is it a girl or a boy?" Why are girls associated with pink and boys with blue?*
The societal norms that associate girls with the color pink and boys with blue. Interestingly, this association has evolved over time. In the Victorian era, blue was associated with women, believed to represent the sky, while pink was linked to men, reflecting the color of blood. However, this has reversed in recent times.

Nandini also talked about how gender stereotypes have been normalized since childhood. These are later on reflected in our society, policies, laws, caste. One example of this is that most intersex newborns are made to undergo sex correction surgery, which is still widespread in many countries. Malta was the first country to ban it. It was also highlighted that it is relatively easier for women to have the said 'masculine' interests but heavily stigmatised for men to have the said 'feminine' interests.

"First and the easiest way to kill a country is to kill its language"

This emphasizes on the fact that gendered stereotypes may manifest in a very casual and harmless way but they are actually suppressing the free expression of ideas and interest, particularly those who cannot align with societal norms.

"A woman is someone who is not born but created" - Simone de Beauvoir
Womanhood may not been an inherent quality, but a social construct created by the patriarchal society.

Nandini Majumdar facilitating her session on Gender and Patriarchy

Nandini went on the discuss that even men are victims of sexual violence but they're expected to be hypersexual beings who will never say no to sex. Their experiences are often dismissed or not taken seriously in discussions of gender based violence.

It was also discussed how society subtly enforces a strict binary, punishing those who deviate from it. This also leads to the perception of power and freedom differently for men and women and unequal treatment by the society. An example of this is the Lays advertisement which promotes chips for women that make less noise and plus size ads are made just to suit the male gaze. All these things reflect how gender roles are reinforced in the media.

The Protectionism Approach has become so prevalent that it gives a pseudo sense of security that women are safe but more often than not, it just adds to the shackles that hold women and makes things difficult. It is a very superficial solution to deeper societal issues. Gender is a hierarchy- all the beliefs and practices are around the cisheteronormative framework.

Feminism is not men versus women and feminists are not only women. This was further discussed with examples like the Indigo policy helps select the seat next to a woman, potentially implying that women are inherently vulnerable or need protection.

"If you're ignorant of the oppression, it's the luxury of your privilege." - Dr Manisha Gupte

In a further discussion, participants agreed that sex and gender are different. Gender is a social construct, an identity- the roles, practices, etc one will have based on their sex at birth. It was noted that even within the trans movement, trans men often remain invisible, highlighting the need for more inclusivity within advocacy spaces.

The idea of feminine and masculine is a modern day concept. Traditionally, men and women were both hunting and there was not strict division of gender roles. A participant pointed out that in the animals, the females took the lead- Tigress, lioness. Being masculine and feminine is not the problem, the problem is when someone dictates it.

The question "What is normal?" was raised pointing out that society's definition of what is considered "normal" excludes a large portion of the population. Many individuals are said to be abnormal simply because they do not fit into narrow, predefined binary.

The discussion also explored how certain cultural practices in India require proof of a woman's virginity after marriage, reflecting deep-rooted patriarchy in the society. One of the greatest vehicles of patriarchy is religion. Men have taken up places of authority and women are considered impure and not included in celebrations,etc.

Toxic masculinity is also a by-product of patriarchy. Women are also the propagators of patriarchy. Patriarchy is a system of oppression that puts men on a pedestal. Genocide and warfare are the extreme forms of patriarchy.

Marriage as an institution of patriarchy. Women entering the workforce often have to take up the double burden of working professionally and in their homes fulfilling all the duties of an ‘ideal wife and mother’.Gender Pay Gap is still an important issue with example from the medical field- Males are surgeons, women often take up branches which are non surgical and considered ‘lighter’ as they need to take care of their family. Patriarchy also rewards women by celebrations such as Mother’s Day which glorify motherhood and elevate the status of women as ‘mothers’ while sidelining their other contributions and roles.A participant shared that male security guards were replaced by the female security guards only to be paid less.

The punishments and social control imposed by patriarchy was also discussed. An example from the Kangaroo courts and Khab Panchayats was taken. These often impose bizzare rules on women where they are not allowed to have a phone or wear jeans, taking away their autonomy and right to decision.

It was also discussed how pleasure is not talked about in this patriarchal society and women are misrepresented in media and pop culture more often than men are

A video was shared to demonstrate how conscious biases exist within us and the idea of a woman being a CEO doesn't even come to our mind. Another example from Tokyo University was shared where evaluators were deliberately deducting the marks of female students because they would eventually start a family and stop working.

The session was a way to open new doors into the world of patriarchy, there are a lot of layers and depths that have not been talked about yet.

Session 2: Sexual and Reproductive Health and Rights (SRHR) and Human Rights

Facilitator: Nandini Majumdar

This session explored the various aspects of SRHR and its connections to human rights. Participants were divided into four groups. Each of these groups had to depict a specific aspect of SRHR: reproductive health, reproductive rights, sexual health, and sexual rights.

The points enlisted by the groups are as follows:

Group 1: Reproductive Health

The group used a tree to show the various aspects of reproductive health. The roots symbolized the definition of reproductive health: a complete state of physical, mental, and social well-being with respect to reproductive health.

The branches included multiple points like:

- The right to decide when and whether to have a baby.

- Government Provisions like antenatal care (ANC), postnatal care (PNC), PCPNDT Act, MTP Act, and contraceptive options.
- The contraceptive burden on women. For example, surveys showing that states like West Bengal run out of oral contraceptive pills (OCPs) more frequently than condoms.
- The decision-making process under the MTP Act remains provider-centric.
- Rights for differently-abled individuals, infantilization of persons with disabilities (PWD) through mandatory guardian consent.
- Lack of comprehensive sex education
- Stigma around menstruation, postpartum depression, and women who do not choose to have children
- Poor Transgender persons healthcare and infertility care within the public sector.
- Budget spent on medical infrastructure.
- Marital rape.

Group 1 explaining their interpretation of Reproductive Health

Group 2: Reproductive Rights

The group defined reproductive rights as both social and legal rights of a person with regard to their reproductive choices.

Points of discussion were:

- Availability of contraceptives like condoms and OCPs through government schemes.

- Family planning initiatives limited to married couples.
- Abortion access under the MTP Act, though conditional and stigmatized.
- Use of terms like "Right of the unborn child".
- Inclusion of paternity and paid menstrual leave.
- Promoting male contraceptive options.
- Need for comprehensive sex education.
- Higher taxes on sanitary pads than alcohol.
- Better government funding for reproductive healthcare.

Group 2 working on a the topic Reproductive RIghts

They concluded saying that there is a need to challenge norms that confine women to unpaid labor without enough support.

Group 3: Sexual Health

The points of discussion raised by group 3 were:

- Limited access to contraception
- Emergency contraceptives being banned as an OTC drug in India
- Need for awareness about sexually transmitted diseases (STDs) through public campaigns, ads, and street plays.
- Education on respect and consent in sexual relationships.
- Female sexual pleasure.
- Unhealthy expectations from pornography, which leads to violence.
- Need for mental health awareness related to sexual abuse.
- Barriers faced by LGBTQIA+ persons in accessing sexual health.

Group 4: Sexual Rights

Group 4 said that sexual rights include the right to choose a partner and explore personal preferences. They said that societal barriers usually limit this freedom.

Points of discussion were:

- Lack of criminalisation of marital rape
- Absence of health-seeking behavior due to stigma. This makes it difficult to access emergency contraceptives and sexual healthcare.
- Limited understanding of LGBTQIA+ needs, such as proper pronoun usage, and addressing stigmatized issues like fistulas.
- Need to reform marriage acts to provide equity to both partners.
- Right to have the desired number of children.
- Moving past terms like ‘deflorate woman’ in medical education.
- Sex education including topics like lubrication.
- The right to explore one’s sexuality without judgement or pressure.
- Safety and dignity for sex workers.

After the group activity, a video on ‘the evolution of human rights’ was played.

Nandini explained how we are all essentially advocating for ‘human rights’ at the end of the day. Simply participating in workshops signified the commitment to advocacy that each of the participants had. The next step was raising awareness.

The session was then closed by Dr. Deepali who said that the foundation of human rights begins with understanding what it means to be human.

Session 3: Values Clarification and Case Studies

Facilitator: Dr. Suchitra Dalvie

Session began by asking the participants:

What do you mean by the term ‘values’?
The following inputs were received from the participants about their understanding of ‘values’:

- What is right and wrong, influences decision makings, affects the choices and decisions
- Imparted by the caregivers and surroundings
- Can change over time

When the context has changed, the values given previously are challenged. Values tend to have a pattern in our lives. Sometimes while questioning and rethinking these, one can feel

lost. A collective/ organisation may help in guiding the values and also helping the individual in thinking things and their actions through and also rethinking them.

Dr Suchitra Dalvie guided the participants through a series of interactive exercises. The participants were asked to stand in the middle of the room and a series of ‘problem statements’ were displayed on the screen. They then had to move to either side of the room based on if they agreed or disagreed with the statement. This exercise helped them challenge their assumptions and adapt to broader perspectives.

Statement 1: A woman should stay with her husband even if he beats her, if he truly loves her.

All of the participants disagreed with this statement. They then debated whether a single slap can be labelled as domestic violence. The participants agreed strongly that no matter the extent of the abuse, the woman should leave the husband.

This led to Dr Dalvie questioning about the places the woman can escape to. She said that it is important for medical professionals to know safe spaces for survivors, as women doctors are often the only point of trust for many.

Another point of discussion was the survivor's autonomy in deciding whether to leave or stay. The trauma bond and the spiraling impact of abuse are often neglected while discussing such cases.

She also said that by labeling it as "domestic” violence, we can undermine the severity. Violence is violence and there is nothing ‘domestic’ about it.

A still from the session ‘Values Clarification’

Statement 2: A sex worker cannot be raped

This statement challenged the participants to consider societal and legal biases. Points of discussion were:

- Who defines rape in these contexts?
- What happens when the survivor approaches law enforcement? Do they receive justice or are they abused further?
- The lack of laws and conversations about sex-work highlights the hypocrisy in the society. It demands sex work but is ashamed to talk about it.
- How is sex work even defined? Can it only be for monetary gain or are other transactions (e.g., promotions or resources) also included in the definition.
- Unpaid sexual services in marriage and marital rape.

Statement 3: Women with HIV/AIDS Should Not Have Babies

The room was divided where some agreed with the statement and some disagreed.

The points raised by the group in support of the statement were: Concerns for the child's health, therapy needs, and the mother's well-being.

The group against the statement said that they couldn't regulate someone else's choices, regardless of the consequences.

The moral dilemma of suggesting sterilization for such groups was introduced by Dr Dalvie. She then replaced the problem statement with 'Poor women should not have babies' and asked if sterilisation was the solution for this problem too.

The participants understood the need to let the woman take the choice when the context was changed. Dr Dalvie too, encouraged providing factual counseling while respecting autonomy of the pregnant person.

Statement 4: Women who have an abortion are ending a life.

This question addressed the philosophical and practical aspects of abortion.
The points of discussion were:

- How do we define life: viability or consciousness?
- The obscurity of viability.
- Prioritizing the 'life' of the pregnant person over the fetus.
- The seeker may also be in the same dilemma.
- Do not encourage or discourage, allow them the space to decide for themselves.

Statement 5: Choosing the sex of one's child is a reproductive right

Most of the participants disagreed with this statement. The points of discussion were:

- How societal norms, such as valuing sons over daughters, impact population dynamics.
- Exploitation of gender: Selection of male childs during war situations.
- The idea of further increase in sexism if the sex ratio is unbalanced was suggested by a participant
- The conversation shifted to chromosomal abnormalities, with participants agreeing on the right to abortion in such cases.
- Reasons for abortion in case of chromosomal abnormalities were cited as: financial liability, negative impact on lifestyle of child, struggle in accessing education employment opportunities and a fair social life.
- The same was then extrapolated in case of a female child. The participants realised that a female child will have to face additional barriers too, just like in the case of a child with chromosomal abnormalities.
- They were unsettled with the idea of sex selection but not ableism. This showed them the hidden biases that they carry.

At the end of the activity the participants reflected on how biases rooted in gender, privilege, and norms shape their perspectives. They realised that poverty, privilege, and patriarchy intersect in decisions around reproduction.

The dehumanizing impact of reducing people to numbers or societal roles was also brought into perspective.

Dr. Dalvie closed the session by reminding the participants that unpacking discomfort and questioning ingrained beliefs is an important yet gradual process.

Session 4: Gender and Sexism in Mass Media

Facilitator: Dr Saraswati Palnitkar

In this session Dr Saraswati talked about the influence of mass media and stereotypes in shaping gender-roles in society, expectations, and behavior.

She started with discussing what stereotypes are. Stereotypes are assumptions or expectations placed on individuals based on their gender, community, or social group. Participants shared examples, such as "girls playing with Barbie dolls" or "women can't drive."

Then she talked about ‘roles’. Roles were described as duties or expected behaviors. Examples: married women should prioritize domestic responsibilities over career ambition.

She said that stereotypes can be harmful as they can:

- Limit growth of an individual by forcing them into predefined roles.
- Create biases in professional fields (e.g., women being steered toward non-clinical medical specialties due to the assumption that they will get married and waste a clinical seat).

- Create systemic inequalities. These lead to maintenance of the power dynamics.
- Influence personality and behavior through years of internalisation.

Participants also said that the phrase “you’re not like other girls,” reinforces negative stereotypes about femininity.

A still of Dr Saraswati Palnitakar facilitating the session on Gender and Mass Media

Next, she showed them examples of sexist problematic statements. Some of these were:

- Disney movie *Snow White:* ableist and patriarchal
  Participants noticed that most fairytales often trivialize consent and normalize rape culture.
- Ads that glorify domestic labor or focus on physical appearances.
- Mother’s Day sales often exploit gender roles to drive profits. They focus on cosmetics or kitchen appliances for women.
- Newer advertisements that are trying to be progressive were also discussed, this provided a contrast.

Then followed an activity wherein the participants were asked to name movies that they associated with words prompted by Dr Saraswati. They could name a lot of movies showing gender based stereotypes but hardly any on topics that should be discussed: like abortion and surrogacy.

They then discussed how stereotypes evolve from subtle jokes or memes into something much bigger. They can manifest in the form of emotional abuse and can escalate to physical violence, rape, and murder. This made it clear that these depictions are not harmless but represent mechanisms of power and control.

Dr Saraswati encouraged participants to question the content they consume, identify problematic messaging, and demand accountability from creators. She said that social media can also do good as it provides a platform to challenge stereotypes and advocate for sensitive representations.

She closed the session by reminding the group that awareness is the first step in creating change.

Session 5: Power Walk and Intersectionality

Facilitator: Nandini Majumdar

Each participant received a chit with an identity that they had to assume for the activity (e.g., a deaf girl from a lower socioeconomic background, a 19-year-old girl facing pressure from her boyfriend, a 14-year-old live-in housemaid). They stood in a single line and took a step forward if the questions asked applied to their identity. Examples of the questions asked are: “Do you know about sex?” “Can you insist on the use of contraception?”

At the end of the exercise, some participants were at the far end of the room, while others had not moved at all. This activity illustrated intersectionality.

Nandini then started going around the room and asking why the participants had taken some steps and not the others.

One participant, who had assumed the identity of a deaf girl from a lower socioeconomic strata, said that they couldn’t communicate without gestures. Thus, the participant did not step forward at all during the exercise. This showed the marginalization of the deaf community in India and Southeast Asia. Nandini explained that lack of access to schools and communication skills further isolates the deaf community.

Another participant had assumed the identity of a 19-Year-Old girl facing sexual pressure from her boyfriend. The participant in this role took 3-4 steps in total. Nandini emphasized that many 19-year-old girls, especially those from disadvantaged backgrounds, might not even attend school or have access to basic information about sex or contraception.

A constant question of ‘Who is responsible?’ was being asked throughout the session.

Another participant was a 14-Year-Old live-in housemaid. When asked “Can you say no to sex?”, this participant stepped forward. Nandini said that this assumption was problematic as usually such individuals may lack the power to protest against sexual abuse. Young victims

of sexual abuse often grow up feeling guilt or confusion. They believe they might have enjoyed the abuse and thus do not have the right to protest later in life.

The next participant was a 25-Year-Old married woman with a traveling husband. This participant took many steps but stopped at questions related to access to safe abortions. Nandini discussed the absence of public awareness campaigns on abortion, whereas other health initiatives such as polio have multiple campaigns.

A still of the participants lining up for the activity ‘Power Walk’

Another participant said that she had taken many steps with the assumption of having a supportive husband. This dependency on goodwill reflects systemic gaps. It forces individuals to rely on personal relationships and luck.

The discussion then moved to another participant who had assumed the identity of a sex worker. Nandini noted how many sex workers in India are unaware that sex work is not illegal. She also said that individual awareness cannot be the ultimate solution. Systemic changes are needed to ensure access to information and resources.

A peculiar case was seen where two participants with the same identity took different numbers of steps. This showed the amount of subconscious bias that a person harbours.

Nandini then discussed the interconnected nature of oppression, quoting Audre Lorde: “No issue is a single issue.” She discussed how identities such as caste, class, and gender

intersect to create unique barriers. These barriers are specific and different for each individual.

She said that protests serve as a reminder of active democracy. Using the example of India's farmer protests, Nandini showed the importance of advocacy to challenge inequities among different sectors.

Participants were reminded that privilege is not inherently bad but comes with the responsibility to advocate for those less privileged. Only 9% of women in India are formally educated, this shows the duty of those with education and resources to give back to society.

Nandini closed the session by encouraging the participants to write, speak up, and connect with communities for knowledge exchange and activism.

DAY 2: Sunday, 6th October 2024

Recap from Day 1

During this activity, the participants reflected on what stuck with them from Day 1. Some shared that learning about the sex ratio was only ever framed within the context of marriage, which limited their understanding.

A participant said that when "why should disabled people be aborted," was substituted with "girl child" during the Values Clarification session, she realised that she too harboured many ingrained biases.

Nandini's session on patriarchy left a strong impression, it reminded the participants of the structures that perpetuate these stigmas. One participant had a realisation during the discussion: *Should women with HIV be denied the right to have a baby?* This "aha" moment challenged her assumptions.

One participant asked her mother if she knew where to access abortion services, only to find out that her mother considered it unimportant. This made her realize that having the resources and knowledge around reproductive health is necessary, regardless of personal need.

Dr. Dalvie asked participants if they knew their mothers' maiden names and then asked about their grandmothers, highlighting how much family history is often lost. Most could not answer beyond a generation or two, whereas they knew their father's surname as it had

been carried forward by them. This showed the part that patriarchy plays in erasing women's history.

A participant admitted, "I used to think I was woke, but this session made me question my awareness." The power walk activity had particularly impacted him, prompting him to reflect on his privilege. He even discussed it with friends afterward. Dr. Dalvie encouraged self-compassion, reminding everyone that unlearning deep seated beliefs takes a lot of time.

Another participant shared a similar realization: "I realized I still cling to biases and stigmas," describing the workshop as eye-opening. The physical manifestation of these ideas during the power walk made the experience very impactful.

Reflecting on the biases within society, a participant shared that she hadn't considered the ableist attitude because it had never directly affected her. The "CEO calls the son" riddle also struck her, challenging her assumptions.

The images in children's textbooks, showing mostly men in professional roles, triggered another participant. She realized how early these biases are created and talked about it with a friend after the workshop.

The power walk also brought out individual backgrounds. One participant observed that in rural settings, people might not take even two steps due to a different sense of privilege. He remarked on how being born in a Tier 1 city brings hidden biases.

For one participant, the "CEO riddle" made her reflect on her privilege. Nandini's instruction to "look around" during the power walk also encouraged her to become more receptive and open.

Another participant talked to his family, asking his sister if she knew about abortion resources. He also shared that "clean comedy" often reinforces misogynistic themes, which challenged his assumptions about "clean" humor.

One participant had debates with 4-5 friends, deliberately playing the "bad cop" to gauge their defenses. This exercise opened up further discussions about biases and beliefs.

A participant recalled the commonly voiced idea that "poor people should be stopped from reproducing." She reflected that numbers aren't the issue; instead, there's a need for government policies to support those in poverty. She shared this with a friend who questioned her feminism, using the stereotype that women can't drive well as an example. She explained to her friend that systemic denial of opportunities, not capability, perpetuates such stereotypes.

Another participant reflected on a question Nandini posed: *Who is responsible?* This led to a conversation with her mother, who shared a personal story about complications from an IUD. It showed the support her mother received, which was a contrast with the norms in their religious community.

Dr. Dalvie acknowledged the overwhelming process of unlearning and reminded participants that they are taking an important first step by being part of the workshop.

One participant shared that her privilege had unconsciously influenced her identity choices in the power walk. The clarification around valuing the pregnant person's life over the fetus's life helped clear her perspective on reproductive rights.

The value clarification exercise led another participant to realize that understanding the cause is crucial. After speaking with her mother, who shared stories of support from her own family, she recognized how upbringing shapes perspectives.

One participant was surprised when her mother struggled to answer the CEO riddle, which helped her mother see the value of what her child was learning. She was also struck by the case studies, realizing that privilege shapes our ability to make choices that others may not have.

Dr. Dalvie emphasized that medicine is often built around the "heteronormative male body" as the default, a fact that shocked some participants.

For another participant, the replacement of "disabled person" with "girl child" did not sit well, as she had grown up advocating for the "Save the Girl Child" movement. She planned to think it over more deeply before fully accepting the shift.

The *Save the Girl Child* slogan itself sparked reflection. Participants discussed how the phrase infantilizes girls, and positions them as weak and in need of protection rather than empowerment. It reinforces traditional roles, tying the girl child's value to her use within the patriarchy. She is expected to eventually marry and become a submissive wife.

One participant shared that her family assigned responsibilities to an unborn "girl child," assuming she would care for her younger brother, a reflection of how expectations are imposed early.

Another participant found the human rights video powerful, feeling unsettled by how long human rights have existed and how we still struggle with them. A friend of hers even changed Siri's voice to male, yet couldn't solve the CEO riddle, showing ingrained biases.

Another participant noted how her friend shifted from loving pink to rejecting it due to bullying and the association with weakness. The human rights video emphasized for her how long we have been battling for equality, and she realized the importance of speaking up. Dr. Dalvie encouraged them to aim to be the second person to support change if they aren't ready to be the first.

The "18 Again" ad also impacted a participant, who shared that she felt an emotional shift when Nandini asked them to look around during the power walk. The disinterest of her roommates triggered her, as did her mother's unsupportive reaction. She expressed feeling that, at times, she was standing against herself.

One participant spoke with her grandmother about the workshop and found her surprisingly supportive, appreciating the encouragement.

Dr. Deepali, left the last impression with the statement: *Don't be complicit in your oppression.*

Session 6: Contraception and Abortion from the Gender and Rights Perspective

Facilitator: Dr Suchitra Dalvie

The session began with a group activity led by Dr. Suchitra Dalvie, where she invited a participant to draw and explain the female reproductive system. She then asked the participant to teach a hypothetical rural school girl about menstruation, while being mindful about her language.

Participant drawing the female reproductive system to explain menstruation during the session 'Contraception and Abortion from the Gender and Rights Perspective'

After the demonstration, Dr Dalvie reminded the group that when discussing reproductive health in rural settings, careful use of terminologies is needed. Incorrect language could lead to unintended consequences, like being asked to leave.

Dr. Dalvie proceeded with a detailed explanation of the menstrual cycle. She covered its duration and phases. She discussed fertilisation and the role of implantation in pregnancy detection. Pregnancy can be confirmed with a urine test (UPT) seven days after fertilization due to the presence of beta-hCG. Before this period, you can get a negative result, which would be a false negative.

Dr. Dalvie then outlined the hormonal changes during the menstrual cycle.

Next, she introduced common contraceptive methods such as barrier methods, intrauterine contraceptive devices (IUCDs), and sterilisation.

To put contraception into perspective, Dr. Dalvie asked participants to consider how many pregnancies a woman could theoretically have during her 40 years of menstruation. She said that in earlier times, late menarche and shorter life spans limited a woman's reproductive capacity to around 10-12 pregnancies. The prerequisites for menarche such as ready access to food, safety, and resources: also limited reproductive capacity earlier.

She then shifted the focus, asking the number of women a man could theoretically impregnate over his lifespan. The answer was much higher. This showed how reproductive potential differs between men and women. This led participants to reflect on how the burden of contraception has been disproportionately placed on women, despite the broader reproductive capability of men.

Dr. Dalvie then asked participants to research contraception methods used by the animals they had selected during the workshop's introductions. They discovered that animals, unlike humans, don't actively use contraception. Instead, animals rely on mating seasons, with females going into heat during these periods solely for procreation. This naturally limits reproductive cycles and ties reproduction to survival instincts. For humans, sexual activity extends beyond procreation. It includes pleasure and power dynamics, making contraception a necessity in modern society.

The discussion then returned to types of contraceptives, including IUCDs, spermicidal creams and jellies, injectables, implants, emergency contraceptives, and barrier methods, highlighting the broad range of options available to women. Dr. Dalvie contrasted this with the limited options for men. Only two main contraceptive methods exist for them. She explained that this disparity places reproductive responsibility mostly on women.

One participant observed that vasectomies are rare in their hospital while tubectomies are common, despite the latter being more invasive and expensive. Dr. Dalvie emphasised that the political agenda of the 1970s led to a shift from vasectomies to tubectomies.

Moving on to the topic of abortion, Dr. Dalvie made the participants list various reasons women seek abortion. The answers ranged from contraceptive failure and rape to health complications and personal choice. She highlighted the complexities introduced by the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, which legally prohibits sex determination but fails to address broader access issues. The act's assumptions around female foeticide complicate abortion access for everyone, with data indicating that only 18% of abortions post-prenatal diagnosis are due to sex selection. The law's punishing nature has created barriers to safe abortion access for many who need it for non-selective reasons.

The potential consequences of restricted abortion access are adoption, abandonment, forced birth, and infanticide. It also includes the risk of suicide or homicide.

She then explained that the Female Infanticide Act, passed in 1871, came into existence a century before the Medical Termination of Pregnancy (MTP) Act.

Dr. Dalvie also pointed out that restrictions such as those under the PCPNDT Act, operate on the assumption that women who learn they are carrying female fetuses will choose abortion. However, women who find out they are carrying a male fetus often actively choose to continue the pregnancy, which is also a type of sex selection.

This reveals the bias within the law. It complicates access to safe abortions without addressing the actual issues of gender bias and pressure to select a particular sex. This shows how legal efforts have always focused more on restricting female autonomy rather than supporting reproductive health rights.

Closing the session, Dr. Dalvie described both medical and surgical abortion methods. Mifepristone and misoprostol were originally explored for other medical purposes but have become widely accepted drugs for abortion. Surgical methods, including D&C, D&E, and MVA, were also discussed, showing the diversity of available options.

Session 7: Criminalisation and Decriminalisation

Facilitator: Nandini Majumdar

The session was initiated by showing a video “It’s her right- to Mr. President”, which is made by the youth champions to the participants . The video is a compilation of stories of women, their unwanted pregnancies and the difficulties faced by them to access abortion services. They spoke about how due to the lack of safe abortion services, they were referred to quacks that used unsafe, unsanitary ways to perform the procedure which resulted in more harm than good. They also spoke about the various barriers that they had to overcome such as financial, social, etc. It tries to give us a glimpse of the lived realities of women of all ages and socioeconomic strata and why access to contraception and abortion services should be made available through social and legal reforms.

Participants shared their thoughts:
They were able to understand the trauma the women went through.

The session is important to us as safe abortion advocates because in most countries, abortion is restricted or illegal. In India, it’s legal but criminalised. Therefore we should have a good understanding of law and policy and apply the feminist lens to it.

Following questions were asked :

- What is crime?
- Who is a criminal?

The participants responded by saying crime is any act that is against the law. Nandini explained that it's any act that causes harm - financial fraud, rape, killing. It's not always a violation of ethics and what ethics is always changing.
They defined a criminal as someone who harms somebody with a bad intent. Nandini explained that intention is important, stating homicide v/s culpable homicide differences.

Participants shared that even if they wanted to access abortion but they didn't fall under the four clauses, they could be considered a criminal. To which Nandini said Law is black and white. She also stated that Suicide was decriminalised under the Mental health act, earlier didn't have a right to end one's own life

She further asked, Who decides what is a crime and who is a criminal? People in authority who have the power, the lawmakers decide that. *Hegemony* is a term that states, those in power determine what's punishable & what's crime. Legality is simply a construct of power and not a reflection of ethics. Crime changes with culture.
Criminalised tribes: Irrespective of what crime occurs, people from the said tribe are caught. Now known as denotified tribes but still carry the stigma. We carry on the colonial ideas of criminalisation. Anyone who speaks against the government, the act is considered *sedition*. No one can question the government, if they do their loyalty is also questioned. UAPA is a non bailable law. Everything is tracked. She further shared the story of Father Stan Swamy.

Nandini went on to ask questions like

- Do you know anyone who has committed a crime?
- Can you ever commit a crime?

She shared that the US influences the policies. Drug possession in the states is decriminalised only because the white population using cannabis increased.
Higher the degree of crime, higher the degree of violation, greater the punishment. She asked the participants if they knew the statistics of crime in our country?
Most prisoners have been accused under false charges or are Muslims or belong to the scheduled tribes or are from the tribal communities. Rich do not commit less crimes but are less likely to be punished.

Nandini discussed stricter forms of slavery in our country which are caste based.
In the War in Palestine - harm, intent, all of it is present. And the States are complicit. Even other western powers are involved. India has signed a treaty with Israel to send workers because of lack of Palestinian labourers. War is profitable for people in power. Law does not mean good, right, or bad. It has nothing to do with ethics but everything to do with people in power. The Chernobyl , Bhopal gas tragedy are examples of how corporate industries do such harm, but individuals are punished.

Nandini stated that Crime is part of culture, changes with time like culture does. *Witches, Midwives and Nurses* - originally healers but with the advent of modern medicine, a system that emerged out of patriarchy, hunted them down as witches and used inhuman ways to detect them. People at the bottom are most vulnerable. Concept of intersectionality is important.

A still of Nandini Majumdar facilitating her session on ‘Criminalisation and Decriminalisation’

She further shared the model of *Panopticon and the surveillance state*- the prison is built in a way that all the prisoners felt like they were being watched so they started self regulating. She went on to state state Punishments against Gay people and trans people, sentenced for treatment camps, lynchings, ostracisation, exclusions and honour killings.

Nandini then discussed Policing and Prison - In the US, since slavery system was abolished, the policing system felt like the next best option for unpaid labor by black people.Custodial torture and violence- extra judicial measures are glorified in India and are harmful. In 2021, 77% prisoners were from poor and oppressed parts of the society.

She told about how Angela Davis talks about how the prison system makes the person go away and not the crime. This falls under the retribution model/ criminal justice system. There needs to be a change towards the social justice model. Death penalty- if wrongly given, cannot be reversed.It has statistically been proven to be not working effectively.

She raised an important question, Is the system built to pacify people? It is a paid system. There is a lack of transparency and a need to re-look at our criminal injustice system and ask for reforms there. Not everything safe is illegal, not everything legal is safe.Making abortions illegal won’t stop abortion, only increase the number of unsafe abortions.

Nandini concluded the session by sharing Alternatives to criminalization: Legalisation - would be regulated under a specific law, requiring licensing and meeting certain criteria to qualify for the license. In context of sex work, decriminalisation model is preferred, not regulated by policies.

Session 8: Abortion Laws and Policies

Facilitator: Dr. Suchitra Dalvie

The session on Abortion Laws and Policy was conducted by Dr Suchitra Dalvie. She started with explaining how laws are codified morals and why it's important to question who they are protecting. She shared a study by the Guttmacher institute that states that around 70% abortions in India happen by medical pills acquired from elsewhere and not from a pharmacy. Only a fourth of abortions happen through the public healthcare system. The group delved into possible reasons as to why abortion seekers are unable to access free and affordable healthcare in India, the barriers being social stigma, lack of awareness, a lack of public health facilities in rural areas and the judgement of the providers themselves. Though the MTP law is considered progressive as compared to other countries, abortion is still criminalised under the IPC sections 312-316 (now BNS). Dr Suchitra explained how the MTP law was created to protect healthcare providers from these IPC sections and is thus heavily provider centric. The requirement for 2 RMPs' opinion to permit abortion beyond 20 weeks is unnecessary as complicated pregnancies and deliveries are managed by a single doctor in a government setup, while abortion is a much simpler procedure. It is important to remember that the words 'legal' and 'safe' are not interchangeable when it comes to abortion. For eg, safe abortion can be provided in a country where it is banned, and legal procedures such as D&C are not considered safe.

Dr Suchitra raised some important questions such as:

- Do we need a law for abortion? The law should not be restricting people from services, but should ensure that their needs are met.
- Major surgery doesn't need a law, if the doctor is qualified, experienced and licensed then the procedure is between patient and doctor. Law for abortion doesn't come from the safety of the procedure or for the health of women. It is about control and social aspects. We have a grievance redressal system in place that allows patients to file negligence cases against the doctor.
- Will creating a law ensure access to safe abortion? Stigma associated with abortion does not allow redressal.
- Should abortion be part of population policy? That would subject abortion to the tides of population changes and would end up being another tool to control women's bodies.
- Who is the guardian of law?
- Who is the law aimed to protect? The recent amendment still has not addressed the skewed power dynamics between the provider and seeker.

She also discussed the morals and societal constructs that shape these laws. Patriarchy glorifies motherhood and the value of a woman is measured by how well she serves her role in the patriarchal system. Hence, bodily autonomy and having control over your own sexual and reproductive choices is a direct threat to the patriarchy. She went on to discuss harm reduction strategies practised by doctors in Latin America where they inform the seeker about abortion pills such as misoprostol in a neutral way, without directly advising it.

Dr Suchitra then shared a map showing the maternal mortality rates around the world, and the participants noted how the areas with the highest maternal mortality coincided were also those with the most regressive abortion laws, this highlighting a direct connection and

proving that making abortions illegal only makes them unsafe, and does not lead to a decrease in abortions. Dr Suchitra also shared an upside down map that took the participants by surprise. She reminded us that it is important to question everything, even a map and understand the colonial mindset and power structure that comes with it.

The session concluded with a reflection on the patriarchy deep-rooted in modern medicine. Dr. Dalvie shared the example of J. Marion Sims, known as the “Father of Gynecology,” who conducted unethical experiments on enslaved women without anesthesia, reflecting the dehumanizing effects of patriarchal and racist practices in medicine. She noted the absence of female figures recognized as "mothers" in medical history, a reminder of the systemic biases embedded in healthcare and society.

Session 9: Ethics, Conscience and Being Pro Choice

Facilitator: Dr. Amar Jesani

The session began with a discussion on morals and ethics and Dr. Jesani about how morality and ethics is about making a judgement. While making this judgement, we imbibe values from our religion, family, culture. Even colour is prejudiced, like black market, black colour is also influenced by morality. Ethics, over time, are codified into guidelines that define acceptable behavior, particularly in sensitive areas like reproductive health. One is said to be ethical if they follow these ethical guidelines.

In reproductive health, one mainly deals with healthy women and hence ethical complexities arise. But when dealing with patients, there's a third party involved which is the elephant in the room- religious, social, patriarchal morality. A significant challenge lies in being ethical in these situations.

Dr Jesani further discussed the influence of religion in abortion and it was noted that no religion says anything good about abortion.
Judaism talks about ensoulment and Islam says that life begins when 120 days after conception, the soul enters the foetus. However, Islamic countries don't allow abortions because it depends on interpretation.

Hinduism includes abortion as part of sacrament, samskara or rites of passage at conception, then for gender , then for mental development of foetus but texts like Manu smriti prescribe punishment for abortion.

Christianity opposes the use of contraception and after colonial times, we inherited criminalisation of abortion from Christianity.

Abortion faced increasing restrictions, with the American Medical Association (AMA) calling for its prohibition in the 18th century. Criminalization became widespread by 1869 and lasted for a century. Only after WHO and UN were established, a code of ethics was developed and it allowed abortion to be decided by the counties of laws.

In India, the MTP Act of 1971 led to the liberalisation of abortion for doctors to terminate pregnancies but left decisions largely to the discretion of healthcare providers, influenced by their personal beliefs.

A still of Dr Amar Jesani facilitating his session on Ethics, Conscience and Being Pro Choice

Dr Jesani also discussed the various kinds of ethical positions and stances that one may have while providing abortion services:

- Conservative position - Early positions were religious, but evolved to the rational standpoint of protecting life. It came to foetus rights and personhood was given to the fetus.

- Liberal position - These views pose the following questions and give importance to pregnant person's rights. '*Can you give the same status to a child and a foetus?'*
  'Who is more important, pregnant woman or foetus?'

- Moderate views- These represent the socio political compromise that shifts depending on political power and scientific progression. Thus, they are unstable.

The use of abortion for family planning, as a backup method , depends on population dynamics and control was also discussed. Abortion is dependent and provisional in such cases.

Topics like sex selection, ectogenesis (artificial uteruses allowing the foetus to develop outside the womb) and neuroscience concept of ‘When does the foetus start feeling pain?’ were discussed in depth and their impact on abortion services was also discussed. The providers used these as grounds for ‘conscientious objection’.

The relationship between ethics and conscience was explored in the context of provision of safe abortion services. Conscience was composed of deeply held moral beliefs, corresponding with religion. It is a broad term, used by those who are rebellious as well as conservative and do not favour providing the abortion services. They also claim that moral injury is caused to doctors by the MTP Act as they are made to do something against conscience. Thus, conscience is used as moral justification for crimes and oppression.

The victims also try to fight against this oppression based on conscience and morality. While some doctors are not providing abortions despite its legalisation based on their conscience, others are providing it despite the legal and social constraints. Conscientious provision is the provision of safe abortion services despite the legal restrictions and societal constraints. Both negative and positive claims of conscience can be seen among the providers.

The session concluded with Dr Jesani saying that the need of the hour is for the healthcare providers to come together and rally for safe abortion access on a rights-based approach. Taking inspiration from when the American Medical Association (AMA) did not agree to the death penalty by injection, the doctors came together. In a similar way, the providers can unite and create a pro choice stand despite political opposition.

Session 10: Literature Review and What does it mean to be Pro-Choice?

Facilitator: Dr. Suchitra Dalvie

The participants were assigned a few articles and were given 30 minutes to read and analyze them. They were then asked to present their critique to all the participants This session was facilitated by Dr. Suchitra Dalvie where she further raised questions and allowed the participants to expand their depths of analysis and gave them pointers on how to present the same. Following articles were discussed in depth:

- Wedding with a Rapist
- Russian Lawmaker
- The role of Women in Nazi Germany
- Tuskegee Trials and HeLa Cell Line
- Brother of Pakistan

Dr. Suchitra Dalvie asked the participants to reflect on the question: ‘*What is the purpose of them being here?’.*
During the last two days, a lot of uncomfortable questions were asked and answered. It was also discovered that we are not comfortable with the current situations, and wanted to know what we can do about it.

Dr Dalvie also pointed out that we are all here as ‘Agents of Change’ who want to change something in ourselves and in the environment.

The brief history of the Asia Safe Abortion Partnership (ASAP) was also put forth. ASAP was started 15 years ago by a group of 35 people who agreed that there was a need for a place where they could talk about Safe Abortion. The name “ASAP” was deliberately chosen to include the word “Abortion,” ensuring the organization remained true to its advocacy mission. Over the years ASAP has been working closely with journalists, doctors, nurses, and midwives to reshape societal perspectives and create change.
A lot of times while doing advocacy, we feel isolated but we must not forget that a lot of people are working towards the cause and this also highlighted the importance of solidarity among the advocates.

An introduction of the ASAP Academy was given. It offers self paced and flexible learning opportunities. It is a platform where one can equip themselves with all the knowledge and resources needed to do advocacy and bring about change.

Dr. Dalvie also discussed Maslow’s Hierarchy of Needs, telling that there are the basic needs like psychological and safety needs which may be fulfilled, the feelings of love and belonging come into play. After that, at the apex, self- actualisation comes into the picture and two questions are often asked, ‘What is the purpose of life?’ and ‘What is the purpose of my life?’

Dr. Dalvie said that it is often said that one needs to seek the purpose of their life but she believes in creating the purpose of our own lives. Once you create this purpose, work towards it. It may change, and if it does, work towards it. It is essential to answer two questions by ourselves, ‘What do we want to change?’ and ‘Who will make the change?’ while working on it.

The concepts of hegemony and subversion were talked about. Hegemony is when the people in power dictate what is right and make everyone believe that it is right and impose it on the people. Subversion, on the other hand, was compared to the Trojan Horse—using familiar concepts to challenge existing systems from within and gradually introduce transformative ideas.

Advocacy is a stepwise process. A lot of people are oblivious towards the problem, some will say it's not their problem, others ask if it's a significant problem. Only information is not enough, for advocacy to be effective, direct engagement and personal connection are crucial. People talking about issues such as global warming online are not as impactful until people are actually having conversations face to face.

Dr. Dalvie revisited the statement, *‘Personal is Political’* from the Women’s Rights Movement emphasizing that our personal struggles may overlap with political issues. For example, abortion should not just be seen as a need but as a fundamental right, reminding us of the importance of personal agency in advocating for systemic change.

Annexure - Objectives and Agenda

Asia Safe Abortion Partnership

Youth Advocacy Institute

Dates: 5, 6 October 2024.
Venue: West End Hotel, Marine Lines, Mumbai, India

Objectives of the institute

1. To create a community of trained and sensitized **youth champions** who have an understanding of access to health care as a gender, sexual and reproductive rights, as well as a human rights issue.
2. To facilitate the utilization of **social media** and other community-level networking and communication by the youth champions through capacity building and ongoing mentoring.
3. To support the **ongoing engagement** of the youth champions, within and outside their community to ensure implementation of the above strategies in order to advocate effectively for improved access to health care services, including medical abortion.

The alumni will be facilitated to emerge as a community with a strong voice on this discourse at local, national, and regional levels and to engage with the issues on an ongoing basis through the online network as well as through participation in relevant meetings.

AGENDA

Day 1 - 5th October, 2024			**Time: 9:00 to 17:00**
Introductions + Breakfast			9:00 to 10:00
Understand Gender and Patriarchy and its link with safe abortion issues	1 hour 30 mins	Nandini Mazumder	10:00 to 11:30
Human Rights & SRHR	1 hour 15 mins	Nandini Mazumder	11:30 to 12:45
Lunch	1 hour		12:45 to 13:45
Values Clarification and Case Studies	1 hour 30 mins	Dr. Suchitra Dalvie	13:45 to 15:15
Gender and Sexism in Mass media	25 mins	Dr. Saraswati Palnitkar	15:15 to 15:40
Tea	20 mins		15:40 to 16:00
Power Walk and Intersectionality	1 hour	ISAY Team	16:00 to 17:00

Day 2 - 6th October, 2024			**Time: 9:00 to 17:00**
Recap			9:00 to 9:30
Contraception and Abortion from the gender and rights perspective	1 hour 30 mins	Dr. Suchitra Dalvie	9:30 to 11:00
Criminalization and Decriminalization	1 hour	Nandini Mazumder	11:00 to 12:00
Lunch	1 hour		12:00 to 13:00
Abortion Laws & Policies	1 hour 30 mins	Dr. Suchitra Dalvie	13:00 to 14:30
Ethics, Conscience and Being Pro Choice	1 hour 10 mins	Dr. Amar Jesani	14:30 to 15:40
Tea	20 mins		15:40 to 16:00
Literature Review + What does it mean to be Pro-choice?	1 hour	Dr. Suchitra Dalvie	16:00 to 17:00