Gender, Sex-Selection And Safe Abortion: Creating Common Ground

Women's Voices Series - 2

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The Women's Voices Series

Rural Women's Social Education Centre (RUWSEC), a grassroots women's organization based in Chengalpattu, Tamil Nadu has been working for women's health through empowerment for close to three decades now. One of RUWSEC's priority areas of interest has been to conduct research from a women centred perspective.

From 2008 onwards, RUWSEC started conducting periodic meetings with grassroots women in order to understand their stands on various issues. The first of these meetings began when the organization had to take a position on the various contentious portions of the draft Assisted Reproductive Technology (Regulation) Bill, 2008. It was felt that it was important to learn from women themselves what they felt about the various issues being raised. The meeting itself was revealing in that some of the stands of the feminist movement did not seem consonant with what women themselves wanted. A need was therefore felt to take the process forward with other women's health issues too. And thus was born the Women's Voices series.

We hope this series will help people working on women's issues incorporate grassroots perspectives in their own struggles for rights and justice.

Gender, Sex-Selection And Safe Abortion: Creating Common Ground

Abortions have been legalised in India since 1971 when the Medical Termination of Pregnancy Act was drafted. However, unsafe abortions still continue to be a large contributor to maternal deaths in India. In recent years, in view of the declining juvenile sex ratio and the fact that sex selective abortions of female fetuses is ongoing, several civil society groups campaigning against sex selective abortions have been asking for changes to the MTP Act – these suggested changes include restricting second trimester abortions and reducing access to abortions for women already having one or more girl children. A need was therefore felt to engage with this issue of declining sex ratios and sex selective abortions while at the same time ensuring access to safe abortion services. It was also felt that it was important to understand what grassroots women felt about the tensions between these two issues. Thus, a consultation on the issue with members from community based organizations in and around Chengalpattu and grassroots women including Self Help Group leaders and dais was organized.

The meeting was organized as a one day consultation on 2nd February 2009. It was facilitated by Dr. T K Sundari Ravindran. The meeting was attended by about 43 people including members of organizations working on health and women's issues and some grassroots women. The list of participants is attached (Annexure 1). The meeting began with Ms. Selvi, Coordinator, RUWSEC welcoming all the participants for the discussion and thanking them for being present for discussing about an important aspect of

women's health. This was followed by a short introduction to the issue of safe abortion in an era of declining sex ratios by Mr. Balasubramanian, Executive Director, RUWSEC. The next was a session on various rights especially those related to sexual and reproductive health, meant as a framework within which the issues and discussions in the meeting would take place. Dr Subha Sri, gynaecologist at RUWSEC clinic, then provided a technical update on the MTP Act and recent advances in abortion methods. Following lunch, the participants broke up into small groups and discussed case scenarios related to abortion and sex selection. This was meant as an exercise to help participants engage with the issue of upholding the right to safe abortion and at the same time, preventing discriminatory sex selection and abortion of the female foetus and these were later discussed in the larger group.

Overview of the issues

Terminating an unwanted pregnancy has been happening in India for centuries, and in the absence of facilities for safe termination, has been an important cause of maternal mortality and morbidity. The Medical Termination of Pregnancy Act [MTP Act] was enacted in the year 1972, with a view to preventing avoidable mortality and morbidity due to unsafe abortions. Abortion services were made legal and available to women for a range of indications. However, many women continue to remain without access to safe abortion services because of lack of knowledge and/or decision-making power, limited availability of services, costs, denial of services by providers for a variety of reasons.

In recent years, the issue of abortion has received attention for a different reason. The preference for male children, pervasive in Indian society, has led to the selective abortion of female foetuses after undergoing a sex-determination test. Prenatal screening technologies, which are supposed to be used for assessing foetal development, are being misused to determine the sex of the foetus. A look at the recent NFHS survey shows that there is an imbalance in the sex ratios in several states of India.

With technological improvement there is thus a contradiction between the need to access safe abortion facilities while challenging the technological prowess for sex selection and abortion of female foetuses. Therefore the challenging task before us is to prevent the discriminatory practice of selectively aborting female foetuses, without creating barriers to accessing safe abortion services. We need to focus on women's rights in both instances.

Locating safe abortion within the sexual and reproductive rights framework

Following this introduction, the facilitator started a discussion on the concept of rights in general and sexual and reproductive rights in particular. She said that many of us assembled here uphold women's right to access safe abortion services. Women have had to struggle for sexual and reproductive rights, such as the right to decide on the number of children they would like to bear and the right to decide on terminating an unwanted pregnancy. At the same time, the ratio of women in the population is decreasing and many movements concerned with women's rights are addressing this. It is now evident that efforts to prevent

the selective abortion of female foetuses are beginning to curtail women's access to safe abortion. Several questions are there before us - how do we distinguish between women approaching the health services for an abortion, and those seeking abortion following sex determination? How do we deal with the fact that denial of any abortion to women amounts to violation of their rights? How do we as activists take positions or offer advice to women? The facilitator shared that she herself had no resolution to this issue. She emphasised the need to consult with women and men affected by these stands and find out what they want. Do we think access to safe abortion should be safeguarded above all else? Do we support curtailing access to safe abortion services in order to prevent sex-selective abortion? For this, we need informed consultations and discussions. This session will focus on what we understand by rights and how we would take positions from a rights perspective.

The facilitator raised a question: What are rights? What are women's rights?

The participants listed several rights including reproductive rights.

Right to

- Give birth to a child, to decide whether and when to give birth, irrespective of it being a boy or girl, and as to how many, to refuse/ choose contraception/ operation or other methods; right to abortion within or outside of marriage (largely Reproductive Rights).
- Life (with dignity), to employment, education (Basic Human Rights).

- ✡ Marry, at the age one chooses and to the partner of choice; against forced sex; against lack of information on sex; against lack of autonomy of/ from sexual relations (largely Sexual Rights or those related to one's body).

The facilitator then asked the participants to share in small groups experiences of denial of sexual and reproductive rights that they had come across. When these experiences were later shared in the larger group, the examples shared were of denial and violation of not just sexual and reproductive rights, but all other rights as well. This made it clear that rights were linked intricately, and for sexual and reproductive rights to be respected, many other rights will also have to be upheld. One person gave an example that spoke eloquently of the connection between all these rights. A woman could not conceive after 6 years of marriage and got a rude shock when her husband revealed that he had been tricked into undergoing sterilisation due to poverty. Thus, the state's violation of the man's reproductive rights, the denial of economic rights to the man had both contributed to his undergoing sterilisation before marriage. He in turn had violated his wife's right to bear a child by not disclosing his status before marriage.

The discussions on women's rights also brought out clearly how women faced violation of their rights frequently and also lacked information and decision making power to realize their rights. A list of these denials/violations as listed by the participants is in the box below.

- *Women face sexual abuse and economic abuse and domestic violence.*
- *Forced sex and unwanted pregnancy.*
- *They lack all kinds of rights in the society.*
- *They do not get clear information about sexual and reproductive health.*
- *They do not have any right in decision making process.*
- *Lack of information on child birth and conception leads to continuous birth of children without any spacing.*
- *They are deprived of medical facilities.*
- *They face suspicion.*
- *They do not get a dignified life.*
- *Their entire life is a story of suffering.*
- *Women do not even have the right to choose their life partner.*
- *Women cannot decide or cannot say no to sexual intercourse.*
- *A woman cannot decide whether to continue her pregnancy or not after conception.*
- *Women cannot decide on using contraceptives or spacing between a child.*
- *Family planning is forced on women and it is felt that it is the responsibility of women.*
- *A women should also have the right to continue her pregnancy safely.*

In conclusion, when asked by the facilitator about who should take the ownership to realize rights, participants responded that society as a whole and each one of us should take steps to demand and realize rights. With this, the session on rights came to a close.

An introduction to the MTP Act and the PCPNDT Act

The next session was a technical update by Dr Subha Sri, gynaecologist in RUWSEC clinic, on the MTP Act and technologies used for abortion. Hand-outs on Medical abortion and MTP Act were circulated to participants. Participants were asked to go through it and give their comments (Annexure 2 and Annexure 3) .

The initial presentation was on the MTP Act. This covered details of the Act like conditions under which abortion can be done, places where abortions could be done and personnel who could do abortions. The MTP Act was enacted without any struggle from the women's groups, unlike in the West, where right to abortion is still non-existent in many countries. Its links with the coercive population policies of the government cannot be denied. Under this Act, pregnancy can be terminated upto 20 weeks for certain conditions given below.

- ✡ Continuation of pregnancy constitutes risk to the life or grave injury to the physical or mental health of woman.
- ✡ Substantial risk of physical or mental abnormalities in the fetus as to render it seriously handicapped.
- ✡ Pregnancy caused by rape (presumed grave injury to mental health).

- ✡ Contraceptive failure in a married couple (presumed grave injury to mental health).

The decision to provide an abortion ultimately rests with the doctor, the law does not provide for abortion on demand by the woman.

The MTP Act was revised in the year 2003 and the procedures were simplified. The medical abortion procedure was recognised in the year 2003 and is now legal upto 49 days amenorrhea.

The Pre Conception and Pre Natal Diagnostic Techniques Act [PCPNDT Act] was framed in 1994 and it was also revised in the year 2003. This Act was enacted as there was a decline in the sex ratio (female/1000 male) in the population. This Act, unlike the MTP Act, came into force due to struggles by health groups and women's groups. As per the PCPNDT Act, determination of the sex of an unborn child is punishable by law.

Technical update on safe abortion technologies

This part of the presentation was followed by a technical update on the various methods used for abortion. This included older methods like Dilatation and curettage (D&C) and newer techniques like vacuum aspiration and medical abortion. The surgical instruments used for D&C and vacuum aspiration were also displayed and passed around for the participants to see and feel. Short videos demonstrating vacuum aspiration and medical abortion were also screened.

During the screening of the video, several participants were quite upset at the vivid portrayal of the abortion procedure. Some shielded their eyes during some portions of the screening. A few male participants said that they had not realized the abortion procedure could be so painful. They also felt that seeing such videos would make men more responsible for contraception and prevent them from putting their partners in situations that make necessary repeated abortions.

Following this presentation, participants shared several instances of women undergoing unsafe abortions because of lack of knowledge that abortion could be sought legally and also because of lack of access to safe abortion services. They felt adolescents and single women cannot access legal abortion and they go in for backstreet abortion due to social stigma. Also, backstreet abortions cost less and information on these services spread through word of mouth.

Some participants also shared experiences of undergoing repeated abortions themselves and their experiences with the health system. Several participants shared that women, especially adolescents and single women, were verbally and emotionally abused by health care providers while seeking abortion services and this was another reason why they sought services from backstreet abortion providers. Many participants also felt that medical abortion seemed a simpler procedure and should be made available widely. There were also clarifications sought on the details of medical abortion and these were provided.

The videos on abortion procedures seemed to have affected the participants deeply. There were discussions about the videos screened even during lunch time – participants commented on the pain women face when undergoing these procedures. Following the lunch session, several of the participants got together in a group and were seen sharing their personal experiences of having undergone an abortion.

Seeking common ground between safe abortion and prevention of sex-selective abortion of the female fetus

In the post lunch session, a few issues were placed for discussion. These were:

- ✡ One of the struggles is to prevent the declining female sex ratio through sex selective abortions, a manifestation of blatant discrimination against girls and women.
- ✡ The other struggle is to fight for women's abortion rights, right to safe abortion.

There are many people and forces in the world who deny women the right to abortion (how the pro-life lobby scares people showing films of the "crying and pleading" foetus was shared). In India too there were several local groups who "watch over" women who are pregnant making them feel guilty if they consider abortion. They use the PNDT Act when women go for tests. But when women seek abortion, do they, or do they not have a right to undergo abortion?

Following this, participants worked in small groups. Each group was given one vignette related to access to abortion

and sex selective abortion. Questions related to the vignettes were given to guide the discussion. These were then presented in the larger group. The vignettes given are in the box below.

Case study – 1

Chitra has been married for three years. She has a daughter. She is now pregnant for the second time. She is in her fourth month of pregnancy. Her husband was upset after the birth of their first child as she was a girl. This time he forces Chitra to check whether the fetus is a boy or a girl. After they came to know that the fetus was a girl, he pressures Chitra to undergo an abortion. Chitra is very confused now as she has watched on the television that this is wrong.

1. What will you do if you were Chitra?
2. What would be the pros and cons to Chitra if she goes in for abortion?
3. What would be the pros and cons if she does not go in for abortion?

Case Study – 2

Lata stays in a village where the ratio of girl children is very low. People in the village feel that the reasons for this is the rise in dowry demands. Lata is pregnant for the second time. Her first child is a girl. Through a scan she has come to know that she is carrying a female fetus. Lata goes to a doctor and seeks abortion services. The doctor feels that this is wrong and refuses to provide

abortion services. Lata delivers a second girl child. Her husband sends her back to her natal home and wishes to marry again.

1. What should a doctor do in situations such as this?
2. If we would like to avoid such happenings in our area, what steps should be taken? Who should take these steps?

Case study – 3

After three children, Muthamma is pregnant for the fourth time. She belongs to a low-income household. It takes her a while to raise the money to go to a health facility to seek an abortion. When she finally reaches the hospital, she is four months pregnant. Doctors and nurses scold her. It is not clear to Muthamma whether or not they will terminate her pregnancy.

1. Why do the doctors and nurses scold Muthamma?
2. What will be the consequences if they refuse abortion services for Muthamma?
3. What can be done so that women like Muthamma get safe abortion services? Who should take these steps?

Case study -4

Indra has two children and her husband did not allow her to go in for sterilisation to stop childbearing. Neither did he take the responsibility of using contraceptives.

Indra did not get her menstrual period this month. She is aware that in case she is pregnant, her husband will not allow her to go in for abortion. But she does not want to have another child.

1. What will you do if you were Indra?

2. What rights do women have regarding terminating an unwanted pregnancy?

Responses from the group members

Case study 1

1. To the question on what one would do if forced by the husband for a sex selective abortion, there were mixed responses from the group members. While a few felt that to avoid domestic conflict, they would go in for the abortion, others felt they would leave the husband and move out to have the girl child.

2. To the question on what would be the advantages if Chitra went in for an abortion, they felt she would get support from family and care and attention from the husband. She may feel happy and contented as she abided by the instructions of the family/husband. On the cons, the participants listed emotional and physical problems due to abortion, especially since she was already in the 4th month, and guilt of having udergone an abortion and taken a life.

3. To the question on consequences of not having an abortion, they felt she could lose support from

the family, be subjected to violence. The husband may go in for another marriage and if violence continued, Chitra may even attempt suicide. The advantage of her saying no to the abortion would be that she would be satisfied that she abided by her conscience.

To a question by the facilitator on whether the guilt listed above was due to the abortion being forced on Chitra or if any abortion could promote feelings of guilt, some felt it was because it was not what Chitra wanted, others felt any abortion would cause feelings of guilt as one was "taking away a life" and that too of "one's own child". The facilitator here raised the question on how should one view abortion – should it be seen as taking away a life – it was decided that this would be discussed later.

Case study 2

1. To the question on what the doctor should have done when Lata approched him/her for an abortion after sex determination, the group felt that the doctor should have called the family and offered counselling. The doctor should have explained the possible physical and emotional consequences of an abortion to the family. In any case, the doctor should have respected the independent decision of the woman and provided abortion services. If he/she were not in a position to provide the abortion services, he/she should have referred the woman elsewhere for the abortion. Also, no doctor should

have revealed the sex of the fetus to Lata – even if she had to leave the house after the birth of the girl, because the sex of the fetus was revealed, she was subjected to violence during pregnancy.

2. On what steps should be taken to avoid such happenings, the participants listed the following –

   - ✡ The Village Health Nurse should counsel the family on how the sex of a child is determined (i.e. the father's genes are responsible for the sex of the offspring).
   - ✡ Panchayat members should be involved in spreading awareness on gender equality.
   - ✡ Sex determination through scan should be banned.
   - ✡ Attitudinal changes in society to treat girls and boys equally must be fostered through various camps and video demonstrations.
   - ✡ That women have a right to abortion should be publicised through hospitals.
   - ✡ People should be given information on the government's financial assistance schemes for girl children.
   - ✡ This should be done through Self Helf Groups (SHGs), NGOs, Panchayat members and other village level functionaries.

The facilitator here raised the question: Do women seek sex selective abortions because they do not know they

should not have sex selective abortions? If they do know this, then what kind of awareness building is actually necessary? This was also marked for later discussion.

Case study 3

1. To the first question on why the health care providers scolded Muthamma, the participants felt they were under the impression that she had come for sex selective abortion. They think that Muthamma had undergone a scan and that would be the main reason for the delay in seeking abortion services. They scold her because she has come a little late for abortion – they felt generally abortion should be done within 12 weeks.
2. On the consequences of the doctors refusing her abortion, they felt she may go for an illegal/backstreet abortion. The other possible consequences listed were
   - ✡ There would be problems in her family.
   - ✡ She may take some tablets and it may lead to a child born with some disability.
   - ✡ She may face psychological problems.
   - ✡ She may try to commit suicide.
   - ✡ She may even face mental problems/worries that society may talk odd about her as she is pregnant when she has grown up children.

- ✡ The child may face female infanticide after birth.

3. On steps to help women like Muthamma, it was felt government and NGOs should take steps to provide safe abortion services for all women.

Role of Government

- ✡ Provide awareness on safe abortion.
- ✡ Doctors should be sensitive and perform their roles better.
- ✡ Government should take steps to provide safe abortion services in all the government hospitals.
- ✡ Government should take steps to provide free medical abortion pills for people who prefer abortion through medicines.

Role of NGOs

- ✡ They should engage in campaign about safe abortion and medical abortion.
- ✡ They should provide awareness through camps and exhibitions.

Case study 4

1. To the question on what one would do if one were Indra, the responses were mixed. Some felt she should confirm pregnancy and go in for an abortion while others felt going for an abortion without the husband's consent would cause problems in the family.

2. On women's rights related to abortion, the group felt that a woman has the right to decide the number of children she wishes to beget, the right to decision making, the right to live healthily and have right to control over her body.

The discussions revealed the following:

- Women who seek abortion services are often assumed to be doing it following sex-selection. This denies women the right over their own bodies.
- We should also be worried about the poor sex ratio.
- A small number of participants expressed concern over 'taking a life'. The facilitator responded by saying that international human rights documents state that a fetus is not a being vested with rights; only after being born does one have "human" rights.

Following this, the facilitator summed up as follows.

There are no rights or wrongs being judged here in these discussions, but we should be informed before taking decisions and everybody needs to understand the situations in which we take decisions. We need to have women alive before they can give birth.

We also need to reflect and act on the root causes underlying the decline in female sex ratio, rather than try to block it at the end point at the cost of denying women their reproductive rights. It is about the pressure to give dowry, women's low status and oppression in society.

Many participants said that we need to spread awareness about the negative consequences of sex-selective abortion. It is usually not because of lack of awareness that people selectively abort the female fetus, it is because of their negative attitude towards having a girl child. Attitudes have to be changed, and that is more difficult than just awareness.

What action can we take part from 'awareness'? We can campaign for women's right to conduct funeral rites; attempt to change the emulative behaviour of wealthy groups; for property rights for women; reflect on why customs such as *parisampodal* (bride price) have shifted to *varadakshinai kodukkal-vaangal* (dowry) among the dalits, for instance.

In our effort to prevent the decline in female sex ratio, many campaigns have put forth recommendations for punitive measures against women seeking sex-selective abortions. Do we want to take actions that would land the woman in jail? Is that consistent with our wish to uphold women's rights and status, which is driving the campaign to prevent sex-selective abortions?

Should we not also reflect on our attitudes? When we as activists advise women not to have an abortion, we believe we are doing the right thing, we are counselling. Why then do we call it "pressure" when families counsel their women to have or not to have an abortion? We need to reflect on this too – our attitudes and strategies, whether we pressure women and neglect their agency. Also we have to ask if society guarantees women a life of dignity? If women are confident that their daughters would have a good life, they would perhaps not seek sex-selective abortion.

In addition, we have to ensure that there are safe abortion facilities for women in our areas.

Even in our language, we should refrain from usage of "foeticide" (*kolai* instead of *kalaippu*). Our campaigns against sex-selection should not deprive women of the right to safe abortion. We need to get to the root of the issue. We can devise different ways to talk of sex-selective abortion without harming our right to abortion.

Members from groups spoke of methods and strategies they would adopt:

- NGOs and CBOs present could include a discussion on safe abortion and prevention of sex-selective abortion of female foetus in training sessions or as part of a programme;

- Self Help Groups (SHGs) could attempt to campaign against dowry and replace it with customs helpful to women;

- The men present would encourage men to take up responsibility for contraception. One way in which this could be initiated would be to screen the Video CD on abortion procedures which will make them realise the trouble women go through;

- Initiate discussion at the Panchayat level and in the Block and District Health Committees on the need to ensure women's access to safe abortion services. Ensure availability of medical abortion services in government health facilities .

The facilitator ended the session by asking participants to prepare an action plan as a follow-up of the discussion.

Action plan

Initiate a Campaign to make access to abortion widespread

- Check whether abortion services are available and accessible to women in our villages/project areas.
- Demand for safe abortion services where/when it is not provided.
- Monitor the quality of abortion services, document any morbidity following abortion.
- Ensure that women's rights and dignity are safe guarded while undergoing an abortion.
- Widely disseminate information to all about all methods of abortion, especially medical abortion.
- A kit should be prepared that can be used to make a presentation or run a session for various target groups about women's right to safe abortion.

Take care not to compromise access to abortion in our campaigns

- Avoid terminology of "feticide" in our campaigns.
- Prevent coercion of women either for or against abortion.
- Campaigns should emphasize that sex selection is illegal, while abortion is legal.
- Address issues of gender discrimination in one's own personal lives.

- Address larger issues of gender discrimination in the campaign instead of narrowly focussing on declining sex ratios.
- Participants came up with a number of slogans like "Don't divide humanity", "Women have the right to perform last rites", "Fight against dowry", "Give women property rights" that should be popularised.

Feedback of the participants

- The videos on abortion techniques should reach many and safe abortion campaign should move ahead.
- A CD on safe abortion should be prepared and presented in all Self help group meetings.
- Video footage of Child birth and Abortion should be prepared in a CD and presented to men too, they should understand the pains of women.
- New information like medical abortion pill should reach many so that they can avail the services.
- Sex selection should be banned as it would lead to imbalance in sex ratio and this should also come under the campaign.

Concluding remarks

In conclusion, the meeting succeeded in drawing attention to the contradictions and the danger of reducing access to safe abortion in our attempt to prevent sex-selective abortion. It was clear from the exchanges in the meeting that termination of an unwanted pregnancy was a common

experience in the communities from which participants were drawn, and many women participants had themselves experienced a pregnancy termination. In their experience, health care providers often denied abortion seekers their right to dignity, and the quality of care was poor. In addition, single women encountered many barriers in accessing safe abortion services. We could also gather that women felt trapped into an unwanted pregnancy because men did not take responsibility for contraception; and were often left with no choice but to terminate the pregnancy whether or not they were comfortable with doing so.

Unlike the issue of access to safe abortion services, the issue of sex-selective abortion appeared to be not a part of the lived experience of the participants. During the discussions and in the informal interactions between sessions, participants did not share any instances of sex-selective abortions that they had personally encountered. However, almost everyone had been exposed to the Campaign against "female feticide". Discussions around this issue appeared to be based on information and awareness gained through the Campaign.

At the end of the day's discussions, a number of participants acknowledged that if they had to choose between upholding a woman's right to abortion and denying her access to abortion in order to prevent the "elimination" of a "future" woman, they would lean on the side of the woman who is alive now and uphold her rights. Many also said that they would refrain from using the language of feticide, and also focus on the larger determinants of sex-selection. However, there was also a significant minority who either

felt that abortion per se was unjustified, or could not make up their minds about whether or not sex-selective abortions should be banned even if these violated women's rights to abortion. The meeting marked the beginning of a process of dialogue and we hope to continue with the interactions and move ahead with the action plan in gradual steps.

Follow up

Subsequent to this meeting, a follow up meeting was held on 18th September 2009 with several members from community based organizations participating. The objective of this meeting was to plan a campaign that would create common ground between the issues of safe abortion and sex selection and address both simultaneously. The participants discussed details of the various target groups to be addressed, messages for each target group, and possible actors who would support and detract the campaign and how to address them. It was decided that the following target groups needed to be addressed in the campaign:

1. Adolescents and young men and women
2. Married women and men between the ages of 20 and 30, seen as the main period of reproduction.
3. Health care providers

Separate strategies for the campaign with each group were planned in small groups. A working group was formed to carry the action plan forwards - this group has subsequently met several times and is involved in implementing the action plan.

Annexure 1

Safe abortion meeting Participant list

Grass Roots Group Meeting Held on Date:

2nd February 2009.

S.No	Name	Place	Organisation Name
1	M.ISABELLA	ARAKKONAM	RWLM (SRED)
2	R.REVATHI	ARAKKONAM	SW (SRED)
3	S.JAMUNABAI	KOTHIMANGALAM	SWEET
4	M.LALITHA	NARASANGKUPPAM	SWEET
5	S.SUMATHI	CHENGALPATTU	SWAT
6	S.GUNASEELI	CHENGALPATTU	SWAT
7	A.ANJALAI	INDRA NAGAR	WASS
8	K.BHAVANI	CHENGALPATTU	SWEET
9	G.KALAVATHY	ACHARAVAKKAM	WEAT
10	P.MAHESWARI	IRUMPULICHERRI	WEAT
11	K.TAMIL SELVI	POOYELUPPAI	GDMMS
12	R.MARY	AMOOR	RUWSEC
13	A.ESTHAR	CHENGALPATTU	RUWSEC CLINIC
14	A.JAYAKUMARI	C.S.I. AGARM	RUWSEC CLINIC
15	M.AMBIGA	ARASAMANGALAM	SED
16	A.BHAVANI	CHENGALPATTU	SED
17	G.BAMA	CHENGALPATTU	RUWSEC CLINIC
18	A.KAMATCHI	ARAKKONAM	SW (SRED)

19	R.UMA	K.K.CHARAM	RWLM
20	AMIRATHAMMA	ARAKKONAM	SRED
21	ARPUTHAMMA	ARAKKONAM	SRED
22	G.SHANTHI	ARAKKONAM	RWLM (SRED)
23	A.THULUKKANAM	MULLIPAKKAM	SDT
24	V.DHAYALAMMAL	THAIYUR	RWDT
25	A.CARIES	SEMBAKKAM	WET
26	T.MOHANALAKSHMI	KELAMBAKKAM	MASS ACTION TRUST
27	A.SELVANATHAN	ACHARAPAKKAM	RSSC
28	A DOMANIC	VELAMOOR	RURAL STAR TRUST
29	J.T.PRABUDOSS	MAMANDUR	MTHED - TRUST
30	AMUDHA	ARAKKONAM	SRED
31	SARASHWATHI	KARUMARAPAKKAM	HEALTH LEADER
32	Y.THERESA	KALANIPAKKAM	RUWSEC
33	MUTHAMMAL	ANDIMADAM	RUWSEC CLINIC
34	P.KOMALA	KALPAKKAM	BOARD MEMBER
35	D.AMUDHA	EDAIYATHUR	SWAT
36	K.JANARTHANAN	THIRUKAZHUKUNDRAM	HRDF
37	E.CHELLAMUTHU	THIRUKAZHUKUNDRAM	RUWSEC
38	MEENA GOPAL	MUMBAI	SNDT, UNIVERSITY MUMBAI

39	N.SRILAKSHMI	CHROMPET	RUWSE
40	B. SUBHASRI	THIRUKAZHUKUNDRAM	RUWSEC CLINIC
41	T.K. SUNDARI RAVINDRAN	KERALA	RUWSEC
42	P. BALASUBRAMANIAN	CHENGALPATTU	RUWSEC
43	D.SELVI	CHEMBAKKAM	RUWSEC

Annexure 2

Background document on MTP Act and PCPNDT Act

Medical Termination of Pregnancy Act

The provision of Medical Termination of Pregnancy (MTP) in India is governed by the Medical Termination of Pregnancy Act enacted in 1971. This Act was enacted to address the issue of high levels of maternal mortality and morbidity due to unsafe abortions. This Act was amended in December 2002 and the rules amended in 2003. The Act allows MTP under certain circumstances upto 20 weeks gestation. It offers protection to providers who perform abortions fulfilling the requirements laid down under this Act.

The significant features of the MTP Act are as follows.

When can MTP be done?

A pregnancy of 20 weeks duration can be medically terminated by a registered medical practitioner in whose opinion any of the following circumstances are met.

- ✡ Continuation of pregnancy constitutes risk to the life or grave injury to the physical or mental health of woman.
- ✡ Substantial risk of physical or mental abnormalities in the fetus as to render it seriously handicapped.
- ✡ Pregnancy caused by rape (presumed grave injury to mental health).
- ✡ Contraceptive failure in married couple (presumed grave injury to mental health).

The opinion of two registered medical practitioners is necessary to terminate a pregnancy between 12 and 20 weeks duration.

Only the consent of the woman is necessary for an MTP. The consent of her husband or guardian is not required. If the girl is under 18 years of age or is mentally ill, the consent of a guardian is required.

Who can perform an MTP?

A medical practitioner (RMP)

- ✡ Who has a recognized medical qualification as defined in the Indian Medical Council Act, 1956
- ✡ Whose name has been entered in a State Medical Register and
- ✡ Who has such experience or training in Gynecology and Obstetrics as prescribed by Rules made under the Act

can perform an MTP.

Where can an MTP be performed?

- ✡ A hospital established or maintained by Government or
- ✡ A place approved for the purpose of this Act by a District-level Committee constituted by the government.

The MTP Act gives power to the central government to make rules and to the state government to make regulations under the Act.

Medical Abortion

Medical abortion is legal in India upto 7 weeks gestation. A registered medical practitioner as defined in the Act can provide medical abortion services with mifepristone and misoprostol in his own clinic provided he/she has access to an approved place. A certificate from the owner of the place agreeing to provide access should be displayed in the clinic.

When is an MTP legal?

An MTP is legal if it fulfills the following conditions.

- The MTP is performed by a registered medical practitioner as defined in the Act.
- It is performed in an approved place under the Act.
- It fulfills all other conditions under the Act including period of gestation, consent, opinion of a registered medical practitioner.

Pre Conception and Prenatal Diagnostic Techniques Act 2003

To address the issue of the increasing incidence of sex selective abortions of the female fetus, the Prenatal Diagnostic Techniques Act was passed in 1994. This was amended in 2003 to become the Pre Conception and Prenatal Diagnostic Techniques Act. The Act regulates all pre conception and prenatal diagnostic techniques and prohibits their use for sex selection.

Adapted from: Medical update: Medical Termination of Pregnancy (Amendment) Act, 2002 and Medical Termination of Pregnancy Rules 2003, IPAS India, 2005.

Annexure 3

Background document on medical abortion

Unsafe abortion continues to be one of the major causes of maternal mortality in India. New medical technologies that make abortion safer are now available - these include Manual Vacuum Aspiration and Medical Abortion.

Medical Abortion

Medical abortion is the termination of pregnancy through the use of a drug or a combination of drugs. The most commonly used combination of drugs for medical abortion is

- Mifepristone, an anti-progestogen drug, taken first, and
- Misoprostol, a prostaglandin drug , taken 24-48 hours later

Mifepristone causes the thinning of the uterine lining and softening of the cervix and combined with misoprostol causes strong contractions in the uterus. Together, the drugs cause the products of pregnancy to be expelled. The result is very much like a spontaneous abortion or miscarriage.

In India, medical abortion is legal upto 7 weeks gestation.

Regimens and dosage

The following regimens are recommended for medical abortion from 4-9 weeks of pregnancy:

Oral mifepristone and oral misoprostol

Between 4 and 7 weeks of pregnancy

Mifepristone: One 200 milligram pill, taken orally, followed by

Misoprostol: 400 micrograms (2 pills of 200 micrograms each), taken orally 24-48 hours after mifepristone

Oral mifepristone and vaginal misoprostol

Between 4 and 9 weeks of pregnancy

Mifepristone : One 200 milligram pill taken orally, followed by

Misoprostol: 800 micrograms (4 pills of 200 micrograms each), to be inserted deep into the vagina 24-48 hours after mifepristone.

In India, a medical abortion usually would cost around ₹ 250 to ₹ 500.

Experience of medical abortion

Women who use medical abortion will experience menstrual-like cramps, pain in the abdomen and bleeding. For most women, uterine cramps and vaginal bleeding start between one hour and seven hours after they take misoprostol. But some 5% of women will start to have cramps already after they take mifepristone.

Vaginal bleeding is heavier than menstruation while abortion is occurring and the products of conception are being expelled. This heavy bleeding lasts only for a short duration, about 1-4 hours. Light bleeding and spotting

will continue for 9-13 days. In rare cases, women may experience light bleeding for up to 45 days after the abortion occurs. The amount of bleeding depends on the duration of pregnancy and the drug used.

Many women compare the process to a spontaneous miscarriage. Women may also notice passing blood clots, tissue or products of conception.

Women may experience other side effects such as diarrhoea, nausea, vomiting, headache, dizziness, back pain and tiredness. These side effects occur after misoprostol administration but last only for about 2-4 hours. Several studies show that nausea, vomiting and diarrhoea with vaginally administered misoprostol are fewer as compared to taking misoprostol orally.

Efficacy of medical abortion

Efficacy of medical abortion may be measured by rates of ongoing pregnancy. In pregnancies up to 9 weeks, only about 1% of women who use the mifepristone/vaginal misoprostol regimen for medical abortion have a continuing pregnancy, and in about 3-5%, abortion is incomplete. Rates of complete abortion are lower when the mifepristone/oral misoprostol (400 microgram) regimen is used in pregnancies of up to 7 weeks. In one study the complete abortion rate was 84 % when mifepristone was followed by 400 micrograms of oral misoprostol, as compared to 96% with mifepristone and 800 micrograms of vaginal misoprostol. Efficacy depends on the length of pregnancy: the more advanced the pregnancy, the lower the complete abortion rate and the higher the rate of ongoing pregnancy.

Danger signs

Heavy bleeding after administration of the drugs and prolonged fever are danger signs that would make medical consultation necessary. No bleeding after 24 hours of administration of misoprostol would also be a danger sign.

How is medical abortion different from surgical abortion?

Medical abortion for pregnancy ≤ 9 weeks	**Surgical abortion using vacuum aspiration for pregnancy ≤ 9 weeks**
Can be used from 4 weeks LMP.	May not be available before 7 weeks LMP.
Resembles a natural miscarriage.	Involves inserting a tube into the uterus to aspirate the contents.
Abortion usually happens at home. If misoprostol is given in the health facility , abortion happens there.	Abortion happens in a health facility.
Abortion process lasts more than one day.	Procedure is completed within 10–15 minutes.
Takes at least two clinic visits.	Takes one to two clinic visits.
May be painful for 2-3 hours or more after using misoprostol.	May be painful during aspiration and afterwards when the uterus contracts.
Severe complications are rare.	Severe complications are rare.

Longer period of bleeding up to several weeks, although amount of blood lost is the same as with surgical abortion.	Shorter period of bleeding, as most blood is aspirated during the procedure.
Anaesthesia is not needed. Pain medication should be available.	Pain medication, light sedation and local anaesthesia should be provided
Most effective for pregnancy of less than 7 weeks.	Most effective in pregnancies of more than 7 weeks.
Woman may see blood clots and the products of conception.	Woman does not see products of conception.

Is emergency contraception the same as medical abortion?

No. Pills used for emergency contraception (EC), also known as the 'morning-after' pill, are used to prevent pregnancy through an effect on ovulation but do not disrupt pregnancy. Medical abortion, on the other hand, induces abortion in women who are already pregnant.

Can a woman use medical abortion if she is breastfeeding?

There is some evidence that mifepristone is excreted into breastmilk but little evidence regarding any effect on the adrenal function of the infant. The evidence that is available suggests that the amounts of mifepristone ingested by the infant are unlikely to cause harm.

Small amounts of misoprostol enter breastmilk soon after administration, but it is not known whether this could have

any effect on the infant. If a woman is worried that the drugs may be excreted in the breastmilk, she may discard her milk for 24 hours following the use of mifepristone/misoprostol.

Can a woman with a reproductive tract infection have a medical abortion?

If a woman has an RTI, then she will be treated for the infection alongside use of medical abortion. There is no reason to wait for RTI treatment to be completed before medical abortion.

Can a woman who is HIV +ve use medical abortion?

There is no reason why HIV positive women cannot use medical abortion. HIV positive women may be at higher risk of reproductive tract infections from retained products of conception, but this may occur with medical or surgical abortion.

Can adolescents use medical abortion?

There is no medical reason why medical abortion may be unsuitable for adolescents. Medical abortion is more painful for anyone who has never been pregnant, and this may mean that young nulliparous women may need more pain medication than women who have previously given birth.

How long ater a medical abortion can a woman become pregnant?

If she does not use an effective method of contraception, a woman can become pregnant before her first period.

Conception can occur within 10 days to two weeks of having a medical abortion, depending on the length of her menstrual cycle.

Are there any women who cannot use medical abortion?

It is advisable for a woman not to use the mifepristone/ misoprostol regimen for medical abortion if she has any one of the following health conditions:

- Her health provider suspects or has confirmed that she has an ectopic pregnancy.
- She has an allergy to mifepristone.
- She has an allergy to misoprostol.
- She has a disease or condition affecting blood's ability to clot.
- She is taking drugs for thinning the blood.
- She is taking certain steroid drugs. If she is taking drugs orally or as injections for treating chronic arthritis, asthma and other allergic conditions, she should check to see if these are (or contain) corticosteroids. If in doubt, her health provider may be consulted.
- She suffers from chronic failure of adrenal glands. Adrenal glands are small, triangular glands located on top of the kidneys and produce a variety of hormones including adrenaline, essential to help the body cope with stress.
- She has inherited porphyrias, which is an uncommon disorder of certain enzymes responsible for the formation of the iron-containing pigments in proteins.

Why do women choose medical abortion?

Women choose medical abortion because of its following features:

- ✡ Belief that it is safer
- ✡ More natural
- ✡ No surgery and/or anaesthesia
- ✡ One or both drugs may be taken at home
- ✡ Can be used in the early stages of pregnancy
- ✡ Easier and simpler

Adapted from: The International Consortium for Medical Abortion. Information Package on Medical Abortion: Information for Women.

RUWSEC

Rural Women's Social Education Centre (RUWSEC) is a non-governmental women's organisation started in the year 1981 by a team of 13 women of whom 12 were dalit women from the local villages of Chengalpattu taluk near Madras (Chennai) in Tamil Nadu.

Achieving women's wellbeing through women's empowerment is our organisation's vision. Our focus has been on enabling women to gain greater control over their bodies and their lives and achieving wellbeing, through promotion of gender equality and sexual and reproductive rights.

Since its inception, RUWSEC was a grassroots organisation with community-based workers drawn from the local villages. Our approach was to motivate, educate and organise women from poor and marginalised communities to stand up for their rights and become agents of change. We wanted rural poor women to be able to analyse the socio-economic and political factors underlying their lack of good health and control over their sexuality and fertility and to have the knowledge and skills to alter their own situations.

Since 2004, the organisation has transformed into a research, training, advocacy and technical support organisation providing inputs to grassroots organisations in Tamil Nadu which are working on gender, reproductive, sexual health and rights. In addition, we have helped the formation of a group of grassroots organisations under the leadership of former RUWSEC workers, working on sexual and reproductive health and rights, and have been providing them with financial support and technical guidance for effective implementation.

The Executive Director,
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