KEY CONCEPTS • ADVOCACY • HUMAN RIGHTS • CONTRACEPTION • SOCIAL MEDIA • LAW • COMMUNICATION MYTHS • COMMUNICATION • SOCIAL MEDIA • मुख्य अवधारणायें – जेंडर एवं यौनिकता मानवाधिकार • कानून • गलत धारणाएं संवाद गर्भनिरोध • सेवाएं • व्यापकता • वकालत वकालत • सोशल मीडिया • KEY CONCEPTS ADVOCACY • HUMAN RIGHTS • MYTHS CONTRACEPTION • COMMUNICATION • LAW • INCIDENCE COMMUNICATION • SOCIAL MEDIA मुख्य अवधारणायें – जेंडर एवं यौनिकता • संवाद मानवाधिकार • कानून • गलत धारणाएं • गर्भनिरोध सेवाएं • व्यापकता • वकालत • सोशल मीडिया • KEY CONCEPTS • ADVOCACY • MYTHS • LAW CONTRACEPTION • COMMUNICATION SOCIAL MEDIA • MYTHS • INCIDENCE COMMUNICATION • CONTRACEPTION LAW • KEY CONCEPTS • ADVOCACY

ABORT THE STIGMA

#AbortTheStigma
A toolkit

Abortion stigma is a powerful deterrent to accessing safe abortion services. As a result, a woman dies every two hours due to unsafe abortion. Despite decades of progressive law, policy reform and huge strides in developing and providing transformative methods to perform abortion (including medical abortion pills), much remains to be done.

This toolkit draws on materials created as part of CREA's #AbortTheStigma campaign, that seeks to normalize conversations around safe abortion. In addition, it draws on the curriculum developed for CREA and CommonHealth's annual Abortion, Gender and Rights Institute.

This toolkit is meant for broadest possible use by trainers, activists, teachers, front-line health workers, peer educators, community-based volunteers and civil society organizations working on issues of comprehensive sexuality education (CSE), women's rights, health, gender and sexuality.

#AbortTheStigma
टूलकिट

गर्भसमापन करने पर औरतों पर जो सामाजिक लांछन लगता है, इसके वजह से औरते सुरक्षित गर्भसम्पन सवाओ तक पहुँच नही पाती। असुरक्षित गर्भसमापन के कारण हर दो घंटे में एक महिला की मृत्यु हो जाती है।

दशकों से प्रगतिशील कानून, नीतिगत सुधार और गर्भसमापन (चिकित्सा गर्भसमापन की गोलियाँ सहित) करने के लिए परिवर्तनकारी तरीके प्रदान करने में भारी प्रगति के बावजूद, बहुत कुछ किया जाना बाकी है।

ये टूलकिट #AbortTheStigma अभियान के हिस्से के रूप में बनाई गई सामग्री है जो सुरक्षित गर्भसमापन बातचीत को सामान्य बनाने का प्रयास करती है। इसके अतिरिक्त, यह क्रिया और कॉमनहेल्थ के वार्षिक गर्भसमापन, जेंडर और अधिकार संस्थान के पाठ्यक्रम से भी कुछ मुद्दो को उठता है।

ये टूलकिट व्यापक यौन शिक्षा (CSE), महिलाओं के अधिकारों, स्वास्थ्य, लिंग और यौनिकता, फ्रंट-लाइन स्वास्थ्य कार्यकर्ताओं, सहकर्मी शिक्षकों और समुदाय आधारित स्वयं सेवकों के मुद्दों पर काम करने वाले लोगो के लिए है।

LANGUAGE • SAFE ABORTION • GUIDE
WORDS • HUMAN RIGHTS • VISUALS
GUIDE • SAFE ABORTION • WORDS
LANGUAGE • AUDIENCE • IMAGES
CONSENT • LANGUAGE • AGENCY
CONTENT • GUIDE • SAFE ABORTION
LANGUAGE • HUMAN RIGHTS
VISUALS • GUIDE • AUDIENCE
HUMAN RIGHTS • SAFE • AGENCY
CONSENT • ABORTION + CONTENT
ABORTION • **COMMUNICATION**
AGENCY • LANGUAGE • IMAGES
GUIDE • VISUALS • SAFE ABORTION
WORDS • GUIDE • LANGUAGE
AUDIENCE • CONSENT • AGENCY
IMAGES • GUIDE • CONTENT • HUMAN
RIGHTS • LANGUAGE • CONSENT
WORDS • VISUALS • AGENCY • GUIDE
CONSENT • CONTENT • LANGUAGE

ABORTION + **COMMUNICATION**

WORDS

Language or words are a means through which stigma is perpetuated, and can also be used to affirm choice and rights. The following guide examines, from a gender and rights perspective, terms that are commonly used while communicating on safe abortion, and recommends alternatives.

DON'T USE	DO USE	WHY
Abortion is illegal	Under the following terms...	Abortion is legal under specific conditions.
Abort a child; terminate a child	Terminate a pregnancy; have an abortion	'Child' is medically inaccurate as it conveys personhood and the fetus is not yet developed to that stage. Terminate a child can have negative connotations as the word can seem harsh.
Female feticide; gendercide; aborting girls	Ending a pregnancy based on the sex of the fetus	The suffix '-cide' denotes 'killing' which is not appropriate when describing abortion.
Get rid of a child; kill an unborn child	Choose to continue the pregnancy	The term 'keep' implies a positive outcome which may not accurately reflect the situation. It is also medically inaccurate to describe the pregnancy as a baby or child.
Baby; dead fetus; unborn baby; unborn child	Embryo (up to week 10 gestation); fetus (from week 10 gestation onwards)	An embryo or fetus is not yet a baby. The term 'unborn child' is a recent anti-abortion invention and a contradiction in terms. Human rights begin only at birth. 'Child' is medically inaccurate.

Develop a guide in the local language and seek inputs from partner organizations who have had some experience communicating on the subject.

DON'T USE	DO USE	WHY
Get rid of a child; kill an unborn child	Choose an abortion; decide to end a pregnancy	Women should not be criminalized. We should highlight a woman's right to choose.
Prevent abortion; reduce the number of abortions	Prevent unintended pregnancies; reduce the number of unintended pregnancies	Women often seek abortion because of unintended pregnancy. Therefore, it is unintended pregnancy that needs to be avoided and reduced.

AVOID USING THE FOLLOWING TERMS INTERCHANGEABLY

ILLEGAL ABORTION

UNSAFE ABORTION

ILLEGAL ABORTIONS ARE A VIOLATION OF THE LAW
but these can be safe

UNSAFE ABORTIONS ARE PERFORMED BY UNTRAINED PROVIDERS
or when women are unable to safely undergo a medical abortion

Unwanted pregnancy is a pregnancy that a woman decides that **she does not want**

UNWANTED PREGNANCY

UNPLANNED PREGNANCY

Unplanned or unintended pregancies refer to pregnancies that occur **when a person is not trying to get pregnant**

An unplanned or unintended pregnancy **can be either a wanted or unwanted pregnancy**

VISUALS

Images or visuals are a powerful means of communicating a thought explicitly and it is important to develop them in accordance with sensitivities associated with safe abortion. The following guide[2] can be used while developing visuals for your communication material.

USE
A pregnancy test kit or test result can be shown to depict a pregnancy.

DON'T USE
Visibly pregnant women.

WHY
Most abortions occur in the first trimester, well before a visible pregnancy 'bump'. By showing a visibly pregnant woman you can perpetuate myths about abortion, such as how developed the pregnancy is at the time most abortions occur.

USE
Materials on abortion should focus on the individual undergoing an abortion, rather than the pregnancy itself.

DON'T USE
Images of babies.

WHY
Including babies in materials about abortion can send a confusing message to some audiences. This is also associated with anti-choice campaigns.

USE
Pictures of women wherever possible, with consent. Realistic sketches, illustrations and cartoons are a very good alternative. **Use diverse depictions of women, to show that a range of women (different ages, professions, social economic status, marital status) have abortions. Choose visuals that reflect the intended audience for the material.**

DON'T USE
Photos of women with blurred or hidden faces.

WHY
Blurred faces indicate that women are not willing to be identified. It can imply that abortion is something that women should feel ashamed or guilty about.

[1] Adapted from the International Planned Parenthood Federation (IPPF) guide on rights-based messaging

USE
Images with 'neutral' expressions, similar to what you expect to see in any material depicting a medical procedure.

DON'T USE
Images of women showing strong negative emotions.

WHY
Individuals experience a range of emotions following abortion. Avoid overly happy or overly sad expressions.

USE
If possible, do not use any images of a fetus. If you want to inform patients or service providers about the abortion process, use an image of an appropriate gestational age (e.g. six weeks).

DON'T USE
Images of fetuses older than three months.

WHY
Most abortions occur in the first trimester. So, images of fetuses older than three months can perpetuate myths about the gestational age at which most abortions occur.

USE
Eye-catching colours, multiple images and clear formatting to increase the visual appeal of materials rather than using graphic images.

DON'T USE
Explicit shock images.

WHY
While graphic and 'shock' images may attract attention, they could cause distress and anxiety to viewers. They also equate abortion with fear, trauma and many other negative associations.

Use these questions to examine your words and visuals

Are the images neutral and/or confidence inspiring?

Refer to the guide above for some pointers.

Why have images/ films been included?

Identifying why can help determine if they have been used correctly e.g. to make the material look more attractive, to increase understanding of the content, to connect the viewer or establish context, etc.

Is there a call to action?

Specify the action you would like the audience to take or direct them to specific services or information sources.

Do you have consent and permissions for images?

Ensure that you have taken all permissions for visuals used, including consent.

Is the language free of stigma?

Be weary of terms which are value-laden. Be especially careful of how these terms translate into your local language and context.

Does the language portray women's choice positively?

Use terminology which respects autonomy and choice.

Do different messages and visuals contradict each other?

Ensure each of your materials focuses on one message, and has a corresponding visual.

Is the language clear?

Keep it simple and avoid jargon.

Is the language accurate?

Use the list above as a reference on what to avoid and why.

MALE STERILIZATION • FEMALE STERILIZATION • SIDE EFFECTS IMPLANTS • INJECTABLES EFFECTIVE • ORAL CONTRACEPTIVE CONDOMS • MALE STERILIZATION FEMALE STERILIZATION • IMPLANTS SIDE EFFECTS • INJECTABLES EFFECTIVE • ORAL CONTRACEPTIVE CONDOMS • EFFECTIVE • MALE STERILIZATION •

ABORTION + **CONTRACEPTION**

CONTRACEPTIVE • FEMALE STERILIZATION • IMPLANTS SIDE EFFECTS • INJECTABLES • ORAL CONDOMS • MALE STERILIZATION FEMALE STERILIZATION • ORAL CONTRACEPTIVE • SIDE EFFECTS IMPLANTS • INJECTABLES • MALE STERILIZATION • CONDOMS EFFECTIVE • FEMALE STERILIZATION

ABORTION + **CONTRACEPTION**

Most effective

<1 pregnancy per 100 women in a year

Emergency Contraceptives

AVAILABLE AT
Sub-centers & higher level public health facilities
Trained ASHAs

(high efficacy when consumed within 3 days of unprotected sex)

Male Sterilization

AVAILABLE AT
Primary health centers & higher level public health facilities
Private hospitals

(most preferred terminal method in men)

Female Sterilization

AVAILABLE AT
Higher level public health facilities

(most preferred method)

Implants

AVAILABLE AT
Select private hospitals

(low cost, easy to administer)

Intrauterine contraceptive devices (IUCDs)

AVAILABLE AT
Sub-centers & higher level public health facilities
Private hospitals

Moderately effective

6-12 pregnancies per 100 women in a year

Oral contraceptives (OCPs)

AVAILABLE AT
Sub-centers & higher level health facilities
ASHAs
Private hospitals
Chemist shops

(scheme available for doorstep delivery of OCPs by ASHA with a minimal charge. The brand MALA-N is available free of charge at all public health facilities.)

Injectables

AVAILABLE AT
Selected districts upto the PHC level
Medical colleges & district hospitals

Least effective

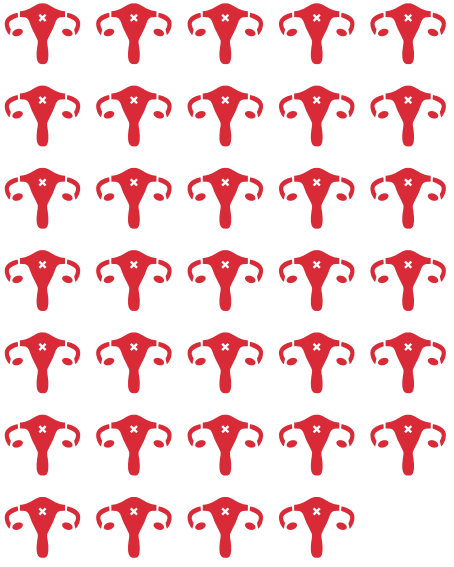
>18 pregnancies per 100 women in a year

Condoms

AVAILABLE AT
Sub-centers & higher level health facilities
Trained ASHAs

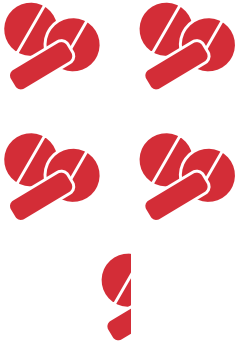
Chemist shops
(the brand 'Nirodh' is available free of cost at all government health facilities and delivered at doorstep by ASHAs)

USAGE OF CONTRACEPTIVE METHODS AMONGST CURRENTLY MARRIED WOMEN IN THE REPRODUCTIVE AGE GROUP (15-49 YEARS)

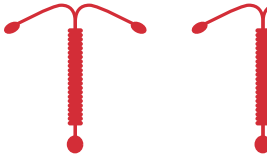


36%
FEMALE STERILIZATION

5.6%
CONDOMS

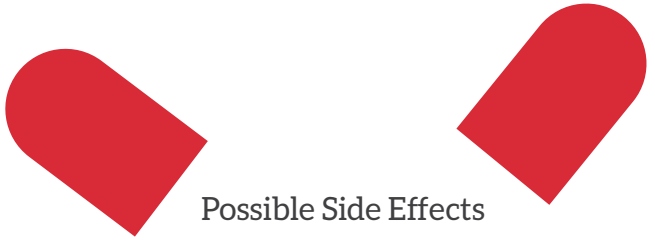


4.1%
ORAL CONTRACEPTIVES



1.5%
INTRAUTERINE CONTRACEPTIVE DEVICES (IUCD)

0.3%
MALE STERILIZATION



Possible Side Effects

Emergency Contraceptives
Menstrual irregularities & acne

Oral Contraceptives
Headache, nausea, amenorrhea (stopped periods), irregular periods, mood swings, acne

Condoms
Latex allergy

Injectable
Loss of bone mineral density, amenorrhea (stopped periods), irregular periods

IUCDs
Possibility of uterine infection

Implants
Menstrual irregularities, loss of bone mineral density

Male Sterilization
Surgical complications

Female Sterilization
Surgical complications

UNIVERSAL DECLARATION OF HUMAN RIGHTS • SAFE ABORTION PREGNANCY • RIGHT TO CHOOSE RIGHT TO HEALTHCARE AND PROTECTION • SECURITY • LIBERTY PRIVACY • BASIC RIGHTS • UNIVERSAL DECLARATION OF HUMAN RIGHTS SAFE ABORTION • RIGHT TO CHOOSE PRIVACY • PREGNANCY • LIBERTY BASIC RIGHTS •

ABORTION + HUMAN RIGHTS

• PREGNANCY • SECURITY • RIGHT TO HEALTHCARE AND PROTECTION • SECURITY LIBERTY • PRIVACY • RIGHT TO HEALTHCARE AND PROTECTION UNIVERSAL DECLARATION OF HUMAN RIGHTS • SAFE ABORTION RIGHT TO CHOOSE LIBERTY PRIVACY • BASIC RIGHTS • SECURITY

ABORTION + **HUMAN RIGHTS**

The Universal Declaration of Human Rights adopted by the UN in 1948 recognizes and upholds the dignity of every human being and their equal and inalienable rights to freedom, justice and peace.

Access to safe abortion, a sexual and reproductive right, falls within the scope of 12 basic human rights sourced from international human rights instruments that have been ratified by a range of countries worldwide. These include the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

1. RIGHT TO HEALTHCARE AND PROTECTION

Right to life

Right to benefit from scientific progress

Restricting access to safe abortion services can put a woman's health and life at risk. The right to safe abortion requires governments to provide **access to healthcare services** that provides safe abortion services and protect women from the risks of unsafe abortions.

Every woman should have **access to the benefits of all available safe and approved reproductive health technology,** including newer methods of contraception, safe abortion, infertility treatment, and information on any possible harmful effects.

Some common barriers to access includes **stigma associated with abortion, lack of legal literacy and awareness on safe abortion methods, access to service,** and lack of equipped staff or proper equipment.

25 MILLION
unsafe abortions every year[1]

8-11%
of maternal deaths around the world relate to abortion

22,800 - 31,000
preventable deaths

[1]Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet 2017

2. RIGHT TO CHOOSE

Right to choose whether or not to marry or plan a family

Right to choose whether or when to have children

Unintended and **unwanted pregnancies can impact women in different ways** based on their relationships, economic resources, availability of medical care and health, among various other factors.

A woman's decision to seek an abortion is based on her unique circumstance, and needs to be respected as a personal preference, an autonomous choice that is **upheld as a sexual and reproductive right.**

A woman **can choose** whether or not to marry or have a child. The right entails **access to sexual and reproductive health services**, including family planning, infertility treatment, and the prevention and treatment of sexually transmitted infections, including HIV/AIDS, in an environment free from stigma and judgment to facilitate her decision.

3. RIGHT TO FREEDOM

Right to liberty and security

Right to privacy

Right to be free from torture or ill treatment

Right to equality and to be free from all forms of discrimination

Gender roles, social pressures, expectations in relationships, etc. restrict an individual's freedom on multiple levels. An unwanted pregnancy and its continuation can severely impact a woman's physical and emotional health on many levels.

Decisions about one's body, especially concerning sexual and reproductive aspects, are a private matter and **ought to be left solely up to the woman.**

A non-discriminative environment that accepts and supports varied expressions of partnership, sexuality and parenthood ensure the realization of these basic rights.

HUMAN RIGHTS LINKED TO ABORTION PROTECTED UNDER DIFFERENT LEGAL INSTRUMENTS[1]

	International Legal Instruments					Conference Documents		
Human Rights Protected	**Universal Declaration of Human Rights (UDHR)**	**International Covenant on Civil and Political Rights (ICCPR)**	**International Covenant on Economic Social and Cultural Rights (ICESCR)**	**Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)**	**Convention on the Rights of the Child (CRC)**	**Vienna Declaration**	**Cairo Declaration**	**Beijing Declaration**
The right to: life, liberty & security	Article 3	Article 6.1; 9.1			Article 6.1; 6.2		Principle 1 Para 7.17; 8.34	Para 96; 106; 108
not be subjected to torture/ cruel, inhuman, degrading treatment/ punishment	Article 5	Article 7			Article 37	Para 56		
be free from gender discrimination	Article 2	Article 2.1	Article 2.2	Article 1; 3	Article 2.1	Para 18	Principle 1; 4	Principle 214
modify customs that discriminate against women			Article 10.2; 12.1; 12.2	Article 2; 5	Article 24.3	Para 18; 49	Para 5.5	Para 224
health, reproductive health & family planning				Article 10; 11.2; 11.3; 12.1; 14.2	Article 24.1; 24.2	Para 41	Principle 8 Para. 7.45	Para 89; 92; 267
privacy		Article 17.1			Article 16.1; 16.2			Para 106; 107
determine number & spacing of one's children				Article 16.1			Principle 8	Para 223

[1]Safe and Legal Abortion is a Woman's Human Right, Briefing Paper, Center for Reproductive Rights, 2004

A WOMAN'S FREEDOM OF CHOICE WHETHER TO BEAR A CHILD OR ABORT HER PREGNANCY ARE AREAS WHICH FALL IN THE REALM OF PRIVACY.

August 2017, Supreme Court of India

INCIDENCE • PREGNANCIES • SURVEY
PREGNANCY RATE • UNINTENDED
UNPLANNED • METHODOLOGY
MEDICATION • EFFECTIVE • SURVEY
ESTIMATE • CONTRACEPTION
DATA • METHODOLOGY • INCIDENCE
RESEARCH • DATA • ESTIMATES • RATE
RECOMMENDATIONS • INCIDENCE
PREGNANCIES • UNINTENDED
CONTRACEPTION • ABORTION +
METHODOLOGY • **INCIDENCE**
UNPLANNED • MEDICATION • DATA
EFFECTIVE • SURVEY • INCIDENCE
RESEARCH • ESTIMATES • RATE
RECOMMENDATIONS • INCIDENCE
PREGNANCIES • UNINTENDED
UNPLANNED • PREGNANCY
RATE • MEDICATION • EFFECTIVE
CONTRACEPTION • INCIDENCE

ABORTION + **INCIDENCE**

India does not have reliable data on the incidence of induced abortion. Guttmacher Institute conducted a study to estimate the national incidence of abortion and unintended pregnancy.

KEY FINDINGS FROM THE STUDY[1]

In 2015, the total number of pregnancies in India were estimated to be

48.1 MILLION,
suggesting a rate of
144.7 pregnancies per 1000 women
in the reproductive age group (15 to 49 years).

Of these 144.7 pregnancies (per 1000 women),

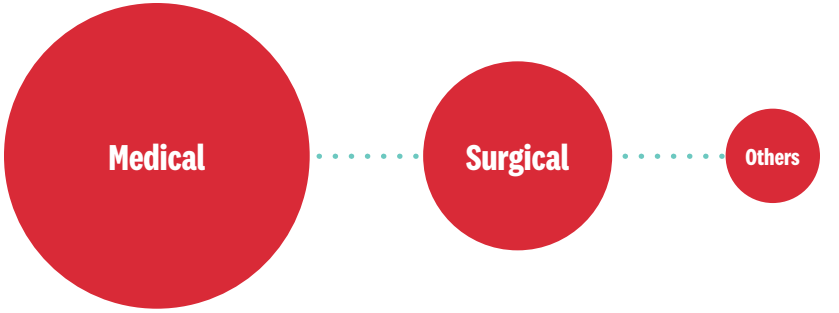
70.1 were unintended pregnancies.

Out of 48.1 million pregnancies, approximately 15.6 million abortions occurred in India in 2015, indicating an abortion rate of 47 abortions per 1000 women in the reproductive age group. **These estimates are five times the number reported by the government sources.**

15.6 MILLION ABORTIONS

0.8 MILLION (5%)
were considered unsafe abortions i.e. conducted by untrained, unrecognized practitioners at unapproved places.

METHODS USED



12.7 MILLION
(81%) abortions

2.2 MILLION
(14%) abortions

0.8 MILLION
(5%) abortions

[1] Singh et al., "The incidence of abortion and unintended pregnancy in India 2015", Lancet Global Health, Volume 6, Issue 1, 2018

KEY FINDINGS FROM THE STUDY

The rate of unintended pregnancy

is consistent with

The level of unmet need for effective contraception

The unmet need for contraception among married women in India was

13%

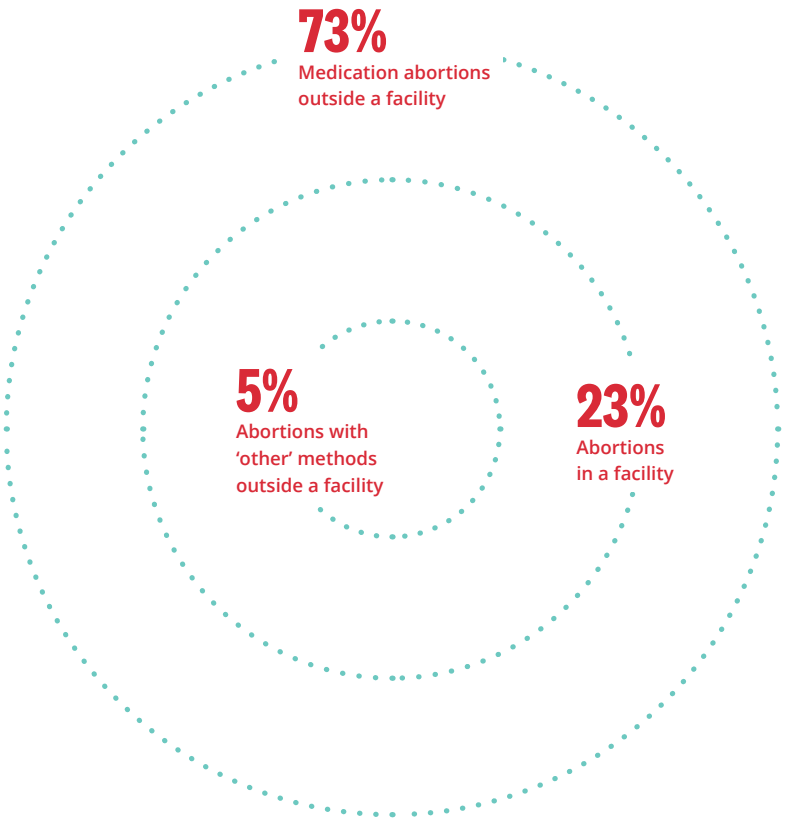
An additional

6%

married women used traditional methods with relatively high failure rates

SAFE VS UNSAFE ABORTIONS

Places of abortion



The study estimated abortions happening within and outside the facilities, with or without use of medication, for the year 2015.

Data on live births and the total number of women of reproductive age (15 to 49 years) was sourced from the UN population database.

Methodology of the study

Data on the proportion of births from unplanned pregnancies & contraceptive use was sourced from the National Family Health Survey 4 (2015-16).

Limitations

Did not account for the use of 'misoprostol' alone for abortions. Given the multiple uses of the drug, it was not feasible to do so.

Private doctors in settings (consulting rooms) that were not included in the Health Facilities Survey could have legally provided some of the medication-based abortions outside health facilities.

DATA SOURCES
Incidence of abortion

[2]The 2015 Health Facilities Survey (HFS), fielded from March to August, 2015, collected data on the number of induced abortions provided annually, by type of procedure (surgical and medication), from 4001 public and private health facilities in Assam, Bihar, Gujarat, Madhya Pradesh, Tamil Nadu, and Uttar Pradesh

RECOMMENDATIONS FROM THE STUDY

1.

Health facilities should be better equipped with requisite **physical infrastructure and human resources** to play a greater role in the provision of quality abortion services.

2.

Chemists and informal vendors should also be provided with **accurate information on these drugs** and follow-up care.

3.

As a majority of women are opting for medication-based abortions, the government **should adopt harm reduction strategies** and provide women with accurate information on these drugs and follow-up care.

4.

Policies and programs should aim at providing **quality contraceptive services** that prevent unintended pregnancies.

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS • INTERSECTIONALITY GENDER • PATRIARCHY • SEX SEXUALITY • SEXUAL HEALTH SEXUAL RIGHTS • GENDER ANALYSIS SEXUAL ORIENTATION • GENDER NORMS • INTIMACY • STIGMA • LACK OF AWARENESS • REPRODUCTION WOMEN'S RIGHTS • SEXUALITY • SEX GENDER • KEY CONCEPTS RIGHTS HEALTH • **GENDER AND SEXUALITY** SEX • SEXUAL AND REPRODUCTIVE HEALTH RIGHTS • INTIMACY • SEX NORMS • STIGMA • SEX • SEXUALITY SEXUAL HEALTH • SEXUAL RIGHTS GENDER ANALYSIS • PATRIARCHY LACK OF AWARENESS • SEXUAL ORIENTATION • GENDER NORMS INTIMACY • FEMALE SEXUALITY

KEY CONCEPTS

GENDER AND SEXUALITY

Work on Sexual and Reproductive Health and Rights (SRHR) in general, and safe abortion specifically, lies at the intersection of multiple issues. While unpacking these issues and engaging with them, it is important to accurately understand and apply concepts such as patriarchy, gender, sexuality, sexual health, sexual rights, reproductive health and reproductive rights. This note attempts to provide a snapshot of concepts related to gender and sexuality and their interlinkages with safe abortion.

: GENDER is what society and culture prescribe as to what it means to be a MAN or a WOMAN. It is a social construction and not biologically determined.

Gender works as a social system

Beliefs in society	Men are strong, men are rational	Women are weak, women area emotional
Gender norms	Men have opinions and can voice them	Women must not express themselves
Gender roles	Men must be breadwinners	Women must be homemakers and caregivers
Division of labor	Productive work with earnings and wages must be done by men	Reproductive work of caring and nurturing must be done by women
Different domains, tasks & activities	Men's tasks are in the public domain	Women's tasks are in the private domain and homes

WHILE UNPACKING THESE ISSUES AND ENGAGING WITH THEM, IT'S IMPORTANT TO ACCURATELY UNDERSTAND AND APPLY CONCEPTS SUCH AS **PATRIARCHY GENDER, SEXUALITY, SEXUAL HEALTH AND RIGHTS, REPRODUCTIVE HEALTH AND RIGHTS.**

: GENDER ANALYSIS

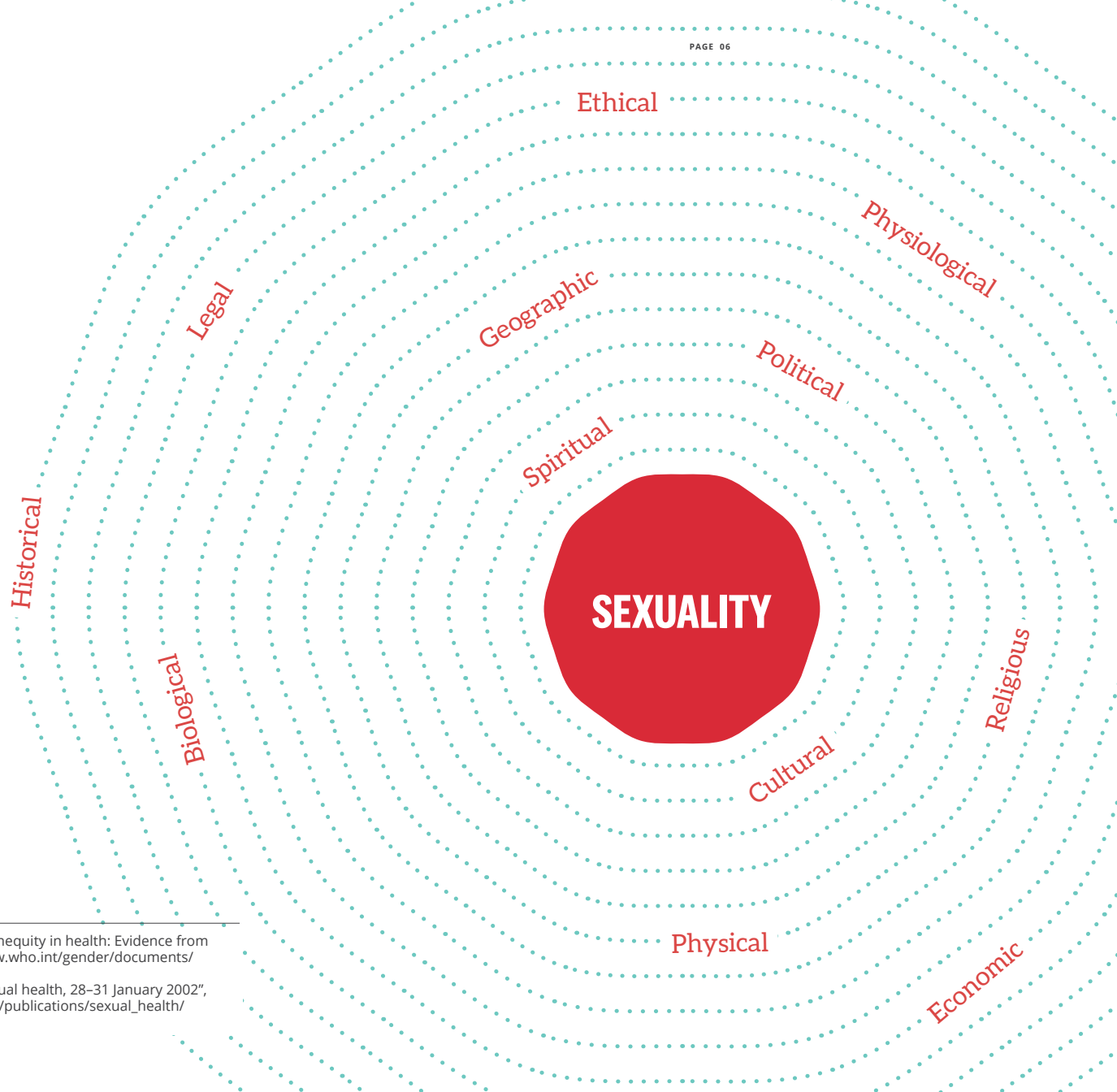
is a social analysis that distinguishes the resources, activities, potentials and constraints of women relative to men in a specific socio-economic group and context.

: PATRIARCHY

refers to historical power imbalances and cultural practices that accord men on aggregate more power in society and offer material benefits, such as higher incomes and informal benefits, including care and domestic service from women and girls in the family. Patriarchy is institutional. It works at multiple levels: individual, family,[1] community, society at large and across systems like health, education, law, etc.

: SEXUALITY

encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed.[2]



[1] Barker et al. "Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions", World Health Organisation (2007), www.who.int/gender/documents/Engaging_men_boys.pdf

[2] "Defining sexual health, Report of a technical consultation on sexual health, 28–31 January 2002", World Health Organisation, 2006 www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

MALE SEXUALITY

Men **initiate sex**, they can demand sex

Boys take the initiative to develop 'friendship' with a girl and if she says no, it is an **insult to his manliness**

Men have **stronger sexual urges**

Men are **promiscuous**

Semen loss is equivalent to **becoming weak**

A man's seed should **not be wasted**

It is okay to display body association with **strength**

Men are strong; men are leaders

FEMALE SEXUALITY

Women should not initiate sex, they should **not show sexual desire**

Whenever a man demands sex, the woman **must comply**

Women have **weaker sexual urges**

Fragile female bodies **must be kept covered**

Women must be **protected** out of modesty

Women are weak; women are implementers of decisions

How is safe abortion linked to gender and sexuality?

1. Women's lack of control over resources

2. Men's relinquishment of responsibility to prevent pregnancies

3. Non-consensual sex within or outside marriage

4. Contraception access

5. Stigma and guilt in relation to abortion

6. Cost of services and lack of access for women, particularly for young women

7. Poor quality, exploitative services

8. Discriminatory nature of services, particularly for young women

9. Lack of awareness of the legal status of abortion

THE MEDICAL TERMINATION OF PREGNANCY ACT • MATERNAL MORTALITY • TERMINATION CONDITIONS • MIFEPRISTONE MISOPROSTOL • DISTRICT COMMITTEE • SEX DETERMINATION THE PRE-CONCEPTION PRE-NATAL DIAGNOSTIC TECHNIQUES ACT ULTRASONOGRAPHY • SEX DETERMINATION • ABORTION + SEXUAL ABUSE • **LAW** THE PROTECTION OF CHILDREN FROM SEXUAL OFFENCES ACT THE MEDICAL TERMINATION OF PREGNANCY ACT • MATERNAL MORTALITY • TERMINATION CONDITIONS • MIFEPRISTONE COMMITTEE • SEX DETERMINATION ULTRASONOGRAPHY • TERMINATION

ABORTION + **LAW**

The Medical Termination of Pregnancy (MTP) Act, India (1971) seeks to

Reduce the high incidence of maternal mortality and morbidity rates associated with unsafe abortions by legalizing abortion.

Promote access to safe abortion services and protect medical practitioners who would otherwise be prosecuted under the Indian Penal Code (1860) (Section 312-316).

It does not give the right to legal abortion to women but **lists out conditions** under which women may be eligible to access safe abortions.

What are the conditions for an abortion under the MTP Act?

Continuation of pregnancy is a **risk to the life** of the pregnant woman or could cause grave injury to her physical or mental health.

There is a substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities.

The pregnancy was caused by rape (presumed to constitute grave injury to mental health).

The pregnancy was caused **due to failure of contraceptives** used by a married woman or her husband (presumed to constitute grave injury to mental health).

Till when can a pregnancy be terminated and who can do this?

Up to **12 weeks,** a pregnancy can be terminated with approval from one service provider.

The approval of two service providers is needed for termination of a pregnancy between **12-20 weeks.**

Where can a pregnancy be terminated ?

A place approved by the government for the time being.

AMENDMENTS TO THE MTP ACT

2002

The Government of India approved two medical abortion drugs 'mifepristone' coupled with 'misoprostol' for early abortions.[1]

2003

Decentralization of site registration to a 3-5 member district level committee chaired by the CMO/DHO that offers more potential to increase number of sites and therefore improved access to legal abortion.
Medical abortion pills were also included in the range of options. Certified providers to prescribe medical abortion drugs outside a registered facility as long as emergency back-up facilities are available to them.[2]

"THE CONSENT OF THE WOMAN IS THE ESSENTIAL FACTOR FOR TERMINATION OF HER PREGNANCY. THE HUSBAND'S CONSENT IS NOT NEEDED BY LAW."

ROLE OF DISTRICT COMMITTEE

The District Level Committee plays an important role in reviewing the application of facilities which seek approval under MTP Act to provide abortion services. The committee considers the application, conducts the inspection, and based on recommendations, provides a certificate of approval for provision of abortion services.

COMPOSITION OF THE DISTRICT LEVEL COMMITTEE

- Chairperson (Chief Medical Officer/ District Health Officer)
- Gynecologist/surgeon/anesthetist
- Local medical professional
- NGO representative
- Panchayati Raj member

* The committee should have at least one woman member

[1] The Medical Termination of Pregnancy Rules: Amendment, Government of India, New Delhi, India, 2003
[2] Stillman M. et al., "Abortion in India: A Literature Review", Guttmacher Institute, New York, 2014

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, India (1994) seeks to

Regulate pre-natal diagnostic techniques and limit them to the detection of genetic/metabolic disorders, chromosomal abnormalities, congenital malformations or sex-linked disorders.

Prevent the misuse of such techniques to curb sex determination that has resulted in a declining child sex ratio (CSR) and sex ratio at birth (SRB) over the last two decades.

What does the Act provide for?

Prohibition of sex determination before and after conception.

Prevention of the misuse of such techniques for sex determination, before or after conception.

Prohibition on the sale of ultrasound machines to persons not registered under this Act.

Regulation of prenatal diagnostic techniques (e.g. amniocentesis and ultrasonography) for the detection of genetic abnormalities, by restricting their use to registered institutions, for a specified purpose, and by a qualified person who is registered for the purpose.

Prohibition of the advertisement of any techniques used for sex determination.

Punishment for violations of the Act (MTP and PCPNDT).

ABORTION AND CURBING OF SEX SELECTION
Understanding the linkage

Though the law is intended to regulate the misuse of technologies for sex determination, an unintended consequence has been a negative impact on safe abortion service provision, flagging the need to recognize that sex 'selection' is part of a continuum of gender discrimination, pre-birth and post-birth.

The current challenge faced by gender justice and sexual and reproductive health and rights (SRHR) advocates is to speak out against sex determination on the one hand, yet defend women's access to the safe termination of an unwanted pregnancy. Safe abortion access is a reproductive and sexual right that upholds a woman's autonomy and her choice with regard to decisions pertaining to her body and life. Gender biased sex determination is a discriminative practice reflective of Indian patriarchal structures. Advocacy initiatives led by feminist groups have identified the need to build more convergences in the interpretation of these two laws by examining the common values and mindsets associated with the subject.

The Protection of Children from Sexual Offences (POCSO) Act, India (2012 seeks to

Effectively address sexual abuse and sexual exploitation of children. All sexual activity under the age of 18 (age of consent) is subject to mandatory reporting. If a pregnant minor goes out and seeks a medical opinion, the doctor is expected by law to report the matter to the authorities.

An abortion is only granted to minors after the consent of a legal guardian and all the conditions stipulated under the MTP Act are met.

MINORS AND ABORTION
While the MTP regulations requires doctors to protect the identity of abortion seekers, POCSO mandates that they should report it in case a minor seeks abortion. This results in underage girls being forced to seek out unregulated and ultimately unsafe options fearing the consequences of going to a trained doctor.

DESPITE THE INTENTIONS OF THE POCSO ACT, IT SERVES AS A BARRIER TO ACCESS OF SAFE ABORTION SERVICES

POCSO Act, 2012

MISCONCEPTIONS • MATERNAL DEATHS • MEDICAL ABORTIONS CONTRACEPTION • EMERGENCY CONTRACEPTIVE PILL • MYTH FACT • BARRIERS • EMBRYO • LAW AWARENESS • INFORMATION MISCONCEPTIONS • MATERNAL DEATHS • MEDICAL ABORTIONS CONTRACEPTION • EMERGENCY CONTRACEPTIVE PILL • MYTH • FACT • LAW • EMBRYO • AWARENESS • BARRIERS INFORMATION • MISCONCEPTIONS MATERNAL DEATHS • MEDICAL ABORTIONS • CONTRACEPTION EMERGENCY CONTRACEPTIVE PILL FACT • BARRIERS • EMBRYO • LAW AWARENESS • INFORMATION • MYTH FACT • MISCONCEPTIONS • EMBRYO

ABORTION + **MYTHS**

ABORTION + **MYTHS**

While abortion is legal in India, barriers to accessing abortion still exist. The predominant barrier is commonly-held myths and misconceptions about abortion.

Myths: The law

MYTH Abortion is illegal

FACT A woman can terminate a pregnancy under 12 weeks with the opinion of one doctor but would need the opinion of two doctors to terminate a pregnancy between 12 to 20 weeks. Permission for an abortion can be granted on conditions detailed under the MTP Act, and could include reasons such as: **risk to a woman's life or grave injury to her mental or physical health; the result of rape; severe fetal abnormalities; contraceptive failure (only for married women).** (For detailed information on the conditions see note on '*Abortion + Law*'.)

MYTH A safe abortion is always legal

FACT **As per the law, doctors and facilities providing abortions need to be registered.** However, registration alone does not make an abortion safe. Abortions need to comply with the latest quality standards.

A married woman needs her husband's consent to get an abortion

The consent of a legal guardians is necessary for cases of abortion involving a minor (woman under the age of 18 years) and a person with a mental illness. A woman above 18 **doesn't need her husband's or her family's consent to get an abortion as per the MTP Act.** This has been further upheld by the Punjab and Haryana High Court (2011) and the Supreme Court (2017).

"IF THE WIFE HAS CONSENTED TO MATRIMONIAL SEX, IT DOES NOT MEAN THAT SHE HAS CONSENTED TO CONCEIVE A CHILD. THE WOMAN IS NOT A MACHINE IN WHICH RAW MATERIAL IS PUT AND A FINISHED PRODUCT COMES OUT. SHE SHOULD BE MENTALLY PREPARED TO GIVE BIRTH TO A CHILD."

-The Punjab and Haryana High Court verdict, 2011

Myths: Medical

MYTH Abortions are dangerous or have long-term health effects

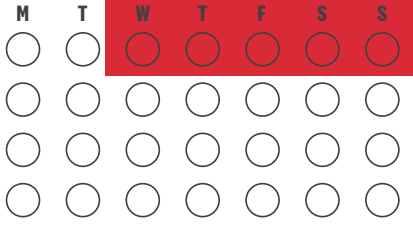
FACT Abortion is one of the safest medical procedures. Future pregnancies are not affected by an abortion and **less than 1% of women** develop an infection or have heavy bleeding after one.

If everyone used contraceptives, no one would have abortions

No form of contraception is 100% effective. Contraceptive failures happen. Condoms break. One can forget to take an oral contraceptive pill. Abortion will always **be a necessary component of comprehensive sexual and reproductive health care.**

Taking an emergency contraceptive pill is the same as having an abortion

Emergency contraceptive pill (EC), also known as the 'morning after pill' or the '72-hour pill', **prevents a pregnancy, it does not terminate it.** Abortion is conducted after conception has already happened.



Myths: Social

MYTH Giving young people information about sexuality and abortion encourages them to have sex and engage in promiscuous behavior

FACT Studies clearly indicate that effective and comprehensive sexual health education, including information on contraception and abortion, encourages young people to make empowered and **informed decisions about their sexual and reproductive health.** This enables them to practice safer sex and better access contraceptives

Most of the abortions that women get in India are due to sex-selection

The sex of the fetus can be determined only in the **second trimester.** The vast majority of abortions are done in the first trimester

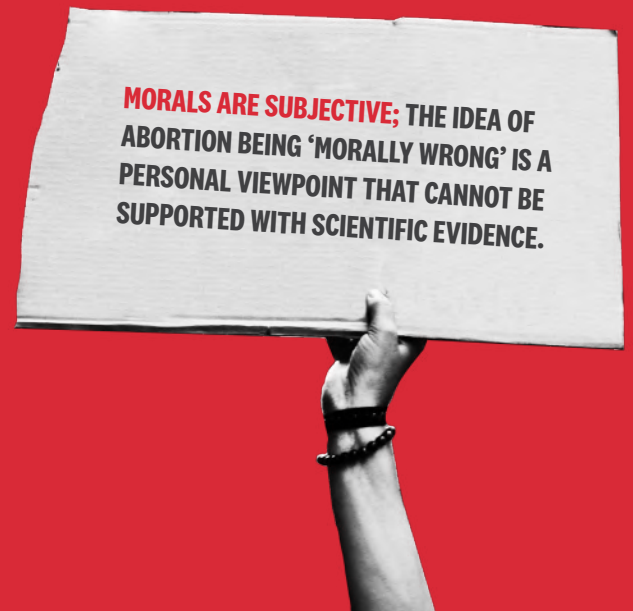
Women who get an abortion regret it

95% of women who have had an abortion felt that it was the right decision for them. Women **do not** experience a higher rate of depression after an abortion, nor is there any scientific evidence of abortion leading to infertility or breast cancer

References:
[1] Say et al., "Global causes of maternal death: a WHO systematic analysis", Lancet Global Health, 2014
[2] "Report on Medical Certification of Cause of Death", Registrar General of India, 2014

MYTH Abortion kills an unborn child and is morally wrong

FACT In the early stages of pregnancy, an embryo would not be able to survive on its own outside the womb. Hence, using words like 'killing' to describe abortion **inaccurately equates the embryo with an actual person**



PREGNANT • PUBLIC FACILITIES
SURGERY • HOSPITALS • DOCTORS
PRESCRIPTION MEDICINE • BARRIERS
OBSTETRICIAN-GYNECOLOGISTS
BARRIERS • LAW • PREGNANT
PUBLIC FACILITIES • SURGERY
HOSPITALS • DOCTORS • BARRIERS
SURGERY • HOSPITAL • DOCTORS
OBSTETRICIAN-GYNECOLOGISTS
PRESCRIPTION

ABORTION + SERVICES

MEDICINE • LAW
PREGNANT • SURGERY • PUBLIC
FACILITIES • DOCTORS • LAW
PRESCRIPTION MEDICINE • PREGNANT
OBSTETRICIAN-GYNECOLOGISTS
BARRIERS • LAW • SURGERY • PUBLIC
FACILITIES • HOSPITALS • DOCTORS
BARRIERS • PRESCRIPTION • LAW
MEDICINE • SURGERY • FACILITIES

ABORTION + **SERVICES**

Abortion Services 101

Who?

A pregnant woman who wishes to terminate **her pregnancy due to physical or mental health, rape or incest**, fetal impairment or due to failure of contraception.

Women above 18 years of age **do not** require the consent of their husband/partner/parent. Girls below 18 years of age require the consent of a parent/guardian.

How?

Medical and surgical methods.

Where?

Public facilities with certified providers, such as Community Health Centers and District Hospitals, as well as Primary Health Centers with certified and trained providers and supportive infrastructure; registered private facilities with certified providers and appropriate facilities .

When?

Up to 20 weeks.

A pregnant woman can seek an abortion up to 12 weeks of gestation with the consent of one doctor. The consent of two doctors is required for pregnancy between 12-20 weeks.

THE SAFEST WAYS OF GETTING AN ABORTION

: MEDICAL ABORTION
A medical abortion uses **prescription medication** given in doses over two or more days to end a pregnancy.

: SURGICAL ABORTION
The procedure takes a day and general or local anesthesia is administered to the woman undergoing it. She will **undergo vacuum aspiration or the suction method**, where a suction tool empties all the contents of the uterus. This method is safer compared to other surgical methods.

If the woman is over 15 weeks pregnant, she will **undergo dilation and evacuation**. In this procedure, the doctor places a synthetic dilator inside the cervix and removes the tissues that line the cervix.

MYTH • Abortion causes infertility and breast cancer.

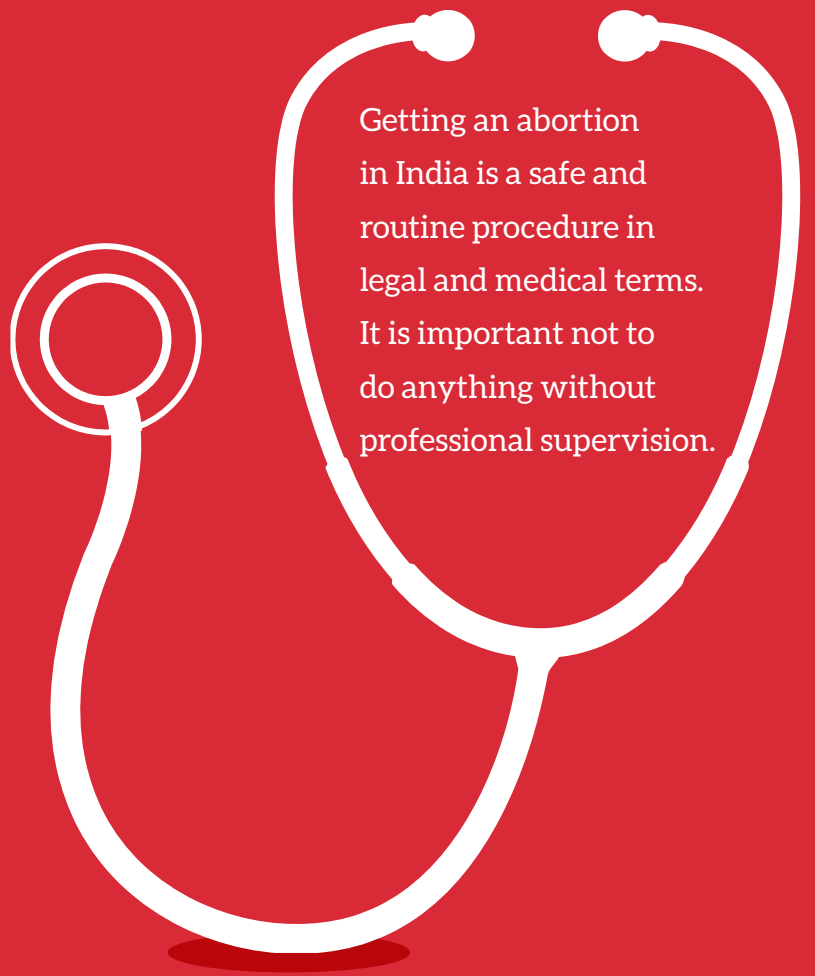
FACT • There is no evidence linking abortion to either.

MYTH • Abortion causes emotional problems or 'post-abortion syndrome'.

FACT • Evidence suggests that women who feel that they have made a free and informed decision will not experience emotional or psychological trauma.

MYTH • Medical abortion is very painful.

FACT • Bleeding and cramps normally take place after an abortion, hence pain relief is advised.



ABORTION PROVISIONS[1]

Only obstetrician-gynecologists and other allopathic physicians who have completed a Bachelor of Medicine/ Bachelor of Surgery Degree, have undergone government-approved training, and have received certification, can legally provide abortions

: PUBLIC SECTOR

All public facilities with certified abortion providers

: PRIVATE SECTOR

Registered facilities certified to offer abortions based on a government-set infrastructure and human resource criteria

THE MEDICAL TERMINATION OF PREGNANCY (MTP) ACT 1971

According to the Act, an abortion is currently permitted to save the life of a woman, **preserve her physical and mental health**, in case of rape or incest, or fetal impairment or due to failure of contraception.[2]

In order to expand safe abortion services, in 2002, the Government of India approved two medical abortion drugs **'mifepristone' coupled with 'misoprostol'** for early abortions.[3]

A 2003 amendment to the MTP Act enabled certified providers to prescribe medical abortion drugs outside a registered facility as long as **emergency back-up** facilities are available to them.[4 5]

The National Comprehensive Abortion Care Guidelines released in 2010, indicated that medical abortion with mifepristone and misoprostol may be provided up to **63 days of gestation**.[6] This change is yet to be reflected in the MTP Act.

[1] Creanga, Andreea A., et al., edited by Ganesh Dangal, "Changes in Abortion Service Provision in Bihar and Jharkhand States, India between 2004 and 2013", PLoS ONE 13.6, 2018
[2] The Medical Termination of Pregnancy Act 1971 (Act No. 34 of 1971), Government of India, 1971
[3] The Medical Termination of Pregnancy Rules: Amendment, Ministry of Health and Family Welfare, Government of India, New Delhi, India, 2003
[4] Stillman M. et al. "Abortion in India: A Literature Review", Guttmacher Institute, New York, 2014
[5] The Medical Termination of Pregnancy Rules: Amendment, Ministry of Health and Family Welfare, Government of India, New Delhi, India, 2003
[6] Acharya R. and Kalyanwala S., "Knowledge, attitudes, and practices of certified providers of medical abortion: Evidence from Bihar and Maharashtra, India", International Journal of Gynaecology & Obstetrics. 118 Suppl., 1: S40–6, Wiley, September 2012

According to Indian government data, only about 1 million abortions are performed annually under the MTP Act, while the number of abortions performed outside the legal framework varies from 2-6 million per year.[7]

[7] The Medical Termination of Pregnancy Rules: Amendment, Ministry of Health and Family Welfare, Government of India, New Delhi, India, 2003

TWITTER • INSTAGRAM • CAPACITY
FACEBOOK • PURPOSE • AUDIENCE
INFLUENCERS • CONTENT • RESOURCES
CAPACITY • CAMPAIGNS • DATA
ENDORSEMENT • NARRATIVE • SHARE
GLOBAL • ENGAGEMENT • TWITTER
INSTAGRAM • FACEBOOK • PURPOSE
AUDIENCE • CONTENT • INFLUENCERS
DATA • CAMPAIGNS • RESOURCES
INFLUENCERS • ABORTION +
ENGAGEMENT • **SOCIAL MEDIA**
NARRATIVE • CAPACITY • SHARE
GLOBAL • RESOURCES • INSTAGRAM
FACEBOOK • SHARE • PURPOSE
AUDIENCE • CONTENT • INFLUENCERS
DATA • CAMPAIGNS • RESOURCES
ENDORSEMENT • ENGAGEMENT
GLOBAL • CAPACITY • TWITTER
FACEBOOK • CAMPAIGNS • SHARE

ABORTION + **SOCIAL MEDIA**

SOCIAL MEDIA CHANNELS

An avenue to reach and engage with audiences and increase visibility of issues.

Useful to connect to influencers and celebrities and share quick, concise opinions on report findings, news bulletins, events.

Use social media only if

1. It will serve your purpose. Don't use it because everyone is on it. **Think about what you want to achieve** by using social media and make a plan.

2. **Your audience is using the social media channel of your choice**. For example, if you want to create awareness on safe abortion and have a Facebook page, then it might be a good option, as the general public can be reached through Facebook. But if you want to advocate for improved access of safe abortion services with your local government official, then a face-to-face meeting may be more effective.

3. You have the **resources and capacity to continue posting on social media**. Sporadic posting may not help the cause. Also, choose one social media channel that's most effective rather than using multiple channels and spreading yourself thin.

Run campaigns

Share/ repost

Use influencer & celebrity endorsement

WHAT CAN YOU DO ON SOCIAL MEDIA?

Package data creatively

Celebrate key global observances

Share personal narratives

: RUN CAMPAIGNS

Online campaigns are a cost-effective way of reaching out to a large audience and engaging them in a dialogue around sexual reproductive rights and safe abortion. #AbortTheStigma and #SuspendJudgement are examples of campaigns that aimed to address awareness, address myths and misconceptions and **raise awareness on the issues around safe abortion and the intersection of sexuality, gender and rights.**

CREA's digital campaign collaterals are available at http://www.creaworld.org/abortthestigma

: USE INFLUENCER & CELEBRITY ENDORSEMENT

Influencers are credible voices in the reproductive justice space whose opinions matter. Lending their voice to your advocacy initiatives multiplies reach and engagement. Reach out to local influencers and celebrities. Speak with them about your initiative. Once they agree to be the face of your initiative get specific bites that will help your cause.

“

ONLY USE SOCIAL MEDIA IF IT WILL SERVE YOUR PURPOSE- DON’T USE IT JUST BECAUSE EVERYONE IS ON IT. THINK ABOUT WHAT YOU WANT TO ACHIEVE AND MAKE A PLAN.

”

: PACKAGE DATA CREATIVELY

Facts and figures and various data can be packaged into ‘Did you Know’ snippets with #DYK so that your post shows up in a hashtag that is widely accessed by multiple audiences across the world. It is not important for you to create data. **Use existing data from reliable sources.**

: SHARE PERSONAL NARRATIVES

Share personal stories with consent, to **inspire people** and enable them to relate.

: SHARE/REPOST

You can share links to articles and updates on policy developments with your thoughts or just to show solidarity. There are many key organizations working in this space, that have social media teams. Use their posts to spread the word and to convince your stakeholders.

: CELEBRATE KEY GLOBAL OBSERVANCES

Make a list of days that are celebrated or commemorated on this issue and related themes/planks. Prepare relevant posts for those days. Share the posts with everyone in your organization so that others could also share on their social media profiles.

MARCH 8TH
INTERNATIONAL WOMEN'S DAY

MAY 17TH
INTERNATIONAL DAY AGAINST HOMOPHOBIA, BIPHOBIA & TRANSPHOBIA

MAY 28TH
INTERNATIONAL DAY FOR ACTION FOR WOMEN'S HEALTH

JUNE 2ND
INTERNATIONAL SEX WORKER DAY

SEP 28TH
INTERNATIONAL SAFE ABORTION DAY

NOV 25TH
INTERNATIONAL DAY OF ELIMINATION OF VIOLENCE AGAINST WOMEN

DOs

Plan ahead and post timely updates. Think ahead and prepare a monthly calendar with the kind of content you would like to post. Developing and designing a post three days ahead will enable you to share it with others within your organization and in your wider networks, increasing the reach of the messaging.

Share links to recent developments like policy updates on the MTP amendments, and share links to articles, blog posts and debates on sexual and reproductive rights. **Keep people updated** on workshops and events around the subject.

Refer to guides in this toolkit on appropriate terminology and visuals while communicating on safe abortion.

Share posts of partner organizations and ask them to reciprocate the love by sharing your posts. This **enhances the visibility** of the topic and increases the scope for dialogue and engagement!

Keep your text short and crisp. Social media is **visual oriented** so ensure that the visual is the dominant element in the post design.

Always generate positive exchanges. Thank and acknowledge people for their positive comments, additional/supplementary information and constructive feedback.

Listen and learn from responses to your posts. It can provide you with data on the very attitudes and beliefs you are trying to change.

Maintain a steady flow in the frequency of your posts.

DON'Ts

Share information that has **not been checked** and verified by a credible source.

Allow debates amongst people to get too contentious and slip into a string of negative comments.

Be defensive or reactive, even if someone makes a comment that strongly opposes your values and ideology. Respond with facts.

Use visuals of visibly pregnant women, babies or fetuses or images with explicit graphics, blurred faces and images of women who look upset, as these are not rights-based and promote stigma.

Use language that perpetuates stigma. This includes terms like unborn child, baby and fetus as they imply personhood.

What if a post from your organization on promoting access to safe abortion and identifying local safe practitioners gets terrible comments for promoting promiscuity? How would you respond?

Keep responses crisp and don't encourage lengthy exchanges. **Make a clear, firm point and don't respond further.** If the negative comments continue and get out of hand, report the user.

Uphold the value of **protecting the safety** and dignity of women through the sharing of this information.

Explain that enhancing safe abortion access **reduces maternal morbidity** and mortality.

Reiterate the **autonomy of choice** that a woman has over her body and the experiences she chooses to have.

Indicate how stigmatizing remarks like this are reflective of **archaic patriarchal structures** that seek to oppress a woman's freedom and expression.

Refer to the legal aspect. Sexual and reproductive rights are human rights. Every human being has the right to **equally express themselves** without fear of judgment or discrimination by virtue of these laws. Indicate that safe provision is articulated in the MTP Act 1971.

ADVOCACY PLAN • AWARENESS OBJECTIVES • STAKEHOLDERS • WORK PLAN • POPULATION • MYTHS AND MISCONCEPTIONS • IMPLEMENT MONITOR • MEASURE • INFLUENCERS ADVOCACY PLAN • AWARENESS OBJECTIVES • STAKEHOLDERS • WORK PLAN • POPULATION • MYTHS AND MISCONCEPTIONS • STAKEHOLDERS INFLUENCERS • ABORTION + LAW AWARENESS • **ADVOCACY** DATA MEASURE • IMPLEMENT • MONITOR DATA • ADVOCACY PLAN • OBJECTIVES AWARENESS • STAKEHOLDERS • WORK PLAN • POPULATION • IMPLEMENT MYTHS AND MISCONCEPTIONS MONITOR • MEASURE • DATA • LAW INFLUENCERS • POPULATION • WORK PLAN • IMPLEMENT • STAKEHOLDERS

ABORTION + **ADVOCACY**

Approximately 15.6 million abortions took place in India in 2015 – an abortion rate of **47 abortions per 1000 women** in the reproductive age group (15 to 49 years).[1]

Of the 15.6 million abortions, 5 percent or 0.8 million were unsafe abortions conducted outside the facility i.e. conducted by untrained or unrecognized practitioners at unapproved places.[2]

Unsafe abortion related maternal mortality is approximately 8 percent.[3]

As advocates of safe abortion, we need to understand data and plan our action so that we not only build support for the issue, but also influence others to support it.

15.6 MILLION ABORTIONS

0.8 MILLION (5%)
abortions conducted outside a facility

8% MORTALITY RATE
is contributed by unsafe abortions[3]

[1] Singh et al., "The incidence of abortion and unintended pregnancy in India 2015", Lancet Global Health, Volume 6, Issue 1, 2018
[2] Ibid.
[3] Ministry of Health and Family Welfare, Government of India www.mohfw.nic.in/WriteReadData/c08032016/8963256321456987523 6.pdf

How do we make an advocacy plan?

Remember, this provides a structured and step-by-step process of undertaking advocacy around safe abortion. However, efforts on advocacy can often be organic and evolve as a response to specific situations.

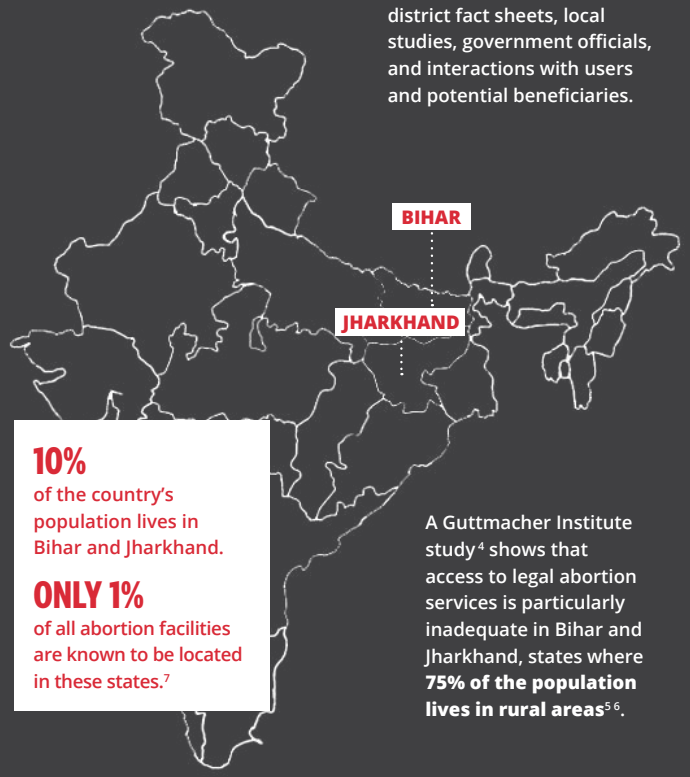
1. Understand the context
2. Set advocacy objective
3. Map the stakeholders
4. Develop workplan
5. Implement workplan
6. Monitor & measure success

STEP 1

UNDERSTAND THE CONTEXT

Study evidence to understand the situation.

Use sources such as NFHS 4, district fact sheets, local studies, government officials, and interactions with users and potential beneficiaries.



10%
of the country's population lives in Bihar and Jharkhand.

ONLY 1%
of all abortion facilities are known to be located in these states.[7]

A Guttmacher Institute study[4] shows that access to legal abortion services is particularly inadequate in Bihar and Jharkhand, states where **75% of the population lives in rural areas**[5][6].

[4] Ibid.
[5] Kalyanwala S, et al., "Adoption and continuation of contraception following medical or surgical abortion in Bihar and Jharkhand, India", International Journal of Gynaecologists and Obstetrics, 118 Suppl 1:S47–51, 2012
[6] Patel L, et al., "Support for provision of early medical abortion by mid-level providers in Bihar and Jharkhand, India", Reproductive Health Matters, 17(33):70–9. pmid:19523584, 2009
[7] Duggal R, et al., "The abortion assessment project India: key findings and recommendations", Reproductive Health Matters, 12 (24 Suppl):122–9, 2004

Lack of coherence
between laws, policies, programs and services

Lack of data
on abortion for planning purposes, with no research available beyond the Guttmacher Institute study

Social stigma

Understand the barriers to safe abortion in your context

Lack of trained providers
and low access to trained providers

Myths and misconceptions

Low knowledge
in communities about safe services

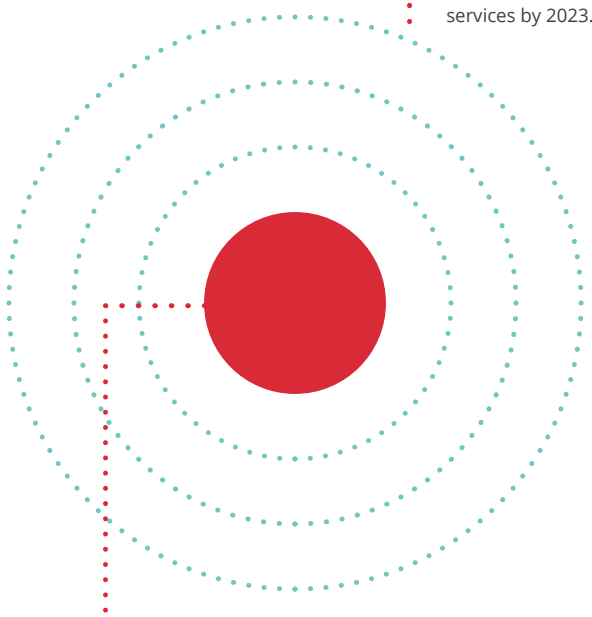
Low legal awareness
on the difference between the PCPNDT Act and MTP Act

SETTING THE ADVOCACY OBJECTIVE

Identify long-term goals and SMART[8] short-term objectives.

BROAD GOAL

To ensure that women of reproductive age in Jharkhand have access to safe and legal abortion services by 2023.



SMART OBJECTIVE

To ensure that there is a 25% increase in the base of legal and trained abortion service providers within the district within one year (by 2019 end).

To ensure that the district level committee is activated (assuming it has already been set up).

[8] SMART Objective: In designing an objective, ensure that it is Specific, Measurable, Attainable, Relevant and Time-bound

MAPPING STAKEHOLDERS

Identifying the decision maker(s) and influencers
Identify who has the power to achieve the objective and can act as a messenger to the decision maker (who does she/he listen to?).

Identifying and aligning allies
This broad range of actors could inform and influence the policy makers' stand. Think of strategic alliances as the process of advocacy may require you to work with stakeholders who were not traditionally seen as allies.

Knowing your opposition
It is important to understand the nature of opposition to the right to abortion and the type of arguments used against it including those that are country/state/region specific.

Decision makers

Chief Medical Officer (CMO)/ District Health Officer (DHO)
Members of the District Level Committee (for site registration)

Direct influencers

Local MLA
Representatives of health service delivery systems
Large NGOs/Technical Support Units working with the government bodies

Influencers-Allies

Media
Academia and researchers
NGOs and women's groups, network/alliances
Professional associations like FOGSI, Lawyers' group

Opposition

Pro-life group
Religious leaders

DEVELOPING AND IMPLEMENTING A WORK PLAN

Platforms that can be used include face-to-face meetings, advocacy kits, fact sheets, public rallies, petitions, public debates, press releases, policy forums, meetings, etc.

A work plan consists of several action steps with the following information:

- ☑ What activities will occur and who will anchor them?
- ☑ Timeline
- ☑ Budget
- ☑ Plan and message development

ACTIVITY 1:
Prepare an advocacy kit

Package data on abortion services and other key facts to suit the information needs of the stakeholders. **Small fact sheets, guidelines, action steps, etc. can be developed and customized for each stakeholder.** Materials developed by other organizations can also be used with a similar purpose.

BY WHOM
NGO's advocacy team

TIMELINE
15 days

BUDGET
INR 10,000

ACTIVITY 2:
Talk to the direct influencers

A. Organize **face-to-face meetings with influencers** to share data collected, enable them to understand the need to take specific action and to request their recommendations to the CMO/DHO. Provide information and support for their meeting with the CMO/DHO or presentation at the district level committee.

OR

B. Arrange a **joint meeting with the influencers and stakeholders** where data is shared, and a platform is provided for discussion. If possible, at the end of the meeting get the CMO/DHO and other members of the district level committee to come in so that the agreed upon points are shared by the participants.

BY WHOM
NGO's advocacy team

TIMELINE
15 days

BUDGET
INR 25,000-50,000

ACTIVITY 3:
Follow up on the meeting

For option A, **follow up with the influencers** to see if they have been able to raise the issue. Support them in doing so.

For option B, meet with the CMO/DHO to ask about progress on agreed upon action points.

BY WHOM
NGO's advocacy team

TIMELINE
1 month

BUDGET
INR 15,000

STEP 6

MONITORING AND MEASURING SUCCESS

Short-term results (outputs) and long-term results (outcomes).

Number of meetings
conducted with influencers

Number of advocacy materials
developed to share with influencers

Number of follow-up meetings
conducted

Increase in number
of site and provider registrations

Dos and **Don'ts**
of an advocacy plan

Do ensure that your objectives meet the SMART criteria.
Don't select overambitious objectives.

Do find out as much as you can about your decision makers and tailor your strategy accordingly.
Don't assume that the decision maker knows as much as you do about abortion – go prepared with fact sheets and advocacy briefs, but don't overdo it.

Do remember that it is okay to change your plan in response to new developments.
Don't Act in isolation. Continue to consult members of your advocacy coalition as you move forward.

Do assess whether the policy environment is favorable and whether the timing is right for the specific objective.
Don't forget to assess the regional and national environment, as it might assist or impede your success.

Do use simple language in your advocacy materials/interactions.
Don't use references like 'unborn baby' or 'death of the fetus'.
Don't use 'mother' and 'pregnant woman' interchangeably. See note on *'Abortion + Communication'* for more information.

#ABORTTHESTIGMA
for safe abortion access & reproductive justice.

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About CREA

Founded in 2000, CREA is a feminist human rights organization based in the global South, and led by Southern feminists, that works at the grassroots, national, regional and international levels. CREA builds feminist leadership, expands sexual and reproductive freedoms and advances human rights of all women, girls and trans people.

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वर्ष 2000 में स्थापित, क्रिया एक नारीवादी मानव अधिकार संस्था है जो दिल्ली, भारत, में स्थित है। क्रिया महिलाओं और लड़कियों को अपने मानव अधिकार की बात कहने, मांग करने और उनको प्राप्त करने के लिए सशक्त करती है। इसके अतिरिक्त, क्रिया मानव अधिकार आंदोलनों और नेटवर्क से जुड़े साथियों के साथ मिलकर, सभी के यौनिक और प्रजनन स्वास्थ्य और अधिकारों की स्वतंत्रता के लिए कार्य करती है। क्रिया सामुदायिक, राष्ट्रीय, प्रादेशिक और अन्तराष्ट्रीय मंचो के माध्यम से सकारात्मक सामाजिक बदलाव के लिए पैरवी करती है और सामाजिक कार्यकर्ताओं को प्रशिक्षण के अवसर प्रदान करती है।

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