ADVOCATING AGAINST SEX SELECTION ISSUES FOR ACCESS TO SAFE ABORTION SERVICES: DOES ADVOCACY WORK?

SAAF
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SAMYAK

Advocating against sex selection issues for access to safe abortion services: Does advocacy work? Assessment of Samyak's work

1. Background:

The current environment in India around provision of abortion services is positive and conducive to efforts being made to increase access to safe services. To increase access to safe services, two amendments were passed to the existing Medical Termination of Pregnancy (MTP) Act of 1972 in 2002-2003. One aimed at liberalizing the process of registration of facilities that could provide abortion and the second permitted medical abortion by certified provider using Mifepristone and Misoprostol for pregnancies up to seven weeks (Government of India 2002, Government of India, 2003a; Government of India, 2003b).

Notwithstanding the two amendments, the situation remains unchanged. Despite campaigns for safe motherhood and attention to safe abortion since the 1960s, morbidity and mortality due to unsafe abortion continues to remain a serious concern contributing to 8-10% of total maternal mortality in the country (Office of the Registrar General of India, 2006). Women continue to obtain abortion services outside registered facilities or from untrained providers due to a range of reasons including limited awareness about legality of abortion or where to access services, concerns about confidentiality, cost and quality of care (Jackson et al 2015; Stillman et al 2014; Barua and Apte 2007, Elul et al 2004; Ganatra 2000). Unfortunately, access is further restricted by sub standard conditions in public health facilities, absence of trained staff or required equipment to provide safe abortion services (Jackson et al 2015; Stillman et al 2014; Sebastian et al 2013; Jejeebhoy et al 2011a, Jejeebhoy et al 2011b).

Sex selective abortion is just one of the many manifestations of gender inequalities in India and, despite the liberal abortion laws controversy over sex-selective abortion is increasing the barriers to many women accessing second trimester abortions in India. Existing patriarchal norms and values are inherently embedded in Indian society resulting in the inferior status of the women and a range of practices that deny women right to equal opportunities in the society. Reasons for son preference or non-preference of girl child have been documented extensively (Jejeebhoy et al 2015; Stillman 2014; Sebastian et al 2013; Mallik 2003). Gender biased sex selection gets further complicated by desire for small families and access to safe technologies to determine the sex of the fetus and continued preference for male children.

Declining and skewed sex ratio (0-6 years) from 927 in 2001 to 918 in 2011 (Office of Registrar General and Census Commissioner, India, 2013) has caused further challenges for women to access safe abortion services. Denying access to safe abortion services compels women from vulnerable and marginalized sections of society to seek abortions from unsafe providers.

Even though a separate law - Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PC&PNDT Act) (Government of India 2003c) - is in place since 1994 (Government of India 1994) that prohibits misuse of technology to determine the sex of the unborn fetus and advertising use of tests – there has been a confusion between MTP Act and the PCPNDT Act. Partly, this is due to major gaps in implementation of PCPNDT Act, the continuing misuse of ultrasound machines to detect the sex of fetus, gender biased sex selection continues (Jejeebhoy et al 2015). By default MTP and women's access to abortion gets targeted and has become the `proxy' to address sex selection.

Though the purposes of the MTP Act and the PCPNDT Act are different, the current public discourse on abortion in India largely revolves around the issue of intersection between the two Acts. Such confusion has quite often resulted in actions and demands to tighten abortion provision resulting in negative fallout and restricting women's access to safe abortion services, particularly for second trimester pregnancies. The punitive measures undertaken by the authorities have scared trained and honest providers who have since stopped providing abortion services for legitimate reasons, particularly in second trimester.

The confusion amongst the general public, media and health care providers about the PCPNDT Act and women's rights to safe abortion services reduces the political space for pro-choice activists to speak out against sex-selective abortion whilst defending the right of a woman to access safe abortion services.

he skewed sex ratio has created an environment of alarm scaring politicians, bureaucrats, policy makers and implementers and forcing them to address gender biased sex selection. What is of concern is the incorrect interpretation of the cause of decline and taking a `magic bullet' approach to addressing gender –based discrimination through laws to regulate technology and not addressing causes of gender discrimination.

The right to abortion in India stands at a crossroads today. There is a need to address not only the confusion between the two Acts but also to address the root cause of sex selection and gender bias abortion including cultural, social and economic causes. This would require sustained involvement of all stakeholders -- NGOs, women's groups, researchers and academicians, professional bodies, lawyers and the media -- with the government being the focal point. An inter-sectoral approach is the need of the hour. At the community level it would entail working with women as well as gate keepers including husbands and mothers in law – as they are the key decision makers for a woman's obstetric needs. Sex selective abortion cannot be looked at in isolation or dealt with as a one-point approach. There is a need to bring different stakeholders including policy makers, women's organizations, and implementing agencies on one platform and bring about a synergy in action.

2. The Project:

The project was envisaged in the context of declining child sex ratio (0-6years) in the state of Maharashtra which has dropped from 913 in 2001 to 894 in 2011. The sex ratio at national level has also dropped from 927 in 2001 to 918 in 2011 (Census of India). The skewed sex ratio alarmed the health officials not only in the state but at national level resulting in stringent measures to implement PCPNDT Act. The resulting fall out has been denial of abortion under legally approved conditions, especially second trimester abortion forcing women to access unsafe and or illegal providers to terminate an unintended pregnancy.

It is within this current environment that Samyak proposed implementing a programme titled ` Advocating against Sex Selection issues and for Access to Safe Abortion Services' in 2014. This project aims to build effective policy and public advocacy for access to safe abortion services by reducing the confusion between the MTP Act and the PCPNDT Act through research and engaging with public health system and private health care providers.

Two regions were purposively selected– Western Maharashtra and Marathwada. Both regions' sex ratio is below the national average , (ranging between 800-900 girls per thousand boys) and cases of denial of abortion services to women, especially in second trimester have been recorded. Additionally Samyak had a relationship with civil society organizations working in both the regions.

In each region five districts were purposively identified. In Western Maharashtra districts identified incldued Kolhapur, Pune, Sangli, Satara and Sholapur. In Marathwada, these were Aurangabad, Beed, Latur, Nanded and Usmanabad.

This report aims to assess this project and the extent to which it succeeded in sensitizing service providers as well as appropriate authorities responsible for monitoring and implementing the PCPNDT Act. It also aims to assess the project's advocacy initiatives and campaigns aimed to strengthen civil society groups and raise public awareness around abortion related issues in Maharashtra.

3. Methodology:

The objective of the report was to critically evaluate the programme implemented by Samyak.

Documents including proposal, donor reports and minutes of State Advisory Group (SAG) and Regional Advisory Group (RAG) meetings, workshop and meeting reports were reviewed.

In addition, key members of Samyak were interviewed to get an in-depth understanding of the rationale, processes undertaken and challenges faced in implementing the program. To assess impact, in depth interviews were conducted with Samyak staff responsible for implementing the project on the ground (N= 3). To understand the processes undertaken to operationalise the project and challenges faced by the RAG, focus group discussions

and in depth interviews were conducted with select RAG members, members of PCPNDT Committee in both regions, the State Advisory Group established for the purpose of this project and one resource person (N=8). An interview guide was prepared to better understand the views and experiences of these selected individuals.

Informed consent was taken from all respondents prior to starting the interview. The consent form described in detail the objective of the interview and benefits and risks as well as voluntariness of their participation. They were assured about confidentiality of the interview and were informed that they could end the interview at any time of their choice or not answer any questions that made them uncomfortable.

The interviews were taped only if the respondent agreed. Tapes were then transcribed in English.

4. Programme description:

This was an advocacy project aimed to ensure that women in need of abortion services from marginalized communities in the project area are not denied services by public or private abortion providers.

The activities were aimed at creating trust among different stakeholders – private and public medical practitioners, officials from health and family welfare and women and child development departments

of the government as well as officials responsible for implementing and monitoring the PCPNDT Act. In addition, it also aimed to work with media personnel in the selected districts to inform them about the differences in the MTP Act and the PCPNDT Act, impact of negative messaging and how actions taken by the government result in denial of services to women in need of terminating an unintended pregnancy, especially second trimester abortions.

Two objectives were outlines in the proposal:

Objective 1: Strengthen advocacy initiatives, through creating the platforms where civil society can come together to advocate for safe abortion services for poor and marginalised women in Maharashtra.

Objective 2: Improve the perceptions and attitudes of health care providers and PCPNDT implementers trained by SAMYAK to one of pro-choice in 10 districts of two regions of Maharashtra, within 3 years of the project.

5. Implementing the program:

This section describes key activities undertaken by Samyak under this project. One must bear in mind that a project of this nature is an ambitious one fraught with challenges at every step of the way. Key activities are described and analysed in terms of how each activity helped in moving the project forward.

5.1 Activities undertaken to fulfill Objective 1:

The key component of this project was to advocate for safe abortion services for poor and marginalised women in Maharashtra. A range of activities were undertaken towards fulfilling this.

5.1.1 State Advisory Group (SAG) was formed to guide the process. Members included medical health professionals as well as NGO activists working at the grassroots level. Senior level practitioners with experience in working with the government machinery were tasked with providing guidance on specific advocacy steps to be taken. Members met regularly to ensure smooth operation of the programme and provide guidance to Samyak in dealing with challenges. SAG has been the mainstay of the programme and has provided valuable guidance, mid-term correction and on-going mentoring support. SAG met three times during the course of the project. At each meeting, Samyak shared the progress made, challenges faced and steps needed to overcome the challenges.

Some of the members took on activities under the project in their respective districts also. For example, they were facilitators and trainers in the training of private providers and media personnel; they were the front face in dialogues with obstetricians and gynaecologists on issues around provision of safe abortion services to women and girls and providing them with specific information on legal requirements of the MTP Act and the PCPNDT Act. They engaged with appropriate authorities including civil surgeons and PCPNDT officials and talked about the two Acts and how strict implementation of PCPNDT Act resulted in denial of services.

At each meeting, advocacy strategies were discussed and key action points were proposed for these activities. The members shared their views on MTP Act and the PCPNDT Act and were unanimous in their view that there is an urgent need to take a position for safe abortion rather than sex selective abortion. They argued that while PCPNDT Act is essential, the appropriate authorities are often main perpetrators of confusion because of lack of clarity on kind of documentation required and hence the harassment of providers. To this end, it was suggested that the Guidance brought out by the Ministry of Health and Family Welfare entitled "Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection" be translated in Marathi.

SAG also suggested bringing safe abortion within the context of reducing maternal mortality, which is high on government's agenda. They also suggested that issues around safe abortion and denial of abortion services should be highlighted and talked about at every meeting attended by SAG members.

Appraisal:

Composition of SAG ensured equal representation of civil society organizations as well as medical practitioners. This helped keep a balanced view of the processes at work and also helped in advocating with the senior state level officials in the Ministry of Health and Family Welfare.

Dialogues with medical practitioners helped in clarifying legal requirements and the obstetricians and gynecologists felt confident in dealing with the authorities when the latter required paperwork that was not legally required to be submitted. As reported by a SAG member:

"The gynaecologists say that because of him (SAG member) and meetings organized by Samyak, there is peace and we can now tell the authorities that we will show you only the papers that are legally required"

Translation of the Government guidance entitled "Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection" in Marathi has been a step towards bringing the key differences in the two Acts to the providers as well as health activists in the state in local language. Having the Government logo on the translated Guidance gives it official recognition and indicates that the state government also supports this.

SAG members have advocated for access to safe abortion services at every available forum. Being service providers themselves, SAG members are affiliated with various professional bodies including FOGSI and used various platforms to talk about safe abortion and sex selective abortion as well as the need to ensure that no woman is denied abortion. They have also guided Samyak in the content of training workshops for private providers and media.

5.1.2 Regional Advocacy Group (RAG) was the key for implementing the advocacy activities. Before the project started, consultations were organized in each region – three district wise consultations in Western Maharashtra and one in Marathwada. The idea was to bring together CSOs and individuals and orient them about the project. At the end of the orientation, Samyak identified members for RAG who could take on work in their respective regions.

RAG was formed in Western Maharashtra and Marathwada region comprising two representatives of civil society and two of private medical practitioners (5 districts in each region) totaling to 12 members in each RAG. Their role was to initiate a dialogue between women's rights groups and healthcare providers, especially on right to safe abortion in second trimester. RAG was also required to monitor the project activities and service delivery by both public and private service providers ensuring access to safe abortion service for women who want to terminate an unintended pregnancy.

Once RAG members were on board, an orientation workshop was organized aimed to inform them about the legality of abortion, gender and equity, issues around sex selection and abortion, differences between the MTP Act and the PCPNDT Act.

RAG in each region met once every four months to develop specific advocacy strategy as well as to share their experiences and lessons learnt on the field while implementing the project activities.

Appraisal:

RAG members have played a crucial role in implementing the project – as will be evident from the description below. RAG did not include private providers, despite attempts made by the team because these providers were not willing to give the amount of time required. So the team consisted largely of activists and CSO and NGO representatives in both regions.

Some of the members had attended Safe Abortion, Gender and Rights Institute organized by Crea and Common Health. This helped participants gain an in depth understanding on safe abortion as a gender and Sexual and Reproductive Health and Rights (SRHR) issue, and will be able to situate sex selection as an issue of gender discrimination and not create barriers for access to safe abortions. This was reinforced by the orientation organized by Samyak for RAG members. At the end of the orientation, RAG members were motivated enough to undertake the proposed activities in their respective areas of work. Members also changed their views about sex selection abortion and understood how negative depiction of sex selection in media and posters impacts access to safe abortion services for women. One RAG member said:

" After joining Samyak's programme, I understood how media uses wrong words and influences people. For example, poster of a knife through a woman's stomach and talking about female feticide. The difference between abortion and sex selective abortion was made clear to me once I joined as RAG member. I realized that women need abortion services and the two Acts are different".

Independent actions taken by RAG members in both regions have brought the issue of sex selection and abortion to the forefront. For example, members have helped authorities in exposing illegal sex selective abortions; some have been working on the use of appropriate language while talking about sex selection. Further, some members facilitated access to abortion to women and unmarried young girls who were denied abortion services by providers.

As a result of the continuous dialogue and conversation with government and providers, RAG members were not only recognized as those who work on implementation of PCPNDT Act but also on safe abortion. Members shared their phone numbers and were available at any time to the provider who was not sure on action needed and resolve issues around provision of abortion services to women who were legally entitled.

Specific activities undertaken by SAG, RAG and Samyak team:

Ownership of the project and its activities by members of RAG was evident in a series of activities that were not part of the planned project activities. These activities were initiated by Samyak and SAG and RAG members to advocate for safe abortion services. Some of the key activities undertaken are described below:

5.1.3 Dialogues with stakeholders through regional advocacy efforts: The project aimed to create a critical mass in support of safe abortion. The project proposed to create a strong network of champions in the state of Maharashtra to advocate for access to safe abortion services. To this end one on one dialogues were proposed with a range of stakeholders including private doctors and appropriate authorities. The key message was *"not to criticize but initiate a dialogue of trust between authorities, NGOs and medical practitioners".* The project activities aimed to take everyone together in the process of making safe abortion available.

Samyak team undertook a series of dialogues with a range of stakeholders, including government authorities, public and private medical practitioners, appropriate authorities of PCPNDT committees, media, civil society organizations and women's group that work on issues around gender biased sex selection and abortion. The dialogues aimed to create awareness about women's right to terminate an unintended pregnancy within the laws of the country, the differences between the MTP act and the PCPNDT Act and how denial of legal abortion leads to unsafe abortion and related maternal morbidity and mortality. It also focused on how messaging around anti sex selection abortion and reporting in media impacts women's access to legal abortion.

In an attempt to build a wide support, RAG members submitted request letters to the respective District Collectors demanding an increase in safe abortion services at public facilities, displaying lists of centres authorised to provide abortion services and information on Marjee and the hotline number.

Public Accounts Committee (PAC) proposed to make sex selection mandatory and track women whose ultrasound indicates a girl child. This step was aimed to enable them to increase the number of girls. RAG members submitted a letter to the Chief Minister of Maharashtra and State Health and Family

Welfare minister opposing this move. Members are now advocating with government to take action according to the demands. Specifically, to assure access to safe abortion services to women.

The team used every opportunity to talk about the project and emphasized the need to enable women to access safe abortion. They also talked about Marjee hotline set up by Samyak in 2013 that provided information on safe abortion and family planning. They also distributed Marjee Newsletter and pamphlets.

A total of 556 dialogues were held during the project period. Additionally, through the dialogues, the project engaged with 44 civil society groups who are now actively working with government and a part of various decision-making forums of government like members of PCPNDT advisory committee and various committees at village level.

5.1.4 State level dissemination meeting: In February 2016 this meeting was organized inviting representatives from public health system, state chapters of private medical practitioners' associations, women's rights groups and health rights groups. The idea was to influence state policies, particularly those related to implementation of PCPNDT Act. A total of 35 participants attended this two days meeting.

The deliberations highlighted the need for clear guidance on safe abortion services, particularly second trimester abortion to ensure that no one in need is denied a safe and legal abortion. Strategies were developed to work with the government, service providers, media as well as the community aimed to increase awareness about legality of abortion, changing the messages around sex selection and abortion, setting up systems to track illegal abortions, sensitizing media personnel to raise issues of safe abortion and so on.

5.1.5 Exposure visits: In addition, visits were undertaken for RAG members with the aim to expose them to other groups working on sexual and reproductive health rights of women in Maharashtra (TATHAPI, Pune and MASUM, Pune) and North India (SAMA, Delhi and SUTRA, Himachal Pradesh). These visits provided an opportunity for RAG members to observe and learn how ideas are translated into advocacy action and reflect and sharpen on their own strategies. These visits also provided an opportunity to RAG members to interact informally with each other.

Appraisal:

RAG members appreciated the opportunity provided to them through the exposure visits to other organisations working on issues around sexual and reproductive health. As mentioned by a RAG member:

"I learnt a lot – planning, team work, style of working. Sometimes, we look at targets that need to be achieved and lose out on quality of work. I realised that quality is also very important"

"Meeting people in these organisations helped me understand that a lot is being done in the field. I decided that I can work on this issue with a lot of energy as this is a daily issue for women."

5.1.6 Communication campaigns: Recognizing the need for communication materials that do not give negative information on abortion, the project developed and disseminated posters, leaflets through existing systems. PRI members, associations of private medical practitioners and civil society organizations and NGOs working in the area were involved in dissemination. All materials were developed after getting approval from the State Ministry of Health to ensure their ownership as well as to ensure that the materials reach to the remotest areas through the public channels. For example, Samyak and its team developed a pocket reader on safe abortion and sex selection in Marathi which provides information on safe abortion and the difference between safe abortion and sex selection. A total of 3000 copies were distributed through various channels.

Marjee is a hotline by Samyak that provides information on safe abortion, services available and family planning counseling those who access the hotline. Marjee newsletter documents stories and case studies of women who have been denied abortion services or experiences from the ground. Through the project, Marjee, newsletters were distributed to private medical practitioners, NGOs,

Medical Institutes, women studies centres, nursing colleges, media representatives and government authorities.

The team distributed more than 8000 hotline posters and abortion information booklets in project area. RAG and SAG members carried copies of pocket reader and Marjee hotline posters with them wherever they went, including meetings and workshops where they were invited as speakers or participants.

Translated version of Central Government's guidance on 'Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection' was used for advocacy on access to safe abortion.

A video documentary film was also made in Marathi with English subtitles capturing experiences of women who were refused abortion services, opinions of health care providers and key stakeholders. The first cut of the film is ready as of now.

5.1.7 Working with media: Print and electronic media are powerful mediums to convey messages to the wider public. Recognising their important role, the project aimed to conduct sensitization workshops addressing a series of issues including gender inequalities, women's health rights and the need for access to safe abortions specifically focusing on issues of separating sex selection from access to safe abortions. These workshops also aimed to separate out issues of abortion from sex selective abortion and encourage participants to use terms like pro-choice rather than pro-life as the former highlights a woman's choice and the latter restricts access to safe abortion. Limiting use of negative words and images that create an image of abortion being equal to a murder were also addressed.

Through these workshops, a total of 130 electronic and print media representatives were trained.

As a direct outcome, local newspapers and television channels carried detailed stories on need for access to safe abortion and highlighted the right of women to access safe and legal abortion. The articles talked key findings of the research undertaken by Samyak as well as information on project activities. A total of 29 articles came out in local newspapers and 5 on line publications were recorded.

Media also covered news on gram sabha resolutions that were passed as a result of advocacy campaign by RAG memebrs

Appraisal:

Advocacy workshops with media personnel have shown some positive results. Samyak team realized that media persons do not have in-depth understanding abortion and they are unable to distinguish between what is legally permitted abortion and what is sex selective abortion which is not legal. They also do not know about the MTP Act and PCPNDT Act and how they serve different purposes. The discussions with them were very intense as they were against any abortion. Perseverance and patience on part of Samyak resulted in changes in reporting language where they sued right based language and changes in use of words for sex selective abortion and legal abortion.

However, while there was a spate of articles after the training, slowly the interest faded away and journalists stopped writing about these issues. What is clear is that even if a journalist wants to write on issues around abortion, it is the editor who makes the final decision on what will be printed. So it is important to bring senior editors in for training to facilitate positive articles on abortion related issues.

There are *"a few journalists who are in continuous touch with Samyak team and who consistently write occasional article on abortion".*

Media personnel, service providers, CSOs, NGOs found the communication materials developed by Samyak very useful. As indicated by a CSO representative:

"Newsletters and brochures explain abortion related issues in clear and simple language. This is a good tool and we use it during trainings and workshops where we need to talk about sex selective abortion and safe abortion."

5.1.8 Advocacy at grassroots level done by Marathwada RAG members:

RAG members from Marathwada took lead in reaching out to representatives of local self governance. The project did not include a component of working at the grassroots level. However, the team realized that unless this is done, access to safe abortion may not be possible.

At the grassroots level, RAG members organized massive outreach drives to involve community health workers (ASHA-Accredited Social Health Activists) appointed under public health services and grassroots workers of Women and Child Development department. A series of dialogues were organized with this cadre of service providers as well as the Panchayati Raj Institution (PRI) members, women and adolescent girls in the community and NGOs working in the area. Additionally, through advocacy, they were able to bring safe abortion within the rural development planning process ensuring that abortion is included in micro planning.

RAG members talked about abortion at self help group meetings and explained the differences between sex selective abortion and legal abortion. As a result, some groups were successful in ensuring that abortion is talked about in government agenda.

They also talked about abortion at all meetings they went to at the community level and shared the MTP and PCPNDT Guidelines.

" We talk about abortion and sex selective abortion at all meetings, we share the Marjee poster and newsletter. ASHA and ANM have said that they found the materials very useful"

The project reached about 108 villages during a programme organized by the team entitled Apala gav apla vikas program.

The highlight is the involvement of Panchayati Raj Institution (PRI) members. Orientation meetings were organized with PRI members. RAG members worked with PRI members and talked about the negative impact of sex selective abortions. At gram sabha (village level meetings) the RAG members talked about status of women, violence they face and that they have a right over their body. Case studies of women who were denied abortions services and what happened to them were shared.

As an outcome, in partnership with the PRI members demands were listed out and shared with authorities at all levels – tehsil, block and district. The demands included i) make media and public aware that abortion is legal; ii) make available a list of certified providers and display that at all public facilities; iii) District Level Committee members list to be displayed and ensure that they are functional; iv) Look at management and administration of civil hospital including availability of a separate ward for women who come for accessing abortion services, number of beds, availability of equipment and supplies for providing abortion services.

A total of 117 Gram Sabha resolutions were passed indicating their stand against sex selective abortion and support for access to safe and legal abortion for women. For example, one resolution read as:

"We resolve that we are against sex determination but we also demand access to safe abortion services to women in need of abortion and no woman should be denied abortion service in public health care system".

In addition, through continuous conversation with PRI members and the community, the project was successful in bringing a demand for allocation of fund for abortion services in the micro-planning through the 14th Finance Commission.

5.2 Voices from the ground: Findings from interviews with SAG and RAG members and resource person

Review of the minutes of three SAG meetings indicates the high level of involvement of the members in fulfilling the objectives of the project. SAG members have engaged proactively with government authorities around the issue of implementation of PCPNDT Act. While they recognize the importance of steps taken by the state government in implementing the PCPNDT Act strictly, they have voiced their concerns and have urged the state government that it should not only focus on strict implementation of PCPNDT Act, but also work with a comprehensive approach to protect reproductive rights of women.

Conversation with SAG and RAG members reiterated the involvement in and the importance of the project. Reports and minutes of the meetings and workshops indicate that members of SAG and RAG in both regions were proactive and were involved in advocating for safe abortion with the key stakeholders as well as the community at large. All RAG members have worked together to achieve the objectives of the project. This was reiterated by participants of Focus Group Discussions (FGD) with members of Marathwada RAG and interviews with Western Maharashtra RAG members.

"We were like a big family. We worked together, collaborated with each other. We discussed our problems and challenges with each other. And found solutions. We have a What's App group and share everything that we do in that."

Meetings with a range of stakeholders including private medical practitioners and appropriate authorities provided an opportunity for all stakeholders to come together on a common platform and air their grievances and problems. For example, the project team would talk about the ground situation on abortion service provision and the legal requirements under PCPNDT Act. Obstetrician and gynaecologists present in the meetings shared their grievances on how they were being harassed by authorities who asked for MTP register and would even sign that they had seen the register. It appears that even the authorities were not aware that they cannot demand the MTP register without a letter from civil surgeon nor are they supposed to sign off. These may be small administrative matters, but they have a deep impact on practitioners willingness to provide abortion services. The feeling that "why should I get involved in all this jhanjhat (problem). I will send the woman who comes for abortion to the government hospital". Steps taken by Samyak and project team have gone a long way in resolving these issues. As reported by SAG and RAG members, the relationship with providers and authorities is so strong that they now call up SAG or RAG members asking them to guide them in certain difficult issues that they face in the course of their work. For example, District Collector of one district asked project members to organize a meeting with FOGSI, doctors, District Reader to talk about issues around PCPNDT Act and requirements. The project member initiated a dialogue with all stakeholders present, and then shared the law with them. This helped clear the confusion about what is needed and what can the authorities legally ask the doctors to produce on demand. Project members are also asked to help practitioners in getting their facility registration done "because of the good relations they have with authorities". The project team in turn tells them that since they are helping them (in getting their registration), they should not deny abortion to any woman/girl.

To quote a SAG member: *"Till now it has been that the gynecologists think NGOs and authorities are enemies while the authorities this NGOs and gynecologists are enemies. We have been able to bridge this gap by talking to all stakeholders and explaining that sex selective abortion and legal abortion are two different issues and should not be merged."*

Meetings provided an opportunity to air grievances and problems. The authorities also realized that Samyak and the team do not have a "hidden agenda". As articulated by a SAG member:

"The authorities realized that the end point for Samyak team and them is the same – women who need access to safe abortion services. They say that while we keep telling the providers to keep good records they do not do so but when you tell them, they follow. In this sense, the project has been 100% successful. The authorities now ask Samyak members to tell the providers to display registration and certification and maintain records. On the other hand, practitioners ask Samyak to talk to the authorities about the difficulties they face because of the harassment from authorities

suspecting everyone for providing sex selective abortion."

A RAG member said: *"It is important to involve the Civil Surgeon because if he agrees with our view point, then no one can refuse him and all doctors will come on board. There can be a healthy discussion when everyone is on the same page".*

The project team realized the political and police pressure that the practitioners face. The meetings and workshops helped explain the differences in the two Acts (MTP and PCPNDT) and the members could talk to them with confidence about the need to work together for women to bring about a positive change in their physical and mental health outcomes.

"Doctors are more positive towards us because when we were working on implementation of PCPNDT Act, we were negative in our approach. But through meetings and dialogues we talked about differences in the two Acts with police and political leaders as well as authorities".

Joint meetings started a trust building process among civil society organizations and women's groups who mainly worked on sex selective abortion on one hand and government officials and private medical practitioners on the other.

"Talking about sex selective abortion is not easy – it is scary. But after being involved in the project, we managed to bring everyone together – we got public and private doctors, civil surgeon, district collector, media – to talk about this".

Media was an equal partner in taking messages around safe abortion to the people. One member said:

"There are two viewpoints – one who have similar ideology like us and another who are totally on the opposite end and are not concerned about this issue at all. The trick is to reach out to the former group and involve them by making them more aware of the legal and rights issues around safe abortion".

Sensitization workshops also highlighted how words can turn the views about abortion. For example, "Use garbh samapan instead of garbhpaat –the former is a positive take on abortion. These words have a deep religious, socio-cultural and political roots and hence one needs to recognize this and use appropriate words that would not impinge on women's right to safe and legal abortion".

Workshops sensitized them about careful use of words that would not make abortion a negative. This group realized that Samyak's work is based on ground reality and are not politically motivated. This resulted in Samyak team reaching out to media at the state and district level, including Lokmat, Divya Marathi, Sakal, Prajapatra, Tarun Bharat, Punya Nagri to mention a few.

SAG and RAG members "owned" the project activities. Some of the activities they undertook were not a part of the proposed activities in the proposal. However, these activities go a long way in ensuring that the issue does not get lost at the end of the project. For example, involving PRI members, ANM and ASHA workers is important as they are the gatekeepers of decisions made by women, especially regarding their sexual and reproductive outcomes. If this group is convinced, women will find it easier to negotiate the decision on terminating unintended pregnancies. That Gram Sabha resolutions were passed indicating their agreement for safe abortion and their voice against sex selection is an indicator of the success of dialogues of RAG members with PRI members and the community at large.

"We talked about abortion with women and men and helped them understand that it is not a sin (paap). Once the community is prepared, we talk about the resolution in Mahila Sabha, which is held a day before Gram Sabha….this is because women cannot talk in front of the men of the village. If this preparation is done, the resolution is easy to pass in the Gram Sabha as there is no opposition or argument at that time. There is no fund required for this".

" We included ASHA, ANM, ANM Supervisors, AWW, in the training because they are the ones women go to for solving problems"

In building a critical mass of support, the project also included women's health rights activists and groups working around issues of sex selection and abortion. Some of the activists were also members of RAG. As expressed by one of the RAG members:

"I have worked on issues around PCPNDT and have been negative towards doctors because we thought that all doctors provide sex selective abortion. After becoming a part of this project, I realized that not all doctors are bad and that abortion is not bad."

"It (the project) changed my mind set and thinking. Earlier I thought all abortions were bad but now I know better".

Appraisal: So does advocacy work?

As evident from the description above, advocacy works. The project had in place mechanisms to ensure that proposed activities took place as scheduled and followed up if there was a delay. Talking about abortion is not a one off thing. There are many layers to this and one needs to work with each layer to ensure that safe abortion is accessible and available to all women.

Conversations with SAG and RAG members provided interesting insights about levels of achievement of the project though advocacy. Respondents were unanimous in their view that a project of this nature has started a process of change among various stakeholders they reached out to. An indicators of success is that the civil surgeons call upon them for advise on complicated cases, doctors ask them for guidance on where to send a woman who has come seeking an abortion if they do not have the required authorization, they ask the RAG members to come and sign off papers in case of abortion provided in difficult conditions (unmarried girls, rape cases, second trimester abortion). As articulated by a RAG member:

" 100% - trust has been built among various stakeholders. Samyak's request for putting up Marjee posters and hotline numbers has been approved by the authorities, civil surgeons have asked Samyak to organize meetings with service providers to talk about MTP Act and PCPNDT Act".

Another respondent said: "Not all doctors are villains. (Through this project) we were able to create a space where we could talk about ensuring that woman is the centre of focus. We learnt to respect each other and recognized that this is a multidimensional issue (and we need to work together)".

Advocacy and training at block and district level has resulted in better understanding of issues around abortion and sex selective abortion. Women in need of abortion now know where to go as lists of authorized abortion providing centers has been put up on websites. This was made possible through conversations undertaken by RAG and SAG. Advocacy was undertaken in multiple ways – workshops, conversations, talking about the issues at every opportunity. It appears that no opportunity was lost to talk about the project and its proposed outcomes. Hence, this style of advocacy does not need a lot funding – it can be done as a part of on-going or existing programmes of an organization or professional body.

The demand letter submitted to District Collectors and others and that it was followed up in some blocks is a clear indicator of advocacy behind submission of the demand letter. As reported by Samyak staff:

" The District Collector in Satara responded in 15 days and ordered all responsible persons to look at the demands and take necessary action. Similar response was received from Aurangabad, Beed, Kolhapur".

RAG members used their rapport with the community and could reach out to them and talk to them about abortion and sex selective abortion. This was significant as these members were trusted not only by the communities they worked in but also appropriate authorities in the government.

IEC materials including Marjee posters and hotline were distributed widely and informed the women and the community at large about where to go for safe abortion. Number of calls at the Hotline increased during the project period.

Sustained advocacy appears to be the key word. One off meeting or conversation does not result in any change. Rather, continuous conversations, meetings, sensitization workshops are key in making long term changes.

5.3 Activities undertaken under Objective 2:

Objective 2 aimed to improve the perceptions and attitudes of health care providers and PCPNDT implementers trained by SAMYAK to one of pro-choice. A key component was also undertaking research and publish articles in peer reviewed journals.

Specific activities undertaken under this objective:

5.3.1 Training of private healthcare providers and implementers of PCPNDT Act:

To this end, the proposal indicated workshops with a range of stakeholders including government authorities, doctors in private and public sectors (ObGyns, Ayurved, Hoemopath doctors) and nurses in Marathwada and Western Maharashtra.

The training included ObGyns, representatives from CSOs and NGOs and doctors from public sector. The key agenda was to sensitize service providers to look at abortion as a *"gender and rights issue with the woman at the center of the dialogue on safe and unsafe abortion".*

The training was proposed in two phases.

First phase aimed to clarify the legality of abortion and how this is distinct from sex selective abortion. Sessions included presentation and discussion on understanding unintended pregnancies and its impact, what is sex ratio, implementation of PCPNDT Act and its implications. They were also informed about maternal morbidity and mortality caused by unsafe abortion.

The workshop helped in clarifying the biases and patriarchal socio cultural norms that govern our attitudes towards women and how these impact their health care seeking behavior. Women are a part of the society and there is a need to understand why even they want a son and hence the need to change the existing norms was reinforced. As mentioned in one of the trainings: *"We need to understand that why that woman wants a boy and does not want a girl is important!"*

The workshop also used data on sex ratio and how this is gender based discrimination and should not be used against abortion provision.

Private providers present in the training shared various conditions under which they deny abortion – gestation over 20 weeks, unmarried girls, woman with 2 girls, and pressure from appropriate authorities to prove that an abortion was conducted due to contraceptive failure. The discussion helped the participants understand the differences between the MTP Act and the PCPNDT Act and how they need to stand together against authorities who impede services by above the law questions.

It also reiterated the need to work together with appropriate authorities to ensure legal abortion was not denied to women. The participants came up with a number of suggestions in the group work that included suggestions to amend the current PCPNDT Act as well as suggestions to authorities while implementing the Act.

The second phase reinforced the concepts of abortion as a right and the need for collective action. In this phase, the participants arrived at specific set of next steps: a) use of positive language while talking about abortion; b) bring providers and appropriate authorities on the same page and steps needed to ensure women's safety; c) ensure that extra legal practices followed by authorities are stopped.

Training was for about four hours and was mainly conducted on weekend evening or Sunday mornings to suit the convenience of service providers. Experts from the field, including ob/gyns and civil surgeons were invited to conduct sessions in the workshops. Training methodology in both phases was participatory and included presentations, group work and interactions. As most of the training manuals and materials are available in English, though proposed , no training materials were translated in Marathi. As mentioned earlier, Central Government's guidance on 'Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection' and the MTP Act were translated for ease in reading and understanding.

Ten workshops were organized in each phase totaling to 20 during the project period.

A total of750 participants attended these workshops (402 in Marathwada and 348 in Western Maharashtra). A special focus was on private providers who may deny abortion services to women even though they were within the law. These dialogues aimed at clarifying myths and misconceptions around provision of legal abortion and sex selective abortion.

The project reached out to a total of 638 private medical practitioners, 15 medical colleges teachers, 52 Government Authorities including Civil Surgeon, Medical Superintendents, Medical officers and MoH and 8 legal Advisors of PCPNDT Act

5.3.2 Research:

Samyak proposed to undertake research to better understand the attitudes of service providers. This was a follow up of an earlier qualitative study undertaken by Samyak in Western Maharashtra to understand the experiences of private medical practitioners with PCPNDT Act implementation authorities and the way it has impacted their abortion services. The pilot study (N= 19 private medical practitioners) revealed that growing inaccessibility of safe abortion services, especially during second trimester is linked with the fear of private medical practitioners regarding PCPNDT machinery. The objectives were to explore the reasons for denial of abortion services to women by medical practitioners, especially in second trimester and to better understand the knowledge, perceptions and attitudes of a range of healthcare providers.

Using the same methodology, this study was replicated in five districts of Marathwada region with private medical practitioners (N=20). The findings of this part are quite similar to the previous study in Western Maharashtra. This study also reveals that the fear related to the implementation of PCPNDT Act was one of the important reasons given by private medical practitioners to deny abortion services to women and therefore refusal to provide abortion services in second trimester is major concern.

Another study was undertaken in Western Maharashtra with AYUSH doctors, ASHA, ANM and Medical Officers. The objectives were to better understand their perceptions of about access to safe abortion and sex selective abortion, to explore their knowledge and opinions about MTP Act and proposed amendments and know about their experiences regarding implementation of MTP and PCPNDT Acts. The sample included focus group discussions with doctors trained in Indian System of Medicine (ISM) mainly Ayurveda and Homeopath doctors (N=10); Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwife (ANM) (N=10); medical officers at Primary Health Centre and Medical Superintendent at Rural Hospitals (N= 5 each)

The study methodology was developed in consultation withSAMYAK team,. Asia Safe Abortion Partnership (ASAP) and research consultants hired for this work have provided guidance and assistance at every step.

There were unforeseen delays in fielding the study. Many respondents, largely from the public sector refused to participate in the study even though they were assured of anonymity and confidentiality. Thus, the sample had to reorganised to include private medical practitioners in different districts. Data collection for both the studies is completed and data analysis is almost completed.

Assessment of Objective 2:

Strategy used by Samyak to ensure participation in the workshops depended on the environment of the district. Letters of invitation were routed through FOGSI in districts where FOGSI had a powerful presence. In other districts, Samyak and SAG members approached appropriate authorities and requested them to send out the letters. Where possible, Civil Surgeon was invited as the chief guest, thereby getting the stamp of approval from the appropriate authorities.

While this worked for private practitioners, attendance of public sector, including representatives from Women and Child Development was poor.

There were examples of putting the learning into practice. For example, Aurangabad and Sholapur associations of gynaecologists decided to issue a notice to stop the use of word 'female foeticide' and displaying pro-abortion messages in their hospital.

There were more participants in the second phase of training because the word had been spread by those who attended the first workshop. The participants talked to their peers about the usefulness of the training and how this benefitted them in their work. Samyak accommodated this increased demand from private practitioners. But this meant that the agenda for second phase of training was changed – instead of moving on from the first phase and talking about deeper engagement, the agenda was similar to the first ohase in order to bring all participants to the same level of learning.

Review of pre and post assessment evaluation indicates that the workshops with private providers changed their thinking to an extent. For example, many more participants agreed that a decision to abort an unintended pregnancy should be made by the woman and not the doctor, that permission of the husband/partner is not necessary if the abortion is legal and knowledge about the role of PCPNDT Act increased. On the other hand, there was not a significant change in notions of providing abortion services to unmarried girls or restricting abortions can help address problems of sex ratio.

However, this evaluation must be seen with caution as the data analysis of post workshop included participants who had not attended the first workshop. Samyak staff may need to clean up this data to measure the actual changes in perceptions and knowledge.

As indicated by a respondent: *"There were many 'aha' moments in the training. Some participants said that no one has talked to them about abortion from this perspective and these issues have not be talked about....They (participants) were grateful for these topics".*

However, it is difficult to bring about attitudinal changes or changes in their practice. The situation in small and remote towns is that the private practitioner is faced with many challenges – they have their own biases and stigma about abortion, they have to be on the right side of the professional association like FOGSI and follow their directives, they have to be careful about not coming under the scanner for PCPNDT or POCSO. They also face the fall out of media reports of female foetuses found – and while these actions may not be done by legal providers, media does not distinguish between them and others. This is the reality on the ground and hence changes in practice will require sustained work at all levels and with all stakeholders.

A major drawback of these workshops was that the doctors from public sector could not be included in the training even though the proposal indicated that. At some workshops, the chief guest was the civil surgeon and at some laces officials responsible for implementation of PCPNDT Act were there, these were few and far between. Focus was more on private practitioners. Reasons for this could be lack of time or not receiving direct orders from the higher authorities. As indicated by a SAG member:

"The differences between the two Acts (MTP and PCPNDT Acts) are still not clear. A lot needs to be done for this. More workshops are required with appropriate authorities including providers, FOGSI, radiologists".

5.4. VOICES OF IMPLEMENTORS:

Samyak staff responsible for the project provided insights into the day to day functioning of the project and the extent to which they perceived the success of the project.

Once the two regions were identified, formation of RAG was done by organizing regional level consultations. Initially, one consultation per region was proposed but finally, one consultation was done in Marathwada and three in Western Maharashtra. This was deemed necessary because of the long distances people would have to travel and time constraints of the invited participants. At the end of these consultations, RAG members were identified. Though part of the proposal, no private provider was in RAG because "they did not have the time required for undertaking these activities". Regular meetings with RAG and telephonic follow up have been a key to smooth functioning of the project. Priority setting of the agenda was done by RAG members. Samyak would set out a broad agenda and the members would then decide what a priority for their local area is. This was a democratic way to implement activities and ensured ownership of the project. As mentioned by a staff "The idea was to build an urge in RAG members to move ahead on their own".

Samyak staff was also responsible for ensuring that letters of invitation went out for the workshops either through FOGSI or appropriate authorities. This required coordination with RAG member of the particular district and follow up about the status. If needed, Samyak staff would pitch in and help in getting the letters to the invited participants.

The environment has changed, albeit not totally. The environment is ready for a dialogue on abortion with a range of stakeholders including civil society, civil surgeons, appropriate authorities, providers and the media. "Through this project, the debate around abortion has reached out to many people. There is energy and a group that is willing to work on it".

The staff was positive in their assessment of the impact of the programme in that it has created a team of champions on safe abortion who talk about legal abortion and sex selective abortion. "RAG members are called upon by providers and asked for their advice on what to do if a woman comes seeking abortion and the provider is not sure on what action to take". This is an indicator of the levels of trust built between service providers and RAG members. NGOs were considered enemies by providers, particularly private providers as the NGOs worked on issues around sex selective abortion. As indicated by a staff "This (changing from enemy to guide) was an interesting process because nothing like this had been done to date. We got good insights into processes and inter-linkages of abortion with other issues and Acts faced by providers. For example, we understood their perspective of the impact of MTP + PCPNDT + POCSO Acts – all of which have an implication on the provider".

Samyak team's dedication and ownership of the project was appreciated by SAG and RAG members. Though small, the team worked together with dedication and ownership of the project.

5.5. Challenges

The project was undertaken at a time when the dialogue around sex selective abortions was at a peak. The appropriate authorities were on a "mission" to improve the sex ratio in the state. The anti-choice activities slowed down the progress and presented situations that needed proactive action from the team. For example, private medical provider's pro-life values "Women who seek abortion should be punished" or "Abortion is a sin" needed sustained interactions to change the mind set. The strict implementation of the PCPNDT Act restricted safe abortion services not only by the provider but also ultrasound services by the radiologists. In response to the government's directives, radiologists went on a nationwide strike which further created panic among service providers.

As a result of this breakdown, the team had to change some of its planned activities like stakeholders training and Media Advocacy Workshop in Western Maharashtra which were held at a later date.

The proposal given by Public Accounts Committee to make sex selection mandatory and track the women who has girl child was yet another event that happened in the state. In response, the team sent out letters opposing this proposal but there are chances that State Government can accept this proposal and compulsory the sex selection in future.

This decision will curb the access to safe abortion. Also it will break the confidentiality of the women who are in need of abortion. The team felt that this move may restrict their work on access to safe abortion and RAG members from all districts and SAMYAK issued a joint statement against this proposal and submitted it to Chief Minister and Health Minister of state of Maharashtra through District Collectors.

Reaching messages to media and the women was yet another challenge. Media personnel were often angry and the team had to work with them to convince them about the differences in the two Acts, the need for positive messaging. The project did not work specifically with women or the community at large on abortion. RAG members talked to women about abortion in meetings which were organized for their own organizations' work and not this project specifically. Hence, even though posters on Marjee hotline were displayed at public hospitals, activities were not planned to increase awareness of legality of abortion.

Since the environment was fraught with controversies, engaging government officials was also a challenge. Repeated requests and personal visits yielded some support but not all were willing to engage with civil society organizations.

Other challenges related to travelling long distances, time constraints of SAG and RAG members posed a challenge in convening regular meetings. What came out from the interviews with SAG and RAG members is limited funding. RAG members were required to work without any remuneration for their time. As these members were already working in organizations, they had to make time for the project activities. While they managed to build in the project in their organizations' activities, there were times when availability of funds would have made a difference. As indicated by a RAG member: "We worked with Gram Sabha on our own initiative because we realized that their involvement is important. We got resolutions passed but this needs more concerted work with PRI representatives, appropriate authorities both at district and state level. This could not be done because there were no funds for this."

The team at Samyak was small. There was no regional coordinator as proposed. There was only one project coordinator and the bulk of the responsibilities fell on this person. It was later that two other staff members were added to the team.

6. FINAL ASSESSMENT:

The project was informed by Samyak's existing body of work in Maharashtra. They have been working on Women's Health Rights Forum for Urban Poor in Maharashtra addressing the lack of health care for urban poor women and Women for Equality, a group of individuals and organizations engaging men for gender equality.

Samyak's interest was the result of an earlier qualitative study in Western Maharashtra to understand the experiences of private medical practitioners with PCPNDT Act implementation authorities and the way it has impacted their abortion services. The findings revealed that growing inaccessibility of safe abortion services, especially during second trimester is linked with the fear of private medical practitioners regarding PCPNDT machinery. Samyak had not worked on abortion or sex selection but realized that post rigorous implementation of the PCPNDT Act, the providers took a collective decision not to provide legal abortion services to women. They realized that "if women were to be brought to the centre of the debate, then there is a need to work with government authorities, service providers and civil society organizations".

This project was conceived within this framework. The idea was to create a platform of different stakeholders and to bring them on the same page. Trust building was deemed important for this. Through the processes described above, the project created an environment where abortion and related issues were discussed. Dialogues and conversations with appropriate authorities, private service providers, NGOs and civil society organizations resulted in informing the stakeholders about the impact on maternal health due to denial of safe abortion services, the negative fall-out of strict and often unreasonable implementation of PCPNDT Act. Though not measurable but there is a perceived

degree of clarification of the differences in the two Acts among these stakeholders. A case in point is the letters of demand submitted to various levels of government officials demanding increased access to safe and legal abortion in public health services and display of list of facilities that are authorized to provide legal abortion services. All members have advocated with government to take action according to the demands.

The diverse participants who attended the State level dissemination meeting were a direct culmination of the trust building activities undertaken during the project. Private providers talked freely about feeling threatened by the government and civil society organizations, government officials talked about feeling threatened by the doctors while civil society organizations, particularly those who worked around sex selection and abortion felt that both doctors and government were at fault. The meeting provided a safe space for these people to air their feelings and perceptions without being held guilty. To quote:

" At the State dissemination meeting, an activist said that she did not realize that doctors feel so oppressed and threatened. She said that the hostile environment created by implementation of PCPNDT Act and sting operations makes them feel this way. So, in a way, this meeting was proof that we can sit in a room and listen to each others' views and perspectives."

To note is the change in understanding of issues around abortion and sex selective abortion in the members. RAG members were activists and CSO representatives who were involved in strict implementation of PCPNDT Act and were against sex selective abortion. They admitted that they had never considered abortion as a right of women. As indicated by a RAG member:

" Earlier we would work with police and authorities and conducted sting operations to catch incidences of sex selective abortions. We did not realize that access to safe abortion is important for women".

It was this change that resulted in the series of activities that were undertaken, both within the scope of the project as well as outside of it. Marathwada RAG members initiated grassroots level activities that are commendable. This was not a part of the proposal but an initiative by the members who realized that talking to senior level officials will not result in tickling down effect. The decision to work with PRI members, women in Self Help Groups, Mahila Mandals and so on resulted in Gram Sabha resolutions that mandated inclusion of safe abortion agenda with the wider issue of village development planning process. Through these activities women were informed about legality of abortion, that abortion is not a sin and is their right if they do not want to continue a pregnancy, service providers and places to go to for a legal abortion and so on.

Workshops with providers and other stakeholders aimed to bring about an attitudinal change in how abortion is perceived and the need to look at it differently from sex selective abortion. To measure the changes in perceptions and attitudes, a pre (first phase) and post (second phase) evaluation forms were administered. Though encouraging, data need to be looked at again as there were consistency issues within that. However, while private sector service providers attended the workshops, those from public sector were missed out. This could be due to a range of reasons – not getting permission, not convinced about the issue and so on. Even among those from public sector who attended the workshops and meetings were not interested in talking about abortion and this needs to be addressed as most women can afford going to public facilities and not private facilities. Changes in practice take sustained intervention, particularly in the context of service delivery. Abortion is a sensitive topic and is fraught with biases and stigma. The attitude that "people in authority endorse their view that abortion is a terrible thing so why should I do anything?" is a difficult one to change. While there were groups who understood the need to have a dialogue around abortion, there were many who did not translate their learning into practice. This could be explained by the politics of small towns where one has to be careful about positions and follow the rule of senior providers.

Work with media also provided some positive outcomes. Advocacy workshops with both electronic and print media brought about a change in language used for sex selective abortion and legal abortion – from a negative to a positive use of language. Post workshop, there were a number of articles, but unfortunately these were not sustained. Journalists said that they understood the topic but were forced to write sensational news because their editors asked them to do so.

Communication materials developed and disseminated provided information on where to go for legal termination of an unintended pregnancy, and on legality of abortion. The "pocket reader" in Marathi and posters on Marjee helpline have been displayed at various public health facilities. As a result, number of calls received by the Helpline has increased during the project period.

Even though RAG members in both regions used every opportunity to talk about abortion and related issues, the levels of involvement of RAG varied between the two regions. Western Maharashtra RAG had representatives of NGOs whose main scope of work was not around access to safe abortion. Hence, even though the individual members were convinced about the issue and the need to take it forward, time and work restrictions of the parent organization was a hindrance in completing the tasks proposed in the quarterly meetings. Marathwada RAG members were more active and committed to the cause. They articulated that abortion has been made a part of their organizations agenda and that they will use every opportunity to talk about this issue as it is an overarching concern that impacts health of women.

Samyak staff has played a key role in facilitating the work done by SAG and RAG members. Quarterly meetings were convened of RAG members in both regions and what was done, not done and challenges were shared by the members. RAG members were appreciative of this and said that they got constant support from Samyak staff.

Lessons learnt and what more can be done:

The project brings out some key lessons learnt during the process and emerging next steps if a scale-up is desired:

1. Convergence model: Changes in the availability of safe and legal abortion will not be possible unless all departments come together. The project included the health and family welfare department successfully. Involving public providers and ministries like Women and Child Development, Panchayat Raj Institution, Law is essential in this respect. A bottom approach where the demand is generated by the communities and puts pressure on the top officials will go a long way in ensuring that abortion is recognized as a reproductive health need of women along with access to safe delivery and family planning.

2. Working with the Center: There is a need to take on the responsibility of pushing the Amendments to the MTP Act. There is a need to work with authorities and bring the issue of negative fall-out of strict implementation of the PCPNDT Act. Use research based evidence to talk about denial of services, especially second trimester abortion and its impact on maternal mortality and morbidity. Work with parliamentarians is another option where they are encouraged to ask questions on abortion services during the parliament sessions. This would mean sensitizing this group to the needs and rights aspects of abortion.

3. Campaign mode for abortion: The model used for HIV/AIDs, immunization and polio campaign can be replicated to the extent possible. This is a huge task. However, examine the processes used for these campaigns and replicate this to safe abortion. This would require working with multiple stakeholders – appropriate authorities, different ministries and departments, service providers in public and private sector including radiologists, NGOs and civil society organizations, representatives of the PRI and communities. Awareness raising, changing perception and advocating for abortion as a public health need should be the key components of the advocacy plan. A dedicated team at the state level who could work proactively on this may serve the purpose as this may bring about a change at the policy level. Use existing networks and organizations for this work may be an option. For example, Asian Safe Abortion Partnership (ASAP), Crea, CommonHealth, Family Planning Association of India, Pratigya Campaign and many others could be involved in this process. The issue needs to be brought out in the open – this would help remove stigma attached to the word abortion – and this could be done through taking out rallies, talking about it in community level meetings etc.

4. Ensuring availability of trained staff, drugs and supplies at the public health facilities: Advocacy for safe abortion will simultaneously require ensuring that public facilities have the required personnel, equipment, drugs and supplies. One cannot create "warriors without swords".

Hence, work with state and district authorities and ensure that women who come to them are not turned away because of lack of personnel, equipment and supplies. It also entails ensuring quality of care for women who come for termination of a pregnancy and the providers are not rude or judgmental in their behavior. Creating political will and commitment is time consuming but without their support, mere advocacy may not work.

5. Expanding the coverage: Women need to know what to do when they are faced with an unintended pregnancy. The advocacy needs to go beyond working with only providers. Men are the gatekeepers in our patriarchal society and hence they need to be involved in the process of making safe abortion accessible to women. Work with adolescents including college students informing them about contraception and safe abortion. ASHA and ANM are the first point of contact for women in rural areas. Involving them, ensuring that there is a module on abortion in their training will also be effective. Additionally, involve Indian Medical Association as women may go to family physicians, radiologists, legal professionals who could help support and provide legal advice to women and service providers. Women's groups and CSOs and NGOs who work on sexual and reproductive health should be encouraged to add this to their agenda.

6. Communication materials: Marjee hotline posters, pocket reader for abortion information are not enough. In today's highly technological era, people have access to smart phones and computers. Use social media, Youtube, films to inform people about legality of abortion, where to go and consequences of unsafe abortion and so on. Street plays, songs, videos and case studies on consequences if unsafe abortion, positive stories on where women accessed safe and legal abortion can be used effectively during meetings at the community level. Post media advocacy workshop, there were many articles but these reduced over time. Hence, there is a need for continuous engagement with media – may be encourage them to bring out an editorial piece or write a discussion piece bimonthly.

7. Funding for partners: People involved in the programme should have dedicated resources to undertake activities. A project mode where specific activities are proposed and implemented may work better rather than expecting people to include this in their on-going work. A separate platform dedicated to abortion will bring more attention and focus from those involved.

8. Scale up or dive deeper: While scaling up of this project would be ideal in the given circumstances, it may be too soon. A lot has been achieved in the two regions yet a lot more needs to be done. The project created a group of champions for safe abortion. It would be beneficial to strengthen their capacities and enable them to work independently in their areas. In addition, create working groups of Obgyns and CSOs and NGOs who could continue to inform their peer and colleagues about the need to talk about abortion from a rights and gender perspective. A sustained and continuous work in these two regions may provide a snow ball effect and as a collective influence the appropriate authorities and other stakeholders to ensure that women are not denied abortion services. Scaling up on the other hand would require systems to be set in place at a larger scale. One needs to weigh the pros and cons of scaling up an initiative of this nature and ways in which quality does not suffer because of scale of work.

Conclusion:

The project was ambitious and demanded working at multiple levels. The most important point is that Samyak had not worked on abortion or sex selection prior to the project. Yet, the results and impact are a direct result of the ownership and pride they took in implementing the proposed activities. They faced a very contentious and negative environment with conviction – a conviction that women are the focus of health delivery and they have a right over their bodies.

It is challenging to evaluate the impact of an advocacy programme as three years is too short a time to bring about any long term sustainable attitudinal changes. Having said this, kudos to the commitment of all involved to take up the issue of safe abortion and sex selective abortion, especially in the context of strict actions taken by the government to increase sex ratio, targeting both ultrasound centers, radiologists as well as service providers.

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