TALKING ABOUT
ABORTION

A guide for journalists and advocates

Developed by:

PRATIGYA · asap · Global Health Strategies

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“When you restrict abortions,
You only restrict safe abortions.”

– Dr. Suchitra Danvie
Coordinator, Asia Safe Abortion Partnership

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ABOUT ASIA SAFE ABORTION PARTNERSHIP, PRATIGYA AND GLOBAL HEALTH STRATEGIES

This guide was developed by the Asia Safe Abortion Partnership (ASAP), Pratigya, and Global Health Strategies (GHS).

ASAP is a regional coalition with members from 23 countries, which works on South-South capacity building for safe abortion advocacy and also provides a forum for experience sharing and learning.

Pratigya is a campaign for 'Gender equality and safe abortion', with the mandate to promote women's rights and access to safe abortion in India. It advocates for more effective action on enabling women's access to safe abortion, as well as dealing with gender-based discrimination in society that underlies sex selection.

GHS uses advocacy, communications and policy analysis to advance issues and power campaigns that improve health and well-being around the world. GHS works across some of the world's most dynamic regions to enable policy innovations, mobilise resources and build political will, engaging global and local audiences to drive change.

Learn more about ASAP at http://www.asap-asia.org
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Learn more about Pratigya at http://www.pratigyacampaign.org/

Learn more about GHS at http://www.globalhealthstrategies.com
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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASAP	Asia Safe Abortion Partnership
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
EVA	Electric Vacuum Aspiration
GHS	Global Health Strategies
ICPD	International Conference on Population and Development
IPC	Indian Penal Code
IPPF	International Planned Parenthood Foundation
IVF	In-Vitro Fertilisation
LMP	Last Menstrual Period
MA	Medical or Medication Abortion
MoHFW	Ministry of Health & Family Welfare
MVA	Manual Vacuum Aspiration
MTP	Medical Termination of Pregnancy
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PMO	Prime Minister's Office
POCSO	Protection of Children from Sexual Offences
RMPs	Registered Medical Practitioners
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

SECTION 1
CONCEPTS

ABORTION: THE BASICS[1,2,3]

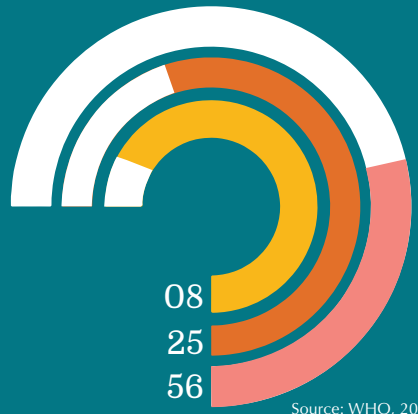
Abortion is one of the most common medical procedures performed globally. Each year, one quarter of all pregnancies end up in abortion. As a result, an estimated 56 million abortions took place globally each year between 2010 and 2014.[4,5]

According to the World Health Organization (WHO) data, abortion is one of the safest medical and surgical procedures, when managed by a trained provider, including nurses and midwives.

56 MILLION ABORTIONS BETWEEN 2010-2014

25 MILLION UNSAFE ABORTIONS

8 MILLION IN LEAST SAFE OR DANGEROUS CONDITIONS



Source: WHO, 2017

Unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

1. IPPF (2017). "How to report on abortion: A guide for journalists, editors and media outlets." https://www.ippf.org/sites/default/files/2018-04/Media%20Guidelines%20on%20how%20to%20report%20on%20Abortion.pdf
2. Ibid.
3. WHO. (2017). "Preventing Unsafe Abortion - Fact Sheet" www.who.int/mediacentre/factsheets/fs388/en
4. Ganatra, B., et al. (2017). Global, regional, and sub regional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *The Lancet*. http://dx.doi.org/10.1016/S0140-6736(17)31794-4
5. Singh, S., et al. (2018). The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*. 6: e111–20. https://www.guttmacher.org/article/2017/12/incidence-abortion-and-unintended-pregnancy-india-2015

Unsafe abortions can be further classified into 'less safe' and 'least safe or dangerous'. According to WHO, abortions are less safe when conducted using outdated methods like sharp curettage even if the provider is trained. In addition, they are less safe if women using medical abortion tablets do not have access to proper information or to a trained person if they need help.

Abortions are dangerous or least safe when they involve ingestion of caustic substances or untrained persons use dangerous methods, such as insertion of foreign bodies, or use of traditional concoctions.

Women, including adolescents, with unwanted pregnancies often resort to unsafe abortion when they cannot access safe abortion. Barriers to accessing safe abortion in various countries include:

- Restrictive laws
- Poor availability of services
- High cost of services
- Stigma
- Conscientious objection by healthcare providers

Each year between 4.7 - 13.2% of maternal deaths can be attributed to unsafe abortion.[6]

Around 7 million women are admitted to hospitals every year in developing countries, due to unsafe abortion. The annual cost of treating major complications globally from unsafe abortion is estimated at USD 553 million.[7]

All but a few countries allow abortion for one or more of the following reasons:

- To protect the life of the woman
- To protect the woman's physical or mental health
- In cases of rape or sexual abuse
- Serious foetal anomaly
- Socio-economic reasons
- At the woman's request

6. WHO. (2017). "Preventing Unsafe Abortion - Fact Sheet" www.who.int/mediacentre/factsheets/fs388/en
7. Ibid

Abortion laws vary considerably between countries, ranging from outright prohibition of the procedure in extremely few countries, to public funding of abortion.[8] There is a total ban on abortion in some countries – not even to save a woman's life. These include **Malta, the Vatican, Dominican Republic, El Salvador and Nicaragua**.

Abortion has been an issue of contention for decades. For many people, abortion is essentially a moral issue. It is about the *moment when a foetus is first recognised as a person.* It is crucially about the rights of the foetus, and a woman's right over her own body. The debate has become a political and legal issue between anti-abortion and abortion rights campaigners. Anti-abortion campaigners seek to enact, maintain and expand anti-abortion laws, while abortion rights campaigners seek the repeal or easing of such laws and expanding access to abortion.

Hence, the point of contention in the debate remains the right to life of a foetus versus giving control to women over their reproductive health, thus allowing them to make decisions about their bodies and health, in a manner that men have been for centuries. A foetus is dependent on a woman for its overall development and health. However, a woman must not be asked to compromise her agency and to risk her health and life to carry the pregnancy to term.

Restricting abortion does not prevent or reduce abortions but makes them unsafe. Rates of unsafe abortion in countries that legally restrict abortion are higher than those where abortion is available on request. A high unmet need for family planning and limited access to the basket of contraceptive choices, also aggravates the situation.

8. Ethics - Abortion: Moral Personhood http://www.bbc.co.uk/ethics/abortion/philosophical/moralperson.shtml

INTRODUCTION TO SEXUAL AND REPRODUCTIVE HEALTH AND REPRODUCTIVE JUSTICE

The right to sexual and reproductive health (SRH) is interlinked with the right to life, health, education, and equality and non-discrimination. At the International Conference on Population and Development held in Cairo in 1994, 179 governments, including India, agreed that free and informed decision-making about pregnancy and childbirth is a basic human right. Access to essential SRH services, including family planning and safe abortion can delay the first birth, space the subsequent births, prevent unintended pregnancies and eliminate unsafe abortions. When a woman is denied this right, she is robbed of her agency and her right over her own body.

India is home to more than 1.2 billion people, of which about 26% (328 million) are women of reproductive age (15-49 years).[9] Yet, several women continue to struggle to access basic SRH services, such as safe abortion and are denied reproductive justice every day.

Reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, based on the full achievement and protection of women's human rights. It is achieved when women and girls have the economic, social and political power, and resources to make decisions about their bodies, sexuality

There are limitations in the law which urgently need to be addressed to improve access to services.

- A lack of awareness amongst providers and government officials around the provisions of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 leads to a clampdown on legal MTP centres and providers, impacting the effective implementation of the MTP Act.
- The conflict of the Protection of Children from Sexual Offences (POCSO) Act, 2012, with the MTP Act also impacts access to safe and legal abortion services.
- Awareness levels regarding the abortion law and its provisions are very low among women in India – many women do not even know that abortion is legal, much less where to seek safe abortion services. Women and young girls, thus, resort to unsafe abortion practices, putting their health and lives at risk.

9. Department of Social Affairs, Population Division, United Nations (UN). (2012). World Population Prospects: The 2012 Revision, Volume II: Demographic Profiles. New York: UN.

and reproduction.[10] A woman's ability to control her reproductive choice is fundamental to her ability to control her life, *and is a core aspect of reproductive justice.*

Unsafe abortions pose undue risks to a woman's health, result in the deaths of many women and girls every year and leave many more temporarily or permanently disabled. When abortion is made legal, safe, and easily accessible, woman's health is protected. By contrast, a woman's health is at great risk when access is difficult or the procedure itself is criminalised.

Despite abortion being legal under the Medical Termination of Pregnancy (MTP) Act, 1971, many women still do not have access to safe abortion services in India. As per a study published in *The Lancet* Global Health last year, 78% of the 15.6 million abortions in 2015 in India, occurred outside of health facilities. 73% of these were medical abortions done outside of health facilities (with or without medical supervision). Furthermore, an estimated 0.8 million (5%) abortions were done outside of health facilities using methods other than medication abortion, that were probably unsafe.[11]

While we have made significant strides in increasing access to safe abortion services, a combination of systemic, policy, legal, socio-economic and cultural barriers have prevented the law from being fully implemented, which restricts women's access to safe abortion services.

Provision of safe abortion services is not just about improving women's health, it is about reproductive choice and entitlement, rights and justice. There is an urgent need to address the gaps in quality abortion services, human resources and infrastructure. Towards this end, advocates across the government, medical fraternity, international organisations and the media can play a crucial role in bringing to the fore challenges that women face in fully realising reproductive justice.

10. Loretta Ross, "What is Reproductive Justice". Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change. https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051
11. Singh, S., et al. (2018). The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*. 6: e111–20. https://www.guttmacher.org/article/2017/12/incidence-abortion-and-unintended-pregnancy-india-2015

TECHNICAL TERMS MADE EASY[12]

Below are some terms you might encounter while reporting on abortion and what they mean.

ABORTION

When someone chooses to end a pregnancy by taking medication or having a surgical procedure, it is called abortion. It is not the same as a miscarriage, which is when a pregnancy ends naturally. Abortion can also sometimes be referred to as 'termination' or 'termination of pregnancy'.[13]

AUTONOMY

Autonomy is a central component of the rights to life, privacy, and liberty, amongst others, and includes individuals' rights to make informed decisions about their bodies, to determine the number and spacing of their children, and to be free from coercion, discrimination and violence.[14]

CHILD SEX RATIO

Child sex ratio is the number of females per 1,000 males in the age group 0-6 years in a human population.[15]

EMBRYO

Conception results in the formation of an embryo. About eight weeks after conception, an embryo develops organs and is then known as a foetus, a status it retains until birth.[16]

FOETUS

This is the medical term for a growing embryo beyond the tenth week of gestation (or from the end of eighth week of conception) until birth.[17]

GESTATION

The time during which the embryo/foetus develops inside the body is called gestation. It begins at fertilisation and ends with birth. Gestational age is a measure of how far along the pregnancy is. It is calculated from the first day of the last menstrual period and is indicated in completed days or completed weeks. The average duration of a pregnancy is 40 weeks.[18]

12. Gender and Genetics. (2010, December 1). Retrieved from http://www.who.int/genomics/gender/en/index4.html
13. IPPF (2016). "A guide for peer educators, teachers and trainers" https://www.ippf.org/sites/default/files/2016-05/ippf_peereducationguide_abortion_final.pdf
14. United Nations Population Fund (UNFPA). (2013). "ICPD AND HUMAN RIGHTS: 20 years of advancing reproductive rights through UN treaty bodies and legal reform" https://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf
15. Census (2011) Gender Composition. http://censusindia.gov.in/Census_And_You/gender_composition.aspx
16. Abortion in South Africa: A Reporting Guide for Journalists. Bhekisisa (2018). http://bhekisisa.org/article/2018-05-08-00-abortion-in-south-africa-a-reporting-guide-for-journalists-media-1
17. Ibid
18. Ibid

MATERNAL MORTALITY RATIO

Maternal mortality ratio measures the number of women who die due to pregnancy-related causes out of 100,000 live births. Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death, but not from accidental or incidental causes.[19]

MEDICAL OR MEDICATION ABORTION (MA)

Medical abortion is a non-surgical, non-invasive method for termination of pregnancy by using a drug or a combination of drugs. The drugs that are normally used are either Misoprostol alone or a combination of Mifepristone and Misoprostol (combipack). This is not the same as emergency contraception ('the morning after pill') which prevents a pregnancy.[20]

LAST MENSTRUAL PERIOD (LMP)

Pregnancies are dated in weeks starting from the first day of a woman's LMP. If her menstrual periods are regular and ovulation occurs on day 14 of her cycle, conception takes place about 2 weeks after her LMP. Ultrasound scans are used to determine gestational age. However, where these machines are not available, nurses and doctors calculate the gestational age by using LMP.[21]

REGISTERED MEDICAL PRACTITIONER (RMP)

Abortions in India can only be provided by RMPs. An RMP is a medical practitioner who has one or more of the following experience or training in gynaecology and obstetrics:

- A medical practitioner registered in a state medical register immediately before the commencement of the Indian Medical Council Act, 1956, with experience in the practice of gynaecology and obstetrics for a period not less than three years
- A medical practitioner registered in a state medical register after the commencement of the Indian Medical Council Act, 1956 and:
- Has completed six months as a house surgeon in gynaecology and obstetrics; or
  - Has experience in any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or
  - Holds a postgraduate degree or diploma in gynaecology and obstetrics; or
  - Has assisted an RMP in the performance of 25 cases of medical termination of pregnancy, of which at least five have been performed independently in a hospital established or maintained by the government, or a training institute approved for this purpose by the government.[22]

REGISTERED MEDICAL FACILITY

Abortions in India can be provided only at a registered medical facility. This includes hospitals established or maintained by the government, or facilities approved by the government or a district-level committee headed by the Chief Medical Officer or District Health Officer.[23]

SAFE ABORTION

Abortion is safe when performed by persons with the necessary training and skills, and in an environment meeting minimal medical standards.[24]

SEX SELECTION

Sex selection refers to the practice of using medical techniques to choose the sex of an offspring. The term sex selection encompasses many practices, including selecting embryos for transfer and implantation following in-vitro fertilisation (IVF), separating sperms, and selectively terminating a pregnancy. There are three core motivations for engaging in sex determination and sex selection:

- Medical reasons, such as preventing the birth of children affected or at risk of X-linked disorders.
- Family balancing reasons, where couples choose to have a child of one sex because they already have one or more children of the other sex.
- Gender preference reasons, often in favour of male offspring stemming from cultural, social, and economic bias in favour of male children.[25]

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

Sexual and reproductive health encompasses the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence.[26]

19. WHO. Maternal mortality ratio. Retrieved on June 8, 2018 from http://www.who.int/healthinfo/statistics/indmaternalmortality/en/
20. Ministry of Health & Family Welfare. (2016). Handbook on Medical Methods of Abortion to Expand Access to New Technologies for Safe Abortion. Government of India.
21. Definition of Last Menstrual Period. https://www.medicinenet.com/script/main/art.asp?articlekey=13608
22. Ministry of Health & Family Welfare. (2015). Guidance: Ensuring Access to safe Abortion and Addressing Gender Biased Sex Selection. Government of India. http://www.nrhmtn.gov.in/guideline/SafeAbortionHandbook.pdf
23. Ministry of Health & Family Welfare. (2015). Guidance: Ensuring Access to safe Abortion and Addressing Gender Biased Sex Selection. Government of India. http://www.nrhmtn.gov.in/guideline/SafeAbortionHandbook.pdf
24. WHO. Safe abortion: Technical and policy guidance for health systems. (2016, February 25). http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/
25. WHO. "Gender and Genetics" http://www.who.int/genomics/gender/en/index4.html
26. UN Foundation. (n.d). "Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda". http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf

SURGICAL ABORTION

Surgical abortion involves a surgical procedure to end a pregnancy. The most common form of surgical abortion is called 'vacuum aspiration', where the products of conception are removed from the uterus through suction.[27]

TRIMESTER

The length of the pregnancy is divided into three periods of three months each, where there is a 'first' (0-12 weeks), 'second' (13-27 weeks) and 'third' trimester (28 weeks until birth).[28]

UNPLANNED OR UNINTENDED PREGNANCY

Unplanned or unintended pregnancies refer to pregnancies that occur either due to non-use or failure of contraception. An unplanned or unintended pregnancy may be either mistimed or an unwanted pregnancy. An unwanted pregnancy refers to a pregnancy that a woman does not wish to carry to term. A mistimed pregnancy refers to a pregnancy that occurs earlier than desired. [29, 30]

UNSAFE ABORTION

Unsafe abortion is a procedure performed either by persons lacking the necessary training and skills, in an environment that fails to meet minimal medical standards, or both. [31]

27. Abortion in South Africa: A Reporting Guide for Journalists. Bhekisisa (2018). http://bhekisisa.org/article/2018-05-08-00-abortion-in-south-africa-a-reporting-guide-for-journalists-media-1
28. Abortion in South Africa: A Reporting Guide for Journalists. Bhekisisa (2018). http://bhekisisa.org/article/2018-05-08-00-abortion-in-south-africa-a-reporting-guide-for-journalists-media-1
29. Differences Between Mistimed and Unwanted Pregnancies Among Women Who Have Live Births. (2016). https://www.guttmacher.org/journals/psrh/2004/differences-between-mistimed-and-unwanted-pregnancies-among-women-who-have
30. Unintended Pregnancy Prevention. (2015). https://www.cdc.gov/reproductivehealth/unintendedpregnancy/
31. Safe Abortion: Technical and Policy Guidance for Health Systems, Geneva: WHO, 2012. http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1

UNDERSTANDING THE TERMINATION OF PREGNANCY METHODS[32]

How does the process start? When a woman enters a registered medical facility seeking an abortion, the first step is to undergo a clinical assessment to determine eligibility to undergo termination of pregnancy. The assessment, which includes taking the medical history, physical and pelvic examination of the patient and potential laboratory investigations, is essential to avoid complications during and after the provision of abortion services. The clinical assessment provides the following information:

- Confirmation of a pregnancy
- Gestation
- General health condition
- Associated gynaecological disorders and infections
- Associated medical problems

MEDICATION ABORTION

Medication abortion is the non-surgical termination of early pregnancy using a combination of drugs. These drugs are Mifepristone and Misoprostol which are used to induce and complete an abortion. The combipack (combination of Mifepristone and Misoprostol) has been approved for use by the Central Drugs Standard Control Organization, Directorate General of Health Services, India for use up to 9 weeks.[33] However, MA is legal in India for up to 7 weeks of gestation, in line with the MTP Rules, 2003.[34]

MA is usually carried out in two phases. Mifepristone is administered orally to stop the pregnancy from growing. In the second phase, misoprostol is administered by placing the pill under the tongue, which allows the uterus to contract and expel the products of conception.

Women undergoing MA usually experience pain or cramps as well as vaginal bleeding similar to a heavy period. Paracetamol or any pain killer that the woman usually uses for her period will suffice.

32. Ministry of Health & Family Welfare. (2010). Comprehensive Abortion Care: Training and Service Delivery Guidelines. Government of India. Retrieved on June 7, 2018 from http://www.nrhmhp.gov.in/sites/default/files/files/Guidelines_CAC Training & Service Delivery .pdf
33. While medical abortion in India is legal in India only up until 7 weeks, WHO allows the use of MA up to 24 weeks.
34. Ministry of Health & Family Welfare. (2016). Handbook on Medical Methods of Abortion to Expand Access to New Technologies for Safe Abortion. Government of India. http://www.nrhmtn.gov.in/modules/MMA_Handbook.pdf

SURGICAL ABORTION

Surgical abortion is the use of a surgical procedure for the termination of pregnancy. It includes the following methods:

A. Vacuum Aspiration, which is of two types with the primary difference between the two being the source of the vacuum.
   - ➲ Manual Vacuum Aspiration (MVA) utilises a hand-held, portable aspirator
   - ➲ Electric Vacuum Aspiration (EVA) employs an electrically operated device referred to as the EVA or suction machine

B. Dilatation and curettage (D&C), which is not recommended by WHO as it is more invasive, has higher risk of injury, including perforation and tissue injury, and requires longer period of recovery.

C. Dilatation and evacuation (D&E), which involves preparing the cervix and evacuating the uterus with a combination of suction and forceps. D&E also requires preparing and dilating the cervix, and evacuating the uterus using vacuum aspiration and ovum/sponge forceps.

D. Hysterotomy, is a mini-caesarean section and is performed in case of failure in the induction of abortion by other methods or excessive bleeding during the procedure, often as a life-saving measure.

SECTION 2
THE MTP ACT, PENDING AMENDMENTS AND WHY IT NEEDS ATTENTION

THE STATUS OF ABORTION IN INDIA

To understand the issues surrounding abortion in India, it is necessary to understand the evolution of the MTP Act, 1971.

The Indian Penal Code (IPC) written in accordance with the British law in 1860 and adopted unchanged by India after 1947 criminalised abortion, except to save the life of a woman.[35] In the 1960s, the unacceptably high maternal mortality ratio prompted the government to constitute a committee headed by Dr Shantilal Shah. Based on the recommendation of this committee, **the MTP Act was passed by the parliament in 1971**, which overrode the IPC. Although considered to be among the most liberal abortion laws when it was passed, it provides for the doctor's protection against the IPC and is not based on a rights-based approach towards women.

FACT: The MTP Act was enacted two years before the landmark judgment of the US Supreme Court in Roe v Wade – which held that laws which criminalise all abortions, except those required to save a mother's life, were unconstitutional and violated the right to privacy of a pregnant woman.

WHAT DOES THE MTP ACT SAY?

Under the Act, abortion can be provided at the discretion of a medical provider at a registered medical facility within the first 20 weeks of pregnancy, under certain conditions (see box 1). It is important to note that only the consent of the woman is needed if she is 18 years of age or above, even if she is married. In India, medical abortion pills can be provided until 7 weeks of pregnancy.

According to the MTP Act, provision of abortion is at the discretion of the medical provider:

- **Up to 12 weeks: Requires the opinion of one medical provider**
- **Between 12 and 20 weeks: Requires the opinion of two medical providers**

In addition, the Act ensures confidentiality to the woman seeking abortion, wherein her identity is not to be disclosed to anyone.

35. The Code held human life – even that of the unborn child – as sacred. The framers of the Code did not use the word 'abortion,' and instead spoke of 'miscarriage' which, according to the IPC, was illegal under all circumstances except when undertaken to save the life of a pregnant woman.

CONDITIONS UNDER WHICH A WOMAN CAN REQUEST AN ABORTION

01 CONTINUATION OF THE PREGNANCY WOULD INVOLVE A RISK TO THE LIFE OF THE PREGNANT WOMAN OR CAUSE GRAVE INJURY TO HER PHYSICAL OR MENTAL HEALTH

02 SUBSTANTIAL RISK THAT THE CHILD, IF BORN, WOULD BE SERIOUSLY HANDICAPPED DUE TO PHYSICAL OR MENTAL ABNORMALITIES

03 PREGNANCY IS CAUSED BY RAPE (PRESUMED TO CONSTITUTE GRAVE INJURY TO MENTAL HEALTH)

04 PREGNANCY IS DUE TO THE FAILURE OF CONTRACEPTION IN MARRIED WOMEN OR HER HUSBAND (PRESUMED TO CAUSE GRAVE INJURY TO HER MENTAL HEALTH)

KEY BARRIERS TO THE EFFECTIVE IMPLEMENTATION OF THE ACT

Despite the MTP Act, many women and girls face challenges in accessing safe abortion services in the country and are compelled to seek unsafe abortion services from unqualified and illegal practitioners. Due to this, many women in India die each year, and many more are temporarily or permanently disabled.

1. LIMITATIONS OF THE MTP ACT, 1971

The 20-week gestation limit in the Act is increasingly proving to be challenging for women. Many women in the recent past have approached the courts to allow terminations of advanced pregnancies, post the 20-week period. These include rape survivors (some of them minors) with unwanted pregnancies or women with severe foetal abnormalities.

Additionally, as per the Act, only married women can cite contraceptive failure as a reason to request for abortion. The law remains ambiguous for unmarried women. Women also require the consent of two medical providers for second trimester abortions. This proves particularly difficult in rural areas where there is a dearth of trained providers, even for basic healthcare services.

2. STIGMA AROUND PRE-MARITAL SEX AND PROVIDER BIAS

Married women face provider bias when they choose to terminate their first pregnancy. Many providers often ask for consent from a woman's spouse, partner or family – consent that is not required by the MTP Act. On the other hand, unmarried women and young girls often face stigma for indulging in pre-marital sexual relations. Indian society largely condemns pre-marital sex. This results in enormous mental stress to an unmarried woman as she deals with the anxiety of getting a safe abortion done and the fear of her family discovering that she is sexually active. The bias and stigma compels women and young girls to seek abortions from illegal providers, which, at times, may be provided under unsafe conditions.

3. LIMITED AWARENESS AMONG WOMEN ABOUT THE LAW

For many women, abortion, like most aspects of sexuality, is a topic that is rarely discussed. Many women do not know that abortion is legal in India and do not have access to information on the availability of safe abortion services.

4. LACK OF ADEQUATE TRAINED PROVIDERS

There is a dearth of trained RMPs in the country, especially in rural areas. In addition, many medical providers lack in-depth knowledge of guidelines for abortion and post abortion care. In addition, there are also many providers who lack specific training in abortion procedures. Thus, many women receive poor-quality abortion services from untrained providers and consequently experience negative health outcomes outcomes.

5. LACK OF AWARENESS AMONGST PROVIDERS AND GOVERNMENT OFFICIALS AROUND THE PROVISIONS OF THE PCPNDT ACT, 1994 AND THE MTP ACT

India banned sex determination under the PCPNDT Act in 1994. Gender-biased sex selection occurs because of an inherent and often culturally influenced discrimination against girls which sees males as the preferred sex, otherwise known as 'son preference'. Before the emergence of pre-natal sex determination techniques in the 1970s and 1980s, female infanticide was practiced in some regions of India.

The availability of sex determination technology, especially since 1980, resulted in many women seeking abortions after sex determination in the second trimester of pregnancy. Although the sex ratio has been declining since the very first census in 1901, the issue caught the attention of Indian policymakers after the 2011 India census. The number of girls per 1000 boys dropped from 927 in 2001 to 914 in 2011 for children aged 0-6 years. With an effort to curb this, the Indian government passed the PCPNDT Act, which regulates prenatal diagnostic techniques in India and prohibits their misuse for sex determination.

However, due to a lack of awareness about the provisions of the Act, there are misconceptions among government officials and the public that abortion as a practice,

According to the United Nations Population Fund (UNFPA) and Ipas Development Foundation, 80-90% of reported abortions take place in the first trimester (when the sex of the foetus cannot be determined through ultrasonography).

This hesitancy of providers to provide safe abortion services will only increase the vulnerability of women and restrict their access to safe abortion services. **There is an urgent need to de-link the issue of gender-biased sex determination from abortion rights discourse.** It is important to note that PCPNDT is a regulatory Act that governs sex determination, while the MTP Act focuses on abortion, women's rights and safety. We also need to adopt strategies to raise awareness about the provisions of both PCPNDT and MTP Acts amongst government officials and the general public, and address the underlying cause of sex selection – gender inequality – through education.

and not just gender-biased sex selection as illegal in India. This misconception helps create a negative environment for women seeking access to safe abortion. Officials carry out stringent inspections, often "clamping down" on registered abortion centres and providers. This has led to many qualified practitioners now being guarded and subsequently denying abortion services (especially during the second trimester). Additionally, misconceptions about when the sex of the foetus can be determined have led to a clamp down on the availability of medical abortion drugs, which is indicated for use only between 7-9 weeks of gestation (first trimester). As a result, many women resort to unsafe methods that pose a greater risk to their health and in some cases, can even cost them their lives.

6. THE LAW ON CHILD SEXUAL ABUSE IN INDIA AND ITS IMPACT ON ACCESS TO ABORTION

A much-needed law, the POCSO Act, 2012 was passed for the protection of children (below the age of 18 years) from sexual abuse and exploitation. However, it treats all pregnant minors as rape survivors, and mandates the medical providers to report these pregnancies to the police. This directly contradicts with the confidentiality clause of the MTP Act, wherein the identity of any woman who seeks an abortion must be kept confidential.

While the POCSO Act is essential, there have been several instances, when providers hesitate and even refuse to provide services to girls under 18 years, even where sex is consensual. This also makes young girls reluctant to approach registered facilities and access safe abortion services, especially when the young couple knows they may be penalised and the young boy may be accused of rape. Sex education and counselling can prevent minor couples from practicing unprotected sex and at the same time, a broader discussion and debate is required on how to address this complex issue.

ARE WE MAKING AMENDS?

LIBERALISING THE MTP ACT, 1971

2002

The MTP Act, 1971 was amended in 2002. The Amendment decentralised the regulation of abortion facilities from the state level to the district-level committees. It also allowed RMPs to provide medical abortion up to seven weeks of pregnancy, in a facility approved to provide abortion. In addition, it enabled an RMP to prescribe MA drugs as long as he has access to a facility that is approved under the MTP Act, 1971, and can display a certificate by the owner of the approved site.[36]

2014

In late 2014, the Ministry of Health & Family Welfare (MoHFW) submitted the MTP (Amendment) Bill, 2014 to the Prime Minister's Office (PMO).

The bill proposed the following amendments to the current MTP Act:

- Allow abortion on request of the woman until 12 weeks
- Increase the gestation limit from 20 to 24 weeks for rape survivors
- Remove the gestation limit in case of foetal abnormalities
- Reduce the number of physician opinions required from two to one in the second trimester
- Expand the base of legal medical abortion providers to include Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) practitioners, Auxiliary Nurse Midwives (ANMs), and nurses
- Remove the word "married" from the clause on contraceptive failure as a condition for seeking abortion

2017

On 26 May 2017, the PMO sent the Bill back to the MoHFW with the recommendation that the existing MTP and PCPNDT Acts be strengthened.[37] A point that continues to be debated is whether the provider base should be expanded to include AYUSH practitioners.

36. MTP Rules | Ministry Of Health and Family Welfare | Goi. https://mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-rules
37. Abortion Law Amendments on Hold. Abantika Ghosh - http://indianexpress.com/article/india/abortion-law-amendments-on-hold-4693900/

RECOGNISING REPRODUCTIVE RIGHTS WITHIN THE REALM OF PRIVACY

In August 2017, the Supreme Court ruled that the citizens of India have a **constitutional right to privacy**. In its statement on abortion, the apex court noted, "A woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy."

Taking a cue from this landmark judgment by the Supreme Court, it is imperative to expedite the amendments. The provision of abortion on request, if accepted would be a fundamental shift in India's abortion law and would recognise the autonomy of a woman over her own body (even if only in the first 12 weeks of pregnancy), and the fundamental right to privacy.

STATEMENT FROM THE FORMER ATTORNEY GENERAL OF INDIA ON ABORTION AND THE RIGHT TO PRIVACY

"In light of the judgment on privacy, a multi-pronged approach needs to be adopted to ensure that no woman resorts to unsafe means and methods to terminate a pregnancy because she is unable to access safe abortion services. At the policy level, the MTP Act, 1971, must be amended to allow women to receive abortion on request, which, in turn, could increase access to safe abortion care. This should simultaneously be supported by efforts to build awareness and educate women and the community on their sexual and reproductive health and rights, including their right to access safe abortion care. More importantly, we must sensitise our healthcare providers and implementers of the law to recognise a woman's right to reproductive choice, privacy and dignity and to provide services free of bias and judgment.

If a woman so chooses to, she should be able to access abortion on request at any point within the legal gestation limit."

Excerpt from an opinion editorial by Mr Soli Sorabjee, former Attorney General of India, published in the Hindustan Times on 8 January 2018.

TIMELINE OF THE MTP ACT AND THE AMENDMENTS

These MTP amendments are extremely crucial and will go a long way in reducing deaths due to unsafe abortions and help in increasing access to safe abortion services.

1971 — MEDICAL TERMINATION OF PREGNANCY (MTP) ACT IS PASSED

2002 — MEDICAL TERMINATION OF PREGNANCY ACT IS AMENDED

2006 — LIMITATIONS AND GAPS WITHIN THE MTP ACT, 1971 ARE IDENTIFIED

2014 — MTP AMENDMENT BILL 2014 SUBMITTED TO THE PRIME MINISTER'S OFFICE BY THE MINISTRY OF HEALTH & FAMILY WELFARE

2017 — PRIME MINISTER'S OFFICE SENDS THE MTP AMENDMENT BILL 2014 SENT BACK TO THE MINISTRY OF HEALTH & FAMILY WELFARE WITH A MANDATE TO STRENGTHEN THE ACT IN ITS CURRENT FORM

2017 — THE SUPREME COURT OF INDIA IN A LANDMARK JUDGEMENT ON THE FUNDAMENTAL RIGHT TO PRIVACY NOTES "A WOMAN'S FREEDOM OF CHOICE WHETHER TO BEAR A CHILD OR ABORT HER PREGNANCY ARE AREAS WHICH FALL UNDER THE RIGHT TO PRIVACY".

SECTION 3
TOOLS FOR MEDIA

HOW TO TALK ABOUT ABORTION

Here is a short guide on language, imagery and reporting that journalists and media can refer to while covering stories on abortion:

LANGUAGE

⊗ DON'T USE	✓ USE	? WHY
Mother	Pregnant woman	A pregnancy is not equivalent to bearing a child. All pregnant women are not mothers. All pregnancies do not result in birth.
Baby Unborn baby/child Dead foetus	Embryo (up to 8 weeks of gestation)	Embryo and foetus are medically accurate terms. An embryo or a foetus is not yet a baby. It can be referred to as "baby" or "child" only after birth.
	Foetus (from 8 weeks of gestation to delivery)	
Get rid of a child Kill an unborn child	End or terminate a pregnancy	Using such terms can give rise to negative perceptions about abortion.
Abort disabled children	Abortion on the grounds of foetal anomaly	The use of the term "children" would be incorrect and the discrimination on the grounds of disability is applicable only after birth.
Abortion is illegal	Abortion is legal under certain conditions	Many people think that abortion is completely illegal in their country when it is, in fact, legal under certain grounds. In India, sex-selective abortion is illegal, while abortion under certain conditions which account for women's health is legal. A lack of awareness about this difference often leads to the assumption (especially among women) that all abortions are illegal.

⊗ DON'T USE	✓ USE	? WHY
Safe and legal Unsafe and illegal	Use the terms separately	An abortion is safe and legal when it carried out under safe conditions, and complies with all the requirements of the MTP Act. An abortion may also be safe, but may not comply with all the requirements of the Act, in which case it will be illegal.
Late term abortion	Second/third trimester Abortion at xx weeks of gestation	Late term refers to any time in the second or third trimester. If necessary, use terms that indicate the specific trimester or gestation. Use of "late" may imply that a woman is late in seeking an abortion (and thus implying some irresponsible behaviour).
Pro-life Pro-family	Anti-abortion Anti-choice Believe abortion should be illegal	Pro-life inaccurately suggests that those who support access to safe, legal abortion are "anti-life". Pro-family implies that abortion and motherhood are mutually exclusive when, in fact, the same women who choose to have abortions may also take certain pregnancies to term. The term to support the right to safe abortion are pro-woman and pro-choice.
Repeat abortion	More than one abortion	Women can become pregnant from early adolescence to menopause for almost 40 years. Contraception is used but can fail more than once in a lifetime. And women may not be able to use them effectively. "*Repeat*" when used about abortion has negative connotations of irresponsibility, such as "*repeat offenders*".

⊗ DON'T USE	✓ USE	? WHY
Keep the baby Keep the child	Choose to continue the pregnancy Continue the pregnancy	The term "*keep*" implies a positive outcome which may not accurately reflect the situation. In addition, it is medically inaccurate to describe the pregnancy as a baby or a child. It is more accurate to describe the situation as a pregnant woman choosing to continue with the pregnancy.
Abortionist	Service provider Abortion provider Healthcare provider	Abortionist is a term used by those opposed to abortion. It perpetuates the negative perceptions associated with abortion. It also adds to the stigma around abortion faced by healthcare providers for providing safe abortion services. Healthcare provider is usually a more accurate term to use than abortion provider, as most of those providing abortions also provide other health services.

IMAGERY ON ABORTION

IMAGES ONE SHOULD AVOID USING

VISIBLY PREGNANT WOMEN

WHY: Abortion take place at various stages of a pregnancy. Showing a visibly pregnent woman can mislead your audience and also may give rise to megative perceptions to abortion as a procedure.

IMAGE OF A FOETUS/ INSTRUMENTS USED FOR ABORTION

WHY: The graphic foetal imagery may lead to a negative association of abortion for those seeking abortion services.

ULTRASOUND SCANS

WHY: Ultrasounds are used to determine how far along a pregnancy is, but they are not essential. many people therefore won't receive an ultrasound scan. But anti-abortion froups, especially internationally, have long advocated that people should be forced to look at scans before tthey undergo termination procedures, hoping that it will help change their minds.

INSTEAD HERE ARE SOME SUGGESTED IMAGES

Pictures and images which frame abortion as a woman's choice, assert her right to bodily autonomy, does not stigmatise abortion or perpetuate somon myths about it can be used.

A FEW SUGGESTED MESSAGES FOR TALKING ABOUT ABORTION

- ☑ Abortion is a common medical procedure.
- ☑ Unsafe abortion is a key sexual and reproductive health concern.
- ☑ Legal, accessible and safe abortion saves women's lives. Medical complications and maternal mortality related to abortion become truly rare only when women have access to safe abortion services and access to information and choices in contraceptive methods.
- ☑ All women have the right to choose whether or not to carry a pregnancy to term. No woman should be forced to carry a pregnancy to term. Every woman has the right to choose if and when she wants to become a mother.
- ☑ All women have the right to access safe, legal and affordable abortion services.
- ☑ Reducing and eliminating mortality and morbidity related to unsafe abortion requires a two-pronged approach: (1) provision of the full range of sexual and reproductive health services including contraception, safe abortion, youth-friendly services and comprehensive sexuality education; and (2) advocacy to make abortion safe and accessible for all women in India.
- ☑ Morbidity and mortality due to complications from unsafe abortions place an unnecessary burden on families, communities and the government.
  - Complications due to unsafe abortions put pressure on the limited clinical, material and financial resources of hospitals, and compromise other maternity and emergency services.
  - The treatment of abortion complications in hospital utilises a significant share of resources, including hospital beds, blood supply, medicines, operating rooms, anaesthesia and medical specialists.
  - In addition, women who undergo unsafe abortion incur physiological, financial and emotional costs.
- ☑ Empowering women with accurate information helps them make informed decisions regarding their bodies, health and well-being. This includes providing them with information on their reproductive rights and provisions under the MTP Act, as well as information on how to access safe abortion services.
- ☑ India is signatory to several international commitments – such as the Sustainable Development Goals (SDGs); International Conference on Population and Development (ICPD) Programme of Action, Cairo, 1994; the Beijing Declaration and Platform for Action, 1995 – to improve health and well-being, reduce poverty and improve gender equality. To realise these goals, the government must take action, respect and protect the reproductive rights of every person, and enable all people to exercise them without any discrimination.

FIVE COMMON MYTHS BUSTED[38, 39]

Myth: Having an abortion makes it more difficult to get pregnant in the future

Fact: A safely conducted abortion does not cause subsequent fertility problems and in fact, fertility can return as soon as two weeks after an abortion.

Myth: Women would not need to have abortions if they used contraception

Fact: Individuals may not be able to access contraception, choose not to use it, or experience contraceptive failure since no method is 100% effective. They may also have been in situations of coercive control by partners or become pregnant through rape. An estimated 33 million women worldwide using contraception will experience unintended pregnancy each year.

Myth: Foetal abnormalities are equal to disabilities

Fact: Foetal abnormalities are conditions that may affect a foetus or embryo. Serious foetal abnormalities are often incompatible with life or may cause major disease after birth. Opponents of abortion often highlight cases of termination for foetal anomalies, and assert that children born with particular disabilities can lead a good life. However, to include all foetal anomalies under the umbrella of disability, and to refer to them as a disability before birth is inaccurate.

Myth: Women commonly experience feelings of intense grief, regret or depression after abortion

Fact: Women experience a whole range of emotions following an abortion. However, evidence suggests that a majority of women do not regret having an abortion. Those who campaign against legal abortion often talk about something called "post-abortion stress/syndrome" a disorder that is not evidence-based.

Myth: All abortions are unsafe

Fact: Abortion is a very safe procedure when conducted in sanitary conditions by a trained provider, using approved methods and medication.

Myth: Legalizing abortion will lead to more abortions occurring

Fact: Highly restrictive abortion laws are not associated with lower abortion rates. For example, the abortion rate in Latin America, where abortion laws are extremely restrictive is 32 per 1,000 women of childbearing age, compared to a rate of 12 per 1,000 women in Western Europe, where abortion laws are generally less restrictive with informed and expanded contraceptive choices

Myth: Majority of (and all second trimester) abortions are sex- selective

Fact: It is estimated that 80-90% of reported abortions in India are carried out in the first trimester. The sex of the foetus can be determined through ultrasonography only in the second trimester of the pregnancy. With technological advancements, it is possible to determine the sex of the foetus earlier. However, it is expensive and not easily accessible.

In addition, most second trimester abortions are either due to foetal abnormalities (which are often detected after 20 weeks of gestation),or sought by vulnerable women (unmarried, widowed or victims of sexual abuse) who are not able to get the required support, information or detect their pregnancy only in the second trimester.

38. IPPF (2015). "How to talk about abortion: A guide to rights-based messaging" https://www.ippf.org/sites/default/files/web-ippf_abortion_messaging_guide.pdf
39. 48 British Pregnancy Advisory Service. (n.d.). Termination of pregnancy for fetal anomaly. Retrieved on June 8, 2018 from https://www.bpas.org/get-involved/advocacy/briefings/fetal-anomaly/

HOW TO REPORT ON ABORTION

THINGS TO KEEP IN MIND

The portrayal of abortion in the media can sway public perception. A sensitive, accurate and rights-based focus has the potential to arouse global outrage at violations of women's rights. A few things that can help media reportage of sexual and reproductive health and rights.

- Build research into your reporting and: use facts from reliable sources. These can include government documents, press releases, articles and research papers from renowned journals, such as The Lancet, UN websites and WHO fact sheets. Citing the year, the research was conducted or published and a hyperlink is essential while reporting on SRHR.
- When quoting a study, mentioning its scale, scope and limitations is advisable. Abstracts in studies give a brief idea about key findings, but not its limitations. In case of shortage of time, it is advisable to read the abstract, discussion and conclusion.
- Normalising the experience can be an important part of the narrative. This can gradually lead to a subtle change in the discourse around "mainstreaming" abortion as a crucial SRHR issue.
- Powerful storytelling often seeks personal experiences of those who have had an abortion. But abortion rights are also a collective issue, affecting policy, law and rights. It is also an issue that highlights inequities in the health sector.
- The complexities of situations of people seeking abortion – adolescents, trans people, unmarried women, married women with children, women in rural areas, survivors of sexual assault and young girls – can help drive diverse narratives and investigative depth to a piece.
- Data that is recent, specific to India is crucial. The usage of regional or global figures can also give a wider arc to the subject being discussed.
- Map out country-specific/state-specific barriers to access. More details are available on page 20 of this toolkit.
- Promoting openness, public discussion and breaking the culture of silence, stigma and discrimination associated with SRHR can be achieved through the right choice of words. Avoid anti-abortion myths, language and imagery in reportage, sometimes used to dramatise cases. For more information, refer to page 27 of this toolkit.
- Guard against a common mistake. The narrative on abortion frequently speaks about "aborting girls" with regard to sex-selective abortion. Sex selection is an outcome of patriarchy and discriminatory cultural norms.
- One way to avoid the usage of inaccurate and ill-informed images like that of heavily pregnant women, or foetuses being killed (such as the use of scissors, noose around the foetus etc.) is to emphasise abortion as an ordinary healthcare service (images of medical professionals or abortion pills). As most pregnancies are terminated in the first trimester, a graphic focus on advanced pregnancies generates a wrongful perception.
- Powerful journalism has always explored intersectionality. Explore, explain and establish relationships between different concepts. SRHRH intersects with many issues of rights, autonomy, gender, healthcare, policy and law.

Many journalists feel that they must present the anti-abortion argument alongside the pro-choice case, in the name of balance. It may help to be mindful that the pro-choice viewpoint respects each woman's right to decide what is best for her.

SOME SUGGESTED SOURCES FOR ABORTION-RELATED DATA AND INFORMATION

STATISTICS

- Guttmacher Institute Data Centre: A comprehensive data set, enabling extraction of abortion and related indicators (contraception, pregnancy, fertility and maternal health funding) by individual countries and regions. www.ippf.org/sites/default/files/positive_approach.pdf
- World Health Organization Unsafe Abortion Estimates: Global and regional estimates of the incidence of unsafe abortion and associated mortality from 2008. http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/
- Preventing Unsafe Abortion: Factsheet http://www.who.int/mediacentre/factsheets/fs388/en/
- Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext
- The incidence of abortion and unintended pregnancy in India, 2015 http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30453-9/fulltext

LAWS AND POLICIES

- Ensuring access to safe abortion and addressing gender-biased sex selection http://www.fogsi.org/wp-content/uploads/2015/12/mtp-guidance-handbook.pdf
- The MTP and POCSO Acts https://www.ipasdevelopmentfoundation.org/download.php?resourceId=138
- World Abortion Laws Map: Produced by the Center for Reproductive Rights, this online map visually displays the legal status of abortion in each country of the world and is regularly updated. http://worldabortionlaws.com/map/
- World Abortion Policies 2013: Produced by the United Nations Population Division, this provides a list for each country on what grounds abortion is permitted alongside national statistics on abortion and contraception use. http://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml
- Country profiles: A website produced by the Asia Safe Abortion Partnership (ASAP) providing easy to read summaries of the abortion laws, policies and practices in 17 countries in Asia. http://asap-asia.org/country-profiles/

SERVICE PROVISION

- Sexual Health and Abortion Services Worldwide: Produced by Women on Waves, this site contains information about abortion services available in most countries of the world. https://www.womenonwaves.org/en/page/4741/sexual-health-and-abortion-services-worldwide
- Where Women Have No Doctor: Abortion and Complications from Abortion: An easy to read, practical online publication from Hesperian Health Guides outlining safe and unsafe abortion, what a safe abortion involves and what to expect after an abortion. It includes instructions for how to give emergency assistance to women who have severe bleeding due to abortion complications. http://en.hesperian.org/hhg/ Where_Women_Have_No_Doctor: Chapter_15:_Abortion_and_Complications_from_Abortion
- World Health Organization Abortion Resources: Key resources published by the World Health Organization on abortion, including clinical guidelines and global and regional estimates of levels of safe and unsafe abortion. www.who.int/reproductivehealth/publications/unsafe_abortion/en/
- Youth and Abortion Guidelines: Produced by IPPF, this guide provides information for young people, health professionals, policy makers and advocates about increasing young people's access to safe abortion services (also available in Spanish and French), www.ippf.org/resource/Youth-and-abortion-guidelines

ABORTION MESSAGING EXAMPLES AND TOOLS

- A Haven in a Land of Unsafe Abortions: A photo-story of one woman's experience of undergoing abortion in India. A good example of how photos of women can be very powerful in capturing the audience's attention and telling the story. www.npr.org/2014/12/31/374253565/a-haven-in-a-land-of-unsafeabortions
- Sexual and Reproductive Health and Rights Terminology Guide: Developed by the IPPF South Asia office, this document provides guidance for using accurate, gender-sensitive, non-discriminatory and culturally-appropriate language for sexual and reproductive health and rights that promotes universal human rights. http://www.ippfsaro.org/sites/ippfsaro/Pages/Publications.aspx

- International Campaign for Women's Safe Right to Abortion at http://www.safeabortionwomensright.org/press-room/

IMAGE LIBRARIES

- Images of Empowerment: This photo library, produced by Jonathan Torgovnik of Getty Images with support of the Hewlett Foundation, provides high quality empowering images of women in Kenya, Senegal and Uganda. All images can be downloaded and used free of charge for non-commercial purposes. www.imagesofempowerment.org
- Hesperian Images: This library contains simple line drawn illustrations from the Hesperian Health Guides. The images are available for download and use in online and print materials for a small cost. http://images.hesperian.org/libraryhome.tlx

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