A REPORT ON GENDER SENSITIZATION WORKSHOP FOR MIDWIFERY EDUCATORS AND INSTRUCTORS

Program details:

Date: 2020/02/15

Venue: Alfa House, Baneshwor, Kathmandu

Time Duration: 8:00 am to 5:30 pm

Facilitators:

- Advocate Sonali Regmi
- Advocate Prabhakar Shrestha (CRR)
- Dr. Savana Pradhan
- Dr. Deeb Shrestha (Ipas Nepal)
- Ms. Shreejana Bajracharya (YoSHAN)
- Ms. Durga Sapkota (YoSHAN)

Background:

About YoSHAN:

A GROUP PICTURE WITH THE PARTICIPANTS AND CONTRIBUTORS AFTER THE WORKSHOP
Youth led Sexual and Reproductive Health Advocacy Nepal (YoSHAN) is committed to reach diverse groups/organizations/individuals who are working on issues of sexual and reproductive health right issues in order to encourage them to explore how we, as a network, can facilitate that for other groups. YoSHAN dedicated to mitigating the gap that exists between SRHR and Safe Abortion Advocacy through meaningful participation.

About Programme

Nepal has come a long way from criminalizing to legalizing abortion in 2002. The Government of Nepal (GoN) has promulgated progressive abortion laws, provisioning for free Safe Abortion Services (SAS) through listed government health facilities nationwide. In 2018, the Government has further endorsed Safe Motherhood and Reproductive Health Rights (SMRHR) Act to ensure the SRHR including right to safe abortion. However, more than half of those pregnancies is unwanted and more than 50% of abortion is conducted through clandestine procedure. Despite these legal arrangements, women are still not being able to exercise their rights due to accessibility and availability as a main barrier followed by social stigma as another major barrier. Consequently, women still do not have the right to make one of the most important and life-transformative decisions.

In a developing country like ours, social stigma persists at different levels: individual, community, institution, law enforcement, mass media and culture. For. e.g. disapproving and prejudiced stereotyping of women who have undergone abortion is the most common form of abortion stigma. Besides the various stigma, there occur complex and embedded patriarchal society and gender power relation that seek to control female sexuality. Deeply ingrained prejudice among women seeking abortion especially towards unmarried women is a barrier for them to access Safe Abortion Service (SAS) where they often witness the denial and unwillingness of the service providers while requesting for the services. The attitude of service providers also reduces the quality of the services as well as effects on how they provide information to the recipients.

In line with the service providers and the curriculum they have been following, there only exist the technical aspect on Safe abortion, Menstruation, Family Planning and child birth. Yet, the curriculum is not able to include the right based approach. With the commencement of Midwifery education since 2016, the Government of Nepal is all geared up to reduce Maternal and neonatal mortality and morbidity by providing skilled compassionate care. All the while, it seems to be an opportunity to train the midwifery instructors on the concept of right based approach on SRHR so that the future providers shall be molded towards delivering holistic quality care inculcating the human rights perspective as well. Hence, it is crucial to frame the attitude of current the midwifery instructors who guide the future service providers so as to ensure that there is right based approach during service delivery at the receiving end.

Midwifery- although a fairly new concept in Nepal, it has been around for ages. With the initiation of Bachelor programme in Midwifery education in Nepal by universities like NAMS, a need had been felt to sensitize the midwifery educators and instructors about the ever so convoluted issues regarding gender, patriarchy, feminism, safe abortion provisions and so on. Our target group for this one-day workshop were the midwifery educators because this will have a ripple effect subsequently on the future midwives, training under them and have an impact on the way they deal with previously mentioned issues.

Stating from evidence, midwives have played a crucial role in reducing maternal and neonatal death and disabilities. With just a nudge that we hope to create from this workshop, the midwives will have
a whole new perspective, and this would contribute for a better maternal reproductive health along with neonatal health scenario in the future.

This small step can change the trajectory of Sexual and Reproductive health service delivery. So YoSHAN in collaboration with ASAP is aiming to conduct one-day gender sensitization training so that they could deliberate the session in their respective universities through feminist lens.

ABOUT THE PARTICIPANTS: The participants selected were from various backgrounds, from different parts of the Nepal to ensure inclusiveness, intersectionality and also to gain a perspective on situations of sexual and reproductive health in different areas of the country.

SESSIONS COVERED THROUGHOUT THE WORKSHOP:

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EXPECTATIONS OF THE PARTICIPANTS:

Before the facilitators took over, we asked all the participants to write down their expectations from the workshops. Some of the excerpts are presented below:

- To know about legal reproductive rights of Nepal
- To understand about conscientious objection
- To better understand the safe motherhood act

- To get more information about Safe Abortion and Reproductive Health Right Act 2075
- To get information about the use of telemedicine for safe abortion
- To know about different perspectives on legal act
- To get clarity about gender dynamics

- To be able to understand the new politics endorsed in the Safe Abortion and Reproductive Health Right Act 2075
- To understand and apply the abortion laws

- To get information on Universal Health Coverage (UHC)
- To learn about gender and society
- To update knowledge on women’s rights
DETAILS OF THE SESSIONS:

Before the sessions started, Youth Champion Srijana Bajracharya explained about YoSHAN and ASAP and showed a short introductory video of YAI. Then, Durga Sapkota being the MC of the programme conducted a formal introduction, thanked all the participants for their time and interest and encouraged everyone for their active participation in the sessions.

SESSION 1: Sexual and Reproductive Health

- **Objectives of the session:** To understand the politics of sex-selection and abortion in patriarchal system
- **Facilitator:** Advocate Sonali Regmi

The session began with the introduction of the facilitator Advocate Sonali Regmi by herself as a policy level advocate. Then, she threw a question at the participants- Why do we really need to talk about sexual and reproductive health? One of the participants answered, “Because it is related to our body.”, emphasizing on the notion ‘MY BODY, MY RIGHTS’.

Despite of the entitlement of one’s sexuality and body to themselves, many decisions regarding our body are still taken by somebody else a.k.a. the policy makers who mostly are males who don't have a smidgen of clue about how a female body functions and it’s needs.

Next, for some self-reflection, Ms. Regmi presented the participants with series of questions; How does this relate to your life? How many of you have had the freedom to choose your life partner? How many of you knew what was going on with your body when you had your very first period?
Proceeding towards the culture of isolation of women during her menstruation, the facilitator mentioned an “aphorism” popular in Maharashtra, India for women during their menstruation—“कागले छोएको” which means that women, during their menstruation are forbidden to enter inside the house.

So, what can we do for a change? The answer is, even if we are chained by the norms of the past, the greatest contribution by us for the change would be to provide freedom to the future generation to breakthrough and rise above all these taboos and practices. In this light, literally everyone needs norm changing, even the high-level advocates need to do so i.e. there must be acceptance in every norm.

Next, Ms. Regmi showed the participants a cycle of a woman’s life and asked the participants to point out discrimination at any stage of her life:

The participants responded that women have to face some sort of partiality in every stage of her life. For instance, education privilege is different for a girl and a boy. The facilitator also gave a number of examples of this instance, starting even before birth i.e, sex selection.
What are reproductive rights?

➢ Reproductive rights are those of couples or individuals to freely decide the timing, number and spacing of their children, and to access information and care in matters related to sexuality and reproduction.
➢ Reproductive rights should be accessible, protected by the law and practical.
➢ There are 12 human rights keys/indicators to reproductive rights:
   1. The Right to Life
   2. The Right to Liberty and Security of Person
   3. The Right to Health, including Sexual and Reproductive Health
   4. The Right to Decide the Number and Spacing of Children
   5. The Right to Consent to Marriage and to Equality in Marriage
   6. The Right to Privacy
   7. The Right to Equality and Non-Discrimination
   8. The Right to be Free from Practices that Harm Women and Girls
   9. The Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment
   10. The Right to be Free from Sexual and Gender-Based Violence
   11. The Right to Access Sexual and Reproductive Health Education and Family Planning Information
   12. The Right to Enjoy Scientific Progress

While discussing the relation between assault and reproductive rights under the 9th key i.e, the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment, the facilitator shared an anecdote with the participants which they found quite surprising:

Anecdote: A woman detained in a hospital after delivery because she couldn’t pay her hospital charges for weeks- this is the violation of her fundamental liberty.

Under the discussion of the 11th key i.e., The Right to Access Sexual and Reproductive Health Education and Family Planning Information, the facilitator pointed out how in our part of the world there is almost no provision of comprehensive sexuality education, limited information included in curriculum, stigmas surrounding the concepts of sex and reproduction and unwillingness to teach about such concepts from the sides of the teachers as well. When this issue is addressed to the policy makers, they simply say that this is not in our “culture”. But if it really were so, what about Kamasutra? Isn’t this the prodigy of our culture too? - the facilitator pointed out sarcastically.

There are many factors constraining us from acquiring our full sexual and reproductive liberty; the first and the most important being our constitution and not to mention- the patriarchy. In this regard, Ms. Regmi shared a dialogue from a Bollywood movie that reads:
“मांग मेरी सिन्दूर तुम्हारे नाम का,
गला मेरा मंगलसूत्र तुम्हारे नाम का,
कलैया मेरी चुडिया तुम्हारे नाम की, यहाँ तक की कोख मेरी, खून मेरा, दूध मेरा और बच्चा तुम्हारे नाम का,
सब कुछ तुम्हारे नाम का………..फिर ये बताओ आखिर तुम्हारे पास क्या है मेरे नाम का”

This is the best representation of how patriarchy constrains our sexual and reproductive rights.

Besides these, there are barriers on many levels that compromises one’s ability to exercise including

1. **Home-based barriers** (Example; a cultural belief that once a man gets vasectomy, he is unfit to perform rituals like shradhha.)

2. **Community-based barriers**

3. **Distance barriers**

4. **Service barriers**

The session then proceeded towards the discussion about **gender biased sex selective abortion**. The facilitator raised a question to all the participants asking them the causes. **Preference to son, social security, dowry system, social status, continuation of the family legacy** were some of the answers given by the participants. The facilitator gave quite an interesting perspective about people who obsess over continuing their “family legacy” by mentioning that in fact, **nobody will know the names of their forefathers 7 generations before. So, what even is the point of all this hassle?**

When asked about the solutions to the issue regarding **gender biased sex selective abortion**, some of the answers given by the participants were:

- Women empowerment
- Educating the males too
- Awareness about sexuality and reproductive health rights
- Equal involvement of both parents in birth of their child
- Equal opportunities for women
- Meaning participation of women in politics
- Impartial laws (Example: equal citizenship rights)

However, **none of the participants thought that banning sex selective abortion will lead to a decrease in gender biased sex selective abortion**. In the contrary, they had a consensus that this ban would further impose a threat to women’s reproductive health as in absence of proper education and empowerment, women will be willing to go any limit for sex selection.
SESSION 2: Safe Motherhood and Reproductive Health Right Act 2075

- **Objectives of the session:**
  1. To know about Safe Motherhood and Reproductive Health Right Act 2075 and its importance in day to day clinical practice
  2. To understand about conscientious objection and its legal aspect
  3. Clarify about legal issues that health service provider may encounter while providing SRHR including safe abortion and family planning services

- **Facilitator: Advocate Prabhakar Shrestha**

The session began with a brief introduction to the current safe motherhood and Reproductive health right act, beginning with the history of abortion laws in Nepal. Abortion was legalized in Nepal in 2002. There were mainly 2 studies that made the policy makers realize the dire need of legalization of safe abortion in Nepal.

The first study was regarding maternal health when the maternal mortality rate was staggeringly high. The results showed that about 50% of maternal death before 2002 was due to unsafe abortion. Also, 54% of all the maternal hospital admissions were due to abortion complication management which tentatively cost each individual about Nrs. 10,000 to 35,000.

Another important study was done in 1998 among women in prisons of Nepal. It showed that 21% of women in the jail were there due to abortion related issues. On the opposite side, only 0.1% of male prisoners were there due to abortion related offence while none of the service providers were imprisoned for this “offence”. In this regard, Mr. Shrestha mentioned a popular saying applicable to Nepalese society at that time- नेपालको कानून गरीबको लागि ऐन , धनीको लागि चेन, which means that the privileged ones could dodge the law, while the underprivileged were the ones who had to bear the consequences as stated by the so called law before 2002. This was the legal implication of criminalization of abortion. The clinical consequences were far more severe as many women, especially those without access to health services, had to face severe morbidity and even mortality due to unsafe abortion practices.

All of these legal and clinical implications led to a concrete realization by the Government of Nepal that banning abortion doesn’t stop abortions, but rather it increases the number of women seeking for unsafe abortion services which could severely pose a threat to their health and overall wellbeing. Later in 2002, 11th amendment to the civil code was made, which still stated abortion as a criminal act, but if abortion was done fulfilling the conditions as mentioned, it was not an abortion but rather a suspension. In 2063, abortion rights were included under fundamental women’s rights.
**Anecdote:** Lakshmi Devi Dhikta’s case, which brought a revolution in women’s human right, legal rights and abortion in Nepal in 2009, is also taken as a case of reference in Harvard University of Law.

**Post-legalization scenario:** The maternal mortality rate (MMR) reduced drastically to 239 per 100,000 women. However, still today about 58% abortions take place outside the government certified safe abortion service centers. 41% of maternal mortality takes place in health care facility. The reason behind this is multiple: delay in seeking health service being one of them. According to Sustainable Development Goals (SDGs), Nepal aims to reduce the MMR to 70 per 100,000 women by 2030, which seems practically unachievable at the present pace.

The facilitator emphasized on the 12 indicators of reproductive health rights and considered them to be the gist of sexual and reproductive health rights. These indicators are universal. Unfortunately, not a single indicator is a hundred percent achieved in case of Nepal. Nonetheless, we have 31 fundamental rights in Nepal, which is exemplary.

Next, the facilitator presented some hurdles in the way of sexual and reproductive health rights in Nepal. For example, when the bill regarding safe abortion laws were first passed, media covered the news entitled “बच्चा मानेकानून” or the law for killing children. While discussing the newest amendment to the abortion laws limiting the time for abortion in a health care facility upto 28 weeks, Mr. Shrestha said that this was “regressive” and was for the protection of health care providers rather than the women.

The facilitator also pointed out some ridiculous provisions in our constitution. For example: In case of any reproductive morbidity of the wife, the husband can file for a divorce. This left the participants truly appalled. He even mentioned an ironical fact: *Despite of all the legal provisions for safe abortion, annually 264 cases are registered regarding abortion while although it is illegal and clearly rampant, only 42 cases of child marriage are registered in the court of law annually.*

**End points:**

- Gestational limit of abortion is decided by the state, it is NOT universal.
- There is NO universal time for foetus viability, **the right to life begins only after birth.**

**SESSION 3: VIDEO CLIP (ACHHAM DOCUMENTARY)**

- **Objectives of the session:**
  1. To interpret the perception of women from this clip
  2. To know the present status of women in rural Nepal
  3. To know about the Universal Health Coverage (UHC)

- **Facilitator:** Dr. Savana Pradhan
After watching a short documentary covering a story of a local woman from one of the remote areas of Nepal who died due to complications caused by unsafe abortion practices, the floor was open to interpretations by the facilitator. Questions were raised regarding the prevalence of such insane abortion practices in Nepal despite of legalization of abortion. This showed a challenge to make abortion facilities accessible and affordable.

Participants seemed particularly ridiculed by the comment made by Nanda Lal Bohara, secretary of The Red Cross in the documentary, who was glorifying the unsafe abortion practice. If a person of his credential can be so ignorant, we can only imagine the condition of the rest of the people who are uneducated, unprivileged and practically clueless.

The session then proceeded to cover the concept of Universal Health Coverage (UHC).

What is UHC?

- **UHC** is firmly based on the WHO constitution of 1948 declaring health a **fundamental human right** and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related **Sustainable Development Goals (SDGs)** and brings hope of better health and protection for the world’s poorest.

- Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

- This definition of UHC embodies three related objectives:
  1. Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
  2. The quality of health services should be good enough to improve the health of those receiving services; and
  3. People should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

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<th>Components of UHC</th>
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<td>Preventive</td>
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<td>Promotive</td>
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<tr>
<td>Treatment</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>Information</td>
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<tr>
<td>Gender Equality</td>
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<td>Health for all</td>
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SESSION 4: VALUE CLARIFICATION AND ATTITUDE TRANSFORMATION

Objectives:

1. To identify values that conform the current beliefs and attitude about abortion and be able to describe alternative values
2. To distinguish between assumptions, myths and realities surrounding unwanted pregnancy and abortion.

Facilitator: Dr. Deeb Shrestha Dangol and Ms. Durga Sapkota

The session began with the facilitator highlighting the fact that in a health care setting, the responsibility of making the service seeker feel safe begins right from the door. So, every personnel in that setting must know the services they provide and must have clear values.

Values are the basic and fundamental beliefs that guide attitudes and actions. They may be universal or communal. Our norms and values basically shape us as a person and provide a different perception.
to everything. Whatever maybe our preconceived notion about something, we must always be open to change.

There are pros and cons to everything. Most of the time, one outweighs the other and that is how we label certain action/intervention/practice as good or bad. The facilitator asked the participants the pros and cons of legalization of safe abortion in Nepal, to which they had some interesting responses:

<table>
<thead>
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<th>PROS</th>
<th>CONS</th>
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<td>• Reproductive and sexual liberty</td>
<td>• Abortion taken as a means of contraception</td>
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<tr>
<td>• Right to own body</td>
<td>• Gender biased sex selective abortion</td>
</tr>
<tr>
<td>• Reduction in complications due to unsafe abortion and many more</td>
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At a glance, the cons so presented look trivial compared to the pros. With deeper look, we will be able to see that for sure. For instance, sex selection cannot be attributed to legalization of safe abortion because sex selection and preference to one sex over the other has been going around for ages and even before legalization of safe abortion, women were willing to risk their everything to have a son.

The facilitator also pointed out how the reproductive health services in Nepal is incomplete and hence, ineffective. In this light, Dr. Shrestha asked how many of the participants had provided counselling to the women after their delivery. Only a few of them agreed to have done so.

Next, each of the 4 groups of the participants were given 4 cases of women who needed an abortion and were directed to prioritize. The cases were:
1. A 45-year-old woman is 18-weeks pregnant. She had stopped having regular menstrual cycles and did not believe she could become pregnant. A detailed ultrasound has revealed severe foetal abnormalities. Her 12-year-old son has numerous physical and developmental disabilities and requires constant attention. She does not feel able to manage another special-needs child.

2. A 21-year-old woman in her third year at university just found out that she is 14-weeks pregnant. Because her menstrual cycle was irregular, she did not realize she was pregnant. This is her first pregnancy. Her contraceptive method failed, even though she is quite certain she used it properly. She is the first person from her poor, rural village ever to attend university. She is experiencing acute anxiety at the thought of continuing this pregnancy.

3. A 25-year-old woman is 8-weeks pregnant. She has two children under the age of four, and she lives with a man who regularly physically abuses her. He opposes the abortion, but she does not want to bring another child into an abusive household, especially if it will only make her more dependent on him for financial support. Her depression has worsened considerably since she found out she was pregnant.

4. A 28-year-old woman is 12-weeks pregnant. She is unemployed, an alcoholic and does not use birth control regularly. She does not know who the father of this baby is. Two of her children were born with foetal alcohol syndrome, and all three of her children are being cared for by her mother in another part of the country.

5. A 23-year-old woman with two young children is 10-weeks pregnant. She and her younger child are HIV positive. Her husband died of AIDS-related illnesses two years ago and left her without any financial support. She is not able to afford anti-retroviral treatment, and she has been hospitalized for opportunistic infections several times in the past year.

6. A 15-year-old girl is 14-weeks pregnant as a result of rape by her stepfather. When she told her mother about the rape and pregnancy, her mother told her to get out of the house. She has been staying at a friend’s house. She continues to attend public school, where she has been a top student. She is experiencing great distress over the rape and pregnancy, and her schoolwork is suffering.

All the groups had a need-based approach and they ranked the cases according to their perceived priority. Number 6 was on the top of their priority list when in reality, according to a rights-based approach, each and every case should have been equally prioritized.

VALUE CLARIFICATION:

Each participant was given a piece of story about a girl who had to lose her life due to an unsafe abortion:
After everyone had gone through the story, the facilitator asked them the people responsible for Uma’s death along with their reasons. These were their responses:

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<th>People accountable to Uma’s death</th>
<th>Reasons</th>
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<td>Her aunt</td>
<td>She was very judgemental and unsupportive</td>
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<td>The pharmacist</td>
<td>Failed to provide proper counselling, instead suggested unsafe abortion</td>
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<td>Hari, her boyfriend</td>
<td>Didn’t support Uma, Didn’t practice safe sex</td>
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<tr>
<td>Her mother</td>
<td>Couldn’t provide a safe space to her daughter to talk about such issues</td>
</tr>
<tr>
<td>Her schoolteacher</td>
<td>Was unable to educate regarding safe sex and abortion</td>
</tr>
<tr>
<td>The unsafe service provider</td>
<td>Jeopardized Uma’s life</td>
</tr>
<tr>
<td>The society</td>
<td>Because of our norms and the stigma surrounding sex before marriage and abortion</td>
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Further Ms. Durga Sapkota shared about state accountability. Since our state has included SRHR as a fundamental right, state is equally accountable to Uma’s death because there are no special provisions to ensure the accessibility of their fundamental rights by the citizens. Basics like provision of Comprehensive Sexuality Education at school levels, campaigns to reduce stigma towards reproduction and sexuality, accessibility of safe abortion facilities have still been untouched by the state. In addition, the state/policy makers still regard abortion as a crime which is pretty clearly evidenced by the inclusion of safe abortion laws in the criminal code while rest of the reproductive and sexual health rights are included in the Safe Motherhood and Reproductive Health act 2075.

To provide an idea about the condition of sexual and reproductive health and rights scenario in our country, Ms. Sapkota shared two anecdotes with the participants:
Anecdote: A young, educated woman was humiliated and accused of committing a “sin” by the health service provider, when she came to seek for an abortion service in a “holy day” when she was fasting because supposedly the act of abortion was ruthless and “unholy”.

Anecdote: A woman faced series of backlashes leading her to continue a triple pregnancy (all female foetuses). She actually wanted a son, and this was her third pregnancy. But she wasn’t there all by her wish, instead there were a dozen of hands pushing her to the place where she stood then.

With this activity, the participants came to realize that there are multiple facets to a single case of a woman seeking an abortion service. So before jumping to any conclusions, we must ponder about the many different factors that led here in that position and we must try to address every one of those factors as a service provider and as an advocate for safe abortion.

SESSION 5: MEDICAL ABORTION DRUGS, IT’S AVAILABILITY AND REGULATION

Objectives: To understand the extent of market availability of registered and unregistered MA pills and dispensing practices of private pharmacy outlets vis-à-vis government regulations and surveillance.

Facilitator: Ms. Shreejana Bajracharya

The session facilitated by Ms. Shreejana Bajracharya (YoSHAN), who had working experience in Marie StOPS revolved around two major abortion pills; mifepristone and misoprostol. Although accessible, these drugs are not available over the counter and only found in specific pharmacies around safe abortion service centers. They are dispensed as per the guidelines provided by the WHO and the state. Abortion induced by such medications is termed as “medical abortion.”

Medical abortion is a method that essentially initiates a miscarriage, which is a natural phenomenon in almost 20% of all pregnancies. They are usually preferred for abortion before 9 weeks of gestation as they are safe, effective and private. The are certain protocols for the use of mife and miso. The recommended method for pregnancy of gestational age upto 9 weeks is:
Mifepristone (200 mg orally. Followed 1 or 2 days by
Misoprostol (vaginal, buccal or sublingual 800mcg. Oral 400mcg can be used before 7 weeks)

According to World Health Organization (WHO), there are some clinical considerations regarding medical abortion:

- Medical abortion is a multistep process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol alone)
- Mifepristone with misoprostol is more effective than misoprostol used alone and is associated with fewer side-effects.
- Allowing home use of misoprostol following provision of mifepristone at a health care facility can improve the privacy, convenience and acceptability of services, without compromising on safety. Facility-based abortion care should be reserved for the management of medical abortion for pregnancies over nine weeks (63 days) and management of severe abortion complications.
- Women must be able to access advice and emergency care in the event of complications, if necessary.
• Inform the woman that misoprostol might have teratogenic effects if the abortion fails and the woman decides to continue the pregnancy.
  ➢ There is no need to insist on termination of an exposed pregnancy; data are limited and inconclusive regarding teratogenicity. However, because of potential risk, follow-up of a continued pregnancy is important in this situation.
• Mifepristone and misoprostol do not terminate ectopic pregnancy.
  ➢ Absence of bleeding is a possible indication that the pregnancy may be ectopic, but it may also signify that an intrauterine pregnancy did not abort.
  ➢ Even if a pregnancy is ectopic, a woman can experience some bleeding after taking mifepristone and misoprostol because the decidua may respond to the medications.
  ➢ Evaluate the woman for ectopic pregnancy if she reports signs or symptoms of ongoing pregnancy after medical abortion.

**WHO RECOMMENDED TREATMENT REGIMEN FOR MA BEFORE 12 WEEKS OF GESTATION**

Out of 28 brand generics of mife and miso, only 4 are registered which includes Mariprist.
Summary of the day:
Towards the end of the programme, Ms. Durga Sapkota summarized the whole day.

Summary of the sessions:

Ms. Durga wrapped up the whole one-day workshop with an insightful presentation:

- Although the laws state our freedom to choose the number of children we want to have, advertisements like this manipulates us and compels us in choosing something we were not on aboard with initially. This is when the politics and the passive manipulation of the media comes to play, which goes unnoticed.
Most of the health care providers make a snap judgement and blame the adolescent either married or unmarried when they seek for safe abortion services. But, what they fail to notice is the rate of unmet need among the adolescents which is staggering. The number is even higher among the age group 15-19 years which sure says a lot about our reproductive and sexual health laws, their accessibility and effectiveness.

We often hear about the “misuse” of safe abortion facility, especially in Kathmandu and how women have been using abortion as an alternative to contraceptives use. But what the media
fails to cover is the high rates of unwanted pregnancies and the rates of unsafe abortion in different regions of Nepal, including province number 3.

- Upon reflection of the data provided by the NDHS, only 9% of total pregnancies is aborted even though the unmet need for family planning is much higher. Even today, 58% of all abortions is unsafe. As advocates of safe abortion, our mission is to reduce the stigma behind abortion and making the system accountable.
• IVF vs Abortion: Despite of having significant risk compared to safe abortion, IVF holds very less stigma. Upon some reflection, it is clearly evident than stigmas related to abortion has nothing to do with being pro-life, but it has everything to do with controlling women or in other word this is the outcome of our patriarchal mindset.

Abortion Rate by Trimester

- Upto 12 weeks : 97%
- 13 to 28 weeks : Around 3%
- 25- 28 weeks : 0.03%

Ref: Dr. Bhim Singh Tinkari (Family Welfare Division)

• The recent amendment to the abortion laws upgraded the legal gestational age for abortion to 28 weeks. This particular change became scandalous for health service providers as they argued that increasing the gestational age legal for abortion would be a challenge for them because the risks are higher in later trimesters. But if we take a peek at the data, only 3.03% of total abortions take place after 13 weeks, which also means that women seek for abortion in later trimesters only in case of emergencies or unavoidable circumstances. So, posing restrictions in abortion laws is basically denying women rights to their own body and living their lives on their own conditions. The only way to reverse this situation is to make abortion unconditional, without any time limit just like any other health services because abortion is not a privilege, but it is a fundamental right of every woman.
• Some stigmas surrounding abortion:

1. It is sinful activity to do abortion
2. Women who does abortion is characterless
3. Abortion Causes infertility, cervical Cancer and Breast Cancer
4. Emergency Contraception causes abortion
5. Pregnancy is safer than abortion
6. Criminalizing abortion will reduce abortion rate
7. Self managed medical abortion is dangerous and should not be encouraged
8. Women are suing abortion as birth control pill
9. Abortion is a Western imperialist export to developing countries.
10. Adoption is good than abortion
11. Due to availability of safe abortion, the trend of premarital sex has been increased and more adolescents are assessing safe abortion services.
ACTION PLANS:

All the participants were asked to make a six-month long plan so that they could disseminate the knowledge that they gained from this workshop. In total, 8 work plans were submitted in following format as some of the participants wanted to execute their plans in groups for a more effective outcome. Ms. Durga Sapkota and Shivani Rayamajhi will follow up the participants to execute their plan of action.

FORMAT OF ACTION PLAN DOCUMENTATION
EVALUATION

This one-day “Gender Sensitization Workshop for Midwifery Educators and Instructors”, was a huge success. The most important indicator of the success of the workshop was the sheer delight and sensitization among the participants at the end of the programme. Apart from the highly experienced facilitators, our participants were highly enthusiastic and had an active participation in every session conducted.

YoSHAN has always encouraged advocacy in every level and this sensitization workshop for midwifery instructors not only had an informative aspect to it, but the participants also got to be acquainted with the real-life issues in the field of sexual and reproductive health and rights. As a health service provider, the two most important qualities are **compassion and comprehension.** And this workshop has undoubtedly contributed to development of both compassion and the ability to comprehend and appropriately act upon various issues surrounding this very sensitive topic of sexual and reproductive health.

The participants were equipped with legal, practical and social aspects of sexual and reproductive health and rights. In my opinion, the VCAT session had the most drastic effect upon the participants as the facilitator wonderfully demonstrated how tangled and sensitive a single case of woman seeking for abortion can be.

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**A PARTICIPANT SHARING HER EXPERIENCE OF THE WORKSHOP**
After the completion of the programme, the participants were also asked to fill an evaluation form and the response was really overwhelming. Below are some of them:

<table>
<thead>
<tr>
<th>Question: What did you like the most about this workshop?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response: VCAT session, highly experienced facilitators, Safe abortion act 2075, Amazing exposure and friendly environment, Conducted by Youths. Besides, the participants were quite impressed by our punctuality, the interactive way that the sessions were conducted, group task assigned in sessions, our work ethics, smooth conduction of the programme and of course, the refreshments!</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: What are the new things you learned from this workshop?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response: History of legalization of safe abortion in Nepal, Legal aspects to safe abortion, Unregistered MA drugs, Hindrances in the path of safe abortion in Nepal, Importance of advocacy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: How do you hope to change your practice as a result of this workshop?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response: Acceptance in values, Dissemination of the knowledge gained, Be more compassionate, Advocacy in any level, Contribute to Value Clarification and attitude transformation of the midwifery students.</td>
</tr>
</tbody>
</table>
GALLERY:

YoSHAN CORE TEAM MEMBER MS. ANJILA THAPA PROVIDING CERTIFICATE OF GRADUATION TO A PARTICIPANT

YoSHAN CORE TEAM MEMBER MS. PRABINA SUJAKHU PROVIDING CERTIFICATE OF GRADUATION TO A PARTICIPANT
YoSHAN CORE TEAM MEMBER MS.BONITA SHARMA PROVIDING CERTIFICATE OF GRADUATION TO A PARTICIPANT

A GROUP PICTURE WITH THE PARTICIPANTS AND CONTRIBUTORS AFTER THE WORKSHOP
Contributors:

Youth Champions

Elisha Joshi
Program Coordinator

Durga Sapkota
Event Manager

Anjila Thapa
Communication Coordinator

Prabina Sujakhu
Finance Coordinator

Siwani Rayamajhi
Report writing

Shrijana Bajracharya, Bonita Sharma and Puspha Joshi Pradhan
Social Media Manager