

Facilitators' Guide for Training Safe Abortion Service Providers

On Strengthening Safe Abortion Service using Human Rights Approach



Author

Durga Sapkota

Advisor

Dirgha Raj Shrestha

Editor

Medha Sharma

Reviewers

Shilpa Lamichhane

Pratigya Kayastha

Bipana Shrestha

Ritendra Badu

Published

August 2024

© Copyrights Reserved - Visible Impact and YUWA

For further information please contact:

Visible Impact

611 Srijanshil Marg, Basundhara, Kathmandu

+977 9847697791

mail.visim@gmail.com

www.visim.org

YUWA

88, Khursanitaar, Lazimpat-2

(+977 1) 4419489 (+977 1) 4418747

info@yuwanepal.org

www.yuwa.org.np

List of Acronyms

AFHS:	Adolescent Friendly Health Services
AIDS:	Acquired Immuno Deficiency Syndrome
ANC:	Antenatal Care
Approx.:	Approximate
BPFA:	Beijing Platform for Action
CEDAW:	Convention on the Elimination of All Forms of Discrimination against Women
CO:	Conscientious Objection
CRC:	Child Rights Convention
CREHPA:	Center for Research on Environment Health and Population Activities
CRPD:	Convention on Rights of Persons with Disabilities
CRR:	Center for Reproductive Rights
D&E:	Dilatation and Evacuation
DDA:	Department of Drug Administration
FY:	Fiscal Year
FWLD:	Forum for Women, Law and Development
GoN:	Government of Nepal
HCP:	Healthcare Providers
HIV:	Human Immunodeficiency Virus
ICPD:	International Conference on Population and Development
ICRPD:	International Convention on Rights of Persons with Disabilities
i.e.:	That is
LGBTIQ+:	Lesbian, Gay, Binary, Trans people, Intersex, Queer and more
LMICs:	Low- and middle-income countries
MA:	Medical Abortion
MVA:	Manual Vacuum Aspiration
NDHS:	Nepal Demographic Health Survey
OCMC:	Onestop Crisis Management Center
OPD:	Organization Working with People with Disabilities
PHCC:	Primary Healthcare Center
PWD:	People with Disabilities
RHD:	Rheumatic Heart Disease
RTI:	Reproductive tract infections
SAS:	Safe Abortion Services
SDG:	Sustainable Development Goals
SMARH Act:	Right to Safe Motherhood and Reproductive Health Act
SRH:	Sexual and Reproductive Health
SRHR:	Sexual and Reproductive Health and Rights
STI:	Sexually transmitted infections
UDHR:	Universal Declaration of Human Rights
UPR:	Universal Periodic Review
VCAT:	Value Clarification and Attitude Transformation
vs.:	Versus
WHO:	World Health Organizations



About the Facilitators' Guide

What is this guide?

This facilitators' guide has been produced by Visible Impact in partnership with YUWA. As both organizations work to ensure an intersectional lens towards Sexual and Reproductive Health and Rights (SRHR), this guide aims to strengthen safe abortion services in Nepal by empowering service providers to consider service provision through that lens.

The guide is being developed as part of Visible Impact's project "Youth for Access to Abortion for Youth", which is funded by the Safe Abortion Action Fund (SAAF). The Safe Abortion Action Fund (SAAF) is the only global fund focused exclusively on the right to safe abortion. SAAF provides funding and support to organizations

in low and middle-income countries to work on abortion advocacy campaigns, conduct research, attitude-transformation, and provide safe, high quality abortion care.

YUWA is developing the manual with the support of Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky (PPGNHAIK), which is a trusted healthcare provider, an informed educator, a passionate advocate, and a global partner helping similar organizations in low and middle-income countries. They deliver vital sexual and reproductive healthcare, provide sex education, and advocate for rights in Alaska, Hawaii, Idaho, Indiana, Kentucky, and western Washington.

Who is this guide for?

This guide has been developed to support facilitators to conduct a three-day residential training for Healthcare Providers (HCPs) on SRHR, with a specific focus on safe abortion through a rights-based approach and on strengthening quality in the provision of adolescent and youth-friendly Sexual and Reproductive Health (SRH) services. Upon completion of the training, HCPs will be able to apply relevant knowledge and skills to provide improved sexual and reproductive services, especially to adolescents and youth. Additionally, trainees will likely be able to share their learnings with peers and other healthcare providers. This guide will help managers and other stakeholders take necessary actions in health facilities to improve the quality of SRH services, ultimately improving the overall quality of SRH services.

While the guide has been primarily targeted to healthcare providers, the session design, contents, and reference materials can be utilized by anyone interested in rights-based SRHR services such as policymakers, public health professionals, adolescents and youth, marginalized people including people with disabilities, activists, service seekers, and others.

How was this guide developed?

Before developing this guide, an extensive literature review was conducted on existing training literature around safe abortion, including those focused on healthcare providers. Frequent meetings were conducted between Visible Impact and YUWA, along with experts, developers and reviewers of this guideline to ensure that this guide becomes a valued addition and a fit for the targeted beneficiaries. Each session have been designed to allow efficiency in learning and its retention. The drafts have gone through multiple iteration of review, and were piloted among two training groups before finalization.

Why is this guide needed?

Women's right to safe and legal abortion is enshrined in numerous international treaties and other instruments.¹ However, the review mechanisms of these treaties and platforms have repeatedly reported maternal deaths due to unsafe abortion, highlighting a violation of women's right to life. For instance, the Program of Action adopted at the International Conference on Population and Development (ICPD) in 1994 called upon governments to consider the consequences of unsafe abortion on women's health, and urged them to address the health impact of unsafe abortion as a major public health concern.² Strengthening access to comprehensive abortion care within the health system is fundamental to meeting the Sustainable Development Goals (SDGs) relating to good health and well-being (Goal 3) and gender equality (Goal 5).³ Considering the importance of safe abortion services, the World Health Organization (WHO) included comprehensive abortion care in its list of essential health services in its operational guideline in 2020,⁴ and recently published abortion care guidelines in 2022.⁵

Despite recent advancements in safe abortion services, there were approximately 121 million unintended pregnancies globally each year from 2015 to 2019, with around 48% of all pregnancies being unintended. 61% of these unintended pregnancies ended in an induced abortion. There were an estimated average of 73 million abortions per year from 2015 to 2019. Global estimates demonstrate that 45% of all abortions are unsafe. Between 4.7% and 13.2% of all maternal deaths annually are attributed to unsafe abortions, highlighting the failure to provide safe abortion services.⁶ Deaths and injuries due to unsafe abortion disproportionately affects young women, people suffering from poverty, individuals residing in rural areas, and those lacking education, as well as those who belong to a racial or ethnic minority or Indigenous group.⁷

1 Center for Reproductive Rights. Safe and Legal Abortion is a Woman's Human Right, Briefing Paper. (2011)

2 Program of Action of the International Conference on Population and Development, Cairo, Egypt, 5-13 September 1994, para. 8.25, U.N. Doc.A/CONF.171/13/Rev.1 (1995)

3 Sustainable Development Goals (SDG), United Nations (2015)

4 Maintaining essential health services: operational guidance for the COVID-19 context, interim guidance. Geneva: World Health Organization (2020)

5 Abortion care guidelines, World Health Organization (2022)

6 Ibid.

7 IPAS. Women's Access to Safe Abortion in the 2030 Agenda for Sustainable Development: Advancing Maternal Health, Gender Equality and Reproductive Rights (2015).

Nepal made abortion legal in 2002, allowing women to terminate a pregnancy under certain conditions. The Constitution of Nepal has guaranteed women's reproductive rights, including safe abortion, as fundamental rights. To operationalize these rights, the Government of Nepal (GoN) developed the Right to Safe Motherhood and Reproductive Health Act (SMARH Act) in 2018, along with its subsequent regulation in 2020 and guidelines in 2021. The Act made slight revisions to the previous conditions for safe abortion services. Since 2016, safe abortion services have also been provided free of cost in all public health service centers in Nepal.

Moreover, Nepal has made remarkable progress in creating an enabling policy environment to address sexual reproductive health as rights and increase access to abortion services. The Manual Vacuum Aspiration (MVA)/Medical Abortion (MA) methods are available in all 77 district hospitals, with MA services offered in selected health facilities across the districts. By the end of FY 2077/78, a total of 912 health facilities had been registered for MA services, 604 for MVA/MA, and 22 for second-trimester services.⁸

However, barriers and challenges persist in ensuring the rights to Safe Abortion Services (SAS) for all individuals in need. Only, two in five (41%) women aged 15-49 are aware that abortion is legal in Nepal.⁹ According to a study conducted by Center for Research on Environment, Health and Population Activities (CREHPA) in 2014, approximately 323,100 induced abortions occurred in Nepal that year. Among them, 58% abortions were illegal and 6% of these abortions (accounting for 3% of all abortions) resulted in complications.¹⁰

In a developing country like Nepal, social stigma surrounding abortion persists at different levels: individual, community, institutional, law enforcement, mass media, and culture. For example, disapproving and prejudiced stereotyping of women who have undergone abortion is the most common form of abortion stigma. In addition to various stigmas, complex and embedded patriarchal society and gender power relations seek to control female sexuality. Deeply ingrained prejudices among adolescents and youth, especially towards unmarried

women, often result in denial and unwillingness from service providers when requesting for services. In some cases, young women have been referred to the Antenatal Care (ANC) checkup by healthcare providers considering their age and gestate, even when facing unwanted pregnancy.

Furthermore, research has shown that healthcare providers and managers often have inadequate knowledge about the human rights-based approach, including adolescent and disability-friendly services, while delivering sexual and reproductive health and services. The attitudes of service providers can reduce the overall service quality and affects how they provide information to recipients.

Safe abortion service providers training is one of the priority interventions of the Government of Nepal. With the commencement of midwifery education in 2016, the Government of Nepal aimed to provide skilled and compassionate care to reduce maternal and neonatal mortality and morbidity. Furthermore, as a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Nepal has been recommended by the CEDAW monitoring committee and the Universal Periodic Review (UPR) to “decriminalize” safe abortion. This indicates that Nepal is obliged to make safe abortion a long-term healthcare service, entitling every healthcare provider to offer these services. This presents an opportunity for us to change the attitude of healthcare providers toward safe abortion.

Hence, Visible Impact, along with YUWA, has developed this guide to provide orientation for service providers. Service providers play a crucial role in the community as they provide information, counseling, services and moral support to girls and women regarding safe abortion. So, they must have correct knowledge, positive attitudes and the skills necessary to provide quality safe abortion services, placing the client at the center of care from a rights-based approach. After receiving the training based on this guide, healthcare providers may become more willing to offer adolescent and youth friendly safe abortion services from a rights-based approach.

8 Paudyal Punya. Presentation done during 7th Safe Abortion Day (2020)

9 Ministry of Health, Nepal; New ERA; and ICF. Nepal Demographic and Health Survey (2016).

10 Puri Mahesh et al. Abortion Incidence and Unintended Pregnancy in Nepal, International Perspectives on Sexual and Reproductive Health, Vol. 42, No. 4 (December 2016), pp. 197-209

How to use this guide?

This guide has been designed in a way that any person with basic facilitation skills can use it. It is divided into five sections, each consisting of several sessions. Each session consists of two parts: The first part includes required time, objectives, necessary materials, and methodology for implementing the session. This part will guide facilitators to conduct the session effectively. The second part contains the content, notes for the facilitator, and references. The reference section is useful for both the facilitators and the participants to explore the topic further. Each session also includes key takeaways to help participants retain what they have learned.

Contents of the guide

Section 1: Preparation for Workshop

Methods of training conduction
Venue set up
Participant's selection
Monitoring and evaluation
Schedule

Section 2: Background Setting and Conceptual Clarity on Safe Abortion

Introduction and Objective Sharing
Understanding Gender Dynamics
Patriarchy and Bodily Autonomy
National and International Instruments on SRHR
Understanding SRHR
Comfort Continuum
Safe abortion History and laws in Nepal
Abortion Ground Realities
Public Health lens on Safe abortion
Clinical Overview of Safe Abortion

Section 3: Values Clarification and Attitude Transformation around Safe Abortion

Agree Vs. Disagree
Why did she die?
Intersectional Walk
Barriers and influencers to Safe Abortion
Last abortion
Decriminalization of Safe abortion in Nepal
Men and Abortion
Abortion Case Studies

Section 4: Adolescent and Disability Friendly Safe Abortion Services

Adolescent Friendly Safe Abortion Services
Disability Friendly Safe Abortion Services

Section 5: Summarizing Safe Abortion Training

Role Play
Action Plan
Review, Evaluation and Closing

Section

1

**PREPARATION
FOR
WORKSHOP**



Methods of training conduction

This training will utilize participatory methods such as interaction, experience and case story sharing, and drawing examples from real life situations. Participatory training encourages participants to share their experiences, reflect on their existing knowledge, skills, and attitudes, and work collectively on common issues and solutions. Focusing on interaction allows all participants to be active members of the learning groups and motivates them to generate new ideas.

The main role of the facilitators in the training is to foster interaction and create an enabling environment, rather than simply completing the subject matter in the guide. Since, the activities and the required materials mentioned in each session complement each other, it is important for facilitators to read the materials thoroughly and prepare themselves accordingly.

However, value clarification sessions sometimes take longer than planned, and facilitators should be comfortable with it. It is essential that participants gain clarity before moving forward. Therefore the guide simply serves as a guideline, and it is not compulsory to complete word for word.

The facilitator should focus on fostering productive discussions rather than supporting one side of the values and imposing their views. It should be clearly conveyed that there are no definitive right or wrong answers in any discussion, and everyone is free to express their opinions without judgment.

The situation regarding sexual and reproductive health and rights varies across contexts, influenced by knowledge and socio-cultural aspects. Furthermore, the participants are healthcare providers who often have more real-life experiences than the facilitators, and may raise issues related to local situations that the facilitators might not be aware of. The contents of this guide are based on findings from national and international studies and interventions. The sessions are designed to cover extensive information and VCAT activities related to safe abortion; however, the contents of the sessions can be chosen according to the local context. The quality of sexual and reproductive health services is affected by different factors including the technical competence of service providers,

the availability of equipment and supplies, and the policies and guidelines of health facilities. Therefore, providing training to service providers alone cannot guarantee an improvement in service quality. Management committee members and managers of health facilities should avail enabling environment in the health facilities so that service providers can apply their knowledge and skills to provide quality services.

The guide is designed to allow one lead facilitator to maintain the flow of the course, while technical sessions can be facilitated by resource persons. Depending on the pool of technical expertise, two or three facilitators can collaborate to conduct the overall training.

Facilitator(s) should conduct the session by referring to the methods outlined in the session plan. The teaching and learning process, as well as exercises, are presented in a clear and simple manner to enable facilitators to read and conduct the session independently. The session plans are intended as guidelines, and facilitators can adapt them according to the context and needs.

Venue setup

- Since the training focuses on healthcare providers, it makes sense to conduct it in familiar and convenient locations for the participants, such as it in health office premises or halls, such as Provincial health training centers, hospitals, or service centers.
- Set up the training hall in a bright and spacious room, where participants engage comfortably and feel safe sharing their views and experiences.
- Arrange chairs in a U-shaped seating without tables at the front to encourage participant interaction, even if it makes some participants feel slightly vulnerable. For group works, set up a round table with 5-6 people at each table. You can also encourage participants to hold group discussions in different areas of the premises, for a change. Try to use various settings for different activities to allow maximum interaction.
- Use colorful Meta cards and cutouts on the walls to explain the processes instead of relying on slides. Minimize the use of slides to allow discussion and interaction.
- Facilitators should always arrive before the participants to set up the venue, arrange

necessary materials, set up registrations, equipment, etc. to avoid loss of time.

Participants selection

The ideal number of participants for each session is 20-25. To ensure effectiveness, participants should be selected based on their knowledge and experience in working at health facilities, specifically in the area of sexual and reproductive health, including safe abortion services.

Monitoring and Evaluation

Monitoring of the training will take place through daily review sessions. The evaluation will focus on two key indicators of change:

- At least 60% of participants should express confidence in providing services with a human rights focus in their community upon completion of the training.
- The knowledge and skills test score increases by at least 30% upon the course completion.
- Pre-post-test questions, along with an evaluation form will be used to assess the course's effectiveness.

Schedule

Timing	Sessions	Objectives of session
Day-1		
9:00-10:00 am	Introduction and Objectives Sharing	<ul style="list-style-type: none"> • Meet and greet each facilitator, organizer, and fellow participants • Understand the objectives of the training • Map the expectations • Set Ground Rules • Conduct pre-evaluation of the training
10:00-11:00 am	Understanding Gender Dynamics	<ul style="list-style-type: none"> • Define and understand the technical differences between gender and sex • Explain different terminologies related to the gender spectrum from a rights-based approach to understand that the need for access to safe abortion services extends beyond just women
11:00-11:45 am	Patriarchy and Bodily Autonomy	<ul style="list-style-type: none"> • Explain the basic concept of patriarchy and bodily autonomy • Define different strategies employed by patriarchy to regulate bodily autonomy • Understand the effect of patriarchy on Sexual and Reproductive Health
11:45-12:00 pm	Health Break	
12:00-1:15 pm	National and International Instruments on SRHR	<ul style="list-style-type: none"> • Understand the different national and international instruments that exist around SRHR and its importance for healthcare provider
1:15-2:15 pm	Lunch	
2:15-3:15 pm	Understanding SRHR	<ul style="list-style-type: none"> • Define SRHR and its components • Understand the importance of SRHR
3:15-4:00 pm	Comfort Continuum	<ul style="list-style-type: none"> • Identify their comfort levels while delivering and discussing safe abortion • Evaluate how comfort levels transform into attitudes and affect societal norms • Discuss how these varying comfort levels relate to societal norms on abortion
4:00-4:15 pm	Health Break	
4:15-5:00 pm	Safe abortion history and laws in Nepal	<ul style="list-style-type: none"> • Understand the impact of the legalization of safe abortion on maternal mortality • Explain the different important milestones related to safe abortion in Nepal • Analyze the difference between the safe abortion laws of 2002 vs. 2018
5:00-5:15 pm	Work Division	<ul style="list-style-type: none"> • Division of work for presentation on clinical overview of abortion for the next day

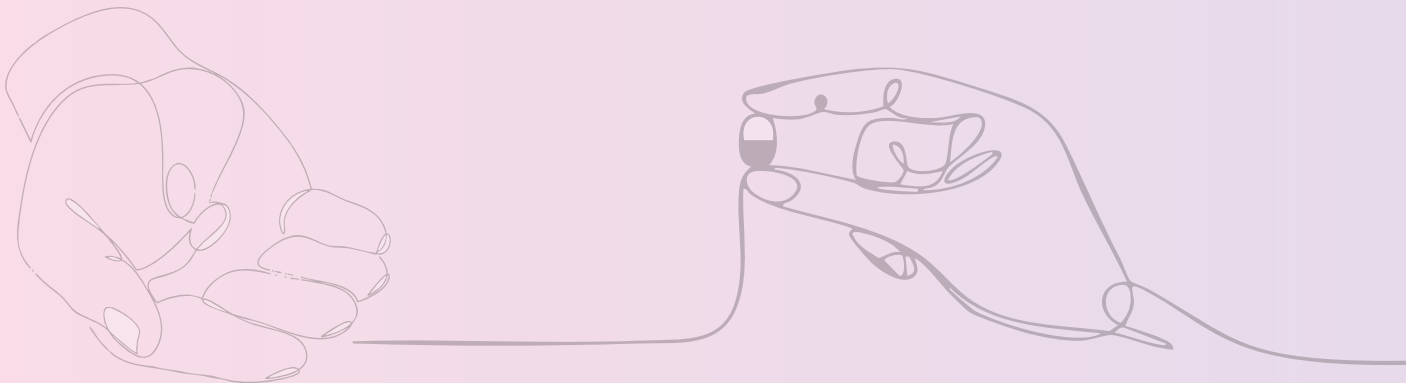
5:15-8:00 pm	Refreshment and Dinner	
8:00-8:30 pm	Abortion Ground Realities [Note: Total duration of this session is one hour, 30 min showing the film and 30 min review on next day]	<ul style="list-style-type: none"> • Reflect upon the ground realities of access to abortion, the attitude of males towards contraception, and the value of women a the patriarchal system with the help of a documentary
Day-2		
9:00-9:45 am	Review of the previous day Reflection on documentary	
9:45-10:45 am	Public Health Lens around Safe Abortion	<ul style="list-style-type: none"> • Understand the broader context of why safe abortion advocacy is necessary in Nepal • Reflect upon the facts and figures related to abortion justifying the importance of safe abortion advocacy more than ever
10:45-11:00 am	Health Break	
11:00-12:00 am	Clinical Overview of Safe Abortion	<ul style="list-style-type: none"> • Review the clinical terms and terminologies related to safe abortion
12:00-1:30 pm	Agree Vs Disagree Activity	<ul style="list-style-type: none"> • Reflect their personal values surrounding different aspects of bodily autonomy
1:30-2:30 pm	Lunch	
2:30-3:15 pm	Why did she die	<ul style="list-style-type: none"> • Understand the sociocultural context surrounding unwanted pregnancy and abortion among young women • Explain the tragic outcomes that can result from restricting access to safe, legal abortion services for young women • Articulate their personal or professional responsibilities in preventing deaths related to unsafe abortions and identify individuals, both within and outside the home, who may pressure a girl or woman to seek unsafe abortion methods
3:15- 4:00 pm	Intersectional walk	<ul style="list-style-type: none"> • Reflect how a variety of social, cultural, and gender values can both limit and enhance our life opportunities and outcomes • Recognize the diversity of young people seeking SRHR services
4:00-4:45 pm	Barriers and Influencers of Safe Abortion	<ul style="list-style-type: none"> • Identify different barriers to accessing and utilizing safe abortion services; especially for young heterogeneous people • Identify challenges healthcare providers face in providing safe abortion services to young people
4:45-5:00 pm	Health Break	
5:00-5:45 pm	Last Abortion	<ul style="list-style-type: none"> • Articulate biases people hold against certain women and their life circumstances with regarding abortion access • Discuss the challenges posed by restrictive abortion laws and policies
5:45-6:15 pm	Decriminalization of Safe abortion	<ul style="list-style-type: none"> • Understand the meaning of decriminalization of safe abortion in the context of Nepal
Day 3		
9:00-9:30 am	Review of the previous day	
9:30-10:15 am	Men and Abortion	<ul style="list-style-type: none"> • Understand the role of men before, during, and after the termination of pregnancy • Understand the importance of engaging men in discussions related abortion- related issues.
10:15-11:15 am	Abortion case studies	<ul style="list-style-type: none"> • Analyze individual case related to abortion and map the consequences of the denial of safe abortion by service providers

11:15-11:30 am	Health Break	
11:30-12:30 am	Adolescent-Friendly Safe Abortion Services	<ul style="list-style-type: none"> • Describe adolescent-friendly services and their characteristics • Explain the differences between adolescent's needs and adult women's needs regarding safe abortion • Identify and explain the barriers adolescents face in receiving information and services related to abortion
12:30-1:30 pm	Lunch	
2:30-3:30 pm	Disability Friendly Safe Abortion Service	<ul style="list-style-type: none"> • Understand the concept of disability friendly SRHR and safe abortion services • Describe the laws and policies in Nepal regarding safe abortion services for People with Disabilities • Explain the barriers that People with Disabilities encounter when seeking information and services related to safe abortion • Propose actions to be implemented for disability-inclusive safe abortion services
3.30-4.30 pm	Role Play	<ul style="list-style-type: none"> • Reflect upon the various criteria for adolescent and disability friendly safe abortion services through role play activities
4:30-4.45 pm	Health Break	
4.45- 5.00 pm	Action planning	<ul style="list-style-type: none"> • Create a tailored action plan that individuals can use as a tool to reflect on further activities
5:00-5:30 pm	Review, Evaluation and Closing	<ul style="list-style-type: none"> • Reflect, evaluate and close the training

Section

2

BACKGROUND SETTING AND CONCEPTUAL CLARITY ON SAFE ABORTION



SESSION: INTRODUCTION AND OBJECTIVES SHARING

Objectives of the session

By the end of the session, participants will be able to:

- Meet and greet each facilitator, organizers, and fellow participants
- Understand the objectives of the training
- Map the expectations
- Set Ground Rules
- Conduct pre-evaluation of the training.

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Registration and logistics information sharing	5 min	Registration	Registration sheet, banners, participants' contact details, attendance sheets
Salutations from the organizing committee	5 min	Lecture	Projector, screen
Introduction of the participants	25 min	Word Pair Game	Word chits
Expectation mapping and objective sharing	10 min	Brainstorming	Markers, newsprints, sticky notes
Setting of ground rules	5 min		
Pre-test	10 min	Quiz	Pre-test questions

Facilitation Instructions

Registration and logistics information sharing

After checking in, register the participants. Collect data about their name, ethnicity, sexuality, contact address etc. Inform the participants about logistics-room arrangement, available services, the nearest restroom from the hall, break times, per diem and travel settlements, etc.

Welcome by the organizers

Invite a senior member of the organization (e.g.: Executive Director) to deliver opening remarks to motivate the participants. Additionally, provide a brief overview of the organization and the project.

Introduction of the participations

Arrange the participants, facilitators and organizers in a circle. Toss the word pair chits in the air, ensuring each person catches a chit that contains a word related to the course. Play a fast-paced, well-known song to energize the room. While the music plays, the participants move around, passing the chits to one another. When the music stops, they shout and find the partner with the same word. They will then form pairs and introduce each other. They also share briefly what they know about the word in the chit.

During the introduction, each pair should address the following questions in one minute: *My friend's name is ... My friend lives in ... And*

works/studies at ... My friend's fun fact is... About the word in the chit, my friend thinks that ...

Sample word for chit game can be

- Sex
- Reproduction
- CSE
- Participation
- Advocacy
- Rights
- SOGIEB
- Governance
- Inclusion
- Respect
- Privacy
- Sexuality
- Communication skill
- Decision makers
- Activism
- Digital safety
- Lobby meeting
- Body image

Expectation Mapping and Objective sharing

Provide two sticky notes to each participant and ask them to write one expectation from the course on each note. The participants then stick the notes on a designated newsprint on the wall. The facilitator will group similar ones together, and explain which of the objectives might be met during the course. If there are any unplanned learning expectations, inform the participants and guide them to resources where they can find that information. To the extent possible, adjust the session timings to address all the expectations of the participants.

Using a PowerPoint slide or newsprint, explain the objectives of the course, including the schedule and key session planned.

Setting ground rules

Set up a newsprint at the front of the hall. Ask the participants to suggest ground rules to be followed during the course. You can also

propose some light-hearted punishments such as dancing, singing, or paying a small fine to buy snacks.

Sample ground rules can be

- Be punctual and respect each other's time.
- Obtain consent for photos/videos at the beginning of the course.
- Optimize mobile phone use by keeping devices on silent mode and answering calls only in emergencies.
- Do not use mobile phone inside the course hall. If there is an urgent call, please step outside to take it.
- Listen actively.
- Avoiding interrupting when someone else is speaking.
- Express your views clearly and concisely.
- Everyone has the right to refrain from participating in any activity that makes them uncomfortable.
- Matters discussed inside the hall should be treated with respect and confidentiality to ensure a safe space for all participants.
- Agree to provide space for equal and active participation. Encourage others to participate actively.
- Agree to disagree: respect each other's ideas and values even if you disagree with them.
- Respect each other irrespective of their geographical, ethnic, religious, sexual or cultural characteristics.

Pre-test

Distribute the pre-test form (Annex) to the participants. Ask them to state their name or any code if they want to be anonymous. If they choose a code, remind them to write it down somewhere so they can remember it for the post-test. Explain that participants should fill in the pre-test based on what they already know and emphasize that they shouldn't worry about getting the answers right. Ensure that participants do not share answers with one another.

SESSION: UNDERSTANDING GENDER DYNAMICS

Objectives of the session

By the end of the session, participants will be able to:

- Define and understand technical differences between gender and sex
- Explain different terminologies related to the gender spectrum from a rights-based approach to understand that the need for safe abortion services extends beyond women

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Pre-test	5 min	Brainstorming, Discussion	-
Gender and Sex Basics	10 min	Lecture	Laptop, PowerPoint, Newsprint, Marker
Difference between Sex and Gender	10 min	Brainstorming, Participation	
Gender and Sex Quiz	10 min	Participation	
Gender Bread Person	20 min		
	5 min	Participation	-

Facilitation Instructions

Pre-test

Ask the participants if they have heard the terms “Gender” and “Sex” and tell them to raise their hands if they have heard these terms below. Note how many participants confidently raise their hands. Then, ask 3-4 participants to share what they know about gender and sex. The facilitator should take note of any misconceptions participants may have about the concepts and emphasize the need to clarify those concepts during the session.

Gender and Sex basics

Explain that sex refers to the biological characteristics that classify human beings into male or female. Building on that, clarify that gender refers to the socially constructed characteristics of women, men, girls and boys. This includes the norms, behaviors and roles associated with being a woman, man, girl, or boy, as well as their relationships with one another. As a social construct, gender varies from society to society and can change over time.

Difference between Sex and Gender

Create two columns on a newsprint paper. Write “Gender” and “Sex” in the two columns. Ask the participants if they know any differences between the two. First record all the differences that they mention. Afterwards, if participants missed any significant points, facilitator should explain those as well.

Gender and Sex Quiz

Take a gender quiz to assess the participants’ confidence in differentiating between gender and sex. The facilitator can present statements related to Sex and Gender which has been listed in the content for facilitator, and ask participants to classify whether the attribute is related to sex or gender.

Gender Bread Person

After the quiz, with the help of the gender bread person picture, explain the terminologies; Gender Identity, Sexual Orientation, Gender Expression, and Sex. Explain that all these exist on a spectrum and are not related to each

Key takeaways from the session

It is a non-negotiable human rights principle to respect the sexual and gender identity of each and every individual. As healthcare providers, we must stay updated about gender and sexual identity and recognize that safe abortion services are not only needed by women and girls. Every individual having a uterus requires these services.

In many societies, women and girls are conditioned to prioritize purity and modesty in their sexual and romantic relationships, while men and boys are encouraged to take more risks and can have multiple partners. Transgender and gender non-confirming individuals are often pressurized to associate themselves with one particular gender to access appropriate sexual health services, and they may face punishment if they are unable or unwilling to do so. Discussing sexuality and reproductive health issues is still considered taboo, despite adolescents' right to access information and use quality services. In matters related to abortion, women and girls often face punishments both legally and socially compared to men and boys.

Parents, teachers, faith leaders and healthcare providers are often uncomfortable about discussing such issues, mistakenly believing that talking about sex and abortion only encourages such behavior.

other. Where possible, invite a resource person from the non-binary community to share their experiences regarding their gender identity or sexual orientation, either in person or online. If not, initiate a discussion by asking participants if they have met a non-binary person and what impressions did they have.

While explaining about Gender Expression, the facilitator should emphasize that a person identifying as a man may have female sex organs (termed Trans man), such as a uterus, thus can menstruate and become pregnant too. This emphasizes the importance of using gender-neutral terminology like “pregnant person” instead of “pregnant woman/girl,” as pregnancy is not exclusive to individuals' assigned female at birth and thus, they require abortion services as well.

Reflection and Conclusion

To conclude the session, ask 2-3 participants to summarize what they have learned about Gender, Sex, Gender Identity, Gender Expression, Sexual Orientation. Facilitators should clarify any misconceptions or gaps in understanding that participants may have had during the discussion.

Note to Facilitator

- It is good to invite a resource person from the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer+ (LGBTIQ+) community/movement.
- If a resource person cannot be invited, the facilitator needs to reflect on their own level of acceptance towards the LGBTIQ+ community before facilitating the session. The facilitator should be updated on the current terminology, philosophy and principles related to LGBTIQ+.
- Participants may initially hold judgmental attitude/prejudice/stigma towards LGBTIQ+ concepts. The facilitator should understand that arguments alone does not help to change the attitude of participants at the beginning of the workshop/training, but they can be built on subsequent sessions.

Contents for facilitators

Sex: Sex refers to a set of biological attributes in humans. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. It is usually categorized as female, male, or intersex but there is variation in the biological attributes that comprise sex and how those attributes are expressed.

Gender: Gender refers to the socially constructed roles, behaviors, expressions and identities of girls, women, boys, men, and gender-diverse individuals. It influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society. Gender identity is not confined to a binary framework (girl/woman, boy/man); it exists along a

continuum and can change over time. There is considerable diversity in how individuals and groups understand, experience, and express gender through the roles they take on, the expectations placed on them, their relationship with others and the complex ways that gender is institutionalized in society. As a social construct, gender varies across societies and can change over time.

Difference between Sex and Gender

Sex	Gender
It refers to the biological and physiological characteristics that defines living beings.	It refers to the social, cultural, behavioral and emotional differences between men and women.
Category: Male, Female and Intersex	Category: Masculine, Feminine and Transgender
Determined or inherited by birth	Socially constructed and influenced by external factors such as social, cultural and behavioral factors.
It is same regardless of the time and culture. However, with advancement of technology, sex reassignment and sex	It is a flexible term and its role can be changed from time to time due to other influencing factors.
Cannot be changed by time and culture naturally. E.g.: Only women can give birth to children and only men can	Highly influenced by time and culture and role is changeable. E.g.: Women can perform man's role like doctor, engineer, etc. Men also can adopt woman's social duties like nurturing kids.

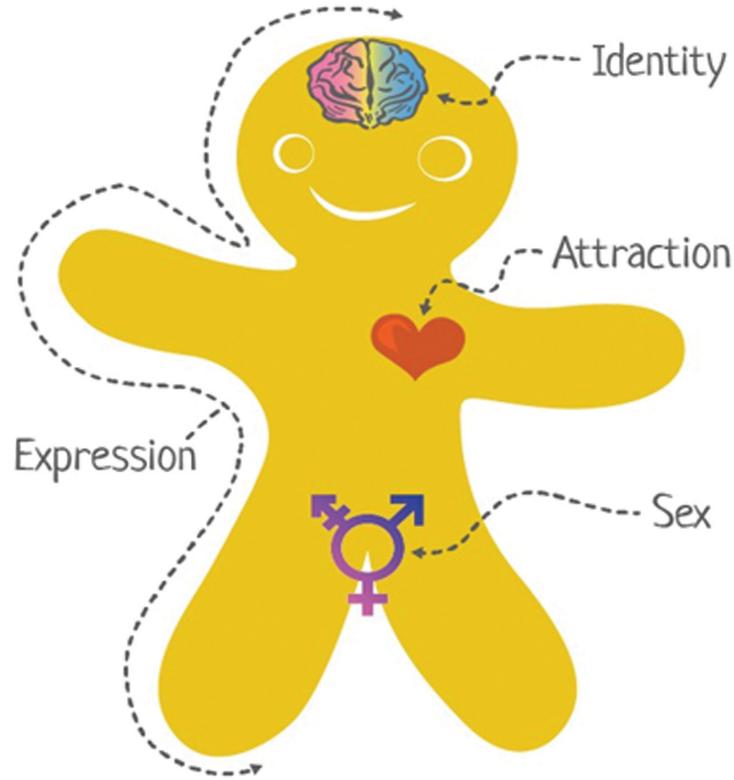
Difference between Sex and Gender

Statements	Answer
Women are better cooks than men.	Gender
A man's voice changes during puberty.	Sex
Women are supposed to be shyer than men.	Gender
Women give birth to babies. Men do not.	Sex
Boys learn faster than girls.	Gender
It's beneficial for a young girl to marry early to increase chances of having healthy babies.	Gender
Female doctors make better gynecologist than male doctors.	Gender
When a couple cannot have a baby, it is because the woman is infertile.	Gender
Women are weaker than male.	Gender

Gender Bread Person

Gender Bread Person is a teaching tool that breaks down the complex concepts of gender into bite-sized, digestible pieces.

The Genderbread Person v4 *by its pronounced METROsexual.com*



⊘ means a lack of what's on the right side

Gender Identity

- Woman-ness
- Man-ness

Gender Expression

- Femininity
- Masculinity

Anatomical Sex

- Female-ness
- Male-ness

Identity ≠ Expression ≠ Sex
Gender ≠ Sexual Orientation

Sex Assigned At Birth
 Female Intersex Male

Sexually Attracted to... and/or (a/o)

- Women a/o Feminine a/o Female People
- Men a/o Masculine a/o Male People

Romantically Attracted to...

- Women a/o Feminine a/o Female People
- Men a/o Masculine a/o Male People

Genderbread Person Version 4 created and uncopyrighted 2017 by Sam Killermann

For a bigger bite, read more at www.genderbread.org

Some of the key terminologies used to illustrate the gender bread person are:

- **Gender identity:** This refers to how you define and understand your own gender in your mind.
- **Sexual orientations:** This defines who you are attracted to, romantically, sexually, or otherwise.
 - o **Sexual attraction:** attraction that makes people desire sexual contact or shows sexual interest in another person(s).
 - o **Romantic attraction:** attraction that makes people desire romantic contact or interaction with another person(s).
- **Gender expression:** This encompasses the ways you demonstrate your gender through your dress, actions, and demeanor
- **Biological sex:** This refers to a set of biological attributes in humans and animals. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. Biological sex is usually categorized as female, male, or intersex but there is variation in the biological

attributes that comprise sex and how those attributes are expressed.

Some additional details about Intersex:

Intersex is a general term used for a variety of situations in which a person is born with reproductive or sexual anatomy that does not fit the boxes of “female” or “male.” Some intersex individuals have genitals or internal sex organs that fall outside the male/female categories — such as a person with both ovarian and testicular tissues. Others may have combinations of chromosomes that differ from XY (usually associated with male) and XX (usually associated with female), such as XXY. Additionally, some people are born with external genitals that fall into the typical male/female categories, but their internal organs or hormones do not.

If a person’s genitals look different from what medical professionals expect at birth, they may be identified as intersex from birth. In some cases, someone might not know they are intersex until later in life, such as during puberty. Sometimes, a person may live their whole life without ever discovering that they are intersex.

Reference Materials

- Gender and sex
<https://cihr-irsc.gc.ca/e/48642.html>
- Gender and sex
https://www.who.int/health-topics/gender#tab=tab_1
- Difference between sex and gender
<https://sexualhealthalliance.com/nymphomedia-blog/the-difference-between-sex- and-gender>
- Examples of gender norms and definition
<https://helpfulprofessor.com/gender-norms-examples/>
- Gender Bread person <https://www.genderbread.org/>
- Intersex people
<https://www.plannedparenthood.org/learn/gender-identity/sex-gender-identity/whats-intersex#:~:text=What%20does%20intersex%20mean%3F,male%E2%80%9D%20or%20%E2%80%9Cfemale%E2%80%9D.>
- Asexuality, attraction, and romantic orientation :
<https://lgbtq.unc.edu/resources/exploring-identities/asexuality-attraction-and-romantic-orientation/#:~:text=Sexual%20attraction%3A%20attraction%20that%20makes,with%20another%20person%20or%20persons.>

SESSION: PATRIARCHY AND BODILY AUTONOMY

Objectives of this session

By the end of the session, participants will be able to:

- Explain the basic concepts of patriarchy and bodily autonomy
- Define the different strategies that patriarchy uses to regulate bodily autonomy
- Understand the effects of patriarchy on Sexual and Reproductive Health

Session Details

Activities	Time (45 min)	Methodology	Materials required
Pre-test	5 min	Brainstorming,	
Patriarchy and Bodily Autonomy	10 min	Discussion	
Group Discussion	20 min	Lecture, Participation, Video	Laptop, PowerPoint, Newsprint, Marker
Conclusion	10 min	Participation	

Facilitation Instructions

Pre-test

Being by asking the participants if they have heard the term “patriarchy”. Observe how many participants confidently raise their hands. Ask 2-3 participants to share what they have heard/know about patriarchy. As a follow-up question, ask “Do you think the patriarchal system is beneficial or harmful for girls, women and people with different gender identity?” Then, ask what they understand by the notion “My body, My Choice”. As a follow-up, inquire how much liberty they believe individuals should have over their own life and body.

Try to collect more views/thoughts around it to gauge their understanding of patriarchy and bodily autonomy.

Patriarchy and Bodily Autonomy

Explain the meaning of patriarchy and how it reflects power dynamics and hierarchy. Clarify that patriarchy exists in different forms, and in this session, the focus will be on its relationship to bodily autonomy/SRHR. Also, discuss the meaning of bodily autonomy.

Group Discussion

Ask the participants to divide themselves in groups of 3 to 5 (based on the number of participants). Provide each group with a set of

questions for discussions and allocate 5 minutes for this. Inform them to appoint a group leader that will share what they have discussed in their own respective groups. Provide 2-3 minutes time for each group to share what they have discussed in their group. Ask the participants not to repeat the points that have already been made by other groups. A sample of questions for group discussion have been listed later in this guide.

Reflect on the meaning of bodily autonomy, linking its relation with patriarchy from the experience shared by the participants from their group discussion. Encourage the participants to consider how much they support exercising the principles of bodily autonomy while providing SRHR services, especially regarding contraception and safe abortion. If participants do not spontaneously share their view, ask them to reflect on their practices, behaviors and attitudes around it.

Conclusion

Ask 2-3 participants to summarize what they have learned about Gender, Patriarchy and their relation with SRH. If anything is missing or if there are any misunderstandings, facilitators should address and clarify these gaps.

Key takeaways from the session

Patriarchy impacts health and social outcomes through various factors like discriminatory values, norms, beliefs and practices; differential exposures and vulnerabilities to disease, disability and injuries; biases in health systems; and biases in health research. Nepali society is largely dictated by rigid gender roles rooted in religious and cultural beliefs. As a result, Nepali women are likely to be significantly affected by these patriarchal structures. It is important to address these patriarchal norms to better understand individual health-seeking behavior and health outcomes for Nepali women.

Note to Facilitators

- Facilitators can use various videos on bodily autonomy produced by different organizations working from a human rights-based approach.
- Since patriarchy refers to power relations and encompasses a broad area, facilitators need to focus specifically on linking the relationship between patriarchy and SRH/ Bodily autonomy.

Contents for facilitators

Patriarchy

Patriarchy refers to a social system in which men hold primary power and authority, often resulting in women being subordinate and disadvantaged.

It is a strong determinant of women's health as it produces unequal living conditions that drives health inequalities. Patriarchy impacts health and social outcomes through various factors like discriminatory values, norms, beliefs and practices; differential exposures and vulnerabilities to disease, disability and injuries; biases in health systems, and biases in health research. The Nepali society is largely dictated by rigid gender roles governed by religious and cultural beliefs. Consequently, Nepali women are likely to be significantly impacted by these patriarchal structures.

Bodily Autonomy

Bodily autonomy is the power to make choices about one's own body without facing coercion or violence. In other words, bodily autonomy means that my body is for me; my body is my own. It's about power, and it's about agency.

It's about choice, and it's about dignity. Bodily autonomy is the foundation for gender equality, and above all, it is a fundamental right.

It is important to discuss how patriarchy has consistently sought to control women's bodies. Gender norms typically assign women sole responsibility for reproductive health while simultaneously denying them decision-making power. Monitoring and discussing bodily autonomy helps women and girls become more aware about their rights regarding their bodies. It also encourages them to exercise choices about what happens to their bodies. When individuals, women and young people, in particular, have control over their bodies, they ultimately gain control over the other aspects of their well-being, lives and futures.

Group Discussion Statements

- How is the decision regarding women's reproduction (including the decision whether to have children, when to have them, and how many, sons/ daughters and so on) made within the family?
- Can women have children outside of marriage in your community? How is a woman treated when she has children outside of marriage compared to how a man treated in the same situation?
- Can women in your community refuse to have children once they are married?
- How are decisions about contraception made within the family?
- Do women in your community have access to safe abortion without fear and stigma?
- How an adolescent girl is be treated by family and community when she becomes pregnant?

How is an adolescent boy, who is the partner of the pregnant girl treated?

- Can a woman say no to her husband or

partner if she does not want to engage in sexual intercourse? What are the possible consequences of doing so?

Reference Materials

- Women's Health, WHO (2018)
<https://www.who.int/health-topics/women-s-health/>
- Health and Gender Equality
https://www.euro.who.int/data/assets/pdf_file/0008/404495/SDG-5-policy-brief_2.pdf
- Video on Bodily autonomy, UNFPA
<https://www.youtube.com/watch?v=TdFz6FiZ2bs>
- Bodily Autonomy, Fundamental Rights
<https://www.unfpa.org/press/bodily-autonomy-fundamentalright#:~:text=Bodily%20autonomy%20means%20my%20body,bodily%20autonomy%20is%20mission%20critical.>
- Why does Bodily Autonomy Matter; World Economic Forum <https://www.weforum.org/agenda/2022/03/what-is-bodily-autonomy-and-why-does-it-matter-for-women/>

SESSION: NATIONAL AND INTERNATIONAL INSTRUMENTS ON SRHR

Objectives of this session

By the end of the session, participants will be able to:

- understand the different national and international instruments that exist around SRHR and its importance for healthcare providers

Session Details

Activities	Time (75 min)	Methodology	Materials Required
Pre-test	5 min	Brainstorming, Discussion	
International Instruments	45 min	Participation	Laptop, PowerPoint, Newsprint, Marker
National Instruments	20 min	Participation	
Reflection and Conclusion	5 min	Participation	

Facilitation Instructions

Pre-Test

Ask participants why it is important for healthcare providers to learn about the national and international law and policies. Listen to their responses.

Again, ask what laws and policies they know related to SRHR at the global level, and subsequently at the national level. Write on the board if they significantly share any specific name of the national and international instruments related to SRHR.

Inform them that we will briefly discuss various international and national laws and policies related to SRHR over the next 45 minutes.

International Instruments

Write the term “Human Rights” on a white board/ newsprint or show the term in a Power Point presentation. Encourage participants to share what they know about the term “human rights”. Note down key phrases that the participants mention like “basic rights”, “Everyone has to get it” “no discrimination should be there”, etc.. Ask and observe if they are aware of why and how the concept of human rights came into existence. Listen to 2-3 responses and thank the participants for sharing.

Briefly explain about human rights: why and how it came into existence, the meaning of human rights, and provide an overview of Universal Declaration of Human Rights (UDHR). Ask the participants, why the concept “Women’s rights are also human rights” echoed during the 1960’s despite the existence of the “Universal Declaration of Human Rights”. See if the participants can relate it to the reproductive rights.

Explain how and why the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was implemented and its importance for the feminist movement. Share the main articles from CEDAW related to bodily autonomy, emphasizing that it is a legally binding document unlike UDHR.

Explain how the International Conference on Population and Development (ICPD) & Beijing Platform for Action (BPFA) prioritized the bodily autonomy and how they are still relevant.

Explain about the Convention on Child Rights (CRC), International Convention on Rights of Person with Disabilities (ICRPD); the main objective of the convention and Nepal as a signatory.

Provide the overviews about the notion “LGBTIQ+” rights are also human rights as evolving feminist movement globally.

National Instruments

Briefly explain Articles 16, 28, 35(1), 38(2), of the Constitution of Nepal linking it with safe abortion. Mention that the Constitution of Nepal has guaranteed SRHR as a fundamental right. Explain the meaning of fundamental rights and its legal obligation on the state part. Briefly mention about how Safe motherhood and Reproductive Health Rights Act, 2075 has come into existence to protect, promote and fulfill the implementation of SRHR as fundamental rights guaranteed by the constitution.

Discuss that Public Health Act, 2075 has ensured

SRHR as emergency health services and its practical implications in relation to safe abortion. Discuss that National Health Policy 2076 has prioritized to make safe motherhood and reproductive health including safe abortion accessible, affordable, acceptable and of quality.

Reflection and Conclusion

At the end, facilitators should summarize the session by linking all the international and national instruments with SRHR, especially safe abortion.

Key takeaways from the session

Universal Declaration of Human Rights is a guiding document for all the other legal documents. Nepal has signed many international conventions like CEDAW, CRC, CRPD and participated in ICPD and BPFA and had shown they are committed to ensure SRHR rights as human rights. So, Nepal being the signatory of many international documents, Nepal has made policies, rules and regulations in line with the convention principles. We all are obliged to respect, promote and fulfill the SRHR rights including

Note to Facilitator

- Don't try to discuss all the article of conventions in the sessions. It will be time consuming and will not help to focus on safe abortion issue due to overloaded information. Share articles that are related to SRHR, particularly safe abortion directly.
- Share the information on simple (non-technical language/ non-legal language)

Contents for facilitators

History of Human Rights

The concept of human rights gained prominence among all the nation states after World War II as the world witnessed the horrific extermination of over six million people (Jews, Romani, homosexuals, and persons with disabilities) by Nazi Germany. The Nuremberg and

Tokyo trials highlighted the inhuman act committed by the Nazis. In response to these incidences, the nation states established the United Nations, with the primary goal of

preventing war; establishing international peace and preventing conflict. People wanted to ensure that no one would ever again be unjustly denied life, freedom, food, shelter, or nationality. Following the establishment of the United Nations in 1945, the Universal Declaration of Human Rights (UDHR) was also drafted and passed in 1948.

Universal Declaration of Human Rights

The UDHR is a document that has articulated the rights and freedom that belong equally and inalienably to every human being. Although it is not a legally binding document, the Universal Declaration has achieved the status of customary international law, as it is regarded "as a common standard of achievement for all people and nations."

Meaning of Human Rights

Human rights are the basic rights and freedom that belong to every person in the world, from birth until death. These rights are based on shared values like dignity, fairness, equality, respect and independence. Human rights are

universal; they belong to everyone, everywhere. They are essential for all individuals, and must be protected, respected and fulfilled for everyone: regardless of sex, marital status, status, identity, age or gender.

Women Rights as Human Rights

Human rights are entitled to every human being, thus are automatically entitled to women and girls too. These include the right to live free from violence and discrimination, to enjoy the highest attainable standard of physical and mental health, to be educated, to own property, to vote, and to earn an equal wage. Despite this, many women and girls around the world still face discrimination on the basis of sex and gender. Specific needs of girls and women were still not addressed by human rights. Thus the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979) was formulated, following a series of global movements. This key international treaty addresses gender-based discrimination and specifically provides protections for women's rights. The convention sets out an international bill of rights for women and girls, and outlines the obligations of states to ensure that women can enjoy their rights, including those for SRH rights.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

On 18 December 1979, the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Among the international human rights treaties, this Convention plays a significant role in bringing the attention of females to the rights of women.. It explicitly acknowledges that "extensive discrimination against women continues to exist", and emphasizes that such discrimination "violates the principles of equality of rights and respect for human dignity". It comprises 30 Articles, some of which specifically addresses women's rights to health, and reproductive rights.

- Article 10(h) of the Convention states that women have the right to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."
- Article 12 of the Convention specifically addresses women's health. It obliges States

Parties: (1) to "take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning"; and (2) to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

- In Article 14, which deals with the rights of rural-women, committing the States Parties to ensure these women the right "[t]o have access to adequate healthcare facilities,

International Conference on Population and Development (ICPD)

ICPD, held in Cairo in 1994, was an important meeting where 179 governments adopted a revolutionary Program of Action that called for women's reproductive health and rights to take center stage in national and global development efforts. The program specifically called for all people to have access to comprehensive reproductive healthcare, including voluntary family planning, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections. It also recognized that reproductive health and women's empowerment are intertwined together, asserting that both are essential for the advancement of society.

Why is ICPD so important?

The ICPD Action Program directly emphasizes the need to focus on women's rights and achieve of gender equality. It highlights the necessity for sex education for adolescents and the provision of comprehensive reproductive health services. During the ICPD, a comprehensive definition of reproductive health was formulated.

Why the ICPD agenda is still of vital importance?

Significant progress has been made since 1994. However, reproductive rights still remain inaccessible to many women, including over 200 million women who want to prevent pregnancy, but lack the access to information and modern contraceptives. "Despite the fact, that in recent years, the range and number of available contraceptives has increased, hundreds of millions of women still have no access to them

and, accordingly, have no opportunity to make their own decision on childbirth through these means," stated UNFPA Executive Director Dr. Natalia Kanem. "Without access to them, these women are deprived of the possibility to make decisions about their own body, including whether they should get pregnant and when to do it".

Beijing Platform of Action (BPFA)

The 1995 Beijing Platform for Action flagged 12 key areas where urgent action was needed to ensure greater equality and opportunities for women and men, girls and boys. It also laid out concrete ways for countries to bring about change. Even 28 years later, it remains a powerful source of guidance and inspiration. The Platform for Action envisioned gender equality across all dimensions of life—yet no country has finished this agenda. Among the 12 areas, Women and Health was the area emphasized upon, underscoring that women need to be healthy in order to reach their full potential. This includes access to proper nutrition, sexual and reproductive rights, mental health, and freedom from violence.

Convention on Rights of Persons with Disabilities (CRPD)

The purpose of the CRPD is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, while also promoting respect for their inherent dignity. Nepal is a signatory to this convention, and has committed to ensuring no discrimination on the grounds of disability, including making healthcare facilities accessible.

LGBTIQ+ Rights

In the context of human rights, lesbian, gay, bisexual and transgender individuals face both common and distinct challenges. They often face institutional violence within healthcare systems, resulting in lifelong consequences to their physical and psychological health. While accessing SRHR services, these groups face exclusion and discrimination from health system, both globally and in Nepal. There have been numerous incidents where trans men have encountered problems accessing safe abortion services. However, the Safe Motherhood and Reproductive Health Rights Act 2018 has

envisioned that only women can become pregnant.

Fundamental Rights

Fundamental rights are the basic human rights enshrined in the Constitution of Nepal, guaranteed to all citizens, without discrimination on the basis of age, sex, religion, gender, or other factors. These fundamental rights are enforceable by the courts, subject to certain conditions. The Constitution of Nepal, 2015 has guaranteed SRHR as fundamental rights under Women's Rights. Article 38(2) of the constitution entails: "Every woman shall have the right to safe motherhood and reproductive health"

SMARHR Act 2075

To respect, protect and fulfill the right to safe motherhood and reproductive health conferred to women by the Constitution of Nepal, the government endorsed the SMARHR Act in 2015. It addresses various issues related to girls and women, including safe abortion.

Note: Details of the Safe abortion policy will be discussed in another session.

Public Health Act 2075

The government of Nepal enacted the Public Health Act, 2075, to establish the necessary legal provisions for implementing the right to get free basic health services and emergency health services guaranteed by the Constitution of Nepal. This Act aims to ensure that citizens have regular, effective, and easily accessible health services. It guarantees that every citizen has the right to obtain quality health service in an easy and convenient manner and further stipulates that all citizens shall have the right to obtain free basic health services, including safe abortion services which are under basic health services.

Disabilities Right

The Constitution of Nepal, 2072, ensures the right of every person to live with dignity, the right to equality, and the right to social justice as a fundamental right. People with disabilities can enjoy these provisions in the same manner as others. The Rights of Persons with Disabilities Act, 2074 defines a 'person with a disability' as someone who is barred from participating fully and effectively in social life on the same basis as others due to a long-term physical, mental,

intellectual, or sensory disability, functional impairment or existing obstruction. For the first time in Nepal, the Act has included 'psychosocial disability in its classification of disability.

The Disability Rights Act classifies disabilities into ten types based on their nature, but most of the time, only physical disabilities are considered. For instance, while ramps in hospitals may be considered disability friendly, other forms of disability than physical disabilities are frequently overlooked. The Act envisions "accessibility" as a condition where persons with disabilities can fully use human-made physical structures, means of transportation, and public services and facilities without barriers, on an equal basis with others, enabling them to live independently and

fully participate in every aspect of life.

Reflecting upon the situation, people with disabilities are often regarded as asexual, and hence, their sexual and reproductive health needs are overlooked. Evidence shows that women with disabilities face socioeconomic challenges (lack of empowerment and family support), structural barriers (distant health facilities, inaccessible-infrastructure), and attitudinal problems (stigmatization, unpleasant behavior from healthcare providers) While the Safe Motherhood and Reproductive Health Rights Act and regulations has envisioned safe abortion services as disability friendly, significant work remains to be done in the implementation phase.

Reference Materials

- Simplified Version of Universal Declaration of Human Rights <https://www.youthforhumanrights.org/what-are-human-rights/universal-declaration-of-human-rights/articles-1-15.html>
- Overview of SRHR <https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights>
- Feminist movement timeline https://interactive.unwomen.org/multimedia/timeline/womenunite/en/index.html?gclid=Cj0KCQiAtICdChCLARIsALUBFcEzG66ihTLDqhGpAl3dnjFHQgZsQGN8EPG_9DcTO8yI94ewtNFmNxkaAiDJEALw_wcB#/2000
- UN report about CEDAW <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women>
- Disability Act, 2075 <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Act-Relating-to-Rights-of-Persons-with-Disabilities-2074-2017.pdf>
- Constitution of Nepal <https://lawcommission.gov.np/en/wp-content/uploads/2021/01/Constitution-of-Nepal.pdf>
- The Public Health Service Act, 2075 <https://lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Public-Health-Service-Act-2075-2018.pdf>
- CEDAW <https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1474&context=aulr>
- Why is ICPD important <https://reliefweb.int/report/world/explainer-what-icpd-and-why-does-it>
- Beijing Platform of Action <https://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf>
- ICRPD <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities#article-6>
- Factors affecting utilization of sexual and reproductive health services among women with disabilities <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-07382-4>
- Attitude of healthcare provider towards disability <https://pubmed.ncbi.nlm.nih.gov/28662710/>

SESSION: UNDERSTANDING SRHR

Objectives of this session

By the end of the session, participants will be able to;

- define SRHR and its components
- understand the importance of SRHR

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Pre-test	5 min	Brainstorming, Discussion	-
Understanding the SRHR dynamics	20 min	Participatory Activity	Laptop, PowerPoint, Newsprint, Marker
Why SRHR?	25 min	Self -reflection	
Reflection and Conclusion	10 min	Participation	

Facilitation Instructions

Pre-test

Begin by asking participants what they understand by the term SRHR: general and technical definition. Additionally, ask about what society (family, friends, and relatives) thinks SRHR incorporates. Inform them that today's session will delve deeper into SRHR to ensure everyone is on the same page and have an accurate understanding about SRHR.

Understanding SRHR dynamics

Write the 4 components of SRHR i.e.; Sexual Health, Reproductive Health, Sexual Rights and Reproductive Rights on different colored meta cards . Prepare small chits with different components related to Sexual Health, Reproductive Health, Sexual Rights and Reproductive Rights and fold it. Ask participants to pick a chit with a component and place it alongside the corresponding Meta card where they deem it fits.

After all the components are picked, the facilitator should summarize what Sexual health, Sexual rights, Reproductive health and Reproductive health entails in brief, linking it

with bodily autonomy, particularly in relation to safe abortion, and their respective components.

Why SRHR?

Create a calm environment for participants to sit comfortably and relax. Play soothing meditative music in the background. Ask the participants to close their eyes to listen carefully to the instructions. Start reading from the script for the visioning exercise.

While reading out questions from the script, pause periodically to allow participants time reflect. Give 10 minutes for the visioning exercise. The script will guide the participants from their childhood to their present stage while also providing space for them to think about the future implications related to their sexual and reproductive health and rights.

After the exercise, listen to 2-3 participants share their reflections on the experience from the exercise. Ask them how they felt during the exercise and give them 5 minutes to share.

Reflection and Conclusion

Ask participants how understanding the importance of SRHR can benefit them in their professional lives.

Key takeaways from the session

Sexual and Reproductive Health and Rights are generally understood as a single concept, but they encompass 4 different components, each having its own dynamics.

A human life goes through various phases of life, from birth to old age. It experiences various consequences related to sexual and reproductive health and rights even before birth. The geographical, political, economic and socio-cultural diversity of a particular place or community largely influences individuals, families, and societies in how they practice traditional norms and values. These factors significantly impact the sexual and reproductive health and rights of people. In many South Asian countries, including Nepal, gender biased sex selective abortion is a major issues, leading to various complications. Adding on, gender discrimination, sexual abuse, child marriage and early pregnancy can affects individuals at any stage of life. There are several issues which arise throughout these stages, such as risks of unsafe sex, unwanted pregnancy, forceful continuation of pregnancy, unsafe abortion due to stigma around safe abortion, inaccessible, unaffordable, and unacceptable SRH services As individuals age, they may encounter issues such as menopause and sexual. Each and every stage of the human life cycle is exposed to risks and vulnerabilities that can hinder people from exercising and enjoying their sexual and reproductive health and rights to the fullest.

Note to Facilitator

- Make sure you mention the components related to Sexual Health, Reproductive Health, Sexual Rights and Reproductive Rights which are directly linked with bodily autonomy, safe abortion and contraception. A general discussion of SRHR dynamics like pregnancy, infertility, HIV, and STIs, can be too broad and vague.
- During the visualization exercise, participants may run into sensitive statement(s) or past traumas that make it difficult for them to continue. In such cases, give them time and space to ventilate. Listen carefully to what they share about their experience, but only if they want choose to do so.
- Facilitators should be mindful of principles of diversity and human rights when discussing the life cycle. The life cycle might be different for every individual. It is not necessarily intact, sequential or linear, meaning that not everyone experiences all the events in the cycle, and might not occur in the sequence mentioned, and several events may occur at the same time in someone's life. For instance, it is okay for individuals to choose to engage in sexual intercourse before marriage or to abstain

altogether. Additionally, Trans women may not experience menstruation as part of their life journey.

Contents for facilitators

Components of Sexual and Reproductive Health and Rights

- Components related to Sexual Health are: A positive attitude towards sex and sexual relationships, Freedom from any kind of sexual health problems, a healthy sexual life and relationship, Safe and pleasurable sexual experience.
- Components related to Sexual Rights are: the freedom to express sexuality and gender identity, Freedom from coercion and any form of sexual torture, No discrimination on the basis of sex and sexuality, Use of advanced technology, Access to information, including CSE and resources for safe abortion, The right to use technology and health services to lead a sexually healthy and dignified life.
- Components related to Reproductive Health are: Family Planning counseling, information, education, communication and services, Prevention and management of abortion complications, Prevention and management of STIs, RTIs, HIV/AIDS, and other reproductive health conditions, Responsible parenthood

for individuals, couples and adolescents.

- Components related to Reproductive Rights are: The right to freely and responsibly decide the number, spacing and timing of children, Access to the information and means necessary for making these decisions, The right to attain the highest standard of sexual and reproductive health, T right to make decisions concerning reproduction free from discrimination, coercion and violence, Accessible, affordable, acceptable and quality services for safe abortion and contraception counseling.

Sexual and Reproductive Health and Rights

Sexual Health

According to the World Health Organization (WHO), sexual health is defined as a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the opportunity of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. Sexual health problems includes a range of issues, including sexual dysfunction such as sexual aversion, dysfunctional sexual arousal, and vaginismus in females, as well as erectile dysfunction and premature ejaculation in males. Other concerns include impairment of emotional attachment, compulsive sexual behavior, gender identity conflict, violence and victimization, and Sexually Transmitted Infection (STI).

Reproductive Health

Reproductive health addresses the reproductive processes, functions and system at all stages of life. It, therefore, implies that individuals can enjoy a responsible, satisfying and safer sex life and possesses the capability to reproduce, along with the freedom to decide if, when, and how often to do so. (Para 7.2a of the Program of Action, ICPD, 1994) The Nepal Reproductive Health Strategy (1998) has adopted nine essential components of Reproductive Health.

1. Family Planning: Counseling, information, education, communication, and services
2. Safe Motherhood: Education and services for healthy pregnancy, safe delivery, and post-

natal care including breastfeeding

3. Care of Newborns
4. Prevention and Management of Abortion Complications
5. Prevention and Management of STIs, RTIs, HIV/AIDS, and other Reproductive Health Conditions
6. Reproductive Health and Responsible Parenthood for individuals, couples, and adolescents
7. Prevention and Management of Sub-Fertility
8. Life cycle issues: Including breast cancer, reproductive system cancers, and care for the elderly
9. Gender-Based Violence

Sexual Rights

Although the concept of basic human rights emerged in 1948, sexual rights have often struggled to be included in discussions surrounding these rights. The International Conference on Population and Development (ICPD) and the Beijing Declaration in 1995 underlined the need to address sexual pleasure and expression. Some also argue that the Beijing Platform of Action (1995) established an applicable definition of sexual rights. However, it was the World Association for Sexual Health, founded in 1978, that paved the way for the Declaration of Sexual Rights in 1997, which declared 16 positions (as of 2014)

1. The right to equality and non-discrimination
2. The right to life, liberty, and security of the person
3. The right to autonomy and bodily integrity
4. The right to be free from torture and cruel, inhuman, or degrading treatment or punishment
5. The right to be free from all forms of violence and coercion
6. The right to privacy
7. The right to the highest attainable standard of health, including sexual health; with the possibility of pleasurable, satisfying, and safe sexual experiences
8. The right to enjoy the benefits of scientific progress and its application
9. The right to information
10. The right to education and the right to comprehensive sexuality education
11. The right to enter, form, and dissolve

- marriage and similar types of relationships based on equality and full and free consent
12. The right to decide whether to have children, the number and spacing of children, and to have the information and the means to do so
 13. The right to the freedom of thought, opinion, and expression
 14. The right to freedom of association and peaceful assembly
 15. The right to participation in public and political life
 16. The right to access to justice and remedies

Reproductive Rights

Nepal has demonstrated its commitment to promoting and protecting the sexual and reproductive health, and rights of its citizens through various legal provisions, policies, and action plans. The National Health Policy (1991), Medium Term Strategic Plans, the National Reproductive Health Strategy (1995), the Adolescent Health and Development Strategy (2000), and the Nepal Health Sector Program II (NHSP II, 2010-2014) outlines broad strategies for reproductive health in the country. The Right to Safe Motherhood and Reproductive Health Act, 2075 (2018) is an important legal policy, endorsed by the government of Nepal to ensure the sexual and reproductive health and rights of the people. Following the International Conference on Human Rights (1968), reproductive rights began to develop as a subset of human rights on the international agenda. Reproductive rights comprises the legal rights and freedoms related to reproduction and reproductive health that can vary among countries. As defined by WHO, Reproductive rights rest on the recognition of the basic right of all couples and individuals to freely and responsibly decide the number, spacing and timing of their children, and to have the information and means to do so, as well as the right to attain the highest standard of sexual and reproductive health services. This definition also includes the right of all individuals to make decisions regarding reproduction free from discrimination, coercion and violence.

Script for Visualization Exercise

Reflect on your life and think about the following questions.

- What was your childhood like?
- What did your parents do? What was your

family like? Was it small or big? What kind of friends did you have? How was your school like?

- As you transitioned from childhood to adolescence, did you see or experience any kind of gender discrimination in your family? If you didn't experience it yourself, did you see such discrimination in your community?
- Have you ever experienced any forms of sexual abuse or harassment? If yes, where was it, and how did it affect you? Have you dealt with cases of sexual harassment in your professional life? If you haven't experienced such cases personally or professionally, , have you seen or heard about such cases? How did you feel after hearing or seeing such cases? Were there any support systems available to share your experience? How would you feel if you were to experienced sexual abuse or harassment?
- For girls: What was your first menstruation experience like? How did you handle the situation? Did you have information about menstrual health management at the time you began your first period? Did you experience any kind of cultural practices after your first menstruation? How did you feel about it, and how did your life change afterwards?
- For boys: If you have sisters, how did you feel when you heard that your sister had menstruation for the first time? Did you ever ask your parents or sister about it? What changes do you notice in your mother and sister's daily lifestyle during their menstruation? Does it affect your lifestyle? For example, if your mother or sister is not allowed to cook during menstruation, who takes on the cooking responsibility?
- Are you currently in a relationship (with partner or with husband?) Have you ever engaged in sexual intercourse with your partner? If yes, are you aware about the safety measures and the risks and complications associated with not following them? If yes, have you felt or been forced by your partner to engage in sexual intercourse? If no, how would you feel if you were forced by your partner to do unsafe sex? How much can you negotiate with your partner regarding your sexual life? How independent do you feel in deciding what to do with your own body?

- In your relationship with your partner, did you have the space and ability to decide whether you want to become pregnant? Did you get to decide when to become pregnant? Did you have control over what decisions regarding your body?
- How do you feel today? Reflecting upon your journey, do you believe you have enjoyed your sexual and reproductive rights?
- What has your experience been in delivering SRHR services, including safe abortion services, to young people? Have you been able to empathize with them while delivering these services? Have you been able to realize that cultural practices can hinder people from enjoying their sexuality?
- Did you manage to actively listen to people seeking SRHR services to empower them and provide counselling for informed choices, or did you tend to give information and make decisions on their behalf, assuming you knew what was best for them?

Reference Materials

- Basic concept and introduction to human rights <https://www.equalityhumanrights.com/en/human-rights/what-are-human-rights>
- Human rights and women rights <https://www.ohchr.org/Documents/Events/WHRD/WomenRightsAreHR.pdf>
- Universal declaration of human rights <https://www.un.org/en/universal-declaration-human-rights/>
- Sexual and reproductive health and rights framework https://www.ippf.org/sites/default/files/report_for_web.pdf
- The Right to Safe Motherhood and Reproductive Health Act 2075- Nepal <http://www.lawcommission.gov.np/en/wpcontent/uploads/2019/07/TheRight-to-Safe-Motherhood-and-Reproductive-Health-Act-2075-2018.pdf>
- Sexual Health and Sexual health and reproductive health issues https://www.who.int/topics/sexual_health/en/ https://www.who.int/reproductivehealth/topics/sexual_health/issues/en/

SESSION: NATIONAL AND INTERNATIONAL INSTRUMENTS ON SRHR

Objectives of this session

By the end of the session, participants will be able to:

- Identify their comfort levels while discussing and delivering about safe abortion
- Evaluate how these comfort levels transform into attitudes and affect societal norms
- Discuss how varying comfort levels relate to societal norms surrounding abortion

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Comfort continuum Activity	20 min	Brainstorming, Discussion, Participation	Three paper signs labeled - “A lot”, - “Little” - “Not at All”
Discuss about the Activity	20 min		
Conclusion	5 min		

Facilitation Instructions

Comfort Continuum Activity

Preparation:

- Keep the comfort continuum statements ready.
- Label three signs on paper: “A Little,” “A Lot” and “Not at All.”
- Ensure there is open space in the room for participants to move around.

Inform participants that this activity will help them assess their comfort levels with advocating for a person’s rights to abortion, safe abortion access or legalization, and/or the expansion of the cadre of service providers. Participants will also have the opportunity reflect on the factors influencing their comfort levels as well as societal norms related to abortion.

Tape the three signs on the floor or on the wall in a way that there is enough room for participants to move around. Place the signs in order in a row to indicate a continuum.

Execution

Explain the rules to be followed during the activity: participants should reflect on their comfort level and position themselves accordingly. They should be honest about their feelings and avoid being influenced by other participants’ placements.

Carefully read each question aloud, inviting participants to move to the point on the continuum that best represents their feelings based on the questions. Ask for volunteers to explain their reason for standing at their chosen point along the continuum. If participants feels strongly about another point on the continuum after hearing someone’s explanation, they can move to a different point if they have strong reasoning.

Ask 2-3 participants to share their feelings about the activity, soliciting a different response from each of the participants. Reference reasons participants provided for their

Not At ALL

A Little

A Lot

places on the continuum as you facilitate a brief discussion about the different comfort levels and responses in the room.

Some discussion questions could include:

- What observations do you have about your responses to the statements? What about other people's responses?
- Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
- What surprised you about your responses? What surprised you about other people's responses?
- What did you learn about your comfort level and that of others' comfort levels regarding abortion?
- What observations do you have about the group's overall level of comfort with young women and abortion (not individual people's responses)?

Ask participants to reflect on life experiences that may have influenced their comfort or discomfort levels. Invite them to imagine how a various circumstances might have led to different levels of comfort with young women and abortion. Ask a few people to share their thoughts.

Discuss how these differing comfort levels among healthcare providers with young women and abortion can impact social norms on abortion. Consider how these attitudes affect young women's feelings about themselves when seeking an abortion, providers' feelings about offering abortion services, and young women's access to safe abortion care.

Facilitate a discussion on how comfort levels impact the provision and quality of abortion services. Emphasize the large impact providers' attitudes have on their provision of services and on young women's experience and satisfaction with those services.

Conclusion

The comfort levels of healthcare providers, including hospital staff, regarding abortion care can impact a person's ability to access safe abortion care services. For example, a provider who is uncomfortable with abortion care or have stigma/prejudice may counsel a woman toward alternative options or might not refer her to safe abortion services.

Despite our individual comfort levels, it is essential to maintain a consistent standard of professionalism and respect for all women seeking abortion services.

Note to Facilitator

- Use statement questions to encourage conversation instead of yes/no questions
- Ensure that you have access to accurate and relevant information on abortion laws, policies and provision in the country, including awareness regarding abortion laws for minors.
- If participants ask for more information while you read questions, instruct them to respond based on their understanding of the question. Do not provide additional details.

Contents for facilitators

Comfort continuum Statements

- How comfortable are you about a young boy (aged 10), having access to sex education, contraceptive counseling, and methods including emergency contraception?
- How comfortable are you about a young girl (aged 17) having consensual sex with her husband?
- How comfortable are you about a young girl having consensual sex with her boyfriend, whom she is in love with?
- How comfortable are you with an adolescent unmarried girl who wants to keep her pregnancy and have a child?
- How comfortable are you with an adolescent unmarried girl who wants to terminate her pregnancy against her parents' wishes?
- How comfortable are you about providing pre-abortion/abortion/post-abortion counseling to a young person aged 18 years?
- How comfortable are you with performing abortions for young women aged 16 years in the first trimester?
- How comfortable are you with providing medical abortion drugs to a young person aged 18 years in the first trimester?
- How comfortable are you with performing an abortion for young person aged 16 years in the second trimester?
- How comfortable are you with providing medical abortion drugs to young person aged 18 years in the second trimester?

- How comfortable would you feel referring a young person to someone who can give her medical abortion drugs and counseling?

Medical abortion / Self Care

- How comfortable do you feel about young people in your community having easy access to information about medical abortion?
- How comfortable are you about a young person having access to medical abortion drugs from health-care providers in their communities easily?
- How supportive are you of a young person

accessing medical abortion drugs over the counter or from non-clinical healthcare providers, such as community health volunteers or pharmacy?

- How comfortable are you with expanding the second trimester safe abortion services providers beyond obstetricians and gynecologists?
- How comfortable are you with equipping non-clinical healthcare providers with relevant knowledge on medical abortion service provision?

Reference Materials

- Values Clarification and Attitudes Transformation (VCAT) For Mid and Senior Level Healthcare Workers
<https://yncsd.org/wp-content/uploads/2020/10/VCAT-Manual.pdf>
- Abortion attitude transformation: A values clarification toolkit by IPAS https://www.ipas.org/wp-content/uploads/2020/06/VALCLARE14_VCATAbortionAttitudeTransformation.pdf

SESSION: SAFE ABORTION HISTORY & LAWS IN NEPAL

Objectives of this session

By the end of the session, participants will be able to:

- Understand the impact of legalization of safe abortion services in maternal mortality
- Explain the different important milestone related to safe abortion in Nepal
- Analyze the differences between the safe abortion laws of 2002 vs. 2018

Session Details

Activities	Time (75 min)	Methodology	Materials Required
Abortion timeline	20 min	Participatory Activity	
Comparative Analysis- Recent and previous Safe Abortion Laws	10 min	Self -reflection	Laptop, PowerPoint, Newsprint, Marker
Conscientious Objection	10 min	Lecture	
Reflection and Conclusion	5 min	Participation	

Facilitation Instructions

Abortion Timeline

Preliminary Preparation: Write the timeline related to major milestone around safe abortion in a Meta card. Inform the participants that this activity will focus on learning about the history, major milestones, and laws and policies around safe abortion. Participants will also learn about the interpretation and implementation of laws and policies. In-depth understanding of laws and policies will lay a strong foundation to address the barriers of safe abortion care. Ask participants to form a semi-circle facing the wall to see the timeline.

Stick blank newsprint in the wall and make a timeline by writing the dates in the header of the newsprint, one after another. As you start with the date, attach the Meta card with information from that particular date and explain its significant events and progress. Refer to the table below for the timeline on safe abortion.

After completing and explaining the timeline, ask 2 participants to summarize their understanding on national abortion laws and policies

Comparative Analysis: Recent and previous safe abortion Laws

Begin the session with a brief overview of the history of safe abortion law in Nepal. Explain that the Government of Nepal first endorsed it in 2002, with certain conditions and revised again in 2018. Talk about the three main ground bases on which safe abortion law was legalized. Similarly, explain the recent policies on safe abortion criteria and highlight that the recent act has confined abortion to 28 weeks of pregnancy. Next, explain how abortion has been defined in the recent law and also talk about the practical challenges healthcare providers and women with unwanted pregnancies face due to delays in the formulation of regulations.



Finally, address any questions raised by the participants and remind them of the significance of an in-depth understanding of abortion laws and policies, which can positively improve access to safe abortion care

Conscientious Objection

Ask the participants the following two questions simultaneously;

- Is it acceptable for healthcare providers to deny patient care if it goes against their morals, ethics, cultural or religious beliefs?
- Is there a legal right for providers to deny

patient care if it goes against their morals, ethics, cultural or religious beliefs?

Explain the literal meaning of Conscientious Objection in healthcare. Further, explain what conscientious objection means in the context of safe abortion services. Discuss the impact of conscientious objection, especially for adolescents and young people dealing with unwanted pregnancies.

Reflection and Conclusion

To wrap up the session, ask 2 participants to share their reflections on the session.

Key takeaways from the session

It is often said that Nepal has progressive laws related to SRHR, including safe abortion, both globally and in South Asia. However, with the amendment of the safe abortion law in 2018, we see a regressive shift when viewed in light of the principle of bodily autonomy. There are still many challenges at the implementation level in making safe abortion accessible, affordable, acceptable, and of high quality. Additionally, the healthcare system and the providers of safe abortion services still lack a rights-based approach while delivering safe abortion services. We must strive to create social, political and economic conditions that enable and empower all individuals to exercise their rights. When states violate, deny, or fail to guarantee an individual's rights, we have to hold them accountable.

Note to Facilitator

- Facilitator should possess detailed knowledge and understanding of each milestone related to safe abortion to effectively address all queries related to each milestone.
- Review the court resolutions from the Laxmi Dhikta case vs. the Government of Nepal to familiarize yourself with the Supreme Court's decision. Detailed study of this case will help justify responses to the participants' questions regarding bodily autonomy, when life begins, the right to life, unwanted pregnancies and women's agency.

Contents for facilitators

Safe Abortion History Timeline

- **Before 2002:** Prior to 2002, Nepal had very restrictive abortion laws that led to the prosecution and imprisonment of women and their family members for undergoing pregnancy terminations. Up to one-fifth of imprisoned women were convicted for abortion-related crimes. Despite the restrictive laws and legal implications, many

unsafe abortions were still performed by untrained providers throughout the country.

- **2002:** Nepal legalized abortion in 2002 with certain conditions.
- **2003:** Developed the National Safe Abortion Policy and Procedure Order
- **2004:** First-trimester surgical abortions were made available nationwide.
- **2007:** Training for second-trimester abortions, including medical abortions, began.
- **2009:** The landmark 2009 Supreme Court decision in Lakshmi Ditka vs. Nepal only reinforced the right to abortion and emphasized that access to abortion is a human right. The court held the government accountable for establishing the necessary institutions and implementing policies to make abortion services affordable and accessible.
- **2009:** Piloted and started Medical Abortion services by Skilled Birth Attendant Auxiliary Nurse Midwives.
- **2011:** Developed the National Safe Abortion Service Implementation Guidelines
- **2016:** Safe abortion services were provided

- free of cost in all government health services.
- **2018:** The Safe Motherhood and Reproductive Health and Rights Act, 2018 was endorsed, revising the safe abortion policy with new provisions that granted pregnant woman the right to obtain safe abortions under certain circumstances.
- **2020:** The Safe motherhood and Reproductive Health Rights Regulation 2020 came into existence. However, this regulation failed to address the need for disability- friendly and adolescent-friendly safe abortion services.
- **2022:** Adolescent friendly and disability friendly safe motherhood services guidelines were introduced.

Supreme Court's decision on Laxmi Ditka's case on Unwanted Pregnancy and Bodily Autonomy:

Laxmi, a mother of five, had an unwanted pregnancy and sought abortion services at a health facility. The charge of service was Rs.1130, which she could not afford. By the time she managed to gather the necessary funds, 12 weeks of gestation had already crossed. Consequently, she was forced to continue her pregnancy against her will.

If women's reproductive rights are not protected, they may be forced to carry unwanted pregnancies, reducing them from being respected as rights holders' into mere instruments of human reproduction. Although becoming pregnant is a noble human act, being forced into it burdensome and condemnable. If a woman is denied the ability to decide whether or not to carry a pregnancy, this outcome cannot be considered as fulfilling one's highest duty; instead, it becomes a form of slavery. This highlights the importance of women being the masters of their own bodies. They must have the right to decide whether to become pregnant, whether to continue a pregnancy, and how to space their pregnancies. This includes the right to make the final decision regarding their bodies, beyond simply seeking voluntarily counseling or giving consent; their ability to make the final decision and to implement it must be acknowledged. From a human rights perspective, in order to ensure the birth and development of free individuals, it is important that mothers

be free themselves. The servitude of a mother cannot be a source of freedom for her children; this is a matter that deserves serious attention.

Comparative Analysis- Recent and previous Safe Abortion Laws: Safe Abortion Policy 2012

In 2002, safe abortion was legalized on three grounds:

- Up to 12 weeks of gestation on request with consent of pregnant women
- Up to 18 weeks of gestation in cases of rape or incest, and at any time if the pregnancy poses a danger to the woman's life or physical or mental health or if there is a fetal abnormality

Safe Abortion Policy of 2018

According to recent Safe Motherhood and Reproductive Health and Rights Act, 2075, abortion is legal in Nepal under following conditions upon the consent of a pregnant woman:

- With the consent of pregnant woman, up to 12 weeks of pregnancy.
- If the pregnancy results from rape or incest, up to 28 weeks of pregnancy, with the pregnant woman's consent.
- Up to 28 weeks of pregnancy, if the pregnancy poses danger to the life or physical or mental health of the pregnant woman or the chance of a birth of a severely physically deformed child as per the suggestion from certified health service provider, with the consent of the woman.
- Up to 28 weeks of pregnancy if the pregnant woman suffers from HIV or any such other incurable diseases, with her consent.
- Up to 28 weeks of pregnancy if the fetus is suffering from a severely debilitating or fatal deformity, as certified by an expert physician.

Major Differences between previous (2002) and recent law (2018) on safe abortion:

• Gestational time

The law of 2002 allowed for abortion at any time if the pregnancy posed danger to the physical or mental health of women, or if the fetus was seriously damaged, provided that it was recommended by an authorized physician. On the contrary, the recent safe abortion law, safe abortion confines the provision of safe abortion to up to 28 weeks.

The new law does not specify what can/has to be done if there is any reason in which pregnancy cannot be continued.

- **Definition of abortion**

In the recent Act, abortion is defined as, "Abortion" means the act of fetus coming out or taking it out of the womb or before the fetus remained in the uterus born naturally". This definition has effectively criminalized miscarriage or natural abortion.

- **Punishable under the following conditions has been added**

- a. Abortion without the consent of pregnant woman
- b. Sex selective abortions
- c. Abortion performed outside the legally permissible conditions

- **Best interest of child**

In the case of a woman who is mentally challenged, who is not in a condition to give consent instantly or who has not completed the age of eighteen years, her guardian or curator shall have to give consent. In the case of a woman who is below the age of eighteen years, safe abortion service shall have to be provided by considering her best interests.

Conscientious objection (CO)

The literal meaning of CO is in the refusal to perform a legal role or responsibility because of personal beliefs. In healthcare, conscientious objection involves practitioners not providing certain treatments to their patients, based on reasons of morality or "conscience." A conscientious objection is based on sincerely held beliefs and moral concerns, mostly based on reason of morality or conscience but not self-interest or discrimination.

Impact of CO

Conscientious objection was found to impact access directly through attempts by health professionals to restrict access, and indirectly by exacerbating pre-existing barriers to access.

- Violation of fundamental rights: Right to self-determination, right to access to healthcare
- Increase chances of unsafe abortion and thus contribute to maternal morbidity and mortality
- Increase healthcare cost and out of pocket expenditure

Reference Materials

- Safe Motherhood and Reproductive Health and Rights Act 2018 <http://www.lawcommission.gov.np/en/archives/category/documents/prevaling-law/statutes-acts/the-right-to-safe-motherhood-and-reproductive-healthact-2075-2018>
- History of Safe abortion law in Nepal https://www.researchgate.net/publication/7804487_Abortion_Law_in_Nepal_The_Road_to_Reform
- Lakshmi Dhikta Case Summary and Translated Excerpts <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf>
- Conscious Objection: <https://www.figo.org/news/conscientious-objection-conscientiously-committed-how-obgyns-can-advocate-bodily-autonomy>
- Facility based abortion study https://crehpa.org.np/wpcontent/uploads/2017/05/summary_report_december_2006.pdf

SESSION: ABORTION GROUND REALITIES

Objectives of this session

By the end of the session, participants will be able to:

- Understand about the patriarchal mindset of society towards women's life
- Explain the linkages between "Patriarchy" and "Bodily Autonomy"
- Understand the ground reality of access to safe abortion

Session Details

Activities	Time (75 min)	Methodology	Materials Required
Documentary Projection	30 min	Video presentation	
Discussion on the documentary	20 min	Brainstorming, Participation	Projector, Documentary on unsafe abortion
Reflection and Conclusion	10 min	Participation	

Facilitation Instructions

Documentary Projection

Inform the participants that we will be watching documentary on abortion. The documentary is in local language of Achham district, but it includes English subtitles. If anyone has difficulty understanding either languages, the facilitator shall summarize the video at the end. Further mention that the video may contain sensitive contents. Beforehand, ensure that the sound system is well connected. Urge participants to maintain silence while watching the video.

Play the documentary "Outside the newsroom" on abortion. After the video is completed, give 1 minute for participants to relax and reflect on the video.

Discussion on the video

Ask how the participants felt while watching the

video. Tell 3-4 to share about their feelings after watching the video. Ask the following questions to start a discussion on the issues raised in the video.

- What is the value of women's life in society?
- How empowered are women to make decisions over their bodies?
- What was the attitude of men towards contraception?
- What is the accountability of the state in ensuring safe abortion as a fundamental right?

Reflection and Conclusion

After listening to the reflection from the participants, facilitators need to share their reflection on the video by highlighting the key issues such as the mindset of society towards safe abortion, value of women, and men's involvement in contraceptives.

Key takeaways from the session

Unsafe abortion still accounts for high levels of maternal mortality and continues to cause irreparable harm to women. The ideology of male superiority undermines abortion as an important issue of status and frames the morality, legality and socio-cultural attitudes towards abortion. As a result, women are often compelled to sacrifice their lives for a preventable cause. Patriarchy sculpts unequal gender power relationships, stripping women of their ability to make decisions about their own bodies.

The stigma that we hold subconsciously helps to transform our attitudes towards safe abortion in the long run. Furthermore, for healthcare providers, conscientious objection is considered a crime under the Safe motherhood and reproductive health rights act 2075.

Note to facilitator

- The facilitator needs to link the video to the patriarchal ideology that exists at the individual, familial, societal and policy level, which continues to control the sexuality and health of girls and women.
- Since the video is quite old, the facilitator can add that the current scenario in most of the places in Nepal remains largely unchanged, despite the legalization of safe abortion in 2002.

Contents for facilitators

Summary of the Video

Attitude of male towards contraception: Male partners often show reluctance to use permanent or any method of family planning, leading to unwanted pregnancies. Consequently, women may feel compelled to use traditional methods, like herbs to terminate their pregnancies.

Patriarchal system: In many families, male partners are the bread winners, with many being foreign migrant workers working abroad in India and coming home only occasionally. Just because husbands are not at home, women forgo any method of family planning. When they do return home, men seem care free and indifferent about using any family planning methods which leads to unwanted pregnancy. When husbands are away, family members become the only immediate source of help and support. If family members agree to send a woman to a health facility for safe abortion then she may gain access to that service. However, most of the time there exists a communication gap, as sex is frequently viewed

as a shameful topic. This stigma can lead women to choose risky traditional methods instead of discussing their situation with their family.

Even women like Sita and the teacher, who appear financially independent, sometimes opt for inhumane and excruciating methods of termination. The question remains: why do educated women make such choices? The answer lies in the fact that women often lack the ability to make independent decisions over their bodies. In our patriarchal society, issues related to sex and sexual relationships are considered to be shameful, and women and girls are nurtured in a way that diminishes their capacity to prioritize their own health and make informed decisions.

Value of Women: Men occupying influential positions within society have a mind-set which devalues women. In the video, we hear a man holding an important and influential position, the Secretary of Red Cross stating- "Condoms are of no use". He further comments, "If it were their own wives, they would take them to a nearby health facility, but who would do the same for someone else's wife?" His only suggested option is to rely on locally available methods, showing a complete disregard for whether she lives or dies. Even though unsafe abortion is prevalent and many women are dying, this individual, associated with such a renowned organization (Red Cross), appears carefree and is seen laughing. If a person of his credential can be so ignorant, we can only imagine the attitudes of those who are uneducated, underprivileged, and largely unaware of these issues. From this, it is quite clear that patriarchal society views women as of being less valuable.

Reference Material

- Google Drive link of Video: Outside the newsroom by Dil Bhushan Pathak https://drive.google.com/drive/u/3/folders/1oxW9xth6nQDZA2XVraM9uQLqK7vFKc4_z
- Service Provider perspective in denying safe abortion service: Policy Brief https://crehpa.org.np/wp-content/uploads/2018/02/RHR-policy-brief-24-nov-2017_Service-Provider-Study.pdf
- Patriarchy, Abortion, and the Criminal System: Policing Female Bodies <https://doi.org/10.1080/08974454.2016.1259601>

SESSION: PUBLIC HEALTH LENS ON SAFE ABORTION

Objectives of this session

By the end of the session, participants will be able to

- Understand the larger context of why safe abortion advocacy is needed in the context of Nepal.
- Reflect upon the facts and figure related to abortion, justifying the importance of safe abortion advocacy now more than ever.

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Pre-test	15 min	Brainstorming, Discussion	
Aims & objectives of safe abortion	15 min	Participation	Chart Paper, marker, Sticky Notes
Urgency of safe abortion advocacy	25 min	Gallery Walk	
Reflection and Conclusion	5 min	Participation	

Facilitation Instructions

Pre-test

Stick three chart papers of different colors on the wall. Write the following 3 questions in different chart papers:

- Do you think safe abortion advocacy is needed in our context?
- If yes, why do you think it is needed?
- If not, why do you think it is not needed?

Provide 3 sticky notes to each of the participants. Instruct participants to write down their answers to these three questions without discussing with them with anyone.

Give 2-3 minutes for them to write their answers. Ask them to stick the answers of the respective questions on the corresponding chart paper attached to the wall and return to their seats.

Facilitators need to analyze what kinds of responses are provided. Look for any common themes and note any typical answers for any questions. Typical answer meaning answers that may contain any misconceptions or stigma related to safe abortion advocacy.

Ask two of the participants who answered “Yes” and “No” to share their reasons concerning if safe abortion advocacy is needed or not

needed. Note: Just listen to what they say, don’t rationalize their point of view at this point.

Aims and Objective of Safe Abortion Advocacy

Make small chits of different colors. The number of chits should correspond to the no. of participants. Out of the total chits, only 5 should include points related to the general objective and specific objective of safe abortion advocacy. The first chit will contain the general objective, while the others will list specific objectives number. Keep all the cheats on a bowl.

Ask each of the participants to pick one chit from the bowl. Instruct them not to open the chits until instructed by the facilitator. Once everyone has selected a chit, ask them to open the chit and read it quietly. Also inform that that some chits may be blank.

Ask the participants with the chit no. 1 to come to the front and read the contents of their chit aloud. Simultaneously, request participants with chits’ number 2, 3, 4, 5 do the same after them. Thank all 5 participants for their active contribution and request them to return to their seats.

As a concluding remark, clarify the aims and objectives of safe abortion advocacy is not

to promote or increase the number of safe abortions in the country. .Instead, the goal is to decrease the number of unsafe abortion, thus reducing maternal mortality and improving the quality-of-life for girls and women. Also, mention that when we talk about the safe abortion advocacy, advocacy for contraception comes automatically as these issues cannot addressed separately. Reflect on the figures around the effectiveness of contraception, the reasons for unwanted pregnancy, and the unmet need for contraception to highlight that safe abortion advocacy and contraception advocacy are two sides of the same coin.

Urgency of Safe Abortion Advocacy

Inform the participants that we will now reflect on some important facts and figures (Global and National) that highlights the absolute necessity to provide safe abortion services and the need to advocate for them. Showcase the global data on abortion first, and then reflect on Nepal’s data on abortion.

Further data pertaining to effectiveness of contraception, unwanted pregnancy rate and unmet need of contraception in Nepal, as well as trends in demand of family planning, and Safe abortion service received by adolescent. Data presentation shall be done through gallery walk.

Gallery walk steps:

- Make the poster of all the facts related to safe abortion. Make sure the posters are clean, comprise of concise data and is attractive to the view.
- Stick the posters in the following order to ensure the relevancy of the data presented in relation to safe abortion: Effectiveness of contraception, Outcome of pregnancy, Trend in demand of family planning, unmet need of contraception in Nepal, abortion data pertaining to Nepal including abortion (safe and unsafe abortion)
- Ask all the participants to stand up and proceed to see all the posters in the gallery.
- Facilitators indirectly can supervise the participants in figuring out the meaning of data in relation to safe abortion need and advocacy.

Reflection and Conclusion

Request two participants to share their thoughts on how they felt after knowing these facts and figures about abortion. Probe further to know more if they viewed abortion as a public health emergency after the discussion? Explore if they were aware of these facts around abortion before (during their medical school/nursing school/safe abortion training)? Thank them for their engagement, and encourage them to reflect onto these data while delivering safe abortion services in their communities.

Key takeaways from the session

Unsafe abortion is a preventable cause of maternal death, yet it significantly contributes to maternal mortality and morbidity. It is a public health emergency, both globally and in Nepal. We need to advocate for making safe abortion services accessible, affordable, acceptable, and of high quality, enabling girls and women to live a respectful and quality life.

Note to Facilitator

- Facilitators can use PowerPoint or newsprint to show facts and figures about abortion to highlight the importance of urgency of safe abortion advocacy.
- Facilitators need to address the myths that advocating for safe abortion promotes abortion itself, and instead focus on the specific objectives mentioned.
- Focus only on those data that are directly linked to safe abortion, too much information can create confusions.

Contents for facilitators

Aims and Objective of Safe Abortion Advocacy

General Objective:

- To reduce morbidity and mortality due to unsafe abortion, and thus helping to improve the quality of sexual and reproductive health status of girls and women.

Specific Objective:

- Reduce the number of unplanned pregnancies
- Prevent unsafe abortions related to unplanned pregnancies and provide an enabling environment to safely terminate unwanted pregnancies
- Provide counseling related to contraception to prevent further unwanted pregnancies
- Timely recognize the problems related to Sexual and Reproductive health and provide accurate treatment or provide referral services as needed.

Urgency of Safe Abortion Advocacy Global

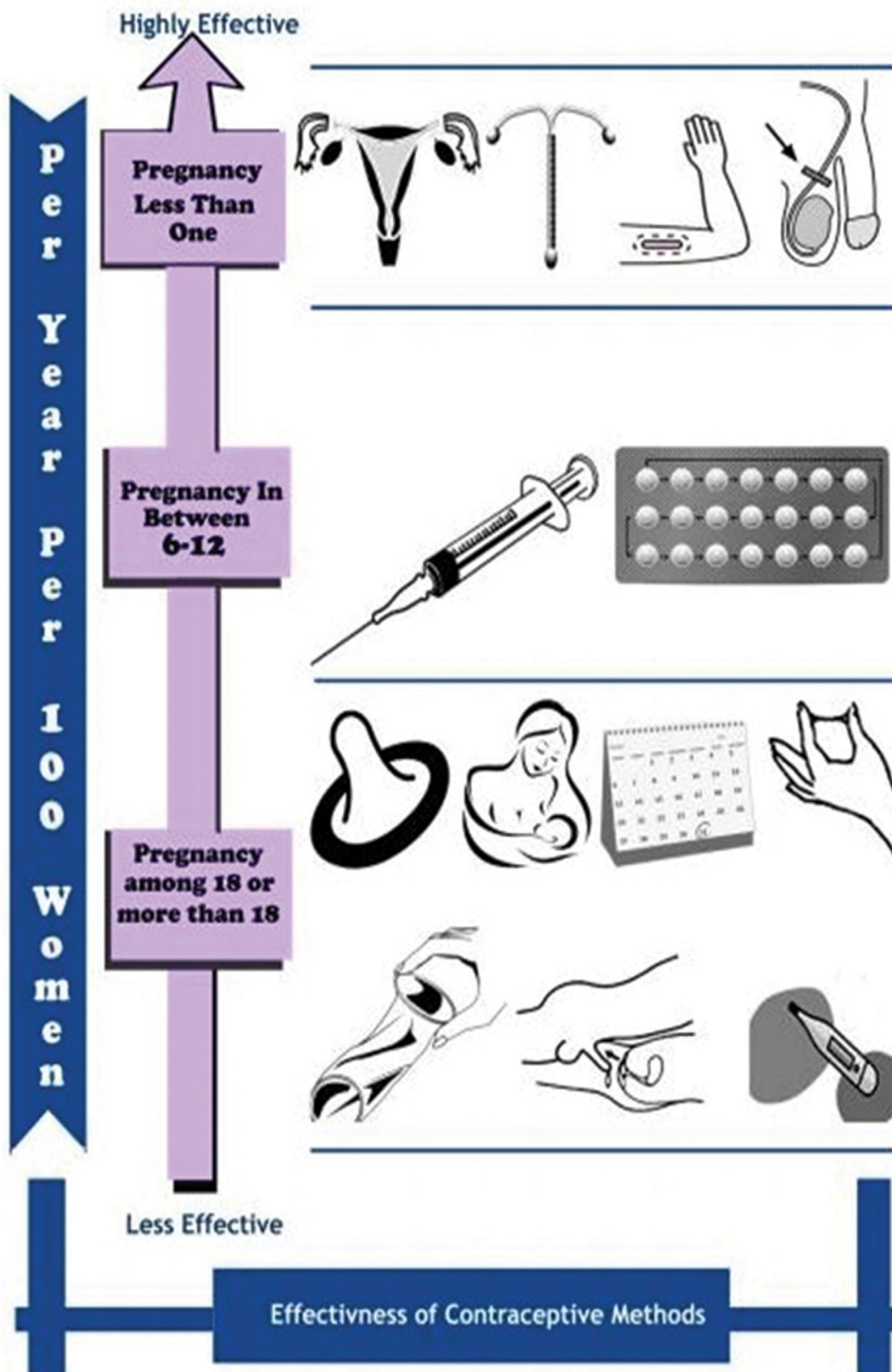
- Unsafe abortion is one of the major cause of maternal mortality globally. It accounts for 5-13% of maternal deaths.
- Approximately 2 crore 50 lakhs individuals choose to terminate pregnant person choose to terminate their pregnancies unsafely, with most of them being from developing countries. (Source: Lancet 2017, Ganatra et.al)
- Annually, 44 thousand pregnant individuals die due to unsafe abortion globally. (Source: Lancet 2017, Ganatra et.al)

Nepal

- Unsafe abortion is one of the major causes of maternal mortality In Nepal. It accounts for 7% of total maternal deaths. (Source; 2008/2009)
- Out of total pregnancy, 50% of the pregnancies are unplanned. (Nepal Demographic Health Survey (NDHS)- 2016)
- An estimated 3 lakhs 32 thousand individuals undergo abortions in Nepal each year, with 58% of procedures being clandestine.
 - a. Every hour, 21 pregnant person does unsafe abortion
 - b. Every day 520 pregnant person does unsafe abortion
 - c. Every month 15512 pregnant person does unsafe abortion
 - d. Every year 183144 pregnant person does unsafe abortion (Source: Guttmacher Institute, CREHPA, 2014)

Some Facts around Contraception and safe abortion

Effectiveness of Contraception

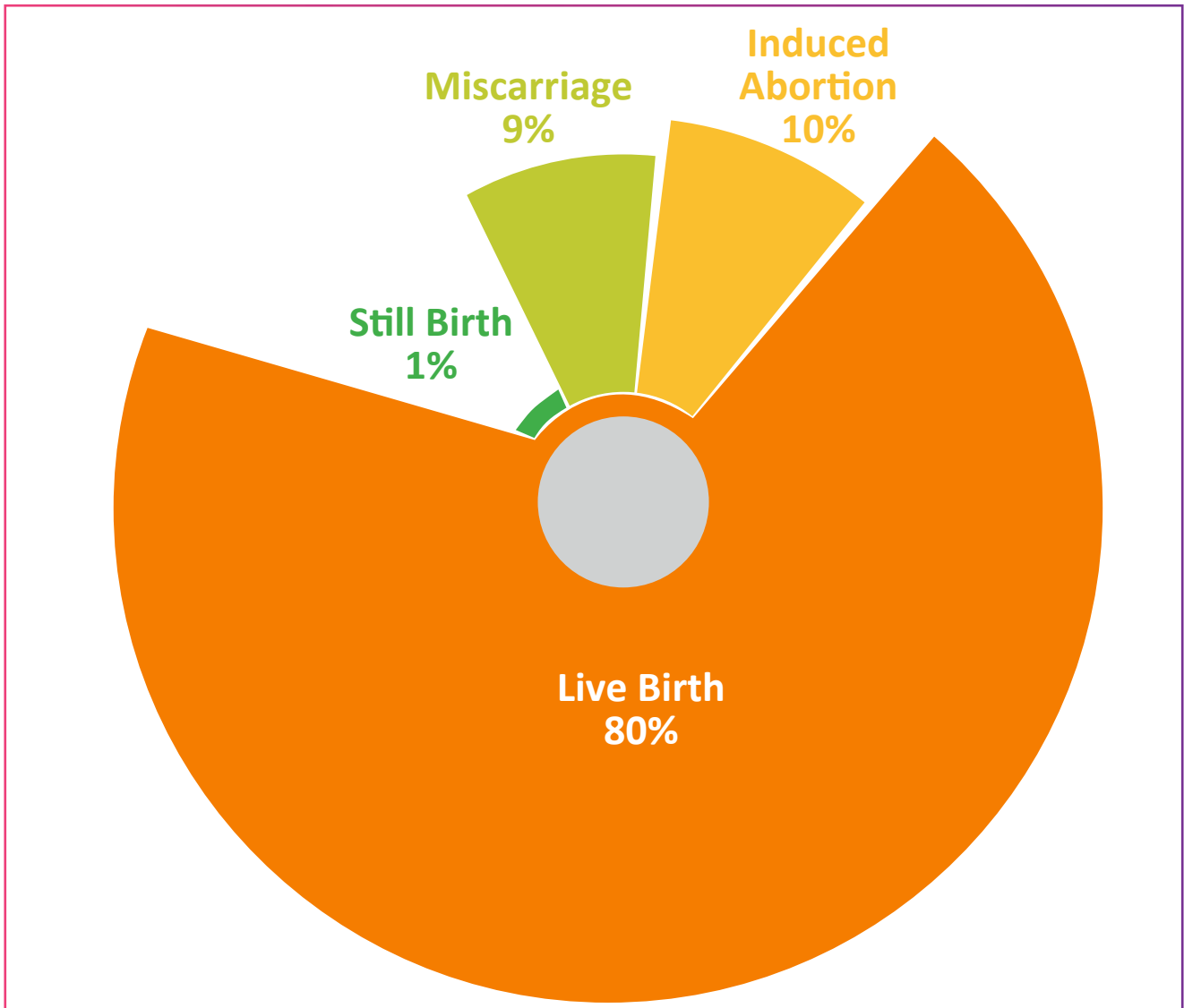


No contraceptive methods is 100% reliable, so there is always a chance of unwanted pregnancy, even on a regular basis. Even married people may also find themselves in need of abortion. It is important to recognize that abortion is not always the result of actions outside social norms.

Pregnancy Outcome

From four out of five pregnancies (80%), 9% resulted in a miscarriage, 10% led to an induced abortion, and 1% ended in a stillbirth. The total abortion rate in Nepal is 0.3 abortions per woman. Miscarriages are most prevalent among women aged 35–44 (17%), followed by those

under 20 (12%). Induced abortions are also highest among women aged 35–44 (30%), and those aged 25–34 (12%). Induced abortions are lowest among the Muslim (3%) and Madhesi (4%) ethnic groups, while they are highest among the Brahmin/Chhetri group (13%).



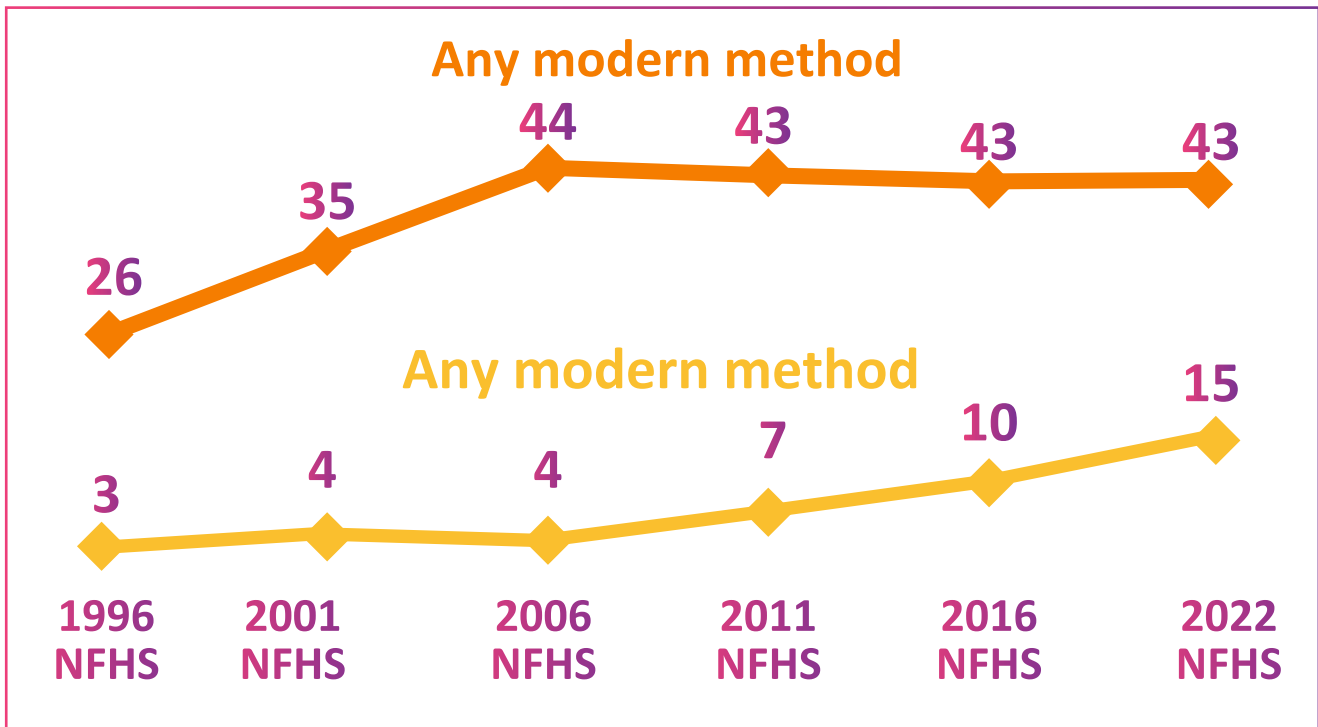
Source: NDHS-2022

Trends of contraceptive methods

The use of any family planning method among currently married women rose from 29% in 1996 to 57% in 2022.

The use of modern methods of contraception increased from 26% in 1996 to 44% in 2006, before experiencing a slight decrease to 43% from 2011 to 2022.

In contrast, the use of traditional methods has steadily increased over time, from 3% in 1996 to 10% in 2016, reaching 15% in 2022.

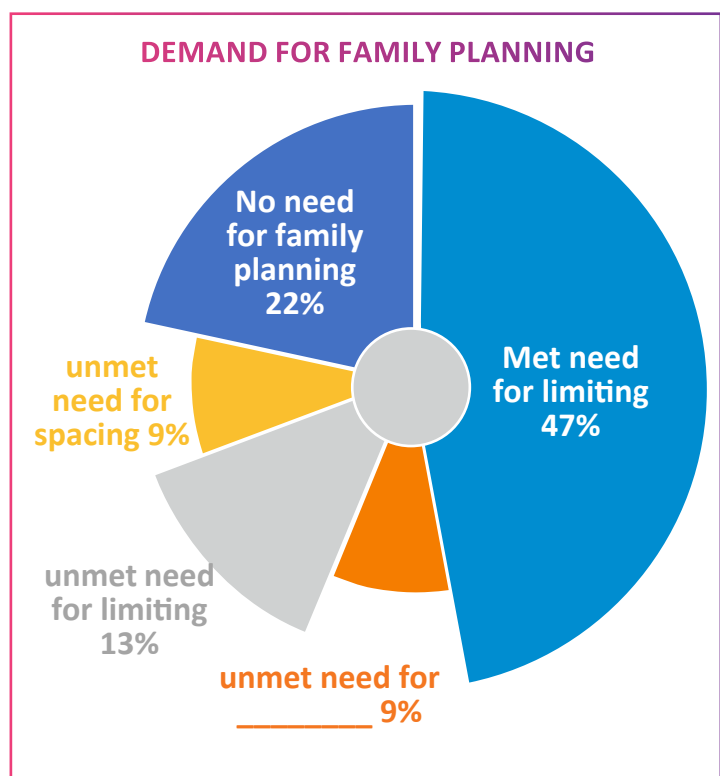


Unmet need for Family Planning

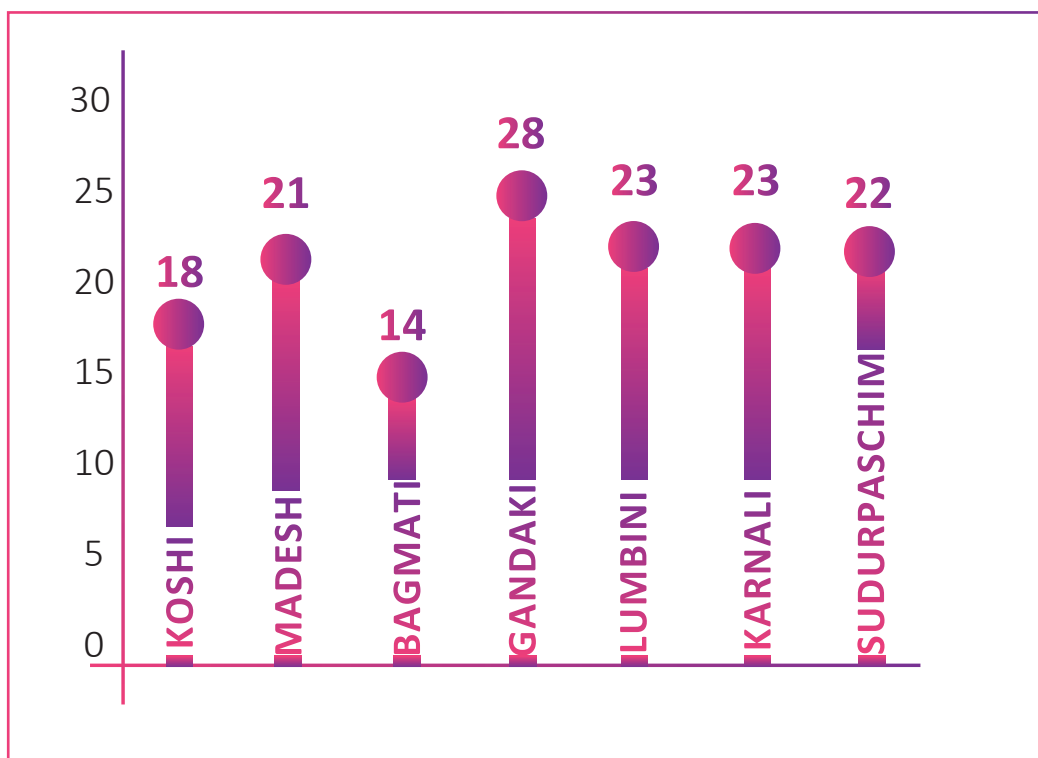
Sixteen percent of all women have an unmet need for family planning, with 9% seeking to limit births and 7% aiming for spacing.

Unmet need is highest among currently married women aged 15–19 (31%), and decreases with age; 10% of women aged 45–49 have an unmet need for family planning. Unmet need for family planning is greater among Dalit (26%) and Muslim (25%) women compared to those in other ethnic groups. Geographically, unmet need ranges from 16% in Bagmati Province to 28% in Gandaki Province.

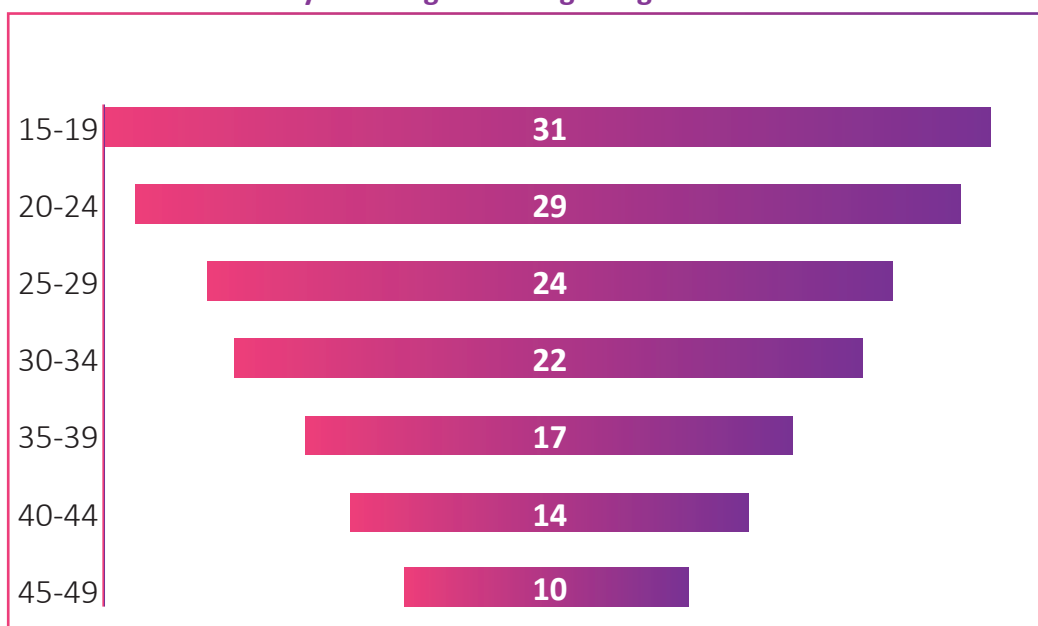
Furthermore, it is higher among women with a basic education and those with secondary education (24% and 23%, respectively) than among women with no education or a higher education (16% each)



Unmet need for family planning by province



Unmet Need for Family Planning according to Age



Relation of Unmet need for Family Planning to Education

Unmet need is higher among women with a basic education and those with secondary education (24% and 23%, respectively) than among women with no education or a higher education (16% each)

Abortion related data (Annual report 2078/79)

- The total abortion rate in Nepal is 0.3

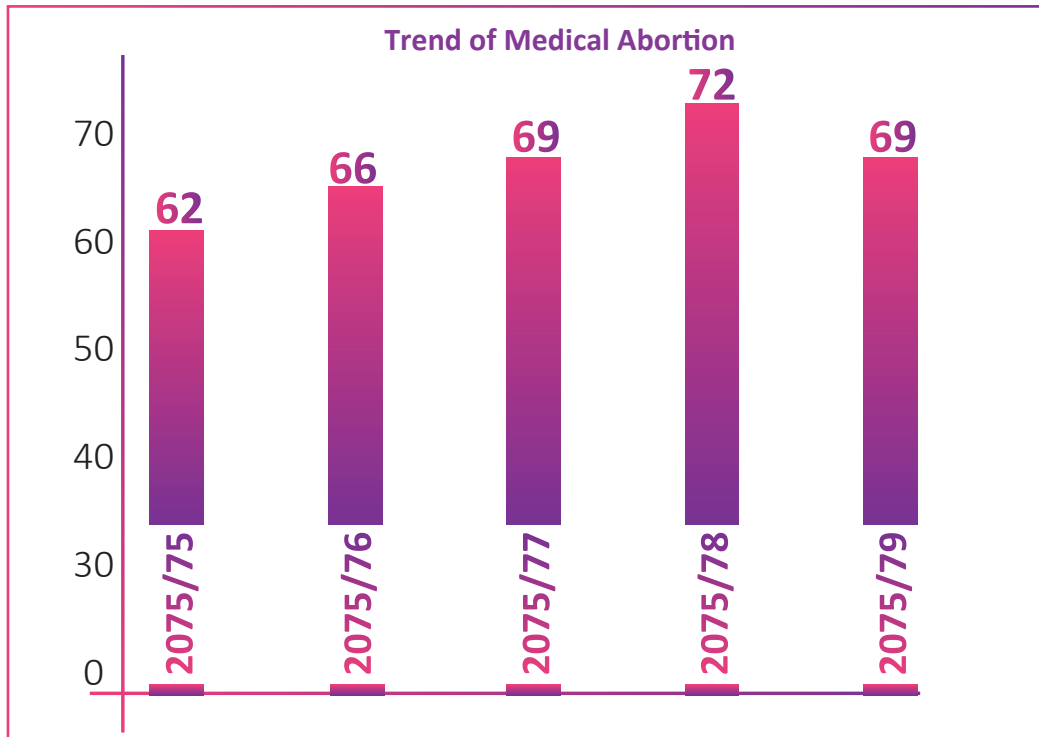
abortions per woman

- The age specific abortion rate is highest among women aged 25–29 (15 abortions per 1,000 women), followed by women aged 20–24 (12 abortions per 1,000 women) and women age 30–34 (11 abortions per 1,000 women).
- Sixty-two percent of pregnancies that ended in an abortion in the 3 years preceding the survey were unwanted, 25% were mistimed, and 13% were wanted.

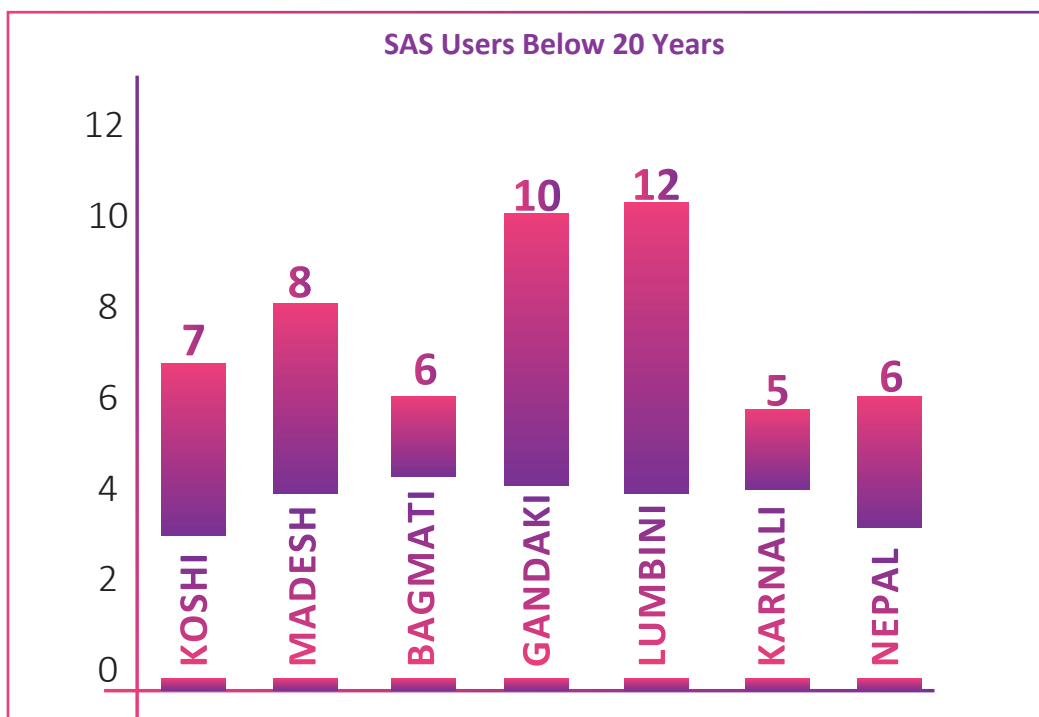
- The number of safe abortion service users increased to 90,733 in FY 2078/79 from 79,952 in FY 2077/78 and 87,869 women in FY 2076/77. Among these, 69% were medical abortions, and 31% were surgical abortions in FY 2078/79. 14.2% of the total pregnancies were terminated by induced procedures at health facilities, and 4.4% were induced using the surgical method.
- Although the safe abortion service users increased in FY 2078/79, the post-abortion

contraception has slightly decreased to 74.7% in FY 2078/79 from 76.7% in FY 2077/78. Among the safe abortion users, approx. 7% of the women were aged below 20 years.

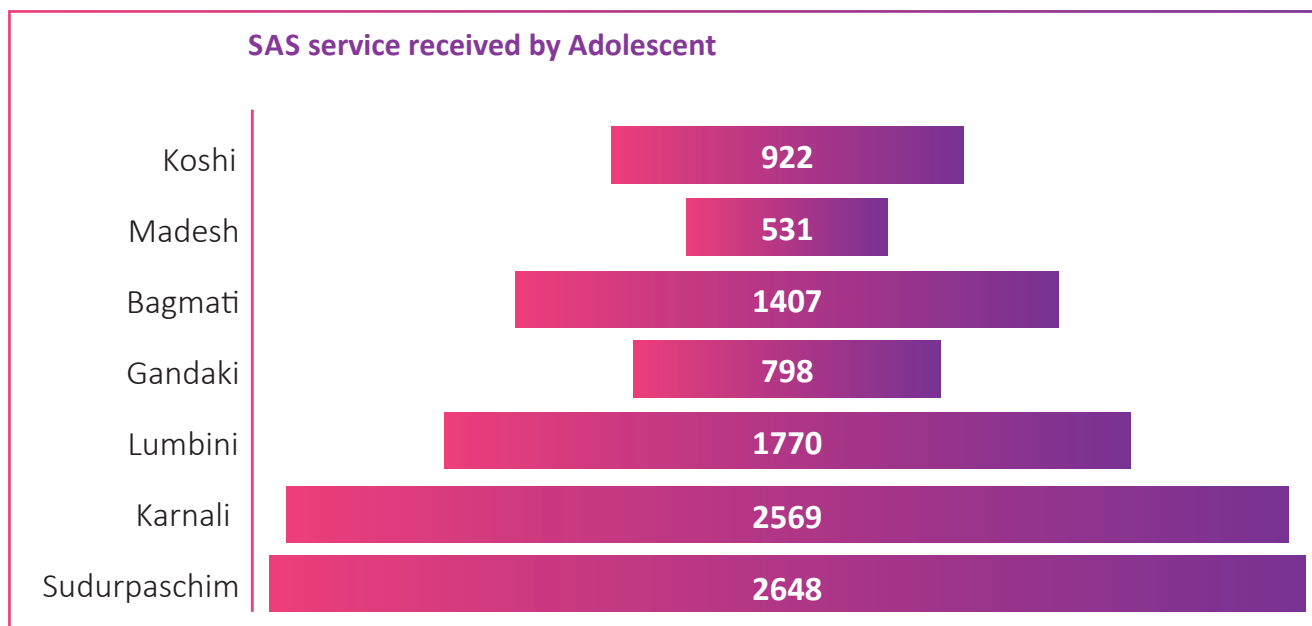
- The highest number of safe abortion services was provided at Bagmati province (18,463) followed by Lumbini province (18415) and Koshi (15911). The least number of abortion services was provided in Karnali province (4,860).



Safe abortion service user below aged 20 years



Safe abortion service received by adolescent - Province wise



Source: Annual report 2078/79

Unsafe abortion

1. Every hour 31 women/ girls
2. Everyday 520 women/ girls
3. Every month 15512 women/ girls
4. Every year 186144 women/ girls
5. 332000 women perform abortion every year among which 58% were unsafe (Guttmacher Institute, CREHPA, 2014)

Induced abortion

- Induced abortions are highest among women aged 35–44 (30%) and women aged 25–34 (12%)
- Induced abortions increase with increasing pregnancy order, from 2% for the first pregnancy

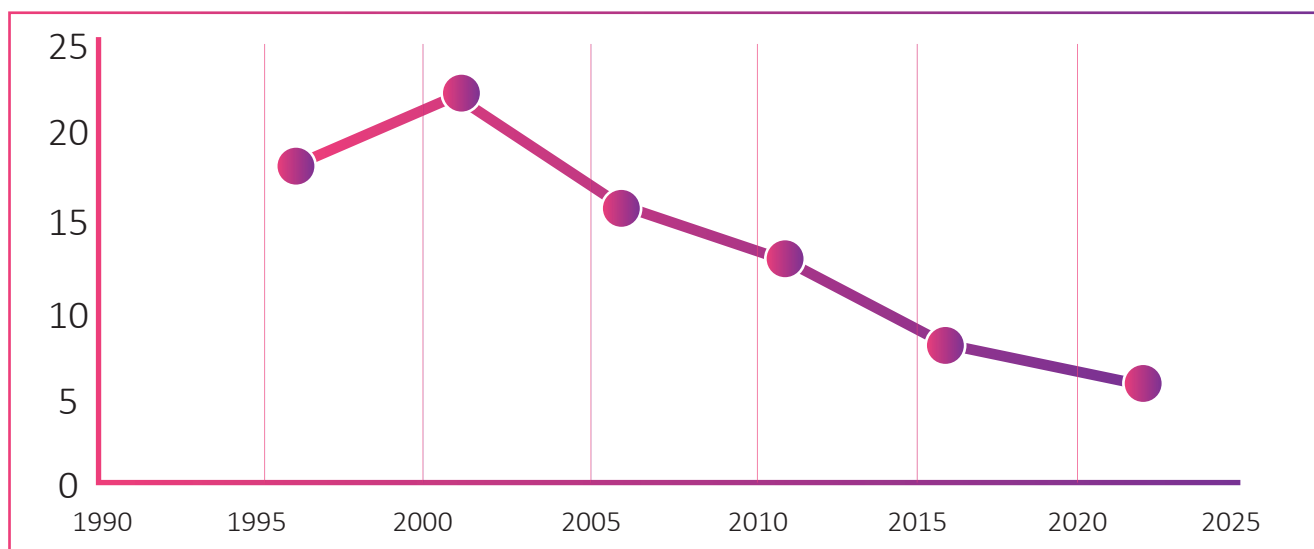
to 29% for the fifth pregnancy or higher

- Induced abortions are lowest in the Muslim (3%) and Madhesi (4%) ethnic groups and highest in the Brahmin/Chhetri group (13%).

Unwanted pregnancy

- Among all pregnancy outcomes, 73% of pregnancies in the 3 years preceding the survey were wanted at the time of conception, 16% were mistimed, and 11% were unwanted.
- Sixty-two percent of pregnancies that ended in abortions were unwanted, 25% were mistimed, and 13% were wanted
- Unwanted births declined from 18% in 1996 to 6% in 2022.

Trend of unwanted pregnancy



Source: NDHS 2022

Reference Materials

- FIGO safe abortion advocacy <https://www.figo.org/what-we-do/safe-abortion>
- Abortion and unintended Pregnancy in Nepal <https://www.gutmacher.org/fact-sheet/abortion-unintended-pregnancy-in-nepal>
- Abortion ;WHO <https://www.who.int/news-room/fact-sheets/detail/abortion>
- Unintended pregnancy and abortion by income, region, and the legal status of abortion [https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(20\)30315-6.pdf](https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(20)30315-6.pdf)
- Four reasons safe abortion is critical healthcare <https://www.rescue.org/article/four-reasons-safe-abortion-critical-health-care>
- Nepal Demographic Health Survey, 2022 <https://dhsprogram.com/pubs/pdf/FR379/FR379.pdf>

SESSION: CLINICAL OVERVIEW OF SAFE ABORTION

Objectives of this session

By the end of the session, participants will be able to:

- Review the clinical terms and terminologies related to safe abortion.

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Presentation	15 min	Participation	Power point, laptop, marker, pen white board
Concluding Presentation	10 min	Lecture	

Facilitation Instructions

Presentation

Divide the whole safe abortion-related content into 5 parts, with the participants being separated into 5 groups. Each group should be assigned a specific topic and content for a 10 min presentation one day before.

Request each group to choose a single member who will present their content on behalf of the group. Presenting groups should be ready to address any queries from the audience regarding their topic.

Concluding presentation

The facilitator should conclude the session by summarizing the main points related to the technical aspect of safe abortion which include but is not limited to; the process of conception, the meaning of viability of the fetus, the difference between natural and induced abortion, types of abortion, safe abortion logo meaning, and criteria for providing safe abortion service (site and service listing)

Note to the Facilitator

- Avoid delving into overly detailed technical aspects of safe abortion. This training is intended for value clarification and attitude transformation.
- Ensure that participants understand the meaning of viability from the point that the fetus is entirely dependent on the pregnant person for survival.

Contents for facilitators

Conception Process

Biologically, conception is the process by which sperm fuses with the ova, resulting in the formation of a single cell. This process, known as fertilization, marks the initial stage of development for human growth. For sexual reproduction to be successful, the fusion of these two cells i.e. Sperm and Ova must occur, leading to the formation of a single cell that undergoes further cell division. During fertilization, both the sperm and the ovum, which are gametes, will each contain 23 chromosomes. When they combine, the total chromosomal number of the new structure is 46; this single cell is called a zygote, or a fertilized egg cell.

Definition of Safe abortion

Abortion refers to the termination of pregnancy before the viability of the fetus. Termination of pregnancy can be natural or be induced. When pregnancy terminated naturally, it is referred as miscarriage/natural abortion and when the termination is induced through some methods, it is referred to as induced abortion.

Viability of Fetus

Viability means the ability to exist independently or to survive or live successfully. Thus, the viability of a fetus means the ability of the fetus to survive outside the uterus. It is generally accepted that a fetus is considered viable around 28 weeks of gestation and does not need resuscitation. However, according to the WHO,

fetal viability can be possibly as early as 22 weeks of pregnancy. When it comes to unwanted pregnancy, it is important to note that, present life i.e. life of a pregnant person matters most.

Type of safe abortion:

- A. Natural/ Spontaneous abortion/ Miscarriage
- B. Induced abortion
 - a. Safe/Legal
 - Medical Abortion
 - Surgical Abortion
 - b. Unsafe/ traditional method

Natural / Spontaneous Abortion / Miscarriage:

Spontaneous expulsion of a fetus from the womb before it can survive independently is known as spontaneous abortion. It occurs in at least 15-20% of all recognized pregnancies and usually takes place in the first trimester. Unlike induced abortion, spontaneous abortion, is purely accidental, that is spontaneous.

Induced Abortion: Induced (elective) abortion is an intentional pregnancy termination by surgical, medical or other means. It can be both safe and unsafe.

Safe abortion: Termination of pregnancy by listed healthcare providers in listed health facility within legal framework is called safe abortion.

Methods of safe abortion services

Safe abortion services can be provided by using appropriate methods and procedures at the listed health facilities and providers.

- **Medical Abortion (MA):** The method of termination of pregnancy within gestational age of 10 weeks using pharmacological drugs is termed as medical abortion. It can be done using a drug named mifepristone and misoprostol.
- **Manual Vacuum Aspiration (MVA):** This is the surgical method of abortion which can be done up to 12 weeks of gestational age.
- **Dilatation and Evacuation (D&E):** This is a surgical method of abortion. This service is provided to women between 13 to 18 weeks of gestational age at the listed Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) site.
- **Medical Induction (MI):** This can be done

for women between 13 weeks to 28 weeks of gestational age at the listed specialized, super-specialty teaching hospitals under the Academy of Health Science or other teaching hospitals through the listed health workers.

Medical Abortion: This term refers to when someone takes medication (in the form of a pill) to end a pregnancy. The World Health Organization recommends a dose of a drug called Mifepristone, followed by a drug called Misoprostol one to two days later. In Nepal, Medical Abortion can be done within 10 weeks of pregnancy.

Medical Abortion (MA) Pills: There are seven Medical Abortion pills which are registered in the Department of Drug Administration (DDA): Medabon, MTP Kit, Mistol, Pregno, Mufty MTP kit, Syno Pill, Anti Preg Kit

Mechanism of action of MA Pills: Mifepristone works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down and pregnancy cannot continue. Misoprostol causes the muscles of the uterus to cramp and expel its contents.

Methods to use MA pills: Take 1st pills (Mifepristone) and keep it under the tongue for 30 minutes. After 30 minutes, the remnants of the pills that do not get dissolve can be swallowed with water or by chewing. After 24 hours, 4 pills (Misoprostol) can be taken orally or can be kept vaginally. Bleeding usually starts within 3 hours after taking the first pills and may feel like heavy menstrual bleeding.

Side effects of Medical Abortion: Side effects can include dizziness, diarrhea, bleeding, mild fever, chills, and headache. To alleviate the pain and discomfort, painkillers like ibuprofen can be used, and paracetamol is recommended for mild fever. Other measures to manage painful and heavy bleeding include using hot water, hot water bags, hot shower, and adequate rest.

Danger signs: Medical abortion is safe and up to 98% effective when Misoprostol and Mifepristone are used as instructed. In case of any signs of complications, it is necessary to visit

the nearby clinic as soon as possible.

Sign of complications are:

- Heavy bleeding: if 2 pads/ hour are filled in the last two hours.
- Intense pain
- Continuous vomiting
- Fever exceeding 38 degree Celsius, seek medical attention. It is necessary to follow up in 2 weeks to confirm that the abortion process was successful and completed.

Unsafe Abortion: Unsafe abortion refers to procedures for terminating a pregnancy that carried out either by person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO). In other words, if a pregnancy is terminated using unsafe methods that may endanger the life of women it is classified as unsafe abortion. Traditional methods like using herbs and unregistered medicines are also unsafe methods.

Safe abortion service provider: Healthcare

providers (Doctors, Nurses, and Auxiliary Nurse Midwives) who have received safe abortion training and are certified are eligible to provide safe abortion services. Both the site and service provider should be listed. If the site is listed but the provider is not certified, then safe abortion service should not be offered, and vice versa

Safe abortion sites: As of November 2016, Medical abortion services are available in all 77 districts of Nepal. Comprehensive Abortion Care (Manual Vacuum Aspiration and Medical Abortion) services have been expanded to all 77 district hospitals and over 50% of Primary Healthcare Centers (PHCCs). Additionally, second-trimester abortion services are available in 22 hospitals, and medical abortion services have been expanded to health posts with additional training for Skilled Birth Attendants (SBA). Of the 962 certified Safe Abortion Service centers, 693 are public, 157 are private and 112 are operated by non-governmental organizations.

Reference Materials

- Safe Abortion Technical Guideline, WHO (2022): https://www.who.int/publications/i/item/9789240039483?gclid=Cj0KCQiAnsQdBhCGARIsAAyjYjRYv1X_idmfJs79DfCRJLmmbSwPIs99IlihdI0KCRK2Y5bYjDYWsU4aAjf5EALw_wcB
- Safe Abortion Program Guideline, Nepal (2016) http://fhd.gov.np/images/pdf/Free_SAS_Guideline_2016-Final_Nov-23-2016.pdf
- Safe Abortion Program Guideline, Nepal (2016) http://fhd.gov.np/images/pdf/Free_SAS_Guideline_2016-Final_Nov-23-2016.pdf

Section

3

**VALUES
CLARIFICATION
AND ATTITUDE
TRANSFORMATION
AROUND SAFE
ABORTION**



SESSION: AGREE VS. DISAGREE ACTIVITY

Objectives of this session

By the end of the session, participants will be able to

- Reflect their own values around different aspect of bodily autonomy

Session Details

Activities	Time (90 min)	Methodology	Materials Required
Introducing Ground Rules	10 min	Participation, Discussion, Brainstorming	Statements for agree disagree activity
Agree Disagree Activity	70 min		
Conclusion of the activity	10 min		

Facilitation Instructions

Introducing Ground Rules

Inform participants that we are going to conduct an “Agree or Disagree” exercise. Establish some ground rules before the activity.

- Share your opinions and beliefs honestly without being influenced by others
- Speak one at a time, ensuring that everyone has the chance and time to talk.
- Agree to disagree, but do so respectfully. Value each person’s unique perspectives
- Maintain confidentiality (if giving actual examples, avoid using identifying details)
- Honor everyone’s input (regardless of educational degree, professional or community status, or personal experiences with the topic)
- Maintain a supportive environment (for those who may experience anxiety talking about emotionally difficult topics)
- Approach all viewpoints with openness and without judgmental

Agree Disagree Activity

Write down “Agree”, “Don't Know”, “Disagree” in 3 meta-cards. Stick ‘Agree’ on one side of the wall, ‘Disagree’ on the other side and ‘Don’t know’ in the middle.

Create an open space in the room for participants to move around during the activity. Request all the participants to lineup at the center. As the facilitator reads out each statement, instruct the participants to move to the area that reflects their stance: agree, disagree or don’t know.

After participants have positioned themselves, ask volunteers at different points along the continuum to explain why they are standing

there. If, based on someone’s explanation, participants want to move to another point on the continuum, tell them it is okay to do so, but they should have strong reasons for the change. Once you have finished reading the statement, ask participants to come in center/ one place. Again, read the statement and repeat the process until all the listed statements are completed.

Facilitate a brief discussion referring to the reasons participants gave about their place on the continuum. Some discussion questions could include:

- What observations do you have about your own responses to the statements? What about other people’s responses?
- Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
- What about your responses to the statements surprised you? How about other people’s responses?
- What did you learn about your own and others’ comfort levels on abortion?
- What observations do you have about the group’s overall level of comfort with abortion (not individual people’s responses)?

Conclusion

Conclude the activity highlighting the fact that the purpose of this activity is to help participants come to a deeper understanding about their own and others’ beliefs regarding the right to bodily autonomy, including safe abortion. Highlight the fact that recognizing our own values and beliefs around these issues surrounding bodily autonomy can help us approach discussions with empathy and reduce judgment when differences arise.

Key takeaways from the session

Women's access to abortion care is often denied or hampered by a range of barriers, many of which are rooted in abortion stigma. Stigma is a learned behavior that affects both the provision of and access to abortion care, as well as the social environment surrounding it.

Research has shown that negative attitudes from healthcare providers can undermine individuals' rights to safe abortion by impeding access to information, creating barriers to care, contributing to stigma and shame, compromising the quality of care, and intersecting with legal and policy constraints. It's essential for healthcare providers to uphold ethical standards and provide nonjudgmental, evidence-based care to ensure that individuals' reproductive rights are respected and protected.

Note to Facilitator

Facilitators need to make sure they have rights-based lens in every statement discussed with participants.

This activity will be too long if facilitators attempt to cover all—or even most—of the statements. 5-6 statements are normally enough to gain the desired effect from the activity. Select the statements that will elicit the most important discussion for that audience and setting. You can select the statements in advance or after you have seen how the participants respond, identifying areas of greatest differences in opinion.

Only trained facilitators should conduct this activity to ensure an emotionally safe environment.

Contents for facilitators

AGREE vs. DISAGREE statements

1. Pre-marital sex is against our culture

It's natural for individuals to experience physical changes and develop sexual desires, regardless of societal expectations. An important question we have to reflect upon is whether we can realistically control these feelings until marriage, especially as the age for marriage has increased for many reasons.

Providing accurate and comprehensive sexual and reproductive health and rights (SRHR) information is crucial. Education and access to resources

regarding safe sexual practices, contraception, and sexually transmitted infections (STIs) are essential for promoting responsible sexual behavior and overall well-being.

Instead of focusing solely on controlling individual behavior, it's more productive to empower them with knowledge and resources to make informed choices about their sexual health. Encouraging open and honest discussions about sexuality, consent, and relationships can help create a supportive environment for individuals to navigate their sexual experiences safely and responsibly.

2. Only women need safe abortion service

Transgender men, who are assigned female at birth but identify and live as men, may still have the potential to become pregnant, especially if they have not undergone certain medical interventions such as hormone therapy or surgery. Therefore, access to safe abortion services is crucial for transgender men as well. Transgender men have the right to control their own reproductive health, just like cisgender women and men. Denying them access to safe abortion services violates their reproductive rights and autonomy. Access to safe abortion services ensures that they have the autonomy to control their fertility and reproductive choices. For transgender men, pregnancy may cause dysphoria and psychological distress due to the incongruence between their gender identity and their body's reproductive capabilities. Access to safe abortion services is vital for their mental health and gender-affirming care.

3. Abortion causes infertility, cervical cancer and breast cancer.

The claim that abortion causes infertility, cervical cancer, and breast cancer is not supported by scientific evidence.

This is a common claim made by those opposed to abortion. However, there is no reputable medical evidence indicating that having an abortion increases the risk of increasing breast cancer. A safely conducted abortion does not cause subsequent fertility problems, and in fact, fertility can return as soon as two weeks after an abortion.

It's important to rely on credible scientific sources and expert consensus when evaluating claims about the health effects of abortion. Misinformation about abortion can contribute to stigma and create barriers to access safe and legal abortion services, which are essential for promoting reproductive health and rights.

4. Pregnancy is better than abortion

Neither pregnancy nor abortion can be comparable to one another. The choice lies entirely with the individual whether they want to continue their pregnancy? Continuing an unwanted pregnancy or terminating a wanted pregnancy are both equally valid decisions but what matters most is respecting the individual's choice regarding their pregnancy and autonomy.

5. Due to the availability of safe abortion, the trend of premarital sex has increased, and adolescents are accessing safe abortion services more than ever.

It's natural for individuals to experience physical changes and develop sexual desires, regardless of societal expectations. An important question we have to reflect upon is whether we can realistically control these desires until marriage, especially as the average age of marriage has risen for many reasons. Some individuals choose to remain sexually active but not marry, which is a fundamental human right.

People will find ways to terminate unwanted pregnancies, and if they choose a safe method, we should be relieved that they are not resorting to any unsafe methods. Instead of stigmatizing safe abortion services, we should focus more

on increasing awareness to reduce unwanted pregnancies and promote safe sex practices. i.e use of contraceptives.

6. These days, abortion is being used as a birth control pill.

Both contraception and abortion aim to prevent or end pregnancy, they operate at different stages in the reproductive process and serve different purposes. Birth control pills/ contraceptive methods, by definition, prevent pregnancy by interfering with ovulation, fertilization or implantation. Abortion ends an established pregnancy, after implantation. These two things differ significantly in terms of their action, yet they are often used synonymously. Why is this the case? It creates the impression that people are not using contraceptives to prevent unwanted pregnancies and that they rely on abortion services to terminate unintended pregnancies. In reality, obtaining contraception is typically easier than accessing abortion services?

Typically, obtaining contraception is easier than accessing abortion services; however, there is no evidence to suggest that people use abortion as a primary method of birth control. Most individuals who seek abortions report having used contraception in the month they became pregnant. No one can assume or know the reasons behind an unplanned pregnancy. The need for an abortion may arise from contraceptive failure, a lack of access to accurate reproductive and sexual health information, insufficient access to accessible and affordable birth control methods, or even sexual assault. Therefore, we should avoid using these two things synonymously without understanding the circumstances of each individual.

7 Sex worker cannot be raped

Sex workers, like all individuals, have the right to bodily autonomy and consent. Rape, by definition, is non-consensual sexual activity. Therefore, if a sex worker does not consent to a sexual encounter, any sexual activity forced upon them constitutes rape.

It's important to recognize that sex work is a profession and like anyone else, have the right to set boundaries, refuse sexual encounters, and expect that their consent is respected.

The notion that sex workers cannot be raped is a harmful misconception that disregards their agency, autonomy, and basic human rights. All individuals, regardless of their occupation or circumstances, have the right to live free from sexual violence and coercion.

8. Due to abortion, we are losing talents like Ronaldo and Messi.

The claim that we are losing talents like Ronaldo and Messi due to abortion is fallacious. It's impossible to determine the potential talents

of individuals with any certainty, who were not born due to abortions. Speculating about the hypothetical talents of nonexistent individuals is not a valid argument.

Focusing on the hypothetical loss of sports talents due to abortion detracts from more meaningful discussions about reproductive rights, individual autonomy, access to healthcare, and social and economic factors that influence individual choices and opportunities.

Reference Materials

- How to talk about abortion. (https://www.ippf.org/sites/default/files/201808/ippf_abortion_messaging_guide_we_b_0.pdf)
- 10 facts about abortion (<https://ipas.azureedge.net/files/TENFACE13-TenFactsAboutAbortion.pdf>)
- Abortion Attitude Transformation (<http://www.redaas.org.ar/archivos-recursos/IPAS.%20abortion%20values%20transformation.pdf>)
- Common Myths About Abortion (<https://www.actioncanadashr.org/campaigns/commit-resist/common-myths-about-abortion>)
- Ask the expert: WHO (<https://www.who.int/news/item/26-09-2022-ask-the-expert-10-questions-on-safe-abortion-care>)

SESSION: WHY DID SHE DIE?

Objectives of this session

By the end of the session, participants will be able to

- Understand the sociocultural context surrounding unwanted pregnancies and abortions among young women
- Explain the tragic outcomes that can result from restricting access to safe, legal abortion services for young women
- Articulate their personal or professional responsibility to prevent deaths, such as those described. Identify different people responsible within and outside home for forcing a girl/ woman to commit an unsafe abortion

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Reading Uma's story	5 min	Lecture	Case story of Uma, Woolen thread
Case story analysis activity	20 min	Brain Storming	
Large group discussion	10 min	Participation	
Conclusion of the session	10 min	Lecture	

Facilitation Instructions

Introduction of the activity

Distribute a copy of 'Uma's story: Why Did She Die?' to all participants and ask them to read the story silently. Allow 5 minutes to read the story. Afterwards, ask the participants to close their eyes and reflect on the case story carefully for 2 minutes.

Case story analysis activity

Setup a chair at the front of the training hall and prepare a woolen ball to start the activity. Similarly, create an open space and ask participants to form a semi-circle facing the chair.

Request a volunteer to come forward and sit

in the chair, holding the tip of the woolen ball. The volunteer assume the role of Uma from the case story. Moving forward, ask participants to identify the person responsible for Uma's death and explain why. The potential answers may be:

- Maternal aunt
- Pharmacy
- Female teacher
- Uma's boyfriend
- Uma's mother and other characters from the story

Ask the participant responding with the answers to stand up and hold the tip of the rope from Uma's character without breaking the network at a distance of 2 to 3 meters. As more participants give their responses, continue building a network with the rope as shown in the picture below:



Photo taken during Gender sensitization program conducted by YoSHAN. Permission taken from YoSHAN team for re-use in this training guide.

Once participants are done with listing all the potential people responsible for Uma's death, ask them to brainstorm whether anyone has been missed or left out. Ensure that all the individuals listed in this module's narrative are mentioned.

After identifying all potential persons linked to Uma's death, appreciate the participants for their effort in this exercise and request them to take their seats. Gather the woolen thread into a ball to prevent it from getting entangled.

Large group discussion

With the help of the following questions, lead an in-depth reflection and discussion on the case story. Don't be judgmental towards the opinions and logic presented by the participants and request everyone to be respectful with each other while expressing one's opinion. The questions are:

- In addition to the young woman, who else was directly affected by her death?
- What real stories or situations does this story make you think of (without revealing any identifying information)?
- What does this story tell us about our responsibility to safeguard young women's health and lives?

- What could have been done to prevent her death? Who could have helped prevent her death?
- What could have made this situation better for her?
- What information or resources may have helped her avoid this situation?
- What will you do, personally or professionally, to prevent deaths such as this one from occurring?

Conclusion

Ask 2 participants to reflect on the messages they got from the activity. As they reflect, emphasize that restricted access to abortion leads to women seeking unsafe abortions. It

is important to remember that if a woman wants an abortion, she will find a way to obtain one. When safe, accessible, affordable, and culturally acceptable abortion options are unavailable, there is high chance that they will resort to unsafe methods, potentially resulting in serious complications, permanent injuries, or deaths. Overall, limited access to abortion care poses significant obstacles to obtaining timely, safe, and legal abortion services, infringing upon individuals' reproductive rights and autonomy.

Key takeaways from the session

Restrictions on access to abortion for young women only leads to increased morbidity and mortality. Comprehensive Sexuality Education Programs has shown to have a positive impact on young people's sexual and reproductive health, as well as their ability to make safe and informed decisions. However, the topic of abortion remains absent from most programs, even though safe abortion is legal in our country. This absence diminishes young people's ability to avoid the dangers of unsafe abortion, make fully informed choices, and exercise their right to safe, legal abortion. When one girl/ women commits unsafe abortion, there are multiple people responsible for her death. If any girl/ woman decide to terminate her unplanned/unwanted pregnant then she will find a way to do so, regardless of the circumstances or the cost. The stigma that we hold subconsciously can help transform our attitudes towards safe abortion in the long run. Furthermore, for healthcare providers, conscientious objection is a crime under the Safe Motherhood and Reproductive Health Rights Act 2075.

Note to Facilitator

- Prepare the ball of string so that it can unwind easily.
- It may be helpful to provide participants with local data on abortion rates and the morbidity and mortality related with unsafe abortion to illustrate that women's deaths from unsafe abortion are both common and preventable. Further, the facilitator should be updated about the international and national statistics

on abortion-related morbidity and mortality, especially among young populations, to illustrate the frequency of tragic events like this one.

- While discussing the individuals responsible for Uma's death, encourage participants to share their own views. Facilitators should refrain from expressing their own views on who they think was responsible.

Contents for facilitators

Uma's story

१६ वर्षकी उमा, कक्षा १० मा पढ्नकोलागि गाउँबाट आफ्नो मामाघर बिराटनगर आईन र शहरको स्कुलमा भर्ना भइन् । विद्यालय जाँदा उनको आफ्नै कक्षामा पढ्ने हरीसंग मित्रता बढ्दै गयो र माया बस्यो । त्यसै क्रममा उनको महिना नाघ्यो तर पहिले पनि कहिलेकाँही महिनावारी ढिलो हुने हुँदा उनले त्यति वास्ता गरिनन् । जब चार महिना नाघ्यो तब उनी आत्तिइन र हरीलाई भनिन् तर दुवै जनालाई कहाँ जाने के गर्ने थाहा भएन । कक्षाकी शिक्षिकासंग भन्ने कि, माईजुलाई भन्ने कि, अस्पतालमा जाने कि । फेरि आफुसंग पैसा पनि छैन । आँट गरेर उमाले आफ्नी माईजुलाई भनिन् । माईजु साह्रै रिसाइन र धेरै गाली गरिन् । उनले उमाकी आमालाई सबै कुरा

भनिदिने भनिन् । त्यो सुनेर उमा ज्यादै डराइन र आत्तिएर नजिकैको औषधी पसलमा गइन र पसलेलाई जसरी भए पनि आफुले गर्भपतन गर्ने पर्ने कुरा भनिन् । पसलेले उमाको गर्भ धेरै महिनाको भइसकेको र गर्भपतन गर्न गाह्रो हुने र खर्च पनि धेरै लाग्ने कुरा बताए । उनले केही सस्तोमा गर्भपतन गर्ने ठाँउको ठेगाना पनि बताए । उमा र हरी खोज्दै सस्तो किर्लिकमा पुगे । त्यहाँ उमाको योनीमा केही काठका टुकामा गोबर जस्तो चीज राखेर उनलाई केही भोल औषधी खान दिई घर पठाइदिए । घर आएपछि माईजुले भोलि उमाकी आमा गाउँबाट आउने र आमालाई सबै कुरा भनेर उमालाई डाक्टर कहाँ लै जाने भनिन् । तर त्यस राति नै धेरै रगत बगेर उमाको मृत्यु भयो ।

Reference Materials

- A values clarification toolkit for global Audiences, IPAS <https://www.ipas.org/resource/abortion-values-clarification-for-action-and-transformation-vcat/>

SESSION: INTERSECTIONAL WALK

Objectives of this session

By the end of the session, participants will be able to:

- Understand how a variety of social, cultural, and gender values both limit and enhance our life opportunities and outcomes;
- Recognize that young people who come for SRHR service are not a homogenous population/group.

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Intersectional Walk Activity	40 min	Participation, Discussion, Brainstorming	Chits of statements related to intersectional walk, Pot/Bowl/Hat for placing chits
Conclusion of the activity	10 min		

Facilitation Instructions

Intersectional Walk

Prepare statements beforehand that represents the diverse SRHR needs among young people, ensuring the number of statements matches the number of participants. Refer to the content for the facilitator. Make sure there is sufficient safe space for this activity.

Ask participants to stand shoulder to shoulder in a straight line, positioning them in a line so that participants will be able to step forward and backward. Walk along the line or circle with a basket full of role description slips, allowing each participant to draw one slip of paper. Ask participants to look at their own slip of paper, but not at anyone else's. Ask them not to tell anyone else what is written on their slip of paper.

Tell participants that for this activity, they will embody the person described on their slip of paper. Ask them to read their slip again, close their eyes, and envision themselves in their given identity. Ask them: In your new identity that you now hold, how do you look? What are you wearing? What does your surroundings look like now? What are you doing? How are your challenges? What are your family, friends, and other surroundings like?

Give participants several seconds to envision and embody their new identity. Tell participants that you are going to read a series of instructions,

and that they should follow those instructions according to their new identity on their slips and whether the instructions apply to them. Read the following statements one at a time, giving all participants sufficient time to follow your instructions.

- If you are a man, take one step forward.
- If you are a woman, take one step backward.
- If you are illiterate and don't know how to read, take one step backward.
- If you have a high school education or attend high school, take one step forward.
- If you live in a rural area, take one step backward.
- If you have a university education or attend university, take one step forward.
- If you were born into a poor family, take one step backward.
- If you have experienced sexual abuse or gender-based violence, take one step backward.
- If you were born into middle -class family or have parents who are professionals, take one step forward.
- If you have a disability, take one step backward.
- If you have more than two children, take a step backward.
- If you know your HIV status, take one step forward.
- If you have been displaced from or forced to leave your home, take one step backward.
- If you are forced to exchange sex for money or other things, take one step backward. If you

have a secret that you are afraid or don't want to tell anyone, take one step backward.

- If you are HIV positive, take one step backward.
- If you are a peer educator, take one step forward.
- If you are discriminated against based on your sexuality and sexual orientation, take one step backward.
- If there is something else that makes you feel good about yourself, take a step forward.
- If there is something else that makes you feel bad about yourself, take a step backward.

After all statements have been read, invite participants to look around the room and observe their positions relative to others. Ask participants what they see and invite responses.

Ask these discussion questions and invite responses. For each participant who answers, ask them to also reveal their identity to the other participants.

- You all started in the same place. How does it feel to be standing where you are?
- How do you feel about where you are standing, in relation to others?
- How do you feel about where others are standing, in relation to you?
- What are some of the factors that caused these differences? What role does gender play?

Also ask participants

- How did you feel in the role of the person you were portraying in this activity?
- Where would you have been standing if you had been representing yourself in this activity rather than someone else?

While participants remain in their positions, point out that although they all started in the same place on the line or in the circle, and although we may be taught to believe that all people are created equal, in reality many factors influence the opportunities, successes, problems, and outcomes we experience in our lives. Social structures, including class and gender structures, mean that some individuals enjoy privileges that others do not. Point out how easy it can be at times to 'blame the victim' for their unhappy circumstances, when in fact, numerous factors may influence their situation. As healthcare providers, we

often fail to understand why people make certain choices and may unjustly place blame on them without trying to understand their situation.

Conclusion

As a healthcare provider, it is important to be mindful of the fact that diverse factors like class, gender structures, disability status, access to information's, geographical area, economic status etc. can influence individuals' experiences. Some people enjoy privileges that others do not, thus should be understanding of their situation and the reasons behind their choices without blaming them. Point out how easy it can be at times to 'blame the victim' for unhappy life situations, particularly when it comes to sensitive issues like pregnancy termination, when in fact, other factors may have influenced that situation. The severity of blaming the victim is deep rooted when it comes to choosing to terminate pregnancy, especially by young people.

Key takeaways from the session

The intersections of an individual's gender, sexuality, ethnicity, cultural background, linguistic background, age, geography, physical and mental health, and more compound factors leads to a variety of needs within similar situations. We are supposedly born equal, with the same opportunities to create fulfilling lives for ourselves and our families. This activity helps us look at the realities of privilege, of advantages and disadvantages that affect our ability to have happy and successful lives. As a healthcare provider delivering SRHR services, including safe abortion, it is crucial to understand that each client seeking these SRHR services comes with a unique set of circumstances. The diversity of needs and choices for each individual seeking safe abortion can vary widely. Thus, it is essential that all of their needs and choices are respected.

Note to Facilitator

Remind participants that when delivering SRHR service, especially safe abortion for young people, we must keep their differences in mind to make sure that we address the needs of specific youth populations. Further, it is necessary to realize that young people comprise a huge diversity of individuals. Beyond age and sexuality, various life experiences and opportunities or disadvantages create huge differences among youth in terms of their needs and desires. Thus, we need to deliver SRHR services addressing individualized need considering their circumstances.

Contents for facilitators

Intersectional walks personas

You are a young woman aged 13. You come from a poor family in Humla. You were married to an older man at age 11. He will not let you continue to go to school.

You are a young man aged 18. You have just learned that your 16 year old girlfriend is pregnant. Neither of you feel ready to become parents. You haven't told your parents or her parents.

You are an unmarried woman, aged 17. You attend high school and were doing very well academically, but then your classmates find out that you have a same sex partner from another school. Some of the young men raped you to "teach you to be with men", and your other classmates are calling you names.

You are a 20 year old man who is illiterate and HIV-positive. You have kept your HIV status a secret since you don't know how to tell anyone about it. You are unsure how to tell your fiancé, who you love.

You are a 19 year old woman who finished high school with honors. Your parents have just chosen a husband for you and said that you may not attend university.

You are a 17 year old man with a mental disability and no education. Your parents cannot afford the care you need and are considering placing you in a government institution where you will be sterilized.

You are a 22 year old wife and mother of three

young children. Your husband died recently, and you think he might have been HIV positive. You are too scared to get tested to find out your own HIV status. You think you will have to exchange sex for money soon to feed your children since you have no other source of income.

You are a 21 year old married man, from a middle class family. You and your wife want to have two children, but first, you both want to complete your graduate degrees.

You are a 12 year old girl born to poor parents who sent you to the home of a middle class married couple to be a domestic servant. The husband of this family has been coming to your room and sexually abusing you.

You are a 20 year old man, a bright law student. You work part-time in a law office downtown. The salary you earn helps with your college tuition.

You are the 18 year old daughter of a physician. You know that on occasion your father has quietly performed abortions. You admire your father and plan to attend medical school after finishing high school.

You are a 19 year old urban male student who has visited sex workers with friends. You've just had an HIV test and you tested positive.

You are a 20 year old female university student in the capital city. You are a peer educator in a group that raises awareness about HIV/AIDS and sexual violence.

You are an adolescent male peer educator who believes that women should be respected and be able to make sexual and reproductive health choices.

You are a young woman from an urban area who is wheelchair bound by a physical disability. You are struggling financially, and are trying to get your high school diploma.

You are a 19 year old gay man; you have been in a loving relationship with your boyfriend for 3 years, but have told no one else about this relationship. It is becoming harder to keep it a secret from your family.

You are a 16 year old woman in a rural town whose boyfriend forced you to have sex; as a result, you got pregnant. Your mother took you

for a clandestine abortion. You bled heavily but survived.

You are a 20 year old woman, living in an urban slum area. You love your husband, but you have not been able to conceive. Your husband has started calling you a bad wife and has threatened to leave you or take a second wife.

You are a young woman forced to flee her village

due to a civil war. You work in a factory in the capital. Your days are long, and you make very little money. You want to learn how to read, write, and attend school.

You are a 15-year-old young man who forced a young woman in your rural town to have sex with you. Feeling too ashamed to stay in town, you fled to a beach community, where you live by selling sex to male tourists.

Reference

Adopted from YoSHAN Advocacy Boot Camp training manual.

SESSION: BARRIERS & INFLUENCERS OF SAFE ABORTION

Objectives of this session

By the end of the session, participants will be able to:

- Identify the different barriers to accessing and utilizing safe abortion services; especially for young heterogeneous people
- Identify the barriers healthcare providers face in providing safe abortion services to young people

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Group Activity	40 min	Participation, Discussion, Brainstorming	Chart paper, Marker
Conclusion of the session	10 min		

Facilitation Instructions

Group Activity

Ask the participants to pick one category (A, B, C, D) to ensure that each group has an equal number of members.

Assign the following tasks for each group:

- Group A: Barriers to accessing and utilize safe abortion services for young heterogeneous people.
- Group B: Influencers that affect access to and utilization of safe abortion services for young heterogeneous people.
- Group C: Barriers to providing inclusive safe abortion service to young heterogeneous people.
- Group D: Influencers that promote inclusive safe abortion services to young heterogeneous people.

Instruct participants that each group will have to identify the barriers and influencers based on the ecological model of healthcare as shown below. Also, ask them to nominate a group leader to present the influencers/ barriers identified after the discussion:

- Individual level

- Family and Peer Level
- Institutional/ health facility level
- Community Level
- Policy level

Allocate 15 min for group discussion. Instruct them that they should identify and list the barriers and influencers that affect young heterogeneous people and service providers at each of the 5 levels mentioned above. Remind them that heterogeneous young people comprises of individuals with different gender identities, those living with disabilities, adolescents, married and unmarried, educated, uneducated, and other various categories might exist.

Allocate 5 minutes for each group to present their findings. Encourage other groups to give feedback or suggest additional influencers and barriers.

Conclusion

The facilitator shall sum up the presentations, highlighting the barriers and influencers in accessing and providing safe abortion services to young people.

Key takeaways from the session

There are multiple factors at different level i.e. at individual, family and peer, institutional, community and policy level that affects both service providers and service receivers in accessing and utilizing safe abortion services. We must intervene at these different levels to make sure that safe abortion services are accessible, available, acceptable, and of high quality, so that no individual has to resort to unsafe abortion practices.

Note to Facilitator

Ensure that participants list out barriers and influencers in relation to heterogeneous population: Adolescent people, people living with

various kind of disability, People with different gender identity, educated and uneducated individuals, and young people from both rural and urban areas, etc.

Reference Materials

- Socio-ecological model of healthcare <https://www.ruralhealthinfo.org/toolkits/health-promotion/2/theories-and-models/ecological>

SESSION: LAST ABORTION

Objectives of this session

By the end of the session, participants will be able to:

- Articulate the biases people hold against certain women and their life circumstances regarding abortion access.
- Discuss the challenges posed by restrictive abortion laws and policies.

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Reading different cases	15 min	Participation, Discussion, Brainstorming	Last abortion hands out (one for each participant), newsprint, marker
Prioritizing the cases	10 min		
Large group discussion	15 min		
Conclusion	5 min		

Facilitation Instructions

Reading different cases

Inform the participants that they will take on the role of policymakers for the next activity. Divide them into 4 different groups maintaining diversity. Each group will represent policymakers with the authority to grant the last abortion to 1 woman. Read out the following statement: according to this (*fictitious*) country's policy, there can be only one safer, legal abortion performed. (*Acknowledge that this is a contrived scenario for the purposes of this activity*)

Distribute copies of "The Last Abortion"

scenarios handout to each participant. Give them five minutes to read the cases individually. The handout contains information about 6 women who have expressed a desire to terminate their pregnancies and have applied for the last abortion.

Inform participants that they have 15 minutes to discuss the scenarios in their small groups and select one woman to be granted the last abortion. Each group will also appoint a spokesperson to briefly present their decision and rationale to the larger group. Each spokesperson will have 2 minutes for their presentation.

By then facilitator should make the following table in a newsprint or board.

Original case	Group 1	Group 2	Group 3	Group 4	Group 5
Case 1					
Case 2					
Case 3					
Case 4					
Case 5					
Case 6					

Prioritizing the cases

Ask each group to prioritize the cases and list them in order, one by one. Take responses from each group and ask them to present their reasons for ranking the cases from low to high priority.

After the group presentations, ask each participant to silently reflect on any biases they may hold against certain women seeking an abortion and how these biases may have affected their decisions about whom they did or did not grant an abortion.

Then, ask participants to return to the larger group for a discussion about the rationales given for choosing or not choosing women for the abortion. Try to maintain neutrality while discussing the participant's rationales.

Large group discussion

Ask participants to reflect and relate on how abortion services are often offered in different settings or countries. Ensure the following points are covered in the discussion.

- Restrictive abortion policies
- Individual providers, often determine which women are more entitled to abortion than others based on their biases about women's reasons and circumstances.
- The decision to grant abortion or deny abortion to women carries lifelong consequences for those women, their families, and their communities.

Remind participants that each women in these scenarios expressed a genuine desire to terminate her pregnancy, and she likely reflected deeply on her reasons for making that decision. Sometimes, counselors or providers may try to convince certain women to continue their pregnancies because of their personal beliefs. This can cause these women to feel pressurized to make decisions that may result in undesirable consequences for their lives. In extreme cases, it may cost women their health and even their lives.

Point out that the likelihood of unsafe abortion increases significantly when providers or policymakers restrict access to abortion for certain women or fail to legalize safe abortion. This can result in women risking their health and lives through illegal and unsafe procedures. They have to go through added expenses and it is difficult to obtain safe abortion services from another provider or continue an unwanted pregnancy and potentially abandon, abuse or neglect the child.

Conclusion

Conclude with the statement that there can never be just one last abortion. It is impossible to decide objectively who is or is not entitled to a safe abortion, and no person has the right to decide for another. Every pregnant person may decide to terminate their pregnancy for all kinds of reasons. Since it is an individual right to exercise control over one's own body, others must support their choice to exercise their right to bodily autonomy.

Key takeaways from the session

Granting certain women access to abortion while denying it to others has negative consequences for individuals, their families, and the broader community. Each woman facing this decision has carefully weighed her circumstances and expressed a genuine desire to terminate her pregnancy. However, external pressures, whether from healthcare professionals or personal circles like family and friends, can sway some women into continuing their pregnancies against their wishes due to the influence of others' beliefs. This coercion can lead to detrimental outcomes, posing risks to women's health and even their lives. It's imperative for healthcare providers and professionals to scrutinize their own beliefs and biases, recognizing how these factors may impact women's choices and behaviors. While there is no such thing as a single "last abortion," restrictive policies and laws can often make it seem like there is. Laws that restrict certain women from receiving services mean that someone is deciding who they think is most deserving of an abortion. As a result, women are judged for their reasons for seeking services and often denied the care they need, leading them to seek unsafe abortions, which can lead to death or lifelong injury. Thank you for all the work you do to ensure that there is never one last abortion.

Note to Facilitator

- The facilitator can share if they have any relevant anecdotes.
- Prepare global, national and local statistics on abortion-related morbidity and mortality among young women and how they relate to restrictions on access to abortion.

Content for Facilitator

The Last Abortion – Scenarios

Instructions: Each of the following women has asked for an abortion. You must choose which woman will be able to receive the last safe, legal abortion. You can only choose one candidate. As a group, discuss each of these scenarios and your rationale for choosing the one candidate.

1. A 45-year-old Sita is 18-weeks pregnant. She had stopped having her regular menstrual cycles and did not believe she could become pregnant again. A detailed ultrasound has revealed severe fetal 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 Amrita in her third year at university just found out that she is 14-weeks pregnant. Due to her having irregular menstrual cycles, she did not realize that she was pregnant. This is her first pregnancy. Her contraceptive method failed, even though she is quite certain that 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 her pregnancy.
3. A 25-year old Chameli is 8-weeks pregnant. She has two children under the age of four, and she lives with a man who regularly abuses her physically. 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 that she was pregnant.
4. A 28-year-old Bindu is 12-weeks pregnant. She is unemployed, an alcoholic and does not use birth control regularly. She does not know who the father of the baby is. Two of her children were born with fetal 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, Champa 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 Anjali 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.

Reference Materials

- Induced abortion worldwide <https://www.guttmacher.org/article/2020/03/covid-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights>
- Criminalizing abortion does not stop abortions; it just makes abortion less safe: <https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/abortion-facts/>
- Unsafe Abortion, Unnecessary Maternal Mortality <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2709326/>
- Factors associated with abortion <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-2011-y>
- Reasons Why Women Have Induced Abortions: Evidence from 27 Countries <https://www.guttmacher.org/journals/ipsrh/1998/09/reasons-why-women-have-induced-abortions-evidence-27-countries>

SESSION: DECRIMINALIZATION OF SAFE ABORTION IN NEPAL

Objectives of this session

By the end of the session, participants will be able to:

- Understand the meaning of decriminalization of safe abortion in the context of Nepal

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Pre-test	3 min	Brainstorming, Discussion	
Meaning of Decriminalization of safe abortion.	10 min	Lecture	Power point
Decriminalization of safe abortion in Nepal	10 min	Participation	
Case Story	10 min	Lecture	
Conclusion	2 min	Participation	

Facilitation Instructions

Explain the meaning of decriminalization in simple terms. Elaborate the context and background of the need to decriminalize safe abortion in Nepal. Share some case story to clarify the impact of restrictive laws on girls and women. Refer to the content “Case Story: Impact of Restrictive laws on Pregnant Individuals”

Conclusion

Criminalization of abortion violates the enjoyment of the constitutionally guaranteed fundamental rights of Nepali women, including their rights to dignified life, to freedom, to equality, to free basic health services and equal access to health services and to safe motherhood and reproductive health.

Key takeaways from the session

To enable Nepali women to realize their fundamental human rights and ensure access to safe abortion services, Nepal must take immediate steps to amend the SMRHR Act to broaden the scope of legal abortion by decriminalizing abortion in all cases, including to end a pregnancy after 28 weeks of gestation when necessary to save the life or health of the woman or girl, or in cases of pregnancies involving fetal impairment. To fully decriminalize abortion, concrete steps must be taken to eliminate punitive actions against women who undergo abortions and against healthcare providers who provide abortion services. This includes repealing the penal provisions on abortion under the Penal Code.

Note to Facilitator

- Provide only the basic information to orient about the decriminalization.
- Refer to the reference section for detail of the case study mentioned in the content

Contents for facilitators

Meaning of Decriminalization of safe abortion:

Decriminalization of abortion refers to the removal of specific criminal sanctions against abortion from the law. This involves repealing or amending laws that criminalize or restrict abortion, thereby allowing individuals to access abortion services without fear of legal repercussions. However, this does not mean that the provision of abortion care is not carefully regulated. Instead, it means that laws, related policies, and regulations are changed so that no one is punished for providing safe abortion or for having an abortion. In practice, decriminalization ensures that the police and the legal system are not involved in the investigation or prosecution of safe abortions. Rather, abortion care is treated like any other essential health issue in medicine, with standards of care based on best practice guidelines, training, and delivery. By contrast, in countries where abortion law has only been liberalized – not fully decriminalized – even safe abortions that follow best practice guidelines may still be subject to prosecution.

Decriminalization of Safe Abortion in Nepal

Nepal has committed to decriminalizing abortion and protecting the SRHR of women and girls. The decision came with Nepal's acceptance of the Report of the Working Group of the Universal Periodic Review (UPR) before the United Nations Human Rights Council on July 18. The Universal Periodic Review is a comprehensive human rights review that occurs for each country before the United Nations Human Rights Council (HRC), typically every four years.

In 2018, prior to the UPR, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee also recommended that Nepal fully decriminalize abortion in all cases and at least legalize it in cases where the mother's health is at risk.

The Safe Motherhood and Reproductive Health Rights (SMARH) Act was intended to respect, protect, and fulfill women's reproductive health

rights, recognizing access to abortion as a right to reproductive health. However, since the Act failed to fully decriminalize abortion, women continued to face the risk of prosecution for seeking abortion care.

The SMRHR Act fails to remove abortion-related provisions from the purview of criminal law. In matters pertaining to the punishment for abortion undertaken beyond legal conditions, the SMRHR Act refers to the provisions of the Penal Code which specifically states that abortion-related punishments will be handled in accordance to the Penal Code. Accordingly, the Penal Code stipulates imprisonment for a term up to one year and a maximum fine of Rs 10,000 for abortions performed within 12 weeks of gestation; up to three years of imprisonment and a maximum fine of Rs 30,000 for abortions of performed between 12 and 25 weeks; and up to five years of imprisonment and a maximum fine of Rs 50,000 for abortions done after 25 weeks of pregnancy.

Moreover, the SMRHR Act introduces regressive provisions by prohibiting abortion after 28 weeks of pregnancy. Unlike the provisions of the Country Code and the Penal Code,

which allowed abortion at any stage of gestation if the pregnancy posed a danger to the pregnant woman's life or physical or mental health, or if there was a risk of fetal impairment, the SMRHR Act permits abortion only up to 28 weeks of gestation in these circumstances.

The SMRHR Act continues to penalize women who seek abortions outside the prescribed legal conditions or when performed by an entity other than approved health institutions or service providers. The SMRHR Regulation covers matters related to the listings of the health service providers and institutions to provide legal abortion services; appropriate technologies and processes for providing abortion service; and procedural matters for seeking a woman's consent for abortion. By prohibiting women from seeking abortions beyond the prescribed legal conditions, the SMRHR Act continues to penalize women who seek abortion after the prescribed gestational limit, or from unlisted service providers or health institutions.

Case Story: Impact of Restrictive laws on Pregnant Individuals

Sita (pseudo Name): Minor Girl

Sita was convicted after taking abortifacient (a substance that induces abortion). Fifteen-year-old Sita, who got pregnant as a result of rape, ended her pregnancy at around 20 weeks by consuming medical pills her father had obtained from a local pharmacist. Sita's district court statement notes that she sought an abortion to safeguard the reputation of herself and her family. The court convicted Sita of an illegal abortion and sentenced her based on her admission. However, the court acquitted both the father and the pharmacist, because the father had asked her not to take the medical pills despite purchasing them for her, and the pharmacist's involvement was not proved.

Kalpana (Pseudo Name): Miscarriage Case

Kalpana was prosecuted on charge of illegal abortion. The Siraha District Court acquitted Kalpana, who had a miscarriage but was accused of illegal abortion by the prosecution.



सीतालाई गर्भपतन गराउने औषधि (abortifacient) सेवन गरेको आरोपमा सजाय दिइयो। १५ वर्षीया सीताको बलात्कारका कारण गर्भ रहेपछि आफ्नै बुबाले स्थानीय औषधि पसलबाट ल्याएको औषधि सेवन गरेर लगभग २ हप्ताको गर्भपतन गराइन जिल्ला अदालतमा उनले दिएको बयान अनुसार, उनले आफ्नो र परिवारको मान प्रतिष्ठा जोगाउन गर्भपतन गरेको बताइन तर अदालतले सीतालाई अवैध गर्भपतन गरेको ठहर गर्दै सजाय सुनायो। बुबा र औषधि विक्रेतालाई भने अदालतले निर्दोष ठहर गर्यो, किनभने बुबाले औषधि किनेर ल्याए पनि सेवन नगर्न भनेका थिए र औषधि विक्रेताको प्रत्यक्ष संलग्नता प्रमाणित हुन सकेको थिएन।



कल्पनालाई अवैध गर्भपतनको अभियोगमा मुद्दा चलाइयो। तर सिराहा जिल्ला अदालतले उनलाई निर्दोष ठहर गर्‍यो, किनभने उनी गर्भपतन गरेको नभई गर्भ तुहिएको पुष्टि भएको थियो।



Note: Both case stories have been retrieved from document prepared by FWLD and CRR.

Reference Materials

- CRR document on Decriminalization <https://reproductiverights.org/nepal-abortion-decriminalization-un-upr/>
- FIGO report on Decriminalization <https://www.figo.org/resources/figo-statements/figo-calls-total-decriminalisation-safe-abortion>
- FWLD & CRR report on decriminalization of abortion in Nepal: https://reproductiverights.org/wp-content/uploads/2021/06/Decriminalization-of-Abortion-in-Nepal_02June021_-Final-Version-1.pdf
- FIGO call for Decriminalization <https://www.figo.org/resources/figo-statements/figo-calls-total-decriminalisation-safe-abortion>

SESSION: MEN AND ABORTION

Objectives of this session

By the end of the session, participants will be able to:

- Understand about the role of men before, during and after the termination of pregnancy.
- Understand the importance of men engagement around abortion related issues.

Session Details

Activities	Time (45 min)	Methodology	Materials Required
Achyut vs. The Government of Nepal Case	20 min	Participation, Discussion, Brainstorming	Chart paper, Marker
Role of men during abortion	20 min		
Conclusion of the session	5 min		

Facilitation Instructions

Achyut vs. Government of Nepal Case

Provide participants with two colored meta-cards: e.g.; Red and Yellow. Ask them what they think it means to have the “Right to be a father”? Many people claim that allowing a woman to terminate a pregnancy based on her own decisions undermines a man’s right to be a father.. What is your view on this?

Instruct participants to write their justifications on the Meta cards: use the Red card if they believe the right to be a father is justified, and Yellow card if they believe the right to be a father is not justified. Inform the participants that they don’t need to disclose their names in the meta-card, allowing them to express their thought(s) freely. Emphasize that this is good opportunity to learn and challenge their own values.

Collect the meta-cards after 5 minutes. See what kind of justification has been mentioned in the meta-card. Read some of the justification which supports and contradicts the “Right to be father” statements. Facilitators need to hold their view at this point.

Inform the participants that we will discuss the landmark judgment of the Supreme Court of Nepal around the right to be father. Provide participants background on the Achyut vs. Government of Nepal case. Explain that the purpose of presenting this particular case is to present a scenario where the right to be a father

was allegedly violated by safe abortion laws, which allows a woman to terminate a pregnancy without requiring her husband’s consent. Read out the decision made in the Achyut vs. Government of Nepal case. Refer to the content section “Achyut vs. Government of Nepal case” for details.

Solicit any questions raised by the participants before moving forward with the conclusion.

Role of men during abortion

Divide participants into 4 groups and ensure that each group includes at least one male participant. Provide 10 minutes for each group to discuss and prepare presentations based on the following questions:

- How can men support women’s access to safe abortion?
- How men/partner can facilitate before, during and after abortion?
- What are the challenges women have to face when boys/men are not involved in safe abortion issue led by the mindset that abortion is only women’s issue?

After the presentations from each group, summarize the key messages and highlight different ways in which men can support women’s reproductive choices and access to safe abortion.

Reflection and Conclusion

Conclude the session by summarizing the role of men in abortion services.

Note to Facilitator

Review the court's resolutions of Achyut vs. the Government of Nepal case to familiarize yourself with Supreme Court's decisions. A detailed study of this case will help you to address questions related to the right to be a father/ right of a partner.

Contents for facilitators

Achyut vs. Government of Nepal case

The Safe abortion law in 2002 allowed women to terminate unwanted pregnancies without the consent of their partner. In 2005, attorney Achyut Kharel challenged this law, arguing that it discriminates against men by allowing a woman to terminate a pregnancy without requiring her husband's consent. He claimed

that equality could not be achieved if the decision to remove a fetus was solely in the hands of women. He highlighted the fact that men's inability to conceive and bear a child should not be ignored, and therefore, spousal consent should be made compulsory in matters of taking decisions regarding fetal removal.. The Court dismissed the petition emphasizing that CEDAW is intended to promote and protect women's rights. The Court stated that interpreting equality in absolute terms would, in fact, would contract this original intent. With this ruling, the Supreme Court of Nepal demonstrated remarkable dedication to protecting and empowering women as a primary goal in interpreting legal conventions on women's rights.

Reference Materials

- Supreme Court judgment on Achyut Vs. Govt of Nepal case <https://reproductiverights.org/case/achyut-prasad-kharel-v-government-of-nepal-amici-supreme-court-of-nepal/#:~:text=Summary%3A%20On%20August%204%2C%20Nepal's,request%20up%20to%2012%20weeks.>
- Story of men's stepping up for safe abortion https://www.icrw.org/wp-content/uploads/2018/11/Abortion-Study_14_Nov_2018-FINAL-web.pdf)
- Men's influences on women's reproductive health <https://sci-hub.tw/10.1016/j.socscimed.2003.11.035>
- Men Aren't Quite Sure How to Be Abortion-Rights Activists <https://www.theatlantic.com/family/archive/2019/06/men-abortion-debate/591259/>
- Abortion is men's issue too. <https://www.dailykos.com/stories/2019/5/16/1858117/-Abortion-is-a-Men-ssue-Too-So-Why-Aren-t-Men-Speaking-Out>

SESSION: ABORTION CASE STUDIES

Objectives of this session

By the end of the session, participants will be able to:

- Analyze each case related to abortion and map the consequences of denying safe abortion by the service provider.

Session Details

Activities	Time (50 min)	Methodology	Materials Required
Case Discussion and Presentation	40 min	Discussion, Participation	Case studies, chart paper, marker
Conclusion	10 min		

Facilitation Instructions

Case Discussion

Inform the participants that we will be discussing real life case scenarios that occurred within the context of Nepal. Divide them into groups of 6, providing a random case to each group.

- Case 1: Triplets Pregnancy Case
- Case 2: Counseled and refereed for ANC Check
- Case 3: Termination of 1st pregnancy
- Case 4: Service Denial case in incest for 22 weeks of gestation
- Case 5: Shaming for not using contraception.
- Case 6: Rheumatic Heart Disease (RHD) case

Instruct them to discuss the case from both the service provider's and service receiver's perspectives, using a rights-based lens. Ask one member from each group to present their

discussions with the other participants, focusing on the following headings;

- How did they feel when they read the case alone?
- Did the healthcare providers breach any rights of the client? Why or why not? Mention some of the rights of the client that were breached, if applicable.
- Did the client face any consequences (physical, psychological, financial, and social, etc.) due to the behavior/ decisions of the healthcare provider over their life? Why or why not?
- How would you have managed the situation alternatively to protect the rights of the client if you feel those rights were breached?

Conclusion

Conclude the session with key takeaways from the session.

Key takeaways from the session

Service provider have specific roles and responsibilities towards their patients, but they cannot make major life decisions on behalf of their patient/client. They need to recognize their own prejudice towards safe abortion and pre-marital sex, and map the consequences of conscientious objection, and service denial from the perspective of the service seeker. By doing so, service providers can play a major role in enabling an environment that ensures that every person with an unwanted pregnancy, who is legally eligible, has ready access to safe abortion care.

Note to Facilitator

- Facilitators need to ensure that service providers approach discussions and case presentations with a rights-based lens. Insist them to apply the learning from m legal sessions on human rights and safe abortion.
- Facilitators can also share their own experience(s) or real case scenarios that aligns with the local context.
- Encourage participants to share similar kinds

Contents for facilitators

Service Denial Cases of Safe Abortion ()

Case 1: Triplets Pregnancy Case

A 38 year old working class woman came to the OPD after a 2 month delay in her menstruation. During the test, it was diagnosed that she was to have triplets. Already a mother of 2 daughters and the sole breadwinner of the household, with her husband having mild intellectual disability, she made the decision to terminate her pregnancy. She requested health professionals for an abortion. A health professional shouted, “How dare you try to abort 3 babies?! Look at the three hearts that are beating at the same time. I cannot commit such a sinful activity”. The woman, after hearing the health professional decided to not go ahead with the abortion and continued her pregnancy. She was asked to get admitted 2 weeks prior to her expected delivery date for a caesarian section. At the end, she gave birth to 3 daughters.

Case 2: Counseled and referral for ANC Check

A 23 years old young married girl, 14 weeks pregnant, came to the safe abortion clinic for an abortion. Healthcare providers identified that she was married, and counseled her about the risk of abortion at the second trimester and referred her for an ANC check-up.

of scenarios during their clinical practice

- Since participants are healthcare providers, they may deny/ reflect upon the attitudes among other health providers. Don't argue at this point. Instead, just share that research has shown many young people, individuals living with disabilities, and those with different gender identity have had similar experiences.



३८ वर्षीया महिलाको २ महिना महिनावारी नभएपछि ओपीडीमा जाँचका लागि आउछिन । परीक्षण गर्दा उनले तीनवटा भ्रुण (ट्रिप्लेट्स) गर्भमा रहेको पत्ता लाग्छ । उनि पहिल्यै २ वटा छोरीकि आमा थिइन् र परिवारको एक मात्र कमाउने सदस्य थिइन् । उनका पति बौद्धिक अपाङ्गता भएका कारण उनी आफैले गर्भपतन गर्ने निर्णय गरिन् उनले स्वास्थ्यकर्मीलाई गर्भपतन गरिदिन अनुरोध गरिन तर स्वास्थ्यकर्मीले थर्काउदै, “तिमीलाई तीन वटा बच्चालाई गर्भपतन गर्न कसरी हिम्मत आयो रु यी तीनवटा बच्चाको मुटु एकैचोटि धड्किरहेको छ, म यति ठूलो पाप गर्न सकिदना” स्वास्थ्यकर्मीको यस्तो कुरा सुनेपछि महिलाले गर्भपतन नगरी गर्भलाई निरन्तरता दिने निर्णय गरिन उनलाई बच्चा पाउने मिति भन्दा २ हप्ता अगाडि अस्पतालमा भर्ना भएर शल्यक्रियामार्फत (Caesarean section) बच्चा जन्माउने सल्लाह दिइयो । अन्ततः उनले ३ छोरीलाई जन्म दिइन् ।



एक जना २३ वर्षीया विवाहित युवती, जो १४ हप्ताको गर्भवती थिइन्, सुरक्षित गर्भपतन क्लिनिकमा गर्भपतन गर्न पुगिन् । स्वास्थ्यकर्मीहरूले उनी विवाहित भएको कुरा पहिचान गरे र दोस्रो त्रैमासिकमा गर्भपतनसँग सम्बन्धित जोखिमबारे परामर्श दिई, उनलाई गर्भ निरन्तरता दिनकोलागि गर्भ जाँचका लागि रिफर गरे ।



Case 3: Termination of 1st pregnancy

A newly married young girl aged 21, 9 weeks pregnant, visited an abortion clinic for the termination of her pregnancy. When asked about the reason for the termination, she answered that she was still studying for her Bachelor's 2nd year, and thus did not want to go ahead with her pregnancy. Healthcare providers questioned why they did not use any method of contraception. She shared that although she was insistent about using contraceptives, her husband was not consistent nor serious about the consequences of not using contraceptives. She further mentioned that all of their relatives suggested them not to use any modern methods of contraception, believing that it may lead to infertility. Healthcare providers counseled about the risk of infertility when first pregnancy is terminated.

Case 4: Service Denial case in incest for 22 weeks of gestation

An 18-year-old girl from a rural part of the country shared that she felt something moving inside her stomach. She was already 21 weeks pregnant at that time. It was a case of incest. Since second-trimester abortion sites were unavailable in nearby village health facilities, she was referred to another site where the Onestop Crisis Management Center (OCMC) service was also available. While dealing with this case, the service provider mentioned that it fell under the legal domain, thus the girl was referred to OCMC, and the

staff at OCMC contacted the police regarding this case. The police took the girl and her family to the police station. At the station, the girl and her family were suggested to file a case. After that, the family members of the girl approached a few private clinics for abortion services. However, they were unable to pay for the second trimester abortion in the private clinic. Upon returning home, they filed a case against the perpetrator. It was difficult for the girl to reside in her village during her pregnancy, so she was transferred to a rehabilitation center. After a few weeks, she gave birth to a daughter.

एक जना २१ वर्षीया नवविवाहिता युवती, जो ९ हप्ताको गर्भवती थिइन्, गर्भपतनको लागि एक क्लिनिकमा पुगिन् गर्भपतन गर्ने कारणबारे सोध्दा उनले आफू हालै स्नातक दोस्रो वर्षमा अध्ययनरत भएकी हुँदा गर्भलाई निरन्तरता दिन नचाहेको बारे बताइन् । स्वास्थ्यकर्मीहरूले गर्भनिरोधक विधि किन प्रयोग नगरेकोबारे प्रश्न गर्दा उनले आफू निरन्तर गर्भनिरोधक प्रयोग गर्न चाहेको तर श्रीमानले गम्भीरतापूर्वक नलिएको र नियमित प्रयोग नगरेको बताइन् साथै, उनका आफन्तहरूले आधुनिक गर्भनिरोधक विधि प्रयोग गर्दा बाँझोपन हुने हुनाले प्रयोग नगर्न सुझाव दिएको समेत उल्लेख गरिन् । यसपछि स्वास्थ्यकर्मीहरूले पहिलो गर्भको गर्भपतन गरेमा यसले निसन्तान गराउन सक्ने सम्भावित जोखिमबारे परामर्श गरे ।

ग्रामीण क्षेत्रक १८ वर्षीया एक युवतीलाई पेटभित्र केही चलिरहेको महसुस भएपछि स्वास्थ्य संस्थामा पुगिन् । स्वास्थ्य परीक्षणमा २१ हप्ताको गर्भ रहेको थाहा हुन्छ । हाड नाता करणी बाट गर्भ रहन गएको बारे पत्ता लाग्छ । उपलब्ध स्वास्थ्य संस्थाहरूमा दोस्रो त्रैमासिक (second trimester) गर्भपतन सुविधा उपलब्ध नभएकाले उनलाई अर्को अस्पतालमा पठाइयो, जहाँ एक द्वार सङ्घट व्यवस्थापन प्रलानी (OCMC) सेवा पनि उपलब्ध थियो । उनीहरू रिफर गरिएको अस्पतालमा पहिले सुरक्षित गर्भपतन सेवा प्रदायककोमा पुगे, सेवा प्रदायकले उक्त केसलाई OCMC मा रिफर गरे। इन्टरनेट को टोलीले यो विषय कानुनी दायरामा पर्न जाने भन्दै युवतीको घटनाबारे प्रहरीलाई जानकारी गरायो । प्रहरीले युवती र उनको परिवारलाई प्रहरी कार्यालयमा लगे र मुद्दा दायर गर्न सल्लाह दियो । त्यसपछि, युवतीका परिवारजनहरूले केही निजी क्लिनिकहरूमा गर्भपतन सेवाका लागि प्रयास गरे, तर दोस्रो त्रैमासिक गर्भपतनको लागत महँगो भएकाले उनीहरूले सेवा लिन सकेनन् । घर फर्किएपछि पीडित परिवारले अपराधी विरुद्ध मुद्दा दायर गरे। गर्भावस्थाका कारण युवतीलाई आफ्नै गाउँमा बस्न कठिन भएपछि, उनलाई एक पुनर्स्थापना केन्द्रमा लगियो । केही सातापछि, उनले एक छोरीलाई जन्म दिइन् ।

Case 5: Shaming for not using contraception.

A 30 year old professional woman who already had 2 children got pregnant. It was an unintended pregnancy. Her husband, working professionally in another city denied using a condom saying that they only met occasionally and that he was consciously adopting withdrawal methods. She went to a gynae OPD in a government hospital to terminate her pregnancy at the tertiary level hospital. The client was surrounded by MBBS and interns for documentation of her medical and menstrual history including reasons for abortion. The senior doctor yelled at the client for being careless for not using any contraceptive methods irrespective of being educated. The client came out of the OPD and went to private clinic and terminated the pregnancy.

Case 6: RHD case

Women diagnosed with Rheumatic Heart Disease attended the gynae OPD at her 14 weeks of gestation. She already had 2 abortions in past. Doctor scolded her for being pregnant even after counseling not to be pregnant due to her disease condition.

३० वर्षीया महिला (पेशेवर), जसका पहिले नै २ सन्तान थिए, अनिच्छित गर्भधारण हुन्छ। उनको श्रीमान, अर्को शहरमा काम गर्छन्। समयसमयमा मात्र भेट हुने भएकाले गर्भनिरोधक साधन (कण्डम) प्रयोग नगरेको र जानाजानी विर्य स्वलन विधि अपनाइरहेका थिए। उनी आफ्नो गर्भपतनका लागि ठुलो सरकारी अस्पतालको स्त्रीरोगको OPD पुगिन्। त्यहाँ MBBS पढ्दै गरेको विद्यार्थीहरू र इन्टनहरूले महिनावारी रोकित्नुको कारण र गर्भपतन गर्नुको कारण सोधी खोजि गर्दै थिए। त्यहाँ वरिष्ठ चिकित्सक आएर, शिक्षित भएर पनि गर्भनिरोधक साधन प्रयोग नगरेको भन्दै गालि गरे। अन्ततः, पीडित महिला इएम बाट बाहिर आईन र निजी क्लिनिकमा गएर गर्भपतन गराइन्।

मुटुको बाथ रोग भएको एक महिला, १४ हप्ताको गर्भावस्थामा स्त्रीरोग OPD मा चेक गर्न आईन्। उनले २ पटक गर्भपतन गराइसकेकी थिइन्। उनको स्वास्थ्य अवस्थाको कारण गर्भधारण नगर्न परामर्श दिइसकिएको भएतापनि, गर्भधारण गरेकाले वरिष्ठ चिकित्सकले उनलाई गालि गर्नु भयो।

Section

4

ADOLESCENT AND DISABILITY FRIENDLY SAFE ABORTION SERVICES



SESSION: ADOLESCENT FRIENDLY SAFE ABORTION SERVICE

Objectives of this session

By the end of the session, participants will be able to

- Describe adolescent-friendly services and its characteristics
- Explain the differences between adolescent's need and adult women's need on safe abortion
- Explain barriers adolescents face to receive information and services

Session Details

Activities	Time (90 min)	Methodology	Materials Required
Pre-test	5 min	Brainstorming, Discussion	
Adolescent and Safe Abortion	20 min	Lecture	Laptop, PowerPoint, Newsprint, Marker
Adolescent friendly Safe Abortion Service	10 min	Lecture cum Group Activity	
Characteristics of Adolescent Friendly SRHR service	30 min	Participation	
Mapping Barriers	20 min	Participation	-
Conclusion of the session	5 min	Participation	-

Facilitation Instructions

Pre-test

Ask questions to know the healthcare provider's understanding about adolescent access to SRHR services including safe abortion services, adolescent friendly SRH services. Some of the questions includes:

- Does your center have trained health personnel for AFHS? If yes, what is the situation?
- What do you do if adolescent comes to your center for receiving safe abortion services?
- Have you provided SRHR services to any individuals (adolescent / young people) from the LGBTIQ+ community? How has your experience been?
- Are you aware about the SRHR need of diverse young people?

Adolescent and Safe abortion

Explain the situation of adolescents concerning safe abortion, both globally and in Nepal's context.. Explain why the need for safe abortion

for adolescents differs from the adult population.

Adolescent friendly safe abortion service

Ask to see how many participants have received adolescent-friendly SRHR services. Ask participants who have received adolescent-friendly health service training what it means to be an adolescent-friendly health service provider. If none of the participants have received or provided AFHS, ask them in general what their understanding about Adolescent-friendly SRHR service is. After the discussion, explain what it actually means from the participants' perspectives.

Characteristic of Adolescent Friendly SRHR services

Divide the participants in 3 groups maintaining the diversity of participants. Diversity of participants here entails: Work Experience in SRHR vs. No Experience in SRHR, Working with adolescent Vs. not working with adolescent, working in AFHS listed facility vs. working in non AFHS site. Etc.

Assign one of the following topics to each group randomly.

- Programmatic Characteristics for Adolescent Friendly SRHR services
- Provider Characteristics for Adolescent Friendly SRHR services
- Health Facility Characteristics for Adolescent Friendly SRHR services

Ask to enlist the characteristics that should be present while providing safe abortion services to adolescents under each of the headings. Allocate 10 minutes for discussion and 5 minutes to list the characteristics. Provide each group 5 minutes to present their findings from their discussions.

After the three groups finish their presentations, the facilitator needs to fill the gaps around the characteristics if any. For exhaustive list of characteristics refer to content section.

Mapping Barriers

Ask the same three groups to identify the barriers for providing AFHS at present context and ways to overcome these barriers from their level of understanding. Allocate 10 minutes for discussion and 5 minutes to map barriers and ways to overcome these barriers. Provide each group 5 minutes to present what they have listed out of their discussion.

Reflection and Conclusion

Request 2 participants to reflect upon the provider and health facility characteristics for adolescent friendly health services.

Note to Facilitator

- Facilitators working with adolescents and young people SRHR (if possible working on

safe abortion) is desirable.

- There might be resistant while talking about premarital sex and the need of abortion services for adolescent. So, try to justify with data and real life incidents always.

**Contents for facilitators
Adolescent and Safe Abortion**

According to the WHO, there are an estimated 1.2 billion adolescents (10–19 years old) or 1 in 6 of the world’s population today; the largest population of adolescents in the history of mankind. They are shaping social and economic development, challenging social norms and values, and building the foundation of the world’s future. Sexual and reproductive health and rights are a cornerstone of youth’s transition to adulthood, influencing outcomes for both adolescents and youth across a range of fronts. Young people’s lives will continue to be negatively impacted unless the sexual and reproductive health and rights of these youths are supported and upheld across a range of dimensions and within a range of settings. As of 2019, adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended, resulting in an estimated 12 million births. Among the unintended pregnancies, 55% adolescent girls aged 15–19 years ended in abortions, many of which are often unsafe in LMICs.

Human rights and safe abortion services for adolescents:

Universal access to safe medical and surgical abortion is an essential element of comprehensive, high-quality adolescent reproductive healthcare. Hence, the right to information and education

Key takeaways from the session

Currently, the world has the large adolescent population in history, with adolescents accounting for one-sixth of the entire global population. They are shaping social and economic development, challenging social norms and values, and building the foundation of the world’s future. Sexual and reproductive health and rights are a cornerstone of youth’s transition to adulthood, influencing outcomes for both adolescents and youth across a range of fronts. Young people’s lives will continue to be negatively impacted unless the sexual and reproductive health and rights of these youths are supported and upheld across a range of dimensions and within a range of settings.

including sexual and reproductive health human rights principles and obligations relevant to abortion has mentioned that;

- States must ensure access to family planning and SRH information and services, including affordable contraceptive methods, to empower women and adolescents to make autonomous and informed decisions regarding their reproductive health.
- Abortion information should be available to all persons without the consent or authorization of a third party. This means that adolescents should have access to abortion information without needing the consent or authorization of a parent, guardian, or other authority.

The Sustainable Development Goals (SDGs) for 2030 renew governments' commitments to reduce maternal mortality; achieve universal access to sexual and reproductive health information, education, and services; ensure reproductive rights; and achieve gender equality as a matter of women's and girls' human rights. Under Goal 5, the SDG focuses on achieving gender equality and empowering all women and girls following two targets.

- Ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Program of Action of the International Conference on Population and Development, the Beijing Platform for Action, and the outcome documents of their review conferences.
- Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Around 73 million induced abortions take place worldwide each year. Six out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies end in induced abortion. [Starrs M Ann. Adolescent Abortion Across Countries: Level and access to safe services, Global Maternal Neonatal Health Conference, 2015

Data on Adolescent and Safe Abortion

Data on the extent to which adolescents—especially those who have yet to enter into a union—have abortions is particularly scarce in the developing world. However, following are some of the key facts about abortion among

adolescents:

- Young women and girls account for nearly one-third of all unsafe abortion-related deaths each year worldwide, with 15% of all unsafe abortions taking place among adolescents' aged 15 and younger.
- Roughly half of the pregnancies among adolescents aged 15–19 in developing regions are unintended, and about half of these end in abortions, most of which are unsafe.
- The levels of unmet need for modern contraception are much higher among single, sexually active women than among those in unions because stigma continues to impede single women—especially adolescents—from receiving contraceptive counseling and services.
- Adolescent women globally are more likely to delay seeking an abortion than older women, as they tend to recognize and acknowledge their pregnancy later. Such delays can prevent young women from getting a legal abortion if they exceed the defined legal gestational limit. Delays also increase distress, especially among adolescents, who are already vulnerable.
- Although single and sexually active young women represent a small proportion of all women with unmet need, they have a high probability of turning to abortion if they experience an unintended pregnancy. This is due to the high opportunity costs of giving birth for young women, who have the most to lose, as well as their fear of potential sexual abuse by service providers and judgmental attitudes from staff.

Adolescent Friendly Service

Adolescent-friendly health services represent an approach that brings together the qualities young people demand with the high standards expected in public services. Such services are accessible, acceptable, and appropriate for adolescents. They are provided in the right place, at the right time, at the right price (free where necessary), and delivered in a style that is appealing to young people. They are equitable because they are inclusive and do not discriminate against any sector of the young clientele on grounds of gender, ethnicity, religion, disability, social status, or any other reason.

Characteristics of adolescent friendly health services

Adolescent-friendly health services needs to be accessible, equitable, acceptable, appropriate, comprehensive, effective, and efficient. In the context of Nepal, adolescent- friendly services have to have the following characteristics based on the WHO-defined standards and Adolescent SRH Implementation Guide 2007.

The National Medical Standard for Reproductive Health Services, Vol. I: Contraceptive Services, 2020 has suggested the following characteristics for the services provided to be called adolescent-friendly:

Programmatic Characteristics

Following are the key program characteristics:

- Adolescents' involvement in program design (adolescent input should be solicited regarding what services should be offered and how, including perceptions of welcome, privacy, and confidentiality)
- Promotion of services in locations where adolescents usually gather, including provision of services in the community
- Both married and unmarried boys and girls are welcomed and served. There should not be a provision for asking about their personal relationship history including the reason for seeking termination of pregnancy.
- Parental involvement is encouraged but not required
- Affordable fees
- Adequate supply of commodities
- Short waiting times
- Educational material available on-site
- Linkages with schools, youth clubs, and other institutions
- Alternative ways to access information, counseling, and services
- Reaching out of school adolescents by conducting community outreach sessions

Provider Characteristics

Adolescent services involve counseling and a variety of services, some of which may not be available on the site. All facilities should have staff capable of providing basic counseling, basic examination and assessment, and know where to refer for services not available on site.

- Counseling: Many appropriate staff (e.g. ANM, Staff Nurse, AHW, HA, MBBS or higher) should be trained on adolescent issues and provide non-judgmental counseling
- Demonstrate respect for young people
- Maintain privacy and confidentiality
- Be non-judgmental
- Allow adequate time for client and provider interaction
- For safe abortion and contraceptive services: The type of care needed will determine which cadre (as above) is appropriate.

Facilities: Health Facility Characteristics

The minimum requirements for providing Adolescent Reproductive Health Services should include:

A place to register for client and an adequate waiting area

- Privacy:
 - A private/curtained area for consultation and counseling
 - A private/curtained procedure area equipped for clinical procedures
- Convenient hours: Holidays and beyond school hours
- Convenient location
- Adequate space
- Comfortable surroundings

Adolescent Friendly Health Service operational guideline, 2019 mentioned the following criteria while providing health services including safe abortion to Adolescents:

- Use of logo at health facility
- Communication about the availability of health services through various medium
- No discrimination on the basis of financial status, sexuality, marital status, ethnicity, geography, language, disability, religion, or on any ground
- Involvement of adolescents in the policymaking process related to their needs

The Safe motherhood and Reproductive Health Act, 2075 also mentioned that safe abortion services should be adolescent-friendly. However, the Safe motherhood and Reproductive Health regulation does not provide detailed guidance on adolescent-friendly safe abortion services.

Reference Materials

- High burden among Young Women; <https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2812%2939598-0>
- UNFPA Strategy on Adolescents and Youth <https://www.unfpa.org/sites/default/files/resourcepdf/UNFPA%20Adolescents%20and%20Youth%20Strategy.pdf>
- Adolescent Pregnancy, WHO. <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>
- Safe abortion: Technical and policy guidance for health systems <https://iris.who.int/bitstream/handle/10665/173586/?sequence=1>
- Abortion care guideline. <https://iris.who.int/bitstream/handle/10665/349316/9789240039483eng.pdf?sequence=1>
- Abortion Among Adolescents and Girls. www.ipas.org
- Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Developing Regions. <https://www.guttmacher.org/report/adding-it-meeting-contraceptive-needs-of-adolescents>
- National Medical Standard for Reproductive Health Services Vol. I: Contraceptive Services. https://nepal.unfpa.org/sites/default/files/pub-pdf/national_medical_standard_final.pdf
- Adolescent Abortion Across Countries: Level and access to safe services, Global Maternal Neonatal Health Conference. <https://www.hsph.harvard.edu/wp-content/uploads/sites/2413/2015/12/Starrs.pdf>

SESSION: DISABILITY FRIENDLY SAFE ABORTION SERVICE

Objectives of this session

By the end of the session, participants will be able to

- Understand the meaning of disability friendly SRHR and safe abortion services.
- Describe the law and policy of Nepal about the safe abortion services to People with Disability
- Explain barriers facing by People with Disability to receive information and services on safe abortion
- Describe actions to be implemented for disability inclusion safe abortion services

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Pre-test	5 min	Brainstorming, Discussion	
Understanding Disability	10 min	Lecture	Laptop, PowerPoint, Newsprint, Marker
Laws and Policies around Disability	15 min	Lecture cum Group Activity	
Mapping Barriers	15 min	Participation	
Actions to be implemented	10 min	Participation	
Conclusion of the session	5 min	Participation	

Facilitation Instructions

Pre-test

Ask participants if they have worked with people with disabilities or if they have provided any SRHR services to people with disabilities. If yes, request them to share their experience briefly. As a follow up question, ask participants about the types of disabilities, as well as the meaning of disability itself.

Understanding Disability

Explain the meaning of disability, different types of disability as per the national guidelines, and the situation of disability in relation to SRHR.

Laws and Policies around Disability

Explain the international and national laws and policies related to Disability, aligning with SRHR and safe abortion.

Mapping Barriers

On a newsprint or paper, list the barriers to accessing safe abortion for adolescents at different level-i) Policies, ii) Service Delivery iii) Community Level and iv) Individual level

Distribute the meta-cards and markers to each

participant. Ask participants to write one or two barriers that people with disabilities in their community face when seeking information and abortion services. Ask participants to stick their Meta cards on the paper or wall or a soft board. After all cards have been placed, refer to the points mentioned by the participants, and use a PowerPoint presentation to list the barriers faced by PWD on getting safe abortion services.

Barriers faced by PWD on getting safe abortion services has been listed in the content for facilitators.

Actions to be implemented for disability inclusion safe abortion services

Divide participants into 4 groups. Request each group to discuss and list important actions to be taken for disability inclusion safe abortion services i) Political commitments, leadership and governance ii) Health facility and healthcare workforce and iii) Community level and iv) Individual level. Ask them to share their important points that they have written with the larger groups. Referring the points mentioned by the participants, explain the main contents/components necessary for disability friendly safe abortion services.

Conclusion

Ask 2-3 participants to summarize what new things they have learnt during this session. The facilitator should then summarize a few action

points that has been listed for disability inclusion safe abortion services, highlighting the role of health facilities and healthcare workforces in making safe abortion service disability friendly.

Key takeaways from the session

SRH services are necessary for everyone, including persons with disabilities, irrespective of their marital status. Persons with disabilities have the same needs for SRH services as the general population. In fact, they may have greater needs for SRH education and care than their counterparts due to existing barriers and their increased vulnerability to abuse. Persons with disabilities are as sexually active as those without disabilities. Despite this, matters regarding their sexuality has often been ignored, and their reproductive rights denied.

It is imperative that access to abortion care is equitable, and that the quality of care does not vary based on personal characteristics of the person seeking care, such as their gender, race, religion, ethnicity, socioeconomic status, education, if they are living with a disability, or geographic location within a country.

Note to Facilitators

- It is good to invite a resource person from the concerned community/movement.
- If not, the facilitator needs to make sure they do not use any stigmatizing language concerning sexuality and sexual desires of people with disabilities.
- Participants might have some judgmental attitude/prejudice/stigma regarding access to safe abortion services by people with disabilities.
- Make sure the discussion focuses specifically on accessing safe abortion services for people living with disabilities. It will be too general and vague if the facilitators focus on all the SRHR dynamics like pregnancy, infertility, HIV, STI etc.
- Facilitators should be aware of principle of diversity and human rights while dealing with this sensitive topic.

Contents for facilitators

Safe Abortion Service for People Living with Disability

Persons with disabilities (PWD) are a part of human diversity; although often referred to as a single population; they are a very diverse group

of people. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) describes persons with disabilities as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction Global report on health equity for persons with disabilities with various barriers may hinder their full and effective participation in society on an equal basis with others”. Persons with disabilities can be of any age, gender identity, race, or religion.

As of 2021, approximately 1.3 billion people – about 16% of the global population – live with a disability. This number has increased substantially over the past decade due to different demographic and epidemiological changes, such as population growth and an increasing number of people with non-communicable diseases, who are living longer and aging with functional limitations. According to the Central Bureau of Statistics of Nepal, approximately over half a million people with disabilities live in Nepal. However, Disability rights activists in Nepal contend that this number can be contested.

Sexual and reproductive health (SRH) is fundamental for individuals, couples and families, and to the social and economic development of communities and nations. SRH services are necessary for all people, including persons with disabilities, both married and unmarried.

All too often, the SRH needs of persons with disabilities has been overlooked by both the disability community as well as those working on SRH. Persons with disabilities have the same needs for SRH services as the rest of the general population. Persons with disabilities may have greater needs for SRH education and care than their counterparts due to existing barriers and their increased vulnerability to abuse. Research shows that persons with disabilities are as sexually active as those without disabilities. Despite this, their sexuality is often ignored, and their reproductive rights are frequently denied. It is imperative that access to abortion care is equitable, and that the quality of care does not vary based on the personal characteristics of the person seeking care, such as their gender, race, religion, ethnicity, socioeconomic status, education, if they are living with a disability, or based on their geographic location within a country.

The rights of women and young persons with disabilities are human rights that are protected in numerous international human rights treaties, including:

- The International Covenant on Civil and Political Rights,
 - The International Covenant on Economic, Social, and Cultural Rights,
 - The Convention against Torture and other Cruel, Inhuman, and Degrading Treatment or Punishment,
 - The Convention on the Rights of Persons with Disabilities (CRPD),
 - The Convention on the Elimination of All Forms of Discrimination against Women, and
 - The Convention on the Rights of the Child.
- The Convention on Rights of Persons with Disabilities (CRPD) is one such framework. The CRPD urges states to remove economic, social, cultural, communication, and physical barriers that aid discriminatory and exclusionary practices. Particularly, articles 23 and 25 of the CRPD state that equal access for persons with disabilities regarding sexual reproductive health services and facilities. Further, the Sustainable Development Goals has emphasized on the concerns of persons with disabilities, with the cross-cutting principle — ‘Leaving No One Behind’ — has increased the attention on the issues of

disability globally.

Despite existing policy provisions and legal frameworks, the situation for persons with disabilities is unsatisfactory. There is very limited research conducted in this area. However, findings and anecdotal evidence have suggested that girls and women with disabilities are at a higher risk of violence and sexual abuse. Evidence also shows that over their lifetime, 57.7% of women report experiencing violence, including emotional violence (55.2%); physical violence (34%); and sexual violence (21.5%). Over the preceding 12 months, 42% of women reported that they had experienced violence. This study found high levels of different types of violence and a variety of barriers to effective support and redress.

Persons with disabilities have an equal right to the highest attainable standard of health, just like anyone else. This right is inherent, universal, and inalienable, and is enshrined in international law through human rights treaties, and in domestic legal frameworks, including national constitutions.

Law and policy in Nepal

The Constitution of Nepal 2015, guarantees health as a fundamental right of the people. Therefore, all tiers of government are constitutionally mandated to ensure the health needs of the people without any discrimination. To respect, protect and fulfill woman’s safe motherhood and reproductive health rights as guaranteed in the Constitution of Nepal, the Government developed the Safe Motherhood and Reproductive Health Rights Act in 2018. This Act has further elaborated and emphasized that each woman and adolescent shall have the right to obtain education, information, counseling and service relating to sexual and reproductive health including safe abortion and contraceptives.

This Act has explicitly mentioned following rights related to PWD;

- Disabled-friendly service: Services under this Act, including family planning, reproductive health, safe motherhood, safe abortion, emergency obstetric care and newborn care, reproductive health morbidity, shall be adolescent and disabled friendly.
- Discrimination prohibited: No one shall be

discriminated in their right to access services, including family planning, reproductive health, safe motherhood, safe abortion, emergency obstetric care and newborn care, reproductive morbidity, menstrual care on the ground of origin, religion, color, caste, ethnicity, sex, community, occupation, business, sexual and gender identity, physical or health condition, disability, marital status, pregnancy, creed, state of being suffering from any disease or infected with virus or vulnerable to such infections, state of reproductive morbidity, personal relationship or any other such grounds.

The Government of Nepal has also developed separate Act related to Persons with Disability called “The Act Relating to Rights of Persons with Disabilities, 2074 (2017)”. This Act has made following provisions related to health services and information:

- The Government of Nepal shall make necessary provisions for the protection of their health and the reproductive right, taking into account the special situation of the women with disabilities
- The persons with disabilities shall have the right to obtain information from public communication media in disabled friendly and accessible formats.
- The Government of Nepal shall make necessary provisions to remove the barriers that exist to the access of the persons with disabilities to hospitals for treatment.
- The healthcare providers of hospitals shall provide quality treatment service to the extent of availability to the persons with disabilities with priority.
- Despite of progressive Acts and Policies, persons with disabilities facing various types of barriers on receiving information, counseling and services. A study conducted in Ilam district found that the utilization of SRH services among women with disabilities was low (15%). Only 12% had ever received maternal and newborn care, 11% had ever utilized contraceptive information and services, 0.3% had ever received prevention and appropriate treatment of infertility services, and 0.5% had ever utilized safe abortion and post-abortion care. None of them had ever utilized other

SRH services related to HIV/AIDS and other sexually transmitted diseases; gender-based violence, elimination of harmful traditional practices such as early and forced marriage; and comprehensive sexuality education and youth-friendly services. No requirement (57%) and unaware of SRH services (24%) were the major reasons for not utilizing SRH services. Among 384 respondents, 121 (32%) had ever experienced pregnancy and childbirth. Among them, only half (51%) had received antenatal checkups, more than two thirds (67%) had delivered their child at home mainly with support from family members (52%). Moreover, only 34% of them had received postnatal care.

Barriers to Access Safe Abortion Services

It is important to understand the barriers to accessing safe abortion services to promote non-discrimination and ensure that people with disabilities can access abortion and contraceptive care actively and meaningfully on an equal basis with others. There are very limited research studies conducted Nepal in this area. However, based on the studies conducted in other countries, following are the major barriers:

• Policy-level barriers:

- o Lack of understanding and de-prioritization of disability inclusion by policymakers and decision makers at national and sub-national levels creates barriers for people with disabilities that block their access to abortion and contraceptive services.
- o Lower rates of registering children with disability. It will create their identification and other facilities provided by government.

• Service delivery-level barriers:

- Although the Safe Motherhood and Reproductive Health Rights Act 2018 has emphasized to develop all health facilities as disable friendly services, the reality is that the majority of these health facilities remain inaccessible. This makes it difficult for them to enter, register, visit different wards/units and get services.
- o Limited time and funding to modify equipment and eliminate physical and

communication/information barriers within health facilities.

- o The rights and needs of people with disabilities are not recognized or prioritized; therefore, addressing these needs can be perceived as a financial burden.
 - o Distance and inadequate transportation to abortion and contraceptive services further aggravate these obstacles, particularly in rural areas.
 - o Many facilities also have limited access to interpreters or other referral networks, inhibiting them from accessing the health facility or receiving quality services upon arrival.
 - o Difficult-to-read or complicated forms and other information materials can make it more challenging for individuals to get abortion or contraceptive services or referrals—especially for those with visual impairments or psycho-social and intellectual disabilities.
 - o Healthcare providers may lack a general understanding of the needs of people with disabilities, such as the need for health professionals to learn their preferred communication methods, schedule additional time to ask and answer questions, and provide adjustable equipment.
 - o Need consent from a guardian in some countries
- **Community-level barriers**
 - o Reliance on family for financial support, physical assistance, or communication when accessing abortion and contraceptive care.
 - o Exclusion from formal and informal education, including comprehensive sexuality education and knowledge of their legal rights.
 - o Not connected organizations for PWD, community-based rehabilitation, sexual and gender-based violence services, or other community groups and opportunities.
 - o Not connected to health services, especially sexual and reproductive healthcare.
 - o Myths and misconceptions about sexuality. In reality, people with disabilities are more likely to experience sexual acts due to violence or coercion, and women with

disabilities are 10 times more likely to experience sexual violence than women without disabilities. People with disabilities often lack legal knowledge and are less likely to report incidents of violence because they depend on their caretakers.

- **Individual-level barriers**

- o Poor knowledge on rights and SRH
- o Low media exposure
- o Low/inferior status in family
- o Lack of empowerment: study showed that women with disabilities were not empowered enough to express their SRH needs or problems.
- o Lack of support from family members
- o Overprotection and low expectations
- o Difficult to access service based on the types of disability

It is the state's obligation, through the health sector and in coordination with other sectors, to address existing health inequities so that persons with disabilities can enjoy their inherent right to the highest attainable standard of health. Obligations to address health inequities arise from international human rights treaties that are binding on the governments of States Parties. Governmental and nongovernmental actors in the health sector may also be bound by domestic policies and legislation.

Actions to be implemented for disability inclusion safe abortion services:

Political commitment, leadership, and governance:

- Prioritize health equity for persons with disabilities.
- Establish a human rights-based approach to health services
- Integrate disability inclusion in national health strategies, including preparedness and response plans for health emergencies.
- Integrate disability inclusion in the accountability mechanisms of the health sector.
- Ensure the existing social protection mechanisms support the diverse health needs of persons with disabilities.
- Include the costs of making facilities and services accessible in healthcare budgets.

Health facility and healthcare workforce:

- Train all non-medical staff working in the health sector on issues relating to accessibility and respectful communication.
- Treat all persons with dignity, respect, empathy and compassion. Health professionals should be empathetic to the individual communication styles, behavior characteristics, and potential vulnerabilities of persons with disabilities when providing respectful and professional care.
- Ensure all aspects of healthcare (including examination, treatment, and interventions) for persons with disabilities are provided in a safe, accessible, dignified, and inclusive manner, on an equal basis with others.
- Maintain the privacy of all information and services related to PWD.
- Implement disability-inclusive feedback mechanisms for quality of health services.
- Integrate indicators for disability inclusion into the monitoring and evaluation frameworks of national health systems.
- Use respectful and non-discriminatory language in all interactions with, and discussions about persons with disabilities, including at the points of contact in the community, health promotion activities, screening and prevention, registration at health facilities, assessments, diagnoses, treatments, discharges, follow-ups, referrals, and rehabilitation.
- Designate a separate section or person to support PWD during visits to health facilities so that they can get information and services with respect and dignity.
- Provide electronic devices or Braille information board, wheel chair, white stick etc. in the health facility.
- Manage disable friendly IEC materials, making them available for individuals to take home as needed.
- Offer home-care services for those who cannot visit health facilities as necessary.
- Ensure that adolescents, particularly adolescent girls with disabilities, do not face barriers to “commodities, information and counseling on SRHR, such as requirements for third-party consent or authorization.

Community level:

- Implement effective communication approach to raise awareness and generate community support for the rights of persons with disabilities, in partnership with local government bodies, schools, community organizations and disabled people’s organizations
- Dispel myths and misconceptions about disability and safe abortion.
- Provide financial support, physical assistance, or communication resources for accessing abortion and contraceptive care.
- Implement formal and informal education, including comprehensive sexuality education and knowledge of legal rights for PWD.
- Advocate for and conduct community interaction programs for ensuring sexual and reproductive health rights of PWD.
- Collaborate with organization working with People with Disability (OPD) and other relevant organizations to strengthen communication and information sharing with persons with disabilities.
- Ensure that persons with disabilities in the catchment area are included in health promotion and prevention activities undertaken by health staff and community-based health volunteers. Make them aware of availability of local health services and resources provided by the local government for persons with disabilities. Provide home-based services if individuals are unable to attend health facilities or community sites.

Individual-level

- Encourage and provide opportunities for individuals to learn about their rights and services.
- Support persons with disabilities in their efforts to achieve self-determination and an independent life. Give examples of successful disabled persons.
- Provide different options to learn about the services.
- In the case of adults who are unable to make independent decisions regarding health services (for example those with intellectual disabilities), provide the necessary

information and advice for their parents, guardians or care givers to make respective decisions.

- The Government of Nepal, through the Ministry of Health and Population, Department of Health Services, Family

Welfare Division has developed separate guidelines to specifically develop reproductive health and safe motherhood services disability-friendly. Please see this guideline for details on disability-friendly policy and services.

Reference materials

- Convention on the Rights of the Persons with Disabilities. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>.
- Global report on health equity for persons with disabilities. <https://www.who.int/publications/i/item/9789240063600>
- Understanding the intersection of disability and sexuality. <https://www.herdint.com/understanding-the-intersections-of-disability-and-sexuality/>
- Promoting sexual and reproductive health for persons with disabilities. <https://www.who.int/publications/i/item/9789241598682>
- Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf
- Prevalence and risk factors for violence against women with disabilities in Nepal. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1610-z>
- Safe Motherhood and Reproductive Health Rights Act, 2075 (2018). www.lawcommission.gov.np
- The Act Relating to Rights of Persons with Disabilities, 2074. <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Act-Relating-to-Rights-of-Persons-with-Disabilities-2074-2017.pdf>
- Factors affecting utilization of sexual and reproductive health services among women with disabilities: <https://doi.org/10.1186/s12913-021-07382-4>
- Access for Everybody Disability Inclusion in Abortion and Contraceptive Care. <https://www.ipas.org/resource/access-for-everybody-disability-inclusion-in-abortion-and-contraceptive-care-overview/>
- Global report on health equity for persons with disabilities. <https://www.who.int/publications/i/item/9789240063600>
- National Guidelines for Disability Inclusive Health Services, Nepal. https://www.nhssp.org.np/Resources/GESI/National_Guidelines_Disability_Inclusive_Health_Services2019.pdf

Part

V

**SUMMARIZING
SAFE ABORTION
TRAINING**



SESSION: ROLE PLAY

Objectives of this session

By the end of the session, participants will be able to;

- Reflect upon the various criteria of adolescent and disability friendly safe abortion services through role play

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Introduction to scenario	5 min	Brainstorming, Discussion	
Role Play	55 min	Lecture	Laptop, PowerPoint, Newsprint, Marker
Summary	15 min	Lecture	

Facilitation Instructions

Introduction to scenario

Divide the participants into 5 groups. Provide each group with 5 different scenarios. Ask them to discuss those scenarios in the group and act

out the given situation. Allocate 10 minutes for each group to prepare. Provide 10 minutes to act upon each scenario. The facilitator needs to point out the choice of words, behaviors, and attitudes displayed by participants during the role plays.

Scenario for role play

Scene 1:

A 22-year-old Trans man living with his partner got pregnant. He has no idea how it happened even though they were using barrier methods. They are unsure where to find safe abortion services, but they somehow managed to reach a health facility for the termination of the pregnancy. The health facility was not listed for SAS service. (Participants should act representing the actual situation as of now)

पार्टनरसँग बस्ने २२ वर्षको ट्रान्स पुरुष, गर्भवती हुन्छन् । उनले र उनकी पार्टनरले गर्भ निरोधक साधन प्रयोग गरिरहेका भए पनि गर्भधारण कसरी भयो भन्नेबारेमा उनलाई पत्तो छैन । उनीहरूले सुरक्षित गर्भपतन सेवाको पहुँच कहाँ छ भन्नेबारे स्पष्ट जानकारी छैन । उनीहरू गर्भपतन सेवा लिन स्वास्थ्य संस्थामा पुग्छन् । तर त्यो स्वास्थ्य संस्था सुरक्षित गर्भपतन सेवा दिनकोलागि सूचीमा सूचीकृत छैन। (सहभागीहरूले वर्तमान वास्तविक अवस्थालाई ध्यानमा राखेर अभिनय गर्नुपर्नेछ ।)

Scene 2

A 22-year-old Trans man living with his partner got pregnant. He has no idea how it happened even though they were using barrier methods. They are unsure where to find safe abortion services, but they somehow managed to reach a health facility for the termination of the pregnancy. The health facility was not listed for SAS service. (Participants should act representing the actual situation as of now)

पार्टनरसँग बस्ने २२ वर्षको ट्रान्स पुरुष, गर्भवती हुन्छन् । उनले र उनकी पार्टनरले गर्भ निरोधक साधन प्रयोग गरिरहेका भए पनि गर्भधारण कसरी भयो भन्नेबारेमा उनलाई पत्तो छैन। उनीहरूले सुरक्षित गर्भपतन सेवाको पहुँच कहाँ छ भन्नेबारे स्पष्ट जानकारी छैन । उनीहरू गर्भपतन सेवा लिन स्वास्थ्य संस्थामा पुग्छन् । तर त्यो स्वास्थ्य संस्था सुरक्षित गर्भपतन सेवा दिनकोलागि सूचीमा सूचीकृत छैन। (सहभागीहरूले वर्तमान वास्तविक अवस्थालाई ध्यानमा राखेर अभिनय गर्नुपर्नेछ ।)

Scene 3

An adolescent girl aged 19 with intellectual disability from a rural town got pregnant. Her parents brought her to a health facility to terminate the pregnancy. Parents request healthcare provider to provide some long-term contraceptive methods. (Participants should act representing the actual situation as of now).

ग्रामीण भेगमा बस्ने, १९ वर्षीया बौद्धिक अपाङ्गता भएकी एक किशोरी गर्भवती हुन्छिन् । उनका अभिभावकहरूले गर्भपतन गराउनका लागि उनलाई स्वास्थ्य संस्थामा ल्याउँछन् । अभिभावकहरूले स्वास्थ्यकर्मीलाई लामो अवधिको गर्भनिरोधक विधि लगाइदिन आग्रह गर्छन् । (सहभागीहरूले वर्तमान वास्तविक अवस्थालाई आधार मानेर अभिनय गर्नुपर्नेछ ।)

Scene 4

An adolescent girl aged 19 with intellectual disability from rural town got pregnant. Her parents brought her to a health facility to terminate the pregnancy. Parents request healthcare provider to provide some long-term contraceptive methods. (Participants should act representing the ideal situation they want to see in future)

ग्रामीण भेगमा बस्ने, १९ वर्षीया बौद्धिक अपाङ्गता भएकी एक किशोरी गर्भवती हुन्छिन् । उनका अभिभावकहरूले गर्भपतन गराउनका लागि उनलाई स्वास्थ्य संस्थामा ल्याउँछन् । अभिभावकहरूले स्वास्थ्यकर्मीलाई लामो अवधिको गर्भनिरोधक विधि लगाइदिन आग्रह गर्छन् । (सहभागीहरूले भविष्यमा देख्न चाहने अवस्थाको प्रतिनिधित्व गर्ने गरी अभिनय गर्नुपर्नेछ ।)

Scene 5

An adolescent girl aged 16 came to a SAS center. She shared that her period was delayed for 2 months, so she took a pregnancy test at home, which came back positive. She is requesting a healthcare provider for termination of pregnancy. She shared that it was impossible for her to share this with her family or friends. (Participants should act envisioning the ideal situation they want to see in the future)

१६ वर्षीया एक किशोरी सुरक्षित गर्भपतन सेवा केन्द्रमा आउँछिन् । उनले आफ्नो महिनावारी दुई महिनादेखि रोकिएको कारण घरमै गर्भ परीक्षण गराएको र आफु गर्भवती भएको थाहा पाउँछिन् । आफु गर्भवती भएको कुरा परिवार वा साथीहरूलाई भन्न मिल्ने कुनै सम्भावना नभएको बताउँछिन् । (सहभागीहरूले भविष्यमा देख्न चाहने अवस्थालाई कल्पना गरेर अभिनय गर्नुपर्नेछ ।)

Scene 6

An adolescent girl aged 16 came to a SAS center. She shared that her period was delayed for 2 months, so she took a pregnancy test at home, which came back positive. She is requesting a healthcare provider for termination of pregnancy. She shared that it was impossible for her to share this with her family or friends. (Participants should act envisioning the ideal situation they want to see in the future)

१६ वर्षीया एक किशोरी सुरक्षित गर्भपतन सेवा केन्द्रमा आउँछिन् । उनले आफ्नो महिनावारी दुई महिनादेखि रोकिएको कारण घरमै गर्भ परीक्षण गराएको र आफु गर्भवती भएको थाहा पाउँछिन् । आफु गर्भवती भएको कुरा परिवार वा साथीहरूलाई भन्न मिल्ने कुनै सम्भावना नभएको बताउँछिन् । (सहभागीहरूले भविष्यमा देख्न चाहने अवस्थालाई कल्पना गरेर अभिनय गर्नुपर्नेछ ।)

Summary

The facilitator shall thank all the participants for their effort for the role play. Also, if there is any sentence(s)/word(s)/instruction(s) that has been used beyond rights-based approach, it can

be pointed politely. It is important to reinforce the need to avoid such language, especially in those roles play where they are given to play an ideal situation.

SESSION: ACTION PLANNING

Objectives of this session

By the end of the session, participants will be able to;

- Create a tailored action plan that people can use as a tool to reflect on further activities

Session Details

Activities	Time (15 min)	Methodology	Materials Required
Introduction to action plan template	5 min	Lecture	
Filling up of the template	10 min	Worksheet	Template

Facilitation Instructions

Introduction to the template

Display the action plan template and explain how it can be filled. Highlight that this plan serves to summarize the training, encouraging participants to take action. The action plan will not be budgeted, nor have a strict deadline; instead, it will function as a self-reflection tool. Based on the plan, the organizers will follow-up with participants every few months to discuss

their progress. Also let the participants know that the action plan should not create any additional workload, but should instead build on what they are already doing.

Filling up the template

Provide participants with a sample template and give them time to reflect and fill it out. They do not need to share their action plans with fellow participants, but may choose to share them with the organizers if they wish.

Reference materials

Action Plan (कार्ययोजना)

How will you implement the things you have learned in this workshop at both the individual and professional/system level?

यो तालिममा सिकेको विषय आफ्नो व्यक्तिगत र पेशागतमा कसरी कार्यान्वयन गर्नुहुन्छ ?

Name (नाम):

Contact No (सम्पर्क नं):

Email Address (ईमेल):

Signature (हस्ताक्षर):

SESSION: REVIEW, EVALUATION AND CLOSING

Objectives of this session

By the end of the session, participants will be able to;

- Reflect, evaluate and close the training

Session Details

Activities	Time (60 min)	Methodology	Materials Required
Post test	10 min	Quiz	Form
Evaluation	10 min	Voice vote	Form
Closing Remarks	10 min	Speech	

Facilitation Instructions

Posttest evaluation

Use the same questionnaire that participants completed in the pretest and ask them to fill it out again. Remind them to use the same name and code they used previously. Emphasize that they should fill it based on their own understanding and not seek help from friends. After all the questionnaires have been collected, discuss the correct answers to ensure participants are aware of the correct answers.

Evaluation

The facilitator will ask open-ended questions to summarize the key learnings from the course. Selected volunteer participants can be requested to provide their overall feedback on the course. The participants will also be asked to fill out a feedback form.

Closing remarks

Invite key representatives from the organizing team to share their remarks and good wishes to the participants

ANNEX: Pre and Posttest form

कोड :

१) यौन तथा प्रजनन स्वास्थ्य तथा अधिकार भनेको के हो ?

- समानता र भेदभाव रहित वातावरणको अधिकार
- यौन स्वास्थ्य सहित स्वास्थ्यको प्राप्त हुन सक्ने उच्चतमस्तरको अधिकारका साथै सुखद, सन्तोषयोग्य र सुरक्षित यौन अनुभवहरूको सम्भावना
- बच्चा जन्माउने वा नजन्माउने, बच्चाको संख्या र जन्मान्तरको निर्णय गर्ने अधिकार र सो को लागि जानकारी र साधनहरू हुने
- माथिका सबै

२) गर्भपतन भनेको के हो ?

- स्वास्थ्य सेवा भन्दा बाहिर रहेर आफ्नै गर्भावस्था समाप्त गर्नको लागि गरिने एउटा प्रक्रिया
- स्वतन्त्र रूपमा बाच्चन सक्नु अघि गर्भबाट भ्रूणको निकास, विशेष गरी अनायास वा दुर्घटनाको परिणामको रूपमा
- भ्रूण स्वभाविक रूपमा जन्मन सक्ने भन्दा अगाडि गर्भासयबाट निकाल्ने प्रक्रिया
- माथिका सबै

३) नेपालमा गर्भपतनले कहिले कानुनी मान्यता पायो ?

- ई.स २००२
- ई.स २००४
- ई.स २००थ
- ई.स २००८

४) निम्न मध्य कुन कुरा ठिक छ ?

- महिला मात्रै गर्भवती हुन सकिछन्
- गर्भवती महिलालाई मात्र गर्भपतनको सेवा आवश्यक पर्छ
- पाठेघर भएको व्यक्तिलाई गर्भपतनको सेवा जुनै बेला पनि आवश्यक पर्न पर्छ
- माथिका सबै

५) शारिरीक स्वतन्त्रता भनेको के हो ?

- कुनै लोभ, प्रलोभन र दबाव बिना मैले मेरो शरिर माथि पूर्ण रूपले निर्णय गर्न पाउनु
- मैले कति ओटा बच्चा जन्माउने, बच्चा नजन्माउने, कति अन्तराल मा जन्माउने
- कुनै पनि अनिश्चित गर्भ रहेमा निर्धक्कसाथ गर्भपतनको सेवा लिन पाउनु
- माथिका सबै

६) औषधिको प्रयोगबाट गरिने गर्भपतन कहिले सम्म गर्न सकिन्छ ?

- १० हप्तामा
- २४ हप्तामा
- ६ हप्तामा
- कुनै पनि समयमा

७) Contentious Objection भन्ने शब्दले के अर्थ जनाउँछ ?

- स्वास्थ्यकर्मीको आफ्नो व्यक्तिगत विश्वासको कारणले गर्दा स्वास्थ्यकर्मी भएर आफुले दिनु पर्ने स्वास्थ्य सेवा प्रदान नगर्नु
- स्वास्थ्यकर्मीले आफ्नो बिबेक प्रयोग गरेर आफुलाई मन नलागेको स्वास्थ्य सेवा प्रदान नगर्नु
- आफ्नो बिबेक प्रयोग गरेर मन नलागेको बिषयमा सेवा नदिनु
- माथिको सबै

८) सुरक्षित गर्भपतन सरकारी स्वास्थ्य केन्द्रहरूमा निःशुल्क उपलब्ध ?

- छ
- छैन

९) सुरक्षित मातृत्व तथा प्रजनन स्वास्थ्य ऐन २०७थ अन्तर्गत कुन सर्तमा गर्भपतन दण्डनीय छ ?

- बलपूर्वक गर्भपतन गराउँदा
- लिंग पहिचान गरी गर्भपतन गराउदा
- कानुनी मापदण्डहरू बाहिर रहि गर्भपतन गराउदा
- माथिका सबै

१०) नेपालमा महिलाले कहिले सम्म आफ्नो इच्छा अनुसार कानुनी रूपमा गर्भपतन गर्न सक्छन् ?

- दोस्रो त्रैमासिक
- पहिलो त्रैमासिक
- २८ हप्ता
- पूरा ९ महिना

सुरक्षित गर्भपातको बारेमा तपाईंको दृष्टिकोण र धारणा उल्लेख गरिदिनु होला ।

बयान	सहमत छु	असहमत छु	थाहा छैन
गर्भवती व्यक्तिले गर्भावस्थाको समाप्ति अघि उनीहरूको पार्टनरको सहमति लिनुपर्दछ ।			
गर्भपतनको सजिलो र निःशुल्क पहुँचले सुरक्षित गर्भपतन सेवाको दुरुपयोगको लागि अग्रसर गर्दछ ।			
गर्भपतन बच्चाको जीवनको अधिकारको उल्लंघन हो ।			
विवाहपूर्व यौन सम्बन्धलाई निरुत्साहित गर्नुपर्दछ किनकि यो हाम्रो संस्कृति विपरीत हो ।			
यदि गर्भनिरोधक साधन प्रयोग गरिएको छ भने गर्भपतनको आवश्यकता छैन ।			
गर्भावस्था गर्भपतन भन्दा राम्रो हो किनभने गर्भपतनले गर्भवती व्यक्तिको स्वास्थ्यलाई जोखिममा पादछ ।			
गर्भपतन केवल महिलाको मुद्दा हो । यसमा पुरुषको कुनै सक्रिय भूमिका छैन ।			
केवल बलात्कार भएका महिलाहरूलाई मात्र गर्भपतन गर्न दिनु पर्दछ ।			
केहि स्वास्थ्यकर्मीको व्यवहारले गर्दा कतिपय अवस्थामा गर्भपतनको सेवा प्रयोग गर्नबाट बन्चित छन् ।			
गर्भपतनलाई नियमन नगरे बिकराल स्वरूप लिन सक्छ ।			
आकस्मिक गर्भनिरोधक चक्कीले गर्भपतन गराउने काम गर्छ ।			
किशोरी र अपाङ्गता भएको व्यक्तिलाई पनि सुरक्षित गर्भपतनको सेवा आवश्यक हुन्छ ।			
असुरक्षित गर्भपतन गर्ने व्यक्ति मात्र यसको कारण हुने कुनै पनि परिणामको लागि जिम्मेवार हुन्छ ।			

ANNEX: Evaluation Form

Please rate the following aspect of the training, in overall from a scale of 1-5 where 1 is lowest, and 5 is highest.

	Lowest			Highest	
	1	2	3	4	5
The training content met my needs.					
The training included interactive activities and tools.					
The trainers were able to facilitate sessions and answer queries properly.					
I was able to interact and learn from other participants as well.					
There was a good balance between breaks, energizers and sessions					
The training venue was good.					
The food quality was good.					
The logistical arrangements and information provided by the organizers before and during the training were effective.					

2. Do you feel confident to provide better services with human rights approach, especially for adolescents and people with disabilities, after the training?

- Yes
- No

3. Please mention three sessions or aspects of the training that you appreciate the most.

- A.
- B.
- C.

4. Please mention three sessions or aspects of the training that needs improvement

- A.
- B.
- C.

