



Asia Safe Abortion Partnership
The Safe Abortion Advocacy Institute for Youth Champions
Dates: Thu 13th –Sat 15th Oct 2016
Venue: Grant Medical College, Mumbai, India

A Brief Report



Objectives of the Institute:

1. To create a community of trained and sensitized youth champions who have an understanding of access to safe abortion as a gender and sexual and reproductive rights, as well as human rights issue.
2. To facilitate the utilization of social media and other community level networking and communication by the youth champions through capacity building and ongoing mentoring.
3. To support the ongoing engagement of the youth champions, within and outside their community to ensure implementation of the above strategies in order to advocate effectively for improved access to safe abortion services, including medical abortion.
4. The alumni will be facilitated to emerge as a community with a strong voice on this discourse at local, national and regional levels and to engage with the issues on an ongoing basis through the online network as well as through participation in relevant meetings.

Day 1

The Youth Advocacy Institute began with an introduction round, allowing participants and facilitators to know each other. The group then established ground rules for the workshop that included punctuality, participation, respect for each other's opinions and confidentiality.

Session 1: Understanding Gender & Patriarchy and linkages to Safe Abortion- Manisha Gupte



Facilitator Manisha Gupte started with a discussion on the difference between sex and gender. She asked participants to explain how we as a society determine the difference between boys and girls at different life stages. This kindled a discussion on how social attributes of gender, such as the length of one's hair, are visible from early childhood and therefore they seem natural and biological. The participants also discussed how social conditioning results in the perpetuation of certain gender myths.

She explained different social constructs of gender and also discussed briefly transgender and the differences. This

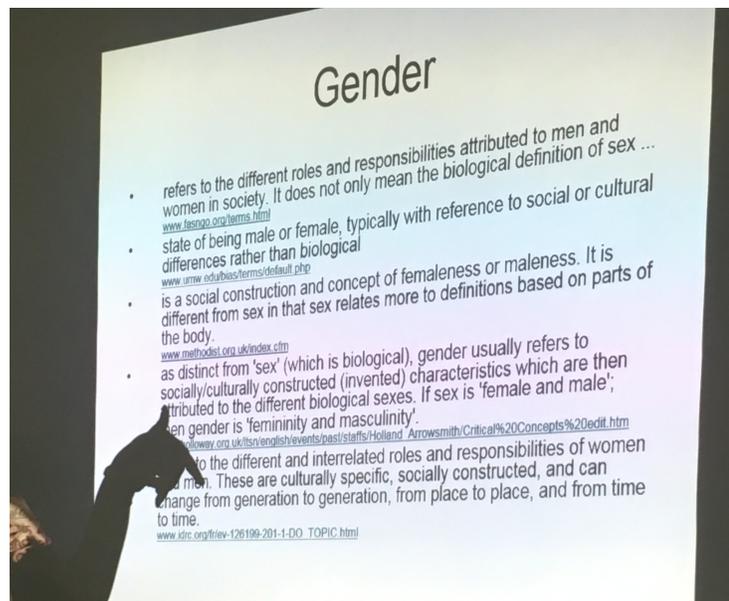
session helped participants recognize that gender norms are not biological but social; but the way we are taught the social become almost natural since we are taught to believe in these differences. Manisha further went on to highlight how it's important to reclaim words and understand the politics behind body shaming. She emphasized on the need to liberate words (just uttering the word vagina is a step towards fighting the stigma), which is critical to liberating bodies.

Participants discussed how gender roles discriminate against some groups, give privileges to some and not others, create risks for certain persons and society gives roles to people based on physical traits not on their desires, capabilities etc. They discussed what happens when men and women don't conform to gender roles and expectations – they are discriminated against. The facilitator also introduced the concept of heteronormativity and how it starts from childhood, when we're given dolls to play with as girls and given sports equipment to play with as boys. These same ideas and expectations come into marriage aspirations. Girls are brought up as 'parayadhan' everything has around them has a reference to being married someday. They are not considered as asset but a liability all their life.

Manisha asked the group to share examples of how conforming to the rules of patriarchy results in rewards and how one's position grows – and examples of how non-confirmation is punishable. She explained how women's reproduction is controlled in order to ensure that pure lines of blood is passed through generations of men. And this control over women's reproduction is done through controlling their sexuality. The group then looked at various agents of patriarchy that perpetuate this control over women's sexuality, reproductive rights and right to abortion in particular. She asserted that biological differences only a few; it's the social differences that far more.

Manisha further discussed at length the kind of socialization kids get (boy/girl) – she helped participants understand how boy's spaces are more open and accommodative given the kind of games they play. On the contrary girls places are restrictive, for them the best friend phenomenon becomes very possessive. This is how they get domesticated owed to the playing spaces they are provided for e.g.- nurturing dolls like babies, kitchen sets, domestic chores etc.

So what is 'Normal' ?? Manisha asked the participants to think about what they think as normal and then try to challenge it each time. She further went to explain that how patriarchy normalizes



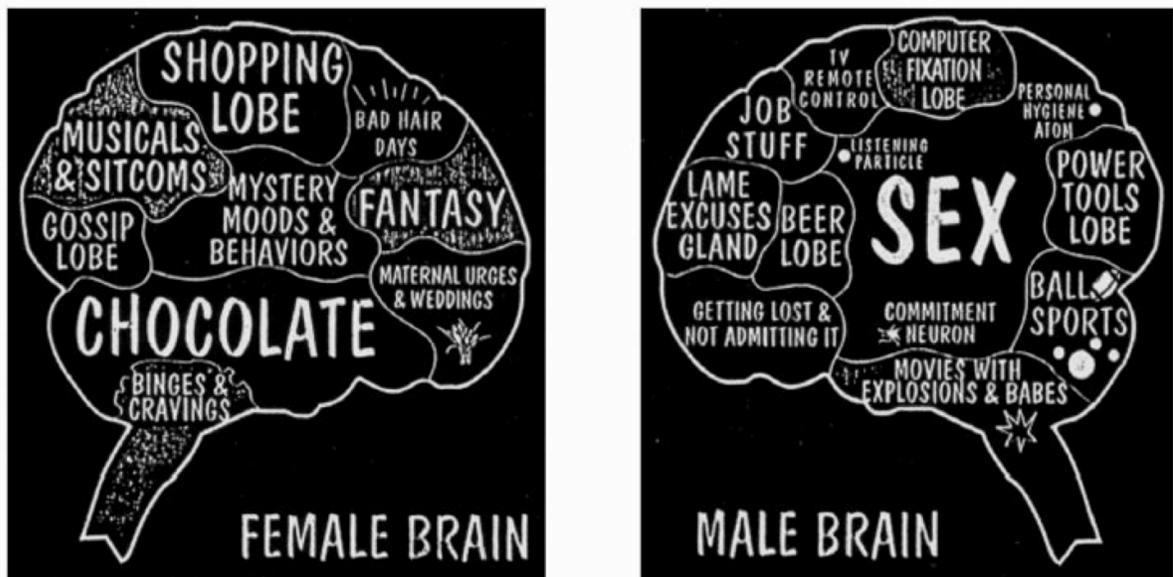
discrimination and therefore we are unable to see the injustices and oppression around us. As agents of change it is important to question what is “normal” and break the stereotypes. “Science changes, so does the normal. Don't be Normal”, said Manisha.

“The moral panic is all about women’s sexual parts getting exposed; it's the worst earth-shattering thing that can happen to a society” added Manisha; but we are not worried about whether its covered or uncovered, the issue is who decides it to be an issue, the intention matters. She further explained that any difference that does not discriminate is diversity. Gender needs to change because it discriminates. Gender is religion, caste, region specific but it discriminates. And although it discriminates against men too but it does give them certain advantage. Today, we have reached a more sophisticated level of gender discrimination but it has not gone away. It’s therefore important that we question; why certain characteristics exist and how they are being enforced upon us.

Explaining how patriarchy operates and how structural violence is sustained Manisha elucidated on the issues of autonomy and control over production, reproduction, and sexuality. Manisha concluded the session by proclaiming that gender can change and must change. This session was an eye-opener for participants; it helped them reflect on their own beliefs and attitudes.

Session 2 Gender and Sexism in Media- Souvik Pyne

Facilitator Souvik Pyne built upon the already discussed concepts of gender and patriarchy. The session was intended to make the participants aware about the representation of gender stereotypes and sexism in mass media.



He started off by showing a diagram which depicted few of the commonly perpetuated stereotypes about all the thoughts reside in a ‘male’ and a ‘female’ brain distinctively. He went on define gender stereotyping as overgeneralization of characteristics, differences

and attributes of a certain group based on their gender and sexism as when gender inequality results on the basis of gender stereotyping.

He then spoke about four common patterns of gender stereotypes with few verbal examples of the same. A photo series of different advertisements were shown and the participants too engaged in recognizing the stereotyping and sexism embedded in them; some were misogynist and offensive too. This was followed by screening of four video ads:

- 1) Saffola gold cooking oil: It depicted how a woman's job is to take care of husband's heart and health; concern about her own heart and health never featured.
- 2) Wild Stone men's talc: It depicted stereotypical differences in men's and women's body language, dressing and expression. It is a marketing strategy to paint a male ego on an otherwise feminine product in order to reach male clientele.
- 3) Vagina tightening cream: It depicted a scientifically impossible effect brought in by the cream and upheld the value of virginity for women.
- 4) I-pill: The male partner was completely absent in the whole discussion and, it emphasizes that abortion is to be avoided at all costs.

He concluded by explaining how these mass media help to magnify and sustain the gender norms and roles. The participants were encouraged to identify such stereotypes and then find ways to address them.

Session 3 Human Rights and SRHR- Manisha Gupte

In this session Manisha Gupte helped the participants understand what we mean by sexual and reproductive health and rights and the linkages with other rights in upholding them. She also emphasized the significance of the paradigm shift at the ICPD, from demographic goals to individual reproductive rights. The participants were able to obtain clarity on the rights based perspective towards safe abortion.

She started by asking the participants to consider what are our basic human needs and how these become rights. Participants enquired into how the market influences wants and creates demands.

Manisha Gupte also spoke to them about **human rights, international covenants** and committees like the UN Declaration of Human Rights and CEDAW, and allowed them understand that Sexual and Reproductive Rights must be understood and discussed within the broader umbrella of human rights.

She further elaborated the ethics based on law, autonomy and personhood and asserted that women should have full control over their bodies and the human rights laws should enable this freedom. Manisha further said that people have agency within themselves to liberate, no one from outside can do that for them.

Human Rights provide courage to revolt and enable this agency. She reminded us that if we are not cognizant of our Human Rights and don't exercise them they become inaccessible.

She highlighted the features of Human Rights as being universal, intrinsic, inalienable, interdependent, and non-hierarchical; and explained each one in detail. Manisha concluded the session by stressing that structural violence exists within structures therefore cannot be seen thus allowing impunity from law.

Session 4 Values Clarification and Case Studies- Manisha Gupte and Dr. Suchitra Dalvie



In this session, various statements were displayed and the participants were asked to take a stance – either ‘agree’ or ‘disagree’ with the statement and they had to explain the reason for their stance. This conjured a meaningful discussion among the participants and the moderators. Participants’ value systems and beliefs came into play and were challenged several times. Some of the highlights of the discussion are documented here:

- Violence is about power and control. Evidence shows that violence increases in depth and frequency if allowed to persist. Many a times, women’s desperate suicidal attempts are an outcry for help; sometimes it's the only way out of chronic violence e.g. self-immolation of child brides in Afghanistan. That is why health providers should be sensitive. Often, ante natal care is the first time she comes in contact with the health system, so one needs to be aware of and look out for signs of Intimate Partner Violence (IPV) too. Often, women do not speak even at their deathbed and refuse to implicate the husband and in –laws in the dying declaration.

- Being in sex work labels the person differently from any other human. Non-consensual sex is criminal irrespective whether it is paid or not. In India, sex work is not illegal per se but soliciting, running brothels and living off wages from sex work are illegal. In the sex work debate, three positions can be taken- abolition, decriminalization and legalization. Abolition has been found to be ineffective in tackling the issue. Thus, decriminalization is the best option till unions gets organized and legalization can be an option.
- Fund donors usually have utilitarian approach and argue against HIV+ women having babies. The cost of treatment for preventing mother-to-child transmission of the infection is unaffordable for the majority in a poor country like India and provision of the same by the government will take a toll on the public health exchequer, which is already meager. So, they believe that not having babies for women with HIV is a better option. But buying to this logic is an infringement on the human rights and reproductive rights of those living with HIV.
- The previous discussion gave cues that many participants were considering ‘eliminating people with problem’ rather than ‘targeting the problem’. So, a modified statement was given: **Women who are poor should not have babies.** Surprisingly, many agreed to it. Then, Manisha and Suchitra went on to give new perspectives to the issue. Malthusian ideas may extend in sterilization of poor people while Marxist ideas are in contradiction to that. It is the distribution of resources which is very critical. A study found out that 1 US child has consumption pattern equivalent to 9 Europeans, 50 Bangladeshi and 250 African children.
- Healthcare providers take decisions based on health priorities but women should decide about what happens to their bodies.
- Many of the participants surprisingly stated ‘Multiple abortions/pregnancies are bad/harmful for women’s health’.

Overall, the values clarification session probed the participants to opine, argue and contemplate on all the views raised in the discussion process.

Session 5 Power Walk and Intersectionalities – Souvik Pyne

Souvik facilitated the ‘power walk’ activity, which helped participants understand intersectionalities. Each participant was assigned a character. They were then all asked to stand in a line near one wall and imagine the life of the assigned character. Successive questions were asked and the participants were asked to take a step forward for each ‘Yes’ answer. At the end, they found themselves standing at varying distances from where they had started. Then, they were asked to read out aloud what their characters were and how they felt being at the position they were. They realized that although we say that all humans are born free and equal, how different the lives of

different people are and all these factors puts them at advantage or disadvantage in terms of autonomy in decision making, acquiring adequate information etc.

The session cognitively imbibed that there are complex intersections of factors contributing to differential access, affordability and autonomy at individual level even if availability of abortion services are there.

Film Screening

The film ‘Hysteria’ was screened which is a romantic comedy showing how the invention of electro-mechanical vibrator happened as a treatment of ‘hysteria’ in Victorian era of London.

Reception Dinner

The day concluded with welcome dinner at Café Mockingbird. The dinner served as a nice informal interaction platform.

Day 2

Review and Recap

Film screening discussion

Participants found the film to be very interesting and few quick thoughts are documented here. One participant noted the false creation of a pathology, which didn’t exist while another noted that the ‘Germ theory’ was not accepted. Yet another participant noted mention of Suffrage movement and understanding the idea of hysteria.

New ideas learnt

The participants mentioned a range of new concepts they imbibed on day one following are some of the highlights:

- Difference between sex and gender
- Dissonance between rights and fundamental rights
- Systemic discrimination of Dalits. Recollected Manisha’s shared story where Dalit children were discriminated during food serving, and how Dr Ambedkar was not treated with dignity even though he was the Chair of the Constituent Assembly.
- Difference between human rights and basic rights
- Idea of ‘hegemony’, ‘unquestioning norms’, ‘partner choosing standards’
- Judgmental attitude of doctors for abortion clients
- Sexual and reproductive rights
- Value clarification was insightful as different people had different ideas but no correct answer as such
- Sex workers perspective

- Use of word ‘black’ in negative way hinting ‘white supremacy’
- Women coming for multiple abortion can be unmarried, victim of rape etc

Challenges in understanding and/or not in agreement with it

The participants mentioned about issues which they were still having doubt or not yet comfortable to accept. These are enlisted below:

- How to ascertain and implement equal distribution of resources.
- Do not believe in equal distribution of resources.
- Do not believe in sex work legalization.
- Dilemma in accepting that disabled foetus can be aborted but not girl foetus
- Do not believe that HIV+ women should have children

Other discussions

Dr. Suchitra discussed about Boko Haram kidnappings of 276 schoolgirls in Nigeria in 2014 and they seemingly wanted to give a message that ‘girls should not have education and if you flout this, such will be the consequences’. Also, they may have felt that breeding with these girls is more desirable since the girls are from better off families. Till now, only few have been released and others are still under their captivity. This also shows the apathy and politics; they are in there in the country and even after 2.5 years couldn’t be traced!

Similar control and captivity of women is going on in the Middle-Eastern countries too.

Session 6 Basic updates on reproduction, contraception, safe abortion- Dr. Suchitra Dalvie



Since all the participants were medical students, they were asked them to enlist a few of the methods of contraception along with its mechanism of action. Condoms, spermicidal jelly, IUDs like CuT, sterilization were mentioned spontaneously but emergency contraceptives and implants were missed.

Suchitra then spoke about sterilization camps. She explained that although sterilization being done in a camp approach may be helpful in resource poor settings but ideally women should have a choice for spacing methods all year round. Also these camps do not adhere to minimum medical standards leading to many complications. In this context she mentioned about the Chhattisgarh deaths due to botched sterilizations. These are clearly public sector failures. Though ‘target based’ approach has been obsolete, still there are implicit ‘targets’ embedded in the system. There exists a big gender gap skewed towards females in the sterilizations performed. Often, the consent taken for sterilization is a ‘no choice’ consent; say for an illiterate woman in a remote village, where she has no contraceptive services available, if the health worker comes and says that a sterilization camp is being organized and whether she is interested, the woman is left with no other option but to agree. She then went on to discuss efficacy and failure rates of different contraceptives based on Pearl Index. No contraceptive has 100% efficacy. Usual pregnancy tests can detect only after a few days since HCG will show up in serum and urine only after a week. Family planning and contraception aren’t interchangeable terms.

Then, methods of safe abortion were discussed which are surgical and medical. The basic working of vacuum aspiration technique was also shown. Among the drugs for medical abortion, Mifepristone blocks Progesterone receptors and stops growth of pregnancy and Misoprostol causes uterine contraction. Foetal vascular damage is caused if Misoprostol fails in terminating pregnancy. Thus, even if medical method fails, the pregnancy shouldn’t be continued. DCGI allows use of MMA drugs till 63 days while MTP Act allows till 49 days. According to estimates, 7 million abortions take place every year in India but 11 million MMA drugs sold last year depicting the actual numbers being much higher. Interestingly, 25% of these drug sales were in Punjab and West Bengal. This can be because both states have international borders and there may be illegal flow of such drugs across them. Also, although abortion comes under maternal health, the unsafe abortion deaths are not reported or counted in Maternal Death Reviews.

Session 7 Abortion Laws in Asia – Dr. Shilpa Shroff

After this session **Dr Shilpa Shroff** started with the session on ‘**Abortion laws in Asia**’. She asked a few questions and had a discussion on why do we need a law? Should abortion be a part of population policy? Who is the creator of law and who is the guardian? Who is it meant to protect?

There was a discussion on why an abortion law was needed. It is the only medical procedure which continues to be criminalized because many countries in South and South East Asia inherit the Penal Code from the colonizers—British, Spanish and Dutch-- which criminalize abortion. For eg. Sections 312 -316 of the Indian Penal Code (1860),

miscarriage is a criminal offence. She then gave a brief idea about how laws are existing in the different parts of the world.

Abortion in China, Vietnam, and Nepal is legal and is a government service available on request for women, with gestational age limits varying. Nepal lawmakers replaced in 2002 what was one of the world's most restrictive abortion laws with one making early abortion available on request and have seen 50% drop in Maternal Mortality in last decade. Indonesia, Sri Lanka permit induced abortion only to save a woman's life. In Pakistan, Indonesia and Sri Lanka, although the law is restrictive, it is not strictly enforced and hence many women do access reasonable 'safe' services for abortion if they can afford them. In the Philippines the Reproductive Health Bill values the unborn child and the mother equally making abortion illegal. In Bangladesh, qualified physicians are permitted to offer menstrual regulation services. In many countries in Asia abortion can be performed on comparatively broader grounds: fetal abnormalities, to save a woman's life or to preserve her physical and mental health, and in cases of rape, incest. However, despite these reasons, it is believed that clandestine abortions are quite common.

Dr. Shilpa explained that currently, 61% of the world's people live in countries where induced abortion is permitted either for a wide range of reasons or without restriction as to reason. In contrast, 26% of all people reside in countries where abortion is generally prohibited.



Source: CRR. Link:

http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_fac_abortionlaws2009_WEB.pdf

The law in India permits abortion for unwanted pregnancy caused by rape, to save the woman's life, for fetal abnormalities and even for failure of contraception (though only for a married woman).

She gave a brief background of how MTP Law came in to existence after the Shantilal Shah Committee Report was presented.

According to the law, MTP is allowed up to 20 weeks gestation, with the consent of the women. If the woman is below 18 years or is mentally ill, then with consent of a guardian. It can be done with the opinion of a registered medical practitioner, formed in good faith, under certain circumstances and with the opinion of two RMPs required for termination of pregnancy between 12 and 20 weeks. Medical Abortion was included in the 2002 amendment. In spite of the law we still see unsafe abortion happening in happening. She then informed about the different laws existing in India to empower women.

Dr. Shilpa also briefly spoke about the PCPNDT act and what the act includes. This process began in the early 1990s when ultrasound techniques gained widespread use in India. She explained that before that there was female infanticide, a prevalent practice in India, which was criminalized by the British. Earlier there was a tendency for families to continuously produce children until a male child was born. Foetal sex determination and sex selective elimination by medical professionals came into existence because of son preferences and daughter unwanted-ness.

In patriarchal societies, such selection is often done because of economic, social, cultural and political structures that selectively empower male members of the society, rendering a son more valuable than the daughter. It is not just son preference but daughter unwanted-ness due to dowry, lack of economic benefits that leads to calling a daughter a burden to the family. Social discrimination against women and a preference for sons have promoted this in various forms skewing the sex ratio of the country towards men. There was a discussion on the skewed sex ratios in affluent families and how the rich gets the benefits of technology while the law catches the poor.

The PCPNDT law passed in 1994, is an act to for the prohibition of sex selection, before or after conception, and for regulation of prenatal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to elimination of female foetus. She explained how the act has got conflated with the MTP law and how the visual messages for PCPNDT have sent wrong messages in the community that MTP is illegal.

She briefly mentioned that because of these entanglements safe abortion services are becoming difficult to access, especially during second. Doctors are denying abortion because of the fear of PCPNDT law official. The PCPNDT official demand the details of MTP patients and so confidentiality of the women is at stake. We need to understand that while ensuring that sex determination is criminalized and violators of the PCPNDT Act are not allowed to go scot-free, abortion services should not be affected and safe and legal abortions should be made easily accessible to women on a large scale, as their right.

Women should have the right to choose whether or not they want to continue with a pregnancy, as it is they who bear the burden of bearing and rearing a child. Shilpa explained that a good law is necessary but not sufficient and there will be challenges to it.

Session 8 Role of Ethics and Conscientious Objection – Dr. Amar Jesani

Dr. Jesani started off with asking the participants about the difference between law and ethics. He then explained that law says what you can and can't do while ethics says what you should or shouldn't do. He tried to analyse what is the basis of good and bad. There are two belief systems – core and peripheral. Contemplation, introspection etc builds belief systems which leads to value systems. Actions and apparent portrayal may not be coming from value systems rather with hidden intentions.

There are 4 major principles for medical ethics – Beneficence (to do good which includes to do no harm), Autonomy (patients' consent matters), Confidentiality (patients' details and information shouldn't be disclosed publicly) and Veracity (truthfulness). Then we were shown a video by Philip Zimbardo, which showcases the 'Stanford prison experiment', a social experimentation depicting the 'Lucifer effect'. It depicted how 'good' and ordinary people can go on to do and be perpetrators of 'evil'. Evil is mainly exercise of power to hurt, destroy or commit crimes. There are situations and power in the system, which causes expression of negative traits embedded in all people.

Dr. Amar then went on to explain positions one can take in such a situation – perpetuate indifference or act upon. There are many barriers especially when one has to act upon in front of the society. Systems (e.g. patriarchy) generate the power balances in which one has to act upon. There has been a shift from generalized consent to informed consent when patient rights became prominent. Gender sensitization is very tricky considering that gender differentiation begins very early. So, there is more time needed to unlearn something they have learnt over a long time. Human rights and ethics are very much connected.

He used a discussion prompt for the participants: 'If Ajmal Kasab would have come to you, would you have treated him?' Few responded 'his actions were unforgivable and so I wouldn't have treated him' while few others responded 'doctor should not be judgmental, judiciary is there'.

A person may adhere to certain ethical standards but may not alter his/her morality of a different stance. For example, a pediatrician is conservative but doesn't bring it in his professional life. He believes 'untouchability' is fine but while at professional practice does not exercise it. Dr. Amar made the participants introspect about where one's ethics come from? Is it 'Caste'? Religion? Profession? Evidence based? Usually our value and belief systems are not evidence based. Death penalty has failed to show utility. Revenge comes from Hammurabi's code while Arthashastra talks of compensation, which involves both politics and economics.

To bring things into perspective about impulsive and revengeful behavior, Dr. Amar asked 'If a doctor's negligence leads to loss of an eye, does the patient gets a right to make the doctor blind in one eye as well? And 'Negligence of doctors in one hospital

leading to beating of doctors elsewhere, as they belong to same fraternity, is justified?'. Though few debated on it stating that the intention matters but they understood the point.

The session was very interactive and Dr Amar concluded with the bottom-line that 'Right and wrong is very tricky, rationality and empirical evidence are essential'.

Session 9 SOGI and access to healthcare services- Koninika Roy

Koninika Roy of Humsafar Trust joined us for this session; she started by asking the participants if they know the meaning of transgender and whether they have ever interacted with one. This led to an exciting discussion about biological differences between Intersex, Gender Identity, transgender FTM/MTF (a person who has undergone medical treatments to change their biological sex (Female To Male, or Male To Female), often times to align it with their gender identity).

Koninika then ensued to talk about the misconceptions that exist around these communities and how it affects their access to health care and services. She also spoke at length about sexuality and sexual orientation. This provided participants with conceptual clarity and also helped clarify various myths that exist. Moving on discussing the provisions of law Koninika explained in detail Section 377 that criminalizes acts of homosexuality. Drawing upon historically she pointed out the loop-holes that exist in the law, which makes it vulnerable and is often used to abuse people.

Participants were surprised to learn that homosexuality was widely accepted in pre-British India and it was in fact the British who criminalized the act- "by definition it criminalizes unnatural sex which is not vaginal. So not only homosexuality but any sex that is non-penovaginal"; thus the law by itself faces grave lack of clarity, its ambiguous nature has made it susceptible to use and has created an environment of fear for the people belonging to LGBTQ community.

Clarifying myths against homosexuality Koninika asserted that it couldn't be transmitted or treated since it's not a disease, and any attempt to therapy is quackery. What we need is not treatment but support; we need to fight against the stigma and discrimination that exists against these communities.

Session 10 What Does it Mean to be Pro-Choice? - Dr. Suchitra Dalvie

In this session Dr. Dalvie helped participants to understand advocacy for safe abortion as a choice and a right for women with reference to sex selection being an issue in India. She also discussed what it entails in being a change agent and the role of healthcare providers in preventing gender based violence. Participants were divided into four groups and each group was given a case study to analyse. The first case study explained about Henrietta Lacks cells which were taken without consent and eventually used for

developing most of the vaccines we use currently. Although many pharmaceutical companies made billions in profit, she and her family got nothing.

The second story was about the Tuskegee trials conducted on African American people who were included in this study without any clear understanding of what it meant. Even after the discovery of penicillin these people were not given treatment and the scientists let the trails continue in order to observe the course of syphilis.

The third story talked about the situation of women in Nazi Germany. Hitler was extremely sexist and the practices observed under him reinforced patriarchy and gender stereotypes. Men were considered to be the breadwinners and soldiers, every couple was expected to have minimum 4 kids and there existed accolades for couple with highest number of kids. There were buildings constructed for women to get pregnant and breed pure Aryans race babies only.

The fourth story talked about the role of doctors in Nazi Germany and the extremities practiced under this regime. Euthanasia was prescribed for disabled, gay and the Jews and sterilization was based on intelligence. Doctors involved in these experiments were renowned academicians. They played a very important role in promoting Nazi ideology in fact they were the ones that worked in gas chambers. Medical ethics got formed as a result of the role played by Doctors in Nazi Germany. Each story provoked the participants to think of issues relating to medical ethics and helped them understand how medical professions often might indulge in practices that violate the rights of individuals.

Moving on Dr. Dalvie helped the participants understand the nuances of the prochoice philosophy. This led to very interesting discussions on the various circumstances under which women might make their choices, and how it was important to protect and preserve these choices. There were several discussions on the need to provide accurate information on physical and sexual abuse, and also to set up support systems that helped women understand the various patriarchal frameworks within which several of their choices are framed. For example, returning to the topic of sex-selection, there was a need to respect the choice to have a termination even if the reason was sex-selection because the denial of selective choices would be against the very foundations of the prochoice philosophy. But at the same time, activists had the additional responsibility to recognize sex-selection as a symptom of gender discrimination and work to equalize women's status in the society. The selective banning of abortion would be counter-productive since it would inevitably further the discrimination against women by preventing them from accessing a procedure that could help them exercise their right over their own bodies and fertility.

Participants were being exposed to these nuanced arguments for the first time, and even though they were plagued with doubts about sex-selection, they were able to agree that you could not be supportive for a few choices, and against the others. The session also emphasized the need to recognize the fact that patriarchal control over women's bodies often resulted in infantilizing women and treating them as entities unable to make decisions for themselves, of for their bodies, their future or their families. The discussion

helped participants to understand the inadequacy of the government policies such as “Save the Girl Child” which fail to address the cause of the situation and continue to feed into the patriarchal system. Gender biased sex selection is a social cultural issue that needs to be dealt that way, therefore their can't be capsule solution. What we are facing today is a cause and effect confusion, choices are influenced by economic value thus; if having a girl is not economically viable this discrimination will continue.

Dr. Dalvie then discussed participants role as pro-choice activists, medical students and agents of change, they learned about ‘advocacy cycle’: how to identify a problem, gather information, make a decision, plan, take action and evaluate. They also learned how they can be more aware of injustices around, what can they change, where to begin e.g. reviewing the medical text books. They learnt how to challenge the status quo by questioning and challenging what is ‘normal’ and using ‘Subversion’.

Day 3

Review and Recap

The day began with looking back into the sessions of Day 2 and some of the new learning's of the participants were:

- Consent for patients and bioethics
- Ethics: how nothing is black and white
- Dilemma between value system and evidence – which to follow
- Homosexual act is criminalized not homosexuality
- Lucifer effect: how good and educated people do such wrong things
- Doctors’ power position
- Details of MTP and PCPNDT Act

Session 11 Interpersonal communication- Souvik Pyne

Souvik started with a small introduction about communication- its etymology and definitions.

This was followed by an activity – ‘Chinese whispers’. All the participants sat in a line and two messages were forwarded from each end of the line. The middle person was instructed to pass the message only when messages from each side reach her. One message was loaded with too many information in disordered manner while the other was simple but in different language. At the end of the game, both the messages got distorted but the longer one got distorted further. Using this as a cue, Souvik explained the communication loop of sender-encoding-medium-decoding-receiver and also about importance of appropriate content. For example, if the doctor gives away a very detailed message for the patient, s/he may not able to grasp it fully and also if it is delivered in a very technical language, then also it stands chance for misinterpretation.

Souvik then discussed four principles of communication viz. inescapable, irreversible, complicated and contextual. It is inescapable because, communication is bound to happen every-time, everywhere; even not communicating gives away a vibe which is again communicating something. It is irreversible because once something has reached the receiver; you cannot take it back; so, it is important to be careful while communicating. It is complicated because each time a communication occurs, at least six types of thought goes into it – ‘what you think of yourself’, ‘what you think of the receiver’, ‘what do you think the receiver thinks of you’, ‘what the receiver thinks of oneself’, ‘what the receiver thinks of you’ and ‘what the receiver thinks that what you think of the receiver’. It is contextual because the communication varies considerably depending on the context, environment, mood etc e.g. communication between friends in a class will starkly be different from that in a café. Souvik also told a about a few types of communication.



Then another activity was conducted to demonstrate the importance of non-verbal communication. The activity is called ‘Silent take’. Two pair of people from the participants was asked to volunteer. The first pair will enact a scenario without using any words while the second pair will observe and then perform the same act by putting words anticipating what the first pair would have said. A scenario where a girl approaches a doctor for abortion, doctor asks for husband’s consent and about calling him, girl requesting not to call him and indicates he beats her, doctor refuses to provide services, girl about to leave, doctor calls her back and hints if more money is given he will provide services. The first pair brilliantly did this in mime and the second pair could almost gauge every probable dialogue in their act. This showed how powerful and important component of communication is the non-verbal part.



Souvik then described the attributes of non-verbal communication. In context of the health providers, the adequate and appropriate use of non-verbal cues goes a long way in making the communication effective.

The next pair of activities was to make understand the importance of feedback and thus completion of the communication loop discussed earlier.

In the first activity, two volunteers from the participants were made to sit back to back. The first volunteer was given a paper on which a simple face with circles, triangle and semicircle was already drawn. She had to give instructions to the second volunteer to replicate the figure but she cannot ask questions. This led to a haphazard drawing of geometrical shapes by the second volunteer. Now a third volunteer was asked to replace the second and now she can ask back questions. This led to recreating the same face as was with the first one.



In the second activity, volunteers from the participants were made to sit facing each other. The first volunteer was asked to tell a story to the second; while the second was secretly told not to make any eye contacts and not to give any form of response while listening. This led to the first volunteer being uncomfortable after a short while and snapping of the

communication. Now a third volunteer was asked to replace the first and she told earlier to make eye contact and give responses. This led to a smooth communication.

Both the activities cumulatively highlighted the importance of feedback in a communication loop. Souvik also added few words about its importance. This was also very much contextual in case of health professionals where they need to reassure what the client/patient have understood through taking and giving space for feedback. Thus, this too ensures effective communication.

Session 12 Digital Security- Dr. Shilpa Shroff

Dr. Shilpa discussed briefly how to be secure online and the issues involved with digital security. Participants learnt how an email gets sent from one point to another and how our security and confidentiality can be compromised during the process. She emphasized that as SRHR activists we need to make sure we're digitally secure because otherwise we compromise the security and confidentiality of others in our networks.

Session 13 Social Media and Politics of the Internet- Garima Shrivastava

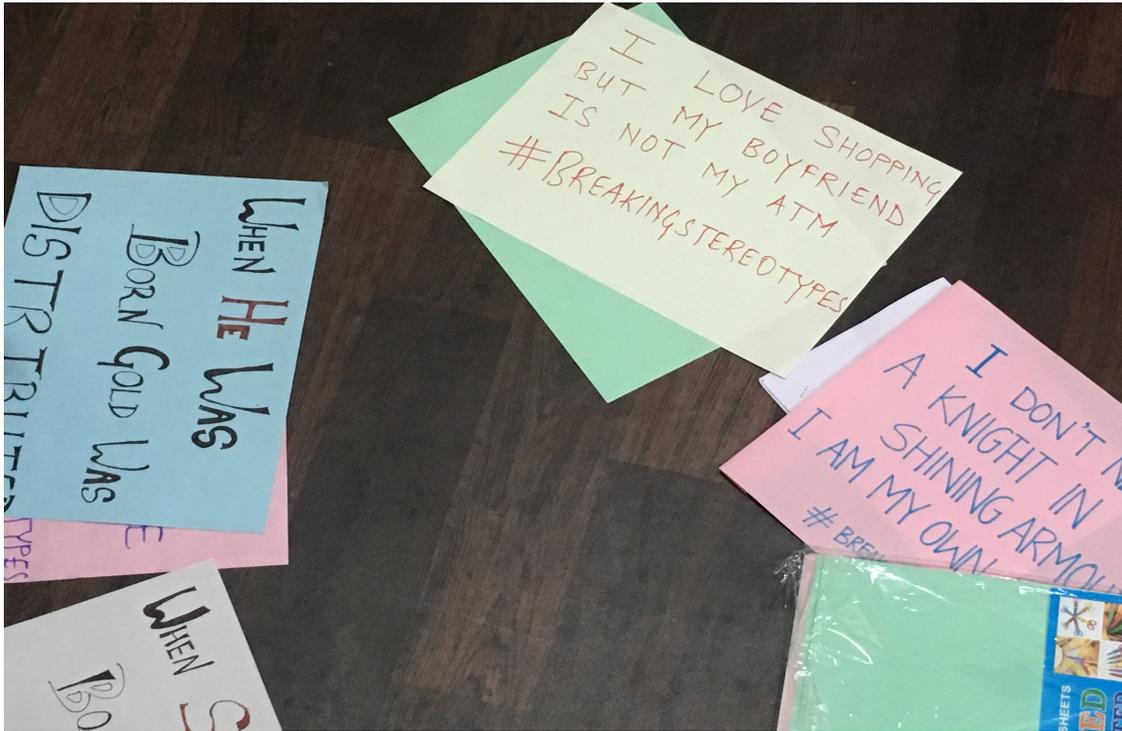


In this session Garima oriented participants with use of social media as an advocacy tool and helped them understand what effective communication entails and how to produce content: curating and creating. She also discussed briefly the politics of the Internet, what we mean by a feminist Internet and why it is important to engage online. Garima elaborated on social media as an effective tool for advocacy, and need to claim the power of Internet to amplify alternate and diverse narratives of women.

Participants also learned how to build audience on Facebook and twitter and how to

create a social media strategy. Garima discussed the need to have a strategy for one's page that could include wanting to share information, show support, recruit volunteers and supporters, influence discourse, interact with supporters, showcase activities etc.

Session 12 Content Creation



Participants worked together to create a short film on breaking gender stereotypes

Small Grants

Dr. Dalvie oriented the participants with previous small grants and projects carried out by youth champions. Participants were then given an opportunity to create their own project proposals

Valedictory



Asia Safe Abortion Partnership
The Safe Abortion Advocacy Institute for Youth Champions

Dates: Thu 13th -Sat 15th Oct 2016

Venue: Grant Medical College, Mumbai, India

Objectives of the Institute

1. To create a community of trained and sensitized **youth champions** who have an understanding of access to safe abortion as a gender and sexual and reproductive rights, as well as human rights issue.
2. To facilitate the utilization of **social media** and other community level networking and communication by the youth champions through capacity building and ongoing mentoring.
3. To support the **ongoing engagement** of the youth champions, within and outside their community to ensure implementation of the above strategies in order to advocate effectively for improved access to safe abortion services, including medical abortion.

The alumni will be facilitated to emerge as a community with a strong voice on this discourse at local, national and regional levels and to engage with the issues on an ongoing basis through the online network as well as through participation in relevant meetings.

Agenda

Thu 13th Oct 9 -10 a.m. - Welcome, Introductions and Expectations
Suchitra Dalvie, Shilpa Shroff and Garima Shrivastava

Sessions

Day One – Thurs 13th Oct 2016

Timings	Session	Learning objectives	Methodology
10.00 am – 11.30 am	Session 1: Understanding Gender and Patriarchy and its linkages with safe abortion issues	Objective: At the end of this session the participants should be able to: <ul style="list-style-type: none"> • Understand the difference between sex and gender, the social construct of gender and the role of patriarchy in perpetuating the gender inequalities. • Understand the cascade effects this has on the differential control over resources and decision-making powers especially with reference to healthcare systems 	Manisha Gupte
11.30 am -11.45 am (tea break)		Gender and sexism in mass media	Souvik Pyne
11.45 -1.15 pm	Session 2: <u>Human rights, sexual and reproductive rights.</u>	Objective: At the end of this session the participants should be able to: <ul style="list-style-type: none"> • Know the definition of sexual and reproductive rights and the linkages with other rights in upholding them. • Understand the significance of the paradigm shift at the ICPD, from demographic goals to 	Manisha Gupte

		<p>individual reproductive rights.</p> <ul style="list-style-type: none"> • Obtain clarity on the rights based perspective towards safe abortion. 	
1.15-2.00 pm	Lunch Break		
2.00 -3.30 p.m.	<u>Session 2: Values Clarification and Case Studies</u>	<p>Objective: At the end of this session the participants should be able to:</p> <ul style="list-style-type: none"> • Appreciate the impact social 'values' can have on individual rights • Understand the nuances of policy interpretations being enabling or disabling • Counter statements made by anti choice groups 	Suchitra Dalvie Manisha Gupte
3.30-3.45 pm	Tea Break		
3.45-4.30 pm		Power walk and intersectionalities	Garima Srivastava Souvik Pyne
4.15pm -7.00pm	Film screening		
7 pm onwards		Reception Dinner	

Day Two – Friday 14th Oct

9:00 – 9:30	Recap and review		Youth Volunteer
9:30 a.m. -10.30 am	Session 4: Basic updates on reproduction, contraception, safe abortion.	Objective: At the end of this session the participants should be able to: <ul style="list-style-type: none"> • Understand how pregnancy occurs and how it can be prevented • Clarify myths and misconceptions around these issues • Explain safe abortion techniques and related concerns in simple language to a layperson • Historical insights— anatomy, clitoris absent, witches, midwives and nurses 	Suchitra Dalvie
10.30 – 11.00 am	Tea Break		
11.00 am -12 noon	Session 5: Abortion laws in Asia:	Objective: At the end of this session the participants should be able to: <ul style="list-style-type: none"> • Understand the implications of the law and its impact on services • Understand the barriers created by laws and practises to safe abortion services • Discuss positive amendments to country laws which would facilitate access. 	Shilpa Shroff

		<ul style="list-style-type: none"> • PCPNDT , MTP, relevance, amendments 	
12 noon – 1.15 pm		<p>Objective: At the end of this session the participants should understand</p> <ul style="list-style-type: none"> • the role of ethics in medicine • patriarchy in healthcare systems (and its impact on abortion) 	Dr Amar Jesani
1.15 pm -2.00 pm	Lunch		
2.00 to 2:30 pm	<u>Session 6</u>	SOGI and access to healthcare services	Sumit Pawar
2:30 pm -3.30 pm	<u>Session 7:</u> What does it mean to be prochoice?	<p>Objective: At the end of this session the participants should be able to understand</p> <ul style="list-style-type: none"> • Advocacy for safe abortion as a choice and a right for women (sex selection as an issue) • Being a change agent. Role of healthcare providers in GBV • Role of Subversion • Critique of articles and publications. 	Suchitra Dalvie
3.30 -4 pm		Medical textbook analysis	Suchitra Dalvie
4:00 pm – 4:30 pm	Tea Break		
4.30 pm -5.30 pm	Assorted clips:	For discussion immediately afterwards	

Day Three – Sat 15th Oct

9:00 – 9:30	Recap and clarifications		Youth Volunteer
9:30 – 11.00 am	Session 8: Interpersonal communication	Objective: At the end of this session the participants should be able to: <ul style="list-style-type: none"> • Understand the communication loop and the importance of message and medium • Recognize the importance of body language and other non- verbal cues • Understand the importance of obtaining feedback • 	Souvik Pyne
11.00-11.30 am		Tea break	
11.30 am -1.00 pm	Session 9: Social media	Objective: At the end of this session participants should understand: <ul style="list-style-type: none"> • Politics of the internet • Using social media for advocacy. 	Garima Srivastava
1.00 pm -1.45	Lunch break		
1.45 pm -3.30 p.m.	Session 10: Creating Content	Objective: At the end of the session participants understand <ul style="list-style-type: none"> • What effective communication entails • How to produce content: curating and creating 	Facilitated by Garima and Souvik
3.30 – 4pm		Tea break	
4-5 pm		Valedictory and closing	