Asia Safe Abortion Partnership (ASAP)

Workshop on

Mid-Level Providers Exchange Tour Programme

25th-30th August 2012
Kathmandu, Nepal

In collaboration with
Ipas- Nepal

The Asia Safe Abortion Partnership (ASAP) conducted a 5 day **"Mid-Level Providers' Exchange Tour in** Kathmandu, Nepal from 25th to 30th August 2012 in collaboration with Ipas –Nepal.

Why abortion advocacy?

Each year, nearly 70 million women have **unwanted** pregnancies. The impact of these pregnancies varies immensely and depends on factors such as a woman's health, family relationships, economic resources, and the availability of medical care. These and other factors influence her decision to either carry this pregnancy to term or seek an abortion. Given the **complexity of this decision**, the only person equipped to make this choice should be the pregnant woman herself. However, it is an unfortunate truth that that the women themselves as well as the service providers are rarely aware of the rights of these women.

A woman who needs an abortion must have access to the appropriate facilities and care that will enable her to terminate the pregnancy safely. It is very important for the women and the Governments to recognize and respect a **woman's human right** to make decisions regarding her reproductive life and make safe abortion services available to her. Many countries are signatory to various international covenants which are supposed to safeguard various human rights and reproductive rights for their citizens but in reality these rarely get effectively implemented.

Millennium Development Goal 5, to improve maternal health, now includes the target of universal access to reproductive health by 2015 Goal 5 (b). Access to safe abortion is recognised as an intrinsic part of reproductive health.

Why work with mid level providers?

Studies conducted across the globe have confirmed that midlevel providers can provide high-quality abortion services in the absence of physicians. The World Medical Association has recognized that in countries facing a critical shortage of physicians**, task shifting** may be used to train alternate health care workers or even laypersons to perform tasks generally considered to be within the purview of the medical profession. The rationale behind the transferring of these tasks is that the alternative would be no service to those in need. In such countries, task shifting is aimed at improving the health of extremely vulnerable populations, mostly to address current shortages of healthcare professionals or tackle specific health issues.

Why Nepal?
Till ten years ago, abortion was criminalized in Nepal. But the high maternal mortality rates and persistent advocacy by woman's groups, lawyers. NGOs and others, turned the government around and now, **Nepal has one of the most liberal laws for first trimester terminations: all women who need the services are provided both medical and surgical care upto 12 weeks of pregnancy, on request, irrespective of their reasons, or their marital status.** Up to 18 weeks, abortion services are provided in case of rape, incest, fetal anomalies, or to preserve the health of the mother. More importantly, Nepal's law allows trained nurses and midwives to provide Comprehensive Abortion Care (CAC) through the Manual Vacuum Aspiration method, and medical abortion pills up to 8 weeks of pregnancy.

An evaluation from a study of the acceptability and quality of CAC services provided by trained nurses in Nepal show that trained nurses provide high quality CAC services in Nepal.

This "task shifting" has done wonders for Nepal, and lightened the setbacks created by its harsh geography. Thanks to these trained mid-level providers, women across the country have access to basic health care; antenatal care; birthing, family planning and safe abortion services at health posts and sub health-posts that punctuate the remote regions of the mountainous country.

This proves the strong need for the **capacity building of mid-level providers** at various levels to ensure access to safe abortion services. ASAP arranged a study tour of nurses and midwives from India, Pakistan and Bangladesh to Nepal to learn about the role of midwives and nurses in safe abortion service delivery systems and to equip them to advocate for similar changes in policy and practise within their local/country systems. This was arranged in Kathmandu in collaboration with Ipas- Nepal.

Goal and Objectives of the workshop:

Goal:

To encourage mid level providers to understand the potential for their own role within safe abortion service delivery systems and to advocate for similar changes in policy and service guidelines within their own country.

Objectives:

- To expand knowledge related to the applied medicine; nursing, care giving and foster gender sensitivity, rights based approach and understanding needs of clients especially related to abortion
- To provide an opportunity to learn from service delivery models in other countries and and to understand the nursing services and programs for providing safe abortion services.
- Visit clinics/ hospitals for practical/ hands on experience of safe abortion techniques.

The exchange tour was attended by **11 selected participants** from Pakistan, Bangladesh, India and Nepal. *(For details on participants please see Annex I)*

WELCOME AND INTRODUCTION

The workshop began with **Dr. Shilpa Shroff, Assistant Coordinator, ASAP,** welcoming all the participants and giving a brief introduction.. The participants were then asked to introduce themselves and fill in the pre-evaluation forms.

The inaugural ceremony was marked by Ms Mohana Ansari, National Women Commission Nepal lighting a lamp and giving a speech.

Ms. Ansari spoke to our participants about the

10-year old abortion law in Nepal, and women's persisting challenges. She explained that access to sound health and education was still elusive to the women of Nepal, as it was to the women of the touring countries, India, Bangladesh and Pakistan. She urged the participants to recognize their roles in helping young women make informed decisions about their families, and their future. Ms. Ansari made a deep impression on our participants, who insisted on taking a break to chat with her. They shared their experiences over tea, and started the day feeling optimistic after being recognized for their efforts in their communities.

Then we started with the first session on issues of sex and gender and their impact on health. Dr.Shilpa Shroff initiated the discussion with some key definitions, and the important points that evolved from the discussions were

SEX

- It is a **biological** identity.
- We are born as male, female or rarely, a hermaphrodite.

GENDER

- **Gender** is a **social or cultural** construct. It is the roles defined by society, personal experience, and class difference. Roles, expectations, differences in culture and religion.
- Gender is not constant and has **power relations** which are the factors affecting women's health. Gender has no fixed roles but it has its own biases. Most of the time it is stereotypes.
- Gender changes geographically, culturally, etc.

When one does not play the "appropriate" role, there can be gender-based violence

The participants were already aware of the differences between gender and sex. So we were able to quickly go through the basics and have a nuanced conversation on gender roles, and how it leads to discrimination. Abortion is about a pregnancy that one doesn't want. The problem with access to safe abortion is due to the construct of society.We must understand the social context and the forces that do not allow the woman to have an abortion or that may force a woman to have an abortion. All key institutions are run by men. Gender roles may be transgressed at some point, but inheritance still goes through father to son and reinforces patriarchy.

She explained further that how this affects the unequal distribution of resources and has an impact on health. Participants (one from each country) enacted a scene: a 16-year old pregnant girl who was pregnant due to a rape and needed an abortion in order to continue with her schooling. She was sent to a police officer by the health care provider, and then denied an abortion because she was over 20 weeks pregnant. All the participants were able to understand the various problems in the system. They were asked to analyze it from a human rights perspective.

This was followed by a discussion on gender-based violence, and discrimination. They were asked to analyze a case study of a girl having faced discrimination at every stage in her life.

Participants were then briefed on the need for health care professionals to go beyond their defined roles of "providers" and be alert to problems faced by a woman (specifically if the woman is a victim of violence.)

Ms Sonali Regmi, Regional Manager for Asia, Asia Regional Office , Centre for Reproductive Rights spoke about human rights and sexual and reproductive rights with examples of cases that have changed the laws of countries.

- L.C. vs. Peru
- Laxmi Dhikta vs. Nepal
- *L.M.R.* v *Argentina* (2011
- Woman living with HIV in Chile was forcibly sterilized while undergoing a cesarean delivery

She further elucidated the attributes of Human Rights:

- Human rights are
  - Universal and inalienable
  - Interdependent and indivisible
  - Equal and non-discriminatory
  - Human rights entail both rights and obligations.

- **Human Rights** are fundamental rights, not created by governments, nor by international treaties. They are universal, intrinsic and self-evident, and are the rightful entitlement of all human beings. They are deemed essential for all human beings to lead a life of dignity and fulfillment. They need to be incorporated into a legally binding agreement if they have to be protected, enforced and monitored.

- **Rights** can be created by formal law or a constitution or may be based on custom and tradition. To be able to claim rights, they have to be codified through law and policy. Violations have to be addressed and remedies claimed through institutions and procedures of redress. Rights can be temporarily limited when there is a political emergency or curtailed for reasons of culture and tradition.

Human Rights are not created but recognized by the Governments. Therefore, in order to be enforced, it has to be put into a treaty, a law, etc. Rights can be curtailed for reasons of culture and tradition. Rights **are** recognized by law. They may not necessarily be in accordance with human rights and may even violate human rights.

States have a primary obligation **to respect, to protect and to fulfill** human rights.

- Respect: The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights.
- Protect: The obligation to protect requires States to protect individuals and groups against human rights abuses.
- Fulfill: The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights. At the individual level, while we are entitled our human rights, we should also respect the human rights of others

Human Rights treaties

- First the Universal Declaration of Human Rights, 1948
- International Covenant on Civil and Political Rights: right to life, liberty and security; freedom of movement including choice of residence; freedom of thought, conscience and peaceful assembly, right to privacy etc
- International Covenant on Economic Social and Cultural Rights: right to food; right to standard of living; right to highest attainable standards of mental and physical health; right to education etc.
- International Convention on Elimination of All Forms of Racial Discrimination: to deal with discrimination especially racial discrimination but is not interpreted more widely.

Obligation of states

- Reporting obligation of the state:

- Upon ratification to a treaty, the State party takes upon itself the responsibility of implementing the rights guaranteed in the treaty.
- It also takes upon itself the obligation of reporting, how these rights are being implemented in the country and what steps the government has taken to implement these rights.
- the reporting system is an important tool for a State in assessing what has been achieved, and what more needs to be done, to promote and protect human rights in the country.

The next session on **'Values clarification'** , conducted by Dr Shilpa Shroff, brought about a very good discussion among the participants on moral, ethical dilemmas; reproductive rights; a scientific definition of life (beginning of life, and beginning of right), sex-selection; rape and abortion.

The participants were read out statements and asked to take a stand on whether they 'agree' or 'disagree' on that particular issue and justification of their stand.

The statements were:

- Women who have an abortion are selfish because they are not good mothers.
- A husband should have the right to divorce his wife if she had an abortion without his knowledge or consent.
- Poor women who are HIV positive should not have children because they will be a burden to the public.
- The baby should not be punished for the rape of the mother.
- Abortion is an action that shirks the consequences of unprotected sex.
- Reproductive rights include the choice to select the sex of the baby.

Day 2:

We started the day with Dr Shilpa Shroff sharing information about 'Maternal Mortality and unsafe abortion', and how providing safe abortion in the first and second trimester could reduce the maternal mortality rate.

She explained in brief the statistics of unwanted pregnancies .

Every minute, across the world 380 women become pregnant,
190 women face an unplanned and unwanted pregnancy,
40 women have an unsafe abortion and
One woman dies as a result of complications related to childbirth.

The only three options available to avoid an unwanted pregnancy is abstinence (which is not practical), Contraception (not easily accessible or available) and Abortion.

Through her various examples she showed how a woman is always dependant on someone else to make a decision regarding her own body and her own need. Can such a woman ever negotiate a condom use with her husband or have access to information and health care, access to safe abortion?

The abortion situation worldwide is a decade of uneven progress. When access is restricted either by laws or facilities, more women get it done in an unsafe way and put their lives at great risk. Even though women's advocates and international bodies have declared that women have the right to control their own bodies, sexuality and reproductive capacity, free of coercion (Beijing Platform for Action); and even though worldwide the trend is for legalization of abortion, still, in so many parts of the world, **women are denied access to safe services**.

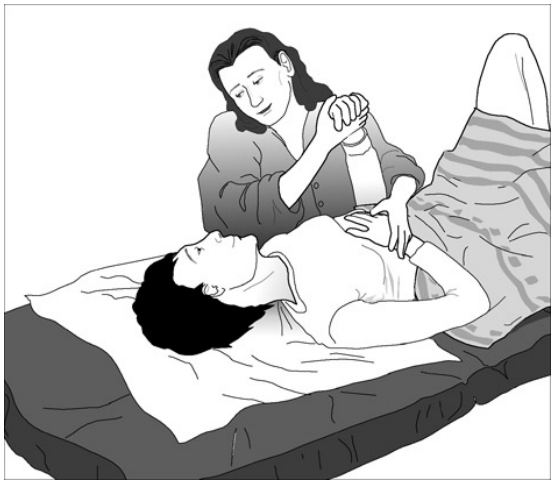
Access to safe abortion services is a problem in Asian countries even where it is legal. There is high fertility, an unmet need for contraception, poor public health service delivery systems, unregulated private sector, and potential for exploitation. To add to that the inequitable geographical distribution of services, economy, lack of trained persons, lack of infrastructure, lack of accountability and follow up, lack of drugs and supplies, stigma, safe abortion not seen as a right, clandestine, not seen as public health issue or social justice are other aspects of these problem.

Following that, Dr. Anjana Karki gave a "Technical Update on MA and MVA" and explained how midwives are trained in Nepal to do the MVA procedure, and continued her presentation with step by step procedure of Manual Vacuum Aspiration.. She also briefed the participants on Medical Abortion regimens and post abortion contraception.

Apart from the technicalities, some of the point she stressed was the **Non-Pharmacological Methods for Relieving Psychological Pain**

- Gentle, respectful interaction and communication
- Verbal support and reassurance
- Gentle, smooth operative technique

  Of course, all these can supplement but not replace medications



She also spoke of the need for post-abortion contraception, and talked about complete abortion care including pre-assessment of the patient, and post abortion care /counseling.

Some points to remember for FP counseling post abortion:

- Most women are eligible for all the methods –except natural methods
- Ovulation may return as early as 10 days post abortion
- Keep in mind the important contraindications
- Ideally the nurse/CAC provider should counsel about FP before and after the procedure
- Tailor the needs
- Same site should provide FP also

Dr Shilpa Shroff, ASAP spoke about the hotlines for Misoprostol information, which are being run by partners in Pakistan and Indonesia , and the participants were shown a short film about these.

Through her presentation she made it clear that these hotlines have been a successful initiative. They are a cost effective method and have the potential to be an effective communication strategy to meet the needs of women living in a country with restricted abortion access. They contribute to women's empowerment by giving the choice in their hands and are a promising way of "Decentralizing Medical Abortion".

We continued post-lunch with a discussion and sharing of the laws of each country, as presented by the participants from Pakistan, Bangladesh, India and Nepal.

All the participants were aware about the laws on safe abortionin their country. Ms Madhabi Bajracharya (Ipas) and Ms Sonali Regmi (CRR) summarized the pros and cons of the laws in each country and explained to the participants how we can interp ret the laws for betterment of access to safe abortions.

Trends in Bangladesh

- Due to the restrictive abortion law, there has been poor reporting of abortion statistics in Bangladesh; therefore the number of pregnancy terminations performed in Bangladesh, either through legal or traditional means, cannot be ascertained with certainty.
- Under reporting has been exacerbated by social and cultural reasons.
- Woman in Bangladesh have limited access to MR services and illegal and unsafe pregnancy terminations are widespread.
- In rural areas in particular, unhygienic and dangerous measures continue to be used under the umbrella of traditional methods and medicines.

Trends in India

- The lack of access to family planning services is a key factor in the need for abortions in India. Those women who are unable to obtain access to safe and effective contraceptives are more likely to face unplanned and unwanted pregnancies and seek out an unsafe abortion; necessarily, this predominantly affects low-income and younger women.
- Despite a mandate to provide abortion services, in most states fewer than 20% of primary health care centers do so. (W.H.O. Study)
- Prevalence of unsafe abortion: Each year, in India, around 20,000 women die from abortion related complications, majority being from unsafe abortions.

Trends in Pakistan

- A study in Pakistan found that about 890,000 induced abortions are performed annually in Pakistan.
- The abortion rate is found to be higher in provinces where contraceptive use is lower and where unwanted childbearing is higher.
- The cost of abortion varies on the type of provider, but generally cost between Rs. 1000 to Rs. 2000.
- Pakistan Demographic and Health Survey 2006-2007 shows that there are 197,000 women treated for any post-abortion related complication in all public facilities and teaching private hospitals.

- These figures however do not give the real picture as it excludes women who sought help elsewhere as well as women not admitting to having received abortions.

The participants were then made into four groups and were given 5 REAL-LIFE SCENARIOS and asked to imagine that

' *You are advisors to the President of an imaginary country who has recently indicated that she will be willing to consider some exceptions to the country's laws that ban abortion in all circumstances, even when the woman's life is in danger. She is asking you to consider these five scenarios and choose three out of the five scenarios (ranked one to three in importance) that you would recommend to be those exceptions.'* (Annexe 1: Details on the five scenarios)
From discussion that followed revealed that all the three groups had chosen the following three as there to priority (in the following order).

- 45year old women with seven children, with a very hard life in a rural area. Her husband drinks and beats her and does not contributes to her welfare, or her children's. She works for her living. After another recent demand for sex from her husband, she found out that she was pregnant she tried warm baths and herbs but nothing worked. She is now 18 weeks pregnant and needs an abortion or she will kill herself.
- A 20 year girl, who was the first person ever from her village and her community to be accepted at the Catholic university in the capital city, met another student named in the university and began dating. They used condoms most of the time but sometimes they were overcome with passion and did not. She just had a pregnancy test and thinks she is 12 weeks late and needs an abortion.
- A 36-year-old professional woman and her husband is keen to have their second child who is a boy. Eighteen weeks into the pregnancy, the doctors explained that her fetus is severely damaged and has Downs's syndrome. They do not feel that they can cope with a disabled child and want to terminate this pregnancy and try again for another baby that will meet their expectations and the reality of their lives.

All participants agreed with abortion for Shiela (Down 's syndrome Fetus); followed by woman Robert + Lucy (fetus with cleft palate), Patricia (multiple pregnancies) and Angela (young unmarried pregnancy).

This case of extra marital consensual sex resulting in pregnancy got just one vote (Pakistan) . It was not given a priority for abortion in the view that the women could negotiate with her husband and still raise the child or give away the child for adoption and continue to stay with her husband. But it was interesting to note that how our circumstances make us stand for a cause. The group who voted felt that for her one mistake of she should not be punished.

The other case which was not considered for abortion was the foetal anomaly which could be corrected by surgery after the child was born.

One more case that was debated was Angela (should she marry instead of choosing an abortion to pursue her career, especially if the boyfriend was very supportive). The people who voted for Angela still seemed to have a judgmental attitude towards the choice she was making.

When asked which is the one case that you would not provide an abortion to at all, it was interesting to note that the groups chose Angela's case (unwed young woman).
This exercise revealed to us the need to examine access to safe abortions in our context and put on the table the demand for access to safe abortion as women's right!!
We discussed about the action plan to be presented on Day 4 of the workshop. Participants were given a brief idea of making a poster to spread awareness on abortion, keeping the country context in mind.

The Objectives of the Action Plan:

- To increase the role of mid-level providers in Comprehensive Abortion Care in the service delivery system.
- Create support from other allied organizations for the issue of safe abortion for e.g work with Violence against women, other NGOs working on SRHR issues, HIV , human rights
- Information and awareness building on safe abortion access
- To include safe abortion in the training and curriculum for mid level providers

Some suggestions made were :

- Create coalition and allies to work on this issue and conduct meetings with key stake holders on the role of mid level providers in providing safe abortion services
- Preparations for training module for mid level providers
- Advocacy campaign for safe abortion access
- Dissemination meeting about this training with ObGyn Society in the country. Prepare a statement to share with the ObGyn Society.
- Support hotlines by dissemination of the information and also and consider starting hotline in the country
- Documentation for advocacy for e.g data collection on ration of doctors / population. How many providers per population and how many trained nursing staff per population/ unsafe abortion as the cause of deaths; young girls and access to abortion

Based on the Action Plan and the approval of the ASAP Steering Committee, we would be able to offer some funding.

After this the participants enjoyed a high tea and were also given information aboutASAP, with highlights of its achievements, and description of our website, and the newly introduced social media platforms. We also briefed them about the safe abortion campaign, and how they could be a part of it.

Dr Shilpa Shroff explained **"What is ASAP?"** and shared the **Goal** and the **Objectives** of the network.

Dr Shweta Krishnan, Communication and Networking Officer, ASAP, spoke about the International Campaign for Women's Right to Safe Abortion, and about the significance of the last week of September. She requested them to endorse the campaign and let us know if they are planning any activities during that time. Nepal already has many activities planned in September since they are celebrating the 10th Anniversary of decriminalizing abortion.

About 10 CAC trainers (midwives) from Ipas Nepal were present for the high tea along with Dr Deepa Shrestha (Ipas-Nepal). The participants had a good opportunity to discuss and learn from the experiences of nurse-midwives from Nepal.

Day 3

The day began with a visit to Thapathali hospital where the participants were given a practical overview of CAC.

Under Dr. Anjana Karki's expert guidance, some of the participants performed MVA on practice dummies. The participants were very impressed to see that the female reproductive organs were accurately modeled in the practice dummies. They believed that this would give them a a very good idea of what it would be like to perform CAC on a patient. After about an hour and a half of practice, participants went to see the operation theaters in two batches. They met with trained CAC providers, and learned that some of these nurses were now instructing medical students as well. They saw CAC being performed by a trained midwife, and then by a doctor, and observed that the nurse was just as proficient, if not more. After one of the procedures was completed, the CAC provider took the participants to the light box, where she observed the products of conception to make sure that gestational sac had been removed, and the abortion was complete. She showed the participants how to identify chorionic villi under a microscope.

Then Dr. Anjana Karki introduced the participants to the entire staff of the Thapathali hospital., In the afternoon, the participants visited a birthing center. These centers offer holistic but basic obstetric care, including antenatal checks, delivery, safe abortion care, and a 24-hour pharmacy offering family planning. In addition, these centers are visited by trained doctors twice a week to help in complicated cases.

The participants learned that these centers run without aid from International donors. Nurses established these centers using their own money. After they proved successful, the government stepped in to offer basic aid. The nurses working in these centers are highly empowered. Laxmi Tamang, the Director of the center just outside Katmandu,was one of the first to invest in this project. She is currently studying fora Ph D in Australia and was a great source of inspiration for all the participants.

Day 4

The participants were requested to re-cap all that they have learnt so far and then present a brief of the action plan that they plan to work on when back home.

The participants came up with action plans at multiple sectoral approaches, but we requested them to focus on the one element that can be achieved within 6 months and will add to the overall goal of reducing unsafe abortions and reducing MMR through access to safe abortion services.

Then we played a 45-mintue edited version of Bol, a Pakistani movie that captures the barriers posed by religious fundamentalism. Following this, the participants discussed the relevance of these problems in health care, and in the daily lives of women living in South Asia.

We then had a panel discussion on "Safe abortion in Nepal: the dramatic change from 10 years ago". The panelists were Dr Indira Basnett, Ipas Country director, Ms Kiran Bajracharya, President, Midwifery Society of Nepal and Ms Ishwori Shrestha, Chief Hospital Administrator in Nursing Service section , Ministry of Health and Population, Nepal.

Some of the points mentioned and discussed:

1. Initially, when Nepal was deciding on task shifting there was some opposition from the ObGyns. However, the question posed was that there was a need of 4500 doctors at the

PHC, CHC level and the ObGyns were unable to fill these posts, hence how could task shifting be opposed?

2. There was also some concern on the efficacy of nurses in providing CAC services at these centers.
3. Ipas initiated a pilot programme in only 3 districts of Nepal. The results showed that nurses and doctors – both trained – were equally efficient at providing CAC. Complications were a little less than 2% for both doctors and nurses. The finding from these was then used to persuade government to reform the laws and make policy level changes.
4. Nepal got the support from Health Ministry and an enabling policy was drafted which included protocols for training, referrals for complication etc.
5. They included mid-wives in the public sector and not as competitors for ObGyn providers, thereby removing the conflict.
6. The nurse-midwives work as a team with doctors and therefore face challenging situations together. This collaborated effort has improved the workplace environment considerably, and strengthened the relationship between doctors and nurses.
7. Initially there was an opposition from nurse-midwives as well, since as they saw this as an increase in their workload. But once they began their training and practice, they felt empowered in being able to provide services that were initially provided only by doctors.
8. Now they train medical students as well.
9. Recently Nepal is trying to provide medical abortion through ANMs particularly in health posts and sub-health posts which are the nearest point of access for rural women, and women who live in remote, hilly areas.
10. Patients also trust nurses, when they see them performing the procedure with confidence.

11. This empowerment has given nursing a much needed boost – more young women, especially from remote areas – are enrolling themselves in nursing schools. They seek to learn and go back to their villages, where they can provide care, improve access and reduce maternal mortality rates.
12. The number of nurses enrolling in Ph.D. Programmes has also increased.

After the panel discussion we had a valedictory session where Dr Indira Basnett distributed the certificates to the participants of the study tour.

The participants also filled out feedback forms and the post-evaluation form. The pre and post evaluation were discussed with the participants on request. (Please see Annex for the analysis of the feedback form and the evaluation .)

At the end of the day Dr Shweta Krishnan gave the vote of thanks.

Day 5

The last day was marked by a short visit to a district hospital in the Bhaktapur district of Nepal. The participants divided themselves into two batches to watch a trained CAC provider provide pre-abortion counselling.

Nepal provides its nurses with a booklet they can use during these counselling sessions. These booklets have detailed explanations of the pros and cons of MVA and Medical Abortion in both writing and in pictures. After the nurse has explained the procedures, patients are given ten minutes to think over the two options in private.

That day, both patients chose medical abortion. While one patient took the first tablet in the hospital under the care of the nurse, the other patient took it home. Both of them left their address and phone numbers with the nurses, and also took the nurses number. They were asked to call if they experienced severe bleeding.

The participants then met the entire staff of the Bhaktapur hospital, and shared notes about the laws and policies in each of their countries. Ipas then took them for lunch, and for a tour of the ancient and historic city of Bhaktapur

Concluding Remarks:

The workshop helped the mid-wives to learn about the potentials of task shifting to midlevel providers in expanding access to safe abortion services. It helped the participants to learn from the shared experiences to strategize for mobilizing their government and the communities to increase access to abortion.

In circumstances where the law permits termination of pregnancy, access to safe induced abortion may still be restricted by the limited availability of trained health-care providers. Nepal is an excellent example to learn that trained nurses, midwives and mid-level health-care providers can be effectively used as an alternative to increase access to safe first trimester abortion and conserve scarce health resources. These mid-level providers have proved to be cost-effective and are ready to work in areas where doctors are scarce making it possible to provide abortion services to underserved women.

In the training, participants had begun to talk about the need for access to abortion in the broad context of women's lives. The values clarification showed that the need for abortion and the right to decide about continuing a pregnancy, implicates a range of other fundamental rights. Through this training it was clear that unsafe abortion not only remains a major public health issue, but it should be addressed in as a matter of reproductive rights. The abortion advocacy is a multilayered complex process which involves advocating from the sphere of human rights, women's health, health care, legislators and policy makers. It is also the most easily preventable cause of maternal mortality if we are able to advocate for the provision of midlevel providers to provide safe abortion services and care.

Understanding the country situation and planning of a suitable action plan with country context, will help advocate for the safer, quality and timely abortion services to the women. It is essential that we use newer tools and think of strategies to shift the abortion services from providers' domain to the mid-level providers' and to women's hands.

Annexe 1

Mid-Level Providers Exchange Study Tour Programme
Conducted by Asia Safe Abortion Partnership in collaboration with Ipas –Nepal
Venue: Kathmandu, Nepal
26-30 August 2012

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Annexe 2

SCENARIO 1: ANGELA

Angela is 20 years of age and was the first person ever from her village to be accepted at the Catholic university in the capital city. Her family, friends and neighbors were really excited by her achievement and had high hopes that her success will be the beginning of real change in the community. A couple of months after starting university, Angela met another student named Jeff and, after they found they had much in common, they began dating. Soon afterwards, they started to have sex. They used condoms most of the time but sometimes they were overcome with passion and did not. Angela has just had a pregnancy test and thinks she is 12 weeks late. She needs you to approve her for an abortion.

SCENARIO 2: ESTHER

Esther has been married to her husband for 15 years. By all accounts she loves him but perhaps now more like a friend and less like a lover. But she does appreciate how great a father he is to their two daughters. On a recent business trip, Esther met a coworker in a bar after a long day. One thing led to another and she had sex with him. She was shocked when she started to miss her periods but ignored it, thinking perhaps she was unwell. But her doctor has now confirmed that she is eight weeks pregnant. Her husband will know that this pregnancy is not his and her marriage and family life will be ruined. She asks that you please give her an abortion.

SCENARIO 3: SHEILA

Sheila is a 36-year-old professional woman and was delighted when she heard that her second child would be a boy. Her husband Allan has dreamed of having a son—even from the early years when they dated. Eighteen weeks into the pregnancy, the doctors explained that her fetus is severely damaged and has Downs syndrome. Allan and Sheila just do not feel that they can cope with a disabled child. They both want to terminate this pregnancy and try again for another baby that will meet their expectations and the reality of their lives. They ask that you please give permission for this abortion.

SCENARIO 4: PATRICIA

Patricia had a very hard life in a rural area. She came to the city with hopes of a better life more than 20 years ago. Now she is 45 with seven children and has a life that most days she feels is not worth living. Her husband William drinks and beats her. He contributes nothing to her welfare, or her children's. She gets by though, taking in laundry from rich people in the suburbs. After another recent demand for sex from her husband she thought she might be pregnant but ignored it. When she found out that she was pregnant she tried warm baths and herbs but nothing worked. She is now 18 weeks pregnant and has made up her mind that she needs an abortion or she will kill herself. A local nurse told her that if she changes her mind and continues the pregnancy a local prolife group will help her with baby clothes and support—and may even be able to arrange an adoption. Patricia is not convinced; she does not want to continue with the pregnancy, and doesn't think she can afford to do so. She asks that you give her this abortion.

SCENARIO 5: ROBERT & LUCY

Robert and Lucy have four children and were perfectly content with their lives. A romantic winter holiday produced a surprise result when Lucy found herself pregnant. Lucy, who is 46 this year, presumed that her baby days were over. At first, she accepted her fate but after 18 weeks the doctors told her that the baby would have a serious cleft palate problem and she decided that she wants to terminate this pregnancy. Her husband feels that perhaps some operations could correct the problem but accepts it is Lucy's decision. Lucy does not feel she has the energy to go through what might be years of operations to correct this condition. She also has fears about what might be the psychological impact on a small baby of having so many operations that probably will never produce a perfect result. Lucy asks you to please give her an abortion as she does not want this baby.

Annexe 3

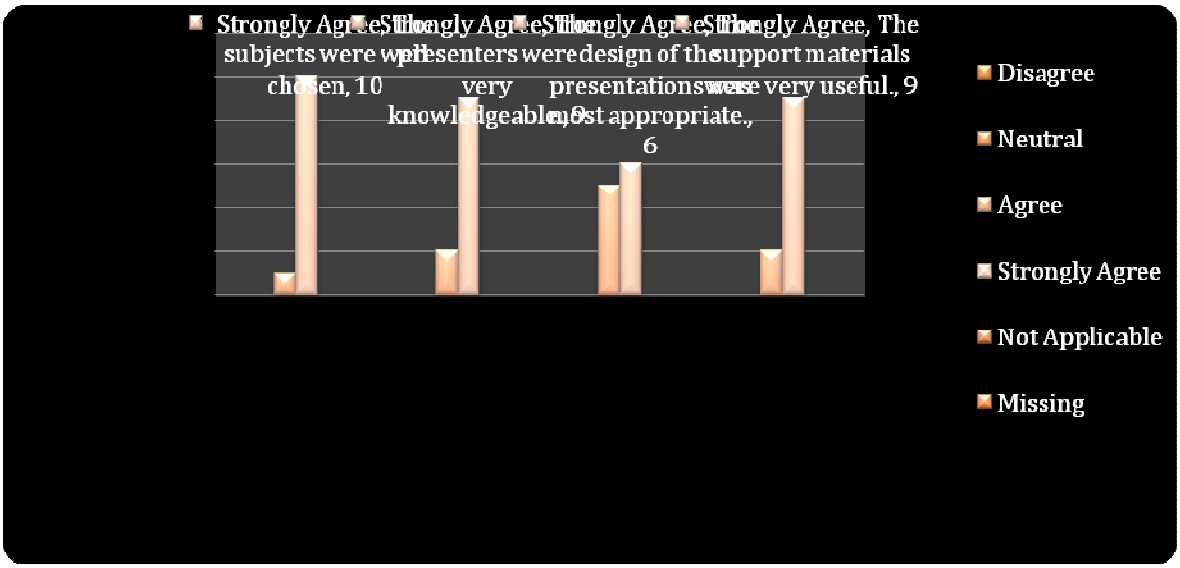
Analysis of the Feedback forms

The feedback forms were gathered from the 11 participants on the last day of the Kathmandu workshop.

The feedback forms received were further analysed to get results of the findings.
The questions asked and responses on the **workshop topics and discussions** were

- All of the participants agreed that the subjects were well chosen. Most (9 out of 11) strongly agreed that the presenters were knowledgeable. Most of the participant agreed that the design of the presentations was appropriate and the supporting material was useful.

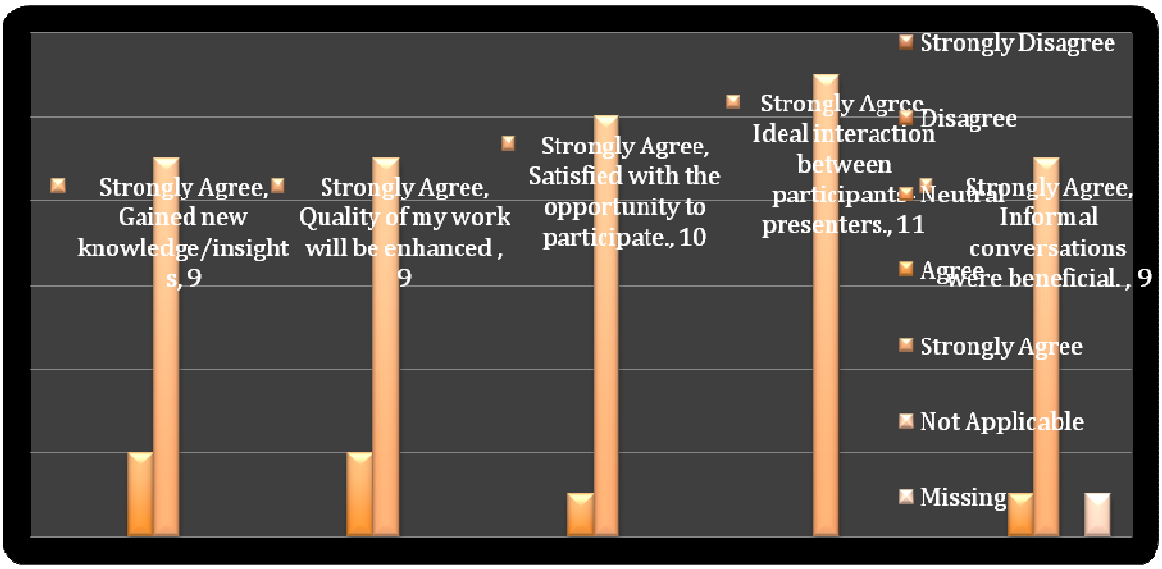
- **Chart 1: Workshop Topics and Discussions**



Questions asked in the context of the **personal value in relation to the worksho**p and the responses on the same were –

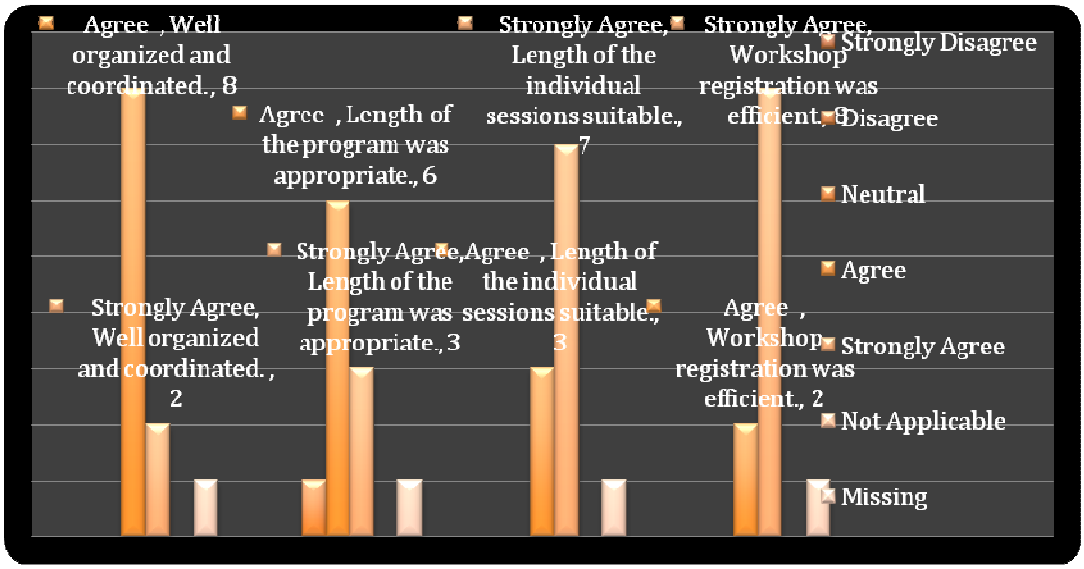
Almost all agreed that they had gained new knowledge and insights and that the quality of their work will be enhanced as a result of participating in the workshop. All of them were satisfied with the opportunity to participate in the workshop and all of them strongly agreed that the interactions between participants and presenters were ideal. All of them agreed that the conversations with other participants were beneficial.

Chart 2: Personal values



Questions asked on **workshops organization and coordination** were responded to as follows:
Most of the participants agreed that the program was well organized and coordinated. (One did not answer this question) and that the length of the program was appropriate (8(73 %) strongly agreed 2 (18 %) agreed and one did not answer this question). Most of the participants agreed that the length of the individual sessions was suitable but 1 stayed neutral and one person had did not responded. Most felt that the workshop registration was efficient, one stayed neutral; one did not answer this question. Except for one all felt that the pre-workshop information was helpful

- **Chart 3: Workshop organization and coordination**



The topics that were found most valuable to the participants were:

- Human rights , MA , MVA, Gender and sex and MMR
- Basic Human Rights and women's empowerment
- MVA – new techniques
- MVA and Values clarification
- Real life scenarios and visit to maternity hospital and seeing mid-level providers in action

The topics that were found least valuable to the participants:

While most of the participants felt that all the topics were relevant and useful, one of them felt that session on gender and sex was least valuable.

In the future sessions of this workshop, they would like to have these areas covered:

- Clinical sessions related to MVA and assessment of gestational age and confirmation of that.
- Documentation, referral and a visit to remote clinical area
- Hands on skills in laboratory
- Expand duration of days of workshop
- Counselling techniques
- Rest of the country profiles in service delivery system for reproductive health
- Social aspect of various culture will add value to better understanding.

Suggestions made to improve the future workshop were:

- Documentation, referral and a visit to remote clinical area
- Involvement of participants from other Asian countries to broaden the level of interaction and sharing
- Exchange program should move beyond Asian countries
- We may divide 15 counties into 3-4 groups and representatives can meet in some time. This will not only help in networking but may be getting a placement of workforce in other country with successful implementation of program of safe abortion care.

Concluding remarks:

Most of them found that the workshop was valuable in terms of content and training. The sessions on HR, MVA, MA, Values clarification, real scenario case studies and the field visits were well appreciated. Some of them felt that more countries and participants should be included for more experience sharing and to make the sessions more interactive.

Some of important suggestions for the future workshop were to include the topics on:

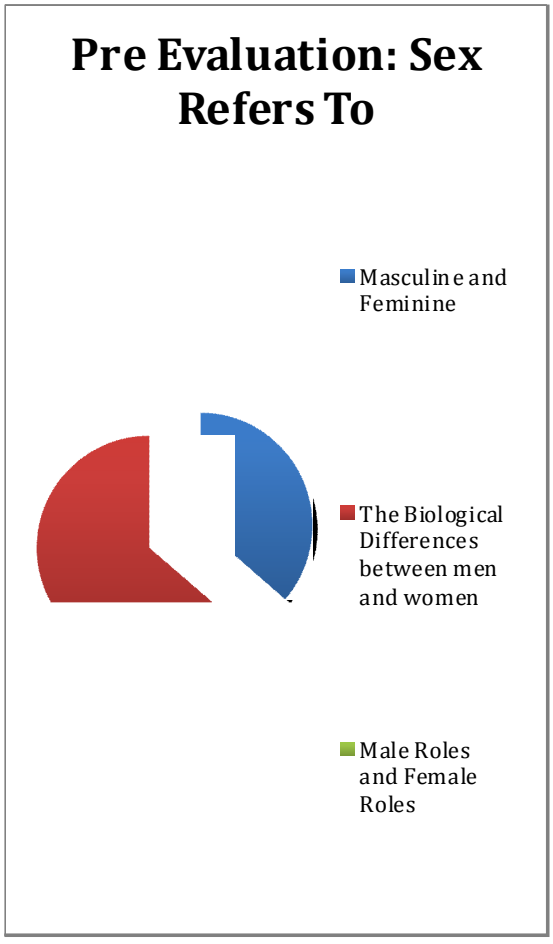
- Documentation, referral and a visit to remote clinical area
- Involvement of participants from other Asian countries to broaden the level of interaction and sharing
- Hands on skills in the laboratory

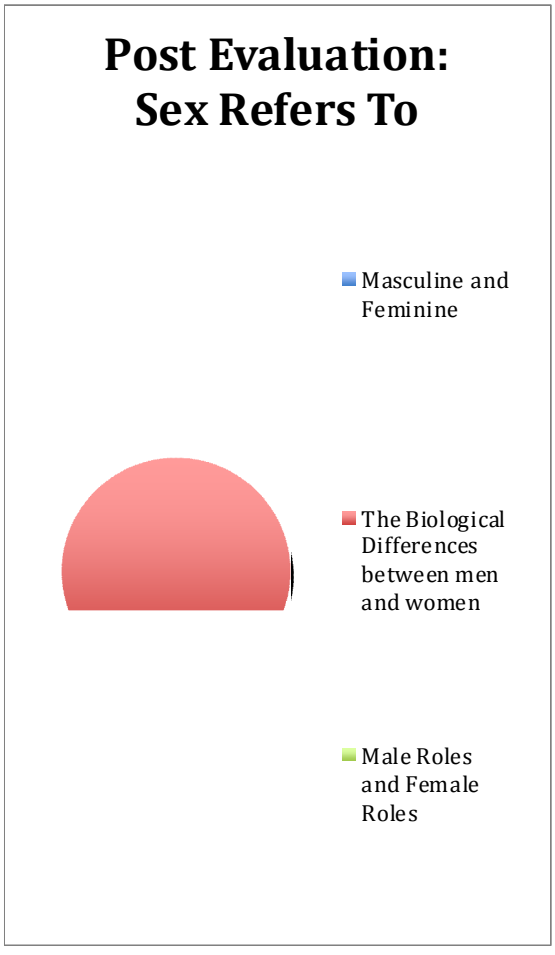
Annexe 4

Mid-Level Providers Exchange Tour Programme – ASAP
Nepal, Aug 26-30, 2012

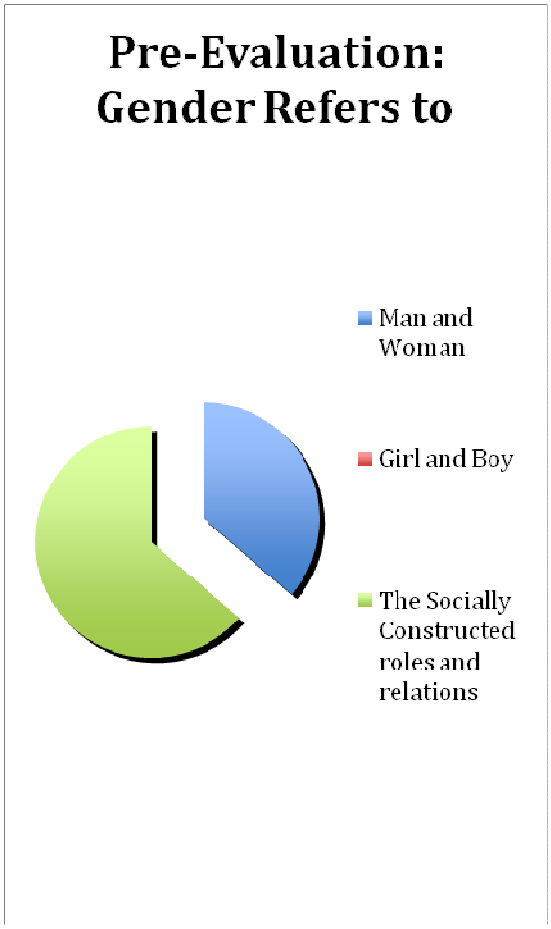
Assessment of the Pre- Evaluation and Post Evaluation Forms

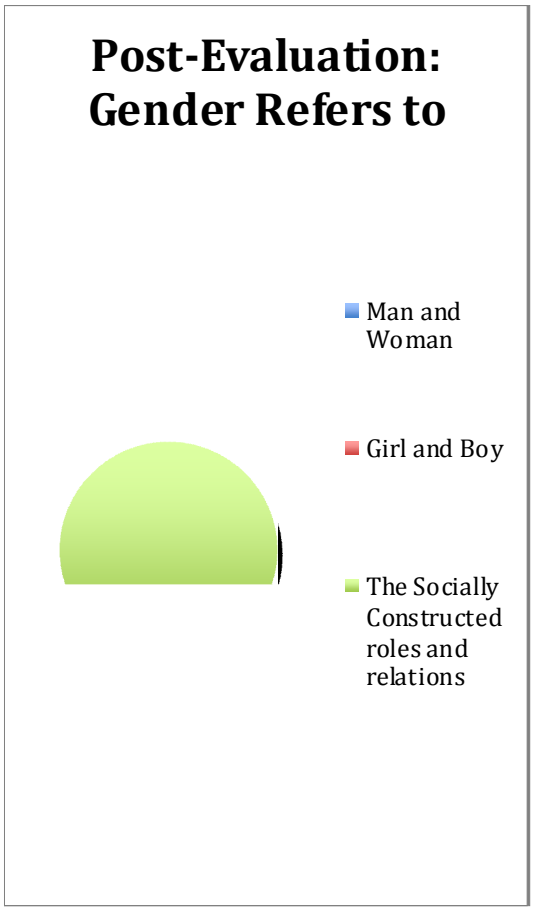
	Pre-Evaluation Answers			**Post Evaluation Answers**		
Sex refers to	Masculine and Feminine	Biological Differences between men and women	Male and Female Roles	Masculine and Feminine	Biological Differences between men and women	Male and Female Roles
	4	**7**	0	0	**11**	0



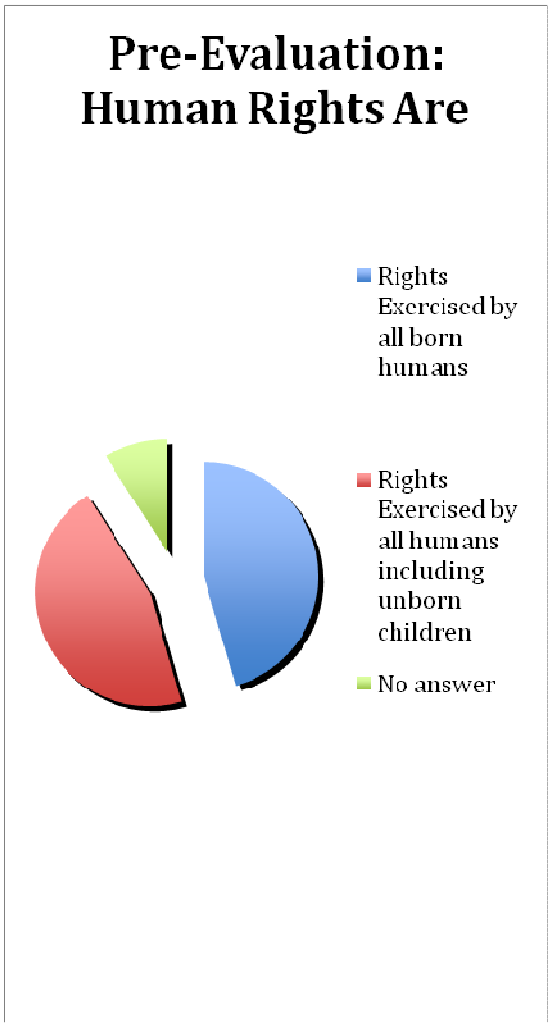


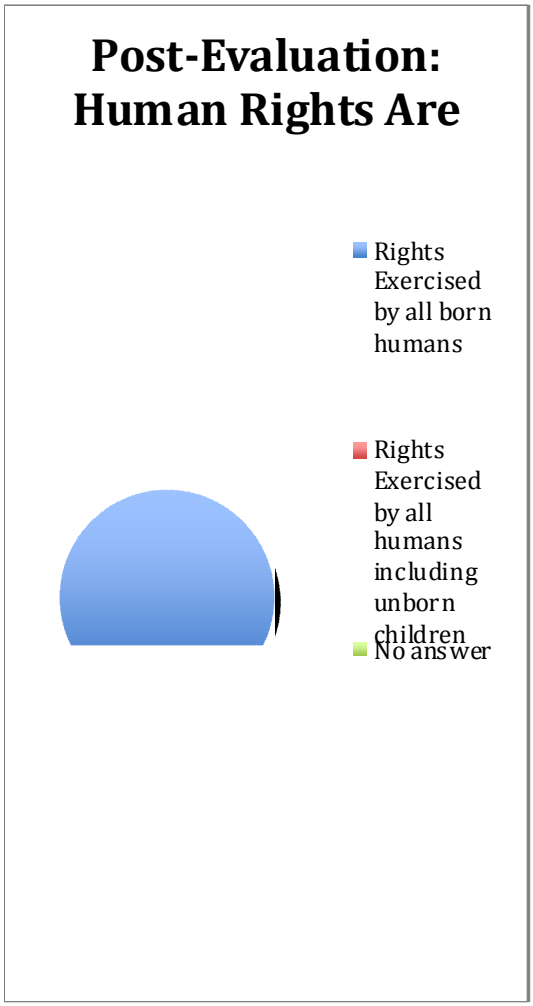
	Pre-Evaluation Answers			Post Evaluation Answers		
Gender Refers to	Man and Woman	Girl and Boy	Socially Constructed roles and relations	Man and Woman	Girl and Boy	Socially Constructed roles and relations
	4	0	**7**	0	0	**11**





	Pre-Evaluation Answers			Post Evaluation Answers		
Human Right are	Rights exercised by all born humans	Rights exercised by all including unborn	No Answer	Rights exercised by all born humans	Rights exercised by all including unborn	No Answer
	5	5	1	**11**	0	0



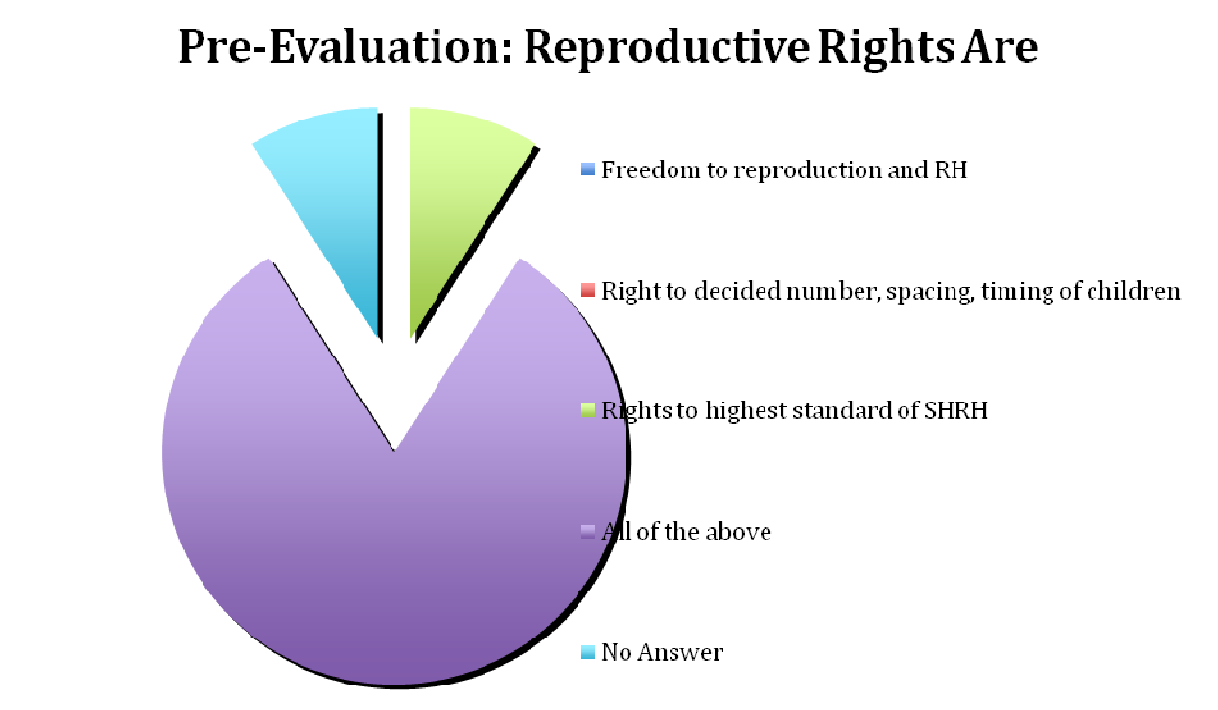


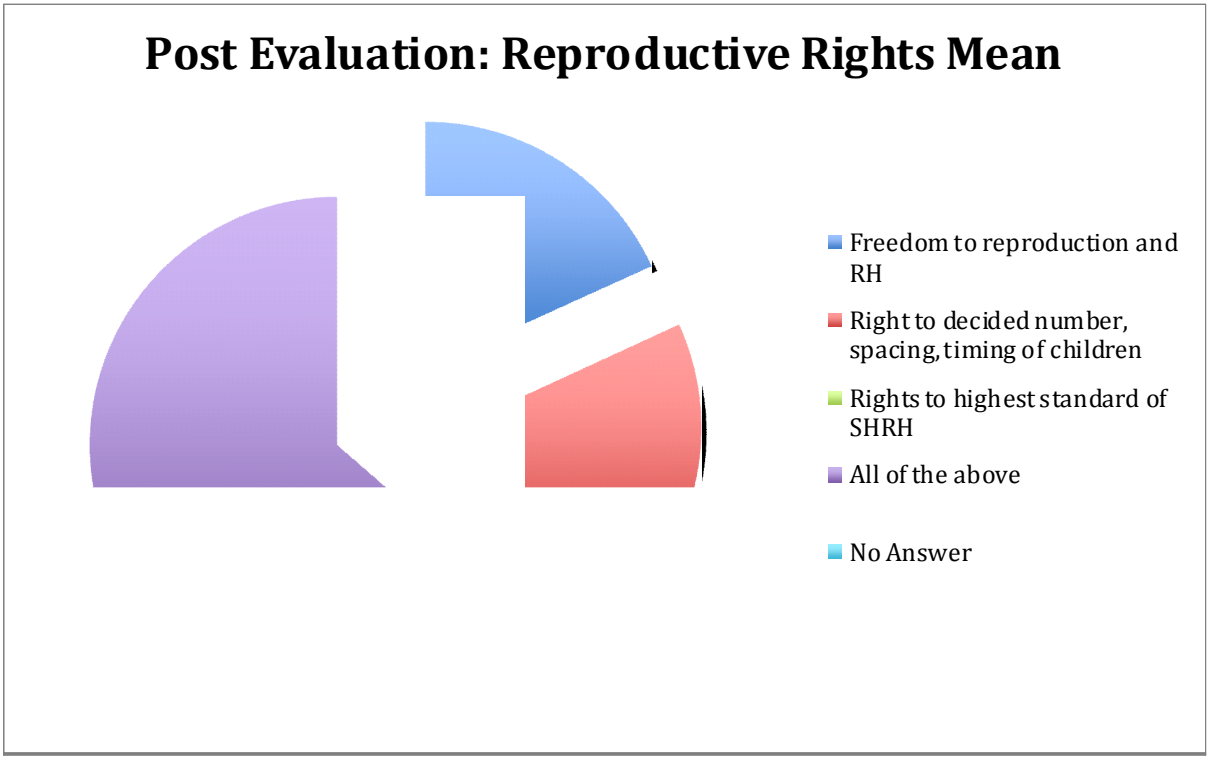
	Pre-Evaluation Answers			Post Evaluation Answers		
MDG stands for	Maternal Development Goals	Maternal Diseases Goals	Millennium Development Goals	Maternal Development Goals	Maternal Diseases Goals	Millennium Development Goals
	0	0	**11**	1	0	**10**

	Pre-Evaluation Answers				
Reproductive Rights Mean	Freedom to reproduction And RH	Right to decided number, spacing, timing of	Rights to highest standard of SHRH	All of the above	No Answer

		children			
	0	0	1	**9**	1

	Post-Evaluation Answers				
Reproductive Rights Mean	Freedom to reproduction And RH	Right to decided number, spacing, timing of children	Rights to highest standard of SHRH	All of the above	No Answer
	2	2	0	**7**	0

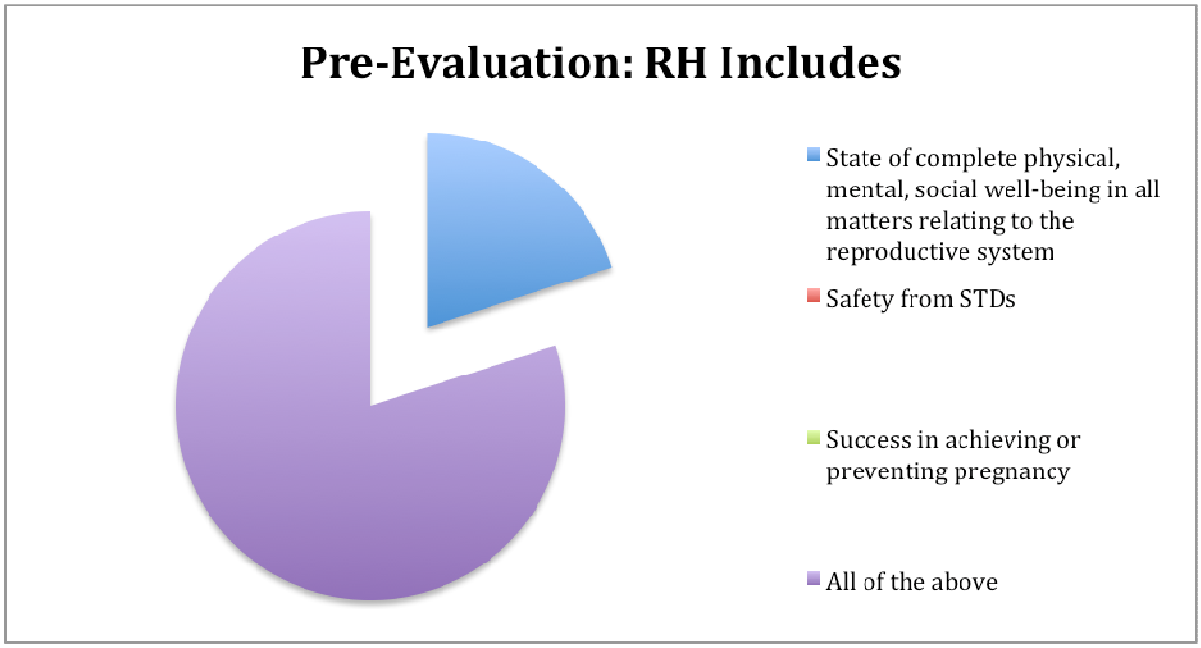


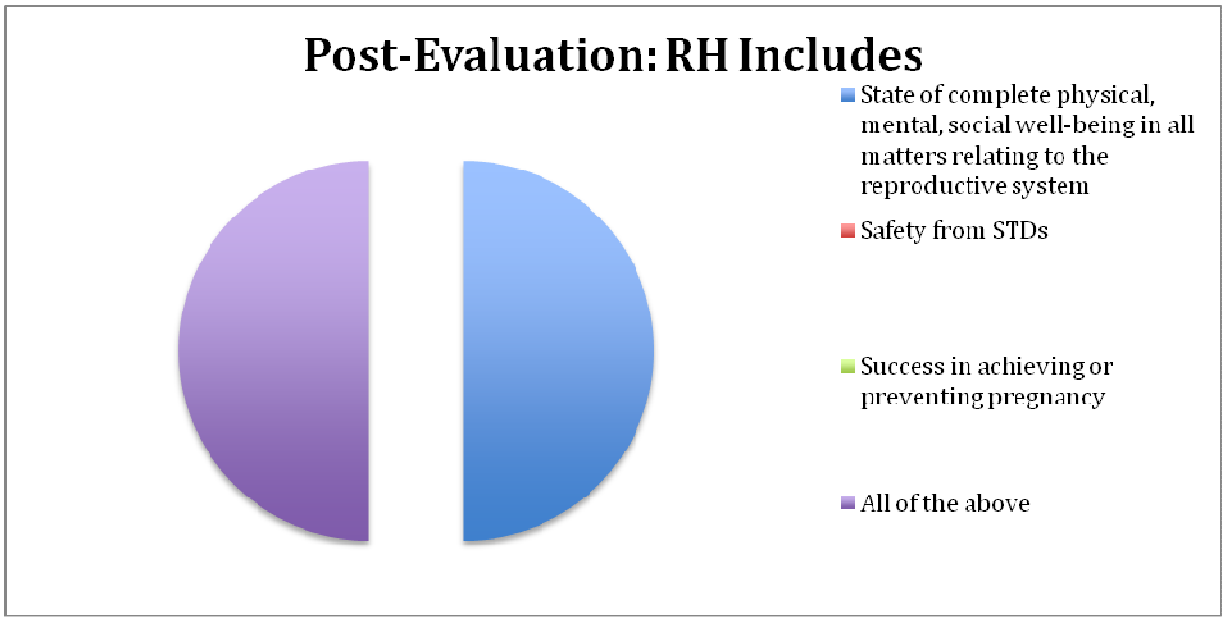


	Pre-Evaluation Answers			
RH includes	State of complete physical, mental, social well-being in all matters relating to the reproductive system	Safety from STDs	Success In Achieving or Preventing Pregnancy	All of the Above
	2	0	0	**8**

	Post-Evaluation Answers			
RH includes	State of complete physical, mental, social well-being in all matters relating to the reproductive system	Safety from STDs	Success In Achieving or Preventing Pregnancy	All of the Above

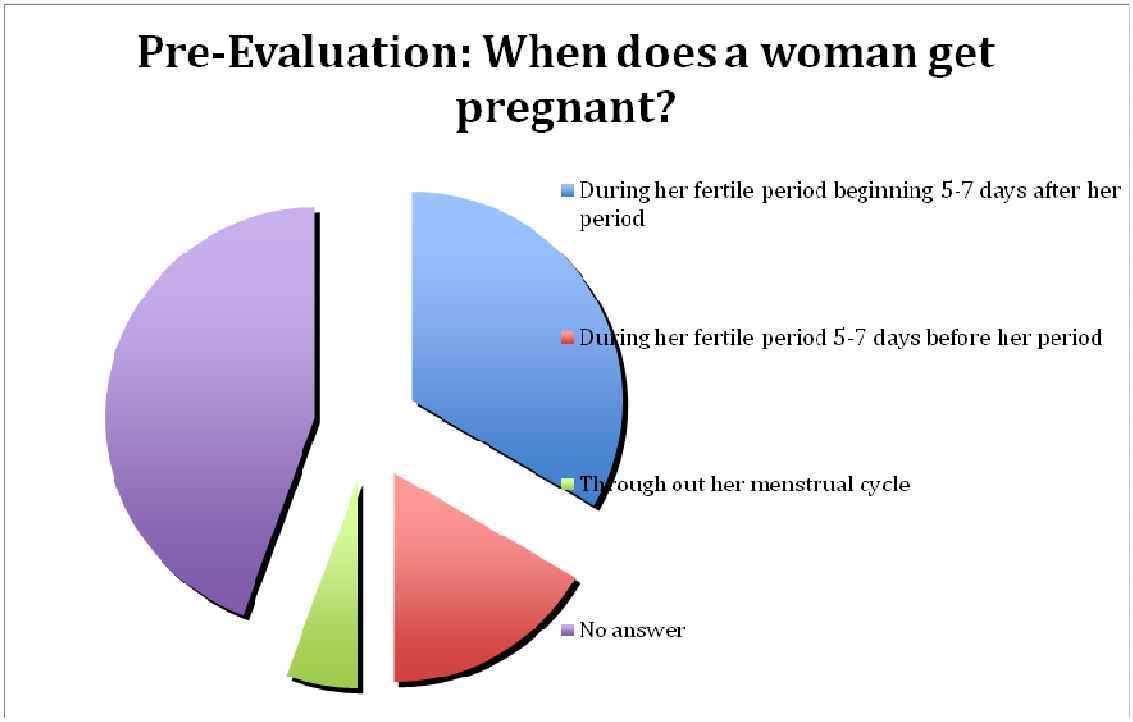
	5	0	0	**5**

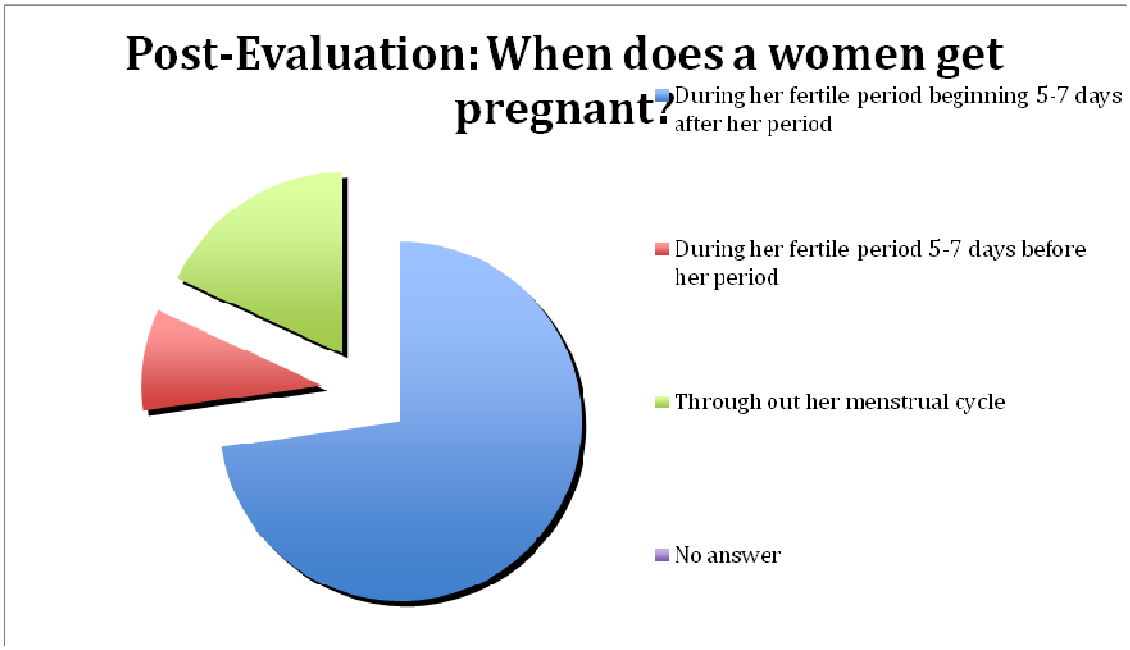

Pre-Evaluation: RH Includes
State of complete physical, mental, social well-being in all matters relating to the reproductive system
Safety from STDs
Success in achieving or preventing pregnancy
All of the above


Post-Evaluation: RH Includes
State of complete physical, mental, social well-being in all matters relating to the reproductive system
Safety from STDs
Success in achieving or preventing pregnancy
All of the above

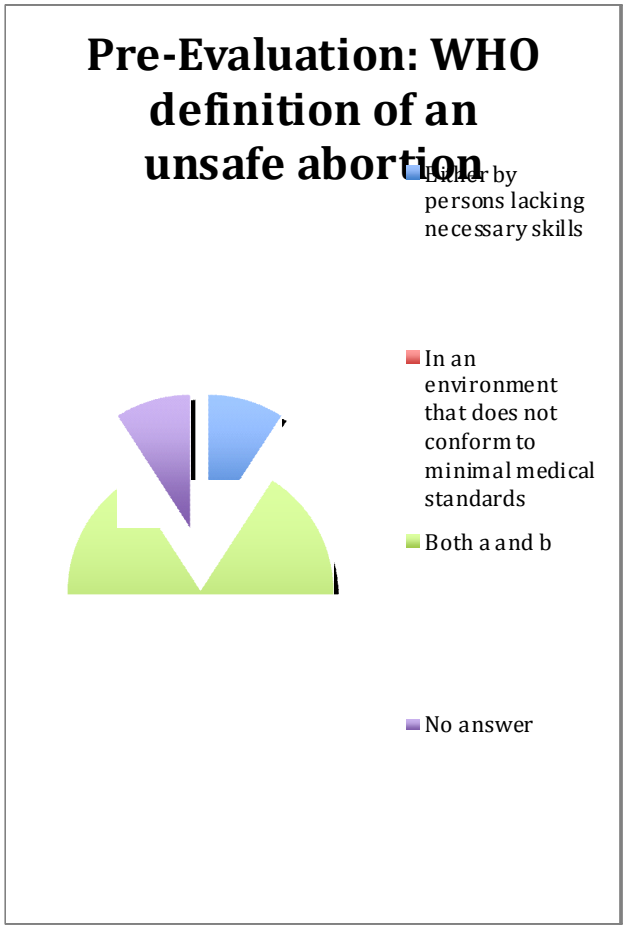
	Pre-Evaluation Answers			
When can a woman get pregnant	During her fertile period beginning 5-7 days after her period	During her fertile period 5-7 days before her period	Through out her menstrual cycle	No answer
	6	**3**	1	1

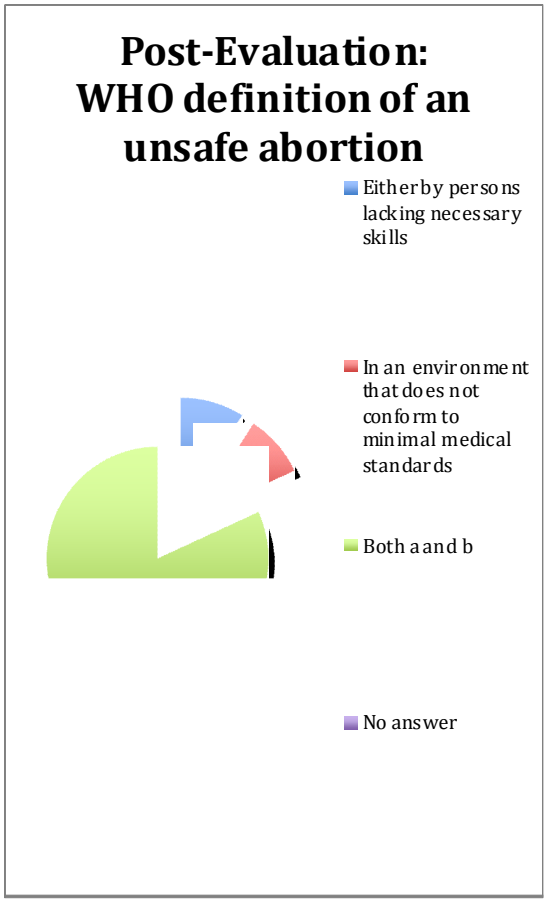
	Post-Evaluation Answers			
When can a woman get pregnant	During her fertile period beginning 5-7 days after her period	During her fertile period 5-7 days before her period	Through out her menstrual cycle	No answer
	8	**1**	2	0



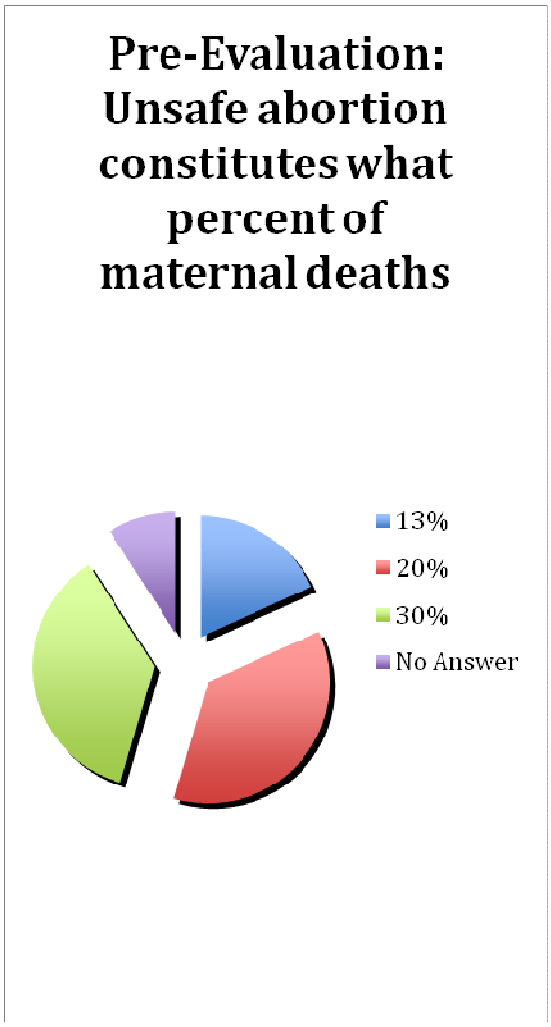


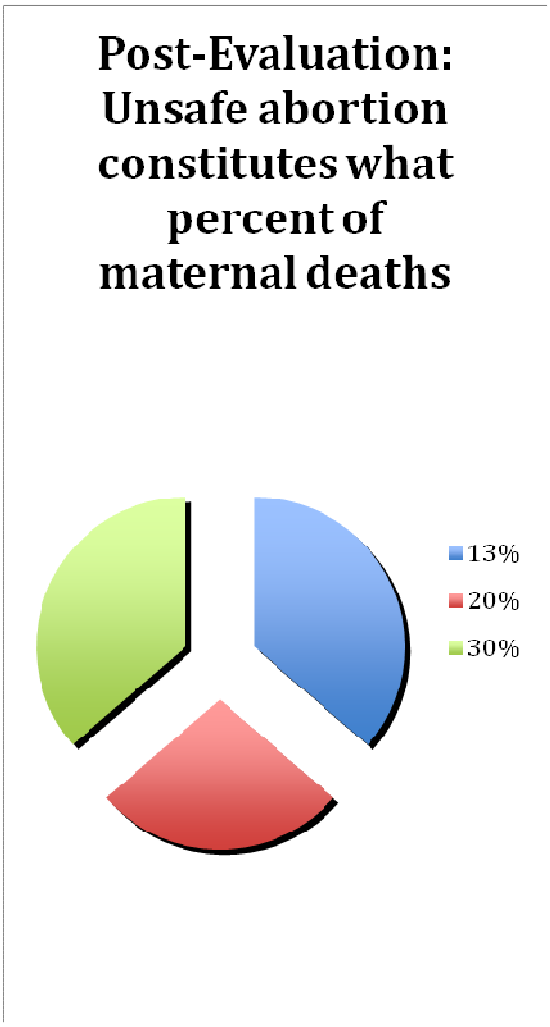
	Pre-Evaluation Answers			
Unsafe abortion is defined by the WHO as a	Either by persons lacking necessary skills	In an environment that does not conform to minimal medical standards	Both a and b	No answer
	1	0	**9**	1
	Pre-Evaluation Answers			
Unsafe abortion is defined by the WHO as a	Either by persons lacking necessary skills	In an environment that does not conform to minimal medical standards	Both a and b	No answer
	1	1	**9**	0



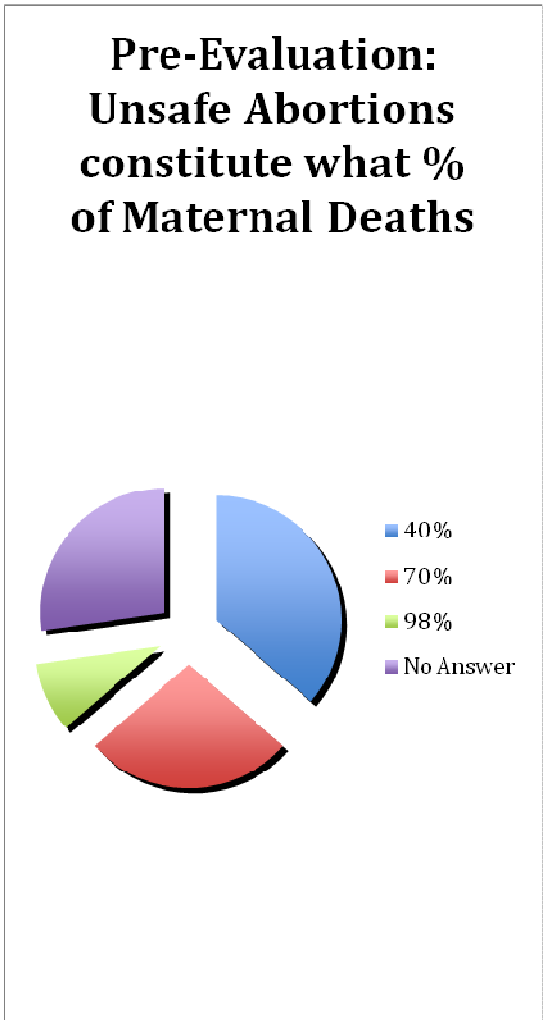


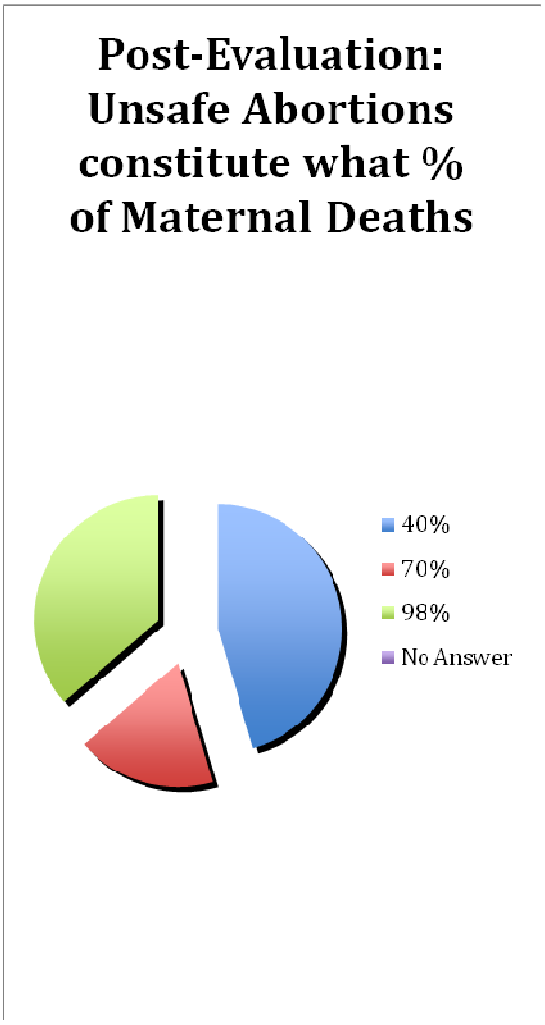
	Pre-Evaluation Answers				Post Evaluation Answers		
Unsafe Abortions constitute what % of Maternal Deaths	13	20	30	No Answer	13	20	30
	2	4	4	1	**4**	3	4





	Pre-Evaluation Answers				Post Evaluation Answers		
Unsafe Abortions constitute what % of Maternal Deaths	40	70	98	No Answer	40	70	98
	4	3	**1**	3	5	2	**4**



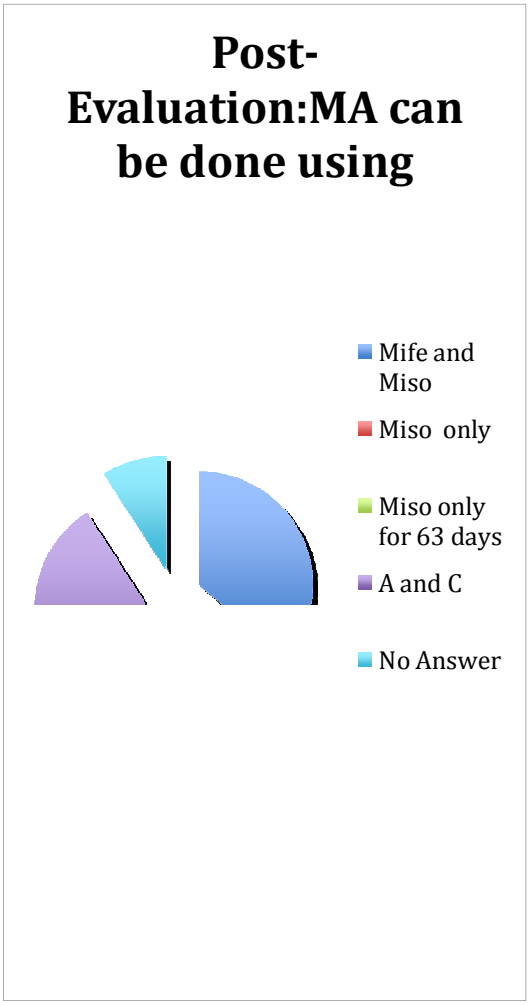


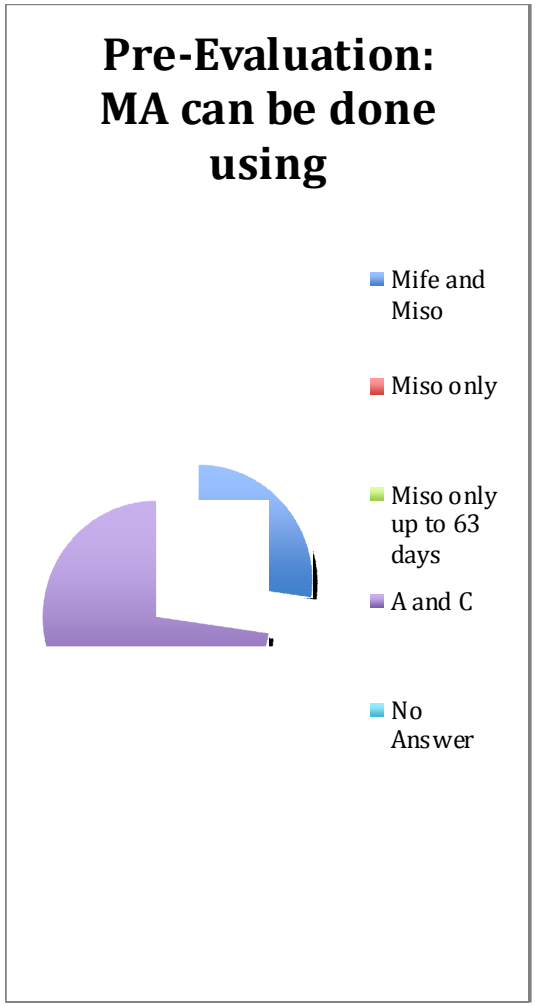
	Pre-Evaluation Answers						Post Evaluation Answers				
Please tick safe and recommended methods of abortions	MVA/ EVA	D&C D&E	M MA	A and C	All	No Answer	MV A/E VA	D&C D&E	M MA	A and C	No Answer
	3	0	0	**5**	2	1	2	0	0	**7**	2

	Pre-Evaluation Answers			Post Evaluation Answers		
Women may start hormonal contraception at the time of surgical abortion, or as early as the time of administration of	True	False	No Answer	True	False	No Answer

the first pill of a medical abortion regimen						
	4	6	1	7	4	0

	Pre-Evaluation Answers				
MA can be done using	Mife and Miso	Only Miso	Only Miso up to 63 days	A and C	No Answer
	4	0	1	**5**	1
	Pre-Evaluation Answers				
MA can be done using	Mife and Miso	Only Miso	Only Miso up to 63 days	A and C	No Answer
	3	0	0	**8**	0





	Pre-Evaluation Answers				Post Evaluation Answers			
Folowing MA when can an IUD be inserted	When the abortion is complete	Day 14	After the next menstrual cycle	No Answer	When the abortion is complete	Day 14	After the next menstrual cycle	No Answer
	9	0	2	0	**11**	0	0	0

	Pre-Evaluation Answers				Post Evaluation Answers		
After MA a woman should	Heavy cramps	Lot of bleeding	Nausea	No Answer	Heavy cramps	Lot of bleeding	Nausea

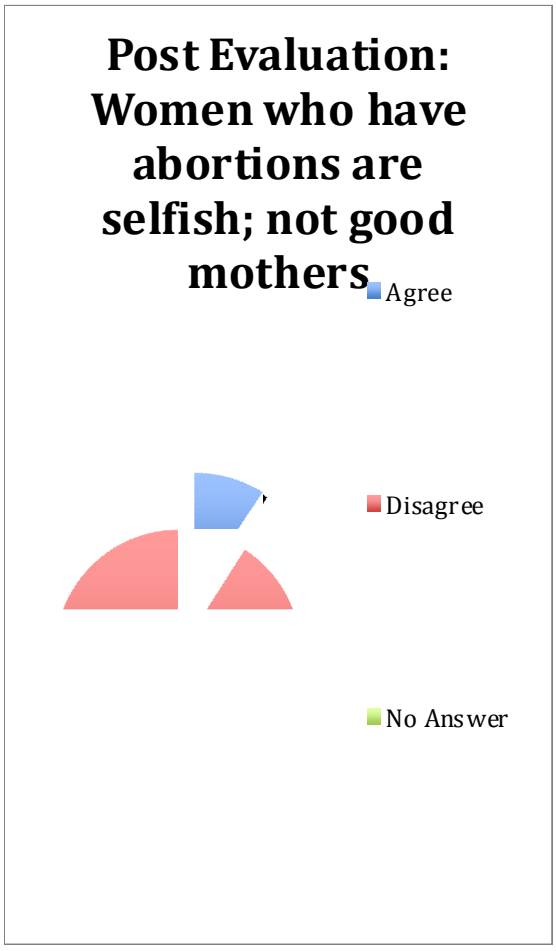
go to the hospital as soon as possible is she has							
	0	**10**	0	1	0	**11**	0

	Pre-Evaluation Answers				**Post Evaluation Answers**		
If the Woman does not bleed after MA the reason is	Too late in her pregnancy	Ectopic	Twin pregnancy	No Answer	Too late in her pregnancy	Ectopic	Twin Pregnancy
	6	**4**	0	1	0	**11**	0

	Pre-Evaluation Answers				**Post Evaluation Answers**		
After an abortion a woman can get pregnant again	Immediately	Within a week of the abortion	After her next menstrual cycle	No Answer	Immediately	Within a week of the abortion	After her next menstrual cycle
	2	2	**6**	1	3	6	**2**

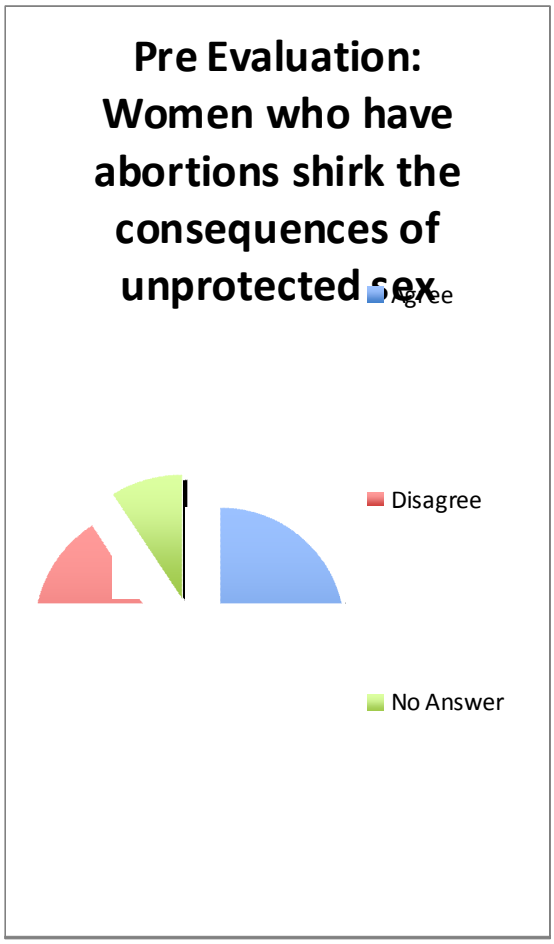
	Pre-Evaluation Answers			**Post Evaluation Answers**		
Women who have abortion are selfish because they are not good mothers	Agree	Disagree	No Answer	Agree	Disagree	No Answer

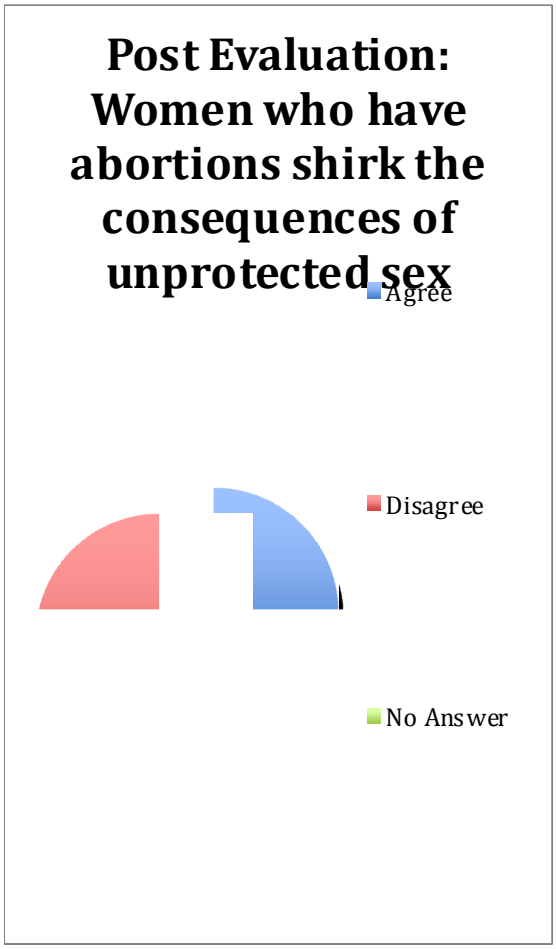
	0	10	1	1	10	0



	Pre-Evaluation Answers			**Post Evaluation Answers**		
Abortions shirks the consequences of unprotected sex	Agree	Disagree	No Answer	Agree	Disagree	No Answer

	6	4	1	4	7	0





	Pre-Evaluation Answers			Post Evaluation Answers		
Baby should not be punished for the rape	Agree	Disagree	No Answer	Agree	Disagree	No Answer

of the mother						
	7	3	1	5	6	0