YOUTH ACT FOR SAFE ABORTION

A training guide for future health professionals

Ipas
Health. Access. Rights.

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Ipas is a nonprofit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraception and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

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YOUTH **ACT** FOR SAFE ABORTION:

A training guide for future health professionals

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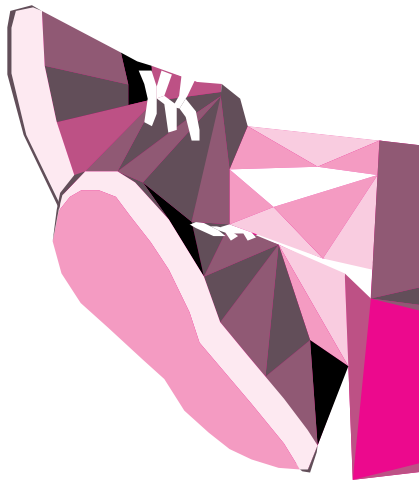

INTRODUCTION
to the guide

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About the guide

OVERVIEW AND WELCOME

Youth act for safe abortion: A training guide for future health professionals was developed jointly by Ipas and the International Federation of Medical Students' Associations (IFMSA). Ipas is a global nongovernmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. IFMSA is a global nongovernmental organization led by medical students committed to uniting, supporting and building capacity among its members in order to positively impact global health issues. We originally developed this guide as a resource for medical students who want to learn about and engage in abortion issues, and we have now expanded the focus of the guide to all future health professionals—including students in nursing, midwifery, pharmacology, public health and other related fields. If this is your first time learning about abortion, an extra warm welcome! Abortion is a critical but often neglected area of women's rights, women's health, and health science education. We hope that you will find the information in the guide valuable. The guide also provides experienced facilitators with the resources, tools and guidance necessary to effectively facilitate workshops on abortion. If you cannot facilitate workshops yourself, try to identify someone through your school or students' association who can. Through the workshops, participants will gain knowledge and skills to take action for safe abortion.

AREAS OF FOCUS

To adequately prepare future health professionals to take action for safe abortion, the guide addresses abortion comprehensively and through human rights, legal and public health frameworks. It covers topics such as sexual and reproductive rights; gender and abortion; national abortion laws and policies; barriers to safe abortion services and strategies to overcome those barriers; and woman-centered comprehensive abortion care (CAC). It also provides information about strategies to increase access to safe abortion through advocacy, peer education and abortion accompaniment.

The module on CAC provides an overview of clinical information; however, **it is not intended to prepare students for abortion**

service delivery. Students interested in developing clinical skills are encouraged to contact Ipas for information about national-level, pre-service training programs. Medical Students for Choice offers another avenue for medical students to gain access to clinical training on abortion at www.msfc.org.

STRUCTURE

The guide consists of five learning modules, a glossary and references. Modules 1–4 build knowledge on abortion, while Module 5 builds skills in advocacy, peer education and accompaniment. Each module begins by identifying module-specific *learning objectives, core resources and supplementary resources*. Web links are provided for all the listed resources. The module narrative provides evidence-based information about the module's topics. It is followed by a handout for participants and activities with tools and detailed instructions for facilitators. The activities are designed to meet the module's learning objectives and effectively build knowledge and skills. Each module ends with a recommended activity on values clarification for abortion attitude transformation, chosen for its relevance to that module. Presentation slides accompany each of the modules to aid facilitators' preparation and implementation of training workshops. All printable materials and presentations are available on the USB accompanying this guide and at www.ipas.org/youthact.

LANGUAGE AND TERMINOLOGY

In the guide, we use the term 'woman' to refer to a person who is biologically female and of reproductive age. We affirm that some people who seek abortion do not identify as women. Their needs and preferences should be understood, respected and met. Programs, services and resources related to abortion should use language that is inclusive and challenges harmful gender stereotypes. When evidence applies to a specific age group, or special considerations or guidance exists, we also use the terms 'adolescent' or 'young woman.' Adolescents are people aged 10–19 years old. Young people are those aged 10–24 years old.

DEVELOPMENT PROCESS

We reviewed current evidence and existing training materials on abortion, as well as recommendations from a program report on Ipas's work with health sciences students from 2000 to 2013. From

December 2013 to January 2014, the first version of the guide was field tested on three continents, including in one Ipas-led Training of Trainers in North Carolina and three regional, IFMSA-led workshops in Sub-Saharan Africa, the Middle East and North Africa, and the Americas. After the workshops, the student facilitators submitted feedback on the guide in writing to Ipas. In February 2014, staff from Ipas led a debrief meeting with the student facilitators to learn more about their experiences using the guide and clarify some of their written feedback. Perspectives of Ipas staff, medical students and youth leaders around the world—as expressed in the aforementioned program report, debrief meeting, written feedback, and countless personal communications—informed the final version of the guide.

Connect and learn with Ipas

Ipas on social media: You can connect and engage with Ipas through various social media channels. The best place to start is by visiting www.ipas.org. Or visit:

Facebook: www.ipas.org/facebook

Twitter:
@IpasOrg
@IpasLatina
@IpasYouth

YouTube: www.ipas.org/youtube

Tumblr: ipasorg.tumblr.com

Ipas updates: Visit www.ipas.org/subscribe to sign up for periodic e-updates on the latest Ipas news and safe abortion-related research and resources.

Clinical resources: To learn more about abortion service delivery and clinical care, we recommend the following Ipas resources: *Medical abortion: Study guide* (2013), *Woman-centered comprehensive abortion care: Reference manual* (2013) and *Woman-centered, comprehensive postabortion care: Reference manual* (2013). *Clinical Updates for Reproductive Health* is an annual publication that provides up-to-date, evidence-based recommendations and clinical protocols. Clinical resources can be accessed at Ipas's website: www.ipas.org.

Values clarification for abortion attitude transformation (VCAT) resources: Ipas has several VCAT resources, including: *Abortion attitude transformation: A values clarification curriculum for global audiences* (Turner and Page, 2008) and *Abortion attitude transformation: Values clarification activities adapted for young women* (McSmith et al., 2011). VCAT resources can be access at Ipas's website: www.ipas.org.

Ipas University: IpasU offers free, online, on-demand courses for reproductive health professionals on safe abortion care and postabortion care. These courses can be used for self-guided learning or as the online component of a blended learning model. Trainers may also want to use videos or other embedded materials during their workshops. For the Ipas University course catalog, see www.ipas.org; to register and take courses, please go to www.IpasU.org.

How to use the guide for workshops

AGENDA

Youth act for safe abortion: A training guide for future health professionals can be implemented as a three-day workshop. To assist facilitators, there is a sample agenda in the workshop tools. The sample agenda covers all the modules and activities in the guide. It also includes select, recommended values clarification for abortion attitude transformation (VCAT) activities. The modules are designed to be used in the order they appear in this training guide. They can also be used separately to meet specific programmatic or training needs. When using only one or some of the modules, it is vital to ensure participants have the appropriate background knowledge from any preceding modules, as the modules build on each other. In the workshop tools there is also a 'Pre-workshop questionnaire' that facilitators can ask participants to complete well in advance of the workshop. Participants' responses can provide valuable information to the facilitators and help them design the agenda to meet participants' interests and needs.

GOAL

The goal of the workshop is to build participants' capacity and commitment to take action for safe abortion. The objectives may vary based on the agenda and the activities that are included. In the workshop tool 'Developing your workshop agenda' we provide a comprehensive list of the learning objectives in the guide, which facilitators can use or adapt as necessary.

ADAPTATIONS

The information in the guide is applicable in most settings. We advise facilitators to identify what activities and tools can be adapted to be more appropriate to their specific setting and relevant to their participants. Before they adapt contents, facilitators may need to gather information on local laws and policies related to abortion, service delivery practices, barriers to access and other considerations. Adaptations may also include translating handouts and tools into other languages to meet participants' linguistic needs and preferences.

Using the guide with other audiences

This guide can easily be adapted for other audiences! This guide was originally developed for medical students, and we have intentionally used the term "future health professionals" throughout the guide to include students in health sciences such as nursing, midwifery, pharmacology or public health. Minor modifications to the guide may be needed to emphasize a particular field of study or for use with other health professionals. For example, you may need to modify discussion questions to better reflect the field(s) of study that participants represent or change subjects in case studies to include other health professionals as appropriate. If you wish to use the guide with students of non-health sciences, slightly more comprehensive adaptations may be necessary to adequately meet the needs and interests of the participants. For example, you may need to re-write case studies to feature the important role of non-health professionals in increasing access to safe abortion.

FACILITATORS

The guide is intended to be used by facilitators who have comprehensive training in sexual and reproductive health and rights and prior experience in planning and facilitating workshops. They should be knowledgeable on and comfortable with abortion. The guide is not designed as a training of trainers, and it does not build basic facilitation skills.

To adequately prepare for workshops, we encourage facilitators to:

- Study the module narratives, including reading them again just before each workshop;
- Review the presentation slides, including the notes sections;
- Read or watch all the core resources (listed at the beginning of each module);
- Familiarize themselves with some or all of the supplementary resources;
- Review all the activity instructions and tools;
- Print all workshop and activity tools. Remember, all printable materials are clearly identified on the USB and at www.ipas.org/youthact;
- Practice facilitating all relevant activities before the actual workshop (perhaps with friends or other facilitators).

PARTICIPANT SELECTION

To be able to participate meaningfully in the workshop, participants should have prior training in sexual and reproductive health and rights. Alternatively, facilitators can add content to the agenda *before* starting the modules in this training guide to build appropriate background knowledge in sexual and reproductive health and rights. Participants should also be interested in clarifying personal values related to abortion and learning more about abortion. Participant selection based on these criteria is crucial for an effective workshop and positive outcomes. Facilitators may wish to ask prospective participants for a letter of motivation briefly explaining why they want to participate in the workshop.

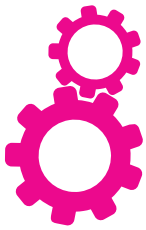
NUMBER OF PARTICIPANTS

The activities presented in this guide were designed or chosen with a time frame that is based on an average number of 20–24 participants. A lower number of participants may reduce the time it takes to conduct the activities. Conversely, a higher number of participants may increase the time it takes to conduct the activities. A higher number of participants can also negatively impact the quality of the workshop. For example, the extent to which all participants have opportunities to participate fully in the activities and discussions may be limited.

ASSESSMENT AND EVALUATION

In the workshop tools there is a 'Pre- and post-workshop assessment' that can be used to assess participants' knowledge and attitudes on abortion, and discern changes from the beginning to the end of the workshop. We encourage facilitators to review the assessment in advance of each workshop. Facilitators should adapt the assessment to make sure it accurately reflects the content that will be covered in that specific workshop. There is also a 'Workshop evaluation form' in the workshop tools. The form is designed to measure participants' satisfaction against the workshop objectives and gather suggestions for improvement.

Thank you for using the guide!



WORKSHOP TOOLS

I. Developing your workshop agenda

II. Pre-workshop participant questionnaire

III. Pre- and post-workshop assessment

IV. Pre- and post-workshop assessment: Facilitator's key

V. Workshop evaluation form

I DEVELOPING YOUR WORKSHOP AGENDA

Youth act for safe abortion: A training guide for future health professionals consists of five modules. Each module consists of two to four activities designed to meet the module's learning objectives and effectively build participants' knowledge and skills. As much as possible, we encourage you to include all of the activities in their current order in the workshop agenda. Each module also has a recommended VCAT activity, which was chosen for its relevance to the content of that module.

We suggest allocating time in the agenda for a workshop introduction, including a welcome statement, participant introductions, an icebreaker and the pre-workshop survey. We also suggest allocating time for a workshop closing statement, the post-workshop survey, the workshop evaluation and certificates of attendance. You can make the introduction and closing longer or shorter than we suggest below depending on your needs and time available.

Remember to build in adequate time for lunch, breaks and energizers in your agenda in accordance with your participants' needs. They are not reflected in Table 1 below.

The importance of clarifying values

Participants should have opportunities to clarify their values on abortion early in the workshop. VCAT is an evidence-based intervention in which trained facilitators support participants to challenge deeply held assumptions about abortion, discover or potentially transform their values, and express their intentions to act in a manner consistent with their affirmed values (Turner et al., 2013). The purpose is to move participants toward acceptance, support and advocacy for safe abortion. If space in the agenda is tight, we recommend that you prioritize the VCAT activities in Modules 1–3 before participants learn about comprehensive abortion care (Module 4) and build skills in abortion advocacy, peer education and accompaniment (Module 5).

TABLE I: Overview of modules and their allocated time in the sample agenda

Module	Time for module activities	Time for VCAT activities
Workshop introduction	2 hours	—
1: Introduction to abortion	2 hours	1 hour
2: Human rights, gender and abortion	2 hours and 30 minutes	45 minutes
3: Barriers to safe abortion and strategies to address them	3 hours	45 minutes
4: Comprehensive abortion care	1 hour and 30 minutes	—
5: Youth act for safe abortion	5 hours and 15 minutes	—
Workshop closing	2 hours	—
	18 hours and 15 minutes	**2 hours and 30 minutes**

SAMPLE AGENDA FOR PARTICIPANTS

Youth act for safe abortion: A workshop for future health professionals

[Time, Location]

Goal: To build participants' capacity and commitment to take action for safe abortion.

Objectives: By the end of the workshop, participants will be able to:

- Demonstrate increased respect for women seeking abortion and support for abortion rights;
- Articulate how their own personal perceptions and attitudes may affect their work on abortion;
- Describe how unsafe abortion affects women and societies;
- Articulate how human rights support access to safe abortion;
- Describe the relationship between gender discrimination and abortion;
- Explain how men can affect women's experiences with abortion;
- Describe different barriers that affect women's and adolescents' access to safe abortion care;
- Identify different strategies to improve access to safe abortion care, and explain which of these strategies future health professionals are well-suited to implement;
- Describe essential elements of woman-centered comprehensive abortion care, including counseling and safe methods for abortion;
- Describe examples of how future health professionals can advocate for safe abortion, and design advocacy messages for safe abortion;
- Explain what considerations may be appropriate when doing peer education on abortion;
- List common components of abortion accompaniment and how they help women overcome barriers to safe abortion care.

	START OF DAY 1	START OF DAY 2	START OF DAY 3	
8:30				8:30
8:45	Welcome address *(15 min)*	Icebreaker (15 min)	Icebreaker (15 min)	8:45
9:00	Workshop objectives and agenda *(15 min)*	**VCAT 2:** Why did she die? *(45 min)*	5: Youth act for safe abortion	**9:00**
9:15	Group norms and logistics *(15 min)*		**ACTIVITY 5.A:** A call to action! *(30 min)*	9:15
9:30	Introductions *(15 min)*			9:30
9:45	Icebreaker *(15 min)*	**ACTIVITY 2.C:** Abortion as a men's issue *(45 min)*	**ACTIVITY 5.B:** Advocacy perspectives and messages *(1 hour and 15 min)*	9:45
10:00	Pre-workshop assessment *(30 min)*			**10:00**
10:15				10:15
10:30	Break	Break		10:30
10:45	1: Introduction to abortion*	3: Barriers and strategies		10:45
11:00	**ACTIVITY 1.A:** The reasons why *(45 min)*	**ACTIVITY 3.A:** Understanding national abortion laws and policies *(1 hour and 15 min)*	Break	**11:00**
11:15			**ACTIVITY 5.C:** Peer education on abortion *(1 hour and 15 min)*	11:15
11:30				11:30
11:45				11:45
12:00	**VCAT 1:** Four corners *(1 hour)*	**VCAT 3:** The last abortion *(45 min)*		**12:00**
12:15				12:15
12:30			**ACTIVITY 5.D (PART I):** Supporting women during their abortion experiences: Accompaniment *(45 min)*	12:30
12:45				12:45
13:00	Lunch	Lunch		**13:00**
13:15			Lunch	13:15
13:30				13:30
13:45				13:45
14:00	**ACTIVITY 1.B:** A new perspective on abortion *(30 min)*	**ACTIVITY 3.B (PART I):** The quest for safe abortion: Barriers *(45 min)*		**14:00**
14:15				14:15
14:30				14:30
14:45	**ACTIVITY 1.C:** Abortion and me *(45 min)*	**ACTIVITY 3.B (PART II):** The quest for safe abortion: Strategies *(1 hour)*	**ACTIVITY 5.D (PART II):** Supporting women during their abortion experiences: Peer counseling *(1 hour and 30 min)*	14:45
15:00				**15:00**
15:15				15:15
15:30	Break			15:30
15:45	2: Human rights, gender and abortion	Break	Break	15:45
16:00	**ACTIVITY 2.A:** Access denied, human rights and abortion *(45 min)*	4: Comprehensive abortion care	Revisit Activity 1.B statements and Activity 1.C posters *(30 min)*	**16:00**
16:15				16:15
16:30		**ACTIVITY 4:A:** Comprehensive abortion care crossword puzzle *(1 hour)*	Post-workshop assessment *(30 min)*	16:30
16:45	**ACTIVITY 2.B:** Gender and abortion *(1 hour)*			16:45
17:00			Discuss post-workshop assessment *(15 min)*	**17:00**
17:15		**ACTIVITY 4.B:** Why I am an abortion provider *(30 min)*	Workshop evaluation *(15 min)*	17:15
17:30			Closing statement *(15 min)*	17:30
17:45	Daily evaluation *(15 min)*	Daily evaluation *(15 min)*	Certificates and group photo *(15 min)*	17:45
18:00	End of Day 1	End of Day 2	End of workshop	**18:00**

* Each module starts with 15 minutes for the facilitator to introduce the module, including learning objectives and activities.

II PRE-WORKSHOP PARTICIPANT QUESTIONNAIRE

This questionnaire encourages participants or prospective participants to reflect on why they want to participate in *Youth act for safe abortion: A workshop for future health professionals*. It can provide valuable information to the facilitators about participants' attitudes, knowledge and commitments to abortion issues. Facilitators can apply this information to develop the workshop objectives and agenda to meet participants' needs and interests.

INSTRUCTIONS FOR FACILITATORS:

1. Review the questionnaire and make adaptations appropriate to your context, if any. Remember adaptations may include translating the questionnaire into other languages.

2. Share the questionnaire with participants in a format that is easily accessible to them—for example, via email—and instruct them to return the completed questionnaire to you by a set date. We recommend that this date is well in advance of the workshop to enable you to consider participants' responses during the design of your agenda and objectives.

3. When you get the responses, review them carefully. You may wish to note what attitudes and knowledge related to abortion participants express and consider them in the context of the workshop agenda and objectives. For example, if several participants express conservative attitudes related to abortion you may need to plan for more values clarification and attitude transformation activities in the agenda.

4. Write down participants' expectations of the workshop. Identify which expectations will be addressed in the workshop and which will not. By communicating this clearly to participants at the beginning of the workshop you will help them get a clear sense of what they will gain in the workshop. It is important that participants have a clear understanding of what will and what will not be covered in the workshop.

5. If anyone expresses strong concerns about participating in the workshop, you may wish to work with them individually to identify whether they should participate or not.

PRE-WORKSHOP PARTICIPANT QUESTIONNAIRE

This questionnaire encourages you to reflect on why you want to participate in *Youth act for safe abortion: A workshop for future health professionals*. Your answers will provide valuable information to the facilitators and help them better prepare the workshop to meet your interests and needs.

Instructions: Please provide brief responses to questions 1–8 below (using less than 200 words per question). This is not a test and there are no wrong answers. Your answers are confidential and will not be shared with anyone other than the facilitators.

1. What do sexual and reproductive rights mean to you?

2. What are your beliefs about women's right to access safe abortion?

3. Why do you want to participate in the workshop?

4. What previous training or experience related to abortion do you have?

5. What knowledge and skills do you anticipate gaining in the workshop?

6. What specific topics related to abortion would you like to learn about during the workshop?

7. Do you have any concerns about participating in the workshop? What are they?

8. Please share any other comments or questions that you have related to the workshop.

Thank you!

The Facilitators

III PRE- AND POST-WORKSHOP ASSESSMENT

Please respond to the questions in this assessment as best you can, according to your knowledge and beliefs at this time. You will complete this assessment twice: once at the beginning of the workshop and again at the workshop's end. There are no implications for you based on the results of this assessment. The purpose is to let the facilitators know how well they are doing in increasing your knowledge and skills in the workshop. They may use the assessment results to improve the workshop or to conduct research activities.

Please **do not** include your name on this assessment. You will create a unique identifier to allow the facilitators to match your pre- and post-workshop assessment responses while maintaining your confidentiality. Before you start the assessment, please complete the table below to create your unique identifier. Remember to provide the same information on the pre- and post-workshop assessments so that the facilitators can compare your responses.

MY UNIQUE IDENTIFIER:

	Number of sisters	Birthday Month	Last three digits of your phone number
Example	0	June	749
Your information			

Part I: Please read each question and write a response to it based on your knowledge and beliefs at this time.

1. Describe what key characteristics make an abortion safe?

2. How do different human rights support women's access to safe abortion?

3. How does gender discrimination and inequality contribute to unsafe abortion?

4. Describe two examples of how future health professionals can address barriers to safe abortion.

Part II: Please read the following statements. For each statement, indicate the level that you agree or disagree with it using the following options: 1) strongly agree; 2) agree; 3) neutral; 4) disagree; or 5) strongly disagree. Please answer in the most honest way possible.

Statement	1. Strongly agree	2. Agree	3. Neutral	4. Disagree	5. Strongly disagree
1. I have the knowledge to explain how unsafe abortion negatively affects women and societies.					
2. I believe that all women—regardless of ethnicity, religion, marital status or age—should be able to access safe abortion services.					
3. I have the knowledge to explain several strategies to address barriers that women face seeking safe abortion services.					
4. I think that a woman who wants to terminate a pregnancy should consult a man first (for example: her husband, sexual partner, father or brother).					
5. I believe that special legal requirements are necessary for adolescents who seek abortion since they cannot make decisions on their own.					
6. I believe that a woman should be able to decide what abortion method to use if she is clinically eligible for more than one method.					
7. I feel empathy with women who need and seek abortion.					
8. I feel empowered to advocate for safe abortion, whether in my students' association, school or community.					
9. I believe that abortion is a difficult topic that cannot be included in peer education programs on sexual and reproductive health and rights.					
10. I think that I am likely to provide safe abortion services in the future, or refer women to safe services.					

IV PRE- AND POST-WORKSHOP ASSESSMENT: FACILITATOR'S KEY

Part I: There are many different ways to answer the questions in Part I of the pre- and post-workshop assessment, and you are likely to get as many unique answers as you have participants. The information below is designed to help the facilitators evaluate the accuracy of the participants' answers. You can also reference the module narratives and the core and supplementary resources. **Remember to discuss the answers with participants after the post-workshop assessment.**

1. **Describe what key characteristics make an abortion safe?**

   "Abortion is safe when performed by persons with the necessary training and skills, and in an environment meeting minimal medical standards. Unsafe abortion is a procedure performed either by persons lacking the necessary training and skills, in an environment that fails to meet minimal medical standards, or both." (Module 1)

   Participants may mention what abortion methods are safe and effective. Example: manual vacuum aspiration and medical abortion in the first trimester; dilation and evacuation and medical abortion in the second trimester.

   Participants may discuss barriers that affect how safe women feel accessing abortion care, such as judgmental provider attitudes, lack of privacy and confidentiality, and other quality-of-care issues.

2. **How do different human rights support women's access to safe abortion?**

   Table 2.1 'Human rights and abortion' provides a comprehensive list of human rights and how each can be translated to abortion. Please refer to it in assessing participants' answer to this question.

   Participants may list examples of international and regional human rights' conferences and agreements that specifically mention abortion. For example: the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).

Participants may discuss cases in which women were denied safe abortion and human rights courts ruled that the women's human rights were violated.

3. How does gender discrimination and inequality contribute to unsafe abortion?

Gender discrimination increases the risk of unintended pregnancy: "*Women's subordinate status can impact their ability to make and act on decisions about relationships and childbearing, including whether to have sex and whether to use contraception. Women often have less power and control than men over the timing and type of sexual relationships they have, and many women experience unintended pregnancy from sexual violence.*" (Module 3)

Women often have unequal access to information, education and resources: "*A lack of information can leave women without the knowledge that safe, legal abortion is an option. With limited agency and control of economic assets, accessing safe abortion services can be challenging.*" (Module 3)

Women often have a lower social standing than men and/or other family members. They may also fear repercussions from their family and social segregation if they seek safe abortion care: "*If a woman fears that her family will control the decision whether to continue or terminate a pregnancy and not respect her wishes, she may seek an unsafe abortion in secret. In some countries, married women need spousal authorization to obtain safe abortion care.*" (Module 3)

Participants may discuss how the social ideal of womanhood is often equated with motherhood, with examples such as female sexuality is accepted solely for procreation, all women are expected to want to become mothers, and women are not seen as 'real women' until they have children.

4. Describe two examples of how future health professionals can address barriers to safe abortion.

Participants may describe different strategies for addressing barriers to safe abortion, as presented in Table 3.1 'Examples of strategies to address barriers to safe abortion care.' They

may also describe the strategies covered in Module 5, including advocacy, peer education and accompaniment, and how future health professionals can support women during their abortion experiences. For example:

Advocacy for safe abortion aims to advance women's health and rights by improving women's access to evidence-based information and quality services. *"As advocates for safe abortion, future health professionals can raise awareness of existing abortion laws and policies, and garner support for reform of abortion laws and policies among professional organizations, policymakers and communities. They can correct myths and misinformation that they hear about abortion in their daily lives. Future health professionals can also improve access to safe abortion information at their schools. This may involve surveying existing materials, leading training opportunities for other students, identifying provider mentors, arranging clinical observations of abortion care, and working toward reform of school curriculum and residency training."* (Module 5)

"Peer education can increase knowledge and skills on safe abortion among young people. Special considerations, such as a risk assessment and risk reduction strategy, may be appropriate when doing peer education on abortion. Peer educators should receive adequate training on abortion and mentoring, and work in partnership with other advocates." (Module 5)

Part II: There are not necessarily correct answers for Part II of the pre- and post-workshop assessment. Ideally, we want to see positive changes in participants' knowledge, beliefs and attitudes because of the training workshop. The placement of the Xs below indicates more positive knowledge, beliefs and attitudes. When you discuss the **post**-workshop assessment, you can share with participants which responses indicate a higher level of comfort.

Statement	1. Strongly agree	2. Agree	3. Neutral	4. Disagree	5. Strongly disagree
1. I have the knowledge to explain how unsafe abortion negatively affects women and societies.	×	×			
2. I believe that all women—regardless of ethnicity, religion, marital status or age—should be able to access safe abortion services.	×	×			
3. I have the knowledge to explain several strategies to address barriers that women face seeking safe abortion services.	×	×			
4. I think that a woman who wants to terminate a pregnancy should consult a man first (for example: her husband, sexual partner, father or brother).				×	×
5. I believe that special legal requirements are necessary for adolescents who seek abortion since they cannot make decisions on their own.				×	×
6. I believe that a woman should be able to decide what abortion method to use if she is clinically eligible for more than one method.	×	×			
7. I feel empathy with women who need and seek abortion.	×	×			
8. I feel empowered to advocate for safe abortion, whether in my students' association, school or community.	×	×			
9. I believe that abortion is a difficult topic that cannot be included in peer education programs on sexual and reproductive health and rights.				×	×
10. I think that I am likely to provide safe abortion services in the future, or refer women to safe services.	×	×			

V WORKSHOP EVALUATION FORM

Before you start the workshop evaluation, please take a moment to review the goal and objectives of the workshop. You will be asked to assess how well the workshop met them.

Goal: The goal of the workshop is to build participants' capacity and commitment to take action for safe abortion.

Objectives: By the end of the workshop, participants will be able to:

- Demonstrate increased respect for women seeking abortion and support for abortion rights;
- Articulate how their own personal perceptions and attitudes may affect their work on abortion;
- Describe how unsafe abortion affects women and societies;
- Articulate how human rights support access to safe abortion;
- Describe the relationship between gender discrimination and abortion;
- Explain how men can affect women's experiences with abortion;
- Describe different barriers that affect women's and adolescents' access to safe abortion care;
- Identify different strategies to improve access to safe abortion care, and explain which of these strategies future health professionals are well-suited to implement;
- Describe essential elements of woman-centered comprehensive abortion care, including counseling and safe methods for abortion;
- Describe examples of how future health professionals can advocate for safe abortion, and design advocacy messages for safe abortion;
- Explain what considerations may be appropriate when doing peer education on abortion;
- List common components of abortion accompaniment and how they help women overcome barriers to safe abortion care.

1. The most significant change that I anticipate in my life or in my work because of this workshop is:

Please read statements 1–24. For each statement, indicate the level that you agree or disagree using the following options: 4) strongly agree; 3) agree; 2) disagree; or 1) strongly disagree. Please be as honest as you can.

Statement	4. Strongly agree	3. Agree	2. Disagree	1. Strongly disagree
Overall workshop				
1. The workshop fulfilled its objectives.				
2. The workshop was well organized.				
3. The facilitators communicated effectively and responded to participants' needs.				
4. The break, lunch and other logistical arrangements were satisfactory.				
Module 1: Introduction to abortion — Activity 1.A: The reasons why Activity 1.B: A new perspective on abortion Activity 1.C: Abortion and me VCAT 1: Four Corners				
5. The activities were relevant to the module topics.				
6. The activities were effective in building knowledge and skills.				
7. The materials (handouts, worksheets, etc.) were appropriate.				
8. There were enough opportunities for discussion.				
Module 2: Human rights, gender and abortion — Activity 2.A: Access denied, human rights and abortion Activity 2.B: Gender and abortion Activity 2.C: Abortion as a men's issue VCAT 2: Why did she die?				
9. The activities were relevant to the module topics.				
10. The activities were effective in building knowledge and skills.				

Statement		4. Strongly agree	3. Agree	2. Disagree	1. Strongly disagree
11. The materials (handouts, worksheets, etc.) were appropriate.					
12. There were enough opportunities for discussion.					
Module 3: Barriers and strategies	Activity 3.A: Understanding national abortion laws and policies Activity 3.B: The quest for safe abortion, Barriers to care and strategies to address them (Parts I-II) VCAT 3: The last abortion				
13. The activities were relevant to the module topics.					
14. The activities were effective in building knowledge and skills.					
15. The materials (handouts, worksheets, etc.) were appropriate.					
16. There were enough opportunities for discussion.					
Module 4: Comprehensive abortion care	Activity 4.A: Comprehensive abortion care crossword puzzle Activity 4.B: Why I am an abortion provider				
17. The activities were relevant to the module topics.					
18. The activities were effective in building knowledge and skills.					
19. The materials (handouts, worksheets, etc.) were appropriate.					
20. There were enough opportunities for discussion.					
Module 5: Youth act for safe abortion	Activity 5.A: A call to action! Activity 5.B: Advocacy perspectives and messages Activity 5.C: Peer education on abortion Activity 5.D: Supporting women during their abortion experiences (Parts I-II)				
21. The activities were relevant to the module topics.					
22. The activities were effective in building knowledge and skills.					
23. The materials (handouts, worksheets, etc.) were appropriate.					
23. There were enough opportunities for discussion.					

Please provide any comments you wish to share with the facilitators.
You can use the back of the page if you need more space.

Thank you!
The Facilitators

MODULE 1:
Introduction to abortion

Photo illustration; original photo © Ipas

Module 1: Introduction to abortion

LEARNING OBJECTIVES

This module sets the stage for subsequent modules. It places abortion in the broader context of sexual and reproductive health and helps participants learn basic information about abortion. The module also builds understanding of how unsafe abortion affects women and societies. Participants will begin to explore their own values and attitudes related to abortion and identify why the issue is relevant to them. By the end of this module, participants will be able to:

- Identify abortion as a critical sexual and reproductive health issue;
- Define abortion and discuss its practice throughout history;
- Describe how unsafe abortion affects women and societies;
- Articulate how their own personal perceptions and attitudes may affect their work on abortion.

CORE RESOURCES

- ❑ Guttmacher Institute. (2012). *Abortion worldwide*. New York, NY: Guttmacher Institute. www.guttmacher.org/media/video/wwa-motion-graphic-script.html
- ❑ Ipas. (2010). *The evidence speaks for itself: Ten facts about abortion*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/The-evidence-speaks-for-itself--Ten-facts-about-abortion.aspx
- ❑ Turner, K. L., Börjesson, E., Huber, A., & Mulligan, C. (2011). Section 1.1: Why focus on young women and abortion? *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas. http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-care-for-young-women--A-training-toolkit.aspx
- ❑ World Health Organization (WHO). (2012). Chapter 1: Safe abortion care: The public health and human rights rationale. *Safe abortion: Technical and policy guidance for health systems* (2nd ed.). Geneva, Switzerland: WHO. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

Facilitators can check off the boxes as they complete the core resources.

SUPPLEMENTARY RESOURCES

SEXUAL AND REPRODUCTIVE HEALTH

De Bruyn, M. (2003). Section 1: The context and manifestations of the problem. *Violence, pregnancy and abortion: Issues of women's rights and public health.* Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Violence--pregnancy-and-abortion--Issues-of-womens-rights-and-public-health.aspx

Guttmacher Institute & International Planned Parenthood Federation. (2010). *Facts on the sexual and reproductive health of adolescent women in the developing world.* New York, NY: Guttmacher Institute. www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf

United Nations. (2012). *Fast facts: Statistics on violence against women and girls.* New York, NY: United Nations. www.endvawnow.org/en/articles/299-fast-facts-statistics-on-violence-against-women-and-girls-.html

UNSAFE ABORTION

World Health Organization (WHO). (2012). *Unsafe abortion incidence and mortality: Global and regional levels in 2008 and trends during 1990–2008.* Geneva, Switzerland: WHO. http://apps.who.int/iris/bitstream/10665/75173/1/WHO_RHR_12.01_eng.pdf

INTRODUCTION TO ABORTION

All people have the right to health. For many women and adolescents around the world this right is neither recognized nor upheld, and their sexual and reproductive health needs are acute. Poverty and gender discrimination result in health disparities that disproportionately affect women. Specific issues that contribute to poor reproductive health outcomes for women include:

- No or inadequate sexuality education;
- Sexual violence, including trafficking;
- Early and forced marriage;
- Female genital mutilation;
- Unmet need for contraception;
- Unintended pregnancy;
- A lack of safe health-care options during pregnancy, including safe abortion, antenatal care, trained assistance during labor and birth, and postpartum care (United Nations, 2012).

Guided by Millennium Development Goal 5 (Improve Maternal Health) the global community is making progress toward reducing maternal mortality and increasing access to reproductive health care. A lot remains to be done. In developing countries, pregnancy and childbirth-related complications continue to be a leading cause of death and disability among women of reproductive age. In 2010, 287,000 women died (WHO et al., 2012). Unsafe abortion-related deaths accounted for about 13 percent of overall maternal mortality in both 2003 and 2008 (WHO, 2011). Prevention of unwanted pregnancy and unsafe abortion is essential to reduce maternal mortality and morbidity.

> ***Women are dying in childbirth, not because the technology for saving them is not available, but because the will, the support, the enthusiasm, the understanding that this is the humane thing to do, the human thing to do, is not there. When you see women dying from preventable and manageable causes, you must do something.***
>
> — **Dr. Fred Sai**, Ghanaian physician, Chairman of the International Conference on Population and Development in Cairo, 1994, and President of the International Planned Parenthood Federation from 1989–1995 (United Nations Foundation, 2012a)

Textbox 1.1: Adolescent girls' disproportionate burden

Adolescent girls face unique vulnerabilities related to their age and socioeconomic status (Turner et al., 2011). Globally, over half of sexual violence acts are committed against girls below the age of 16 (United Nations, 2012). About 16 million adolescents 15–19 years old experience pregnancy each year (WHO, 2012a), and maternal deaths are the leading cause of death and disability among this population (Patton et al., 2009). Adolescents are less likely to have used contraceptives and more likely to have unsafe abortions than adults (WHO, 2012a).

1.1 DEFINING ABORTION

Abortion is the termination of pregnancy before fetal viability. A spontaneous abortion happens without any deliberate intervention and is sometimes called pregnancy loss or miscarriage (Ipas, 2013d). When the evacuation of the uterus is intentional and takes place without confirmation of pregnancy, it can be called menstrual regulation. Menstrual regulation may be available to women who report recent delayed menses (WHO, 2012b). Induced abortion is the intentional termination of a confirmed pregnancy. In this guide, we use the term abortion to refer to induced abortion. Abortion can be characterized in different ways:

- **Safe versus unsafe.** Abortion is safe when performed by persons with the necessary training and skills, and in an environment meeting minimal medical standards. Unsafe abortion is a procedure performed either by persons lacking the necessary training and skills, in an environment that fails to meet minimal medical standards, or both (WHO, 2012b). See Textbox 1.2 for information about the safety of abortion.
- **Legal versus illegal.** An abortion is legal when it is allowed by the state, under the direction of national health institutions and guidelines. There are very few countries where abortion is illegal. Most countries have one or more legal indications for abortion, and some allow it on demand (Center for Reproductive Rights, 2009).
- **Unrestricted versus restricted.** Even where abortion is legal, women's access to safe services may be restricted, such as with few legal indications, national guidelines that impose barriers not mandated by law, abortion stigma, cost of services, and a lack of facilities that offer the services. Barriers that restrict access to safe abortion are discussed in detail in Module 3.

- **Voluntary versus forced.** A voluntary abortion is an abortion that is done deliberately and with this purpose, under the woman's petition and by her free choice. Forced abortion happens when a woman is pressured, coerced or physically forced to terminate a pregnancy. No woman or adolescent should be forced to undergo an abortion against her will or without her consent.

Safe abortion is an essential component of reproductive health care, which complements other important services such as contraception and adoption. Access to safe abortion ensures women's health and well-being. Woman-centered comprehensive abortion care (CAC) is a holistic approach to providing safe abortion. It entails a range of medical and related health services, including counseling, abortion, contraception and referrals to other reproductive health-care services as appropriate (Ipas, 2013c). CAC also includes postabortion care (PAC). PAC is designed to provide women presenting after spontaneous or induced abortion with the care they need. It includes treatment for incomplete, missed or unsafe abortion, as well as other medical services (Ipas, 2013d). Globally, no country's penal code limits provision of PAC. It is essential emergency care that saves women's lives, and should be immediately accessible to all women who need it.

Textbox 1.2: The safety of abortion

When performed in accordance with recommended global medical standards, abortion is one of the safest medical procedures (IPPF, 2004). In the United States, the mortality rate from legal abortion is 0.6 deaths per 100,000 procedures (Pazol et al., 2012). In early pregnancy, it is as low as 0.1 deaths per 100,000 procedures (Bartlett et al., 2004). Childbirth carries significantly higher risks. The mortality rate from childbirth in the United States was 17.8 deaths per 100,000 births in 2009 (Center for Disease Control, 2013). Complications from safe abortion are extremely rare too. Separate studies in India, South Africa, the United States and Vietnam found the total minor complication rate to be around one percent, and the total major complication rate to be 0 to 0.1 percent (Hakim-Elahi et al., 1990; Jejeebhoy et al., 2011; Warriner et al., 2006; Weitz et al., 2013). In contrast, unsafe abortion carries significant risks to the woman's health and life. In 2008, the mortality rate from unsafe abortion was 220 deaths per 100,000 abortions in developing countries and 520 deaths in Sub-Saharan Africa (WHO, 2011).

1.2 HISTORICAL PERSPECTIVES ON ABORTION

Women have managed their fertility for millennia. Abortion is an ancient and universal phenomenon (Devereux, 1967). Evidence of its practice has been found in hunting and gathering groups, agricultural peasant societies, and in pre-industrial, industrial and post-industrial communities around the world (Shain, 1986). Early writings on abortion date back to medical scripts from Ancient Egypt in 1,500 B.C.E.[1], Ancient China in 500 B.C.E. and the Greek and Roman Empires (Potts & Campbell, 2002). In the 11th century, Islamic philosopher and physician Avicenna wrote *The Canon of Medicine*, an influential encyclopedia, which included a chapter on abortion methods (Riddle, 1997).

Techniques described in these texts include abortifacient herbs, surgical methods, and magic and superstition (Kapparis, 2002). In the fourth century C.E., Roman doctors documented using a mixture of aloe, opopanax root and myrrh to induce abortion in women considered too young to safely carry a pregnancy to term and deliver a baby (McLaren, 1990). Aloe was still used by midwives and pharmacists for menstrual regulation in the 19th century. Other common techniques, which are often very dangerous, included the use of sharpened tools, the application of abdominal pressure ('massage abortion') and potentially harmful physical activities such as strenuous labor (Ipas, 2010). In Cambodia and Indonesia, sculptures and carvings of women undergoing 'massage abortion' have been found, dating back to 900–1,200 C.E. (Potts et al., 2007).

Over the course of the 20th century, fertility rates among married couples in the West dropped dramatically (Potts & Campbell, 2002). This reduction in total fertility took place before the advent of modern methods of contraception, and abortion was one important factor. In 1889, the British doctor Rentoul wrote:

"Everyone must notice that, although the number of marriages is on the increase, the number of births to each couple is decreasing, and no satisfactory explanation is forthcoming. Instead of the number of cases of abortion [decreasing], an enormous increase is taking place."

From Ancient Egypt and China to the Greek and Roman Empires, and post-industrial Europe and North America, abortion has been known to all societies and cultures throughout human history.

1 B.C.E. denotes Before the Common Era (increasingly replacing B.C. or Before Christ). Conversely, C.E. stands for Common Era (replacing A.D. or *Anno Domini*).

1.3 UNSAFE ABORTION: A MODERN DAY PANDEMIC

Today, safe and effective methods for preventing and terminating pregnancy exist. Despite these modern medical technologies, unsafe abortion remains a pandemic. Nearly all unsafe abortions (98 percent) take place in the Global South (Grimes et al., 2006). Unsafe abortion is an issue in the Global North too. In many developed countries the legal right to abortion continues to be infringed upon, services are not affordable and abortion stigma is pervasive. Globally, the direct burden of unsafe abortion on women is sobering. In 2008:

- An estimated 22 million unsafe abortions took place;
- 47,000 women died;
- At least five million women suffered physical disabilities (WHO, 2012c). Women who are socially ostracized after an abortion may also suffer emotionally.

Adolescent girls aged 15–19 are disproportionately affected by unsafe abortion. Among the estimated 3.2 million abortions in adolescents, almost half are in the Africa region (Shah and Ahman, 2012). In Sub-Saharan Africa, adolescent girls account for about 70 percent of all hospitalizations from unsafe abortion-related complications (United Nations, 2004).

The cost of unsafe abortion for societies is also substantial:

- When women are not able or allowed to contribute to their community, economic productivity decreases (Grimes et al., 2006).
- Children who lose their mothers to unsafe abortion-related deaths often receive less health and social care, and are more likely to die than children who have two living parents (Vlassoff et al., 2004).
- Treatment of unsafe abortion-related complications places a significant burden on public health systems in the developing world (Vlassoff et al., 2009). Ensuring women's access to safe abortion in the first place lowers costs for health systems. PAC offered by physicians in tertiary hospitals is estimated to cost health systems ten times more than elective abortion services offered by midlevel practitioners in a primary care setting (Grimes et al., 2006).

1.4 HOW ABORTION AFFECTS FUTURE HEALTH PROFESSIONALS

Future health professionals educate themselves and take action on abortion issues for many different reasons. As a group of young people, health sciences students are diverse and share many of the same sexual and reproductive health needs as their peers. Some have experienced unintended pregnancy and unsafe abortion, or know someone close to them—such as a partner, family member or friend—who has (Börjesson & Villa Torres, 2013). If unsafe abortion is prevalent in the community where the student lives, or a key contributor to maternal mortality and morbidity in their country, they may want to be part of the movement to save women's lives.

Future health professionals can be affected by abortion professionally too. Many engage in abortion issues because they trust women to make decisions about their own bodies and for their families, and want women to have safe reproductive health choices. Some students are active in associations that work on sexual and reproductive health issues. Others advocate for integration of abortion in their school curriculum. As health professionals, they may meet women and adolescents who have experienced abortion, and may choose to:

- Advocate for safe abortion within their place of study or practice, community, professional organizations and health system;
- Provide safe abortion services;
- Support fellow health professionals who provide abortion services and women who seek such services, and help them mitigate the effects of abortion stigma.

> ***We are going to shape health-care in our countries, and for people to have a chance at respectful health-care we need to talk about hard issues like abortion.***
>
> — Female medical student (Börjesson & Villa Torres, 2013) speaking on the issue of unsafe abortion

THE BOTTOM LINE

- Abortion is the termination of pregnancy before fetal viability. It can be safe or unsafe.
- An abortion is safe when performed by persons with the necessary training and skills, and in an environment meeting minimal medical standards. In early pregnancy, it is one of the safest medical procedures (IPPF, 2004).
- Even though safe methods for preventing and terminating pregnancy exist, unsafe abortion continues to claim the lives of thousands of women each year. The extremely high number of women who continue to risk their health and lives makes unsafe abortion an important global public health issue.
- Almost all unsafe abortion-related mortality and morbidity can be prevented by addressing unmet needs for contraception and by making safe abortion care readily accessible (Grimes et al., 2006). Access to safe abortion is essential to ensure women's health and well-being.

> ***Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.***
>
> — **Mahmoud Fathalla, MD, PhD**, past president of the International Federation of Obstetricians and Gynecologists, speaking on the issue of unsafe abortion

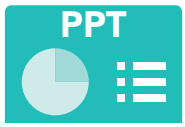
MODULE 1 TOOLS

Handout 1: Introduction to abortion

Activity 1.A: The reasons why (45 minutes)

Activity 1.B: A new perspective on abortion (30 minutes)

Activity 1.C: Abortion and me (45 minutes)



This module is accompanied by presentation '**MODULE 1**' **(Slides 1–21)**. Remember, all printable materials and presentation slides are available on the USB and at www.ipas.org/youthact.

Want more attitude transformation?

Depending on your learning objectives, participants' preferences and the training workshop agenda, you may also wish to conduct the activity below.

FOUR CORNERS: This activity helps participants come to a deeper understanding of their own and others' beliefs about abortion; empathize with the underlying values that inform a range of beliefs and consider how their beliefs affect societal stigma on abortion; and, if they are health-care providers, understand how personal beliefs can affect the provision of high-quality services. This activity takes about 45 minutes.

A detailed activity description and facilitator instructions can be found in:

Turner, K. L., & Page, K. C. (2011). *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation--A-values-clarification-toolkit-for-global-audiences-2.aspx

A youth-specific adaptation of Four Corners can be found in:

McSmith, D., Börjesson, E., Villa, L., & Turner, K. L. (2011). *Abortion attitude transformation: Values clarification activities adapted for young women*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation--Values-clarification-activities-adapted-for-young-women.aspx

REMEMBER! It is important that participants have opportunities to clarify their values related to abortion. Attitude transformation is an evidence-based approach designed to move participants toward acceptance and support for safe abortion. **The activity 'Four Corners' was one of the best-liked activities among participants when we tested the training guide**.

Handout 1: Introduction to abortion

All people have the right to health. For many women around the world this right is neither recognized nor upheld (Turner et al., 2011), and their sexual and reproductive health needs are acute. Prevention of unwanted pregnancy and unsafe abortion is essential to reduce maternal mortality and morbidity. Here are some key facts about abortion for future health professionals to know:

- Abortion is the termination of pregnancy before fetal viability.
- A spontaneous abortion (miscarriage) happens without any deliberate intervention.
- An induced abortion is safe when performed by persons with the necessary training and skills and in an environment meeting minimal medical standards (WHO, 2012b). In early pregnancy, it is one of the safest medical procedures (IPPF, 2004).
- Unsafe abortion carries significant risks to women's health and life. Today, it is a preventable pandemic throughout the Global South (Grimes et al., 2006).
- In 2008, an estimated 22 million unsafe abortions took place globally, resulting in 47,000 women dying and an additional five million suffering disabilities (WHO, 2012c).
- The burden of unsafe abortion on societies is also substantial: poor health outcomes for children whose mothers die or suffer long-term disabilities, loss of economic productivity in communities, and draining of scarce health-care resources.

Public health problem with a solution: With modern methods for preventing and terminating pregnancy, almost all unsafe abortion-related mortality and morbidity can be prevented safely and effectively. Yet the high number of women who still risk their health and lives by resorting to unsafe abortion makes it an important global public health issue.

> ***Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.***
>
> — **Mahmoud Fathalla, MD, PhD**, past president of the International Federation of Obstetricians and Gynecologists, speaking on the issue of unsafe abortion

Reasons to advocate: Future health professionals educate themselves and take action on abortion issues for many different reasons. Unsafe abortion may be prevalent in their country and someone close to them may have been personally affected by it. Many believe that women have the right to make decisions about their bodies, and identify professional responsibilities to save women's lives.

> ***We are going to shape health-care in our countries, and for people to have a chance at respectful health-care we need to talk about hard issues like abortion.***
>
> — Female medical student speaking on the issue of unsafe abortion (Börjesson & Villa Torres, 2013)

Activity 1.A: The reasons why

Adapted from Barcklow D'Amica et al., 2010; Turner & Page, 2011

PURPOSE

Participants will identify women's sexual and reproductive health needs and explore reasons women and adolescents get pregnant and have abortions. They will also discuss how social norms and beliefs about these reasons affect women's reproductive health and well-being.

TIME

45 minutes

MATERIALS

» Supporting document 'List of reasons'

» Flipchart, tape and markers

PREPARATIONS

1. Read the 'List of reasons.' Add any other reasons you can think of.
2. Write this definition of reproductive health on a flipchart:

   Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (Article 7.20, International Conference on Population and Development, Cairo, 1994)

3. Write the questions below on flipchart.

   a. *What are the reasons women (over the age of 20) get pregnant?*

   b. *What are the reasons adolescents (under the age of 20) get pregnant?*

4. Write the questions below on flipchart.

   c. *What are the reasons women (over the age of 20) have abortions?*

   d. *What are the reasons adolescents (under the age of 20) have abortions?*

INSTRUCTIONS 1 2 3

1. Invite participants to participate actively in this activity. Inform them the purpose of this activity is to identify women's sexual and reproductive health needs, and explore reasons women and adolescents get pregnant and have abortions. Participants will also discuss how social norms and beliefs about these reasons affect women's reproductive health and well-being.
2. Ask if anyone can define reproductive health. Invite a few participants to share their thoughts. You may wish to write the responses on flipchart.
3. After a few responses, post the flipchart 'Reproductive health' that you prepared in advance. Ask a participant to read it, and explain that this definition is an internationally recognized definition of reproductive health, agreed to at the International Conference on Population and Development in Cairo in 1994.
4. Next, ask participants to mention different sexual and reproductive health needs women face. You may wish to write the responses on flipchart. Make sure all the examples listed in this module's narrative are mentioned.
5. Divide participants into two groups. Give each group flipchart and markers.
6. Tell the groups they are going to identify reasons why women or adolescents get pregnant. Post the flipchart with questions A and B. Ask one group to answer question A and the other group to answer question B. Instruct the groups to write down their answers on flipchart. Allow five minutes for the groups to identify reasons.
7. Ask the first group to post their flipchart and present the reasons they identified why women get pregnant. Ask the second group to present their reasons why adolescents get pregnant. Allow five minutes for sharing.
8. Once the groups have presented, ask if anyone can think of any other reasons to add. Record any additional reasons on the appropriate flipcharts. Use the supporting document 'List of reasons' to add any remaining reasons which have not been mentioned.
9. Tell the groups that now they are going to identify reasons why women or adolescents have abortions. Remind everyone that people have different beliefs and experiences related to abortion. It is important to respect each other's differences and be mindful that to some people it may be a very personal subject.

10. Post the flipchart with questions C and D. Ask one group to answer question C and the other group to answer question D. Repeat instructions 6–8 to identify, present and discuss reasons why women and adolescents have abortions.
11. Invite participants to study the reasons noted on the flipcharts and facilitate a brief discussion. You may wish to use the discussion questions below. Ask one question at a time, and allow time for participants to respond to it before you move on to the next question. Make sure you have at least 15 minutes for this discussion.
    a. *What observations can you make about women's reproductive health needs based on this activity?*
    b. *Are there differences between the reasons adult women get pregnant and have abortions, and the reasons adolescents get pregnant and have abortions? If there are differences, why do you think that is?*
    c. *What reasons that women or adolescents get pregnant may society view as more acceptable?*
    d. *What reasons that women or adolescents have abortions may society view as more acceptable?*
    e. *How do these norms and attitudes affect women's and adolescents' opportunities to achieve reproductive health and well-being?*
12. Summarize key points from the discussion.
13. To close the activity, emphasize there are many reasons women and adolescents get pregnant and have abortions. Some of these reasons are outside their control. We seldom know everything about a woman's circumstance, how she got pregnant or why she is terminating the pregnancy. And we should be careful not to judge her actions. All women have the right to live free from violence and coercion and the right to bodily autonomy and to decide whether, when and with whom to have a child.
14. Thank participants for participating in this activity.

The order of the suggested discussion questions matters! The first question is less personal and possibly perceived as less sensitive. It is designed to create comfort for all participants to participate in the discussion. The following questions may require more self-reflection to answer, which can make them more effective for learning.

LIST OF REASONS

PREGNANCY: These are some of the reasons why women and adolescents become pregnant. There may be others that you and the participants think of.	
Desire for children and family	• To have children • To start or grow a family
Proving womanhood	• To become 'a real woman' • To prove they can get pregnant
Perceived or actual benefits of motherhood	• To feel companionship with other pregnant women or new mothers • To attain a higher social status in the family or community • To be treated special and get more love from partner • To overcome loneliness or abandonment • To become responsible for something important • To get access to social welfare programs
Enjoying sexuality	• To enjoy sex • To have fun
Lack of information	• To think 'it will never happen to me' • Lack of information about how pregnancy occurs and how to prevent it
Issues with contraception	• Contraception is not available or affordable in their community • Social stigma about using contraception is too high • Lack of comfort negotiating contraceptive use • Incorrect or inconsistent use of contraceptives • Contraceptive failure
Social pressure or violence	• To fulfill a 'duty' as a wife • Family or partner demands for a child • Pressured to have sex • Physically forced to have sex • Relied on sex work to feed themselves and other family members

ABORTION: These are some of the reasons why women and adolescents have abortions. There may be others that you and the participants can think of.	
Lack of desire for children and family	• To avoid starting a family • To avoid taking care of children
Health	• To protect the woman's life or health, which may be threatened if she continues the pregnancy • Unviable fetus
Change in family circumstances	• Romantic relationship ended • Loss of job and financial income • Illness or death of another family member • Other family emergencies
Financial	• Inability to afford a child (or another child)
Thinking about the future	• To continue education • To advance career • To save motherhood until the woman feels ready to become a mother
Social pressure and lack of decisionmaking power	• Lack of decisionmaking power within their relationship or family • Desire to keep the pregnancy is not respected • Pressure from partner, family or friends to have an abortion
Violence	• Unhealthy or unsafe relationship • Pregnancy is the result of rape and the woman does not know the perpetrator • Pregnancy is the result of rape and the woman knows the perpetrator, and does not want to subject a child to violence too
Forced abortion	• Physically forced to undergo an abortion procedure • Given medical abortion drugs without her knowledge and consent

Activity 1.B: A new perspective on abortion

PURPOSE

Participants will learn basic information about abortion, including the magnitude of unsafe abortion and how it affects women and societies. They will also begin to explore and broaden their own personal perspectives on abortion.

TIME

30 minutes

MATERIALS

» Presentation 'Module 1,' **Slides 8–19**

» Supporting document 'A new perspective: Cards'

PREPARATIONS

1. Review the presentation slides.
2. Read the 'A new perspective: Cards' and print copies of all the cards. If possible, print the cards on different colored papers.

INSTRUCTIONS

1. Invite participants to actively participate in this activity. Inform them the purpose of this activity is to learn basic information about abortion, including definitions and the impact of unsafe abortion on women and societies. We will also begin to explore and broaden our own personal perspectives on abortion.
2. Write the following, unfinished sentence on flipchart: *"Abortion is…"*
3. Ask participants to complete the sentence without discussing it with anyone else. Instruct them to write down their answer in their notebooks.
4. While participants are writing, quietly tape the 'A new perspective: Cards' around the room.
5. Tell participants they are going to complete a gallery walk and see other perspectives of abortion. Allow 10 minutes for participants to walk around and read the cards.
6. Ask participants to return to plenary. Invite them to revisit their answer to the statement *"Abortion is…"* and make any edits they want to it.

7. Facilitate a brief, large group discussion. You may wish to use the discussion questions below. Allow 10 minutes for the discussion.
    a. *How would you describe your new statement compared to your original one?*
    b. *If you edited your statement after the walk, what made you edit it?*
    c. *What did you learn about your own perceptions of abortion through this activity?*
    d. *What did you learn about abortion through this activity?*
8. Summarize key points from the discussion. If you want, you can present the slides for this activity **(slides 8–19)** to reinforce learning messages. Allow 10 minutes for this presentation.
9. Solicit any final thoughts or comments from participants. Thank them for their participation and segue to the next activity.

NOTE TO FACILITATOR

At the end of the workshop, ask participants to revisit their statement on abortion once more. Invite them to reflect on how their beliefs, attitudes, knowledge and skills related to abortion have changed as a result of the workshop, and ask them to write a new statement. Make sure there is space in your agenda for this. If you use the sample agenda in the Workshop Tools, time has been built in for this already

A NEW PERSPECTIVE: CARDS

Print the cards that follow on different colored paper and post them around the workshop venue.

Abortion is...

THE TERMINATION OF PREGNANCY BEFORE FETAL VIABILITY

Abortion is the termination of pregnancy, through the evacuation of the contents of the uterus. It can be induced or spontaneous. A spontaneous abortion happens without any deliberate intervention, and is sometimes called pregnancy loss or miscarriage. An induced abortion is the intentional termination of a confirmed pregnancy.

Abortion is...

AN ANCIENT AND CROSS-CULTURAL PRACTICE

Women have managed their fertility for millennia. Evidence that women have practiced abortion has been found in hunting and gathering groups, agricultural peasant societies, and in pre-industrial, industrial and post-industrial communities around the world (Shain, 1986). Early writings on abortion date back to medical scripts from Ancient Egypt in 1,500 B.C.E., Ancient China in 500 B.C.E. and the Greek and Roman Empires (Potts & Campbell, 2002). In the 11th century, Islamic philosopher and physician Avicenna wrote *The Canon of Medicine*, an influential medical textbook, which included a whole chapter on regimens of abortion (Riddle, 1997).

Abortion *can be*...

ONE OF THE SAFEST MEDICAL PROCEDURES

An induced abortion is safe when performed by persons with the necessary training and skills, and in an environment meeting minimal medical standards. In early pregnancy, safe abortion is one of the safest medical procedures (IPPF, 2004). Data from the United States indicate that the maternal mortality rate for childbirth is approximately 25 times higher than that for safe, legal abortion. Research worldwide shows that complications from safe abortion are extremely rare too.

Abortion *can be*...

AN UNSAFE PROCEDURE when:

It is performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both. Unsafe abortion carries significant risks to the woman's health and life.

UNSAFE abortion is...

A LEADING CAUSE OF DEATH AND DISABILITY AMONG WOMEN

In 2010, 287,000 women died from pregnancy and childbirth-related complications (WHO et al., 2012). Unsafe abortion-related deaths accounted for about 13 percent of overall maternal mortality in both 2003 and 2008 (WHO, 2011). In individual countries, the ratio may be much higher.

Adolescent girls aged 15–19 are disproportionately affected by unsafe abortion. In Sub-Saharan Africa, adolescent girls account for about 70 percent of all hospitalizations from unsafe abortion-related complications (United Nations, 2004).

UNSAFE abortion is...

A PREVENTABLE PANDEMIC

In 2008, an estimated 22 million unsafe abortions took place globally, resulting in 47,000 women dying and an additional five million suffering disabilities (WHO, 2012c). Almost all unsafe abortion-related mortality and morbidity can be prevented by addressing unmet needs for contraception and by making safe abortion services readily accessible (Grimes et al., 2006).

UNSAFE abortion is...

A DRAIN ON PUBLIC HEALTH RESOURCES

Treatment of unsafe abortion-related complications places a significant burden on public health systems in the developing world (Vlassoff et al., 2009). Ensuring women's access to safe abortion services in the first place lowers costs for health systems. Postabortion care offered by physicians in tertiary hospitals was estimated to cost health systems ten times more than elective abortion services offered by midlevel practitioners in a primary care setting (Grimes et al., 2006).

UNSAFE abortion is...

A TRAGEDY FOR SOCIETIES

The indirect costs of unsafe abortion to women and societies are substantial. Children who lose their mothers from unsafe abortion-related deaths often receive less health and social care and are more likely to die than children who have two living parents (Vlassoff et al., 2004). Unsafe abortion can lower economic productivity in a community. It drains scarce health-care resources.

Abortion is...

A GLOBAL PUBLIC HEALTH ISSUE

The extremely high number of women and adolescents who continue to risk their health and lives by resorting to unsafe abortion makes it an important global public health issue.

"Unsafe abortion has eaten into our society, gradually destroying the lives of young women, as people have closed their eyes at the issue hoping it will disappear: but [in doing so] they are also directly and indirectly worsening the situation."

— Young woman, Nigeria (Youth Coalition, 2007)

SAFE abortion is...

AN ESSENTIAL COMPONENT OF REPRODUCTIVE HEALTH CARE

Access to safe abortion is essential to ensure women's reproductive health and well-being. It complements other important services such as contraception, antenatal care and adoption. A lack of safe health-care choices during pregnancy, including safe abortion, contributes to poor reproductive health outcomes for women.

SAFE abortion is...

A HUMAN RIGHT

Human rights can be applied to safe abortion. A woman's access to safe, legal abortion protects several of her human rights. For example: Women have the right to decide whether and when to have children. Women also have the right to health and health care. Women's physical and mental health should not be compromised by forced motherhood or unsafe abortion.

Abortion is...

A DEEPLY PERSONAL DECISION

"Before I had the abortion, I prayed and cried to God... I thanked Him for the pregnancy, but I asked if He could just hold on to my baby for a little while longer until I'm ready to be a mother. I didn't see it as killing a baby—I was giving the life within me back to God to protect and hold onto until the right time."

(Source: www.imnotsorry.net)

Activity 1.C: Abortion and me

Adapted from: McSmith, D., Börjesson, E., Villa, L., & Turner, K. L., 2011

PURPOSE

Participants will visually explore and show themselves and other participants how they relate to or have been affected by abortion. It encourages honesty through self-reflection and discourages participants from mimicking others.

TIME

45 minutes

MATERIALS

» Flipchart, tape and markers (enough markers for each participant to have one).

PREPARATIONS

1. On flipchart, write the question *"How does abortion affect you?"*

INSTRUCTIONS

1. Invite participants to actively participate in this activity. Inform them this activity is an opportunity to think about what abortion means to them on a more personal level. You may wish to say:

   Often, conversations about abortion are about whether people approve or disapprove of it, or on differences in our beliefs and values. Yet few people thoughtfully examine their own personal feelings and experiences with abortion. In this activity, we are going to focus on how abortion affects each of us personally. This may include what we think and feel, as well as what we have experienced.

2. Give each participant a flipchart and make multiple markers available on all tables.

3. Ask participants to quickly draw the contours (outlines) of their own body on their flipchart. Instruct the participants to take two minutes to personalize their drawings and make each drawing unique and representative of the individual. Participants may draw their hair or eye color, earrings, favorite shoes, a hat or scarf, or other identifying details.

4. Ask participants to identify different roles they have in their life, and write those on their flipchart. For example: sister, brother, best friend, partner, medical student, sports practitioner, etc.

5. Tell participants:

   Your drawing represents you. Whether you have or have not had an abortion, and whether you do or do not know someone who has had an abortion, chances are that you have been affected in some way by the issue of abortion. Abortion may affect you in different ways as a family member, friend or professional. Please take a few moments to quietly consider your own thoughts, feelings and experiences related to abortion. Then draw or write on your flipchart how abortion affects you and some of your own thoughts, feelings and experiences with abortion. Please work silently while you draw.

6. Post the flipchart: "*How does abortion affect you?*" This allows for easier visual reflection for participants as they work

7. Invite the group to draw whatever this activity prompts them to draw. Allow participants to sit with any uncertainty until they are able and ready to begin. Allow 15 minutes for this task.

8. After 15 minutes, tell the group the drawing time is finished. Ask participants to pair up with someone sitting close to them. Invite participants to share what they drew or wrote and why in their pairs. *Remind participants about the group norm of confidentiality established at the beginning of the workshop. Respect the wishes of those who prefer not to share. Allow five minutes for this sharing.*

9. *When participants have finished sharing their drawings with each other, acknowledge the creativity of the group and the many ways in which they responded to the question, "How does abortion affect you?"* Invite them to tape their drawings on the wall.

10. If you sense the group wants to share more about their experiences, facilitate a brief, large group discussion. Make sure you have 10–15 minutes left for discussion.

    a. *How did you feel as you were working? Were you surprised by any of the thoughts, feelings or experiences that you drew or wrote down?*

    b. *What did you learn about how abortion affects you? How it matters to you?*

    c. *How might this activity help you set a personal intention for this workshop? For working on abortion issues beyond this workshop?*

11. Thank participants for their creativity and honesty in this activity, and inform them that they will have an opportunity to revisit their drawings at the end of the workshop.

Participants may feel confused by these instructions. They may ask you to explain more clearly what you mean, or may offer various interpretations of what they think you mean. If they ask questions or for clarification, reassure them there is no wrong interpretation of this activity. Whatever comes to mind is right for them to draw on their flipchart.

Dedicate a wall in the venue for the participants' drawings in this activity, and leave them up there for the duration of the workshop. At the end of the workshop, ask participants if they want to modify their drawings. If they do, make sure you have markers available. Additions or changes to the drawings provide an opportunity for both participants and facilitators to assess whether and how they have changed as a result of the workshop. Make sure there is space in your agenda for this.

MODULE 2:
Human rights, gender and abortion

Photo illustration; original photo © Richard Lord

Module 2: Human rights, gender and abortion

LEARNING OBJECTIVES

This module introduces participants to human rights and sexual and reproductive rights—and provides rights-based arguments for universal access to safe, legal abortion. It also helps participants understand how gender norms and discrimination affect women's and adolescents' experiences with abortion. This module encourages participants to challenge preconceived notions and develop more critical perspectives of the different societies in which we live. By the end of this module, participants will be able to:

- Articulate how human rights support access to safe abortion;
- Describe the relationship between gender discrimination and abortion;
- Explain how men can affect women's experiences with abortion.

CORE RESOURCES

- ❑ Pizarro, P., Baker, T., Chagas, J., Miranda, M. E., & Ribadeneira, N. (2007). Chapter 3: Abortion and Human Rights. *Freedom of choice, a youth activist's guide to safe abortion advocacy.* Ontario, Ottawa: Youth Coalition for Sexual and Reproductive Rights. http://issuu.com/youthcoalition/docs/abortion_advocacy_guide/1
- ❑ International Planned Parenthood Federation (IPPF). (2009). *Sexual rights, an IPPF declaration* (abridged version). London, UK: IPPF. www.ippf.org/sites/default/files/ippf_sexual_rights_declaration_abridged.pdf
- ❑ Ipas. (2011). *What can men do to support reproductive choice?* Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/What-can-men-do-to-support-reproductive-choice-.aspx

Facilitators can check off the boxes as they complete the core resources.

SUPPLEMENTARY RESOURCES

HUMAN RIGHTS

International Federation of Medical Student Associations (IFMSA). (2012). *Women's rights to sexual and reproductive health.* Published online at: www.ifmsa.org/Media-center/Policy-Statements/Women-s-Rights-to-Sexual-and-Reproductive-Health2

International Federation of Medical Student Associations (IFMSA). (2014). *Access to safe abortion*. Published online at: www.ifmsa.org/Media-center/Policy-Statements/Access-to-Safe-Abortion

Ipas. (2013). Chapter 2: Reproductive Rights. *Woman-centered comprehensive abortion care: Reference manual* (2nd ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Woman-Centered--Comprehensive-Abortion-Care-Reference-Manual--Second-Edition.aspx

Skuster, P. (2013). *Young women and abortion: Avoiding legal and policy barriers*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Young-Women-and-Abortion--Avoiding-Legal-and-Policy-Barriers.aspx

GENDER

International Sexuality and HIV Curriculum Working Group. (2009). Unit 2: Gender. *It's all one curriculum.* New York, NY: Population Council. www.popcouncil.org/publications/books/2010_ItsAllOne.asp

Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising abortion stigma. *Culture, Health and Sexuality*, 11(6): 625–39. www.ipas.org/en/Resources/Ipas%20External%20Publications/Conceptualising-abortion-stigma.aspx

MEN AND ABORTION

Abortion Care Network. *Especially for men*. Published online at: www.abortioncarenetwork.org/images/men/EspeciallyForMen.pdf

Ipas. (2009). *Exploring men's roles in women's decisions to end pregnancies. A literature review with suggestions for action*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Exploring-mens-roles-in-women-s-decisions-to-end-pregnancies--A-literature-review-with-sug.aspx

Katz, J. (2012). *Violence against women—it's a men's issue*. TEDx FiDi Women. www.ted.com/talks/jackson_katz_violence_against_women_it_s_a_men_s_issue.html

HUMAN RIGHTS, GENDER AND ABORTION

Decisionmaking about fertility and childbearing does not happen in a vacuum. Social norms and conditions influence women's rights and abilities to make and act on reproductive health decisions. These norms and conditions also affect women's experiences with abortion. Knowledge on human rights, sexual and reproductive rights and gender can help advocates to stand confident and strong in support for safe, legal abortion.

> ***Women and girls anywhere in the world should have the right of choice over their lives and command over the integrity of their bodies.***
>
> —**Vaira Vike-Freiberga**, first Female President of Latvia (United Nations Foundation, 2012b)

2.1 A RIGHTS-BASED APPROACH TO ABORTION

What are human rights? Human rights are basic prerogatives and protections, for example: equal treatment under the law; freedom from discrimination, ill-treatment and torture; freedom of thought, expression and religion; access to shelter, food, and water; and the right to health and health-care, among others (United Nations, 2013). Human rights are the social justice aspirations of contemporary societies, and they guide us to live in ways that are fair and respectful for all people. They continuously evolve to respond to the needs of groups of people previously not recognized. Principles that apply to human rights include:

- **Universality:** All human beings worldwide are born with and possess the same human rights.
- **Inalienability:** Human rights are unconditional and cannot be taken away from any human being by any state, institution or other person.
- **Non-discrimination:** Everyone is entitled to all human rights regardless of their personal differences, such as sex, gender, sexual identity, ethnicity, religion or political affiliation.
- **Indivisible:** All human rights are essential to the integrity of every human being. They have equal status and one right is not more important than another right.
- **Interdependency:** A person cannot fully exercise one human right without access to the other rights. When one right is advanced or violated, other rights are affected as well.

Human rights are formalized in international agreements, which become legally binding when states ratify them. Everyone in the global community, particularly states, has responsibilities for promoting, protecting and guaranteeing human rights, and for refraining from acts that violate those rights (United Nations, 2013). In reality, states and institutions often threaten to or directly violate human rights (International Sexuality and HIV Curriculum Working Group, 2009). People who experience human rights violations can seek redress through their national justice system. If national-level courts do not adequately address a case, it may be possible to bring it to a regional or international court such as the Inter-American Human Rights Court, the African Court on Human and People's Rights, or the European Court of Human Rights.

What are sexual and reproductive rights? Sexual and reproductive rights are prerogatives and protections related to the exercise and expression of sexuality and human reproduction. These rights include free and informed decisionmaking about intimacy and sex, long-term relationships and marriage, and childbearing (IPPF, 2009). Most human rights can be applied to the sphere of sexuality and reproduction too. Freedom from discrimination, ill-treatment and torture includes freedom from discrimination based on one's gender or sexual identity and freedom from sexual violence and abuse. The right to health necessitates that all people have access to reproductive health-care services and commodities. Sexual and reproductive rights imply that:

> *"... people are able to enjoy mutually satisfying and safe relationships free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences"* (IPPF, 2003).

Do women have a right to abortion? A woman's access to safe, legal abortion protects several of her human rights and sexual and reproductive rights. Conversely, when a woman resorts to unsafe abortion, several of these rights are compromised. Table 2.1 lists examples of how human rights can be applied to abortion. It can serve as a guide if you are in doubt of whether an abortion-related situation is potentially violating a woman's rights. Several human rights agreements and regional treaties also specifically address abortion:

- In 1992, the Committee on the Elimination of All Forms of Discrimination Against Women recommended that states "*ensure women are not forced to seek unsafe medical procedures such*

as illegal abortion because of lack of appropriate [safe] services in regard to fertility control" (United Nations, 1992).

- In 1994, the International Conference on Population and Development (ICPD) defined reproductive health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" and recommended that in circumstances where abortion is not against the law it should be safe, and that optimal access to quality postabortion care should always be ensured (UNFPA, 1995). This recommendation was reaffirmed by the Commission on Population and Development in 2009.
- In 1995, the Fourth World Conference on Women urged states to "*consider reviewing laws containing punitive measures against women who have undergone illegal abortions*" (UNESCO, 1995).
- In 1999, a Special Session of the United Nations General Assembly stated that "*health systems should train and equip health-service providers and should take other measures to ensure that abortion is safe and accessible [for all indications for which it is legal]"* (United Nations, 1999).
- In 2003, the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also known as the Maputo Protocol). Article 14 affirms that states shall "*protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus*" (African Commission on Human and People's Rights, 2003).

TABLE 2.1 HUMAN RIGHTS AND ABORTION (Adapted from Donnelly, 1993; Ipas, 2008)

Human right	Applications to safe abortion
Right to life [A, C]	No woman's life should be put at risk because of pregnancy or unsafe abortion.
Right to liberty and security of the person [A, C]	No woman should be forced to continue an unwanted pregnancy. No woman should be forced to have an abortion against her will. Her decision should be taken in conditions that guarantee her physical and mental integrity as a person.
Right to equality and to be free from all forms of discrimination [A, B, C, D]	Only biologically female persons can become pregnant. Women who are not legally supported to manage their fertility are discriminated against based on their sex. Women should not be discriminated against by abortion laws that restrict their reproductive decisionmaking.
Right to freedom of thought, conscience and religion [A, C]	Women are capable of making decisions in accordance with their own conscience and religious beliefs. No woman should be forced to continue a pregnancy based on the religious beliefs of third parties. A woman should not be put in a situation where people try to make decisions on her behalf.
Right to information and education [A, B, D]	Women should have access to education that empowers them to prevent unintended pregnancy, including information about their bodies, human reproduction and contraception. Women should know their options for managing an unintended pregnancy, including carrying the pregnancy to term and terminating it safely. Women should be able to continue their formal education, despite being pregnant, having an abortion or having a child.
Right to work and a job with favorable conditions [A, B, D]	Women should have access to jobs that provide fair and equal income. Women should work in conditions where their physical and mental integrity is not compromised. This includes a work place and employment conditions that do not place women at risk of experiencing sexual violence, unwanted pregnancy or unsafe abortion. In countries where health-care insurance is part of work compensation it should cover contraception and safe abortion.
Right to choose the number and spacing of their children [D]	Women should be able to choose how many children they will have and how to space them. When women experience forced pregnancy or unwanted pregnancy without safe options for terminating it, this right is violated.
Right to health care and health protection [A, B, D]	Women should have access to abortion in a health-care setting that meets minimal medical standards and with adequate guidance of a trained provider. Services should be accessible and affordable for all women. Women's physical and mental health should not be compromised by an unsafe abortion.
Right to the benefits of scientific progress [B, D]	Women should have access to safe, recommended abortion methods. Providers need to be trained in the use of vacuum aspiration and medical abortion. Health systems need to ensure the correct and timely availability of these technologies. Cost should not be a barrier to access safe, recommended technologies.
Right to freedom of assembly and political participation [A, C, D]	All people are free to organize themselves to advocate for better laws, guidelines, funding and services related to safe abortion. Their rights and integrity should not be jeopardized by participating in these activities.
Right to be free from torture and ill-treatment [A, C, D]	Women should not be forced to continue a pregnancy when they do not want to. This is particularly critical in situations where the woman's health and life are at risk, either because the pregnancy is causing or worsening dangerous medical conditions, or is contributing to situations that put the woman at greater risk, such as domestic violence or abuse, including honor killing.
Right to live free from violence [D]	Women should not get pregnant against their will due to sexual violence. Women who experience sexual violence should not be re-victimized by providers and legal systems (for example: mandating police reports as a condition for safe, legal abortion). Providers and law enforcement individuals re-victimize a woman when they question her decision to interrupt her pregnancy or when they doubt her testimony about experiencing violence.

Referenced treaties and conventions: A) Universal Declaration of Human Rights; B) International Covenant on Economic, Social and Cultural Rights; C) International Covenant on Civil and Political Rights; D) Convention on the Elimination of all Forms of Discrimination Against Women.

What rights do adolescents have? Adolescents have the same human rights as adults. They are also entitled to unique protections, which are outlined in the Convention on the Rights of the Child (CRC). The CRC identifies responsibilities of families and states to ensure those rights. In the CRC there are three principles that can provide guidance in the context of sexual and reproductive health, including abortion (Skuster, 2013).

- **The child's best interests** must be the primary concern in all actions concerning the child (Article 3). Ensuring access to safe, legal abortion for an adolescent who wishes to terminate a pregnancy can protect her life and health, and thus be in her best interest.
- **The principle of evolving capacities** recognizes that parents and caregivers should provide direction in a manner consistent with the child's capacities (Article 5). As a child's capacities evolve, her rights and responsibilities gradually supersede those of her parents and caregivers (Lansdown, 2005). No adult should attempt to direct an adolescent's abortion decisionmaking if the adolescent has the capacity to make the decision (Turner et al., 2011).
- **Confidentiality** must be protected to ensure that health-care services are accessible to children (Committee on Economic, Social and Cultural Rights, 2000). Children have a right to access "*private and confidential medical advice without parental consent, irrespective of the child's age, where this is needed for the child's safety and well-being*" (United Nations, 2009). All sexual and reproductive health-care services, including counseling, should be made available to adolescents on a basis that respects their privacy and confidentiality (IPPF, 2009).

More states have ratified the CRC than any other human rights agreement. Only Somalia and the United States have not ratified it. The Committee on the Rights of the Child is tasked with monitoring national-level implementation of the CRC. In 2011, the Committee on the Rights of the Child called on the Ukraine to take urgent measures "*to ensure by law and in practice that the views of the child should always be heard and respected in abortion decisions*" (United Nations, 2011). National laws or practices that restrict adolescents' right to consent to safe abortion services in accordance with their capacities can drive adolescents to seek life-threatening, unsafe abortions instead (Turner et al., 2011). Module 4 provides more information on adolescents' capabilities to make health-care decisions, including on abortion.

TEXTBOX 2.1: REPRODUCTIVE JUSTICE AND ABORTION

Before Nepal liberalized its abortion law in 2002, thousands of women accused of abortion were arrested, prosecuted and imprisoned; many wrongfully and without legal representation. One inmate and mother of four recalls:

I went into labor digging in the fields. I hadn't taken any precautions just because I was pregnant; I ***had*** *to work. I was five months and the fetus was expelled dead. I told the village elder that I had miscarried but he responded by saying "You killed it!"… The police came and arrested me for "the murder of a fetus." I was kept in custody for 25 days. The police made me give a statement saying that I killed my child. I told the court that I didn't. I was confronted with the question "Then who did?" I continued to deny having killed the fetus but no one listened. I didn't have a lawyer and wasn't informed about my right to legal representation. No one tried to get a lawyer for me and I didn't ask for one because I didn't know that I could. I was taken to court a couple of times, but not on the day of the final hearing. The court handed down a sentence of 12 years in prison using their discretionary power.* (Center for Reproductive Rights and Forum for Women, Law and Development, 2002, emphasis added)

Many countries in Latin America and elsewhere around the world still have restrictive abortion laws; some ban abortion even to save the woman's life. In Argentina, Bolivia and Brazil, most women who are arrested on charges of abortion are marginalized in some way. They are predominantly poor, indigenous, Afro-descendent, or young, and lacking legal representation (Kane et al., 2013).

These human rights violations and socioeconomic and legal injustices illustrate the importance of looking at reproductive rights issues through multiple lenses, such as gender- and age-based discrimination, racism, poverty, and migration. Access to safe abortion is just one of many priorities for women who are marginalized and who lack the power to make and act on decisions about their life and health (Stillman et al., 2004). This is the essence of the 'reproductive justice' framework. It recognizes that women's reproductive health is directly linked to conditions in the communities where they live (Ross, 2007) and affirms that **all** women have the right to:

- Prevent pregnancy, and continue or end a pregnancy;
- Parent their children with dignity, respect and the necessary social support, and in safe environments (Pope, 2013).

When we apply the 'reproductive justice' framework to abortion we:

- See the whole woman, including her needs and circumstances, holistically;
- Address socioeconomic injustices that contribute to unintended pregnancy and unsafe abortion;
- Support women to make and act on reproductive health decisions freely, fully and safely;
- Partner with marginalized women most affected by discrimination and inequalities;
- Build movements and allies across interrelated social issues.

2.2 GENDER AND ABORTION

What is gender? Gender is a socially constructed system of categorizing people based on sociocultural beliefs about what behaviors, characteristics and attributes are inherently masculine and feminine (Turner et al., 2011). Gender identity is a person's internal sense of self. There are many different gender identities, including man, woman, transman, transwoman, bi-gender and a-gender. A person's gender identity may be the same or different from the identity they were assigned at birth, and can change

throughout life. Worldwide, sociocultural beliefs about gender can lead to stereotyping, discrimination and violence (International Sexuality and HIV Curriculum Working Group, 2009). Examples of this discrimination include limits on women's—particularly young women's—access to formal and informal education and restrictions on women's economic assets based on their subordinate status in society.

How does gender affect abortion? Gender stereotypes, discrimination and violence influence women's experiences with abortion in many different ways. For example:

- **Unintended pregnancy.** Women's subordinate status can impact their ability to make and act on decisions about relationships and childbearing, including whether to have sex and whether to use contraception. Women often have less power and control than men over the timing and type of sexual relationships they have, and many women experience unintended pregnancy from sexual violence (IPPF/WHR, 2002).
- **Social ideal of womanhood.** The social ideal of womanhood is often equated with motherhood. For example, female sexuality is accepted solely for the purpose of reproduction, all women are expected to want to become mothers, and women are not seen as 'real women' until they have children (Kumar, 2013). For many women worldwide, seeking abortion challenges deep-rooted beliefs and attitudes about womanhood (Kumar, 2013).
- **The decision whether to continue or end a pregnancy**. For an unmarried, young woman the decision whether to continue or end a pregnancy may be controlled by her parents. A married woman may have to surrender to the wishes of her husband or mother-in-law. A study with 1,400 Indian women identified limited agency among rural young women in terms of making decisions, freedom of mobility, self-efficacy and sense of self-worth. Of the married women who had experienced abortion, one third had had *no* role in the decisionmaking (Banerjee et al., 2013).
- **Access to safe abortion.** A lack of information can leave women without the knowledge that safe, legal abortion is an

Textbox 2.2: What's the latest in defining and understanding gender?

The words gender, sex and sexuality are increasingly part of public discourse. There are some commonly used definitions of these concepts in the Glossary. Because their meanings are constantly changing in response to people's lived experiences and needs, and global and local conversations, it is important that you revisit these concepts on a continued basis.

option. With limited agency and control of economic assets, accessing safe abortion services can be challenging. In some countries, married women need spousal authorization to obtain safe abortion care (Center for Reproductive Rights, 2009). Registration paperwork that requires a husband's name may leave unmarried women feeling that services are not available to them (Turner et al., 2011). Fear of social repercussions and segregation can also drive women to seek unsafe abortion.

- **Quality of abortion care.** A provider's beliefs and attitudes about gender, womanhood and female sexuality can influence the care he or she provides. For example, if a woman is young and unmarried, the provider may withhold pain management during the abortion procedure to discourage what they consider to be inappropriate sexual behavior. If a woman is married, the provider may believe that she should be happy about the possibility of motherhood and refuse to provide abortion services. In Bangladesh, one in five health-care facilities surveyed on menstrual regulation services reported completely denying care if the woman did not already have children (Guttmacher Institute, 2012).

Promotion of gender equality improves women's access to sexual and reproductive health information and care, including abortion (Interagency Gender Working Group, 2010). Programs that aim to increase access to safe abortion should critically examine gender norms; strengthen already equitable norms; and challenge gender stereotypes. In communities where gender discrimination is entrenched and pervasive, a strategic first step can be to raise awareness of the existing inequalities (FHI360, 2012). Consider the example of abortion law reform: Advocacy for legal abortion on demand recognizes the right to safe abortion for all women, but it may encounter too much opposition to be successful. Advocacy to expand access to legal abortion in cases of rape may garner widespread support, but it can also perpetuate sociocultural beliefs that certain sexual behaviors are 'unacceptable' for women, and that some women are more 'worthy' of safe abortion services based on the circumstances surrounding their pregnancies. In this case, it would be important to recognize the gender stereotypes that limit the extent to which the abortion law can be reformed, and gradually work toward challenging those beliefs.

Abortion as a men's issue: Abortion is often understood narrowly as a women's issue. The many different ways that men relate to abortion, personally and professionally, are mostly

absent in information, programs and services (Ipas, 2009). Men are the fathers, brothers, sons, husbands, partners and friends of the thousands of women who have abortions every day. Male sexual partners have shared responsibility for the pregnancy. Men are also among the health professionals, the legislators, the judges and the attorneys who come in direct contact with women who seek or have had abortions.

Men's beliefs and attitudes affect women's experiences with abortion. In patriarchal societies, where men are expected to be dominant and 'in control,' some men think of abortion as a strategy for women to hide promiscuity or infidelity (Izugbara, 2007). As a result, many women seek abortion in secret and unsafely. While some men negatively influence or control women's decisionmaking processes (Center for Research on Environment Health and Population Activities, 2007), others provide compassionate, respectful support that help women to make free and informed choices. Social beliefs and practices related to sexual and reproductive health and rights will not change if they are addressed as women's issues (Katz, 2013). There are many ways for men to take action:

- Reflect on their own beliefs and attitudes and how those affect women's experiences;
- Educate themselves about human rights, sexual and reproductive rights, and reproductive justice;
- Take responsibility by living in mutually respectful, healthy relationships;
- Talk to family members and friends about these issues;
- Advocate against barriers to safe reproductive health care, including contraception and abortion services, that women face at local and national levels;
- Provide support to women who need help in accessing those services (Ipas, 2011). Research from Africa shows that many women welcome the logistical support men can provide (Calvès, 2002; Svanemyr & Sundby, 2007).
- Accompany women through the abortion process.

When a man accompanies a woman through an abortion process, he may feel concern for her and wonder how he can best support her (Ipas, 2009), or he may have personal feelings about the pregnancy and the woman's decision to terminate it (Shostak et al., 2006). Health-care facilities and professionals can

offer abortion-related information and counseling to men too (Ipas, 2011).

THE BOTTOM LINE

- Human rights are basic prerogatives and protections to which all human beings are entitled at birth. Sexual and reproductive rights are rights related to the exercise and expression of sexuality and human reproduction. If a woman is denied access to safe abortion care, several of these rights may be violated.
- When we analyze sexual and reproductive rights issues through multiple lenses, such as gender, racism and poverty, we are better able to identify what different women need to make and act on reproductive health decisions freely, fully and safely in their own communities.
- Gender is a socially constructed system of categorizing people based on social beliefs about what behaviors, characteristics and attributes are inherently masculine and feminine. Gender discrimination affects women's experiences with abortion in different ways, such as by placing women at risk for unintended pregnancy, restricting their autonomous decisionmaking, and limiting access to safe abortion services.
- Men can support women by taking responsibility within their own relationships, and advocating for women's reproductive choices within their communities and beyond.

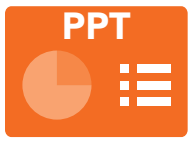
MODULE 2 TOOLS

Handout 2: Human rights, gender and abortion

Activity 2.A: Access denied: Human rights and abortion (45 minutes)

Activity 2.B: Gender and abortion (1 hour)

Activity 2.C: Abortion as a men's issue (45 minutes)



This module is accompanied by presentation '**MODULE 2**' **(Slides 1–30)**. Remember, all printable materials and presentation slides are available on the USB and at www.ipas.org/youthact.

Want more attitude transformation?

Depending on your learning objectives, participants' preferences and the training workshop agenda, you may also wish to conduct the activity below.

WHY DID SHE DIE? This activity features a case study that highlights the sociocultural context around a woman's unwanted pregnancy and abortion decision. Participants are confronted with the tragic consequences that can result when access to safe, legal abortion services is restricted; then participants are asked to articulate their personal or professional responsibility to prevent such tragic consequences. This activity takes about 45 minutes.

A detailed activity description and facilitator instructions can be found in:

Turner, K. L., & Page, K. C. (2011). *Abortion attitude transformation: A values clarification curriculum for global audiences.* Chapel Hill, NC: Ipas.

A youth-specific adaptation of 'Why did she die?' can be found in:

McSmith, D., Börjesson, E., Villa, L., & Turner, K. L. (2011). *Abortion attitude transformation: Values clarification activities adapted for young women.* Chapel Hill, NC: Ipas.

Handout 2: Human rights, gender and abortion

Human rights are universal and unconditional protections that all human beings—regardless of our many differences—are entitled to from birth, such as the rights to health and to freedom from discrimination. They guide us to live in ways that are fair and respectful. When states ratify human rights agreements, those agreements become legally binding.

Sexual and reproductive rights relate to the exercise and expression of sexuality and human reproduction, including women's right to decide whether, when and with whom to have children (IPPF, 2009). When a woman resorts to unsafe abortion, several of these rights may be violated.

Different international and regional human rights agreements address abortion:

- *"In circumstances where abortion is not against the law, [it] should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion."* (ICPD, 1994)
- States should "*consider reviewing laws containing punitive measures against women who have undergone illegal abortions*" (Fourth World Conference on Women, 1995)
- Health systems should *"train and equip health-service providers and take other measures to ensure that abortion is safe and accessible [for all indications for which it is legal]"* (United Nations, 1999)
- The member states of the African Union should "*protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus*" (African Commission on Human and People's Rights, 2003)

Gender is a socially-constructed system of categorizing people based on social beliefs about what behaviors, characteristics and attributes are inherently masculine and feminine (Turner et al., 2011). Gender discrimination affects women's experiences with abortion in many different ways:

- Women's subordinate status can impact their agency in sexual relationships, and put them at risk of sexual violence and unintended pregnancy.

- In many societies, female sexuality is only accepted for procreation. Women who seek abortion challenge social ideals of womanhood (Kumar, 2013).
- Other family members often control the decision whether to continue or end a pregnancy.
- With limited freedom of mobility and control of economic resources, accessing safe abortion services can be challenging. In some countries, spousal authorization is legally required.
- When abortion care is accessible, the provider's beliefs and attitudes about gender, womanhood and female sexuality can influence the quality of care.

In their roles as partners, fathers, brothers and sons, men relate to abortion personally. If they are health-care professionals and policymakers they may also come into contact with abortion professionally. Men can advocate for women's reproductive choices and against barriers to safe abortion services. They can provide emotional and logistical support to women they know.

Activity 2.A: Access denied: Human rights and abortion

PURPOSE

Participants will increase their understanding of human rights and sexual and reproductive rights and examine, through real-life case studies, how a lack of safe abortion care can be a violation of these rights. Participants will also discuss how conditions in a woman's community can affect whether her rights are fully realized.

TIME

45 minutes

MATERIALS

» Presentation 'Module 2,' **Slides 5–15**

» Supporting document 'Case studies'

» Supporting document 'Case resolutions'

» Table 2.1 'Human rights and abortion' (from this module's narrative)

» Flipchart, tape and markers

PREPARATIONS

1 Review the presentation slides.

2. Review the court resolutions of the different cases to familiarize yourself with the different ways international and regional courts have resolved cases in which women were denied safe abortions.

3. Print two copies of the 'Case studies.'

4. Print copies of Table 2.1 'Human rights and abortion,' enough for all participants.

5. Write the following discussion questions on flipchart. These questions will guide participants through the discussion of the cases.

    a. *What human rights do you think were violated, or were not guaranteed, in your case? How?*

    b. *What conditions need to be in place in a community for all women's human rights to be fully realized?*

    c. *What do you think is the role of health sciences students in protecting and guaranteeing human rights, including safe abortion? What is the role of practicing health professionals?*

INSTRUCTIONS 1 2 3

1. Invite everyone to actively participate in this activity. Inform them the purpose of this activity is for participants to increase their understanding of human rights and sexual and reproductive rights and examine, through real-life case studies, how denied access to safe abortion care can violate these rights. Participants will also discuss how conditions in a woman's community can affect whether her rights are fully realized.
2. Show participants all the slides for this activity **(slides 5–15)**. Allow 10 minutes for this presentation. Encourage participants to ask clarifying questions as needed.
3. After the presentation, post the flipchart with the discussion questions.
    a. *What human rights do you think were violated, or were not guaranteed, in your case? How?*
    b. *What conditions need to be in place in a community for all women's human rights to be fully realized?*
    c. *What do you think is the role of health sciences students in protecting and guaranteeing human rights, including safe abortion? What is the role of future health professionals?*
4. Divide participants into four small groups. Provide each participant a copy of Table 2.1 'Human rights and abortion.' Give each group one of the case studies. There are only two cases, so therefore two groups will have the same case. Ask the groups to read their case and answer the discussion questions you posted on flipchart. Ask the groups to write their answers on a flipchart. Allow 20 minutes for this small group discussion.
5. Ask participants to come back together in plenary. Invite one representative from each group to briefly summarize their case and share highlights of their discussions.
6. Summarize key points from the participant-led discussions.
7. Tell participants how each case was resolved in the regional courts of human rights that tried them, using the supporting document 'Case resolutions.'
8. Ask participants to share their reactions and thoughts about the resolutions of the cases.
9. If time permits, you can invite the groups to elaborate on how they as future health professionals could have advocated for the women in their cases.

10. To close this activity, tell participants:

    All people have the right to enjoy mutually satisfying and safe relationships, free from discrimination or violence. Women have the right to manage their fertility without adverse or dangerous consequences, which includes access to safe contraceptive and abortion services. As members of a global community, we have a responsibility to work every day to protect and guarantee human rights and sexual and reproductive rights for all people. We have to strive to create the social, political and economic conditions that enable and empower all people to exercise their rights. When states violate, deny or fail to guarantee an individual's rights, we have to hold them accountable. We can support justice through national, regional or international courts, and through our advocacy work.

11. Solicit any final thoughts from participants.

12. Thank the group for participating in this activity.

CASE STUDIES

Case A: Lidia

In 1999, Lidia was 13 years old when an unknown man came into her house and raped her in front of her sister and her sister's children aged two and five years old. A few weeks later, she and her mom found out she was pregnant. The doctor at the hospital informed them that Lidia had the right to abortion because the pregnancy was less than 12 weeks gestation and the outcome of a crime, but she needed legal authorization. Lidia decided she wanted to terminate her pregnancy and her mom supported her decision. They went to get legal authorization from the public prosecutor and it was granted. The public prosecutor sent the legal authorization to terminate Lidia's pregnancy to the local health authorities. A series of bureaucratic barriers, harassment and abuse by the local health authorities, providers' misunderstandings of the law and psychological pressures and violence from conservative and religious individuals working at public institutions prevented Lidia from ever having an abortion. Lidia gave birth to her son. It took over six years for the government of her country to recognize, through a resolution by the Inter-American Human Rights Court, that her human rights had been violated.

cut here

Case B: Margaret

Margaret got pregnant for the third time in 2000 when she was 29 years old. At that point, she had severe myopia (nearsightedness) and was evaluated as having a visual disability of medium severity. She was taking care of her two children by herself. Yet she did not qualify for disability payments by the state. Three ophthalmologists recommended termination of the pregnancy given the risk of retinal detachment, but all three refused to issue an abortion certificate to Margaret even though she decided to terminate the pregnancy on their recommendations. A general practitioner also recommended abortion because Margaret had had two Cesarean sections and her risk of uterine rupture was elevated. When Margaret visited her obstetrician and gynecologist, he refused to perform the abortion, saying that a Cesarean section would prevent retinal detachment. He ordered bed rest for Margaret to avoid more damage to her eyes. Bed rest was almost impossible for Margaret since she was the primary caregiver of her two children. Margaret never had her abortion. She gave birth by Cesarean section. Six weeks after the delivery, she was taken to the emergency unit of an ophthalmologic clinic, but surgery was not possible since the damage done to her eyes could not have been corrected by it. Almost a year after her third child was born, the state declared her significantly disabled due to her myopia. Her government recognized violations of her human rights through a ruling by the European Court of Human Rights.

CASE RESOLUTIONS

LIDIA and the Inter-American Human Rights Court resolution:

In 2007, the Inter-American Human Rights Court resolved that several rights were violated by the state, including: the right to non-discrimination and protection of the law; the right to bodily integrity; the right to freedom; the right to judicial guarantees and judicial protection; the right to protection of personal dignity; the right to freedom of conscience and religion; and the right of minors to be protected by family, society and the state. Among the treaties referenced in the resolution are the Universal Declaration of Human Rights; The Convention on the Rights of the Child; The American Covenant on Economic, Social and Cultural Rights; and The Inter-American Convention for the Prevention and Elimination of Violence against Women. The Court also facilitated a "friendly settlement" of the case between the state and Lidia, in which several personal benefits were granted to her and her son, as well as changes in national guidelines for the provision of safe abortion in cases of rape.

MARGARET and the European Court of Human Rights resolution:

In 2007, the European Court of Human Rights ruled that in Margaret's case the state violated human rights #3 (the right to not be subjected to inhuman or degrading treatment) and #8 (the right to private life and non-interference by a public authority with the exercise of the right to privacy) of the European Convention on Human Rights. Margaret was compensated with 25,000 euros in respect of non-pecuniary damage and 14,000 euros in respect of legal costs and expenses.

Activity 2.B: Gender and abortion

Adapted from Turner et al., 2011; *International Sexuality and HIV Curriculum Working Group*, 2009

PURPOSE

Participants will explore how gender norms and social beliefs about sexuality affect women's experiences with abortion. Participants will also discuss how these norms and beliefs can affect quality of abortion care.

TIME

1 hour

MATERIALS

» Presentation 'Module 2,' **Slides 16–24**

» Flipchart, tape, markers

» Supporting materials 'Activity worksheet A' and 'Activity worksheet B'

PREPARATIONS

1. Review the presentation slides.
2. Print two copies of 'Activity worksheet A' and two copies of 'Activity worksheet B.'

INSTRUCTIONS

1. Welcome participants to this activity. Inform them that the purpose of this activity is for participants to explore how gender norms and social beliefs about sexuality affect women's experiences with abortion. Participants will also discuss how these norms and beliefs can affect quality of abortion care.
2. Present the slides 'Introduction to gender' **(slides 17–18)**.
3. Divide the participants into four small groups. Without saying that there are two different case studies, give two of the groups copies of 'Activity worksheet A' and the other two groups copies of 'Activity worksheet B.'
4. Explain to the groups that they have 20 minutes to read the case study and answer the questions on their worksheet. Instruct the groups to assign a note-taker and reporter who can share highlights from their discussion later.

NOTE TO FACILITATOR

In the presentations and discussion that follow, clearly point out common stereotypes of female and male sexuality that participants share. Encourage participants to challenge those stereotypes. Examples of stereotypes that may come up include: women alone are responsible for using contraception and avoiding pregnancy; female sexuality is only for procreation; and a woman's sexual history makes her more or less 'worthy' of health-care services.

5. Ask participants to return to the large group. Explain that the details of all the case studies were identical. Reveal that there was only one difference: For half of the groups Person X was a young woman, and for the other half Person Y was a young man.
6. Invite each group's reporter to briefly summarize their group's responses, first stating whether the person in their case study was a young woman or a young man.
7. Facilitate a discussion of the groups' responses. You may wish to use the discussion questions below. Allow 10 minutes for the discussion.
    a. *What differences or similarities did you notice between the groups' responses?*
    b. *What beliefs and attitudes do we, as a group, hold about female and male sexuality? About womanhood?*
    c. *How can beliefs and attitudes like these affect how socially acceptable a pregnancy is? How socially acceptable abortion is?*
8. Continue the discussion and focus on how gender discrimination affects women's experiences with abortion. You may wish to use the discussion questions below. Allow 10 minutes for the discussion.
    a. *How does gender discrimination contribute to unintended pregnancy?*
    b. *How does gender discrimination affect women's reproductive choices when they are pregnant?*
    c. *How does it affect women's access to safe abortion? The quality of abortion services they are entitled to?*
9. Summarize the discussions, and present the remaining slides related to gender and abortion **(slides 19–24)**. Allow five minutes for this presentation.
10. Solicit and discuss any outstanding questions, comments or concerns with participants.
11. Thank the group for their participation.

ACTIVITY WORKSHEET A

Case study:

Person X is 18 years old. This person has had three sexual relationships over the past two years. This person has stated that they would have liked to remain abstinent until they married, and that they do plan to marry, just not very soon. In their most recent relationship, this person had sex, which resulted in a pregnancy and abortion.

Person X is a woman.

Questions:

1. What were your first reactions to this case study?

2. What assumptions did you make about this young woman? About her life, gender identity and sexual orientation?

3. What conditions in this young woman's community may have influenced her experiences?

4. If her family and friends knew about her sexual history, how is this young woman likely to be perceived and treated by them?

5. Would her family and friends perceive this young woman differently if she was a young man? How?

6. If this young woman's health-care provider knew about her sexual history, how may that affect her access to reproductive health care, including safe abortion?

ACTIVITY WORKSHEET B

Case study:

Person Y is 18 years old. This person has had three sexual relationships over the past two years. This person has stated that they would have liked to remain abstinent until they married, and that they do plan to marry, just not very soon. In their most recent relationship, this person had sex, which resulted in a pregnancy and abortion.

Person Y is a man.

Questions:

1. What were your first reactions to this case study?

2. What assumptions did you make about this young man? About his life, gender identity and sexual orientation?

3. What conditions in this young man's community may have influenced his experiences?

4. If his family and friends knew about his sexual history, how is this young man likely to be perceived and treated by them?

5. Would his family and friends perceive this young man differently if he was a young woman? How?

6. If this young man's health-care provider knew about his sexual history, how may that affect his access to reproductive health care?

Activity 2.C: Abortion as a men's issue

PURPOSE

Participants will identify reasons why abortion is not just a women's issue and discuss how men can affect women's experiences with abortion in different ways.

TIME

45 minutes

MATERIALS

» Presentation 'Module 2,' **Slides 25–29**

» Flipchart, paper and/or index cards, tape

» Crayons, colored pencils and pens, colored markers (and any other art supplies available)

PREPARATIONS

1. Review the presentation slides.

INSTRUCTIONS

1. Welcome participants to this activity. Inform them that the purpose of this activity is for participants to identify reasons why abortion is not just a women's issue and discuss how men can affect women's experiences with abortion in different ways.
2. Ask participants the following discussion questions. Allow 10 minutes for discussion.
    a. *In what personal and professional roles do men experience abortion?*
    b. *How are men affected by abortion?*
    c. *How can social beliefs and attitudes about masculinity and what it means to 'be a man' affect women's reproductive choices?*
3. Present the slides on men and abortion **(slides 25–28)**. Allow five minutes for this presentation.
4. Solicit and answer any clarifying questions participants may have.
5. Ask participants to reflect silently on the following question for a few minutes: *How can men support women's access to safe abortion?*

6. Instruct participants to answer the question in a creative way, for example with a poem, song lyrics, drawings, comic strips or brief role plays. Encourage participants to identify and illustrate examples of actions that men can take, and reassure them there is no right or wrong way to answer the question. Participants can choose whether to work alone or in small groups. Give participants 20 minutes to complete this task.
7. After 20 minutes, ask participants to tape their art work on the walls around the room. Invite participants to walk around the room to see some of the art. Allow five minutes for this step.
8. Invite participants to return to their seats. Ask if anyone wants to read or present their art work to the group and explain a little bit about it. If anyone prepared a role play, invite them to perform it at this time.
9. Summarize key messages from participants' art work and role plays, and highlight different ways in which men can support women's reproductive choices and access to safe abortion.
10. Solicit any last thoughts about this activity.
11. Thank participants for the creativity they brought to this activity.
12. Present the final slide 'Key Messages' **(slide 29)** and continue to the next module.

MODULE 3:
Barriers to safe abortion and strategies to address them

Photo illustration; original photo © Benjamin Porter

Module 3: Barriers to safe abortion and strategies to address them

LEARNING OBJECTIVES

This module increases participants' understanding of barriers that women and adolescents encounter seeking safe abortion, and helps them identify strategies to address those barriers. It encourages participants to explore the role of future and practicing health professionals in increasing access to safe abortion services. By the end of this module, participants will be able to:

- Describe different barriers that affect women's and adolescents' access to safe abortion care.
- Identify different strategies to improve access to safe abortion care, and explain which of these strategies future health professionals are well-suited to implement.

CORE RESOURCES

- ❑ Turner, K. L., Börjesson, E., Huber, A., & Mulligan, C. (2011). Module 2: Barriers to care; Module 5: Making abortion care accessible. *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Abortion-care-for-young-women--A-training-toolkit.aspx
- ❑ Ipas University. (2013). *Legal and policy barriers to abortion*. Online course available at www.ipasu.org
- ❑ Center for Reproductive Rights (CRR). (2005). *Religious voices world-wide support choice: Pro-choice perspectives in five world religions*. New York, NY: CRR. http://reproductiverights.org/sites/default/files/documents/pub_bp_tk_religious.pdf
- ❑ Berer, M. (2009). Provision of abortion by midlevel providers: International policy, practice and perspectives. *Bulletin of the World Health Organization*, 2009(87), 58–63. www.who.int/bulletin/volumes/87/1/07-050138/en/
- ❑ International Federation of Gynecology and Obstetrics (FIGO). (2006). *Resolution on 'conscientious objection.'* London, United Kingdom: FIGO. http://www.figo.org/sites/default/files/uploads/Our-Work/2006%20Resolution%20on%20Conscientious%20Objection.pdf

Facilitators can check off the boxes as they complete the core resources.

SUPPLEMENTARY RESOURCES

LEGAL AND POLICY

International Planned Parenthood Federation (IPPF). (2008). *Access to safe abortion: A tool for assessing obstacles*. London, United Kingdom: IPPF. www.ippf.org/resource/Access-Safe-Abortion-tool-assessing-obstacles

Ipas. (2008). *Access to abortion for reasons of mental health*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Access-to-abortion-for-reasons-of-mental-health.aspx

Ipas. (2012). *A better place for women: Abortion care in Nepal a decade after law reform*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/A-better-place-for-women--Abortion-care-in-Nepal-a-decade-after-law-reform.aspx

COMMUNITY

Börjesson, E., Izquierdo, J., de Guzman, A., McSmith, D., & Villa Torres, L. (2011). *Young women and abortion: A situation assessment guide*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Young-women-and-abortion--A-situation-assessment-guide.aspx

Ipas. (2011). *Community voices: Strategies to address unsafe abortion*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Community-Voices--Strategies-to-address-unsafe-abortion.aspx

HEALTH SYSTEMS

EngenderHealth, Ipas & Reducing Maternal Mortality and Morbidity Ghana. (2009). *COPE for comprehensive abortion care services: A toolbook to accompany the COPE handbook*. New York, NY: EngenderHealth. www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf

Save the Children. (2008). *Partnership-defined quality for youth: A process manual for improving reproductive health services through youth-provider collaboration*. Westport, CT: Save the Children. www.k4health.org/sites/default/files/PDQ%20for%20Youth%20Manual.pdf

Barriers to safe abortion and strategies to address them

Women face many barriers to safe abortion, including legal and policy, sociocultural, and health systems barriers. Because of these barriers, women who seek to terminate pregnancies sometimes have no choice but to resort to unsafe abortion, even in settings where their circumstances fit legal indications for safe abortion (Turner et al., 2011). Women, especially adolescents, may delay seeking abortion care because of barriers that they cannot initially overcome. Adolescents also often delay seeking help for abortion-related complications (WHO et al., 2006).

> ***We do not have access to contraception. We are stigmatized if we have a child before marriage. We do not have the right to abortion. What a dilemma! How can we not die if we are exposed to risky [unsafe] abortions? How can we not resort to abortion if a child before marriage is a sacrilege? How can we avoid having children when there are no contraceptive services? We wish to affirm that one of the best weapons in the fight against risky [unsafe] abortions among the young is to respect our rights, starting with the right to information.***
>
> — Young woman, Democratic Republic of the Congo (Greene et al., 2010)

3.1 LEGAL AND POLICY BARRIERS

Legal frameworks on abortion vary between countries. Abortion can be regulated in the constitution, the criminal code, and implementation documents such as national policies and standards and guidelines (McCulloch, 2011). In some countries abortion is prohibited for all legal indications, while in others it is legally available on demand up to a specified gestational age. Most countries, however, allow abortion for some indications, for example to save the pregnant woman's life, to protect her physical or emotional health, or in cases of rape and incest. (Center for Reproductive Rights, 2009). Even laws with multiple indications for abortion can create barriers when they:

- Are vague and require interpretation, leaving providers unclear about whether they can legally perform the service (de Bruyn & Packer, 2004);
- Are in conflict with other laws, creating confusion over which law takes precedence (McQuoid-Mason, 2010).

Implementation documents outline steps and procedures meant to ensure quality of care and protect against mistakes or abuses (Turner et al., 2011). However, they sometimes add barriers to safe, legal abortion, which are not mandated by law. For example:

- Limit what cadre of providers can perform the abortion procedure;
- Require the signatures of multiple specialists before the abortion can be provided;
- Mandate waiting periods or multiple facility visits to get an abortion;
- Mandate involvement of a third party, for example a parent or a spouse, through notification or consent. This particularly affects adolescents.

Legal and policy barriers result in delayed or denied abortion care for women and adolescents. Third-party involvement requirements can cause delays to the point where abortion is no longer an option because of gestational age limits (Human Rights Watch, 2010). Many women and adolescents will not seek safe abortion care at all because of actual or perceived legal barriers. Of those who do, some are turned away by providers who are unfamiliar with the law, lack knowledge and support to interpret its indications fully, or use the legal framework as a pretext to deny services. While many providers risk their lives and professional careers to help women obtain safe abortion care, others are "deeply implicated in reporting women to the justice system for punishment" (International Campaign for Women's Right to Safe Abortion, 2013).

Textbox 3.1: Respecting client confidentiality

Certain professionals, such as health workers, attorneys and priests, have an ethical and often legal duty to respect client confidentiality. It encourages honesty by the client in order for the professional to better serve the client. It also protects the professional from implication in a crime. In countries that require people to report women who have had abortions to the police, health professionals may affirm that their ethical and legal duty is to protect the confidentiality, health and life of the women they serve.

3.2 SOCIAL AND CULTURAL BARRIERS

There are many social and cultural barriers to safe abortion. **Gender discrimination** reinforces beliefs and practices that put women at risk for sexual violence, unintended pregnancy and unsafe abortion. For example, a woman's partner may control when they have sex and whether they use contraception. Laws that require spousal authorization for safe abortion can make access to such services more challenging and are discriminatory.

In Module 2, gender is discussed in detail as a separate topic.

Many people hold faith-based opinions about abortion and religious leaders are often vocal in their opposition to it. **Religious institutions** can be influential in restricting access to safe abortion, from swaying policy debates to excluding individual members associated with abortion. However, the relationship between religion and abortion is not an inherently negative one. Within most religions, there is a diversity of opinions on issues of morality, such as abortion. For example, many Catholics affirm that it is their religious duty to obey their own conscience in matters of morality (Catholics for Choice, 2011). Within Islam some schools of thought allow abortion before the fetus is considered a full human being ('ensoulment'). Many schools recognize exceptions even after ensoulment when the pregnancy puts the life of the woman or her breastfeeding baby at risk, or in cases of rape or fetal impairment (Shaikh, 2003). Globally, there are coalitions of religious leaders that have endorsed international treaties on sexual and reproductive rights (Center for Reproductive Rights, 2005).

Abortion stigma can imply that women who seek or have an abortion are inferior to the ideal of womanhood and should feel shame or remorse, even where abortion is legal (Kumar et al., 2009). Stigma is a powerful barrier, and can make a woman afraid to seek an abortion or lead her to seek an unsafe abortion. An unmarried adolescent who decides to terminate an unwanted pregnancy may experience stigma related to her age, marital status and decision to have an abortion. Abortion stigma affects health professionals in different ways too. Some providers may be less likely to provide abortion services because of it (Turner et al., 2011), while others "*can feel stigmatized and simultaneously proud of their ability to provide life-altering care to women*" (Kumar, 2013).

Because of cultural taboos against speaking openly about sexuality and reproduction, many women and adolescents **lack access to information** about reproductive health issues, including contraception and safe abortion. A lack of knowledge about their body and rights impacts women's ability to manage their fertility and make informed health-care decisions. These taboos also result in a **lack of social support** for women's sexual and reproductive health and rights. Research conducted in Nepal shows

Textbox 3.2: Components of stigma

Components of stigma include labeling, stereotyping and separation, and status loss, all of which can result in discrimination at both individual and structural levels. Stigma is dependent on power imbalances that allow these expressions to occur (Link & Phelan, 2001).

that social networks are important for young women in reaching decisions about abortion, locating a provider, and paying for the services (Puri, 2002). Without a supportive social network, a woman or adolescent may not be able to identify anyone who can help her overcome barriers to safe abortion. If she reaches out for help, she may not receive any or face negative repercussions (Turner et al., 2011).

3.3 HEALTH SYSTEMS BARRIERS

Women and adolescents face barriers at the health systems level too. Around the world, there is a **lack of health-care facilities** that provide safe abortion services. In some countries, national regulations make it challenging and time-consuming for facilities to become authorized to provide abortion care. In other countries, such as India and the United States, the passage of stricter regulations has forced facilities previously authorized to provide abortion care to close. Facilities that do offer services are often far apart or inaccessible due to geography and inadequate infrastructure, especially in rural areas (Turner et al., 2011).

India and the United States, along with many other countries, also **lack providers** who are trained in and committed to providing safe abortion care (Ministry of Health and Family Welfare, Federal Government of India, 2013; Shotorbani, 2004). In countries where only doctors or specialists, such as obstetricians and gynecologists, are allowed to perform abortion it is more difficult for health systems to ensure access to safe services (Berer, 2009). When

Textbox 3.3: The limits of conscientious refusal

Health professionals who are authorized to perform abortion services can refuse to perform such services based on conscientious convictions only under certain circumstances. Regardless of a provider's convictions, the provider must:

- Inform a pregnant woman of all possible health-care options, including abortion, and respect her choice. This includes abiding by scientific definitions of reproductive health services and not mischaracterizing those services based on personal beliefs (FIGO, 2006);
- Clearly state what services they refuse to provide, and refer women to a nearby provider who offers those services (FIGO, 2006);
- When a referral could cause delays and put the woman's health at risk, provide timely abortion services regardless of personal objections (FIGO, 2006);
- Provide abortion care when a woman's life is in danger and the law permits abortion to save a woman's life (Ipas, 2013c);
- Provide life-saving postabortion care without delay to all women who need it.

health sciences schools exclude abortion from their curricula, or the content taught is outdated, new health professionals graduate without adequate knowledge and skills in safe abortion care.

Lack of privacy is one of the primary issues women, particularly adolescents, raise when surveyed about their concerns with health-care services (Anh et al., 2003). In communities where abortion stigma is pervasive, women and adolescents often do not want to be seen seeking abortion care. An adolescent may be afraid of meeting someone she knows in the waiting room or of other clients overhearing the reason for her visit when she checks in. Any perceptions, real or perceived, that privacy and confidentiality will not be protected create barriers to safe abortion care.

Judgmental provider attitudes affect quality of care and care-seeking behaviors (Kipp et al., 2007). People begin to learn their community's norms related to sexuality at birth, and those norms are often reinforced on a daily basis throughout life (Turner et al., 2011). Without opportunities to clarify their values and transform their attitudes, future and practicing health professionals are at risk of judging a woman without being fully aware of their own expressions and actions. This may manifest itself in their body language or how they treat the woman. For example, a provider may not offer pain management as part of abortion services or charge higher fees from unmarried women or women who have had more than one abortion.

Cost is a significant barrier for many women, particularly adolescents, who rarely have autonomous control over financial resources even when they do earn an income.

All of these barriers are interdependent and reinforce each other. For example, gender discrimination and policymakers' conscientious convictions affect both design and enforcement of abortion laws and policies. Abortion stigma may make decisionmakers in health sciences schools unwilling to integrate abortion in the curriculum, which maintains the status-quo of an ill-prepared and unsupported workforce. All of these barriers lead to perceptions that abortion is outside the scope of legitimate sexual and reproductive health care. A study from Kenya found that young women did not identify abortion as a health-care service:

> ***Women don't go to doctors to terminate their pregnancies. Doctors don't terminate pregnancies!***
>
> — Young woman (Center for Reproductive Rights, 2010)

3.4 ADDRESSING THE BARRIERS

> ***In order to uphold the right to abortion care we must ensure that it is available, affordable, and free of burdensome hurdles.***
>
> — Youth advocate for safe abortion (Manes, 2013)

The complex, often sensitive context surrounding abortion and the myriad barriers women and adolescents face can make it difficult to increase access to safe services. It can be particularly challenging to address contextual barriers, such as gender discrimination and poverty. Multi-level programs, which work at the health systems, community and policy levels, have the most positive outcomes (Dick et al., 2006). A culturally appropriate community assessment of women's and adolescents' needs, experiences and recommendations is a valuable first step in any program design process. It can maximize program effectiveness and establish participatory processes and local ownership (Börjesson et al., 2011). Implementing community and youth-generated solutions can address barriers that women and adolescents face (Turner et al., 2011). For example, health professionals partnering with young people to define high-quality health care are better able to meet young people's needs and encourage positive care-seeking behaviors (Save the Children, 2008).

Table 3.1 shows examples of strategies to address barriers to safe abortion care. Several of the listed strategies can be combined into one program. Future health professionals can work on most of these strategies, particularly if they partner with other professional associations and stakeholders. Depending on the context and desired program outcomes, some strategies may be more effective or realistic for future health professionals to implement. These strategies are indicated with a star (*).

THE BOTTOM LINE

- Barriers such as restrictive guidelines for abortion care, pervasive abortion stigma and a lack of health-care facilities that offer safe services mean that women who seek to terminate pregnancies may have no choice but to resort to unsafe abortion, even in settings where their circumstances fit the legal indications.
- Efforts to increase access to safe abortion are more effective when they address the problem at multiple levels (including legal and policy, sociocultural, and health systems), and in

culturally relevant and participatory ways.

- Everyone, including community members and future and practicing health professionals, has a role to play in expanding access to safe abortion.
- Future health professionals can raise awareness of existing abortion laws, support movements for more progressive laws and policies, conduct community education and engagement activities, and advocate for the inclusion of safe abortion in their curricula and clinical practice.

TABLE 3.1:
EXAMPLES OF STRATEGIES TO ADDRESS BARRIERS TO SAFE ABORTION CARE

Levels	Strategies
Legal & policy	• Sensitize providers, facility staff and policymakers on abortion, increase their understanding of the existing legal framework and build their capacity to interpret legal indications fully. • Seek to influence the legal framework. Public health research can provide powerful justifications to reform a country's abortion law and expand legal indications. Professional and student associations can make consensus documents and lobby policymakers. They can testify in legislative hearings and conduct media outreach.* • Develop or revise clinical standards and guidelines to reflect evidence-based practices and remove restrictions to abortion that are not legally mandated. • Support the implementation of new or revised standards and guidelines.
Community	• Raise community awareness of unintended pregnancy, pregnancy prevention, unsafe abortion and abortion laws, and garner support to reduce stigma and expand access to safe abortion services. Examples of activities include street theatre, coffee and tea ceremonies, community conversations, etc.* • Conduct sensitization and attitude transformation interventions with community and religious leaders, and develop a network of community champions for safe abortion.* • Train peer educators and integrate abortion in peer education programs that intend to provide sensitization, social support and referrals.* • Use media, hotlines, SMS services and other outreach methods to provide women with information on how, when, and where to access safe services.* • Run informal or formal social networks that provide women resources, emotional support, and referrals or accompaniment to safe services.*
Health systems	• Advocate for the inclusion of safe abortion in health sciences curricula and ensure clinical training opportunities for future providers.* • Simplify facility certification processes and expand the number of facilities, both public and private, authorized to offer abortion care. • Enable midlevel providers to legally provide abortion care, particularly in the first 12 weeks of pregnancy. • Conduct sensitization and clinical training workshops for providers and facility staff to build capacity and commitment for safe abortion care. • Offer medical abortion to increase access to services in a range of settings. • Implement youth-friendly abortion care services. • Provide services free of charge or advocate for subsidies so that facilities can offer services at reduced rates based on women's ability to pay. • Make necessary infrastructure changes and update facility protocols and practices to strengthen privacy and confidentiality for all clients.

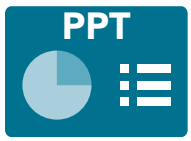
* Strategies which future health professionals are well-positioned to implement

MODULE 3 TOOLS

Handout 3: Barriers to safe abortion and strategies to address them

Activity 3.A: Understanding national abortion laws and policies (1 hour and 15 minutes)

Activity 3.B: The quest for safe abortion: Barriers and strategies to address them (1 hour and 45 minutes)



This module is accompanied by presentation '**MODULE 3**' **(Slides 1–19)**. Remember, all printable materials and presentation slides are available on the USB and at www.ipas.org/youthact.

Want more attitude transformation?

Depending on your learning objectives, participants' preferences and the training workshop agenda, you may also wish to conduct the activity below.

THE LAST ABORTION: This activity highlights the complex circumstances surrounding a woman's decision to seek an abortion. Participants are encouraged to examine and challenge their biases against certain pregnant women or certain circumstances, as well as their beliefs about abortion laws and policies that restrict access to safe abortion. This activity illustrates the difficulty and dangers of valuing one woman's reasons for abortion over another woman's reasons. It takes approximately 40 minutes.

A detailed activity description and facilitator instructions can be found in:

Turner, K. L., & Page, K. C. (2011). *Abortion attitude transformation: A values clarification curriculum for global audiences*. Chapel Hill, NC: Ipas.

A youth-specific adaptation of 'The last abortion' can be found in:

McSmith, D., Börjesson, E., Villa, L., & Turner, K. L. (2011). *Abortion attitude transformation: Values clarification activities adapted for young women*. Chapel Hill, NC: Ipas.

Handout 3: Barriers to safe abortion and strategies to address them

Women and adolescents face many barriers to safe abortion. These barriers help explain why women who seek to terminate pregnancies may have no choice but to resort to unsafe abortion, even when their circumstances fit legal indications (Turner et al., 2011). They also shed light on why adolescents often delay seeking help for abortion-related complications (WHO et al., 2006).

Legal and policy barriers	Social and cultural barriers	Health systems barriers
Restrictive abortion laws and/or national guidelines that: • Limit indications for safe, legal abortion • Limit what type of providers can perform abortion • Require signatures of multiple providers • Mandate waiting periods • Mandate third-party involvement (such as parents or spouse)	• Gender discrimination • Poverty and unequal access to financial resources for women • Religious institutions and beliefs • Abortion stigma • Inadequate access to information and education • Lack of social support systems	• Lack of health-care facilities providing safe abortion services • Shortages of providers capable of and committed to providing safe abortion care • Low quality of care, including lack of privacy and judgmental provider and staff attitudes • Cost of services

The complex, often sensitive context surrounding abortion and the myriad interdependent barriers can make it difficult to increase access to safe abortion. Programs that include policy, community and health system-level strategies have the most positive outcomes (Dick et al., 2006). A culturally relevant community assessment of women's and adolescents' needs, experiences and recommendations is a valuable first step in any program design process (Börjesson et al., 2011). Future health professionals can work on many different strategies to increase access to safe abortion. Examples of strategies that may be effective and realistic for future health professionals to implement include:

Legal and policy-related strategies	Community-related strategies	Health systems-related strategies
• Seek to influence the legal and policy frameworks by making consensus documents and lobbying policymakers, testifying in legislative hearings and conducting media outreach	• Raise community awareness of unsafe abortion and/or existing abortion law • Sensitize community and religious leaders, and support champions for safe abortion • Train peer educators and do peer education on abortion • Run social networks that provide safe abortion accompaniment	• Advocate for the inclusion of safe abortion in health sciences curricula and ensure clinical training opportunities to build capacity and commitment of future providers

Activity 3.A: Understanding national abortion laws and policies

Adapted from Turner et al., 2009

PURPOSE

Participants will increase their understanding of national abortion laws and policies and how they are interpreted and implemented. In-depth understanding of laws and policies provides an important basis for addressing barriers to safe abortion care.

TIME

1 hour and 15 minutes

MATERIALS

» Video by Newsy World: *Death of woman denied abortion* in Ireland causes outrage. This short video (under two minutes) describes the circumstances surrounding the 2012 death of Savita Halappanavar and is available at: www.youtube.com/watch?v=58GR0RuIJbA. In the event this video is not available, please search YouTube or reputable news sources online—such as BBC, Al Jazeera or the New York Times—for a similar short video covering the basic facts of this story. For more information on the story, please see the BBC News article "How Savita Halappanavar's death called attention to Irish abortion law," available at: www.bbc.com/news/world-europe-22204377.

» Supporting document 'National abortion laws and policies worksheet'

» Background documents for the countries and regions represented by participants:

  › National abortion laws

  › National implementation documents on abortion, which may include reproductive health policies, standards and guidelines, and clinical protocols

  › Abortion-related magnitude studies and maternal mortality and morbidity data estimates, and other relevant local abortion data

» Flipchart, tape and markers

PREPARATIONS

1. Gather and review background documents for the countries that participants represent. Remember to look beyond legal texts and include national health policies and standards and guidelines for abortion care too, if you can.

NOTE TO FACILITATOR

The Ipas Abortion Guidance Documents Archive is a searchable collection of government-issued documents on abortion service delivery and care. It includes documents from more than 50 countries and is regularly updated. You can access the archive on Ipas's website at www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Standards-and-Guidelines.aspx.

Other possible sources for the background documents include:

- www.hsph.harvard.edu/population/abortion/abortionlaws.htm
- http://worldabortionlaws.com
- http://reproductiverights.org/en/resources
- http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_abortion-laws2009_WEB.pdf
- www.who.int/making_pregnancy_safer/topics/maternal_mortality
- Ministries of Health, Reproductive Health Divisions

2. If most of the participants come from countries with restrictive abortion laws, add examples of more progressive abortion laws and policies from within the same region to illustrate the full spectrum of indications for legal abortion. This can also help participants learn more about abortion in different countries. Examples of more progressive abortion laws, by region, include:
    a. Americas: Canada and Cuba
    b. Asia: Nepal and Vietnam
    c. Middle East and North Africa: Bahrain and Tunisia
    d. Sub-Saharan Africa: Ethiopia and South Africa
3. Share the selected background documents with participants and ask them to read the documents in advance of this activity. You can share the documents via email before the training workshop starts, or disseminate hard copies on the first day of the workshop.
4. Print copies of the 'National abortion laws and policies worksheet.'
5. Download the video and play it in the workshop venue to test audiovisuals.
6. Consider whether it is possible and beneficial to invite a lawyer to assist with this activity. The lawyer needs to be fully informed about reproductive rights and abortion laws in your region, and be supportive of broader interpretations of those laws to increase access to safe, legal abortion.

INSTRUCTIONS 1 2 3

1. Invite everyone to actively participate in this activity. Tell participants the purpose of this activity is for them to increase their understanding of national abortion laws and policies and how they are interpreted and implemented. In-depth understanding of laws and policies provides an important basis for addressing barriers to safe abortion care.
2. Confirm whether participants have read the background documents you shared with them before the activity (Preparation #3).
3. Invite a few participants to summarize what they learned about national abortion laws and policies from the documents, clearly identifying and listing different indications for legal abortion on flipchart. Make sure you cover all the different countries represented among participants, as well as any other countries that you may have chosen to include as examples.

NOTE TO FACILITATOR

Participants may describe abortion as illegal in their country. Unless that country has a total ban on therapeutic abortion, this is a misleading statement. Encourage participants to consider alternative phrases. For example: "*In my country, abortion is legal when…;*" "*In my country, abortion is legal in some circumstances;*" or "*In my country, abortion is legally restricted.*"

4. Divide participants into small groups of four to five people per group (if possible by country or region). Hand out copies of the supporting document 'National abortion laws and policies worksheet.' Ask the groups to use the background documents to complete their worksheet. Instruct them to write short, bulleted responses to each question. Allow 20 minutes for this task. If groups finish sooner, continue to the next activity instruction.
5. Ask the groups to select a group reporter, and invite each reporter to share key points from their group's responses. Write key responses on a flipchart. Allow 15 minutes for sharing.
6. Screen the video *Death of woman denied abortion in Ireland causes outrage*.
7. Facilitate a discussion of the video. Allow 15 minutes for discussion. You may wish to ask the following discussion questions.
    a. *What is your first impression about the case presented in the video?*
    b. *What are some examples of legal and policy barriers that contributed to Savita's death?*
    c. *What opportunities did providers have to act differently?*
    d. *What factors influence how providers interpret the law and legal indications for abortion?*
    e. *What can future health professionals do to address legal and policy barriers to safe abortion?*
8. Close the activity by highlighting key points made by participants and reminding them of how an in-depth understanding of abortion laws and policies can positively impact access to safe abortion care.
9. Thank the group for their participation and continue to the next activity.

NOTE TO FACILITATOR

ACTIVITY 3.A may bring up sensitive questions from participants. The information below can help you answer some of those questions. If you want help answering other sensitive questions, check out *The Evidence Speaks for Itself: Ten Facts about Abortion* (Ipas, 2010).

Question: If we expand legal indications for safe abortion, won't women become more promiscuous?

» There is no evidence to suggest that expanding legal indications for safe abortion increases 'promiscuous behaviors.' Different people have different perceptions of promiscuity, and those perceptions are rooted in gender stereotypes and cultural and religious beliefs about how men, women and adolescents should (or should not) express their sexuality. We often hold double-standards about what behaviors we consider promiscuous among women versus among men.

» Expanding legal indications for safe abortion saves women's lives and improves their health. Research from around the world shows that maternal mortality and morbidity decrease when abortion becomes more legally accessible. In the decade after Barbados reformed its abortion law, there was a 73 percent drop in admissions for sepsis (severe infection, which can be caused by unsafe abortion) at the Queen Elizabeth Hospital (Nunes & Delph, 1996), and in the first year after Romania liberalized its law there was a 67 percent decrease in maternal mortality (Hord et al., 1991; Stephenson et al., 1992). In South Africa, there was a 91 percent reduction in deaths from unsafe abortion from 1994–2001 (the Choice on Termination of Pregnancy Act became law in February, 1997) (Jewkes et al., 2005).

Question: How can abortion be legal if it kills a baby?

» We all hold different personal beliefs about whether and when an embryo or fetus can be considered a human being that is equal in rights to born people. In science, philosophy and theology there is a range of opinions about when human life begins. In 1974, the Vatican acknowledged that it does not know when a fetus becomes a person (Catholics for Choice, 2011). The European Court of Human Rights has ruled that "there is no European consensus on the scientific and legal definition of the beginning of life" (IPPF, 2008). Within Islam some schools of thought allow abortion before the fetus is considered a full human being ('ensoulment'). Many schools recognize exceptions even after ensoulment when the pregnancy puts the life of the woman or her breastfeeding baby at risk, or in cases of rape and fetal impairment (Shaikh, 2003).

» Not everyone believes that terminating a pregnancy is the same as killing a baby. In some Buddhist traditions, an individual's intentions are more important in determining the morality of an act than the act itself (Center for Reproductive Rights, 2005). Many people believe that allowing women to die preventable deaths from unsafe abortion is an immoral act (Turner & Page, 2008).

National abortion laws and policies worksheet

Please review the background documents again and write short, bulleted responses to questions 1–5 below. You can divide the worksheet questions among participants in your group.

If neither you nor the facilitator can find answers to these questions in the background documents for your country, you can pick another country for which the necessary documents are available. We encourage you to continue exploring the answers for your country's context when you return home after the training workshop.

1. **How is abortion regarded in the legal framework of your country?** What indications for abortion does your country's current law specify? What other elements regulating provision of abortion care are present in the law, if any?

2. **What elements of abortion care provision are not explicitly mentioned or are unclear in the law?** Examples can include details on which types of providers are authorized to perform abortion or gestational age limits for abortion care.

3. **Does your country have national policies, standards and guidelines or clinical protocols related to abortion?** If yes, how do they compare to the abortion law? What barriers exist in these implementation documents that are not mandated by the abortion law?

4. **In your country, what impact do legal and policy barriers have on:**

   a. **Women's and adolescents' access to safe abortion care?**

   b. **Providers' willingness and ability to provide safe abortion services?**

   c. **The magnitude of unsafe abortion and related maternal mortality and morbidity?**

5. **In your country, how could laws and policies be more broadly interpreted to expand access to safe abortion care?** What language in the law is open to broader interpretation to expand access to safe abortion? Examples: A medical practitioner could be interpreted to mean a physician, midwife or other midlevel provider. Clinical depression and suicidal thoughts can constitute threats to the pregnant woman's life. Socioeconomic struggles can be interpreted as threats to a woman's mental health.

Activity 3.B: The quest for safe abortion: Barriers and strategies to address them

Adapted from Turner et al., 2011

PURPOSE

Participants will understand different barriers women, particularly adolescents, encounter when seeking safe abortion care. They will learn different strategies to address those barriers, particularly strategies that can be implemented by future health professionals.

TIME

1 hour and 45 minutes. This is a two-part activity that benefits from a break or an energizer. Part I is 45 minutes and Part II is 1 hour.

MATERIALS

- Presentation 'Module 3,' **Slides 7–18**
- Flipcharts, tape and markers
- Supporting document 'Barriers to care story'
- Supporting document 'Barriers to care handout' in *Abortion Care for Young Women: A Training Toolkit* (Turner et al., 2011, Tool 2.A). This handout is optional and you may wish to adapt it if you decide to use it.
- Supporting document 'Making abortion care accessible handout' in *Abortion Care for Young Women: A Training Toolkit* (Turner et al., 2011, Tool 5.A). This handout is also optional and you may wish to adapt it if you decide to use it.

PREPARATIONS

1. Review the presentation slides.
2. Compile a list of different barriers women and adolescents face when seeking safe abortion care.
3. Draw the 'Barriers to care story' template on flipchart.
4. If you choose to use the optional handouts, print enough copies for all participants.

INSTRUCTIONS

PART I (Barriers)

1. Invite everyone to actively participate in this activity. Inform them the purpose of this activity is for participants to understand different

barriers women, particularly adolescents, encounter when seeking safe abortion care. We will learn different strategies to address those barriers, focusing on strategies that can be implemented by future health professionals.

2. Ask participants to close their eyes and think of an adolescent girl in their country. You may wish to use these guiding questions. Pause for a moment between each question. At the end, let participants sit in silence for a few moments before you invite them to open their eyes.

    a. *Think of an adolescent girl in your country. What does she look like? What is she wearing?*

    b. *Where is she right now?*

    c. *What does she enjoy doing?*

    d. *What challenges does she have in life?*

    e. *Imagine that this adolescent girl is pregnant. How does she feel?*

    f. *Who might she tell about her pregnancy?*

    g. *Who will influence the decision on what to do about the pregnancy?*

    h. *If she decides to have an abortion, what sources of support and care does she have in her community?*

3. Divide participants into small groups of four to five participants in each. Give each group flipchart sheets, tape and markers.

4. Post the flipchart with the 'Barriers to care story' template, and ask the groups to quietly copy it onto a flipchart of their own.

5. Ask the groups to identify who the adolescent in their 'Barriers to care story' is. Encourage them to think of a regular adolescent in their country who may have access to fewer resources or face more challenges in life, perhaps like the girl they envisioned earlier in this activity. Ask them to draw a picture of her and write her name in the first box of their story template.

6. Invite the groups to discuss the first category of barriers that the adolescent girl faces: legal and policy barriers. Instruct the groups to list, by drawing symbols or writing, the different barriers they identify in the second box.

7. After a few minutes, invite one group to share the legal and policy barriers they identified.

8. Invite the other groups to share any other legal and policy barriers that were not previously mentioned. Continue around the room until no group has any more legal and policy barriers to share. If you are short on time, you can skip this instruction and move directly from #7 to #9. If you do, make sure you call on different groups for each of the remaining barriers.

9. Summarize all the key legal and policy barriers, and (if necessary) identify barriers that were not mentioned by the groups.

10. Repeat Instructions #6–9 for each of the other categories of barriers: social and cultural barriers, health systems barriers, and other barriers. Discuss one category at a time.

11. Once all categories of barriers have been discussed, provide a few examples of how different categories of barriers are interdependent, and invite participants to reflect on their impact. You may wish to use the discussion questions below. Allow five minutes for discussion.

    a. *How are the different barriers interdependent?*

    b. *What is the likelihood that the adolescent girls in your stories will have a safe abortion?*

    c. *How do barriers like the ones we have identified explain adolescent girls' disproportionately high rate of unsafe abortion and unsafe abortion-related complications?*

12. If you are using the optional handouts, disseminate copies of the 'Barriers to care handout' at this time.

13. Highlight key points from the discussion. You may wish to summarize by saying:

    Women and adolescents face many barriers to safe abortion, such as gender discrimination; unequal access to and control of financial resources, which makes safe abortion services unattainable because of their cost; abortion stigma; fear of a judgmental provider; and a lack of privacy at the facility. Because of these barriers, many women and adolescents who seek to terminate pregnancies have no choice but to resort to unsafe abortion, even when their circumstances fit the legal indications for safe abortion. The barriers explain why adolescents tend to access abortion care later in pregnancy than adults, and why they are more likely to delay seeking help for complications than adults. It is urgent to remove as many of these barriers as possible to ensure that women and adolescents get the care they need and to which they are entitled.

PART II (Strategies)

1. Present the slides on barriers (**slides 7–14**). If you just completed Part 1 of this activity, use no more than 10 minutes to summarize the content of the slides.
2. Invite the small groups to take their flipchart 'Barriers to care story' and switch it with another group's story. Each group should have a story they did not prepare themselves.
3. Ask the groups to post the flipchart they have been given on the wall and gather around it.
4. Then ask them to identify strategies that can address the barriers on their new flipchart. Instruct them to list, by drawing symbols of or writing, the strategies on the edges of their new flipchart. Allow 15 minutes for this task.
5. Invite the small groups to discuss which strategies are most effective and feasible for future health professionals to work on, either independently in their associations or in partnership with other stakeholders. The groups should identify these strategies in a uniform way. For example, by drawing a star next to them.
6. Next, invite participants to walk around the room to read the strategies the different groups have identified. It may be particularly interesting for participants to find their original 'Barriers to care story' and read what strategies their colleagues listed for it.
7. Invite participants to sit back down. Acknowledge the wealth of ideas they shared. Summarize the strategies listed and highlight strategies marked as effective and feasible for future health professionals to work on.
    a. If the following strategies have not been listed, mention them before moving on to the next instruction: values clarification for abortion attitude transformation (VCAT) with diverse groups of stakeholders, engaging religious leaders, safe abortion hotlines and funds, and empowering midlevel providers to offer safe abortion services.
8. Facilitate a large group discussion. You may wish to use the questions below. Make sure you have 20 minutes remaining for this discussion. If time is a concern, we encourage you to focus on questions c, d and e.
    a. *Who is responsible for improving access to safe, legal abortion?*
    b. *What are the consequences for women and societies if we do not reduce barriers to safe, legal abortion?*

c. *What was easy or hard about identifying strategies that increase access to safe abortion?*

d. *What opportunities do future health professionals have to implement strategies for safe abortion?*

e. *What are some challenges that future health professionals may encounter implementing strategies for safe abortion? How can we overcome those challenges?*

9. Present the slides on addressing barriers (**slides 15–18**).
10. If you are using the optional handouts, disseminate copies of 'Making abortion care accessible handout' at this time.
11. Close the activity by summarizing key points from the activity.
12. Remind participants that in Module 5 of this training workshop they will practice different actions future health professionals can take to promote safe abortion.
13. Thank the group for their participation and continue to the next module.

BARRIERS TO CARE STORY

Instructions: Copy the following table in the center of a flipchart. Make sure there is space around the edges of the flipchart to add adhesive notes or index cards later.

Leave space on the flipchart here

This is the story of an adolescent girl who needed a safe abortion:	
[Draw or tape a picture of an adolescent girl here]	LEGAL AND POLICY BARRIERS
SOCIAL AND CULTURAL BARRIERS	HEALTH SYSTEMS BARRIERS
OTHER BARRIERS	[Draw or tape a picture of a symbol representing a safe abortion here. For example: a facility, provider, safe abortion methods, etc.]

Leave space on the flipchart here

Leave space on the flipchart here

Leave space on the flipchart here

MODULE 4:
Comprehensive abortion care

Photo illustration; original photo © Ipas

Module 4: Comprehensive abortion care

LEARNING OBJECTIVES

This module introduces participants to essential elements of woman-centered comprehensive abortion care (CAC), including counseling and safe methods for abortion. Knowledge of what safe abortion entails can help demystify the process and procedure, and counter myths and misinformation that participants may have come across in media. The module also helps participants identify signs of abortion-related complications. While this module discusses clinical aspects of safe abortion, **it does not prepare participants for abortion service delivery**. By the end of this module, participants will be able to:

- Describe essential elements of woman-centered comprehensive abortion care, including counseling and safe methods for abortion.
- Identify signs of abortion-related complications.

CORE RESOURCES

- ❑ Ipas. (2013). Chapter: Informed consent, information and counseling. *Woman-centered comprehensive abortion care: Reference manual* (2nd ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Woman-Centered--Comprehensive-Abortion-Care-Reference-Manual--Second-Edition.aspx
- ❑ World Health Organization (WHO). (2012). Chapter 2: Clinical care for women undergoing abortion. *Safe Abortion: Technical and policy guidance for health systems* (2nd ed.). Geneva, Switzerland: WHO. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf
- ❑ Ipas University. *Introduction to uterine evacuation with medicines* OR *What women need to know to successfully use medical abortion pills*. Both courses are available at www.ipasu.org
- ❑ Renner, R. M., de Guzman, A., & Brahmi, D. (2013). *Provision of abortion care for adolescent and young women: A systematic review*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Provision-of-Abortion-Care-for-Adolescent-and-Young-Women--A-Systematic-Review.aspx
- ❑ Ipas. (2014). *Clinical updates in reproductive health.* Chapel Hill, NC: Ipas. This biannual publication provides Ipas's most up-to-date clinical guidance. www.ipas.org/clinicalupdates

Facilitators can check off the boxes as they complete the core resources.

SUPPLEMENTARY RESOURCES

CLINICAL GUIDANCE

Ipas. (2013). *WHO safe abortion guidance: Updates and recommendations*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/WHO-safe-abortion-guidance--Updates-and-recommendations.aspx

World Health Organization (WHO). (2014). *Clinical practice handbook for safe abortion*. Geneva, Switzerland: WHO. www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/

MEDICAL ABORTION

Ipas University. (2009). *First-trimester abortion with misoprostol*. Chapel Hill, NC: Ipas. www.ipasu.org

Ipas University. (2010). *First-trimester abortion with mifepristone and misoprostol*. Chapel Hill, NC: Ipas. www.ipasu.org

Ipas. (2013). *Medical abortion study guide* (2nd ed.). K. L. Turner (Ed.). Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Medical-Abortion-Training-Package.aspx

Ipas. (2013). New findings support both outpatient medical abortion up to 10 weeks gestation and home use of mifepristone. *Medical Abortion Matters*. May 2013. Chapel Hill, NC: Ipas. www.ipas.org/en/News/2013/May/New-findings-support-both-outpatient-medical-abortion-up-to-10-weeks-gestation-and-home-us.aspx

MANUAL VACUUM ASPIRATION

Ipas. (2013). Steps for performing manual vacuum aspiration: *Using the Ipas MVA Plus® and Ipas EasyGrip® cannula* (wall chart). Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Steps-for-performing-manual-vacuum-aspiration--Using-the-Ipas-MVA-Plus--and-EasyGrip--cann-3.aspx

Ipas University. (2009). *Uterine evacuation with Ipas MVA Plus®*. Chapel Hill, NC: Ipas. www.ipasu.org

ABORTION CARE FOR YOUNG WOMEN

Dobkin, L. M., Perrucci, A. C., & Dehlendorf, C. (2013). Pregnancy options counseling for adolescents: Overcoming barriers to care and preserving preference. *Current Problems in Pediatric and Adolescent Health Care*, 2013(43), 96–102.

Turner, K. L., Börjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Abortion-care-for-young-women--A-training-toolkit.aspx

Comprehensive abortion care

Women of all ages, ethnicities and religions terminate pregnancies. Some have no formal education; others have advanced university degrees. Some are married with children; for others it is their first experience with pregnancy. Woman-centered comprehensive abortion care (CAC) is a holistic model of care that includes a range of medical services, tailored to each woman's circumstances and health needs (Ipas, 2013c). It recognizes the woman's right to privacy and confidentiality, informed consent and autonomy in decisionmaking (Ipas, 2013c). Essential elements of CAC include counseling, induced abortion, treatment of incomplete or unsafe abortion, contraceptive services, and provision of or referrals to other reproductive health-care services (Ipas, 2013c).

> ***Good health cannot be a privilege; it is a human right.***
>
> — **Joy Phumaphi**, former Minister of Health of Botswana (United Nations Foundation, 2012c)

4.1 COUNSELING

What are key components of counseling? Counseling is an essential element of abortion care. A provider's knowledge, attitudes, verbal and non-verbal communication skills, and professionalism contribute to the quality of counseling. Components of counseling include:

- **Emotional support and empathetic listening:** The provider should build rapport by showing compassion and respect. She or he should encourage the woman to speak freely and listen with the intention to understand—intellectually and emotionally—the woman's circumstances, needs and preferences. The provider should validate the woman's feelings and concerns. If the woman still is in a place where she needs emotional support, or if she feels judged, she is not receptive to processing information (Lauwers & Swisher, 2011).
- **Privacy and confidentiality:** The provider should explain and enforce privacy policies, and reassure the woman that information exchanged is confidential. Systems that protect privacy and confidentiality should be in place. A third party should only be present if the woman expresses clearly her desire to be accompanied (Turner et al., 2011).
- **Information and facilitated discussion:** Comprehensive information, presented in an easy-to-understand way without

judgment or bias, helps the woman to problem-solve and make an informed decision. There may be clinical eligibility indications to consider and the provider should give medical recommendations and advice.

- **Respect for decision:** The woman has the right to make a free, informed decision. The provider should ensure that the woman is not being coerced by anyone. The provider should respect the woman's decision even if she or he disagrees with it (Turner et al., 2011).
- **Referrals:** If the woman requests services that the provider refuses to offer, the provider must give a timely referral to another practitioner who provides those services and who is accessible to the woman (FIGO, 2006).

What topics are covered in counseling? Three main topics may be covered during counseling: pregnancy options, abortion methods and postabortion contraception. There are special considerations for women terminating a pregnancy for health reasons, especially if the pregnancy was wanted (Baird et al., 2007).

- **Pregnancy options:** A woman who is pregnant can 1) continue the pregnancy, with the intention to parent the child or release the child for adoption, or 2) terminate the pregnancy. A woman who seeks abortion has usually carefully considered these options already (Ipas, 2013c). If the woman has questions about her options, the provider should provide information and support to the woman in a compassionate, non-judgmental way. If a woman has made up her mind that she wants an abortion, she does not need pregnancy options counseling (Ipas, 2013c; WHO, 2012b).
- **Abortion methods:** The provider should provide information about the different methods for safe abortion and determine clinical eligibility. In the first trimester, vacuum aspiration and medical abortion are recommended methods (Ipas, 2013c). In the second trimester, dilation and evacuation (D&E) and medical abortion are recommended methods (WHO, 2012b). A woman who is clinically eligible for either method should be supported to choose her preferred method since this makes her more likely to find it acceptable (WHO, 2012b).

> *[A nurse] went through all the options with me. It was a lot of information to take in, but I felt like it was my decision and the most important thing was I didn't feel ready to be a mama myself.*
>
> — Young woman (IPPF, 2010)

- **Postabortion contraception:** A woman may become pregnant as early as eight days after an abortion (Schreiber et al., 2011). The provider should support the woman to clarify and express any need or desire to prevent future pregnancy (Ipas, 2013c). If the woman wants contraception, she and the provider should identify what method best meets her medical needs and personal circumstances. After a successful abortion, most contraceptive methods can be used immediately (Ipas, 2013c; WHO, 2010). After medical abortion, intrauterine devices (IUDs) and sterilization can be used once it can reasonably be ascertained that the woman is no longer pregnant (Ipas, 2013c). Natural methods, such as fertility awareness, can be used once the woman has had one postabortion menses (Ipas, 2013c) and if her menstrual cycles are regular (WHO, 2012b). Accepting postabortion contraception should never be a condition for abortion services (Turner et al., 2011).

REMEMBER! Long-acting methods, like IUDs, have higher continuation rates and lower repeat pregnancy rates compared to short-acting methods (Cameron et al., 2012; Madden et al., 2012), but only constant abstinence or correct use of condoms reduce the risk of HIV.

What counseling considerations exist for adolescents? Counseling should consider the special rights and protections that adolescents are entitled to per the Convention on the Rights of the Child (CRC), the unique barriers adolescents may face to access safe services, as well as the adolescent's individual needs and wishes. States and adults have an obligation to create environments in which adolescents can freely and fully exercise these rights (United Nations, 2003):

- **Confidential medical counseling:** Adolescents have the right to confidential medical counseling (CRC, Article 16). National laws that mandate third-party involvement for medical treatment, such as parental consent, usually do not cover counseling. If an adolescent is accompanied by someone, the provider should ask the adolescent in private whether she wants that person present during counseling (Turner et al., 2011).

- **Autonomous decisionmaking:** Adolescents have the right to autonomy in decisionmaking in accordance with their capacities (CRC, Article 5). In structured situations, such as health-care service provision, many adolescents can compare the risks and benefits of different medical procedures and make decisions about their care as well as adults can (Dobkin et al., 2013; Ehrlich, 2003; IPPF, 2011; Steinberg et al., 2009; Tillett, 2005). No adult should control an adolescent's decisionmaking when the adolescent has the capacity to make the decision on her own (Lansdown, 2005). Providers should be aware that adolescents often feel or are pressured to make certain decisions about their pregnancy (Brady et al., 2008; WHO, 2012a). The provider should ensure whatever decision an adolescent makes is fully hers.
- **Confidential medical services:** When an adolescent is capable of autonomous decisionmaking, she may request confidential medical treatment (United Nations, 2003). The provider should consider the adolescent's best interests, health and safety, and support service provision to the fullest extent of the law.

To the extent permitted by national law, providers should also apply the **principle of capability** when they work with adolescents. An adolescent who understands the need to protect his or her reproductive health and who requests safe health-care services to that end can be considered capable of consenting to those services without parental oversight (Cook & Dickens, 2000). An adolescent who has 1) identified that she is pregnant, 2) decided that she wants to terminate the pregnancy, and 3) sought safe abortion care, can be presumed capable of freely consenting to abortion services (Turner et al., 2011). Through her health-care seeking behavior, she has demonstrated her capability.

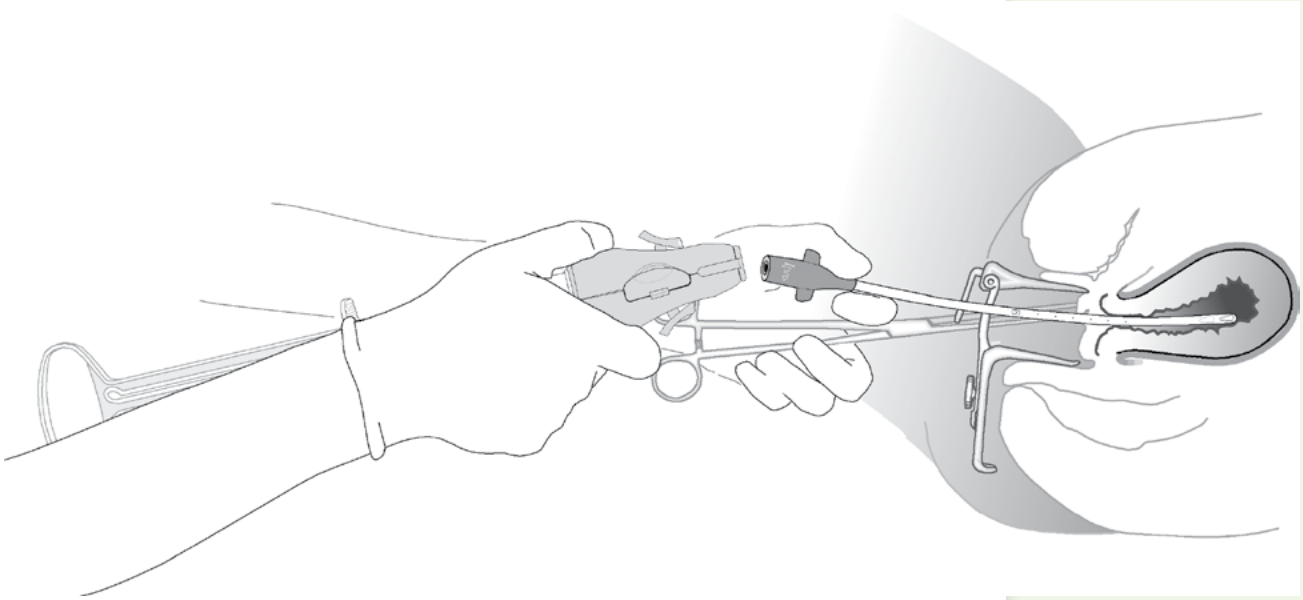
4.2 ABORTION IN THE FIRST TRIMESTER

What methods are recommended? Vacuum aspiration and medical abortion are recommended methods for abortion in the first trimester. Both methods are safe and effective, including for adolescents (Renner et al., 2013). Sharp curettage, also known as dilation and curettage (D&C), is an outdated method that is no longer recommended for either first- or second-trimester abortion.

How do they work? With *vacuum aspiration* the contents of the uterus are evacuated, using suction, through a cannula that is attached to a vacuum source (either a manual aspirator or an electric pump). Depending on the uterine size, different sized

cannulas are used. Vacuum aspiration is also called instrumented or surgical abortion. The procedure involves dilating the cervix, inserting the cannula and suctioning the uterine contents. It usually takes three to ten minutes to complete (WHO, 2012b). Before the procedure, the provider and woman should agree on a pain management plan.

ILLUSTRATION 4.1: PROVIDER ATTACHING THE MANUAL VACUUM ASPIRATOR TO THE CANNULA



With *medical abortion* the contents of the uterus are expelled through the use of medicines. Two regimens exist: mifepristone and misoprostol, and misoprostol only. Mifepristone blocks progesterone and interferes with the continuation of the pregnancy (WHO, 2012b), and misoprostol causes cervical ripening and uterine contractions (Ipas, 2013b). In countries where mifepristone is not approved, the misoprostol-only regimen offers an important, low-cost alternative that can reduce unsafe abortion rates (Ipas, 2013b).

> ***Medical abortion represents a revolution in reproductive health. It saves women's lives and has enormous potential to increase access to safe abortion at minimal cost.***
>
> — **Dana Hovig**, Chief Executive of Marie Stopes International (Kristof, 2010)

If mifepristone is available, the woman takes this first, usually in the health-care facility. Later she takes the misoprostol in a place where she feels safe, such as her home or in the facility. After administration of misoprostol, the average expulsion time is three

to four hours for the combined regimen, and seven to eight hours for misoprostol only (Ipas, 2013b). The average duration of vaginal bleeding is nine to 14 days (Davis et al., 2000; WHO, 2012b). The provider should give the woman thorough information about what she can expect, including the range of normal bleeding, common side effects, how to manage pain and warning signs of complications. This is particularly important since the abortion is often completed in an outpatient setting until nine weeks gestation (Ipas, 2013b).

How do women feel after an abortion? Women can experience a range of emotions after an abortion. There is no 'right' or 'wrong' way to feel. Some women feel relief, happiness, sadness and grief all at the same time. The circumstances surrounding the pregnancy—such as whether the pregnancy was intended, whether the woman's partner was supportive, and whether there were health reasons for terminating the pregnancy—can influence how a woman feels. It is important that a woman who decides to have an abortion does so freely and gives informed consent for the procedure (Kimport et al., 2011). Many women who wanted to terminate their pregnancies feel relief afterwards and identify abortion as the better decision for them (Foster et al., 2013). Conversely, if a woman is pressured or forced to have an abortion, she may experience long-lasting negative emotions (Elliot, 2009; Kimport et al., 2011). There are organizations that provide emotional support to women who want to talk anonymously about their abortion experiences. One such organization: www.exhaleprovoice.org.

Textbox 4.1: Unwanted pregnancy and mental health

Women who have an unwanted pregnancy are at an increased risk of mental health problems, regardless of whether the woman carries the pregnancy to term or has an abortion. The most reliable predictor of postabortion mental health problems is having a history of mental health problems before the abortion (National Collaborating Centre for Mental Health, 2011).

TABLE 4.1: COMPARISON OF SAFE ABORTION METHODS USED IN THE FIRST TRIMESTER

(Hakim-Elahi et al., 1990; Ipas, 2010; Ipas, 2013b; Ipas, 2013c; Renner et al., 2013; WHO, 2012b)

	Vacuum aspiration	Medical abortion
Efficacy	Vacuum aspiration is highly effective. The rate of successful abortion is 99–100 percent.	Medical abortion is very effective. The combined regimen of mifepristone and misoprostol has a 95–98 percent rate of successful abortion without further intervention. For misoprostol only the rate is about 85 percent.
Gestational dating	Ultrasound is not routinely required. Gestational age can be established through patient history and physical examination by a person with the necessary training and skills.	Ultrasound is not routinely required. Gestational age can be established through patient history and physical examination by a person with the necessary training and skills.
Pain management	A combination of verbal reassurance, gentle clinical techniques, a calming environment, oral medications and local anesthesia (paracervical block).	Oral medications. A heating pad or hot water bottle may also provide relief.
Side effects	Nausea, vomiting, uterine cramping, and menstrual-like bleeding.	Nausea, vomiting, diarrhea, headache, dizziness and fever. Bleeding and cramping are not side effects of medical abortion since they are necessary to expel the pregnancy.
Advantages	The procedure takes only a few minutes; it can be completed in one visit; predictable process; reassurance that the pregnancy is terminated before leaving facility.	Feels more natural; appears to others as a spontaneous abortion; no instruments and less invasive; can be used in private and low-resource settings; providers who are uncomfortable with vacuum aspiration may still provide medical abortion.
Disadvantages	Low risk of uterine perforation and cervical laceration; higher risk of infection than medical abortion.	More days of bleeding; higher risk of incomplete abortion than vacuum aspiration, especially with the misoprostol-only regimen.

TABLE 4.2 COMPARISON OF DOSES FOR MEDICAL ABORTION, BY REGIMEN AND GESTATIONAL AGE (first and second trimesters)

Mifepristone and misoprostol	Misoprostol only
Up to nine weeks gestation: Mifepristone 200mg orally followed 24–48 hours later by misoprostol 800mcg buccally, sublingually or vaginally (Ipas, 2014). **Nine to ten weeks gestation:** Mifepristone 200mg orally followed 24–48 hours later by misoprostol 800mcg buccally (Ipas, 2014). **Ten to 13 weeks gestation:** Mifepristone 200mg orally followed 36–48 hours later by misoprostol 800mcg vaginally then 400mcg vaginally or sublingually every three hours for a maximum of five doses (Ipas, 2014). **13 to 24 weeks gestation:** Mifepristone 200mg by mouth followed 36–48 hours later by misoprostol 800mcg vaginally for one dose then 400mcg vaginally or sublingually every three hours for four more doses (WHO, 2012b).	**Up to 13 weeks gestation:** Misoprostol 800mcg vaginally every three to 12 hours for a maximum of three doses, or misoprostol 800mcg sublingually every three hours for a maximum of three doses (von Hertzen et al., 2007). **13 to 24 weeks gestation:** Misoprostol 400mcg vaginally or sublingually every three hours for up to five doses. Vaginal dosing is more effective than sublingual dosing for women who have not given birth before (WHO, 2012b).

Textbox 4.2: What's the latest clinical guidance for abortion care?

This section contains clinical information—which can change! It is important that you stay informed of the most up-to-date evidence and guidance. We recommend that you check out Ipas's publication Clinical Updates in Reproductive Health regularly. Updated twice a year, it provides the most current clinical evidence and guidance. Recommendations in Clinical Updates in Reproductive Health supersede information in other Ipas resources, including this guide. You can access the latest version of the document at www.ipas.org/clinicalupdates.

4.3 ABORTION IN THE SECOND TRIMESTER

Why do women have abortions in the second trimester? A woman may seek abortion in the second trimester because she encountered barriers to safe abortion services earlier in the pregnancy. For example, she may have needed time to save money to be able to afford the cost of the services. In addition, local clinics may not have been able to offer the services earlier due to a lack of trained providers. Medical conditions that affect the woman or the fetus may not be detected until later in the pregnancy and can make it unsafe to continue the pregnancy.

What methods are recommended? *Dilation and evacuation* is a safe and effective method for abortion after 14 weeks gestation. It uses a combination of vacuum aspiration and specialized forceps. Cervical preparation with dilators or medicines should be done before the procedure (WHO, 2012b). After cervical preparation, the procedure usually takes no more than 30 minutes (WHO, 2012b). Providers need special training and clinical skills to perform dilation and evacuation procedures safely. They may also need emotional support from their colleagues and community because of stigma related to second-trimester abortion.

The other recommended method for second-trimester abortion is *medical abortion*. The clinical protocol and doses for medical abortion in the second trimester differ from those in the first trimester (Ipas, 2013b; WHO, 2012b). Once misoprostol is initiated, women are typically admitted to hospital until the pregnancy has expelled, which may take a few hours to two days. All women undergoing second-trimester abortion should receive appropriate pain management, as agreed upon by the woman and her provider.

4.4 ABORTION-RELATED COMPLICATIONS AND POSTABORTION CARE

In many countries, complications from unsafe second-trimester abortion cause the majority of abortion-related mortality (Gebreselassie et al., 2005; Jewkes et al., 2004). Conversely, complications from safe, legal abortion, especially in early pregnancy, are very rare (WHO, 2012b). It is important to remove as many barriers to safe first-trimester abortion as possible because a delay in inducing abortion increases the risk of complications (Bartlett, 2004). Possible major complications, such as incomplete or failed abortion, cervical or uterine injury, sepsis, hemorrhage and allergic reactions to medicines used for abortion or pain management,

have been reported in less than 0.1 percent of safe, legal abortions (Hakim-Elahi et al., 1990; Jejeebhoy et al., 2011; Warriner et al., 2006; Weitz et al., 2013). Please refer back to Textbox 1.2 'The safety of abortion' for more detailed data.

Postabortion care includes medical treatment of abortion-related complications, as well as counseling, contraceptive services, and provision of or referrals to other reproductive health-care services. In life-threatening situations, a complete clinical assessment and informed consent may be deferred until after the woman is stabilized (Ipas, 2013c). Vacuum aspiration and misoprostol only are both recommended methods for postabortion care (Ipas, 2013c). Timely access to postabortion care for all women who need it reduces abortion-related mortality and morbidity.

Textbox 4.3: Warning signs of abortion-related complications

If a woman shows any of the warning signs of abortion-related complications, she should go to the nearest health-care facility or emergency room. Someone familiar with these warning signs may be able to help her access life-saving postabortion care.

- Excessive bleeding (soaking more than two sanitary pads per hour for two consecutive hours);
- Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain;
- Fever any day after the day misoprostol is used;
- Severe abdominal pain that occurs any day after the day misoprostol is taken or vacuum aspiration completed;
- Persistent severe nausea and vomiting;
- Feeling very sick and weak, unable to get out of bed (Ipas, 2013c).

THE BOTTOM LINE

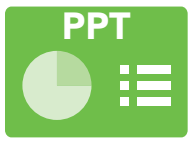
- The essential elements of woman-centered comprehensive abortion care include counseling, induced abortion, treatment of incomplete or unsafe abortion, contraceptive services, and provision of or referrals to other reproductive health-care services. Ultrasound is not routinely required.
- Vacuum aspiration and medical abortion are safe and effective methods in the first trimester. Vacuum aspiration uses suction to evacuate the contents of the uterus. Medical abortion uses medicines to detach and expel the pregnancy. There are two regimens for medical abortion: mifepristone and misoprostol, and misoprostol only. Doses vary and depend on gestational age.
- If a woman decides to terminate a pregnancy, she has the right to give informed consent for the abortion procedure. A woman who is clinically eligible for more than one method also has the right to decide which method she prefers.
- Complications from safe, legal abortion are extremely rare. A woman who displays warning signs of abortion-related complications should seek postabortion care without delay. Warning signs include excessive vaginal bleeding, unusual or bad-smelling vaginal discharge, severe abdominal pain, persistent nausea and vomiting, and feeling very sick.

MODULE 4 TOOLS

Handout 4: Comprehensive abortion care

Activity 4.A: Comprehensive abortion care crossword puzzle (1 hour)

Activity 4.B: Why I am an abortion provider (30 minutes)



This module is accompanied by presentation '**MODULE 4**' **(Slides 1–35)**. Remember, all printable materials and presentation slides are available on the USB and at www.ipas.org/youthact.

Want more attitude transformation?

Depending on your learning objectives, participants' preferences and the training workshop agenda, you may also wish to conduct the activity below.

PERSONAL BELIEFS VERSUS PROFESSIONAL RESPONSIBILITIES: This activity is appropriate for highly literate health-care providers involved in direct clinical care, or for non-health-care providers whose work pertains to abortion care, referrals or advocacy. It is intended to help people realize and resolve conflict between their personal beliefs and professional responsibilities and to recognize the link between these beliefs and their behaviors. This activity raises the issue of conscientious objection and emphasizes providers' responsibilities to ensure women's right to reproductive health care, including safe abortion. It takes approximately one hour.

A detailed activity description and facilitator instructions can be found in:

Turner, K. L., & Page, K. C. (2011). *Abortion attitude transformation: A values clarification curriculum for global audiences*. Chapel Hill, NC: Ipas.

At the time of publication, no youth-specific adaptation of this activity existed.

Handout 4: Comprehensive abortion care

Woman-centered comprehensive abortion care is a holistic model of care tailored to each woman's personal circumstances and health needs. It includes counseling, induced abortion, treatment of incomplete or unsafe abortion, contraceptive services, and provision of or referrals to other reproductive health-care services (Ipas, 2013c). Counseling may address pregnancy options, abortion methods and postabortion contraception. Women have the right to give free and informed consent to abortion services. Woman who are clinically eligible also have the right to decide which abortion method they prefer.

COMPARISON OF FIRST-TRIMESTER ABORTION METHODS

	Vacuum aspiration	Medical abortion
Mechanism of action	The uterus is evacuated using suction.	Medicines detach and expel the pregnancy. There are two regimens: mifepristone and misoprostol, and misoprostol only.
Process	The procedure involves dilating the cervix, inserting a cannula and suctioning the uterine contents with a manual aspirator or an electric pump. It usually takes three to ten minutes to complete.	If mifepristone is available, the woman first takes it by mouth. Up to two days later, she takes misoprostol (doses and route of administration vary depending on gestational age). She may expel the pregnancy in a few hours, and bleed or have spotting for around two weeks.
Efficacy	The rate of successful abortion is 99–100 percent.	The rate of successful abortion with mifepristone and misoprostol is 95–98 percent. For misoprostol only the rate is about 85 percent.
Advantages	It can be completed in one visit. The woman is reassured that the pregnancy is terminated before leaving the facility.	It feels more natural and appears to others as a miscarriage. It can be used in private settings (such as at home) and in low-resource settings.

After a complete, uncomplicated abortion, all contraceptive methods are recommended and most can be used immediately (WHO, 2010).

Complications from safe, legal abortion are extremely rare (WHO, 2012b). A woman who displays warning signs of abortion-related complications should seek postabortion care without delay. Warning signs include excessive vaginal bleeding, unusual or bad-smelling vaginal discharge, severe abdominal pain, persistent nausea and vomiting, and feeling very sick.

Activity 4.A: Comprehensive abortion care crossword puzzle

PURPOSE

Participants will learn about comprehensive abortion care, including safe and effective abortion methods. Participants will also discuss warning signs of abortion-related complications.

TIME

1 hour

MATERIALS

» Presentation 'Module 4,' **Slides 5–30**

» Supporting document 'Comprehensive abortion care crossword puzzle'

» Prizes, enough for all participants

PREPARATIONS

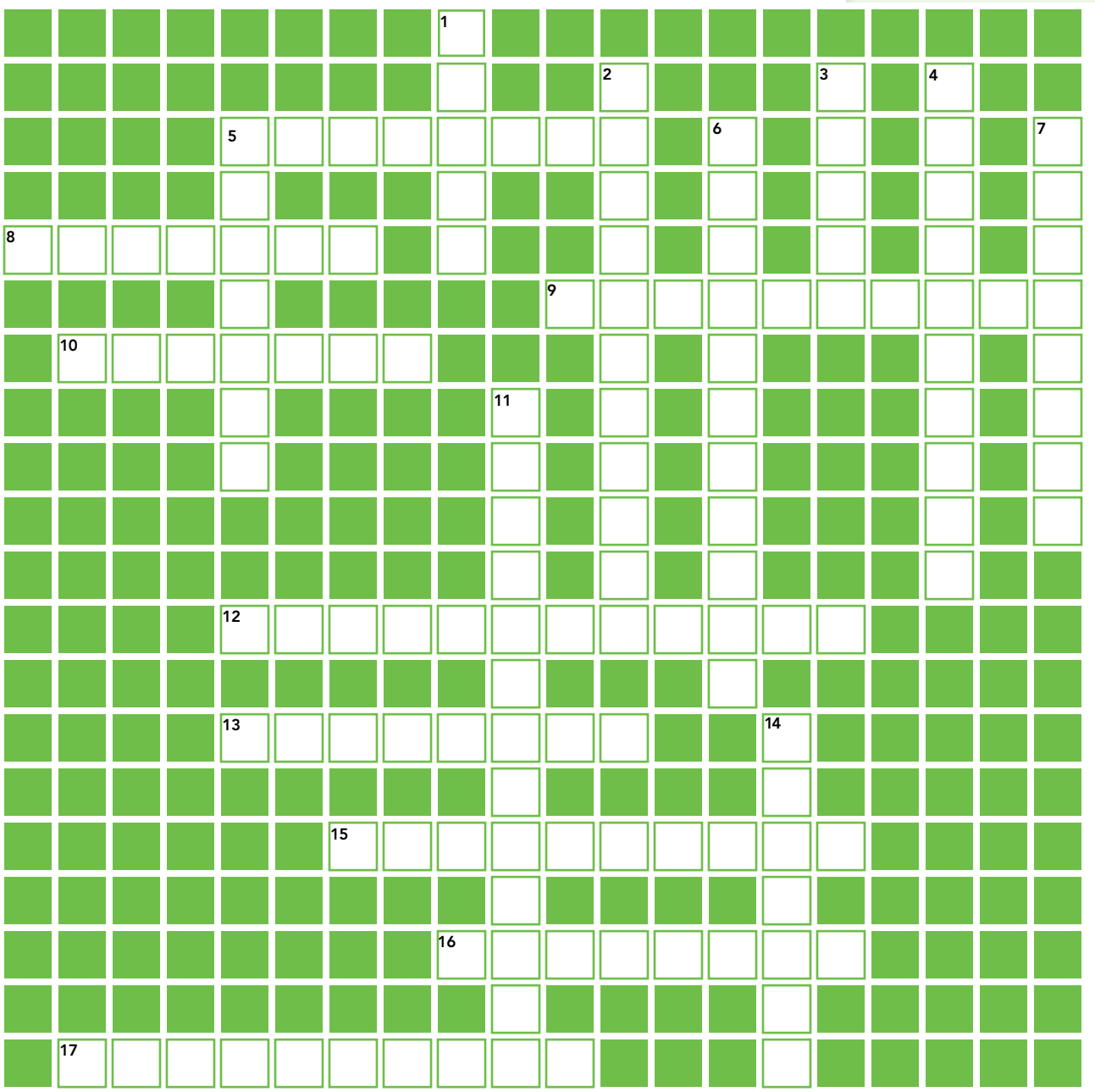
1. Review the presentation slides.
2. Print copies of the 'Comprehensive abortion care crossword puzzle.' Make sure you print both pages. Print half as many copies as there are participants (since two participants will share one copy).
3. Get small prizes, enough for all participants.

INSTRUCTIONS

1. Welcome participants to this activity. Inform them the purpose of this activity is for participants to become familiar with comprehensive abortion care and recommended methods for abortion. We will also discuss warning signs of abortion-related complications.
2. Tell participants that this activity gives them an introduction to clinical aspects of safe abortion, but it does **not** prepare them for abortion service delivery. Explain that you will share resources for participants who are interested in learning more about abortion service delivery later in this activity.
3. Present all the slides for this activity (**slides 5–30**). Allow 30–40 minutes for this presentation.
4. Solicit and answer any clarifying questions participants have. If participants have clinical questions about comprehensive abortion care that

you cannot or do not feel comfortable to answer, tell them this. Refer them to the resources listed in this module for more information.

5. Invite participants to divide into pairs.
6. Tell participants that each pair will receive a comprehensive abortion care crossword puzzle. The task is for each pair to complete the puzzle as quickly as possible. As soon as they have completed all words, the pair should indicate verbally that they are finished (for example, by saying "*Done!*" loudly). Ask if anyone has any questions about the activity instructions. Make sure everyone is familiar with crossword puzzles and how to complete them.
7. Give each pair a copy of the 'Comprehensive abortion care crossword.' Place the crossword face down on the table and instruct participants to leave it there until you invite them to start. This ensures everyone gets a chance to start at the same time. Once all pairs have a copy, invite them to turn the crosswords over and begin.
8. Once a team indicates they are done, instruct everyone to stop writing. Ask the team that is done to hand you their crossword and check whether all of their answers are correct. If all of their answers are correct, the game is over, and you can ask the winning team to read their answers out loud to the whole group. If one or more of their answers are incorrect, instruct the teams to continue working on their crosswords. Once a new team says they are done, start instruction #8 again to see whether this team has successfully completed the crossword or not.
9. Award the winning team their prizes first and then share prizes with all participants.
10. Solicit and answer any questions participants have about comprehensive abortion care.
11. Thank the group for participating in this activity.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Across

5. This regimen for medical abortion is slightly more effective
8. One of the routes for misoprostol administration
9. A very rare complication from safe, legal abortion
10. Many women prefer medical abortion because it feels more like this to them
12. Drug that blocks progesterone and stops the continuation of the pregnancy
13. This is an alternative name for vacuum aspiration abortion
15. Until nine to ten weeks of gestation, medical abortion can be used in this type of setting
16. Side effect of medical abortion
17. Essential element of comprehensive abortion care that takes places before an abortion procedure

Down

1. An advantage of the vacuum aspiration procedure
2. Both vacuum aspiration and medical abortion are appropriate for this group of women
3. Warning sign of complication if it presents any day after the day misoprostol is taken
4. This is not routinely required for gestational dating before abortion services
5. Part of instrument used in vacuum aspiration
6. Drug that causes cervical ripening and uterine contractions
7. Warning sign of complication when excessive
11. Comprehensive abortion care includes this postabortion service
14. This should be informed and provided freely by a woman before abortion services

FACILITATOR'S KEY

Across

5. Combined
8. Vaginal
9. Hemorrhage
10. Natural
12. Mifepristone
13. Surgical
15. Outpatient
16. Diarrhea
17. Counseling

Down

1. Quick
2. Adolescents
3. Fever
4. Ultrasound
5. Cannula
6. Misoprostol
7. Bleeding
11. Contraception
14. Consent

Activity 4.B: Why I am an abortion provider

PURPOSE

During Module 4, participants may become interested in learning more about what motivates health-care professionals to provide comprehensive abortion care, and explore their own feelings about providing abortion services in the future. In this activity, participants will identify reasons why health-care professionals provide abortion services and briefly discuss what it means to be an abortion provider.

TIME

30 minutes

MATERIALS

» Presentation 'Module 4,' **Slides 31–34**

» *Dr. Nozer Sheriar: Why I'm an abortion provider*. Video available at: www.youtube.com/watch?v=a1H1m365ZC4
The video is also available with Spanish subtitles at: www.youtube.com/watch?v=x8XvgxTezO4

PREPARATIONS

1. Review the presentation slides. **We encourage you to adapt them with supportive and illustrative quotes from providers in your region if possible.**
2. Download the video and play it in the workshop venue to test audiovisuals.
3. You may wish to identify a local provider or faculty member who can speak to participants about their experiences providing safe abortion services. If the training workshop takes place in a country where Ipas has an office or program, the Ipas staff in-country may be able to recommend a suitable speaker. If you find a suitable speaker, you can exclude the video and slides from this activity to allow more time for the speaker.

INSTRUCTIONS

1. Welcome participants to this activity. Inform them the purpose of this activity is for participants to identify reasons why health-care professionals provide abortion services and discuss what it means to be an abortion provider.
2. Facilitate a group discussion. You may wish to use the questions

below. Allow five minutes for this discussion.

   a. *Do you think that you will provide abortion care in the future? Why? Why not?*

   b. *What do you think motivates health-care professionals to provide abortion services?*

3. Play the video *Dr. Nozer Sheriar: Why I'm an abortion provider*. Ask participants to identify the reasons Dr. Sheriar shares for providing abortion services.

4. Present **slide 32** and invite participants to read it silently. Ask participants to identify the reasons Dr. Perrin shares for providing abortion services.

5. Summarize key points from the discussion. Make sure several different reasons for providing abortion care are mentioned. Examples include: saving women's lives, reducing unsafe abortion rates, providing complete care to women, ensuring a standard of excellence in women's health care, honoring women's choices about their bodies, trusting women's decisions about what is best for them and their family, serving their clients' best interests, being a role model for younger providers, and gaining professional respect.

6. Facilitate a group discussion. You may wish to use the questions below. Allow 10–15 minutes for this discussion.

   a. *What does it mean to be an abortion care provider?*

   b. *What are some challenges that abortion care providers face in their daily lives? How can those challenges be addressed?*

   c. *What motivates abortion care providers to continue offering safe abortion services?*

7. Summarize key points from the discussion.

8. Present **slide 33** and invite a participant to read it out loud.

9. Ask participants what similarities and differences they notice between Dr. Broekhuizen's reasons for continuing to offer safe abortion services and the reasons participants listed in the previous discussion.

10. Solicit any final thoughts from the participants.

11. Present the final slide 'Key Messages' **(slide 34**).

12. Thank everyone for participating in the activity and continue to the final module.

MODULE 5: Youth act for safe abortion

Photo illustration; original photo © Ipas

Module 5: Youth act for safe abortion

LEARNING OBJECTIVES

This module helps participants recognize the potential of student-led action for safe abortion. Participants will learn about different strategies for advancing abortion rights and increasing women's access to safe services—including advocacy, peer education and accompaniment—and develop practical skills in these areas. The module also briefly discusses self-care and how to prevent personal 'burn out.' By the end of the module, participants will be able to:

- Describe examples of how future health professionals can advocate for safe abortion, and design advocacy messages for safe abortion.
- Explain what considerations may be appropriate when doing peer education on abortion.
- List common components of abortion accompaniment and how accompaniment helps women overcome barriers to safe abortion care.

CORE RESOURCES

- ❑ Barcklow D'Amica, E. L. & Sánchez, J. R. (2010). *Young women and their experiences with abortion: A guide for activists*. Mexico City, Mexico: DECIDIR Coalición de Jóvenes por la Ciudadanía Sexual.
- ❑ Gasman, N., Blandon, M.M., & Crane, B. B. (2006). Abortion, social inequity and women's health: Obstetrician-gynecologists as agents of change. *International Journal of Gynecology and Obstetrics*, 94, 310–316. Particularly sections 4 and 5. www.genderbias.net/docs/resources/guideline/Abortion,%20social%20inequity,%20and%20women%92s%20health.pdf
- ❑ Turner, K. L., Weiss, E., & Gulati-Partee, G. (2009). *Providers as advocates for safe abortion: A training manual*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Providers-as-advocates-for-safe-abortion-care--A-training-manual.aspx
- ❑ International Planned Parenthood Federation (IPPF). (2007). Chapter 3: Framework of good practice for an effective IPPF peer education programme. *Included, involved, inspired: A framework for youth peer education programmes*. London, UK: IPPF. www.ippf.org/sites/default/files/peer_education_framework.pdf
- ❑ Centro Las Libres & Ipas. (2014). *Supporting women during medical abortion (full version with subtitles)*. Chapel Hill, NC: Ipas. Video available at: www.youtube.com/watch?v=MC8jxYGzdWQ

Facilitators can check off the boxes as they complete the core resources.

SUPPLEMENTARY RESOURCES

ADVOCACY

International Planned Parenthood Federation (IPPF). (2011). *Young people as advocates: Your action for change toolkit*. London, United Kingdom: IPPF. www.ippf.org/sites/default/files/web_young_people_as_advocates.pdf

International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR). (2010). *Handbook for advocacy planning*. New York, NY: IPPF/WHR. www.IPPF/WHR.org/en/publications/handbook-for-advocacy-planning

Women Deliver. (2010). *Youth guide to action on maternal health*. New York, NY: Women Deliver. www.womendeliver.org/assets/Youth_Guide_to_Maternal_Health_FINAL.pdf

PEER EDUCATION

Advocates for Youth. Resource library on peer education (multiple resources). www.advocatesforyouth.org/peer-education-workingwithyouth

FHI360. (2010). *Evidence-based guidelines for youth peer education*. Research Triangle Park, NC: FHI360. www.fhi360.org/resource/evidence-based-guidelines-youth-peer-education

Ipas. (2013). *Empowering women workers through youth-led education on reproductive health and safe abortion in Nepal*. Chapel Hill, NC: Ipas. www.ipas.org/en/Resources/Ipas%20Publications/Empowering-women-workers-through-youth-led-education-on-reproductive-health-and-safe-abort.aspx

United Nations Population Fund (UNFPA), Youth Peer Education Network (Y-PEER) & FHI360. (2005). *Peer education toolkit*. New York, NY: UNFPA. www.unfpa.org/public/home/publications/pid/360

SELF-CARE

Bernal, M. (2008). *Self-care and self-defense manual for feminist activists*. New Delhi, India and New York, NY: CREA. http://issuu.com/marina.bernal/docs/selfcareandselfdefense

Clark, N. & Utah, A. (2012). *The revolution starts with me! Promoting self care & preventing activist burnout*. Nicole Clark Consulting and SouLar Bliss. http://origin.library.constantcontact.com/download/get/file/1106245061519-168/The+Revolution+Starts+with+Me+Zine.pdf

Sexplanations. (2013). *How to deal with sexual injustices*. Video available at: www.youtube.com/watch?v=TX-9jmmiWoY

Youth act for safe abortion

Young people have the right to influence institutions, processes and services that affect their lives. Adults and youth allies have a responsibility to support youth voices in decisionmaking and ensure that young people's participation is not merely symbolic. Meaningful youth participation is important because it can build civic engagement and improve intergenerational communication (Instituto Promundo et al., 2009). It can also reduce barriers to health-care services and improve quality of care (Save the Children, 2008). As a group of young people, future health professionals can be powerful agents of social change. School is a formative time of learning and civic engagement. Many students join associations that work on different global health issues, including sexual and reproductive health and rights. Collectively, association members take action against inequalities that shape health-care access, quality of care and health outcomes.

In this module, we discuss three different ways in which future health professionals can take action for safe abortion: advocacy, peer education and accompaniment. There are many different ways to support women's access to safe abortion. We chose advocacy and peer education because those are avenues for change that many future health professionals already have experience with. We added accompaniment because it can be an effective way of increasing women's access to safe abortion services and support. We also think future health professionals are likely to be approached by family, friends and other people who have health-related questions and concerns, and skills in accompaniment are useful in these situations. For students who become health-care providers, they can also positively influence women's access to safe abortion through service provision, support, and referrals.

> ***…because it starts with medical students becoming physicians who are not shallow-minded on the issue of reproductive health and abortion.***
>
> — Medical student (Börjesson & Villa Torres, 2013)

5.1 ABORTION ADVOCACY

Advocacy means different things to different people and groups. It is often explained as a political and social process that involves planned, organized action to raise awareness of a defined issue and influence commitment, capacity and resources to transform

that issue. Advocacy can also be more informal or personal in nature: for example, speaking up and making a difference on an issue you believe strongly in within your family, place of work or community. More informal advocacy is sometimes called activism.

> *"Advocacy is a process that involves a series of political actions conducted by organized citizens in order to transform power relations." (Arias Foundation)*

> *"Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision makers toward a solution. Advocacy is working with other people and organizations to make a difference." (The Center for Development and Population Activities)*

Who can advocate for safe abortion? Anyone can be an advocate for safe abortion! Health professionals benefit from a unique combination of skills, experiences and privileges. For example, physicians are often perceived as bearers of objective, evidence-based information. Many have first-hand experiences with unsafe abortion-related mortality and morbidity through their personal lives or professional practice or both (Turner et al., 2009). Physicians also hold a certain status in their community that allows them special influence with policymakers and other stakeholders (Gasman et al., 2006). As members of the health-care community, medical students and students of other health sciences may enjoy many of these same privileges, including social status among other groups of young people. Both future and practicing health professionals have access to advocacy platforms in the form of active professional and students' associations at the local, national and international levels.

What are ways to advocate for safe abortion? Advocates for safe abortion work to advance women's health and rights by improving women's access to evidence-based information and quality services. Conversely, opponents of abortion seek to restrict women's access to safe services and sometimes even penalize providers and women. Some ways to advocate for safe abortion include:

- Raising awareness of the magnitude and consequences of unsafe abortion, and of the circumstances in which safe abortion is already legal. Almost all countries have one or more legal indications for abortion;
- Building support for safe, legal abortion in communities and among professional associations;

- Supporting the passing and implementation of laws and policies that improve access to safe, legal abortion. This can involve sensitizing and lobbying policymakers, testifying in legislative processes and holding public demonstrations;
- Correcting misinformation and myths about abortion in our daily lives, whether in the news, our offices or classrooms, or at the dining room table at home.

How can future health professionals advocate for training on abortion? Many medical students and students of other health sciences believe that they, as potential future providers, should be taught how to provide safe abortion and postabortion services and safely manage incomplete and missed spontaneous abortions. Medical Students for Choice is an international organization that works to make reproductive health care, including contraception and safe abortion, a standard component of medical education and residency training. They advocate for increased opportunities for medical students to gain knowledge and clinical skills in these essential components of health care. They also offer resources and mentoring by medical students for medical students. To learn more, visit www.msfc.org.

> ***We encourage students to take medical education reform into their own hands and advocate within their medical schools to affect change.***
>
> — Medical Students for Choice

Health sciences students who want to improve abortion training in their school can take action through existing student-led associations. Medical students can organize a local Medical Students for Choice chapter. Once group members are themselves adequately trained in abortion, advocacy and peer education, they can implement a range of activities:

- Surveying and assessing the current level of abortion training offered at the school;
- Conducting elective training opportunities for other students, such as peer education, lecture series and talks;
- Identifying experienced and supportive abortion care providers who are able to speak to and/or mentor students interested in training on abortion—for example, by arranging a 'meet the doctor' event;

- Identifying abortion service providers who are willing and able to accommodate 'externships' in which qualified students observe abortion care in a clinical setting for a certain period of time;
- Contacting a local Ipas office or office of another non-governmental organization working on abortion to identify whether they offer pre-service abortion training or can help identify provider mentors;
- Researching and implementing a training reform strategy in which you lobby and collaborate with school officials, students and other stakeholders to integrate safe abortion in the school curriculum and clinical practicum.

5.2 PEER EDUCATION ON ABORTION

Peer education harnesses the potential power within a group of people to influence knowledge, attitudes and practices of members in the group (Advocates for Youth, 2011). It has well-established, positive outcomes on the young people who are trained and serve as peer educators. Data on its effectiveness on other youth participants is inconclusive. Systematic reviews of peer education programs for HIV prevention found that they significantly increased knowledge, but did not change biological outcomes such as rate of sexually transmitted infections (Medley et al., 2009). Peer education programs can have more positive outcomes when they are part of larger projects (FHI360, 2010) and aimed at strengthening social support and creating referrals to services (Avahan: India AIDS Initiative, 2009). Tracking and follow-up on referrals is vital (Rimal & Shattuck, 2010).

Peer education is frequently used in youth sexual and reproductive health and rights programs. Few of these programs cover abortion,[2] and many peer educators may lack training and skills related to abortion. Because adolescents and young women are disproportionately affected by unsafe abortion, peer education programs on sexual and reproductive health and rights should provide evidence-based information, social support and referrals to services related to abortion.

2 In May, 2013, a search in PubMed for the terms "abortion" AND "peer educators" OR "peer education" OR "community education" OR "community educators" resulted in 12 articles after sorting for relevance. In contrast, excluding the term "abortion" resulted in almost 500 articles.

Special considerations may be appropriate when integrating safe abortion in peer education programs:

- **Risk assessment:** An assessment should be done to identify potential risks of addressing abortion for peer educators and strategies for how to mitigate those risks. The safety of peer educators and the people they work with, including women seeking abortion, is paramount.
- **Training and mentoring:** Peer educators should receive comprehensive training on abortion, including attitude transformation. Skills-building on how to talk about abortion with diverse groups of people can build comfort and commitment to address the issue. Mentoring throughout program implementation is an important extension of any initial capacity building.
- **Partnerships:** Programs should support partnerships between peer educators, community stakeholders and providers, including advocates for safe abortion. Social support is important to mitigate effects of abortion stigma and opposition. Connections with local providers can also help peer educators make referrals to safe services.
- **Information:** Information on abortion should be accurate and unbiased, and presented in a way that is accessible and appropriate for the audience. It should be framed in the context of broader sexual and reproductive health and rights and counter fears people have about abortion. A lot of myths and misinformation about abortion exist, particularly among youth.

5.3 ABORTION ACCOMPANIMENT

What is abortion accompaniment? A person who provides abortion accompaniment offers emotional, physical and logistical support to women during their abortion experiences (Barcklow D'Amica & Reyes Sánchez, 2010). Below we refer to this person as the 'accompanier.' The premise behind abortion accompaniment is that all women should have access to safe, legal abortion plus whatever support they need throughout the abortion experience.

Who provides accompaniment? A trusted family member or friend can be an informal accompanier. Many women seek support from someone they know when faced with an unwanted pregnancy. Other women have to hide their pregnancies at all costs. For these women it can be difficult to confide in someone within their immediate social network. More formal abortion accompaniment is offered

by non-governmental organizations, such as women's groups and abortion access funds, as well as peer education programs. Staff and peers who provide accompaniment should have knowledge on abortion, including on local laws and service delivery points, and experience in counseling.

Textbox 5.1: What's an abortion access fund?

Abortion access funds work to create the socioeconomic conditions necessary for women to make and act on reproductive health decisions more fully and safely. Specifically, they provide information, referrals and financial assistance to pay for safe abortion services. Some funds also offer accompaniment and transportation, or link women to safe sources for misoprostol. The MARIA Abortion Fund for Social Justice works in Mexico. On its website, it explains: "*Abortion in most states is a matter of social justice since wealthy women can pay for private providers or travel to [places where safe services are available] while poor women are forced to risk their health and lives in back-alley abortions. The MARIA Fund was founded in order to help these women.*"

What are key components of accompaniment? Abortion accompaniment consists of several components that can help women overcome barriers to safe abortion care. The components listed below were developed using information from the DECIDIR Youth Coalition for Sexual Citizenship, the MARIA Abortion Fund for Social Justice and the Doula Project.

- **Peer counseling:** The accompanier should provide emotional support and listen empathetically with the intention to understand the woman's circumstances, needs and preferences. They should offer unbiased, evidence-based information. If the woman is set on termination before counseling begins, the accompanier may ask her what motivated her decision to ensure she is not pressured. In contrast to a provider, the accompanier does **not** assess clinical eligibility or give medical advice.

> ***As [accompaniers] we need to understand clearly that the woman's decision is not up to us.***
>
> — **Emily Louise Barcklow D'Amica** & **Jessica Reyes Sánchez** (2010)

- **Identification of services:** If the woman has decided to terminate the pregnancy, the accompanier should refer her to safe abortion services and may help her schedule appointments. In settings where abortion is legally restricted and stigmatized, the safety of both the provider and the woman must be protected. The accompanier should only make referrals to

providers they know and with whom they have established referral procedures. The nearest service delivery point may be outside the woman's community, district or country. If there are no service delivery points accessible to the woman, another option may be to identify whether and how the woman can safely access and use misoprostol on her own.

- **Financial assistance:** If the accompanier works with an abortion access fund, the fund may be able to cover all or some of the cost of the abortion for the woman. If the accompanier is a peer, they may be able to help the woman identify other possible sources of funds.
- **Transportation to and from services:** This may range from walking with the woman through town or helping her arrange travel across the country or to another country for services.
- **Support during the abortion procedure and recovery period:** If the woman wants, and it is allowed by facility protocols, the accompanier can stay with the woman throughout the procedure and in recovery. This can give the woman confidence to self-advocate in a medical setting and ensure her choices are respected. For medical abortion, the woman may wish to have company when she begins to bleed and as she expels the pregnancy. The accompanier can also help the woman talk to a trusted family member or friend; it can be comforting for women to have someone emotionally close to them present.
- **Follow-up:** The accompanier should continue to give emotional support and remain in touch with the woman for as long as she desires after the abortion. Learning about the woman's experiences and feelings before, during and after the abortion can help the accompanier improve their accompaniment to other women and give feedback to providers on the quality of care.

5.4 SELF-CARE

> ***Caring for myself is not self-indulgence. It is self-preservation—that is an act of political warfare.***
>
> — **Audre Lorde**, Caribbean-American civil rights activist (Clark & Utah, 2012)

To successfully take action for safe abortion you have to dedicate time and energy to care for yourself. Many advocates 'burn out' when their own physical, emotional and spiritual needs are not balanced with the demands of their work (Clark & Utah, 2012).

Advocacy on topics that are culturally sensitive or taboo, such as abortion, can place another layer of stress on your well-being. Sometimes, advocates are targets of public criticism and shaming, and experience threats or violence against their privacy, person or possessions (Bernal, 2008). Gender norms that associate caring for others as a desirable feminine trait can push women advocates in particular to put the needs of others before their own well-being (Bernal, 2008).

Self-care can involve a combination of strategies such as:

- Developing awareness and a deeper sense of yourself and your personal and family history;
- Identifying, respecting and expressing your own feelings and emotions;
- Developing personal autonomy;
- Caring for your physical being through adequate sleep, regular exercise and a healthy diet;
- Using therapies such as massage, acupressure, reflexology, aromatherapy and meditation;
- Connecting or reconnecting with spiritual practices;
- Setting boundaries on your advocacy work, saying 'no' to things, and doing fewer things better;
- Reaching out to your family, friends and formal self-care support groups for advocates (Bernal, 2008; Clark & Utah, 2012).

If you want more information and tools to do self-care, check out the supplementary resources. The resources offer self-assessments, activities, recipes and other remedies.

THE BOTTOM LINE

- Medical students—as well as students of many other health sciences—enjoy privileges, such as access to information, social status, and membership in activism communities and students' associations, which make them well-positioned to take action for safe abortion.
- Advocates for safe abortion can raise awareness of existing laws and indications for abortion, build support for reforming abortion laws and policies, and monitor implementation of those laws and policies. They can correct myths and misinformation about abortion in their daily lives. Medical students and students of other health sciences can also work to add safe abortion information to the training agenda at their schools, and work to reform the official curriculum and residency training.
- Peer education programs can increase knowledge and skills on safe abortion among young people. Peer educators who work on abortion should receive training and mentoring, and be supported to act safely and in partnership with other advocates.
- Abortion accompaniment addresses socioeconomic barriers to safe abortion services. An 'accompanier' provides women with emotional, physical and logistical support during their abortion experiences. This support may include counseling before the abortion, identification of safe services, finding financial assistance, transportation, presence during the abortion, and follow-up.
- Self-care is an important component of working for safe abortion. It includes different strategies for emotional, physical and spiritual well-being, and helps to prevent personal 'burn out.'

MODULE 5 TOOLS

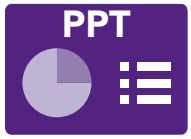
Handout 5: Youth act for safe abortion

Activity 5.A: A call to action! (30 minutes)

Activity 5.B: Advocacy perspectives and messages (1 hour and 15 minutes)

Activity 5.C: Peer education on abortion (1 hour and 15 minutes)

Activity 5.D: Supporting women during their abortion experiences (2 hours and 15 minutes)



This module is accompanied by presentation '**MODULE 5**' **(Slides 1–43)**. Remember, all printable materials and presentation slides are available on the USB and at www.ipas.org/youthact.

Want more attitude transformation?

Depending on your learning objectives, participants' preferences and the training workshop agenda, you may wish to conduct the activity below.

TALKING ABOUT ABORTION:
This activity helps participants anticipate negative comments and reactions from people we care about and who oppose or have different levels of comfort with abortion. Participants learn to develop and articulate appropriate, respectful responses to disapproving questions or comments. It takes approximately one hour.

A detailed activity description and facilitator instructions can be found in:

Turner, K. L., & Page, K. C. (2011). *Abortion attitude transformation: A values clarification curriculum for global audiences*. Chapel Hill, NC: Ipas.

A youth-specific adaptation of 'Talking about abortion' can be found in:

McSmith, D., Börjesson, E., Villa, L., & Turner, K. L. (2011). *Abortion attitude transformation: Values clarification activities adapted for young women*. Chapel Hill, NC: Ipas.

Handout 5: Youth act for safe abortion

School is a formative time of learning and civic engagement. Many students join associations that work on different global health issues, including sexual and reproductive health and rights. As a group of young people, future health professionals can be powerful agents of social change. They can take action for safe abortion in many different ways, which can include advocacy, peer education and accompaniment activities. Students who become health-care providers can also positively influence women's access to safe abortion through service provision and referrals.

Advocacy: Advocates for safe abortion work to advance women's health and rights by improving women's access to information and services. Anyone can be an advocate for safe abortion, and medical students and students of other health sciences are well-positioned because they enjoy social status among peers, access to information, and membership in activism communities and associations. Future health professionals can:

- Raise awareness of existing abortion laws and policies, and garner support for reform of abortion laws and policies among professional organizations, policymakers and communities;
- Correct myths and misinformation that they hear about abortion in their daily lives;
- Improve access to evidence-based safe abortion information at their schools. This may involve surveying existing materials, leading training opportunities for other students, identifying provider mentors, arranging clinical observations of abortion care, and working toward reform of school curriculum and residency training.

Peer education: Peer education can have positive outcomes on young people's knowledge, attitudes and practices related to abortion. Peer education programs should work to strengthen social support for abortion and facilitate referrals to services. Special considerations, such as a risk assessment and risk reduction strategy, may be appropriate before starting peer education programs on abortion. Peer educators also need adequate training and mentoring, and should partner with other advocates.

Accompaniment: A person who provides abortion accompaniment offers emotional, physical and logistical support to women during their abortion experiences. Accompaniment can be

informal, when provided by a friend or family member, or formal, when offered by someone with the appropriate knowledge and skills. Accompaniment helps women overcome barriers to safe abortion in many different ways:

- Peer counseling to support free and informed decisionmaking;
- Identification of safe abortion services, including medical abortion;
- Identification of funds to pay for the service—for example, from an abortion access fund;
- Transportation to and from the services;
- Support during the procedure and in the recovery period. With medical abortion, the woman may want company when she begins to bleed and as she expels the pregnancy;
- Follow-up and emotional support for as long as the woman desires after the abortion.

Activity 5.A: A call to action!

PURPOSE

Participants will discuss why abortion matters to future health professionals and begin to identify ways in which they can take action for safe abortion.

TIME

30 minutes

MATERIALS

» Flipchart, tape and markers (enough markers for each participant to have one)

PREPARATIONS

1. Write the statement: "*Abortion matters to [X] students because…*" on flipchart. Instead of writing "X" use the term that best describes your participants' field(s) of study.
   Example: *"Abortion matters to medical students because…"* (Note: We'll use the example of medical students in the instructions below, but you should adapt it to best describe the participants in your workshop!)

INSTRUCTIONS

1. Invite participants to participate actively in this activity. Inform them the purpose of this activity is to discuss why abortion matters to future health professionals and begin to identify ways in which they can take action for safe abortion.
2. Divide participants into four or five small groups. If possible, group participants based on the countries or associations they represent. Give each group a flipchart and markers.
3. Post the flipchart with the statement: "*Abortion matters to medical students because…*" Ask the groups to discuss and complete the statement on their flipchart. Allow five minutes for the groups to complete this task.
4. Ask the groups to hang their completed flipcharts on the walls around the room. Space the flipcharts on the wall so that participants can comfortably walk from one flipchart to the next without crowding in a large group.
5. Invite participants to walk around the room and read all the flipcharts. Instruct them to bring a marker on their walk. Tell participants to mark

with a star any reasons they think are particularly important or compelling. Allow five minutes to complete this task.

6. After the participants have completed the gallery walk, take a few minutes to reflect on their flipcharts in a group discussion. You may wish to use the discussion questions below. Use approximately 10 minutes for this discussion.

    a. *What similarities do you see on the flipcharts? What differences?*

    b. *Which reasons to work on abortion are particularly important or compelling to the group? (draw participants' attention to reasons with a high number of stars next to them)*

    c. *How can these reasons motivate medical students to take action for safe abortion?*

7. Ask participants to identify ways in which future health professionals can take action for safe abortion. You may wish to ask them: *What are examples of ways in which medical students can act for safe abortion?* Make sure you have 5–10 minutes left for this discussion.

8. Tell participants that in the next three activities they will discuss three different strategies to take action for safe abortion, including advocacy, peer education and accompaniment.

9. Solicit any final thoughts or comments from the participants.

10. Thank participants for participating in this activity, and segue to the next activity.

Activity 5.B: Advocacy perspectives and messages

Adapted from Turner et al., 2009

PURPOSE

Participants will be supported to adopt an advocacy perspective by identifying and responding to opportunities for advocacy in their everyday work and lives. Participants will also discuss and design effective advocacy messages on safe abortion.

TIME

1 hour and 15 minutes

MATERIALS

» Presentation 'Module 5,' **slides 6–19**

» Supporting document 'Advocacy opportunity cards'

» Tape

PREPARATIONS

1. Review the presentation slides.
2. Review the 'Advocacy opportunity cards.' **You may wish to adapt them to your context.**
3. Print copies of the 'Advocacy opportunity cards.' One copy of each card is sufficient. Alternatively, you can use colorful index cards and hand-write the cards.
4. Tape one 'Advocacy opportunity card' under one chair per round table. Each round table should have one 'Advocacy opportunity card' under a randomly chosen chair.

INSTRUCTIONS

1. Invite everyone to actively participate in this activity. Tell them the purpose of this activity is to encourage participants to adopt an advocacy perspective by identifying and responding to opportunities for advocacy in our everyday work and lives. We will also discuss and design effective advocacy messages.
2. Divide participants into five small groups and ask them to sit around round tables or in small circles.
3. Facilitate a brief discussion about advocacy. Allow 15 minutes for this

discussion. You may wish to use the following discussion questions:

   a. *What comes to mind when you hear the word advocacy?*

   b. *What are examples of advocacy for safe abortion?*

   c. *What do we need to be effective advocates for safe abortion?*

   d. *Why are future and practicing health professionals well-positioned to advocate for safe abortion?*

4. Present the first seven slides on advocacy in the presentation (**slides 7–13**). Allow 5–10 minutes for this presentation.

5. Show the next slide 'Activity case story' (**slide 14**) and ask a participant to read it out loud.

6. Show the slides 'Doctor X's response' and 'Doctor Y's response' (**slides 15–16**) and ask another participant to read them out loud.

7. Ask participants to briefly compare the responses of Doctor X and Doctor Y. You may wish to use the following discussion questions:

   a. *Who has an advocacy perspective?*

   b. *What do you perceive as the benefits and risks of Doctor X's advocacy?*

   c. *What do you perceive as the benefits and risks of Doctor Y's actions?*

8. Show the slide 'Advocacy opportunities' (**slide 17**) and ask a participant to read it out loud.

9. Ask the participants to reach under their chairs to see who at each table has an 'Advocacy opportunity card.' (If you have not taped these cards at the bottom of one randomly assigned chair per table, hand one card to each small group at this time.)

10. Explain that each small group has a different 'Advocacy opportunity card' and their task is to read and respond to the scenario on their card. If they want, they can prepare a short role play of their scenario. Allow participants 15 minutes to prepare responses to their scenarios.

11. Invite one group at a time to present their 'Advocacy opportunity card' and their response to it. Ask them to briefly summarize key points from their discussion. Allow 15–20 minutes for presentations.

12. Once every group has presented, allow participants to reflect on the activity and different advocacy opportunities and responses. Allow 15 minutes for this discussion. You may wish to use the following

discussion questions:

a. *What was easy in responding to your scenario? What was hard?*
b. *What obstacles exist to advocacy for safe abortion? How could you overcome them?*
c. *What are the potential benefits of advocacy for safe abortion? For women who seek abortion? For providers? For advocates?*
d. *What are some risks of assuming an advocacy role? Within your family? Professionally? Socially?*

13. Present the last two slides on advocacy in the presentation (**slides 18–19**).
14. Close the activity by summarizing key messages related to advocacy.
15. Solicit any final questions or thoughts from participants.
16. Thank the group for participating in this activity.

ADVOCACY OPPORTUNITY CARDS

Advocacy opportunity card 1:

Instructions: Please read the scenario below. Assign a note-taker for the group. Discuss questions 1–6. Design your group's one-minute message. The note-taker will be asked to briefly summarize key points from your discussion and present the group's one-minute message in plenary. (The one-minute message should only take one minute to present!)

Scenario: New clinical standards and guidelines for safe abortion are being drafted by the National Committee to Reduce Maternal Mortality of the Ministry of Health. As a recognized youth group in the country, the national medical students' association has been invited to submit verbal testimony on the first draft to the committee. When you (a medical student) read the draft, you identify new language that mandates third-party involvement, specifically parental consent, for anyone under the age of 18 who requests abortion. The only exception is for a young person to stand up in front of a local judge and seek a judicial bypass. The national abortion law has no language on age of consent. You are a member of the Standing Committee of Reproductive Health and Rights of the medical students' association and discuss this situation with them.

Questions: Please discuss and answer the following questions.

1. What are the issues of concern in this situation?
2. In what ways could you advocate? How could you deliver your message?
3. Who is the audience for your advocacy?
4. What are some benefits of advocacy in this situation?
5. What are some possible risks in this situation? Are there any risks that would prevent you from responding?
6. How does this situation relate to your real life?

One-minute message: Please design a one-minute message based on the following format and example:

» One statement (*Unsafe abortion is a preventable pandemic in the Global South.*)

» One piece of evidence (*According to the World Health Organization, almost all of the 47,000 unsafe abortion-related deaths annually take place in the Global South.*)

» One case or story (*Hauwa was a loving, caring mother of three when she became pregnant again at age 41. She learned the fetus had severe malformations. Because abortion is only legal to save the pregnant woman's life in her country, Hauwa resorted to an unsafe abortion…*)

» One call to action (*We call on the state to revisit the country's restrictive abortion law and make safe abortion legal and accessible to all women who need it.*)

Advocacy opportunity card 2:

Instructions: Please read the scenario below. Assign a note-taker for the group. Discuss questions 1–6. Design your group's one-minute message. The note-taker will be asked to briefly summarize key points from your discussion and present the group's one-minute message in plenary. (The one-minute message should only take one minute to present!)

Scenario: You and several other students are meeting at your professor's house for an informal class discussion on global reproductive health issues. The TV is playing in the background and in the show one of the characters has just found out that she is pregnant and is contemplating abortion. The professor catches this and remarks that abortion should never be an option for women. He uses incorrect information to support his remarks in opposition of abortion. He asserts that if abortion was completely outlawed, women would not have sex outside of marriage.

Questions: Please discuss and answer the following questions.

1. What are the issues of concern in this situation?
2. In what ways could you advocate? How could you deliver your message?
3. Who is the audience of your advocacy?
4. What are some benefits of advocacy in this situation?
5. What are some possible risks in this situation? Are there any risks that would prevent you from responding?
6. How does this situation relate to your real life?

One-minute message: Please design a one-minute message based on the following format and example:

» One statement (*Unsafe abortion is a preventable pandemic in the Global South.*)

» One piece of evidence (*According to the World Health Organization, almost all of the 47,000 unsafe abortion-related deaths annually take place in the Global South.*)

» One case or story (*Hauwa was a loving, caring mother of three when she became pregnant again at age 41. She learned the fetus had severe malformations. Because abortion is only legal to save the pregnant woman's life in her country, Hauwa resorted to an unsafe abortion…*)

» One call to action (*We call on the state to revisit the country's restrictive abortion law and make safe abortion legal and accessible to all women who need it.*)

Advocacy opportunity card 3:

Instructions: Please read the scenario below. Assign a note-taker for the group. Discuss questions 1–6. Design your group's one-minute message. The note-taker will be asked to briefly summarize key points from your discussion and present the group's one-minute message in plenary. (The one-minute message should only take one minute to present!)

Scenario: A popular radio show with national reach airs a story about the rise in use of misoprostol for abortion. You (a health sciences student) identify that the story contains misinformation about the safety and efficacy of misoprostol. It warns that adolescents will "*have more sex and take misoprostol like candy*." The radio host recommends that the drug should be completely banned in the country. Most listeners who call in support the radio host. Some callers want misoprostol to be available for other health indications, including ulcers and post-partum hemorrhage. Only a handful of callers express support for access to safe medical abortion.

Questions: Please discuss and answer the following questions.

1. What are the issues of concern in this situation?
2. In what ways could you advocate? How could you deliver your message?
3. Who is the audience of your advocacy?
4. What are some benefits of advocacy in this situation?
5. What are some possible risks in this situation? Are there any risks that would prevent you from responding?
6. How does this situation relate to your real life?

One-minute message: Please design a one-minute message based on the following format and example:

» One statement (*Unsafe abortion is a preventable pandemic in the Global South.*)

» One piece of evidence (*According to the World Health Organization, almost all of the 47,000 unsafe abortion-related deaths annually take place in the Global South.*)

» One case or story (*Hauwa was a loving, caring mother of three when she became pregnant again at age 41. She learned the fetus had severe malformations. Because abortion is only legal to save the pregnant woman's life in her country, Hauwa resorted to an unsafe abortion…*)

» One call to action (*We call on the state to revisit the country's restrictive abortion law and make safe abortion legal and accessible to all women who need it.*)

Advocacy opportunity card 4:

Instructions: Please read the scenario below. Assign a note-taker for the group. Discuss questions 1–6. Design your group's one-minute message. The note-taker will be asked to briefly summarize key points from your discussion and present the group's one-minute message in plenary. (The one-minute message should only take one minute to present!)

Scenario: You have recently completed your residency training in obstetrics and gynecology and are attending your first meeting of the National Obstetrics and Gynecology Association. A group of providers are concerned about new draft bill proposed by a member of Parliament (MP). He is backed by one of the leading churches in the country. The bill, if passed, would remove all indications for legal abortion except to save the life of the pregnant woman. The MP has stated publicly that abortion should not be available in cases of rape because "*it is immoral to punish the innocent child,*" and that "*very few rapes result in pregnancy because the female body can shut down during rape so pregnancy cannot occur.*" In the past when legislation has been drafted, the National Obstetrics and Gynecology Association has been invited to provide guidance on matters of reproductive health to Parliament.

Questions: Please discuss and answer the following questions.

1. What are the issues of concern in this situation?
2. In what ways could you advocate? How could you deliver your message?
3. Who is the audience of your advocacy?
4. What are some benefits of advocacy in this situation?
5. What are some possible risks in this situation? Are there any risks that would prevent you from responding?
6. How does this situation relate to your real life?

One-minute message: Please design a one-minute message based on the following format and example:

» One statement (*Unsafe abortion is a preventable pandemic in the Global South.*)

» One piece of evidence (*According to the World Health Organization, almost all of the 47,000 unsafe abortion-related deaths annually take place in the Global South.*)

» One case or story (*Hauwa was a loving, caring mother of three when she became pregnant again at age 41. She learned the fetus had severe malformations. Because abortion is only legal to save the pregnant woman's life in her country, Hauwa resorted to an unsafe abortion…*)

» One call to action (*We call on the state to revisit the country's restrictive abortion law and make safe abortion legal and accessible to all women who need it.*)

Advocacy opportunity card 5:

Instructions: Please read the scenario below. Assign a note-taker for the group. Discuss questions 1–6. Design your group's one-minute message. The note-taker will be asked to briefly summarize key points from your discussion and present the group's one-minute message in plenary. (The one-minute message should only take one minute to present!)

Scenario: After attending a regional workshop on abortion you (a health sciences student) review the content related to sexual and reproductive health in your school's curriculum. You realize that abortion is not mentioned at all. Unsafe abortion is common in your country. A majority of emergency cases in the teaching hospital's maternity ward are severe infection from unsafe abortion. You know that several students in your class are interested in gaining knowledge and clinical skills in safe, comprehensive abortion care. However, there is also an active Pro-Life Students Chapter at your university.

Questions: Please discuss and answer the following questions.

1. What are the issues of concern in this situation?
2. In what ways could you advocate? How could you deliver your message?
3. Who is the audience of your advocacy?
4. What are some benefits of advocacy in this situation?
5. What are some possible risks in this situation? Are there any risks that would prevent you from responding?
6. How does this situation relate to your real life?

One-minute message: Please design a one-minute message based on the following format and example:

» One statement (*Unsafe abortion is a preventable pandemic in the Global South.*)

» One piece of evidence (*According to the World Health Organization, almost all of the 47,000 unsafe abortion-related deaths annually take place in the Global South.*)

» One case or story (*Hauwa was a loving, caring mother of three when she became pregnant again at age 41. She learned the fetus had severe malformations. Because abortion is only legal to save the pregnant woman's life in her country, Hauwa resorted to an unsafe abortion…*)

» One call to action (*We call on the state to revisit the country's restrictive abortion law and make safe abortion legal and accessible to all women who need it.*)

Activity 5.C: Peer education on abortion

PURPOSE

Participants will identify considerations that may be appropriate when doing peer education on abortion. We will also learn how to use a planning tool called 'SWOT' to identify what Strengths and Weaknesses, Opportunities and Threats affect health sciences students' associations interested in doing peer education on abortion. This is one step in planning effective peer education programs, including on abortion.

TIME

1 hour and 15 minutes

MATERIALS

» Presentation 'Module 5,' **slides 20–24**

» Supporting document 'Introduction to SWOT for participants'

» Supporting document 'SWOT template'

» Flipchart, markers and tape

PREPARATIONS

1. Review the presentation slides.
2. Print five copies of 'Introduction to SWOT for participants.'
3. Copy the 'SWOT template' on flipchart.

INSTRUCTIONS

1. Invite participants to actively participate in this activity. Inform them the purpose of this activity is for participants to discuss peer education on abortion. We will also learn how to use a planning tool called 'SWOT' to identify what Strengths and Weaknesses, Opportunities and Threats affect health sciences students' associations interested in doing peer education on abortion. This is one step in planning effective peer education programs, including on abortion.
2. Facilitate a brief discussion to introduce the topic of this activity. Allow 10 minutes for this discussion. You may wish to use the following discussion questions:
    a. *What is a peer?*
    b. *What is peer education?*

c. *Why do we do peer education? What are some benefits of peer education?*

3. Ask participants whether their students' associations have any peer education programs on sexual and reproductive health and rights.

4. Invite two participants to share a two- to three-minute overview of their peer education program. You may wish to ask the following discussion questions:

   a. *What topics does your peer education program cover?*

   b. *Does it cover abortion? How?*

   c. *If abortion is not covered, what were the reasons for not including it?*

   d. *If abortion is covered, what special considerations do you take? What have your experiences to-date been?*

5. Acknowledge that few peer education programs adequately address abortion, and it can be challenging to do peer education on abortion. You can tell participants that many peer educators lack the necessary training and skills.

6. Ask participants: *Why is it important to include abortion in peer education on sexual and reproductive health and rights?*

7. As participants identify reasons to do peer education on abortion, write the reasons on flipchart. Remind participants that young women are disproportionately affected by unsafe abortion, and that peer education programs can improve young women's health and lives by increasing access to safe abortion information.

8. Present all the slides for this activity (**slides 20–24**). Allow five minutes for this step.

9. Solicit and answer any clarifying questions that participants have.

10. Divide participants into five small groups. If possible, group participants by the countries or associations they represent.

11. Post the flipchart 'SWOT template' and ask if anyone knows what a SWOT analysis is.

12. If the participants do not mention it, explain that SWOT stands for strengths and weaknesses (which are internal to the organization doing the analysis) and opportunities and threats (which are external). A SWOT analysis is designed to help an organization understand how it relates to its external environment, and can be a

helpful tool in strategic planning.

13. Give each group a copy of 'Introduction to SWOT for participants' and review the document.
14. Ask the small groups to envision that their students' association has decided to start a peer education program on abortion or integrate abortion in an existing peer education program. What internal strengths will support you? What internal weaknesses need to be addressed before you can start? What external opportunities and threats may affect you and how?
15. Instruct the groups to copy the 'SWOT template' on flipchart and complete it for their students' association. Allow 30 minutes for the groups to complete their SWOT.
16. After 30 minutes, bring the groups back to plenary and facilitate a discussion. Allow 15–20 minutes for the discussion. You may wish to use the discussion questions below.
    a. *What observations can you make about your SWOT analysis? Did anything surprise you?*
    b. *What factors in the internal strengths and external opportunities represent support for peer education on abortion?*
    c. *What factors in the internal weaknesses and external threats need to be addressed for your students' association to successfully do peer education on abortion?*
    d. *What ideas or inspiration did you gain in this activity that you can bring home to your association?*
    e. *What are some next steps you can take with your association?*
17. Summarize highlights from the discussion.
18. Remind participants that an important next step for any association interested in doing peer education on abortion is to develop strategies to turn the internal weaknesses and external threats into strengths and opportunities (or mitigate their effects), as well as complete a program design.
19. Solicit any final thoughts and comments from participants.
20. Thank the group for participating in this activity.

Adapted from ABARIS Consulting Inc., 2001

What is SWOT?

SWOT stands for Strengths, Weaknesses, Opportunities and Threats. It is a process designed to help an organization understand itself and how it relates to its external environment. SWOT can help to evaluate if an organization is aligned with the world going on around it. Many people see SWOT as synonymous with strategic planning. In fact, SWOT is only one of many tools that can be used in an organization's strategic planning process. On its own, it is not sufficient to develop a strategic plan.

What is the purpose of a SWOT analysis?

The analysis should provide you with information that helps in making decisions. As such, lists of Strengths, Weaknesses, Opportunities and Threats are not unto themselves helpful. It is only when their potential implications for the organization are analyzed that you start to get any really meaningful inputs.

What are the steps of a SWOT analysis?

Key steps in a SWOT analysis include:

1. Brainstorm your Strengths, Weaknesses, Opportunities and Threats. The strengths and weaknesses should be internally focused (inside the organization). Opportunities and threats should be externally focused (outside of the organization).
2. Next, review one category at a time. Take all of the ideas within the category and reduce them to the top five ideas.
3. Discuss the top five ideas and analyze their potential implications on the organization and any desired program.
4. Repeat #2 and #3 for the remaining three categories.
5. Remember that the idea with SWOT analysis is to gain a better understanding of how your organization can relate to its external environment. Next, consider how the strengths and weaknesses internal to the organization relate to the opportunities and threats external to the organization.
    a. Those factors that represent both strengths of the organization and opportunities in the external environment represent potential areas for growth.
    b. Those factors that represent weaknesses of the organization and threats in the external environment represent areas that need to be addressed.

6. Identify next steps for sharing and applying the findings from the SWOT analysis. This may include designing strategies to overcome internal weaknesses and external threats.

SWOT TEMPLATE

Copy this template on flipchart.

SWOT analysis: Integrating abortion in peer education programs led by health sciences students' associations	
STRENGTHS (internal)	OPPORTUNITIES (external)
WEAKNESSES (internal)	THREATS (external)

Activity 5.D: Supporting women during their abortion experiences

Adapted from Breastfeeding USA, 2013; Turner et al., 2011

PURPOSE

Participants will gain knowledge on abortion accompaniment and build skills in peer counseling. The activity encourages participants to explore abortion from women's points of view and discuss how to support women's access to safe services.

TIME

2 hours and 15 minutes

This is a two-part activity that benefits from a short break or energizer. Part I is 45 minutes and Part II is 90 minutes.

MATERIALS

» Presentation 'Module 5,' **slides 25–42**

» Supporting document 'Instructions for participants'

» Supporting documents 'Scenarios'

PREPARATIONS

1. Carefully review the instructions for this activity. It is the longest activity in this training guide and it requires strong facilitation skills. Part I provides an introduction to abortion accompaniment with ample opportunities for participant discussion. Part II helps participants to build skills in peer counseling through live role plays. If time is limited in the workshop agenda, either part can be implemented as a standalone activity.
2. Review the presentation slides and additional instructions in the notes sections.
3. You can choose whether to write the different sets of discussion questions in Part I on flipchart. It can help participants to focus during the discussion if they can visually see the discussion questions. If you do, use one flipchart per set of questions.
4. Review the supporting documents, which are used in Part II. **You may wish to adapt the scenarios to your local context. This can help participants relate to the women in the scenarios.**

5. Print the 'Instructions for participants.' Make enough copies for all participants.
6. Print the 'Scenarios.' Make enough copies for each participant to get one of the scenarios (not all three).

INSTRUCTIONS 1 2 3

PART I (Abortion accompaniment)

1. Welcome participants to this activity. Inform them the purpose of this activity is for participants to gain knowledge on abortion accompaniment (Part I) and build skills in peer counseling (Part II). We will explore abortion from women's points of view and discuss how to support women's access to safe services.
2. To introduce Part I, ask participants to share a few examples of what abortion accompaniment means to them: *What is abortion accompaniment? What does it entail?*
3. Present the slides on abortion accompaniment in the presentation (**slides 26–34**).
4. Continue the conversation and discuss who can provide abortion accompaniment. You may wish to use the discussion questions below. If you prepared a flipchart with these discussion questions, post it now. Allow five minutes for this discussion.
    a. *What knowledge, skills and resources should an accompanier have?*
    b. *What are some reasons people provide abortion accompaniment?*
5. If participants do not mention these important reasons why people provide abortion accompaniment, mention them before moving on:
    a. *They may know the woman personally and care deeply for her health and well-being.*
    b. *They may believe that letting women die from unsafe abortion is unethical and that all women have a right to bodily autonomy and health care.*
    c. *They may want to reduce maternal mortality and morbidity in their community.*
6. Emphasize to participants that an accompanier often has many other roles and responsibilities in their life—they may be a student, an advocate, a social worker, a lawyer, a health professional, etc. Being an accompanier is one 'hat' they wear.

7. Facilitate a discussion about the benefits and risks of abortion accompaniment. You may wish to use the discussion questions below. If you prepared a flipchart with these discussion questions in advance, post it now. Allow 10 minutes for this discussion.

    a. *How can accompaniment improve women's experiences with abortion? Access to safe services?*

    b. *What are some obstacles to providing abortion accompaniment?*

    c. *What are some risks? For the accompanier? For women seeking abortion? For providers?*

8. Give participants examples of how abortion accompaniment can be done in different ways depending on the legal context. You may wish to say:

    There are many different ways to provide abortion accompaniment. In a country with many legal indications for abortion, a woman may feel comfortable asking someone close to her for support. There may be women's groups that publicly advertise their accompaniment services. In a country with few or no legal indications for abortion, accompaniment can be about access to evidence-based information and harm reduction. In some Latin American countries—where abortion is not legal even to save the life of the woman—abortion hotlines give women who call information on how to use misoprostol for abortion safely on their own. This is a harm reduction approach because misoprostol for abortion is safe and effective, and without this information the woman may resort to unsafe methods that jeopardize her life and health. And access to information is a human right. Some groups help women travel to a state or a country where safe, legal abortion is accessible. At the international level, groups like Women on Web provide physician-led counseling and medical abortion services online to women who live where abortion is legally restricted.

9. Ask participants to reflect on what opportunities future health professionals have to provide abortion accompaniment. You may wish to use the discussion questions below. If you prepared a flipchart with these discussion questions, post it now. Allow 10–15 minutes for this discussion.

    a. *Can you think of any situations in which you, as a future health professional, may be approached by a woman who seeks an abortion?*

    b. *How can future health professionals support women who need abortions?*

c. *Are future health professionals well-positioned to provide abortion accompaniment? Why? Why not?*

d. *What support and resources would help future health professionals to provide abortion accompaniment?*

10. Summarize key points from the discussions.

11. Solicit and answer any clarifying questions participants have.

12. After a break, continue to Part II of this activity.

PART II (Peer counseling)

1. If participants expressed interest in providing abortion accompaniment in Part I, tell them that this part of the activity gives them an opportunity to practice some of the necessary skills. Encourage them to continue building skills after the workshop too. If participants did not express interest in providing abortion accompaniment, reassure them that this part of the activity is a great way to explore abortion from different women's points of view.

2. Remind participants that an important component of abortion accompaniment is counseling. Tell them that many formal accompaniers have training in peer counseling.

3. Facilitate a discussion about counseling. You may wish to use the discussion questions below. Allow 20 minutes for this discussion.

   a. *What is counseling?*

   b. *What is the difference between education and counseling?*

   c. *Why are emotional support and empathy important aspects of counseling?*

   d. *How does non-verbal communication affect counseling?*

   e. *What are some benefits of good counseling? What are some risks of bad counseling?*

4. Present the slides on peer counseling in the presentation (**slides 35–40**). Make sure you identify clearly the difference between peer counseling and professional counseling. Tell participants that peer counseling does **not** include medical advice and recommendations.

5. Next, divide participants into small groups with three people in each group. It is important that each small group consists of three people. If there is one group of two people, a facilitator can join that group once the role plays are ready to begin.

6. Present the slide 'Role play scenarios' (**slide 41**). Explain that each small group will enact three different role plays about women seeking abortion. Everyone will get a chance to play the woman (or her partner), a peer counselor and an observer. Leave the slide posted for the remainder of the activity. It allows participants to see an overview of the different scenarios and it can be a helpful visual reminder as they work through the role plays.

7. Give each participant a copy of the 'Instructions' and *one* of the 'Scenarios.' Give participants in one small group **different** scenarios. In each small group there should be one person with Scenario A, one with B and one with C.

8. Review the instructions first. Ask participants to take turns reading the seven basic steps for peer counseling out loud. Answer any questions participants may have before moving on.

9. Instruct participants to read their assigned scenario and choose whether to play the woman or her partner. Remind participants to keep the details of their scenario confidential.

10. Invite the groups to begin the role plays. Allow the groups to work for up to 40 minutes on the three scenarios. If possible, allow the groups to leave the main workshop venue and use different, more private spaces during the role plays.

11. Move between the small groups throughout the role plays as a silent observer. Take notes of examples of good counseling. Also note examples of counseling that can be improved and any inaccurate information you hear so you can gently correct it after the role plays. Bring the groups' attention to time, as necessary. For example, you might inform them when it is time to wrap up each role play (about every 10–15 minutes).

12. After the role plays, instruct all groups to meet back in the main workshop venue.

13. Once everyone is back in plenary, lead a discussion about the role plays. You may wish to use the discussion questions below. This is also a good time for you as the facilitator to briefly share some of the observations you made during the role plays, without dominating the discussion. Allow at least 20 minutes for the discussion.

    a. *How do you feel the role plays went? What was challenging or easy in your counseling sessions?*

    b. *What feelings did you have when you played the woman or her partner? The peer counselor?*

c. *What examples of good counseling did you observe in the role plays?*

d. *What were some important issues that arose? How could we address them in the future?*

e. *If these were real-life scenarios, what would you have done next to help the woman access safe services?*

14. Summarize key points from the discussion.
15. Solicit any final thoughts or questions from participants.
16. Thank the group for participating in this activity.
17. Present the final slide 'Key messages' (**slide 42**).
18. Congratulate participants on completing all the activities in the training workshop, and continue to the workshop closing.

INSTRUCTIONS FOR PARTICIPANTS

This is a peer counseling role play activity. There are three different scenarios. Your group will enact all three scenarios. So you will get the chance to play: 1) a woman seeking safe abortion (or her partner); 2) a peer counselor; and 3) an observer. Review the instructions below and raise any questions with the facilitator before you start the first role play.

Instructions:

1. Briefly discuss and agree on the legal context for your role plays. You can specify legal indications for abortion. Remember: There are different ways to provide accompaniment depending on the legal context—and access to information is a human right.
2. Read your assigned scenario so you are familiar with it and can act as naturally as possible when you play **the woman** or her partner. Your group members should not know the details of your scenario until you enact them in the role play.
3. When you are the **peer counselor**, respond to the woman or her partner with effective counseling techniques and relevant, evidence-based information as the scenario unfolds. The basic steps listed below can guide you through the counseling process. Take a moment to review them before you start.
4. When you are the **observer,** remain silent during the role play and practice active listening. Write down examples of good counseling and examples of counseling that can be improved.
5. Now you are ready to start the first role play. You have 40 minutes to complete the three role plays (or about 10–15 minutes per role play).

Basic steps for peer counseling:

1. **Build rapport and trust.** Greet the woman, help her relax and make her feel comfortable.
2. **Provide emotional support.** Show respect and empathy; validate her feelings and concerns.
3. **Encourage her to speak freely.** Listen actively, ask open-ended questions to understand her situation, needs and preferences—this helps you determine what information she needs.
4. **Share evidence-based information** that is relevant to the woman and can help her consider her choices and make a decision (pregnancy options, safe abortion methods, side effects and warning signs of abortion-related complications, etc.).

5. **Ensure the woman's decision is free and informed.** Clarify what motivated her decision in a supportive, non-judgmental way; affirm her decision whether you agree with it or not.

6. **Make arrangements to refer or accompany the woman to services.** In real-life, this may involve different physical and logistical support, including setting up appointments, arranging travel, etc.

7. **Close the session.** Agree on next steps, make a follow-up plan, reassure the woman and affirm her positive actions.

Remember, peer counselors do **not** give personal medical advice or recommendations, and they do **not** conduct clinical assessments.

Scenarios

Scenario A

You are a second-year medical student living in a large city. Your boyfriend is also a medical student and you have been seeing each other for a year. Although you are both medical students and understand human reproduction, neither of you are comfortable discussing contraception with each other. Studying for your final second-year exams, you realize you cannot remember the last time you had your period. When you have a pregnancy test the next day, it is positive.

At first you are scared and in disbelief about the pregnancy. You would like to finish medical school before starting a family. Your parents are very religious. They do not approve of children outside of marriage, but they are also opposed to abortion. You become increasingly anxious and begin to show signs of depression. For example, you have difficulties sleeping, you have lost your appetite and you do not take care of your physical appearance anymore. In search of support, you finally contact a peer counselor at the university. You seem distant when you meet the peer counselor.

You are not sure how far along the pregnancy is, but you think it must be about seven or eight weeks since your last period. If you can, you would like to terminate the pregnancy before your exams begin.

It is important to you that you can be sure the pregnancy is terminated in one procedure.

Textbox: Alternative scenario A: The partner

[Use this scenario if you prefer to play a male role. Read the scenario above to understand the woman's circumstances and preferences.]

You are the boyfriend of the young woman in the scenario above. She confides her pregnancy and feelings about it to you. In search of support and information, you contact one the university's peer counselors.

Scenario B

You are a mother of four young children living in a rural district. Your husband has a bicycle repair shop and is seldom home, so you raise the children and look after the home mostly on your own. When you find yourself pregnant again, you feel overwhelmed and sad. Both you and your husband wished to prevent another pregnancy.

One day at the marketplace there is a street drama about women's health and you approach the peer counselors afterwards to ask about your situation. You are aware there are treatments a woman can have to terminate a pregnancy, but you are very nervous to talk about this because abortion is stigmatized in your community.

You recognize the symptoms of pregnancy early this time because they are similar to what you experienced in past pregnancies. You think it has only been four to five weeks since your last period. If you can, you would like to terminate the pregnancy.

It is important to you that it seems natural, like a miscarriage, in case anyone finds out that you are pregnant.

Textbox: Alternative scenario B: The partner

[Use this scenario if you prefer to play a male role. Read the scenario above to understand the woman's circumstances and preferences.]

You are the husband of the woman in the scenario above. She confides her pregnancy and feelings about it to you. One day outside your bicycle repair shop there is a street drama about women's health and you approach the peer educators afterwards to ask about your wife's situation.

Scenario C

You are an adolescent woman living in a large urban slum. You help support your family by working in a local factory.

After a one-time sexual encounter you become pregnant. When you realize you are pregnant, you have mixed feelings. You feel proud and amazed over your body's ability to become pregnant, but you do not feel ready to become a mother. Given your family's unstable financial situation, you also do not think it would be possible to support another person.

You go to the youth center in your community and meet one of the peer counselors there. You get a good impression of her/him, but you struggle to understand some of the information she/he shares with you.

You remember that your last period was around your dad's birthday 13 weeks ago. If you can, you would like to terminate the pregnancy.

You are afraid of surgeries and needles and would like to have as few medical interventions as possible.

Textbox: Alternative scenario C: The brother

[Use this scenario if you prefer to play a male role. Read the scenario above to understand the woman's circumstances and preferences.]

You are the brother of the young woman in the scenario above. She confides her pregnancy and feelings about it to you. In search of support and information, you go to the youth center in your community and meet the peer counselor there.

Glossary of terms

Adapted from Turner et al., 2011

Abortion accompaniment: Abortion accompaniment involves a person providing emotional, physical and logistical support to a woman during her abortion experience. It may include peer counseling, identification of safe abortion services, transportation to and from services, support during the abortion procedure, and postabortion follow-up. Accompaniment is based on the premise that women should have access to safe abortion services that respect their human rights, which includes being fully informed about every step in the process.

Access to abortion care: Encompasses the availability of abortion care services and the utilization of such services.

Comprehensive abortion care (CAC): Woman-centered comprehensive abortion care (CAC) is a holistic approach to providing abortion services that takes into account the various factors that influence a woman's individual health needs—both physical and emotional—as well as her personal circumstances. CAC includes a range of medical and related health services, including counseling, induced abortion, treatment for incomplete and unsafe abortion, contraceptive services, and provision of or referral to other reproductive health-care services. A woman-centered model for abortion care is comprised of three key elements: choice, access and quality. It supports women in exercising their sexual and reproductive rights.

Contraceptive counseling: Talking and listening to people about their needs and desires for a future pregnancy to help them determine whether they need contraceptive methods and, if so, help them choose the most suitable methods for their needs and lifestyles. It is also known as family-planning counseling. It can be provided by health professionals and health educators.

Contraceptive services: The provision of contraception counseling, methods and care appropriate to people's needs and lifestyles that help them control their fertility by preventing, delaying or spacing pregnancies. It is also known as family-planning services. Contraceptive services can be a stand-alone sexual and reproductive health-care service, or a component of other, comprehensive health-care services, including comprehensive abortion care.

Contraindication: Any factor in a client's condition that renders a particular course of medical treatment undesirable or inadvisable.

Emotional support: Gentle, caring assistance to demonstrate affirmation and support and allay fears and negative feelings. Emotional support can be physical (such as holding a person's hand), verbal (such as using reassuring words) and non-verbal (such as giving an encouraging nod).

Evolving capacity: Refers specifically to the ability of children to be able to make decisions about their lives on their own. It is also the concept that children's ability to make decisions evolves as they make the transition from infancy to child and from child to adolescent.

Gender: A socially constructed system of categorizing people based on social beliefs about what behaviors, characteristics and attributes are inherently masculine and feminine (Turner et al., 2011). Gender identity is a person's internal sense of self. There are many different gender identities—for example man, woman, transman, transwoman, bigender and agender. For explanations of different gender identities, we recommend the Gender Equity's Resource Center at the University of California at Berkeley, available online: http://geneq.berkeley.edu/lgbt_resources_definiton_of_terms. An individual's lived gender identity may or may not be the same as the identity they were assigned at birth, and can change throughout life. Since gender is a social construct, social beliefs about it can also change over time.

Gender-based violence: Any act of violence against persons who identify as or are perceived to belong to a certain gender category, which results in (or is likely to result in) physical, sexual or mental harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Gender equality: Means all people, regardless of their gender, have equal opportunities, freedoms and conditions. It does not imply that all people are the same, but that they have equal value and should be accorded equal treatment. Gender equality is a human right.

Human rights: A set of basic prerogatives and protections inherent to all human beings, regardless of our many differences, including sex, gender, sexual orientation, nationality, race, ethnicity, religion and language. Human rights are universal, inalienable, interdependent and non-discriminatory.

Induced abortion: The termination of pregnancy by a deliberate intervention toward this purpose.

Masculinity: A set of qualities, characteristics or roles generally considered typical of or appropriate to a man.

Medical abortion: The use of one or more medications to end pregnancy. These medications terminate the pregnancy, which is then expelled by the uterus in a process similar to miscarriage. Medical abortion is sometimes called medication abortion, pharmacological abortion, pharmaceutical abortion or the abortion pill. Medical abortion is different from emergency contraception (EC), also known as the "morning-after pill," which prevents pregnancy from occurring.

Pain management: The use of medications, emotional and psychological support, changes in the physical environment and other means to decrease a person's experience of pain, which can be caused by anxiety, cervical dilation (before uterine evacuation procedures), and uterine cramping (during and after uterine evacuation or medical abortion). Studies have shown that clients who are scared or nervous are more likely to experience greater levels of pain during an abortion procedure than those whose fears or concerns have been allayed.

Peer counseling: Counseling and support performed by those who are considered similar in age or other respect to the person who is being counseled, and who have completed appropriate training.

Peer education: Information and skills building by those who are considered similar in age or other respect to the people who receive the education, and who have completed appropriate training.

Postabortion care (PAC): A series of clinical and related interventions—including uterine evacuation, counseling, postabortion contraception, other sexual and reproductive health services, and partnership with communities—designed to manage incomplete abortion and complications related to unsafe abortion.

Reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Sexual health: Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sex: Refers to "socially constructed categories based on culturally accepted **biological attributes**" (Ferber, 2013, emphasis added). Common ways to categorize individuals as biologically female or male include chromosome composition, appearance of genitalia regardless of chromosome composition (vulva or penis), reproductive organs, and reproductive capacity (production of eggs or sperm). Individuals who have both of any given set of attributes are categorized as intersex.

Sexual and reproductive rights (SRR): Prerogatives and protections that affect the exercise and expression of sexuality and human reproduction. These rights imply that "people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences. Sexual and reproductive rights provide the framework within which sexual and reproductive well-being can be achieved" (IPPF, 2003).

Sexual identity: Describes how a person identifies themselves in terms of sexual attraction and practice, based on the person's primary sexual preference to the same, opposite or both sexes. It is also a category that encompasses self-identification with a group. For example: lesbian, gay, bisexual or queer. A person's sexual identity is independent of their sex and gender.

Sexual violence: Violence which is specifically sexual in nature, or directed against persons of one sex because of their sex.

Sexuality: Captures "a range of concepts, ideologies, identities, behaviors and expressions to sexual personhood and desire" (Ferber, 2013). Commonly, it describes how a person lives their sexuality and relates to people with whom they engage sexually and emotionally. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships (Turner et al., 2011).

Sexually healthy person: Someone who feels they have the rights, opportunities and ability—through accurate information and safe, respectful and comprehensive sexual and reproductive health care—to enjoy and express their sexuality. They are able to make good decisions to protect themselves while providing themselves with opportunities for love and intimacy.

Spontaneous abortion: The termination of pregnancy without any deliberate intervention. It is commonly referred to as a miscarriage or pregnancy loss.

Unsafe abortion: An abortion that is performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both.

Young people: Men and women aged 10–24 years old. This group encompasses adolescents (10–19 years old) and youth (15–24 years old).

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