

# Disability inclusion in reproductive health programs

An orientation and values  
clarification toolkit

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Produced in the United States of America.

Suggested citation: Ipas. (2021). *Disability inclusion in reproductive health programs: An orientation and values clarification toolkit*. Ipas: Chapel Hill, NC

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We gratefully acknowledge the support of UK aid for production of this publication.



This document is an output from a project funded with UK aid from the UK government for the benefit of developing countries. However, the views expressed and information contained in it is not necessarily those of, or endorsed by the UK government, which can accept no responsibility for such views or information or for any reliance placed on them.

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# Introduction

This toolkit is a resource for organizations that want to build a disability inclusion mindset among staff and partners who design and implement abortion and sexual and reproductive health and rights (SRHR) programming. This toolkit is written specifically for trained VCAT facilitators with experience delivering VCAT workshops in the field of abortion and SRHR.

While this toolkit can be used to deliver a stand-alone workshop, it is intended to be for a follow-on workshop for stakeholders who have already been through an abortion VCAT workshop. As such, this toolkit does not address the topics of disability and abortion in equal depth. Instead, familiar abortion VCAT activities have been adapted and new ones created to support participants in exploring the topic of disability, more specifically, and building on the insights gained in a prior abortion VCAT workshop by linking them with the topic of disability. The ultimate goal of this curriculum is to help a wide range of stakeholders—including policymakers, health-care providers, development organization and donor agency staff, and civil society members—build a disability inclusion mindset. This mindset will assist them in designing and implementing abortion and SRHR programs, policies and services that respect, protect and fulfill the rights of women and gender non-binary people living with disabilities.

The toolkit can be used to facilitate workshops in a variety of settings, including settings with liberal or restrictive abortion laws.

## About the authors

This toolkit was produced in collaboration between Ipas, Leonard Cheshire and MSI Choices as part of the broader Women's Integrated Sexual Health (WISH) Lot 1 joint programme delivered by MSI Reproductive Choices, IPPF, Ipas, DKT, Options, ThinkPlace and Leonard Cheshire, and funded by UKAID.

### About Ipas

Ipas works globally to expand access to abortion and contraception. We believe in a world where every person can determine their own future—including women, girls and gender non-binary people living with disabilities.

### About Leonard Cheshire

Leonard Cheshire is a UK-based charity with over 65 years' experience and is one of the world's largest charities wholly dedicated to supporting persons with disabilities. Leonard Cheshire believes that children and adults with disabilities should have the rights, freedom and opportunities to access education, contribute economically and to participate fully and equitably in society.

### About MSI Reproductive Choices

MSI Reproductive Choices provides contraception and safe abortion services in 37 countries around the world supporting people to make decisions about their bodies, their lives and their futures. MSI is committed to closing the gap on access to reproductive health care once and for all, to ensure that everyone is only one contact away from a safe provider.

### Acknowledgements

We wish to acknowledge the staff who led the development and production of this toolkit including: Alexandra Teixeira, Senior Technical Advisor, Ipas; Hope Tyson, Human Centered Design Advisor, Ipas; Kate Austen, Institutional Resilience Lead, MSI Reproductive Choices; Sarah Palmer, Disability Advisor, Leonard Cheshire; Amalie Quevedo, International Project Support Officer, Leonard Cheshire.

In addition, Gabriel Hines, Associate Program Manager, Ipas; and Brittany Thurston, Senior Executive Designer, ThinkPlace; Mike Mpoyi, Senior Technical Advisor, Ipas; and Jean-Claude Mulunda, Program Manager, Ipas were instrumental to the conceptualization of this toolkit.

Finally, this toolkit could not have come to fruition without the expertise, insights and feedback provided by our ODP Consultants, Helen Beyioku-Alase, Chairperson, Deaf Women Association of Nigeria and Dr Tshitenge Badimu Valentin with the Congolese Association of the Liberation and Development of Mothers with Disabilities (l'Association Congolaise pour la Libération et le Développement de la Maman Handicapée, ACOLDEMHA) as well as all of the participants of the two pilot workshops that this toolkit is based on.

The VCAT activities included in this toolkit have been adapted from:

- Turner, K.L. and Page, K.C. (2008). *Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences*. Chapel Hill, NC: Ipas.
- Ipas. (2018). *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences*. Chapel Hill, NC: Ipas.

Additionally, we wish to acknowledge the contributions to an earlier version of this toolkit including Florence Amadi, Nadia Shamsuddin, Elizabeth Guthrie, Alex Teixeira, Tanvi Monga and Tamara Fethers. In addition, we gratefully acknowledge Leonard Cheshire for providing disability-specific content and expertise. We also wish to acknowledge the assistance of Dr. Mark Carew, Senior Research Fellow, and Professor Nora Groce, Department of Epidemiology and Public Health, University of London.

## Why this toolkit?

Healthy sexuality, reproductive freedom and bodily autonomy are important indicators of health and well-being—regardless of gender, age, class, economic status, ethnicity, religion, sexual orientation, ability or other social factors. This is also true for people living with disabilities, who represent 15% of the world's population, and 80% of whom live in low-resource settings (WHO and World Bank, 2011). Despite being a considerable percentage of the population, people living with disabilities are underserved and overlooked by sexual and reproductive health services (Addlakha, Price, & Heidari, 2017), especially abortion and contraceptive care.

In addition to stigma regarding abortion and contraception, people with disabilities must navigate additional barriers at all levels, such as attitudinal, environmental, institutional and procedural barriers. Furthermore, people living with disabilities are often stereotyped as sexually inactive or unable to understand and comply with what their society deems appropriate and inappropriate “moral” sexual behavior (Grabois, 2001; Kim, 2011; Milligan & Neufeldt, 2001). Compounding this, inequitable access to education, employment and social networks often leaves people with disabilities poorer, more marginalized and at greater risk for sexual and physical abuse than their peers living without disabilities.

## Understanding disability

To promote non-discrimination and ensure that women living with disabilities can actively and meaningfully access abortion and contraceptive care on an equal basis with others, it is critical to understand the additional barriers that people living with disabilities encounter at the policy, service, community and family levels. Stigmatizing attitudes about disability by community influencers, politicians and religious leaders can lead to population-level and community-wide exclusion of women and gender non-binary people living with disabilities.

### Models of disability

The **charity model** of disability is probably the oldest model and still informs to some extent attitudes toward disabilities in every country in the world. It is based on the belief that people living with disabilities are objects of pity and suffer with their impairments. They are seen as desperately in need of charity and looking after. Furthermore, there is a strong belief that people living with disabilities are unable to make decisions for themselves. Thus, decisions such as who they will marry and what job they will do are undertaken by members of their families and by medical professionals. Similar to the charity model, the **medical model** assumes a passive role for people living with a disability and sees them as unable to make decisions for themselves. It again assumes that people living with disabilities want to be as “normal” as possible and wish to be cured so that they can be like people living without disabilities.

In the **social/rights-based model**, the focus of attention has shifted to the disabling society, examining how systemic, environmental, attitudinal, and institutional barriers impede people living with disabilities from participating in society on an equitable basis with their peers living without disabilities.

The social/rights-based model of disability is very much aligned with the rise of the international disability rights movement. The underlying principles of the social/rights-based model are founded upon human rights and inclusion, and the model is now linked in with the fundamental principles of the UN Convention on the Rights of Persons with Disabilities (CRPD).

### The landscape surrounding disability and reproductive rights advocacy

Of all the sexual and reproductive issues faced by women and gender non-binary people living with disabilities, access to safe abortion is perhaps the least understood or addressed. Strong cultural assumptions exist about whether a woman with a disability should become a mother because of fears about inheritability of some health conditions (often based on antiquated Eugenic laws) or stigmatizing attitudes about a disabled woman's ability to care for her child. This has resulted in many women with disabilities being encouraged or pressured to have an abortion. But overlooked in these discussions has been the equally important issue of access to safe abortion for women living with disabilities who decide that they want to terminate a pregnancy.

The provision of reproductive health care for people with disabilities has gained attention over the past decade. Large global initiatives, frameworks and reports focused on disability inclusion have increased awareness and the willingness of donors, implementers and activists to include disability in sexual and reproductive health services. The Convention on the Rights of Persons with Disabilities (CRPD) and the Optional Protocol detail the rights of persons with disabilities and set out a code of implementation and compliance monitoring (United Nations, 2006). Almost 180 countries have now signed and ratified the CRPD and are thus legally committed to developing and carrying out policies, laws and administrative measures for securing the rights recognized in the Convention, and to abolishing or adapting

laws, regulations, customs and practices that constitute discrimination against people living with disabilities.

A country's signatory, ratification and compliance status can be a key tool in policy interventions to advocate and hold governments to account for disability inclusion in abortion and contraceptive care. Importantly, the CRPD also works to ensure that parents, guardians, partners, health-care providers or others do not have the right to make decisions on behalf of persons living with disabilities. This includes the decision to have an abortion. However, comprehensive reproductive health services, including safe abortion care, are still not readily available and accessible to women living with disabilities. This puts them at increased risk of unwanted pregnancy and potentially seeking unsafe abortions.

While donors, sexual and reproductive health program implementers, universities and activists are beginning to examine the needs and rights of people living with disabilities, considerable gaps persist in the specific areas of abortion and contraceptive care (United Nations, 2018). An emerging body of research now clearly shows that people living with disabilities are sexually active at the same rate and in the same ways as all other members of the population (Rohleder, Braathen, Carew, 2018). Building on the CRPD, the United Nations Sustainable Development Goals (SDGs) include people living with disabilities in all Goals, Targets and Indicators, with their call to "Leave No One Behind"—as well in a series of specific references throughout the document (United Nations, 2015). This includes equal entitlement to access to all SRH services and supports.

### Defining disability

In this toolkit, we use the definition of disability found in the United Nations Convention on Persons with Disabilities (CRPD) which states that disability is an evolving concept in which:

"Persons with disabilities include those who have physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (Article 1)

This definition is important because it emphasizes the fact that many of the barriers faced by people with impairments are physical, social, cultural or economic and imposed on them by the surrounding environment. These barriers are what disable people with impairments, not their impairments themselves, which is why it is important to identify and remove them so people with disabilities can exercise their rights. For example, a girl with a physical impairment may not be able to attend school because the classroom is located at the top of a stairway. The barrier here is the stairway which prevents the girl from accessing the classroom. This barrier can be removed by moving the classroom to the ground floor so she can have access to it. It is also important to note that not all impairments will be disabling; someone with a visual impairment who wears glasses would not necessarily face environmental barriers that prevent them from fully and effectively participating in society and on an equal basis with others. However, this can be context-specific: the same impairment may also have different consequences due to the environment. Someone with a visual impairment living in the United Kingdom can easily be provided with eyeglasses, but someone living in an internally displaced camp with the same visual impairment may not have access to eyeglasses.

## Barriers

The safe abortion needs of women living with disabilities are no different than those of all women—but for many women with disabilities there are an additional series of barriers that further complicate their ability to get the information and care they need.

Some of these barriers begin long before the issue of abortion access arises. For example, it is frequently yet incorrectly assumed that people with disabilities will not become sexually active. This means they are often not provided with SRH information by parents, schools, friends or relatives. Another example is that some women (and men) with disabilities find it difficult or impossible to leave their home without assistance. Thus, even a simple task, such as going to a pharmacy to buy condoms or get birth control pills, may be something that they face severe constraints doing.

In addition, public health campaigns providing information on SRH do not reach some populations living with disabilities. A radio campaign will not reach people who are deaf, and billboard and newspaper ads and articles often do not reach those who are blind or have significant vision impairments.

Going to a clinic is often complicated by the fact that the environment is not accessible, so some women living with disabilities must rely on a family member, caregiver or partner to take them or arrange for their transportation or pay for them to be seen—imposing unacceptable invasions of privacy and confidentiality. Compounding this, women with disabilities are at increased risk of sexual abuse and rape, and, not infrequently, those who are the abusers are also the people upon whom they rely to bring them to a clinic or pay for their care. And too often, women with disabilities who show up for SRH services still report that they are abused by health professionals who tell them they should not be sexually active or scold them for getting pregnant.

Barriers continue even after arrival at SRH facilities. Many offices and clinics are simply inaccessible with stairs, narrow doorways, inaccessible bathrooms for wheelchair users, lack of sign language interpreters or layouts that make it difficult for women who are blind to navigate. There is an emerging body of good information and toolkits online about making facilities—including health services—accessible for people with disabilities. In many places now, clinics and other organizations can consult with a local Organisation of People with Disabilities or a disability-focused NGO, to review accessibility and make improvements where needed.

### Adaptations based on type of disability

In this toolkit, we refer to “people living with disabilities” or “women living with disabilities” as part of a large and underserved population. It is important to note that people living with different types of disabilities may need adaptations and support specific to their particular impairment. For example:

- Women with a physical disability may find it difficult or impossible to find accessible transportation to go to a clinic for care.

- Women who are deaf may be sign language users who need to bring in or be provided a competent sign language interpreter to discuss and understand what their options are. Other women with hearing impairments may prefer to read or have images to follow-along with what is being said in an appointment.
- Women who are blind or low vision may benefit from materials in Braille, large print or high color contrast, including permission forms. But not all people who are blind now use Braille, as tablet, computer and phone apps are quickly emerging in some places.
- Women with intellectual disabilities may need more time and support to understand their options or the procedures proposed. Service providers may need to explain options and what will take place in procedures in clear and plain language and to repeat this information to ensure clarity.

### Resources on disability and inclusion

World Health Organization and The World Bank. (2011). *World Report on Disability*.

Addlakha, R., Price, J., & Heidari, S. (2017). Disability and sexuality: Claiming sexual and reproductive rights. *Reproductive Health Matters*, 25:50, 4-9, DOI: 10.1080/09688080.2017.1336375

Grabois, E. (2001). Guide to Getting Reproductive Health Care Services for Women with Disabilities Under the Americans with Disabilities Act of 1990. *Sexuality and Disability* 19:3, 191-208.

Kim, E. (2011) Asexuality in disability narratives. *Sexualities*, 14:4, 479-493, DOI: 10.1177/1363460711406463

Milligan, M.S. & Neufeldt, A.H. (2001). The Myth of Asexuality: A Survey of Social and Empirical Evidence. *Sexuality and Disability* 19, 91–109, DOI: 10.1023/A:1010621705591

United Nations. (2006). The Convention on the Rights of Persons with Disabilities and its Optional Protocol (A/RES/61/106).

United Nations Department of Economic and Social Affairs. (2018). *Disability and Development Report: Realizing the Sustainable Development Goals by, for and with persons with disabilities*.

Rohleder, P., Braathen, S.H., & Carew, M.T. (2018). *Disability and Sexual Health: A Critical Exploration of Key Issues* (1st ed.). Routledge. DOI: 10.4324/9781315648682

United Nations General Assembly. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development* (A/RES/70/1).

## What is VCAT and how does it work?

Values clarification and attitude transformation (VCAT) is the process of examining one's basic values and reasoning for the purpose of understanding oneself, to discover what is important and meaningful (Rokeach, 1973; Steele, 1979). It is both a theory and an intervention.

A major barrier to the provision of abortion care for women living with disabilities is disability-related stigma and lack of knowledge/information about sexual and reproductive health, including access to safe abortion care, for women with disabilities. This toolkit is designed to explore these issues to help close the service-delivery gap in abortion care for women living with disabilities—a critical and necessary step for reducing maternal deaths and suffering and advancing equitable access to sexual and reproductive health and rights for all people.

Abortion-related VCAT workshops use a variety of activities to engage participants in open dialogue to explore their values and attitudes about abortion and related sexual and reproductive health issues, often leading to increased awareness and comfort with the provision of safe abortion care. The workshops are conducted in a safe environment in which individuals take responsibility to engage in honest, open-minded and critical reflection and evaluation of new or reframed information and situations. The content is designed to be accessible and personally relevant.

VCAT workshops are designed to help participants:

- Challenge deeply held assumptions and myths
- Clarify and affirm their values and potentially resolve values conflicts
- Potentially transform their beliefs and attitudes that impact behaviors
- State their intentions to act in accordance with their affirmed values

VCAT is not designed to change people's values. Once participants have

examined the values that inform their beliefs about abortion and understand the root causes and consequences of unsafe abortion, they may undergo a transformation of attitude on the provision of safe abortion care and their role in assuring women's access to safe care to prevent women from dying from unsafe abortion.

## The VCAT theoretical framework

The theoretical framework informing the development and organization of this toolkit (see [Figure 1](#) below) can serve as a visual aid when explaining the abortion VCAT process and as a reference when designing VCAT workshops. It conceptualizes the VCAT process, which is informed by and includes critical elements of Ajzen's Theory of Planned Behavior (TPB) (Ajzen, 1985; 1988; 1991); values theory (Rokeach, 1973; 1979); and the three main stages of the values clarification process—choosing, prizing and acting (Raths, 1966; Rokeach, 1973).

**Choosing:** A value must be chosen freely from alternatives with an understanding of both positive and negative consequences of that choice.

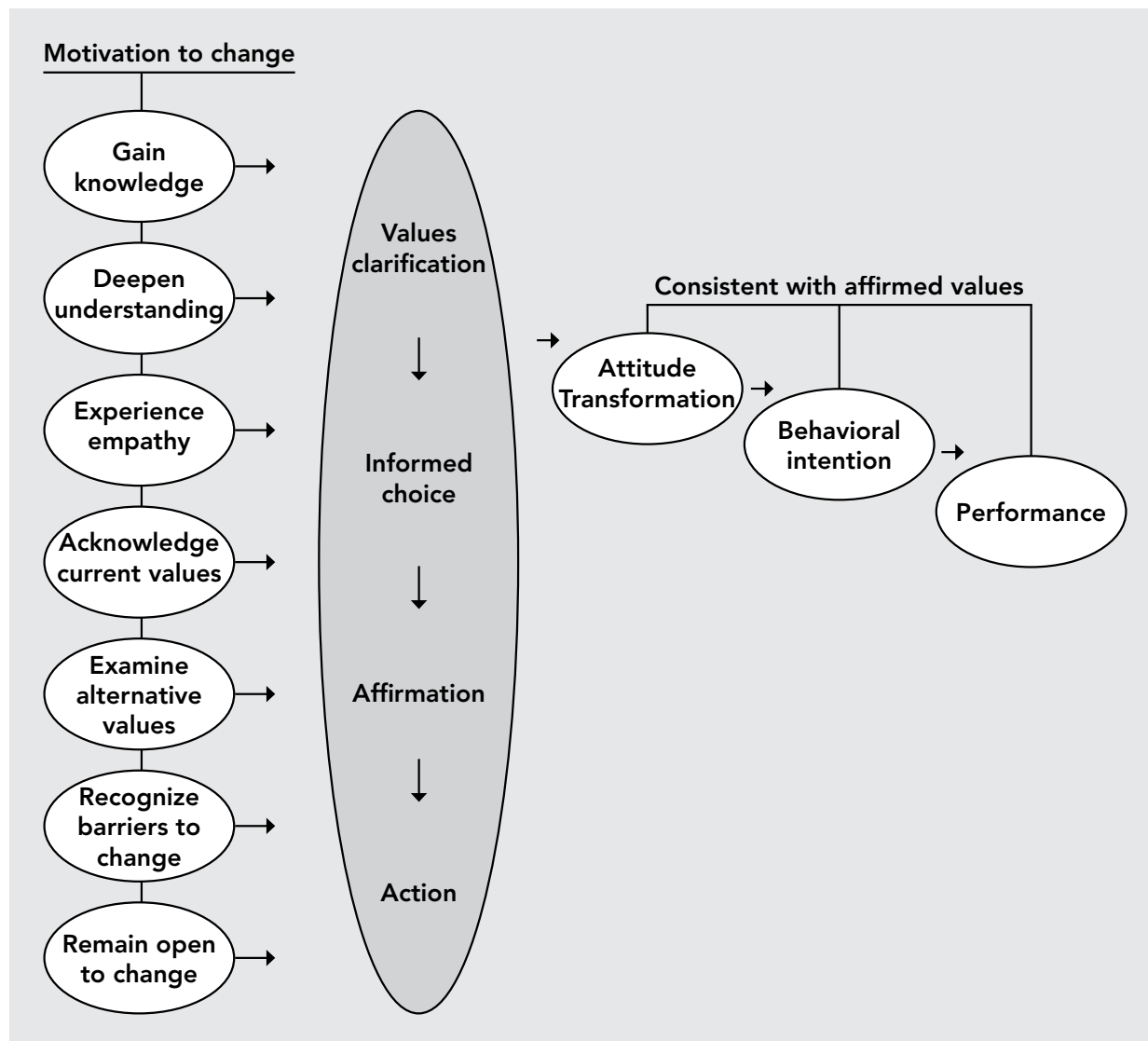
**Prizing:** A chosen value must be associated with some level of satisfaction and affirmation, as well as confidence in the value.

**Acting:** A freely chosen, affirmed value must translate into action. Ideally, the action will lead to some positive outcome and be done repeatedly.

Ipas has modified the three main stages of values clarification to:

- Making an informed value choice
- Affirming that choice
- Acting on the chosen value

**Figure 1:** VCAT takes place within existing cultural and social structures and ideologies



Starting to the left of the framework, we begin with the motivation to change—people must be open to examining and potentially changing their attitudes and behaviors, or VCAT cannot be expected to have any impact. To effectively engage in the abortion values clarification process, one must gain new knowledge; deepen understanding of existing or new knowledge; experience empathy for people affected by or who provide abortion; acknowledge current values on abortion; examine alternative values; recognize barriers to change and remain open to change.

This method reflects the process and cognitions an individual would go through when thoughtfully choosing among competing alternatives, affirming those choices and deciding on a particular course of action.

A study by Ipas (Turner, et al, 2018) found that VCAT workshops are effective at improving participants' knowledge, attitudes and behavioral intentions related to abortion care, especially among those who come to the workshops with the least knowledge and most negative attitudes about abortion. Published in the *Journal of Reproductive Health*, the study analyzed pre- and post-workshop surveys of participants in 43 VCAT workshops conducted in 12 countries in Asia, Africa and Latin America.

### VCAT foundational theories and research

Ajzen, I. (1985). *From intentions to actions: A theory of planned behavior*. In Kuhl, J., and J. Beckman, eds. *Action-control: From cognition to behavior*. Heidelberg, Springer.

Ajzen, I. (1988). *Attitudes, personality, and behavior*. Chicago, IL, Dorsey Press.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50:179–211.

Armitage, C., & J. Christian, eds. (2004). *From attitudes to behavior: Basic and applied research on the theory of planned behavior*. New Brunswick, NJ, Transaction Publishers.

Millstein, S. G. (1996). Utility of the theories of reasoned action and planned behavior for predicting physician behavior: A prospective analysis. *Health Psychology*, 15(5):398–402.

Raths, L., Harmin, M., & Simon, S. (1966). *Values and teaching: Working with values in the classroom*. Columbus, OH, Charles E. Merrill Publishing Co.

Rokeach, M. (1973). *The nature of human values*. New York, Free Press.

Rokeach, M. (1979). *Understanding human values: Individual and societal*. New York, Free Press.

Turner, K., Pearson, E., George, A. & Andersen, K. (2018). Values clarification workshops to improve abortion knowledge, attitudes and intentions: A pre-post assessment in 12 countries. *Reproductive Health*, 15:40.

# Virtual VCAT Workshops: Planning Guidance

## Creating the right virtual space

Facilitation determines how people learn and interact, and VCAT facilitation requires creating the conditions for meaningful, personal, and respectful dialogue. As facilitators, our goal is to create trust, balanced interaction, and safety in the virtual space so everyone can participate. High-quality virtual programming takes time, and it's essential to allow space for participants to think, reflect, and contribute.

We can achieve this. There are a few essential mindsets that will support you to plan an effective and meaningful virtual gathering and achieve your objectives.

### Trust participants

Our expectations influence the environment we create, so assuming participants consider the workshop a high-value opportunity and are enthusiastic to join will help create a warm environment conducive to collaboration. Trust your participants' commitment, professionalism, and capacity to make the best decisions for themselves. Operate under the assumption that people want to participate, want to learn, and believe that the workshop is worth their time and effort. You might even provide people with optional reflection activities, assuming they will participate at their own level of interest and comfort.

### Always start with a clear purpose

Make sure you have clear objectives and articulable purpose. Always start with what you want to achieve, and everything from the technology to the schedule to the facilitation techniques will follow from there. When in doubt, return to your purpose and try to make the choice that

you believe will best help you achieve it—even when it means creating something new or doing something unusual.

### Know your audience

Approach your planning process with the participants in mind. Who are they? What challenges and problems are they facing? What are their goals? Why are they joining? What organizations are they representing, and what are those organizations' priorities? Participants' time is a gift, and the best you can do is to give them a respectful gift in return. By thinking about their broader context and needs, you will be able to better design a workshop that is a great use of everyone's time and helps all the participants to advance in their thinking and their important work.

## Checklist: The planning process

- ☐ Clarify the purpose of your workshop
- ☐ Get to know your participants, perhaps through a survey
- ☐ Establish facilitation team roles
- ☐ Establish workshop structure and timing
- ☐ Identify technology you will use based on needed features
  - ☐ Consider bandwidth boosting for participants
  - ☐ Identify interpretation needs and engage interpreters
- ☐ Plan your facilitation
  - ☐ Identify culture and tone you hope to create
  - ☐ Vary engagement mechanisms
  - ☐ Document your session plans for facilitation team
- ☐ Prepare technology facilitation guides
- ☐ Communicate with participants
  - ☐ Set expectations
  - ☐ Prepare them to participate
- ☐ Practice your choreography
- ☐ Test your technology
- ☐ Run a technology prep session for participants
- ☐ Start your workshop
- ☐ Set the tone from the beginning
- ☐ Allow connection to develop naturally
- ☐ Adapt as needed to achieve your purpose

### Prepare, prepare, prepare

For every hour of a workshop, you will need approximately five hours of preparation time. A detailed workplan and role clarity are critical to successful implementation. Establish facilitation roles, facilitator guides, and contingency plans ahead of time. Make sure you leave plenty of space in your agenda for flexibility, but balance flexibility with thorough preparation and stay true to the core commitments you make to participants.

### Know your audience and prepare them for success

Facilitators should send out a pre-workshop questionnaire to get a better understanding of participants' perspectives on the topic as well as the technology they do or don't have access to. How will they be joining—via computer or mobile phone? What accessibility needs do they have? Do they have reliable internet? Do they have headsets and/or cameras to use for video? Can you allocate budget to help upgrade participants' data plans for the time of the workshop, upgrade their modems or to purchase a headset and/or video for their computer system? Do they need any documents or materials ahead of time? Getting relevant information ahead of time will help inform your workshop planning and budgeting.

### Establish facilitation roles

You will need at least two facilitators for any virtual VCAT activity, but you may need more facilitators depending on your workshop deliverables, size, duration, and specific activities.

Do not facilitate virtual workshops alone. Make sure you have enough facilitators to adequately support the size of your group. Assign dedicated co-facilitators, tech support and someone to capture key learnings throughout.

Facilitation roles may include:

- **Lead content facilitator:** Introduces the activity, each statement and structures discussion. The lead facilitator is responsible for pacing and for adjusting the number of statements used based on time.

- **Chat moderator** (Content co-facilitator): Responsible for drawing out content and themes presented in the chat box and ensuring they are added to the whiteboard or flagged in the discussion.
- **Breakout room manager:** Responsible for creating and naming breakout rooms, assigning participants to each room, communicating with breakout rooms, offering tech support related to breakout rooms, and opening/closing rooms
- **Tech support:** Responsible for providing real-time assistance and problem solving with technology issues. Role can be combined with Content Co-facilitator if that feels reasonable and realistic and depending on the size of the group and their relative skill level or context with regard to technology and accessibility issues.
- **Note-taker or synthesizer:** Responsible for listening, capturing key points in the discussion, and flagging any participant needs or gaps with the facilitation team. In breakout groups, sometimes it works well for a participant to take notes.
- **Interpreter:** In many meetings, it's appropriate and necessary to have an interpreter. Based on the needs of your participants, consider what languages (including sign language) you will need interpretation for. Make sure you put interpreters in breakout groups as needed.
- **Back-up roles for each role:** You don't necessarily need an entire second set of facilitators, but you should at least think about who will step in to carry the activity along if the main facilitator or the tech support person has technical issues.

This might seem like a lot of people, and that's because it is! You will need a lot of support to run a seamless virtual VCAT workshop, but with the proper team it is possible to plan a very effective and engaging experience.

## Taking it virtual: A workshop example

An Ipas team planning to conduct a workshop in person at the beginning of the COVID-19 pandemic had to translate their in-person workshop plans to a virtual space. Although they originally planned a week of day-long workshop activities, for their virtual adaptation, they chose to conduct two 90-minute sessions per day with a two-hour break between each session. This allowed them to cover key content while being mindful of the challenges of long virtual sessions. Workshop budget was allocated for bandwidth adjustment stipends, and participants from Nigeria, the Democratic Republic of Congo, Ethiopia, Ghana, Zambia, and Malawi were able to participate using video teleconference.

### Determine workshop structure and timing

In the virtual world, we are released from the constraint of having day-long sessions day after day. Consider your objectives, the schedules of your participants, and the balance of group sizes you would like to implement. It is a best practice to conduct online sessions no longer than two hours at a time, and you should plan 10-15 minute breaks at least every hour.

Consider whether participants will need to spend time during their day on other parts of their roles, and plan accordingly. For example, you may want to plan a long lunch breaks, so that participants have time to catch up on their urgent tasks and relax a little bit, too.

Workshops that might have been 2-5 days in person could be held over the course of weeks, with time in between for material review, self-reflection on the new concepts, implementation of new ideas, or one-on-one connection between participants to discuss the content.

## Taking it virtual: A workshop example

Virtual settings present new challenges but also offer new opportunities for flexibility and space. For example, in March 2020, one of Ipas's week-long, in-person workshops had to be rescheduled and moved to a virtual setting. A lot of important decisions had to be made by the group, and the facilitators wanted to use online time as effectively as possible. To give participants time to review materials and consider them carefully, 90-minute sessions were spaced over the course of three weeks. Regional subgroups were organized for participants to discuss in smaller groups between meetings, and large-group time was used to make effective, informed decisions.

### Identify technology

First, think through the objectives, agenda, and structure of your workshop. What activities will you be conducting? Do you need video, whiteboard, annotation, or recording tools? Choose a communication platform that will help you create the type of environment you need to achieve your objectives. In making this selection, consider the platform that will deliver the best possible experience while also being accessible to your participants. You may need several different communication channels to achieve your objectives. Take the time to familiarize yourself with the platforms you choose, seeking out tutorials and support as needed.

## Key questions for technology selection

What platforms are participants already most familiar using?

Which platforms will allow you to create the warm and open environment that helps VCAT make an impact?

What asynchronous or between-session activities could supplement participants' engagement and learning while respecting participants' time?

Consider selecting:

- A conferencing technology, such as Zoom, Microsoft Teams, or WebEx.
- Survey technology to gather pre-workshop information for participant pre-tests and activities like Four Corners.
- An online visual workspace for brainstorming, making lists, or system mapping, such as Mural, Miro, or Jamboard. This will be referred to as a virtual facilitation board in the activity instructions.
- A chat-based technology, such as Slack or Microsoft teams, for communicating between live sessions.
- A filesharing platform, such as DropBox or Google Drive, for storing documents

## Sample facilitation plan for roles and technology

Session	Language and Terminology				
<b>Virtual facilitation board host</b>	Gabriel	Gabriel	Gabriel	Gabriel	Gabriel
<b>Length</b>	15 minutes	15 minutes	15 minutes	15 minutes	10 minutes
<b>Facilitator</b>	Sarah	Sarah	Sarah	Sarah	Sarah
<b>Co-facilitator</b>	Kate	1. Kate + Irene 2. Alex 3. Hope + Helen 4. Sarah (Brittany roaming)	Kate	1. Kate + Irene 2. Alex 3. Hope + Helen 4. Sarah (Brittany roaming)	Kate
<b>Tool</b>	Yes—Mural	Yes—Mural / breakout facilitators	Yes—Mural	Yes—Mural/ breakout facilitators	
<b>Breakout rooms</b>	No—Plenary	Yes 4 groups / 4–5 participants 2 activities same group each time.	No—Plenary	YES—4 groups / 4-5 participants 2 activities same group each time.	No
<b>Screen share</b>	YES	YES	YES	YES	NO
<b>Comments</b>	Presentation on Mural	Facilitators each share their screen with Mural		Facilitators each share their screen with Mural	

Using a plan for roles and technology like the sample included here, the facilitation team can make sure everyone is clear on the timing of each segment within a session, the roles each person will play, and the technological aspects of the activities. Documents like these take time to prepare, but the clarity they provide can make all the difference.

Consider accessibility and participant needs in your choice. For example, in terms of accessibility does the platform provide an interpretation feature? Is it compatible with screen readers? Does it offer captioning? Make sure your participants' needs can be met with the technology you choose.

### Prepare facilitator guides

Virtual VCAT workshops can be delicate dances of planning and flexibility. It's important to think through your choreography and practice it ahead of time! Although you will want to plan the timing of your activities carefully, you should also remain flexible and allow important conversations to come to a natural conclusion as much as possible. This will be a lot easier if you do not over-plan your sessions. Make sure you allow extra time for warm opening greetings, technical troubleshooting, the slower start to discussions that we sometimes see on virtual platforms, and for questions and points of clarification. Document your plans clearly in a shared document with other facilitators.

Another important type of facilitator guide is one you will use to map roles and responsibilities of the team throughout each part of the workshop. Decide who will play each role described above for each session, and document this in an easy-to-access format that your team can refer to during the session. An example is provided here of one format for this "technology facilitator guide."

### Help participants prepare to participate

Conduct a "Tech Session" with the participants to introduce and practice using the technology and virtual platform features you'll be using during the workshop. This session can also allow participants to become more familiar with one another in an informal setting and ensures that the

workshop time is focused on content and interaction rather than on the basics of technology.

### Breakout sessions

Presenting content followed by small group sessions provides deliberate opportunities for participants to build connections and trust. Once this trust is developed, participants will feel encouraged to share and work towards virtual collaboration. You may not need to schedule a “report back” from every small group session—sometimes, the connection forged in conversation is an outcome in and of itself.

### Practice

Before you begin your workshop, it’s a good idea to practice a full run-through of at least one session so that you feel at ease with the tools and transitions you’ve planned. Don’t let the opening session be the first time you log on!

### Communicate expectations and objectives

Be clear about the expectations for the workshop, from the quality of presence you’re expecting to the kind of technology each participant is expected to have and use. Ask people only to commit if they are able to participate meaningfully. What is meaningful is different from person to person, so you may not get completely even participation; however, communicating expectations can help you trust your participants to make the choice that is best for them. Be clear about what will happen and how people can engage best.

### Vary engagement mechanisms

Structure is important for all engagement but plays a special role in virtual spaces. Use a balance of different ways for participants to engage with one another. It can seem appealing to have lots of open space for free-form discussion, but these spaces are best supported by a generous

structure that helps people to become comfortable. Support people to learn how to engage.

You may do some activities offline between sessions—an opportunity that virtual workshops uniquely offer! Asynchronous activities can save time during the workshop and help participants integrate their learning.

Be genuine. If you truly need to share a lot of content with the participants, be creative about when you do that. Time together is precious and you should trust your participants to read preparatory materials.

### Plan for accessibility

Make sure you ask participants what accessibility accommodations they might need to participate fully. If interpretation, supplemental materials, slower pace, or adjusted schedule is necessary, take the time to modify your schedule as best you can to meet participant needs.

## During the workshop

### Set a tone from the start

Think about how you want participants to feel during the session and make sure you are modeling the behaviors you hope to see from participants. Before the workshop sessions, take time to prepare yourself just like you would if you were facilitating in person. What do you need to do to make sure you are focused and ready to model the tone you want to create?

You can vary your activities to support these goals, too. If you hope to create a warm, safe environment, you might make sure to encourage that people use their videos, plan a long and fun introduction activity, and be careful not to interrupt participants. If you are more focused on speed and quick thinking, you might play a quick game to help people get into the right mindset.

Another supportive quality of well-facilitated workshops is a feeling of rhythm that helps the participants know what to expect. This rhythm can

be different in virtual workshops, but it still plays a vital role. Consistency between sessions, regular practices in each session such as grounding and group greetings, and clearly articulated expectations can all contribute to the heartbeat of a strong workshop.

### Limit comparisons to the in-person version of the activity

For those of us who are used to delivering VCAT in-person or are newer to virtual facilitation, we may go into the activity thinking about the differences between the in-person and virtual versions of the activity. As much as you can, try to let that go. Avoid making statements such as “if we were in person, we would have...”. Let the virtual activity stand on its own. Focus on achieving the objectives, not on comparing it to the in-person version. Participants are showing up for this workshop, and it’s best to focus on what we can do—which is a lot!

### Acknowledge differences

Difference is what makes collaboration meaningful. Strive to be aware of your assumptions about participants and their contexts. Embrace curiosity. It is also helpful to remember and acknowledge that participants are coming from different country contexts and working in different remote environments (location, time, etc.).

### Give everyone a chance

It is difficult to taking turns in remote settings. By using the chat box, breakout session group discussions, Mural boards and RingCentral annotation we were able to create space for people to communicate through their preferred method.

### Be flexible with timing

As a facilitator, it is important not to focus so much on your timing and plans that you forget you are talking to human beings with different needs. Make space and leave extra time for reflection and discussion. In

order to reach activity objectives, you may need to slow down or allow an off-agenda conversation to occur. Be flexible and maintain your focus on the higher-level purpose of the workshop.

### Create opportunities for connection to develop

In VCAT workshops, rapport amongst the group plays an important role in learning and engagement with new ideas. It's important to give participants a lot of opportunities to engage with one another in different size groups.

While many facilitators default to doing "report-back" sessions after small group work, it can be useful to ask whether there is value to this in each session. Sometimes, a small group may really benefit from simple connection and unsupervised conversation.

When you do choose to hear from small groups, make sure you listen fully to participants when they are contributing and try to tie new comments to past ideas to demonstrate this effort. Trusting and valuing participants' contributions is an essential part of developing connection, and it must be genuine.

### Adapt to achieve your purpose

Sometimes things take longer than we expect. If things aren't going according to plan, take a moment to ask yourself what will be in service of the group and its broader objectives. Sometimes spending more time on a conversation can mean the difference later in the workshop.

You may need to reconsider your agenda if things are moving a lot more slowly than you anticipated. Don't be afraid to make changes if it is needed to achieve the workshop objectives and serve the group. However, remember your core commitments to participants and try to minimize changes that will be disruptive such as adding additional sessions, changing the expectations for participation, or making other large shift to the goals or objectives of the workshop.

## Evaluate

Evaluation can be a challenge in virtual workshops. You might consider spending a few minutes of your last session on evaluation or waiting to send out participant certificates until after all the evaluations are completed.

# After the workshop

## Honor participants

Many of the traditions of in-person workshops don't carry over into virtual settings, but you should still plan to honor participants' contributions and learnings in some way. Consider sending out a certificate (maybe after participants fill out their evaluation forms!), taking a group photo, or holding a closing ceremony of some kind.

## Follow up

If you said you would follow up, do so quickly. Send participants all the information they need to wrap up, evaluate the workshop, and share back their learning with their colleagues.

You may wish to encourage participants to share any changes relevant to the workshop objectives. If you are expecting to evaluate change after a few months, make sure you inform participants, so they are prepared.

## Facilitation debrief

As a facilitation team, make sure you take a little bit of time to reflect on how things went and what you learned. You may wish to do an After Action Review or just have a simple conversation and document what you would change next time. Sharing this type of learning is very valuable to organizations and the field as we all work to improve our practices over time.

### Invite continued contact

Many participants may want to stay in touch with each other after the workshop to continue learning. Help this continued connection to evolve by setting up structures as needed.

# Planning for Accessibility in VCAT Workshops

## Making the workshop accessible

Running an inclusive workshop is as much about the culture as it is about physical adaptations or technology. Developing a culture of inclusivity will maximize participation of everyone in the workshop.

Plan ahead and allow space for participants to highlight ways that would improve their inclusion through the workshop. Participants should be encouraged to share. For example, if they would like a facilitator to slow down, or to provide a verbal explanation when we use a diagram.

### Essential considerations

Find out what your participants need

- Make sure all invitations include a request for people to register their accessibility requirements. These could include requests for large-print documents or braille, handouts in advance, a sign language interpreter, captions, or an assistant to attend
- Manage expectations and agree what can and can't be provided for example you may be able to send documents in advance, but not provide captions on all videos.

Choose an accessible venue

- Try to choose a venue with disabled parking, wheelchair access, quiet spaces, easy to access upper floors and accessible toilets. It is best to view the venue in advance of the workshop.

Include accessibility in your budget

- Include travel budget for assistants, interpreters and appropriate modes of transport to the venue (e.g. some participants may need a

taxi rather than local bus).

- Budget for a large room. If you have 15 participants—book a space for 25 (this will allow space for assistive devices e.g. crutches and wheelchairs).

### Things to think about

#### Accessible content

- Have a few printouts of your slides and materials ready for off-the-cuff requests.
- Consider having large print handouts.

#### Interpreters

- If participants request sign language interpreters or other communication support—best practice is for a minimum of two interpreters (to allow for taking a break). Ask participants to recommend interpreters they use and trust.

#### Buddies

- Consider assigning a buddy to a guest who may benefit from one. The buddy can describe the room and what's happening, help with refreshments and directions and read out event materials.

#### Online workshops

- Online meetings can be very tiring, and require high levels of concentration, be mindful of cognitive overload.
- Discuss with the participants how they would like to use video cameras. It can improve engagement, but it can also be stressful to be "on" all the time, and it may affect audio quality. There are different video settings that may be beneficial for example only viewing the speaker rather than a gallery of participants or turning off self-view if that is distracting.
- Discuss accessibility requirements and preferences during the tech check session

- Maximise sound quality—use a headset and microphone, and mute when not speaking. Encourage participants to be in a quiet space.

## Accessibility checklist

Events that have considered accessibility have benefits for all participants. Using this checklist can be a valuable planning tool irrelevant of the number of participants that identify specific requirements.

### Invitation

Check	Yes	No	Notes
Have participants/facilitators/keynote speakers been asked whether they have any accessibility requirements?			
Does the invitation provide information on accessibility of the meeting venue?			
Recommended question: We aim to make our workshop accessible and inclusive for all participants. Is there anything we can do to enable you to be able to fully participate?			

### Venue — Accessibility

Check	Yes	No	Notes
Has the meeting venue been checked in advance for accessibility?			
Is the building physically accessible?			
Is there step-free access:			
To the main entrance			
To the rooms and break out areas			
To the toilets			

Check	Yes	No	Notes
To the restaurant/break areas			
To the fire exits from all areas			
If there is not step-free access:			
Does the hotel have temporary ramps available?			
Are there other ways to make adjustments (for example, available support staff or alternative rooms or routes)?			
Are the toilets physically accessible for persons with disabilities?			
If there are ramps, are they at a sensible incline? You may not see "regulation standard" ramps but use your own judgment.			

*The venue may not be fully accessible. However, doing this assessment in advance gives time to allow for reasonable adjustments to be planned if required.*

### How people will get to the event

Check	Yes	No	Notes
Has information been provided to participants on the meeting venue: how to get there, what support they can receive at the meeting, and if there is any reimbursement for extra expenses?			
Is someone at the entrance of the event, to direct people where they need to go and provide assistance?			

### How people will be able to participate in the workshop

Check	Yes	No	Notes
Do you have information from invitees (including speakers/facilitators) whether they have any special requirements for accessibility or whether they are bringing a personal assistant?			
Have interpreters been booked for the event?  For example, best practice for sign language interpreters is to have two interpreters per session with a break after 45 minutes.			
Have interpreters been sent presentations and event resources in advance for preparation.			
Has information in braille, large print or audio been organized and budgeted for if there are people with a visual impairment who are coming?			
Have speakers at the meeting been informed about communication? Ask speakers to speak slowly and clearly and give any translators who are present time to translate.			
Has the room been arranged so that wheelchairs can pass through? Are there no objects that people can trip over?			

Check	Yes	No	Notes
Is the timetable suitable for all participants?			
Have regular breaks been scheduled—especially for interpreters and people using interpreters?			
<b>Remote participation</b>			
Have facilitators been briefed on the inclusion of remote participants?			
Have presentations been shared in advance?			
Have audio and video for remote participation been tested?			

### Considerations for virtual workshops with people living with disabilities

Most importantly, be patient with participants and be prepared to explain questions in different ways to participants who may have intellectual, developmental or learning disabilities. Record your workshop so people can refer to it later. Here are some specific considerations for different types of workshop participants:

#### People with visual impairments

- Make sure that statements are read out loud for people who have a visual impairment or have learning disabilities. Read out or describe images on PowerPoint presentations or virtual whiteboards for people with visual impairments.<sup>1</sup>
- Offer to read out comments made in the chat box for people with

<sup>1</sup> NYC Mayors Office for People with Disabilities, 2020: *Accessible Virtual Meetings Guide*. ([https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide\\_05-01-2020.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide_05-01-2020.pdf))

visual impairments who don't have screen readers.

- Request that anyone who wants to speak identifies themselves by their name so that everyone can know who is speaking.
- Consider using Q&As instead of the chat box. People who use screen readers will not be able to select which messages should be read out and it can be overwhelming. You may want to consider at the least doing a mixture of both chat box and Q&As.<sup>1</sup>
- Send slides to any presentations beforehand.

### **People with hearing impairments**

- Provide live captioning on the platform you would be using (i.e. Zoom, Microsoft Teams, Google Hangout).
- If you are using PowerPoint, you can select captioning by clicking on "slideshow" ribbon and tick the "always use subtitles" option in the right-hand corner.
- If possible, facilitators should have their cameras on when speaking for people who have a hearing impairment and lip read.<sup>2</sup> It is also important to ensure that enough light is on the person speaking.

### **People with intellectual and/or developmental impairments (i.e. Autism, Dyslexia, Dyspraxia, Cerebral Palsy)**

- Use plain language to make it more accessible for people with developmental/learning disabilities to understand. This will also be efficient for participants whose native tongue is not the one you are using for the workshop. If you need to use certain technical terms, make sure to explain what these terms mean.
- Consider providing a set of instructions in a document on how the activity will be run or how to use the online platform you will be using for the activity.<sup>3</sup> This can help people feel more comfortable about

1 AbilityNet blog, 2020: How to host an accessible online meeting (<https://abilitynet.org.uk/news-blogs/how-host-accessible-online-meeting>)

2 Internet Society blog, 2020: Are your virtual meetings accessible for people with disabilities? Start with this checklist (<https://www.internetsociety.org/blog/2020/07/are-your-virtual-meetings-accessible-for-people-with-disabilities-start-with-this-checklist/>)

3 Rooted in Rights blog, 2020: How to Make Your Virtual Meetings and Events Accessible to the Disability Community (<https://www.internetsociety.org/blog/2020/07/are-your-virtual-meetings-accessible-for-people->

the directions they will be given.

- Give enough time for people to process information and ensure that any slides in presentations you will be displaying do not have an overload of information.
- Pay attention to energy and fatigue. Online meetings mean we need to work harder to process non-verbal cues like facial expressions, the tone and pitch of the voice, and body language. Digital fatigue is very real for all sensory disabilities as well because of the extra concentration it takes, and especially for those with cognitive disabilities.”<sup>1</sup> In these situations, suggest to the participants that they can take a 5–10 minute break if needed.

### Accessible online platforms

It is important to consider the different reasonable adjustments to include for people with disabilities when holding a virtual VCAT workshop. There are different online platforms that can be used which come with different accessibility features. To find out about these platforms’ accessibility features, you can read pages 2–3 of this [Accessible Virtual Meetings Guide](#)<sup>2</sup> from the NYC Mayor’s Office for People with Disabilities. The [Big Hack](#)<sup>3</sup> also has information on the best video conferencing apps and software for accessibility.

You can also read more about different platforms on [Big Hack](#).<sup>4</sup>

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[with-disabilities-start-with-this-checklist/](#)

1 [Disability Advocacy Resource Unit Blog, 2020: Accessible online meetings](#)

2 [https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide\\_05-01-2020.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide_05-01-2020.pdf)

3 <https://bighack.org/best-videoconferencing-apps-and-software-for-accessibility/>

4 <https://bighack.org/best-videoconferencing-apps-and-software-for-accessibility/>

# Sample workshop agendas

## Timing recommendations

In-person: 2 full days (7 hours with breaks), or

Virtual: 4.5 full days (1 virtual day = 2 sessions of 1.5 hours each)

## In-person workshop: Sample agenda

Day 1	
TIME	SESSION
9:00–9:45am	Welcome and introductions
9:45–10:30am	Cross the Line
10:30–10:45am	<b>BREAK</b>
10:45–11:45am	The Wall
11:45–12:45pm	Terminologies 1
12:45–1:45pm	<b>LUNCH</b>
1:45–2:00pm	Ice breaker
2:00–3:30pm	Terminologies 2
3:30–4:00pm	End of day evaluation and closing

Day 2	
TIME	SESSION
9:00–9:30am	Reflections from day 1
9:30–10:00am	Guessing Game
10:00–11:00am	Why Did She Die
11:00–11:15am	<b>BREAK</b>
11:15–12:30pm	Reasons Why
12:30–1:30pm	<b>LUNCH</b>
1:30–3:00pm	Gender norms and disability
3:00–3:15pm	<b>BREAK</b>
3:15–4:15	The Last Abortion
4:15–5:00pm	Closing session and post-workshop survey

## Virtual workshop: Sample agenda

Virtual workshop: 13.5 hours over 4.5 days	
<b>MONDAY</b>	
10:30 – 12:00	Welcome and introduction Cross the Line
14:00 – 15:30	The Wall
<b>TUESDAY</b>	
10:30 – 12:00	Terminologies 1
14:00 – 15:30	Terminologies 2
<b>WEDNESDAY</b>	
10:30 – 12:00	Reasons Why
14:00 – 15:30	Guessing Game Why Did She Die?
<b>THURSDAY</b>	
10:30 – 12:00	Disability and Gender Norms
14:00 – 15:30	The Last Abortion
<b>FRIDAY</b>	
10:30 – 12:00	Closing

## ACTIVITY:

# Cross the Line



### Purpose:

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This activity helps participants begin to reflect on their personal experiences with disability and get a sense of the perspectives that other participants might hold. Although SRHR professionals tend to think of clients with disabilities as an unusual or unfamiliar group, the majority of us have a connection with someone with a disability in our personal lives. *Cross the Line* begins to draw on these experiences, connecting personal learning to inform disability-inclusive practices in our professional lives.

For facilitators, this activity can also help assess the range of views and experiences among participants in the room. This can help facilitators be prepared to contribute perspectives that might not be present among the participants for consideration. Facilitators can also use this activity to start to draw out some of the messages that fuel stigma related to people living with disabilities who are seeking SRH services and highlight the personal and professional relevance of focusing on disability inclusion.



### Duration: 30 – 45 minutes

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### Key messages:

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- People living with disabilities have the same rights and needs related to sexual and reproductive health as people living without disabilities
- There is often a gap in our capacity or confidence to deliver services to people with disabilities
- We need to think about people with disabilities when we think about sexual and reproductive health information and care in order to increase accessibility
- Unfortunately, living with a disability is stigmatized in nearly every culture around the world

- Because of isolation and separation, many people's experience with disability inclusion doesn't reflect the prevalence of people living with disabilities in the world
- Our experiences of disability within the culture we live in can influence how we think about serving clients with disabilities and meeting their sexual and reproductive health needs
- Disability inclusion is relevant to all of our lives and professional roles

## In-person activity instructions

### Materials and preparation:

Review the *Cross the Line* statements. Adapt statements as needed to ensure that they are appropriate for the cultural context in which you are using this activity, and that they bring up any particularly relevant or timely nuances about abortion in this context. Select the statements you will use in advance; we recommend choosing 6 statements total for the time allotted. It can be useful to end with a statement upon which you think all participants can agree such as the last one in the trainer tool.

#### **Materials needed:**

Training Tool: *Cross the Line* statements

Masking tape or string, approximately 3 meters long. If no tape or string is available, ask participants to imagine a line on the floor.

#### **Preparation required:**

Clear a large area of the room and place a line down the middle using the tape or string. If possible, make the line long enough that all participants can stand in a row along the line.

### Facilitation instructions:

Introduce the activity to participants as an icebreaker to start to explore the diversity of beliefs about abortion that are present in the room.

Explain in your own words that the purpose of this activity is to reflect on how our attitudes and beliefs about abortion were shaped: this is not a quiz and there are no “right” or “wrong” answers.

1. Ask all participants to gather on one side of the line.
2. Explain that you will read a series of statements and that if the statement applies to their beliefs or experiences, that they should move all the way across the line. Clarify that there is no “in between” in this activity, they must stand on one side of the line or the other.
3. Ask participants not to talk during the exercise unless they need clarification or do not understand the statement that is read.
4. Give participants an easy practice statement, such as: Cross the line if you had fruit for breakfast this morning. After the statement has been read and participants have crossed the line, invite the participants to silently observe how many people crossed the line and how many did not. Invite participants to notice how it feels to be where they are.
5. Ask participants to move back to their starting position on the initial side of the line.
6. Read each statement on abortion you have chosen and give people a chance to cross the line. After each statement:
  - Invite participants to notice how they feel about what side of the line they are on;
  - Ask for a volunteer who crossed the line to briefly share a little bit about why they crossed the line.
  - Next, ask for a volunteer who did not cross the line to share a little bit about why they did not cross the line. As you go through the different statements vary whether you start with the volunteer who did cross the line or with the one who did not. If at any point someone is alone on one side of the line, appreciate that they are brave to stand alone and ask if they would be willing to share how it feels to be the only person who did or did not cross the line.
7. Repeat this for each of the statements that you have prepared. If you start to notice that you will not have time to go through all of your

prepared statements, choose which you want to prioritize and which you will cut.

If there is time, close this part of the activity with one final statement: Cross the line if you believe we can discuss the topic of abortion respectfully, even if we have different experiences and beliefs about it. Note if most people agree or disagree, and either begin the debrief in place or invite participants to retake their seats for a debrief.

In a full group, discuss the activity using the following prompts:

- How did it feel to participate in this activity?
- What did you learn about your own and others' experiences with abortion?
- Were there times where you felt pressure to move with the majority of the group? How did you handle that pressure?
- What does this activity teach us about the stigma surrounding abortion?

Ask if participants have other questions, comments, or concerns. Finish the activity by reiterating the key messages in your own words, including elements of the conversation during the activity as much as you can. Emphasize that understanding how our attitudes and beliefs about abortion were shaped can help us break through stigmatizing messages and more consciously align our actions and attitudes with our values.

## Virtual activity instructions

### Materials and preparation:

Review the *Cross the Line* statements. Adapt statements as needed to ensure that they are appropriate for the cultural context in which you are using this activity, and that they bring up any particularly relevant or timely nuances about abortion in this context. Select the statements you will use in advance; we recommend choosing 6 statements total for the time allotted. It can be useful to end with a statement upon which you think all participants can agree such as the last one in the trainer tool.

#### **Materials needed:**

- *Cross the Line* Slides
- Annotation tools enabled (available in Zoom)<sup>1</sup>

#### **Preparation required:**

Select *Cross the Line* statements and prepare a slide deck that includes a slide for each statement, a slide on how to use the relevant Annotation tools and a slide for the debrief

### Facilitation instructions:

Introduce the activity to participants as an icebreaker to start to explore the diversity of beliefs about abortion that are present in the room. Explain in your own words that the purpose of this activity is to reflect on how our attitudes and beliefs about abortion were shaped: this is not a quiz and there are no “right” or “wrong” answers.

Introduce the technology you will be using and make sure that participants are able to find and use it.

1. Explain that you will read a series of statements and that if the statement applies to their beliefs or experiences, that they should write

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<sup>1</sup> <https://support.zoom.us/hc/en-us/articles/115005706806-Using-annotation-tools-on-a-shared-screen-or-whiteboard>

their name on the “yes” side of the line. If the statement does not apply to their beliefs or experiences, they should write their name on the “no” side. Clarify that there is no “in between” in this activity and they must choose one side.

2. Give participants an easy practice statement, such as: Cross the line if you had fruit for breakfast this morning. After the statement has been read and participants have crossed the line, invite the participants to silently observe how many people crossed the line and how many did not. Invite participants to notice how it feels to be where they are.
3. Use the virtual tools to clear the writing on the slide before advancing to the next slide.
4. Read each statement on abortion you have chosen and give people a chance to write their names. After each statement:
  - Invite participants to notice how they feel about what side of the line they are on;
  - Ask for a volunteer who “crossed the line” to the “yes” side to briefly share a little bit about why.
  - Next, ask for a volunteer from the “no” side to share a little bit. As you go through the different statements vary whether you start with the “yes” or “no” sides. If at any point someone is the only person who wrote their name on one side, appreciate that they are brave to stand alone and ask if they would be willing to share how it feels to be the only person on their side.
5. Repeat this for each of the statements that you have prepared. If you start to notice that you will not have time to go through all of your prepared statements, choose which you want to prioritize and which you will cut.

If there is time, close this part of the activity with one final statement: Cross the line if you believe we can discuss the topic of abortion respectfully, even if we have different experiences and beliefs about it. Note if most people agree or disagree and begin the debrief.

In a full group, discuss the activity using the following prompts:

- How did it feel to participate in this activity?
- What did you learn about your own and others' experiences with abortion?
- Were there times where you felt pressure to move with the majority of the group? How did you handle that pressure?
- What does this activity teach us about the stigma surrounding abortion?

Ask if participants have other questions, comments, or concerns. Finish the activity by reiterating the key messages in your own words, including elements of the conversation during the activity as much as you can. Emphasize that understanding how our attitudes and beliefs about abortion were shaped can help us break through stigmatizing messages and more consciously align our actions and attitudes with our values.

## TRAINER TOOL:

## Cross the Line statements

### Cross the line if...

Experience with people living with disabilities

- You have a friend or a family member that has difficulty walking, seeing, hearing, remembering, or concentrating that affects how they go about their day to day life
- You have heard friends or family talking in a negative way about people with a disability
- You've not known what to do or say when meeting someone with a physical disability

Experience with disability and SRH

- You have heard someone talking in a negative way about people with a disability accessing SRH services, carrying a pregnancy, or raising children
- You or someone you know has provided SRH services to someone with disabilities

### Note on adaptation:

If you add more statements of your own, please use the same statement structure, so that the activity keeps its **focus on experience, and not on personal opinions**.

#### Statement structure:

"Cross the line if you + have ever heard ... / were raised to believe ... / were taught ... / know someone who ..."

Do not ask people to cross the line if they think / believe / feel something. Other VCAT activities focus on articulating those beliefs and views.

## ACTIVITY:

# The Wall



### Purpose:

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This activity introduces the social model of disability and forms an important foundation for participants to approach disability inclusion. In this activity, participants will develop an understanding of disability beyond a focus on impairment towards a social model of disability. They will explore the barriers that people with disabilities experience in everyday life and in relation to accessing sexual and reproductive health services. The barriers will be visually represented as a wall, using post-it notes or paper cards as “bricks” to enhance empathy and understanding for the barriers people living with disabilities face.



### Duration: 60 minutes

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### Key messages:

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People living with disabilities experience barriers in their day-to-day life which prevent them from accessing sexual and reproductive health services on an equal basis to people living without disabilities.

The barriers they face fall into three main categories: **environmental**, **institutional** and **attitudinal**. However, these three areas are often inter-linked—for example our clinics do not have ramps (environmental barrier), this is because our organization doesn’t budget for accessibility (institutional barrier), this is because we haven’t prioritized the equal rights of persons with disabilities (attitudinal barrier).

Attitudinal barriers underpin many of the other barriers which have been identified, which is why VCAT activities are a powerful tool for building a disability inclusion mindset.

## In-person activity instructions

### Materials and preparation:

#### **Materials required:**

- Sticky notes or index cards to represent your bricks
- Pens
- Bluetak/masking tape

#### **Preparation required:**

Flip chart or PowerPoint of diagrams:

- Impairment + Barrier = Disability
- Barrier domains (individual, environmental, institutional, attitudinal)

Create wall out of 3 sheets of flip chart paper with 4 designated boxes labeled: individual, environmental, institutional, and attitudinal. (See [Figure 2: The Building Blocks of Disability and Inclusion.](#))

#### **Accessibility:**

- Ensure that “the wall” is at an accessible height for all participants—this could be on the wall, a table, or on the floor.
- Ensure that what is on the card is read out so that all the participants can know

### Facilitation instructions:

#### **Full Plenary Individual Reflection (5 minutes): Imagining Obstacles**

1. Ask everyone to take a few moments to think about their daily life—work, social, home etc. Imagine what obstacles might exist if they had a disability. For groups of people living with disabilities (i.e. hearing/physical/intellectual/visual impairment) ask them to describe what obstacles they face on a daily basis. Encourage participants to think as widely as possible—don’t just focus on physical things.

Write a list. See some examples below:

- My office does not have a ramp to access with a wheelchair
- I am ignored/not respected because of my disability

### **Small Group Work (12 minutes): Identifying Barriers**

2. Divide participants into small groups of 3-5 people
3. Ask the groups to share the barriers they think of for persons living with disabilities. If the focus is only on physical barriers, encourage teams to think wider and focus on how attitudes are influential as this is relevant for VCAT. Try to get people to be specific e.g. Refusing to serve a client due to their disability. Rather than "Discrimination."
4. **Documentation:** Ask each small group to combine their observations and select and write down 5-6 barriers—one idea per sticky note /index card.

### **Full Plenary (25 minutes): Building the Wall**

5. Bring the whole group back together and present the barriers equation slide + barrier domains slide—Environmental/Attitudinal/Institutional.
6. Next, prepare to build a 'wall' of all the barriers that people with disabilities might experience using the sticky notes (or index cards) to represent the bricks in the wall by displaying the prepared flip chart sheets to represent the wall.
7. Gather the group around your wall.
8. Ask participants to place their sticky notes/index cards into one of the categories (individual, attitude, environment, institutional) on the 'wall' one by one and explain why they chose that category. If there is disagreement or uncertainty about which category an obstacle should go in, encourage discussion and debate. Discussions should flow as people try to decide where to place their obstacles and why. If people aren't talking, and you can see ideas going into barriers that are not appropriate, lead a discussion on it. Use this to help

people understand the reasons behind the barriers and categories.

### **Full Plenary (15 minutes): Making Meaning of the Wall**

9. Once all the group's "bricks" are up on the Wall, invite participants to deepen and debrief their discussion by asking the following questions:
  - What do you notice about this wall?
  - How might these barriers impact women living with disabilities who are trying to access abortion options?
  - What are you taking away from this activity?
10. Close the activity by sharing the key messages and linking them as much as possible to what came up in the activity.



## Virtual activity instructions

Applications and functions needed:

- Breakout rooms
- Jamboard, Google Slides, Mural or another application that enables visual collaboration



### Advance preparation:

Prepare to create breakout rooms

Set up your visual collaboration slides in Jamboard (or other similar application) so that each small group has a designated slide/frame in which to build their wall

- Slides with the following:
- The Building Blocks of Disability and Inclusion ([Figure 2](#))
- Barriers to Inclusion (individual, environmental, institutional, attitudinal ([Figure 3](#)))
- Instructions for breakout room work

## Facilitation instructions:

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### **Full Plenary / Videos on: Opening & Imagining Obstacles (10 minutes)**

1. Briefly introduce the activity
2. Ask everyone to take a few moments to think about their daily life—work, social, home etc. Imagine what obstacles might exist if they had a disability. For groups of people living with disabilities (ex: hearing/physical/intellectual/visual impairment) ask them to describe what obstacles they face on a daily basis. Encourage participants to think as widely as possible—don't just focus on physical things. Write a list. See some examples below:
  - My office does not have a ramp to access with a wheelchair
  - I am ignored/not respected because of my disability
3. Let participants know that they're going to share and work with their lists in breakout rooms and proceed to the breakout room instructions

### **Breakout Rooms & Visual Collaboration App: Identifying Barriers (10 minutes)**

4. Review breakout room instructions by sharing a screen with the instructions slide:  
 When you arrive in your breakout room:
  - Take turns sharing 2–3 obstacles you came up with
  - Using sticky notes with one idea per sticky note, come up with as many obstacles as you can think of in the time allotted
  - Try to imagine a wide variety of contexts and types of impairments
5. In the chat box, provide a link to the collaboration application that participants will be working in. If participants have not used this application in a prior activity, build in time to show participants how to use it.
6. Send participants into small groups of 3–5 people per breakout room for 8 minutes

### **Full Plenary / Video On: Learning How to Build the Wall (10 minutes)**

7. Bring the whole group back together and present the barriers equation slide + barrier domains slide—Environmental/Attitudinal/Institutional.
8. Ask one person from each breakout group to share 1 barrier that they've identified and to propose which domain it fits into. If there is disagreement about which category any obstacle belongs in, encourage participants to share more about why they think it belongs in the category proposed.
9. Let participants know that they are going to go back into their small groups and now organize the rest of the obstacles they discussed into these categories. Point out that a copy of this visual is available in their collaboration slides and show them how to find it.
10. In their breakout rooms, participants should color code and group their sticky notes by category: individual, environmental, institutional, attitudinal to effectively build their Wall.

### **Second Breakout Rooms / Same groups: Building the Wall (10 minutes)**

### **Full Plenary/ Videos on / Screen Sharing: Making Meaning of the Wall (20 minutes)**

11. Bring back participants from breakout rooms to the plenary. Have a co-facilitator ready to share their screen and show the virtual collaboration slides and prepared to add content to the relevant slide.
12. Ask one group to volunteer to share their wall, category by category. After each category, invite other groups to contribute—did they have other barriers included in this category? Have someone add them.
13. Once all of the categories have been discussed, invite participants to deepen and debrief the discussion by asking the following questions:
  - What do you notice about the wall we built?
  - How might these barriers impact a woman living with disabilities who are trying to access abortion options?

- What are you taking away from this activity?
14. Close the activity by sharing the key messages and linking them as much as possible to what came up in the activity.

**Figure 2: The Building Blocks of Disability and Inclusion**



**Figure 3: Barriers to Inclusion**



This activity is adapted from World Vision. (2010). Travelling together: How to include disabled people on the main road of development. Accessed online: [https://www.wvi.org/sites/default/files/Travelling\\_together%5B1%5D.pdf](https://www.wvi.org/sites/default/files/Travelling_together%5B1%5D.pdf)

## HANDOUT:

# Factors affecting access to and uptake of family planning for women and girls living with disabilities

## Individual

**Intersecting and compounding** forms of discrimination and disadvantage, with barriers differing depending on *type and severity of impairment*

**Universal factors** (aspects of one's identity regardless of setting), including age, gender, disability, and health status.

**Contextual factors** (more complex and changeable factors that vary by setting), including language, race/ethnicity/caste, migration and refugee status, sexual orientation, family status.

## Environmental

**Physical barriers to access** at health centers and clinics, e.g. a lack of ramps, adjustable beds, wheelchairs, and disability-friendly sanitation facilities.

**Queues at health facilities** can compound physical barriers to accessing services.

**Long and difficult journeys to clinics**, particularly in rural and remote areas.

**Accessibility of family planning messaging**, e.g., difficulty understanding radio messages for people with hearing impairments, or TV not captioned or sign language

## Attitudinal

**Perceptions that persons living with disabilities are asexual** can lead to withholding information on the assumption that they won't need it.

**Stigma, negative attitudes and discrimination** from health workers.

**Overprotective attitudes** and lack of communication by parents and caregivers.

**Gender-based violence and particularly intimate partner violence** can limit access to and uptake of family planning methods.

## Institutional

**Need for national policies** to tackle the reproductive rights of people living with disabilities.

**Lack of age-, gender- and impairment-disaggregated data** on access to and uptake of family planning.

**Lack of technical expertise** around family planning programming from a disability perspective.

**High costs** to persons with disabilities of accessing family planning services

Source: Fraser, E and Corby, N (2019) *Family Planning for women and girls with disabilities*, Disability Inclusion Helpdesk Research Report No. 2 (pilot). London, UK: Disability Inclusion Helpdesk.

## ACTIVITY:

# Language and Terminologies (Part 1)



### Purpose:

Language and how we talk about people living with disabilities shape how we think and how we act. This activity, “Language and Terminologies,” has two parts. Part one explores the language we use to talk about disability in depth, focused on building familiarity with the terminology and how to approach accessible language. Part two focuses on using this language and reflecting on how using inclusive language can foster a disability inclusive mindset and practice. In these activities, participants will build confidence and vocabulary to talk more competently and confidently with and about people living with disabilities.



### Duration: 60 Minutes



### Key messages:

The language we use to talk about disability is rarely neutral, regardless of our intentions. Many of us have inherited stigmatizing and demeaning language to talk about people living with disabilities. The words we use are always rooted in a particular history and point of view and can contribute to respect and inclusion or can reinforce stigma and separation.

Learning to use people-centered, rights-based, and adaptation-focused language conveys respect and helps eliminate stigma against people living with a disability.

The language we use to describe people living with disabilities is constantly evolving. There is no universal agreement on the right terms and definitions to use. However, if we default to using the terms people living with disabilities use to describe themselves and/or people-centered,

rights-based or adaptation-focused terms, we can be sure to signal respect and a disability inclusive mindset.

Our everyday language and terminology related to disability comes from a history. We mustn't assume our language is neutral just because it is what we have always used. Using inclusive language can help us develop a disability inclusive mindset which focuses on the rights of people living with disabilities.

## In-person activity instructions

### Materials and preparation:

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It is important and hugely beneficial to co-facilitate this session with an expert from an Organization of People with Disabilities (OPD). They will be able to support you to manage questions participants raise and bring their own perspective which will ground this activity in lived experience.

Review this activity with your OPD co-facilitator or resource person in advance and prepare them to share their own personal experience or examples from their work, highlighting the impact of stigmatizing or rights-based terms (see step 8).

Watch the following videos as part of your own preparation and consider sharing them with participants after the activity has been conducted:

- This video provides do's and don'ts on language to refer to people with disabilities: [International Day of Persons Living with Disabilities](https://www.youtube.com/watch?v=LrxR9Mu0_KE)<sup>1</sup>
- This video, titled “Don't underestimate me,”<sup>2</sup> talks about the importance of positive framing and focusing on what people with disabilities can do.

Prepare and review the slides on the charity and medical models of disability (Figure 4) and the human rights approach (or social model) of disability (Figure 5).

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1 [https://www.youtube.com/watch?v=LrxR9Mu0\\_KE](https://www.youtube.com/watch?v=LrxR9Mu0_KE)

2 <https://www.youtube.com/watch?v=BMgwEIQRPE>

Prepare 4 sheets of flip chart paper (1 per small group) with 3 columns with the following headings:

- Charity or Medical Model
- Stigmatizing
- Rights-Based or Social Model

Prepare “sticky notes” or index cards with the set of terms for each of the following disability-related issues (see Terminologies chart at end of this activity):

- Group 1: Terms related to *Visual Impairments*
- Group 2: Terms related to *Hearing Impairments*
- Group 3: Terms related to *Physical Impairments*
- Group 4: Terms related to *Developmental Impairments*



## Facilitation instructions:

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1. Introduce the activity: *In this activity we’re going to explore the language that gets used to talk about disability and examine how the words we use can either contribute to disability inclusion or reinforce stigma.*
2. Present the slides depicting the two models of disability (charity/medical model and rights-based/social model) which represent different ways of understanding and describing disability. Emphasize and summarize that:
  - a. Medical model focuses on impairment as a deficiency of an individual.
  - b. Social model focuses on the deficiency of the social environment to support a diversity of abilities and emphasizes the rights of the individual.
3. Take impressions and questions from the participants about the two models.

4. First small group activity: Provide the instructions for small group work:
  - a. We will break into 4 small groups
  - b. Each group will work with a set of pre-populated terms related to a category of impairment (visual, hearing, physical or developmental)
  - c. Task: As a group, discuss whether each term falls under the charity/medical model, stigmatizing, or the rights-based/social model heading. There may not always be an obvious fit. If this is the case, leave the term to the side and discuss this when you return to the full plenary.
  - d. Assign someone to report back a summary of your work in the full plenary.
5. Divide participants into 4 small groups and give them 12 minutes to complete the task.
6. Return to Plenary and review each group's work (3 minutes per group for up to 15 min total)
 

Correct any terms that may be miscategorized and discuss why they go where they go.
7. Facilitate a discussion using the following questions and facilitator talking points (10 min):
  - a. What do you notice about the language used in each category—what are the common features?
  - b. What do we notice about impairment language? Some possible answers:
    - Tends to focus on medical
    - Medical language is longest and often most complex
    - Medical/impairment language is often adopted within our common ways of speaking—focusing on the person not the impairment is a relatively new way of talking about disability

- Framed in the negative—impairment linguistically is a negative word
  - Emphasis on the impairment rather than the person and barriers they experience
  - Link back to impairment + barriers formula.
- c. What are the signs of a person-centered, rights-based term?  
Possible answers:
- The term mentions a person (people with disabilities/disabled people)
  - The term is fact-based but without judgement (wheelchair user/blind people/person who have ...)
  - Contrasts are neutral (people without disabilities, people with disabilities)
  - Emphasis on the person and the barriers they experience rather than their impairment.
- d. What are the signs of a stigmatizing term? Possible answers:
- The person is not considered/the term is dehumanized (The Disabled/The Blind/referring to people as an acronym PWD)
  - The term is victimizing ('sufferers')
  - The term is disempowering (confined to a wheelchair)
  - Contrasting terms imply a bias (normal people/normal activities)
  - Over-medicalized language can be stigmatizing particularly when not in a medical context
  - Overemphasis on impairment out of context can be stigmatizing
8. Invite reflections from your OPD resource person about their personal experience or examples from their work which highlight the

impact of stigmatizing or rights-based terms.

9. Second small group activity: Provide instructions.
  - a. Return to your same small group.
  - b. Come up with 3-4 additional terms that get used in your context for talking about your group's category of impairment or people living with a disability more generally and discuss which of the two categories each of those terms belongs in.
  - c. Assign another person to report back to the full group two of the terms and how they were categorized.
10. Send participants back into their small groups for 10 minutes.
11. Return to plenary and review each group's work.
  - a. Have each group share 2 of their terms and how they were categorized.
  - b. Respectfully challenge or correct any mis-categorization and discuss.
12. Facilitate a discussion using some of the following prompts:
  - a. What stands out to you from this activity?
  - b. How did this activity make you feel?
  - c. What did this activity reveal about the way we think about disability in our contexts?
13. Close the activity by summarizing the key messages and thanking everyone for their active participation.



## Virtual activity instructions

### Materials and preparation:

It is important and hugely beneficial to co-facilitate this session with an expert from an Organization of People with Disabilities (OPD). They will

be able to support you to manage questions participants raise and bring their own perspective which will ground this activity in lived experience.

Review this activity with your OPD co-facilitator or resource person in advance and prepare them to share their own personal experience or examples from their work which highlight the impact of stigmatizing or rights-based terms (see step 8).

Watch the following videos as part of your own preparation and consider sharing them with participants after the activity has been conducted:

- This video provides do's and don'ts on language to refer to people with disabilities: International Day of Persons Living with Disabilities<sup>1</sup>:
- This video, titled "Don't underestimate me," talks about the importance of positive framing and focusing on what people with disabilities can do.<sup>2</sup>

Prepare and review the slides on the charity and medical models of disability (Figure 4) and the human rights approach (or social model) of disability (Figure 5).

In the virtual collaboration application (Jamboard, Google Slides or Mural), create a workspace for 4 breakout groups. For each breakout group create a frame/slide with:

- 3 columns/areas with the following headings:
  - Charity or Medical Model
  - Stigmatizing
  - Rights-Based or Social Model
- A set of pre-populated "sticky notes" with the set of terms for each of the following disability-related issues (see Terminologies chart at end of this activity):
  - Breakout Group 1: Terms related to *Visual Impairments*

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1 [https://www.youtube.com/watch?v=LrxR9Mu0\\_KE](https://www.youtube.com/watch?v=LrxR9Mu0_KE)

2 <https://www.youtube.com/watch?v=BMgwEIQRPE>

- Breakout Group 2: Terms related to *Hearing Impairments*
- Breakout Group 3: Terms related to *Physical Impairments*
- Breakout Group 4: Terms related to *Developmental Impairments*



## Facilitation instructions:

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1. Introduce the activity: *In this activity we're going to explore the language that gets used to talk about disability and examine how the words we use can either contribute to disability inclusion or reinforce stigma.*
2. Present the slides depicting the two models of disability (charity/medical model and rights-based / social model) which represent different ways of understanding and describing disability. Emphasize and summarize that:
  - a. Medical model focuses on impairment as a deficiency of an individual.
  - b. Social model focuses on the deficiency of the social environment to support a diversity of abilities and emphasizes the rights of the individual.
3. Take impressions and questions from the participants about the two models.
4. First breakout group activity: Provide the instructions for small group work:
  - a. Participants will be assigned to one of 4 breakout groups
  - b. Each breakout group will work with a set of pre-populated terms related to a category of impairment (visual, hearing, physical or developmental)
  - c. Task: As a group, discuss whether each term falls under the charity/medical model, stigmatizing, or the rights-based/social model heading.

- d. As a breakout group look at the post-its and discuss which category fits the statement best. There may not always be an obvious fit.
5. Initiate Breakout Rooms for 10 minutes.
6. Return to Plenary and review each group's work (3 minutes per group for up to 15 min total)
  - a. Correct any terms that may be mis-categorized and discuss why they go where they go.
7. Facilitate a discussion using the following questions and facilitator talking points (10 min):
  - a. What do you notice about the language used in each category—what are the common features?
  - b. What do we notice about impairment language? Some possible answers:
    - Tends to focus on medical
    - Medical language is longest and often most complex
    - Medical/impairment language is often adopted within our common ways of speaking—focusing on the person not the impairment is a relatively new way of talking about disability
    - Framed in the negative—impairment linguistically is a negative word
    - Emphasis on the impairment rather than the person and barriers they experience
    - Link back to impairment + barriers formula.
  - c. What are the signs of a person-centered, rights-based term? Possible answers:
    - The term mentions a person (people with disabilities/disabled people)

- The term is fact-based but without judgement (wheelchair user/blind people/person who has ...)
  - Contrasts are neutral (people without disabilities, people with disabilities)
  - Emphasis on the person and the barriers they experience rather than their impairment.
- d. What are the signs of a stigmatizing term? Possible answers:
- The person is not considered/the term is dehumanized (The Disabled/The Blind/referring to people as an acronym PWD)
  - The term is victimizing ('sufferers')
  - The term is disempowering (confined to a wheelchair)
  - Contrasting terms imply a bias (normal people/normal activities)
  - Over medicalized language can be stigmatizing particularly when not in a medical context
  - Over emphasis on impairment out of context can be stigmatizing
8. Invite reflections from your OPD resource person about their own or their personal experience or examples from their work which highlight the impact of stigmatizing or rights-based terms.
9. Second breakout group activity: Provide instructions.
- a. Come up with 3–4 additional terms that get used in your context for talking about your group's category of impairment or people living with a disability more generally and discuss which of the two categories each of those terms belongs in.
  - b. Assign one person to report back to the full group two of the terms and how they were categorized.
10. Initiate breakout rooms for 8 minutes.

11. Return to plenary and review each group's work.
  - a. Have each group share 2 of their terms and how they were categorized.
  - b. Respectfully challenge or correct any mis-categorization and discuss.
12. Facilitate a discussion using some of the following prompts:
  - a. What stands out to you from this activity?
  - b. How did this activity make you feel?
  - c. What did this activity reveal about the way we think about disability in our contexts?
13. Close the activity by summarizing the key messages and thanking everyone for their active participation.

### Key terms:

**IMPAIRMENT** always focuses upon the *individual*, mainly on their physical and/or intellectual differences when compared with those who do not have such impairments. Impairment does not cause or justify disability; it is always present when disability occurs.

**DISABILITY** always focuses on society, and the way it systematically excludes those with impairments from participating in society, primarily as a result of attitudinal, environmental and institutional barriers.

### Definition of “persons with disabilities” from the United Nations Convention on the Rights of Persons with Disabilities (CRPD):

Persons living with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Note for facilitators: Remember that everyone is an individual and is not defined by their disability. Some people with disabilities, through their own choice, do not wish to see themselves or be identified as disabled.

For example, some people with hearing impairment identify as a Deaf person with a unique culture and language (sign language), and don't identify as having a disability—they just use a different language.

Equally, a person who acquires a mild hearing loss as they become older may not identify as having a disability. This is less stigmatized in society and technology can help them minimize the impact of this impairment.

## TRAINER TOOL:

## Terminologies defined

## Hearing-related terminology

<b>Medical (Impairment) focused</b>	<b>Definitions</b>	The total or partial inability to hear sounds
	<b>Terms</b>	Hearing impaired Hard of hearing
<b>Stigmatizing language</b>	<b>Informal terms</b>	Deaf and dumb Can't hear Mute The Deaf
<b>Social focus: Barriers and adaptations</b>	<b>People-first language</b>	Person with hearing loss A Deaf person
	<b>Adaptation focused</b>	A sign language user A hearing aid user A lip reader

## Sight-related terminology

<b>Medical (Impairment) focused</b>	<b>Definitions</b>	Visual acuity of less than 20/20 with correction or a field of less than 20 degrees
	<b>Terms</b>	Partially sighted Visual impairment Hard of seeing
<b>Stigmatizing language</b>	<b>Informal terms</b>	Can't see The Blind

## Sight-related terminology

<b>Social focus: Barriers and adaptations</b>	<b>People-first language</b>	Person living with sight loss or low vision A blind person
	<b>Adaptation focused</b>	Braille user White can user Glasses wearer

## Physical ability-related terminology

<b>Medical (Impairment) focused</b>	<b>Definitions</b>	Damage to the spinal cord that causes temporary or permanent changes in its function Muscle weakness Paralysis
	<b>Terms</b>	Physically impaired
<b>Stigmatizing language</b>	<b>Informal terms</b>	Cripple Invalid Lame Confined to a wheelchair Spastic
<b>Social focus: Barriers and adaptations</b>	<b>People-first language</b>	Person with a physical disability Illness survivor (ex: polio survivor)
	<b>Adaptation focused</b>	Wheelchair user Crutch user

## Cognitive ability-related terminology

<b>Medical (Impairment) focused</b>	<b>Definitions</b>	Diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills
	<b>Terms</b>	
<b>Stigmatizing language</b>	<b>Informal terms</b>	Mental Mad Slow learner
<b>Social focus: Barriers and adaptations</b>	<b>People-first language</b>	Memory loss
	<b>Adaptation focused</b>	Benefits from receiving information in simple formats Benefits from more time to process information
<b>Medical (Impairment) focused</b>	<b>Definitions</b>	A developmental disorder
	<b>Terms</b>	Difficulties with interpreting both verbal and non-verbal language
<b>Stigmatizing language</b>	<b>Informal terms</b>	Defective Retarded
<b>Social focus: Barriers and adaptations</b>	<b>People-first language</b>	A person living with autism A person with dyslexia
	<b>Adaptation focused</b>	Benefit from routine Benefit from calm environments

**Other language to discuss:**

**Differently abled:** A well-meaning term, however it's often viewed as patronizing or euphemistic and shifts focus away from the social barriers and discrimination that people with disabilities experience.

**Handicap:** While this is used for disability in French, many people living with disabilities find this term stigmatizing.











## ACTIVITY:

# Terminology and Language (Part 2)



## Purpose:

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After Part 1, which focused on language and different terminology around disability, the purpose of this activity is to practice the way to talk about disability in a respectful, rights-based and non-stigmatizing way. It will encourage participants to explore and reflect upon the connection between language and mindsets around disability and how that influences the way we go about finding solutions for barriers to inclusion.



## Duration: 90 minutes

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## Key messages:

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- It is useful to practice using new language, so that we become more confident with the terminology and the subject we're talking about. Feeling confident talking about disability in the context of SRH and abortion makes it more likely that we consider the needs of people with disabilities in our programming and approach inclusive programming in a respectful and rights-based way: "changing the language we use can change the way we think."
- Referring back to the social model of disability, it is not our responsibility to fix someone's impairment, but we can devise solutions for clients with disabilities by applying a rights-based lens.
- We need to consider that some actions to ensure disability inclusion in SRH can be addressed immediately, while others will need to be planned for and actualized in due course.

- The questions we ask will reveal whether we are prepared to operate from a rights-based and inclusive approach or from the charity/medicalization approach that blames and penalizes people living with disabilities.

## In-person activity instructions

### Materials and preparation:

In order for participants to gain the most out of this workshop, it would be ideal for one of the facilitators to be someone living with a disability (it could be someone who works for an Organization of Persons with Disabilities).

#### **Materials needed:**

- Flip chart paper to write statements on and post its to represent people's thoughts (this will be for Group Work Part 2)
- Duct tape
- Pens

#### **Prepare in advance:**

- Review Figures [2](#), [4](#), and [5](#) for a refresher on disability inclusion and the charity/medical and social models of disability.
- Prepare to introduce a person with a disability for Group Work: Part 1 of this activity by putting the list of questions in Part 1, step #2 below on a flip chart sheet.
- Prepare a flip chart with the Stigmatizing statements for Group Work: Part 2 (see below) and another with the questions to reflect on during this part of the activity (see Part 2, step #3).
- Prepare a flip chart with the content of the Training tool: Stigmatizing versus rights-based language.

The lead facilitator should assign participants into breakout groups. Each breakout group should have a designated note-taker who can document

the conversation on the flip chart, whether they are a facilitator, the content co-facilitator or a participant.

### **Stigmatizing statements for Group Work: Part 2**

1. A deaf client who uses sign language-seeking services.

Stigmatizing sentence: She is deaf and doesn't understand what we are saying.

Rights-based sentence: *to be completed by groups*

2. A client with an intellectual impairment needs to give their informed consent.

Stigmatizing sentence: She can't give her consent.

Rights-based sentence: *to be completed by groups*

3. A client with sight impairment or a client who is illiterate or speaks a different language.

Stigmatizing sentence: They can't read the form.

Rights-based sentence: *to be completed by groups*

4. A person who uses a wheelchair when applying for a new job.

Stigmatizing sentence: They can't even get in the building for the interview."

Rights-based sentence: *to be completed by groups*

## Facilitation instructions:

### Group Work: Part 1

Introduction to Activity (15 minutes)

1. Explain to the group that they are now going to practice shifting away from impairment/medicalization language and using rights-based/adaptation-oriented language based on the terminologies and categories they learned this morning.
2. Demonstration: Display the following questions (a–f) and then the facilitator or OPD representative gives a demonstration of how to talk about a person with disabilities in a rights-based way, using the following questions:
  - a. Who are they?
  - b. What disability do they have?
  - c. How do they describe their disability?
  - d. To what extent does the person with a disability and the participant see their disability as part of their identity?
  - e. What adaptations do they use to overcome it?
  - f. What, if anything do you do differently when you are with this person?

Example: “My sister’s name is Eloise, and she has a physical disability. She uses crutches and braces to walk. She describes herself as someone who has a physical disability and gets frustrated when people refer to her as “handicapped.” She strongly feels that her disability has taught her to be resilient and to quickly adapt to change. I learnt over the years of living with her that she is incredibly independent, and that I should not assume that I know better what she can and can’t do. When she cooks or cleans, she uses a desk chair with wheels, so she doesn’t lose her balance. Sometimes, if she asks for help, I will take on one of the two tasks whereby I will vacuum, and she will mop the floor.”

3. Ask participants what they noticed about how you spoke about your sister; What are some examples of rights or adaptation-oriented language that they heard you use?
4. You will now ask them to take turns to describe the person they know using these questions as a guide.

Explain: The goal isn't to get it perfect, but rather to practice, notice and feel the difference between the ways we typically talk about people living with a disability and a more deliberately rights/ people-first/adaptation oriented way.

5. Divide the participants into small groups to describe someone with a disability that they know (2–3 people per group). This should take 10–15 minutes.
6. Regroup and ask volunteers to reflect back on the activity by asking the questions below. This should take 10 minutes:
  - a. What did you notice about the introductions you just heard?
  - b. What are some examples of people-first or adaptation-focused language you heard?
  - c. How did this feel different from how you typically hear people living with disabilities being described?
7. Share the following: While there are linguistic ways to use people first language, in practice, putting people first means defaulting to their preferred terms, regardless of what category the terms themselves fit in. When in doubt, having these categories helps us speak in a way that conveys our commitment and desire to operate from a rights and asset based orientation. As a rule, terminology that refers to a “person” or focuses on the adaptation a person uses, is preferred over other terminology which may be stigmatizing or disempowering. But when you learn the terms that someone living with disabilities uses to describe themselves, you should adopt their choice of language when talking with or about them.

## Group Work: Part 2

Introduction to activity (10 minutes)

1. Explain to participants that this activity will help them explore and reflect upon the values and mindsets they have around disability and will help them to practice language options in work environments to have more practical conversations. This can also be a good opportunity for people to come up with good examples of what may need to be changed in the workplace to be more disability-inclusive, and that action points will come up here and will be written down, so it can be taken forward to management and operationalized.
2. Model a pre-prepared example of a stigmatizing statement versus a rights-based statement and lead the group through the three reflective questions for discussion. Refer to Training tool: Stigmatizing versus rights-based language.

Example: A service-delivery scenario with a client who has a mobility impairment

- Stigmatizing: The client cannot get on the examination bed.
  - Rights-based: Our examination bed is not suitable or accessible for this client.
3. Share the following: Try to put yourself in a client's shoes- what would it feel like for them to be hearing or be given these kinds of statements? Let us reflect on this with the example provided, and answer the prompts below:
    - a. What type of language is this, stigmatizing or rights-based?
    - b. What is the impact of the language used? What kind of conversation does each statement lead to?
    - c. Whose responsibility is it to find a solution in each case?
  4. Give each group a flip chart paper with a stigmatizing statement as well as post it notes.

5. Ask them to answer the following prompts when they reflect on the statements you've given them:
  - a. How can you change this statement into a rights-based statement?
  - b. What is the impact of the language used? What kind of conversation does each statement lead to?
  - c. Whose responsibility is it to find a solution?
  - d. Why is it important?
6. Divide the participants into their groups.
7. Use the "stigmatizing vs. rights-based language table" to prompt participants.
8. You or another facilitator should write down the action points raised by participants onto a flip chart paper.
9. Bring the group back together.
10. Ask a volunteer from each group to share reflections on what type of language the statement uses, whose responsibility it is to find a solution, and how the statement can be changed into a rights-based one.
11. Invite the group to reflect on the activity by asking the questions below:
  - a. How did this activity feel?
  - b. What stood out to you?
12. Close the session with key messages and link them as much as possible to comments/points that were made throughout this session.

## Virtual activity instructions

### Materials and preparation:

In order for participants to gain the most out of this workshop, it would be ideal for one of the facilitators to be someone living with a disability (it could be someone who works for an Organization of Persons with Disabilities).

#### **Materials needed:**

- Instructions for Group Work: Part 1 (see below)
- A sample stigmatizing sentence for the group to work through in Group Work: Part 2 (see Part 2, step 2 below)
- Small group “worksheets” for Group Work: Part 2 that contain stigmatizing sentences for each small group (see Stigmatizing statements for Group Work: Part 2 in the In-Person Activity instructions)

#### **Prepare in advance:**

The lead facilitator should pre-assign participants into groups and decide which statements for the group work part 2 will be assigned to which groups. Each breakout group should have a designated note-taker who can document the conversation on the virtual facilitation board, whether they are a facilitator, the content co-facilitator or a participant.

### Facilitation instructions:

#### Group Work: Part 1

Introduction to activity (15 minutes)

1. Explain to the group that they are now going to practice shifting away from impairment/medicalization language and using rights-based/adaptation-oriented language based on the terminologies and categories they learned this morning.

2. Demonstration: Display the following questions (a–f) and then the facilitator or OPD representative gives a demonstration of who to talk about a person with disabilities in a rights-based way, using following questions:
  - a. Who are they?
  - b. What disability do they have?
  - c. How do they describe their disability?
  - d. To what extent does the person with a disability and the participant see their disability as part of their identity?
  - e. What adaptations do they use to overcome it?
  - f. What, if anything do you do differently when you are with this person?

Example: “My sister’s name is Eloise, and she has a physical disability. She uses crutches and braces to walk. She describes herself as someone who has a physical disability and gets frustrated when people refer to her as “handicapped.” She strongly feels that her disability has taught her to be resilient and to quickly adapt to change. I learnt over the years of living with her that she is incredibly independent, and that I should not assume that I know better what she can and can’t do. When she cooks or cleans, she uses a desk chair with wheels, so she doesn’t lose her balance. Sometimes, if she asks for help, I will take on one of the two tasks whereby I will vacuum, and she will mop the floor.”

3. Ask participants what they noticed about how you spoke about your sister; What are some examples of rights or adaptation-oriented language that they heard you use?
4. You will now ask them to take turns to describe the person they know using these questions as a guide.

Explain: The goal isn’t to get it perfect, but rather to practice, notice and feel the difference between the ways we typically talk about people living with a disability and a more deliberately rights/

people-first/adaptation oriented way.

5. Divide the participants into small groups to describe someone with a disability that they know (2–3 people per group). This should take 10–15 minutes.
6. Regroup and ask volunteers to reflect back on the activity by asking the questions below. This should take 10 minutes:
  - a. What did you notice about the introductions you just heard?
  - b. What are some examples of people-first or adaptation-focused language you heard?
  - c. How did this feel different from how you typically hear people living with disabilities being described?
7. Share the following: While there are linguistic ways to use people first language, in practice, putting people first means defaulting to their preferred terms, regardless of what category the terms themselves fit in. When in doubt, having these categories helps us speak in a way that conveys our commitment and desire to operate from a rights and asset based orientation. As a rule, terminology that refers to a “person” or focuses on the adaptation a person uses, is preferred over other terminology which may be stigmatizing or disempowering. But when you learn the terms that someone living with disabilities uses to describe themselves, you should adopt their choice of language when talking with or about them.

## Group Work: Part 2

Introduction to activity (10 minutes)

1. Explain that this activity will help them explore and reflect upon the values and mindsets they have around disability and will help them to practice language options in work environments to have more practical conversations. This can also be a good opportunity for people to come up with good examples of what may need to be changed in the workplace to be more disability-inclusive, and that

action points will come up here and will be written down, so it can be taken forward to management and operationalized.

2. Model a pre-prepared example of a stigmatizing statement versus a rights-based statement and lead the group through the three reflective questions for discussion. Refer to Training tool: Stigmatizing versus rights-based language.

Example: A service-delivery scenario with a client who has a mobility impairment

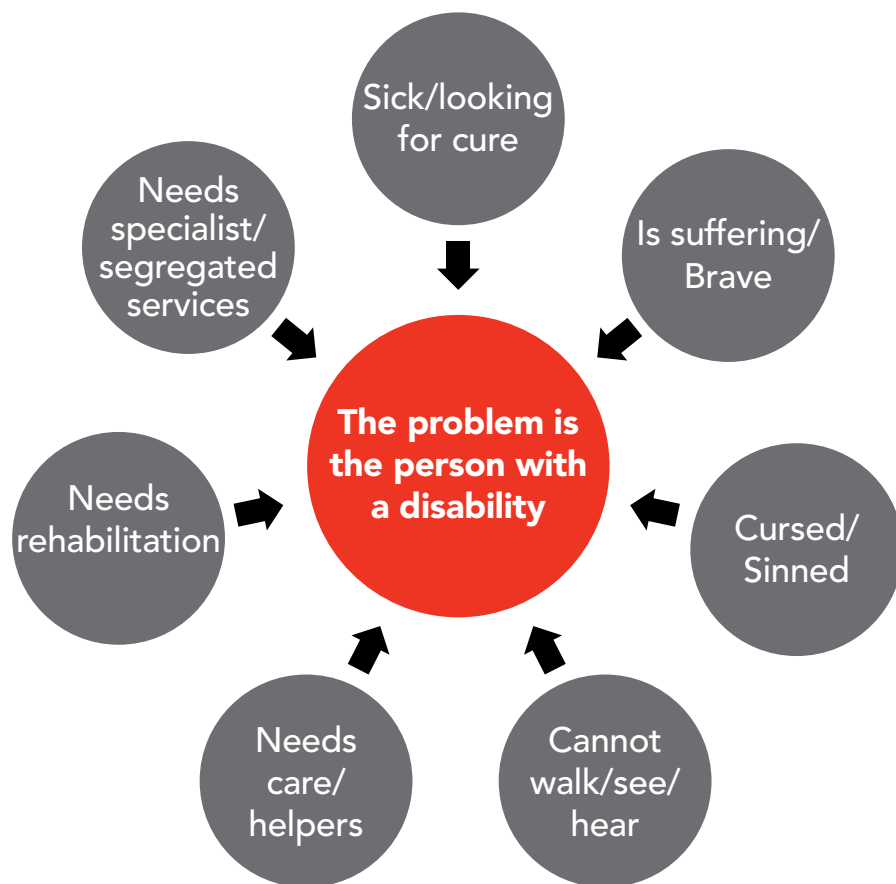
- Stigmatizing: The client cannot get on the examination bed.
  - Rights-based: Our examination bed is not suitable or accessible for this client.
3. Share the following: Try to put yourself in a client's shoes- what would it feel like for them to be hearing or be given these kinds of statements? Let us reflect on this with the example provided, and answer the prompts below:
    - a. What type of language is this, stigmatizing or rights-based?
    - b. What is the impact of the language used? What kind of conversation does each statement lead to?
    - c. Whose responsibility is it to find a solution in each case?
  4. Ensure each group has their preassigned stigmatizing statement
  5. Ask them to answer the following prompts when they reflect on the statements you've given them (12 minutes):
    - a. How can you change this statement into a rights-based statement?
    - b. What is the impact of the language used? What kind of conversation does each statement lead to?
    - c. Whose responsibility is it to find a solution?
    - d. Why is it important?

6. Divide the participants into their groups.
7. Use the “Trainer tool: Stigmatizing versus rights-based language” to prompt participants.
8. Ensure that you or another facilitator is writing the points made on the virtual facilitation board. You can then share them on the group chat box.
9. Bring the group back together.
10. Ask a volunteer from each group to share reflections on what type of language the statement uses, whose responsibility it is to find a solution, and how the statement can be changed into a rights-based one.
11. Invite the group to reflect on the activity by asking the questions below:
  - a. How did this activity feel?
  - b. What stood out to you?
12. Close the session with key messages and link them as much as possible to comments/points that were made throughout this session.

## TRAINER TOOL:

# Stigmatizing versus rights-based language

Stigmatizing language	Rights-based language
<b>Focuses on individual limitation</b>	<b>Focuses on facility's limitations</b>
Just shows or describes the limitations of the individual	Shows the limitation from the available resource
Stigmatizes the person and focuses on what they cannot do	Realizes facility hasn't considered all the types of people who will use services
<b>Shows speaker's lack of initiative</b>	<b>Focuses on the client</b>
Makes no effort to make service accessible	Is reflective and open to adaptation of policies and premises
Denies the person their rights	Focuses on what skills or capacity the staff and facility lack
Denies service or offers no solution	Shows awareness that facility must adapt to be more inclusive
<b>Puts responsibility on individual</b>	<b>Puts responsibility on facility or service provider</b>
Blames client for the problem	Shows desire to serve clients with accessible services
Doesn't recognize role of facility or provider in the problem	Looks for solutions (how can we make things more accessible?)
Discriminates or assumes an adult with disabilities can't give consent	May still deny service but desire is clear to obtain consent and make service accessible
Doesn't consider the person being served	Aims to adapt service or resource for many types of people
<b>Creates negative client experience</b>	<b>Creates positive client experience</b>
Makes client feel not seen, embarrassed, shamed and/or traumatized	Makes client feel welcomed, included, respected, listened to, in control and/or like reasonable adjustments have been made

**Figure 2:** The Building Blocks of Disability and Inclusion**Figure 4:** Charity and medical models of disability

**Figure 5:** Human rights approach (social model) of disability



## ACTIVITY:

# Reasons Why

This activity explores a broad range of reasons why women living with disabilities have sex, get pregnant, choose to terminate a pregnancy and make decisions about a pregnancy that they don't want to make. It supports participants to recognize that while women living with disabilities make SRH decisions for all of the same reasons as women living without disabilities, they face undue burdens and unique barriers to exercising their sexual and reproductive rights. Finally, this activity supports participants in identifying some of the biases they may have inherited about women living with disabilities and the values they hold that can better support them in acting from a rights-based approach to disability inclusion.

 **Duration: 90 minutes**

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 **Key messages:**

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- Women living with disabilities make SRH decisions for the same reasons as people living without disabilities. However, because of stigma, increased rates of sexual violence, and disabling practices and environments, women living with disabilities are forced to navigate undue barriers to their sexual and reproductive rights.
- People living with disabilities have the same sexual and reproductive rights as people living without disabilities. This includes, among others, the right to contraception, to comprehensive sexuality education, the right to have children, the right to parent the children they have and the right to terminate a pregnancy.
- Our personal discomfort with the reasons why women living with disabilities choose to get pregnant and choose to continue or terminate a pregnancy may be rooted in unexamined stigmatizing beliefs about women living with disabilities.

- At a societal level, stigmatizing beliefs create disabling attitudes, environments and policies and procedures that deny women living with disabilities the right to make the decisions they want to make about their sexual and reproductive health.
- A disability inclusion mindset asks us to shift away from a charity approach to disability to a rights-based approach. Taking the time to examine the root causes of our discomfort with the some of the choices and reasons why women living with disabilities make SRH decisions is an important step towards clarifying the values we hold and taking actions that affirm the rights of women living with a disability.

## In-person activity instructions

### Materials and preparation:

#### **Materials**

- Trainer tool: Reasons Why questions
- Trainer tool: Reasons Why answer sheet
- Flipchart paper and markers
- Masking tape
- Small prizes for winning team members (candy or similarly small token prize)

#### **Prepare materials**

- Review the “Trainer tool: Reasons Why answer sheet” to familiarize yourself with content that is likely to be raised in this activity. Add additional reasons that may reflect your context or the contexts of the anticipated participants.
- Print a copy of “Trainer tool: Reasons Why questions.” Cut the statements into strips. Make more than one copy if you have a large group where more than one small group will be using the same question.

- Print a copy of “Trainer tool: Reasons Why answer sheet for each member of the facilitation team.
- Review discussion questions for pairs and small groups from activity step by step below and write them up onto flip chart pages.
- Gather a small prize for participants of the winning small group (candy or similar size).



## Activity instructions:

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1. Introduce the activity. Explain that during this activity we'll be working in small groups to imagine all the reasons why women living with disabilities have sex, get pregnant and make other sexual and reproductive health decisions and then explore some of those reasons in greater depth.
2. Explain that you are going to divide the group into small groups and each small group is going to get a question. The group will have approximately 10 minutes to try to brainstorm as many possible answers to the question as possible within the timeframe and write them down on the piece of flipchart paper they will be given. There will be a prize for the most creative flipchart, so each group should feel free to draw and use color creatively to present their answers in the time given. Let them know you're going to divide them now and when they are in their small groups you'll give them a few more instructions.
3. Divide participants into groups of 3 to 5 people each. Give each group a piece of flipchart paper, a set of 3–4 color markers and one of the *Reasons Why* Questions.
4. When they are all seated with their small groups and have had a chance to see their question, provide the following additional instructions:
  - Encourage each group to think as deeply and broadly as possible about all of the possible *reasons why*.
  - Remind groups that they will have approximately 10 minutes to brainstorm and prepare their flipcharts. You'll check in at the 10-minute mark and see if more time is needed or not. Allow for

up to 5 more minutes if needed but no more to ensure you have time for the other steps in the activity. There will be an opportunity for the rest of the group to add additional reasons during the report backs.

- Each group should select one person to report back to the larger group. That person will have 2–3 minutes to present to the larger group.
  - Remind groups that the most creative flipchart will receive a prize.
5. After 10 minutes have passed, check to see if groups have generated all of the ideas they can. If they need more time, give them 5 more minutes. After 15 minutes maximum, invite groups to post their flipchart pages on the wall. Give each group 2–3 minutes to have one member present the “reasons” they have brainstormed. After each 3-minute presentation, ask the larger group if they have any additional reasons they can think to add to the presenting group’s list and add them. Join the brainstorm to suggest additional responses that were not identified after other groups have made their contributions.
  6. After all of the groups have presented, have participants quickly vote on the most creative flipchart by having them clap for each flipchart one by one. Let them know that they cannot vote for their own flipchart. The group with the loudest applause wins the prize. Present the winning team with a prize or let them know that their prize is the esteem of their peers!
  7. Next, invite participants to take 3–5 minutes to reflect on all of the reasons identified for why women and girls terminate a pregnancy and identify 2 reasons they are most comfortable with and 2 reasons that they are the least comfortable with. Then ask them to then take an additional 2 minutes to reflect on how their core values influence their comfort and discomfort with the reasons they selected.
  8. After all of the groups are finished presenting ask:  
  
How would these lists be different if they were only about women living **without** disabilities? Participants should come to the conclusion that they would be mostly the same.

9. Next present the following statistics on women living with disabilities:

- 80% of people living with a disability live in developing countries<sup>1</sup>
- 90% of children living with a disability in developing countries are not in school<sup>1</sup>
- Worldwide women and girls living with a disability are at a significantly increased risk for sexual and gender based violence<sup>2</sup>
- People living with disabilities are more likely to experience high poverty rates<sup>3</sup>

10. Return participants to the same groups and give them 8 minutes to discuss the following question:

*While women living with disabilities make SRH decisions for all of the same reasons as women living without disabilities, what do these statistics suggest about the possible differences between women living with disabilities and women living without disabilities when it comes to making SRH decisions?*

11. Return to full plenary and ask a few volunteers to share an insight from their group discussion. Elicit or share the following key message:

While women living with disabilities make SRH decisions for the same reasons as people living without disabilities, at a population level, women living with disabilities are more likely to have to navigate unjust and harmful barriers to their sexual and reproductive health and rights. They bear an undue share of the sub-optimal circumstances that force many women to make decisions about their pregnancies that they don't want to make.

12. For the final part of this activity, invite participants to now all look at the list of reasons identified for why women living with disabilities

1 Global Citizen blog, 2018: *5 Facts About Living with a Disability in the Developing World* (<https://www.globalcitizen.org/en/content/disability-in-the-developing-world/>)

2 Commission on the Status of Women Factsheet, 2013: *Violence against Women and Girls with Disabilities* ([https://www.un.org/womenwatch/daw/csw/csw57/side\\_events/Fact%20sheet%20%20VAWG%20with%20disabilities%20FINAL%20.pdf](https://www.un.org/womenwatch/daw/csw/csw57/side_events/Fact%20sheet%20%20VAWG%20with%20disabilities%20FINAL%20.pdf))

3 World Bank, 2020: *Disability Inclusion* (<https://www.worldbank.org/en/topic/disability>)

make decisions about their pregnancy that they don't want to make. Do this by zooming in on this list while screen sharing. Ask participants to reflect in silence for 3–4 minutes on the following questions before going back into breakout groups:

- What is one reason that makes you very uncomfortable and why?
- What biases or stigmatizing messages might you have inherited about women living with disabilities that perpetuates disabling conditions for their sexual and reproductive health decisions?
- What is one core personal value which could help shift your mindset and behaviors more decidedly towards a rights-based approach, rather than a charity-approach, to disability inclusion?

13. Break up participants into pairs or if needed in groups of 3, give participants up to 10–12 min to discuss their answers to these questions.
14. Invite participants to shift into a full group discussion. With the remaining time, facilitate a large group discussion using some of the following questions:

*What stood out from your discussion?*

*What are some of the core values we can draw on collectively to help us shift more decidedly into a rights-based approach to disability inclusion.*

*What new insights have you gained from this discussion?*

15. Close with the Key Messages and as much as possible succinctly link key messages to comments that came up during the exercise.



## Virtual activity instructions



### Materials and preparation:

- Virtual facilitation board
- Ensure that you have breakout room functionality on the software you use and a facilitator to organize breakout rooms

## Prepare materials

- Review the “Trainer tool: Reasons Why answer sheet” to familiarize yourself with content that is likely to be raised in this activity. Add additional reasons that may reflect your context or the contexts of the anticipated participants.
- Review discussion questions for pairs and small groups. Create slides or discussion prompts as appropriate.
- This activity is designed to break participants into 4 groups of 4–5 people per group. If you have a large group you can create more groups and duplicate some of the questions.



## Activity instructions:

1. Introduce the activity. Explain that during this activity we'll be working in small groups to imagine all the reasons why women living with disabilities have sex, get pregnant and make other sexual and reproductive health decisions and then explore some of those reasons in greater depth. Move participants into break out groups.
2. Using a virtual facilitation board and 1 facilitator per group who is only playing the role of recording reasons on to the virtual facilitation board, groups will have 10–12 min to brainstorm and list “reasons” for their assigned question. Ensure that the lists are written in large font.

Questions for each group:

**Group 1:** What are all the reasons why people living with disabilities have sex?

**Group 2:** What are all the reasons why people living with disabilities get pregnant?

**Group 3:** What are all of the reasons why people living with a disability have an abortion?

**Group 4:** What are all of the reasons why women living with a disability make choices about their pregnancy that they don't want to make?

3. Starting with the first question and for each of the questions:
  - Review lists in order in full plenary by having a spokesperson from each group summarize or quickly read each list out loud, allocating the share back time evenly between each group.
  - For each question, ask the group if there are other reasons they can think to add. Take additional suggestions and have a pre-designated facilitator note them on the virtual facilitation board.
4. After all of the groups are finished presenting ask:
 

How would these lists be different if they were only about women living **without** disabilities? Participants should come to the conclusion that they would be mostly the same.
5. Next present the following statistics on women living with disabilities:
  - 80% of people living with a disability live in developing countries<sup>1</sup>
  - 90% of children living with a disability in developing countries are not in school<sup>4</sup>
  - Worldwide women and girls living with a disability are at a significantly increased risk for sexual and gender-based violence
  - People living with disabilities are more likely to experience high poverty rates<sup>2</sup>
6. Return participants to the same breakout groups and provide a way for participants to continue to see these statistics while in the breakout rooms by typing them in the chat box or having facilitators in each group share a pre-prepared screen view of them. Give participants 8 minutes to discuss the following question:
 

*While women living with disabilities make SRH decisions for all of the same reasons as women living without disabilities, what do these statistics suggest about the possible differences between women living*

1 Global Citizen blog, 2018: 5 Facts About Living with a Disability in the Developing World (<https://www.globalcitizen.org/en/content/disability-in-the-developing-world/>)

2 World Bank, 2020: Disability Inclusion (<https://www.worldbank.org/en/topic/disability>)

*with disabilities and women living without disabilities when it comes to making SRH decisions?*

7. Return to full plenary and ask a few volunteers to share an insight from their group discussion. Elicit or share the following key message:

*While women living with disabilities make SRH decisions for the same reasons as people living without disabilities, at a population level, women living with disabilities are more likely to have to navigate unjust and harmful barriers to their sexual and reproductive health and rights. They bear an undue share of the sub-optimal circumstances that force many women to make decisions about their pregnancies that they don't want to make.*

8. For the final part of this activity, invite participants to now all look at the list of reasons identified for why women living with disabilities make decisions about their pregnancy that they don't want to make. Do this by zooming in on this list while screen sharing. Ask participants to reflect in silence for 3–4 minutes on the following questions before going back into breakout groups:
  - What is one reason that makes you very uncomfortable and why?
  - What biases or stigmatizing messages might you have inherited about women living with disabilities that perpetuates disabling conditions for their sexual and reproductive health decisions?
  - What is one core personal value that could help shift your mindset and behaviors toward a rights-based approach to disability inclusion, rather than a charity-approach?

Tell participants that although it may be tempting to multitask or step away (silence together virtually can be awkward) everyone should try it and commit to the activity.

9. Move participants into new breakout rooms in pairs or if needed in groups of 3, give participants up to 10–12 min to discuss their answers to these questions.

10. Invite participants to shift into a full group discussion. With the remaining time, facilitate a large group discussion using some of the following questions:
  - What stood out from your discussion?
  - What are some of the core values we can draw on collectively to help us shift more decidedly into a rights-based approach to disability inclusion.
  - What new insights have you gained from this discussion?
11. Close with the Key Messages and as much as possible succinctly link key messages to comments that came up during the exercise.

## TRAINER TOOL:

## Reasons Why questions

**Group 1:**

What are all the reasons why people living with disabilities have sex?

**Group 2:**

What are all the reasons why people living with disabilities get pregnant?

**Group 3:**

What are all of the reasons why people living with a disability have an abortion?

**Group 4:**

What are all of the reasons why women living with a disability make choices about their pregnancy that they don't want to make?

## TRAINER TOOL:

## Reasons Why answer sheet

Review the following responses and add your own.

**Reasons why women living with a disability have sex:** pleasure, to feel closer to someone, to maintain a relationship, curiosity, to get pregnant, obligation, to get something in exchange, because they don't have a choice, to avoid violence, rape, incest...

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**Reasons why women living with a disability get pregnant:** desire for children, lack of knowledge about relationships and sex, lack of access to contraception, lack of knowledge about contraception, lack of knowledge or inaccurate information about sex and pregnancy, denial of contraceptive services, fear of discrimination in seeking contraception, unplanned sexual activity, contraceptive failure, rape, violence, pressure from family members, ambivalence about whether or not they want to get pregnant, to maintain a relationship or gain greater commitment from a partner...

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**Reasons why women living with a disability terminate a pregnancy:**

don't want to be pregnant, already have all of the children they want, change in a relationship status, cost/economic burden of raising a child, lack of social support to raise a child, rape, incest, family pressure, limit family size, poverty, mental health issues, fetal anomalies they don't feel prepared to support, their own health, pregnancy the result of sex work, because it violates their gender identity, sex selection, coercion from family/partner/social groups, coercion from health providers, afraid of the stigma of having a child outside of marriage, pregnancy is the result of an affair...

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**Reasons why women living with a disability make decisions about pregnancy they don't want to make:** This could mean that they carry a pregnancy to term that they didn't want or that they terminate a pregnancy that they wanted to keep: coercion or pressure from family/partner/social groups, concerns about cost of pregnancy or concerns about cost of additional children, health concerns, violence, denied access to abortion or health information or services, timing, restrictive laws...

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## ACTIVITY:

# Guessing Game



### Purpose:

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This activity highlights the inaccuracy and limitations of guesses—and the importance of recognizing the need to ask questions. This activity can be used as an introduction to *Why Did She Die*, or it can be used as an icebreaker with a new group.



### Duration: 30 minutes

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### Key messages:

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- Guessing is something we do consciously: we know that we're guessing and we might guess wrong. Making an assumption is guessing without knowing you're guessing—or thinking that you already know something that you *don't* actually know.
- Making assumptions is part of being human, but this can also be dangerous. When we make assumptions, we may overlook important information or forget to ask questions. Knowing that we will make assumptions, we must adopt a strategy of “challenging our assumptions” or simply “asking questions” so that a person can share as much information with us as they need to.



## In-person activity instructions



### Materials and preparation:

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- Write 4–5 prompts (see examples below) on a flipchart or PowerPoint slide.
- Have more flipchart and pens to write takeaway messages at the end.

## Facilitation instructions:

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### 1. Introduce the task (5mins):

Participants will break into pairs with someone you don't know well if possible. You are not going to speak for 2 full minutes. During those 2 minutes, you are going to guess the following things about your partner (you can write them down):

- a. favorite color
- b. favorite musical artist/band
- c. what time they go to bed
- d. their favorite subject at school
- e. what they'll have for dinner at the weekend

After 2 minutes, you and your partner will have 2 more minutes to reveal to each other what you guessed.

### 2. Divide your group and make sure no one is talking for the first 2 minutes

Give a signal after 2 minutes and ask the pairs to share their guesses with each other.

### 3. Regroup and ask for volunteers to share (10 mins).

### 4. How was it? Were you right about some things? Did you get anything very wrong?!

### 5. For those who guessed right, how did you do it?

### 6. Would you feel comfortable with people guessing about more important things: about your relationship? About your sex life? About your future? About your health or medication? (Hopefully not!)

### 7. Share the following: Guessing is something we do consciously: we know that we're guessing and we might guess wrongly. Making an assumption is guessing without knowing you're guessing—or thinking that you already know something that you don't actually know.

8. Introduce the following (5–10 mins):

Assumptions may start from something we think we know about someone (their age / appearance / job / impairment) and then we draw a conclusion. This can often be wrong and can be to the disadvantage of the other person. Even if sometimes we guess correctly, the potential harm of making assumptions, when it comes to disability, should be avoided.

Here are some examples:

- “Because I’m a girl, people assume that I can’t play soccer, but I’m really good at it.”
- “Because I work at the market, people assume that I am not educated, but I finished school and am saving money to train as a nurse.”
- “Because I have a disability, people assume that I’m not sexually active, but I have a sexual relationship with my boyfriend.”
- “Because I’m young, people assume that I’m in full health, but I take medication for a heart condition.”

9. Ask the group to reflect on these, and to share their thoughts on guessing or making assumptions as a healthcare professional. (If you have time, you can ask people to share personal experiences of assumptions made.) Use the key message below if needed to guide the conversation to a conclusion.

Making assumptions is part of being human, but this can also be dangerous, because when we make assumptions, we may overlook important information or forget to ask questions.

Knowing that we will make assumptions, we must adopt a strategy of “challenging our assumptions” or simply “asking questions” so that a person can share as much information with us as they need to.

This can be explored more in the activity *Why Did She Die*.



## Virtual activity instructions



### Materials and preparation:

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- You will need to use breakout rooms for this session—pair people up with people they know less well, if possible. (not essential)
- You can use the chat function to give a list of prompts.
- Write the “assumptions” messages in a slide to share with your group.



### Facilitation instructions:

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1. Introduce the task (5mins):

Participants will break into pairs with someone you don't know well if possible. You are not going to speak for 2 full minutes. During those 2 minutes, you are going to guess the following things about your partner (you can write them down):

- a. favorite color
  - b. favorite musical artist/band
  - c. what time they go to bed
  - d. their favorite subject at school
  - e. what they'll have for dinner at the weekend
2. Divide the group into breakout groups and remind everyone not to speak for the first 2 minutes
  3. After 2 minutes, give a signal that participants have 2 minutes to share.
  4. Regroup and ask for volunteers to share (10 mins).
  5. How was it? Were you right about some things? Did you get anything very wrong?!
  6. For those who guessed right, how did you do it?
  7. Would you feel comfortable with people guessing about more

important things: about your relationship? About your sex life? About your future? About your health or medication? (Hopefully not!)

8. Share the following: Guessing is something we do consciously: we know that we're guessing and we might guess wrongly. Making an assumption is guessing without knowing you're guessing—or thinking that you already know something that you don't actually know.
9. Introduce the following (5–10 mins):

Assumptions may start from something we think we know about someone (their age / appearance / job / impairment) and then we draw a conclusion. This can often be wrong and can be to the disadvantage of the other person. Even if sometimes we guess correctly, the potential harm of making assumptions, when it comes to disability, should be avoided.

Here are some examples:

- “Because I’m a girl, people assume that I can’t play soccer, but I’m really good at it.”
  - “Because I work at the market, people assume that I am not educated, but I finished school and am saving money to train as a nurse.”
  - “Because I have a disability, people assume that I’m not sexually active, but I have a sexual relationship with my boyfriend.”
  - “Because I’m young, people assume that I’m in full health, but I take medication for a heart condition.”
10. Ask the group to reflect on these, and to share their thoughts on guessing or making assumptions as a healthcare professional. (If you have time, you can ask people to share personal experiences of assumptions made.) Use the key message below if needed to guide the conversation to a conclusion.

Making assumptions is part of being human, but this can also be dangerous, because when we make assumptions, we may overlook important information or forget to ask questions.

Knowing that we will make assumptions, we must adopt a strategy of “challenging our assumptions” or simply “asking questions” so that a person can share as much information with us as they need to.

This can be explored more in the activity *Why Did She Die*.

## ACTIVITY:

# Why Did She Die?



### Purpose:

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This activity features the journey of a woman living with a disability to terminate a pregnancy. The activity helps participants to examine the complex context around this woman's unwanted pregnancy and abortion more closely, particularly the specific barriers she faces in seeking help and care. Participants are confronted with the consequences that can result when access to abortion is restricted or when assumptions are made, and they are asked to articulate their personal or professional responsibility to prevent deaths such as this one. Facilitators should be prepared for and warn participants that this activity contains a short description of violence that could be triggering for some participants.



### Duration: 45–60 mins

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(following the *Guessing Game*)



### Key messages:

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- The sexuality and SRH needs of people living with disabilities are often overlooked, but access to SRH information and services is essential and must not be withheld.
- Like people without disabilities, the majority of people with disabilities will be having consensual sex. However, people living with disabilities may be more likely to be survivors of SGBV than people living without disabilities. This should not be assumed, but it is important to consider this higher risk.
- Making assumptions about people with disabilities can be harmful, and it can mean missing out on essential information or services. Ask questions, listen, and look beyond a person's impairment to see their full story.

- Whose decision? People living with disabilities have the right to be in charge of their lives, to be supported to exercise this right and to be consulted in their health care. “Nothing about us, without us.”

## In-person activity instructions

### Materials and preparation:

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Materials required:

- Printed copies or PowerPoint with the Why Did She Die story
- Flipchart to write “Nothing about us, without us” and “Nothing about me, without me” for conclusion of activity.

Review the background documents to familiarize yourself with statistics related to disability and gender-based violence:

- UNFPA Report, 2018: *Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights*<sup>1</sup>
- *World Bank Blog, 2019: Five facts to know about violence against women and girls with disabilities*<sup>2</sup>

Familiarize yourself with the Rita story. Think about how you will make the link between this story and the question of assumptions from the Guessing Game. Assumptions means “guessing without knowing that you’re guessing” —or “thinking you know something that you don’t know.”

This activity focuses on two main assumptions in the story:

1. The overprotective parents who have assumed Rita does not need to know about sex and contraception (assumption that Rita will not be sexually active)

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1 <https://www.unfpa.org/publications/young-persons-disabilities>

2 <https://blogs.worldbank.org/sustainablecities/five-facts-know-about-violence-against-women-and-girls-disabilities>

2. The provider who assumes Rita's pregnancy concern is about her impairment and does not listen to her (assumption of low self-esteem).



## Facilitation instructions:

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1. Introduce the activity, as some people will be familiar with *Why Did She Die*, but this will be a little different. Ask people to keep in mind the *Guessing Game*, as this activity will focus on the danger of making assumptions. Look out for people who make an assumption about Rita, which has a negative impact on her story. (Note: Assumptions can be made with good intentions.)
2. Distribute copies of the Rita story—or show them on PowerPoint. Ask for volunteers to read one paragraph at a time. If this is a virtual activity, share your screen and ask for a volunteer with a good internet connection to read aloud.
3. Take a moment to digest the story. Ask for five or six people to give one reason only to the question “why did Rita die?” Thank the group for their contributions.
4. Ask what assumptions made about Rita people found that had a harmful impact? (Check that both main points have been made, write them at the top of a flipchart page. If the group also notes others, write these below.) If this is a virtual activity, divide participants into smaller groups for 20 minutes to offer reasons for “why did Rita die?” (10 mins) and to identify points in the story where assumptions were made about Rita that had a negative impact (10 mins). Make sure the groups understand the two tasks before you break out—repeat the instruction if needed. Return participants to the main group to review what they discussed.
5. Display the quote “Nothing about us, without us” or “Nothing about me, without me.” Ask the group to reflect on this and share their thoughts about what it means in terms of disability inclusion and in relation to this story.
6. Ask the group to focus on the parents and the provider, and the impact of their assumptions and actions.

- a. What did Rita's parents assume, and what decision did they make?
  - b. What did the provider assume, and how did this affect the way he responded to Rita?
  - c. How could this principle of "Nothing about us, without us" or "Nothing about me, without me" have made them think differently?
  - d. How can we adopt this principle to guide our work?
7. Discuss with the group: Rita was raped by Tebogo. And compared with people without disabilities, a far higher proportion of people with disabilities are survivors of sexual and gender-based violence. Should the provider in the story have assumed that this was the case?

*Note:* No, the provider should not assume this—*remember the Guessing Game*. However, the provider should keep in mind that there is a statistically higher chance. As such, they should listen closely to everything that the client is saying.

It can make a big difference to kindly ask, "is there anything else you need from me?" or "is there anything else you need to tell me?" The intention here is not to coerce a client to reveal more than they are comfortable with, but to make them feel safe and to feel heard.

## Relevant facts

- Women with disabilities face up to three times greater risk of rape than their non-disabled peers.
- The WHO does not recommend universal screening for violence against women attending any form of health care.
- The WHO does encourage health-care providers to raise the topic with women who have injuries or conditions that they suspect may be related to violence.

## Virtual activity instructions

### Materials and preparation:

#### Materials required:

- Share your screen with the Why Did She Die story
- Slide with “Nothing about us, without us” and “Nothing about me, without me”

Review the background documents to familiarize yourself with statistics related to disability and gender-based violence.

- UNFPA Report, 2018: Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights<sup>1</sup>
- World Bank Blog, 2019: Five facts to know about violence against women and girls with disabilities<sup>2</sup>

Familiarize yourself with the Rita story. Think about how you will make the link between this story and the question of assumptions from the Guessing Game. Assumptions means “guessing without knowing that you’re guessing” —or “thinking you know something that you don’t know.”

This activity focuses on two main assumptions in the story:

1. The overprotective parents who have assumed Rita does not need to know about sex and contraception (assumption that Rita will not be sexually active)
2. The provider who assumes Rita’s pregnancy concern is about her impairment, and does not listen to her (assumption of low self-esteem)

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<sup>1</sup> <https://www.unfpa.org/publications/young-persons-disabilities>

<sup>2</sup> <https://blogs.worldbank.org/sustainablecities/five-facts-know-about-violence-against-women-and-girls-disabilities>

## Facilitation instructions:

1. Introduce the activity, as some people will be familiar with *Why Did She Die*, but this will be a little different. Ask people to keep in mind the *Guessing Game*, as this activity will focus on the danger of making assumptions. Look out for people who make an assumption about Rita, which has a negative impact on her story. (Note: Assumptions can be made with good intentions.)
2. Distribute copies of the Rita story—or show them on PowerPoint. Ask for volunteers to read one paragraph at a time. If this is a virtual activity, share your screen and ask for a volunteer with a good internet connection to read aloud.
3. Take a moment to digest the story. Ask for five or six people to give one reason only to the question “why did Rita die?” Thank the group for their contributions.

Ask what assumptions made about Rita people found that had a harmful impact? (Check that both main points have been made, write them at the top of a flipchart page. If the group also notes others, write these below.) If this is a virtual activity, divide participants into smaller groups for 20 minutes to offer reasons for “why did Rita die?” (10 mins) and to identify points in the story where assumptions were made about Rita that had a negative impact (10 mins). Make sure the groups understand the two tasks before you break out—repeat the instruction if needed. Return participants to the main group to review what they discussed.

4. Display the quote “Nothing about us, without us” or “Nothing about me, without me.” Ask the group to reflect on this and share their thoughts about what it means in terms of disability inclusion and in relation to this story.
5. Ask the group to focus on the parents and the provider, and the impact of their assumptions and actions.
  - a. What did Rita’s parents assume, and what decision did they make?
  - b. What did the provider assume, and how did this affect the way he responded to Rita?

- c. How could this principle of “Nothing about us, without us” or “Nothing about me, without me” have made them think differently?
  - d. How can we adopt this principle to guide our work?
6. Discuss with the group: Rita was raped by Tebogo. And compared with people without disabilities, a far higher proportion of people with disabilities are survivors of sexual and gender-based violence. Should the provider in the story have assumed that this was the case?

Note: No, the provider should not assume this—*remember the Guessing Game*. However, the provider should keep in mind that there is a statistically higher chance. As such, they should listen closely to everything that the client is saying.

It can make a big difference to kindly ask, “is there anything else you need from me?” or “is there anything else you need to tell me?” The intention here is not to coerce a client to reveal more than they are comfortable with, but to make them feel safe and to feel heard.

7. Summarize the key messages, linking to contributions from your participants to close.
- a. The sexuality and SRH needs of people with disabilities are often overlooked, but access to SRH information and services is essential and must not be withheld.
  - b. Like people without disabilities, the majority of people with disabilities will be having consensual sex. However, people with disabilities may be more likely to be survivors of SGBV than people without disabilities. This should not be assumed, but it is important to consider this higher risk.
  - c. Making assumptions about people with disabilities can be harmful, and it can mean missing out on essential information or services. Ask questions, listen, and look beyond a person’s impairment to see their full story.
  - d. Whose decision? People with disabilities have the right to be in charge of their lives, to be supported to exercise this right and to be consulted in their health care. “Nothing about us,

## TRAINER TOOL:

## Rita's story

My name is Rita. I grew up in a village in Northwest province. When I was six, I was sick with polio but survived. My right leg is very weak, so I need to use a cane. My parents sheltered me quite a lot and were a bit over-protective, but I can do everything my sisters and brothers can do. At school I was always intelligent and hardworking and often came first in my class.

I was delighted when I won a scholarship to go to University. Even though my parents were worried about how I would cope, I reassured them I would be fine, and I settled in really well.

I loved university and my new life. After some time, I fell in love with my classmate, Tebogo. At first, he was sweet with me, but after some time he became distant and unkind. One day a friend told me that Tebogo had another girlfriend. I was shocked and upset.

I confronted him, but instead of looking ashamed or apologetic, he became very angry. He called me a "cripple" and said I was lucky to get any man to pay attention to me at all. He threw my cane to the other side of the room, so I could not get away, and then he forced himself on me. I told him to stop but he wouldn't. Afterwards, I was devastated at what had happened. I found my cane and left as quickly as I could.

As the end of the academic year approached, I tried to focus on my future, studying as hard as I could and applying for jobs and internships. But since the day Tebogo attacked me, I had not been myself at all. I often felt tired and nauseous, but I tried to put it out of my mind.

When it was exam time, I felt worse, so I went to see a nurse at the student clinic. They did some routine tests and I was shocked to learn that I was pregnant. I couldn't believe it.

I didn't know anything about sex and pregnancy, and my period would surprise me every time it came. No one at home or school had ever talked to me about sex; it was all about school and future and getting a job. What else had I missed?

Quietly, I asked the nurse if it was possible to end the pregnancy. He didn't ask me anything about the circumstances, and I felt ashamed to say I had been raped. Instead, he patted me on the shoulder and said that having a limp shouldn't be a barrier to being a mother. He said I should be pleased, and he told me to come back for antenatal visits.

Thoughts were racing through my head. The idea of abandoning everything to have a child on my own—or worse, having to go back to Tebogo—was terrible. And how could I expect to get a job if I am pregnant? Getting a job as a woman with a disability is already very hard.

The district hospital was far away, and I couldn't get there without help or a lot of money for transport. I went to another clinic to ask about terminating the pregnancy, but they also turned me away saying I was “too far gone.” I was terrified for my future.

I was desperate. Back at home, I made a concoction of household chemicals and I drank it with a packet of painkillers. I felt terribly sick but was sure that this must work to end the pregnancy. I gradually fell asleep.

Later that night, my roommate found me unconscious in my room. She called for an ambulance but by the time I arrived at the hospital, it was too late.

*Why did Rita die?*

## ACTIVITY:

# Exploring the Intersections Between Gender and Disability



## Purpose:

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This activity helps participants to explore how gender norms and roles intersect with stigmatizing beliefs about women living with disabilities and result in harmful barriers to the sexual and reproductive health and rights of people living with disabilities.



## Duration: 90 minutes

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## Definitions:

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- **Sex** refers to the biological and physiological characteristics of a person. It refers to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female, male or intersex.
- **Gender** refers to the ways that we are socialized to behave and dress as men and women. These roles are taught, reinforced, and internalized. We sometimes assume that the different ways in which men and women (or girls and boys) behave are “natural,” however these behaviors are rooted in how we are raised. We develop ideas and expectations about gender from many sources, including family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, and the media.
- **Gender norms** shape the rules, behaviors and social status that are considered acceptable, appropriate or desirable for people based on their biological sex. These are rules and expectations about what

it means to 'be a man' or 'be a woman' in the world. Gender norms reveal and reinforce clear differences between the roles and status of men and women in society. These differences often result in men having more social, economic and decision-making power than women. However, many of these differences are constructed by society and are not because of our biological make-up.

### Key messages:

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- Gender norms reinforce gender inequalities, and this has a negative impact on women's SRH. Examples of this include judgment and stigma, lack of autonomy and decision-making power around sex, contraception and pregnancy, and sexual and gender based violence. For women with disabilities, the negative impact on SRH is often greater not the same. This is the compounding effect of the intersectionality of gender and disability.
- Female sexuality outside a formal marriage is often stigmatized by society. For women and girls with disabilities, sexuality itself is further stigmatized by misconceptions that women with disabilities are not sexually active; cannot consent to sex; are not desirable as partners; or are not able to be mothers. These myths exacerbate already unequal gender norms, leading to further inequality for women living with disabilities.
- SRH rights of women living with disabilities and women living without disabilities are the same—but the lived experience is often not the same.

## In-person activity instructions

### Materials and preparation:

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#### **Materials required:**

- Flipchart or slide showing some typical gender norms to illustrate sex and gender.
- Flipchart paper

It is advisable to facilitate this session with a representative from an OPD present to either assist facilitate or provide inputs to the conversation. Many OPDs have gender officers; discuss the content in advance, to agree who would be well placed to support this discussion.

### Activity instructions:

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1. In plenary, ask someone in the group to give a definition of sex vs gender, and come to agreement on a definition that identifies gender as a social construct, and sex as a biological trait at birth. Write this down.
  2. Ask for a volunteer to give a definition of gender norms. This should identify norms as roles or behaviors that society 'expects' people to follow, in line with their biological sex.  
  
 \*\*If needed, you can refer to the definitions provided in Key Messages above.
  3. Display your prepared list of gender norms and ask the group to confirm if they agree that these are representative of gender norms in their society. Discuss and make additions or edits as needed. You might show the group [Figure 7](#) to see if contains any additional gender norms they want to add to the list.
  4. Explain that the group will now focus on society's female gender norms and will check to see if the same norms apply to women with disabilities. Focus on maternal traits, marriage, attractiveness. The group should agree that many do not apply in the same way.
-  **Note:** this is, by nature, an uncomfortable conversation. Remind participants that they are answering from the point of view of society's expectations—this is not about their personal views or about individuals. Bring your OPD facilitator into the discussion regularly and invite them to steer the group and provide their perspective to help you make this point.
5. Ask the group what effect it may have on women living with disabilities, not to be seen as sexual beings, or as potential wives or mothers. How does this affect our attitude to their SRH rights? The

group should agree that this can mean they and their needs may be overlooked.

6. In plenary or small groups, participants will now discuss two questions. If breaking out, explain these clearly in advance and share on flipchart or in the chat.
  - a. Looking at the original list of gender norms, what are the potential negative SRH consequences of these expectations of women? (note: Do not focus on disability for this part)
  - b. Now consider: are these negatives impacts worse, better or the same for women living with disabilities? In what way?
7. Feedback to the plenary to discuss observations
8. Share the image in [Figure 6](#) and ask the group to reflect on it in relation to the task.
9. Summarize the discussion, keeping in mind the key messages, linking them to what participants have shared during the session.
  - Gender norms reinforce gender inequalities, and this has a negative impact on women's SRH; examples of this include: judgment and stigma, lack of autonomy and decision-making power around sex, contraception and pregnancy, and SGBV. For women with disabilities, the negative impact on SRH is often greater, not the same. This is the compounding effect of the intersectionality of gender and disability.
  - Female sexuality outside a formal marriage is often stigmatized by society. For women and girls living with disabilities, sexuality itself is further stigmatized by misconceptions that women living with disabilities are not sexually active; cannot consent to sex; are not desirable as partners; or are not able to be mothers. These myths exacerbate already unequal gender norms, leading to further inequality for women living with disabilities.
  - SRH rights of women living with disabilities and women living without disabilities are the same—but the lived experience is

often not the same.



## Virtual activity instructions

### Materials and preparation:

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#### Materials required:

- Slide showing some typical gender norms to illustrate sex and gender.
- Breakout rooms function

It is advisable to facilitate this session with a representative from an OPD present to either assist facilitate or provide inputs to the conversation. Many OPDs have gender officers; discuss the content in advance, to agree who would be well placed to support this discussion.


### Activity instructions:

---

1. In plenary, ask someone in the group to give a definition of sex vs gender, and come to agreement on a definition that identifies gender as a social construct, and sex as a biological trait at birth. Write this down.
2. Ask for a volunteer to give a definition of gender norms. This should identify norms as roles or behaviors that society 'expects' people to follow, in line with their biological sex.

**\*\*If needed, you can refer to the definitions provided in Key Messages above.**

3. Display your prepared list of gender norms and ask the group to confirm if they agree that these are representative of gender norms in their society. Discuss and make additions or edits as needed. You might show the group [Figure 7](#) to see if contains any additional gender norms they want to add to the list.
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-  Note: this is, by nature, an uncomfortable conversation. Remind participants that they are answering from the point of view of society's expectations—this is not about their personal views or about individuals. Bring your OPD facilitator into the discussion regularly and invite them to steer the group and provide their perspective to help you make this point.
5. Ask the group what effect it may have on women living with disabilities, not to be seen as sexual beings, or as potential wives or mothers. How does this affect our attitude to their SRH rights? The group should agree that this can mean they and their needs may be overlooked.
  6. In plenary or small groups (recommended to use breakout rooms if online), participants will now discuss two questions. If breaking out, explain these clearly in advance and share on flipchart or in the chat.
    - a. Looking at the original list of gender norms, what are the potential negative SRH consequences of these expectations of women? (note: Do not focus on disability for this part)
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- Female sexuality outside a formal marriage is often stigmatized by society. For women and girls living with disabilities, sexuality itself is further stigmatized by misconceptions that women living with disabilities are not sexually active; cannot consent to sex; are not desirable as partners; or are not able to be mothers. These myths exacerbate already unequal gender norms, leading to further inequality for women living with disabilities.
- SRH rights of women living with disabilities and women living without disabilities are the same—but the lived experience is often not the same.

**Figure 6:** Equality versus equity

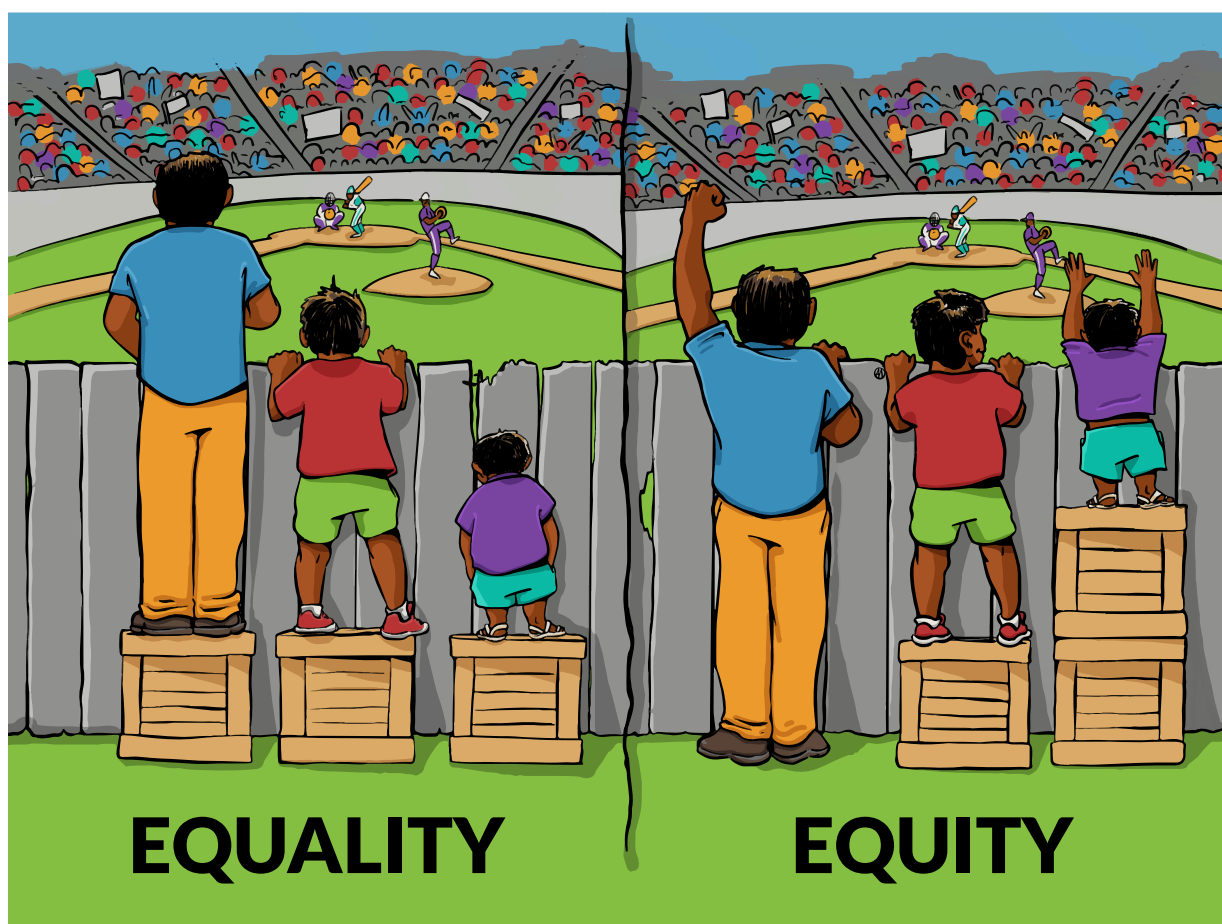
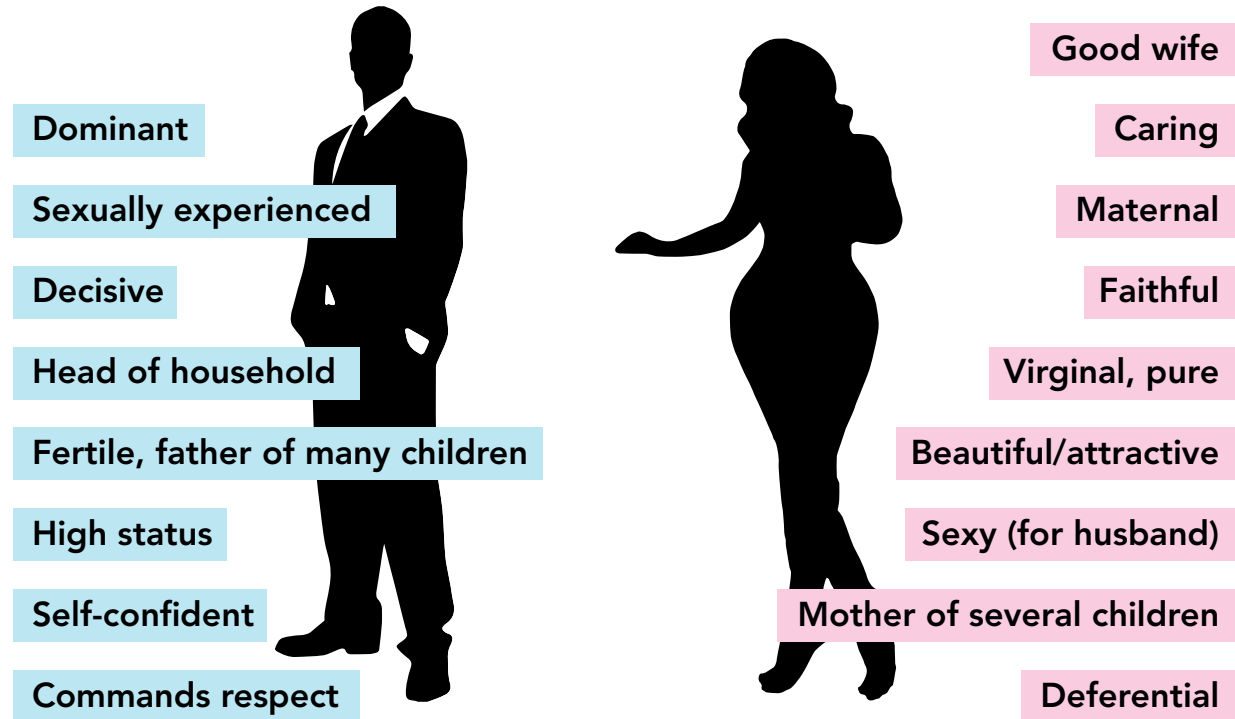


Image source: [Interaction Institute for Social Change](#) | Artist: [Angus Maguire](#).

**Figure 7:** Examples of traditional male and female gender norms



## ACTIVITY:

# The Last Abortion

This activity illustrates the difficulty and dangers of valuing one person's reasons for abortion over another's. It provides us with an opportunity to examine our assumptions and biases about disability and abortion. By role-playing the difficult task of selecting one woman to receive the "last abortion," participants gain insight into the ways that restrictive laws and social stigma about both abortion and disability create barriers and inequitable access to safe abortion options.

 **Duration: 60 minutes**

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 **Key messages:**

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- The decision to grant some women an abortion and not others carries lifelong consequences for women, their families and communities. This is no less true for women living with disabilities than for all women living without disabilities.
- Individual and social biases about women living with disabilities can lead health professionals, family members and friends to put pressure on women living with disabilities to make a decision about their pregnancy that they don't want to make.
- People living with disabilities have the same sexual and reproductive rights as people living without disabilities. This includes the right to access SRH services and the right to decide if you want to have children and how many. Almost all people living with disabilities, including people with intellectual disabilities, can be supported to make decisions about their sexual and reproductive health, including the decision to have an abortion. Our starting point should always be that they have the capacity to consent. Service provider organizations should have protocols in place to provide supported decision making.<sup>1</sup>

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1 Devi, Nandini & Stucki, Prof. Dr. med. Gerold. (2011). *Moving towards substituted or supported decision-making? Article 12 of the Convention on the Rights of Persons with Disabilities*. ALTER—European Journal of Disability Research. (<https://core.ac.uk/download/pdf/82319524.pdf>)

## In-person activity instructions

### Materials and preparation:

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#### **Materials needed:**

- *The Last Abortion* scenarios, printed
- Optional slides for instructions

#### **Preparation:**

- Review the scenarios and instructions beforehand. If you choose, you may pre-assign breakout groups.
- Review the [Nairobi Principles on Abortion, Pre-natal Testing and Disability](https://nairobiprinciples.creaworld.org/principles/)<sup>1</sup> for background context and framing on key points of intersection on abortion and disability

#### **Accessibility:**

If desired, facilitators may review this [additional resource](https://core.ac.uk/download/pdf/82319524.pdf)<sup>2</sup> on supported decision making for people living with disabilities.

### Activity instructions:

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1. Divide participants into groups of 4 to 6 people each.
2. Tell participants that for this exercise, they will be imagining that they're in a (fictional) country where there can be only *one more* safe, legal abortion performed. Explain that you will give them a hand-out that describes six people who have applied to be granted this last abortion. The small groups represent the policy makers who are reviewing the applications and have to decide who should receive the last abortion.

Note: You may want to acknowledge that this is a contrived scenario for the purposes of this activity.

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<sup>1</sup> <https://nairobiprinciples.creaworld.org/principles/>

<sup>2</sup> <https://core.ac.uk/download/pdf/82319524.pdf>

3. Give each participant (or group) a copy of the Participant Handout: *The Last Abortion Scenarios* that you have prepared. Ask them to spend 5 minutes in their groups reading the scenarios.
4. Instruct the groups to spend 20 minutes discussing the scenarios, and that each group should choose which applicant they will award the last abortion. Tell each group to identify a spokesperson to announce their decision and rationale.

Note: While groups are discussing, members of the facilitation team should be rotating between the groups to ensure that participants understand the assignment and are able to finish the task on time.

5. When 20 minutes are up, ask for the group spokespeople to join you at the front of the room. Explain that each group will have up to 2 minutes to present their decision and rationale. Ask other participants to hold off from commenting on individual presentations.
6. Group Discussion: Lead a group discussion using the following prompts:
  - How did it feel to participate in this activity?
  - What assumptions did your group make in order to get to your decision?
    - There is always more to a person's circumstances than we can know. Often we fill in the gaps in order to justify our opinions or judgments. Where legal restrictions draw hard lines on what kinds of abortions, what reasons, are seen as valid—they often grossly miss and put constraints on many of the nuances that people are confronted with as they navigate the decision to terminate a pregnancy. For example, rape and incest is often a legal indication for abortion but economic and financial situation is not. Similarly, to save a woman's life is a common legal indication but the interpretation is based exclusively on physical life or death and not about quality of life or to preserve mental health.
  - Who did you not select and why?

- For the groups who did not choose scenario 4: What did your group think about the application from the young woman with a learning disability who is accompanied by her aunt?
  - What questions were raised as you discussed this case?
  - What assumptions might we erroneously make about this scenario?
  - Offer this key message: Almost all people living with disabilities, including people with intellectual disabilities, can be supported to make decisions about their sexual and reproductive health. Our starting point should always be that they have the capacity to consent and not assume automatically that because the client has a disability, they will not be able to make an informed decision. As we become more competent in applying a disability inclusion and adaptation-oriented mindset we will become more aware of and skilled at finding ways to support autonomous decision making whenever possible.
- How does this activity relate to the way disability and abortion intersect in our contexts?
  - Elicit or highlight some of the following key points:
  - In many of our contexts there is a prevalent mindset that defaults to assumptions of “incapability” —that women living with a disability are not capable of being a parent. This can lead to pressures on and even coercion of women living with disabilities to terminate a pregnancy against their desires.
  - Default assumptions like this result in denying women living with disabilities the right to bodily autonomy and self-determination —the right to make their own SRH decisions. Women living with disabilities have the right to make their own decisions even if we would make a different decision in what we perceive to be their situation.
  - More broadly, well-meaning intentions to protect people

living with disabilities result in constraints that are based more on social biases than on actual capacities. A disability inclusion mindset demands that we promote *the rights* of people living with disabilities by enabling them to make their own decisions, rather than make decisions for them in the name of protection.

- In many contexts, social stigma and biased prenatal testing and counseling practices also create an undue pressure for disability-selective abortions. This is a complex issue that sometimes gets misused as a reason to restrict abortion access. Instead, disability and abortion activists have come together to assert the right to abortion on demand for any reason while simultaneously calling for more enabling environments and social support for children with disabilities.<sup>1</sup>

Thank goodness there is no one “last abortion,” but our biases and restrictive laws can make it seem like there is.



## Virtual activity instructions

### Materials and preparation:

- Review the Nairobi Principles on Abortion, Pre-natal Testing and Disability<sup>1</sup> for background context and framing on key points of intersection on abortion and disability
- Email *The Last Abortion* scenarios to participants the evening before this activity and ask them to read it in advance of the session.

Set up break-out rooms for small groups of 3–5 participants

### Accessibility:

If desired, facilitators may review this additional resource<sup>2</sup> on supported decision making for people living with disabilities.

1 Nairobi Principles on Abortion, Prenatal Testing and Disability, 2019 (<https://nairobiprinciples.creaworld.org/principles/>)

2 <https://core.ac.uk/download/pdf/82319524.pdf>



## Activity instructions:

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1. Introduce the activity by highlighting the following:
  - This activity will put us in the uncomfortable position of valuing one person's reasons for an abortion over another's and will allow us to explore the instinct to fill gaps in information with assumptions and biases.
  - Invite participants to imagine they are policymakers in a (fictional) country (give the country a name like Zoomland, for example.)
  - In this country, it has been decreed that there will only be *one more* safe and legally sanctioned abortion.
  - Explain that you will review the scenarios sent out the day before all together. These scenarios describe the seven women who have applied to be granted this last abortion.
  - As policy makers, your small group will review the applications and select one woman to receive the last abortion.
2. Full Group: Read scenarios together. Verify that each participant has the scenarios and invite them to open the virtual facilitation board in preparation for the small group work to come.
 

Once everyone is prepared for the session, use share screen to project the scenarios (either on PowerPoint Slides or on the Scenarios Document). Invite participants to take turns reading each of the seven scenarios out loud in the full group. You may call on people to read the stories or ask for volunteers.
3. Present instructions for breakout rooms: Let participants know that they will now go into breakout rooms and remind them that they are policymakers responsible for deciding which of the applicants will receive the last abortion.
  - You will have 15 minutes to discuss the scenarios in your small groups, decide who you will grant the last abortion to and appoint a spokesperson to briefly present your group's decision and rationale for your choice to the large group.

- Warn participants that in every workshop there is a group who tries to refuse to pick just one. If this is difficult for you or your group, just notice that. Treat this as an experiment and see what insights may lay on the other side of this activity which has proven to be very valuable to many people.
  - When we come back to the large group, your spokesperson will have up to two minutes to present your group's decision and rationale.
4. Breakout rooms: Send participants into breakout rooms for a 15-minute discussion. Make sure they have the scenarios available to them and, if they choose to and know how to, they can have one person in their group share their screen with the scenarios so that everyone can follow along (optional). Give participants warnings when they have 5 minutes left. After 15 minutes, bring participants back to the large group.
  5. Full Group: Sharing back each group's decision and rationale. Give each group 2 minutes to share their decision and rationale. Ask others not to comment yet on individual presentations.
  6. Full Group Discussion: Lead a group discussion using the following prompts:
    - How did it feel to participate in this activity?
    - What assumptions did your group make in order to get to your decision?
      - There is always more to a person's circumstances than we can know. Often we fill in the gaps in order to justify our opinions or judgments. Where legal restrictions draw hard lines on what kinds of abortions, what reasons, are seen as valid—they often grossly miss and put constraints on many of the nuances that people are confronted with as they navigate the decision to terminate a pregnancy. For example, rape and incest is often a legal indication for abortion but economic and financial situation is not. Similarly, to save a woman's life is a common legal indication but the

interpretation is based exclusively on physical life or death and not about quality of life or to preserve mental health.

- Who did you not select and why?
- For the groups who did not choose scenario 4: What did your group think about the application from the young woman with a learning disability who is accompanied by her aunt?
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- How does this activity relate to the way disability and abortion intersect in our contexts?
  - Elicit or highlight some of the following key points:
  - In many of our contexts there is a prevalent mindset that defaults to assumptions of “incapability” —that women living with a disability are not capable of being a parent. This can lead to pressures on and even coercion of women living with disabilities to terminate a pregnancy against their desires.
  - Default assumptions like this result in denying women living with disabilities the right to bodily autonomy and self-determination —the right to make their own SRH decisions.

Women living with disabilities have the right to make their own decisions even if we would make a different decision in what we perceive to be their situation.

- More broadly, well-meaning intentions to protect people living with disabilities result in constraints that are based more on social biases than on actual capacities. A disability inclusion mindset demands that we promote *the rights* of people living with disabilities by enabling them to make their own decisions, rather than make decisions for them in the name of protection.
- In many contexts, social stigma and biased prenatal testing and counseling practices also create an undue pressure for disability-selective abortions. This is a complex issue that sometimes gets misused as a reason to restrict abortion access. Instead, disability and abortion activists have come together to assert the right to abortion on demand for any reason while simultaneously calling for more enabling environments and social support for children with disabilities.<sup>1</sup>

Thank goodness there is no one “last abortion,” but our biases and restrictive laws can make it seem like there is.

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1 Nairobi Principles on Abortion, Prenatal Testing and Disability, 2019 (<https://nairobiprinciples.creaworld.org/principles/>)

## HANDOUT:

## Applicants for the last abortion

1. A 45-year-old woman is 18 weeks pregnant. She had stopped having regular menstrual cycles and did not believe she could become pregnant. Her 12-year-old son has cerebral palsy and she has joyfully devoted her life to his wellbeing. However, she does not feel financially nor emotionally able to parent another child.
2. A 25-year old woman is eight weeks pregnant. She has two children under the age of four, and she lives with a man who regularly physically abuses her. As the children get older, she worries that they will also be hurt. She does not want to bring another child into an abusive household, especially if it will only make her more dependent on him for financial support, so that she cannot leave.
3. A 32-year-old woman with two young children is 10 weeks pregnant. She and her youngest child are HIV positive. Her husband died of AIDS-related illnesses two years ago and she now supports the family on her small income alone. Her health is not good and she has been hospitalized several times in the past year.
4. A 20-year-old woman with a learning disability is brought to the clinic by her aunt, who says that her niece needs an abortion. The aunt says she thinks her niece is about 7 or 8 weeks pregnant. She says her niece already has one child and that the family can't afford to support another. The woman does not say anything.
5. A 30-year-old woman is married and is pregnant with her first child. A 20-week scan reveals signs of a fetal anomaly, which would have implications for the future health of the child. The woman has decided to have an abortion.
6. A 29-year-old woman was initially happy to learn that she was pregnant. However, she has a hereditary spinal condition that doctors told

her increases the risk of complications during pregnancy and that she may become partially paralysed. She and her partner have decided to terminate the pregnancy.

7. A 16-year-old girl is now 14 weeks pregnant. She was not aware of the signs of pregnancy and after feeling sick for months she only recently discovered that she was pregnant. She is experiencing acute anxiety at the thought of being forced to continue this pregnancy.

# ABORTION **VCAT**

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