INTRODUCTION

CONTENTS

ACKNOWLEDGMENTS

and Irina Asaftei (Philippines); Sisters Taking Charge – Caroline Mutoola and Penias Miti (Zambia); Society for Women and AIDS in Zambia – Gift Lukama (Zambia); Women for a Change – Violet Fokum and Zoneziwoh Mbondgulo-Wondieh (Cameroon); Women in Law and Development in Africa – Khuta Hara Hanyama (Zambia); Women's Global Network for Reproductive Rights – Marevic Parcon, (Philippines); Youth Advocacy Action Team – Lindsay Memory Mwansa and Eddick Njobvu (Zambia); Youth Vision Zambia – Vincent Nacidze (Zambia); and Young Women in Action – Vivien Bwembya (Zambia).

ABOUT IPAS

Ipas works globally to improve access to safe abortion and contraception so that every woman and girl can determine her own future. Across Africa, Asia and Latin America, we work with partners to make safe abortion and contraception widely available, to connect women with vital information so they can access safe services and to advocate for safe, legal abortion.

ABOUT THIS TOOLKIT

WHY WAS THIS TOOLKIT DEVELOPED?

Abortion stigma plays a critical role in the social, medical and legal marginalization of abortion care around the world and leads to negative health outcomes for women, girls, trans people and their communities. Stigma shames and silences people seeking abortions, providers of abortion care and anyone who demonstrates support for a person's right to decide whether to continue or terminate a pregnancy. As a result, abortion stigma drives the high number of preventable deaths and injuries around the world due to unsafe abortion.

Sexual and reproductive health organizations, women's rights organizations and other social justice advocates have been raising awareness about abortion stigma in communities, in advocacy and information campaigns and in programs designed to meet women's reproductive health needs. Many have expressed the desire for a collection of tools and activities to address abortion stigma in various settings and contexts. This toolkit was created to help meet that need.

WHO IS THIS TOOLKIT DESIGNED FOR?

This toolkit is **designed for use** with the staff or members of community-based organizations (CBOs) and/or non-governmental organizations (NGOs), community health workers and community members themselves with a range of education and literacy levels.

This toolkit was originally developed for Ipas staff and community partners working to reduce abortion stigma and increase access to safe abortion. However, thanks to tremendous support from inroads (The International Network for the Reduction of Abortion Discrimination and Stigma) members, who piloted and reviewed activities, we have edited the toolkit to be used by others who want to raise awareness about and plan action to address abortion stigma.

The activities are designed to be **led by trained facilitators** who may be CBO or NGO staff or members, community health workers and/or individual trainers or activists.

They are also designed to be **easily adapted to fit different settings and contexts.** For example, they can be carried out in multi-day workshops with typical workshop supplies or included in meetings over a longer stretch of time in settings requiring few or no extra resources. They can be used in community dialogues, in awareness-raising campaigns, in schools or in outdoor health talks. They can also be integrated into other training, educational or capacity-building programs such as comprehensive sexuality curricula in schools, training curricula in nursing or medical programs, community outreach programs or staff capacity-building initiatives of an organization implementing programming to advance abortion access.

While the intended audience for this toolkit is non-professional community members, community health workers, activists and the staff of CBOs, many activities **can be used or adapted for use with other specialized audiences.** These audiences include doctors, nurses and other health-care providers; journalists and media professionals; police, lawyers and policymakers; and faith-based leaders, local chiefs and other influential community members in terms of their professional or formal roles and influence on abortion access.

How was the content of this toolkit developed?

Some of the activities are based on stigma-reduction exercises that have been tested in other fields (for example, HIV stigma). Some have been used by Ipas for several years to help people reflect on and clarify the values that they hold around abortion. And some are new exercises that have been tested in several countries by community organizations.

Is this toolkit a stigma-reduction intervention?

Naming abortion stigma is a way to start reducing it. However, this toolkit does not take participants through the process of developing a stigma-reduction intervention. This toolkit was designed to increase understanding of abortion stigma and to support individuals and organizations in naming what abortion stigma looks like in their settings. It was also designed to build the capacity of individuals and organizations to address and help eliminate abortion stigma.

Building a collective understanding of abortion stigma and helping a group of people determine how to think or talk about abortion differently helps to interrupt abortion stigma. In this sense, this toolkit can provide the structure and content for an intervention focused on building a group or organization's understanding of and capacity to reduce abortion stigma.

The activities in this toolkit can also be used to build the capacity of individuals and/or organizations to create a broader abortion stigma-reduction strategy, campaign or programmatic intervention. While there is not specific guidance included on how to do

this, the toolkit's activities serve as a foundation for a common language, understanding and shared analysis of abortion stigma that is needed to design such strategies.

HOW DOES THIS TOOLKIT DIFFER FROM THE ABORTION VALUES CLARIFICATION AND ATTITUDE TRANSFORMATION TOOLKIT?

This toolkit is dedicated to increasing understanding of abortion stigma and to supporting individuals and organizations (CBOs, small NGOs, etc.) in naming what abortion stigma looks like in their settings. *Abortion attitude transformation: A values clarification toolkit for global audiences,* created by Ipas in 2008, was designed to help groups clarify their values and reach more supportive actions and attitudes toward abortion care.

While separate and distinct, the two toolkits—along with the *Abortion care for young women: A training toolkit*—complement one another, and together, will help groups begin to address abortion stigma. If you are looking for additional ideas, we encourage you to consult all three resources when designing your workshop. This toolkit uses activities adapted from *Abortion attitude transformation: A values clarification toolkit for global audiences,* which are marked as "VCAT." Please note that the activities have been adapted to focus on abortion stigma, so review them before facilitating to note how they might be different than the VCAT activities to which you are accustomed.

LANGUAGE IN THIS TOOLKIT

Throughout this toolkit, we use the terms "women, girls and trans people," "people who are pregnant," and at times, the gender-neutral "people," to refer to those who have had—or may someday have—an abortion. We seek to acknowledge the full range of gender identities held by people who have abortions. While abortion stigma affects everyone, we name women, girls, trans people and people who are pregnant—rather than exclusively using gender-neutral language—to recognize that abortion stigma is rooted in gender inequity and oppression. Because of this, women, girls, trans people and other people who are pregnant specifically experience the impact of abortion stigma. We recognize that the language to express a richer diversity of gender identity and expression is evolving, and we seek to contribute to more inclusive language in the abortion field. We welcome your feedback and suggestions on how we might do better in the future.

WHAT DOES LGBTIQ REFER TO AND WHY IS IT IN THIS TOOLKIT?

LGBTIQ stands for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning. It refers to identities based on sexual orientation that exist in addition to a heterosexual sexual orientation. There are many other identities and expressions of sexual orientation in addition to these. However, LGBTIQ—and other similar combinations—are often used as a common starting point for recognizing the diverse ways that we as humans orient in our sexual relationships and interactions.

Because people who identify as LGBTIQ can become pregnant and have abortions, and yet are frequently underserved in sexual and reproductive health and rights (SRHR) programming, this toolkit strives to include examples, activities and references that demonstrate how abortion stigma impacts LGBTIQ people. It also aims to explore how abortion stigma—and stigma based on sexual orientation and gender identity—compound one another and cause harm. Ipas believes that it is important to address the ways in which abortion stigma affects all members of our communities, including

LGBTIQ people, who often experience extreme marginalization, discrimination and violence.

Some facilitators and groups of participants will have greater familiarity with this terminology and segment of people than others. We acknowledge that in some settings it is difficult and even risky to discuss LGBTIQ rights explicitly. Where possible, we encourage you to include these examples, activities and references in your workshops and to get support so that you do not have to avoid what can feel like a difficult subject. For more information on including these topics in your workshops, please contact Ipas (www.ipas.org) or a local LGBTIQ organization in your community. You can also refer to the "Key resources" section of Module 5 for more resources.

HOW TO USE THIS TOOLKIT

The activities contained in *Abortion stigma ends here: A toolkit for understanding and action* are designed to support an increased understanding of abortion stigma and the ability to address it. Activities are clustered into thematic modules to emphasize different aspects and experiences of abortion stigma. The idea is not to work through all the exercises in order, or in a single workshop—it is not a "one size fits all" approach. Instead, facilitators are encouraged to develop their own workshop agenda by picking a diverse set of activities that suits the goals of the gathering, the participants' needs, the facilitators' skill level and the time available.

We have created a CORE agenda made up of selected exercises from each module for those who may want a pre-set agenda that covers a diverse range of activities from each of the modules. These activities are marked as "CORE" and they are connected to the pre-set CORE agenda (page 13 of the Facilitation Guide). In addition, there is a Training-of-Trainers Agenda (page 15 of the Facilitation Guide) that combines activities from the CORE agenda and structured time for training facilitators to conduct workshops on abortion stigma, using the activities in this toolkit.

How is the toolkit structured?

The toolkit has seven thematic modules which each contain four to six activities. The first module provides activities focused on understanding abortion in general. It is geared toward those who are unfamiliar with the topic or the practice of abortion, or for mixed groups of people, some of whom have likely been exposed to a range of myths and misconceptions about abortion. The second and third modules introduce the concept of abortion stigma and support participants in starting to recognize specific aspects of what abortion stigma looks and feels like and how it spreads. Participants also begin to address how abortion stigma can be reduced. The next three modules (four to six) emphasize additional aspects of abortion stigma, such as how it impacts our communities, how it intersects with other forms of stigma and how it manifests in health facilities, laws and policies. The final module is focused on taking action to reduce and help eliminate abortion stigma.

Overview of the modules

Module 1: Abortion basics

Module 2: What is abortion stigma? Learning to recognize abortion stigma around us

Module 3: Where does abortion stigma come from? Exploring our beliefs and their roots

Module 4: Standing in each other's shoes: How we are all affected by abortion stigma

Module 5: Intersectionality: When abortion stigma and other stigmas join forces

Module 6: Abortion stigma in health care and the law

Module 7: Actions to end abortion stigma

Each module begins with a table that provides an overview of the activities. This table explains each activity's purpose, summarizes it and assigns it a level of complexity. The levels will help facilitators select activities that align with their own experience level and the background and needs of the participants.

- **Introductory activities:** These can be used with a broad range of participants, from those with little to no familiarity with abortion and/or stigma to those with a lot of familiarity, or with mixed groups of participants with a range of familiarity. These activities are simple in content and/or format and require minimal background knowledge. They are also designed to be relatively easy for a broad range of facilitators, from those who are somewhat new to facilitation to more advanced facilitators.

- **Intermediate activities:** These can be used with most groups, but require additional critical thinking and/or problem-solving skills and background knowledge. These activities require experienced facilitators, or newer facilitators who are willing to put in extra preparation time and have a mentor or coach to help prepare or co-facilitate.

- **Advanced activities:** These are intended for use with groups that have an existing familiarity with abortion and/or abortion stigma, or for use toward the end of a workshop focused on abortion stigma reduction. These activities require facilitators with a high level of comfort and familiarity with advanced facilitation techniques, as well as content knowledge about abortion. They can sometimes require considerable preparation and adaptation.

HOW IS EACH ACTIVITY STRUCTURED?

Each activity is laid out in the same format so that it is easy to follow and facilitate.

Facilitator notes: Brief background information on the topic, notes about the overall aim of the activity and advice on how to facilitate it.

Time: Estimated amount of time needed for the activity. This is a rough guide. It will vary according to the size and energy of the group as well as each group's comfort level with participatory methodologies (a facilitation style designed to promote participants' interaction with the content).

Goals: The aim of the activity—what participants will know or be able to do by the end of the activity.

Materials and preparation: Basic materials like flipcharts, markers and masking tape are not always listed, as these should be readily available. Preparation includes things to consider before you start the activity. This includes arrangement of the room or chairs and materials needed for the activity.

Facilitation steps: Step-by-step guide on how to run the activity.

- Step 1 instructs you on how to introduce the activity so that participants will know what they are being invited to do.

- Each step includes an estimated time (in parentheses).

- Questions or instructions for you to say out loud are written in italics. You can read them out or adapt them for your audience as needed.

- Information *not* written in italics is information or direction for you as the facilitator. Do not read this out loud.

Processing: Most activities have a processing step toward the end. This step helps participants reflect on what they have learned and how it may change the way they see or do things. This is an important step in a stigma-reduction activity, as it leads to the beginning of action and change.

Summarize: Try to provide closure at the end of each activity. Use points the participants have raised and add some of your own. Each activity has a few key messages to include in your summary.

INTRODUCTION TO ABORTION STIGMA

Before jumping into the activities, some facilitators may want to understand the more conceptual side of abortion stigma. You do not need to be an abortion stigma expert to work through this toolkit, but this section will introduce you to some of the current thinking that defines what abortion stigma is, how it occurs at various levels of society and what consequences arise because of its existence.

WHAT IS ABORTION STIGMA?

Definitions

There are a few working definitions of abortion stigma that can be used to summarize the focus of the activities in this toolkit. Below are three options from various sources that facilitators can draw from to inform their work, as needed.

Abortion stigma is:

1. The negative and shaming treatment of any person or group of people associated with abortion (Ipas);

2. A negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideal of 'womanhood' (Kumar, Hessini, & Mitchell, 2009);

3. A shared understanding that abortion is wrong and/or morally unacceptable within a community or society (Cockrill, Herold, Blanchard, Grossman, Upadhyay, & Baum, 2013).

Types of stigma

(Kumar, Hessini, & Mitchell, 2009; Link & Phelan, 2001; Shellenberg, Moore, Bankole, Juarez, Omideyi, Palomino et al., 2011)

Anticipated (or perceived) stigma

Anticipated (or perceived) stigma: The fear of how others will react to a certain condition or situation. The fear of being stigmatized. For example, a young woman may anticipate that her family members would condemn her if they found out she was contemplating an abortion, without knowing for sure if they would.

Experienced stigma: The actual experience of being discriminated against or treated negatively by others. This includes rejection by a spouse, family member, friends and peers; physical, verbal or emotional abuse; being de-valued as a wife or mother; and being mistreated in the home, community or health-care setting. For example, after a woman receives an abortion, her husband is upset with her and demands a divorce.

Experienced stigma

"Internalized" or "self-stigma": When a person unconsciously or emotionally absorbs stigmatizing messages or negative stereotypes and comes to believe that they apply to her or himself. Self-stigma can result in low self-esteem, social isolation, depression and withdrawal. Self-stigma only occurs because of, or in a context of, wider social stigma. For example, a woman might feel shame about her abortion because she hears her family and friends say negative things about other people who have had abortions. She believes that these negative things are also true about herself, and she becomes depressed.

Discrimination: This is *enacted* stigma. Discrimination occurs when a distinction is made about a person that results in her or him being treated unfairly or unjustly on the basis of belonging to, or being perceived to belong to, a particular group. Stigma destroys a person's dignity. It marginalizes affected individuals, diminishes their chances of reaching their full potential and seriously hampers their pursuit of happiness.

"Internalized" or "self-stigma"

Intersecting stigma: Stigma exists in a context of existing prejudices and inequalities. Groups who are already marginalized in society because of other factors like social class, race, gender, sexual orientation, gender identity and occupation (for example, sex work) are likely to face greater stigma and greater consequences of stigma. Stigma is intricately linked to social inequality because it can limit the ability of stigmatized individuals to access important services and institutions.

How does abortion stigma happen?
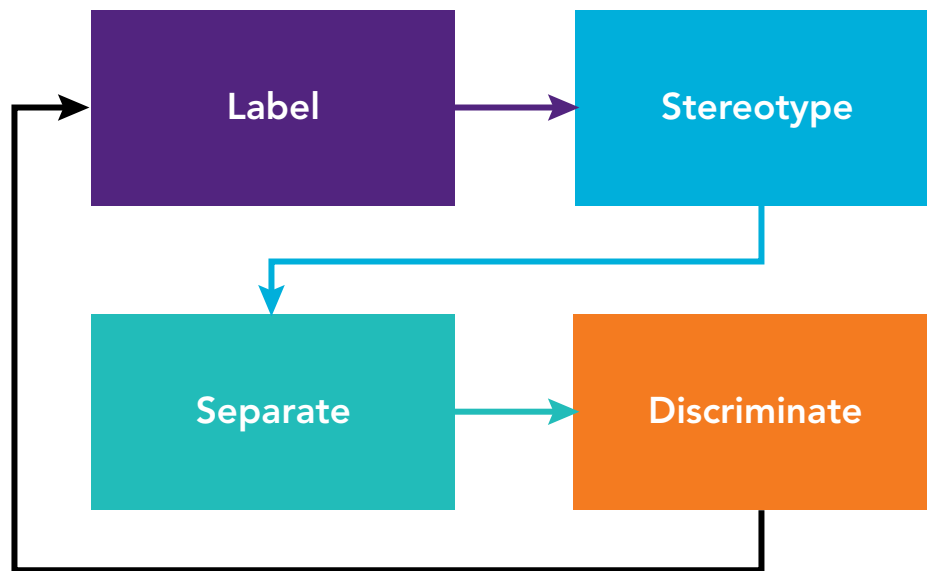
The cycle of stigmatizing abortion happens in the following ways (Link & Phelan, 2001; Shellenberg et al., 2011):

Labeling abortion: Abortion is portrayed in a community as an *abnormal* event and people who have abortions are viewed as *deviant, different* or *themselves abnormal.* Behind this concept is the oversimplification of pregnancy termination, which ignores the reality that abortion is common.

Stereotyping: People who have abortions are judged as promiscuous, careless, selfish and/or lacking compassion for human life. Abortion providers are often stereotyped as cold, unfeeling individuals who dislike children and only provide abortions for the money.

Separation: Separation occurs when "abnormal" people and providers are moved into a separate category of the population or community. This separation creates an "us" and "them" split. This separation is often created by sharing inaccurate information about abortion and people who have them. Examples of inaccurate information are that abortions are dangerous or that only "bad" people have abortions. This separation serves to shame people who have abortions, which leads to a fear of social exclusion and often forces people to remain silent about their abortion experience.

Discrimination and status loss: A person who has an abortion may experience rejection, exclusion or discrimination because of the abortion being revealed to the community (whether voluntarily or involuntarily).

Forms of discrimination vary, but common examples include verbal or physical abuse, public shaming, excessive fees charged by health-care providers, and the provision of inaccurate medical information at appointments. People can also experience low-quality treatment from health-care professionals, including those providing abortion services.

For providers, discrimination can mean that they have difficulty in getting trained to provide safe abortion services or, once trained, they may not have the supplies and support necessary to safely provide abortion services.

Abortion stigma also leads to criminalization and extreme regulation of abortion, including laws that unfairly target providers. The criminalization and regulation of abortion is another way of discriminating against people who have abortions and those who provide them.

Discrimination creates social norms and practices that further reinforce labeling, stereotyping, and separation. In this way, the cycle of abortion stigma is self-reinforcing.

LEVELS OF ABORTION STIGMA

(Hessini, 2014; inroads, 2015)
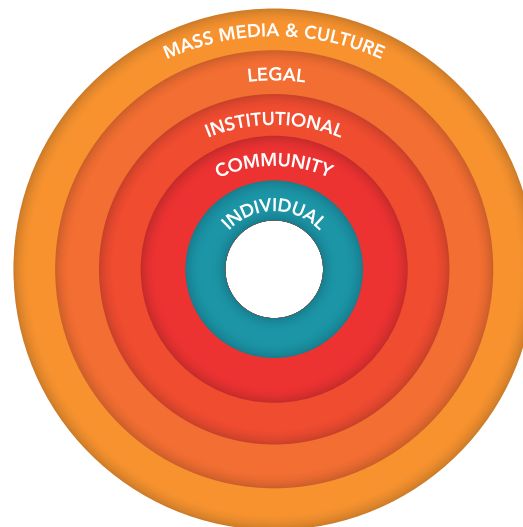
Abortion stigma plays out across and between different levels of society, as shown in the diagram above.

Mass media and culture: These represent the images, environment and norms related to abortion that are perpetuated by mainstream society. This representation of abortion can frame it in terms that can lead to stigma. For example, women, girls and trans people who receive abortion services can be labeled as *careless* or *promiscuous* in the media. On the other hand, if they are not represented seeking abortions in a television drama, for example, that might further preserve the idea that abortion is abnormal.

At the legal level (or the governmental level): Laws and policies can criminalize and restrict access to abortion. For example, laws can include restrictions on abortion to prevent people from receiving services for specific reasons or at certain stages of pregnancy. These restrictions label some abortions as being "bad" or criminal and make value judgements around which reasons for wanting an abortion are acceptable.

At the institutional level: Institutional-level abortion stigma can play out in different ways. Examples include the separation of abortion services from other health services at a facility, or the existence of policies that mandate health-care workers to report induced abortions to police. When managing an abortion complication, abortion providers may be denied support by staff who are unwilling to participate in providing abortion care, or there may be a hospital practice in place to withhold pain management support during abortion.

At the community level: Since abortion is also a social and community issue, stigma can be perpetuated at the community level. Examples include situations like a father disowning his daughter after learning of her abortion, or a community custom to inform local authorities about abortion providers and people who seek their services.

At the individual level: Stigma can also be maintained or perpetuated at the individual level. People who have abortions may be doing so in silence or alone, particularly in communities with limited access or where abortion is stigmatized. Health-care providers who do abortions may keep the kind of medicine that they practice a secret from colleagues or family members.

IMPACT AND CONSEQUENCES OF ABORTION STIGMA

The criminalization of abortion leads to an environment of *secrecy and denial,* where people do not ask for support around abortion because they fear rejection and judgment. This can lead to *internalized stigma,* where feelings of shame and guilt are internalized. This can have serious effects on a person's mental well-being and ability to cope in the social world (Moore, Jagwe-Wadda, & Bankole, 2011; Shellenberg et al., 2011).

The impact of abortion stigma is vast. Here are some examples of the consequences of abortion stigma:

- Unclear or poorly implemented laws, which mean most citizens do not know whether abortion is legal in their own country;

- Abortion services are less accessible due to secrecy or a lack of visibility;

- Lack of general knowledge about abortion options and procedures;

- People not disclosing their intention to have an abortion, which can lead them to resort to unsafe abortion practices;

- Barriers to reducing maternal mortality from unsafe abortion, as unsafe abortion is one of the biggest causes of maternal mortality;

- Harm to social and professional relationships between abortion service providers and other health workers;

- Lack of support and training on comprehensive abortion care for health professionals;

- Women's, girls' and trans people's rights are not recognized as human rights.

The exercises in this toolkit will allow you to identify and discuss examples that are specific to your community context and begin to create action plans for ending abortion stigma.

GLOSSARY OF KEY TERMS

Abortion stigma: The negative and shaming treatment of any person or group of people associated with abortion.

Bisexual: An individual who is physically, romantically and/or emotionally attracted to both men and women.

Cisgender: A term used to describe a person whose gender identity matches the sex they were assigned at birth.

Contraception and family planning: *Contraception* is the intentional prevention of pregnancy through the use of various drugs, techniques or devices.

Family planning refers to the practice of planning the number of children in a family and the timing between the birth of children, typically by using contraceptive methods.

Be careful when using the term *family planning*—only use it when you intend to refer to the spacing of children. When talking about preventing pregnancy more generally, use the term *contraception* instead to avoid being restrictive or dismissive—young people and others may not currently (or may never) be thinking about planning a family. Using the term *contraception* ensures you are referring to the practice of preventing pregnancy or using contraceptive methods for other benefits, like sexually transmitted infection prevention or less bleeding during menstruation, for example.

Gay: A man whose physical, romantic and/or emotional attractions are to other men. It can also be used as a general term to describe people whose physical, romantic and/or emotional attractions are to people of the same sex.

Gender: *Gender* refers to the economic, social and cultural attributes and opportunities associated with being male or female at a particular time and place. This may include social norms, traditions, roles and expectations of one gender or another. Stereotypes assigned to different genders exist within all cultures.

Gender identity refers to an internalized sense of one's gender, regardless of whether it matches the sex assigned at birth or the way one dresses or acts.

Gender expression is the way a person demonstrates gender to others. This may include an individual's physical characteristics, behaviors and presentation, which are linked to either masculinity or femininity in a traditional sense, such as appearance, dress, mannerisms, speech patterns and social interactions.

Intersectionality/Intersecting stigma: *Intersectionality* refers to the idea that we all have multiple identities that intersect, or come together, to make us who we are. These multiple, intersecting identities can result in systems of discrimination or privilege in society (Crenshaw, 1989).

Groups who are already marginalized in society because of other factors like social class, race, gender, sexual orientation, gender identity and occupation (for example, sex work) are likely to face more stigma and greater consequences of stigma if their identity includes more than one marginalized factor. For example, a poor lesbian woman will likely face greater discrimination in the workplace than a wealthy woman of any sexual orientation. This concept describes intersecting stigma.

Lesbian: A woman whose physical, romantic and/or emotional attraction is to other women.

LGBTIQ: *LGBTIQ* stands for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning. It refers to identities based on sexual orientation that exist in addition to a heterosexual sexual orientation. There are many other identities and expressions of sexual orientation beyond even these. However, LGBTIQ—and other similar combinations—are often used as a common starting point for recognizing the diverse ways that we as humans position ourselves in our sexual relationships and interactions.

Maternal mortality and morbidity: *Maternal mortality* refers to the death of a woman while pregnant as a result of any cause related to the pregnancy or the management of a pregnancy, but not from accidental causes.

Maternal morbidity refers to any health condition that is caused by pregnancy and/or childbirth that has a negative impact on the woman.

Men who have sex with men (MSM): *MSM* refers to men, including those who do not identify as homosexual or bisexual, who engage in sexual activity with other men.

Multiple/Repeat abortions vs. More than one abortion: The terms *multiple abortions* or *repeat abortions* tend to have negative connotations and can imply that all abortion experiences are the same. A better way to talk about this is to say that a person has had *more than one abortion* (International Planned Parenthood Federation, 2015).

For more information, see the International Planned Parenthood Federation tool *How to talk about abortion: A guide to rights-based messaging.*

Power dynamics: *Power* is the ability to influence or outright control the behavior of others.

It is important to explore how certain groups of individuals experience different degrees of feeling empowered or disempowered, advantaged or disadvantaged, and having or lacking control. Power dynamics can play a large role in abortion-related experiences, behaviors and social norms.

Queer: Used as a term to refer to all people with non-heterosexual sexual orientations or all people who are marginalized on the basis of sexual orientation. Some people who identify as queer choose to use the word to refer to an attraction to people along a gender spectrum.

Historically, *queer* has been used as a derogatory term to refer to non-heterosexual people, but in some communities, it is being reclaimed by individuals who identify as queer. This is particularly common within academic and activist spaces.

Questioning: The process of considering or exploring one's sexual orientation and/or gender identity.

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.

Sexual and reproductive health and rights (SRHR): *SRHR* are the rights of all individuals to make decisions concerning their sexual activity and reproductive health, free from discrimination, coercion and violence.

Sexual orientation: The scientifically accurate term for an individual's physical, romantic and/or emotional attraction to members of the same and/or opposite sex.

Sex worker: *Sex workers* are people who receive money or goods in exchange for sexual services.

Sex workers are often stigmatized in their communities due to the nature of their work. As a result, sex workers can face increased marginalization when they try to access abortion services. With these intersecting layers of stigma, it can be challenging for sex workers to access contraception and abortion services and to find a service provider who will treat them with respect and confidentiality.

Transgender: A broad umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth.

Unintended vs. Unwanted pregnancy (International Planned Parenthood Federation, 2015): *Unwanted pregnancy* is a pregnancy that a woman decides she does not desire.

Unplanned or unintended pregnancies refer to pregnancies that occur when a person is not trying to get pregnant.

An unplanned or unintended pregnancy may be either a wanted or unwanted pregnancy.

We should avoid using "unintended'" and "unwanted'" interchangeably to describe pregnancies. Instead, we should use the correct, specific term to describe each case.

For more information, see the International Planned Parenthood Federation tool *How to talk about abortion: A guide to rights-based messaging.*

Unsafe Abortion, Safe Abortion, Illegal Abortion (International Planned Parenthood Federation, 2015): WHO defines
unsafe abortion as a procedure for termination of an unintended pregnancy done either by people lacking the necessary skills, or in an environment that does not conform to minimum medical standards, or both. The two categories of "less safe" and "least safe" combine to make up the category of unsafe abortion.

Throughout this toolkit we use the term "safe abortion" to refer to pregnancies that are terminated using a method recognized as safe by the World Health Organization. This includes abortions that are performed with the assistance of a trained healthcare provider—in a well-equipped, clean health facility—using appropriate modern techniques either dilation and evacuation (D&E) or medical abortion (MA). This also includes self-managed abortions using the correct regimen of MA drugs according to the correct eligibility parameters. Therefore, safe abortion care can be obtained in a clinic with a trained and caring provider, and safe abortion care can also be obtained through accurate information and use of pills outside a clinic.

Illegal abortions do not comply with a country's legal framework, but they may be safe if they are performed by a trained provider or when a woman has access to abortion services with high-quality medical standards, information or support. It is also possible to have an unsafe, legal abortion.

We should avoid using *unsafe* and *illegal* interchangeably to describe abortions. Instead, we should use the correct, specific term to describe each case.

For more information, see the International Planned Parenthood Federation tool *How to talk about abortion: A guide to rights-based messaging.*

KEY RESOURCES

Induced abortion worldwide: Fact sheet (Guttmacher, 2018)

The world's abortion laws, 2018 (Center for Reproductive Rights, 2018)

The history of abortion timeline (1 in 3 Campaign)

Abortion facts (National Abortion Federation)

How to educate about abortion: A guide for peer educators, teachers and trainers (International Planned Parenthood Federation, 2016)

How to talk about abortion: A guide to rights-based messaging (International Planned Parenthood Federation, 2015)

The International Network for the Reduction of Abortion Discrimination and Stigma (inroads)

What is abortion stigma? Summary video (Sea Change Program, 2015)

Abortion stigma: What is it and how does it affect women's health? (University of California, San Francisco)

REFERENCES

Cockrill, K., Herold, S., Blanchard, K., Grossman, D., Upadhyay, U., & Baum, S. (2013). *Addressing Abortion Stigma Through Service Delivery: A White Paper.* Retrieved from Ibis Reproductive Health: https://ibisreproductivehealth.org/publications/addressing-abortion-stigma-through-service-delivery-white-paper

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum, 1989*(8).

Hessini, L. (2014). A learning agenda for abortion stigma: recommendations from the Bellagio expert group meeting. *Women & Health, 54*(7), 617-621. doi:10.1080/03630242.2014.919987

Inroads. (2015). Inroads. Retrieved from https://www.endabortionstigma.org/en.aspx

International Planned Parenthood Federation. (2015). How to talk about abortion: A guide to rights-based messaging. Retrieved from https://www.ippf.org/resource/how-talk-about-abortion-guide-rights-based-messaging

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality, 11*(6), 625-639. doi:10.1080/13691050902842741

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*(1), 363-385. doi:10.1146/annurev.soc.27.1.363

Moore, A. M., Jagwe-Wadda, G., & Bankole, A. (2011). Mens' attitudes about abortion in Uganda. *Journal of Biosocial Science, 43*(1), 31-45. doi:10.1017/S0021932010000507

Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., Palomino, N., . . .Tsui, A. O. (2011). Social stigma and disclosure about induced abortion: results from an exploratory study. *Global Public Health, 6 Suppl 1,* S111-125. doi:10.1080/17441692. 2011.594072