



Abortion care for young women: A training toolkit

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and Cansas Mulligan



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Table of contents

| | |
|---|----|
| Acknowledgements | 1 |
| About this toolkit | 2 |
| Part I: Introduction and barriers to care | 7 |
| Module 1: Introduction | 9 |
| 1.1 Why focus on young women and abortion? | 10 |
| 1.2 Defining and understanding young women | 11 |
| 1.3 Abortion care for young women | 14 |
| 1.4 Additional resources | 16 |
| 1.5 References | 16 |
| Module 1 Tools | 18 |
| TOOL 1A: Introduction handout | 19 |
| TOOL 1B: Young women are | 20 |
| TOOL 1C: Gender and abortion | 23 |
| TOOL 1D: Defining a sexually healthy young person | 27 |
| TOOL 1E: Support we needed as youth | 29 |
| Module 2: Barriers to care | 33 |
| 2.1 Introduction | 34 |
| 2.2 Social barriers | 34 |
| 2.3 Economic and logistical barriers | 37 |
| 2.4 Legal and policy barriers | 38 |
| 2.5 Health system barriers | 40 |

| | |
|--|-----------|
| 2.6 The interrelation of barriers | 42 |
| 2.7 Additional resources | 43 |
| 2.8 References..... | 43 |
| Module 2 Tools | 46 |
| TOOL 2A: Barriers to care handout | 47 |
| TOOL 2B: Barriers to care..... | 49 |
| Part II: Abortion care for young women..... | 53 |
| Module 3: A rights-based approach to care..... | 55 |
| 3.1 Introduction | 56 |
| 3.2 Young people’s sexual and reproductive rights | 56 |
| 3.3 Evolving capacities and the principle of capability | 57 |
| 3.4 Additional resources | 60 |
| 3.5 References..... | 61 |
| Module 3 Tools | 62 |
| TOOL 3A: A rights-based approach to care handout..... | 63 |
| TOOL 3B: Young women, international rights and abortion..... | 65 |
| TOOL 3C: The principle of capability | 73 |
| Module 4: Building partnerships between young people and adults | 77 |
| 4.1 Introduction | 78 |
| 4.2 Definition..... | 78 |
| 4.3 Benefits..... | 78 |
| 4.4 Partnering in abortion care..... | 81 |
| 4.5 Monitoring and evaluation | 83 |

| | |
|---|------------|
| 4.6 Additional resources | 83 |
| 4.7 References..... | 84 |
| Module 4 Tools | 86 |
| TOOL 4A: Building partnerships between young people and adults handout..... | 87 |
| TOOL 4B: Working with young people..... | 88 |
| TOOL 4C: How young people can partner in, lead and transform abortion care | 96 |
| TOOL 4D: Barriers to establishing successful partnerships with young people and how to overcome them..... | 97 |
| TOOL 4E: Evaluating partnerships with young people | 99 |
| Module 5: Making abortion care accessible | 101 |
| 5.1 Introduction | 102 |
| 5.2 Addressing social barriers | 102 |
| 5.3 Addressing economic and logistical barriers..... | 102 |
| 5.4 Addressing legal and policy barriers..... | 103 |
| 5.5 Addressing health system barriers..... | 104 |
| 5.6 Additional resources | 108 |
| 5.7 References..... | 109 |
| Module 5 Tools | 110 |
| TOOL 5A: Making abortion care accessible handout | 111 |
| TOOL 5B: Addressing barriers to care | 113 |
| TOOL 5C: Service readiness assessment questions for providing abortion care to young women..... | 117 |
| TOOL 5D: Improving abortion standards and guidelines for young women..... | 120 |
| TOOL 5E: Improving abortion access for young women | 123 |

| | |
|--|-----|
| Module 6: Making abortion care clinically appropriate | 129 |
| 6.1 Introduction | 130 |
| 6.2 Provider attitudes | 130 |
| 6.3 Options counseling | 130 |
| 6.4 Abortion counseling | 132 |
| 6.5 Postabortion contraceptive counseling and methods | 136 |
| 6.6 Clinical care | 138 |
| 6.7 Additional resources | 141 |
| 6.8 References | 142 |
| Module 6 Tools | 146 |
| TOOL 6A: Making abortion care clinically appropriate handout | 147 |
| TOOL 6B: Through their eyes: Young women’s experiences with abortion | 150 |
| TOOL 6C: Counseling skills | 152 |
| TOOL 6D: Abortion counseling for young women skills checklist | 158 |
| TOOL 6E: Young women’s perception of abortion care survey | 161 |
| TOOL 6F: Sample wall poster | 170 |
| Glossary of terms | 171 |
| Workshop tools | 174 |
| Four-day workshop agenda | 175 |
| Pre-workshop survey | 178 |
| Post-workshop survey | 185 |
| Workshop survey answer key | 192 |
| Workshop evaluation form | 196 |

| | |
|------------------------------------|-----|
| Certificate of participation | 199 |
|------------------------------------|-----|

CD-ROM contents

Toolkit documents

- *Abortion care for young women: A training toolkit*
- Abortion care for young women PowerPoint presentation
- Abortion care for young women: Needs assessment survey results and recommendations
 - Abortion care for young women: Literature review
- Sample wall poster
- Workshop tools

Resources

- *Abortion attitude transformation: A values clarification toolkit for global audiences, including:*
 - Activities adapted for young women and abortion
- *Effective training in reproductive health: Course design and delivery. Reference and Trainer's manuals*
- *Exploring abortion: A collection of self-reflection and sensitization activities for global audiences*
- *Woman-centered abortion care. Reference and Trainer's manuals*

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About this toolkit

This toolkit was created to help ensure that all abortion care programs and services are accessible to and appropriate for young women. It is a global resource for health-care providers, trainers, administrators, program managers, health system officials and technical advisors of abortion care programs and services. It is designed to provide information and guidance on delivering and ensuring access to appropriate induced abortion care for young women (ages 10-24). It also provides experienced trainers with the background information, materials, instructions and tips necessary to effectively facilitate training sessions.

Focus

The focus of this toolkit is on induced abortion care for young women for all applicable legal indications. All but a few countries have one or more legal indications for abortion, although some laws are very restrictive. The intention is for health systems and providers to deliver abortion care to the full extent of the law and to ensure that all eligible women, including young women, are able to access the services to which they are rightfully entitled. This toolkit does not specifically address postabortion care (PAC) or other related services, although much of the content is also applicable to PAC and other health services. There are excellent existing resources on the provision of postabortion care to young women, such as Pathfinder International's youth-friendly postabortion care tool (Hainsworth et al. 2008). This toolkit focuses on the provision of and access to abortion care for young women. Guidance and tools on abortion care for women in general are covered in other resource documents, such as Ipas's woman-centered abortion care curriculum (Hyman and Castleman 2005, Hyman et al. 2005), available on the CD-ROM and www.ipas.org.

The toolkit contains more on advocacy, partnerships and service delivery than clinical issues because there is little empirical evidence on the clinical aspects of abortion care for young women specifically. Existing research demonstrates few differences in the clinical needs of young women compared to adults. Programmatic considerations, and the different ways providers address young women, are more significant. This toolkit provides guidance on identifying and removing barriers to abortion care and ensuring the care provided to young women is appropriate.

Toolkit development

To develop guidance on abortion care for young women, the authors reviewed current clinical evidence (particularly peer-reviewed journal articles), a global literature review of research on youth-oriented health service models, a survey and literature review of existing abortion-related training materials and approaches, and the perspectives of young people around the world as expressed through published research, survey responses, essays, poems and art work. A young master's student intern was actively involved in researching and gathering information for the toolkit. In addition, young people from four countries were also asked to review the toolkit, and their comments were incorporated into the final version.

Audiences

While the primary audiences for this toolkit are health-care providers, trainers, administrators, program managers, health system officials and technical advisors of abortion care programs and services, some materials can also be used to engage a variety of stakeholders, including community groups, young people, policymakers, advocates and donors. Because this was developed as a global toolkit, content and activities were not tailored to any specific country or context. The content should be adapted to meet the needs of the specific audience. Information on adaptation is provided below.

Language

We refer to “young women” throughout most of the toolkit. Where the issues apply to both young women and men, we discuss “young people” and the roles and inclusion of young men in abortion care. We describe the distinction between sex and gender in Module 1 and respectfully acknowledge the important nuances of – and right to – people’s unique sexual and gender identities and expressions.

In this toolkit we discuss abortion care that is appropriate for, accessible to and developed in partnership with young women. Ipas and partner agencies endorsing this toolkit recommend and promote health care for young people which respects human rights, engages young people as partners and leaders in their own health, is accessible to all young people and is clinically safe and appropriate.

Background research

In 2010, Ipas conducted a needs assessment on training and educational materials, experiences and provider practices on safe abortion care for young women using a literature review and survey. The literature review synthesized information from 45 key documents found in extensive searches of grey literature as well as published articles. The survey gathered data from Ipas staff, consultants and partner organization staff. The assessment found that the most commonly used training and educational materials were not youth-specific ones. Although there were materials on providing sexual and reproductive health care to young people, no materials were available on providing abortion to young women. The few youth-focused materials that did mention abortion mainly referred to postabortion care and contraception, avoiding inclusion of comprehensive abortion care. Many materials seemed to reflect the dearth of research on young people and sexual and reproductive health care, particularly abortion, and resultant scant evidence base for recommendations. The survey indicated that providers desired specialized training in the provision of abortion care to young women. Based on these findings, Ipas determined that a training toolkit on providing safe abortion to young women that addressed these considerations was needed, in addition to more research (Westervelt et al. 2011). The needs assessment report, including the literature review, is available on the CD-ROM.

Organization of this toolkit

Part I provides background, core terms and key issues involved in abortion care for young women:

- Module 1 demonstrates why a focus on young women and abortion is necessary. It is an introduction to the topic and provides definitions of basic terms and issues.
- Module 2 describes the social, economic, logistical, legal, policy and health systems barriers to safe abortion care for young women. It can be used to identify areas that need improvement.

Part II provides guidance and tools for implementing the Four Pillars of abortion care for young women:

- Module 3 introduces sexual and reproductive rights for young people and young people's rights to decisionmaking in health care. It establishes abortion care that is rights-based.
- Module 4 is about building partnerships between adults and young people on abortion care to ensure that abortion care is participatory at all stages of service delivery.
- Module 5 discusses how to make abortion care accessible to young women by removing many of the social, logistical, policy and health systems barriers facing them.
- Module 6 presents considerations health-care providers should make in providing abortion care that is clinically safe and appropriate for young women.

Each module includes tools to improve abortion service delivery for young women, as well as a list of additional resources and references.

How to use this toolkit

The modules in this toolkit can be used in the order they appear in a comprehensive workshop or separately to meet specific programmatic or training needs. When using only one or a few modules, it is essential to ensure that participants have the appropriate background knowledge of the information provided in the preceding modules, as the modules build on each other.

Adaptation

Because nearly all countries in the world currently have one or more legal indications for abortion, the information in this toolkit is applicable in most settings. However, advance preparation and facilitator notes in the activity instructions provide guidance on when the content or format may need to be adapted to be more appropriate and relevant to the participants. Facilitators should gather information on local laws and policies, sociocultural norms, service delivery practices, barriers to access and other considerations and adapt content as needed.

It is important to consider the following:

- A regional workshop with participants from different countries lends itself to opportunities for people to be grouped in country teams for certain activities. Sessions that are offered in country may present the opportunity to group participants by regions or states.
- Participants' level of experience and skills may be varied. This will need to be addressed in advance when designing the workshop and tailoring activities and scenarios, although most of the materials are appropriate for a wide range of skills and experience.

Participant and workshop considerations

Number of participants and room layout: These activities were designed with a time frame that is based on an average number of 24 participants. Because many of the activities are designed for small group work, an ideal physical layout for the room is clusters of 6-8 people per table.

Participant screening: Support for abortion care is crucial for an effective workshop and outcomes. This toolkit is intended for people who are already supportive of sexual and reproductive rights, including abortion care. Providers who are still questioning their values or who are not supportive of abortion care may need to attend a **values clarification** workshop in advance. Please see *Abortion attitude transformation: A values clarification toolkit for global audiences* (Turner and Page 2008) on the CD-ROM or at www.ipas.org for more information.

Training methods and materials: Facilitators will need to read the toolkit in advance to familiarize themselves with the content and references. Facilitators can cover the content using PowerPoint slides, participant handouts and materials and activities that are facilitated according to the included instructions. The PowerPoint slides are not sufficient when used alone because they do not cover all of the content. In addition, using only the lecture method is strongly discouraged as it significantly decreases participants' learning and retention. Instructions for flipcharts are included for facilitators who prefer them to PowerPoint slides. Each module has a participant handout that summarizes key information and should be distributed to participants after covering the module contents. The activities and their accompanying materials were designed according to adult learning principles to facilitate active engagement and knowledge and skills acquisition for a range of learning styles.

For overall guidance and resources on effective training methodologies, including examples of icebreakers, energizers and evaluations, please see Ipas's *Effective training in reproductive health: Course design and delivery*, Reference and Trainer's manuals (Turner et al. 2003, Wegs et al. 2003), available on the CD-ROM and at www.ipas.org.

Evaluation and follow-up: Sample pre- and post-workshop surveys are included and can be used to assess initial knowledge, comfort levels and attitudes on abortion care for young women and discern changes from the beginning to the end of the workshop. Facilitators should review the surveys in advance and make any changes to reflect the content that will be covered in that workshop. A sample workshop evaluation form is also included to measure participant satisfaction against the objectives and suggestions for improvement.

Sample agenda: A sample four-day agenda is included to provide guidance on designing workshops. The sample agenda includes values clarification activities that have been adapted specifically to address abortion care for young women. We also recommend conducting general abortion values clarification before any workshop focusing on abortion care for young women. Facilitators should create a tailored agenda that meets the time frame and specific objectives for each workshop. Facilitators can also incorporate individual activities from this manual into workshops on other related topics.

Additional workshop content: We recommend additional content for workshops related to abortion care for young women that is not included in this toolkit. These include:
Abortion attitude transformation: A *values clarification toolkit for global audiences*, including "Activities adapted for young women and abortion" (Turner and Page 2008) and "Exploring abortion: A collection of self-reflection and sensitization activities for global audiences" (McSmith et al. 2011), both available on the CD-ROM and at www.ipas.org. You can also consult the Additional Resources section in each module.

Workshop goal and objectives

GOAL: The goal of this workshop is to engage providers, health-care professionals and other stakeholders to ensure access to rights-based, participatory, clinically safe and appropriate abortion care for young women.

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

- Articulate how their perceptions and assumptions may affect their interactions and delivery of abortion care to young women.
- Demonstrate increased empathy for young women seeking abortion.
- Articulate how assumptions about gender and sexuality may affect their attitudes about young women's needs for abortion care.
- Define a sexually healthy young person.
- Describe the different barriers young women encounter when seeking safe abortion care.

- Identify human, sexual and reproductive rights that support a young woman's right to safe abortion.
- Describe their role in ensuring a young woman's right to safe abortion.
- Identify the assumptions they make about the decisionmaking capabilities of young women.
- Determine if a young woman can be considered capable of deciding if she needs abortion care, using the "principle of capability."
- Explore how young women can participate in abortion-related services and programs at the community and clinic levels.
- Identify strategies to address the challenges young women face in accessing abortion care, including involvement of young people.
- Develop strategies to improve abortion access and service delivery for young women.
- Identify strengths and weaknesses of an abortion counseling session.

References

Hainsworth Gwyn, Carolyn Boyce and Ellen Israel. 2008. *Assessment of youth-friendly postabortion care services: A global tool for assessing and improving postabortion care for youth*. Watertown, MA: Pathfinder International.

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Part I: Introduction and barriers to care

1. Introduction
2. Barriers to care

part one

Module 1: Introduction



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1.1 Why focus on young women and abortion?

Human rights provide the foundation for the recommendations in this toolkit. All people, including young women, have a right to health. Young women face unique vulnerabilities and barriers to health-care access related to their age and gender, and their rights are often neither recognized nor upheld. Safe, respectful abortion information and care are essential to ensure young women's sexual and reproductive health and well-being. A rights-based approach assumes young women's capacity to be actively involved in and consent to their own health care in accordance with their capacities.

There are over 1.7 billion young people aged 10-24 in the world (PRB 2006). This is the largest population of young people in history. Their sociocultural environment and circumstances are changing, which can affect the likelihood of unwanted pregnancy and abortion:

- Girls are reaching puberty earlier now than in previous decades; for example, the average age of menarche in Kenya was 14.4 years in the late 1970s, compared to 12.9 years in the late 1980s (WHO et al. 2006).
- Due to global efforts to broaden opportunities for young women, many are now staying in school longer, migrating further away from their birth place, entering the workforce in larger numbers and marrying later.
- While puberty arrives earlier, the average age of marriage is increasing for both men and women in many countries; for example, in Eastern and Southern Africa, 37 percent of women currently 20-24, compared to 53 percent of women currently aged 40-44, were married by age 18 (Bremner et al. 2009). The time period during which young women may be unmarried while also able to become pregnant is expanding (Cook and Dickens 2000, Singh et al. 2000).
- Pregnancy and motherhood outside of marriage are stigmatized in many societies, which may cause young, unmarried pregnant women to seek abortion. Other reasons that are independent of marital status include a desire to continue education; an unsupportive or absent partner; inadequate resources; the pregnancy resulted from violence or abuse; health risks; or the woman does not want to become a mother at that time, or at all.

Pregnancy and childbirth-related complications continue to be one of the leading causes of death for women 15-19 years old (Rowbottom 2007). The United Nations estimates that more than 14 million young women give birth each year, and over 90 percent of these young women live in developing countries. Prevention of young women's unwanted pregnancy is essential to reduce pregnancy and childbirth complications and death. If contraception was accessible and used consistently and correctly by women wanting to avoid pregnancy, maternal deaths would decline by an estimated 25-35 percent (Lule et al. 2007). Because of the many barriers to safe abortion care, a young woman who decides to terminate her pregnancy is likely to resort to unsafe abortion. Unsafe abortion is a large contributor to maternal mortality and morbidity among young women:

- Adolescent girls in developing countries undergo at least 2.2 to 4 million unsafe abortions each year (WHO 2007).
- In Sub-Saharan Africa, over 60 percent of unsafe abortions are among women younger than 25 years (Greene et al. 2010).
- Worldwide, young women under the age of 20 make up 70 percent of all hospitalizations from unsafe abortion complications (Plan 2007).
- Approximately 47,000 women per year die from unsafe abortion complications (Shah and Ahman 2010). In 2003, young women accounted for approximately 45 percent of the estimated unsafe abortion-related deaths (WHO 2007).

The extremely high number of young women who continue to resort to unsafe abortion makes it critical to ensure that young women, independent of marital status, have access to safe abortion as part of comprehensive health-care services.

There are many social, economic, logistical, policy and health system barriers to safe abortion care for young women, including: stigma and negative attitudes, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources, cost of care, transportation, involvement laws and concerns over privacy and confidentiality. They explain why young women often find no alternative than to resort to unsafe abortion, even in settings where safe abortion is legal. They also shed light on why young women who obtain abortion care tend to access it later in the pregnancy than adults (Finer et al. 2006), and are more likely to delay seeking help for abortion-related complications than adults (WHO et al. 2006).

The changing environment and circumstances of young women, the extremely high number of young women who continue to risk their lives and health by resorting to unsafe abortion, and the many barriers they face in attempting to access safe care indicate a need for abortion care that is focused on young women.

Role and inclusion of young men

We focus on young women in this toolkit because they experience unwanted pregnancy and abortion in their bodies and bear the primary burden of the consequences. However, it is crucial to engage young men to take a proactive role in preventing unwanted pregnancy, supporting women's right to make decisions about their sexual and reproductive health and ensuring availability and access to safe abortion care. Young men should be considered and included in abortion care access and delivery in a constructive way that addresses challenges and barriers and does not limit or diminish women's rights.

*"Involving young men from the early stages of their adolescence is an effective way of positively changing the traditional relationship between young men and women and their sexual and reproductive health practices."
(IPPF 2004)*

1.2 Defining and understanding young women

Defining young women

To provide abortion care that is appropriate for young women, we have to define and understand who young women are. People in the developmental stage between the onset of puberty and a culturally-determined entrance to adulthood are called adolescents, youth and young people. During the transition from childhood to adulthood, young people undergo significant biological, psychological, cognitive, sociocultural and economic changes (PRB 2000, WHO et al. 2006). People aged 10-19 are widely accepted as "adolescents," while "youth" are 15-24 years of age and "young people" encompasses both age ranges, ages 10-24 (PRB 2000, WHO et al. 2006). In this toolkit, "young women" will be used to refer to females aged 10-24.

Age alone cannot define young women or help us understand their needs. Young women are diverse and their circumstances, including marital, educational and socioeconomic status and living conditions, differ. The 10-24 years age range encompasses many developmental stages. Young women experience and express their gender and sexuality in different ways. Young women may engage in sexual relationships with women, men or both, whether or not they choose to identify as lesbian, bisexual or heterosexual. Their gender identity may exist at different points along a continuum. To better serve the needs of young women, it is important to recognize their diversity and their varying and fluctuating experiences.

Development

Young women's physical development is characterized by:

- Growth spurts and changes in body composition;
- The appearance of secondary sexual characteristics: breast development, hip enlargement and pubic and underarm hair;
- Enhancement of sexual capacity and establishment of reproductive capacity: increase in size, function and maturation of the sexual organs and onset of menstruation and fertility. (EngenderHealth 2002, PRB 2000, WHO et al. 2006).

Social development and a culturally-recognized transition into adulthood are more contextual. Adulthood is typically associated with possessing social maturity and independence from parents and other elders. Because the transition into adulthood is not a discrete event but occurs over several years, there is often uncertainty about when adulthood has been achieved and the degree of control young people should have over decisions affecting themselves and others; this includes codified markers such as the right to consent to sex, vote and bear legal responsibility for one's actions. As such, young people are often economically, politically and socially marginalized. Historically, however, they have frequently been powerful agents of social change (Ginwright et al. 2006).

Sex, gender and sexuality

For young people, the process of exploring and embracing their sexual and gender identity can be confusing amid the many sociocultural messages about what is "normal" or desirable. This process can be smoother for young people when adults, including health-care providers, offer non-judgmental support and factual information. Sex, gender and sexuality are all important and relevant concepts for people involved in abortion care to understand and address.

Sex is a biological trait, determined by whether a person has female or male chromosomes and/or genitals. It is distinct from gender. Most people's sex is relatively straightforward to determine. However, some people's appearance may not fit strict social norms for their sex. Some people are born with genitalia, reproductive organs or chromosomes that do not fit the typical definitions of "male" and "female," and when they further develop during puberty, it becomes apparent that their sex is different than they had assumed at birth (SIECUS 2004).

Gender is complex and exists on multiple levels. At the individual level, it is a psychological trait, a person's internal sense of self that is somewhere along a continuum of female to male which can fluctuate throughout the life cycle. A person's gender self-perception, expression and preferences can be different from their sex; this may be challenging for some young people, especially in societies where gender non-conformity is taboo and stigmatized.

At a societal level, gender roles are a culture's expectations of how a girl/woman or boy/man should behave and cultural beliefs about what is inherently "feminine" and "masculine." Gender inequalities mean that gender roles are inextricably linked to power imbalances between women and men in most societies (EngenderHealth 2002, SIECUS 2004). Many mainstream societies see gender as binary, whereas some people may find that their gender is in fact more fluid and does not fit into one of two categories. Kumar et al. suggest that a woman terminating her pregnancy conflicts with widely-held ideas of what is "feminine": that female sexuality is solely for procreation, that motherhood is inevitable and that women instinctively nurture (2009). Cultural beliefs about gender can vary by age; certain behaviors are considered strictly feminine or masculine in adults but not necessarily in children or young people. For example, being interested in or curious about sex may be considered feminine, and thus desirable, in an adult, married woman but masculine, and thus undesirable, in a young woman. Cultural gender roles may also make it difficult for a young woman to refuse sex or marriage with a man because of a cultural value placed on women having a male partner. All of these cultural gender beliefs may make decisionmaking and access to abortion care difficult for young women if family members, abortion facility staff and providers have not examined their gender assumptions.

Sexuality is highly relevant to the issue of safe abortion care. A sexually healthy person, adult or youth, is someone who feels they have the right and ability – through accurate information and safe, respectful and comprehensive sexual and reproductive health care – to enjoy and express their sexuality. They are able to protect themselves while experiencing opportunities for love and intimacy (EngenderHealth 2002, SIECUS 2004). Societies contribute to the sexual health of their citizens if they provide low social stigma and strong social support, as well as decreased risks of sexually transmitted infections (STIs), unwanted pregnancy, coercion, violence and discrimination.

Sexuality is shaped by a person's understanding of their own sex and gender, their culture's gender roles, as well as their:

- Relationships with family, friends, romantic and sexual partners;
- Sexual behavior such as masturbation, kissing, touching, sexual intercourse, abstinence and fantasy;
- Sexual health, including knowledge of and access to counseling, contraception, abortion, prevention and treatment of STIs, other reproductive health concerns, and sexual dysfunction.

"sexuality i think refers to many things that are present in connection with sex, but not only to sexual intercourse. therefore, healthy sexuality refers to all the feelings/emotions, attitudes, towards having sex and the timing of having it, in its entirety." - young person, ethiopia

Sexuality can also be strongly influenced by sexual violence, defined as any abusive or unjust use of power that has a sexual aspect, including the use of sexuality to manipulate others (Irvin 2004).

Expectations

*I am expected to be;
But still remain weak.
I am expected to become professional;
But also a good mother.
I am expected to submit,
And never to rebel.
I am expected to be caring;
And never selfish.
I am expected to satisfy my partner;
No matter my feelings.
I am expected to wash, cook and clean;
And never feel tired.
I have the right to freedom;
But it is a myth to me.*

(By Renee Maria Cozier, Trinidad, Youth Coalition, 2007)

1.3 Abortion care for young women

Abortion care for young women has Four Pillars:

- Respect for young women and their rights
- Participation by young women in all stages of service delivery
- Accessibility
- Safety and appropriateness

Guiding principles of abortion care for young women include:

- Young women have the right to decide whether, when and with whom to have sex.
- Young women have the right to decide whether, when and with whom to have a child.
- Young women have a right to high-quality health care which includes comprehensive abortion care and contraceptive services.
- Young women have a right to confidential care that protects their privacy and safety.
- Young women are the most important stakeholders in their sexual and reproductive health care.

- Young women have perspectives and experiences that older people do not, which can help improve service provision.
- By voluntarily seeking safe abortion care, young women can be presumed capable of informed consent to such care.

These principles should not be limited by a young woman's age, sexuality, marital, HIV or socioeconomic status or the legal framework for abortion in her country.

Key characteristics of abortion care for young women include:
(Adapted from Senderowitz 1999)

- Young women are welcomed as clients.
- Facility staff show respect to all young women.
- Facility staff are trained in abortion care for young women.
- The facility/provider partners with young people in service delivery; for example: youth advisory board, youth counselor or young clients' advocate.
- The facility/provider collaborates with other community stakeholders where possible.
- Privacy and confidentiality are maintained.
- Involvement by a supportive adult is encouraged but not required.
- The facility has convenient hours and location.
- Fees are affordable.
- Waiting times are short and drop-ins are allowed.
- There is adequate time for services.
- A wide range of services are available, or referrals can be made.

1.4 Additional resources

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MODULE 1 TOOLS

TOOL 1A: Introduction handout

TOOL 1B: Young women are...

TOOL 1C: Gender and abortion

TOOL 1D: Defining a sexually healthy young person

TOOL 1E: Support we needed as youth



TOOL 1A: Introduction handout

Why focus on young women and abortion?

- Young women have a right to health, including safe abortion.
- Pregnancy and childbirth complications are a leading cause of death for women 15-19 years old.
- Young women are more likely than adults to resort to unsafe abortion, and in 2003, young women accounted for approximately 45 percent of unsafe abortion-related deaths.
- Young women face unique barriers to access abortion care.

Defining and understanding young women

Young women – In this toolkit, “young women” refers to females aged 10-24. They are diverse and their circumstances differ.

Development – Physical development is well-defined, while social development and a culturally-recognized transition into adulthood – around which there is often uncertainty – are determined by local culture.

Sex – This is a biological trait, determined by chromosomes and genitalia.

Gender – A person’s internal sense of their place along a continuum of female to male may be different from their sex. At a societal level, gender roles are a culture’s expectations of how a girl/woman or boy/man should behave and what is inherently “feminine” and “masculine.”

Sexuality – Sexuality is shaped by a person’s understanding of their sex and gender, their culture’s gender roles, relationships, sexual behavior and sexual health. A sexually healthy person feels they have the right and ability to enjoy and express their sexuality.

Abortion care for young women

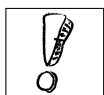
The Four Pillars:

- Respect for young women and their rights
- Participation by young women in all stages of service delivery
- Accessibility
- Safety and appropriateness

This toolkit provides information and tools to:

- Provide abortion care based on the sexual and reproductive rights of young people.
- Build partnerships between adults and young people in abortion care.
- Remove barriers to young women in accessing abortion care.
- Provide clinically safe and appropriate abortion care to young women.

TOOL 1B: Young women are...



Purpose

This activity is intended as an icebreaker to introduce the topic of working with young women, and young people in general, on safe abortion care.



Objectives

By the end of this activity, participants will be able to:

- Identify their perceptions and assumptions about young women, and young people in general.
- Articulate how these perceptions and assumptions may affect their interactions with young people and the delivery of abortion care to young women.



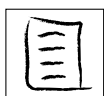
Materials

- Pens
- Young women are... worksheet



Time

20 minutes total time



Instructions

1. Distribute a worksheet and a pen to each participant.
2. Explain to participants that you will first say a word; each participant should write down the word followed by the first three words that come to mind. Ask them not to respond out loud, but rather to think and write in silence, without censoring or editing their responses. Explain that you will say six words in all.
3. Say the following words, one word or phrase at a time, allowing participants enough time to write the word followed by the first three words that come to mind, but not too much time to censor or edit their responses.
 - *Children*
 - *Adolescents*
 - *Young women*
 - *Young men*
 - *Young people*
 - *Minors*

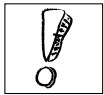
4. After you have said all six words, ask the participants to look over and reflect on their responses. Remind participants that they should not judge or criticize what they wrote but rather simply reflect on what their responses might mean.
5. In a large group, review each word and solicit a few participants to share their responses to each word. Then discuss their responses by asking the following questions:
 - *What observations do you have about the words you wrote?*
 - *Are the words you wrote mostly positive, negative or neutral? If they are negative, how would you explain that?*
 - *If your words for “young women” versus “young men” were very different, how would you explain that?*
 - *What assumptions do we sometimes make about young women? Young men? Young people?*
 - *How might your perceptions about young people affect your interactions with them? The abortion care you provide them?*
 - *Look at your words again. Do they convey that young people are active or passive? Did you denote a difference between young women and men in this regard? Did your words describe young women and men as agents of their own lives?*
6. Highlight important points from the previous discussion. Ensure you address the following:
 - Many of us make assumptions about young people.
 - Some of us may even have negative associations with young people.
 - We may also tend to see young people as passive rather than active agents of their own lives.
 - This awareness of our perceptions and assumptions is the first step we take in assessing and improving our interactions and abortion care delivery.
 - We may need to make adjustments in how we think and speak about and with young people to improve the quality and effectiveness of our interactions and care delivery.
 - We can challenge ourselves and others to see young people in a broader and more nuanced and positive way.
7. Ask a few participants to share their reflections about this activity. End the session by sharing the following:
 - *The purpose of this activity was to increase our awareness of our unexamined perceptions and assumptions about young people. We can use this awareness to assess and improve our interactions and delivery of care. We can also challenge ourselves to think more broadly and openly about young people.*
8. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Young women are... worksheet

Instructions: When you hear each word, write it down, followed by the first three words that come into your mind. Please think and write in silence. Please do not censor or change your responses.

| Word | First three words that come to mind |
|------|-------------------------------------|
| | |
| | |
| | |
| | |
| | |
| | |

TOOL 1C: Gender and abortion



Purpose

To explore how our understanding of gender may affect attitudes about young women and abortion care.



Objectives

By the end of this activity, participants will be able to:

- Identify their assumptions about young women's and men's sexuality.
- Articulate how assumptions about gender and sexuality may affect their attitudes about young women's needs for abortion care.



Materials

- Flipchart, easel, tape, markers
- Gender and abortion worksheets A and B



Time

5 minutes: Introduction

20 minutes: Small group work

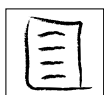
15 minutes: Large group discussion

40 minutes total time



Preparation

- If participants need a better base understanding of gender, sex and gender socialization to get the maximum benefit from this activity, it may be advisable to first facilitate activities from Ipas's *Gender or sex: Who cares?*, which can be found in Module 1's Additional Resources section.
- Determine if you will divide participants into sex-segregated or mixed groups. While the discussion may be richer in mixed groups, in some contexts it may be unacceptable to discuss sexuality with people of another sex.



Instructions

1. Introduce the activity by saying the following:
 - *Gender is complex and exists on multiple levels. At the individual level, it is a psychological trait, a person's internal sense of self that is somewhere along a continuum of female to male. This can fluctuate throughout the life cycle. A person's gender self-perception, expression and preferences can be different from their sex; this may be challenging for some young people, especially in societies where gender non-conformity is taboo and stigmatized.*
 - *At a societal level, gender roles are a culture's expectations of how a girl/woman or boy/man should behave and cultural beliefs about what is inherently "feminine" and "masculine."*
 - *Gender inequalities mean that gender roles are inextricably linked to power imbalances between women and men in most societies.*
 - *A better understanding of gender allows us to analyze the relationships between young women and men, including the balance of opportunities and power.*
2. Have participants form small groups, which may be sex-segregated or mixed.
3. Distribute the Gender and abortion worksheet A to one half of the groups and worksheet B to the other half of the groups. Explain that they will have 20 minutes to read the description and respond to all of the questions. Ask each group to designate one person to write the group's responses to questions and briefly present them to the large group.
4. Ask participants to return to the large group. Explain that, while each group had the same description, for half of the groups, Person X was a young woman and for the other half of the groups, Person X was a young man. Ask each group's presenter to first state whether they had a young woman or young man and then briefly summarize their group's responses. Then use some of the following questions to facilitate a discussion:
 - *What differences did you see in group responses for the young woman versus young man?*
 - *What do these different responses tell us about the gender perceptions and assumptions we make about sexuality?*
 - *How might our perceptions and assumptions about young women versus young men affect our interactions with them? Our judgments about whether or not they should be entitled to engage in sexual activity? Whether or not they should be entitled to decide to terminate a pregnancy? The quality of care they are entitled to?*
5. Summarize the discussion and highlight the following key points:
 - *Through this activity, we gained a better understanding of gender that allows us to analyze the relationships between young women and men, including the balance of opportunities and power.*
 - *We can also gain a deeper understanding about how gender exists along a continuum and how gender stereotypes do not allow us to appreciate the diversity of people's gender expression.*
 - *Young women are often judged negatively for engaging in consensual sexual behavior.*
 - *We must ensure that providers' perceptions about sexuality and gender do not negatively impact a young woman's access to and quality of abortion care.*
6. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Gender and abortion: Worksheet A

Description:

Person X is 18 years old. This person has had three consensual sexual relationships over the past two years. This person has stated that they would have liked to remain abstinent until they married, and that they do plan to marry, but not right away. In the last relationship, this person had sex that resulted in a pregnancy and decided to terminate the pregnancy. This person has been treated for chlamydia, a sexually transmitted infection (STI).

Person X is a young woman.

Questions:

- *If they knew about her sexual history, how is this young woman likely to be perceived by her family? Community? Peers?*
- *If she talked openly about her sexual history to the abortion or STI provider, how might their perceptions about her sexuality affect their interactions with her? The care they provide her?*
- *Would they perceive this young woman's sexual activity and STI diagnosis differently if she was a young man?*
- *How might she be treated or counseled differently than a young man with the same sexual history?*
- *What do these responses tell us about how we perceive young women's and men's sexuality differently?*
- *How might our perceptions, assumptions and judgments about young women's versus young men's sexuality affect our interactions with them? Our judgments about whether or not they should be entitled to engage in consensual sexual activity outside of marriage? Whether or not they should be entitled to decide to terminate a pregnancy? The quality of abortion care they are entitled to?*

Case example adapted from: International Sexuality and HIV Curriculum Working Group. 2009. "First impressions." In *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education*, International Sexuality and HIV Curriculum Working Group, 56-58. New York, NY: The Population Council.

Gender and abortion: Worksheet B

Description:

Person X is 18 years old. This person has had three consensual sexual relationships over the past two years. This person has stated that they would have liked to remain abstinent until they married, and that they do plan to marry, but not right away. In the last relationship, this person had sex that resulted in a pregnancy and decided to terminate the pregnancy. This person has been treated for chlamydia, a sexually transmitted infection (STI).

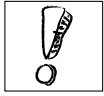
Person X is a young man.

Questions:

- *If they knew about his sexual history, how is this young man likely to be perceived by his family? Community? Peers?*
- *If he talked openly about his sexual history to the abortion or STI provider, how might their perceptions about his sexuality affect their interactions with him? The care they provided him?*
- *Would they perceive this young man's sexual activity and STI diagnosis differently if he was a young woman?*
- *How might he be treated or counseled differently than a young woman with the same sexual history?*
- *What do these responses tell us about how we perceive young women's and men's sexuality differently?*
- *How might our perceptions, assumptions and judgments about young women's versus young men's sexuality affect our interactions with them? Our judgments about whether or not they should be entitled to engage in consensual sexual activity outside of marriage? Whether or not they should be entitled to decide to terminate a pregnancy? The quality of abortion care they are entitled to?*

Case example adapted from: The International Sexuality and HIV Curriculum Working Group. 2009. "First impressions." In *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education*, International Sexuality and HIV Curriculum Working Group, 56-58. New York, NY: The Population Council.

TOOL 1D: Defining a sexually healthy young person



Purpose

This activity is used to examine young people's definitions of healthy sexuality and a sexually healthy young person, and how they may differ from the definitions of providers and other adults.



Objectives

By the end of this activity, participants will be able to:

- Articulate their definitions of a sexually healthy young person.
- Identify diverse views among participants and young people.



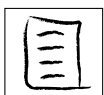
Materials

- Flipchart or board
- Markers or chalk
- PowerPoint slides



Time

25 minutes total time



Instructions

1. Ask participants to define a sexually healthy young person. Record all responses on a board or flipchart. Responses may include:
 - Having accurate information
 - Able to express their sexuality positively and pleasurable
 - Having opportunities for love and intimacy
 - Having access to safe and respectful sexual and reproductive health care
 - Sexual health encompasses psychological and social health in addition to physical health
 - Able to make decisions and act to protect themselves from sexually transmitted infections (STIs), unwanted pregnancy and other negative outcomes
2. Show slides and review some young people's definitions of healthy sexuality.

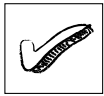
3. Solicit participants' reactions to young people's definitions compared with their own.
4. Discuss the experience. Some discussion questions may include:
 - *What did you learn about your views on healthy sexuality for young people compared with those of some young people?*
 - *How do we consider sexual health differently for young people in comparison to adults? What does this tell us about our views on young people's sexuality?*
 - *Some definitions focused on avoiding harmful outcomes, such as disease or pregnancy, instead of positive aspects of sexuality, such as love, pleasure and intimacy. Why might some people focus on the negative instead of the positive aspects?*
 - *How might a provider's definition of a sexually healthy young person affect their provision of abortion care to young women?*
5. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

TOOL 1E: Support we needed as youth



Purpose

This activity is designed to remind participants about their experiences with gender, sexuality and abortion in their youth, raise their awareness of the support young people need on sexuality-related concerns and increase their empathy for young women seeking abortion. At least two facilitators are needed.



Objectives

By the end of this activity, participants will be able to:

- Identify the feelings and perceptions they had about their bodies and sexuality when they were young.
- Demonstrate increased empathy for young women.



Materials

None



Time

10 minutes: Introduction

20 minutes: Guided imagery

20 minutes: Small group discussion

10 minutes: Large group summary

1 hour total time



Preparation

Take a break immediately before this activity and create a comfortable, safe atmosphere in the room with comfortable chairs or cushions on the floor, dim lights, soft, instrumental music and other items to create comfort and reduce external distractions.

Note to facilitators: This activity centers on a guided imagery process that encourages participants to remember emotional experiences from their youth. It may bring up uncomfortable or even traumatic thoughts or memories for participants. This requires at least two highly-skilled facilitators who have the capacity to continue the large group discussion while providing individual emotional support when necessary. Be prepared to support participants to take care of their emotions; they may need to do this by stopping their participation in the activity, leaving the room, asking for a facilitator to accompany them out of the room, or anything else that makes them feel safe. In some contexts, it may be more appropriate to hold separate discussions with women and men.



Instructions

1. Introduction: Begin the activity by saying the following:
 - *In this activity, we will examine how our views on gender and sexuality influence our values and beliefs about abortion. Many factors influence how we see ourselves as sexual beings, how we feel and behave sexually, our sexual and reproductive choices and, specifically, our values and beliefs about abortion. One important influence is our gender socialization, or how we were raised by our family and society to view ourselves and our expected roles as girls and boys, women and men. Typically, we are taught early in life what physical and sexual characteristics and behaviors are considered acceptable for girls and boys and for women and men. We learn this from our parents and extended family, community members, religious or spiritual leaders, educators, the media and other sources. How our family and society taught us to view ourselves and our sexuality in childhood continues to shape our values and beliefs about abortion into adulthood.*
2. Explain the guided imagery process:
 - Explain that you will lead them through a guided imagery process, or journey in their minds, during which they will close their eyes and imagine they are experiencing feelings and events that happened during puberty. Invite them to participate as fully as they are comfortable.
 - Let participants know that if they become uncomfortable with the images or feelings they are experiencing, they can open their eyes and stop the exercise or even leave the room. If they need support from a facilitator, they should raise their hand. They should do whatever they need to feel comfortable and safe.
 - Explain that some of the questions focus on sexual intercourse and pregnancy. For those participants who were not engaging in heterosexual intercourse during this time in their lives, ask them to imagine how they might have been feeling if they were.
 - Explain that you would like them to silently experience the journey without expressing anything out loud.
 - When the exercise is finished, they will have the opportunity to share their experience, first in small groups and then in the large group, if they choose.
3. Prepare participants for the guided imagery.
 - Ask participants to find a comfortable position and close their eyes. Lead participants through a series of several relaxing deep breaths. Guide participants through the following scenarios and questions, using an even, soothing tone of voice and remaining silent for a long time after each statement or question to allow participants time to reflect.

Note to facilitators: When reading each statement out loud, be sure to pause between each one longer than you may think is necessary or comfortable. It is important to give participants enough time to remember this period of their lives and enter the right frame of mind to respond to the question or statement.

4. Facilitate the guided imagery.
 - *Travel back in time to your puberty, when your body was maturing and you were becoming aware of your sexual feelings. Remember your body's state of physical and sexual development. Imagine a clear image of yourself and see yourself exactly as you were at that time.*
 - *Remember what things were most important to you at that time. Travel into your mind and remember some of your most important thoughts. Travel into your heart and remember some of your most important feelings. Think about the people who were in your life at that time and who the most influential people were.*

- As you ask the following questions, ask participants to imagine and feel what they were experiencing during that period of time. Remind them not to say their responses out loud.
 - *What were you feeling about the physical changes in your body? How were you feeling about your sexual development?*
 - *Was anyone talking to you about your developing body and sexuality and what it meant to be a young woman or young man? Who were they? Adults? Which adults? Peers? What were they saying? What were you learning on your own?*
 - *What were you being told were “normal” feelings for a young woman or young man of your age? How did your actual feelings relate to what you were being told was “normal”?*
 - *How were you told you should behave sexually?*
 - *What did you know about how women become pregnant and how to prevent pregnancy?*
 - *If you were having heterosexual intercourse, were you able to obtain effective contraception?*
 - *Was anyone talking to you about preventing unwanted pregnancy? Was anyone talking to you about abortion? What were they telling you? Was there silence surrounding these issues?*
 - *Now, staying in your body as you were in puberty, imagine that you might be pregnant. If you are a man, imagine that your girlfriend or close female friend might be pregnant. Even if you were not having intercourse at the time, imagine what it would have felt like to be pregnant.*
 - *What are the first thoughts and images going through your mind?*
 - *What are your fears?*
 - *What information and resources do you need?*
 - *Who might you talk to – or not talk to – about the possible pregnancy? Would you tell your parents or guardians? Other family members? Friends? If you’re a young woman, would you tell the person who fathered the pregnancy?*
 - *What might you decide to do about this pregnancy?*
 - *If you decide to terminate the pregnancy, where would you go?*
 - *What is your likelihood of getting a safe versus unsafe abortion?*
 - *How do you think you would be treated by the person performing the abortion?*
 - *Where would you go for contraception to prevent a future unwanted pregnancy?*
 - *How do you think you would be treated by the person offering contraceptive services?*
 - *What is your likelihood of obtaining and using your contraceptive methods of choice over the long term?*
 - Invite participants to gently return to the present when they are ready. Ask them to open their eyes, stretch and readjust to their surroundings. Observe how participants are doing and whether anyone needs emotional assistance. Be mindful of the shifts in energy in the room and transition slowly to the next part of the activity.
5. Tell participants that they will divide into small groups to discuss their experiences with the guided imagery. Ask one person per group to keep notes and report a summary of the discussions to the large group.
 6. Invite participants to talk about their experiences in youth:
 - *As a youth, what messages were you given – from adults or peers – about your developing body and sexuality and what it meant to be a young woman or young man?*
 - *What were you being told were “normal” feelings for a young woman or young man of your age?*
 - *What were you told about unwanted pregnancy and abortion? Was there only silence on these?*

- *What parts of your experience would you like to remain the same for the next generation of young people? What would you like to change?*
7. Solicit participants' experiences when they imagined they or a girlfriend might be pregnant. Acknowledge that not all participants may have had such concerns but that we asked them to imagine that they did.
 - *What were the first thoughts and images to go through your mind?*
 - *What were your fears?*
 - *What information and resources did you need?*
 - *Who might you have talked to – or not talked to – about the possible pregnancy?*
 - *If you decided to terminate the pregnancy, where would you have gone? What is the likelihood that you would have gotten a safe abortion?*
 - *How would the person performing the abortion have been likely to treat you?*
 - *Where would you have gone for contraception to prevent a future unwanted pregnancy?*
 - *What is the likelihood you would have been able to obtain and use your contraceptive methods of choice over the long term?*
 8. Ask participants to return to the large group for discussion. Ask group note takers to briefly summarize the main themes raised in small group discussions.
 9. Ask participants to imagine the thousands of young people all over the world who are in similar situations.
 - *From our discussions, what have we learned about the information, resources and support young people may need from us?*
 - *From our discussions, what have we learned about the diversity of needs among young people?*
 - *What do we need to know and do in order to provide young people with better support?*
 - *What are initial steps we can take today?*
 10. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Adapted from: Turner, Katherine L. and Kimberly Chapman Page. 2008. "Gender, Sexuality and Abortion" and "What Would You Do." In *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas.

Module 2: Barriers to care

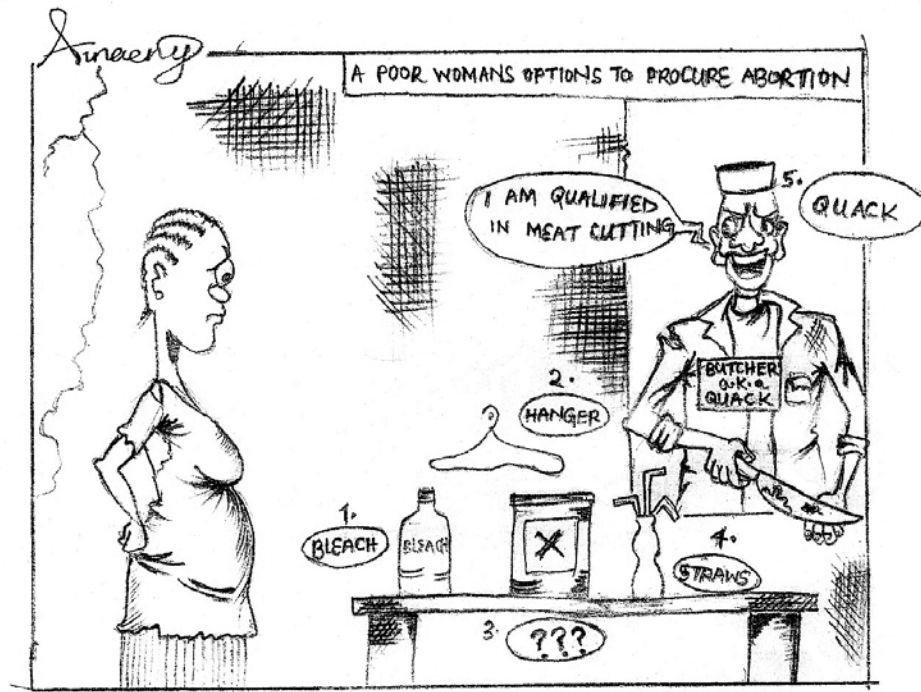


Image by Ipas's African Youth Art Contest winner Kiwelu Ainaeny of Kenya

2.1 Introduction

The purpose of this module is to increase understanding of the social, economic, logistical, legal, policy and health system barriers young women face when seeking safe abortion care. These barriers drive young women to resort to unsafe abortion or delay seeking care until later in the pregnancy when the risk of complications increases. Part II of this toolkit will discuss how to overcome many of these barriers and increase access to safe abortion care for young women.

“unsafe abortion has eaten into our society, gradually destroying the lives of young women, as people have closed their eyes at the issue hoping it will disappear: but on the other hand they are also directly and indirectly worsening the situation.” - young woman, Nigeria (youth coalition 2007)

2.2 Social barriers

Social barriers to safe abortion care for young women include gender and age discrimination, gender-based violence, sexuality and abortion stigma, and the lack of information and social support.

Gender discrimination occurs when a distinction is made about a person based on the particular group they belong to, in this case women and girls, that results in unfair and unjust treatment expressed through negative attitudes and behaviors (EngenderHealth and ICW 2006). Gender discrimination has a direct effect on access to abortion care. For example, young women may be required to do more house chores and have less personal freedom than young men of the same age, leaving them little opportunity to seek health care. In many countries, girls are less likely to attend school than boys are. If they work for pay, they are likely to be paid less than young men and have less ability to pay for health services on their own. Many cultural beliefs about gender include that young, unmarried women should not be sexually active and therefore should not need to access sexual and reproductive health services. Young women may have to hide trips to a health-care facility or may be prevented from going at all. They may therefore not have the means to prevent pregnancy, and they may deny a pregnancy and delay seeking care due to fear of repercussions from family members or a partner (Davis and Beasley 2009).

Gender-based violence is the abuse of power to control another individual who is in a submissive position due to social beliefs about gender. It can be physical, sexual or mental (de Bruyn and France 2001).

Violence against women and girls includes physical, sexual, psychological, and economic abuse. It is often known as “gender-based” violence because it evolves in part from women’s subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimize and therefore perpetuate violence against women. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family (Heise et al. 1999).

Beyond gender discrimination, women may fear or experience violence for seeking abortion or other sexual and reproductive health services. Perpetrators can be family members, intimate partners or even abortion providers. Because of their socioeconomic status, young women are often more vulnerable and sometimes intentionally targeted for assault. Studies suggest that at least one-third of all rape survivors worldwide are less than 16 years old (Heise et al. 1999). Shame, particularly after a sexual assault, or physical injury may cause a woman not to access care. Perpetrators may threaten further violence to maintain secrecy, particularly within a family.

Violence may also be directed against young women who do not conform to cultural gender expectations or who have sexual orientations other than heterosexual. These women may be subjected to “corrective” sexual assaults, ostensibly to make them heterosexual or more feminine.

Women who experience gender-based violence often wish to abort any resulting pregnancy.

Stigma is a characteristic or attribute that causes a person to become “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman 1963). Sexuality, age and abortion stigma can all be barriers to young women seeking safe abortion care.

- **Abortion stigma** is a cultural belief that women who have or seek an abortion are inferior to the ideal of womanhood and should feel shame or remorse, even in countries where abortion is legal and safe services are available (Kumar et al. 2009). Many religious leaders and institutions maintain that abortion is immoral and that a woman who has an abortion has transgressed against religious tenets. In communities or families where these beliefs predominate, a woman may be afraid to have an abortion and risk negative judgment. A woman from Zambia, a country in Africa where abortion is legal for a number of indications, expressed stigma this way: “The one that has an abortion is treated as bad, as a killer and the other one is a good woman, she has a good heart, she loves children” (Mupeta et al. 2010). Young women who rely upon their communities for economic and social support may be especially hesitant to risk being stigmatized and potentially ostracized for seeking an abortion. In addition, stigma against abortion often makes health system and facility administrators and providers less likely to offer abortion services and leads to underreporting of abortions, which in turn reinforces the idea of abortion as a deviant practice rather than a routine component of women’s health care.

“When students know that another female student has induced an abortion, the students, especially the boys will organize a funeral ceremony for the aborted child. They will make a coffin for that child, organize a morning ceremony during which they will cry, roll on the ground just to humiliate the girl. Girls are not always left out in this practice. Once the boys start, the girls too follow.”

- woman, Zambia (Mupeta et al. 2010)

- **Sexuality stigma** is characterized by a culture’s unwillingness to discuss sex and sexuality, often even in private, and the assigning of pejorative labels to any people who are known to be sexually active or who talk about sex and sexuality openly. This stigma is sometimes related to religion. For example, in many Islamic schools of thought, sexuality within marriage is permitted and socially accepted, while outside of marriage it is seen as illegitimate and stigmatized (Smerecnik et al. 2010). In many Islamic, Christian and other religious schools of thought, sexuality stigma often makes young people feel that they must conceal sexual activity (Wood and Aggleton 2003), and young women particularly may pretend that they do not know anything about sex or sexuality in order to avoid being labeled as promiscuous. This makes it difficult to prepare for sexual activity in any way, including gathering information and obtaining contraceptives, and is also a barrier to finding and accessing abortion care.

"the reason they may not go to the community is because in the village information spreads like bushfire... by the time i buy the condom or go to the health unit - the person in the health unit is well known to everyone - and if i go there to get a condom, i will be tagged as a wrong person in the community because our society is not yet fully open to discussing sex freely."

- participant, uganda (kipp et al. 2007)

- **Age stigma** is also a barrier to care for young people, because they are often not considered mature enough to make decisions about having sex, using contraceptives, or handling an unwanted pregnancy. In most cultures, adults are expected to have control over young people's lives, including their access to health care. Even in nongovernmental organizations (NGOs) and health services that specifically assist young people, they are often not included in any level of decisionmaking (Wood and Aggleton 2003). See Module 4: Building partnerships between young people and adults.

Lack of information: Because of cultural taboos against speaking openly about sexuality, young women may not have been given factually correct information on menstruation, pregnancy, preventing pregnancy, recognizing the signs and symptoms of pregnancy, and where and how to seek qualified assistance. Peers can be an additional source of misinformation about sexual and reproductive health, because parents and other adults or the young people themselves are often embarrassed or fearful to discuss these issues, due to sexuality stigma (Ngweni et al. 2005, Olukoya et al. 2001). Studies have shown that lack of or inaccurate information is a primary reason that young women tend to seek abortion services later than adult women (Davis and Beasley 2009, Finer et al. 2006).

"some grown-ups think that we are too young to know. they should know that we are too young to die."

- young person, honduras (youth incentives and ipas 2010)

Young people's lack of recognition of abortion as a legitimate health-care service

The Center for Reproductive Rights found that adolescents and young women across Kenya did not identify abortion care as a service that a legitimate health-care provider would provide. One young participant said, "Women don't go to doctors to terminate their pregnancies. Doctors don't terminate pregnancies." (2010)

Lack of social support: Research conducted with young female factory workers in Nepal shows that “social networks were important for the young factory workers in reaching decisions regarding the method for termination of pregnancy, to locate a provider and pay the cost for the services. Firstly, the young workers reported to mothers, sisters-in law, female friends, relatives and partners about their unwanted pregnancy and sought advice from them. Female friends and husbands or boyfriends occasionally forced a young girl to undergo an abortion or to carry the unwanted pregnancy to full term, against the girl’s wishes” (Puri 2002). Because of beliefs, stigma and lack of information in her community, a young woman may be unable to ask for information or help in getting to or paying for services for fear of negative repercussions and refusal to assist in any way. If she seeks support, she may be denied it or faced with actions that compromise her safety.

“while on holiday, the first thing i asked my sister was if it was true that every month blood comes out of the vagina of young women who have reached puberty. she angrily asked me how i had found out. i told her about the discussions at school and she said: ‘it seems that you want to become a loose woman now? i tell you, if i found out that blood is coming out of your vagina, i will kill you because it shows you are having sex with a man and that is a sin.’”

– young woman, tanzania (youth incentives and ipas 2010)

These social barriers reinforce each other to a large degree. Gender discrimination leads to a lack of or inaccurate information being provided to young women. This makes gender-based violence more possible and sustains the illusion that a “good” young woman is not willingly sexual and thus healthy sexuality in young women should not be supported. This also supports the notion that “good” women do not have abortions, which decreases the likelihood that a young woman will have social support if she chooses to seek an abortion. Adults can learn techniques and increase their own awareness to address these barriers, as will be explored in later modules.

2.3 Economic and logistical barriers

Even with accurate information and social support, young women may not be able to access abortion care if they do not have transportation or sufficient financial resources.

Financial resources: For some women, it can take time to gather enough money to pay for an abortion, thereby delaying care and increasing the risks and costs associated with later procedures (Finer et al. 2006). Young women are less likely than adult women to have money of their own, and any money they have may be controlled or monitored by their guardians. Because of this economic disadvantage, young women may also be more likely than adults to resort to providing sex in exchange for money or food. Financial help from peers is often unrealistic since young people generally have few financial resources. Lacking funds, young women are especially vulnerable to coercion by abortion providers to pay by other means, including sexual favors. Some young women without the means to pay for safe services resort to unsafe abortion. Research in Nepal shows that young female factory workers are particularly at risk for unsafe abortion due to their inability to pay for safe services (Puri 2002). In settings where there are no facilities offering free or subsidized care, safe abortion is only available to women with money, regardless of the law.

"i went to the medical shop in sallaghari and got a liquid medicine for rs.150 (2 u.s. dollars). i took it regularly but it didn't work. when i went there again to complain, they said that they couldn't get rid of it (the pregnancy) unless i gave them rs. 4000 (55 usd). the women around told me to carry heavy things to get rid of it since it was only one month old. it also didn't work out. i didn't have much money so i decided to keep the baby." - young woman, 18 years old, nepal (puri 2002)

In countries where abortion is illegal, or not legally accessible to young women, abortion services are driven underground and providers typically charge higher, sometimes exorbitant, fees to provide them. In these cases, young women who cannot afford services, regardless of their legality, often resort to unsafe methods that are cheaper, and often ineffective, such as drinking laundry detergent.

Transportation: Young women, especially those who live in rural areas, may be far from any health-care facility. Lack of transportation is a barrier for many young women. In some communities, young or unmarried women cannot or are unlikely to own a car, scooter or bicycle. Public transportation, even for emergencies, may not exist at all or may be too expensive or unsafe to use for young women in particular.

Economic and logistical barriers also reinforce each other. Young women who must travel to find a facility that offers abortion services may find that they need to take more time off of work, which could result in lost income or unemployment. Transportation also costs money, so the farther away the facility is, the more expensive the full cost of an abortion becomes.

2.4 Legal and policy barriers

Laws prohibiting abortion are obvious barriers to anyone seeking safe abortion services. As of 2009, at least 26 percent of people in the world live in countries where abortion is generally prohibited although most of these countries have at least one legal indication for abortion (Center for Reproductive Rights 2009).

Abortion laws: National and state laws can be major barriers to young women seeking abortion services. Most countries permit abortion for some indications, such as pregnancies resulting from rape or incest or that endanger the woman's health or life (Center for Reproductive Rights 2009). Some countries' laws specify young age as an indication for legal abortion. Mental health may be an indication that enables access to young women, as denying abortion services to a young woman can have particular risks to her mental health. Some laws are vague on age or other limitations, requiring interpretation by the provider or a judge, and causing confusion for providers who are unclear about whether they can legally perform the service (de Bruyn and Packer 2004). Statutory rape is also an indication for legal abortion in some countries, if the young woman is below the legal age of consent. See 2.7 Additional Resources for links to the full text of abortion laws in most countries and general interpretation of those laws.

Third-party involvement laws: For legal indications, one of the largest barriers for young women is the mandated notification and/or consent of a third-party (parent, guardian, psychiatrist or other adult) in the decision to have an abortion. Involvement laws are based on one of the following approaches:

- A fixed minimum age limit
- A capability determination by the provider

- A fixed minimum age limit combined with capability determination (by which a minor can acquire the right to majority at an earlier age)
- A presumption of capability (no third-party consent needed unless the minor is proven incapable).

Research shows that involvement laws do not increase communication within families, and can cause harm by driving young women to have an unsafe abortion. A U.S. coalition of medical experts states:

The American Medical Association, the Society for Adolescent Medicine, the American Public Health Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and other health professional organizations have reached a consensus that **minors should not be compelled or required to involve their parents in their decisions to obtain abortions**, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults. These conclusions result from objective analyses of current data, which indicate that legislation mandating parental involvement does not achieve the intended benefit of promoting family communication but does increase the risk of harm to the adolescent by delaying access to appropriate medical care. (American Academy of Pediatrics 1996, emphasis added)

While some third-party involvement laws allow for an alternative process, where a young woman asks permission from a judge to have an abortion (judicial bypass), this tends to cause significant delays or denial of care. Third-party involvement laws also “wholly ignore the health needs of young people who do not live with their parents or who head their own households” (IPPF 2011). Despite this, at least 24 countries had third-party notification or consent requirements for abortions for minors in 2003 (de Bruyn and Packer 2004). Where national laws permit young women to have an abortion without third-party involvement, state or local laws may override that right, or facility policies (such as a committee review) may still cause delays, even to the point where abortion is no longer an option (Human Rights Watch 2010).

“where restrictive laws or provider practices deny young women access to safe and confidential health services and counseling, without regard to their individual capacity, this constitutes age-based discrimination.” - ippf 2011

Sexual violence: Types of sexual violence, especially rape and incest, are indications for legal abortion in many countries. However, some of these laws make it difficult or impossible for a woman to maintain confidentiality; in addition, getting official permission for the abortion can be a difficult, slow and emotionally painful process. Proof of rape may be required, or believed to be required, in order to have a legal abortion. Obtaining proof or even filing a complaint can be particularly difficult in societies where women need male witnesses or tangible proof of the rape. Going through the bureaucratic procedures to have the rape investigated and validated can be emotionally painful and may subject the woman to further discrimination and victimization. If consent of a third-party is legally necessary for a young woman to have an abortion, this may be especially difficult to obtain if the rapist is a family member.

Interaction with other laws: In the case where the abortion law is in conflict with other laws, providers or facilities may not know which law takes precedence and refuse to provide care, while confused clients may simply avoid seeking care. This is particularly true for young women, as there may be separate laws on the age of consent for general health procedures. For example, the South African Choice on Termination of Pregnancy (CTOP) Act states that young women of any age can consent to an abortion. However, separate legislation, the Children’s Act, provides ages of consent for medical and surgical procedures. The CTOP Act takes legal precedence, but many people remain unclear on this point (McQuoid-Mason 2010, Strode et al. 2010).

Reporting requirements for sexual violence can also complicate the process and create a barrier. In South Africa, for example, the Criminal Law (Sexual Offenses and Related Matters) Amendment Act (“the Sexual Offenses Act”) requires the reporting of sexual offenses against children; however, the CTOP Act supersedes this and leaves the young woman to decide whether or not to report an offense. When providers or young women do not interpret the laws correctly, the breach of confidentiality may prevent some young women from seeking care, including abortion care after sexual violence (McQuoid-Mason 2010).

Implementation documents: Often, implementation documents include steps and procedures (policies, standards and protocols) meant to protect against mistakes or abuses but which end up creating barriers to service. Examples that particularly affect young women include the addition of third-party notification or consent measures that do not exist in the law, or waiting periods required in protocol that do not exist in the law. These procedures result in additional time, and increased expense and exposure for young women, who must return later for the actual procedure.

Policies, standards and protocols to implement laws at all levels should follow the WHO’s (2003) recommendations on non-evidence-based policies and protocols, and make abortion care available unless specifically prohibited by the law:

- to unmarried and married women
- without spousal or parental notification or consent
- without minimum age requirement
- without proof of police certification, legal action, or court authorization for rape cases
- without authorization required by hospital abortion committees or other committees
- without a waiting period
- without mandatory contraception after abortion
- with “conscientious objector” providers required to refer the woman to another provider

2.5 Health system barriers

Young people face barriers at the health system and facility levels. Services that meet the particular needs of young people sometimes cannot be within the same systems that serve adults (Heunis et al. 2000, Mouli 2003, Ngwena et al. 2005, Van Look 2003), but sometimes serve young people’s needs better when they are integrated. Privacy, provider and staff attitudes, hours of operation, and some aspects of processes and paperwork as well as cost are under the direct control of individual facilities, or can be mandated by a health system. Improving these barriers to care can go a long way toward making abortion care more accessible to young women.

Lack of or unavailability of facilities providing abortion: Facilities providing abortion are often far apart geographically and may be concentrated in urban areas. They may also be open at inconvenient times for young women: transportation may be unavailable or more expensive during open hours; open hours may conflict with work or school hours and missing work/school would result in loss of job or grade; or open hours may be during the busiest hours of the facility and the young woman may fear being seen by someone she knows. Finally, services are often not appropriate for young women in terms of timing, privacy and provider/staff attitudes, which may further deter young women from requesting care. If safe abortion services are only available in the private sector, this also limits the facilities at which young women can access services.

Lack of privacy and confidentiality: Privacy and confidentiality are important issues in reproductive health care, and are an even greater concern for young people, who may

want to avoid being seen by a family member or neighbor while seeking sexual and reproductive health services. A young person may not seek care at a facility that presents long waiting times, lengthy detailed medical history and counseling sessions, and poorly isolated counseling and treatment rooms (Ngwena et al. 2005). Exit interviews in a study in Ghana found that, pre-intervention, a quarter of young women felt that they did not have enough physical privacy, and more than half were unsure that the health provider would keep their situation confidential. Processes that violate confidentiality include paperwork posted outside examination rooms or left in a visible place, and access to records by non-abortion service staff and providers.

Processes and forms: For example, registration paperwork that includes the husband's name as required information even though unmarried women are legally allowed to receive services may make young, often unmarried, women feel unwelcome. Protocols requiring numerous visits are also a barrier, creating more economic and logistical challenges with each trip to the facility.

Providers may assume that processes are more complex or restrictive than they actually are. In restrictive legal environments, for example, facilities and providers may not be aware of or clearly understand the legal indications for abortion and may refuse to provide care. In general, a lack of institutional clarity on the legal indications for abortion care create a barrier for young women, as providers may feel they are taking a risk even when providing high-quality services appropriately.

Cost: Young women often cite their inability to pay as the reason they delay seeking abortion services. In addition, some health systems and facilities may set higher fees as a punitive measure or to offset the cost of other services they deem less morally difficult. Other facilities may offer free or low-cost abortion care only if the young woman accepts a contraceptive method, usually a long-term or permanent method, which is coercive.

Negative provider and staff attitudes about youth sexuality and abortion: Provider and staff attitudes can be significant barriers to care, and may be the final barrier that drives a young woman to unsafe abortion. A study in South Africa found that, of health-care providers who were asked for a referral to a facility that provided abortion, a third only gave referrals for special cases such as rape despite the country's broad legal indications, and nearly a third refused to provide information on abortion to those requesting a referral (Ngwena et al. 2005). A young woman who visits a facility where she is denied care and/or a referral may feel discouraged at the prospect of challenging barriers at another facility and may not seek care. In addition, the counseling provided to young people often focuses on the risks and dangers of sexuality (Klingberg-Allvin et al. 2006) rather than assisting them in achieving a healthy sexuality.

"when it would come time to talk to doctors about my options, my birth control options... it was written all over their face like disgust... i would just feel like so horrible and this doctor who is supposed to be knowledgeable thinks i am doing something completely horrible."

- young woman, united states (california latinas for reproductive justice 2010)

It is important to note that past negative attitudes on the part of providers and staff can be an ongoing barrier, as young women may hear of other women's past treatment, or have their own negative past experiences, and decide not to risk going to the same facility. A health worker in Uganda states:

"For example, somebody comes here, a young girl of 14, imagine a service provider says 'even at your age, you have started doing this?' Just imagine. Immediately that girl will never come back and even tell others 'you don't go there.' These adolescents you have to appreciate that it is hard to come and even what they want to discuss is confidential. Some of these service providers will go and share some of these things with people outside and these adolescents come to know about it. Something small like that can spread very, very fast, and the other people will never come back." (Kipp et al. 2007)

Many health system barriers originate in negative staff and provider attitudes, as there is no will to make services available to young people, and there may be a desire to actively discourage young women seeking abortion. For example, young women may be charged more for abortion services than adult women, not given appropriate pain management, or their privacy intentionally violated, in order to punish them for being sexually active or getting an abortion.

2.6 The interrelation of barriers

Social barriers like stigma and gender discrimination heavily influence other barriers, particularly the laws, policies, processes, documentation, and provider/staff attitudes. They may also influence availability of facilities offering safe abortion care to young women; for example, in countries where abortion and young people's sexuality are stigmatized many providers do not want to be associated with providing abortion care at all and in particular not to young women. Laws that limit legal abortion indications also serve to reinforce social barriers. Addressing health system and logistical barriers may cause facilities to incur more costs, causing them to raise the price of abortion care and thus create even more of a cost barrier for young women.

"we do not have access to contraception. we are stigmatized if we have a child before marriage. we do not have the right to abortion. what a dilemma! how can we not die if we are exposed to risky [unsafe] abortions? how can we not resort to abortion if a child before marriage is a sacrilege? how can we avoid having children when there are no contraceptive services? we wish to affirm that one of the best weapons in the fight against risky [unsafe] abortions among the young is to respect our rights, starting with the right to information."
 - young woman, democratic republic of the congo
 (greene et al. 2010)

2.7 Additional resources

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MODULE 2 TOOLS

TOOL 2A: Barriers to care handout

TOOL 2B: Barriers to care



TOOL 2A: Barriers to care handout

Social barriers

Gender discrimination – Women are often treated unfairly on the basis of being female, and may not have the freedom or means to access safe abortion care because of it.

Gender-based violence – Young women are particularly vulnerable to gender-based violence and fear of or shame after such violence may prevent them from accessing abortion services.

Stigma – Stigma is defined as a characteristic or attribute for which a person is considered tainted or lesser.

Abortion stigma – Young women who depend on others may be especially hesitant to risk being stigmatized for seeking an abortion, and stigma may make health facilities and providers less likely to offer abortion services.

Sexuality stigma – Young women may not enjoy their sexuality, prepare for sexual activity, or seek sexual and reproductive health care to avoid being labeled as promiscuous.

Age stigma – Young people often are not considered mature enough to make decisions about having sex, using contraceptives, and how to handle an unwanted pregnancy.

Lack of social support – Because of stigma in her community, a young woman may be unable to ask for information or help regarding safe abortion for fear of negative repercussions.

Economic and logistical barriers

Financial resources – Young women often don't have access to money.

Transportation – Distances may be far and transportation unavailable or expensive.

Legal and policy barriers

Abortion laws – These may be restrictive, although they rarely completely outlaw abortion.

Third-party involvement laws – Mandated notification and/or consent of a parent, guardian, psychiatrist or other adult is a significant barrier for young women.

Sexual violence – Sexual violence is often a legal indication, but the process may not protect confidentiality, and may be difficult, slow and emotionally painful.

Interaction with other laws – Providers or facilities may not know which law takes precedence and refuse care; confused clients may not seek care.

Implementation documents – Steps or procedures required by policies, standards or guidelines that are not required by the law act as barriers, even when they are intended to be helpful.

Health system barriers

- Lack of/unavailability of facilities providing abortions
- Lack of privacy and confidentiality
- Unnecessarily complex or adult-focused processes and forms
- Cost
- Negative provider and staff attitudes about youth sexuality and abortion

Interrelation of barriers

Many barriers influence other barriers, such as stigma's impact on policies and attitudes.

TOOL 2B: Barriers to care



Objectives

By the end of this activity, participants will be able to:

- Identify the different barriers young women encounter when seeking safe abortion.
- Recognize the ways these barriers affect young women differently than older women.



Materials

- Flipcharts, markers, tape, post-it notes (or other note cards), color paper



Time

15 minutes: Identification and grouping of barriers

15 minutes: Barriers to care story

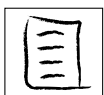
20 minutes: Discussion and presentation

50 minutes total time



Preparation

- Review the barriers to care in Module 2.
- Place several post-it notes (or note cards and tape) on each table.
- Write the four categories of barriers on different color papers: 1) Social, 2) Economic and logistical, 3) Legal and policy and 4) Health system.
- Draw a sample story about barriers to care on a flipchart.
- Write discussion questions on a flipchart.



Instructions

1. Inform participants that in this activity they will identify the barriers to abortion care that young women encounter and explore how those barriers may impact young women's access differently than for older women.
2. Ask participants to write down barriers young women may encounter to abortion care on post-it notes. Instruct participants to only write one barrier per note, in large handwriting, and then place the note on the wall. Each participant can write several notes.
3. Tell participants that they will group the barriers into categories. Put the four color papers with the categories of barriers on the wall with the notes and read them aloud.

4. Ask a participant to come to the wall and, with input from other participants, group the barriers under the most appropriate category.

Note to facilitator: If there is a barrier that participants decide does not fit under one of the four categories, temporarily place it to the side and then revisit it after all others have been categorized. Ask participants to consider if an additional or different category might be needed.

5. Make sure participants have mentioned all the key barriers covered in Module 2. Add any barriers that might be missing under each category.
6. Tell participants that for the next part of the activity they will explore how these barriers affect young women.
7. Instruct participants to form small groups of no more than five people each. Give each group a flipchart sheet and markers. Ask one person per group to take notes and report a summary of the discussions to the large group.
8. Give the following instructions on how to draw their story about barriers to safe abortion care:
 - *Divide your group's flipchart sheet into six boxes.*
 - *Number the boxes from one to six. Draw a picture of a young woman with an unwanted pregnancy in the first box and a picture of a facility that provides safe abortion care in the last box. (Show example.)*
 - *The story begins in the first box and ends in the sixth box.*
 - *Draw a picture for each box, portraying different barriers that this young woman encounters as she tries to seek a safe abortion.*

| | |
|--|---|
| <p>1</p> <p><i>Picture of young woman</i></p> | <p>2</p> |
| <p>3</p> | <p>4</p> |
| <p>5</p> | <p>6</p> <p><i>Picture of facility</i></p> |

9. Inform the groups that they have 15 minutes to draw their story. Check in with all the groups as they work.

10. When groups are finished drawing their barrier story, post the flipchart with questions and ask them to discuss.
 - *How does each of these barriers impede the young woman's efforts to terminate her pregnancy safely?*
 - *What is this young woman's likelihood of having a safe abortion?*
 - *How might young women experience these barriers differently than older women? Which barriers may be unique to young women?*
 - *How do barriers like these explain young women's disproportionately high rate of unsafe abortion? Reluctance to seek care? Delay in seeking care?*
11. Invite each group to post their flipchart, share their story and briefly summarize their group discussion.
12. After all of the groups have presented, highlight key points from the discussion. You may wish to summarize by saying:
 - *Young women face many barriers to abortion care. They can be as large as social attitudes and beliefs that allow gender and age discrimination to occur. They can be a lack of financial resources. Even something as seemingly small as being required to fill in a blank for a husband's name when one is unmarried can become a barrier.*
 - *These barriers can be divided into categories such as social, economic and logistical, legal and policy, and health system barriers.*
 - *Young women often experience these barriers differently than adult women. Some barriers like consent laws or policies may even be unique to young women below a certain age.*
 - *The barriers that they face make young women especially vulnerable to delays in seeking and receiving care and feeling that unsafe abortion is their only option. Young women who obtain abortion care tend to access it later in pregnancy than adults. Young women who have an unsafe abortion are more likely to delay seeking help for complications than adults. They risk possible injury or death because of these barriers.*
 - *Some young women will be forced to become mothers against their will, while others will become socially ostracized from their community and forced to leave home.*
 - *It is therefore urgent to remove as many barriers as possible to ensure that young women get the care they need and have a right to, and do not resort to life-threatening unsafe abortions.*
 - *Parents, peers, the community, policymakers, and health-care providers and staff can all play an important role in removing barriers to abortion care for young people.*
13. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Note to facilitator: If you select this exercise, make sure also to cover Module 5: Making abortion care accessible, including Tool 5B: Addressing barriers to care.

Part II: Abortion care for young women

- 3. A rights-based approach to care
- 4. Building partnerships between young people and adults
- 5. Making abortion care accessible
- 6. Making abortion care clinically appropriate

part two

Safe Abortion Services for Young People

Services for young people

Advocacy efforts towards starting up new services & upgrading the existing ones

Fair & equal treatment from service providers

Enabling youth – Friendly environment

Ample of information

Bridge the information with back-up of confidential services

Organized efforts on the part of [government organizations] & [non-governmental organizations]

Respect our decision

Trust us

Informed choices

Off with the myths and misconceptions

Need your support

(By Smita Pawar, India, Youth Coalition 2007)

Module 3: A rights-based approach to care



Image used with permission of Youth Coalition for Sexual and Reproductive Rights © 2007. Special thanks to the participants of the 2007 National Safe Abortion Advocacy Workshop in Ecuador.

3.1 Introduction

Recognition of and respect for young people's rights to health and information should guide abortion care for young women. It means that all young women are entitled to safe abortion care, and there are no conditions or circumstances that make some young women more "worthy" of safe services than others. It also implies upholding young women's capacity to be actively involved in and consent to their own health-care treatment. A deeper understanding of young women's rights can positively impact health system and social barriers, as well as legal and policy barriers like consent laws. This module provides information and tools on young people's sexual and reproductive rights, and young women's right to decisionmaking in abortion care.

3.2 Young people's sexual and reproductive rights

Health is a human right to which all people are entitled under the 1948 Universal Declaration of Human Rights. The Declaration also establishes that all humans are born equal and have rights to life, liberty, security of person, to own property and to information and education, among others (1948, Arts. 3, 17, 25). Human rights are the foundation of the recommendations in this toolkit.

Since 1948, additional international conventions and conferences have clarified and expanded human rights. While conventions and covenants are legally binding for governments who sign and ratify them, conferences result only in recommendations for governments. Conventions and covenants are protected by Committees that monitor violations against them. Aside from the Declaration of Human Rights, some important conventions and conferences for young women's access to safe abortion care include:

- **The International Covenant on Economic, Social and Cultural Rights (1966)**

It affirms all persons' right to self-determination and to freely pursue economic and social development (Art. 1). If a young woman is denied safe abortion, her right to self-determination could be violated. The Covenant also affirms the right to the highest attainable standard of health, both physical and mental (Art. 12). If a young woman is denied safe abortion, her right to health is violated.

- **The International Conference on Population and Development (ICPD) (1994)**

While the concept of "reproductive rights" grew out of the 1968 International Conference on Human Rights in Tehran, reproductive health was defined at the ICPD as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (UNFPA 1995 Art. 7.2).

If a young woman is denied safe abortion, her right to control her own fertility has been violated. If she subsequently seeks an unsafe abortion and experiences complications, her right to have a satisfying and safe sex life may be violated too.

The ICPD established a number of goals and targets, including universal access to reproductive health services by 2015 (UNFPA 1995). On induced abortion, the ICPD consensus statement noted:

All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services...In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for management of complications arising from abortion. Postabortion counseling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortion (UNFPA 1995, Arts. 7.6, 7.16 and 8.25).

- **The Fourth World Conference on Women in Beijing's Platform for Action (1995)**

The conference urged countries to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” (UNESCO 1995). Then, in 1999, a Special Session of the United Nations General Assembly stated that, for the indications legal in each country, “health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible” (UN 1999).

All human beings are entitled to these rights independent of any biological, social, economic or political distinctions, such as gender or age. For example, the Convention on the Rights of the Child affirms the right of the child to freedom of thought and expression, and health (UN 1989, Arts. 13, 14, 24). It has been ratified by all countries worldwide except the United States and Somalia. The Committee on the Rights of the Child further specifies that governments should “provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law [to girls and young women]” (UN 2003).

Denying young women safe abortion care violates many of their human rights, including the right to health and sometimes life, and numerous sexual and reproductive rights. To be able to access safe abortion care young women need other human rights to be realized first: without information and education it is much harder to identify pregnancy, options for handling the pregnancy, and where to seek care. Without the confidence that their rights to privacy and confidentiality will be fulfilled, young women may refrain from seeking safe abortion and resort to unsafe, but more private, options instead. Access to safe abortion is closely linked to many different human rights.

3.3 Evolving capacities and the principle of capability

While there are no universally accepted definitions of young people's capacity to make decisions, it is widely recognized that this capacity is evolving, and is not linked directly to chronological age (Lansdown 2005). Young people of a given age can have a wide range of decisionmaking capacities. The Convention on the Rights of the Child affirms children's and young people's right to independent decisionmaking in accordance with their capacities. It requires that:

States parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family...or other persons legally responsible for the child, to provide, **in a manner consistent with the evolving capacities of the child**, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention (UN 2003, emphasis added).

This international convention recognizes that support and guidance can be helpful for any young person, but parents and guardians should provide direction only “in a manner consistent with” the young person's capacities. No adult should attempt to direct a young person's decisionmaking if s/he has the capacity to make a decision. In further recommendations, the Committee on the Rights of the Child called on the Ukraine to “take urgent measures to reduce maternal deaths related to teenage abortions and to ensure by law and in practice that **the views of the child should always be heard and respected in abortion decisions**” (UN 2011, emphasis added).

Furthermore, different decisions require different types and thresholds of capacity. A young person who is otherwise inclined to impulsive decisionmaking, and perhaps made such a decision when choosing to have unprotected sex, is unlikely to make decisions on medical care, including abortion, in the same way. In structured situations, such as medical care and basic information processing, the American Psychological Association has found that most young people can understand the risks and benefits of medical procedures as well as adults, and are able to make decisions about their medical care independently (Ehrlich 2003, IPPF 2011, Steinberg et al. 2009, Tillett 2005). When local laws and policies allow, providers should assume a young person's capacity to make a decision, unless counseling reveals the young woman desires the support of a guardian in decisionmaking. The International Planned Parenthood Federation-Western Hemisphere Region states:

The professional's assessment aims to determine not whether or not young people have the right to make decisions, but the degree of support they require to appropriate and make use of the capacities that enable them to exercise their rights (2010).

"basing the capacity to consent to abortion on chronological age as opposed to ability to understand the procedure, its inherent risks, and alternatives is oblivious to the human rights duty to recognize and give expression to the evolving capacity of the child. it diminishes the dignity of many adolescents and certainly all young women." (ngweni 2010)

Because determining capacity (or incapacity) remains subjective, a useful **principle of capability** has been provided by Cook and Dickens in their article in the *International Journal of Gynecology and Obstetrics*: Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight (2000).

The same principle of capability can be applied to abortion care for young women. A young woman – who identifies that she has an unwanted pregnancy and voluntarily requests a safe abortion to terminate her pregnancy – is capable to consent to a safe abortion procedure.

If an involvement law restricts young women's right to decide to have an abortion, providers can still play an important role in protecting young women's lives and health without third-party consent or notification:

- The Committee on the Rights of the Child affirms the right to private and confidential counseling and advice as distinct from the right to give medical consent, which is not subject to any age limit: Children have a right to access "[private and] confidential medical counseling and advice without parental consent, irrespective of the child's age, where this is needed for the child's safety or well-being" (UN 2009). Providers should give accurate and comprehensive information about safe abortion, which may include information about local abortion hotlines and organizations like Women on Web, as well as provide counseling and advice about medical abortion, without third-party involvement.
- Providers have an ethical duty to provide care without delay when a young woman's life is in danger. Almost all national abortion laws in the world allow abortion when the life of the woman is in danger, and most involvement laws also make exceptions to third-party consent or notification when the young woman's life is in danger or the pregnancy is due to incest.
- Postabortion care, for women presenting complications from incomplete or unsafe abortion, should always be available to all women who need it, independent of age.
- Providers can also work to address legal and policy barriers in direct ways, as described in Module 5 (5.4 Addressing legal and policy barriers).
- See *Successful strategies in restrictive settings* in Module 5 for more examples.

SOME DAY, I HOPE...

*With a heavy heart I approach the place
All eyes I feel stare at my face
“I don’t want a child” is all I say.
“You don’t want ‘this’ child” is what they say
As if there is always a child in there.
I have made my mind.
I know it’s right.
Even the law I know is on my side.
These are people I know who believe in me
But then there are others who just don’t see.
My honor, my body, my health is my own
Yet they think of someone who is unborn,
Something which is just cells, yet to be grown.
I walk inside, hoping some day,
My rights will be mine and not put at stake.
Someday I hope all people will understand,
Respect me as a person and give my decision
a stand.*

(By Arpita Chaudhary, India, Youth Coalition 2007)

3.4 Additional resources

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Women on Web. <http://www.womenonweb.org/>

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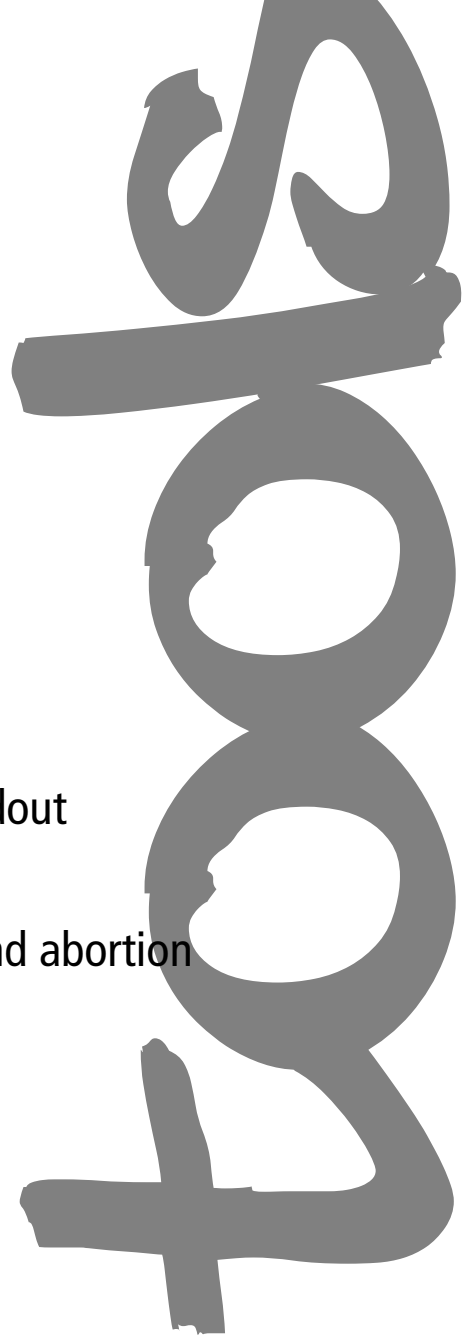
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MODULE 3 TOOLS

Tool 3A: A rights-based approach to care handout

Tool 3B: Young women, international rights and abortion

Tool 3C: The principle of capability



TOOL 3A: A rights-based approach to care handout

Sexual and reproductive rights of young people

Conventions and covenants are legally binding for governments who sign and ratify them, while conferences provide recommendations for governments.

Universal Declaration of Human Rights (1948)

- Health is a human right to which all people are entitled.
- All humans are born equal.
- They have the rights to life, liberty, security of person, to own property, and to information and education, among others.

The International Covenant on Economic, Social and Cultural Rights (1966)

All people have the right to:

- self-determination
- freely pursue economic and social development
- the highest attainable standard of health, both physical and mental

The International Conference on Population and Development (1994)

- Health includes reproductive health.
- Where abortion is not against the law, abortion should be safe.
- Postabortion counseling, education and contraception should be offered promptly.

Special Session of the United Nations General Assembly (1999)

Health systems should train and equip health-service providers and take other measures to ensure that abortion is safe and accessible.

Convention on the Rights of the Child (1989)

Children have the right to health.

Committee on the Rights of the Child (2003)

Governments should provide access for young people to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law.

The right to decisionmaking: Evolving capacities and the principle of capability

It is widely accepted that the capacity to make decisions evolves and is not linked directly to chronological age.

Convention on the Rights of the Child (1989)

Children and young people have the right to independent decisionmaking in accordance with their capacities. The Committee on the Rights of the Child (2011) has interpreted this to apply to abortion.

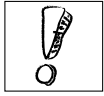
Principle of capability

Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight, including abortion.

The right to information

The Committee on the Rights of the Child (2009) affirms that children of any age have a right to private and confidential medical counseling and advice without parental consent, where needed for their safety or well-being.

TOOL 3B: Young women, international rights and abortion



Purpose

For participants to understand how certain international conferences, conventions and declarations uphold young women's human, sexual and reproductive rights and their role in ensuring young women's rights are respected.



Objectives

By the end of this activity, participants will be able to:

- Identify human, sexual and reproductive rights that support a young woman's right to a safe abortion.
- Describe possible consequences when a young woman's human, sexual and reproductive rights are violated.
- Describe their role in ensuring a young woman's right to a safe abortion.



Materials

- Flipchart, tape, markers
- Prepared flipchart: Timeline of Rights (optional)
- Prepared flipchart: Discussion questions
- Copies of Timeline of Rights
- Copies of case study: Why did she die?



Time

40 minutes: Part 1: A Question of Rights

35 minutes: Part 2: Why did she die?

75 minutes total time



Preparation

- Photocopy Timeline of Rights handout, one per participant.
- Research which of the conventions, conferences and declarations on the Timeline of Rights have been signed or ratified by participants' countries.
- Adapt Why did she die? handout to your local context, if necessary.
- Photocopy Why did she die? handout, one per participant.

- Photocopy discussion questions, one per group.
- Write Timeline of Rights discussion questions on flipchart.
- Write Timeline of Rights on flipchart (optional).



Instructions

Part 1:

1. Introduce the activity by telling participants that during this activity they will discuss rights, in particular sexual and reproductive rights, as they apply to young women 10 – 24 years of age.
2. Ask participants what they think of when they hear the term “human rights.” Allow for a few responses. Show slide and read the following definition:
Human rights are basic rights held by all persons by virtue of being born a human being. They are inalienable and interlinked, and protect our freedom, safety, health and quality of life. All human beings are entitled to these rights independent of any biological, social, economic or political distinctions, such as gender or age.
3. Ask participants to share any international conventions and conferences that they think are relevant to a young woman’s sexual and reproductive rights, and specify how. List responses on a flipchart.
4. Give each participant a copy of the Timeline of Rights handout. (**Note to facilitator:** Post Timeline of Rights flipchart at this time if you have chosen to include it.) Briefly highlight similarities or differences to the list that the group identified.
5. Divide participants into five small groups. Inform the groups that they have 25 minutes to read the Timeline of Rights handout and answer all five discussion questions. However, tell them that they will only present their response to one question to the larger group. Ask each group to identify one person who will report back.
6. Post the Timeline of Rights discussion questions flipchart:
 - *What human rights are covered in the Timeline of Rights? How do rights like these change or evolve over time?*
 - *Which of these rights and conventions are ratified, and legally enforced or upheld in your country? How are they upheld?*
 - *How do these conventions and conferences relate to the sexual and reproductive health and rights of young women? What are the sexual and reproductive rights of young women? How do they relate to safe abortion?*
 - *What do these rights and conventions mean for abortion care providers who are or want to serve young women?*
 - *How do you provide abortion care while respecting the laws in your country, the human, sexual and reproductive rights of the individual young woman, and medical ethics? What are some of the challenges and how can you overcome them?*
7. Ask participants to join the larger group. Assign each group one of the five questions. Invite each group to share their assigned question and highlights from their group’s discussion. After each group presents, allow time for additional discussion, asking other groups to add anything that is missing.
8. Summarize highlights from the participants’ discussions and conclude with the following key points:
All human beings are born with a set of inalienable rights that provide basic protections to life, safety, shelter and health among others. These rights are not limited by any factors such as gender or age. Young women have the same human rights as all other persons. Denying a young woman accurate and comprehensive information about safe abortion or safe abortion care is a violation of her rights. When local laws and policies allow, providers should provide safe abortion care to all young women who want or

need it. In cases of legal restrictions, providers can play important roles in protecting young women's lives and health – by giving information, counseling and advice, identifying alternative legal indications for safe abortion, and advocating for legal and policy changes.

9. Inform participants that for the second half of this activity they will practice applying these international rights to a young woman's situation.

Note to facilitator: An option for this activity is to extend Part 1 and add an overview of national laws and rights frameworks for the country participants come from. Allow time for participants to discuss how their national laws and rights frameworks interact with international human rights.

Part 2:

10. Provide all participants with a Why did she die? handout.
11. Inform participants that for this activity they will read the handout, Why did she die? and then, in their small groups, identify the various human, sexual and reproductive rights that have been violated in the case study. Inform the groups that they have 15 minutes for this task. You may wish to refer participants back to the Timeline of Rights handout and their discussion about the different rights.
12. Ask the participants to join the larger group.
13. Read the first paragraph and ask one of the small groups to identify the rights that have been violated. Ask other groups for additional input if not all of the rights violations were identified. Use the Why did she die? key as a guide and point out any rights violations that the groups did not identify.
14. Continue in a similar fashion, asking a different small group to identify the rights violated for each of the four paragraphs.
15. Ask participants to reflect on the human rights, particularly the sexual and reproductive rights that they have identified as being violated. Use the following questions to facilitate the discussion. Allow approximately 15 minutes for the discussion.
 - *What are the different circumstances that lead to violations of young women's rights?*
 - *What challenges do young women face in exercising their rights? How does this affect their options?*
 - *What challenges exist for young women to exercise their full rights in your country/region?*
 - *Who is responsible for fulfilling young women's rights? What needs to happen to uphold young women's rights at the government level? At the facility level? At the community level? At the individual level?*
 - *What is your responsibility in ensuring Meena's rights are respected? What actions can you take at your level?*
16. Highlight unique points and summarize using the following key points:
 - *Across the world, young women face human rights violations each day. They are disproportionately affected by violations compared to their male peers or adults.*
 - *We have also seen how interconnected human rights are: without information it can be much harder to seek or receive health care. Similarly, without freedom from discrimination – equal pay, for example – safe abortion care may not be financially accessible to a young woman.*
 - *This means that we have to work for young women's rights at many levels, from the government to communities to individuals, and in many different areas. We are all responsible for fulfilling the human rights of young women.*
 - *As providers of health care and safe abortion, you have a particularly important role to play.*
17. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

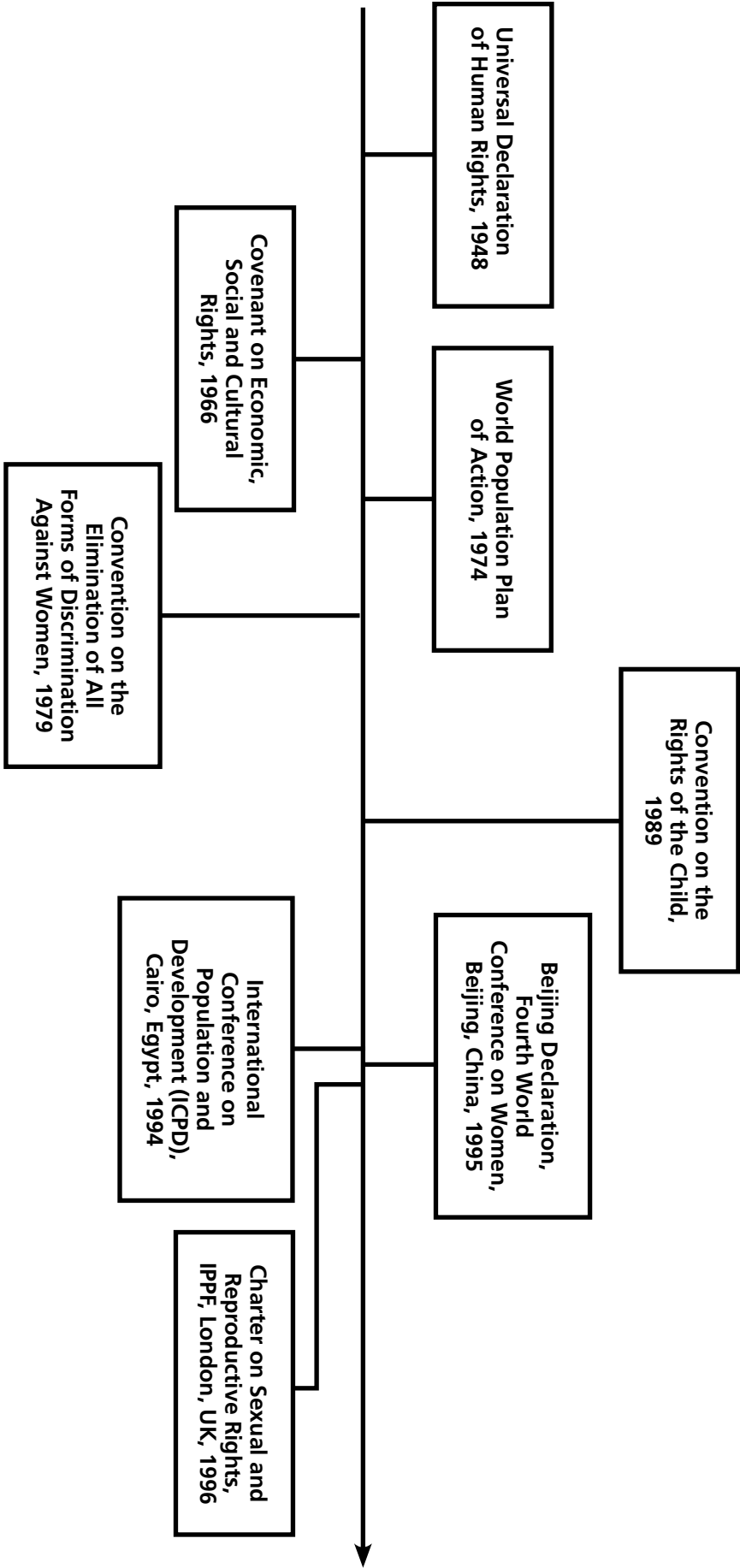
Timeline of Rights handout

| | |
|-------------|---|
| 1948 | Universal Declaration of Human Rights Art. 1: "All human beings are born free and equal in dignity and rights." All humans have rights to life, liberty and security of person, health, to own property, and education, among others (Arts. 3, 17, 25). |
| 1966 | International Covenant on Economic, Social and Cultural Rights Art. 1: "All people have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development." Art. 12: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." |
| 1974 | World Population Plan of Action Art. 14(f): "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so." |
| 1979 | Convention on the Elimination of All Forms of Discrimination Against Women Art. 12.1: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." |
| 1989 | Convention on the Rights of the Child Art. 5: "States parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family...or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention." Art. 24: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." In 2003, the Committee on the Rights of the Child called on governments to "provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law [to girls and young women]" and in 2009, it urged the Ukraine to ensure by law and in practice that the views of the child should always be heard and respected in abortion decisions." |

| | |
|-------------|--|
| 1994 | <p>International Conference on Population and Development (ICPD), Cairo, Egypt</p> <p>Art. 7.20: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."</p> <p>Art. 8.19: "Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion."</p> <p>Art. 8.25: "In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for management of complications arising from abortion."</p> |
| 1995 | <p>Beijing Declaration, Fourth World Conference on Women, Beijing, China</p> <p>The conference urged countries to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions" (UNESCO1995).</p> |
| 1996 | <p>Charter on Sexual and Reproductive Rights, IPPF, London, United Kingdom</p> <p>The original 1996 charter highlights established human rights such as the right to choose whether or not to marry and to found and plan a family, the right to decide whether or when to have children, the right to health care and health protection, and the right to the benefits of scientific progress, among others.</p> |
| 2009 | <p>The Berlin Call to Action, ICPD+15, Berlin, Germany</p> <p>Para. 3: "Ensure the sexual and reproductive rights of adolescents and young people: Empower young people to make informed decisions about their life and livelihood in an environment that removes all barriers to accessing the full range of sexual and reproductive health information and services. Guarantee confidentiality and eliminate parental and spousal consent and age restrictions. Expand and allocate the resources needed to deliver effective, continuous, gender sensitive and youth-friendly services and evidence-based, timely, and comprehensive sexuality education. Acknowledge and respect the diversity of young people and collect age and gender disaggregated data."</p> |

Timeline of Rights flipchart (optional)

Note to facilitator: This image can be drawn on a flipchart or a chalkboard to provide a visual presentation of the timeline.



Why did she die? Handout

My name is Meena, and I am a 17-year-old woman. I have worked in a factory for over a year. It is hard work, and I earn a very small salary, far below the national standard. Most of what I earn I send home to my family in a rural area. I can read and write a little, but I did not go to school very long because my parents could not afford the fees for both my brother and me, and so he went. I did not receive any information about sexual and reproductive health issues at home or school.

During my first month at the factory, one of the supervisors pressured me to have sex with him. He did not use a condom or any other protection. He told me to wash afterwards so I would not get pregnant and not to tell anyone. Because no one talks about such things, I never told anyone. Luckily I did not get pregnant. My parents want to arrange my marriage to a boy from a neighboring village soon, and they want me to stay pure for him.

Not too long ago I met a boy in the factory. He treated me nicely and asked me if I wanted to go out with him. We started going out, and after a while, we started having sex. When we could get them, we used condoms. But it was hard to get condoms, and sometimes when we had a condom we put it on late, after already starting to have sex.

Last month I missed my bleeding. My breasts became tender and a little bigger. I wasn't sure if I was pregnant, but I knew that I could not have a child. My manager would make me leave my job at the factory if he found out. I could never travel home because it would bring such shame on my parents and I could no longer be married. I heard of a lady who helps young women with these situations. She charges less money than the health clinic, and I wouldn't risk being seen by someone who knows me, so I went to her. She inserted something deep inside of me. It hurt a lot and there was a lot of blood. All night I felt very weak and was in a lot of pain. My friend found me dead the next morning.

Why did she die? Key

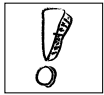
My name is Meena, and I am a 17-year-old woman. I have worked in a factory for over a year. It is hard work, and I earn a very small salary, far below the national standard. **(Right to fair and equitable income, freedom from discrimination)**. Most of what I earn I send home to my family in a rural area. I can read and write a little, but I did not go to school very long because my parents could not afford the fees for both my brother and me, and so he went. **(Rights to information and education, and freedom from discrimination)**. I did not receive any information about sexual and reproductive health issues at home or school. **(Right to information and education)**.

During my first month at the factory, one of the supervisors pressured me to have sex with him. **(Right to security of person)**. He did not use a condom or any other protection. He told me to wash afterwards so I would not get pregnant and not to tell anyone. **(Right to information and education)**. Because no one talks about such things, I never told anyone. Luckily I did not get pregnant. My parents want to arrange my marriage to a boy from a neighboring village soon, and they want me to stay pure for him. **(Right to decide if, when and with whom to marry)**.

Not too long ago I met a boy in the factory. He treated me nicely and asked me if I wanted to go out with him. We started going out, and after a while, we started having sex. When we could get them, we used condoms. But it was hard to get condoms, **(Rights to health care and benefits of scientific progress)** and sometimes when we had a condom we put it on late, after already starting to have sex. **(Right to information and education)**.

Last month I missed my bleeding. My breasts became tender and a little bigger. I wasn't sure if I was pregnant, but I knew that I could not have a child. My manager would make me leave my job at the factory if he found out. **(Right to freedom from discrimination)**. I could never travel home because it would bring such shame on my parents and I could no longer be married. **(Right to decide if, when and with whom to marry)**. I heard of a lady who helps young women with these situations. She charges less money than the health clinic, and I wouldn't risk being seen by someone who knows me, so I went to her. She inserted something deep inside of me. It hurt a lot and there was a lot of blood. **(Right to health care and benefits of scientific progress)**. All night I felt very weak and was in a lot of pain. My friend found me dead the next morning **(Rights to life, and to decide if, when and with whom to have a child)**.

TOOL 3C: The principle of capability



Purpose

Participants will question assumptions about young women's capability to make decisions about abortion and understand the possible negative consequences when they are denied care based on these assumptions.



Objectives

By the end of this activity, participants will be able to:

- Identify the assumptions they make about the decisionmaking capabilities of young women.
- Describe possible consequences when a young woman is denied access to abortion care services based on these assumptions.
- Identify the two indicators for the "principle of capability," which helps determine if a young woman can be considered capable of deciding if she needs abortion care services.



Materials

- Laptop, LCD projector, screen
- Flipchart, easel, tape, markers
- PowerPoint slides (4): Is she capable?; Evolving capacities definition; Evolving capacities quotes; Principle of capability



Time

25 minutes: Activity: Is she capable?

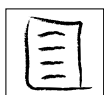
50 minutes: Discussion: Evolving capacities and the principle of capability

75 minutes total time



Preparation

- Set up LCD projector and screen in advance.
- Upload the Activity 3C PowerPoint onto the computer that will be used.
- Alternative: If no LCD projector or computer is available, write the case studies on a flipchart, and print copies of the case study pictures, enough for each participant or table.
- Write Is she capable? questions on flipchart.



Instructions

Part 1:

Is she capable?

1. Show the activity objectives slide. (If you are not using slides, you can write the objectives on the flipchart.) Inform participants that for this activity they will discuss when a young woman should be considered capable of making the decision to have an abortion.
2. Inform participants that they will see images of four young women. Highlight that in this activity each of the four young women live in countries where there are no third-party involvement laws so the provider is allowed to determine whether the young woman is capable of making the decision to have an abortion.
3. Tell participants that for each image, they should write their responses to the following questions. Post the Is she capable? flipchart, and read the questions aloud:
 - *Is she capable of making the decision to have an abortion? Why? or, Why not?*
4. Show the four slides. (If you are not using slides, you can write the case studies on the flipchart, and hand out pictures of the young women.) Read the descriptions that correspond to each of the slides:
 - *Slide 1: Neena is 15 years old. She won't disclose anything about her circumstances other than the fact that she had unprotected sex six weeks ago and believes she is pregnant. She says she wants an abortion.*
 - *Slide 2: Bintu is 17 years old and accompanied by her aunt. She is approximately eight weeks pregnant. Her aunt is answering all of the questions for her and states that Bintu wants an abortion.*
 - *Slide 3: Ana-Maria is 22 years old and married. She is 11 weeks pregnant and wants an abortion. She says that she has been pregnant twice before and terminated each pregnancy.*
 - *Slide 4: Anjula is 12 and unaccompanied. She says that she lives with her aunt and uncle. She says she was raped by her uncle. She knows that it may result in pregnancy, which she says she doesn't want. Her cousin told her to come here. She appears very calm.*
5. Invite participants to pair up with the person next to them. Ask them to discuss the slides and their responses to the questions in pairs for 10 minutes.
6. Ask participants to return to the larger group. Ask several pairs to share what they discussed. Use the following questions to facilitate discussion. It may be helpful to write the discussion questions on a flipchart. Allow 10 minutes for discussion:
 - *Which, if any, of the young women were considered capable by your group? How did your group come to that conclusion?*
 - *Which, if any, of the young women were not considered capable by your group? How did your group come to that conclusion?*
 - *How did it feel to decide if the young woman was capable or not? Did anything surprise you about the process of deciding her capacity? Was anything difficult?*
7. Thank participants for sharing their discussions. Inform them that during the next part of the activity they will further discuss how to determine capacity.

Part 2:

Evolving capacities and the principle of capability

8. Divide the participants into small groups.

9. Ask participants if they are familiar with the term “evolving capacities.” Ask a volunteer to share what they know, if applicable.
10. Share the slide, **Evolving capacities definition.**
11. Share the slides, **Evolving capacities quotes 1 - 3.**
12. Ask the small groups to reflect upon the concept of evolving capacities and what the quotes are saying.
 - *If we do not base our decision on chronological age, how do we determine when a young woman is capable of consenting to abortion?*
 - *How do we evaluate her ability to understand the procedure, risks and alternatives?*
 - *How might our evaluation impact her human, sexual and reproductive rights?*
13. Ask participants if any of them are familiar with the “principle of capability.” Ask a volunteer to share what they know, if applicable.
14. Share the slide, **Principle of capability:**

Say the following:

Because determining capacity is subjective, a useful principle has been provided by Cook and Dickens in their article in the International Journal of Gynecology and Obstetrics: Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight.

*When applied to abortion care for young women, this **principle of capability** means that a young woman – who identifies that she has an unwanted pregnancy and voluntarily requests a safe abortion to terminate the pregnancy – is capable to consent to a safe abortion procedure. This principle limits the role of the provider in assessing capacity, and supports the ‘presumption of capacity’ approach. The young woman’s capacity is sufficiently demonstrated by her voluntary action to seek and request safe abortion.*

15. Ask the small groups to apply the principle of capability to the cases of Neena, Bintu, Ana-Maria, and Anjula from Part 1 of the activity.

Which young women should be considered capable of deciding they want an abortion according to this definition?

Note to facilitator: Neena, Ana-Maria and Anjula can all be considered capable according to the principle of capability. Bintu’s case may be put into question because her aunt is speaking for her, but a conversation with Bintu without her aunt could show that it is indeed her own decision to have an abortion. In Anjula’s case, participants may be concerned about any regulations on reporting sexual abuse of a minor, but this is a separate issue from her capacity to consent to abortion care.

16. Ask the small groups to discuss the principle of capability. Inform them they have 15 minutes to answer four discussion questions. Inform the groups that they should try to answer all questions, and they will present key points for one of the discussion questions. Ask the groups to identify a presenter who will report out to the larger group. Use the following questions to facilitate discussion:
 - *What are the benefits of using the principle of capability? For young women seeking services? For your clinic or organization? For you personally?*
 - *What are the challenges? For young women seeking services? For your clinic or organization? For you personally?*
 - *How can you address some of the challenges?*
 - *What are the options for young women who are determined incapable of deciding to have an abortion? What are the different risks associated with those options?*

17. Assign each group one of the questions. Invite each group to share their assigned question and brief highlights from their group's discussion. After each group presents, allow time for additional discussion, asking other groups to add anything that is missing.
18. Remind participants of the risks associated with delayed or unsafe abortion and childbirth, particularly for very young women, if they are not mentioned:
 - *Evidence shows that young women who are denied safe abortion care are less likely than adult women to seek care from another provider.*
 - *Anecdotal evidence also shows that young women who are considered incapable of independent decisionmaking or requested to get third-party consent for an abortion procedure are likely to resort to unsafe abortion, commit suicide or are forced to carry the pregnancy to term, rather than give up their privacy. Even in the cases when a young woman goes to another provider or gets third-party consent the abortion will be delayed, which also carries higher risks.*
 - *Unsafe abortion or childbirth at an early age both have a higher risk of death than safe abortion. There are health risks from delayed or unsafe abortion, as well as childbirth at an early age, including for example hemorrhage, infection, obstetric fistula or ruptured uterus.*
 - *There are social risks including becoming ostracized, kicked out of the parental home or from school, or bullied, tormented and threatened.*

Note to facilitator: It is important to highlight the risks that a young woman is likely to face if she is denied safe abortion care. In addition, the facilitator may also want to point out the flawed logic that determines that a young woman is not capable (or mature enough) to consent to a safe abortion procedure, but considers her capable (or mature enough) of raising a child.

19. Summarize what has been discussed in this activity and reinforce the following key points:
 - *Evolving capacities means that maturity is not linked to chronological age, and that young women have a right to independent decisionmaking in accordance with their capacities.*
 - *A young woman – who identifies that she has an unwanted pregnancy and voluntarily requests a safe abortion to terminate the pregnancy – can be considered capable to consent to a safe abortion procedure.*
 - *If a young woman is denied safe abortion care her life and health may be jeopardized.*
 - *See toolkit section 3.3 for more information.*
20. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Module 4: Building partnerships between young people and adults

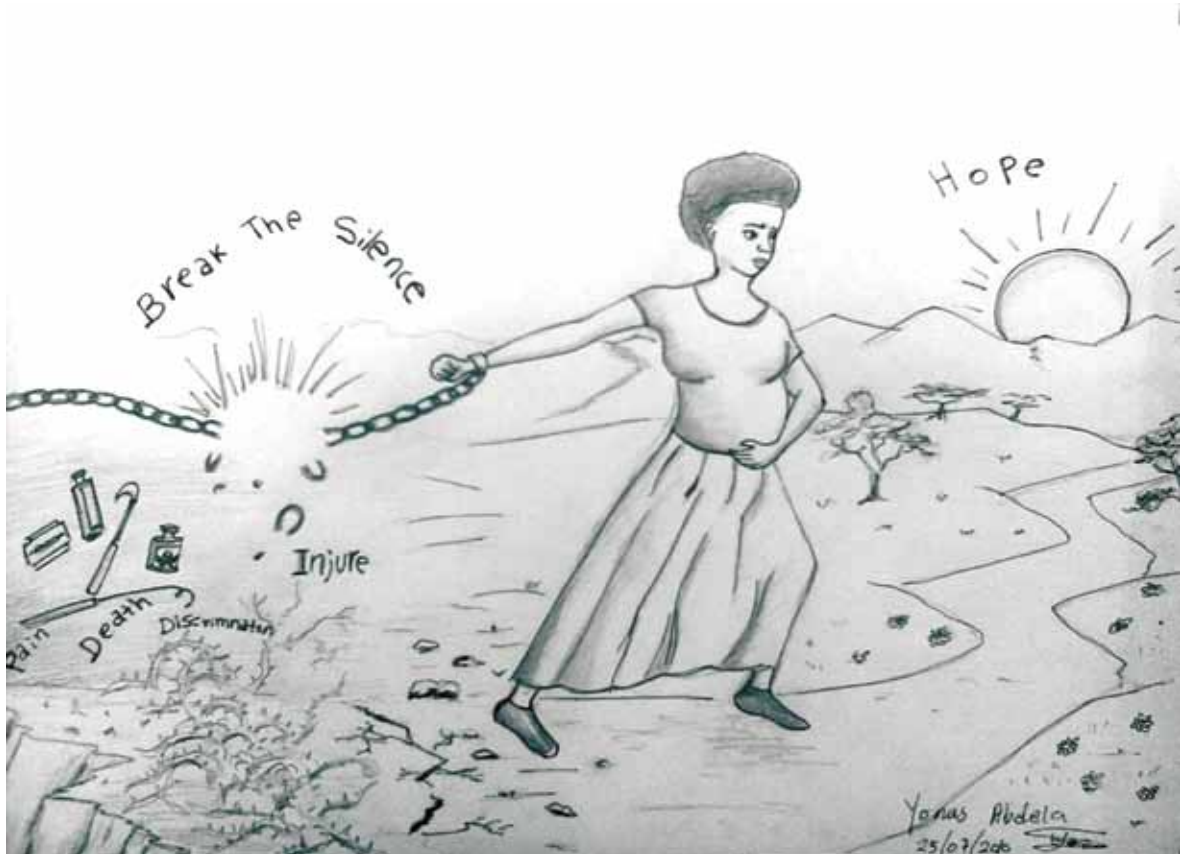


Image by Ipas's African Youth Art Contest winner Yonas Abdela of Ethiopia.

4.1 Introduction

Abortion care for young women should be participatory and should recognize that young women are not just beneficiaries of services but key stakeholders in their own health care. Building partnerships between young people and adults is an important and effective way of including young women's experiences, skills and ideas in abortion care. We often rely on adult-generated information to determine health care that is appropriate for young people – which commonly results in inaccurate assumptions about what young people need and want. This module provides guidance and tools for building partnerships between young people and adults in abortion care.

"youth are resources... they are not problems to be solved." - provider, nigeria

4.2 Definition

A partnership between adults and young people is a relationship in which both parties work together to address issues facing young people or on programs meant to serve young people. In a true partnership each party has the opportunity to make suggestions and decisions and the contribution of each is recognized and valued (Advocates for Youth 2001). A partnership also implies:

- Voluntary and meaningful participation. Participation implies work *with and by* people, not merely *for* them (DFID 2010, Royal College of Pediatrics and Child Health 2010).
- Transfer of responsibility to young people (YouthNet and FHI 2005). When young people are either only assigned tasks or consulted about certain processes, they cannot be considered partners. As young people receive and take responsibility they transition from being beneficiaries of programs to partners and leaders (DFID 2010).

"when i am handed responsibility, i feel as if people trust me... if an adult trusts a young person, the youth is most likely to treat that responsibility with care and pride and grow as a person." - christine, north america *curtis 2008*

4.3 Benefits

Partnering with young people has many benefits:

- Fulfilling rights and desires: Partnering with young people fulfills their right and desire to be actively involved in any program meant to serve them. It can also build civic engagement skills and empower young people to become active citizens. The International Covenant on Civil and Political Rights and the Convention on the Rights of the Child establishes participation as a right for all children and young people, which is not limited by age, sex, gender, socioeconomic status, physical or mental ability, or any other characteristic of the child or young person (UN 1966, UN 1989, Arts. 12, 23 and 24). Young people all over the world want opportunities to exercise their right to participation.

**"nothing for us without us."
- south african peer educators' mantra**

- Learning and empowerment: Partnerships with adults can support young people to learn about and question laws, policies and norms that generate and perpetuate inequalities, such as restrictive abortion or consent laws. Through these learning processes, young people can begin to realize their own power to affect change (Instituto Promundo et al. 2009). By partnering with young people, service providers and managers of abortion care can gain an increased understanding of what young women need and want and become empowered to serve young women better.

"we the children are experts on being 8, 12 or 17 years old in the societies of today, to consult us would make your work more effective and give better results for children." - young woman, norway (greene et al. 2010)

- Improving communication about difficult topics: Partnerships between young people and adults facilitate intergenerational communication about subjects that are considered taboo or difficult (Instituto Promundo et al. 2009). This is especially important for abortion, as it is a taboo and stigmatized topic in many cultures, and practices related to abortion are often shrouded in secrecy and shame (Kumar et al. 2009). Improved provider-client communication in health-care delivery can also improve the quality of care (Ngo-Metzger et al. 2010).
- Reducing barriers to and improving health care: Community involvement increases the likelihood of meeting clients' needs and improves health outcomes (Ahluwalia et al. 2003). This is the principle behind Save the Children's tool "partnership defined quality" (2003) (see textbox).

"remedies for service quality issues may rest within the youth themselves, if they are engaged and empowered to share their views."
- save the children 2008

Partnership Defined Quality for Youth (PDQ-Y)

PDQ-Y is a method used to increase the quality and accessibility of health-care services for young people, through youth-provider collaboration. Responsibility for better health goes beyond the health system, and solutions to deficiencies in care for young people can be found outside facility walls. Because of this, it is important for providers and young people to come to a shared understanding of what constitutes high-quality care: "Perception of poor quality health services can cause delays in seeking and receiving appropriate service, which can lead to greater morbidity and mortality" (Save the Children 2003). The PDQ-Y process includes four steps: Building Support, Exploring Quality, Bridging the Gap, and Working in Partnership. Young people must be valued and active partners or leaders in all steps.

The PDQ-Y toolkit can be found in the additional resources.

Health-care providers and managers partnering with young people to define high-quality abortion care together are better able to meet young women's abortion-related needs and encourage positive care-seeking behaviors. Implementing community and youth-generated solutions could also mitigate or eliminate barriers that young women face when trying to access safe abortion care. Partnering with young people is therefore a crucial component of abortion care for young women.

"never underestimate the absolutely profound impact [you] can have on the world by working with youth... and never underestimate what they can do." - michael, united states *quoted in curtis 2008*

4.4 Partnering in abortion care

There are many ways to partner with young people. Contacting local organizations that work with young people, including diverse and marginalized communities, can help to identify possible partnerships. Since adults do not know what type of partnership is most beneficial from young people's perspectives, young people must be active partners not only in implementing the partnership, but in designing and establishing it (Save the Children 2008). Providers may find young people eager to lead a partnership in which they serve as resources.

Through partnerships young people can:

- Define and design more accessible and appropriate abortion care for young women.
For example:
 - Conduct or participate in interviews, focus groups, surveys and non-traditional forms of information gathering, analyze responses and make recommendations for or design services.
 - Lead or participate in clinic walkthroughs to assess service delivery gaps.
 - Lead or participate in (youth) advisory councils or boards that make recommendations and decisions about services, including resource allocation.
- Lead and contribute to service provision.
For example:
 - Conduct community outreach, information and education to increase awareness of services, including designing and leading non-traditional forms of outreach that may be more appropriate for youth.
 - Provide or direct accompaniment, resources and social support before, during and/or after the abortion.
 - Provide services, which may include pre- and postabortion counseling, medical abortion, voluntary counseling and testing for HIV, postabortion contraception counseling and provision of select contraceptive methods.
 - Work in facility management or administration.
- Evaluate quality of services and influence quality improvement efforts.
For example:
 - Conduct or participate in client exit interviews, focus groups and surveys, analyze responses and make recommendations for quality improvement.
 - Implement non-traditional evaluation processes designed by and for young women.
 - Serve as a young clients' advocate within the facility or district.

Example: Young women leading the way to increase access to abortion care in Mexico

Abortion care is legal and available in Mexico City; however, it remains highly restricted in the rest of the country. Many women travel great distances from rural areas to the city to access abortion services, experiencing an enormous strain on their time and resources. Wealthy women can often afford the arrangements and care needed, but many poor women may not have the means to, turning abortion access into a class issue, in addition to a human rights issue. In response to this, two young women formed the MARIA Abortion Fund for Social Justice (MARIA), which helps women plan and pay for transportation and lodging costs, assists with scheduling and paying (fully or partially) for the procedure, and provides counseling, information and education tools. In addition, MARIA fosters awareness of women's right to abortion, and creates a feeling of solidarity between women who believe in and protect this right.

To learn more, visit http://www.redbalance.org/marial/inicio_maria_usa.html.

There are several barriers to establishing and maintaining successful partnerships between young people and adults; it is important to be aware of common pitfalls and how to avoid them. One of them is tokenism, which occurs when young people are included in, but not allowed to influence processes or decisions (Royal College of Pediatrics and Child Health 2010). Tokenism can prevent partnerships from being formed. A partnership can also deteriorate into tokenism if it is not structured or implemented well (Bergdorf 2008).

Tokenism

In an attempt to increase service use among young people, a district health management team has taken the important step to improve youth participation. They agree that a certain number or percentage of their decisionmaking body should include youth and invite a few young people from the local university to join. They report success once they have included the desired number of youth participants. However, the young people are not supported with the necessary skills or trusted to participate meaningfully. As a result, their contributions are not taken into consideration in decisionmaking or translated into action. The young people grow frustrated, resign from the decisionmaking body and lose faith in adult-driven processes.

Negative personal attitudes held by adults or young people, stereotyping of young people, and institutions or communities that do not value young people's participation or are directly prejudicial against their participation all constitute additional barriers (Bergdorf 2008, IPPF 2004, Tayo 2002, YouthNet and FHI 2005). Stigma around young people's age, sexuality, gender and abortion can also affect partnerships that are dealing specifically with abortion care (see Module 2: Barriers to care).

In order to succeed, partnerships must be based on guiding principles of trust, respect and civic values that put young people's best interest first (Bergdorf 2008, Instituto Promundo et al. 2009). In partnerships on sexual and reproductive health and abortion care, it is also important to value access to health care as a right for all young people.

4.5 Monitoring and evaluation

Monitoring and evaluation (M&E) is a critical component of partnering with young people, who should be trained to participate in or lead M&E activities (IPPF 2008). For example, to most effectively evaluate if a partnership with young people is successful, young people and adults must have a shared understanding of what success looks like. The definition of success must be co-created, supported and evaluated by the young people in and throughout the partnership.

Monitoring and evaluation should be an ongoing practice that occurs throughout a project rather than as an afterthought or separate activity (Participation Works 2008). When monitoring and evaluating partnerships with young people it is important to assess participants' satisfaction with partnership processes, the partnership's effectiveness and impact toward reaching the identified goal, and any unexpected outcomes. Conducting ongoing M&E throughout the lifespan of the partnership will help to strengthen and improve it (IPPF 2008, YouthNet and FHI 2005).

4.6 Additional resources

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MODULE 4 TOOLS

TOOL 4A: Building partnerships between young people and adults
handout

TOOL 4B: Working with young people

TOOL 4C: How young people can partner in, lead and transform
abortion care

TOOL 4D: Barriers to establishing successful partnerships with young
people and how to overcome them

TOOL 4E: Evaluating partnerships with young people

TOOL 4A: Building partnerships between young people and adults handout

Definition

A partnership between adults and young people is a relationship in which both parties work together to address issues facing young people, or on programs meant to serve young people. It includes:

- Voluntary and meaningful participation
- Transfer of responsibility to young people

Benefits

- Fulfilling rights and desires
- Learning and empowerment
- Improving communication about difficult topics
- Reducing barriers and improving health care

Partnering in abortion care

Young people must be active participants in implementing, designing and establishing the partnership. A successful partnership is based on trust, respect and civic values, including health care as a right for young people, and puts young people's best interest first.

Young people can:

- Define and design more accessible and appropriate abortion care for young women
- Lead and contribute to service provision
- Evaluate quality of services and influence quality improvement efforts

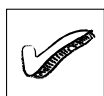
Barriers to a successful partnership include:

- Tokenism – young people are included in name only
- Negative attitudes from adults or young people
- Stereotyping of young people
- Institutions or communities that do not value young people's participation
- Stigma based on age, sexuality, gender and abortion

Monitoring and Evaluation

Young people should be provided skills and support to participate in or lead monitoring and evaluation activities throughout the course of a project.

TOOL 4B: Working with young people



Objectives

By the end of this activity, participants will be able to:

- Use case studies to identify the different levels of young people's participation in health-related activities.
- Explore the different ways young women can participate in abortion-related services and programs at the community and clinic levels.



Materials

- Flipchart, markers, tape
- Ladder of Participation flipchart
- Handout 1: Ladder of Participation, enough copies for each participant
- Handout 2: Case studies, enough copies for each participant



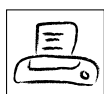
Time

10 minutes: Introduction

20 minutes: Group work

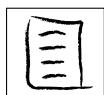
20 minutes: Large group discussion

50 minutes total time



Preparation

- Print copies of both handouts
- Draw Ladder of Participation on flipchart and label levels



Instructions

1. Review the session objectives with the participants.
2. Ask participants to share the different ways they have worked with young people on sexual and reproductive health issues in their facilities and communities (not just as clients). Write their responses on the flipchart.
3. Ask them to identify additional ways they could work with young women to better meet their needs for abortion care. Write their responses on the flipchart.

4. Post the Ladder of Participation flipchart and give each participant a copy of the Ladder of Participation handout. Review the definition and examples for each rung of the ladder. Conclude the review by saying:
 - *The ladder shows how manipulation, decoration and tokenism are levels of non-participation.*
 - *There are five levels of actual participation, in which young people have varying degrees of responsibility.*
 - *While in the “Ladder of Participation” these different levels are presented in a hierarchical relationship to one another, many youth groups recognize that one form of participation is not always preferable over another. Rather it is dependent on the overall goal of the partnership and young people’s own thoughts about how they want to participate.*
5. Compare the different rungs of the ladder to the examples participants gave earlier on how they have worked or could work with young people on sexual and reproductive health issues. Link some of their examples to the appropriate rungs on the ladder.
6. Ask participants to give a few more examples for each rung of the ladder. Provide additional examples as needed, and gently point out if a participant’s example actually fits better in another rung.
7. Divide participants into groups of three or four. Provide each participant a copy of the Case studies handout. Inform participants they have 20 minutes to review the case studies and discuss and answer the questions. Ask each group to choose a presenter.
8. Ask participants to return to the large group. Review the first case study. Ask the group speaker to share their responses to the first case study. Continue with each case study, encouraging discussion after one of the groups has presented their responses.

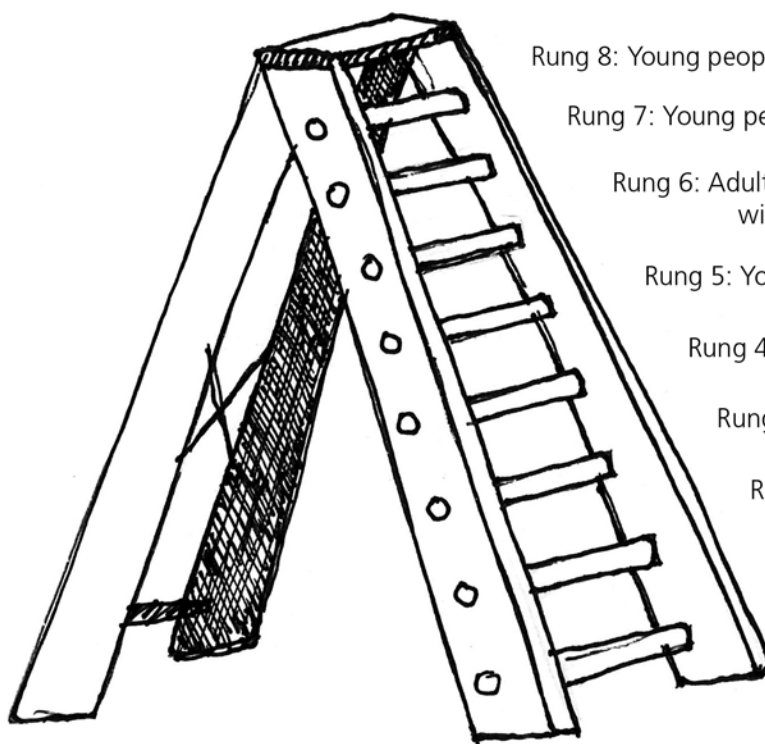
Note to facilitator: Refer to the Answer key below during the large group discussion. If some responses differ from the answer key, discuss them with the larger group for input and feedback rather than insisting on one right answer.

9. After all case studies have been discussed, ask participants to share some of their ideas for working with young people at their facilities. Use the discussion questions on Handout 2 as a guide.
10. Review highlights of the discussions. End the activity by reminding participants that there is no one right answer or way to partner with young people, but that young people have a right and often a desire to participate in services meant for them.
 - Partnering with young people has many positive benefits for programs meant to serve them.
 - We want to explore different ways to improve how providers can work with young people to improve abortion service delivery and access for young women.
11. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Handout 1: Ladder of Participation

| Rung | Definition | Example |
|--|---|---|
| 1: Manipulation (non-participation) | Young people are not informed or do not understand what they are being asked to do, or they are pressured into doing something that will benefit adults or adult-driven causes. | A young woman is convinced to have her photo taken but she is not informed that it will be used for a brochure about abortion care services for young women. |
| 2: Decoration (non-participation) | This looks very much like manipulation but in this case young people might understand their actions. However, young people are just used to support the adult's cause in an indirect way. | A group of girls are given flags and told to wave them as the Minister of Health arrives to open a new women's health facility in their town. |
| 3: Tokenism (non-participation) | Young people are included, but in fact have little voice about the subject or the style of communicating it and little or no opportunity to formulate their own opinions. | A small group of university-educated young people are invited to serve as advisors on a community health board, but they are not given support or responsibility to make decisions. |
| 4: Assigned and informed | Young people understand the aim of the project, they know who made the decisions concerning their involvement and why, and they have a meaningful role. | A group of female students are given the specific task of conducting peer exit interviews at a local abortion clinic, but they are not allowed to change the questionnaires. |
| 5: Consulted and informed | Adults design and run the project, but young people understand the process, are consulted and their opinions are treated seriously. | A girls' club is invited to help a local maternity ward improve their waiting area for young expecting mothers by giving input on the current space. |
| 6: Adult-initiated, shared decisionmaking | Though the projects are initiated by adults, the decisionmaking is shared with young people. At this level, a youth-adult partnership can be implemented, but since the partnership would still be adult-initiated it is especially important to make sure that there is shared and equitable decisionmaking. | Community elders invite young women to serve on the community health advisory board. The young women are able to present ideas, influence decisionmaking and advocate for the board's recommendations with local health officials. |
| 7: Youth-led decisionmaking | When the conditions are supportive, youth can work together to design and run their own projects. At this level, a youth-adult partnership can be implemented, but since adults only play a supportive role it may not be an equitable partnership. There is no shared decisionmaking. Rather decisionmaking lies solely with the young people. Sometimes this is more appropriate to achieve the desired goal. | Young women design an abortion hotline project and seek support from adults to start it. Adults work with the young women on the project but decisionmaking rests solely with the young people running the hotline. |
| 8: Youth-initiated, shared decisionmaking | Young people ask adults to join in an activity they have initiated. At this level, a youth-adult partnership can be implemented. | Providers and a young women's group agree to improve abortion care services for young women. They define quality of care and create a service improvement plan together. The young women's club is involved in directing and implementing abortion care services for young women. |

Roger Hart's Ladder of Young People's Participation



Rung 8: Young people & adults share decision-making

Rung 7: Young people lead & initiate

Rung 6: Adult-initiated, shared decisions
with young people

Rung 5: Young people consulted and informed

Rung 4: Young people assigned and informed

Rung 3: Young people tokenized*

Rung 2: Young people are decoration*

Rung 1: Young people are manipulated*

Note: Hart explains that the last three
rungs are **non-participation**

Adapted from Hart, R. (1992). *Children's Participation from Tokenism to Citizenship*.
Florence: UNICEF Innocenti Research Centre.

Activity adapted from: YouAct. 2007. *Young People's Intercultural Dialogue on Sexuality, Politics and Human Rights: Report of the study session held by YouAct in co-operation with the European Youth Centre Budapest of the Council of Europe*. Hilversum, The Netherlands: YouAct.

Handout 2: Case studies

The case studies in this tool are based on sexual and reproductive health-care projects that are not specifically about, but are relevant to, abortion care for young women.

Instructions:

Read the case studies.

Review and answer the following two questions after each case study:

- *What level of participation do young people have in this case?*
- *What could be changed in this case to increase the level of participation or establish and improve a partnership with young people? How could the case include more “youth-initiated, shared decisions with adults”?*

Use the discussion questions below to explore ways to increase youth participation at your facility or in your community.

- *How do you currently support youth participation in your facility?*
- *How would you want to include young people in your work?*
- *What are the benefits and challenges of working with young people in delivering abortion care to young women in your setting?*
- *What roles would you want young people to play? What are possible roles for young women in increasing access to abortion-related services? At the facility? In the community?*
- *What initial steps can you take to make that happen?*

Case study 1: Youth counselors providing HIV testing in Uganda

Two health-care clinics in an urban area in Uganda are adding youth-oriented HIV voluntary counseling and testing to their services. Because both clinics also serve adults, the adult facility managers make arrangements to establish small “youth corners.” They also hire and train youth peer counselors to conduct community outreach and provide counseling. But the youth peer counselors are not asked to make recommendations for the “youth corners,” or the outreach or counseling processes, only to implement them according to the set protocols. Despite achieving programmatic success in reaching and serving more young people, several youth peer counselors report that sometimes they feel lonely in their work and less confident about their skills compared to their adult colleagues. In addition, unlike their adult colleagues, the youth peer counselors are volunteers and have to secure permanent and paid employment.

Case study inspired by research conducted by: Horizons and Population Council. 2004. Attracting Youth to Voluntary Counseling and Testing Services in Uganda. Washington, DC: Population Council.

Case study 2: Youth peer providers delivering contraceptive services in Ecuador

In February 2008, the Planned Parenthood Federation of America and CEMOPLAF, an Ecuadorian reproductive health organization, launched an innovative adolescent project to address the particular reproductive health needs of rural, indigenous youth in the Chimborazo province of Ecuador. Ecuadorian young people are trained to become community health workers (youth peer providers), skilled in providing contraceptive counseling and methods to peers. All youth peer providers attend a four-part training, including an introduction to injections in general; training on Depo Provera in particular; and training in bio-safety procedures. They also learn about other contraceptive options. Youth peer providers then meet weekly at a central clinic location to discuss challenges and attend further trainings. CEMOPLAF provides lunch, transportation costs and job-skills training. This program is successful in meeting the needs of a particularly underserved and hard-to-reach group of youth.

From: Planned Parenthood Federation of America. Ecuador Country Program. <http://www.plannedparenthood.org/about-us/international-program/ecuador-country-program-19002.htm>

Personal communication with Planned Parenthood Federation of American staff.

Case study 3: Youth group participates in resource guide creation

A local nongovernmental organization (NGO) invites a youth group to help create a resource guide about contraception for young people in their community. The young men and women in the group are excited because they often visit this NGO to get more information about contraception. The girls in the group are invited to come to the NGO for a meeting. The 15 girls who come are divided into smaller groups and led into separate rooms. Someone comes in and takes pictures of some of the girls. They are then asked questions about abortion – how they feel about it and what type of services they want. A few are interviewed as individuals, in addition to participating in the focus groups. After an hour or so they are thanked for their time and led to the door. They do not hear back from the NGO again. The NGO creates a publication about abortion care services for young women and uses some of the pictures they took of the girls in the group.

Answer key for case studies

The following are the current levels of participation for each of the case studies.

Case study 1: Young people assigned and informed.

Case study 2: Young people assigned and informed, or Young people consulted and informed. (There is not sufficient information in the case study to make a clear distinction between these two rungs.)

Case study 3: Manipulation

The following are examples of how to improve each of the case studies. Other examples may be possible. Because the case studies are either accounts of or inspired by real programs, these examples may already be implemented by the organizations. They should therefore not be considered as advice or critiques of those organizations or programs.

Case study 1:

- Staff and youth peer counselors (or a local or community-based youth group) conduct a youth-led assessment to find out if HIV testing is the most needed and wanted service by local young people, what other services they would like, and if the two clinics are the most suitable venues in terms of accessibility.
- Young people from the local community select their own representatives to contribute to the design, implementation and monitoring of the HIV testing services.
- Youth peer counselors and local young people have an active role in designing the services, including the youth corner (or other alternative space), and the outreach and counseling activities, protocols and materials.
- Clinic staff provides improved skills-building and professional support and mentoring for the youth peer counselors.
- Youth peer counselors are (better) compensated or rewarded for their contributions.
- The two clinics create or maintain a system for considering young peer counselors' and local young people's opinions in decisionmaking processes.
- Systems are put in place to ensure prompt replacements of youth peer counselors who "age out."
- With support from adult community stakeholders, youth peer counselors and local young people establish their own youth group which offers youth-led HIV testing services, and create a referral system between the group and the clinics that is co-run by adults and young people.

Case study 2:

- Staff and youth peer providers conduct a youth-led assessment to find out the sexual and reproductive health and rights needs and wishes of local young people, particularly those who are underserved and hard-to-reach, and how the project can better meet those needs (for example: Are injections the most desired contraceptive method?).
- Youth peer providers and local young people define what success for the project looks like and design ways to monitor and evaluate progress. They also participate in or lead M&E processes, analyze the findings and make recommendations for improvements.
- More experienced youth peer providers help with new and refresher trainings.
- Youth peer providers are given additional skills-building and professional support and mentoring.
- Youth peer providers are financially compensated and receive professional development opportunities.
- CEMOPLAF creates or maintains a system for considering young people's opinions in decisionmaking processes.
- Youth peer providers and local young people establish their own youth groups with support from CEMOPLAF.

Case study 3:

- The youth group or young women receive sexual and reproductive health and rights information or classes from the NGO. They are encouraged to assess the needs and interests of their peers in this area, as well as give suggestions on how to make improvements.
- The youth group or young women are invited to participate in or lead the design, implementation, management and evaluation of the larger project which the resource guide is meant for.
- The youth group or young women decide if this type of resource guide will best meet the needs and interests of their peers, and make recommendation for possible alternative communication methods.
- The youth group or young women design or influence the creation of the resource guide and how it is used.
- The NGO staff explains the process for creating the resource guide and its intended use more honestly and clearly, and provides opportunities for each individual young woman to decide if and how she wants to contribute.
- The NGO respects, values and recognizes the young women's inputs, and does not use their statements or photos without informed consent.
- The NGO protects the privacy of the young women in the resource guide. *Using the young women's pictures in a local publication about abortion may compromise their safety and should be cautioned against until a risk analysis has been completed and each individual young woman has provided informed consent to be featured in the publication.*
- The youth group or young women review and edit the resource guide. The NGO accounts for how it is using the youth group or young women's inputs, and recognizes them.

Tool 4C: How young people can partner in, lead and transform abortion care

| Planning and design of abortion care | Delivery of abortion care | Evaluation of abortion care |
|--|---|--|
| <p>Young people can define high-quality abortion care and how it should be provided to maximize access. Partnering with young people can help you establish:</p> <p><i>What abortion care for young women should look like.</i></p> <p><i>How and from whom young women want to hear about the availability of abortion care.</i></p> <p><i>How and from whom young women want to receive abortion care, including preferred service providers, and where and when young women prefer to access services.</i></p> <p><i>What barriers young women face in accessing abortion care, and how to overcome them.</i></p> <p><i>How young women want to contribute to the delivery and evaluation of abortion care.</i></p> | <p>Young people can be partners in service delivery, particularly if they have received training in sexual and reproductive health and rights. Partnering with young people can help you make abortion care more accessible to young women, and improve quality of care.</p> | <p>Young people can lead or support the evaluation of abortion care services. Partnering with young people can help you improve quality of care and better meet the needs of young women. It can help you find out:</p> <p><i>How young women perceive the services offered at the facility (non-clients and clients).</i></p> <p><i>What young women think of the services they received (clients).</i></p> <p><i>How young women think the services could be improved to better meet their needs and desires.</i></p> <p><i>How young women want to contribute to or lead quality improvement efforts.</i></p> |
| <p>Conduct and/or participate in interviews, focus groups, surveys and non-traditional forms of information gathering, analyze responses and make recommendations for or design services.</p> | <p>Conduct community outreach, information and education to increase awareness of services, including designing and leading non-traditional forms of outreach that may be more appropriate for youth.</p> | <p>Conduct and/or participate in client exit interviews, focus groups and surveys, analyze responses and make recommendations for quality improvement.</p> |
| <p>Lead and/or participate in clinic walkthroughs to assess service delivery gaps.</p> | <p>Provide or direct accompaniment, resources and social support before, during and/or after the abortion.</p> | <p>Implement non-traditional evaluation processes designed by and for young women.</p> |
| <p>Lead and/or participate in (youth) advisory councils or boards to make strategic recommendations and decisions, including resource allocation, with adults.</p> | <p>Provide services, which may include pre- and postabortion counseling, medical abortion, voluntary counseling and testing for HIV, postabortion contraception counseling and provision of select contraceptive methods, or work in facility management or administration.</p> | <p>Serve as a young clients' advocate within the facility or district.</p> |

TOOL 4D: Barriers to establishing successful partnerships with young people and how to overcome them

| Barriers | Tips |
|--|---|
| Many adults hold negative and stereotypical attitudes about young people, sometimes without realizing it: "[The adults in the project] believed young people could not and should not be involved in decisionmaking." ³ Similarly, young people sometimes hold negative attitudes about adults. | <ul style="list-style-type: none"> ✓ Engage young people with an open mind, even if they do not look or talk like you.¹ ✓ Be aware of different communication styles. Different styles of communication do not necessarily imply disrespect, disinterest or different goals and expectations.² ✓ Offer and attend cultural competency training for adults on how to interact and communicate with young people. Attend youth-led events. ✓ Don't assume all young people feel the same way. Just as adults, young people disagree. Treat them as individuals. ✓ Be patient and factor in time to build trust in the partnership. Until young participants trust adults, their level of participation may be compromised. ✓ Support the participation of young people from diverse backgrounds, taking into consideration both age and gender disparities. ✓ Allow young people to elect their own representatives. ✓ Set realistic goals and reach agreement on the process, roles, responsibilities and ground rules of the partnership <i>together</i>.^{2,3} ✓ Build in mechanisms to mitigate inequities between participants. ✓ Build in processes for recruitment of and handover to new young participants as older ones "age out" by working with youth groups, not just individuals. ✓ Accommodate the needs of young participants; be flexible with schedules, meeting times and venues and provide transportation when needed. Compromise is vital.⁴ ✓ Make it valuable for young people to participate in the partnership by offering rewards or compensation, which can include training or skills-building opportunities, certificates of participation or references and support to gain paid employment. ✓ Value participation as a successful process in itself. |
| Lack of youth-driven member selection: Adults commonly select which young people to invite into a partnership, sometimes leading to the overrepresentation of youth with specific attributes, such as high education, and leaving out marginalized youth. ³ | |
| Intergenerational power dynamics can lead to inequity among adults and young people. "Pretending that all participants have equal say when they don't... can deeply undermine participation." ³ | |
| Maintaining young members: Youth is a temporary stage in life and young people "age out." This can result in the partnership losing its young participants either because they leave or because they stay on but are no longer young. | |
| Young people may struggle with other commitments that affect their ability to participate . Often young people are only offered volunteer positions and must maintain competing engagements such as school or work. This can limit their contributions and availability. | |
| Many adult-controlled spaces, such as businesses, health systems and professional organizations, do not value or adhere to a culture of participation , or are even prejudicial against participation. "If [an] organization is operating within an autocratic and traditional style of leadership... then youth participation is not expected to flourish. It is hard to preach something one does not practice." ⁷ | |

| | |
|--|---|
| <p>Mistaking tokenism for participation: Many young participants feel that while they are present in discussions, their opinions are not considered or implemented.⁸</p> | <ul style="list-style-type: none"> ✓ Get commitment for the partnership from the highest level of the institution, including financial resources. ✓ See the partnership as a mutually beneficial relationship, and an opportunity to learn from young people. Avoid one-way communication within the partnership. ✓ Encourage young participants to present solutions to problems, rather than just problems – they may present ideas you had not thought of.⁵ Affirm their inputs. ✓ Share decisionmaking with young participants: “If youth have no power to make decisions, their participation is not one of partnership.”² ✓ If there is no word for partnership in the local language, or a direct translation is not suitable, consider what partnership processes already take place in the community and build on those. ✓ Become familiar with the laws that control abortion care and information dissemination and how they are implemented locally. All partners should discuss the risks and benefits of moving ahead with the partnership and give their informed decision on whether to join or not. ✓ Raise awareness among influential community members on evidence that sexuality education does not “promote” or “encourage” sexual activity: <i>“The evidence is strong that programs do not hasten or increase sexual behavior but, instead, some programs delay or decrease sexual behaviors or increase condom or contraceptive use.”</i>⁶ ✓ Get commitment for the partnership from community members, including individual consent from participating young people or third parties if this is mandated for minors. |
| <p>There may be cultural or social biases against partnering with young people. In some communities, the word partnership may not exist in the local language, and/or young people may not be valued enough to be participants. “Unless we adults develop a major paradigm shift in how we view children and youth, it will be very difficult to create a conducive environment ... for young people to participate.”⁷</p> <p>In a partnership on abortion there may also be barriers related to addressing the issue of abortion. For example: liability or fears of liability, stigma on engaging young women on sexuality and abortion, and concerns that this will “promote” or “encourage” sexual activity or abortion, as well as consent issues if the partnership includes research-based activities.⁹</p> | |

¹YouthNet and FHI 2005²YouthNet and FHI 2005³PPF 2004⁴YouthNet and FHI 2005⁵Balas 2003⁶Kirby et al. 2007⁷Tayo 2002⁸Bergdorf 2008⁹Villa, Laura. 2010. Personal communication.

Tool 4E: Evaluating partnerships with young people

Below are some sample questions and indicators, by topic, that can inspire the design of your monitoring and evaluation (M&E). The questions can also be reworded as indicators against which you and youth partners can monitor progress together. Remember to involve young people throughout all stages of M&E: seek their input on processes, questions and indicators, and alternative ways to evaluate the partnership, which may be more appropriate for young people in your community. With skills and support, young people can also gather data, analyze it and make recommendations based on the findings.

Recruitment and membership

- *How do young people influence the recruitment process?*
- *How successful has recruitment for diverse young people been? By age? Gender? Etc.*
- *What system is in place to replace young people “aging out”? How well is it working?*
- *What is the number of young people who are paid staff, interns and volunteers (by position)?*
- *What is the number of young people who serve on decisionmaking groups (ratio of young people to adults)?*

Processes

- *What support do young people have to participate in the partnership fully?*
- *How can young people influence the partnership and their/your role in it?*
- *How have young people influenced decisionmaking?*
- *What would you do if you wanted to share an idea or concern about the partnership?*
- *Are all members treated with respect for their ideas and opinions? What are some examples of this?*

Effectiveness

- *How do you use the resources and creativity of all members to accomplish your goals?*
- *Do you think that decisions have been improved by including young people? Why?*
- *How satisfied are you with the progress the team is making? Is it matching your expectations?*
- *How many members of the partnership have attended skills-building events (ratio of young people to adults)?*
- *How could the partnership be improved in the future?*

Impact

- *Is it valuable for you to participate in this partnership? Why?*
- *What have you learned about working with young people?*
- *What new things have you learned about young people’s sexual and reproductive health and rights?*
- *What new things have you learned about abortion?*
- *What is the most valuable thing you have learned? How will you use this in other aspects of your life?*

The following questions are suggested for use with community members who have *not* participated directly in the partnership:

- *Have you heard of (name of partnership or institution)?*
- *What do you know about what they do?*
- *What do you think about their work? Why?*
- *Has their work benefitted you directly in any way? How so?*
- *What benefits do you think their work has had on young women in your community?*
- *What benefits do you think their work has had on your community at large?*
- *What else should (name of partnership or institution) do in your community?*

Impact indicators

- Number of youth-led events or initiatives the partnership has implemented
- Number of people reached with information about young people's sexual and reproductive health and rights and/or abortion
- Number of young women who have received postabortion care and safe abortion care
- Number of young women who asked for and received postabortion contraception
- Increased knowledge about sexual and reproductive health and rights and abortion among young women
- Increased ability to access sexual and reproductive health and rights services, including postabortion and/or abortion care, among young women
- Decreased mortality and morbidity from unsafe abortion among young women

Some questions come from, or have been inspired by:

Royal College of Pediatrics and Child Health. 2010. *Not Just a Phase, a Guide to the Participation of Children and Young People in Health Services*. London: Royal College of Pediatrics and Child Health.

YouthNet and Family Health International. 2005. *Youth Participation Guide: Assessment, Planning and Implementation*. Arlington, VA: Family Health International.

Save the Children 2003. *Partnership-Defined Quality: A tool book for community and health provider collaboration for quality improvement*. Westport, CT: Save the Children.

Save the Children 2008. *Partnership-Defined Quality: A Process Manual for Improving Reproductive Health Services through Youth-Provider Collaboration*. Westport, CT: Save the Children.

Module 5: Making abortion care accessible



Image by Ipas's African Youth Art contestant Seble Weldeamanuel Berga of Ethiopia.

5.1 Introduction

Safe abortion care consists of counseling, uterine evacuation, postabortion contraception and referrals for other sexual and reproductive health needs. As seen in Module 2, young women face many barriers to safe abortion care and evidence suggests that they have a harder time accessing safe abortion care than adult women (Finer et al. 2006, WHO et al. 2006). Because of this, access to safe abortion care for young women cannot be measured only in terms of availability of appropriate services. For the purposes of this toolkit, access is therefore defined as encompassing both service provision and the use of these services by young women. This module discusses how barriers to access can be addressed and provides further guidance on how abortion care can be made more accessible for young women.

5.2 Addressing social barriers

Cultural beliefs and norms about gender, age, sexuality and abortion are taught to community members from birth and reinforced on a daily basis, often in unspoken, unconscious ways. Because social barriers that young women face to access abortion care often originate in cultural beliefs and norms, they can be addressed through different community interventions. For example, community groups, community members, young women and health-care providers can:

- Conduct community outreach and education (for example: through media, drama or street theater, tea or coffee ceremonies, or sensitization and values clarification activities), which can make communities more open to talking about the issue of unsafe abortion, and young women's rights and needs.
- Provide information to community leaders, including religious leaders, on the impact of unsafe abortion on young women, as well as the barriers to care. Core religious texts are often not specific on the issue of abortion, leaving interpretation to religious leaders and individuals. Supportive religious leaders can facilitate conversations with their congregations in support of young women's access to life-saving care.
- Set up informal or formal social support networks that provide accompaniment, resources and anonymous support (Gayen and Raeside 2010).
- Show support for and participate in community-driven interventions on abortion care for young women.

In addition to community interventions, health systems and facilities can provide opportunities such as values clarification workshops for health-care providers and staff to examine preconceived notions of gender, age, sexuality and abortion. They may also use values clarification processes to select, hire and prepare providers and staff that are best-suited to the provision of abortion care to young women.

5.3 Addressing economic and logistical barriers

Economic and logistical barriers, such as financial resources and transportation, also impede young women's access to abortion care.

- A lack of financial resources is one of the most common barriers for young people; lowering the cost of health-care treatment is the most direct way providers can help alleviate this barrier.
- Providers commonly have limited influence on the amount of resources that young women have access to or control in a community. However, they can employ young women in their clinics and advocate for economic gender equality (equal pay, for example) in their community.
- Transportation issues are, for the most part, not the responsibility of a health-care system or facility. However, health systems or facilities can run a shuttle, or ask the local government to implement public transportation routes.

- Communities can set up a transportation network linking young women to facilities with trained providers (Ahluwalia 2003).
- A community fund can help clients cover costs, including care and transportation.

5.4 Addressing legal and policy barriers

Until legal and policy barriers are addressed, young women's access to abortion care will remain compromised. Some examples of how stakeholders – community groups, community members, young women and health-care systems and providers – can address such barriers include:

- Know the current abortion law and which law takes precedence in the case of conflicting laws (such as laws on the rights of children). This can help identify what laws act as barriers for young women.
- Educate community members about the specifics of these laws.
- Ensure that facilities are providing abortion services to the full extent of the law.
- Seek to influence abortion laws when they are being discussed by the government, making suggestions to minimize the barriers for young women. Many stakeholders have the ability to influence laws and policies to facilitate the provision of safe abortion services to young women. Providers' professional associations can make recommendations to decrease barriers to abortion care for young people. For example, professional medical and public health organizations in the United States created a consensus document stating that young people should not be required to involve their parents in abortion decisions (American Academy of Pediatrics 1996).
- It should be facility policy to ask a woman's permission in private whether she would like to include a third-party in her counseling.

"...Minors should not be compelled or required to involve their parents in their decisions to obtain abortions, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults. These conclusions result from objective analyses of current data, which indicate that legislation mandating parental involvement does not achieve the intended benefit of promoting family communication but does increase the risk of harm to the adolescent by delaying access to appropriate medical care. In this statement, the AAP reaffirms its position that the rights of adolescents to confidential care when considering abortion should be protected." – American Academy of Pediatrics (AAP)

- Be familiar with clinical standards, guidelines and facility-based protocols. This will help identify possible barriers to young women's access to abortion care.
- If clinical standards, guidelines and protocols do not exist, create them to clarify the cadre of provider who can provide abortion services, at which levels of the health system, and how services should be delivered. Facility-level protocols should also be developed to give clear guidance on how services are to be provided in that facility. These implementing documents should not add any restrictions to abortion services that are not in the law, and should spell out the legal indications clearly, including any particular allowances or requirements based on age.

- Remove barrier language in existing clinical standards and guidelines and protocols when it is not required by current law. For example:
 - If there is no provision in the law on third-party notification or consent, or proof or reporting of sexual violence based on age, no such steps should be required. Requiring third-party consent by a parent or family member suspected of abusing the young woman will put her at greater risk and may result in either forced or denied care.
 - For abortion in cases of gender-based violence, which young women are especially vulnerable to, it is important not to delay or require more paperwork or proof than the law explicitly requires. When possible, requiring the woman to talk about the rape more than once should be avoided. Sexual violence support services must be offered to women who need them.
 - Any protocol should use language that is broad enough to allow the possibility of a friend or family member – not only a parent – to accompany the young woman.
 - Documents should clearly indicate that abortion fees are not to be based on acceptance of contraceptive method or vaccinations, or any other coercion.
- Implementing documents should be actively disseminated to providers. Ideally, an orientation session should be given, as many providers are very busy and may not read the documents carefully without additional support.
- If a client, young or adult, seeks abortion care, providers should try to identify a legal means for them to get that service, such as a statutory rape provision, mental health provisions, and other legal indications for abortion that may be less commonly applied because of incomplete knowledge of the law. Abortion should be provided on the first visit, with no waiting period unless required by law. Otherwise, young clients may seek an unsafe abortion, or have an unwanted child who may be abandoned or abused (Panel on Research on Child Abuse and Neglect 1993).

5.5 Addressing health system barriers

This is the area in which health-care systems, facilities and providers can have the most direct effect on barriers to young women seeking abortion. Communities can encourage health systems and facilities to adopt the changes necessary to make appropriate abortion services more available to young women.

Lack of or unavailability of facilities providing abortion: The number and distribution of facilities that provide abortion care that meets the needs of young women interacts with other barriers such as abortion stigma, transportation and cost (see Module 2: Barriers to care). To alleviate this, individual providers can provide abortion care for young women in their private practice as well as at a public facility; facilities can opt to add abortion care for young women to the services offered; and systems can make strategic decisions to have abortion care for young women available at geographically optimal locations. To be most effective in addressing this barrier, young women should be included in the process of determining which locations are preferable.

Open hours should be as long as possible. Where 24-hour, 7-day-per-week services are not feasible, typical schedules affecting young women such as school or work hours should be taken into account when determining open hours. When possible, ask young women what hours would best suit their schedules. Engaging and soliciting input from young women can also be a way to raise awareness of services, and to foster broader partnerships with them. (See Module 4: Building partnerships between young people and adults.)

Medical abortion

Medical abortion using mifepristone and misoprostol or misoprostol only has the potential to change many aspects of abortion care: who provides it, where it's provided and/or carried out, who has access, who approves – in short, who exerts control over the decision and implementation of care. Young women are among those who would most greatly benefit from medical abortion.

Medical abortion is safe and effective for most women, including young women. Because it can be offered in a range of settings, medical abortion expands access to safe abortion for young women. Some young women prefer medical abortion because it is less invasive and in some cases may give them a more confidential, affordable and accessible option.

Lack of privacy and confidentiality: Privacy is often one of the primary issues young people raise when surveyed about their concerns with health-care services (Anh et al. 2003). Health systems and facilities can provide privacy by building facilities with private rooms in an area separate from other services' waiting and recovery rooms, and providing toilets specifically for abortion clients and of sufficient number if medical abortion is being provided onsite. Facilities and providers must ensure auditory and visual privacy during counseling and procedures with minimal interruptions. Privacy issues can also include waiting times, when the client is visible to others. Short wait times are an indicator of service quality. Efforts should be made to minimize waiting times before services and between counseling, procedure and post-procedure steps.

Confidentiality for all clients, including young people, should be assured and enforced through policies and protocols. Facilities must take steps to ensure secure recordkeeping and discretion of providers and staff. For example, completed forms should not be left in easily visible places or insecure files.

Processes and forms: Facility processes should not include unnecessary return visits, and should be based on facility protocols that respond to the needs of young women (see 5.4 Addressing legal and policy barriers). Forms should be neutral in regards to marital status.

Facilities and health systems should clearly prioritize the provision of care to young women and ensure providers have guidelines and are supported in providing that care.

Cost: If cost of care is not within the control of an individual provider, it is often within the control of the health system or facility. Many systems and facilities provide services free of charge to clients who have little or no income, or who are minors. Prices may also be presented on a sliding scale, so that the cost of services is free or low for those with no income, and rises in proportion with income to some upper limit. Abortion service prices should never be dependent upon accepting a contraceptive method, as this is coercive. However, lowering costs should not be made to the detriment of the facility, which should recover costs through efficiency, allocating funds to provide services to poor or young people and perhaps by charging those who can afford it slightly more in order to subsidize those who cannot pay.

For young people especially, but also for all health-care clients, determination of income (also called "means testing") should be as private and non-invasive as possible. For example, if a client indicates they need free or sliding scale prices, some facilities merely ask the client to tick a box in a range of incomes. "How much income do you have access to?" may be a better question for young people as they may not fully control any income they make. In some facilities, clients speak to a representative in a room where they cannot be overheard, so that they can share more information without embarrassment.

Requiring documentation of poverty may be humiliating to a client, and will delay care if the client has not brought the necessary paperwork.

Negative attitudes of health policy makers, administrators, providers and workers about youth sexuality and abortion: Health systems and facilities should provide values clarification opportunities to all staff, not just providers (see Module 6: Counseling, contraception and clinical care for full description of values clarification). Refusal of services to eligible young clients should be explicitly identified as unacceptable, and clients should be encouraged to provide anonymous feedback on services as they leave the facility, perhaps as part of regular evaluation efforts (see Module 4: Building partnerships between young people and adults).

"the sweetest smile came from the receptionist of the abortion clinic... her smile was one of comfort and peace. i had been looking for that smile for what had seemed like forever. what had surrounded me were faces of doubt, judgment, and concern.... within her face, i found my refuge." - young woman, trinidad (youth coalition 2007)

In addition to values clarification, providers should practice framing statements about sexual and reproductive health in a positive way. This can help the young person feel that sexuality is a positive part of a healthy life, rather than the common health-care perspective of sexuality as solely a source of potential disease and injury to be delayed and controlled (see Tool 6C: Counseling skills).

Successful strategies in restrictive settings

In settings where there are few legal indications for abortion, efforts to provide safe abortion services to young women can focus on these areas:

- **Provide comprehensive and accurate information.** (See Module 3 on young women's right to information.)
- **Interpret current legal indications broadly** when determining whether a young woman is eligible for abortion services.
- **Draft standards and guidelines to implement those legal indications** – how care will be delivered, which cadres of health-care providers are authorized to perform elements of abortion, and what care can be provided at each level of the health system – and train and equip providers in accordance with them (see Tool 5C).
- **Provide life-saving abortion and postabortion care** to all women who need it, independent of age.
- **Ensure the availability of misoprostol**, and have information easily available on its safe use for medical abortion.
- **Research** the knowledge of legal indications and the magnitude of mortality and morbidity due to unsafe abortion and the restrictive law.
- **Educate** health system staff, providers and communities on the existing legal indications, the consequences of restrictive laws, and legal reform as a way to save young women's lives.
- **Advocate for broader legal indications**, specifying availability of services to young women.
- **Where no other option is available, providers can take a harm reduction approach**, giving confidential information about safe and unsafe methods (misoprostol being the safest method explained within the context of the consultation) and providing follow-up services for women who decide to use one of those methods.

Kenyan advocates recently revised the constitution to include broader indications for abortion services. While advocating for the revisions, the Medical Practitioners and Dentists Board provided clear guidelines for providing abortion care under the current indications.

*The laws of Kenya do not allow for termination of pregnancy on demand and severe penalties are meted out to those found guilty of procuring or attempting to procure an abortion or miscarriage. **There is room, however, for carrying out termination when, in the opinion of attending doctors, it is necessary in the interest of the health of the mother or baby (emphasis ours).** In these circumstances, it is strongly advised that the practitioner consult with at least two senior and experienced colleagues, obtain their opinion in writing, and perform the operation openly in hospital if he considers himself competent to do so in the absence of a gynecologist. In all cases of illegal termination of pregnancies, the sentences shall be suspension or erasure.*

5.6 Additional resources

Alford, Sue. 2009. Best practices for youth friendly clinical services. Washington, DC: Advocates for Youth. Available online at http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=1347&Itemid=336

Bornstein, Kate. 1998. *My Gender Workbook: How to become a real man, a real woman, the real you, or something else entirely*. New York: Routledge Press.

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Ipas. 2010. *The evidence speaks for itself: Ten facts about abortion*. Chapel Hill, NC: Ipas. Available online at: http://www.ipas.org/Publications/The_evidence_speaks_for_itself_Ten_facts_about_abortion.aspx

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Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas. See in particular, "Activities adapted for young women and abortion." Available online at http://www.ipas.org/Publications/Abortion_attitude_transformation_A_values_clarification_toolkit_for_global_audiences.aspx

5.7 References

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Gayen, Kaberi and Robert Raeside. 2010. Social networks and contraception practice of women in rural Bangladesh. *Social Science and Medicine*, 71 (9): 1584-92.

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MODULE 5 TOOLS

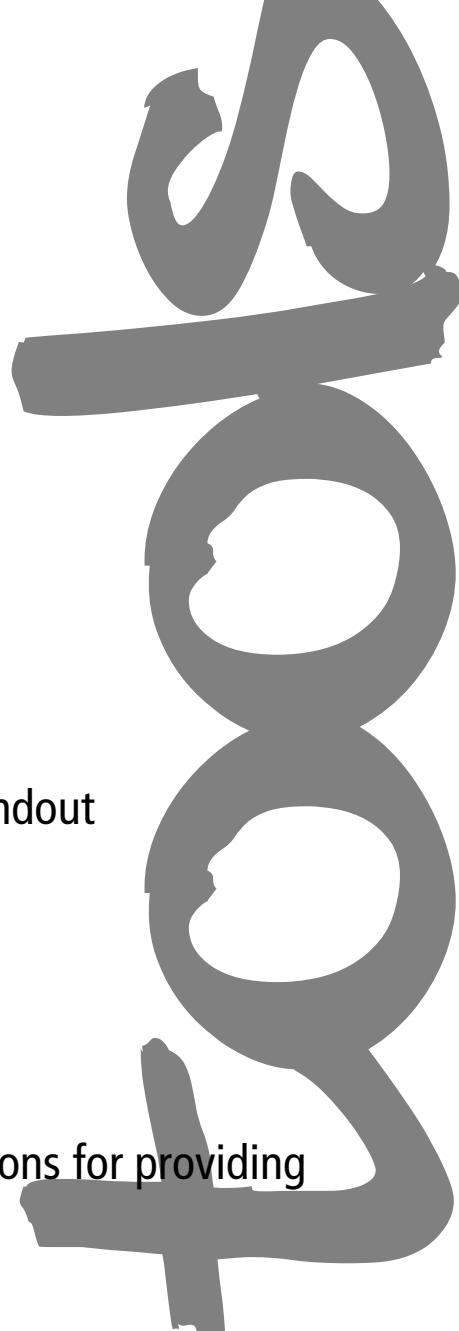
TOOL 5A: Making abortion care accessible handout

TOOL 5B: Addressing barriers to care

TOOL 5C: Service readiness assessment questions for providing abortion care to young women

TOOL 5D: Improving abortion standards and guidelines for young women

TOOL 5E: Improving abortion access for young women



TOOL 5A: Making abortion care accessible handout

Addressing social barriers

- Conduct community outreach and education
- Provide information to community leaders
- Set up informal or formal social support networks
- Show support for and participate in community-driven interventions
- Values clarification workshops for health-care providers and staff

Addressing economic and logistical barriers

- Lower the cost of abortion care
- Employ young women and advocate for economic gender equality
- Request public transport routes, or facilities can run a shuttle
- Create community-run transportation network
- Use a community fund to assist in covering costs

Addressing legal and policy barriers

- Be familiar with current abortion law, and clinical standards, guidelines and protocols. If possible, be part of their development in order to minimize barriers.
- Educate community about the specifics of the laws.
- * Ensure that facilities provide abortion services to the full extent of the law.
- Help professional associations make recommendations to decrease barriers.
- Create good clinical standards and guidelines if they do not exist, and remove barrier language in those that do exist.
- Disseminate those implementing documents to providers.
- Strive to identify legal indications for any client who seeks abortion care.

Addressing health system barriers

Unavailability of facilities

- Provide abortion care for young women in geographically optimal locations.
- Make open hours as long as possible.
- Ensure that medical abortion medications are available locally and provide them.

Lack of privacy and confidentiality

- When possible, provide private rooms and separate toilets for abortion clients.
- Ensure auditory and visual privacy during counseling and procedures.
- Enforce confidentiality for all clients, including young people.
- Secure records and train providers and staff to be discreet.

Processes and forms

- Use neutral forms and do not require unnecessary return visits. Facilities and health systems should clarify their commitment to serving young women.

Cost

- Charge on a sliding scale based on access to funds, determined in private without documentation.

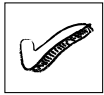
Negative attitudes

- Facilitate values clarification opportunities for all staff.
- Frame statements about sexual and reproductive health positively.

Restrictive settings

- Interpret legal indications broadly.
- Educate stakeholders on the existing legal indications and draft standards and guidelines to implement them.
- Ensure the availability of misoprostol.
- Take a harm reduction approach.

TOOL 5B: Addressing barriers to care



Objectives

By the end of the session the participants will be able to:

- Summarize challenges that young women face in accessing abortion care
- Identify different strategies to address those challenges
- Explore how to involve young people in addressing the challenges



Materials

- Flipchart, markers, tape
- Handout, Case studies
- Flipchart, Case studies discussion questions



Time

5 minutes: Introduction – Identifying the challenges

20 minutes: Case studies

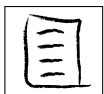
20 minutes: Presentations and wrap-up

45 minutes total time



Preparation

- Write the case studies discussion questions on a flipchart.
- Make copies of the Case studies handout, enough for each participant.



Instructions

1. Review the session objectives with the participants.
2. Ask the participants to identify challenges that young women may face when accessing abortion care. List them on a flipchart. If the group has already completed Tool 2B, Barriers to care, summarize the answers recorded on flipcharts during that activity instead.

Note to facilitator: Responses should include social barriers (such as stigma and resistance from the community), economic and logistical barriers, legal and policy barriers, and health system barriers (such as negative provider attitudes, concerns about privacy and confidentiality and appropriate training for staff).

3. Divide the participants into at least six small groups of three or four participants. Depending on the total group size you may need to create more than six small groups.
4. Inform small groups that they will each review a case study describing a challenge young women or providers may encounter, or have encountered, related to abortion care, and prepare a strategy to address it.
5. Give each participant a copy of the Case studies handout. Assign each group a different case study. More than one group may work on the same case study depending on the number of small groups.
6. Post the flipchart with the Case study discussion questions and review them. Instruct groups to first read the case study, then brainstorm ideas and record answers to the discussion questions. Inform groups that they have 20 minutes to complete the task.
7. After 20 minutes, ask the participants to join the larger group. Ask a representative from each group to read aloud their case study and present the strategy the group created to address the challenge. If more than one group reports on the same case study, ask them to report only on the different ways they addressed the issue.
8. On a flipchart, record the solutions provided. Compare how different groups addressed similar issues.
9. Ask participants to identify any common elements that appear in the strategies, and elements that might be lacking, such as strong partnerships with young people.
10. Process the activity by using the following questions to facilitate discussion:
 - *How did it feel to create a strategy that addresses some of the challenges that young women face accessing abortion care?*
 - *What, if any, were challenges that your group faced in creating that strategy?*
 - *Do you think you face any of these challenges in your community? If so, how would these strategies be applicable there?*
 - *What steps will you take when you get to your facility to address these challenges?*
11. Close the activity by highlighting key points made by participants, and reminding them that:

Each facility is different – in the challenges they encounter and in the strategies they implement. But working with others at the facility and community levels, particularly young women in the community, is critical to properly identify the problem and choose the most viable strategy to address it.
12. Ask participants if they have any questions about the activity. Thank them for their participation.

Case studies handout

Case study 1: Community resistance (social barriers)

Parents and religious leaders in the community are not happy that their primary level clinic offers abortion care services, especially to young women. They feel the clinic is promoting promiscuity, teaching the girls to hide things from their family, and going against the teachings of the church. Many young women are admitted to the clinic with complications from unsafe abortion, but few come for safe abortion care.

Case study 2: Cost and transportation (economic and logistical barriers)

A district hospital serves a large rural area. Not many young women come to the hospital for abortion services and when they do they usually don't have enough money to cover the cost of the service and transportation back home. They usually come alone and need to return home, a trip that takes several hours, the same day they come for the abortion.

Case study 3: Consent law (legal and policy barriers)

A private clinic recently started implementing the new national consent law for young women below the age of 17 who are seeking abortion care. They need to have either a parent's consent or a judicial bypass to receive the procedure. Since the clinic started implementing the new policy the number of young women who come for abortion care has reduced by half, but the number of postabortion care cases has dramatically increased.

Case study 4: Privacy and confidentiality (health system barriers)

Many young women are not coming to the facility for abortion services because they are afraid that they will see someone they know while they are there, or that one of the people working in the facility will tell their family or someone who knows them.

Case study 5: Negative provider attitudes (health system barriers)

When a young woman comes to a public health clinic in her town, the receptionist loudly repeats that the young woman is here for an abortion, asks her age twice, and then shakes her head. She then asks the young woman to pay a fee which is more than advertised. When the young woman meets the provider, he asks her age and then asks where her husband is and if he knows she is getting an abortion. He denies her request for an abortion without telling her why.

Case study 6: Low service use among young women (multiple or all barriers)

A tertiary referral hospital is not receiving the expected number of young women for abortion care. Yet research from the facility catchment area shows that unsafe abortion is very common among young women and several deaths from complications have been recorded.

Case studies discussion questions flipchart

1. What are the challenge(s) identified in the case study?

2. What possible strategies exist to address the challenge(s)?

3. How could you determine which is the best strategy to implement? How would you involve young people?

4. Which do you think is the best strategy?

5. What would be the key steps you would take to implement the strategy? How would you involve young people?

6. How do you think health officers and/or facility administrators would react to the proposed strategy?

TOOL 5C: Service readiness assessment questions for providing abortion care to young women

This tool outlines sample questions to assess a facility's readiness to provide abortion care services for young women. While the tool is intended to provide guidance on useful service readiness assessment questions, we recommend reviewing, selecting and adapting questions with local young women to ensure that their actual needs and desires for high quality abortion care are met most effectively.

Is the facility offering rights-based abortion care for young women?

1. Does the facility have written policies or protocols that affirm young women's rights to sexual and reproductive health-care information and services? Privacy and confidentiality? Independent decisionmaking in accordance with individual capacity?

Is the facility offering participatory abortion care for young women?

2. Are young women involved in service delivery in any other way than as clients? How?
3. Did young women participate or partner in the design of services? How?
4. Do young women participate or partner in service provision? How?
5. Do young women participate or partner in evaluation of services? How?
6. Does a partnership with young people or youth groups exist?

Is the facility making abortion care services accessible to young women?

Facility environment

Note – not all questions may be applicable to your facility. Choose questions based on what local young women have indicated they would like available.

7. Is the facility accessible via public transportation?
8. Do opening hours extend outside of typical school and work hours?
9. Is there a separate entrance for young women?
10. Do key areas of the facility provide both visual and auditory privacy?
 - a. reception and waiting room
 - b. counseling room
 - c. examination and procedure room
 - d. recovery room and bathrooms/toilet facilities
11. Can young women be seen without an appointment?
12. Does scheduling allow for the possibility of longer counseling time when needed?
13. Are medical records secure and never left easily visible to other clients or staff not directly involved in the client's care?

Policies

14. Do clinical standards and protocols for abortion care for young women exist, and if so have they been distributed to and are they known by providers?
15. Do facility policies or protocols require additional reporting on, or apply restrictions to, abortion care for young women not present in the law? (A “yes” answer to this question indicates an issue to be addressed.)

Education and information

16. Does the facility conduct or support community outreach and education about young women’s sexual and reproductive rights, including the issue of unsafe abortion?
17. Does the facility have any client materials or handouts about abortion that are designed by and for young women?

Payment

18. Do payment options (sliding scale, free, other) exist for low-income young women?

Staff preparedness

19. Have all staff members received at least an orientation on serving young women?
20. Have all staff members attended a values clarification workshop on providing abortion care to young women?
21. Can young women be seen by a female provider if requested?
22. Do peer educators/counselors exist to help young women or accompany them throughout the service if requested?

Referrals and other health services

23. Are referrals made for any services not provided at the facility?
24. Are those referrals made as part of official referral agreements between institutions and/or are there processes to ensure client follow-up?
25. Are other health-care services provided during the same visit if needed?

Is the facility offering abortion care that is clinically appropriate to young women?

26. Are providers trained to counsel young women on sexuality, sexual and reproductive health, and abortion care?
27. Are providers trained in the clinical specifics of providing abortion care for young women?
28. Are providers prepared to alleviate young women’s pain, keeping in mind that young women may experience more anxiety or have a lower pain tolerance than adult women?

Is the facility recording abortion care service statistics for young women? *(In places which restrict access to abortion below a certain age, facilities may decide not to do this if not required by law.)*

29. Does a logbook/register exist for abortion services, which includes client age?
30. Is the facility recording, and disaggregating data by age for:
 - a. Number of clients asking for safe abortion in the last year
 - b. Number of clients receiving safe abortion in the last year
 - c. Number of clients seeking postabortion care in the last year
 - d. Number of clients receiving postabortion care in the last year

- e. Percentage of postabortion clients likely to have had induced abortion (based on provider's informed opinion – this data should not to be considered conclusive)
- f. Percentage of clients asking for postabortion contraception in the last year (by method if possible)
- g. Percentage of clients receiving postabortion contraception in the last year (by method if possible)
- h. Number and type of unsafe abortion complications seen in the facility in the last year

If disaggregation by age is not possible, estimate the most affected age groups, by question:

| Age group | Estimated proportion (percentage) |
|--------------------|-----------------------------------|
| 10 – 14 years | |
| 15 – 19 years | |
| 20 – 24 years | |
| 25 – 30 years | |
| 31 years and above | |

Adapted from:

Hainsworth Gwyn, Carolyn Boyce and Ellen Israel. 2008. *Assessment of youth-friendly postabortion care services: A global tool for assessing and improving postabortion care for youth*. Watertown, MA: Pathfinder International.

Osuri, Joachim. 2010. *lpas service delivery point assessment tool for initiation of abortion related services*. Kenya: Ipas Africa Alliance. Unpublished.

Senderowitz, Judith, Gwyn Hainsworth and Cathy Solter. 2002. *Clinic assessment of youth-friendly services*. Watertown, MA: Pathfinder International.

TOOL 5D: Improving abortion standards and guidelines for young women

Creating and disseminating evidence-based standards and guidelines for legal abortion services helps to ensure that such services are safe and accessible. Yet in many countries, where an abortion would otherwise be legal, young women are often blocked from seeking and obtaining safe services by involvement laws for minors (McCulloch 2010). All standards and guidelines must address the needs and fulfill the rights of young women.

The questions below can help evaluate how appropriate existing standards and guidelines are for young women. They can also be useful when drafting new standards and guidelines to ensure that barriers for young women are not included. Sample language is given for each question where appropriate, often drawn from existing standards and guidelines. “Yes” to each of these questions is characteristic of good standards and guidelines.

1. Do they protect confidentiality of individual clients independent of age or majority status? Service statistics can and should be gathered, and disaggregated by age, but data that identifies an individual should not.
“All service providers involved in providing abortion services, taking all reasonable precautions, must keep the information confidential.”
2. Do they require privacy for both the counseling and clinical services independent of the client’s age or majority status?
“Each patient must have a private opportunity to discuss issues and concerns about her abortion, and be provided services in an area with at least visual, and preferably auditory, privacy.”
3. Do they address potential negative attitudes of providers and facility staff?
“The national health system shall provide values clarification workshops for all providers and staff involved in providing abortion care. ‘Conscientious objection’ to the provision of abortion is allowed only insofar as the provider ensures an immediate successful referral to a provider willing to perform the abortion. Providers found to have refused abortion care to three or more patients who subsequently did not receive abortion care may be censured by the Ministry of Health, up to and including the loss of their medical license.”
4. Do they acknowledge that violence and coercion are often related to abortion, and seek to meet the needs of those who have experienced it?
“Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where the pregnancy is the result of rape or incest.”
5. Does the facility provide referrals when necessary?
“A well-functioning referral system is vital to providing safe and high-quality abortion services. All health personnel involved in the care of the woman have an ethical responsibility to direct her to appropriate services at any time. Referral arrangements enable women to access routine care and prompt treatment for complications.
 - *Refer a woman if the type of care that she needs is beyond the capacity of your institution.*
 - *Clearly state her condition at the time of referral, what was done, and the reason for referral on the referral paper.*
 - *Alert the receiving health facility, particularly if the woman is suffering from complications and needs immediate care, transportation, care during transport, including accompanying health personnel, and/or free services, as appropriate.*
 - *The referral center should provide feedback to the referring center on the type of complication, the care provided, the outcome of the treatment, and the plan for subsequent care.*
 - *Inform victims of rape about legal and psychological support and refer as needed.*

- *All women referred to the next level are entitled to care without any precondition.*
- *Referral arrangements for social support and care are an integral part of overall abortion care."*

6. Do they seek to ensure that the client is not being coerced to have an abortion?

"Standard 3: Facilities should ensure that adolescents and youths make informed and free decisions without coercion from interested parties.

Guidelines:

1. *Ensure respect of autonomy in decisionmaking without third-party authorization.*
2. *Ensure that the adolescent is adequately counseled.*
3. *Providers should act in good faith in the interest of the minor and this may involve leaving out parental or guardian consent."*

7. Do they codify only evidence-based practices?

"Based on research that has shown third-party involvement requirements for minors do not result in increased communication with parents and other adults, and has negative consequences on the health of the minor, no third-party involvement is required, nor may be required within the authority of this document."

8. Do they avoid any restrictions or requirements as to age or majority status (such as third-party involvement for women below the age of majority), marital status, or proof of rape unless required by law?

"Consent:

1. *The termination of a pregnancy may only take place with the informed consent of the pregnant woman.*
2. *Notwithstanding any other law or the common law, no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.*
3. *In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them."*

9. If ability to consent to an abortion procedure is legally restricted by age or capacity, are the applicable laws and source documents included, as well as the legal definition of a medical procedure, and mechanisms for proxy consent (by parents, next of kin, any adult, legal bypass, medical provider discretion, etc.) described? Are the mechanisms as easy and rapid to use as possible, given the law?

10. If ability to consent to an abortion procedure is legally restricted by the concept of evolving capacities (rather than or in addition to age), do they affirm the broadest possible interpretation of capacity? For example, the "principle of capability"?

11. If third-party involvement is required by law, do they avoid adding additional processes or restrictions?

12. If third-party involvement is required by law, do they affirm the woman's rights to consent to the abortion service (in addition to proxy consent by the third-party), and independent decisionmaking and consent for all other related services, for which third-party consent is not required by law (for example postabortion contraception)?

"Third-party is notified only of the provision of abortion services. The minor will also provide her own consent to the abortion service to ensure it is her free will to have such procedure. All other services provided in the course of care and their results – counseling, contraception, testing, referrals, etc. – are the sole provenance of the minor."

13. If third-party involvement is required by law, are there exceptions in cases where the young woman's life or health is endangered or she has experienced incest?

"If a criminal charge of incest is pending against a parent of such minor, or if it is determined by a licensed

physician that carrying the pregnancy to term would put the minor's life or health at serious risk, the written consent of such parent or other third-party is not required."

14. Do they avoid requiring any waiting period unless required by law, independent of the client's age or majority status?
"A woman must undergo the abortion as quickly as possible in accordance with good medical practice. This precludes requiring medically-unnecessary waiting periods."
15. Do they otherwise avoid making the process of getting abortion services more difficult or slower than the law requires?
16. Do they specify that postabortion contraception counseling and a range of methods should be offered to, but not required of, all clients?
"Information about contraceptives must be offered to all women during counseling, and methods provided during the postabortion recovery period if selected by the woman."
17. Do they state that the provision of abortion services, and the fee for such services, is not tied to the client's acceptance of other care such as contraceptives or vaccinations?

Below are some examples of barriers that may exist for young women or women below the age of majority in abortion standards and guidelines.

1. Demanding proof of age if it is not required by law.
2. Mandating third-party involvement for women below the age of majority if it is not required by law.
3. Standardizing written third-party consent forms if only verbal consent is required by law.
4. Requiring third-party consent by more than one adult if only one adult is required to give consent by law.
5. Accepting third-party consent only by the nearest relative if any adult can give consent by law.
6. Mandating waiting periods for women below the age of majority if they are not required by law.

If they address consent for young women or women below the age of majority, standards and guidelines should adopt language on evolving capacities, modeled in the Convention on the Rights of the Child and other applicable regional laws (McCulloch 2010). They should take the broadest interpretation of applicable national and local laws. Providing detailed recommended language for standards and guidelines requires knowledge of such national and local laws and practices. It should be done in collaboration with local stakeholders, including those who can most effectively represent different young women's interests and rights.

Adapted from:

Huber, Amanda and Karen Otsea. 2004. "Checklist for creating and implementing standards of safe abortion care" and "10 Steps to Developing Standards and Guidelines for Safe Abortion Care." In *Safe Abortion Standards and Guidelines Toolkit*. Chapel Hill, NC: Ipas. Unpublished.

McCulloch, Lauren. 2010. *Legal Frameworks of Medical Consent: Girl's and Adolescent Women's Access to Legal Abortion Care*. Chapel Hill, NC: Ipas. Unpublished.

National Abortion Federation. 2010. 2010 Clinical Policy Guidelines. Washington, DC: National Abortion Federation.

Republic of South Africa. 2008. Choice on Termination of Pregnancy Amendment Act, 2008. Cape Town: Republic of South Africa.

Government of the Republic of Zambia, Ministry of Health. 2009. *Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia*. Lusaka: Government of the Republic of Zambia.

TOOL 5E: Improving abortion access for young women



Objectives

By the end of this activity, participants will be able to:

- Explore the different health system barriers that young women may encounter when seeking an abortion.
- Develop strategies to improve access to abortion care and service delivery for young women.
- Identify the ways providers may individually influence a young woman's abortion experience both negatively and positively.



Materials

- Flipchart, markers, tape
- Role play instructions handout
- Partnership defined quality flipchart
- *Optional:* Tool 4C, How young people can partner in, lead and transform abortion care



Time

25 minutes: Introduction and facility mapping

35 minutes: Role plays (4 scenarios)

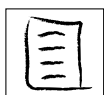
15 minutes: Discussion and partnership defined quality

1 hour 15 minutes total time



Preparation

- Print copies of the Role play instructions handout, enough for each small group
- Write up Partnership defined quality on a flipchart
- *Optional:* Print copies of Tool 4C, enough for each participant



Instructions

1. Review the session objectives.
2. Divide participants into small groups of no more than five participants per group. Assign each group a facility level: primary clinic, secondary-level hospital, or tertiary teaching hospital. You may have more than one small group per facility level depending on the total number of participants.

Note to facilitator: If you know what type of facilities the different participants work in, you can divide them accordingly and assign them the type of facility they are most familiar with.

3. Give each group flipchart papers and markers. Ask each group to draw a young woman to the left on one flipchart and then draw an image of a “typical” facility that offers abortion services – at the level they were assigned – on the same flipchart, next to the young woman.
4. Ask participants to think through and list the different elements of service delivery that the young woman would go through if she were to have an abortion at the facility, using the same flipchart or a new one if needed. Allow 5 minutes for this task.
5. Ask the groups to discuss and write down the potential barriers or challenges that the young woman might encounter at each step in the service delivery process. Allow 10 minutes for this discussion.
6. Ask the groups to share their flipcharts and briefly summarize what they discussed.

Note to facilitator: The elements, or steps, in the service delivery process should include the following: waiting and intake, counseling, preparation, abortion procedure, recovery and postabortion counseling.

The barriers may include: lack of trained providers and unavailable services, lack of privacy and confidentiality, processes and forms, cost, and negative attitudes among providers and other facility staff.

7. Inform participants that they will continue exploring the young woman’s experiences through role play. Tell them that the different steps of service delivery will become four role plays: a) Waiting and intake, b) Counseling, c) Preparation and abortion procedure, d) Recovery and postabortion counseling.
8. Let the small groups pick which one of the four steps they wish to prepare and enact, making sure all steps are picked at least once. Ensure participants that no one has to act in the role play unless they want to, but everyone should help prepare one.
9. Give each small group one or a few copies of the Role play instructions handout. Ask them to review the instructions and prepare the role plays. Tell the small groups they have 10 minutes to do this.
10. Invite one of the small groups that prepared a) Waiting and intake, to enact their negative scenario.
11. At the end of the negative scenario, invite participants to comment on what they saw:
 - *What problems did the young woman encounter?*
 - *What was the young woman’s response to the different problems?*
 - *How could we turn these negative experiences into positive ones for the young woman?*
12. Ask the participants who were in the role play how it felt to play each of their roles:
 - *How did it feel to play the young woman who needs an abortion but does not get any support?*
 - *How did it feel to be a provider or individual who caused the young woman to have a negative experience?*
13. Invite the same group to enact their positive version of the scenario.

14. At the end of the positive scenario invite participants to comment on what they saw:
 - *How did the characters transform this experience into a positive one for the young woman?*
15. Ask the participants who were in the role play how it felt to play each of their roles:
 - *How did it feel to play the young woman who needs an abortion and gets support?*
 - *How did it feel to be a provider or individual that contributed to a positive experience?*
 - *What feels different for you between the two scenarios? Why do you think that is?*
16. Repeat instructions # 11 – 16 for the remaining three steps: b) Counseling, c) Preparation and abortion procedure, and d) Recovery and postabortion counseling.

Note to facilitator: Depending on the role play and the group, you may want to ask participants to re-enact the positive scenario again, trying to get an even more positive experience. Encourage participants to think of outcomes where the young woman is empowered or takes power to change the scenario, not just the facility staff.

17. After all four steps have been enacted with both negative and positive scenarios, ask the participants to reflect on the role plays. You may wish to use the following questions to facilitate the discussion.
 - *What did you learn from the scenarios about young women's experiences with abortion?*
 - *What different factors made the experience more positive for the young woman?*
 - *What does it take to transform young women's negative experiences into positive ones? At the individual level? At the facility level? At the health system level?*
 - *What did you learn from the scenarios about people's individual capacity and responsibility to ensure that young women have positive experiences with abortion?*

Record some of the answers on a flipchart.

18. Remind participants that even well-intended processes to improve abortion care and service delivery for young women can fail if young women themselves are not involved. You may wish to say:
 - *Even well-intended processes to improve abortion care and service delivery for young women can fail if young women themselves are not involved. Young women can share experiences and perspectives with providers that providers do not have. (See Module 4: Building partnerships between young people and adults).*
 - *Service delivery improvements have a better impact if they are achieved through collaborative efforts with the people they are intended to serve – in this case, young women. We therefore encourage going through some of these processes together with young women in your community.*
19. Post and review the Partnership defined quality flipchart.

Note to facilitator: You may also wish to refer participants to Module 4: Building partnerships between young people and adults, and hand all participants copies of Tool 4C: How young people can partner in, lead and transform abortion care.

20. Highlight key points from the discussion and summarize by saying the following:
 - *Providers can serve as supporters of young women who need and want safe abortion care. Improving accessibility and service delivery will lead to more positive experiences for young women in need of abortion care, and help save their lives and improve their health.*

Role play instructions handout

By enacting a scenario, first with negative outcomes and then again with positive outcomes, participants will explore how to improve access to safe abortion care for young women at the facility level. The exercise will also show participants how changes to individual behaviors can lead to more positive experiences for young women. In preparation, participants have 10 minutes to:

1. Select one scenario from the list below.
2. Prepare a brief two to four minute role play for that scenario which has a negative outcome. You may wish to use some of the health system barriers you identified earlier in this session.
3. Prepare a brief two to four minute role play for the same scenario, but with a positive outcome.
4. Assign participants the character they will play. Playing a character is voluntary.
5. If time allows, you may practice either or both scenarios.

List of Scenarios

- A. Waiting and intake
- B. Counseling
- C. Preparation and abortion procedure
- D. Recovery and postabortion counseling

Example

Scenario: Recovery and postabortion counseling

Roles: Young unmarried woman, recovery room nurse, counselor

Negative experience: The young woman is resting in the recovery room but is worried that she is bleeding too much and she feels a little nauseous. She calls across the room that she needs to use the bathroom. The recovery room nurse yells at her to quiet down and stop fussing, and says "loose girls like you should not complain when kind doctors are helping you." After ignoring her for a while the recovery room nurse tells the young woman she can go see the counselor. The counselor informs the young woman that since she needed an abortion she also needs contraceptives and prescribes birth control pills without engaging the young woman.

Positive experience: The young woman is resting in the recovery room but is worried that she is bleeding too much and she feels a little nauseous. She calls across the room that she needs to use the bathroom. The recovery room nurse asks her to be quiet in order not to disturb the other women and helps her to the bathroom. After ensuring that she is okay, the recovery nurse lets the young woman go to the counselor. The counselor is kind and respectful towards the young woman. They discuss contraceptive options. The young woman says she wants to prevent another pregnancy but does not want birth control pills because she is afraid of the side effects. They agree on a different method.

Partnership defined quality flipchart

Partnership defined quality:

- Is a method to increase the quality and accessibility of health-care services for young people.
- Recognizes that young people are critical participants in processes to improve health-care services for them.
- Is collaborative and based on partnerships between health-care professionals and providers, and young people.
- Requires commitment from all stakeholders including young people.
- Includes four steps:
 - Building support
 - Exploring quality
 - Bridging the gap
 - Working in partnership

Note to facilitator: The four steps of Partnership defined quality for youth include:

Building support: Presents the process and obtains commitment for participation from key groups in the community, including young people (and their parents), community leaders, and health system professionals and providers.

Exploring quality: Creates an understanding of different perspectives of quality among young people and health-care providers. During this step meetings are held separately with young people, community members and health workers to explore their ideas in an open and safe environment.

Bridging the gap: Brings together health-care professionals and providers, and young people in a workshop to hear each other's' ideas. Through discussion they begin to work as a team to develop a shared vision of quality, and establish a "quality improvement team."

Working in partnership: Determines root causes and identifies solutions for achieving the desired level of quality. The group also establishes indicators to monitor progress.

See **Partnership Defined Quality for Youth (PDQ-Y)** in Module 4.

Module 6: Making abortion care clinically appropriate



Image used with permission of Youth Coalition for Sexual and Reproductive Rights © 2007. Special thanks to the participants of the 2007 National Safe Abortion Advocacy Workshop in Ecuador.

6.1 Introduction

This module provides guidance for providers and others involved in service delivery on abortion counseling, and contraceptive and clinical care that is appropriate for young women. Physically, young women's clinical needs are mostly similar to those of adult women; however, their life and social circumstances are often very different, requiring care tailored to their unique circumstances, especially concerning counseling and provider attitudes.

Although more research is needed to examine clinical differences in abortion care for young versus older women in order to make evidence-based recommendations, the primary differences mostly relate to counseling and provider attitudes. For general guidance on how to provide abortion counseling, contraceptive and clinical care, please consult Ipas's *Woman-Centered Abortion Care: Reference and Trainer's Manuals* (available on the CD-ROM and at www.ipas.org).

6.2 Provider attitudes

Providers hold a range of attitudes – both conscious and unconscious – about young people's sexuality, which can have a significant impact on the content and quality of abortion-related care for young women. Abortion values clarification and attitude transformation (VCAT) workshops are recommended for all providers and staff who interact with young abortion clients. The abortion VCAT approach recognizes that values affecting attitudes and beliefs about abortion and related issues can change over time in response to new experiences and a deeper understanding of the issues and context. The goal of an abortion VCAT workshop is for participants to explore, question, clarify and affirm their values and beliefs about abortion and related sexual and reproductive health, such that their awareness and comfort with the provision of comprehensive, woman-centered abortion care is increased (Turner and Page 2008). Abortion VCAT is a particularly important process for providers preparing to offer abortion care that is appropriate for and respectful to young women. See *Abortion attitude transformation: A values clarification toolkit for global audiences*, in particular "Activities adapted for young women and abortion," included on the CD-ROM.

Individual providers can mitigate the impact of social barriers and help young people get the care they need by providing health care in an environment in which preconceived notions of gender, age, sexuality and abortion have been thoughtfully examined, and by recognizing and respecting that young women have a right to life and health, to accurate information and the highest attainable standard of health care. Providers should make a conscious effort to keep personal beliefs from limiting their ability to give the best care possible to young women.

6.3 Options counseling

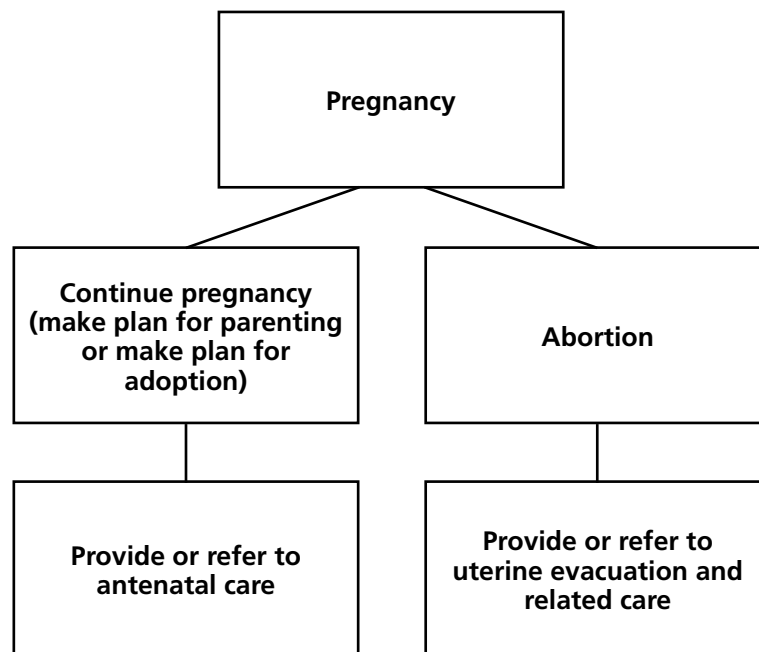
When a young woman requests an abortion, she is likely to have carefully considered her options and decisions prior to seeking care. However, young women may want more information on which to base their decision. For the purpose of informed consent, it is important that counselors review the woman's medical condition and the basic options available to her: to continue the pregnancy to term and then parent or release the child for adoption; or to terminate the pregnancy. Young women should be allowed to make a free, informed decision and that decision should be respected. Providers are more likely to respect a decision with which they agree (Dickens and Cook 2005), but it is important for providers to respect a young woman's decision even if they do not agree with it. If information is requested, providers should make sure that a young pregnant woman understands all of her options, help her examine how her decision will affect her and the people important to her and support her decisions.

If a third-party may be involved in the counseling, providers should ask the client in private first if she wants to involve the third-party in her decisionmaking. If she says yes, but appears nervous, they can help her decide how to discuss her feelings with the third-party.

If she says no, her decision to not include the third-party should be accepted (de Bruyn and Packer 2004). If the young woman must, by law, notify or get consent from a third-party, and she is not eligible for any exemption or alternative, providers should explain this obligation and offer to help her talk to the third-party (Fischer et al. 2007).

Decisionmaking on abortion often takes place mostly outside the clinic setting (Lee 2004), and a young woman may be particularly susceptible to adults' influence, especially from a partner or someone who has power over her (Bailey et al. 2004, Brown et al. forthcoming). These adults may have internalized negative stereotypes about teen pregnancy and young women's ability to be responsible, which may strongly influence the young woman's decision to terminate a pregnancy (Brady et al. 2008). Providers should ask questions to ensure that she has not been pressured or coerced by anyone, including a partner, family, community or friends, to make her decision. To make sure that her decision is fully hers:

- Meet alone with the woman first to have a private conversation free from other people's influence.
- Ask her to carefully explain her decision, paying attention to any personal views or desires she expresses.
- Listen for language that can indicate other people's influence in her decisionmaking, such as "my boyfriend thinks I should..." or "my mother wants me to..."
- She may factor in other people's views and desires, but she needs to be clear that her own life will be most directly affected by her decision and that the decision is hers to make.



Particularly in settings where abortion is legally restricted, young women need to know that safe abortion is a legitimate health-care service and be referred to medically sound health-care providers and facilities. Once the young woman has made a decision, providers should be prepared to provide abortion care or antenatal care if the client chooses to carry the pregnancy to term, including information and referrals on parenting support, financial assistance, childcare, adoption, prevention of mother-to-child transmission of HIV/AIDS and other topics related to maternal health (de Bruyn and Packer 2004).

"it is seen as 'you're too young' ... and when they're told - like the girl i was meeting with earlier this week - 'you can't even keep your room tidy, how do you think you'll cope with a baby?' ..., it was a very strong voice saying that was what she ought to do."

- counselor (brady et al. 2008)

6.4 Abortion counseling

"listen to me, no one else, listen to me. it's my body, listen to me: it's my life, listen to me."

- young person, united kingdom (participation works 2008)

Stigma around young women's sexuality, consent laws and policies, and cultural and social conditioning by parents create particular challenges in counseling. Providers who want to offer high-quality counseling should be aware of these particular needs, and also recognize their own underlying attitudes toward young women's sexuality which may negatively affect service provision. When possible, young women should be offered counseling from a youth peer counselor or from a support person of their choice (see Module 4: Building partnerships between young people and adults). In addition, we advise care and respect in asking and then referring to people as they prefer to be identified, regardless of their physiology.

A counselor who works effectively with young people:

- Has the ability to build rapport with young women and earn their trust;
- Respects their different life circumstances;
- Has excellent communication skills;
- Understands that young people sometimes communicate differently than adults;
- Has accurate knowledge of sexual and reproductive health and local guidelines, laws and cultural beliefs (Fischer et al. 2007).

Providers should be especially sensitive to the following:

Respect: All health-care clients should be treated with respect. Providers should treat young women with the respect they would give a peer, regardless of age, gender or any other consideration. A young woman's questions, concerns and opinions about her health and health care are valid. By providing a clinic environment in which young women feel comfortable talking about their aspirations and concerns, providers will support open communication. Providers should also be aware that the young woman may have experienced mistreatment or abuse by previous health-care providers and this may cause her to distrust or fear providers. A woman's experience can have a profound influence on her future care-seeking behavior and that of other women she talks to. When different treatment options are available, for uterine evacuation and pain management methods for example, providers should respect the young woman's informed decision about the treatment she prefers.

A nurse in Kenya was observed by a visiting doctor to berate a 16 year-old STI patient into tears. "I can see you think I am being a bit hard," she said. "That's how it is with these up-country girls who have no morals. I have to scare them — and it works." When asked how she knows it works, she replied, "Because they never come back!" (WHO 2002)

Interaction and communication: The first action a provider should take in an abortion counseling session is to affirm the positive step the young woman has taken by seeking care.

During one-on-one interactions with young women, providers should:

- Provide all relevant information on the implications of each treatment option and help the woman choose the one best suited to her needs, respond to questions fully and honestly, and respect her decision even if it is not the choice the provider wanted her to make. This is likely to increase adherence to treatment.
- Avoid lecturing or scolding.
- Pause and think before doing or saying anything that seems to come from a feeling of anger or judgment. This includes body language.
- Use positive, open body language by facing her, removing any physical barriers such as a desk, leaning slightly forward, making appropriate eye contact, and nodding.
- Provide information as neutrally but warmly as possible and listen to what the young woman asks and wants. Young people may never have been asked their opinions and may not know how to articulate them well. Providers should give the woman opportunities to express what she already knows and her opinions, through leading questions if necessary, before providing more information.
- Provide an environment in which both the provider and the young woman feel comfortable discussing sexuality. If possible (and true), providers should try to normalize the conversation by saying "I have treated a number of young women with the same concern you have."
- Use the third person where possible, as young people may feel more comfortable answering indirect questions. For example, not "Do you smoke cigarettes?" but "Do any of your friends smoke?" and then, if the answer is yes, asking "Have you ever joined them?" and then following with questions about frequency.
- When possible, provide picture-based and printed information in the woman's language if she wants it, in addition to telling her.
- Young people may use different words for various terms than the ones providers use. Providers should ask the young woman what words she uses, and ask what they mean if the provider doesn't understand those words. The provider should then explain the meaning of common medical terms such as vagina, vulva, sexual intercourse, abortion, and then use those words during counseling (de Bruyn and France 2001).

(De Bruyn and Packer 2004, WHO 2010a)

Confidentiality: Providers' explanation and enforcement of confidentiality are crucial elements of appropriate care for young women. Providers should begin each counseling and consultation session by reassuring the young woman that all of the information exchanged and care she receives are confidential and will not be shared without her permission. Administrators and providers need to have strong confidentiality policies and uphold them so young women feel secure seeking services, knowing their privacy will be respected. Rather than focusing only on the infrequent circumstances under which they

may be obligated to breach confidentiality, providers should clearly state their professional commitment to maintain confidentiality. Otherwise the young woman may focus only on the fact that providers can breach confidentiality; this can increase stress and fear of others learning their private information. It is useful to explain to the young woman how staff protects confidentiality in the facility.

Educating versus counseling: Providers should be aware that they are often seen as authority figures. Young women may be intimidated and afraid to ask for more information, options, or additional services; or may accept the provider's recommendations even if these make them uncomfortable. Providers should explicitly encourage young women to ask questions, and solicit the woman's opinion before making any suggestions (EngenderHealth and ICW 2006); this includes encouraging the young woman to voice her desires and think about possible solutions to her health-care needs, rather than only asking her to talk about her problems. To ensure that the young woman understands the information being provided, providers should ask questions that will enable them to determine any gaps in comprehension. However, providers should not ask "Do you understand?" as young women may be embarrassed to admit if they do not (Fischer et al. 2007).

Counseling is a structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions.

Counseling is...

- *Soliciting the person's feelings and thoughts*
- *Accepting the person's perceptions and feelings, regardless of societal norms*
- *Respecting the person's privacy and confidentiality*
- *Focusing on the person's – not the counselor's – needs and concerns*
- *Communicating effectively*
- *Supporting the person in making her own decision and acting on it*
- *Providing information and helping the person apply that information to meet her needs and desires*

Counseling is not...

- *Only or mainly informing*
- *Giving advice*
- *Trying to influence the person's attitudes, beliefs and behaviors by persuading, admonishing, threatening or compelling (Herrick et al. 2004)*

Length of time and presentation: Young women may have had little opportunity to learn about sexual and reproductive health, and so may need more information than many adult women. They may also not know how to ask for information, or feel uncomfortable asking for it. Young women may require that the same information be provided more than once, perhaps in different ways. They may also be uncomfortable talking about topics related to sex and sexuality and require careful rapport-building. These differences are likely to make the counseling session longer than those with older women (de Bruyn and Packer 2004, Fischer et al. 2007).

Sexuality: Young women may have little to no knowledge about sexuality. Understanding their own sexuality can give young women a solid base from which to make informed decisions about sexual activity; conversely, young women who are uninformed, misinformed, confused, embarrassed or ashamed may act in ways that detract from their health and well-being. The counseling session is an opportunity for providers to introduce and discuss sex, gender, healthy sexuality and adolescence with young women in an appropriate and respectful manner that encourages two-way dialogue and mutual learning. This may be a young woman's only opportunity to have such a conversation. Providers should present any information as positively and naturally as possible, though like many people, they may have their own biases and discomforts around sexuality.

Risks versus benefits: Providers should give complete information about possible complications and side effects in an objective manner, as they may be the woman's only source of accurate information; omitting information betrays the woman's trust (Fischer et al. 2007). The provider can then help her weigh the potential risks against the benefits she has identified to help her make an informed decision. It may be helpful to compare the risks of a safe abortion or a given contraceptive method to carrying a pregnancy to term or other non-reproductive health medical procedures. Young women may also have difficulty imagining the level of pain associated with the abortion or complications, compared with heavy periods or childbirth, so providers need to give other examples for comparison. Most facilities have standard language on the risks and benefits of a medical procedure as part of the informed consent process and forms.

Countering misinformation: A young woman may fear that an abortion will harm her, based on misinformation from adults or peers, or anti-choice campaigns and messages, which providers should be prepared to counteract. Young women may also fear that this pregnancy is their only chance to bear a child, because of stories they have heard about the unpredictability of fertility. Providers should be aware of this and be able to answer any concerns about safety accurately and completely. Men are also often targets of anti-choice campaigns (Blustein 2008, Ipas 2009a); the people who accompany young women may therefore have questions or fears as well.

"i'm probably going to be very worried... it feels like i am going to be anxious... i feel terrified."

- young woman, sweden, speaking about her planned induced abortion (halldén et al. 2005)

Referrals: Because of the barriers they face in accessing health-care services, young women may use services less than adult women. The provider should seize the opportunity to provide or refer for any other health-related information and services young women may need. These can include services related to age-appropriate physical and psychosocial development, physical and sexual abuse, substance abuse, nutritional status, vision, STIs and tuberculosis (Ministry of Health, Ethiopia 2008). Providers should know where to refer young women for services that cannot be provided at their facility, and make sure that the referrals are made to knowledgeable providers who serve young women with respect (Fischer et al. 2007).

6.5 Postabortion contraceptive counseling and methods

Young women's contraceptive needs vary greatly. A young married woman with one child who wants to avoid having a second may have different considerations than a young woman with more casual sexual relationships and who may be at higher risk for STIs, including HIV. Women at high risk for HIV should consider using condoms with another contraceptive method (often called "dual protection") to reduce the risk of exposure to HIV while also having a contraceptive with higher efficacy rates than condoms have in practical usage. Women being treated for HIV need information on contraceptive options in relation to their treatment regimens. Some young women may want to become pregnant immediately and not require contraception. When providing contraceptive counseling and services, it is important to ask rather than assume what the young woman's immediate and longer-term reproductive plans are and structure the discussion to match. Contraceptive counseling should also include information on fertility awareness, by asking what the client knows about her menstrual cycle and fertility and building on that to educate her about the fertile and infertile points in her cycle, or that they are erratic if her cycle is irregular. A young woman's privacy needs can also influence her selection of contraceptive method; for example, injectables may suit a young woman with high privacy needs, even if her preferred method might otherwise be something else.

Providers must bear in mind that different women experience different levels of side effects with the same contraceptive method. All reported side effects should be taken seriously by the provider, even if they are not health-threatening. It is helpful to differentiate side effects from complications and assure clients that side effects are fully reversible (Ministry of Health, Ethiopia 2008). Clients experiencing persistent, undesirable side effects should be counseled and provided better, alternative methods.

As with abortion, young women may have concerns about the safety or efficacy of contraceptive methods, which may be based on misinformation. They may not know how pregnancy occurs or is prevented. For example, they may have heard that pregnancy won't occur if they have intercourse in certain positions, in water or during menstruation. Young Nigerian women have low levels of contraceptive use and relatively high frequency of unsafe abortion, resulting in many abortion-related complications, including infertility. A qualitative study has shown that this is because many young women believe that contraception will cause future permanent infertility (Otoide et al. 2001). Because of misinformation like this, it is important that providers explain how a contraceptive works, including efficacy, potential side effects such as weight gain or breast tenderness and their incidence, and the long-term clinical implications of any such side effects. Providers can ask indirect questions such as "What are some things your friends say about how you can and can't get pregnant?" and "What are some things you heard about this method?" to find out whether a young woman is misinformed. Contraceptive counseling should be reality-based, that is, should begin by uncovering and addressing what clients believe, whether or not it is accurate, in order to avoid the method's discontinuation. Providers should also learn from the young woman what barriers she may face in using different contraceptive methods and help the young woman identify the most appropriate option for her.

"a lot of my friends, we discuss options for birth control, but i am not a doctor, i am not a nurse. we need someone to talk to us... someone who is educated to give us better answers with respect." - young woman, united states (california latinas for reproductive justice 2010)

Making a larger range of contraceptive methods available is correlated with increased acceptance of a method, among young and adult women (McDougall et al. 2009, WHO 2010a). In addition to her method of choice, the young woman should be offered to leave the facility with at least one dose of emergency contraception (EC), in case of accident or

contraceptive failure. In a survey of 2,560 Scottish women aged 16-29 who were given advance supplies of EC, eighty-four percent of those surveyed reported that it was good in some or all circumstances (Ziebland et al. 2005). Perceived benefits included: convenience; quicker use, with resultant greater efficacy; reductions in physician time; reductions in the embarrassment and stigma of obtaining EC from general practitioners or family planning clinics; the option of sharing supplies with friends; and the comfort of “knowing it’s there” if the need arises.

Terminology: Contraception versus family planning

The term “contraception” is used in this toolkit rather than “family planning.” While the term “family planning” is more culturally acceptable in some settings, most young women receiving contraceptive services are simply trying to avoid getting pregnant as opposed to planning a family. Using the term “contraception” helps remind counselors not to make assumptions about women’s reproductive intentions.

Younger women, particularly if they are unmarried, are likely to seek contraception to prevent pregnancy rather than space births (the implication of the term “family planning”). This may also be true of adult and married women, but is more likely for young women. However, “family planning” may be the more culturally acceptable term for some contraceptive services.

Clinical eligibility guidelines for postabortion contraceptives for young women are the same as for adult women. Three methods have implications for young women that bear additional discussion: sterilization, intrauterine devices (IUDs) and injectables.

Sterilization

There is no clinical contraindication for sterilization in young women (WHO 2010b). However, women under the age of 30 are significantly more likely to experience regret after sterilization (Curtis et al. 2006, WHO 2010b). During counseling, providers should emphasize that it is a permanent method, and make it clear that there is no extra benefit to doing the procedure at the time of the abortion versus using a non-permanent method for some time to be sure it is the method she wants. There may be laws and policies in place that affect a minor’s ability to consent to permanent surgical modification and whether sterilization is an option for minors. Providers should offer information in a factual manner and support the young woman’s informed decision.

Long-acting contraceptive methods

Young women have a higher failure rate than adult women for combined oral contraceptive pills (Dinerman et al. 1995, O’Dell et al. 1998, Templeman et al. 2000), and long-term contraceptives that do not require daily administration seem to be more effective in preventing subsequent pregnancies (Roberts et al. 2010, Stevens-Simon et al. 2001, Tolaymat and Kaunitz 2007).

Intrauterine devices (IUDs): Young women are medically eligible to use IUDs. There are no clinical contraindications based on age alone (WHO 2010b). IUDs are less likely to be selected by young women than by older women in some countries, as found by Roberts et al. and supported by Demographic and Health Survey (DHS) data from several countries including Honduras, Burkina Faso and Cambodia (INSD and ORC Macro 2004, National Institute of Public Health et al. 2006, Roberts et al. 2010, Secretaría de Salud [Honduras]

et al. 2006). It is unclear whether this is in part due to providers' reluctance to offer IUDs to young women or young women's reluctance after being given accurate, unbiased information on the method. However, a study in New Zealand found that women who did leave with an IUD in place were 70 percent less likely to return for an abortion in the next three years than those who left with combined oral contraceptive pills (Roberts et al. 2010). Providers should give this information to women but not push them to accept an IUD if the young women are not interested in doing so.

Injectables: Injectables include progestin-only and estrogen and progestin ("combined") formulas, including Depo-Provera (DMPA) and Mesigyna and Norigynon (NET-EN). In the same New Zealand study, DMPA was associated with a 40 percent decrease in likelihood of returning for abortion, compared to combined oral contraceptive pills (Roberts et al. 2010).

There has been some concern that DMPA may permanently decrease bone mineral density (BMD) in young women, as it does temporarily decrease BMD and adolescents have not yet attained their peak bone mass. A study specifically on adolescent women found that all of them had complete recovery of BMD within 12 months of discontinuation, and length of use of DMPA did not affect this recovery (Scholes et al. 2005). However, WHO's latest recommendations on medical eligibility for contraceptives states that most studies have found that women regain BMD after discontinuing DMPA but that it is unclear whether use in young women will affect peak bone mass, and thus list it as a category 2 method ("generally use the method" – in comparison, category 1 means "use method in any circumstances") for women under 18 (WHO 2010b).

6.6 Clinical care

Clinical provision of abortion care for young women is generally the same as for adult women. Specific questions can be directed to clinicalaffairs@ipas.org. A few clinical differences should be considered.

First pelvic exam

It is possible that this will be a young woman's first pelvic exam, and she may be nervous or afraid. As for all physical examinations, ensure that there is at least visual and preferably auditory privacy – that is, ensure that she is not visible to anyone besides the provider and any assistant, and preferably that their conversation cannot be overheard by anyone else. Explain what will be done and why, let her see the speculum if she wants to, and allow her to keep on clothes that do not have to be removed for the examination (leave on shirt or pull up dress). Do not begin to examine her until receiving her consent, even if an adult has legally consented on her behalf (WHO 2010a). Do not leave her undressed in an examination room for longer than a few minutes. If possible in that setting, offer to have a female health worker, or a relative, friend or partner, stand near her and talk to and support her during the pelvic examination if the young woman wants it.

When the pelvic examination begins, ask permission before touching her with a hand or speculum. Touch her leg first, then her labia. As you insert the speculum, ask her to bear down and take slow, deep breaths; have her continue to breathe deeply throughout the examination. Explain what you are doing at each step, and provide her with a mirror to see her vagina and cervix if she wants to. Take care to perform the examination as gently and smoothly as possible to minimize discomfort and anxiety (Ministry of Health, Ethiopia 2008). This can be especially important, as a young woman's impression of her first gynecological experience may influence future health-care seeking behavior.

Vacuum aspiration

Although no studies have been done on the subject, providers may find that a young, particularly nulliparous, woman's cervix may be more difficult to dilate than that of an older woman and thus may require a slower dilation process. This can be accomplished either by starting with a smaller dilator than is required by women with one or more children, or by priming the cervix with misoprostol. The latter may be clinical protocol for all uterine evacuations in some facilities. Anesthesia dosages remain the same as for older women.

"i was scared. there are four people in the room with you: the doctor, the nurse, the needle man, and some other woman. i was so nervous. obviously i had sex but having your stuff wide open and three people staring at it - that's just uncomfortable... i was so scared." - young woman, united states (exhale 2006)

"the nurse who held my hand during the abortion saved me from going into a full-blown panic. wiping the sweat off my face and looking me directly in my eyes, she told me that i would be all right and that there was nothing for me to be ashamed of. she also told me that there is a time and place for everything, and that includes children. when the procedure was over, she helped me off the table, cleaned me up, and walked me to a recovery room and introduced me to the women there." - young woman, unites states (exhale 2007)

Medical abortion

Medical abortion has been proven to be safe, effective and acceptable for young women, as for adult women. Dosage regimens are the same as for older women. Efficacy rates remain at 83-98 percent overall (Carbonell et al. 2001, Creinin et al. 1999, Ipas 2009b, Phelps et al. 2001), and medical abortion has actually been shown in two studies to be slightly more effective for women experiencing their first pregnancy than for subsequent ones (Chien et al. 2009, LeFebvre et al. 2008). In studies from Cuba, South Africa, Australia and the United States, most young women who chose medical abortion reported high or very high levels of satisfaction with the method (Carbonell et al. 2001, Creinin et al. 1999, Ladha 2010, Mamers et al. 1997, Phelps et al. 2001, Velazco et al. 2000) and 92 percent of the adolescents in the Cuba studies would recommend the method to a friend (Carbonell et al. 2001, Velazco et al. 2000). Young women, like adult women, often opt for medical abortion because they perceive it to be safer and more natural than aspiration abortion (Creinin et al. 1999, Gold and Coupey 1998, Harvey et al. 2001).

Medical abortion and perception of pain in young women

Research indicates that young women's experiences with medical abortion are similar to those of older women. However, in studies from Cuba, the United States and the United Kingdom, pain perception appears to be related to age: The perception of pain and use of analgesia has been found to be higher in younger women than older women (Hamoda et al. 2004, Ingham and Lee 2008, Velazco et al. 2000, Westhoff et al. 2000a and 2000b). Lower parity has also been associated with more perceived pain and/or analgesia need in Finland, the United States, the United Kingdom, and in countries included in the WHO multinational study (Bartley et al. 2000, Hamoda et al. 2004, Honkanen et al. 2004, Suhonen et al. 2003, Teal et al. 2007, Westhoff et al. 2000a, Westhoff et al. 2000b). Age is not a contraindication for medical abortion, but providers who are aware that young women may be more sensitive to pain can take the necessary measures to improve a young women's abortion experience.

Follow-up

Young women may prefer different approaches to follow-up due to access to and comfort level with communication technology as well as social factors. A recent study suggests that where text messaging is common, it is worth exploring as an effective follow-up medium. Young women who were prescribed oral contraceptives and received daily educational text messages had higher continuation rates at six months than did those who did not receive daily educational texts (Castaño et al. 2010). Facilities may want to try innovative methods for follow-up with young women.

6.7 Additional resources

Herrick, Jeannine, Katherine Turner, Teresa McInerney and Laura Castleman. 2004. *Woman-centered postabortion care: Reference manual*. Chapel Hill, NC: Ipas.

Hyman, Alyson G. and Laura Castleman. 2005. *Woman-centered abortion care: Reference manual*. Chapel Hill, NC: Ipas. Available on the CD-ROM and at http://www.ipas.org/Publications/Woman-centered_abortion_care_Reference_manual.aspx

Hyman, Alyson G., Teresa McInerney and Katherine Turner. 2005. *Woman-centered abortion care: Trainer's manual*. Chapel Hill, NC: Ipas. Available on the CD-ROM and at http://www.ipas.org/Publications/Woman-centered_abortion_care_Trainers_manual.aspx

Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas. Available on the CD-ROM and at http://www.ipas.org/Publications/Abortion_attitude_transformation_A_values_clarification_toolkit_for_global_audiences.aspx

Turner, Katherine, Teresa McInerney and Jeannine Herrick. 2004. *Woman-centered postabortion care: Trainer's manual*. Chapel Hill, NC, USA, Ipas.

Misinformation examples

American Life League. Abortion. American Life League. <http://www.all.org/nav/index/heading/OQ/cat/MzQ/>

Campaign Life Coalition. Harm to Women. Campaign Life Coalition. http://www.campaignlifecoalition.com/index.php?p=Harm_to_Women

Heritage House. 2005. Abortion as your option. AbortionFacts.com. http://abortionfacts.com/literature/literature_904AO.asp

Responses to misinformation

Ipas. 2010. *The evidence speaks for itself: Ten facts about abortion*. Chapel Hill, NC: Ipas. Available online at: http://www.ipas.org/Publications/The_evidence_speaks_for_itself_Ten_facts_about_abortion.aspx

First pelvic exam information examples

Planned Parenthood Federation of America. Pelvic Exam. Planned Parenthood Federation of America. <http://www.plannedparenthood.org/health-topics/womens-health/pelvic-exam-4306.htm>

CYWH Staff at Children's Hospital Boston. Your First Pelvic Exam. Centre for Young Women's Health. <http://www.youngwomenshealth.org/pelvicinfo.html>

Materials for those accompanying and supporting young women

Emily Louise Barcklow D'Amica, and Jessica Reyes Sánchez. 2010. *Young Women and their experiences with Abortion: A guide for Activists*. Mexico: DECIDIR Coalición de Jóvenes por la Ciudadanía Sexual.

Exhale. For Significant Others. Exhale. <http://www.4exhale.org/others.php>

Hope Clinic for Women. For Men. Hope Clinic for Women. <http://hopeclinic.com/formen.html>

Hope Clinic for Women. For Parents. Hope Clinic for Women. <http://hopeclinic.com/forparents.html>

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MODULE 6 TOOLS

TOOL 6A: Making abortion care clinically appropriate handout

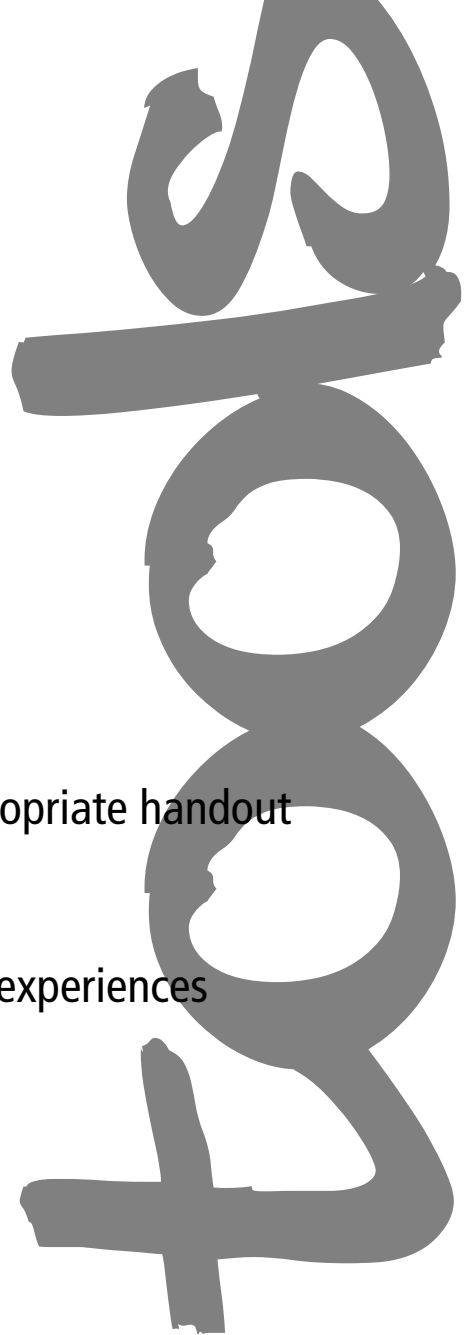
TOOL 6B: Through their eyes: Young women's experiences with abortion

TOOL 6C: Counseling skills

TOOL 6D: Abortion counseling for young women skills checklist

TOOL 6E: Young women's perception of abortion care survey

TOOL 6F: Sample wall poster



TOOL 6A: Making abortion care clinically appropriate handout

Provider attitudes

Provide care in an environment in which beliefs about gender, age, sexuality and abortion have been thoughtfully examined.

Options counseling

Ensure that her decision has not been coerced by anyone and that she understands the three options: carry to term and raise, adoption, and abortion. Respect her decision even if you disagree with it.

Abortion counseling

Respect

- Her questions, concerns and opinions about her health and health care are valid.

Interaction and communication

- Affirm the positive step the young woman has taken by seeking care.
- Be warm and without bias, anger or judgment, including body language.
- Let her talk before providing more information.
- Use indirect questions.
- Explain the meaning of common medical terms. Ask what words she uses.
- Respect her decision.

Confidentiality

- Explain and discuss issues of confidentiality.

Educating versus counseling

- Encourage questions and solicit her opinion before making any suggestions.
- Ask questions to determine any gaps in comprehension.

Length of time and presentation

- Counseling may take longer for young women than adults.

Sexuality

- Objectively discuss the concepts of sex, gender, healthy sexuality and adolescence.

Risks versus benefits

- Directly counter inaccurate information on the risks of abortion.
- Help her weigh potential risks against the benefits she has identified for herself.

Referrals

- Provide or refer for any other health-related information and services she may need.

Postabortion contraceptive counseling and methods

- Ask her reproductive goals and phrase further discussion to match those goals.
- Remember that privacy needs can influence her selection of contraceptive method.
- Offer all young women the option of leaving the facility with at least one dose of emergency contraception.

Side effects

- When discussing side effects, differentiate them from complications.

Safety concerns

- Inform on safety of methods and address any concerns.

Clinical eligibility

Guidelines are the same for young women as for adult women.

- Sterilization - Not clinically contraindicated, but young women are significantly more likely to experience regret after sterilization.
- Injectables – Due to bone mass concerns, WHO lists as category 2 (“generally use the method”) for women under 18.

Clinical care

Mostly the same as for adult women

First pelvic exam

This may be her first pelvic exam, and she may be nervous or afraid.

- Ensure that there is at least visual and preferably auditory privacy.
- Explain what you are doing at each step.
- Perform the examination as gently and smoothly as possible.

Vacuum aspiration

A nulliparous woman is more likely to have a tight cervix and thus require a slower dilation process.

Medical abortion

Safe, effective and acceptable for young women, with the same dosages.

- The perception of pain and use of analgesia has been found to be higher in younger women than older women.

Follow-up

- Text messaging may be an effective follow-up medium.

TOOL 6B: Through their eyes: Young women's experiences with abortion



Objectives

By the end of this activity, participants will be able to:

- Understand the wide range of different experiences that young women have with abortion.
- Identify assumptions they may hold about young women's experiences with abortion.
- Recognize how their assumptions may affect abortion care services for young women.



Materials

- 12 posters (PowerPoint printouts), flipcharts, markers, tape, paper and pens



Time

10 minutes: Introduction and Silent journaling, Part 1

15 minutes: Gallery walk and Silent journaling, Part 2

20 minutes: Discussion

45 minutes total time



Preparation

- Print the 12 PowerPoint posters



Instructions

1. Tell participants that in this activity they will explore and discuss young women's experiences with abortion.
2. Distribute papers and pens to all participants. Ask participants to reflect on how they think a young woman receiving abortion care at their clinic would describe her experience. Instruct participants that they have a few minutes to write down their ideas. You may say:
 - *Imagine a young woman receiving abortion care in your clinic. How do you think she would describe the experience? Please take a few minutes to write down your thoughts.*
3. After five minutes, ask if anyone feels comfortable sharing their thoughts. Write down their answers on a flipchart.
4. Post the 12 PowerPoint printouts around the room. Tell participants that the posters are actual quotes, drawings and stories from young women about their experiences or perceptions about abortion. Remind

participants that these are only a sample and do not represent all young women's views and experiences. Invite the participants to do a gallery walk around the room.

5. When the participants have had a chance to see all the posters, invite them to sit down and reflect on young women's experiences and perceptions. Instruct participants that they have five minutes to write down their reflections.
6. After five minutes, invite a few participants to share their thoughts about the young women's experiences. Write down their answers on a flipchart. You may wish to use the questions below to guide the discussion.
 - *Thank you for completing the gallery walk. Please take five minutes to write down your reflections about these young women's experiences with and perceptions about abortion.*
 - *What did you notice about young women's experiences? What about young women's perceptions of abortion?*
 - *What did they make you think or feel?*
 - *What do you notice when you compare your earlier thoughts with these experiences and perceptions?*
7. Ask participants if they feel the group made any assumptions about young women's experiences, and if so, why they made those assumptions and what effect they can have on quality of care. You may wish to use these discussion questions:
 - *Do you feel the group as a whole made any assumptions about young women's experiences with abortion care? What are those assumptions?*
 - *Do you think that providers in general make assumptions about young women's experiences with abortion care? What are those assumptions?*
 - *Why do you think providers make such assumptions?*
 - *Why should providers care about the experiences that young women have with abortion?*
 - *What effects may assumptions about young women's experiences have on the quality of care providers give them?*

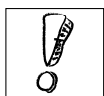
Note to facilitator: You may wish to gently remind participants how traditional gender roles and social power dynamics can affect assumptions about young women's experiences. For example, in many communities, some people think that a woman, particularly a young woman, should be grateful to see a provider at all and her experience may therefore not be valued. Providers may also believe that the actions that led to her need for an abortion mean a young woman does not deserve to have a good experience. Reinforce that young women have a right to high quality safe abortion care and that a positive experience can have a positive impact on future care-seeking behaviors of both her and other women she knows.

8. Summarize some of the main discussion points of the activity. Reinforce that young women have a wide range of experiences with abortion care, and that providers play a critical role in ensuring that those experiences are positive.
9. Ask if any participants have any final thoughts about this activity.
10. Thank participants for participating in the activity.

Some PowerPoint slides for this activity are from:

International Planned Parenthood Federation (IPPF). 2010. I decide: Young women's journeys to seek abortion care. London, UK: IPPF.

TOOL 6C: Counseling skills



Purpose

This activity helps participants identify important aspects of abortion counseling for young women and provides an opportunity for them to practice those skills and receive feedback for performance improvement.



Objectives

By the end of this activity, participants will be able to:

- Identify strengths and weaknesses in an abortion counseling session.
- Give feedback to other participants on their counseling skills.
- Use others' feedback to improve their own counseling skills.



Materials

- Flipchart or board, and pens or chalk
- Copies of Counseling role play scenarios, Abortion counseling for young women skills checklist (Tool 6D) and Counseling skills improvement plan for each participant.



Time

5 minutes: Introduction

20 minutes: First role play demonstration and discussion

20 minutes: Reframing statements

20 minutes: Second role play demonstration and discussion

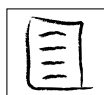
55 minutes: Role play practice and conclusion

2 hours total time



Preparation

Solicit two participants who would be good at role playing an abortion counselor and young woman, demonstrating both effective and ineffective counseling skills. Alternatively, arrange for a youth educator to play the role of the young woman. Well before the activity is scheduled, ask them to participate, give them the scenarios and discuss together in detail how to demonstrate the skit, including time limits.



Instructions

1. Introduce the activity by discussing the importance of effective abortion counseling that is tailored to the needs of young women. Refer them to the sections on options and abortion counseling in Module 6 in the toolkit and review the following:
 - Young women's clinical abortion needs are mostly similar to those of adult women, but their life and social circumstances may be very different, impacting the nature of abortion counseling for them.
 - Providers need to be particularly aware of their own underlying attitudes toward young women's sexuality that may negatively affect counseling.
 - When possible, young women should be offered to receive counseling with a support person of their choice, or from a youth peer counselor.
 - A counselor who works effectively with young people has the ability to build rapport and earn their trust, respects their different life circumstances, has excellent communication skills, understands that young people may communicate differently than adults and has accurate knowledge of sexual and reproductive health and local guidelines, laws and cultural beliefs.
 - Providers should reassure young women at the beginning of the counseling session that they will provide the service but that there is some information they need to exchange beforehand.
 - Providers should be especially sensitive when it comes to the following:
 - Respect
 - Interaction and communication
 - Confidentiality
 - Educating versus counseling
 - Length of time and presentation
 - Sexuality
 - Risks versus benefits
 - Countering misinformation
 - Referrals
 - Involvement of male partner or other person
2. Inform participants that they are going to watch and then discuss a role play demonstration of a young woman's abortion counseling session. Designated participants will play the roles of counselor and young woman.
3. Distribute and review the contents of the Abortion counseling for young women skills checklist (Tool 6D), highlighting the main skill areas:
 - Positive rapport and woman-centered approach
 - Verbal and non-verbal communication
 - Empathy
 - Privacy and confidentiality
 - Professionalism
 - Abortion-specific content
 - Resources and referrals

4. Ask participants to note the counselor's effectiveness in these main skill areas as they observe the role play.
5. At the end of the role play, ask the following questions to the group, noting all responses on the flipchart:
 - *What did you observe happening in this role play?*
 - *What did you observe about the young woman's experience in this counseling session?*
 - *What did you observe about the counselor?*
6. Post a flipchart with three columns labeled *Effective*, *Not effective* and *How to improve* and say that, drawing from the preceding discussion, you will list what the counselor did and said that was effective, not effective and how the counselor can improve skills.
 - First ask participants what the counselor did and said that was effective, noting each item under the label *Effective*. Then ask participants what the counselor did and said that was not effective, noting each item under the label *Not Effective*. Once you have the list of what was not effective, ask participants to state how the counselor can improve each skill area.
 - Ensure that participants cover the main items from the Abortion counseling for young women skills checklist (Tool 6D). Participants may also want to refer to Modules 5 and 6.
7. Tell participants that they are going to practice framing sexual and reproductive health information in a positive way. Provide examples, such as:
 - Negatively framed: *You neglected to use contraception to prevent this unwanted pregnancy, and now you want us to perform an abortion.*
Positively framed: *Once you realized you had an unwanted pregnancy, I'm glad you took steps to get safe abortion care with us.*
 - Negatively framed: *The procedure is very painful, so we'll give you pain medication.*
Positively framed: *We'll work with you to help you feel comfortable and safe. Some women feel very little or no discomfort and for others, it's quite painful. We will give you pain medication and take other steps to lower your discomfort, and you can tell us if you need more.*
 - Divide participants into pairs and give them 10 minutes to reframe negative statements in a more positive way. Some negative examples include:
 - Healthy sexuality is about protecting yourself from diseases and unwanted pregnancy.
 - You should talk to your parents about this pregnancy, because you're too young to make an important decision about abortion on your own.
 - Once you have this abortion, you'll see why you need to abstain from sex until you are married and ready to have a baby.
 - You need to tell your boyfriend that when he wants to have sex with you, he needs to wear a condom so you don't get infected or pregnant.
 - You'll probably forget to take the pill and get pregnant again; you should get a long-term contraceptive method instead.
8. Have participants come back together and, for each negative statement, have 1-2 pairs share their positively-framed statement. Some positive examples include:
 - *Healthy sexuality means you are able to express your sexuality in a positive and pleasurable way, have opportunities for love and intimacy, and have accurate information and access to appropriate health-care to make good decisions about protecting yourself from health problems.*
 - *The decision to have an abortion is an important one. Have you considered talking to a trusted adult who you think can support you and not impose their own views? I can help you practice telling them if you like.*
 - *It is difficult to know now how you will feel about having sex after the abortion. Let's talk about how you can protect yourself from another unwanted pregnancy before you decide to have sex again.*

- *It can be difficult to talk to a sexual partner about using contraception and preventing STIs before you have sex. Would you like to practice having that conversation and figuring out how you can make sure you are protected so you can feel secure and enjoy yourself?*
 - *How well do you remember to do other things on a daily basis? If you think you might forget to take a pill every day, you can consider using a long-term or other contraceptive method.*
9. Tell participants that we will now return to the counseling role play demonstration. This time the person playing the counselor will improve the weaknesses identified in the first role play by incorporating the effective skills participants listed, as well as suggestions on framing information in a positive way.
 10. Ask participants to observe the second role play, noting the counselor's effectiveness in demonstrating the skills outlined in the Abortion counseling for young women skills checklist.
 11. At the end of the role play, ask participants to list what the counselor did and said that was effective and which skills still need improvement. Note all responses on a flipchart.
 12. Tell participants that they will now have an opportunity to practice their skills for counseling young women on abortion through role plays.
 - Explain that you will divide them into groups of three: one person will play the role of the young woman, another will play the counselor and the third will be the observer.
 - Ask participants to review the Abortion counseling for young women skills checklist before beginning. The participant playing the role of the young woman can select a scenario from the Counseling role play scenarios.
 - The counselor and the woman will role play for 10 minutes, while the observer evaluates the role play using the Abortion counseling for young women skills checklist.
 - At the end of each role play, groups will take five minutes for evaluation. The counselors will complete a self-assessment on the counseling skills they felt they performed well and areas for improvement. The women and the observers will then use the checklist to give feedback to the counselors.
 - The groups will then switch roles and conduct two more role plays, allowing each person the opportunity to play the role of counselor, young woman and observer.
 13. Monitor time closely during role play practice, indicating when groups should transition from role plays to evaluation during each of the three role plays.
 14. Return to the large group and discuss the activity with the following questions:
 - *What were the most important counseling issues to arise?*
 - *How were the young women feeling about the counseling they received?*
 - *What were skills that counselors performed well?*
 - *Which counseling skills needed the most improvement?*
 - *What are some challenges in providing effective counseling to young women?*
 - *What steps will we take to improve our counseling skills for young women?*
 15. Distribute the Counseling skills improvement plan handouts and instruct participants to complete the form in 10 minutes. They should identify the skill improvement needed and plans for improvement. Ask them to use these plans to improve their skills once they are back at their facilities.
 16. Solicit and discuss any outstanding questions, comments or concerns with participants. Thank the group for their participation.

Counseling role play scenarios

Scenario 1

Marianna is a 17-year-old married woman who had a manual vacuum aspiration (MVA) abortion last year. She is pregnant again. She tells you she doesn't want to continue the pregnancy and wants an abortion, but is afraid of having another MVA. She says that she was using the pill when she got pregnant. Her husband, who is a year older, came with her to the clinic and is concerned about her health.

Scenario 2

Anita is a 14-year-old unmarried woman who comes to the clinic with her guardian. Her guardian says she needs an abortion because she cannot care for a child. Anita is very uncertain and fearful about the procedure.

Scenario 3

May is a 14-year-old unmarried woman who is a refugee in your country. She was raped in the refugee camp and became pregnant. She does not want to continue the pregnancy. Her family doesn't know about the rape or the pregnancy. She can't ask her family for support because they will disown her if they find out she was raped. May wonders if the clinic can help her.

Scenario 4

Zahera is a 17-year-old woman who comes to your clinic for a medical abortion. She tells you she doesn't want a baby yet, but she thinks that if she has an abortion, she may never be able to get pregnant again.

Scenario 5

Hope is a 22-year-old married woman who is HIV-positive. She is very shy and seems intimidated by the counselor. She says she and her husband want a baby very much but they think she should terminate the pregnancy because they don't want the baby to become infected with HIV.

Counseling skills improvement plan

Instructions: Write the counseling skills you do not routinely perform well in the appropriate boxes, then complete the remaining boxes for each skill. You should identify the desired skill, improvement needed and plans for improvement.

| Skill | Skill not routinely performed well | Desired skills and practices | Improvement needed | Plans for improvement |
|---|---|-------------------------------------|---------------------------|------------------------------|
| Positive rapport and woman-centered approach | | | | |
| Verbal communication | | | | |
| Nonverbal communication | | | | |
| Empathy | | | | |
| Privacy and confidentiality | | | | |
| Professionalism | | | | |
| Abortion-specific content | | | | |
| Resources and referral | | | | |
| Special populations in the abortion-care setting | | | | |

From: Hyman, Alyson G., Teresa McInerney and Katherine Turner. 2005. *Woman-centered abortion care: Trainer's manual*. Chapel Hill, NC: Ipas

TOOL 6D: Abortion counseling for young women skills checklist

Instructions for self-assessment: Check “yes” or “no” depending on whether you routinely demonstrate each skill during your counseling sessions, and write comments.

Instructions for observation: Silently observe and evaluate the counseling session. Do not interact verbally or nonverbally with the woman or the counselor. Check “yes” or “no” depending on whether the counselor effectively demonstrates each skill during the counseling session and write comments. Discuss your evaluation and comments to the counselor in private at the end of the session.

| Positive rapport and woman-centered approach | Yes | No | Comments |
|--|------------|-----------|-----------------|
| Is aware of own attitudes about young women’s sexuality | | | |
| Treats questions, concerns and opinions as valid | | | |
| Is aware of when educating or counseling is needed | | | |
| Explicitly encourages young woman to ask questions | | | |
| Solicits young woman’s opinion before making suggestions | | | |
| Accepts young woman’s decisions, whether agreeing with them or not | | | |
| Verbal communication | Yes | No | Comments |
| Affirms the young woman’s decision to seek care | | | |
| Asks what the young woman knows before giving more information | | | |
| Provides all relevant information on each treatment option | | | |
| Responds fully and honestly to all questions | | | |
| Avoids lecturing or scolding | | | |

| | | | |
|--|------------|-----------|-----------------|
| Provides information neutrally but warmly | | | |
| Listens to the young woman's questions and opinions | | | |
| Normalizes the conversation | | | |
| Uses the third person where possible | | | |
| Explains the meaning of common medical terms appropriately | | | |
| Asks what terms the young woman uses or for explanation of terms she uses that are unclear | | | |
| Determines that the young woman has understood information | | | |
| Provides comparisons for pain that the young woman has experienced | | | |
| Nonverbal communication | Yes | No | Comments |
| Provides picture-based and printed information | | | |
| Uses positive body language towards the young woman | | | |
| Empathy | Yes | No | Comments |
| Avoids judgment or anger | | | |
| Is patient | | | |
| Responds to the young woman's concerns and fears | | | |

| | | | |
|--|------------|-----------|-----------------|
| Offers support from a youth peer counselor, if available | | | |
| Privacy and confidentiality | Yes | No | Comments |
| Explains and discusses issues of confidentiality | | | |
| Asks the young woman in private whether she wants anyone else in the session | | | |
| Professionalism | Yes | No | Comments |
| Separates personal beliefs from professional responsibilities | | | |
| Ensures practices conform to professional standards | | | |
| Abortion-specific content | Yes | No | Comments |
| Knows applicable laws and policies | | | |
| Seeks to find legal means to provide requested services | | | |
| Informs on sex, gender, healthy sexuality and adolescence | | | |
| Resources and referral | Yes | No | Comments |
| Assesses need for other health services | | | |
| Refers for or provides other needed health services | | | |

TOOL 6E: Young women's perception of abortion care survey

Description: This survey can be used to evaluate young women's perception of abortion care they received so that the quality of care can be improved. While this survey is intended to address the special needs of young women as is, it is recommended that the provider or clinic partner with local youth groups or young people to adapt the form (see Tool 4B, Working with young people). The form could also easily be adapted or used as is with adult women. There are two versions of the survey. The A-version is for aspiration abortion and the M-version is for medical abortion. It is recommended that young women themselves give input on any adaptations to the survey. **Surveys should be anonymous to ensure confidentiality.**

Instructions:

Distribute the survey to ALL abortion clients on the day they have their procedure or receive their medical abortion drugs.

1. Tell each client that it is important for your facility's staff to understand her experience and how your facility can improve care. Assure her that the survey is completely anonymous – no one will find out her name, or that she had an abortion, from the survey.
2. Ask the woman to fill out the survey today or tomorrow while the experience is still fresh in her mind.
3. Hand the appropriate version of the survey to the client.
4. It is helpful to review or read through the survey questions with the client (without having her answer) and address any questions she may have. If the woman has a low literacy level, offer to have someone, such as a youth peer counselor, administer the survey verbally. In this case, the survey is not technically anonymous; although her name should not be written anywhere on the survey and her confidentiality should be upheld. Another option is for her to have a friend or family member help her fill it out and still submit anonymously.
5. Explain how she should submit the survey. If possible, provide a postage-paid envelope so that she may mail the survey without cost to her. If mailing the survey is not possible, provide an alternative way for clients to anonymously submit surveys.

These surveys are adapted from: Planned Parenthood Federation of America. 2011. CAPS Patient Perception of Care Survey. New York, NY: Planned Parenthood Federation of America.

Your experience

A – version

We are always trying to make our services better. Please let us know how we are doing by answering the questions below.

All survey responses are anonymous to ensure confidentiality.

Please select only one response to the questions below unless otherwise noted.

FIRST CONTACT

1. When you first contacted us for an appointment, was the person friendly and helpful?
☐ Yes ☐ Could have been better ☐ No
2. Did the person tell you:
 - a. What would happen at the center? ☐ Yes ☐ No
 - b. What to do before you came in? ☐ Yes ☐ No
 - c. How long you would be here? ☐ Yes ☐ No
 - d. If you needed to bring an adult or other person with you?
☐ Yes ☐ No
3. Did the person answer all of your questions? ☐ Yes ☐ No

IN THE CENTER

4. Were you nervous when you came to the center? ☐ Yes ☐ No
If yes, did we help you feel better? ☐ Yes ☐ A little bit ☐ No
5. How long did you sit in the waiting area before you were brought inside the clinic area?
☐ Less than 15 minutes
☐ About half an hour
☐ About an hour
☐ More than an hour
6. Was the waiting area:
 - a. Clean? ☐ Yes ☐ No
 - b. Comfortable? ☐ Yes ☐ No
7. If someone came with you to your appointment (like a friend or relative), were you able to decide if they should be present during the information session?
☐ Yes ☐ No
8. During the information session, was the information explained to you clearly?
☐ Yes ☐ A little bit ☐ No

9. During the information session, was the information explained to you objectively (without bias)?
☐ Yes ☐ A little bit ☐ No
10. During the information session, were you given enough time to ask questions?
☐ Yes ☐ No
11. Did you understand all of your options?
☐ Yes ☐ A little bit ☐ No
12. Were you able to decide for yourself what option to choose?
☐ Yes ☐ A little bit ☐ No
13. Do you feel that your decision was respected by the people in the center?
☐ Yes ☐ A little bit ☐ No
14. Do you feel the people in the center really listened to you?
☐ Yes ☐ A little bit ☐ No
15. Were you given information on contraceptives, if you wanted them?
☐ Yes ☐ No

If yes:

Were the options explained to you clearly and objectively (without bias)?

- ☐ Yes ☐ No

Did you leave with the method of your choice?

- ☐ Yes ☐ No

WITH THE DOCTOR OR CLINICIAN

16. Did the doctor (or clinician) tell you beforehand what would happen during the procedure?
☐ Yes ☐ A little bit ☐ No
17. If someone came with you to your appointment (like a friend or relative), were you allowed to decide if they would be present during the procedure?
☐ Yes ☐ No
18. Did you have enough time to ask the doctor (or clinician) any questions that you had?
☐ Yes ☐ Not really ☐ No
19. Did you feel comfortable asking the doctor (or clinician) any questions that you had?
☐ Yes ☐ Not really ☐ No
20. Did the doctor (or clinician) answer all of your questions and provide you with any information you requested?
☐ Yes ☐ Not really ☐ No

21. Did the doctor (or clinician) help you feel relaxed during the procedure?
- ☐ Yes ☐ A little bit ☐ No
22. What type of medicine did you have before or during the procedure to help you with the pain? (Mark all that apply.)
- ☐ I took pain pills before the procedure.
- ☐ I got medicine in a vein in my arm.
- ☐ I got an injection inside my vagina.
- ☐ I got medicine that put me to sleep.
- ☐ I received something for the pain, but I am not sure what.
- ☐ I did not have any pain medicine for the procedure.
23. How painful was the procedure?
- ☐ Not painful at all
- ☐ A little painful
- ☐ Painful
- ☐ Very painful
24. Did the staff do enough to help you with pain or discomfort?
- ☐ Yes ☐ A little bit ☐ No
25. How would you describe the care you received from the doctor (or clinician)?
- ☐ Great ☐ OK ☐ Bad

RECOVERY AND GOING HOME

26. Were you told what phone number to call if you were worried or needed help?
- ☐ Yes ☐ No
27. Did you understand when to call if you were worried or needed help?
- ☐ Yes ☐ I wasn't sure ☐ No

THINKING ABOUT YOUR HEALTH CARE

28. Did you have enough privacy in the center?
- ☐ Yes ☐ Could have been better ☐ No
29. Were you assured that your information would remain confidential?
- ☐ Yes ☐ A little bit ☐ No
30. Did we treat you with care and respect?
- ☐ Yes ☐ Sometimes ☐ No

31. The staff gave me exactly what I needed when I needed it.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

32. On the scale below, how would you rate the health care you received at the center?

Worst

Best

0 1 2 3 4 5 6 7 8 9 10

33. My age is:

- ☐ Under 18
- ☐ 18-24
- ☐ 25 or older

34. Do you have any suggestions for how we can improve our abortion care?

[illegible]

Thank you for taking the time to answer these questions!

Your experience

M – version

We are always trying to make our services better. Please let us know how we are doing by answering the questions below.

All survey responses are anonymous to ensure confidentiality.

Please select only one response to the questions below unless otherwise noted.

FIRST CONTACT

1. When you first contacted us for an appointment, was the person friendly and helpful?
☐ Yes ☐ Could have been better ☐ No
2. Did the person tell you:
 - a. What would happen at the center? ☐ Yes ☐ No
 - b. What to do before you came in? ☐ Yes ☐ No
 - c. How long you would be here? ☐ Yes ☐ No
 - d. If you needed to bring an adult or other person with you?
☐ Yes ☐ No
3. Did the person answer all of your questions? ☐ Yes ☐ No

IN THE CENTER

4. Were you nervous when you came to the center? ☐ Yes ☐ No
If yes, did we help you feel better? ☐ Yes ☐ A little bit ☐ No
5. How long did you sit in the waiting area before you were brought inside the clinic area?
☐ Less than 15 minutes
☐ About half an hour
☐ About an hour
☐ More than an hour
6. Was the waiting area:
 - a. Clean? ☐ Yes ☐ No
 - b. Comfortable? ☐ Yes ☐ No
7. If someone came with you to your appointment (like a friend or relative), were you able to decide if they should be present during the information session?
☐ Yes ☐ No
8. During the information session, was the information explained to you clearly?
☐ Yes ☐ A little bit ☐ No

9. During the information session, was the information explained to you objectively (without bias)?
☐ Yes ☐ A little bit ☐ No
10. During the information session, were you given enough time to ask questions?
☐ Yes ☐ No
11. Did you understand all of your options?
☐ Yes ☐ A little bit ☐ No
12. Were you able to decide for yourself what option to choose?
☐ Yes ☐ A little bit ☐ No
13. Do you feel that your decision was respected by the people in the center?
☐ Yes ☐ A little bit ☐ No
14. Do you feel the people in the center really listened to you?
☐ Yes ☐ A little bit ☐ No
15. Were you given information on contraceptives, if you wanted them?
☐ Yes ☐ No

If yes:

Were the options explained to you clearly and objectively (without bias)?

- ☐ Yes ☐ No

Did you leave with the method of your choice?

- ☐ Yes ☐ No

WITH THE DOCTOR OR CLINICIAN

16. Did the doctor (or clinician) tell you what would happen after you took the pills?
☐ Yes ☐ A little bit ☐ No
17. Did you have enough time to ask the doctor (or clinician) any questions that you had?
☐ Yes ☐ Not really ☐ No
18. Did you feel comfortable asking the doctor (or clinician) any questions that you had?
☐ Yes ☐ Not really ☐ No
19. Did the doctor (or clinician) answer all of your questions and provide you with any information you requested?
☐ Yes ☐ Not really ☐ No
20. Did the doctor (or clinician) who gave you the pills make you feel relaxed?
☐ Yes ☐ Not really ☐ No

21. Did the doctor (or clinician) ensure that you would have a safe place to take the pills?
- ☐ Yes ☐ No
22. Did the doctor (or clinician) do a good job explaining how to take the pills at home (or other safe place)?
- ☐ Yes ☐ A little bit ☐ No
23. Did the doctor (or clinician) tell you about problems you might have after taking the pills?
- ☐ Yes ☐ Not really ☐ No
24. Were you told what phone number to call if you were worried or needed help?
- ☐ Yes ☐ No
25. Did you understand when to call if you were worried or needed help?
- ☐ Yes ☐ I wasn't sure ☐ No
26. How would you describe the care you received from the doctor (or clinician)?
- ☐ Great ☐ OK ☐ Bad

AT HOME (OUTSIDE CLINIC)

27. How much bleeding did you have after you took the pills?
- ☐ Much heavier than a period
- ☐ Like a heavy day on my period
- ☐ Lighter than my period
28. How painful were your cramps after you took the pills?
- ☐ Not painful at all
- ☐ Not too bad
- ☐ Very painful

THINKING ABOUT YOUR HEALTH CARE

29. Did you have enough privacy in the center?
- ☐ Yes ☐ Could have been better ☐ No
30. Were you assured that your information would remain confidential?
- ☐ Yes ☐ A little bit ☐ No
31. Did we treat you with care and respect?
- ☐ Yes ☐ Sometimes ☐ No

32. The staff gave me exactly what I needed when I needed it.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

33. On the scale below, how would you rate the health care you received at the center?

Worst

Best

0 1 2 3 4 5 6 7 8 9 10

34. My age is:

- ☐ Under 18
- ☐ 18-24
- ☐ 25 or older

35. Do you have any suggestions for how we can improve our abortion care?

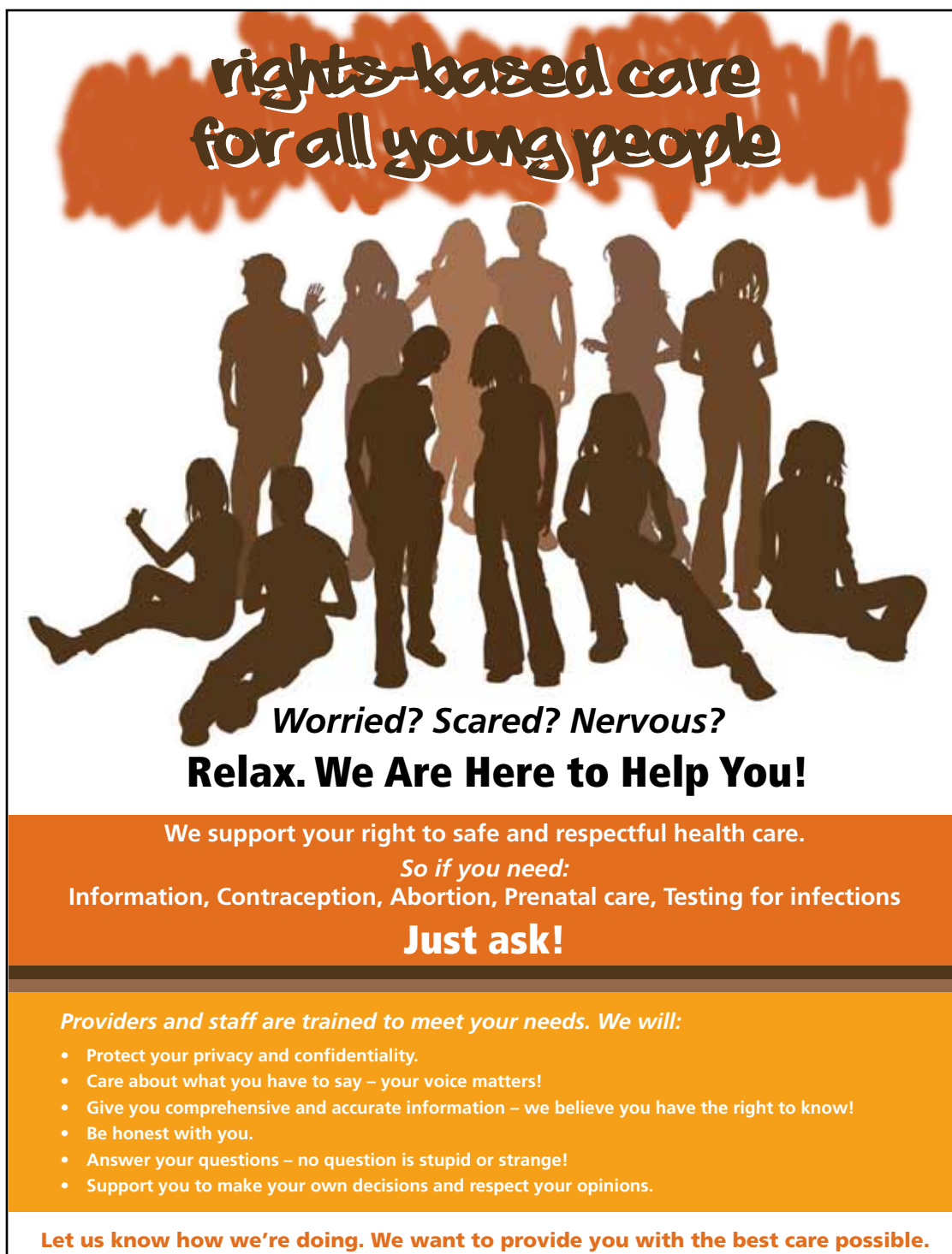
[illegible]

Thank you for taking the time to answer these questions!

TOOL 6F: Sample wall poster

Description

This is a sample wall poster that providers and health facility staff may wish to adapt and use in their facility. We recommend partnering with local young people, particularly young women, to determine if they think this is a helpful tool. Young people or youth groups can also help to adapt the content of the poster, or create their own alternative poster together with providers.



Glossary of Terms

Abortion care for young women: Abortion care for young women is rights-based, participatory, accessible, and clinically safe and appropriate.

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

Contraceptive counseling: Talking and listening to people about their needs and desires for a future pregnancy to help them determine whether they need contraceptive methods, and, if so, help them choose the most suitable methods for their needs and lifestyle. Also known as family-planning counseling.

Contraceptive services: The provision of contraceptive counseling, methods and care appropriate to people's needs and lifestyles that help them control their fertility by preventing, delaying or spacing pregnancies. Also known as family-planning services.

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

Emotional support: Gentle, caring assistance that demonstrates affirmation and support and allays fears and negative feelings. Emotional support can be physical, such as holding a person's hand, verbal, such as using reassuring words and nonverbal, such as giving an encouraging nod.

Evolving capacity: Refers specifically to children's ability to make decisions about their lives on their own. It is also the concept that a child's ability to make decisions evolves during the transition from infancy to childhood to adolescence.

Family-planning services: Another term for contraceptive services. The provision of contraceptive counseling, methods and care appropriate to people's needs and lifestyle that help them control their fertility by preventing, delaying or spacing pregnancies.

Gender: A person's internal sense of being somewhere along a continuum of female to male, which can be different from their sex and can fluctuate throughout the life cycle. Gender roles are shaped by a culture's expectations of how females and males should behave and cultural beliefs about what is inherently feminine and masculine.

Gender discrimination: The prejudicial treatment of women and girls based on gender.

Gender equality: When women and men have equal opportunities, freedoms and conditions. It does not imply that women and men are the same but that they have equal value and should be accorded equal treatment. Gender equality is a human right.

Gender identity: The way and state of being by which individuals choose to define/identify themselves along a gender continuum.

Gender-based violence: Any act of violence against women, independent of age, that results in, or is likely to result in, physical, sexual or mental harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Human right: Any basic right or freedom to which all human beings are entitled and in whose exercise a government may not interfere.

Monitoring and Evaluation (M&E): Monitoring is the routine assessment of health-care services in order to provide feedback for ongoing quality improvement. Evaluation is the periodic assessment of overall improvements in health-care services. Monitoring looks at what is being done, whereas evaluation examines what has been achieved or what impact has been made.

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

Partnership between adults and young people: A relationship in which both parties work together to address issues facing young people or on programs meant to serve young people. In a true partnership each party has the opportunity to make suggestions and decisions and the contribution of each is recognized and valued. A partnership also implies:

Voluntary and meaningful participation. Participation implies work *with and by* people, not merely *for* them.

Transfer of responsibility to young people. When young people are either only assigned tasks or consulted about certain processes, they cannot be considered partners. As young people receive and take responsibility they transition from being beneficiaries of programs to partners and leaders.

Partnership Defined Quality for Youth (PDQ-Y): A method used to increase the quality and accessibility of health-care services for young people, through youth-provider collaboration.

Peer counseling: Counseling and support performed by those who are considered similar in age or in other respects to the person who is being counseled.

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

Principle of capability: Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight, including abortion care.

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

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

Sex: Refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.

Sexual and reproductive rights: They embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons to:

- be free of coercion, discrimination and violence;
- the highest attainable standard of sexual health, including access to sexual and reproductive health-care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children;
- pursue a satisfying, safe and pleasurable sexual life.

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

Sexual orientation: Refers to the primary sexual attraction to the same, opposite or both sexes.

Sexuality: For most, sexuality is an important aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships.

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

Tokenism: Occurs when young people are included in, but not allowed to influence processes or decisions.

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

Young people: Men and women aged 10-24 years old.

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WORKSHOP TOOLS

Four-day workshop agenda

Pre-workshop survey

Post-workshop survey

Workshop survey answer key

Workshop evaluation form

Certificate of completion



Abortion care for young women

Four-day workshop agenda

DAY ONE

| Time | Activity | Materials ¹ |
|-------------------------------|---|------------------------|
| 30 minutes | Participant registration | |
| 10 minutes | Workshop pre-survey | |
| 30 minutes | Workshop introduction ² | |
| 15 minutes | Introductory icebreaker ³ | |
| Module 1: Introduction | | |
| 5 minutes | Introduce Module 1 | PPT slides |
| 20 minutes | Young women are... | Tool 1B |
| 15 minutes | BREAK | |
| 40 minutes | VCAT activity: Comfort continuum ⁴ | |
| 5 minutes | Interactive lecture: Section 1.1 | PPT slides |
| 40 minutes | VCAT activity: Reasons why ⁴ | |
| 40 minutes | Gender and abortion | Tool 1C |
| 1 hour | LUNCH | |
| 5 minutes | Interactive lecture: Section 1.2 | PPT slides |
| 25 minutes | Defining a sexually healthy young person | Tool 1D |
| 5 minutes | Energizer | |
| 40 minutes | VCAT activity: The last abortion ⁴ | |
| 5 minutes | Interactive lecture: Section 1.3 | PPT slides |
| 15 minutes | BREAK | |
| 1 hour | Support we needed as youth | Tool 1E |
| 10 minutes | Module 1 summary | Tool 1A |
| 5 minutes | Daily evaluation | |
| | Co-facilitators debrief | |

DAY TWO

| Time | Activity | Materials ¹ |
|-----------------------------------|--|------------------------|
| Module 2: Barriers to care | | |
| 10 minutes | Review yesterday's activities/preview today's agenda | |
| 10 minutes | Icebreaker | |
| 5 minutes | Introduce Module 2 | PPT slides |
| 50 minutes | Barriers to care | Tool 2B |
| 20 minutes | Interactive lecture: Sections 2.1-2.6 | PPT slides |
| 10 minutes | Module 2 summary | Tool 2A |

| | | |
|---|--|------------|
| 15 minutes | BREAK | |
| Module 3: A rights-based approach to care | | |
| 5 minutes | Introduce Module 3 | PPT slides |
| 50 minutes | VCAT activity: Four corners ⁴ | |
| 1 hour, 15 minutes | Young women, international rights and abortion | Tool 3B |
| 1 hour | LUNCH | |
| 5 minutes | Energizer | |
| 10 minutes | Interactive lecture: Sections 3.1-3.2 | PPT slides |
| 1 hour, 15 minutes | The principle of capability | Tool 3C |
| 15 minutes | BREAK | |
| 5 minutes | Interactive lecture: Section 3.3 | PPT slides |
| 10 minutes | Module 3 summary | Tool 3A |
| 5 minutes | Daily evaluation | |
| | Co-facilitators debrief | |

DAY THREE

| Time | Activity | Materials ¹ |
|--|---|------------------------|
| 10 minutes | Review yesterday's activities/preview today's agenda | |
| 10 minutes | Icebreaker | |
| Module 4: Building partnerships between young people and adults | | |
| 5 minutes | Introduce Module 4 | PPT slides |
| 50 minutes | Working with young people | Tool 4B |
| 15 minutes | Interactive lecture: Sections 4.1-4.4 | PPT slides |
| 15 minutes | Review and discuss: How young people can partner in, lead and transform abortion care | Tool 4C |
| 15 minutes | BREAK | |
| 15 minutes | Review and discuss: Barriers to establishing successful partnerships with young people and how to overcome them | Tool 4D |
| 5 minutes | Interactive lecture: Section 4.5 | PPT slides |
| 15 minutes | Review and discuss: Evaluating partnerships with young people | Tool 4E |
| 10 minutes | Module 4 summary | Tool 4A |
| Module 5: Making abortion care accessible | | |
| 5 minutes | Introduce Module 5 | PPT slides |
| 45 minutes | Addressing barriers to care | Tool 5B |
| 1 hour | LUNCH | |
| 5 minutes | Energizer | |
| 20 minutes | Interactive lecture: Sections 5.1-5.5 | PPT slides |
| 15 minutes | Review and discuss: Service readiness assessment questions for providing abortion care to young women | Tool 5C |
| 15 minutes | Review and discuss: Improving abortion standards and guidelines for young women | Tool 5D |

| | | |
|--------------------|--|---------|
| 1 hour, 15 minutes | Improving abortion access for young women | Tool 5E |
| 15 minutes | BREAK | |
| 10 minutes | Module 5 summary | Tool 5A |
| 1 hour | VCAT activity: Talking about abortion ⁴ | |
| 5 minutes | Daily evaluation | |
| | Co-facilitators debrief | |

DAY FOUR

| Time | Activity | Materials ¹ |
|--|--|------------------------|
| Module 6: Making abortion care clinically appropriate | | |
| 10 minutes | Review yesterday's activities/preview today's agenda | |
| 10 minutes | Icebreaker | |
| 5 minutes | Introduce Module 6 | PPT slides |
| 45 minutes | Through their eyes: Young women's experiences with abortion | Tool 6B |
| 15 minutes | BREAK | |
| 2 hours | Counseling skills | Tools 6C/D |
| 1 hour | LUNCH | |
| 5 minutes | Energizer | |
| 20 minutes | Interactive lecture: Sections 6.1-6.6 | PPT slides |
| 15 minutes | Review and discuss: Young women's perception of abortion care survey | Tool 6E |
| 15 minutes | Review and discuss: Sample wall poster | Tool 6F |
| 10 minutes | Module 6 summary | Tool 6A |
| 15 minutes | BREAK | |
| 15 minutes | Workshop closing | |
| 25 minutes | VCAT activity: Closing reflections ⁴ | |
| 20 minutes | Post-workshop survey and evaluation | |
| 15 minutes | Presentation of Certificates of participation | |
| | Co-facilitators debrief | |

¹ Please refer to the materials list for each activity.

² See *Abortion attitude transformation: A values clarification toolkit for global audiences* for a sample workshop introduction (available on the CD-ROM and at www.ipas.org).

³ See *Effective training in reproductive health: Course design and delivery* for examples of icebreakers and energizers (available on the CD-ROM and at www.ipas.org).

⁴ See *Abortion attitude transformation: A values clarification toolkit for global audience* for the VCAT activities suggested in this agenda (available on the CD-ROM and at www.ipas.org). Use activities adapted for youth, where available.

Abortion care for young women

Pre-workshop survey

Please answer the following questions according to your knowledge and beliefs at this time. Please do not include your name. You will create a unique identifier to allow us to match your pre- and post-survey responses while maintaining your confidentiality. Responses without identifying information may be used for evaluation purposes and professional presentations and publications. Thank you!

Your unique identifier:

| | Number of sisters: | Birthday month: | Last 3 digits of your mobile phone number: | Name of the region where you were born: |
|-------------------|--------------------|-----------------|--|---|
| <i>Example:</i> | <i>0</i> | <i>April</i> | <i>024</i> | <i>Ashanti Region</i> |
| Your information: | | | | |

PLEASE NOTE: The term “young” in this survey refers to people ages 10-24.

Please circle TRUE, FALSE or I DON'T KNOW for each question below.

- Pregnancy and childbirth-related complications continue to be one of the leading causes of death for women 15-19 years old.
 - True
 - False
 - I don't know.
- Gender is the same as sex.
 - True
 - False
 - I don't know.
- Stigma is a characteristic or attribute for which a person is considered tainted or lesser.
 - True
 - False
 - I don't know.
- Young women often do not seek access to safe abortion care because they do not have access to money.
 - True
 - False
 - I don't know.

5. The Convention on the Rights of the Child (1989) states that children and young people have the right to independent decisionmaking in accordance with their capacities. The Committee on the Rights of the Child (2011) has interpreted this to apply to abortion.
 - a. True
 - b. False
 - c. I don't know.
6. The Committee on the Rights of the Child (2009) affirms that children of any age have a right to private and confidential medical counseling and advice only with parental consent.
 - a. True
 - b. False
 - c. I don't know.
7. Tokenism occurs when young people have full participation in a partnership with adults.
 - a. True
 - b. False
 - c. I don't know.
8. A partnership between adults and young people includes both voluntary and meaningful participation and a transfer of responsibility to young people.
 - a. True
 - b. False
 - c. I don't know.
9. Facilities should be open between 9am and 5pm to ensure access to young women.
 - a. True
 - b. False
 - c. I don't know.
10. Providers and staff with negative attitudes towards abortion care for young women are recommended to attend values clarification workshops.
 - a. True
 - b. False
 - c. I don't know.
11. Counseling sessions with young women will usually be shorter than with adult women.
 - a. True
 - b. False
 - c. I don't know

12. The provider should help the young woman make her decision based on what the provider knows is best.
- a. True
 - b. False
 - c. I don't know

Please circle only ONE correct response for each question below.

13. In 2003, young women accounted for approximately _____ of the estimated unsafe abortion-related deaths globally.
- a. 10 percent
 - b. 25 percent
 - c. 45 percent
14. One of the *social* barriers that young women face when seeking safe abortion care is:
- a. Gender discrimination
 - b. Cost
 - c. Transportation
 - d. None of the above
15. The principle of capability states that young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services:
- a. with parental consent.
 - b. without parental involvement, excluding abortion.
 - c. without parental involvement, including abortion.
16. A successful partnership between young people and adults should be based on:
- a. Tokenism
 - b. Trust, respect and civic values
 - c. Stereotyping of young people
 - d. Young people always getting what they want
 - e. Both b and d
17. Which of the following strategies could reduce economic or logistical barriers to safe abortion care for young women?
- a. Lower the cost of abortion care.
 - b. Ensure auditory and visual privacy during counseling and procedures.
 - c. Create community-run transportation network.
 - d. Educate community about the specifics of the laws.
 - e. Both a and c

18. What is the first thing a provider/staff person should do when a young woman comes in for safe abortion care?
- a. Let her talk before providing more information.
 - b. Encourage questions and solicit her opinion.
 - c. Affirm the positive step she has taken by seeking safe care.
 - d. Explain and discuss issues of confidentiality.

Please circle ALL of the correct responses for each question below. (There may be more than one correct response.)

19. The Four Pillars of abortion care for young women are:
- a. Confidentiality
 - b. Privacy
 - c. Respect for young women and their rights
 - d. Participation by young women in all stages of service delivery
 - e. Safety and appropriateness
 - f. Countering misinformation
 - g. Accessibility
20. The benefits of a partnership with young people and adults can include which of the following?
- a. Fulfilling rights and desires
 - b. Adults have less work to do
 - c. Learning and empowerment
 - d. There are no benefits
 - e. Improving communication about difficult topics
 - f. Reducing barriers and improving health care
21. Which of the following may require special considerations for young women?
- a. Pelvic exam
 - b. No touch technique
 - c. Vacuum aspiration
 - d. Medical abortion
 - e. Sterilization

Please respond below based on your current beliefs and comfort levels. Please circle only one response for each question.

| | Please circle one: | | | | |
|--|--------------------|---|---|---|----------------|
| | Strongly disagree | | | | Strongly agree |
| I support the sexual and reproductive rights of young people. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable discussing young people's sexuality. | 1 | 2 | 3 | 4 | 5 |
| I agree that young people have a right to accurate information about sexual and reproductive health. | 1 | 2 | 3 | 4 | 5 |
| I support the provision of contraceptive services to young women. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable working to increase access to contraceptive services for young women. | 1 | 2 | 3 | 4 | 5 |
| I support the provision of abortion services to young women as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I support young women's right to decide whether, when and with whom to have a child. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable working to increase access to abortion services for young women as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I agree that by voluntarily seeking safe abortion care, young women should be presumed capable of informed consent to such care as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I agree that young women deserve respectful and nonjudgmental abortion care. | 1 | 2 | 3 | 4 | 5 |
| I agree that young people have the right to be actively involved in designing, providing and evaluating abortion services for young women. | 1 | 2 | 3 | 4 | 5 |
| I would feel comfortable observing an abortion procedure on a young woman. | 1 | 2 | 3 | 4 | 5 |
| I would feel comfortable performing or assisting an abortion procedure on a young woman. | 1 | 2 | 3 | 4 | 5 |
| I am clear about my personal values concerning abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I feel very conflicted about abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I can clearly explain my personal values concerning abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I can respectfully explain values concerning abortion care for young women that conflict with mine. | 1 | 2 | 3 | 4 | 5 |
| I feel empathy for young women who have experienced abortion. | 1 | 2 | 3 | 4 | 5 |
| All young women should have access to safe, comprehensive abortion care. | 1 | 2 | 3 | 4 | 5 |
| Young women's access to abortion should be restricted to certain circumstances. | 1 | 2 | 3 | 4 | 5 |

Please briefly describe your greatest values conflict about abortion care for young women. (This is a conflict between two or more different values concerning abortion care for young women.) Please copy the exact wording of your values conflict on a separate paper where you can refer to it again for the post-workshop survey.

| I intend to do the following within the next six months: | Please circle one: | | |
|---|--------------------|----|----------------|
| Learn more about the need for safe, comprehensive abortion care for young women in my community. | Yes | No | |
| Raise awareness about the need for safe, comprehensive abortion care for young women in my community. | Yes | No | |
| Advocate making safe, comprehensive abortion care widely available to young women in my community. | Yes | No | |
| Work to reduce the barriers to abortion care for young women that exist in my community/facility. | Yes | No | |
| Educate members of my community, including young women, about safe abortion services. | Yes | No | |
| Refer young women seeking abortion to safe services. | Yes | No | |
| Partner with young people to improve abortion services for young women in my community/facility. | Yes | No | |
| (For health-care workers) Provide or assist with safe, comprehensive abortion procedures on young women. | Yes | No | Not applicable |
| (For clinical trainers) Train other providers to perform or assist with safe, comprehensive abortion procedures on young women. | Yes | No | Not applicable |

Please respond below so we can plan a productive, satisfying workshop:

Two topics I hope we will address in this workshop are:

1. _____
2. _____

What else would you like the facilitators to know as they are leading this workshop?

Please provide us with some information about you.

Your gender: _____

Your religious or faith affiliation: _____

Your primary professional affiliation: (Please select *one*)

___ Ob-gyn

___ Nurse midwife

___ Other health-care provider (please specify): _____

___ Health facility administrator

___ Lawyer

___ Ministry of Health

___ NGO staff

___ Women's group

___ Media professional

___ Elected official

___ Other (please specify): _____

Abortion care for young women

Post-workshop survey

Please answer the following questions according to your knowledge and beliefs at this time. Please do not include your name. You will create a unique identifier to allow us to match your pre- and post-survey responses while maintaining your confidentiality. Responses without identifying information may be used for evaluation purposes and professional presentations and publications. Thank you!

Your unique identifier:

| | Number of sisters: | Birthday month: | Last 3 digits of your mobile phone number: | Name of the region where you were born: |
|-------------------|--------------------|-----------------|--|---|
| <i>Example:</i> | <i>0</i> | <i>April</i> | <i>024</i> | <i>Ashanti Region</i> |
| Your information: | | | | |

PLEASE NOTE: The term “young” in this survey refers to people ages 10-24.

Please circle TRUE, FALSE or I DON'T KNOW for each question below.

- Pregnancy and childbirth-related complications continue to be one of the leading causes of death for women 15-19 years old.
 - True
 - False
 - I don't know.
- Gender is the same as sex.
 - True
 - False
 - I don't know.
- Stigma is a characteristic or attribute for which a person is considered tainted or lesser.
 - True
 - False
 - I don't know.
- Young women often do not seek access to safe abortion care because they do not have access to money.
 - True
 - False
 - I don't know.

5. The Convention on the Rights of the Child (1989) states that children and young people have the right to independent decisionmaking in accordance with their capacities. The Committee on the Rights of the Child (2011) has interpreted this to apply to abortion.
 - a. True
 - b. False
 - c. I don't know.
6. The Committee on the Rights of the Child (2009) affirms that children of any age have a right to private and confidential medical counseling and advice only with parental consent.
 - a. True
 - b. False
 - c. I don't know.
7. Tokenism occurs when young people have full participation in a partnership with adults.
 - a. True
 - b. False
 - c. I don't know.
8. A partnership between adults and young people includes both voluntary and meaningful participation and a transfer of responsibility to young people.
 - a. True
 - b. False
 - c. I don't know.
9. Facilities should be open between 9am and 5pm to ensure access to young women.
 - a. True
 - b. False
 - c. I don't know.
10. Providers and staff with negative attitudes towards abortion care for young women are recommended to attend values clarification workshops.
 - a. True
 - b. False
 - c. I don't know.
11. Counseling sessions with young women will usually be shorter than with adult women.
 - a. True
 - b. False
 - c. I don't know

12. The provider should help the young woman make her decision based on what the provider knows is best.
 - a. True
 - b. False
 - c. I don't know

Please circle only ONE correct response for each question below.

13. In 2003, young women accounted for approximately _____ of the estimated unsafe abortion-related deaths globally.
 - a. 10 percent
 - b. 25 percent
 - c. 45 percent
14. One of the *social* barriers that young women face when seeking safe abortion care is:
 - a. Gender discrimination
 - b. Cost
 - c. Transportation
 - d. None of the above
15. The principle of capability states that young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services:
 - a. with parental consent.
 - b. without parental involvement, excluding abortion.
 - c. without parental involvement, including abortion.
16. A successful partnership between young people and adults should be based on:
 - a. Tokenism
 - b. Trust, respect and civic values
 - c. Stereotyping of young people
 - d. Young people always getting what they want
 - e. Both b and d
17. Which of the following strategies could reduce economic or logistical barriers to safe abortion care for young women?
 - a. Lower the cost of abortion care.
 - b. Ensure auditory and visual privacy during counseling and procedures.
 - c. Create community-run transportation network.
 - d. Educate community about the specifics of the laws.
 - e. Both a and c

18. What is the first thing a provider/staff person should do when a young woman comes in for safe abortion care?
- a. Let her talk before providing more information.
 - b. Encourage questions and solicit her opinion.
 - c. Affirm the positive step she has taken by seeking safe care.
 - d. Explain and discuss issues of confidentiality.

Please circle ALL of the correct responses for each question below. (There may be more than one correct response.)

19. The Four Pillars of abortion care for young women are:
- a. Confidentiality
 - b. Privacy
 - c. Respect for young women and their rights
 - d. Participation by young women in all stages of service delivery
 - e. Safety and appropriateness
 - f. Countering misinformation
 - g. Accessibility
20. The benefits of a partnership with young people and adults can include which of the following?
- a. Fulfilling rights and desires
 - b. Adults have less work to do
 - c. Learning and empowerment
 - d. There are no benefits
 - e. Improving communication about difficult topics
 - f. Reducing barriers and improving health care
21. Which of the following may require special considerations for young women?
- a. Pelvic exam
 - b. No touch technique
 - c. Vacuum aspiration
 - d. Medical abortion
 - e. Sterilization

Please respond below based on your current beliefs and comfort levels. Please circle only one response for each question.

| | Please circle one: | | | | |
|--|--------------------|---|---|---|----------------|
| | Strongly disagree | | | | Strongly agree |
| I support the sexual and reproductive rights of young people. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable discussing young people's sexuality. | 1 | 2 | 3 | 4 | 5 |
| I agree that young people have a right to accurate information about sexual and reproductive health. | 1 | 2 | 3 | 4 | 5 |
| I support the provision of contraceptive services to young women. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable working to increase access to contraceptive services for young women. | 1 | 2 | 3 | 4 | 5 |
| I support the provision of abortion services to young women as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I support young women's right to decide whether, when and with whom to have a child. | 1 | 2 | 3 | 4 | 5 |
| I feel comfortable working to increase access to abortion services for young women as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I agree that by voluntarily seeking safe abortion care, young women should be presumed capable of informed consent to such care as permitted by law in my country. | 1 | 2 | 3 | 4 | 5 |
| I agree that young women deserve respectful and nonjudgmental abortion care. | 1 | 2 | 3 | 4 | 5 |
| I agree that young people have the right to be actively involved in designing, providing and evaluating abortion services for young women. | 1 | 2 | 3 | 4 | 5 |
| I would feel comfortable observing an abortion procedure on a young woman. | 1 | 2 | 3 | 4 | 5 |
| I would feel comfortable performing or assisting an abortion procedure on a young woman. | 1 | 2 | 3 | 4 | 5 |
| I am clear about my personal values concerning abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I feel very conflicted about abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I can clearly explain my personal values concerning abortion care for young women. | 1 | 2 | 3 | 4 | 5 |
| I can respectfully explain values concerning abortion care for young women that conflict with mine. | 1 | 2 | 3 | 4 | 5 |
| I feel empathy for young women who have experienced abortion. | 1 | 2 | 3 | 4 | 5 |
| All young women should have access to safe, comprehensive abortion care. | 1 | 2 | 3 | 4 | 5 |
| Young women's access to abortion should be restricted to certain circumstances. | 1 | 2 | 3 | 4 | 5 |

Please rewrite here the same values conflict about abortion care for young women you wrote on your pre-workshop survey.

| I intend to do the following within the next six months: | Please circle one: | | |
|---|--------------------|----|----------------|
| Learn more about the need for safe, comprehensive abortion care for young women in my community. | Yes | No | |
| Raise awareness about the need for safe, comprehensive abortion care for young women in my community. | Yes | No | |
| Advocate making safe, comprehensive abortion care widely available to young women in my community. | Yes | No | |
| Work to reduce the barriers to abortion care for young women that exist in my community/facility. | Yes | No | |
| Educate members of my community, including young women, about safe abortion services. | Yes | No | |
| Refer young women seeking abortion to safe services. | Yes | No | |
| Partner with young people to improve abortion services for young women in my community/facility. | Yes | No | |
| (For health-care workers) Provide or assist with safe, comprehensive abortion procedures on young women. | Yes | No | Not applicable |
| (For clinical trainers) Train other providers to perform or assist with safe, comprehensive abortion procedures on young women. | Yes | No | Not applicable |

Please provide us with some information about you.

Your gender: _____

Your religious or faith affiliation: _____

Your primary professional affiliation: (Please select *one*)

- ☐ Ob-gyn
- ☐ Nurse midwife
- ☐ Other health-care provider (please specify): _____
- ☐ Health facility administrator
- ☐ Lawyer
- ☐ Ministry of Health
- ☐ NGO staff
- ☐ Women's group
- ☐ Media professional
- ☐ Elected official
- ☐ Other (please specify): _____

Abortion Care for Young Women

Workshop survey answer key

Correct answers appear in bold.

1. Pregnancy and childbirth-related complications continue to be one of the leading causes of death for women 15-19 years old.
 - a. **True**
 - b. False
 - c. I don't know.
2. Gender is the same as sex.
 - a. True
 - b. **False**
 - c. I don't know.
3. Stigma is a characteristic or attribute for which a person is considered tainted or lesser.
 - a. **True**
 - b. False
 - c. I don't know.
4. Young women often do not seek access to safe abortion care because they do not have access to money.
 - a. **True**
 - b. False
 - c. I don't know.
5. The Convention on the Rights of the Child (1989) states that children and young people have the right to independent decisionmaking in accordance with their capacities. The Committee on the Rights of the Child (2011) has interpreted this to apply to abortion.
 - a. **True**
 - b. False
 - c. I don't know.
6. The Committee on the Rights of the Child (2009) affirms that children of any age have a right to private and confidential medical counseling and advice only with parental consent.
 - a. True
 - b. **False**, without parental consent.
 - c. I don't know.

7. Tokenism occurs when young people have full participation in a partnership with adults.
 - a. True
 - b. False,** young people are included in name only.
 - c. I don't know.
8. A partnership between adults and young people includes both voluntary and meaningful participation and a transfer of responsibility to young people.
 - a. True**
 - b. False
 - c. I don't know.
9. Facilities should be open between 9am and 5pm to ensure access to young women.
 - a. True
 - b. False,** make open hours as long as possible.
 - c. I don't know.
10. Providers and staff with negative attitudes towards abortion care for young women are recommended to attend values clarification workshops.
 - a. True**
 - b. False
 - c. I don't know.
11. Counseling sessions with young women will usually be shorter than with adult women.
 - a. True
 - b. False,** they may take longer.
 - c. I don't know
12. The provider should help the young woman make her decision based on what the provider knows is best.
 - a. True
 - b. False,** the provider should help her weigh the benefits and risks and solicit her opinion before making any suggestions. The provider should respect the young woman's final decision.
 - c. I don't know
13. In 2003, young women accounted for approximately _____ of the estimated unsafe abortion-related deaths globally.
 - a. 10 percent
 - b. 25 percent
 - c. 45 percent**

14. One of the *social* barriers that young women face when seeking safe abortion care is:
- a. Gender discrimination**
 - b. Cost
 - c. Transportation
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20. The benefits of a partnership with young people and adults can include which of the following?
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 - b. Adults have less work to do
 - c. Learning and empowerment**
 - d. There are no benefits
 - e. Improving communication about difficult topics**
 - f. Reducing barriers and improving health care**
21. Which of the following may require special considerations for young women?
 - a. Pelvic exam**
 - b. No touch technique
 - c. Vacuum aspiration**
 - d. Medical abortion**
 - e. Sterilization**

Abortion care for young women workshop

Workshop evaluation form

GOAL: The goal of this workshop is to engage providers, health-care professionals and other stakeholders to ensure access to rights-based, participatory, clinically safe and appropriate abortion care for young women.

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

- Articulate how their perceptions and assumptions may affect their interactions and delivery of abortion care for young women.
- Demonstrate increased empathy for young women seeking abortion.
- Articulate how assumptions about gender and sexuality may affect their attitudes about young women's needs for abortion care.
- Define a sexually healthy young person.
- Describe the different barriers young women encounter when seeking safe abortion care.
- Identify human, sexual and reproductive rights that support a young woman's right to safe abortion.
- Describe their role in ensuring a young woman's right to safe abortion.
- Identify the assumptions they make about the decisionmaking capabilities of young women.
- Determine if a young woman can be considered capable of deciding if she needs abortion care, using the "principle of capability."
- Explore how young women can participate in abortion-related services and programs at the community and clinic levels.
- Identify different strategies to address the challenges young women face in accessing abortion care, including involvement of young people.
- Develop strategies to improve abortion access and service delivery for young women.
- Identify strengths and weaknesses in an abortion counseling session.

Please rate the workshop on each item below using the following scale. Please use the comments section to provide more information about the rating and suggestions for improvement.

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree

Rating

The workshop fulfilled its goal and objectives (see above).

Comments:

The workshop was well organized.

Comments:

The workshop topics were appropriate.

Comments:

The facilitators used effective training methods.

Comments:

The facilitators responded to participants' needs.

Comments:

The workshop materials (handouts, worksheets, etc.) were effective.

Comments:

There were enough opportunities for discussion.

Comments:

The break, lunch and other logistical arrangements were satisfactory.

Comments:

What suggestions can you make to improve this workshop in the future?

Your general comments and suggestions:

**Abortion Care for Young Women
Workshop**

CERTIFICATE OF PARTICIPATION

Awarded to

Name

Place

Date Completed

Signature

Hours Completed

