Safe Abortion Advocacy Initiative
Global South Engagement

Reclaiming the Right to Safe Abortion – Reproductive Justice for All

Learnings from SAIGE Convention 2025

8-9 August 2025
Colombo, Sri Lanka

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ABOUT THE PUBLICATION
This report synthesizes learnings from 2025 SAIGE Convention, capturing the methodologies, discussions, reflections, and key learnings from the Convention.

ABOUT SAIGE
The Safe Abortion Advocacy Initiative- A Global South Engagement (SAIGE) is a platform for Global South advocates, activists, academics and services providers committed towards realizing safe abortion as a human right.

Abbreviations

AAAQ	Affordable, Accessible, Available, Quality
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CO	Conscientious objection
CSE	Comprehensive sexuality education
CSO	Civil society organisation
CSR	Corporate social responsibility
D&C	Dilation and curettage
FCHVs	Female community health volunteers
FOGSI	Federation of Obstetrics and Gynaecological Societies of India
FRHAM	Federation of Reproductive Health Associations Malaysia
GBV	Gender-based violence
ICPD	International Conference on Population and Development
ICPD25	25th Anniversary of the International Conference on Population and Development (2019 Nairobi Summit)
IEC	Information, education, and communication
IPPF ESEAOR	East & South East Asia and Oceania Region of International Planned Parenthood Federation
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, and diverse communities
MoH	Ministry of Health
MP	Member of Parliament
MTP Act	Medical Termination of Pregnancy Act of 1971 (India)
MVA	Manual vacuum aspiration
OB-GYN	Obstetrician-gynaecologist
PAC	Post-abortion care
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act of 1994 (India)
POCSO Act	Protection of Children from Sexual Offences Act of 2012 (India)
Q&A	Question and answer
RHNK	Reproductive Health Network Kenya
SAHAJ	Society for Health Alternatives (India)
SRHR	Sexual and reproductive health and rights
TOT	Training of trainers
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

Executive Summary

This report distils the collective intelligence generated at the SAIGE Convention 2025–Reclaiming the Right to Safe Abortion: Reproductive Justice for All– where advocates, providers, researchers, lawyers, movement leaders and youth from across the Global South convened to exchange lessons, map barriers, and co-create strategies for advancing safe abortion within a reproductive justice frame. The proceedings combined plenaries, panels, participatory group work, and scenario-based strategy labs, producing both context-specific insights and cross-cutting approaches that can travel across settings.

Across country reflections participants underscored that progress hinges on narrative change, alliance-building, and health-system strengthening carried out alongside legal and policy work. The Convention deliberately centred plural voices from youth leaders, indigenous advocates, LGBTQ+ people, persons with disabilities, service providers, and SRHR advocates – so that strategies are grounded in lived realities as well as political analysis.

A practical decision framework emerged for responding to opposition: Observe, then engage, then push back. Observing is useful when risk or intent is unclear; engage where dialogue can unlock access or shift narratives (including with institutional gatekeepers); and pushback rapidly where rights and safety are at stake or when misinformation is propagated by authority figures. This ladder helps calibrate speed, safety, and leverage, and guided responses across religion, media, education, health, and justice spheres.

Key areas of engagement that emerged as critical needs were as follows.

- Religious discourse: pairing discreet engagement (ally mapping, interfaith dialogues, values-based harm-reduction) with principled pushback (separating religion and state; countering myths) depending on context and risk.
- Media narratives: investing in sensitisation (VCAT for journalists), providing evidence/toolkits, building allyship, and actively correcting misinformation while promoting positive coverage.
- Justice systems: integrating SRHR into legal education and prioritising rights-anchored pushback where narrow or moralistic interpretations have wide impact.

Looking ahead, participants articulated what success in five years looks like and how to get there across seven pillars:

1. Inclusive movements & alliances: stronger cross-sector coalitions (queer, disability, HIV, women's), intentional inclusion, decolonised approaches, and platforms explicitly pro-abortion.
2. Funding with resource justice: locally resourced, equitably distributed financing; integrate abortion within SRHR and maternal health; engage ethical private sector actors.
3. Health system strengthening: expand trained providers, ensure commodity security, improve data, and scale task-sharing with frontline workers and pharmacies.
4. Multi-stakeholder partnerships: work with tech companies, elected representatives, schools, judiciary, media, and donors; secure public budgets for abortion care.

5. Linking, learning & capacity strengthening: legal reform, reduced unsafe abortion, stronger provider capacities, progressive countries mentoring restrictive ones.
6. Advocacy: build a larger, younger movement; normalise public discourse; generate and deploy evidence; create shared repositories and digital assets.
7. Research & evidence: elevate qualitative and participatory methods; fill evidence gaps on unsafe abortion in restrictive contexts; embed data advocacy.

Finally, participants stressed the need to proactively monitor and pre-empt transnational anti-rights coordination (including online), coupling rapid narrative response with legal, policy, and movement-security tools.

This Convention provided inspiration and guidance for the way forward– linking narrative power, system change, and resource justice – so that safe abortion is accessible, affordable, stigma-free, and rights-based for everyone, everywhere.

Content

Background

This report captures the collective intelligence, discussions, and strategies that emerged from the SAIGE Convention 2025: *Reclaiming the Right to Safe Abortion – Reproductive Justice for All.* Over two days, safe abortion advocates from across the Global South came together to share experiences, reflect on challenges, and imagine new possibilities for advancing access to safe abortion. The Convention created a participatory space for diverse voices – activists, service providers, legal practitioners, researchers, and movement leaders – to articulate strategies for resisting anti-choice narratives, strengthening movements, and embedding abortion within broader reproductive justice agendas.

The report presents the outputs of plenary and group discussions, panel reflections, and participatory exercises. It highlights context-specific insights that surfaced during the Convention, while also documenting cross-cutting strategies relevant across national and regional contexts. These include approaches to narrative change, movement building, abortion solidarity and collective resistance, health system strengthening, and strategies to address stigma and opposition.

The compilation reflects the spirit of participatory movement building that SAIGE embodies. It brings together a plurality of perspectives – youth, Indigenous leaders, persons with disabilities, LGBTQ+ advocates, health providers, and others – each contributing to a collective vision of reproductive justice. The process and the report are deliberately inclusive, ensuring that strategies are grounded in lived realities as well as political analysis.

By documenting these deliberations, the report aims to serve as both a **record and a tool**: a reference point for continued advocacy, a brainstorming resource for programming, and a reminder of the collective strength and creativity within the movement. It underscores that advancing safe abortion is not the responsibility of any single country or group, but part of a shared global struggle for equality, dignity, and rights.

What does it mean to be a safe abortion advocate?

Methodology

This panel discussion brought together advocates from diverse contexts who shared their personal journeys, national legal frameworks, and movement-building strategies for advancing safe abortion. Each panellist presented in turn, followed by an open Q&A where participants raised questions and offered reflections on challenges, and possible pathways for advocacy across different settings.

From Population Control to Reproductive Justice: The Journey of Abortion Advocacy in India

Renu Khanna

Abortion is central to women's control over their own bodies and their reproductive choices. The need for abortion arises from unwanted pregnancies, which are often the result of contraceptive failure. Contraceptive failure is rooted in lack of knowledge about contraceptives, limited information on availability and function, and a broader lack of body literacy. Girls and women do not always have accurate knowledge of their fertility.

There is also strong family and community pressure on young women to prove fertility and to bear sons. Spousal non-cooperation, non-consensual sex within marriage, and sexual violence outside marriage all contribute to unwanted pregnancies. These are the underlying causes for which women require access to abortion services. Abortion is therefore both a gender issue and a rights issue.

Stigma remains widespread. Women are socially constructed as 'people who are meant to be mothers'. When they decide not to bear children, they are judged and often ostracised within families and communities. Addressing stigma is a prerequisite for ensuring safe abortion access.

In India, advocacy around abortion intersected with other issues in the late 1980s and early 1990s, when the crisis of missing girls and declining sex ratios emerged. The women's and health movements demanded regulation of sex selection, leading to the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act of 1994, which prohibits sex determination and sex selection. Although abortion is not mentioned in the Act, in practice it became conflated with anti-abortion regulation. Many providers assumed all abortions were sex-selective, creating a chilling effect that reduced women's access to safe abortion services.

In the early 2000s, a large-scale Abortion Assessment Project was conducted in India. This included two community-based surveys, 16 facility surveys, policy analysis, and qualitative studies. The findings

highlighted systemic gaps and priorities for advocacy, including:

- The need to strengthen abortion services at primary and community health centre levels.
- Expanding the provider base to include more cadres.
- Promoting safer technologies such as manual vacuum aspiration (MVA) and medical abortion, instead of continued reliance on dilation and curettage (D&C), which remained widely practised.

The Medical Termination of Pregnancy (MTP) Act of 1971 provided a comparatively progressive framework for safe abortion. However, its origins were not rooted in women's demands for autonomy. The Act was shaped by a public health logic to reduce maternal mortality and a population control mindset that viewed abortion as part of family planning. Access under the MTP Act has always been provider-controlled and conditional.

Amendments in 2021 expanded the gestational limit to 20 weeks and, in some cases, to 24 weeks for specific categories, including for survivors of rape and incest and women with disabilities. Importantly, unmarried women were explicitly included in the amendment, allowing them to access abortions.

Despite these improvements, tensions remain. The PCPNDT Act, the MTP Act, and the Protection of Children from Sexual Offences (POCSO) Act of 2012 interact in ways that restrict access. Under POCSO, providers are required to report any minor seeking abortion, which breaches privacy and deters adolescents from seeking safe services. This legal overlap continues to jeopardise access and pushes minors towards unsafe abortions. Providers face fear of criminal liability, further limiting willingness to provide services.

Advocacy efforts have included the Pratigya Campaign, with over 120 members, which works on medical abortion access, provider engagement, and legal advocacy, including collaboration with the Federation of Obstetrics and Gynaecological Societies of India (FOGSI). CommonHealth India, a coalition, has facilitated common ground workshops to bridge the divide between safe abortion advocates and those focused on sex ratio decline. Judicial and legal strategies have also been pursued, alongside research into court cases relating to abortion.

Navigating Law, Religion, and Stigma: The Struggle for Safe Abortion in Pakistan

Khawar Mumtaz

Pakistan has a high rate of unintended pregnancies, a high rate of unsafe abortion, and a low prevalence of contraceptive use. Abortion is often used as a method of family planning because people do not know what else to do.

The autonomous women's movement in Pakistan emerged in 1981, against state measures that reduced women to second-class status. At that time, abortion was taboo, and even violence against women was not

discussed publicly. One of the first demands made by the movement was that rape survivors should have the right to abortion. This demand was raised by the Women's Action Forum, alongside advocacy to bring violence against women into the public sphere.

Legal reform that followed criminalised abortion but permitted it if a woman's life or health was at risk. Health has since been interpreted to include mental as well as physical health, which provides an opening to argue for broader access.

Early marriage was identified as a root cause of unwanted pregnancies, unsafe abortions, and maternal mortality. Girls under 18 lacked the right to consent to sex, had no say in the number of children they bore, and faced pressure to produce sons. Early marriage was linked to high maternal deaths, stillbirths, and low-weight infants. Advocacy focused on raising the legal age of marriage to 18, which has now been achieved, although 24–25% of girls in Pakistan are still married below 18.

Unsafe abortion remains widespread. Studies show that the rate of unsafe abortion doubled within a ten-year period, reflecting poor contraceptive services and inadequate reproductive health services. Husbands often take wives for abortions, indicating that while abortion is taboo, it is practised. In rural and remote areas, traditional birth attendants provide unsafe abortions, contributing to high levels of maternal death and injury.

The women's movement and the health movement have worked closely, with health advocates providing evidence for safe abortion advocacy, for delaying marriage, and for bodily autonomy. Communication and media advocacy have also been important.

Over the years, new issues have emerged. Women with disabilities and transgender persons have started to demand recognition of their reproductive health rights, including the right to safe pregnancy and abortion. Services remain ill-equipped to meet their needs, with reports of hospitals being uncertain about where to admit transgender persons or who should provide care. Advocacy from women with disabilities has pushed for recognition of their right to normal sexual lives, to have children, and to access safe abortion.

Religious arguments are often used against abortion, with claims that it is taking a life. However, Islamic jurisprudence recognises 120 days before ensoulment as a period where abortion is permissible. How this is interpreted becomes crucial for advocacy within religious frameworks.

There are deep contradictions in society. Abortion is criminalised, yet clinics provide it; unsafe practices continue at the community level; and medical commodities are approved but organisations providing them risk being banned. These contradictions create barriers to safe access.

Unsafe abortions can result in severe health consequences such as fistula. Research into these outcomes has provided advocacy entry points with doctors and health professionals. The women's movement has learned

that it is essential to identify specific entry points, use evidence, and adapt strategies to context in order to move the issue forward.

Breaking Barriers of Age, Identity, and Geography: Indigenous and Youth Perspectives on Abortion in Malaysia

Eden-Joy Kalom

Eden's journey began when she was appointed at the age of 27 as the youngest executive director of the Federation of Reproductive Health Associations Malaysia (FRHAM), a national SRHR organisation and a member of IPPF ESEAOR. At 29, she reflects on leading not only the fight for reproductive health and rights but also the struggle to be taken seriously as a young leader.

Coming from the Iban indigenous community in Sarawak, Borneo, her identity shapes her leadership. In many rural and indigenous areas of Sarawak, the nearest clinic can be hours away, requiring travel by boat across rivers or through jungles. These barriers mean that reproductive health, including abortion, is cloaked in silence and difficult to access.

Cultural hierarchies also restrict young leaders. In Malaysia and across Asia, traditions of respecting elders create invisible walls. Young people, women, and queer persons are often dismissed or excluded from serious decision-making, especially on sensitive issues like abortion.

Abortion in Malaysia is legal only under specific circumstances, when a doctor determines that the physical or mental health of the pregnant woman is at risk. In practice, access remains extremely difficult. Colonial-era laws continue to shape the legal framework, and providers often lack confidence or willingness to apply the health exception. Essential abortion medications are banned or restricted, forcing women to unsafe methods. Religious and cultural pressures create stigma and fear of judgement.

Importance of youth inclusion in policymaking must be emphasised. Young people are more open to conversations on sexuality, contraception, and reproductive rights. They can bridge peer realities with policy spaces, but too often their perspectives are sidelined. Youth voices must be included meaningfully, not symbolically, in decisions that shape reproductive health and rights.

From the perspective of indigenous communities, barriers are compounded by geography, poverty, language, and discrimination. In remote villages, clinics may be unreachable, and even when abortion is legal, providers may be untrained, uninformed, or opposed to abortion. Fear of community backlash prevents women from seeking services. Women sometimes travel for hours or days for basic care, placing their lives at risk.

Humanitarian responses must therefore go beyond building clinics or drafting policies. Indigenous voices must be included in design and decision-making. Health education must be culturally relevant and accessible in local languages and dialects. Communities must know that abortion is legal under certain conditions, but many remain unaware because information is not delivered in accessible forms.

Advocacy must address intersecting discrimination based on age, identity, and culture. Empathy and inclusion are central – meeting people where they are, reducing stigma without dismissing culture, and ensuring women are not forced into unsafe choices because safe ones are out of reach. The loudest voices in advocacy are not always the most affected; those who live with the consequences must be at the centre of policy discussions.

Intersectional Advocacy and Financing for SRHR in Uganda

Tasha Sandra

Tasha's advocacy was shaped by the understanding that those who cannot speak out or face health workers deserve representation. Experiences of being denied services, combined with systemic marginalisation, pushed their work towards ensuring that the gaps in access and discrimination were exposed. The goal became to voice not only personal needs but those of sisters and brothers who are unable to seek help openly.

In 2023, the passage of the Anti-Homosexuality Act in Uganda intensified barriers for LGBTQ+ people. Even accessing basic medication such as Panadol became impossible. This created a crisis that required immediate community mobilisation, collective strategies, and solidarity. Movement building became essential for survival. The struggle was not only about access to abortion or reproductive health but about the fundamental right to exist and receive healthcare.

Discrimination and marginalisation push gender diverse persons to the extreme margins. Advocacy has therefore centred on connection, collective organising, and moving the agenda across and beyond Uganda's borders to ensure visibility and protection for LGBTQ+ communities in sexual and reproductive health and rights (SRHR) spaces.

On financing SRHR, Tasha emphasised that one-size-fits-all funding models do not work. To be meaningful, resource mobilisation must be intersectional, recognising that marginalised people face multiple, overlapping barriers. Healthcare access is not the only challenge – safe spaces, legal support, and protection from social exclusion are equally critical.

Three insights define intersectional financing:

- Intersectional approach: Recognising that people face multiple barriers beyond healthcare, such as legal or social exclusion, and tailoring support to address these.
- Targeted support: Ensuring funding is responsive to the specific needs of different groups. For

example, a person may identify as both LGBTQ+ and living with a disability; funding must recognise and address both identities.

- Community-driven solutions: Resource mobilisation must centre grassroots organisations and communities. They understand their realities and have the solutions. Their voices must be included at the planning stage, not only at implementation.

Religious arguments are often used against abortion, with claims that it is taking a life. However, Islamic jurisprudence recognises 120 days before ensoulment as a period where abortion is permissible. How this is interpreted becomes crucial for advocacy within religious frameworks.

From Green Scarves to Global Resistance: The Feminist Struggle for Abortion Rights in Argentina

Majo Corvalán

The experience of Argentina's struggle to legalise abortion reflects political and social contexts shared across the Global South. The National Campaign for the Right to Legal, Safe, and Free Abortion was built as an alliance across political forces. While not all actors were feminist groups, the campaign's strategies were deeply feminist, personal, and intersectoral. Intersectionality was not just a concept but a lived reality: women seeking abortions faced discrimination on the basis of class, religion, and other identities.

Activism was built from personal experience as much as political conviction. The campaign combined knowledge, lived experience, pain, and strategy, bringing together social, student, and political movements to push for legalising abortion. Legalisation was understood not as the end, but only one step towards universal and unrestricted access.

The campaign used innovative communication strategies: collaborative actions, creative messaging, and widespread use of social media to shift narratives. Abortion was deliberately brought 'out of the closet', made visible in universities, in the streets, in homes, and even in intimate spaces. Communication was coordinated with political strategy, including systematic lobbying in Congress. Activists knew each legislator, who could approach them, and what arguments to use. This strategic blend of grassroots mobilisation, narrative power, and direct lobbying led to the historic victory of 2020.

Yet the struggle continues. At the start of the campaign, the now-iconic green scarf (pañuelo verde) was not widely accepted, even within feminist movements. Over time, it became a symbol of resistance across the region and globally.

Opposition forces remain strong. Fundamentalist groups finance political candidates across Latin America,

including Bolsonaro in Brazil, Bukele in El Salvador, and conservative leaders in Bolivia. These groups erode rights once gained. In Argentina, the current government under Javier Milei brands feminist and rights-based agendas as a 'bloody agenda'. Milei positions himself as a leader of the new global far-right, allied with Spain's Vox party. This hostile environment demands international solidarity and resistance networks to defend rights under attack.

The backlash is visible in hospitals and communities. Although abortion is legal, shortages of misoprostol and other supplies undermine access. Stigma is re-emerging. Activists sustain a 24-hour safe abortion hotline voluntarily, monitor hospitals to track new barriers, and support youth advocating for comprehensive sexuality education – a law that exists but is not fully implemented.

The effects of hate speech are immediate and violent. The presidential spokesperson calls gay and lesbian people 'perverts'. Soon after, three lesbian women were killed in an arson attack. Hate speech becomes hate crime, underscoring the urgency of resisting harmful narratives.

Current advocacy involves multilevel political engagement and narrative counter-laboratories to respond to hate speech. Activists draw inspiration from the Mothers and Grandmothers of Plaza de Mayo, who denounced abuses during the dictatorship, and apply similar strategies today to expose attacks on rights internationally.

Finally, advocacy must strategically intersect financing, care agendas, and SRHR. Global institutions now promote 'care' as a theme, but true care cannot exist while lives are at risk from unsafe and clandestine abortion. Resources must align with defending reproductive rights.

Call for full Decriminalisation: Addressing CSE and Unsafe Abortion in Sri Lanka

Paba Deshapriya

Paba's advocacy journey started with the realisation that her body belonged to her. Over time, frustration grew from recognising the systemic factors driving unplanned pregnancies and unsafe abortions, including gender-based violence, lack of comprehensive sexuality education, non-recognition of marital rape, weak child protection, and restrictive contraceptive and education policies.

Decriminalisation of abortion is central. Negotiations limited to exceptions such as rape and incest do not address the structural problems. Criminalisation has created a monopoly where healthcare providers profit, while women are denied safe, affordable access. Misoprostol and mifepristone are widely available in pharmacies, yet access is blocked by cost and stigma. Prices range from LKR 40,000 at the lower end to LKR

400,000 at the higher end for a course of pills. This economic barrier particularly harms rural women, ethnic minorities, unmarried and unemployed women, and survivors of gender-based violence.

According to WHO guidance, medical abortion can be self-administered safely at home. In Sri Lanka, criminalisation prevents this. Women dependent on male partners face severe challenges. Those unable to afford medical abortion resort to traditional, unsafe methods, leading to septicaemia and death. Criminalisation also prevents accountability of providers; women may not even know what kind of medication they are given.

Decriminalisation is therefore the only pathway to ensure safety, affordability, and accountability.

In a recent case where Paba's organisation supported a survivor, a 15-year-old girl went through an entire cycle of abuse, pregnancy, and costly termination within three months. This illustrates the compounded risks created by the absence of comprehensive sexuality education.

Experiences from schools further highlight the gap. Teachers report cases of sexual harassment in school buses, child sexual abuse, and teenage pregnancies. Families often attempt to cover up pregnancies or resort to unsafe traditional methods of abortion. Domestic violence and marital rape remain unaddressed.

Healthcare institutions act as barriers. Survivors referred to hospitals are often pushed into law enforcement processes, which families and communities wish to avoid due to lengthy court proceedings. As a result, some survivors do not seek healthcare at all. Even basic interventions such as emergency contraception are delayed; in one case, a midwife could not deliver contraceptives to a 15-year-old for two months, leaving her exposed to further risk.

The healthcare system is overburdened and restrictive, and education reforms must be pursued in parallel with health reforms. Comprehensive sexuality education must be unpacked, clearly explained, and prioritised as foundational for addressing unsafe abortion and gender-based violence.

Advancing Comprehensive Abortion Care in Kenya

Nelly Munyasia

Nelly's journey started from the health sector. Trained as a nurse in a patriarchal society where nurses are expected to remain in clinical care without leadership roles, she chose not to return to clinical work. The daily experience of watching women suffer in hospitals without having a voice to advocate for them pushed her to find a platform where she could use her voice both as a nurse and as a woman to speak for vulnerable women and girls in all their diversities.

Nelly joined the Reproductive Health Network Kenya (RHNK), the country's largest network of healthcare

providers, where 90% are nurse-midwives working in hard-to-reach communities. RHNK emerged around 2009–2010, during constitutional reforms that introduced Article 26(4), allowing abortion when the life or health of the pregnant woman is at risk, and defining health according to the WHO to include physical, mental, and social wellbeing. This provision empowered healthcare providers to make decisions and anchored their work in the Constitution.

Despite this framework, providers face constant harassment. Every year four to five cases arise in which providers are arrested. Facilities are raided, providers are taken to court, and health workers are trolled on social media. Some facilities are targeted by opposition groups who demand closure. Providers respond by asserting their rights, refusing to give statements without lawyers, and even teaching law enforcement officials about Article 26(4). The judiciary has consistently acquitted providers under this provision, reinforcing that they have the authority to provide life-saving services.

Engagement with policymakers, many of whom are also health professionals, has allowed progress. Through sustained advocacy, misoprostol and mifepristone were added to Kenya's essential drug list, and supportive policies have been developed. Narrative framing has been critical to securing these wins, even as opposition remains strong.

Movement building has been essential. Collective solidarity means that whenever a provider is arrested, women and activists show up in the streets to demand their release. SRHR advocates across sectors–family planning, LGBTQ+ rights, and comprehensive abortion care–stand together under the principle that abortion is healthcare.

Advocacy also takes place in regional and global spaces. In one instance, while on a Nordic ministerial panel, opposition members distributed leaflets labelling abortion as murder. The experience was intimidating but highlighted the global trend of anti-choice organising. Regional and global advocacy has shown that unsafe abortion is not the core problem; the problem is lack of comprehensive sexuality education, weak policies, and failures to address gender-based violence, LGBTQ+ rights, and incest.

In Kenya, comprehensive sexuality education exists mainly through civil society initiatives but has not been adopted by the government. Teenage pregnancy remains widespread. Incest is a major issue, often settled informally in 'kangaroo courts'. Such cases rarely reach formal justice systems and result in children born with deformities or health challenges.

Learning from global spaces has helped to frame abortion advocacy intersectionally, ensuring policies and curricula address abortion within broader reproductive health and rights. Opposition movements often combine anti-abortion and anti-LGBTQ+ agendas, as seen in Uganda and replicated in Kenya, Ghana, and Senegal. This requires advocates to take a multi-sectoral approach.

International commitments also play a role. Kenya hosted the ICPD25 in 2019 and made extensive commitments on SRHR, but implementation remains weak. Global advocacy platforms provide opportunities to remind governments of these commitments, push for financing, and demand accountability.

Questions and reflections

Q1. What concrete strategies work to address hypocrisy and double standards around access to safe abortion–beyond value clarification?

Evidence-based advocacy is effective. Presenting medical and public-health evidence of the harms of current policies (e.g., high rates of unsafe abortion, maternal morbidity/mortality) places governments and implementers on the defensive and creates pressure for change.

In Pakistan, **medical evidence** has been more persuasive with policymakers than moral arguments and helped secure reforms like raising the legal age of marriage. Addressing societal backlash requires sustained use of health data and strategic messaging aligned to specific entry points and moments.

Religious and professional gatekeeping are part of the double standard. In Argentina, powerful religious institutions define who counts as a 'good citizen', relegating women and dissidents to second-class status; institutionalized conscientious objection functions as a systemic barrier when obstetricians refuse essential obstetric care.

Provider-network standards can reduce hypocrisy in service delivery. In Kenya, RHNK handles conscience claims at the point of recruitment: members must be committed to providing safe abortion care; those unwilling to provide life-saving services are not admitted to the network.

Q2. Is there a parallel in Pakistan to Sri Lanka's decline in septic abortion morbidity after wider (though informal) access to misoprostol/mifepristone? If not, why?

Maternal mortality has declined overall in Pakistan, but improvements are uneven. Remote and less developed areas–with more early marriages and limited access to resources–continue to see high maternal mortality and unsafe abortion. Misoprostol is approved, yet provider and community knowledge on correct use is limited; accessibility varies by location and resources. Post-abortion care (PAC) is widely available in public facilities, **but shifting from PAC to safe abortion remains an active goal** (e.g., Pakistan Alliance for Post-Abortion Care).

From India's experience: population-level morbidity has fallen with medical abortion, but perceived complications and unnecessary facility visits have increased because many people use over-the-counter pills without counselling and are alarmed by heavier-than-menses bleeding; many then undergo Manual Vacuum Aspiration (MVA) in hospitals. This underscores the need for accurate information, counselling, and system

readiness alongside drug availability.

Q3. How should we negotiate language – 'abortion', 'termination', 'public health' –without compromising goals? And how to resist piecemeal decriminalisation (e.g., only for fatal fetal anomaly) while pushing full decriminalisation?

Argentina's lesson: for two decades, the campaign refused euphemisms and insisted on naming abortion publicly, pairing narrative power with legislative strategy. In the current anti-rights climate, narrative must also explicitly defend democracy and human rights to protect gains.

Sri Lanka's current debate limited to fatal fetal anomaly is insufficient. It is important to pursue full decriminalisation, while using strategic framings tactically (rights-based, public-health, decolonial) depending on venue and audience.

Context-tailoring helps with specific audiences. In Kenya, engagement with religious leaders progresses more smoothly using 'termination' language; framing the issue in terms of reducing hospital admissions and public-sector expenditure for PAC has also moved government actors in resource-constrained settings.

Q4. How to bring a decolonial approach and deal with unsupportive media, bureaucracy, and unclear institutional entry points (Parliament vs. Supreme Court vs. committees) in Sri Lanka?

Participants called for explicitly naming colonial legal inheritances (penal code) to undercut claims that criminalisation reflects 'national values'. Where media are hostile, movements have combined direct community communication, targeted legislative lobbying, and coalition work to keep narrative and policy tracks aligned (Argentina's model of mapping every legislator and tailoring messengers/arguments). Clarifying institutional pathways requires parallel engagement: legal analysis to identify competent bodies, and political mapping to cultivate allies inside each (ministries, parliamentary committees, judiciary-adjacent forums).

Q5. Is today's anti-rights moment unusually severe? How are movements responding in different contexts?

Multiple contexts report a steep escalation since 2018–2019. Anti-rights coalitions operate transnationally, tying anti-abortion and anti-LGBTQ+ agendas, influencing candidate selection (including judiciary), and occupying technical policy spaces (e.g., MoH working groups). Messaging like the "Geneva Consensus Declaration" advances abstinence and attacks comprehensive sexuality education. Argentina faces a government that brands feminist/human-rights agendas as "bloody"; activists report supply shortages (e.g., misoprostol), resurging stigma in hospitals, and direct consequences of hate speech (violence against LGBTQ+ people). Movement responses include **multilevel advocacy, rapid-response narrative work, hospital monitoring, youth support for CSE implementation, and international solidarity networks.**

Q6. What practical examples can be drawn from Benin's experience on audience-appropriate language and legislative progress that others can adapt?

Benin moved from a restrictive 2003 law (rape/incest, serious risk to woman's health, severe fetal anomaly) to a 2021 law that also allows abortion at the woman's request when continuing the pregnancy would likely cause or worsen material, educational, professional, or moral distress incompatible with the interests of the woman or future child. The Ministry of Health, with civil society, produced a 'adapted language' guide endorsed by stakeholders. This tool tailors terminology and framing for each audience – Parliament, executive, civil society, religious leaders, students–reducing friction and improving message uptake.

Reflections on institutionalising education

Irrespective of legal environment, resistance will arise; **institutionalising sexuality education and safe abortion content** in curricula (primary, vocational, professional training) improves social perceptions and builds durable understanding of SRHR and abortion.

Reflections on global solidarity and materials sharing

Participants noted the value of **shared resources and cross-learning**. Argentina's campaign provided a QR code leading to research, data, and campaign materials, reinforcing the importance of transferable tools for narrative, lobbying, and countering fundamentalism.

Journey to Reproductive Justice: A Collective Adventure

Methodology

Participants were divided into small groups, and each group was assigned a specific persona/role within the abortion ecosystem. Using that persona, groups mapped the real-world context by identifying key challenges and systemic barriers the character encounters; internal dilemmas, fears, and constraints affecting decisions and behaviour; and concrete supports the movement can 'pack in their bag' – information, legal tools, clinical pathways, funding, safety protocols, messaging frames, allies, and referral networks – to help this person navigate the system and advance safe abortion access.

Getting to know an abortion counsellor

This is an abortion counsellor. He is a 40-year-old male reproductive health service provider. His personal vision is Mon corps, mon choix, mon corps, mon droit ("My body, my choice, my body, my right").

He lives in a setting where economic and geographic disparities, restrictive laws, social norms, family and community rejection, and stigmatisation make abortion care difficult to access. Religious and traditional pressures, poverty, and a lack of supportive health systems shape these lived realities.

His personal struggles include fear, remorse, hypocrisy, and isolation. He wrestles with society's judgement, his personal religion, and a lack of self-confidence – these are his internal struggles.

Restrictive legal frameworks, anti-rights and anti-choice movements, opposition from religious and traditional leaders, and entrenched social norms are the barriers he faces, and professional threats, community rejection, limited resources, criminalisation, and the constant tension of reconciling personal values with professional duties are his challenges.

What sustains him are his foundational qualities and skills which include empathy, active listening, discretion, availability, wisdom, commitment, hard work, and strong knowledge of legal frameworks.

Finally, we fill his bag with continuous training opportunities, financial resources, networking, and strong advocacy skills so that he does not walk alone, but can sustain his vision of rights-based care and carve a path towards reproductive justice.

A frontline community worker

This is a frontline community worker. They are a 28-year-old queer person from a rural area in Bangladesh. Their personal vision is to ensure rights-based, quality services and information for all people in their diversity.

They live in a context shaped by restrictive abortion laws, discrimination based on gender identity, strong socio-cultural and religious beliefs, and constant social backlash. Services such as menstrual regulation are permitted by policy, but implementation is patchy and not rights-based – these are their lived realities.

Sometimes they struggle with limited access to information, mental-health pressures, lack of family support, and the absence of monitoring or accountability from government service providers – these are their internal struggles.

Anti-rights groups, restrictive laws and policies, requirements for parental and spousal consent, and hostile environments that reinforce exclusion are the barriers they face, and limited mobility, financial constraints, threats of violence, very few respectful referral points, stigma and taboo in communities, and unavailability of trained healthcare providers are their challenges.

What sustains them are foundational qualities and skills such as integrity, consistency, purpose, respectfulness, intersectionality, empathy, motivation, resourcefulness, training, and education.

Finally, we fill their bag with holistic funding support to sustain and protect frontline workers and to strengthen their ability to provide safe, rights-based services so that they do not walk alone but continue bridging communities to reproductive justice.

Kumari seeks an abortion

This is Kumari, a 16-year-old Sri Lankan schoolgirl navigating one of the most restrictive abortion contexts in South Asia. Her personal vision is to access safe abortion services that are non-discriminatory, accessible, affordable, and of high quality, with full support from family, school, and community before and after abortion.

She lives in a setting where legally and culturally restricted access to abortion, lack of family and institutional support, and the risk of dropping out of school due to stigma and pressure define her lived realities.

She struggles with family pressure, financial constraints, fear of the future and how others will judge her, and the weight of discrimination – these are her internal struggles.

Restrictive legal frameworks, cultural and religious taboos, and the absence of enabling structures such as consent and supportive policies are the barriers she faces, and lack of comprehensive knowledge, difficulty in accessing safe services, limited supportive referral points, and economic dependency that worsens her vulnerability are her challenges.

What sustains her are the foundational qualities and skills already around her: partial SRHR education, free healthcare, government services like Yowun Piyasa (youth clinics), post-abortion care provisions, and – albeit limited – medical abortion pills through black markets.

Finally, we fill her bag with advocacy for accessible medical abortion pills, counselling, legal aid, financial support, and comprehensive sexuality education, alongside hotlines, information, and emergency support services, so that she does not walk alone but can move safely towards reproductive justice.

Meet Justice

This is Justice. They are a 30-year-old queer person from Nepal working as a midwife. Their personal vision is to provide safe abortion care that is feminist-centred, non-judgmental, confidential, and supportive – while also being safe, supported, and properly compensated in their role.

They work in an environment where heavy workloads, limited recognition, and legal restrictions that conflict with patients' reproductive health needs shape their lived realities.
Their personal struggles include mental-health challenges, burnout from excessive workload, and financial insecurity due to low pay – these are their internal struggles.

Stigma and discrimination as a queer provider, combined with cultural norms that normalise overwork and undervalue midwives, are the barriers they face, and low salary, lack of mental-health support, and systemic undervaluing of midwifery as a profession are their challenges.

What sustains them are foundational qualities and skills such as empathy, technical knowledge and skills, non-judgmental care, confidentiality, respect for patients' rights, patient-centred practice, reliability, approachability, feminist values, and strong counselling and communication skills.

Finally, we fill their bag with timely training, feminist-centred care frameworks, legal protections, and supportive environments that uphold their identity and professional wellbeing, so they do not walk alone but can continue offering safe, rights-based care.

Hello Genji!

This is Genji, a 16-year-old non-binary indigenous person from a Global South village, described as an abortion activist. Their personal vision is unconditional, affordable, safe abortion without judgement for everyone, everywhere.

They live in a setting that confronts criminalisation of abortion, lack of comprehensive sexuality education, age-of-consent laws, lack of family and peer support, absence of inclusive legal recognition, and weak confidentiality protections – these are their lived realities.

They struggle with imposter syndrome, burnout, pressure from peers and community, competing priorities, and mental-health challenges – these are their internal struggles. Patriarchy and gender stereotypes, surveillance and risks from oppressive governments, funding limitations, restrictive laws and policies, mobility restrictions, and internal conflicts within movements are the barriers they face, and tokenism, lack of networking opportunities, lack of agency, and not being taken seriously within decision-making spaces are their challenges.

What sustains them are foundational qualities and skills such as intersectional feminist values, creativity, advocacy, courage, innovation, lived experience, compassion, empathy, curiosity, critical thinking, adaptability, resistance, and fierce storytelling.

Finally, we fill their bag with funding, mentorship, partnerships, intergenerational dialogue, space for learning, allies, recognition, and acknowledgement so that they do not walk alone but continue leading with courage towards reproductive justice.

An abortion companion

This is an abortion companion. He is a 30-year-old Sri Lankan man from a rural area, presented as the boyfriend of a woman seeking abortion. His personal vision is that his partner is able to access safe, legal, and affordable abortion services without stigma or judgement.

He lives in a small, closely-knit village community where privacy and confidentiality are difficult. Poverty limits access to services, and social stigma surrounds both abortion and premarital relationships – these are his lived realities.

His personal struggles include cultural and religious conflicts, fear of criminalisation or arrest, worry about health complications for his partner, and emotional stress from the secrecy required – these are his internal struggles.

Criminalisation of abortion, lack of nearby services, and community stigma around premarital sex and abortion are the barriers he faces, and high cost of abortion services, transportation expenses, and difficulties in taking his girlfriend out of the village to seek care are his challenges.

What sustains him are foundational qualities and skills such as empathy, kindness, respect, cooperation, love, care, good communication, internet literacy, and a strong, supportive mindset.

Finally, we fill his bag with legal protection and information on abortion laws, knowledge of safe services, psychosocial counselling and hotlines, financial or subsidised support, and access to abortion pills so that he does not walk alone but can support his partner and others on the path to reproductive justice.

A policy maker

This is a policy maker. He is a 57-year-old conservative male serving as Secretary at the Ministry of Health, generally pro-abortion under limited circumstances. His personal vision is to have his name recognised as the person who pioneered the decriminalisation of abortion.

He operates in a context where abortion without clear justification is seen as a sin; his conservative worldview is shaped by religious influence, and he struggles with limited pay and bureaucratic constraints. Lack of access to reliable data restricts informed decision-making – these are his lived realities.

His internal struggles include fear of losing his job or status if he openly supports decriminalisation, wrestling with his own beliefs and biases on women's rights, and experiencing conflict between personal conservatism and professional responsibilities.
Religious institutions, bureaucratic red tape, outdated colonial laws, entrenched social conservatism, lack of political will and support, and the broader context of patriarchy are the barriers he faces, and scarcity of resources, resistance within the ministry, the risk of being transferred, lack of public acceptance and awareness, and the difficulty of sustaining momentum for reform are his challenges.

What sustains him are foundational qualities and skills such as visionary outlook, education, and years of experience, strong negotiation and interpersonal skills, knowledge of navigating bureaucracy, understanding of society and rights frameworks, technical expertise in public health and abortion, closeness to political power, and good communication and oratory abilities.

Finally, we fill his bag with case studies and lived realities, rights-based approaches, reliable data and evidence, and support from civil society organisations – CSOs, communities, professional bodies, experts, and religious leaders – to push reform forward so that he does not walk alone but can translate his vision into real change.

Reflections

The persona-building exercise helped participants see abortion and reproductive justice from multiple perspectives within the ecosystem – seekers, providers, companions, activists, community workers, and policymakers. By embodying these roles, participants surfaced the realities, struggles, and contradictions that shape access to safe abortion across contexts. This broadened understanding revealed that barriers are not only legal and structural, but also deeply personal, cultural, and emotional.

A key lesson learned was that reproductive justice requires collective strategies that respond to different lived realities. The exercise highlighted how stigma, restrictive laws, religious pressures, and resource limitations intersect with internal struggles such as fear, guilt, or imposter syndrome. At the same time, it showed how movements can 'pack the bag' with tools – solidarity, training, resources, legal protections, and narrative change – to support actors across the ecosystem. Overall, the activity reinforced that every individual's story contributes to the larger movement, and that achieving reproductive justice demands empathy, collaboration, and sustained commitment.

As a fundamental reflection, it was recognised that abortion access sits within an interconnected ecosystem of diverse actors coming together – each holding essential knowledge and skills, and each overcoming their own unique challenges – to collectively advance reproductive justice. Every individual's story contributes to the larger movement, and that achieving reproductive justice demands empathy, collaboration, and sustained commitment.

Voices and Realities: Advancing Safe Abortion Rights for Marginalized Persons

Methodology

This session combined storytelling with participatory group work. Panellists shared anonymised real-life stories from their advocacy and community work, highlighting the lived realities of people often excluded from abortion narratives – including adolescents, refugees, women with disabilities, people living with HIV, LGBTQ+ persons, sex workers, and those in conflict-affected contexts. Following the stories, participants worked in groups on case study scenarios modelled on these realities. Each group identified barriers faced by the character, opportunities for empowerment and inclusion, and developed a key message or policy ask for the safe abortion movement.

Story of Achieng

(shared by Lilian Kivuti, Women Spaces Africa)

Lilian shared the story of Achieng, a 24-year-old woman with a physical disability living in a small village in western Kenya: Achieng was born with a disability that affected both her legs, and she uses a wheelchair for mobility, relying on her grandmother for support. Without a job or income, she was economically dependent. In 2023, a shopkeeper near her home began offering her small gifts such as soap and sanitary pads. Eventually, he forced himself on her, and when she missed her period, she realised she was pregnant.

Achieng travelled 15 kilometres in her wheelchair to seek an abortion at a health facility, since rape is a legal ground for abortion in Kenya. However, the provider refused, telling her abortion was illegal, and other staff dismissed her concerns by saying she should consider herself lucky to be pregnant. No alternatives or referrals were offered. Overwhelmed and unsupported, she returned home, where her grandmother comforted her, but the stress led to a miscarriage.

Her story reflects the wider experience of many women and girls with disabilities in Kenya and across the Global South. People with disabilities are often denied access to contraceptives and abortion services, while at other times abortions are performed without their consent. They face systemic exclusion from decision-making around their bodies and sexuality due to lack of information, stigma, and discriminatory myths. Accessibility barriers persist – from the absence of ramps and interpreters to the unavailability of information in formats such as Braille. Most critically, the attitudes of healthcare providers remain the greatest barrier: when providers hold stigma and discriminatory views, services are withheld, but when providers adopt inclusive and respectful attitudes, they can ensure people with disabilities access the care they need.

Story of Meena

(shared by Dr. Nilangi Sardeshpande, SAHAJ India)

Dr. Nilangi shared the story of Meena, a 24-year-old Dalit woman from Beed district in Maharashtra, India. Beed is one of the state's most underprivileged districts, where families survive as seasonal migrant sugarcane cutters. Families are given advance payments and bound to cut a fixed tonnage of sugarcane, leaving them with no room to miss a day's work.

Meena already had two young children, aged two and five, when she migrated with her husband for the season. During the cutting period, she realised she had missed her period and suspected she was pregnant. When she told her husband, he said they could not afford to lose even a day's work and told her to manage however she could. Determined, Meena borrowed money and travelled nearly 70 miles to the nearest district hospital.

At the hospital, she discovered that only one doctor was authorised to provide abortions – and he was on leave. She had no option but to return and wait another week. When she came back, the doctor was available, but as a Dalit woman and labourer she faced discriminatory treatment. Health workers openly expressed disdain, asking why she had so many children, why she had not used contraception, and labelling women like her as irresponsible. She was given medical abortion pills without any explanation on their use or side effects.

After taking the pills, Meena suffered heavy bleeding and was forced to make the same long and expensive journey back to the hospital. Only then was she given surgical intervention to stop the bleeding. Her story illustrates the multiple layers of barriers Dalit women face: economic precarity, distance and cost of accessing care, lack of trained providers, poor quality of services, and above all, caste-based stigma and discrimination within the health system. For something as basic as an abortion, Meena endured repeated journeys, humiliation, and unsafe conditions – a stark reminder of the compounded marginalisation faced by Dalit and rural women.

Story of Maya

(shared by Lina Sabra, Lebanese Association for Family Health)

Lina shared the story of Maya, a young Lebanese woman whose life was uprooted by the 2024 war in Lebanon. When heavy fighting broke out, Maya was forced to flee her home in southern Lebanon and take shelter in Bekaa, in a school that had been converted into a temporary camp. Life in the shelter was extremely harsh – food and water were scarce, safety was uncertain, and basic health services were unavailable. Even the clinics that normally operated in Bekaa had been forced to shut down as the area itself became a war zone.

In the midst of this displacement and instability, Maya discovered she was pregnant. Abortion is illegal in Lebanon, and the fear of stigma and judgement compounded her situation. Without access to safe services, Maya resorted to an unsafe abortion that resulted in severe complications. She suffered not only physical consequences but also deep emotional distress.

It was during outreach visits by the Lebanese Association for Family Health (Salama) that Maya finally received the support she needed. The team provided urgent medical treatment to address her complications, counselling to help her process her trauma, and information on family planning for the future. Lina explained that Maya was treated with dignity and compassion, which restored some sense of hope during a time of overwhelming loss and uncertainty. Her story illustrates how war, displacement, and restrictive abortion laws intersect to strip women of their rights and safety – and how humanitarian responses can play a critical role in restoring dignity and access to care.

Story of Sheetal

(shared by Preetam Manjusha, SAMYAK)

Preetam shared the story of Sheetal, a 15-year-old girl from an urban area in Pune, India. She was the eldest of four children in a financially struggling household and had been forced to drop out of school to care for her younger siblings. In her neighbourhood, she met a 19-year-old boy who was there temporarily for work. They developed a relationship, and he promised marriage. However, he soon disappeared without any contact, leaving Sheetal feeling abandoned and betrayed.

When Sheetal missed her period, she confided in her mother. Together they went to a clinic, where it was confirmed that she was 12 weeks pregnant. As a minor, her case was legally complicated. Under India's Medical Termination of Pregnancy (MTP) Act, abortion is permitted for minors with parental consent. However, under the Protection of Children from Sexual Offences (POCSO) Act, any case of pregnancy involving a minor in a relationship with an adult must be reported to the authorities.

Her father, overwhelmed with shock and anger, was initially reluctant to take her to a government hospital. Eventually, she was admitted, and the police were informed, though no formal complaint was filed. The hospital also required a written statement from her parents before proceeding.

Doctors determined that the abortion could not be performed immediately and advised waiting until the

pregnancy reached 18 weeks. During this stressful period, Sheetal's parents considered taking her back to their village to pursue an abortion through unsafe methods that might have been quicker. After much deliberation, however, they decided to keep her under hospital care.

Three weeks later, at 18 weeks, the abortion was carried out safely. As Sheetal was discharged, she quietly told her parents that remaining in the hospital had 'saved her life'.
This story underscores the multiple vulnerabilities faced by adolescent girls like Sheetal –poverty, lack of education, predatory relationships, and the intersection of conflicting legal frameworks. It highlights the urgent need for policies and services that centre adolescent realities, provide confidential and compassionate care, and remove barriers created by contradictory laws.

Story of a transman survivor

(shared by Tasha Sandra, FEM Alliance Uganda)

Tasha shared the story of a close friend, a trans man in Uganda who became pregnant after surviving corrective rape by members of his own family in 2023, shortly after the passage of the Anti-Homosexuality Act. The violence was not only physical but also deeply psychosocial, driven by the family's desire to erase his identity and force him into conformity with the gender they assigned to him.

The trauma of the assault was compounded by silence and fear around seeking care. In Uganda, abortion is only permitted in life-threatening situations, and queer identities are criminalised. For someone visibly trans, seeking services in a health facility could be a death sentence. In despair, he remarked, *'Even if I could afford it, where would I go? Who would treat me like a human being?'*

Ultimately, he was forced to undergo an unsafe abortion in secrecy, with no medical follow-up, no emotional support, and no protection. He survived, but Tasha stressed that many others in similar situations do not. His experience illustrates how gender-diverse persons are rendered invisible in laws, clinics, and funding frameworks. This invisibility is not neutral–it is deadly.

Tasha emphasised that the safe abortion movement must constantly ask: safe for who? If advocacy, strategies, and policies do not explicitly speak to the realities of trans and gender-diverse persons, then they are not expanding access but instead reproducing exclusion.

Group reflections based on case scenarios inspired by real life stories

Hope for Faith – the story of a sex worker in Uganda

Scenario

Faith, a 24-year-old sex worker in Uganda, became pregnant after a client refused to use protection. Already caring for two children, she sought an abortion but was denied because of her profession. When she turned to a private clinic, staff dismissed her upon learning she was a sex worker, leaving her with no safe options.

Barriers

- Social stigma and discrimination against sex workers
- Abortion remains illegal in Uganda
- Financial constraints due to her caregiving responsibilities
- Lack of family support
- Absence of legal protections for sex workers
- Lack of empathy and bias among health workers

Opportunities

- Broader interpretation of 'life endangerment' as grounds for abortion
- Legal exceptions that allow abortion if a woman's life is at risk
- Existence of some private clinics that provide abortion services
- Awareness among women like Faith of their bodies and choices, fuelling demand for safe and legal services

Key message / policy ask

- Legalise abortion and ensure services are accessible, affordable, and included in health coverage for all
- Decriminalise sex work and recognise sex work as work, protecting sex workers' human rights

Situation: Maya's story – a displaced Lebanese woman

Scenario

Maya, a young woman displaced during the 2024 war in Lebanon, was forced to live in an overcrowded school shelter after fleeing conflict. While struggling with scarce food, water, and safety, she became pregnant and had no access to safe abortion due to legal restrictions and closed health facilities. Her case reflects the compounded vulnerabilities of women in humanitarian crises.

Barriers

- Overburdened healthcare system during conflict
- Lack of accurate information about safe abortion and self managed abortion
- Criminalisation of abortion, made worse in crisis contexts
- Forgotten populations in protracted emergencies (e.g., displaced women, refugees)

Opportunities

- Referral systems that link survivors to available services
- Comprehensive approach to safe abortion as part of humanitarian response
- Evidence-based advocacy highlighting abortion as an essential service in crises
- Strengthening the right to information, especially for displaced and marginalised women

Key message / policy ask

integrate non-judgmental and confidential safe abortion services in all humanitarian settings and emergency responses.

Situation: Unheard and unseen – where disability meets reproductive injustice

Scenario

The case of Achieng, a young woman with physical disabilities, illustrates the compounded barriers faced by persons with disabilities in accessing safe abortion. Despite her needs, she is excluded by inaccessible health systems, discriminatory attitudes, and harmful social norms that glorify motherhood while denying her autonomy.

Barriers

- Accessibility barriers:
    - Infrastructure: lack of ramps, equipment, and accessible facilities
    - Information: absence of disability-friendly formats such as Braille or sign language
    - Attitudinal: discriminatory views from health workers questioning sexuality or rights of persons with disabilities
- Glorification of motherhood that enforces harmful social norms
- Unavailability of safe abortion services, leading to isolation and stigma
- Lack of access to formal employment, making abortion services unaffordable
- Heightened vulnerability of people with disabilities to sexual violence

Opportunities

- VCAT training for health service providers, including disability and sexuality awareness
- Expansion of telemedicine as an accessible service model, especially in crises or remote areas
- Stronger collaboration with local community organisations who reach marginalised groups
- Institutionalisation of accessibility at all levels – policy, service provision, and community outreach
- Meaningful engagement of people with disabilities in decision-making, guided by the principle “nothing about us without us”
- Collaboration with pharmaceutical companies to ensure medical abortion information (e.g., leaflet inside the medical abortion pill packets) is available in accessible formats such as Braille
- Adoption of a code of ethics and conduct for health workers on respectful, dignified treatment of persons with disabilities

Key message / policy ask

Reproductive justice can only be achieved if every person, in all their diversities, is heard and seen.

Situation: Myriam – a woman living with HIV facing reproductive injustice

Scenario

Myriam, a 29-year-old woman living with HIV, was stigmatised and rejected by a nurse at a health centre when she sought abortion services. Her experience highlights the multiple layers of exclusion faced by people living with HIV when it comes to sexual and reproductive health, particularly safe abortion.

Barriers

- Absence of narratives about people living with HIV within abortion rights and advocacy spaces
- Limited access to health services and pervasive discrimination against people living with HIV
- Lack of confidentiality from health providers
- Insufficient knowledge among health workers about laws and rights of people living with HIV in relation to abortion
- Absence of legal protections ensuring the right to health for people living with HIV
- Harmful socio-cultural norms and stigma
- Restrictions on civic space that limit advocacy for people living with HIV and women's health
- Systemic de-prioritisation of health needs of women and people living with HIV

Opportunities

- Mainstreaming narratives on people living with HIV within SRHR advocacy, with a specific focus on safe abortion
- Building advocacy efforts on international conventions ratified by states
- Documenting and disseminating cases and evidence on the experiences of people living with HIV and abortion access
- Raising public awareness and sensitising communities about the rights of people living with HIV to safe abortion
- Creating stronger linkages between organisations working on HIV and those working on abortion rights
- Engaging people living with HIV themselves in abortion rights advocacy
- Identifying and mobilising donors who fund both HIV and abortion-related initiatives
- Leveraging international platforms (e.g. ICPD) to amplify voices of people living with HIV and share their experiences

Key message / policy ask

Safe abortion for all (avortement sécurisé pour tous) – regardless of HIV status or any other identity.

Situation: 15-year-old girl from a nomadic tribal community in India

Scenario

A 15-year-old girl from a nomadic tribal community, engaged in sugarcane harvesting and married at a very young age, experienced a spontaneous abortion. Despite the physical and emotional trauma, she received no post-abortion medical attention and had to return to work immediately. Her condition worsened due to weakness and fatigue, but poverty, mobility restrictions, lack of awareness, and normalisation of her suffering prevented her from accessing healthcare.

Barriers

- Poverty and restrictions on mobility, including long distances from health facilities
- Caste-based discrimination
- Early marriage and lack of autonomy
- Lack of access to information on sexual and reproductive health and post-abortion care
- Misconceptions and stigma around abortion
- Lack of family and social support

Opportunities

- Expanding access to contraception and comprehensive sexuality education
- Providing discreet and sensitive support for individuals in vulnerable communities
- Offering information in local languages to address language barriers
- Promoting information on self-managed abortion and post-abortion care where relevant
- Integrating mental health and emotional wellbeing into post-abortion care frameworks

Key message / policy ask

Improve access to community-based, sensitive SRHR services –including post-abortion care –in local languages.

Situation: 30-year-old woman from a rural village in India

Scenario

A 30-year-old woman living in a rural village in India became pregnant and sought support from a community health worker, but received no useful information. Left without guidance, she turned to a local chemist, who illegally sold her medical abortion pills. The pills led to an incomplete abortion, forcing her to seek emergency care in a private hospital, which was both costly and unregulated. Her experience reflects the multiple layers of barriers rural women face when trying to access safe abortion.

Barriers

- Non-accessible public health services in rural areas
- Expensive and unregulated private healthcare providers
- Illegal and unregulated sale of medical abortion pills by chemists or pharmacists
- Geographic challenges that limit access to health facilities
- Educational and economic disadvantage
- Lack of recognition of women's autonomy and decision-making power

Opportunities

- Ensuring abortion services meet the AAAQ framework (Affordable, Accessible, Available, Quality) within public health systems
- Legalising and regulating self-managed abortion through pharmacists
- Expanding telemedicine options to reach women in remote areas
- Promoting better education and economic opportunities for women to increase autonomy and informed decision-making

Key message / policy ask

Make abortion services safe, accessible, affordable, of quality, and client-centred.

Situation: Ash, a 22-year-old gender diverse person

Scenario

Ash, a 22-year-old gender diverse person, became pregnant as a result of sexual violence. They accessed an abortion through an underground network, but complications arose. Seeking post-abortion care at a public hospital, Ash was met with humiliation, delays, and dehumanisation. Laughter, whispers, and refusal of dignified treatment forced Ash to leave untreated, feeling unsafe and fearful of seeking medical help again.

Barriers

- Unavailability of queer- and trans-affirmative health services
- Restrictive laws criminalising or limiting access to abortion and gender diversity
- Healthcare systems not designed to be queer-affirmative (curricula, infrastructure, admission systems)
- Lack of trained and gender-sensitive providers
- Violence and heightened vulnerability to sexual violence faced by queer and trans people

Opportunities

- Access to supportive networks of healthcare providers, even in restrictive contexts
- Strengthening and capacitating healthcare providers on gender inclusion through trainings, revised curricula, and value clarification and attitude transformation (VCAT) sessions
- Building advocacy momentum to push for systemic change in policies and practices

Key message / policy ask

Ensure inclusive, non-discriminatory, non-violent, confidential, equitable, and reliable health services for all.

This requires multi-sectoral advocacy, including:

- Curriculums and mandatory trainings on gender sensitivity
- Creation of safe spaces for queer and trans persons
- Legal redress mechanisms to ensure accountability and protection

Policy asks (consolidated)

- **Legalise abortion and ensure services are accessible, affordable, and included in health coverage for all.**
- **Decriminalise sex work and recognise sex work as work, protecting sex workers' human rights.**
- **Integrate non-judgmental and confidential safe abortion services in all humanitarian settings and emergency responses.**
- **Reproductive justice can only be achieved if every person, in all their diversities, is heard and seen.**
- **Safe abortion for all (avortement sécurisé pour tous) – regardless of HIV status or any other identity.**
- **Improve access to community-based, sensitive SRHR services –including post-abortion care –in local languages.**
- **Make abortion services safe, accessible, affordable, of quality, and client-centred.**
- **Ensure inclusive, non-discriminatory, non-violent, confidential, equitable, and reliable health services for all.**

This requires multi-sectoral advocacy, including:

- **Curriculums and mandatory trainings on gender sensitivity**
- **Creation of safe spaces for queer and trans persons**
- **Legal redress mechanisms to ensure accountability and protection**

Closing

This session closed with a powerful reminder that our bodies are both political and sacred, and that the lived realities shared are not mere footnotes but central to the struggle for justice. Participants were urged to carry forward the reflections, key messages, and policy asks into their communities, ensuring that advocacy is inclusive of all diversities and rooted in real experiences. The call for safe abortion for all resonated as a unifying demand, emphasising that the movement must continue to resist exclusion, reimagine possibilities, and build pathways toward reproductive justice both within the room and beyond.

Co-creating a policy canvas

Methodology

To conclude the session, participants were invited to co-create a collective canvas of key messages and policy asks on safe abortion. Each person wrote their commitments or reflections on sticky notes, which were then placed together on a shared board. The canvas symbolises a collective vision for reproductive justice and will be preserved and framed at the ARROW office as a reminder of the commitments made at the SAIGE Convention 2025.

Toujours engagé pour "Safe abortion for all."

Our stories challenge the hostile silence. We speak not just to survive but to change everything.
– Tasha, Uganda

Inclusive safe abortion regardless of any identity.

Every abortion should be accessible and safe.
– Hajei Naceul

Safe abortion should be the rule, not an exception.

Rights-based, quality abortion services for all.
– Samia

Safe abortion is fundamentally a healthcare service and a critical part of bodily autonomy. Compassion, empathy, and understanding must guide our approach–for individuals navigating difficult decisions and for healthcare providers to ensure these choices are handled with care and dignity.
– Rasylta

Health care centres available in rural areas with non-discrimination and accessibility for all.
– MAP

Decriminalise abortion!

Comprehensive abortion services for all.

Safe abortion is life.

Complete decriminalisation

Reproductive justice includes disability justice.
– Lilian Kilele

Informed service providers who can give stigma-free abortion services.
– Christine, Inroads

Decriminalise abortion and address all structural barriers to make safe abortion inclusive and accessible for all.
– Pushpa Joshi

Ensure access to safe abortion means social, psychological, and health well-being of an individual.
– Samia Gull, Pakistan

Abortion is our focus for achieving organisational goals.
– Healthcare professionals

Religion should not be used to deny people's human rights ❤

Free and accessible safe abortion.
– Tamtang

Respect, dignity, privacy.

Safe abortion is fundamentally a healthcare service and a critical part of bodily autonomy. Compassion, empathy, and understanding must guide our approach–for individuals navigating difficult decisions and for healthcare providers to ensure these choices are handled with care and dignity.
– Rasylta

A proper budget allocation for awareness and legal and safe abortion services.
– Pritam

Everyone should be able to decide about their own bodies without moral or state control, and have access to all services about their bodies without any barriers.
– Mihitha, Sri Lanka

Safe abortion for all. Safe abortion is health services and should be client-centred.
– Nanda

Access to safe and affordable abortion services with empathetic healthcare service providers.

Increased access to safe and legal abortion services.

The right to safe abortion is integral to women's bodily rights.
– Khawa Mumtaz

Nothing about us without us!

Right to choose is a human right.
– Uda

Wrap up

Day 1 of the SAIGE Convention was concluded by recalling the experiences and learnings of the day. The morning panel highlighted how movements in Kenya, Argentina, and elsewhere had advanced safe abortion rights, and how young people with excluded identities were taking leadership roles, while stressing the need to decriminalise abortion, counter anti-rights narratives, and centre the voices of those most marginalised.

Participants engaged deeply in building an "abortion roadmap," identifying empathy, curiosity, and care as essential qualities for the movement while also acknowledging the persistent challenges of stigma, economic constraints, and discriminatory health provider attitudes. Despite these obstacles, all groups shared the same dream – a future where safe abortion is accessible without fear, discrimination, or stigma.

The afternoon brought forward stories of trans people, adolescents, persons with disabilities, Dalit women, refugees, sex workers, and people living with HIV. These narratives made visible how intersecting marginalisations shape access to safe abortion, and the group work that followed translated these lived realities into clear barriers, opportunities, and policy asks. The collective exercise was a reminder of how rich and powerful collective discussions can be, and how they create shared strategies rooted in real experiences.

Dr. Raphael added: *"This workshop brought together a diversity of actors from different contexts. We have learnt so much from the richness of each country's experiences, and this strengthens our commitment to continue the struggle. We are reassured that this is not the fight of one country alone, but a global struggle for the advancement of women's rights."*

The strength of the movement lies in shared reflection and collective vision.

Beyond the Rhetoric of Stigma and Opposition: What could be our way forward?

Methodology

Facilitators presented five scenarios reflecting common opposition strategies and asked participants to decide – using Menti meter – whether they would observe, push back, or engage. Participants were then divided into seven groups according to spheres of influence, including religion, media, judiciary, healthcare, family and community, education, and law and policy. Each group identified three anti-choice narratives relevant to their contexts and discussed how best to respond, before rotating in a gallery walk to reflect on each other's work. Finally, groups returned to synthesise insights and propose region-specific as well as transnational strategies for engagement.

Why this session

"Inroads is a global network which is working to end abortion stigma and discrimination. At Inroads, we do a lot of work to ensure that we achieve the end of stigma. In recent years, we have seen a shift in the global landscape of how reproductive rights and the autonomy of our bodies has been affected. We've seen a lot of increase on the right-wing government, which is having a lot of ripple effect in terms of funding to our organisation, in terms of global gag rule, in terms of narrative changes and having more tradition-aligned values. So, when these ideologies are on the increase, it leads to increase of abortion stigma, because it's then compounded into the person. The voices around us are overwhelming, such that we are not able to work and keep pushing for abortion justice.

The internal biases and societal stigma work towards increase of abortion stigma, and that makes it hard for us to continue our work or rather makes our work more challenging, because we have to continue our work. We have also seen is a shift in funding for our organisations to do this work. We've seen donors who have been faithfully funding us for a while, some of them stepping back and saying they are reviewing their strategy. So that is an impact which is showing up because of the increased opposition.

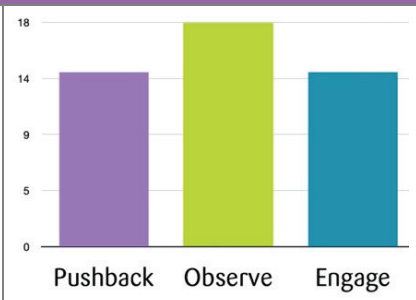
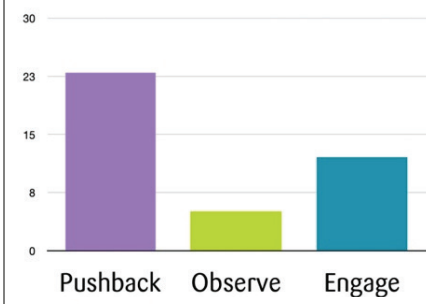
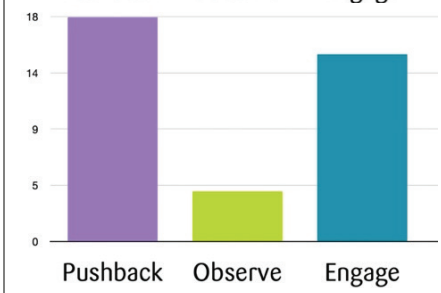
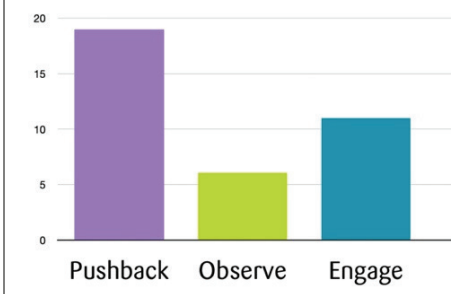
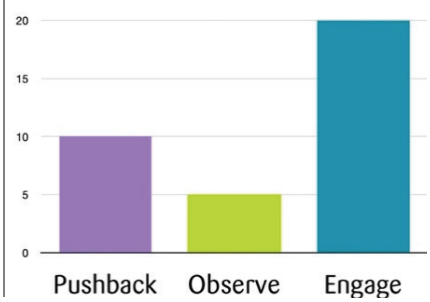
Another impact of stigma we have seen is our service providers and the advocates being targeted. We have dispensaries being ambushed. We have our advocates being arrested. We are here together because we still know that the work we are doing is very important, to our organisations and to our communities."
–Christine

"Clearly it is a tipping point. What we are seeing is a global pushback against reproductive rights and reproductive autonomy, and this has been exacerbated and worsened by conservative ideologies and fundamentalism. Yesterday, we talked about how some of us across the Global South, across different countries, have achieved milestones in the journey of achieving reproductive justice. But there has also been an emergence of a very well-coordinated, well-funded anti-rights movement. This anti-rights movement is not simply going out against a single point agenda of advocating against abortion rights, but a whole spectrum of civil rights, including sexual and reproductive rights, diverse gender identities and sexual orientations, and mostly the right to choose.

In India, we tried to do a study that looked into how some of these narratives are emerging and what we found out was that those narratives were not just concentrated in India, but were reflected across the Global South.

The very reason to do this exercise here is to leverage the collective intelligence that we have and see what kind of narratives are emerging in the different domains that we work on, and how we can co-ideate, co-strategize, and move forward to safeguard reproductive rights in these turbulent times."
–Ragini

Collective responses: Pushback, observe, or engage?

Case scenario	*Menti meter result*
Lexi is a minister in your country who has a prominent influence and has won the election with a majority of votes consistently for 3 terms. She has been vocal about labour and women's rights issues. Recently, she demanded that the women in her constituency are encouraged to have more children so that there is more representation from her constituency, and demanded more stringent action for those who seek abortion.	
A private company owns several private hospitals in your state. Their CEO is also a board member of a prominent 'pro-life' organisation. Recently, in their annual celebration, they decided to award the best performing hospitals, and one of the criteria is the lowest number of cases registered for abortion/ post-abortion care.	
Shal is a bright young adolescent studying in Rainbow School. Shal secretly underwent an abortion three months back. They tried to bury all loopholes, considering the consequences for them and their family. However, the rumours caught on. The principal didn't report to the police, but suspended Shal from school.	
A new mainstream movie is set to release in your town. The story is a coming-of-age story of a girl who wishes to be a successful drummer.The story has a subplot of the main character navigating a teenage pregnancy and sets out giving a foetus-centric narrative, criticising those who seek abortion, and giving misinformation on the procedure, instilling fear around the subject. The movie is praised for its moving female-driven plot, and is even considered 'feminist' for showing the challenges of navigating ambition, having intersecting identities of race/caste and gender.	
Rukhsa is a 32-year-old woman who visits a well-known private hospital for a second-trimester abortion. She meets Dr. A, the only senior gynaecologist on duty. After reviewing her documents, Dr. Arvind firmly tells her, "I'm sorry, I don't perform abortions. It goes against my personal beliefs. I believe every life is sacred, even unborn ones. You'll have to go elsewhere." Despite Rukhsa's repeated requests and explanation of her situation, Dr. A refuses to provide the service or refer her to another doctor. The delay puts her at risk of crossing the legal gestation limit.	

Collective reflections

Effective responses to anti-rights scenarios require a calibrated approach that aligns with human rights standards, the principle of do no harm, and strategic advocacy objectives. Participants distinguished between the three response modes – observe, engage, and push back – and applied them with reference to proportionality, necessity, and risk to individuals. Selection of a mode turned on clarity of facts and intent; immediacy and severity of harm; availability of less intrusive means to secure redress; and the presence of duties owed by state and private actors, including the duty of care, non-discrimination, and the standard of health services.

What led to OBSERVE

Observation emerged from the exercise as a deliberate and protective first step rather than passivity. Participants treated it as structured due diligence where facts, intent, or legal authority were unclear. In this mode, they sought to establish a factual record, map actors and allies, and assess timing before intervening. This approach reflects both the proportionality principle and the duty to do no harm, especially where disclosure or premature escalation could endanger individuals. Observation also functions as an evidentiary foundation for later engagement or remedial action, enabling advocacy that is precise, proportionate and targeted.

Highlights

- **Need for intel before action –** 'Observe first' applies when facts are murky or stakes unclear–e.g., a minister with a mixed record on women's rights. The first step is to map intent, allies, and timing before moving.
- **Risk calibration –** Observation serves as a first move even for eventual counter-narratives: monitor, collect evidence, then act with precision rather than emotion.
- **Protecting individuals –** If immediate pushback might out or endanger a person (e.g., a student facing rumor-based sanctions), observation allows brief assessment of harm pathways and safer options.

What led to ENGAGE

Engagement was identified as the appropriate response where actors were not absolutely adversarial or where they exercised gatekeeping power over services, referral pathways, or public narratives. Participants saw it as a means to secure immediate remedies and shift policy or practice through dialogue grounded in evidence, ethics, and applicable standards of care. This mode prioritises timely harm-reduction. Engagement also allows advocates to de-couple conflated issues and to challenge misinformation while maintaining open channels for influencing future behaviour.

Highlights

- **Convertible actors –** When the 'opposition' is not absolute–e.g., anti–sex-selective-abortion groups in India, or a powerful minister open to women's rights–dialogue allows nuance to be unpacked, evidence shared, and narratives reframed.
- **Gatekeepers that must be reached –** With private hospital chains or a conscientious-objector clinician,

engagement secures referral, shifts internal metrics (such as awards rewarding 'low abortions'), or negotiates immediate care.

- **Public narratives with 'feminist' veneers –** For hit films promoting foetus-centric myths while claiming to "protect women," engagement with creators is seen as valuable for shaping future projects, alongside public critique.

What led to PUSH BACK

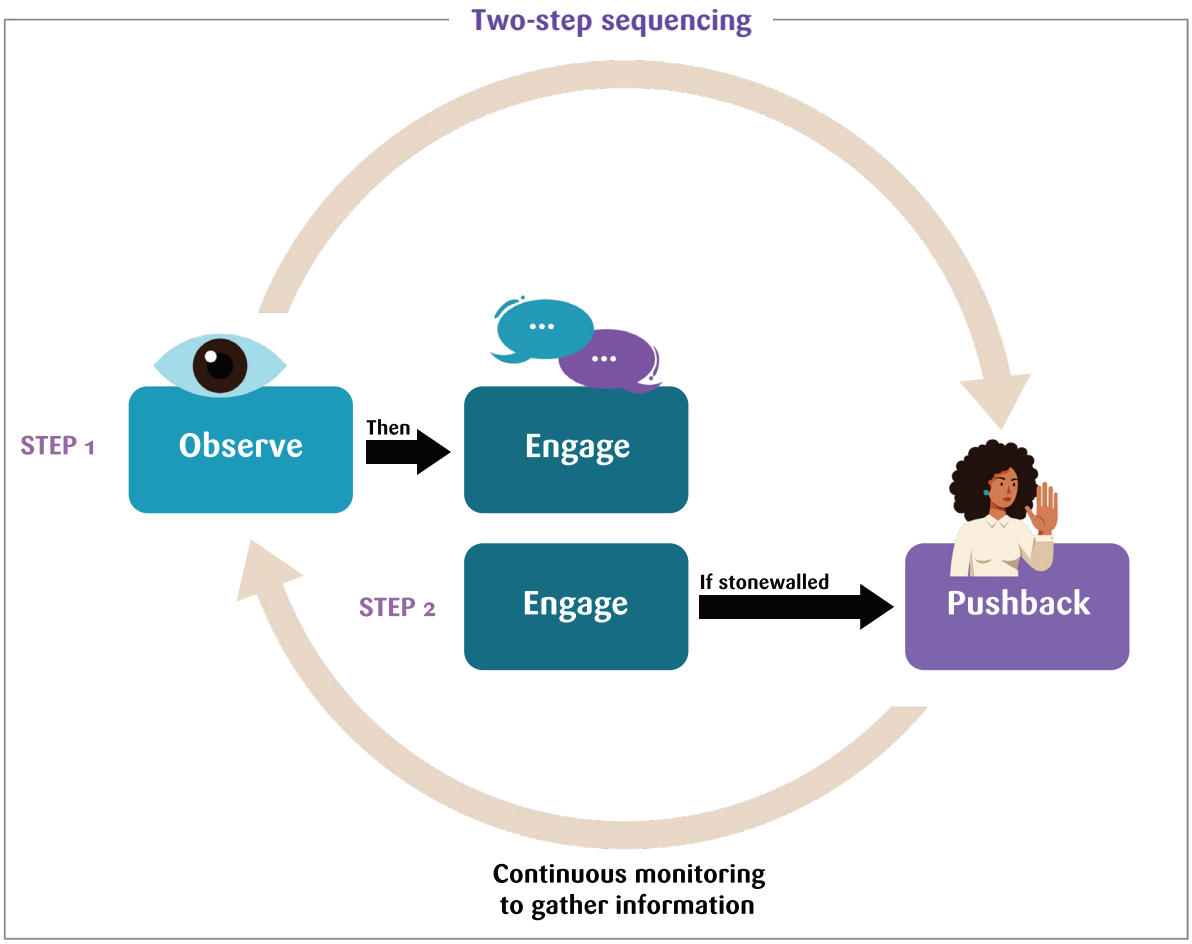
Pushback was reserved for clear rights violations, high-impact misinformation, or refusals that create immediate or irreparable harm. Participants stressed that in such cases visible counter-action is necessary to protect individuals, ensure that human rights standards are implemented, and to deter future breaches. Where conscientious objection is invoked without referral, or where public authorities misuse power, pushback is both ethically required and strategically necessary. Timing is critical: if delay itself causes harm or normalises a violation, immediate and public counteraction is needed.

Highlights

- **High-impact harms and power misuse –** Clear rights-violating actions require immediate pushback–e.g., a minister promoting pronatalism, or a school suspending a student on rumours that infringe rights to education, privacy, and due process.
- **Medical misinformation by authority figures –** When doctors spread myths (such as cancer or infertility claims), open counters with evidence and professional standards are essential.
- **Conscientious objection without referral –** When refusal jeopardises legal limits or safety, pushback is an ethical and legal necessity, anchored in duty to treat or refer and prioritising the patient first.

Strategies identified

- **Two-step sequencing –** Observe, then engage; engage, then push back if stonewalled–balancing speed with safety.



- **Rapid communications –** Press releases and public statements counter ministerial pronatalism (e.g., Tunisia example).
- **Ally activation –** Feminist support networks (Argentina), convertible stakeholders in health systems, and multisector coalitions expand reach.
- **Rights framing –** Responses are anchored in rights (health, privacy, education), professional ethics (duty to refer), and existing law/policy.
- **Narrative correction –** Fact sheets, op-eds, and social content rebut misinformation and expose 'we protect women' co-optation with survivor- and evidence-led messaging.
- **System levers –** Perverse incentives (awards for 'fewest abortions') are challenged, referral protocols lobbied for, and provider training expanded (e.g., VCAT).

Contextual challenges shaping choices

- **Profit logics in private care –** Engagement framed around profitability risks backfiring if hospitals prioritise higher-margin services (e.g., IVF) over abortion.
- **Safety and visibility risks –** Marginalised groups (adolescents, queer/trans, migrants) face retaliation; strategies must minimise outing and secondary harms.
- **Religious and cultural frames –** In many settings, religion or 'morality/African values' shape policy and judicial attitudes, making engagement with faith actors and carefully chosen messengers crucial.
- **Time sensitivity –** Legal gestational limits and urgent clinical needs often dictate "engage now/push back next" sequencing to safeguard care.

Observe/engage/push back are not fixed camps but a situational ladder: start with information-gathering when risk or intent is unclear, engage where dialogue can unlock access or shift narratives, and push back fast and visibly when rights, safety, or public misinformation demand it.

Collective strategising on emerging narratives

In groups, the participants identified three emerging anti-choice narratives relevant to the sphere of influence they focused on – namely, religious institutions, media, justice system, healthcare system, families and communities, schools and education system, lawmakers and policy makers – and discussed how best to respond to these narratives.

Religious institutions

Emerging anti-choice narratives

1. Life begins at conception
2. Abortion is a sin
3. Abortion destroys families

Overall strategy (observe, engage, pushback)

Strategies differ by context– In Pakistan and Cambodia: engage. In Uganda: engage. In Argentina: pushback. In Sri Lanka: pushback.

Case example: In Pakistan, religious leaders hold more power than the Senate, creating extreme risks for activists and women. In July 2025, a woman was killed in an 'honour' killing after marrying by choice. Public protest is unsafe; advocacy must be discreet.

Specific strategies

Engage
- Build partnerships and long-term relationships
- Involve broader stakeholders such as policymakers and parliamentarians
- Use religious values to highlight lived realities, e.g. rape and harm reduction

Pushback
- Reframe abortion as a political issue, not within religious ambit
- Counter myths and misconceptions from religious institutions
- Promote separation of religion and state through legal and policy change (Sri Lanka, Lebanon examples)

Cross-cutting strategies
- Use local languages and social media to amplify supportive religious voices
- Identify and collaborate with religious leaders who align with rights-based values
- Share personal stories of people of faith who have had abortions
- Host interfaith dialogues centring compassion and lived realities
- Draw on scripture or spiritual teachings that emphasise care, health, and justice
- Use context-specific interpretations, e.g. The interpretation based on the Quran that life is considered to begin at 100 days or three months can be used in certain contexts such as in Lebanon

Best practices referenced
- Women of Faith in Action (Uganda)
- Soulforce
- Interfaith dialogues and scripture-based reframing

Media

Emerging narratives

1. Fetus-centric imagery dominates abortion coverage (e.g. big belly photos, surgical tools, visual framing of abortion as murder).
2. Abortion is portrayed as the outcome of carelessness, cheating, or immorality.
3. Abortion is framed as sin or murder.

Overall strategy (observe, engage, pushback)

The dominant approach identified was engagement, though responses vary by context and by narrative. For fetus-centric imagery, engagement is emphasised. For morality-based portrayals, some favour engagement while others do not. For sin/murder framings, the approach is mixed.

Specific strategies

- Values clarification and attitude transformation: Conduct sensitisation workshops with journalists, media students, and influencers to shift attitudes and highlight the real-life impact of stigmatising

narratives.
- Debunk misinformation/disinformation: Use social media and organisational channels to correct false claims and counter abortion-related stigma.
- Media allyship: Build long-term relationships with journalists and influencers, ensuring regular engagement.
- Provide resources and evidence: Supply media actors with toolkits, data, and evidence-based content to support accurate reporting.
- Counter negative articles: Respond to harmful media outputs with counter-articles, op-eds, letters, or direct engagement.
- Promote positive coverage: Organise competitions or awards for high-quality, progressive abortion reporting.

Justice system

Emerging narratives

1. Narrow interpretation of the law linked to family values.
2. Laws based on religion.
3. Emphasis on protecting morality and national values.

Overall strategy (observe, engage, pushback)

Narrow interpretations connected to family values were seen as contexts for observation or engagement.

Religious-based laws and morality/national values framings require pushback or engagement, with pushback prioritised where judicial rulings have wide and lasting impact.

Specific strategies

- Integrate SRHR into legal education: Introduce CSE and SRHR modules into the law school curriculum to ensure future lawyers and judges are equipped with rights-based knowledge.
- Judicial advocacy: Organise advocacy and learning meetings with judges, judicial associations, and bar councils to build awareness of reproductive rights and feminist perspectives in legal interpretation.
- Ally and champion cultivation: Identify and work with champions within the judiciary, as well as supportive religious and cultural leaders, to promote progressive interpretations of law.
- Engagement with religious leaders: Where feasible, collaborate with religious leaders open to dialogue, beginning with consensus-building on sensitive areas such as abortion in cases of rape, then expanding the conversation.

Healthcare system

Emerging narratives

1. Forced motherhood – health providers discouraging abortion and pressuring patients to give birth, often framed as moralising ('others struggle to have children').
2. Foetal viability – refusals to provide abortion after a set gestational limit (e.g., 22 weeks), framed as the foetus being 'savable'.
3. Conscientious objection and faith-based denial – providers refusing services on religious grounds, sometimes selectively (e.g., on fasting days), creating arbitrary barriers to care.

Overall strategy (observe, engage, pushback)

- Forced motherhood: pushback.
- Foetal viability: engage or pushback depending on legal and medical context.
- Conscientious objection/faith-based denial: engage where referral pathways can be secured, pushback where refusal undermines law, ethics, or safety.

Specific strategies

- Values clarification and attitude transformation: Expand and institutionalise trainings for health providers to address personal bias and align practice with patient rights.
- Intersectional alliances: Build movements and national coalitions linking abortion rights with disability rights, sex workers' rights, and broader justice struggles.
- Curriculum reform: Integrate inclusive SRHR and rights-based care into medical, nursing, and midwifery curricula; engage with curriculum committees to ensure systemic change.
- Engage faith leaders: Collaborate with progressive religious leaders and faith-based organisations to counter moral opposition within healthcare spaces.
- Peer influence among providers: Partner with progressive doctors to influence peers and shift professional culture.
- Referral networks: Compile and publicise lists of progressive health workers to ensure timely access when denial occurs.

Families and communities

Emerging narratives

1. Abortion goes against family values and culture, framed as immoral, sinful, or against social norms.
2. Abortion leads to infertility.
3. Abortion is a Western agenda, grouped with ideas like queerness and transness as 'foreign imports'.

Overall strategy (observe, engage, pushback)

- Family: engage, recognising the close and often dependent relationships, and the risk of violence or backlash if met with outright pushback.
- Community: pushback or engage depending on who within the community is opposing abortion and how much influence they hold.

Specific strategies

- Evidence-based engagement: simplify medical information (e.g., abortion does not cause infertility), adapting explanations into clear, non-technical language.
- Context-sensitive dialogue: start by understanding the perspective of the person or group, then tailor the approach with facts, lived experiences, or values they connect with.
- Appeal to emotions: use personal stories, testimonials, and case studies to show positive experiences of safe abortion access.
- Information, education, and communication: develop materials in local languages and distribute them in community centres and family settings.
- Dialogue spaces: hold family and community dialogues, one-to-one conversations, and targeted engagements with politicians and community leaders who can influence public opinion.
- Creative advocacy: use art, media, films, and music–including community-generated songs and cultural products–to normalise safe abortion and connect emotionally with audiences.

Schools and education system

Emerging narratives

1. The Ministry of Education does not include comprehensive sexuality education (CSE) in the curriculum due to fears it will encourage premarital sex.
2. Students who seek abortion face expulsion.
3. Schools selectively decide what information to share on abortion, leaving students without access to comprehensive and accurate information.

Overall strategy (observe, engage, pushback)

- Narrative 1: Pushback, by holding governments accountable to their international and national commitments.
- Narrative 2: Engage, by working with school leaders to ensure students are informed about safe abortion.
- Narrative 3: Engage, by creating youth-friendly spaces within schools and training counsellors.

Specific strategies

- Accountability measures: hold governments to their CEDAW and other international commitments through monitoring reports and advocacy to ensure CSE is included in curricula.
- Capacity building: provide training of trainers (TOTs) for teachers on safe abortion to equip them with accurate, comprehensive knowledge.
- Youth-friendly spaces: establish health rooms and school-based youth-friendly corners with resources on SRHR and safe abortion.
- Accessible information: publish resources that are age-appropriate and available in local languages to reduce barriers for adolescents.
- Evidence generation: collect and share data to strengthen evidence-based advocacy for CSE and abortion information in schools.

Lawmakers and policy makers

Emerging narratives

1. Allowing abortion after 20 weeks would contribute to increased sex determination and sex-selective abortion.
2. Legalising abortion will increase sexual activity among adolescents.
3. Abortion is a sin.

Overall strategy (observe, engage, pushback)

- Narrative 1: engage through evidence and dialogue.
- Narrative 2: engage first, with the option to push back if engagement fails.
- Narrative 3: engage or push back depending on context.

Specific strategies

- Evidence-based advocacy: share stories, testimonies, and data to counter misinformation.
- Media engagement: use features, data journalism, and storytelling to influence broader public opinion.
- Creative advocacy: employ art forms such as films, exhibitions, theatre, and music concerts to challenge stigma and reshape narratives.
- Direct engagement: hold consultations and dialogues with lawmakers; cultivate informal relationships (e.g., casual meetings, tea/lunch sessions) to humanise perspectives and open dialogue.
- Accountability tools: prepare shadow reports to track government commitments and gaps.
- Mobilisation: organise signature campaigns with clear demands to demonstrate public support for safe abortion access.

Context specific observations

In **Sri Lanka**, a key dilemma lies in whether to continue avoiding hardline opposition groups or to directly engage them. Formations such as the nationalist Buddhist clergy and the 'mothers' movement' have become central vehicles of anti-rights and anti-gender sentiment. Their narratives are transnationally reinforced – for example by reframing Sinhala Buddhists as 'chosen people' tasked with protecting Buddhism – raising the question of whether ignoring them is still viable. At the same time, new women parliamentarians from progressive backgrounds face a coordinated backlash, particularly on social media, which risks silencing their voices unless external allies create supportive narratives and solidarity around their positions.

In **Pakistan**, religious authority continues to dominate, shaping both law and political discourse. Within such contexts, engagement becomes complex but remains essential. Women legislators gain traction only when supported by civil society networks that feed them arguments, evidence, and policy frames. Positive legislative outcomes have often depended on this external backing. The tension persists between widespread illegality of abortion and the sheer scale of unsafe procedures, making rights-based, fact-anchored advocacy critical despite accusations of being 'anti-religious' or 'westernised'.

In **India**, strategies against entrenched moral conservatism have drawn from lessons in other rights struggles. The campaign to overturn Section 377 illustrated how personal stories and individual testimonies could be politicised into powerful narratives that influenced judges and policymakers. Framing abortion similarly–as lived realities embedded in communities–was seen as a way to humanise rights claims in spaces dominated by abstract morality or tradition.

In **Tanzania and Kenya**, experimentation is underway with proactive monitoring of anti-rights movements. Rapid response teams track opposition narratives online, sometimes infiltrating groups to anticipate strategies and messaging. By gathering this intelligence early, activists aim to pre-empt disinformation with accurate, data-driven content and to convene informed stakeholders before anti-rights campaigns gain traction. Regional initiatives, such as reproductive justice litigation barazas, have been used to prepare judiciaries and legislators with rights-based arguments before anti-rights groups push family-values legislation.

What would success look like?

Methodology

Seven groups were formed around key themes: inclusive movements, funding with a resource justice lens, health systems strengthening, multi-stakeholder partnerships, linking and learning, advocacy, and research and evidence. Participants chose which group to join based on their interest. Each group discussed what success for the safe abortion movement would look like in five years and how their theme could be reimagined to advance safe abortion. Reflections were noted and later shared in plenary.

Inclusive movements and alliances for safe abortion	Multi-stakeholder partnerships at all levels	Linking and learning and capacity strengthening
What success looks like in the next five years		
- Strong cross-sectional movement alliances (queer, HIV, women's, disability) - Referral systems, sensitised service delivery, and expanded access to safe abortion through network building - Addressing the needs of rural and marginalised people - Representation of all voices - Diverse, inclusive, and intersectional movements - Intentional inclusion across all strategies - Decolonised approaches that define outreach and meet people where they are, rooted in transformative justice - Tackling social discrimination and advancing social decriminalisation (e.g., rights movement + medical system) - Use of evidence to strengthen advocacy - Platforms that are explicitly pro-abortion (e.g., alternatives to Google and Meta) - Alliances with unusual suspects, neutral parties, or those who can be swayed - Integration into broader spaces such as universal healthcare and rights frameworks - Linkages with disability movements, and discussion of eugenics and fetal abnormalities to build complex alliances - Building global alliances in response to backlash (e.g., Argentina, CSW anti-feminist positioning, universal rights under attack)	- Partnerships with tech companies - Engagement with elected representatives - Involvement of institutions such as schools and colleges - Support from donors and youth clubs - Active pressure groups advocating for safe abortion - Reduced opposition to safe abortion - Solid networks of key stakeholders - Improved access to safe abortion - Government allocation and budget for safe abortion care	- Amendment of laws that criminalise abortion - Reduced deaths due to unsafe abortions, reduced unwanted pregnancies, reduced teenage pregnancies - Fully accessible post-abortion care - Strengthened health systems and providers with accurate information - Increased access to abortion services - More feminist organisations openly talking about abortion - Accessible and accurate information on safe medical abortion - Greater capacity to build discourse beyond usual topics and boundaries
How to reimagine movements and alliances	**Partnerships to leverage for advancing the safe abortion agenda**	**How linking, learning, and capacity strengthening can advance safe abortion services**
- Centre queer people in the discourse (e.g., trans men whose identities are erased in anti-gender movements) - Examine and address exclusion within existing movements - Prioritise self-care as part of activism - Include healthcare providers as allies within the movement - Forge connections with wider human rights, climate, labour, and digital rights movements (e.g., freedom to receive information, freedom of expression) - Contribute to broader decriminalisation efforts (e.g., Argentina) - Open forums in universities for wider community participation, led by teachers as activists alongside women, LGBTQ+, and Indigenous activists - Build alliances with unions and student groups - Be intentional about inclusion in all spaces - Explore strategic alliances with opposition where possible - Leverage community resources to sustain advocacy - Integrate abortion into every activity rather than siloing it - If we reimagine, the movement will have unlimited resources!!	- Civil society to build and sustain the movement - Media, including digital platforms, to spread pro-choice language - Women's rights activists and CSOs - Healthcare professionals to facilitate access - Judiciary to advance supportive legal interpretation - Donors to ensure sustainable funding	- Documenting progress and good practices - Benchmarking through lessons from both mistakes and successes - Progressive countries mentoring restrictive ones (involving feminist organisations and government officials) - Engaging legislators, e.g., female parliamentarians, as allies

Funding with resource justice	Health systems strengthening	Advocacy	Research and evidence
What success looks like in the next five years			
- Locally resourced and equitably distributed funding, with an increased healthcare budget - Decriminalisation of abortion leading to reduced unsafe abortion and greater allocation of funds for safe pre- and post-abortion care - Removal of barriers to receiving funding from foreign funders - Greater demands on governments to fund and allocate resources for services provided by NGOs	- More trained providers delivering safe, non-judgmental, quality, stigma-free services - More accessible facilities providing safe abortion services (expansion and functionalisation) - Safe abortion commodities available at all approved facilities - Complete and robust data recording and reporting -	- Stigma-free, accessible services inclusive of all - A solid collective movement for safe abortion - More young, progressive advocates for safe abortion - Abortion openly discussed in public discourse - Citizens aware of their abortion rights - Implementation of laws supporting safe abortion services - Free post-abortion care widely known and stigma-free - Advocacy spaces to leverage amid shrinking funding and multilateral arenas	- High-quality research that overcomes constraints on quantitative data - Evidence generated on unsafe abortion (especially in restrictive settings) - Policymakers and legislators engaged to use evidence effectively - Improved quality of safe abortion services for all - Data advocacy integrated into broader strategies
How to link safe abortion to resource justice principles and make sustainable use of funds	**How to re-strategise to enable safe abortion action at scale**	**Identify common ground/entry points to advocate for safe abortion**	**Research approaches and methodologies**
- Position safe abortion as an integral part of comprehensive SRHR and maternal health services - Engage with the private sector to ensure provision of ethical safe abortion services - Strategise around crowdfunding and corporate social responsibility (CSR) initiatives - Secure funding dedicated to advocacy and communication efforts -	- Task shifting and task sharing with frontline workers, female community health volunteers (FCHVs), and pharmacies by ensuring access to accurate information and skills	- Explore advocacy spaces at regional levels - Build collective movements - Work with religious leaders to influence public discourse - Generate stronger evidence for advocacy - Run public campaigns to raise awareness - Provide and disseminate digital advocacy materials - Offer technical assistance for relevant government bodies (e.g., Ministry of Health) - Engage private sector and philanthropy for funding - Create linking and learning spaces for advocacy and campaign collaboration - Develop repositories of language, evidence generation guides, and security/intelligence-sharing practices - Use technology to address gender-based violence - Link with global initiatives such as September 28 campaigns	- Reinforce the value of qualitative data - Adopt community-centric, participatory, inclusive, and intersectional approaches - Strengthen collaborative research models

Context specific strategies

Indonesia

Religious legitimacy is a key lever: progressive Islamic women scholars issued fatwas in 2022, including permitting abortion to save a woman's life and addressing GBV; these are now used with religious constituencies and government as advocacy tools. Success over five years may look like the current (narrow) law implemented non-discriminatorily.

Strategies that have worked/are being tried:

- Leverage fatwas to open doors with clerics and officials
- Technical assistance to the Ministry/District Health Offices for continuous provider training
- Use GBV/sexual-violence framing as the public entry point
- Early outreach to CSR/philanthropy spaces (still nascent)

Challenges: narrow legal exceptions (medical emergency, rape/sexual violence with a 14-week limit); OB-GYN resistance to self-managed abortion; prevailing religious influence on policy and service attitudes.

Benin

Legal framework is comparatively progressive and open to safe abortion. Success in five years will be a sharp reduction of stigma and removal of conscientious objection (CO) that blocks access; at the same time shrinking opposition 'pockets' will be a success.

Strategies that have worked/are being tried:

- Advocacy to eliminate CO in service delivery

Challenges: CO widely used by providers; inclusive legal reform still needed in other countries across the region.

Sri Lanka

Law allows abortion only to save the woman's life; misoprostol is tightly controlled in government hospitals but widely (and expensively) available on the black market; wealthier people travel abroad while poorer people are forced to continue pregnancies or resort to unsafe methods. A left-leaning government and some progressive MPs create a narrow reform window (rape/ incest/ fetal anomalies), while professional colleges push only for cases of fatal fetal anomaly without engaging feminist groups.

Strategies that have worked/are being tried:

- Targeted push for limited legal exceptions as a first step

Challenges: no funding for abortion work; highly medicalised, provider-led reform agenda; conservative social/religious norms; unequal access and ongoing unsafe practices.

Cambodia

Abortion is legal to 12 weeks (conditional thereafter), but stigma and taboo keep people from knowing it's legal or where to get care. Five-year success would be widespread public awareness of legality and service points, and normalised discussion.

Strategies that have worked/are being tried:

- Public information and normalisation efforts about legality and service pathways

Challenges: pervasive stigma; low legal literacy on abortion.

Philippines

The constitution equates the life of the unborn with the pregnant person, producing a highly restrictive environment. Decriminalisation is the medium-term aim but seen as unlikely within five years; success will be a vibrant, multi-sector movement with champions (health workers, legislators, youth) across the system.

Strategies that have worked/are being tried:

- Movement-building and cultivating champions in multiple sectors

Challenges: extreme stigma; corporate/CSR reluctance to be associated even with post-abortion care.

Pakistan

Law hinges on the pregnant person's health; major legal change is not expected soon. Near-term success would look like more public discourse and critical engagement with abortion; youth involvement and awareness first, then advocacy.

Strategies that have worked/are being tried:

- Community theatre with young couples on contraception and bodily autonomy (awareness first, advocacy later)
- Partnerships with existing clinic networks (e.g., social-marketing clinics) to connect communities to services
- Push for flexible, youth-led funding models; cultivate local funding (CSR) by framing under "health" rather than "rights"

Challenges: rigid donor models and over-reliance on international funds; religious vetting of laws; need for careful language to avoid backlash.

Nepal

Policy environment described as 'progressive' (access reportedly up to 28 weeks) with many designated sites–yet rural facilities often lack trained staff; provider values impede care for young/unmarried people. Five-year success will be providers acting as advocates, more youth leadership, and eventual decriminalisation.

Strategies that have worked/are being tried:

- Expand and standardise provider training; values clarification to reduce bias
- Create national/regional learning spaces among CSOs; collaborate to mobilise resources

Challenges: staffing and skills gaps at certified sites; judgmental attitudes toward youth/unmarried clients; limited youth presence in policy rooms.

Final remarks

The concluding discussion highlighted concrete needs from SAIGE and reinforced the value of the network as a collective platform. Members called for stronger coordination, structured connections, and curated knowledge exchange. Many emphasised the importance of organising members not only by geography but also by role and area of expertise–service provision, legal advocacy, research, youth mobilisation, and digital rights–and establishing thematic working groups on resources and fundraising, security and intelligence, advocacy spaces, and language and narratives.

'We run a platform that provides abortion information, and people are finding us online. We need to know who in this network is actually providing services so that we can connect seekers to real options. What we can contribute is on the digital rights side, because physical spaces are shrinking and so are digital ones–there is more surveillance, more repressive platform policies, and governments censor sites. Linking the abortion access community with digital rights defenders is crucial, especially because many of us still live under colonial-era laws that police our bodies, sexuality, and reproductive choices. In such contexts, a free and open digital space is not just important; it may be the only space where we can access the information we need to make informed decisions about our lives', explained Sangeetha.

The need for knowledge sharing was raised on two levels. First, members sought timely intelligence to anticipate and respond to anti-rights strategies. Gordon stressed: *"If you take on the opposition, they will strategise to neutralise you. They name and shame; they gag institutions; they litigate. We need SAIGE to facilitate intelligence sharing across the network, and we need training and capacity building on security, because this is not abstract–it is targeted."* Second, participants called for a longer-term repository of tools, success stories, and shared language. Members agreed that the SAIGE website should serve as a discreet yet comprehensive hub for resources, translations, and member contributions, without seeking high visibility through search algorithms.

Resourcing was another priority. While recognising that SAIGE cannot directly provide grants, members proposed a Resources Working Group to explore alternative models–including local giving, mutual aid, and CSR–while also exchanging funding opportunities and strengthening proposal development. 'We all say funding is shrinking, but there is still money in the world. What we need is flexible, locally rooted funding models–and a space to pool proposals so smaller organisations can actually access opportunities', a participant added.

Members further requested that SAIGE strengthen its role in signalling key advocacy moments, particularly in multilateral and professional spaces, with sufficient lead time for preparation and fundraising. The upcoming 28 September International Safe Abortion Day was highlighted as an anchor point. Muriel outlined the approach: *"On 12–13 August we will hold global dialogues to set the theme and the call to action. Last year's theme–abortion solidarity–reached 12.2 million people across platforms. This year, campaign materials will again be provided for adaptation, translation, and local dissemination, so that messages are rooted in each*

context. Sharing back what you create will help us all to go further together."

'These exchanges are already a movement–diverse expertise, practical innovations. If we continue to share what works and protect one another in the process, we will have the confidence to take bigger risks in the places that matter most', one of the participants remarked.

The meeting concluded with a strong sense of appreciation for SAIGE's convening power and the collective expertise in the room. Several participants requested that SAIGE expand membership across the Global South, with members volunteering to help vet new applicants to ensure that the space remains safe and secure. *'While ARROW anchors SAIGE, the collective expertise lies with all of you'*, recalled the organizing team.

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