Training booklet for providers

A GENDER TRANSFORMATIVE APPROACH TO SAFE ABORTION

A gender transformative approach to safe abortion - a training booklet for providers

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This booklet is inspired by the toolkit on gender transformative approaches to Sexual and Reproductive Health and Rights (SRHR) that was developed by Rutgers and partners in Africa and Asia. As the focus is on safe abortion care and services, this booklet is based especially on module 3 of the toolkit, which focuses on a gender transformative approach to youth-friendly SRH services. The exercises and examples in this booklet have been adapted as much as possible to safe abortion services in the Kenyan context.

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Disclaimer:
Names used in the exercises and handouts of this booklet are fictional; any resemblance to actual persons or actual events is purely coincidental.

Introduction

"GTA training is a must have for all SRH service providers. It helps us provide safe abortion services efficiently, while taking into account the rights of our clients. I gained a lot of insights during the trainings. For example, we don't talk about men, yet, they are the main culprits making girls pregnant. Because of the unequal power relations within relationships, men often decide whether the pregnancy will be carried to term or aborted, against the wishes of the woman or girl. This has to change. The decision-making power and rights of women with regard to safe abortion has to be on the lead.
Another important aspect we learnt was gender and sexual diversity. Before, we never took into account other genders besides the mainstream genders - male and female. Now that we learnt about this diversity, we feel it is important to provide services without discrimination. The GTA training has strengthened our resolve to uphold the rights of clients in safe abortion provision in Kenya."

Daluma Warombo, CEO of Sau Health Services, Likoni-Mombasa
RHNK member

Worldwide there is increasing attention for gender equality issues and momentum to stand up for sexual and reproductive health and rights of all people. Abortion is health care and access to safe abortion is a human right. In Kenya, as elsewhere in the world, access to abortion is often a challenge, as both people with an unintended pregnancy as well as abortion service providers are faced with stigma, taboo, unequal power relations, and harmful gender norms. Such gender inequality is based on social norms, often with underlying discriminatory values and stereotypes. Addressing this is important, yet not easy. This training booklet "A gender transformative approach to safe abortion" is intended to support health care providers, in particular abortion service providers, to strengthen their service provision by applying a Gender Transformative Approach (GTA). We developed this booklet with a focus on the Kenyan context, referring to situations and names from Kenya as much as possible, but the approaches and insights can be applied and/or adapted to other country contexts too.

By the end of the training that is outlined in this booklet, abortion service providers will:

- Feel positive and encouraged to promote abortion rights as human rights for all;
- Be aware of harmful gender norms and related power imbalances that negatively impact access to safe abortion;
- Be equipped to reduce provider bias in safe abortion service provision.

What is a gender transformative approach?

A Gender Transformative Approach, or GTA for short, is a type of gender lens that can be applied to any kind of work. It is particularly relevant to sexual and reproductive health and rights (SRHR) as gender and sexuality are closely connected. The goal of a GTA is to reduce gender bias and their underlying unequal power relations. It ultimately aims to transform negative gender norms and power imbalances into positive norms and equity, that is where the "transformative" comes from.

Gender transformation is different from gender sensitive approaches: gender sensitive approaches recognize gender inequalities, whereas gender transformative approaches work to actively understand the root causes of gender inequalities, such as underlying gender norms and power dynamics, and to create interventions and activities that work to address inequality at its root.

Because of a variety of contexts, specific objectives and people who are involved, it is impossible to speak of only one gender transformative approach; GTAs differ in their strategies and implementation.

Why a gender transformative approach to safe abortion?

This booklet is intended for health care providers, and in particular for abortion service providers. When we write "abortion" we are referring to all information, care, counselling, services, products and outreach provided by trained health providers, related to all aspects of safe abortion, including Comprehensive Abortion Care (CAC), Post Abortion Care (PAC), and abortion self-care. A GTA is important for access to safe abortion for three reasons.

Firstly, bias and prejudice from providers towards women or lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI) people with an unintended pregnancy (and their partner) causing them to fear going to a health clinic, or maybe not even going at all. Bias and prejudice have disastrous effects for those needing and seeking help in getting a safe abortion, in particular since abortion care is so time sensitive. This applies to clinic/facility settings, but increasingly in abortion self-care too, as provider prejudice against abortion self-care through medical abortion is high, and abortion service providers may be uncertain about their role in guiding and supporting a client along their abortion self-care journey.

Secondly, rejecting a person because of their gender identity or expression takes away a person's power to decide over their own body and future. This, again, has a serious impact on a person's right to reproductive health care which affects their physical and mental health.

Thirdly, harmful gender norms, prejudice and bias interferes with the provider's code of ethics to provide reproductive health services. The right to health must be enjoyed regardless of and without discrimination on grounds of a person's race, age, ethnicity or any other status. Since 1946, the WHO envisages the highest attainable standard of health as a fundamental right of every human being. Sexual and reproductive rights are human rights; this includes the right to access safe abortion care and services. In Kenya, access to safe abortion is a constitutional right, although limited as per article 26 (4) of the Kenyan constitution, and abortion is also included in the Kenyan Covid-19 Reproductive, Maternal and Neonatal Health guidelines published in April 2020 (see: Kenya Covid19 RMNH Guidelines).

In order to ensure access to safe abortion, and by extension, sexual and reproductive health and rights for all, the gender transformative approach is broken down into six principles that can be used in provision of safe abortion services:

1. Use of human rights-based approach

Everybody is a rights holder irrespective of their age, gender, race, ethnicity and sexual orientation and as such, they are entitled to opportunities that seek to advance their rights. This includes the right to life, the right to self-determination, the right to health, the right to be free from torture and equal treatment. These rights are anchored in national, regional and international frameworks, and they all apply to safe abortion and SRHR in the broader sense. According to the human rights-based approach, a service provider has the duty to uphold these rights, and to treat clients as the holders of these rights.

2. Address harmful gender norms

These refer to those rigid norms and cultural beliefs that undermine the rights of girls and women (but also LGBTIQ people – see principle 4). An example of a harmful norm is the belief that an unmarried woman who is pregnant is promiscuous and less deserving of safe abortion services than a married woman.

Another example is the rape culture that is being glorified in communities worldwide, including in Kenya, which continues to give men and boys power and a "license" to violate women and girls, using excuses regarding a woman's way of dressing or the hour at which she is walking outside. But gender norms can also be harmful for men.

For example, in Kenya, the masculinity syndrome of "being a man", where boys are expected to be physically strong, aggressive, and showing little emotion in order to maintain their image of being "tough" and where they are expected to oppress girls and women, which leaves no room for boys to show their feelings, to cry, to be physically weak, or to take up caring roles. This also translates into reproductive health issues; in Kenyan society it is the man who decides on this, including on whether or not to use contraception, and whether a pregnancy is being to be carried to term or whether and how it is being terminated. Cultural norms also give power to men as having the right to enjoy sex anytime they want, without considering the woman. Poverty also plays a role here, where a man is in a position of power and can more easily tempt a woman for money or material goods. When practiced, such norms and values can lead to violation of rights. As service providers, there is a need to always challenge those norms that undermine your work.

3. Address unequal power relations

Gender identity and expression is closely related to the power an individual hold in society. In general, men who conform to the dominant norms in a society hold the most power. But also race, ethnicity, sexual orientation, health, ability, religion, age, social status and other determinants influence the power we have to make decisions for ourselves or even others. Often those seeking safe abortion are not wielding great power, while abortion service providers may not be aware of the power they hold. Being aware of those power dynamics is a first step towards empowerment, which is further discussed in principle 5.

4. Embrace sexual and gender diversity

In our society we have individuals of different gender and sexual orientations who are entitled to rights just as everyone else. LGBTQI+ persons[1] are disproportionately affected by gender stereotypes because they often do not fit any of the traditional norms in society. Trans men can get pregnant, as well as lesbian and bi women and non-binary people. They too, have the right to access safe abortion and to be treated with respect. For service providers is it important to understand their specific needs so that every person feels safe to come to them.

[1] LGBTQI+ is the internationally agreed abbreviation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex persons, and all genders, sexual orientations and gender identities other than those listed above (hence the "+" symbol). These minority groups face specific obstacles when it comes to their rights. In this booklet, we mainly focus on Kenya, where the term "LGBTQ+" is common; the abbreviation is spelled without the "I" as Intersex people have been constitutionally recognized in Kenya since 2019.

5. Empower women and girls

When women and girls are empowered, they are better placed to make informed decisions about their life and self-advocate. As service providers, there is a need to take a proactive role of facilitating the empowerment of girls and women by enabling them to make informed decisions and support their right to self-determination.

6. Engage men and boys

Often when we talk about SRHR and gender, we talk about women. In safe abortion service provision this is no different. However, engaging men and boys is crucial; on the one hand they can play a positive and supportive role as (sexual) partner, and on the other hand, men and boys are often the main contributors of negative health outcomes that girls and women face, including unintended pregnancies. Service providers need to make deliberate efforts to engage men and boys on the important role they play in advancing the rights of girls and women, especially in accessing services and information about safe abortion and accessing safe abortion products and services.

In order to bring about real positive change through a gender transformative approach, we must work with all levels of society at the same time. Rutgers uses the socio-ecological model (first described by Bronfenbrenner in 1979) to analyze and interfere with the complex interplay in the relationships between individuals and others at the family, community, and institutional/policy level. In an individual's life, various formal and informal rules and practices enable and constrain their agency, and rigid stereotypical and discriminatory gender ideologies and norms are often perpetuated. GTA interventions focus not only on norm change at the individual, cultural and interpersonal level, but also in a person's environment (e.g. school, work place, family, health center, community, media, government, etc.). As the figure below shows, health service providers have a crucial role to play: they are part of the organizational level of the socio-ecological model. But that is at the professional level; at the personal level they are also involved at the individual and interpersonal level. This training booklet focuses on these different levels, so that long-lasting impact can be generated.

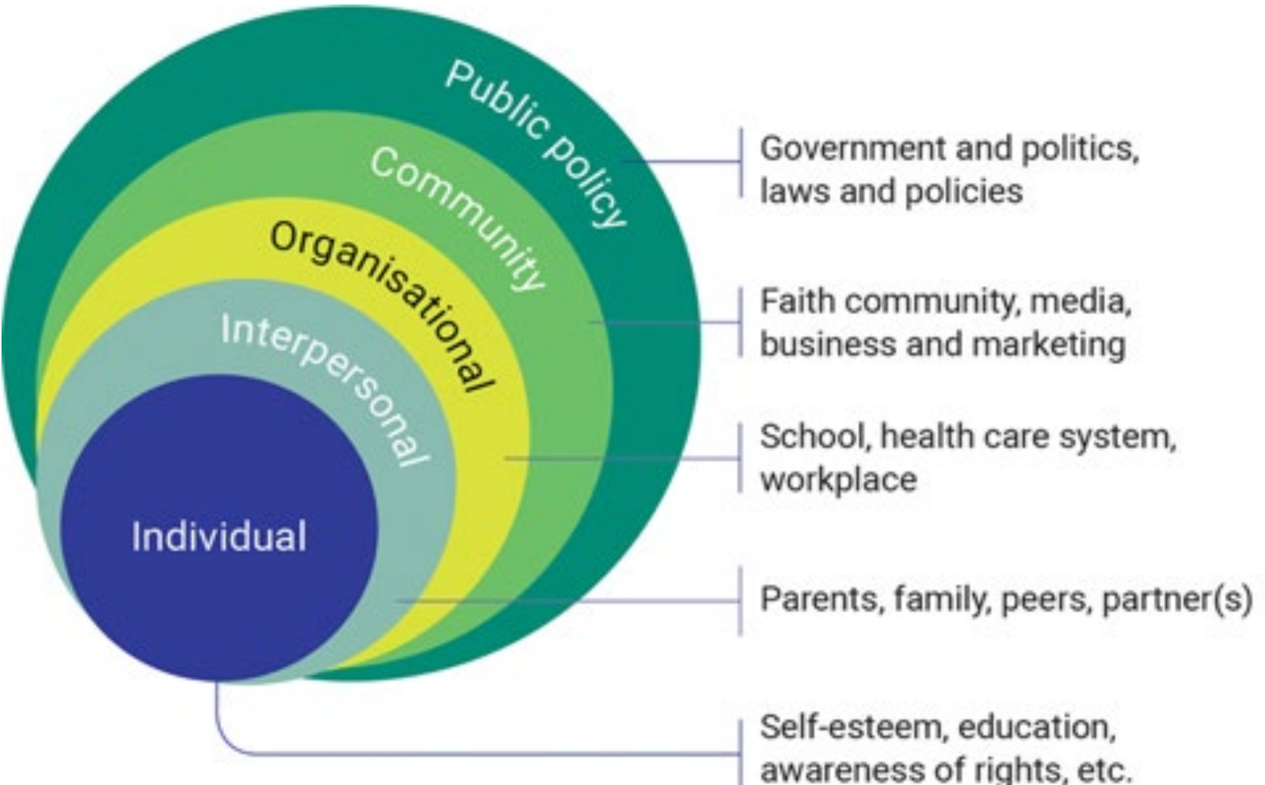


Figure 1: The socio-ecological model

Evidence for GTA in SRHR service provision

We already know that by strengthening the GTA capacity of SRHR service providers, the quality of care provided can be improved. In 2020, Rutgers conducted research on the impact of GTA training for SRHR service providers, including in the context of Kenya. The research report concluded that changes within the service providers, in terms of attitudes, skills and knowledge, positively reinforced young people's experiences in accessing SRHR. The figure below is a depiction of how the application of the 6 GTA principles by service providers improved young people's access to SRHR in Kenya. For more details, please see the full research report which can be found here: https://rutgers.international/resources/gta-research-report-kenya/

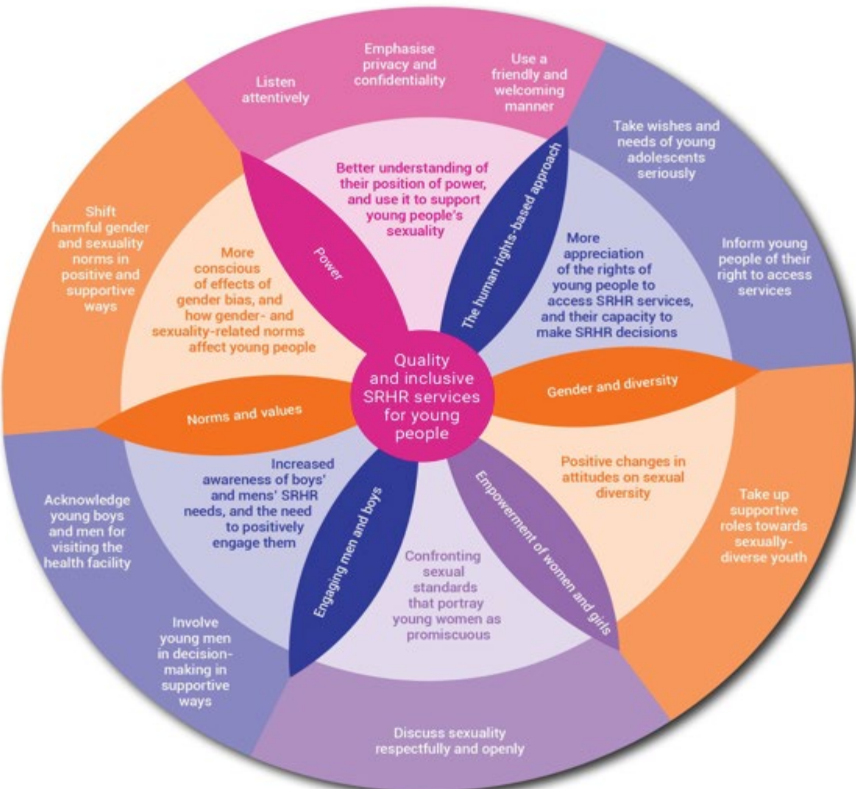


***Figure 2:* The flower - visualizing the ways in which the Rutgers GTA approach contributes to quality and inclusive SRHR services for young people.**

The above flower figure is derived from Rutgers' research on Youth Friendly Services, and it can also be applied to safe abortion service provision, as the same elements apply. The flower can be explored through the colours; for most health care providers who are providing sexual and reproductive health services, these colors represent lived realities in their professional journey.

Pink is the colour of love and understanding. Most often clients (whether young people or persons with an unintended pregnancy) will shy away from visiting health care facilities because of a provider's harsh attitude. For abortion service providers, offering a listening ear and a safe space for every client will create a quality consultation, with better history/record taking, and more tailored services provided.

Blue is the colour of provider awareness. Generally, in Kenya the assumption is that the final decision is with the health care provider. However, in quality sexual health care, the decision lies with the client. Understanding these clients' rights and their environment makes a health care provider more effective, and more trusted by clients, because they provide what the client needs, are open to learning, and give power to the client to decide what fits best with their body, their life, and their future.

Orange is the colour for inclusion and acceptance. SRHR services are not only limited to married, heterosexual women. Anecdotal evidence from abortion services in Kenya shows several lesbian women with an unintended pregnancy who were turned away and denied services because of their sexual orientation. It is essential in provider ethics to provide quality services without discrimination based on age, gender, or sexual orientation.

Purple is the colour for respect. In all SRHR services respect is important. Having respectful and open conversations with a client who faces an unintended pregnancy allows them to feel more at ease and to share more information, which allows abortion service providers to administer correct and tailored care and counselling.

With the above figures and insights, we aim to provide sufficient background for a GTA in safe abortion. The remainder of this booklet consists of practical training sessions, with practical guidance and handouts. A list of additional resources is also provided, for trainers and abortion service providers who wish to dive deeper. **Good luck and have fun!**

Training outline

The sessions in this booklet comprise a training that is structured in such a way that it follows the six principles of the gender-transformative approach (GTA). The first session introduces the GTA and the six principles, session 2 to 7 each focus on one principle of the GTA within the context of safe abortion service provision. Session 8 focuses on lessons learned and moving forward.

As can be seen from the below table, this booklet is designed for face-to-face as well as online training sessions for abortion service providers. While we recognize that face-to-face sessions may create a more interactive atmosphere and better learning environment, we have designed the sessions in this booklet in such a way that also in an online format sufficient learning and reflection is facilitated. The duration of each session will differ between face-to-face and online, as indicated below. Handouts and additional information may be printed (face-to-face) or sent via email to all participants.

Sessions Session	Learning objective	Duration face-to-face	Duration online
Session 1. A gender-transformative approach to safe abortion	Abortion service providers have a basic understanding of what a gender-transformative approach means for safe abortion provision and feel connected to the 6 principles of GTA	50 mins	35 mins
Session 2. Making sense of sexual rights	Abortion service providers understand that access to safe abortion is a human rights issue, regardless of the person needing an abortion	45 mins	30 mins
Session 3. Talking about gender norms	Abortion service providers understand how rigid gender norms and gender bias negatively influences access to safe abortion and feel motivated to challenge gender bias in service provision	50 mins	40 mins
Session 4. Power walk	Abortion service providers understand how power dynamics influence service delivery and are aware of their own position of power	45 mins	35 mins
Session 5. In their shoes	Abortion service providers have increased understanding of gender and sexual diversity and are motivated to support transgender persons, lesbian and bisexual women in their access to safe abortion	55 mins	45 mins
Session 6. Facilitating empowerment	Abortion service providers know how to facilitate empowerment for women, girls and LGBTIQ people in their health clinic	55 mins	45 mins
Session 7. Engaging men and boys in safe abortion care	Abortion service providers understand how they can better engage men and boys in safe abortion care	40 mins	30 mins
Session 8. Moving forward	Abortion service providers feel motivated and capable to apply a gender-transformative approach to safe abortion at their clinic	30 mins	25 mins
Total hours		**6h15mins**	**4h45mins**

The training is designed to be facilitated in one-two days (16 hours), including opening, tea breaks, lunch, etc., when face-to-face, and in two sessions of 3 hours when facilitated online. This leaves ample time to introduce breaks, have warming up exercises and icebreakers and of course space for delays due to unforeseen circumstances.

The online training can be spread over two days, preferably in the mornings. It is also possible to spread the training out to have one session per week, or to focus on one specific topic if it needs more attention at the clinic. Above all, the training must take availability and concentration span into account and needs to acknowledge the hectic working days of a safe abortion service provider. Service providers are bound to be more concentrated during face-to-face workshops as they will be away from their clinic. When organizing an online training, be sure that service providers can actually take some time off their daily work, so that they are not distracted by their responsibilities at the clinic during the training.

Facilitator instructions

In each session, facilitator instructions are outlined for face-to-face as well as online facilitation. Online facilitation is quite a bit different from face-to-face facilitation: you are dealing with possible internet connectivity problems from participants, loss of concentration and so-called "Zoom fatigue". But there are ways to make online sessions accessible, energizing and fun. We have outlined some important considerations for you to take into account if you are going to facilitate this training online (see the text box). Read these well, along with the online facilitation instructions in each of the sessions.

Overall, there are two essential points that we would like you to keep in mind as a facilitator:

1. Create a safe space. During this training, you are asking participants to be open about their own bias and prejudice. You are also asking them to do a lot of self-reflection and possibly discuss moments in their past that were difficult to them. For this training to be transformative, it is essential that you create a safe space where people are not afraid to be critical or to be themselves. One way to do this is to collectively establish ground rules for engagement at the beginning of the training, with a focus on mutual respect and being non-judgmental towards each other. You can also make agreements on confidentiality if necessary. Ensure to check back in on these ground rules throughout the training and remind participants of the rules you have established together. Be mindful of power dynamics within the (online) space, try to make sure that everyone has spoken and restrict dominant voices in the group.

Another way to create trust among participants is to ask them to share some personal information with each other, so that participants get to know each other better. Especially for online sessions this is a great way to break the ice and have people feel connected with each other. Beware that the personal information is not sensitive information and stick to safe topics such as favorite things to do and see, greatest work achievements, greatest inspiration, role models etc.

2. Take a breather. This training is intense and highly participatory; therefore, it asks a lot of participants' concentration and energy. Allow them to take a breather by introducing short breaks, quick games or exercises in between sessions or by allowing participants to walk around when doing work in pairs, for example. For the online training, it can already help to ask participants to share their favorite song, dish or place in the chat, or ask them to find a certain object in their house or to draw their spirit animal and show it on screen. It should not take up much time, but these types of mini-breaks are important to refresh participant's energy and thought processes.

Important considerations for online facilitation

- *Use a script:* because of the shorter attention span of participants, online sessions need to be short and to the point. Timing your sessions is essential to keep a good flow; it may not feel natural to you at first but it will come across as such for the participants. Make use of a script to time your sessions well, it's worth it! Another advantage is that you can also use it to give clear instructions to your tech buddy (see point below). An example of a script can be found in Annex 1.

- *Work with accessible tech:* use online platforms that you are used to and that your participants know how to work with too. Be sure that you have a platform that allows you to set up break out rooms in your virtual session, because this is really important for interaction. Online collaboration tools such as Google slides, Google Docs or Google Jamboard work well because they are freely accessible and do not require much bandwidth.

- *Get a tech host:* ask a colleague with technical knowledge to help you out with the tech side of things: preparing break out rooms, having back-ups of slides, helping people out who have trouble connecting or participating. That way, you can focus solely on facilitation of the session. You can use the script (see Annex 1) to provide clear instructions to your tech host. If you work with a co facilitator, you can help each other out by doing the tech side when the other is facilitating or presenting.

- *Maximize participation:* have you ever been in one of those online meetings where people just keep on talking for ages and you completely lose interest? Let's not do that! There are ways to keep everyone involved in online meetings: by keeping presentations to a maximum of 5 minutes, by having lots of time in break out rooms where people can discuss in smaller groups, and by making ample use of the chat function. The latter serves three purposes: it allows people to contribute even with unstable internet connection, it prevents people from taking the floor too much, and when it is possible to save the chat you'll have a great basis for your training report.

Further reading, watching, and doing

Next to the sessions and annexes in this booklet, we have also created a list of interesting short reads, videos and tests that participants can use to further develop their knowledge and skills in relation to applying a GTA in their work. The list is thematically divided and connected to the sessions of the training on gender transformative approaches to safe abortion. In preparation, make sure that you share this list with all participants at the end of your training session.

Session 1. A gender transformative approach to safe abortion

Learning objective:	Abortion service providers have a basic understanding of what a GTA means for safe abortion care and feel connected to the 6 principles of GTA.
Methodology:	Presentation, group discussion, storytelling in pairs.
Materials:	Face-to-face: flipchart, markers, PPT slide, pen and paper, printouts of Annex 2.
Online:	PPT slide, pen and paper, electronic copy of Annex 2.
Duration:	Face-to-face: 50 minutes
Online:	35 minutes

Preparations

- For face-to-face and online sessions: select three images/pictures that challenge traditional gender roles and power structures and put them on a PowerPoint (PPT) slide. Examples could be of a father in caring roles, of LGBTIQ people being included, of women taking charge in non-traditional ways. The best images are those that are recognizable in your context.
- For face-to-face session: write down the definition of a GTA on a flip chart, as well as the 6 principles. For this, you can use Annex 2 of this booklet - but stay with the principles themselves and do not add the explanation of each principle. Once these are discussed they should remain visible throughout the workshop so that you can refer back to them. Also print out Annex 2 as handout.
- For online session: put definition of a GTA on a PPT slide, as well as the 6 principles. Once they are discussed, make sure to refer back to them by showing the slides again at other times during the training and share the link to Annex 2 in the chat, so that participants can refer back to them any time during the training.

Facilitator instructions

Face-to-face	Online
Step 1 (5 mins). Show a PowerPoint slide with 3 images that challenge traditional gender roles in your context. Ask some participants what their definition of a GTA is, based on the images they see.	**Step 1 (5 mins).** Show a PowerPoint slide with 3 images that challenge traditional gender roles in your context. Ask participants to write down in the chat what their definition of a GTA is, based on the images they see.
Step 2 (5 mins). Share the definition of a GTA, and mention the 6 principles briefly. Show the flipcharts you have prepared. Make sure that they remain visible throughout the training. Share the printouts of Annex 2.	**Step 2 (5 mins).** Share the definition of a GTA, and mention the 6 principles briefly. Show the PowerPoint slides.
Step 3 (10 mins). Ask all participants to write down the answer to the question: *How do you think a GTA could help your work on safe abortion?* After 5 minutes, ask who would like to share what they wrote down.	**Step 3 (5 mins).** Ask all participants to write in the chat, the answer to the question: *How do you think a GTA could help your work on safe abortion?* Share the question in the chat or on a slide. If time permits, ask some participants to elaborate on their answer.
Step 4 (15 mins). Ask the group to break out in pairs and discuss the following: *Which principle resonates most with you and why?* Can you share a story about when this principle was applied to your work on safe abortion? Put the question on a flip chart or PPT slide and refer to the flip chart that has the 6 principles on it.	**Step 4 (10 mins).** Tell the group that they will go to break out rooms in pairs to discuss the following: *Which principle resonates most with you and why?* Can you share a story about when this principle was applied to your work on safe abortion? They will have 9 minutes in the break out room for this discussion. Write the question down in the chat, as well as the 6 principles.

Step 5 (15 minutes). Go back to the flipchart with the 6 principles. Per principle, ask someone to share why this principle is important for the provision of safe abortion. Conclude by stating that we will now go into each of the six principles of the GTA, one principle per session.	**Step 5 (10 minutes).** Ask the group to write down in the chat, the answer to the following question: *Which principle did you discuss and why is it important for the provision of safe abortion?* Write the question in the chat. Depending on available time, ask someone to elaborate on their answer. Conclude by stating that we will now go into each of the six principles of the GTA, one principle per session.

Session 2. Making sense of sexual rights

Learning objective:	Abortion service providers understand that access to safe abortion is a human rights issue, regardless of the person seeking an abortion.
Methodology:	Case study, plenary discussion.
Materials:	Face-to-face: pen and paper, flipchart, markers, printouts of case scenarios in Annex 3 and Annex 4.
Online:	pen and paper, Google slides, case scenarios in Annex 3 and link to Annex 4.
Duration:	Face-to-face: 45 minutes
Online:	30 minutes

Preparations

- For face-to-face session: print and cut out the different case scenarios that are in Annex 3 so that you can hand them out to the participants during the session.
- For online session: put each case scenario on a different Google slide that you can make available to all participants during the session.

Facilitator instructions

Face-to-face	Online
Step 1 (23 mins). Explain to the group that this session is all about human rights in relation to safe abortion. Human rights are the first principle of GTA. Explain that the group will be divided into four smaller groups and that they will each analyze a case that will be handed to them. Divide the participants in four groups and hand them one case each (from Annex 3). Ask them to read the case and discuss the following questions: *(1) What human rights do you think are violated? (2) As a safe abortion provider, what would you do differently?* Share the questions on a flipchart or PPT. Tell the groups that they have 15 minutes to discuss and write down their responses to the questions. Tell them that, afterwards, they are asked to give a short presentation of maximum 5 minutes about their conclusions.	**Step 1 (18 mins).** Explain to the group that this session is all about human rights in relation to safe abortion. Explain that the group will be divided into four break out groups and that they will each analyze a case (from Annex 3) that will be shared on a Google slide. Explain that group one will look at slide one, group two at slide two, etcetera. Ask them to read the case and discuss the following questions: *(1) What human rights do you think are violated? (2) As a safe abortion provider, what would you do differently?* Write the questions in the chat. Share the link to the Google slides in the chat. Tell the groups that they have 14 minutes to discuss and write down their responses to the questions. Tell them that, after wards, they are asked to share their conclusions in the chat.
Step 2 (20 mins). Back in plenary, ask each group to briefly share their conclusions. Each group gets 5 minutes for this.	**Step 2 (10 mins).** Back in plenary, share question 1 in the chat and ask participants to respond in the chat. After 5 minutes, share question 2 in the chat and ask participants to share their responses in the chat. Read out some responses to keep the flow.
Step 3 (2 mins). Conclude the session by stating that we see here that access to safe abortion is indeed a human rights issue. As abortion service providers, it is our mandate to uphold the human rights of the people we service wherever we can. Share the printed Annex 4, “sexual rights” with participants.	**Step 3 (2 mins).** Conclude the session by stating that we see here that access to safe abortion is indeed a human rights issue. As abortion service providers, it is our mandate to uphold the human rights of the people we service wherever we can. Share the link to Annex 4, “sexual rights”, with participants.

Session 3. Talking about gender norms

Learning objective:	Abortion service providers understand how rigid gender norms and gender bias negatively influences access to safe abortion and feel motivated to challenge gender bias in service provision.
Methodology:	Small group discussion and storytelling.
Materials:	Face-to-face: flipchart and markers.
Online:	none.
Duration:	Face-to-face: 50 minutes
Online:	40 minutes

Preparations

For face-to-face session: draw three columns on a flipchart and write WOMEN in the first column, MEN in the second and NON-BINARY in the third.

Facilitator instructions

Face-to-face	Online
Step 1 (15 mins). Explain to the participants that we are going to discuss harmful gender norms, which is principle 2 of the GTA. Show the flip chart which has WOMEN| MEN | NON-BINARY on it. Per column, ask the participants the following question: *What gender bias and prejudices exist about this group?* Write down participants' answers in the columns. Add onto the list if you feel important elements are missing.	**Step 1 (15 mins).** Explain to the participants that we are going to discuss harmful gender norms, which is principle 2 of the GTA. In the chat, write down the following question: *What gender bias and prejudice exist towards women?* Ask participants to write down their answers in the chat. Subsequently, write down the question: What gender bias and prejudice exist against men? Again, ask participants to write down their answer in the chat. Finally, write the following question in the chat: *What gender bias and prejudice exist towards non-binary and transgender people?* Ask participants to write down their answers in the chat. Reflect and add onto the list if you feel important elements are missing.
Step 2 (15 mins). Ask participants to look at the lists they created together. Ask them to share why these gender bias and prejudices negatively impact access to safe abortion. Ask participants to give examples.	**Step 2 (10 mins).** Ask participants to look at the lists they created together. Write down the following question in the chat: *Why do gender bias and prejudice negatively impact access to safe abortion?* Ask participants to share their thoughts in the chat.
Step 3 (18 mins). Tell the participants to break out in groups of three. Ask the participants to share a story in their group about a situation in which they saw how prejudice and gender bias negatively impacted a client and how they dealt with that situation.	**Step 3 (13 mins).** Tell the participants that they will break out in pairs. Ask the participants to share a story with their colleague about a situation in which they saw how prejudice and gender bias negatively impacted a client and how they dealt with that situation. Write the instructions in the chat. Tell the participants they have 12 minutes to discuss in pairs.

Step 4 (2 mins). Back in plenary, conclude by saying that we all carry gender bias and prejudice with us. It is something that was taught to us, by our parents, uncles and aunts, peers and teachers. What is important, is that we are aware of persisting gender bias and prejudice and that we challenge these in order to secure access to safe abortion for everyone who seeks it.

Step 4 (2 mins). Back in plenary, conclude by saying that we all carry gender bias and prejudice with us. It is something that was taught to us, by our parents, uncles and aunts, peers and teachers. What is important, is that we are aware of persisting gender bias and prejudice and that we challenge these in order to secure access to safe abortion for everyone who seeks it.

Session 4. Power walk

Learning objective:	Abortion service providers understand how power dynamics influence service delivery and are aware of their own position of power.
Methodology:	Small group discussion and power walk.
Materials:	Pen and paper, PPT slide or print-out of the Wheel of Power (Annex 5). Duration: Face-to-face: 45 minutes
Online:	35 minutes

Preparations

Prepare a PPT slide with the image of the wheel of power, copied from: https://pbs.twimg.com/media/EhVqvuAWAAEb3d2.jpg)

Facilitator instructions

Face-to-face	Online
Step 1 (10 mins). Tell the group that this session is about GTA principle 3, which is about power dynamics. *Facilitate a game to split participants out in pairs and interview each other about the following question: When have you felt powerful and why?* And when have you felt powerless?	**Step 1 (8 mins).** Tell the group that this session is about GTA principle 3, which is about power. *Tell the group that they will be paired in break out rooms to interview each other about the following question: When have you felt powerful and why?* And when have you felt powerless? Write the question in the chat and set the break out rooms at 6 minutes.
Step 2 (5 mins). Back in plenary, ask some people if they are willing to share how they felt about this exercise.	**Step 2 (5 mins).** Back in plenary, ask the group to put in the chat, the answer to the following question: How did you feel about this exercise? Write the question in the chat and invite some participants to reflect.
Step 3 (10 mins). You will now go into the Power Walk. Ask the participants to grab pen and paper as they will be asked to draw a line without the pen leaving the paper. Explain that you are going to read out statements, and that participants are asked to draw an ascending line if they agree, and a descending line if they disagree with the statement. They are asked to base this on their own experience and identity. Read out the statements that are written below this instruction box.	**Step 3 (7 mins).** You will now go into the Power Walk. Ask the participants to grab pen and paper as they will be asked to draw a line without the pen leaving the paper. Explain that you are going to read out statements, and that participants are asked to draw an ascending line if they agree, and a descending line if they disagree with the statement. They are asked to base this on their own experience and identity. Read out the statements that are written below this instruction box.
Step 4 (15 mins). Ask the group to break out in groups of three to discuss the following: • What does this exercise tell you about the power you have? • What would the line look like for a transgender person, or an underage girl? • How does the power or privileges a person have influence their access to safe abortion? Write the questions on a flip chart. Tell the group that they are not obliged to show or share their sheet with the line on it.	**Step 4 (10 mins).** Tell the group that they will break out in pairs to discuss the following: • What does this exercise tell you about the power you have? • What would the line look like for a transgender person, or an underage girl? • How does the power or privileges a person have influence their access to safe abortion? Write the questions in the chat. Set the break out rooms at 8 minutes. Tell the group that they are not obliged to show or share their sheet with the line on it.

Step 5 (5 minutes). Conclude the session by sharing the PPT slide with the wheel of power on it, stating that a person's access to SRHR services, information and safe abortion is influenced by power and privilege. This in turn is influenced by gender, but also by other factors such as ethnicity, sexual orientation, social status or age. This is called intersectionality. At the same time, abortion service providers all wield some form of power to increase accessibility to safe abortion for underprivileged or marginalized groups. In session 6, we will look into how we can help empower these groups at our respective clinics.

Step 5 (5 minutes). Conclude the session by sharing the PPT slide with the wheel of power on it, stating that a person's access to SRHR services, information and safe abortion is influenced by power and privilege. This in turn is influenced by gender, but also by other factors such as ethnicity, sexual orientation, social status or age. This is called intersectionality. At the same time, abortion service providers all wield some form of power to increase accessibility to safe abortion for underprivileged or marginalized groups. In session 6, we will look into how we can help empower these groups at our respective clinics.

Powerwalk statements

1. I can influence decisions made at the clinic where I work.
2. I am NOT in danger of being sexually harassed or abused.
3. I can afford Wi-Fi at my home.
4. I am regularly consulted on technical issues to do with safe abortion.
5. I have access to loans from a bank.
6. The Ministry of Health is willing to listen to my advice and feedback.
7. I am aware of the abortion laws, policies and guidelines in Kenya.
8. I am NOT likely to be discriminated against because of my ethnicity.
9. My sexual orientation is accepted within the community where I live.
10. I enrolled in secondary education.

Session 5. In their shoes

Learning objective:	Abortion service providers have increased understanding of gender and sexual diversity and are motivated to support transgender persons, lesbian and bisexual women in their access to safe abortion.
Methodology:	Role play
Materials:	PPT with the role plays (Annex 6) and the gender unicorn (Annex 7). For face-to-face session: printouts of Annex 6 and 7.
Online:	PPT slide with gender unicorn, and provide a link to Annex 7.
Duration:	Face-to-face: 50 minutes
Online:	45 minutes

Preparations

- For face-to-face and online session: copy the role plays from Annex 6 and copy the image of the gender unicorn from Annex 7 to a PPT slide, so that you can share the information during the session. You will choose one of the two role plays, depending on what information gap is greater among participants: the experience of trans people or the experience of lesbian and bisexual women.
- For face-to-face session: print out Annex 6 to share with participants at the end of the session. If you want to, you can lay out some materials/clothes that people can use for the role play.
- For online session: share the (link to) the PPT slides with Annex 6 and 7 with participants.

Facilitator instructions

Face-to-face	Online
Step 1 (15 mins). Explain to the participants that this session is about understanding LGBTQ+ persons better, as this session relates to principle 4 of the GTA. Explain that we will first dive into the meaning of LGBTQ+. Share the PPT with the gender unicorn and explain the different elements of gender and sexual diversity by using the additional information in Annex 7. Make the presentation interactive by asking participants if they have encountered LGBTQ+ clients in their clinic, and ask one or two how they handled themselves in that situation. Allow space for questions.	**Step 1 (12 mins).** Explain to the participants that this session is about understanding LGBTQ+ persons better, as this session relates to principle 4 of the GTA. Explain that we will first dive into the meaning of LGBTQ+. Share the PPT with the gender unicorn and explain the different elements of gender and sexual diversity by using the information in Annex 7. Make the presentation interactive by asking participants in the chat if they have encountered LGBTQ+ clients in their clinic, and ask one or two how they handled themselves in that situation. Allow space for questions.
Step 2 (5 mins). Choose one of the two role plays from Annex 6, depending on the information needs of the participants. Invite participants to the role play sharing that they will be taking up new characters to show real issues within service provision. Remind participants that these roles are not them and after the training they will all unzip from the character and resume their own identity. Share the PPT with one of the role plays on it, including the character descriptions. Ask someone to read out loud what is on the PPT. Two or three volunteers will be asked to start by acting out the characters, and after three minutes' other participants are invited to intervene by clapping their hands and taking the place of the provider. The character of a client is permanent all through the session.	**Step 2 (5 mins).** Choose one of the two role plays from Annex 6, depending on the information needs of the participants. Invite participants to the role play sharing that they will be taking up new characters to show real issues within service provision. Remind participants that these roles are not them and after the training they will all unzip from the character and resume their own identity. Share the PPT with one of the role plays on it, including the character descriptions. Ask someone to read out loud what is on the PPT. Two or three volunteers will be asked to start by acting out the characters, and after three minutes' other participants are invited to intervene by clapping their hands and taking the place of the provider. The character of a client is permanent all through the session. Once the two "actors" are ready, everyone except them is asked to turn off their cameras so that they can focus on the role play.

Step 3 (15 mins). Initiate the role play by having the volunteers act out their characters in the setting of a health clinic. They have 3 minutes for this. After 3 minutes, clap once to indicate STOP. Invite another participant to take the role of provider and share how they could solve the situation. State that other participants are invited to clap and intervene by taking the role of the provider. The cycle continues until a maximum of 3 changes have taken place. Encourage all participants to watch and listen keenly to how each provider handles the issue.	**Step 3 (13 mins).** Initiate the role play by having the volunteers act out their characters. They have 3 minutes for this. After 3 minutes, clap once to indicate STOP. Invite another participant to take the role of provider and share on how they could solve the situation. State that other participants are invited to clap and intervene by taking the role of the provider. This person would have to turn on their camera while the first "actor" turns their camera off. The cycle continues until a max of 3 changes have taken place. Encourage all participants to watch and listen keenly to how each provider handles the issue.
Step 4 (10 mins). Invite participants to step out of their role and resume their identity by asking them to shout their own names at once. First, ask the per son(s) who played the character of the provider how they felt about this role play. Ask others who stepped in to tell how they felt about changing the role play. Finally, ask the person who played the client how it felt to be in the shoes of this particular client. Did it help to understand the experience of an LGBTQ+ person better?	**Step 4 (10 mins).** Invite participants to step out of their role and resume their identity by asking them to shout their own names at once. Ask the person who played the client how it felt to be in the shoes of this particular client. Did it help to understand the experience of an LGBTQ+ person better? If time allows, ask other participants to add their observations about the role play.
Step 5 (10 mins). Conclude by asking the question: What are the best ways for abortion service providers to support LGBTQ+ persons?	**Step 5 (5 mins).** Conclude by asking the question: What are the best ways for abortion service providers to support LGBTQ+ persons? Write the question in the chat and ask participants to respond in the chat as well.

Session 6. Facilitating empowerment

Learning objective:	Abortion service providers know how to facilitate empowerment for women and non-binary/trans persons at their clinic.
Methodology:	Small group discussion, power analysis.
Materials:	Face-to-face: flip charts and markers.
Online:	prepared Google slides and break-out rooms.
Duration:	Face-to-face: 60 minutes
Online:	45 minutes

Preparations

For online session: create three Google slides and write MEN on slide 1, WOMEN on slide 2 and ONG-BINARY/TRANS on slide 3. Create a text box in each slide so that participants can write in them during the session. Make sure that break-out rooms are ready, and that the Google slides allow for editing by everyone.

Facilitator instructions

Face-to-face	Online
Step 1 (5 mins). Explain that we are discussing empowerment of women and girls, the fifth principle of GTA. With women and girls, we mean all people who identify as such, including trans women.	**Step 1 (2 mins).** Explain that we are discussing empowerment of women and girls, the fifth principle of GTA. With women and girls, we mean all people who identify as such, including trans women.
Step 2 (5 mins). Ask participants what they think "empowerment" means. Allow for some responses and then explain that with empowerment, we mean that a person gains the ability to make choices that they could not make before. The reason they are able to do so now is because they have access to power and rights that they did not have before. We cannot empower a person, but we can facilitate empowerment. As health providers, we can facilitate empowerment by removing barriers for people to make their own informed choices. We will get into that later.	**Step 2 (5 mins).** Ask participants what they think "empowerment" means. Allow for some responses and then explain that with empowerment, we mean that a person gains the ability to make choices that they could not make before. The reason they are able to do so now is because they have access to power and rights that they did not have before. We cannot empower a person, but we can facilitate empowerment. As health providers, we can facilitate empowerment by removing barriers for people to make their own informed choices. We will get into that later.
Step 3 (15 mins). Explain that the participants will do a power analysis, divided in three groups: 1 group to look at men, 1 group to look at women, and 1 group to look at non-binary and trans per sons. Each group gets a flipchart sheet and markers to write down for their gender: *what forms of power does this gender possess*? Tell the groups that they have 10 minutes for this brainstorm. Ask the groups to hang their sheet in a place that is visible for all to see.	**Step 3 (15 mins).** Explain that the participants will do a power analysis, divided in three groups: 1 group to look at men, 1 group to look at women, and 1 group to look at non-binary and trans persons. Explain that we will work on Google slides for this exercise and that group 1 focuses on slide 1, group 2 on slide 2, and group 3 on slide 3. Each group is asked to write on the Google slide: *what forms of power does this gender possess?* Tell the groups that they have 10 minutes for this brainstorm in their break out room. After 10 minutes, they will be asked to stop their brainstorm and take another 3 minutes to look at the other two slides. Share the link to the Google slides as well as the instructions in the chat. Set the break out rooms at 13 minutes; after 10 minutes broadcast a message to tell the groups to start looking at their colleagues' slides.

Step 4 (10 mins). Gather all participants and ask them to walk past the different flipcharts. Ask participants what they notice about the differences between the three genders. If necessary, reiterate that girls, young women and young people who do not fit gender and sexual norms are most affected by unequal power relations. This, in turn, affects their access to SRH care and information, including safe abortion.	**Step 4 (5 mins).** Back in plenary, ask the group to write in the chat, the answer to the question: *what did you notice about the differences between the three genders?* Write the question in the chat. If necessary, reiterate that girls, young women and young people who do not fit gender and sexual norms are most affected by unequal power relations. This, in turn, affects their access to SRH care and information, including safe abortion.
Step 5 (15 mins). Ask participants to break out in pairs and find an answer to the question: *As an abortion service provider, how can I facilitate the empowerment of women, girls, and trans and non-bi nary persons?* Tell participants they have 10 minutes for this discussion.	**Step 5 (13 mins).** Tell participants they will break out in pairs and find an answer to the question: *As an abortion service provider, how can I facilitate the empowerment of women, girls, and trans and non-binary persons?* Tell participants they have 10 minutes for this discussion. Put the question in the chat.
Step 6 (10 mins). Ask participants to share some of their conclusions. Repeat that some ways to facilitate empowerment are: being non-judgmental, creating a safe space, ensuring access to the right information, active listening, and upholding your professional values as a service provider.	**Step 6 (5 mins).** Back in plenary, put the question *"As an abortion service provider, how can I facilitate the empowerment of women, girls, and trans and non-binary persons?"* in the chat. Ask participants to share their conclusions in the chat. Repeat that some ways to facilitate empowerment are: being non-judgmental, creating a safe space, ensuring access to the right information, active listening, and upholding your professional values as a service provider.

Session 7. Engaging men and boys in abortion care

Learning objective:	Abortion service providers understand how they can better engage men and boys in abortion care.
Methodology:	Small group discussion.
Materials:	Face-to-face: PPT slide, flip charts, markers.
Online:	PPT slide.
Duration:	Face-to-face: 40 minutes
Online:	30 minutes

Preparations

Write on a flipchart or put on a slide, the sentence: "Safe abortion is solely a women's issue".

Facilitator instructions

Face-to-face	Online
Step 1 (15 mins). Show the PPT slide (or flip chart) with the sentence: "Safe abortion is solely a women's issue". Ask participants to reflect on this statement, and to share whether they agree or disagree and why. Emphasize that safe abortion care encompasses abortion services and counselling, and stress that men should be involved in safe abortion care, as they are often the partners of those seeking abortion and can bring in a positive supporting role, among others by respecting their partners' choices and boundaries. Also, engaging men and boys in safe abortion care can actually help prevent GBV and unintended pregnancies. Explain to the participants that we are going to discuss the last principle of GTA: "engaging men and boys".	**Step 1 (10 mins).** Show PPT slide with the sentence: *"Safe abortion is solely a women's issue".* Write the following question in the chat: Do you agree or disagree with this statement, and why? Ask participants to write their answers in the chat. If time allows, ask some participants to elaborate. Emphasize that safe abortion care encompasses abortion services and counselling, and stress that men should be involved in safe abortion care, as they are often the partners of those seeking abortion and can bring in a positive supporting role, among others by respecting their partners' choices and boundaries. Also, engaging men and boys in safe abortion care can actually help prevent GBV and unintended pregnancies. Explain to the participants that we are going to discuss the last principle of GTA: "engaging men and boys".
Step 2 (15 mins). Ask the participants to break out in pairs and interview each other about what successful strategies they have seen or implemented themselves to engage men and boys in in safe abortion care. (if this is too complex, focus on SRH services in the broader sense instead of safe abortion services).	**Step 2 (12 mins).** Tell the participants that they will join break-out rooms in pairs to interview each other with the following question: *What successful strategies have you seen or implemented that engage men and boys in in safe abortion care?* (if this is too complex, focus on SRH services in the broader sense instead of safe abortion services). Put the question and instructions in the chat.
Step 3 (10 mins). Back in plenary, ask participants to share their most important strategy. Write these down on a flipchart. Ask participants to add onto what is on the flipchart. Explain that you will share a picture of the flipchart afterwards so that participants can use them in their work.	**Step 3 (8 mins).** Back in plenary, ask participants to share their most important strategy in the chat. Explain that you will share the chat log afterwards so that participants can use the shared strategies in their work.

Session 8. Moving forward

Learning objective:	Abortion service providers feel motivated and capable to apply a gender-transformative approach to safe abortion programming at their clinic
Methodology:	Personal reflection, action planning
Materials:	Flipcharts (for face-to-face), action plan format copied from Annex 8 (on paper or online) for each participant to fill.
Duration:	Face-to-face: 30 minutes
Online:	25 minutes

Preparations

Face-to-face session: divide a flipchart paper in three parts/columns. One the first you write WHAT, on the second SO WHAT, and on the third NOW WHAT. Leave ample space for participants to write in the parts/columns. Repeat this for each group that will be in the session – for this session, the participants will be divided in groups of 4.

Facilitator instructions

Face-to-face	Online
Step 1 (10 mins). Introduce this final exercise to the participants. The group will be divided into groups of 4, and each group gets a flipchart sheet. Once all are seated in their groups, ask all to think about what they learned during this workshop. What struck them most? Give participants 5 minutes to share and write down their ideas in the WHAT part of the flipchart.	**Step 1 (5 mins).** Ask the group to find an answer to the question: *WHAT did you learn from this workshop?* Put the question in the chat and ask participants to respond in the chat as well. If time allows, ask someone to elaborate on their answer.
Step 2 (5 mins). Ask the groups to then take 5 minutes to answer the question: Why is what you learned important for your work? Ask the groups to write down their thoughts in the SO WHAT part of the flipchart.	**Step 2 (5 mins).** Ask the participants to then answer the question: *SO WHAT? Why is what you learned important for your work?* Write the question in the chat and ask participants to respond in the chat as well. If time allows, ask someone to elaborate on their answer.
Step 3 (5 mins). Finally ask the groups to take 5 minutes to answer the question: *What will you do with this information?* How are you going to apply it in your work? Ask the groups to write down their answers in the NOW WHAT part of the flipchart.	**Step 3 (5 mins).** Finally ask participants to respond to the question: *NOW WHAT? How are you going to apply it in your work?* Write the question in the chat and ask participants to respond in the chat as well. If time allows, ask someone to elaborate on their answer.

Step 4 (10 mins). Gather the flipcharts and make them visible for all to see. Ensure participants that they will receive pictures of the flipcharts. Praise the participants for the commitment they are making to use a gender-transformative approach in their safe abortion work. Ask the group what they need in terms of support (think of a WhatsApp or Facebook group for participants to discuss dilemmas and support each other, sharing of extra information from the booklet, organizational support, refresher trainings, etc.). Make sure this information is captured so that it can be shared with the host organisation and the participants in a follow-up email where any follow-up actions can be taken by those responsible. In this email, other valuable information (workshop report, pictures etc.) can also be shared.	**Step 4 (10 mins).** Praise the participants for the commitment they are making to use a gen der-transformative approach in their safe abortion work. Ask the group what they need in terms of support (think of a WhatsApp or Facebook group for participants to discuss dilemmas and support each other, sharing of extra information from the booklet, organizational support, refresher trainings, etc.). Make sure this information is captured so that it can be shared with the host organisation and the participants in a follow-up email where any follow-up actions can be taken by those responsible. In this email, other valuable information (workshop report, pictures etc.) can also be shared.
Copy the example for a personal GTA action plan from Annex 8 (copy-paste an empty table for participants to fill). Make sure to agree on a date for participants to submit their individual plan to you for further support and implementation.	Copy the example for a personal GTA action plan from Annex 8 (copy-paste an empty table for participants to fill). Make sure to agree on a date for participants to submit their individual plan to you for further support and implementation.

Further reading, watching and doing

In this chapter, you will find interesting short reads, videos and tests that all relate to gender transformative approaches. The list is thematically divided and connected to the sessions of the training on gender transformative approaches to safe abortion. Have fun!

Session 1: Introduction to GTA and safe abortion programming

- Watch this 2,5 minute GTA introduction video: https://www.youtube.com/watch?v=-DNMFZG8n7E&t=17s
- Read this 2-page evidence brief by Rutgers on what impact GTA trainings have had on the quality of SRHR service provision among youth in Kenya: https://rutgers.international/resources/gta-evidence-brief/

Session 2: Making sense of sexual rights

- Read this 8-page explainer by the Center for Reproductive Rights about how safe abortion is a human right: https://reproductiverights.org/sites/crr.civicactions.net/files/documents/Safe%20and%20 Legal%20Abortion%20is%20a%20Womans%20Human%20Right.pdf
- Check out International Planned Parenthood Federation's sexual rights declaration: https://www.ippf.org/sites/default/files/ippf_sexual_rights_declaration_pocket_guide.pdf
- Read about how sexual rights are embedded in international human rights: https://www.sexualrightsinitiative.com/sexual-rights
- Check WHO's key facts on human rights and health:https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

Session 3: Talking about gender norms

- Take the Harvard implicit gender bias test to discover your hidden biases: https://implicit.harvard.edu/implicit/user/agg/blindspot/indexgc.htm
- Read the CRR publication on Kenyan Women Denied Safe, Legal Abortion Services: https://reproductiverights.org/kenyan-women-denied-safe-legal-abortion-services/

Session 4: Power walk

- Watch this 4-minute video about the impact of power and privilege: https://www.youtube.com/watch?v=hD5f8GuNuGQ
- Watch this 1-minute video about intersectionality: https://www.youtube.com/watch?v=-885E7gqVB4

Session 5: In their shoes

- Watch this 3-minute video about the range of gender identities: https://www.youtube.com/watch=i83VQIaDlQw
- Watch this 7-minute video on gender identity and sexual orientation in health care systems: https://www.youtube.com/watch?v=xCMmZUu07IQ
- Watch this 4-minute video about the difference between gender identity and sexual orientation: https://www.youtube.com/watch?v=xPIiph0gg1w
- Watch this 16 minutes' video on coming out and being bold by Makena Njeri: Choose to be Bold | Makena Njeri | TEDxParklands - YouTube
- Watch this 15 minutes' video about the dangers of coming out as LGBT in Kenya: Horror of being LGBT in Kenya. - YouTube
- Read this short article about LGBT lives in Kenya: https://variety.com/2014/film/festivals/stores-of-our-lives-lgbt-kenya-community1201299178-1201299178/

Session 6: Facilitating empowerment

- Read this 3-paged article in Hong Kong Medical Journal about a how to work with a patient-centered approach: https://www.hkmj.org/system/files/hkm0210p372.pdf
- Read Rutgers' full research report on GTA to improve youth SRHR:
- Both, R. and Kageha, E. (2020) Gender transformative approaches to improving youth SRHR: Improving the sexual and reproductive health and rights of young people in Kenya by training health care providers in the GTA. Utrecht: Rutgers.Available at: https://rutgers.international/resources/gta-research-report-kenya/
- Read this short article about empowerment and how to facilitate it: https://commonthreads.sgi.org/post/139558970833/the-meaning-of-empowerment-and-how-to-facilitate

Session 7: Engaging men and boys in safe abortion programming

- Read this article about male involvement in premarital abortion in India: https://promundoglobal.org/new-research-explores-male-engagement-in-premarital-abortions-in-new-delhi-india/
- Read this online article from NAYA Kenya on including men in conversations about safe abortion: https://nayakenya.org/2021/10/16/include-men-in-conversations-about-safe-abortion-to-dispel myths/
- Read this research overview on engaging men and boys in GTA to improve SRHR: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7554509/

Note: the limited links and further reading listed for Session 7 is not a coincidence: increasingly research and implementing partners worldwide acknowledge that there is a bias in overall available evidence, with particular important gaps in evidence related to safe abortion.

Other resources related to abortion

- Check out the Maputo Protocol: The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) on safeguarding and upholding the rights of women and girls across the African continent: https://www.ohchr.org/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf
- Find out more about the ratification and implementation of the Maputo Protocol from the Solidarity for Africa Women's Rights (SOAWR) website: https://soawr.org/protocol-watch/
- Read this policy brief on abortion and the Maputo Protocol, by NAYA Kenya: https://nayakenya.org/wp-content/uploads/2020/04/Maputo_Protocol_POLICY_BRIEF-2.pdf
- Find out all about African Laws on Abortion in this Handbook by KELIN: http://www.kelinkenya.org/wp-content/uploads/2015/12/HANDBOOK-ON-AFRICAN-ABORTION-LAWS.pdf

Annex 1: Example script for online sessions

Time	Script	Facilitator/speaker	Tech host
Script to the minute: put in the time you start with each new step.	Put actual spoken text here, you can use bullet points or write out what you want to say, whichever feels more natural. This allows you to time what you are saying and ensures good time management of the sessions.	If you are in a team of facilitators, this is where you put the name of the person facilitating this particular step	The instructions for the tech host can be put here, for example: prepare x amount of break out rooms for x amount of minutes, launch poll, put writing prompt in chat. The questions from the sessions that are in italic can be put down here, so that the tech host can copy paste them right into the chat of your online platform.
09.00	Welcome to this online session on gender transformative approaches, or GTA for short. By the end of this session you will have learned about what a gender transformative approach means for your work, and what the six principles of a GTA are. My name is Otieno and together with Wambo, we are facilitating this session today.	Otieno	Show an optional picture or welcoming slide.
09.03	Let's first start with some introductions. I am going to ask you to write in the chat, the answer to the following question: where do your feet touch the ground?	Wambo	Chat prompt: ***Where do your feet touch the ground? Please write in the chat.
09.08	That is great, such diversity. Now you will break out in pairs where you will have 6 minutes to intro duce yourselves to each other and ask each other the following question: What do you want to learn from this session? Tech host, are we ready? Off you go!	Wambo	Prepare break out rooms: pairs, random, 6 minutes, 10 sec countdown. Chat prompt: ***Interview in pairs, 6 mins: What do you want to learn from this session? Open the break out rooms
09.15	Welcome back everyone. Please write in the chat: what does your interviewee want to learn from this session? [if time allows, ask some participants to elaborate]	Otieno	Chat prompt: ***What does your interviewee want to learn from this session? Write in chat.

Annex 2: Six principles of the gender transformative approach

A gender transformative approach, or GTA for short, is a type of gender lens that we can apply to any kind of work. It is particularly relevant to Sexual and Reproductive Health and Rights (SRHR) as gender and sexuality are closely connected. The goal of a GTA is to reduce gender bias and their underlying power relations. It ultimately aims to transform negative gender norms and power imbalances into positive norms and equity, that is where the "transformative" comes from. In order to ensure access to safe abortion, and by extension, sexual and reproductive health and rights for all, the gender-transformative approach is broken down into six principles. The six principles can be used in safe abortion provision. They are:

1. Use a human rights-based approach

Everybody is a rights holder irrespective of their age, gender, race, ethnicity or sexual orientation, and as such, every person is entitled to opportunities that seek to advance their rights. This includes the right to life, the right to self-determination, the right to health, the right to be free from torture, and the right to equal treatment. These rights are anchored in national, regional and international frameworks, and they all apply to safe abortion and SRHR in the broader sense. According to the human rights-based approach, every service provider has the duty to uphold these rights, and to treat clients as the holders of these rights.

2. Address harmful gender norms

These refer to those rigid norms and cultural beliefs that undermine the rights of girls and women (but also LGBTQI+ people – see principle 4). An example of a harmful norm in Kenya is the belief that an unmarried woman who is pregnant is promiscuous and less deserving of safe abortion services than a married woman. But gender norms can also be harmful for men. Examples of this are widely practiced harmful traditions during initiation of boys, or the false notion that men should not cry or cannot be physically weak. When these norms and values are practiced, this can lead to violation of rights. As service providers, there is a need to always challenge those norms that undermine your work.

3. Address unequal power relations

Gender identity and expression is closely related to the power that an individual hold in society. In general, men who conform to the dominant norms in society hold the most power. But also race, ethnicity, sexual orientation, health, ability, religion, age, social status and other determinants influence the power we have to make decisions for ourselves or even for others. Often those seeking a safe abortion are not wielding great power, while abortion service providers may not be aware of the power they hold. Being aware of those power dynamics is a first step towards empowerment, which is further explained in principle 5.

4. Embrace sexual and gender diversity

In our society we have individuals of different gender and sexual orientations who are entitled to rights just as everyone else. LGBTQI+ persons are disproportionately affected by gender stereotypes because they often do not fit any of the traditional norms in society. Trans men can get pregnant, as well as lesbian and bi-sexual women and non-binary people. They too, have the right to access safe abortion and to be treated with respect. For service providers is it important to understand their specific needs so that they feel safe to come to the clinic or to reach out to a service provider for counselling support.

5. Empower women and girls

When women and girls are empowered, they are better placed to make informed decisions about their life and body. As service providers, there is a need to take a proactive role of facilitating the empowerment of girls and women by enabling them to make informed decisions and support their right to self-determination.

6. Engage men and boys

Often when we talk about SRHR and gender, we talk about women. In safe abortion service provision this is no different. However, engaging men and boys is crucial; on the one hand they can play a positive and supportive role as (sexual) partner, and on the other hand, men and boys are often the main contributors of negative health outcomes that girls and women face, including unintended pregnancies. Service providers need to make deliberate efforts to engage men and boys on the important role they play in advancing the rights of girls and women, especially in accessing information about safe abortion and accessing safe abortion products and services.

Annex 3: Case scenarios: human rights and safe abortion

** All names used here are fictional **

Case scenario 1

Wangari, a 15-year-old, is 13 weeks pregnant. Her parents are religious and there is a very high possibility of her father chasing her out if he learns she is pregnant, terming it a shame and disgrace to the family. She sorts help from her peers who advised her to access a safe abortion. She walks far from her village to find the services and she lands at Hera Medical Center. Desperate for care, she asks if she can access a safe abortion here. Upon seeing Wangari, the health care provider turns her away because of her age, and asks her to come back with her parents. This poses a huge challenge to Wangari, as her parents are the last people she would wish to know that she is pregnant.

Case scenario 2

Poverty continues to be a major accelerator for adolescent sex work in Kenya. Atieno, 17 years old, lives in one of the informal settlements in Nairobi and she is constantly forced by her mother to engage in sex with men who are much older than her in exchange for money and material goods. This is their main source of income as her parents and siblings expect her to provide for them daily. Atieno recently got a client who refused to use a condom and as a result she is now 5 weeks pregnant. Upon realizing Atieno is pregnant, her mother wants her to get an abortion. Due to limited information on how to access safe abortion services, Atieno's mother takes her to a Japolo who terminates the pregnancy unsafely, leading to severe bleeding.

Case scenario 3

A young man in the age of 20-25, called a hotline to seek information about abortion for his girlfriend. He shared that his girlfriend is one month pregnant, that it is unintended, and that he is not in a position to care for his girlfriend. The health provider shared all necessary information including safe and quality abortion self-care methods. However, the girlfriend wasn't aware of his plan to terminate the pregnancy. The young man buys the abortion pills and coerces his girlfriend to take the pills claiming these would support her pregnancy. After a few hours, the girl starts to bleed heavily. He panics and sees no other solution than to take his girlfriend to a health facility for emergency care.

Case scenario 4

Amina is a schoolgirl from a poor family in rural Kenya. At 14 years old, she was forced into sexual inter course by an older man. After two months she suspected that she could be pregnant, when she started feeling nausea. Aware of the blame always being placed on rape/defilement survivors and fearing that she would be held responsible and rejected by her family and community, she turned to the only person she thought would help her without judging her: her older niece with whom she shares her bedroom. In an effort to help her, the niece introduced her to a quack who performed an unsafe abortion on Amina. A few weeks later, Amina died from the complications due to the unsafe abortion.

Annex 4: Sexual rights

As health care providers, it is good to have some knowledge about the non-medical side of SRHR and the international context in which this thematic area is discussed and agreed upon. This annex provides texts and excerpts from human rights treaty bodies, United Nations institutions, and regional protocols that stress the importance of women's sexual and reproductive health and rights, and governments' / state's obligation of upholding these rights. For a deeper dive into this, please see handout 4.4 of Rutgers' GTA toolkit Module 4 on advocacy: https://rutgers.international/resources/rutgers-gta-toolkit-module-4/

About women's and girls' rights:

- To eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection. → **ICPD Programme of Action Par. 4.16: (a)**
- Access to specific educational information to help to ensure the health and wellbeing of families, including information and advice on family planning. → **CEDAW art. 10h**
- States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. → **CEDAW art. 12.1**
- To have access to adequate health care facilities, including information, counselling and services in family planning. → **CEDAW art. 14b**
- States Parties shall take appropriate and effective measures to: ...c) identify the causes and con sequences of violence against women and take appropriate measures to prevent and eliminate such violence; d) actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimize and exacerbate the persistence and tolerance of violence against women. → **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003, Article 4(2)**

About reproductive rights:

Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction, free of discrimination, coercion and violence, as expressed in human rights documents.

→ **International Conference on Population and Development, Programme of Action 1994, Para 7.3**

About abortion rights:

In a Summit in Maputo, Mozambique, in 2003, Member States of the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. This "Maputo Protocol" aims to safeguard and uphold the rights of women and girls across the African continent. While to date 42 of the 55 African Member States (including Kenya) have signed and ratified the Protocol, implementation is still lacking in most countries. Along with provisions related to women's economic and political empowerment, and health and well-being, the Maputo Protocol is the first Pan-African treaty to explicitly recognize abortion as a human right, under specific circumstances. Under the Proto col, Member States are called upon to take all appropriate measures to "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother. → **Maputo Protocol, Article 14, 2 c).**

This is in line with the **Kenyan Constitution Article 26 (4)** where abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or when the life or health of the mother is in danger, or if permitted by any other written law - like the 2019 Supreme Court

Ruling where abortion is permitted in cases of rape, and defilement. *Constitution of Kenya (2010), Article 26(4).*
The 2012 Standards and guidelines for reducing morbidity and mortality from unsafe abortion in Kenya are meant to regulate quality of care across health facilities in Kenya, as well as to guide quality of services to be provided by different cadres of health workers. The core role and guiding principle of these Standards and Guidelines is to bring together all the aspects of care in preventing unsafe abortion, using the multi-sectorial approach. The Kenyan Ministry of Health therefore sees this document as crucial; the safety and well-being of clients depends on the level of adherence to the Standards and Guidelines by health workers. The document also provides guidance on implementation, monitoring and evaluation of health workers' use of the Guidelines.

While the right to safe and legal abortion is a fundamental human right, and is protected under numerous international and regional human rights treaties as well as national constitutions, there are still millions of women of reproductive age who have no access to safe and legal abortion. According to estimates by the WHO 47,000 women die of unsafe abortion each year and millions are left with temporary or permanent injury, see *WHO | Preventing unsafe abortion.* The Centre for Reproductive Rights (CRR) notes that legal restrictions on abortion do not result in fewer abortions, but instead compel women and girls to risk their lives and health by seeking unsafe options. The legal status of abortion shows where women and girls are treated with equality and are afforded an opportunity to direct the course of their own lives. CRR tracks the legal status of abortion of all countries around the world: *https://reproductiverights.org/maps/worlds-abortion-laws/*

About sexual rights:

Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination. → **WHO, 2006a, updated 2010.**
Sexual rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. They rest on the recognition that all individuals have the right - free of coercion, violence, and discrimination of any kind - to the highest attainable standard of sexual health; to pursue a satisfying, safe, and pleasurable sexual life; to have control over and decide freely, and with due regard for the rights of others, on matters related to their sexuality, reproduction, sexual orientation, bodily integrity, choice of partner, and gender identity; and to the services, education, and information, including comprehensive sexuality education, necessary to do so. The International Women's Health Coalition (IWHC) wrote several articles and statements to this respect.

Some international human rights instruments or principles that connect to sexual rights include: The right to equality: → **SDG 10 and → Universal Declaration of Human Rights (UDHR), Article 7 and → CEDAW Article 2 and → Yogyakarta Principles (non-binding), Article 2.**
The right to freedom from discrimination: → **UDHR 7 and → CEDAW Article 2 and → Yogyakarta Principles (non-binding), Article 2.**

The right to wellbeing and the highest attainable standard of health, (including sexual health) and social security:→ **SDG 3 and → Yogyakarta Principles (non-binding), Article 17.**

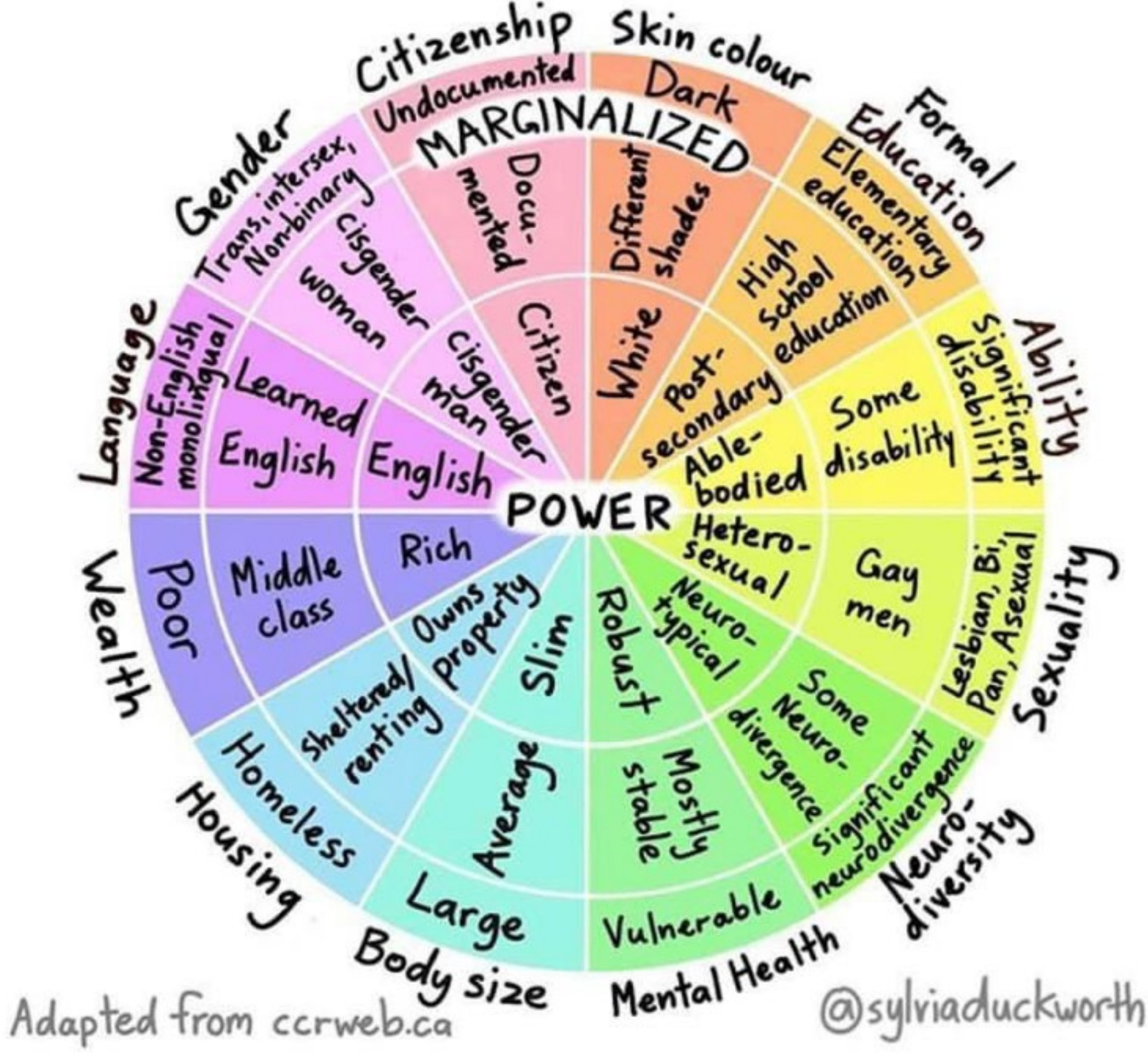
The right to privacy: → **UDHR, Article 12 and → CEDAW Article 17 and → Yogyakarta Principles (non-binding), Article 6.**

The right to found a family: → **Yogyakarta Principles (non-binding), Article 24.**

The right to support and information so that people may live accordingly to their sexual orientation and gender identity: → **Yogyakarta Principles (non-binding), Article 28.**

The right to protection against torture, inhumane or degrading treatment: → **UDHR 2016 and → Yogyakarta Principles (non-binding), Article 10.**

Annex 5: Wheel of Power



Annex 6: Role plays “in their shoes”

Role play 1: trans person at the clinic

Samuel is a trans man who is living in a highly stigmatized community. His neighbors have constantly made threats of turning him back to his assigned gender at birth. He was recently gang-raped and ended with an unintended pregnancy. He wants to access safe termination of the pregnancy as soon as possible and visits a health facility. Once he is in, he is met by Wanjiku, who first thinks that Samuel is a man seeking general SRHR information. Samuel, heavily traumatized by the rape and pregnancy, tries to explain his situation. Once Wanjiku understands his request, she tells him that she can only help him if he stops living a sinful life.

Character 1 – Samuel, trans man

Samuel is a transman in his late 20s and a survivor of sexual violence after being gang-raped as a way to show him that he, in the biological sense, is still a woman. In a community that fuels stigma against the LGBTQ+ community, Samuel lives daily fearing for his life. His family has chased him, and every day in his neighborhood, he receives threats and is constantly denied access to basic amenities like markets. Samuel is currently 6 weeks pregnant and wants to terminate the pregnancy as soon as possible. Samuel is particularly stressed about the bodily changes that are caused by the pregnancy, fueling his gender dysphoria. He is also worried that he cannot afford an abortion, as he lives with financial problems be cause of stigma and discrimination.

Character 2 – Wanjiku, health provider

Wanjiku, 35 years old, has a strong religious background. As a nurse from a catholic background and living in an urban area, she believes that LGBTQ+ is a sin and shouldn’t be tolerated. Although she is a trained health care professional who has signed into providing quality care for all, Wanjiku privately swore to never provide services to LGBTQ+ persons even in an emergency, claiming LGBTQ+ people are sinful and their death is decided for.

Role play 2 : lesbian couple at the clinic

Lorna lives together with her girlfriend, Njoki. Njoki and Lorna have an open relationship. Njoki just discovered she is pregnant; Lorna and she make the decision to terminate the pregnancy because they aren’t ready to raise a child in the discriminatory environment they are living in. At their community health facility, the couple feels very watched and unsafe. They are met by nurse Ami, who recognizes Lorna. Ami first asks what they are doing at the clinic, before they even enter a private consultation room. After Lorna and Njoki explain their situation, Ami exclaims that she has never heard of such nonsense and directs Lorna and Njoki out of the clinic.

Character 1- Lorna, lesbian woman

Lorna is a 23-year-old well-educated woman who lives in Pumwani. She identifies as a lesbian and is known as such in the community. Lorna is a well-educated and outspoken individual and known in her community. She takes Njoki, her girlfriend who is one month pregnant, to the nearest health facility to access safe abortion services.

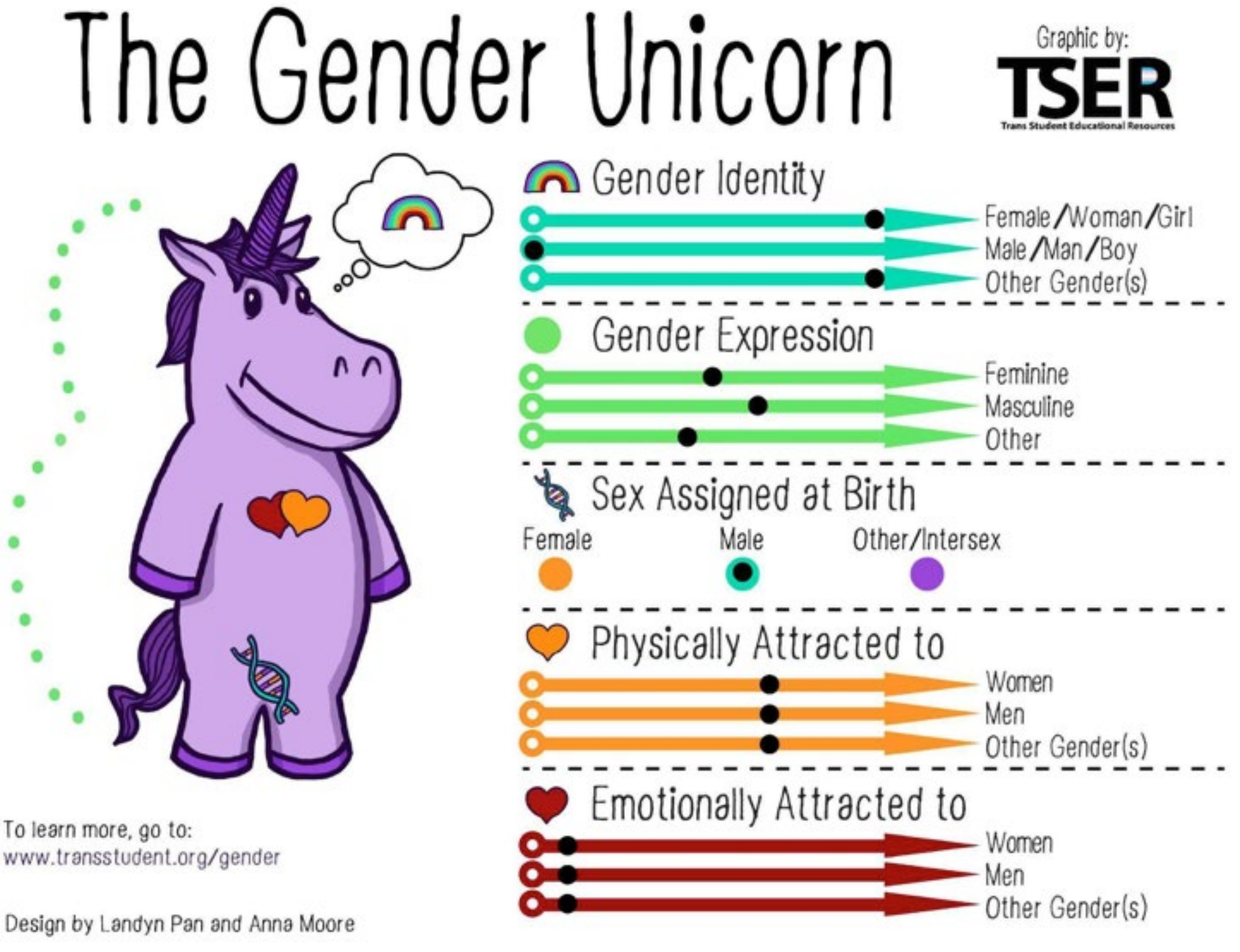
Character 2 - Njoki, bisexual woman

Njoki is 22 and identifies as bisexual. She is an introverted woman who just discovered she is pregnant from an encounter with a man, about a month ago. She has discussed her discovery with her partner Lorna, and together they decide to end the pregnancy.

Character 3 - Ami, nurse

Ami is a 40-year-old educated health professional and the highest skilled in her community. She believes that a child is a blessing, and under no circumstances is one allowed to terminate a pregnancy. She grew up with no knowledge about sexual and gender diversity. She strongly beliefs that a healthy relationship is only possible between a man and a woman, and that being gay is being unnatural.

Annex 7: The Gender Unicorn



Additional information *

Gender identity is someone's innermost concept of self as male, female, a blend of both or either – how individuals perceive themselves and what they call themselves. Your gender identity can be the same or different from the sex assigned at birth.

Gender expression or gender presentation is one's outward appearance, body language, and general behavior. Society has to date categorized this using the conventional gender binary. Sex assigned at birth includes physical attributes such as external genitalia, sex chromosomes, sex hormones and internal reproductive structures. At birth, it is used to assign sex, that is, to identify individuals as male or female. Physical attraction is commonly understood as an emotional response resulting in a desire for sexual contact with a person. There are different types of sexual attraction: heterosexual attraction – towards the opposite sex; homosexual attraction – to a person of the same sex; bisexual attraction – to two or more genders; and people who lack sexual attraction (asexual).

Emotional attraction is an emotional response that most people experience, resulting in a desire for a romantic relationship with the person for whom the attraction is felt. Asexual people often experience romantic attraction even though they do not feel sexual attraction. Romantic attractions can be experienced towards any person and any gender. This understanding has led to the distinction between sexual orientations and romantic orientations.

It is important to note that gender is fluid and that sexual identity and expression, as well as gender identity and expression, vary between people and even within one person over time.

*This additional information is slightly adapted from Rutgers' GTA toolkit Module 3: GTA and youth friendly services.

Annex 8: Example for personal GTA Action Planning

Name: ____________

Date: ____________

Action:	Support needed from:	Resources needed:	Outcome:	Due date:
Keep a GTA provider diary. (Note this is specially for documenting GTA instances at your clinic that can be used during provider share workshops)		Paper / booklet	Notes related to GTA in practice. Experiences shared in provider share workshop.	July 2022
Sharing back knowledge to members of my health facility		Support from RHNK Secretariat	x colleagues / members reached. Feedback noted	March 2022
Organise a GTA training for my team	Clinic manager	Training materials printed.	x members trained	September 2022
Organise a dialogue on GTA in my community	Community leaders and/or CHMT Clinic manager		x community members aware about GTA	December 2022
Reach out about GTA to young people in my community.	Youth advocates / youth champions		x young people aware of GTA	December 2022

Glossary

Accountability: Hold duty-bearers to account to respect, protect and fulfil human rights. Agency: The capacity of individuals to act independently and make their own choices. Asexual: Not motivated/attracted to have sexual relationships.

Bias: A tendency to believe that some people, ideas, etc., are better than others that usually results in treating some people unfairly.

Bisexual: People who are consistently (sexually and/or romantically) oriented to attraction to more than one sex.

Consent: Informed agreement for a particular course of action.

Duty-bearers: Institutions and people who have to respect, protect and fulfil the human rights of all people, and to abstain from the violation of those rights.

Empowerment: The expansion of choice and strengthening of voice through the transformation of power relations.

Gay: Men who are consistently sexually and/or romantically oriented to men

Gender: The social, psychological and cultural representations of masculinity and femininity, as a construct that entails gender identity, roles, stereotypes, norms, attitudes and expression. A set of socially constructed relationships which are produced and reproduced through people's actions by dynamic, dialectic relationships. Ascribed by society, gender is identified in one's actions, and in interactions with others. Most importantly, gender does not reside in the person, but rather in social transactions defined as gendered. From this perspective, gender is viewed as a dynamic social structure.

Gender-based violence: Any crime committed against persons, whether male or female (including gen der and sexual minorities), because of their sex and/or socially constructed gender roles.

Gender dysphoria: the distress a person feels due to a mismatch between their gender identity and their sex assigned at birth.

Gender equality: When women and men have equal conditions, treatment, and opportunities for realizing their full potential, human rights and dignity, and for contributing to (and benefiting from) economic, social, cultural, and political development. Gender equality is, therefore, the equal valuing by society of the similarities and differences of men and women and the roles they play. It is based on women and men being full partners in the home, community and society.

Gender equity: Referring to the process to achieve gender equality, gender equity recognizes the different needs, preferences and interests of men and women. This means true fairness and justice in the distribution of benefits and responsibilities between men and women.

Gender expression/gender presentation: One's outward appearance, body language, and general behavior.

Gender fluidity: A flexible range of gender expressions, behaviors and identification can change from moment to moment. Children and adults who are 'gender fluid' often feel they do not fit within the restrictive boundaries or stereotypical expectations defined by the operating gender binary in their society.

Gender identity: Someone's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. Your gender identity can be the same as or different from the sex assigned at birth.

Gender expression: One's outward appearance, body language and general behavior that are associated with gender.

Gender norms: Powerful, pervasive values and attitudes, about gender-based social roles and behaviors that are deeply embedded in social structures. They manifest within households and families, communities, neighborhoods, and wider society, ensuring the maintenance of social order, punishing or sanctioning deviance from the established norms.

Gender roles: Activities, expectations and behaviors assigned to people on the basis of gender by the society they live in. Many cultures recognize two basic gender roles: masculine (having the qualities attributed to males) and feminine (having the qualities attributed to females).

Gender stereotypes: Gender stereotypes are preconceived ideas whereby females and males are arbitrarily assigned characteristics and roles determined and limited by their gender. Stereotypes about women both result from, and are the cause of, deeply ingrained attitudes, values, norms and prejudices against women/girls and people with diverse SOGIESC. They are used to justify and maintain the historical relations of power of men over women and minority SOGIESC as well as sexist attitudes that hold back their advancement.

Gender transformative approaches (GTA): Approaches that actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of achieving SRHR objectives, as well as gender equality objectives at all levels of the socioecological model. Programmes and policies may transform gender relations through:

- Using a human rights-based approach
- Addressing harmful gender norms
- Addressing unequal power relations
- Embracing sexual and gender diversity
- Facilitating the empowerment of women and girls
- Engaging men and boys

By applying these six principles, we can change harmful, inequitable gender norms into positive, equitable and inclusive ones and lead to improved SRHR of men/boys and women/ girls, the prevention of GBV and gender equality.

Heteronormativity: Where male and female sexuality are depicted as fundamentally different and complementary: that the activity of sex comes from a masculine drive, that masculine sex is active and active sexuality is a precondition for masculinity (male assertiveness, competitiveness) and that feminine sexuality is the opposite, reluctant, subservient and vulnerable (compare feminine modesty and caregiving).

Heterosexual: People exclusively attracted to the opposite sex; consistently (sexually and/or romantically) oriented to people of a different sex than their own.

Human rights-based approach: Key elements are accountability, participation, non-discrimination, equality and transparency. Human rights (political, civil, social, economic and cultural) as enshrined in international/national legislation can be held onto when advocating for and claiming equality, human dignity and opportunities for all people to receive education, healthcare and to fight poverty, violence, discrimination and exclusion.

Informed choice is when a person is given options to choose from several diagnostic tests or treatments, knowing the details, benefits, risks and expected outcome of each.

Informed consent is when a person agrees to the test or treatment they have been offered, knowing the details, benefits, risks and expected outcome.

Intersectionality: An analytical tool for studying, understanding and responding to the ways in which gender and other identities intersect (gender, race, social class, ethnicity, nationality, sexual orientation, religion, age, mental or physical disability), and how these intersections contribute to unique experiences of oppression and privilege.

Intersex: A combination of the 'objectively' measurable organs, hormones and chromosomes, i.e. female = vagina, ovaries, XX chromosomes; male = penis, testes, XY chromosomes.

Lesbian: A woman who is consistently sexually and/or romantically oriented to women.

Masculinity: The socially constructed roles and relationships, and attitudes, beliefs and behavior, associated with being male. Different cultures, tribes, social classes, ages or other sub-groups have different versions of 'masculinity'. However, there are many characteristics of masculinity that are consistent across groups.

Manual Vacuum Aspirator (MVA): a procedure where a healthcare provider removes the contents from the uterus using a handheld device (the aspirator). The Manual Vacuum Aspirator is critical to providing a safe abortion as recognized by the World Health Organization (WHO).

Medical Abortion (MA): The use of WHO prequalified drugs (pills) to terminate a pregnancy. In Kenya a common DKT brand of those "abortion pills" is MA Kare.

Norms: Patterns of behavior that are widespread, are generally tolerated or accepted as proper, are reinforced by responses of others and are quite hard to resist even if they run against what is felt to be right.

Provider: A health professional who is trained and licensed to provide health care diagnosis and treatment services including medication, surgery and medical devices.

Queer: Questioning or critiquing the binary notions of gender and/or sexual orientation; a term increasingly used by some as an umbrella for all diverse SOGIESC, but remaining controversial with sections of the LGBTI community.

Romantic attraction: An emotional response that most people experience, resulting in a desire for a romantic relationship with the person that the attraction is felt towards. Romantic attraction may be felt without sexual attraction and can be experienced towards any person and any gender.

Reproductive rights: *"Embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents.*

These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." International Conference on Population and Development, Programme of Action 1994, Para 7

Rights-holders: Refers to all people.

Safe abortion: an abortion is considered safe if it is done with a method recommended by the World Health Organization (WHO) and appropriate to the pregnancy duration, and if the person providing or supporting the abortion is trained. If either of these conditions is not met, the abortion is unsafe. See WHO *safe abortion technical and policy guidelines.*

Self-care: abortion self-care is the ability of pregnant individuals to manage their unintended pregnancy with or without the support of a health care provider, in the early weeks of pregnancy (up to 12 weeks' gestation). The advent of Medical Abortion (MA) has made this possible, as early self-managed MA at home is a safe, acceptable and cost-effective method of pregnancy termination. See also: *this article by the Guttmacher Institute* and *this WHO publication.*

Services: reproductive health services cover a broad spectrum of care, including maternal and newborn care, access to contraception and the prevention and treatment of HIV and other sexually transmitted infections. Abortion is health care and is hence part of reproductive health service provision. This remains however contested by conservative, anti-choice groups worldwide.

Sex: The biological characteristics that we are born with, that define humans as either male or female, such as the 'objectively' measurable organs (i.e. female = vagina, ovaries; male = penis, testes), hormones, genetics/chromosomes (XX, XY).

Sexual attraction: An emotional response resulting in a desire for sexual contact with another person.

Sexual orientation: A person's sexual identity in relation to the gender to which they are attracted; the fact of being asexual, heterosexual, homosexual, or bisexual.

Sexual rights: "Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination" WHO, 2006a, updated 2010.

Socio-ecological model: Visualizes the personal, interpersonal, organizational, community and public levels, where arrangements of formal and informal rules and practices enable and constrain the agency of women/girls and men/boys and where rigid stereotypical and discriminatory gender ideologies and norms are often perpetuated.

SOGIESC: Sexual Orientation, Gender Identity and Expression, and Sex Characteristics – used in phrases like "people with diverse SOGIESC" and "avoiding discrimination on grounds of SOGIESC".

Stigma: A complex social phenomenon or process that results in powerful and discrediting social labels and/or radically changes the way individuals view themselves and are viewed by others.

Transgender: A person whose gender identity is different from their sex assigned at birth; they can have any sexual orientation.

Values Clarification and Attitudes Transformation (VCAT) for abortion: a (training) process to move participants toward support, acceptance and advocacy for comprehensive abortion care and related sexual and reproductive health care and rights. The abortion VCAT approach recognizes that values affecting attitudes and beliefs about abortion and related issues can change over time. [Definition from Ipas, see their toolkit]

Women's/girls' rights: The rights and entitlements claimed for women and girls worldwide.

Youth-friendly services: A broad range of sexual and reproductive health services that are responsive to the lived realities, specific needs and vulnerabilities of young people.

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