

**INTERNATIONAL
CAMPAIGN
FOR WOMEN'S
RIGHT TO SAFE
ABORTION**

**Developing an Advocacy Agenda for Abortion in the 21st
Century and Making Change Happen**

An International Forum, 5-6-7 September 2018, Lisbon, Portugal

AGENDA



Welcome, opening statement and goals

Time: 9:00 – 9:30 am

Opening the Forum: Marge Berer

Welcome to Lisbon

Speaker: Duarte Vilar (Former Director, Associação para o Planeamento da Família)

Opening Inspirational Speech

Speaker: Ivana Radacic (Chair, Working Group on the issue of discrimination against women in law and in practice, OHCHR)

Goals and Process

Speaker: Marge Berer (International Campaign for Women's Right to Safe Abortion)

Broad stroke analysis of the landscape worldwide, main trends of both regression and transformation. Provide a back-drop against which the three substantive topics will evolve but that can also be referred back to in each area of debate. Set the tone of the conference, a map of conditions under which medical abortion exists and is accessed worldwide (huge differences within and across regions). Raise questions: Why are we fighting for better laws instead of no law at all? What kind of law or law reform do we in this room want? What kind of law reform we are likely to achieve in our countries at this moment. Short-term and longer-term planning. Despite UN and human rights bodies support for safe abortion and WHO guidelines, the legal landscape contains 200+ laws which boil down to the same 1-6 legal grounds whose differences hide their one-ness of control, barriers and limitations, and a bottom line of criminalisation. Then there is the regulatory landscape for MA that is a total mess, from the extreme of complete prohibition (Brazil and Egypt), to self-use in the absence of information on how to use, to criminalisation of self-use, and restricted access via health services in legal settings, plus situations where misoprostol is on the market but not for abortion. The role of the internet in terms of digital/tele medicine but also as a marketplace. How and how far does MA challenge traditional ways of providing abortion. Lastly, thriving local versions of anti-abortion controls and stigma are being used to keep women down. Reviving the concept of a critical mass of support by focusing building a movement of women for abortion rights and promoting strategic assessments to involve governments, legal and human rights experts, and health professionals.

Day 1

Medical abortion pills: Re-conceptualising access to abortion

Plenary Sessions

Time: 9:30 am – 1:30 pm

Moderators: Silvina Ramos (Centro de Estudios de Estado y Sociedad) and Suzanne Belton (Charles Darwin University)

1.1 Accessing medical abortion pills

Speaker: Beverly Winikoff (Gynuity Health Projects)

Time: 9:30 – 10:15 am (30 min and 15 min discussion from floor)

What do we want? Regulation, registration/approval vs actual access, telemedicine, internet, pharmacies, legislation, health services (what kind, at what level of the health system), harm reduction? Is it worth fighting for mifepristone approval when it still isn't approved in so many places? Old thinking about "performing abortions", abortion as a surgical act in the hands of doctors. Terminology needs to change due to abortion with pills (perform/provide abortion) and the language of how to use the pills most effectively needs to be improved by being sharpened and made simple and clear (e.g. not 1st pill, 2nd pill). "Old" thinking, such as trimesters, causes constraints in creating a 21st century service. Access is heavily restricted in many places: MA pills vs paracetamol and contraceptives. Behaviour of pharma companies like Pfizer, Linepharma in exercising control over access. Why MA use means we have no idea how many abortions there are, and current published data do not acknowledge this.

1.2 Self-managed abortion: What is happening with medical abortion on the ground?

Speaker: Kinga Jelinska (Women Help Women)

Time: 10:15 – 11:00 am (30 min and 15 min discussion from floor)

People are self-sourcing pills and self-managing the abortion process outside of clinical contexts. Pills and power are in women's hands. Self-managed abortion has profoundly challenged public and movement thinking around service delivery requirements, quality of care, language and discourse on abortion, and the relationship between formal healthcare systems and informal community-based care. Self-managed abortion is as much a harm reduction strategy, revealing social determinants of harm such as stigma, over-medicalisation and restrictive laws, as it is a form of feminist activism, reproductive justice and human rights. Critical thinking is needed on how to capture the full phenomenon of self-managed abortion. What do we know about why people seek care outside clinical settings and about those providing care? How do people access information and source drugs, with the support of what resources and with the protection from what risks? What are the interactions between formal and informal systems? What are relevant research questions about self-managed abortion, and how do we integrate lessons learned from these novel practices to revitalise and improve health care systems?

Tea and Coffee Break

Time: 11:00 – 11:30 am

1.3 Transforming regulatory frameworks and health care systems to integrate the self-use of medical abortion pills

Speakers: Susan Yanow (Women Help Women)

Time: 11:30 am – 12:00 pm (20 min and 10 min discussion from floor)

Currently, self-managed abortion is positioned outside of mainstream abortion provision and SRHR advocacy, as an interim solution or in opposition to safe, legal abortion care provided by formal health systems. Critical thinking is needed to transform this paradigm and to frame self-managed abortion as part of a progressive advocacy agenda for abortion rights and access. The whole ethos of provision needs to change in the direction of putting the pills into women's hands, of promoting MA use as soon as a period is missed, of convincing policymakers and health professionals that it is safe as long as back-up is there if needed, and getting pills into pharmacies. Multiple models have been created and we can learn from these. The redefinition of "providers" is about much more than task shifting/sharing. New models of back-up and follow-up need to embrace lessons learned from dozens of hotlines, accompaniment collectives and telemedicine projects around the world. The key issue of who controls the medicines and the process must be re-conceptualised.

1.4 Medical abortion pills in legally restricted settings – from harm reduction to women's autonomy

Speakers: Inna Hudaya (SAMSARA), Ruth Zurbriggen (Socorristas) and Jedidah Maina (Trust for Indigenous Culture and Health)

Time: 12:00 – 1:00 pm (15 min per speaker and 15 min discussion from floor)

Self-use of medical abortion almost always means misoprostol alone. This is about the role and importance of national and international safe abortion information hotlines and providers of pills, the range of sources of pills, whatsapp self-use groups, community-based distributors, the range of internet sellers of pills (bona fide and not) and who is selling/buying them. Medico/political reactions when women take the pills into their own hands illegally, especially for abortions after 8-9 weeks. Medics say that because women self-using misoprostol are coming with complications, the pills must be kept out of women's hands. But self-use of MA pills has brought about harm reduction compared to traditional unsafe methods, even in the poorest and legally most restricted settings. And it also requires us to develop new concepts of what is safe and unsafe (clandestine = unsafe, but also new aspects of safety beyond clinical outcomes, such as social isolation, psychological harms). Two systems are in conflict with each other – underground and above ground – i.e. self-use vs. medical provision. Inappropriate interventions in hospital emergency clinics for post-abortion care are common due to lack of knowledge of what is needed. Information and the role of pharmacy workers to provide MA pills, with differences in outcomes for women between trained and untrained providers. Role of internet providers of pills and information – positive outcomes and limitations, such as that pills can take 4 weeks to arrive and may be confiscated by customs authorities.

1.5 Increasing access to quality medical abortion: a new commodities database

Speaker: Jennifer Blum (Gynuity Health Projects)

Time: 1:00 – 1:20 pm (15 min presentation and 5 min discussion from the floor)

IPPF is launching the Medical Abortion Commodities Database on 28 September 2018. The database is an online, searchable database that houses information on quality misoprostol, mifepristone and co-packaged mifepristone and misoprostol (combipacks) that are registered and available at the country level. The primary audience for the database includes organisations and procurement managers seeking information on the quality and availability of different medical abortion commodities to inform policy and use in programmes. These include public health and

service delivery managers, staff involved in safe abortion programmes, donors funding projects on safe abortion and maternal health, policy analysts, clinical service providers, and supply chain personnel. IPPF has worked closely with Gynuity Health Projects and the Concept Foundation to develop this database.

Discussion from the floor and announcements

What are the five most important issues from this morning's session?

Time: 1:20 – 1:30 pm

Lunch

Time: 1:30 – 2:30 pm

Parallel Discussion Workshops: Abortion information and services

Time: 2:30 – 5:30 pm (including Tea and Coffee Break from 3:30 – 4:00 pm)

Output from each workshop: 5 recommendations for future action

1.6.1 New forms of provision of information on medical abortion use – national examples and perspectives

Moderators: Jedidah Maina, Kelly Blanchard and Anand Tamang

New forms of provision and how to use MA pills in very different national settings – national information hotlines; pharmacy provision; telemedicine; internet sales; apps; other forms of innovative service delivery – from the poorest to the richest settings. Use of new technology to demedicalise the medical abortion experience and reduce clinic visits to a minimum from start to finish, e.g. to determine length of pregnancy, and ways to check if abortion is complete to reduce the need for follow-up.

1.6.2 Developing a national abortion service and training providers

Moderators: Mariana Romero, Mary Favier and Monica Oguttu

Introduction of new abortion services and training for service providers in legally restricted settings where the law has changed – experience in Argentina and Chile; thinking through different kinds of processes that will work in different settings. How to enable public health facilities to provide abortion services without medicalising them in a 20th century way. Taking provision of medical abortion down to community/primary level. Developing a valid training programme for nurses/midwives, GPs and pharmacy workers to deliver that programme. Reducing the role of hospitals and of obstetrician/gynaecologists to emergency, complex and late cases.

Examples/models of women-centred abortion clinics, e.g. Orientame, Colombia and its transition from its early days when legal abortion was not available, and the advocacy and information work they do in conjunction with the national advocacy coalition.

1.6.3 National registration/approval of one or both MA drugs and national guidelines to ensure their use

Moderators: Beverly Winikoff, Jennifer Blum and Selma Hajri

What must be done to register MA pills, and is it the same in all countries? What then has to be done to get the pills available? What's holding up approval of mifepristone globally? What is misoprostol approved for? Does approval lead to provision being initiated, usage going up, safety and effectiveness increasing? Shifting provision from hospitals/doctors to primary and community level, yes, in theory, but what blockages/ barriers are there in health systems, the law, guidelines and regulations (or the lack of them), training. What is actually on the market and where? What

has happened with Cytotec in France and the consequences and how to avoid such events in the future. Information and experience from the MA data project.

1.6.4 Abortion for fetal anomaly: in legal and illegal settings

Moderators: Jane Fisher and Lieta Vivaldi

These often start out as wanted pregnancies, and the issue of continuing the pregnancy arises mostly in the second trimester due to an unexpected diagnosis, making them very different from the great majority of abortions. Providers are often isolated from other abortion providers, in hospital obstetric clinics. How new, improved techniques for antenatal screening for fetal anomaly are substantially changing the type and timing of screening and its accuracy, and the consequences for women and providers. The importance of counselling and support for making the abortion decision. Which abortion methods are offered to/preferred by women, medical or surgical, and why, with what consequences? Dealing with feticide may be the first step of the abortion and with fetal (tissue) disposal. The WHO definitions of miscarriage, stillbirth and viability are about to change – consequences for an upper time limit on abortion.

Fetal anomaly as a legal ground for abortion in the law. What about countries where these abortions are not permitted in law, e.g. Brazil where Zika virus has been rife in one region. Why did the legal distinction between fatal and serious fetal anomaly come in to law reform bills and should it be opposed?

Anti-abortion opposition to these abortions, e.g. in Poland, is making this issue exceedingly sensitive: The fact that Iceland has eliminated Downs' syndrome is treated by some as a tragedy. The Chair of the UN Committee on Rights of People with Disabilities recommendation to remove fetal anomaly as a legal ground.

1.6.5 Role of health professionals as advocates for safe abortion

Moderators: Suchitra Dalvie, Ana Cristina Gonzalez Velez, Alongkone Phengsavanh and Dilfuza Kurbanbekova

How health professionals can work individually and as part of professional associations and groups, such as a midwives' association, Global Doctors for Choice or Medical Students for Choice, FIGO Unsafe Abortion Project, and in wider coalitions to support access to safe abortion, campaign for improved training, and for excellent guidelines on best practice. Also promoting awareness among health professionals as to why it is important to limit the control by health professionals of access to abortion; challenging perceptions of conscientious objection as an ethical choice for providers due to the restrictions it places on women. Abortion care as part of an employment contract/job description, as in Sweden, to make CO unnecessary.

Day 2

Working towards Decriminalisation

Plenary Sessions

Time: 9:00 am – 1:30 pm

Moderators: Françoise Girard (International Women's Health Coalition) and Rada Tzaneva (Amnesty International)

2.1 What does decriminalisation of abortion mean? Who supports it?

Speaker: Marge Berer (International Campaign for Women's Right to Safe Abortion)

Time: 9:00 – 9:45 am (30 min and 15 min discussion from the floor)

Criminal laws and restrictions on abortion do not meet women's needs or make public health sense. Yet abortion remains subject to restrictions in national constitutions, Supreme Court rulings, judgements in case law, customary or religious law, as well as regulations and consent/age requirements. Total decriminalisation means no law at all on abortion. Legalising abortion means focusing on when it is allowed. There is a major difference between these. This matters, as not everyone who is "pro-choice" is aiming for the same normative ideal. In some settings, a good law might provide more protection of women's rights/decisions than no law at all. Or it may be the only feasible option. Wording is critical, e.g. legal grounds based on threat or risk are particularly tricky. Eliminating gatekeepers is very difficult. The law changes slowly and cannot keep up with new methods and technology. But for many, especially elected politicians, complete decriminalisation is not possible (political compromise). A recent proposal by the French Gender Equality Commission calls for a constitutional clause guaranteeing abortion on grounds of gender equality only. Are legal experts, parliamentarians, judges, and health professionals ready to consider/accept decriminalisation?

2.2 Theorising time and power in abortion law and human rights

Speaker: Joanna Erdman (Dalhousie University)

Time: 9:45 – 10:30 am (30 min and 15 min discussion from the floor)

Struggles over the decriminalization of abortion are ultimately struggles over rights and power. This presentation will address time-based decriminalization (i.e. to 12 or 14 week limits and by indication to 20-24 week limits). The legal regulation of abortion by length of pregnancy is an under-debated dimension of abortion and human rights. Yet struggles over time in abortion law, and its competing representations and meanings, are ultimately struggles over ethical and political values, authority and power, the very stakes that human rights on abortion engage. This presentation focuses on three struggles over time in abortion and human rights law: those related to morality, health, and justice. With respect to morality, the article concludes that collective faith and trust should be placed in the moral judgment of those most affected by the passage of time in pregnancy and by later abortion—pregnant women. With respect to health, abortion law as health regulation should be evidence-based to counter the stigma of later abortion, which leads to overregulation and access barriers. With respect to justice, in recognising that there will always be a need for abortion services later in pregnancy, such services should be safe, legal, and accessible without hardship or risk. At the same time, justice must address the structural conditions of women's capacity to make timely decisions about abortion, and to access abortion services early in pregnancy.

Tea and Coffee Break

Time: 10:30 – 11:00 am

2.3 The progressive and restrictive roles of national courts in upholding /failing to uphold rights; using strategic litigation to challenge restrictive abortion law

Speaker: Godfrey Kangaude (Coalition for the Prevention of Unsafe Abortion)

Time: 11:00 – 11:30 am (20 min presentation and 10 min discussion from the floor)

The range of roles of different kinds of courts (constitutional, criminal, civil) in relation to legal and illegal abortion and abortion regulations – e.g. giving someone permission to have an abortion, determining whether an abortion is legal or not, putting on trial and punishing a woman or provider who has transgressed the law, challenging whether a law on abortion is constitutional or not. Using strategic litigation to take cases in regional human rights courts such as in the Americas and Europe, and in courts of justice or national Supreme Courts or Constitutional Courts. The differences between all these kinds of courts. Current/recent examples of litigation and court judgements have made an important difference: examples of successes and losses, how it can take years to take a case through to a conclusion, and when/how to decide to take a case to different courts. The value and risks of litigation to reform abortion law. Lessons learned from recent key cases from different countries.

2.4 Convincing parliamentarians to take abortion out of the penal code

Speakers: Ana Cristina Gonzalez (La Mesa por la Vida y la Salud de las Mujeres and Global Doctors for Choice) and Clara Rita Padilla (EnGender Rights)

Time: 11:30 am – 12:20 pm (20 min per speaker and 10 min discussion from the floor)

Grounds for abortion and upper time limits on weeks of pregnancy are both full of limitations in the recognition of women's reproductive autonomy. Yet in most of the world these have been the main political goals for the feminist movement in the fight to make abortion legal and safe in recent decades. Of course, other strategies, like harm reduction, improvement of standards and regulations, and expansion of the interpretation of existing grounds have also been a part of these goals. But in each case, abortion remains a crime. Yet there is no way to talk about full decriminalization without repealing the crime of abortion as the way to achieve women's reproductive autonomy. Even then, we still have to discuss whether we need a law to ensure public access to abortion services and whether that law must include specific grounds and upper time limits, or if it means we need to fight for social decriminalization as well and for the ground of the woman's life to be the only ground for abortion. Every abortion law under-values women's lives – biologically and biographically – and this should be the moral fight that feminism puts in place from now. The arguments why we should move forward with this strategy are presented.

2.5 Evolving legal strategies for abortion law reform in Latin America and the role of the biennial CLACAI/PPFA legal conferences

Speakers: Ximena Casas (Planned Parenthood Federation of America) and Susana Chavez (CLACAI)

Time: 12:20 – 12:50 pm (20 min presentation and 10 min discussion from the floor)

The evolving situation in Latin America for abortion law reform and turning threats of restrictions into opportunities. Legal strategies for responding to opponents and approaching experts in other fields of law – e.g. civil law, family law, consumer rights – for support. Holding legal conferences for judges, lawyers, police and other law enforcement officials to teach them about abortion as a legal and more than a legal issue. Aims, goals, participants and agendas of these conferences, and their outcomes in terms of awareness, advocacy and action on the part of participants. How these conferences have changed over time. Whether they can be adapted for development in other world regions.

2.6 Government-approved guidelines and regulations on abortion

Speaker: Evelyne Opondo (Center for Reproductive Rights)

Time: 12:50 – 1:15 pm (15 min presentation and 10 min discussion from the floor)

An overview of existing government-approved national guidelines and regulations on abortion, which are treated as a necessary adjunct to the law, in that they provide a green light for implementation of the law. Conversely, removal of the guidelines makes them a political football and an effective way to stop implementation of any service provision. Their importance is mainly as protection for providers; this needs more recognition. Guidelines must be applicable to both public and private service providers and evidence-based. The case of Kenya. How to address the fact that the guidelines became a focus of anti-abortion opposition. Role of the courts in supporting/allowing their enforcement, or the refusal to do so. If you decriminalise abortion, are guidelines/regulations still necessary?

Discussion from the floor

What are the five most important issues from this morning's session?

Time: 1:15 – 1:30 pm

Lunch

Time: 1:30 – 2:30 pm

Parallel Discussion Workshops: Challenging restrictive abortion laws at national level

Time: 2:30 – 5:30 pm (including Tea and Coffee Break from 3:30 - 4:00pm)

Output from each workshop: 5 recommendations for future action

2.7.1 Working with government officials, parliamentarians, politicians, civil servants, and UN bodies to advance abortion rights

Moderators: Satang Nabaneh, Judith Okal, Marion Stevens, Clara Rita Padilla and Lilian Abracinkas

Working with progressive parliamentarians, politicians and civil servants, and UN bodies to reform the law and campaigning against conservative/reactionary policies.

2.7.2 The most difficult national situations

Moderators: Junice Melgar, Lise-Marie Dejean, Wafa Adam, Natalia Broniarczyk, Krystyna Kacpura and Beatriz Galli

Some of the most difficult national situations, powerful anti-abortion parties and groups, and the feeling of inability to make any progress – Brazil, Poland, Philippines, Haiti, Sudan, Nicaragua.

2.7.3 Developing national advocacy campaigns for abortion law reform on human rights grounds

Moderators: Rebecca Cook, Monica Roa, Mireille Rabenoro, Dalia El-Hameed

How to make human rights understandable as a critical basis for abortion law reform in the eyes of the public, parliamentarians, health professionals, the media, and faith leaders. Addressing and overcoming hostility towards human rights as a universal concept where human rights are mistrusted or rejected as being imposed from outside/culturally foreign, often based on gender

stereotypes and rejected because they will empower women. Contextualisation of human rights at country level instead of just endlessly quoting what CEDAW said in its latest document, etc.

2.7.4 Criminalising women and providers: trials and imprisonment for abortion

Moderators: Sonia Correa, Regina Tames, Sara Garcia, Ana Cristina Vera, Rebecca Brown and Evelyne Opondo

Trials and imprisonment for abortion – Prosecutions are only happening in some countries, why? Where are women and providers in prison (for homicide, infanticide) in addition to El Salvador, Peru, Kenya, USA, UK, Mexico, Senegal. Information is hard to come by, governments do not keep or publish records, sometimes we find out only from local newspaper reports. Why, in many countries where abortion laws are equally restrictive, is no one prosecuted and people simply work around the law. What's the difference? Conflict for health professionals in terms of the requirement of confidentiality but also reporting any crime to the police. In Central America, the USA and elsewhere, pregnant women who don't produce a live baby but have a stillbirth or miscarriage are being criminalised, imprisoned, and stigmatised – why? Is this the criminalisation of anything except a live birth, and how do we counter it as a right-wing campaign against women, especially when led by the police and supported by the courts.

2.7.5 Unwanted pregnancy following child sexual abuse: the role of the courts, medical professionals, parents and the girl herself

Moderators: Sangeeta Rege and Diakhomba Gassama

What should be our stance on unwanted pregnancies resulting from child sexual abuse? Consent and welfare of the child issues, parental involvement. Do such cases belong in court? Role of the law and of clinicians. Would it be valuable to develop universally relevant guidelines? Is second and third trimester abortion "too dangerous" for a child, more dangerous than continuing the pregnancy or having a hysterotomy/c-section? How are these alternatives viewed in different countries? Should we develop an international position paper on this issue?

Day 3

Advocacy and the differing faces of success: National case studies

Plenary Sessions

Time: 9:00 am – 1:30 pm

Moderators: Sonia Correa (Sexuality Policy Watch) and Suchitra Dalvie (Asia Safe Abortion Partnership)

3.1 Argentina

Speaker: Silvina Ramos (Centro de Estudios de Estado y Sociedad) and Mariana Romero (Centro de Estudios de Estado y Sociedad)

Time: 9:00 – 9:30 am (20 min presentation and 10 min discussion from the floor)

A national uprising after years of slow sometimes invisible change. How cases of women in prison have had a major effect for movement building. All the quiet influences that no one outside hears about until they burst into flower. How the change of government mattered. The importance of having a bill ready that was widely supported. The unique process of hundreds of short presentations in the congress and how that played out. Did the anti-abortion movement help or hurt their own cause? The outcome. The effect in other Latin American countries?

3.2 Ireland

Speakers: Grainne Griffin (Abortion Rights Campaign) and Mary Favier (Doctors for Choice Ireland)

Time: 9:30 – 10:00 am (20 min presentation and 10 min discussion from the floor)

Creating a grassroots movement of women to make change happen outside the law in order to challenge the opposition. Advocacy strategies. #MeToo movement made feminism and violence against women a public topic. Social decriminalisation. Public health vs human rights reasons for safe abortion. The influence of the Citizens' Assembly and the referendum as the focus. The argument that women are dying doesn't work in some regions or isn't relevant, and then what? There are other public health arguments e.g. mental health consequences, women having to travel to other countries, dealing with the complexity of fetal anomaly, women who have been raped, women who are denied a legal abortion. But will the new law be saddled with restrictions?

3.3 Chile

Speaker: Gloria Maira (Mesa de Acción por el Aborto) (with Lidia Casas)

Time: 10:00 – 10:30 am (20 min presentation and 10 min discussion from the floor)

How did change take place in Chile and why did it take so long after Pinochet fell? Is there a lowest common denominator of law reform due to the strength of the opposition and is a very narrow reform that only allows a few hundred legal abortions a year worth it? Below what level do we have to say we are shooting ourselves in the foot to accept a limited reform? Or must we just realise it will take 100 years more and take it in slow, tiny steps. Is it a good thing that one political party is already proposing a new reform bill? Has access to medical abortion pills, which was very good, decreased since the new law was passed in Chile? How is implementation going, given the opposition and the new anti-abortion president's shadow?

Tea and Coffee Break

Time: 10:30 – 11:00 am

3.4 Africa: Ethiopia, Mozambique and the African Commission for Human and Peoples' Rights

Speakers: Saba Kidanamariam (Ipas), Dalmazia Cossa (Ministry of Health, Mozambique) and Vania Kibui (Ipas Africa Alliance)

Time: 11:00 – 11.45 (15 min per speaker)

Why did law reform succeed in Ethiopia and Mozambique but not (so far) in Kenya, Malawi or Sierra Leone? How is the African Commission for Human and Peoples' Rights decriminalisation campaign proceeding in the region as a whole? Are other countries being held back by the polemics of resistance to a "Western radical sexual agenda"? What about resistance to anti-abortion "cultural colonialism" imported and funded and managed by conservative religious organisations from the United States.

3.5 Middle East and North Africa

Speakers: Rola Yasmine (American University of Beirut), Dalia Abd El-Hameed (American University in Cairo), Amina Stavridis (Palestinian Family Planning & Protection Association) and Selma Hajri (Groupe Tawhida Ben Cheikh)

Time: 11:45 – 12:25 pm (10 min per speaker)

What's happening in the Middle East and North Africa as regards abortion campaigning and law reform? Who is doing what? Are any governments/health professionals/women's groups advocating for change and is it having any effect? Which governments are actively opposing change, which are staying silent and remote? Are abortions being provided in refugee and displaced persons' camps, and is that influencing mainstream services?

3.6 Central/Eastern Europe and Central/Western Asia

Speaker: Krystyna Kacpura (Federation for Women and Family Planning)

Time: 12:25 – 12:40 pm (15 min presentation)

Abortion is legal, often on broad grounds in this region as an afterlife from the Soviet Union, but abortion services are very conservative and traditional, e.g. still based in hospitals and provided only by gynaecologists, mostly D&C. Medical abortion is hardly available, and abortion mortality is still high. Right-wing governments are constantly threatening to restrict the law, using the "demographic crisis" (birth rates below replacement level) as one of their arguments.

Discussion from the floor for presentations 3.4 – 3.6

Time: 12:40 – 1:00 pm

3.7 Engagement from the top: using the WHO Strategic Approach to assess and reform abortion law, policy and services and importance of WHO guidelines

Speakers: Rodica Comendant (Reproductive Health Training Center) and Ayguli Boobekova (Ministry of Health, Kyrgyzstan)

Time: 1:00 – 1:30 pm (20 min presentation and 10 min discussion from the floor)

The WHO Strategic Approach and how it is applied to studying abortion law, services, politics, opposition, and social attitudes to do a broad assessment of a country's situation in order to mobilise to bring about change. Examples of assessments in Romania, Moldova, Ukraine, Russia, Vietnam, Mongolia, and most recently Kyrgyzstan. Brief history of this approach – it brings together WHO staff, national government ministers, parliamentarians, health policymakers, health professionals and representatives of relevant NGOs and women's groups, to conduct an intensive

analysis of the current state of affairs nationally, making recommendations, piloting interventions and scaling them up nationally – with the aim of improving law, policy, guidelines, service delivery and training, and information for women. Can motivate a renewed national effort to draw key people on board. Relationship between national guidelines and WHO guidelines. How to ensure WHO guidance is implemented, e.g. use of safest methods, stopping use of outdated methods, which health professionals can best provide access to abortion and where, safe self-use guidance for women.

Lunch

Time: 1:30 – 2:30 pm

Parallel Discussion Workshops: Advocacy, strategy and networking

Time: 2:30 – 4:00pm

Output from each workshop: 5 recommendations for future action

3.8.1 National coalition-building to promote change: who, what, how

Moderators: Ana Maria Mendez, Kritaya Archavanitkul, Satang Nabaneh, Teresa Bombas, Sybil Nmezi and Ninuk Widyantoro

Building a national movement and coalition for legal decriminalisation and social decriminalisation. Coalition building and issues of compromise across political affiliations, e.g. NGOs, women's groups, health professionals' associations, drawing in the media, legal people, human rights people, policymakers, parliamentarians, health systems managers, finance people, pro-choice traditional and faith leaders.

3.8.2 International and regional networks and networking

Moderators: Susana Chavez, Judith Okal, Vania Kibui, Suchitra Dalvie, Galyna Maistruk, Beverly Winikoff, Patty Skuster and Rebecca Brown

Building international and regional networks: sharing some history and talking about goals and plans for the future, including cross-regional networking.

3.8.3 Creating a national grassroots movement of women to achieve a critical mass of support for change

Moderators: Lilian Abracinskas, Khadiza Maheen, Daniela Tejas Miguez, Sabine Lamour and Na Young Kim

As Ireland, Chile and Argentina have so powerfully shown in the past year, the notion of a critical mass of support, first and foremost among women, is a crucial element in making change happen on abortion. Building a national women's movement – experience, lessons.

3.8.4 Proposals for youth engagement and participation within the International Campaign, representing the Campaign globally, and sharing experiences of working as young women and with young women on abortion rights

Moderators: Shruti Arora, Kulapa Vajanasara, Wafa Adam, Natalia Broniarczyk, Lola Guerra, Gulalai Ismail, Dhivya Kanagasingham, Elida Luz Garcia and Laura Molinari Alonso

Is there interest in creating a youth network within the Campaign to have a voice and take action as a part of the Campaign? Priorities, goals and proposals. Sharing experiences of working as

young women and with young women on abortion rights in different national settings, creating a movement, activities, resources, using new technologies, social media, videos and visual arts, projects, community outreach, gathering personal stories and support.

3.8.5 Violence and death threats by the anti-abortion movement

Moderators: Sonia Correa, Ana Cristina Gonzalez, Mariana Romero

This workshop is being called at the last minute to discuss the death threats against abortion rights advocates taking place in Brazil, Argentina, UK and Mexico, and perhaps elsewhere too.

Tea and Coffee Break

Time: 4:00 – 4:30 pm

Closing Plenary

Time: 4:30 – 5:30 pm

Moderators: Marge Berer and Vania Kibui

Future work of the Campaign

Time: 4:30 – 4:45 pm

Plans for/report on regional meetings

Susana Chavez, Rodica Comendant and Satang Nabaneh

Time: 4:45 – 5:00 pm

– CLACAI, Latin America, November 2018

– Reproductive Health Training Center, Eastern Europe/Central Asia, November 2018

– Report of the Campaign workshops at the Abortion & Reproductive Justice Conference in South Africa, 9-11 July 2018

Inspirational Concluding Speech

Speaker: Melissa Upreti (Working Group on the issue of discrimination against women in law and in practice, OHCHR)

Time: 5:00 – 5:15 pm

Closing and acknowledgements

Time: 5:15 – 5:30 pm

Acknowledgements

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- Catholics for Choice, USA
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