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Assessing Youth Friendliness of Abortion Services

An analysis of youth-led audits of 48 abortion facilities across 2 states of India

ACKNOWLEDGEMENTS

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Written by: Kavya Ecofeminist

Youth leaders who led the audit: Anjali Mirdha, Amos, Bidisha Ghoshal, Bobita Saikia, Firsha V, Neha Anwar, Nikumoni Sarmah, and Jincy.

ABOUT THE YP FOUNDATION

The YP Foundation (TYPF) is a youth-led and focused organisation that facilitates young people's feminist and rights-based leadership on issues of health equity, gender justice, sexuality rights, and social justice. TYPF's Safe Abortion For Everyone programme works with young people from Assam and Kerala to undertake evidence-based narrative building for safe abortion issues using a rights-based framework, and facilitate policy-level interventions with government stakeholders to improve abortion service delivery.

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INTRODUCTION

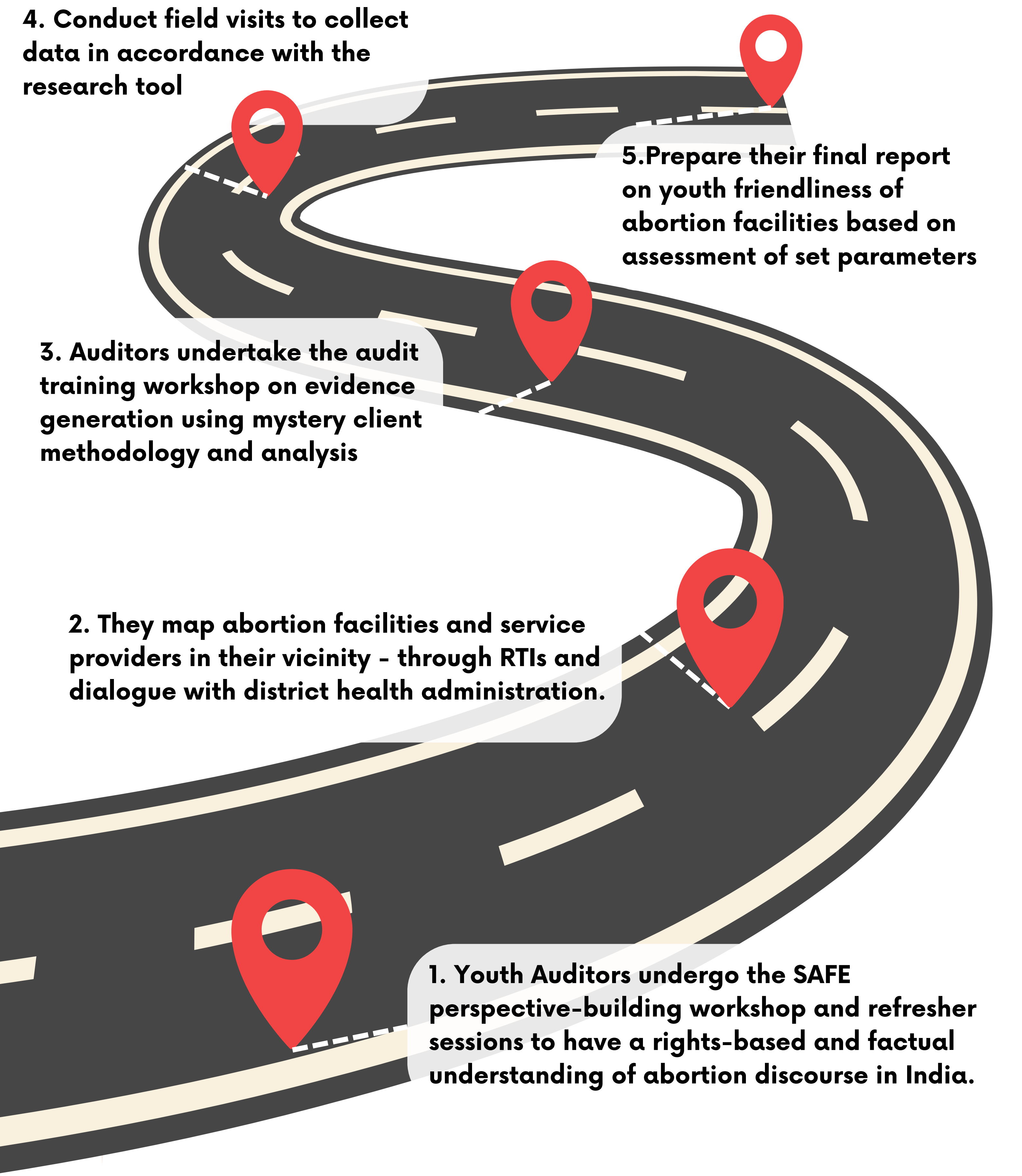
While the Medical Termination of Pregnancy Act (MTP) of 1971 legalizes abortion in India, its acceptance is overshadowed by religious, moral, ethical, and socio-cultural considerations. Persistent negative community attitudes, coupled with insufficient access to accurate information on safe sex practices and abortion, as well as challenges in upholding the bodily autonomy of young individuals, contribute to deterring individuals from seeking healthcare services. The existing stigma surrounding pre-marital sex and contraception usage exacerbates the situation, emphasizing the need for a rights-based and pleasure-affirmative approach to address the complexities of young people's sexual and reproductive healthcare needs.

The fear of judgment from service providers, uncertainties regarding medico-legal restrictions, and a lack of privacy and confidentiality in health facilities can influence young abortion seekers to resort to unsafe methods, exposing them to severe health risks and exorbitant costs.

Are existing healthcare services and facilities well-equipped to accommodate the unique needs of young people? How should interventions be designed and implemented to make abortion facilities youth-friendly?

In an attempt to answer these questions, the **Safe Abortion For Everyone (SAFE) programme** led by The YP Foundation aims to equip young people with evidence-based and factually accurate information on safe abortion and engage them in generating evidence that is grounded in their lived experiences as well as identifying and assessing gaps in service delivery, providers' attitudes and accessibility of abortion services from a young person's perspective. This report aims to analyse the evidence on the status of abortion services for young people generated by 8 youth leaders from two states of India (Assam and Keralawho were onboarded and trained to conduct audits of abortion facilities in their respective districts.

IMPLEMENTATION ROADMAP



METHODOLOGY

The primary objective of the research study is to map the youth-friendliness of abortion facilities and service providers by making a qualitative assessment of the responsiveness, attitude, accessibility of the abortion providers and the authorities involved as well as by identifying potential barriers. To ensure the validity of quality assessments and to get insight into actual experiences of young beneficiaries, the mystery client methodology is used,

Mystery Client (MC) methodology is a form of participatory research that aims to provide a unique opportunity to monitor and evaluate the performance of health care providers or health facilities, in this case - abortion facilities, from the perspective of the service user. It has been used in several studies to assess the quality of health care delivery and evaluate areas for improvement.

Training workshops were conducted prior to the field surveys to familiarize the researchers with the process and make them comfortable with their role as undercover auditors. Moreover, an audit tool was developed for the purposes of data collection.

Indicators with the potential to evaluate the quality and responsiveness of abortion service providers were identified and incorporated into the tool. To identify provider bias, participants posed as unmarried and, in some cases, married individuals. Some participants were accompanied by male company (spouse or boyfriend), female company (sister or friend), and in some facilities went alone as well.

To collate a list of service providers in their respective districts, the auditors also filed RTI applications in the 4 districts (Jorhat and Sonitpur in Assam and Trivandrum and Kozhikode in Kerala). In cases where the response did not come through, auditors contacted the district medical office and other government health stakeholders to compile a list of abortion service providers to audit.

STUDY SETTING

48 audits were conducted across 2 states – Kerala and Assam, by 8 auditors – 7 female and 1 male, across 23 government and 25 private facilities.

AUDIT TOOL

Audit tool is presented in a tabular format with all the parameters assessed and the variables under each parameter below:

Audit Tool Analysis

Sl No.	Assessment Parameters	Variables Involved			
1	Accessibility of service	Location of the facilities	Proximity to public transportation services	Availability of directional signage	Disability-friendly infrastructure
2	Timing and duration of availability of services at the facility	Operational hours of the facilities	Operational days of the facilities	Whether they open and close at convenient hours	
3	Waiting time to avail the services	Duration of waiting time at the facility - more or less than 30 minutes	Time availed with the service provider	Was time spent with the service provider adequate	

4	Cost of services	Cost of registration	Consulting fees	Total cost of undergoing an abortion	
5	Overall infrastructure of the facility	Availability of way finding signage systems within the facilities	Adequate space in the waiting area	Adequate seats in the waiting area	Quality of the toilets
6	Availability of abortion-specific IEC material	Type of IEC material displayed in the consultation area	Is the IEC material displayed abortion-centric		
7	Privacy and confidentiality	Maintenance of discretion at the reception desk	Presence of other patients in the consultation room	Interference by staff during consultation	Whether the consultation room provided auditory and visual privacy
8	Insistence on knowing marital status	Whether the service providers probed to know the marital status of the service seeker	Whether the service providers denied services on grounds of marital status		

9	Insistence on guardian/parental consent	Whether the service providers insisted on getting parental consent despite the abortion seeker's age being 18 and above	Whether the service providers denied services on grounds of guardian/parental consent		
10	Respect and sensitivity by the service providers	Whether the service provider was non-judgmental	Whether the service provider was sensitive	Whether the service provider was respectful	Would you refer the service provider to your peers
11	Provision of comprehensive information by services providers	Whether the service provider provided accurate information	Was the information provided sufficient to answer the queries and concerns		
12	Feedback mechanism within the facility	Whether any verbal or written feedback was sought from the patient	Whether grievance redressal was ensured		

The data has been analysed across the variables and parameters to help us understand the gaps and opportunities in this area and effectively advocate for policy changes that will benefit a young client who wants to avail safe and healthy abortion service, because this is everyone's undeniable right.

ACCESSIBILITY OF SERVICE

The variables considered are the location of the facilities, their proximity to public transportation services, and, the availability of directional signage and disability-friendly infrastructure.

- For a young beneficiary of abortion services, the location of access points is a crucial criterion that decides the overall convenience and cost of accessing the required services. The centrality of location along with reliable public transport accessibility ensures mobility and cost-saving. It is to be noted that certain Taluk hospitals and PHCs among the facilities audited are not easily accessible and do not even provide the desired service, but they do serve as the first point of getting the essential medical service, and getting referrals for bigger hospitals.

- 91.66% of the facilities audited were centrally located and were easily accessible via public transportation services like auto-rickshaws and buses. The 4 facilities that were not centrally located were in Assam. 2 of these were private and 2 were Primary Health Centres.

- The availability of clear and reliable directional signage on the road is important for easier navigation. However, directions on the road were available for only 35.42% of the facilities out of which 14 were Government facilities and 17 were private. Even without signages, it was possible to find the facilities via guidance from locals. This is a critical issue, because youth who are either not married or seeking abortion are both a stigma in the society and in that situation, it may not be a pleasant experience asking for directions to the hospital, especially if there is a fear of exposing identity.

- Only 3 out of the 48 audited facilities did not have ramps, wheelchairs, and lifts for disabled persons. Out of these 2 are in Kerala (1 government and 1 private facility each) and the 3rd is a private facility in Assam. In this government facility with no disability-friendly infrastructure, the gynaecology department where the service can be availed, is on the first floor. This can be especially difficult for pregnant persons with disability and anyone who wants to avail abortion services. However, the mere availability of ramps and elevators is not sufficient, they must be properly maintained to ensure inclusivity.

TIMING AND DURATION OF AVAILABILITY OF SERVICES AT THE FACILITY

The variables considered are the operational hours and days of the facilities, and whether they open and close at convenient hours. To arrive at an objective assessment of convenience, MNREGA working hours (8 AM- 5PM) and school/college hours on weekdays (9 AM- 3PM) are taken into account.

- All facilities are open on weekdays and are mostly operational from 10 AM to 2PM, which makes it inconvenient for most clients. 6 private facilities (2 in Kerala and 4 in Assam) are open after 5 PM, which is helpful for many people to access after work or school/college. 2 government facilities in Kerala are open from 6 am, also assuring better access. Only 14 facilities are operational 24×7, out of which 8 are private and 6 are government facilities.

WAITING TIME TO AVAIL THE SERVICES

The variable considered is whether the waiting time at the facility was more or less than 30 minutes, and the time availed with the service provider and whether it was effective; at least 10 minutes with the service provider is considered as reasonable.

- 70.83% of facilities had a reasonable waiting time, out of which 15 were private and 19 were government facilities. Unlike the results in the last audit, it was seen this time that more government facilities had less waiting time.

- Longer waiting time (30 minutes- 2 hours) corresponded to longer time available with the service provider. Apart from the crowd, service providers investing time with the patients could be the reason for this. However, the time spent with the service provider was not a direct indication of the effectiveness of the interaction. 37% of cases where the auditor got more than 10 minutes with the service provider did not translate into satisfaction from the consultation. In many situations, either the service provider or the supporting staff or both used the extra time to judge, intimidate, manipulate, or even question provocatively or, flirt etc with the auditor, instead of examining thoroughly, or providing comprehensive information or generally making them comfortable.

- In one government facility in Kerala the auditor had to go a second time to be able to meet the service provider, and in another government facility in Kerala meeting was possible only on the 3rd visit due to excessive crowding.

COST OF SERVICES

The variables considered are the cost of registration and consulting fees. Information provided by a few service providers on total cost of undergoing an abortion is also taken into account.

- Registration and consultation were mostly free and subsidized in Government facilities with a minimal fee of Rs. 5-10 in most cases.

- The cost of registration and consultation in private facilities ranged from Rs. 250-500.

- During consultation, the cost of MTP kit and surgical abortion was discussed. The cost of a MTP kit varied from 2000-5000. Few service providers at government hospitals were asking the auditors who dressed as wealthy clients to come to their clinic and pay a high sum for the same. Some even offered to get these expenses in smaller amounts multiple times via Google pay. In the 5 private facilities that confirmed to perform abortion, they charged between 20,000 to 40,000 INR.

- In most cases, the service providers asked the auditors to go outside and get an ultrasound scan to see the size of the uterus and told that they could design an abortion plan only after that. In most cases, the auditor offered to come back with a scan and so could not discuss the rates further.

- In two cases the auditors were forced to undergo a scan, despite their protests. It also scared the auditors as they worried about the consequences of being discovered with a fake pregnancy. In one of these cases, the auditor was able to evade these attempts with the help of companions who accompanied. In another case, there was no sign of an embryo in the scan which the doctor said was common in the early days of conception. Another auditor was able to evade a scan, but the doctor forcibly touched her, and said that there was a mild growth of an embryo.

OVERALL INFRASTRUCTURE OF THE FACILITY

The variables considered are the availability of wayfinding signage systems within the facilities, adequate space and seats in the waiting area, and the quality of the toilets.

- Out of the 48 facilities, the auditors found it challenging to navigate the facility only in the case of 2 government facilities, both of which are extremely big hospitals and hence difficult to navigate, and also at 1 private facility in Kerala. In all other hospitals, there was either a reception desk or staff who would easily help identify the required facility.

- While most facilities had decently spaced waiting areas with adequate seats, auditors who visited government facilities during peak visiting hours (11 AM- 1 PM) reported a crowded waiting area. A similar situation was experienced in the smaller private facilities too. Most private facilities had a fan and provision for free drinking water too.

- Toilets at 2 facilities (1 private and 1 government) could not be audited since they were not accessible. Around a quarter 25% of the toilets were unusable - dirty, broken, no water, stinky, etc, while the rest were usable. None had any menstrual products in the toilet.

PRIVACY AND CONFIDENTIALITY

The variables considered are maintenance of discretion at the reception desk, presence of other patients in the consultation room, interference by staff during consultation, and whether the consultation room provided auditory and visual privacy.

"The doctor's behavior was unprofessional and inappropriate. He exhibited flirty and intrusive conduct, including attempting to touch me inappropriately, and showed a concerning level of interest in my personal life. This behavior was highly unbecoming of a healthcare professional.." In a government facility in Assam accessed by a married female.

- In only 18 facilities, discretion was maintained at the reception; of these 15 are private facilities. Extreme crowding and lack of space is a common feature of most government facilities. Many government facilities allowed two or more patients into the consultation room where already 2-4 doctors will be consulting patients simultaneously, sometimes with a cloth curtain between them, making communication difficult and uncomfortable for the abortion seeker. Too much privacy up to a stage where even nurse is not present in the consultation room was also a problem, as a service provider started asking too personal information about body and family and started flirting and attempted to touch inappropriately.

"there were many patients, our interaction with doctor took place in the middle of a crowd." In a government facility in Kerala accessed by an unmarried female.

Even the supporting staff would stare or behave awkwardly - "the reception area was crowded with male individuals. The receptionist (male) was not only staring but also persistently asking questions and displaying a high level of interest throughout our entire visit, which created a significant degree of discomfort." In a government facility in Assam accessed by an unmarried female.

INSISTENCE ON KNOWING MARITAL STATUS

The variables considered are whether the service providers probed unnecessarily to know the marital status of the service seekers and if they denied services on those grounds.

"The service provider after speaking to me, loudly said to the senior doctor, 'unmarried, need MTP'; this was followed by extremely uncomfortable stares from other patients and staff. "In such hospitals, I wish there could be adolescent/youth health counselling facilities. So that we can avoid all the insecurities and fear in seeking services."
In a Govt. facility in Kerala, accessed by an unmarried female.

Doctor said "Services cannot be provided from here since you are unmarried; here all your details will have to be entered into the system and this may cause trouble for you later. Instead you can come to my clinic with the scanning report, along with 5000Rs for the pills. If you don't have the entire amount with you at present, you many send it later in multiple smaller amounts via Gpay." The doctor asked me to sign a stamp paper. There was a concern that if there were any complications in the future, the doctor would have to answer.
In a Govt. facility in Kerala, accessed by an unmarried female.

"Go home and think well, and come back only after that. It is easy to regret after making these decisions."
In Govt. and in private facilities in Kerala, accessed by an unmarried male.

- Service providers in 40 facilities (20 government and 20 private) insisted on knowing marital status. 10 private facilities (9 in Assam and 1 in Kerala) denied abortion services to unmarried persons. Doctors of general medicine at 2 government hospitals in Kerala and at 1 private hospital in Assam informed that they are not allowed to provide service to unmarried abortion seekers. Gynecologists at 2 government hospitals in Kerala informed that the service cannot be provided through the government facility and asked to go later to their private clinic to get the procedure done after taking the ultrasound scans.

The male auditor received fewer instances of awkward stares and moral policing for engaging in pre-marital sex.

INSISTENCE ON GUARDIAN/PARENTAL CONSENT

The variables considered are whether the service providers insisted on getting parental consent despite the abortion seeker's age being 18 and above and if they denied services on those grounds.

"There was a lot of scrutiny and judgment along the lines of "Is your family aware of this? How can you come here without letting them know?"
In a private facility in Kerala, accessed by an unmarried female.

- Service providers in 27 facilities, 13 government and 14 private, insisted on having parent's consent. In circumstances where some of the auditors posed as married individuals, their husband's consent was demanded. Similarly, the presence of any family member too made the service provider empath etic to the abortion seeker.

In the case of a private facility from Kerala, the doctor did not seem to have a moral issue with the abortion itself but was hesitant due to other reasons. She spoke of past instances, saying **"There have been cases where we are held responsible by families and communities for doing these things. So it is always better to come with a parent or a spouse. Otherwise, it can later become very difficult."**

Service providers from 42% facilities (10 private and 10 government) denied service without the presence of a parent/guardian.

A female auditor was denied service by 4 facilities (3 government & 1 private) unless she brought along a guardian. One of these government facilities was a Woman and Child hospital, catering primarily to pregnant women. One facility, denied service no matter the client's situation as she believed that abortion is a sin and all associating with it would also be sinners. A private hospital with a male service provider was extremely sensitive, respectful and provided complete information, and agreed to provide service when the pregnant person wanted it, irrespective of marital status, parental or spousal consent.

RESPECT AND SENSITIVITY BY SERVICE PROVIDERS

The variable considered is whether the service provider was non-judgemental, sensitive, and respectful during consultation.

"The room lacked privacy, as Asha workers were frequently entering and exiting, and patients waiting near the door were in close proximity, making it possible for them to overhear all conversations between the doctor and the patient."
In a government facility in Assam, accessed by an unmarried female.

- In 19 facilities (9 private and 10 government), auditors observed that service providers and staff showed respectful and sensitive behaviour. There were 5 service providers (1 female and 4 males, across 2 private and 3 government facilities) who did not even ask anything about marital status or the absence of parents or guardian.

It was also seen that when the service provider was non-judgmental and sensitive, the junior/trainee service providers and the supporting staff also followed the same attitude and behavior. However, extremely opposite behaviors were also displayed. 2 female service providers from two different private facilities in Kerala asked the auditor to never abort as they considered abortion as a sin, and anyone associated with it as a sinner. Another male doctor who had religious symbols on him, asked multiple personal questions to an auditor to ascertain their religion, and quoted their religious tenets to make them rethink the decision to abort.

DISPLAY OF ABORTION RELATED IEC MATERIAL

The variable considered is the type of IEC material displayed in the consultation area and whether it is abortion-centric.

- A lack of IEC materials with comprehensive information on safe abortion was reported across all facilities.
- While brochures and posters on pre-natal care, maternal care and breastfeeding were available in most facilities, only 2 private facilities in Assam had IEC material on the female reproductive system and PCPNDT Act

PROVISION OF COMPREHENSIVE INFORMATION BY SERVICE PROVIDERS

- 40% of service providers were found to provide comprehensive information on abortion and contraception, of this 11 were government facilities and 8 were private facilities. 1 male (from Trivandrum) and 1 female (from Kozhikode) service provider from different private facilities took extra effort to explain all details and also exhibited extreme sensitivity; whereas some other service providers were not interested to even have eye contact during the consultation, whereas some other provider was on the phone and never even completed the consultation.
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- Wrong information such as aborting a first pregnancy can harm the pregnant person's health, abortion is a complicated process that will involve hospital admission, extreme pain and bleeding etc., were provided by all 5 of the service providers who seemed to not agree to abortion as a safe reproductive service.

FEEDBACK MECHANISM WITHIN THE FACILITY

The variables considered are whether any verbal or written feedback was sought from the patient and whether grievance redressal was ensured.

- Patient feedback can be considered a strategic tool to improve the quality of patient-centered care and increase accountability.

- In all the 48 facilities, there was no mechanism for seeking any verbal or written feedback post-consultation.

KEY OBSERVATIONS

1. Unregulated overpricing of abortion services was observed in private and government facilities. Abortion kits and pills are sold at hiked prices in their own clinics. This was done by service providers of both government and private clinics. The cost ranged from 750Rs to 5000Rs.

2. Service providers and staff were observed engaging in unethical practices in some facilities. A private hospital referred one of the auditors to an unregistered facility and offered to get payments in installments via google pay. In another private facility, the service provider tried to conduct a two-finger test, which was banned by the Supreme Court in 2013, on an unmarried researcher.

   "She forced me a lot to do a vaginal examination to check for growth of foetus; I was scared and objected a lot as I was scared that she would penalize me heavily for displaying a 'fake' pregnancy. Finally I had to let her check my stomach externally. She checked and said that there was some growth. I was relieved and found it funny in the end."

3. There was a tendency among service providers to impose value judgments on pre-marital sex and have a moralistic perspective on abortion. 12 private facilities (9 in Assam and 1 in Kerala) denied abortion service to unmarried persons. and one tertiary-level government facility in Assam denied abortion service to unmarried persons.

   "**They made it clear that if I proceeded without a guardian, they would not assume responsibility for any potential consequences that might occur afterward."**
   In a government and private facility in Assam, accessed by an unmarried female.

4. A gender-based disparity was observed when a man accompanied the beneficiary as a spouse/boyfriend and a woman accompanied them as a sister/friend. Provider bias was observed based on who their companion was. In the former case, it was felt that service providers and supporting staff were cordial but faced some cases of moral policing to be "responsible adults". In the latter, it was felt that the staff were likely to be inhospitable, intimidating, and unsympathetic.

5. The lack of clarity on legal knowledge such as provisions of the MTP Act, 1971, its amendments, and its conflations with the PC-PNDT Act, 1994, and POCSO Act, 2012 was observed among service providers. For example, instances faced by the auditors included doctors suggesting a two-finger test or forcing to externally touch the pelvic area, conduct an ultrasound scan, etc for pregnancy verification, using unmarried status, forcing their personal beliefs that abortion is a sin or even trying to convince the auditor using the auditor's religious tenets (the doctor could identify the religion with their name) - to deny abortion services, or insisting on parental/family consent for adults, especially citing past experiences where family members had harassed the doctor for aborting in the absence of family.

6. Confidentiality was breached mostly in government hospitals due to allowing two patients together in the consultation room or due to overcrowding.

7. Even though the auditors were over 18 years old, in 27 establishments, service providers insisted on obtaining parental or in some cases spousal consent. This demonstrates a blatant disregard for both legal requirements and the recent Supreme Court judgment that broadened the provisions of the MTP Act.

8. Requests made through RTIs to obtain information about abortion service providers in the two states (spanning four districts) received responses solely from one district in Assam. In the remaining instances, no responses were received. In Trivandrum, the RTI reply indicated that the District Medical Office lacked information on government facilities offering abortion services.

TO IMPROVE YOUTH FRIENDLINESS AT THE PROVIDER LEVEL

1. Communicate is a sensitive and non-judgemental manner:

Address communication barriers by fostering an environment where young abortion seekers and service providers can discuss sensitive aspects of their sexual and reproductive health openly. Prioritize emotional safety of young people belonging to marginalized social locations to encourage service utilization, focusing on reducing intimidation and enhancing trust through improved client-provider interactions.

2. Uphold the young client's autonomy:

Overcome societal and religious taboos by ensuring service providers uphold the autonomy of young clients in their decisions regarding abortion. This requires periodic sensitization of service providers so that despite their moral perspectives on pre-marital sex, they can deliver unbiased and comprehensive information. Only with the support of service providers, we can promote the informed and autonomous decision-making of abortion seekers while safeguarding the continuity of safe abortion services.

3. Seek informed consent:

Young unmarried clients and abortion seekers belonging to marginalized groups often fear judgement which dissuades them from asking all their queries and concerns. Hence its of utmost importance to safeguard the decision-making capacity of young abortion seekers by providing clear, simple explanations about the procedure, its benefits, potential risks, and their right to make decisions about their own bodies. Uphold the principles of informed consent to empower clients with accurate information.

4. Adopt a rights- based approach:

Despite their subjective opinions and perspectives, service providers must recognise access to abortion as an essential human right and denial of service based on preconceived biases is a violation of that right. Providers should be well-versed in the MTP Act, understanding its interplay with the POCSO Act and PCPNDT Act to navigate medico-legal restrictions effectively.

5. Avoid using stigmatising language:

Mitigate unintentional stigmatization of abortion by refraining from terms such as "aborting a baby" or "female foeticide." Use neutral language like "embryo/foetus," "terminating a pregnancy," and "gender-based sex selection" to dispel myths and promote accurate information.

6. Maintain privacy and confidentiality:

Address the fear of social repercussions by ensuring strict confidentiality during consultations, and protecting the identity of young clients. This measure prevents potential violence and stigmatization related to pre-marital sex and abortion.

7. Equip young clients with comprehensive information on abortion:

Prevent potential health risks by offering young clients accessible, comprehensive information on abortion. Avoid denying information based on age and marital status, or imposing religious views on the abortion seeker.

8. Provide counselling on safe sex practices and contraceptive services:

It is crucial to provide counselling on safe sex and contraception to young abortion seekers in order to avoid unplanned pregnancies in the future and maximise their autonomy and choice. Establish follow-up support services for young individuals after abortion procedures. This could include counseling, access to contraception, and guidance on reproductive health to ensure holistic care and support. Provide options to consult for mental health support - BEFORE AND AFTER AVAILING ABORTION SERVICES

9. Care for survivors of violence:

Acknowledge the link between unwanted pregnancies and sexual violence. Sensitize providers to relevant laws, facilitating redress for victims of violence while offering necessary medical aid.

10. Do not pressurize parental consent:

Navigate abortion stigma by assessing situational contexts to balance the dynamics between young clients and parents. Uphold the autonomy of clients aged 18 and above, while for minors, adhere to the POCSO Act, suggesting a trusted adult in lieu of parental consent.

TO IMPROVE YOUTH FRIENDLINESS AT THE FACILITY LEVEL:

1. Stock Essential commodities and other supplies:

Pregnancy test kits, medical abortion pills and other contraceptive devices like condoms, oral contraceptive pills, etc. should be made easily available in clinics and hospitals.

2. Ensure effective wayfinding signage system within the facility:

To help young abortion seekers easily navigate the facility on their own, it is crucial to install physical/digital signages that helps them locate and identify the service providers.

3. Ensure availability of service providers of the same gender:

To address communication barriers and increase comfort, the provision of service providers of the same gender must be ensured. In case of a consultation of a female client by a male provider, it is essential to have a female chaperone in the room, unless requested otherwise by the young client.

4. Maintain infrastructure and cleanliness:

It is crucial to ensure that the facility premises, including the OPD and consultation room, are kept clean and maintained in good physical condition. Moreover, it is important to comply with WASH guidelines. It is to be noted that lack of access to clean water and sanitation can especially discourage menstruating and assigned female at birth (AFAB) clients from seeking healthcare services.

5. Train support staff to be more sensitive:

Support staff should be trained on following protocols, upholding rights, maintaining privacy and confidentiality of young abortion seekers as well as helping them to navigate the facility.

6. Displaying IEC material on safe abortion:

Ensuring availability of pamphlets, brochures and other IEC material that provides accurate and easily comprehensible information on safe abortion, its legalities and associated stigma can play a pivotal role in bringing awareness, eradicating myths and misinformation, and championing the cause for access to safe abortion.

7. Develop mechanism for feedback and engagement:

Providers should ensure that verbal feedback is sought post consultation to confirm whether all doubts were addressed and comprehensive information was provided. To increase accountability and identify gaps in service delivery, a mechanism to get feedback from young people anonymously should be organised. These inputs and grievances should be periodically assessed and addressed.

8. Ensure auditory and visual privacy:

To make young abortion seekers feel safe to consult the service provider, the environment of the facility must ensure that privacy is maintained. Visual privacy should be ensured by installing separate enclosures and curtains. Moreover, auditory privacy should be maintained by keeping other people out of the room and not letting people in OPD overhear conversations with the young person.

9. Provide mental health support to clients requiring abortion - both before and after providing the service.

RECOMMENDATIONS FOR GOVERNMENT STAKEHOLDERS:

1. Establish youth-friendly health services:

Develop guidelines and standards for healthcare providers, ensuring that clinics offering reproductive health services, including abortion, are youth-friendly. Encourage training programs for healthcare professionals on effective communication and addressing the specific needs of young clients.

2. Regulate pricing of abortion services:

Affordability of abortion services is a crucial factor that influences a young person's decision to seek safe abortion. Higher costs at private facilities and lack of information on standard costs can lead to overpricing. The state must focus on regulating the abortion economy in India to make safe abortions accessible to all.

3. Provide comprehensive abortion care (CAC) training to providers:

To ensure the provision of high-quality comprehensive abortion services to young people, periodic training should be provided to healthcare providers with relevant specializations and skills. Engage in dialogue and sensitization of service providers to enable them to challenge their own stigma in order to foster a supportive environment for young individuals seeking reproductive healthcare.Moreover, service providers have to be made aware of the socio-cultural barriers surrounding abortion so that they can assist young abortion seekers to engage in health-promoting behaviours and opt for safe services.

4. Orientation of ASHA workers:

ASHA workers in many cases are companions for abortion seekers who are not equipped to navigate the heath system. With this in regard, training should be provided to community health workers to increase their competency in providing information, support and supervision as well as assist young people in visiting safe abortion facilities while maintaining confidentiality.

5. Undertake public messaging on safe abortion:

Launch statewide public awareness campaigns to destigmatize abortion and promote accurate information on reproductive health. Involve government agencies in disseminating information through various media channels to reach a wide audience. Existing IEC material that uses stigmatizing language and inappropriate images like pregnant women with 'baby bumps' or fully formed foetuses with a sense of sadness or trauma around abortion should be reviewed and revised.

6. Invest in comprehensive sexuality education:

Allocate resources for the development and implementation of comprehensive sex education programs in schools and colleges. Support curriculum development that includes age-appropriate information on reproductive health, contraception, and abortion to empower young individuals with accurate knowledge.

Registered Office:
A-16, Geetanjali Enclave,
Malviya Nagar, New Delhi
(110017)

@TheYPFoundation

theypfoundation.org