REPORT: RESULTS OF THE INTERNATIONAL SURVEY OF ABORTION PROVIDERS AND COMPANIONS

safe2choose

Ipas SALUD ACCESO DERECHOS
CAM | Centroamérica y México

This document presents the results of a safe2choose international survey, which was available on its website and social media. The results were also shared with partner organizations in 2018. The objective of the survey was to understand the experiences of abortion companions and providers around the world. A total of 341 companions/providers from 6 regions in the world participated. The analysis of results used mixed methods. The results focus on the stressors and stigmas that survey respondents faced in their experiences as providers/companions and the differences in these issues based on each person's characteristics.

REPORT: RESULTS OF THE INTERNATIONAL SURVEY OF ABORTION PROVIDERS AND COMPANIONS

safe2choose

Ipas SALUD ACCESO DERECHOS
CAM | Centroamérica y México

INDEX

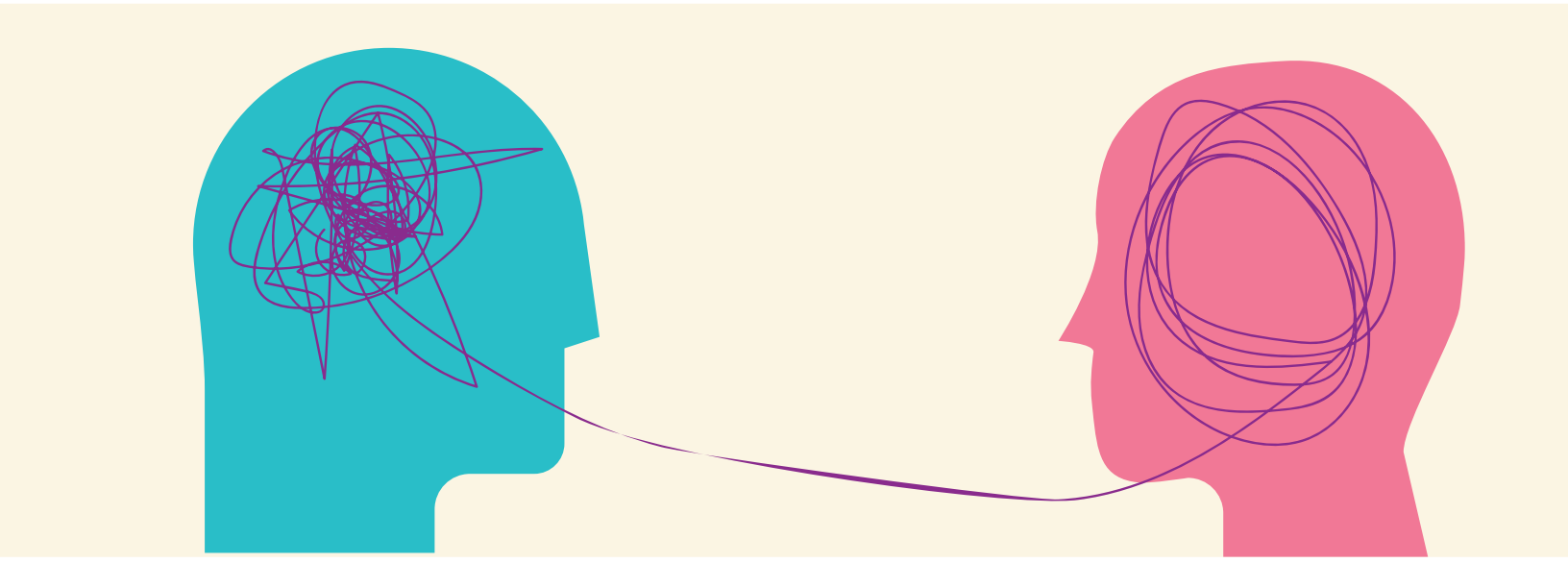
1. OBJECTIVES OF THIS DOCUMENT

General objective

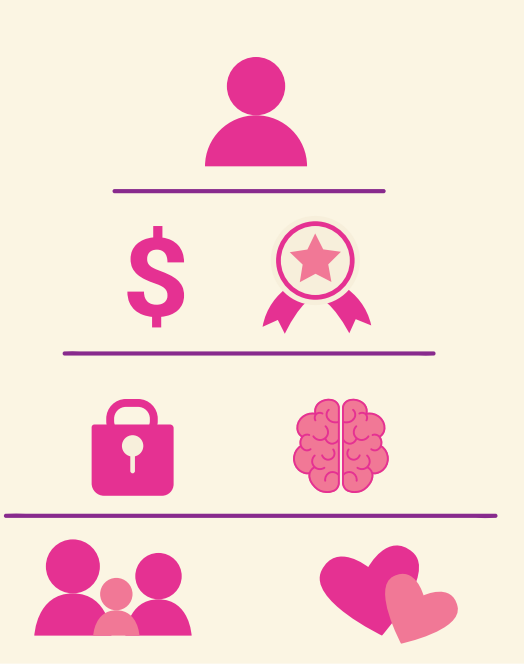
Describe the experiences of abortion service providers/companions that participated in the online survey regarding strengths and challenges in the context where they provide abortion.

Specific objectives

- Identify the most significant stressors and stigmas that abortion service providers/companions face at work.
- Identify the most significant stressors and stigmas that abortion service providers/companions face in their private life.
- Identify the differences in the stressors and stigmas of abortion service providers/companions based on their sociodemographic characteristics.
- Identify the differences in the stressors and stigmas of abortion service providers/companions based on their professional, commitment, training, and identity characteristics.
- Identify the differences in the stressors and stigmas based on the characteristics of the legal framework of abortion in the regions or countries where abortion service providers/companions work.



2. METHODOLOGY



DESIGN

The main objective of the questions was to measure the stigma encountered by abortion providers on different levels. The questions were designed based on previous research led by Martin *et al.*, (2012; 2014; 2018).

Participants

A total of 341 people participated in the survey. To participate in the survey, respondents had to be abortion providers or companions from any part of the world, regardless of the legal restrictions concerning the termination of pregnancy in their country.

Instrument

The survey consisted of 50 questions that included:

1. **Sociodemographic characteristics:** region, age, nationality, country where they work, gender, schooling level, marital status, ethnic identity, religion, and whether they have children.
2. **Professional characteristics:** profession, experience in the field of reproductive health, type of organization they work for, the number of abortions said organization provides and that they provide, the type of abortion methods, and the trimester in which they perform it.
3. **Identity characteristics:** where they received training on abortion methods, whether they consider their training sufficient, and what aspects, if any, they would like to strengthen. In addition, they were asked whether they enjoy companionship/provision, if they are proud of their work, and what makes them most proud.
4. **Stressors:** whether they believe their job is stressful, and if so, which areas are most stressful; what they consider to be the most significant challenges in their role as companions/providers; and what would help them overcome those difficulties.
5. **Stigma:** whether they feel guilt or shame because of their job and if so, why. Whether they believe it is hard to share with others what their work in abortion care consists of and why, and the reasons they continue to do this work.
6. **Experiences of violence or discrimination:** whether the provider or companion, or a loved one, experienced violence due to their work in abortion care, and if so, what happened; whether they were discriminated against in their professional life due to their work in abortion care and why they felt that wa; if they did feel

discriminated against in their professional life due to their work in abortion care, how, and an example of that discrimination; whether they ever had to hide their work from someone; whether they ever felt their personal values conflicted with their work, and which values were questioned in those situations.

7. **Characteristics of the context:** legal restrictions on the grounds for abortion and the temporality of each one.
8. **Companionship experiences and advice for other companions:** What has been their most memorable moment as an abortion provider, and what advice would they give to other providers who face similar challenges.

The survey consisted of 50 questions that included:

- ☑ Sociodemographic characteristics
- ☑ Professional characteristics
- ☑ Identity characteristics
- ☑ Stressors
- ☑ Stigma
- ☑ Experiences of violence or discrimination
- ☑ Characteristics of the context
- ☑ Companionship experiences

Prrocedure

A link with the survey was available on the safe2choose.org website in 2018. In addition, an invitation was sent to the safe2choose network partner organizations and providers (persons). The information was also shared on social media.

Data analysis

The quantitative data analysis was done using SPSS V.27.0.0.0. Variables with closed-ended options were automatically coded, and then manually recoded for the work with the database. Closed-ended questions that included an "Other" option were considered quantitative questions. The specific answers provided for these questions were manually reclassified or coded; the results are included in the breakdown of the tables in each section.

The qualitative data analysis software MaxQDA 20.1.0 was used for the qualitative questions, and open-ended questions were analyzed and coded following the standard procedure. A total of 339 documents were imported, and documents without a response were not registered. Items from the survey that were analyzed using this methodology are described in Table 1.

Table 1. Items that were analyzed using qualitative methodology

Category	Identifier	Question	Analyzable entries
Commitment to companionship/provision of services	Q24	If yes, why did you choose to be an abortion provider?	259
	Q25	If not, how did you end up being an abortion provider?	35
Identity	Q31	If yes, what makes you most proud?	267
Stressors	Q36	What could help you overcome these challenges?	233
Stigma	Q41	What makes you continue doing what you do?	266
Violence/discrimination	Q48	If you have been discriminated against in your personal life due to your work on abortion services, can you give an example?	86
Companionship experiences Advice for other companions	Q56	What is your most memorable moment as an abortion provider?	188
	Q57	What advice would you give to other abortion providers who face similar challenges?	175
	Q58	What does a day in your life look like?	172
	Q59	We're done! Would you like to add something else?	126

The steps for qualitative analysis are described below:

Step 1. The search, analysis, and classification of information combined a computerized approach and a manual approach to categorize data. All answers in English were used (the original ones and the translated ones); the coding was done in English.

- **Computerized approach:** the frequency, search, and grouping of words was done using the word count method in MaxQDA. Based on the greatest frequencies, an initial group of codes was proposed per item.

- **Manual approach:** once frequency-based codes were established, the coding was analyzed case by case. New codes were then established based on the content or the main ideas in the answers that the software does not recognize during the automatic counting. The resulting codes enabled an analysis beyond the vocabulary used in the answers. Since the objective was to explore the answers, every code had the same weight.

Step 2. During the labeling process, the codes attributed to each response generated analyzable segments. Therefore, each response could contain more than one segment with a code. The labeling was complete once all answers contained at least one coded segment. Using the "survey categorization" function ensured that all material was analyzable.

It is important to note that in some cases, answers had to be included in more than one code. Although no specific weight was determined per fragment, when necessary, more than one code was given per entry. For example:

> *"In my country, abortion is not legal and it's taboo (Stigma). I was always neutral on the issue, until it was me who had to get an abortion (Own experience). From then, I understood many things that hadn't occurred to me. I understood it's a public health issue (Health); I understood that we don't have to be ashamed because we want to decide on our bodies (Free choice). So, after going through my own process, I decided to support other girls (Help/Support) who are in the same situation because that's a way to take a stand in this fight (Commitment)."*

Step 3. Tables with the frequency of codes were created to observe the rate of codes for each item. Code clouds were also created to visualize the relationship and rate between codes per item. For questions that required exploring the relationships of answers with other variables from the database—such as region or type of procedure—the "crosstab" function was used for mixed analyses.

The data analysis and cleaning revealed two pages of respondents who did not match the survey inclusion criteria and who, additionally, had not completed the survey, or whose answers were not comparable with the sample characteristics. The decision was made to exclude those pages from analyses; therefore, the actual analysis consisted of 339 people (see Table 2).

Table 2. Reasons for exclusion per page

Page	Reasons for exclusion
19	65-year-old white woman living in the United States with doctoral studies. She stated that she was not a provider; rather, that based on a personal experience in the 1970s, she started working in academia and became an abortion activist. She even provided her website with relevant information. However, she did not answer the questions regarding the type of abortion performed and some related to experiences of stigma.
265	She only answered some questions regarding sociodemographic and personal characteristics, stating that she was between 38 and 44, from Argentina, and that she had a university degree; that she was in a relationship and was a professor. Additionally, she stated that she had between 1 and 12 months of experience working in the field of reproduction. She stated that she worked in an NGO, but that she was not an abortion provider. In the final comments, she wrote "Murderers" and "No to abortion in Argentina".

Region was used as the main stratification/comparison variable for all results in both methodologies. Accordingly, it was not included in the sections on the differences in the stressors, as those distinctions are a given due to the context in which providers/companions work.

Results

Who participated?

Sociodemographic characteristics

A total of 339 abortion providers/companions participated from 40 countries and 6 regions. A little over half (56.3%) work in a Latin American country, Mexico specifically. This is followed by almost 15% who work in Europe, specifically France. Almost a tenth of participants work in Africa (9.4%), North America (9.1%), or Asia (8.8%). A small number of respondents said they worked in Oceania (2.1%), particularly in Australia and New Zealand (Graph 1 and Table 3).

Graph 1. Rate of participants per region

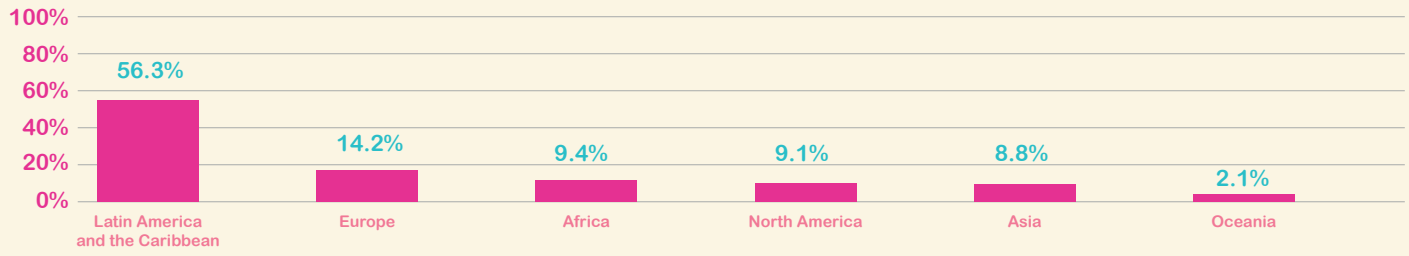


Table 3. Countries where participating abortion providers or companions work, by region

Region	Country where participant works	Frequency	%
Latin America and the Caribbean	Mexico	114	59.7%
	Argentina	37	19.4%
	Colombia	11	5.8%
	Ecuador	5	2.6%
	Honduras	5	2.6%
	Venezuela	4	2.1%
	Chile	3	1.6%
	Bolivia	2	1.0%
	Peru	2	1.0%
	Puerto Rico	2	1.0%
	Brazil	1	0.5%
	Dominican Republic	1	0.5%
	El Salvador	1	0.5%
	Guatemala	1	0.5%
	Nicaragua	1	0.5%
	Paraguay	1	0.5%
	Total	**191**	**100%**
Europe	France	36	75.0%
	Spain	5	10.4%
	Portugal	4	8.3%
	Albania	1	2.1%
	Bulgaria	1	2.1%

Region	Country where participant works	Frequency	%
Europe	Poland	1	2.1%
	Total	**48**	**100.0%**
Africa	Kenya	9	28.1%
	South Africa	6	18.8%
	Democratic Republic of the Congo	5	15.6%
	Uganda	4	12.5%
	Malawi	3	9.4%
	Burundi	2	6.3%
	Mozambique	1	3.1%
	Rwanda	1	3.1%
	Tanzania	1	3.1%
	Total	**32**	**100.0%**
North America	United States	22	71.0%
	Canada	9	29.0%
	Total	**31**	**100.0%**
Asia	Thailand	24	80.0%
	Philippines	3	10.0%
	India	1	3.3%
	Lebanon	1	3.3%
	South Korea	1	3.3%
	Total	**30**	**100.0%**
Oceania	Australia	6	85.7%
	New Zealand	1	14.3%
	Total	**7**	**100.0%**

The majority of participants (33.3%) were between 25 and 34, followed by those between 35 and 44 (23%) (Graph 1). However, a specific issue stands out: when comparing age groups by region, Oceania (14.3%), North America (12.9%), and Asia (10%) have the highest rate of providers or companions between 18 and 24, compared to the rest of the regions. North America has the highest rate of providers or companions over 65 (Table 4).

Graph 2. Age of participants

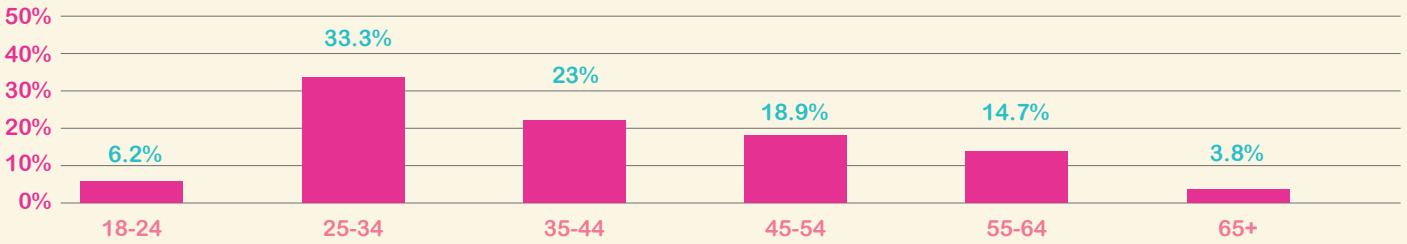
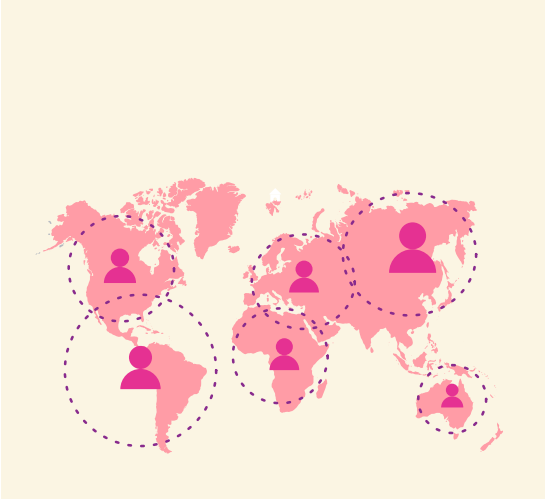


Table 4. Age range of participants by region

	Age range						
Region	**18-24**	**25- 34**	**35-44**	**45-54**	**55-64**	**65+**	**Total**
Latin America and the Caribbean	10	74	46	31	26	4	191
	5.2%	38.7%	24.1%	16.2%	13.6%	2.1%	100%
Europe	2	10	11	13	10	2	48
	4.2%	20.8%	22.9%	27.1%	20.8%	4.2%	100%
Africa	1	9	6	8	7	1	32
	3.1%	28.1%	18.8%	25.0%	21.9%	3.1%	100%
North America	4	9	4	5	4	5	31
	12.9%	29.0%	12.9%	16.1%	12.9%	16.1%	100%
Asia	3	10	11	4	1	1	30
	10.0%	33.3%	36.7%	13.3%	3.3%	3.3%	100%
Oceania	1	1	0	3	2	0	7
	14.3%	14.3%	0.0%	42.9%	28.6%	0.0%	100%

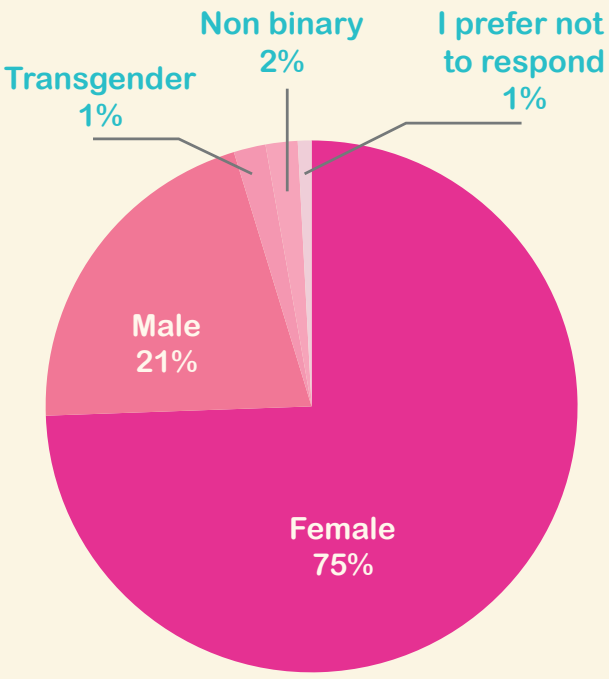


The majority of respondents work as an abortion provider or companion in their country of origin. However, there were ten cases of people who do not work in their countries of origin. Table 5 shows the nationality and place where these respondents work. All of them are people of female gender, except for some respondents who are Congolese and work in Burundi, who are people of male gender. In addition, two Mexican women reported Guatemala as their second place of work.

Table 5. Nationality and country of providers/companions who work in countries different from their country of origin

Nationality	Country where participant works
Argentine	Peru
American	Canada Mexico
Colombian	Argentina
Congolese	Burundi (2)
German	South Africa
European	United States
Finnish	United States
Mexican	Chile

Graph 3. Gender of participants



75% of survey respondents self-identified as female, while 21.5% as male. 1.8% said they were non-binary and 1.2% were transgender; a minority (0.6%) preferred not to specify (Graph 3). The distributions by country show that in North America (100%) and Oceania (100%), all respondents self-identified as female. In Europe, 8 in 10 respondents self-identified as female (85.4%); in Latin America and the Caribbean (75.9%) and Asia (66.7%), 7 in 10 self-identified as female. All transgender respondents (12.5%) were from Africa, and so were the majority of respondents who did not wish to specify (12.5%) (Table 6).

Table 6. Gender of participants by region where the participants work

Region	Gender					
	Female	Male	Non-binary	I prefer not to respond	Transgender	Total
Latin America and the Caribbean	145	41	3	2	0	191
	75.9%	21.5%	1.6%	1.0%	0.0%	100.0%
Europe	40	6	1	1	0	48
	85.4%	12.5%	2.1%	0.0%	0.0%	100.0%
Africa	8	16	0	4	4	32
	25.0%	50.0%	0.0%	12.5%	12.5%	100.0%
North America	31	0	0	0	0	31
	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Asia	20	8	2	0	0	30
	66.7%	26.7%	6.7%	0.0%	0.0%	100.0%
Oceania	7	0	0	0	0	7
	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%

All respondents have completed a high school level of education. Half have a postgraduate degree (master's or doctoral) (48.1%) and are specialists in their profession. Almost 40% have completed university studies and 4.7% have incomplete university studies (Graph 4). 81.3% of European respondents had a postgraduate degree, double the rate of respondents from other regions. This is followed by Asia (56.7%) and Africa (50%), regions with a higher rate of respondents with university studies (1 in every 2). In Oceania, 14.3% of respondents have a technical degree. North America (6.5%) has higher rates of respondents with a basic and secondary education, compared to the rest of the regions (3.2%) (Table 7).

All respondents have completed a high school level of education:

48.1% have a postgraduate degree (master's or doctoral)

40% have completed university studies

4.7% have incomplete university studies

Graph 4. Schooling of respondents

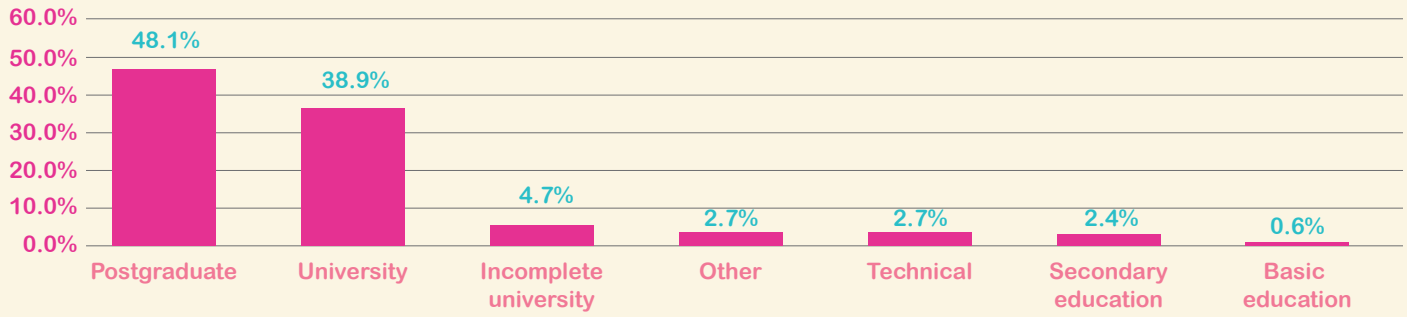


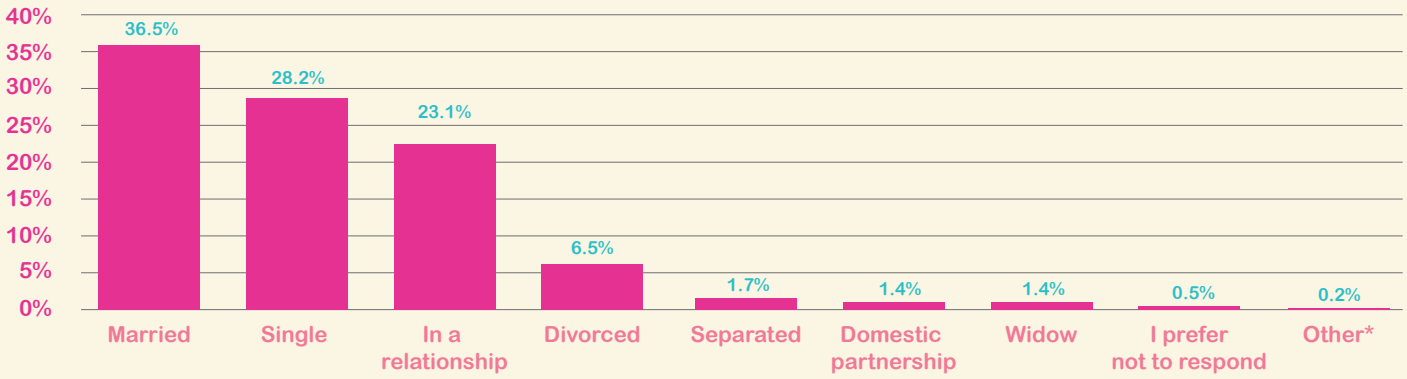
Table 7. Schooling of respondents by region

Region	Level of schooling							
	Postgraduate	University	Incomplete university	Other	Technical	Secondary education	Basic education	Total
Latin America and the Caribbean	86	82	9	7	2	4	1	191
	45.0%	42.9%	4.7%	3.7%	1.0%	2.1%	0.5%	100.0%
Europe	39	6	0	0	3	0	0	48
	81.3%	12.5%	0.0%	0.0%	6.3%	0.0%	0.0%	100.0%
Africa	9	16	3	1	2	1	0	32
	28.1%	50.0%	9.4%	3.1%	6.3%	3.1%	0.0%	100.0%
North America	16	8	3	0	1	2	1	31
	51.6%	25.8%	9.7%	0.0%	3.2%	6.5%	3.2%	100.0%
Asia	10	17	1	1	0	1	0	30
	33.3%	56.7%	3.3%	3.3%	0.0%	3.3%	0.0%	100.0%
Oceania	3	3	0	0	1	0	0	7
	42.9%	42.9%	0.0%	0.0%	14.3%	0.0%	0.0%	100.0%

1 in every 3 respondents said they were married (36.5%) and a lower rate said they were single (28.2%). Almost a fourth of respondents were in a relationship (23.1%); a lower rate said they were divorced (6.5%) and the rest said they were separated (1.8%); only 1.5% said they were in a domestic partnership, and 1.5% were widows. Some respondents did not answer (0.6%) (Graph 5). In Africa, most respondents were married (56.3%); the same for North America (45.2%) and Europe (42.6%). In Latin America, 1 in every 3 respondents was single (33.7%);

this was also the case in Asia (34.5%). In Oceania, almost half of respondents were in a relationship (42.9%), while in Europe, only 1 in every 3 selected their marital status (29.8%) as in relationship. In Latin America and North America, 1 in every 4 respondents stated that they are in a relationship, 24.7% and 22.6%, respectively (Table 8).

Graph 5. Marital status of participants



**Other corresponds to "conjoint a fait", which is a marital status in Canada.*

Table 8. Marital status of participants by region

	Marital status									
Region	Married	Single	In a relationship	Divorced	Separated	Domestic partnership	Widow	I prefer not to respond	Other*	Total
Latin America and the Caribbean	58	64	47	11	3	4	3	0	0	190
	30.5%	33.7%	24.7%	5.8%	1.6%	2.1%	1.6%	0.0%	0.0%	100.0%
Europe	20	8	14	3	0	1	0	1	0	47
	42.6%	17.0%	29.8%	6.4%	0.0%	2.1%	0.0%	2.1%	0.0%	100.0%
Africa	18	6	2	2	2	0	2	0	0	32
	56.3%	18.8%	6.3%	6.3%	6.3%	0.0%	6.3%	0.0%	0.0%	100.0%
North America	14	6	7	3	0	0	0	0	1	31
	45.2%	19.4%	22.6%	9.7%	0.0%	0.0%	0.0%	0.0%	3.2%	100.0%
Asia	11	10	5	2	0	0	0	1	0	29
	37.9%	34.5%	17.2%	6.9%	0.0%	0.0%	0.0%	3.4%	0.0%	100.0%
Oceania	2	0	3	1	1	0	0	0	0	7
	28.6%	0.0%	42.9%	14.3%	14.3%	0.0%	0.0%	0.0%	0.0%	100.0%

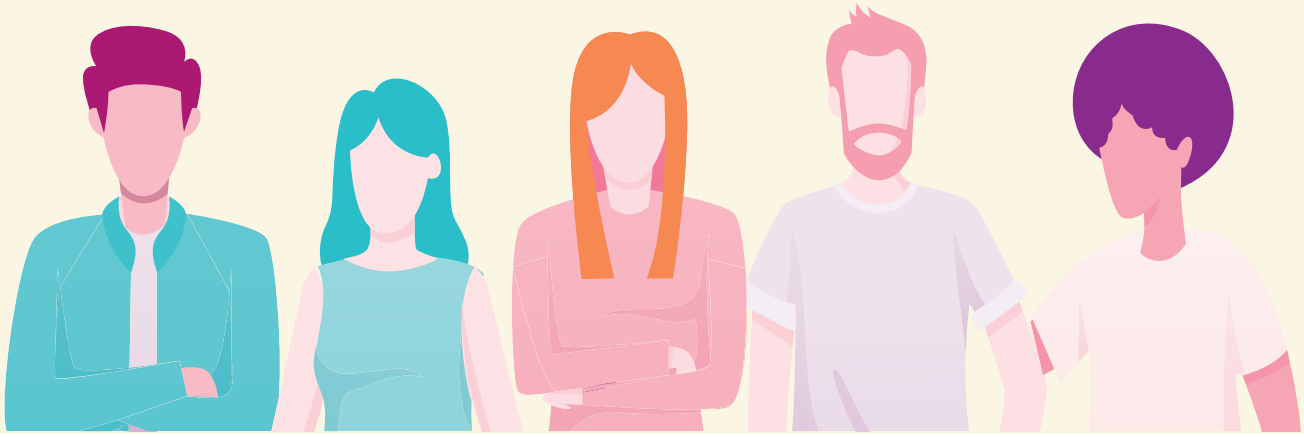
Survey respondents defined themselves as:

46.4% Latino

25% White

8.7% Asian

8.4% Black



Half of participants identified as Latino (46.4%), a fourth as White (25%), a little less than a tenth as Asian (8.7%), and a similar rate as Black (8.4%) (Graph 6). In Latin America, there is a high number of Latinos, although there was also a small number in Oceania (20%). The majority of respondents who work in Europe (85.1%) and North America (83.3%) are White, while a little over 6% are White women in Latin America and Africa. Asia has the highest number of Asian respondents (93.1%), although there is a small rate of Asian women in North America (6.7%). In Africa, 84.4% are Black women. There is only one case of a Black woman in Latin America. In North America, 13.3% self-identifies as multiethnic. 6.4% of respondents who work in Europe did not want to answer this question. Arab women account for.a small rate of respondents in Europe (4.3%), Asia (3.4%), and North America (3.3%). Likewise, only in Africa (3.1%) and Latin America (1.8%) were there respondents who self-identified as indigenous (Table 9).

Graph 6. Ethnicity of participants

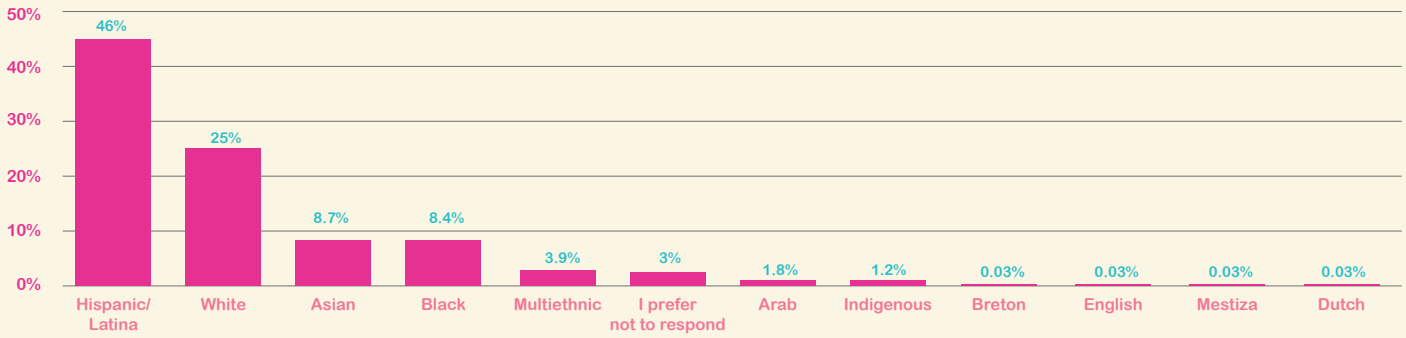


Table 9. Ethnicity of participants by region

Region	Ethnic group*							
	Hispanic/ Latina	White	Asian	Black	Multiethnic	I prefer not to respond	Arab	Indigenous
Latin America and the Caribbean	150	11	0	1	6	4	2	3
	89.3%	6.5%	0.0%	0.6%	3.6%	2.4%	1.2%	1.8%
Europe	2	40	0	0	2	3	2	0
	4.3%	85.1%	0.0%	0.0%	4.3%	6.4%	4.3%	0.0%
Africa	0	2	0	27	1	1	0	1
	0.0%	6.3%	0.0%	84.4%	3.1%	3.1%	0.0%	3.1%
North America	1	25	2	0	4	1	1	0
	3.3%	83.3%	6.7%	0.0%	13.3%	3.3%	3.3%	0.0%
Asia	0	0	27	0	0	1	1	0
	0.0%	0.0%	93.1%	0.0%	0.0%	3.4%	3.4%	0.0%
Oceania	1	5	0	0	0	0	0	0
	20.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

**Ethnic identity is not mutually exclusive, which is why the sum could be greater than 100%.*

1 in 3 said they were Catholic (31%), a fourth said they were Atheist (22.6%), and a little over a tenth said they were Agnostic (11.9%). Also, 8.9% said they are Christian and 7.4% said they are Buddhist. 5.7% preferred not to answer. There is a small rate of Jewish people (2.1%), Muslim (2.1%), and 3.6% said they had no religion (Graph 7).

In Latin America, the majority of respondents are Catholic (43.9%) and in Europe, Atheist (44.7%). In Africa, the majority said they are Christian (56.3%). In North America, the majority was divided between Atheist (29%) and Agnostic (22.6%). In Asia, 73.3% of respondents said they were Buddhists and in Oceania, the majority said they were Atheist (42.9%) (Table 10).

Graph 7. Religion of participants

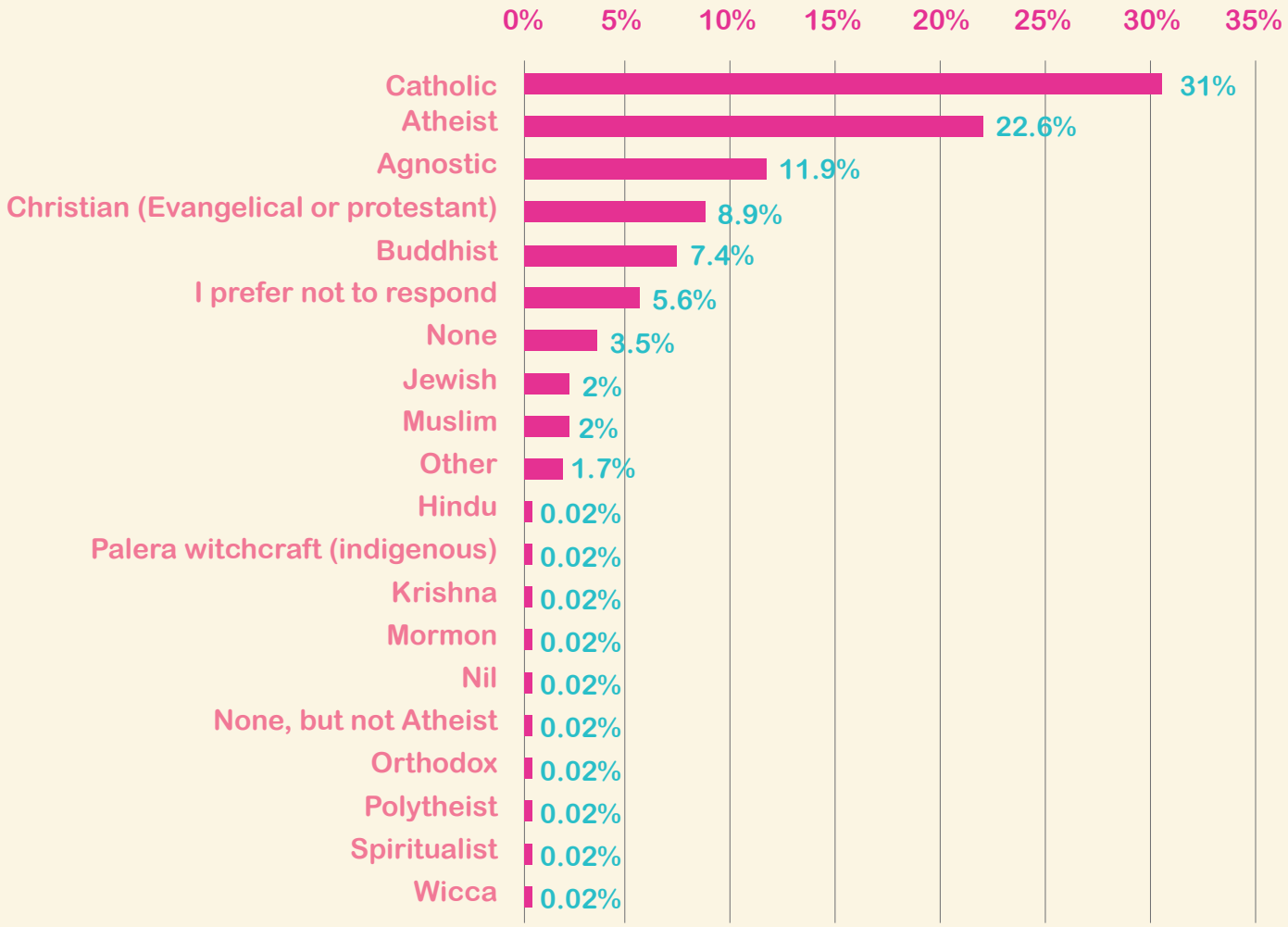


Table 10. Religion of participants by region

Religion	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Catholic	83	10	8	2	1	0
	43.9%	21.3%	25.0%	6.5%	3.3%	0.0%
Atheist	38	21	3	9	2	3
	20.1%	44.7%	9.4%	29.0%	6.7%	42.9%

Religion	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Agnostic	26	4	0	7	1	2
	13.8%	8.5%	0.0%	22.6%	3.3%	28.6%
Christian (Evangelical or protestant)	7	1	18	3	0	1
	3.7%	2.1%	56.3%	9.7%	0.0%	14.3%
Buddhist	1	1	0	1	22	0
	0.5%	2.1%	0.0%	3.2%	73.3%	0.0%
I prefer not to respond	11	4	0	2	2	0
	5.8%	8.5%	0.0%	6.5%	6.7%	0.0%
None	11	1	0	0	0	0
	5.8%	2.1%	0.0%	0.0%	0.0%	0.0%
Jewish	3	1	0	3	0	0
	1.6%	2.1%	0.0%	9.7%	0.0%	0.0%
Muslim	1	2	3	1	0	0
	0.5%	4.3%	9.4%	3.2%	0.0%	0.0%
Other	1	1	0	3	1	0
	0.5%	2.1%	0.0%	9.7%	3.3%	0.0%
Hindu	0	0	0	0	1	0
	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%
Palera witchcraft (indigenous)	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Krishna	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Mormon	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%

Religion	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Nil	0	0	0	0	0	1
	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%
None, but not Atheist	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Orthodox	0	1	0	0	0	0
	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%
Polytheist	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Spiritualist	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Wicca	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	189	47	32	31	30	7
	100%	100%	100%	100%	100%	100%

58% of survey participants do not have children (Graph 8). However, in Europe (72.9%) and Africa (84.4%) a significant majority said they do have children. In contrast, in the rest of the world, although the majority said they do have children, the rates of those who do and those who do not are very similar (Table 11).

Graph 8. Rate of participants with and without children

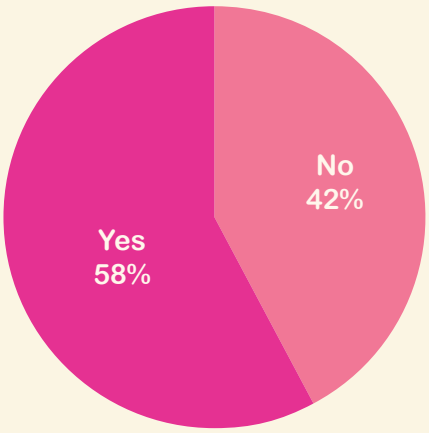


Table 11. Rate of participants with and without children by region

Region	No	Yes	Total
Latin America and the Caribbean	91	100	191
	47.6%	52.4%	100.0%
Europe	13	35	48
	27.1%	72.9%	100.0%
Africa	5	27	32
	15.6%	84.4%	100.0%
North America	15	16	31
	48.4%	51.6%	100.0%
Asia	14	16	30
	46.7%	53.3%	100.0%
Oceania	3	4	7
	42.9%	57.1%	100.0%

Professional characteristics

A significant rate of respondents are doctors: 1 in 4 is a general physician (22.2%), 1 in 5 is a gynecologist or obstetrician (20.1%), and 1 in 10 is a midwife or doula (10.2%). 7.8% do not have a medical or clinical profession but volunteer to accompany women in terminating their pregnancies. Likewise, 1 in 5 respondents said they had a profession in the health sector, such as: Psychology (6.3%), Nursing (5.7%), Medicine in another specialization (5.7%), and counseling (4.8%). 4.5% are professionals in other areas, such as biology, anthropology, law, or education. 3.6% are social workers and 2.7% are community health promoters. There is a small number from other professions such as a medical student, medical assistant, pharmaceutical provider, and an NGO worker.

On the other hand, when observing the data by region, Latin America has a greater rate of general physicians (25.7%) and gynecologists/obstetricians (20.9%) than other professions. In contrast, in Europe, the profession with the highest rate is midwife or doula (41.7%). For Africa, the greatest rate are general physicians (32.3%), followed by gynecologists (16.1%) and nurses (16.1%). In North America, a fourth are midwives/doulas (25.8%) and another fourth are non-medical partners (25.8%). In Asia, the majority are gynecologists (26.7%), followed by nurses (20%). In Oceania, the greatest rate are general physicians (57.1%).

Graph 9. Profession of participants

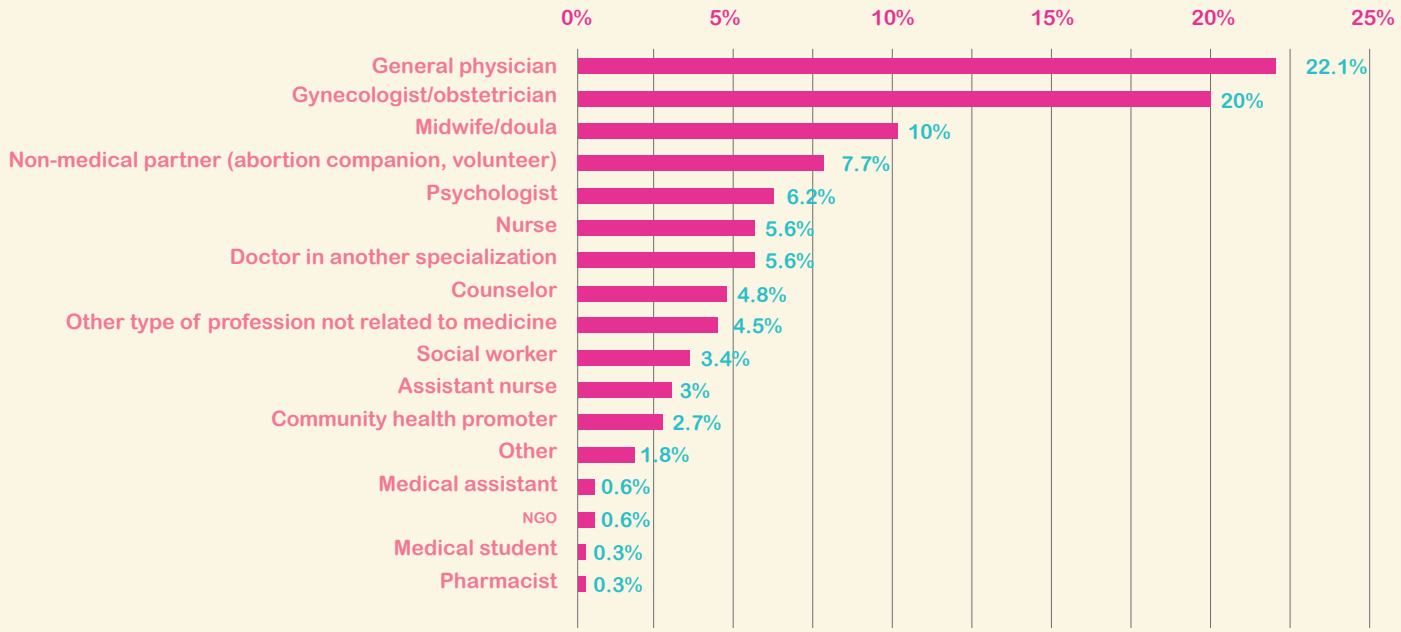


Table 12. Profession of participants by region

Profession	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
General physician	48	7	10	2	3	4
	25.7%	14.6%	32.3%	6.5%	10.0%	57.1%
Gynecologist/ obstetrician	39	12	5	2	8	1
		25.0%	16.1%	6.5%	26.7%	14.3%
Midwife/*doula*	5	20	1	8	0	0
	2.7%	41.7%	3.2%	25.8%	0.0%	0.0%
Non-medical partner (abortion companion, volunteer)	17	0	1	8	0	0
	9.1%	0.0%	3.2%	25.8%	0.0%	0.0%

Profession	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Psychologist	21	0	0	0	0	0
	11.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Nurse	2	1	5	4	6	1
	1.1%	2.1%	16.1%	12.9%	20.0%	14.3%
Doctor in another specialization	14	2	0	2	1	0
	7.5%	4.2%	0.0%	6.5%	3.3%	0.0%
Counselor	4	5	1	2	4	0
		10.4%	3.2%	6.5%	13.3%	0.0%
Other type of profession not related to medicine	11	0	2	1	1	0
	5.9%	0.0%	6.5%	3.2%	3.3%	0.0%
Social worker	9	0	0	0	3	0
	4.8%	0.0%	0.0%	0.0%	10.0%	0.0%
Assistant nurse	10	0	0	0	0	0
		0.0%	0.0%	0.0%	0.0%	0.0%
Community health promoter	4	0	5	0	0	0
	2.1%	0.0%	16.1%	0.0%	0.0%	0.0%
Other	2	0	0	2	2	0
	1.1%	0.0%	0.0%	6.5%	6.7%	0.0%
Medical assistant	0	1	0	0	0	1
	0.0%	2.1%	0.0%	0.0%	0.0%	14.3%
NGO	0	0	0	0	2	0
	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%

Profession	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Medical student	1	0	0	0	0	0
	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacist	0	0	1	0	0	0
		0.0%	3.2%	0.0%	0.0%	0.0%
Total	187	48	31	31	30	7
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Half (49.5%) of respondents have between 3 and 5 years of experience working in the field of reproductive health. 1 in 3 respondents (30.8%) have more than 15 years of experience in this field, and a little less than a tenth have between 1 and 12 months (8.5%) of experience, and 1 and 2 years (8.2%) (Graph 10). In Latin America (52.4%), Europe, (50%), Africa (51.6%), and North America (54.8%), the greatest rate of providers/companions have between 3 and 5 years of experience. In Asia, the greatest rate (34.5%) have more than 6 years of experience, and in Oceania, the majority have 15 years or more of experience. There is an aspect that stands out: Latin America (11.4%) and Oceania (14.3%) has the highest rate of providers/companions with less than one year of experience (Table 13).

Graph 10. Experience in the area of reproductive health

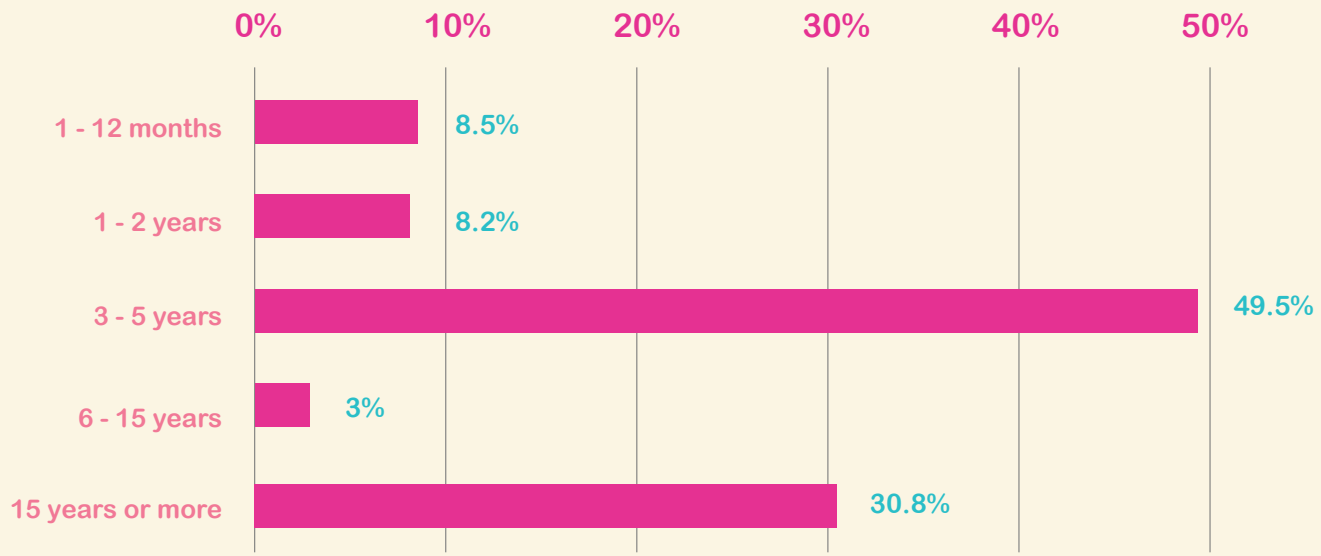


Table 13. Experience in the area of reproductive health by region

Region	Experience in the area of reproductive health					
	1 - 12 months	1 - 2 years	3 - 5 years	6 - 15 years	15 years or more	Total
Latin America and the Caribbean	21	17	97	0	50	185
	11.4%	9.2%	52.4%	0.0%	27.0%	100.0%
Europe	2	0	24	0	22	48
	4.2%	0.0%	50.0%	0.0%	45.8%	100.0%
Africa	0	2	16	0	13	31
	0.0%	6.5%	51.6%	0.0%	41.9%	100.0%
North America	2	4	17	0	8	31
	6.5%	12.9%	54.8%	0.0%	25.8%	100.0%
Asia	2	4	8	10	5	29
	6.9%	13.8%	27.6%	34.5%	17.2%	100.0%
Oceania	1	0	2	0	4	7
	14.3%	0.0%	28.6%	0.0%	57.1%	100.0%

In general, 1 in every 3 respondents works in a hospital (29.2%), followed by 1 in 4 that works in an NGO (25.1%) or abortion clinic (22.4%). A little less than a fifth works in a medical office (18.9%) or in a health center (17.7%), and 15.9% are members of an autonomous network (Graph 11). In Latin America, 1 in every 3 respondents works in an NGO (31%) or in a hospital (30.4%), followed by a medical office (24.4%) or an autonomous network (23.8%). In Europe, the majority work in a hospital (37.5%) or a medical office (33.3%). In Africa, half work in an NGO (58.1%), followed by an abortion clinic (38.7%). In North America, the majority work in an abortion clinic (48.4%); in Asia, almost 70% of people work in a hospital; and in Oceania, the greatest rate work in an abortion clinic (42.9%) (Table 14).

Graph 11. Rate of organizations where participants work

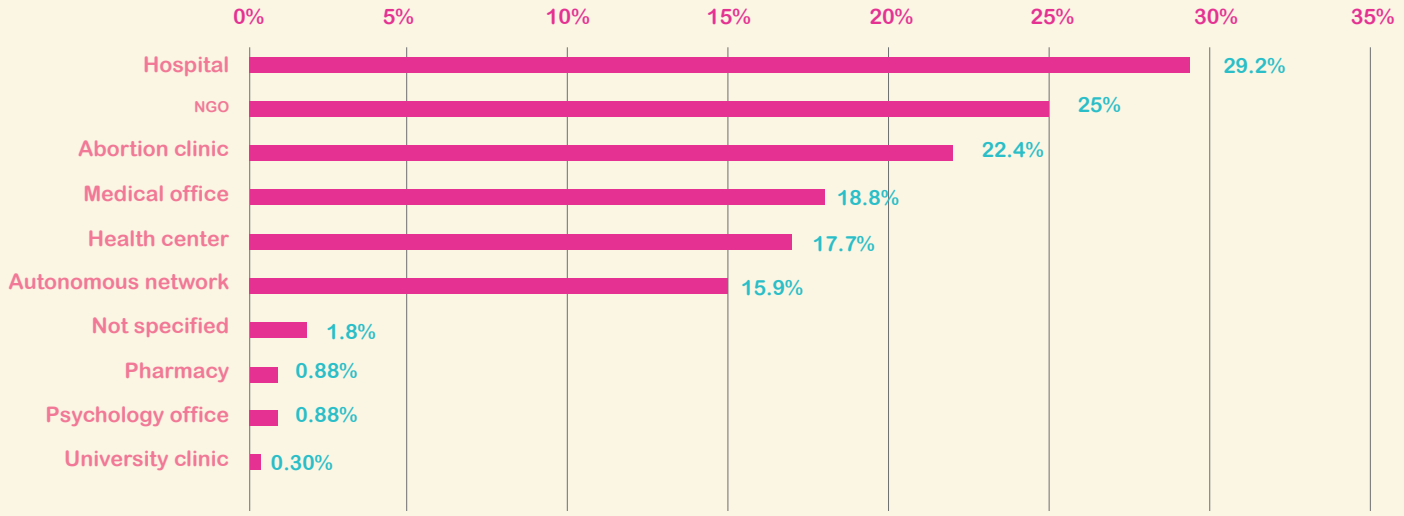


Table 14. Organizations of participants by region

Organization	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Hospital	51	18	8	1	19	2
	30.4%	37.5%	25.8%	3.2%	67.9%	28.6%
NGO	52	2	18	5	6	2
	31.0%	4.2%	58.1%	16.1%	21.4%	28.6%
Abortion clinic	29	13	12	15	4	3
	17.3%	27.1%	38.7%	48.4%	14.3%	42.9%
Medical office	41	16	2	0	4	1
	24.4%	33.3%	6.5%	0.0%	14.3%	14.3%
Health center	35	10	5	7	2	1
	20.8%	20.8%	16.1%	22.6%	7.1%	14.3%

Organization	Region					
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania
Autonomous network	40	0	1	11	2	0
	23.8%	0.0%	3.2%	35.5%	7.1%	0.0%
Not specified	1	2	0	3	0	0
	0.6%	4.2%	0.0%	9.7%	0.0%	0.0%
Pharmacy	2	0	0	0	1	0
	1.2%	0.0%	0.0%	0.0%	3.6%	0.0%
Psychology office	1	0	0	0	0	0
	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
University clinic	2	1	0	0	0	0
	1.2%	2.1%	0.0%	0.0%	0.0%	0.0%

**Organizations are not mutually exclusive, which is why totals are not included and the sum of the columns could be greater than 100%.*

The majority of respondents work for organizations that are not part of the government (77%) (Graph 12). These rates remain for all regions, except Asia where 60% of respondents do work for a government organization (Table 15).

Graph 12. Rate of respondents that work for a government organization

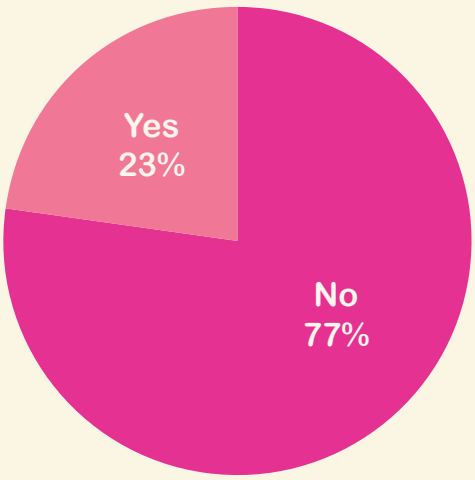
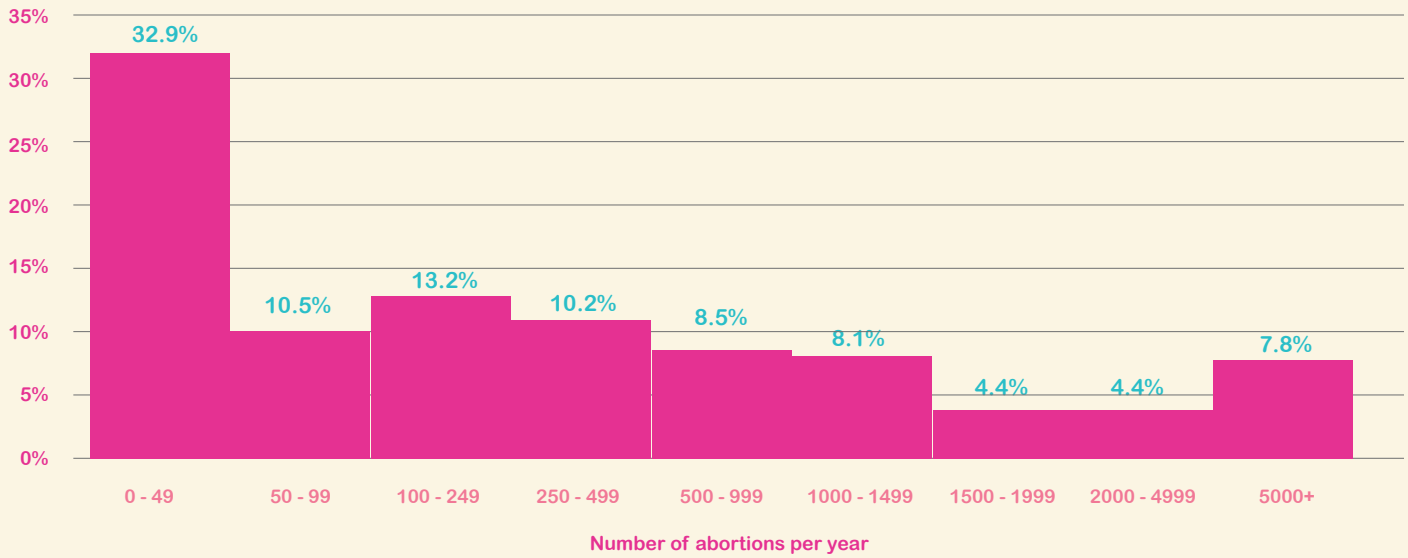


Table 15. Rate of respondents that work for a government organization by region

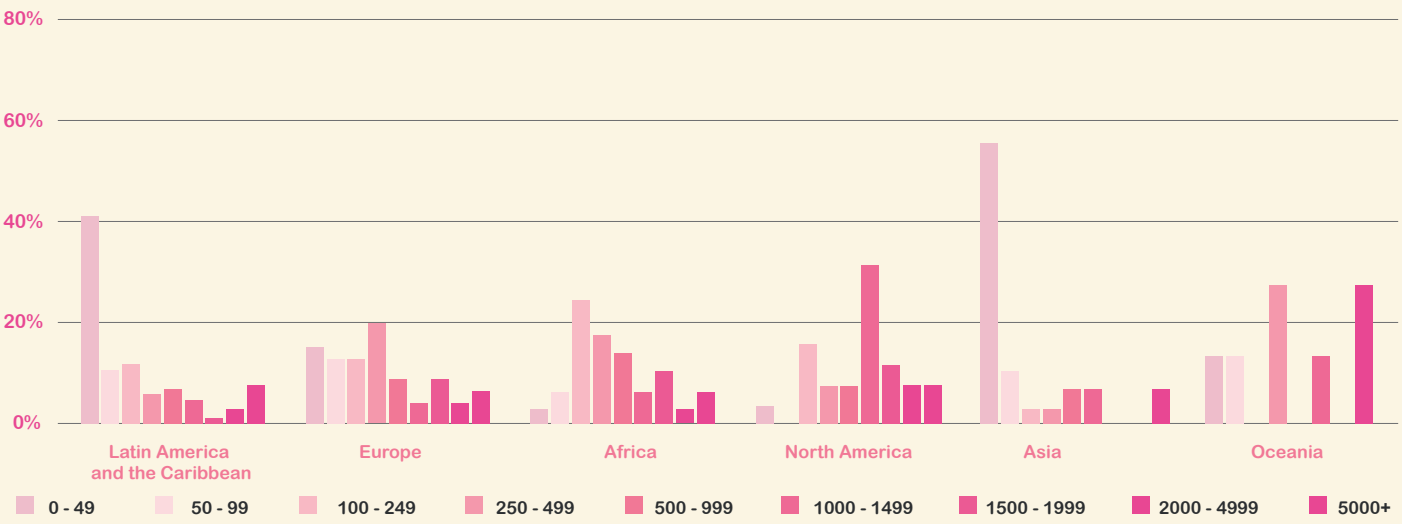
Region	Government organization		
	No	Yes	Total
Latin America and the Caribbean	148	39	187
	79.2%	20.8%	100.0%
Europe	33	11	44
	75.0%	25.0%	100.0%
Africa	27	4	31
	87.1%	12.9%	100.0%
North America	28	3	31
	90.3%	9.7%	100.0%
Asia	12	18	30
	40.0%	60.0%	100.0%
Oceania	5	2	7
	71.4%	28.6%	100.0%

32.9% of organizations perform between 0 and 49 abortions every year. A tenth of the organizations perform between 50 and 99, a similar number performs between 100 and 249, and 10.2% perform between 250 and 499 abortions every year. 7.8% of organizations perform more than 5,000 abortions annually (Graph 13). In Latin America (43%) and Asia, the majority of organizations perform less than 50 abortions a year (58%). In Europe, 21% of organizations perform between 250 and 499 abortions a year. In Africa, 26% of organizations perform between 100 and 249 abortions a year. In North America, the largest group (33%) of organizations performs between 1,000 and 1,499 abortions a year. In Oceania, the numbers are divided among organizations that perform between 500 and 999 abortions a year (29%) and those that perform more than 5,000 annually (29%) (Graph 14).

Graph 13. Percentage of abortions that organizations perform per year

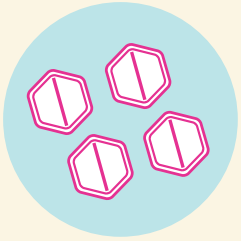


Graph 14. Number of abortions that organizations perform per year by region



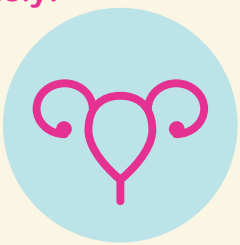
Regarding the methods provided by organizations where respondents work or the procedures they accompany autonomously, 80% are medical abortions. This is followed by abortions through vacuum aspiration (50.1%). Half of them also provide post-abortion companionship (49.3%) A small number perform curettage and evacuation. 3.2% indicated that they also provide counseling. In some cases, they also provide other methods, including "fetal lysis for therapeutic abortions" or fetal reduction. Around the world, the most common method used by providers/companions is medical abortion (Graph 15). In Latin America (54.3%), North America (69.6%), and Asia (38.5%) the method most used by providers/companions—in addition to vacuum aspiration—is dilatation and evacuation. In contrast, in Africa (86.7%) and Oceania (85.7%), dilatation and evacuation is more frequently used than vacuum aspiration (66.7% and 71.4%, respectively). This does not mean that these were the most frequently used methods; rather, that these were the methods that organizations or companions can perform. Compared to other regions, post-abortion companionship takes place at higher rates in North America (60.9%) and Oceania (42.9%) (Graph 16).

Methods provided by organizations where respondents work or the procedures they accompany autonomously:



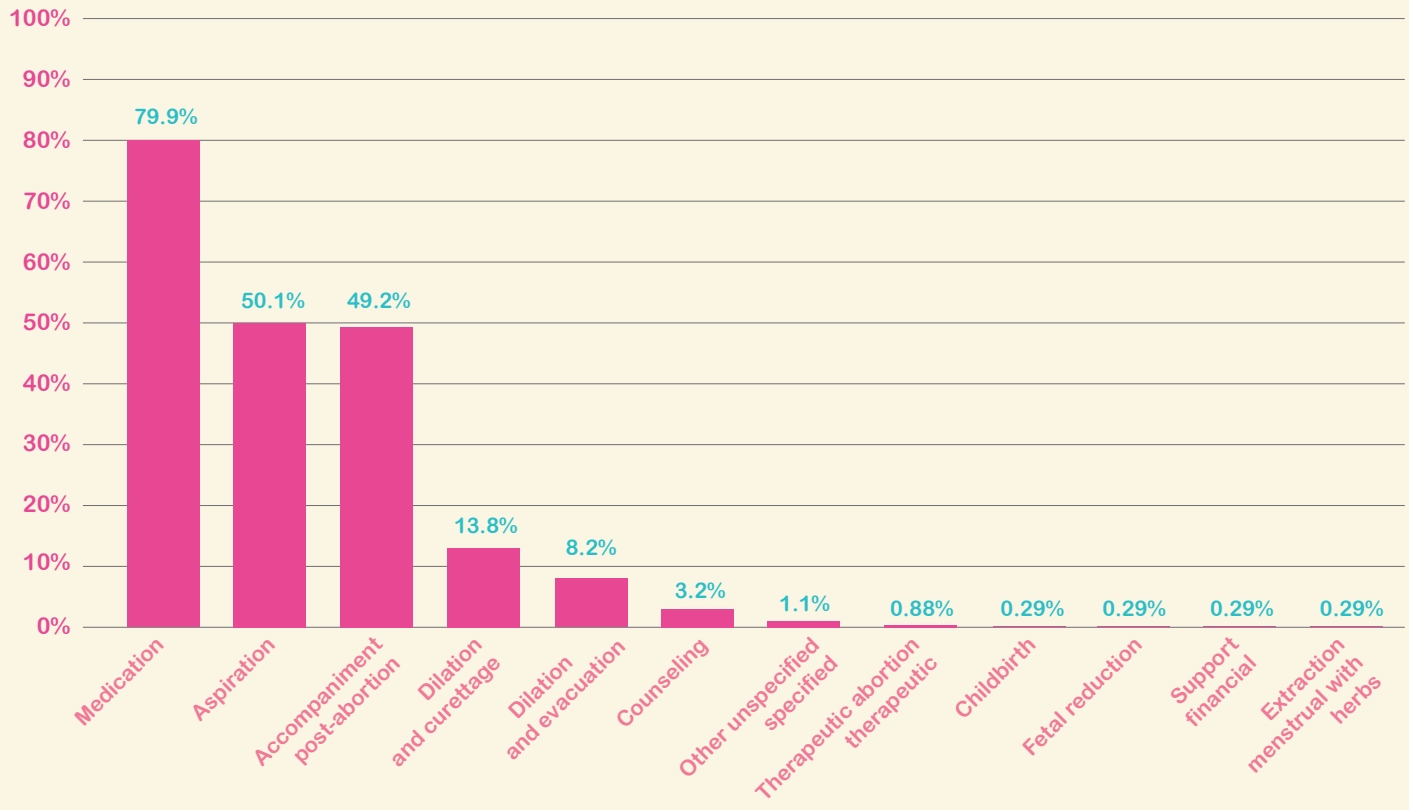
Medical abortion

Vacuum aspiration



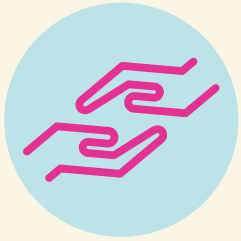
Curettage and evacuation

Graph 15. Methods that providers/companions performed in abortion services



*Methods are not mutually exclusive, which is why totals are not included and the sum of the columns could be greater than 100%.

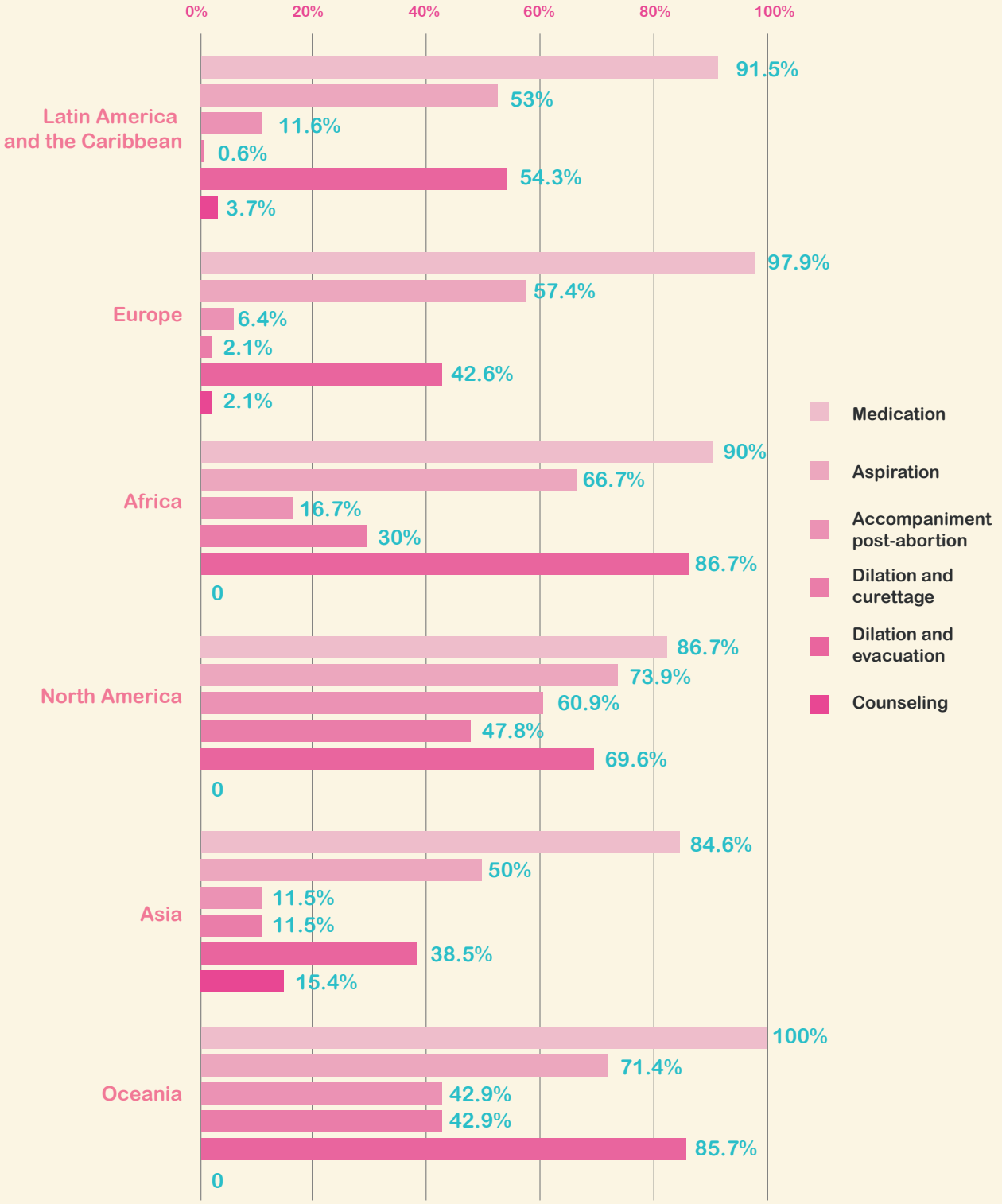
In addition to the provision of abortion services, some people indicated that:



Post-abortion companionship

Counseling

Graph 16. Methods that providers/companions performed in abortion services by region



*Methods are not mutually exclusive, which is why totals are not included and the sum of the columns could be greater than 100%.

In line with this, globally the majority of abortions that providers/companions perform occur during the first trimester. In North America, Oceania, and Africa, between 71% and 60% of companions perform abortions in the second trimester. The rate is lower in Asia (40%), Latin America (33.5%), and Europe (22.9%). The regions with the highest number of companions that perform abortions in the third trimester are Asia (16.7%), Oceania (14.3%), and Africa (9.4%) (Table 16).

Tabla 16. Types of abortions that providers/companions perform by region

Region	Type of abortion (n=339)					
	First trimester		Second trimester		Third trimester	
	Frequency	%	Frequency	%	Frequency	%
Latin America and the Caribbean	164	85.9%	64	33.5%	16	8.4%
Europe	47	97.9%	11	22.9%	3	6.3%
Africa	29	90.6%	19	59.4%	3	9.4%
North America	24	77.4%	22	71.0%	1	3.2%
Asia	26	86.7%	12	40.0%	5	16.7%
Oceania	7	100.0%	5	71.4%	1	14.3%

**The types of abortion are not mutually exclusive, which is why totals are not included and the sum of the columns could be greater than 100%.*

A. Identity and commitment characteristics

That majority of participants (85.5%) stated that being a prover/companion in abortion was a choice. Of those who said it was not a choice but ended up being providers/companions anyway, the rates stand out in Asia (27.6%) and North America (17.9%). The rates of those who said it was not a choice but ended being providers/companions were similar in Latin America and the Caribbean (14.9%) and Oceania (14.3%) (Table 17).

Table 17. Choice of providers/companions regarding working in something related to abortion by region

Region	Chose to be providers/companions					
	Yes		No		Total	
	Frequency	%	Frequency	%	Frequency	%
Latin America and the Caribbean	160	85.1%	28	14.9%	188	100.0%
Europe	44	93.6%	3	6.4%	47	100.0%
Africa	29	90.6%	3	9.4%	32	100.0%
North America	23	82.1%	5	17.9%	28	100.0%
Asia	21	72.4%	8	27.6%	29	100.0%
Oceania	6	85.7%	1	14.3%	7	100.0%
Total	283	85.5%	48	14.5%	331	100.0%

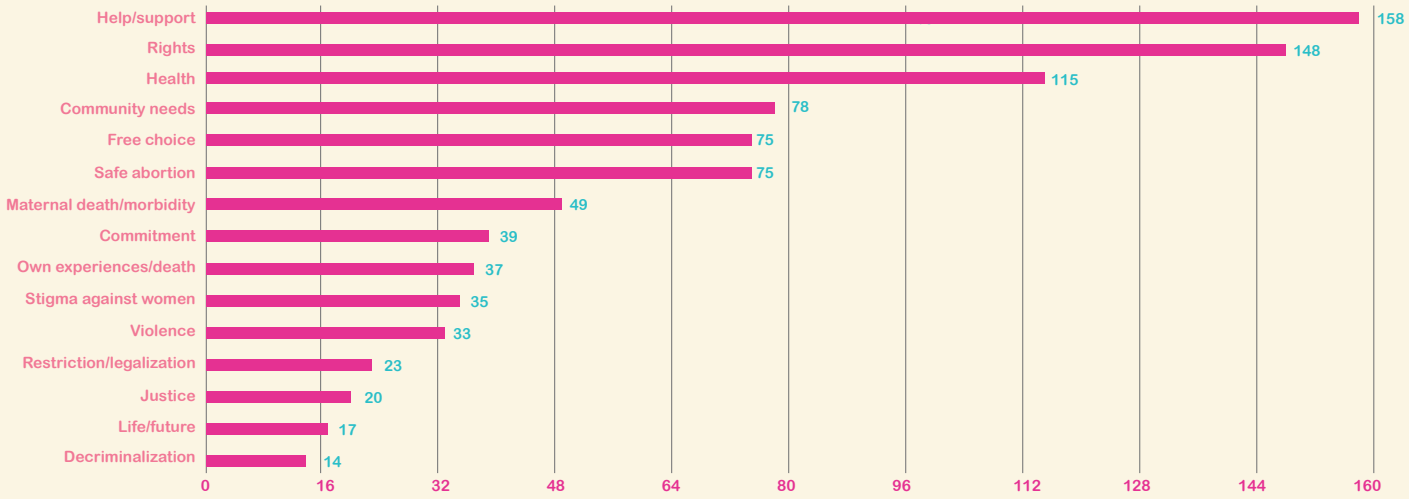
The majority of respondents who chose to be providers of abortion services gave reasons related to:

- **Helping**
- **Seeking access to rights**
- **Access to health**
- **community needs**

Those who said it was a choice were asked why they chose to do so (Q.24). This question used qualitative analysis methods. The 259 entries that were analyzable resulted in a total of 916 codified segments. The question regarding why they chose to be providers/companions of abortion services resulted in 15 codes (Graph 17) (to consult the Book of codes, see Annex 1).

The majority of respondents who chose to be providers of abortion services gave reasons related to helping, seeking access to rights, access to health, and community needs. The least given reasons for choosing to be providers were seeking access to justice, concern over the prospects of women who terminate a pregnancy, and the decriminalization of abortion.

Graph 17. Distribution of frequencies per code for answers to item Q.24



Why did you decide to become an abortion service provider?

The code cloud below visualizes the frequency of each of the codes that emerged from the answers. Codes that are included in the graph appeared at least once. Among the reasons that respondents stated for choosing to work in abortion service provision were the needs of the community, which refer to the lack of services and the lack of trained staff. Another important reason was their own experience, whether having had an abortion or having witnessed procedures and their complications in the health services where they work. Other reasons included violence against women, obstetric violence, and, in general, gender-based violence. Some respondents stated that they chose to work in this field due to their political commitment or awareness on this issue.

Another important reasons were:

- **Their own experience**
- **Violence against women, obstetric violence, and, in general, gender-based violence**
- **Political commitment or awareness**

Figure 1. Code cloud for reasons why respondents decided to work as providers/companions in abortion services

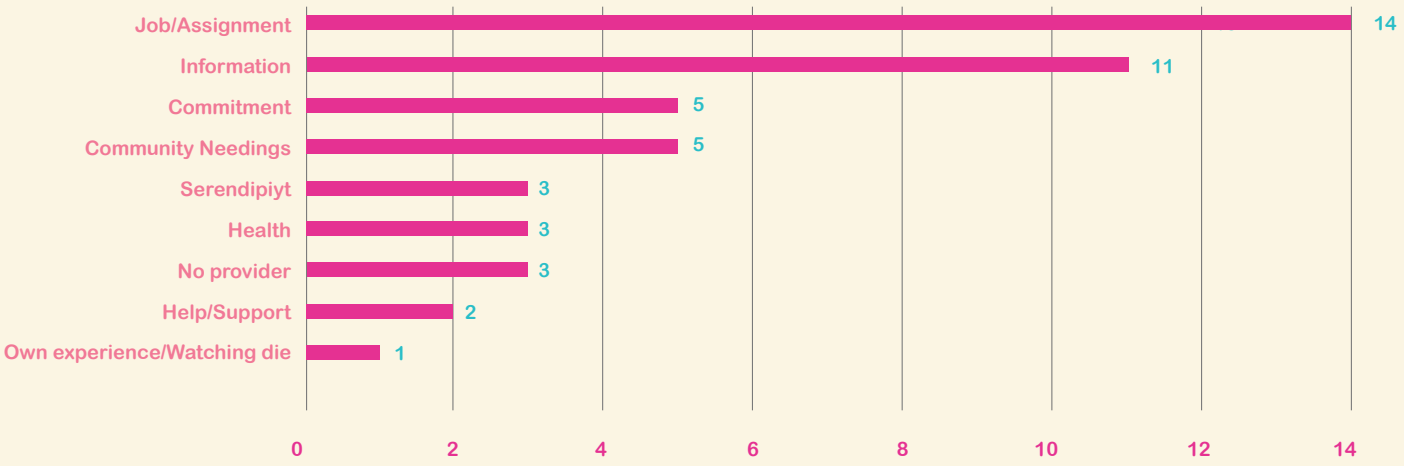
The analysis showed that in Latin America, the reasons with the highest rate relate to ***Help/support***, followed ***by Rights and health***. In contrast, in Europe, Africa, and North America, the main reason why respondents chose to work as ***providers/companions*** relates to the code ***Rights***, followed by ***Help/suppor***t. In Asia, the second most important reason relates to the code ***Safe abortion***, which refers to the search for the conditions to access a safe abortion. In Oceania, reasons related to access to rights and healthcare had the same importance. Reasons related to the legal framework did not show up as main reasons for service provision. However, they did appear more in Latin America than in the rest of the regions. Regarding reasons related to decriminalization, Latin America was the only region where this was reported (Table 18).

Table 18. Distribution of frequencies and percentages of codified segments by region for Q.24

	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Help/support	100	16.9%	20	18.5%	11	12.0%	12	18.0%	14	33.0%	1	7.0%	158	17.0%
Rights	89	15.0%	23	21.3%	14	15.0%	13	20.0%	6	14.0%	3	21.0%	148	16.0%
Health	77	13.0%	12	11.1%	13	14.0%	6	9.0%	4	10.0%	3	21.0%	115	13.0%
Community needs	55	9.3%	9	8.3%	6	6.0%	5	8.0%	2	5.0%	1	7.0%	78	9.0%
Free choice	39	6.6%	14	13.0%	8	9.0%	11	17.0%	1	2.0%	2	14.0%	75	8.0%
Safe abortion	50	8.4%	3	2.8%	12	13.0%	2	3.0%	7	17.0%	1	7.0%	75	8.0%
Maternal death/ morbidity	33	5.6%	1	0.9%	9	10.0%	1	2.0%	4	10.0%	1	7.0%	49	5.0%
Commitment	21	3.5%	6	5.6%	3	3.0%	8	12.0%	0	0.0%	1	7.0%	39	4.0%
Own experiences/ death	26	4.0%	5	5.0%	4	4.0%	2	3.0%	0	0.0%	0	0.0%	37	4.0%
Stigma against women	24	4.0%	1	0.9%	3	3.0%	4	6.0%	2	5.0%	1	7.0%	35	4.0%
Violence	21	3.5%	7	6.5%	3	3.0%	0	0.0%	2	5.0%	0	0.0%	33	4.0%
Restriction/legali- zation	20	3.4%	2	1.9%	1	1.0%	0	0.0%	0	0.0%	0	0.0%	23	3.0%
Justice	14	2.4%	1	0.9%	3	3.0%	2	3.0%	0	0.0%	0	0.0%	20	2.0%
Life/future	10	1.7%	4	3.7%	3	3.0%	0	0.0%	0	0.0%	0	0.0%	17	2.0%
Decriminalization	14	2.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	14	2.0%
Total	593	100.0%	108	100.0%	93	100.0%	66	100.0%	42	100.0%	14	100.0%	916	100.0%
N = Documents	191		48		32		31		30		7		339	

Respondents who did not choose to work as providers/companions were asked how they ended up in this role. This question also followed a qualitative methodology (Q.25). Although this question was linked to the previous one, it was analyzed separately. Graph 18 shows how reasons changed for participants who took a different stance about abortion service provision, when they had not chosen it. The 35 analyzable entries resulted in 44 codified segments, distributed in the following way:

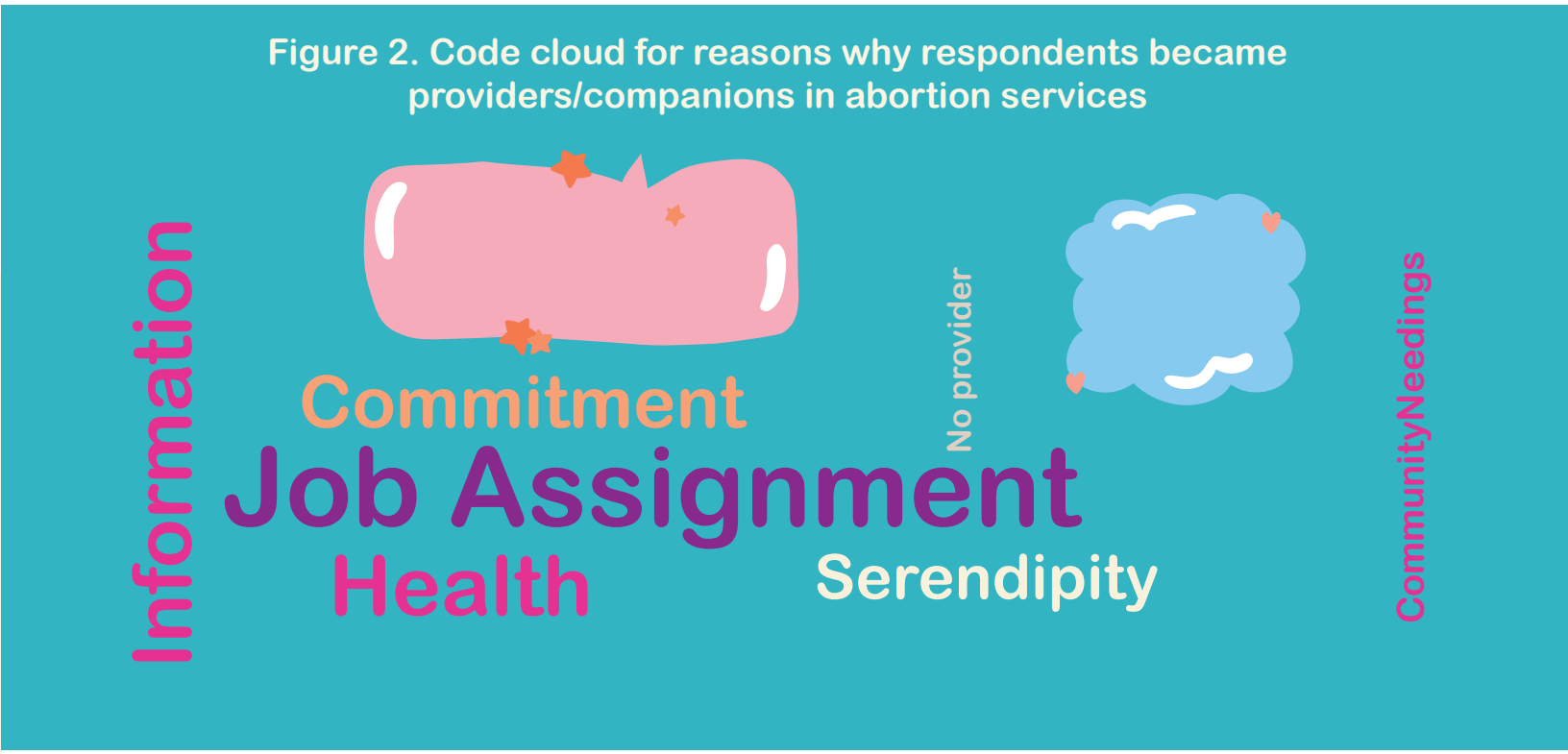
Graph 18. Distribution of frequencies per code for answers to item Q.25



How did you become an abortion service provider?

The code cloud shows that the main reason participants stated for why they ended up working as abortion providers or companions was ***Job/assignment***, which refers to providing services to meet a work contract or obligation. This code also included medical staff that provided abortion services as part of their clinical training process. Other reasons are those that fit in with the code ***Information***, which includes people who changed their opinion regarding abortion service provision after receiving information/awareness. ***Community needings*** was also included as an explanation for why some respondents ended up working in abortion service provision. This code groups respondents that began performing abortion when there was no one else to do so in their workplace. Answers regarding chance or coincidence were gathered under the code ***Serendipity***. In addition, there were 3 cases of respondents who did not identify themselves as service providers or who had worked in this field and had ceased to do so. These cases were coded as ***No provider***; they were included in the survey because they answered all questions based on their previous experience working in the field.

Figure 2. Code cloud for reasons why respondents became providers/companions in abortion services



The analysis by region did not show differences in the reasons; as a result, a table is not included. On the one hand, this is due to the number of segments, which is smaller as only 44 participants reported not choosing their job. On the other hand, it is because codes by region are distributed in a similar manner, therefore assignment and awareness were the main reasons in all regions.

Subsequently, providers/companions were asked where they developed their skills to work in the field of abortion. The majority of respondents stated that they received their training in workshops (45.1%) or in non-governmental organizations (41.4%), followed by social movements (19.1%) and family planning clinics (18.8%). In Latin America, the largest number mentioned that they received training in non-governmental organizations (53%), while in Europe, the majority said that they attended Medical School (43.8%). In Africa, the rate for workshops (56.3%) and NGOs (50%) remained relatively consistent; however, 1 in 3 respondents also stated that they attended Medical School (28.1%). In North America, the majority of respondents received their training in family planning clinics (52%) and in social movements (36%), while in Asia, the majority received their training in workshops (66.7%) and in NGOs (33.3%). A number that stands out is that 1 in 3 respondents stated that they learned abortion-related practices in their first job (29.6%). In Oceania, the highest rates correspond to NGOs, the first job, online training, and others (28.6% for each one) (Table 19).

Table 19. Place where respondents received training by region

Place where training occurred	Region						
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania	Total n=324
Medical School	17	21	9	3	7	1	58
	9.2%	43.8%	28.1%	12.0%	25.9%	14.3%	17.9%
Medical residency	32	7	7	4	7	1	58
	17.3%	14.6%	21.9%	16.0%	25.9%	14.3%	17.9%
Family planning clinic	20	15	8	13	4	1	61
		31.3%	25.0%	52.0%	14.8%	14.3%	18.8%
Workshops	88	12	18	9	18	1	146
	47.6%	25.0%	56.3%	36.0%	66.7%	14.3%	45.1%
Civil society organizations	98	5	16	4	9	2	134
	53.0%	10.4%	50.0%	16.0%	33.3%	28.6%	41.4%
Social movements	40	1	4	9	8	0	62
		2.1%	12.5%	36.0%	29.6%	0.0%	19.1%
First job	24	10	4	4	8	2	52
	13.0%	20.8%	12.5%	16.0%	29.6%	28.6%	16.0%
Online	27	2	6	3	4	2	44
	14.6%	4.2%	18.8%	12.0%	14.8%	28.6%	13.6%
Other	12	8	0	4	3	2	29
		16.7%	0.0%	16.0%	11.1%	28.6%	9.0%
Total	185	48	32	25	27	7	324
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**The places where training took place are not mutually exclusive, which is why the sum could be greater than 100%.*

Of the respondents that mentioned other training options, the ones that stand out are those who stated they were self-taught or whose own experience with abortion led to becoming providers/companions; as well as those who learned by watching or working with other specialists (Table 20).

Table 20. Place where training occurred specified by region

Region	Topics of interest (cases)
Latin America and the Caribbean	In companionship or volunteer work (2) Based on my own experience (1) Watching or working with other specialists (2) Self-taught (1) Public programs (1) In my current job (1) Not specified (4)
Europe	Midwifery school (3) Watching or working with other specialists (2) Based on my own experience (1) Not specified (2)
North America	Self-taught (1) Midwifery school (1) Not specified (2)
Asia	Watching or working with other specialists (1) Not specified (2)
Oceania	Watching or working with other specialists (2)

1 in 3 respondents considered that their training in abortion methods was insufficient (31.3%). The greatest number of respondents who consider their training insufficient works in Africa (43.8%), followed by those who work in Latin America and the Caribbean (38.9%). The percentages of those who consider this to be the case were lower in Asia (16%), Europe (15.2%), and Oceania (14.3%) (Table 21).

1 in 3 respondents

considered that their training in abortion methods was insufficient

Table 21. Respondents' perception regarding having sufficient training on abortion methods by region

Region	Sufficient training on abortion methods					
	Yes		No		Total	
	N	%	N	%	N	%
Latin America and the Caribbean	113	61.1%	72	38.9%	185	100%
Europe	39	84.8%	7	15.2%	46	100%
Africa	18	56.3%	14	43.8%	32	100%
North America	23	92.0%	2	8.0%	25	100%
Asia	21	84.0%	4	16.0%	25	100%
Oceanla	6	85.7%	1	14.3%	7	100%
Total	220	68.8%	100	31.3%	320	100%

The majority (51.9%) of providers/companions reported that they would like to receive further training on managing complications, followed by counseling on stigma (48.8%), legal policies (48.4%), and abortion methods (42.8%). In Latin America, interest in training on managing complications (63.2%) was followed by interest in legislation and legal policies (58.8%). In contrast, in Europe the majority of respondents (41.3%) stated that they do not need further training. In Africa (75%), Asia (69%), and Oceania (40%) respondents are most interested in further training in counseling on stigmas (Table 22).

Providers/companions reported that they would like to receive further training on:

51.9%
Managing complications

48.8%
Counseling on stigma

48.4%
Legal policies

42.8%
Abortion methods

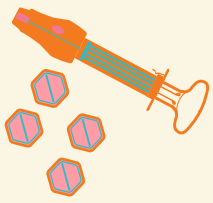


Table 22. Topics in which respondents would like to receive further training by region

Region	Topics of interest for training						
	Identification and management of complications	Counseling on stigma	Legislation/ legal policies	Abortion methods and protocols	Nothing, I already know what I need	Other	Total
Latin America and the Caribbean	115	87	107	90	14	5	182
	63.2%	47.8%	58.8%	49.5%	7.7%	2.7%	100.0%
Europe	12	11	5	12	19	2	46
	26.1%	23.9%	10.9%	26.1%	41.3%	4.3%	100.0%
Africa	15	24	13	14	3	2	32
	46.9%	75.0%	40.6%	43.8%	9.4%	6.3%	100.0%
North America	8	12	12	8	4	3	26
	30.8%	46.2%	46.2%	30.8%	15.4%	11.5%	100.0%
Asia	15	20	18	12	1	0	29
	51.7%	69.0%	62.1%	41.4%	3.4%	0.0%	100.0%
Oceania	1	2	0	1	1	1	5
	20.0%	40.0%	0.0%	20.0%	20.0%	20.0%	100.0%
Total	166	156	155	137	42	13	320
	51.9%	48.8%	48.4%	42.8%	13.1%	4.1%	100.0%

**The topics are not mutually exclusive, which is why the sum could be greater than 100%.*

Table 23 includes the training topics of interests that were specified under "others", and some comments that were added to be specified, for example, the types of abortion methods in which they are interested, particularly abortion in the second and third trimester. The fact that in Oceania respondents did not specify topics in which they would like to receive training stands out.

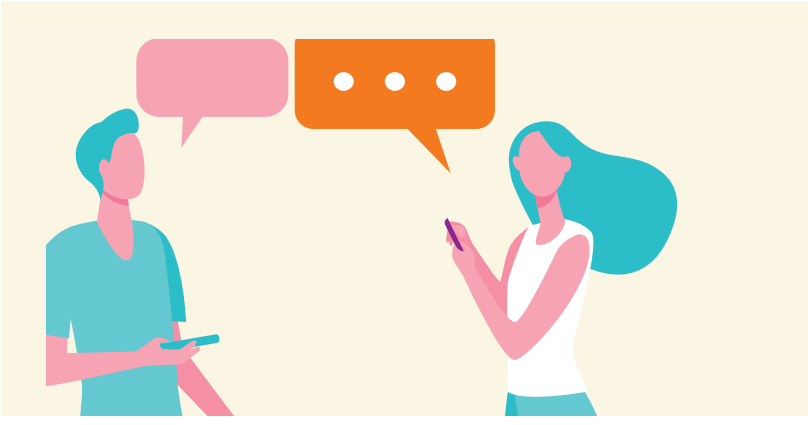
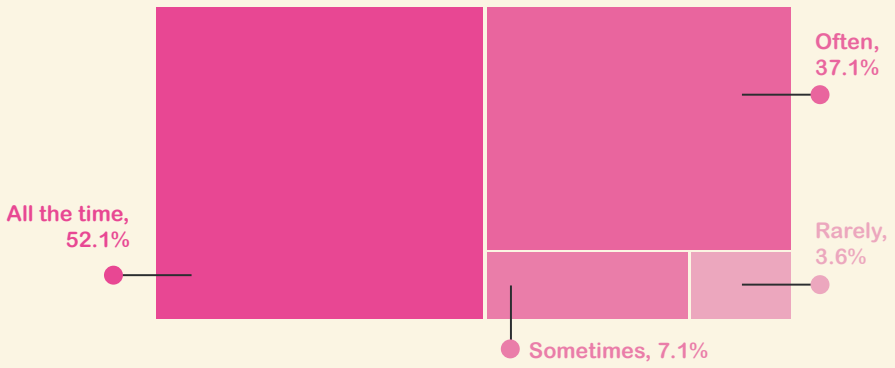


Table 23. Specific topics of interest in which to receive further training regarding abortion provision/companionship

Region	Topics of interest (cases)
Latin America and the Caribbean	Bioethics (1) Embryonic development (1) Trans masculinities and second trimester abortions (1) Advocacy (1) Statistical reports of the information (1) Other specifications: Post-abortion methods and protocols (1) Second trimester abortion methods (4) Third trimester abortion methods (1) Manual vacuum aspiration (1) Legal context, distance counseling for medical abortion in the second trimester (1)
Europe	Surgical methods for second trimester abortion (1) Advocacy (1)
Africa	Advocacy (2) Other specifications: Second trimester abortion methods (1)
North America	Ultrasound (1)
Asia	Other specifications: Manual vacuum aspiration (1)

The question on whether provision/companionship was a job respondents enjoyed was only available for a part of the sample. Of those respondents (n=140), the majority (52.1%) enjoy their job all the time and 37.1% enjoy it often (Graph 19).

Graph 19. Frequency with which participants enjoy their job



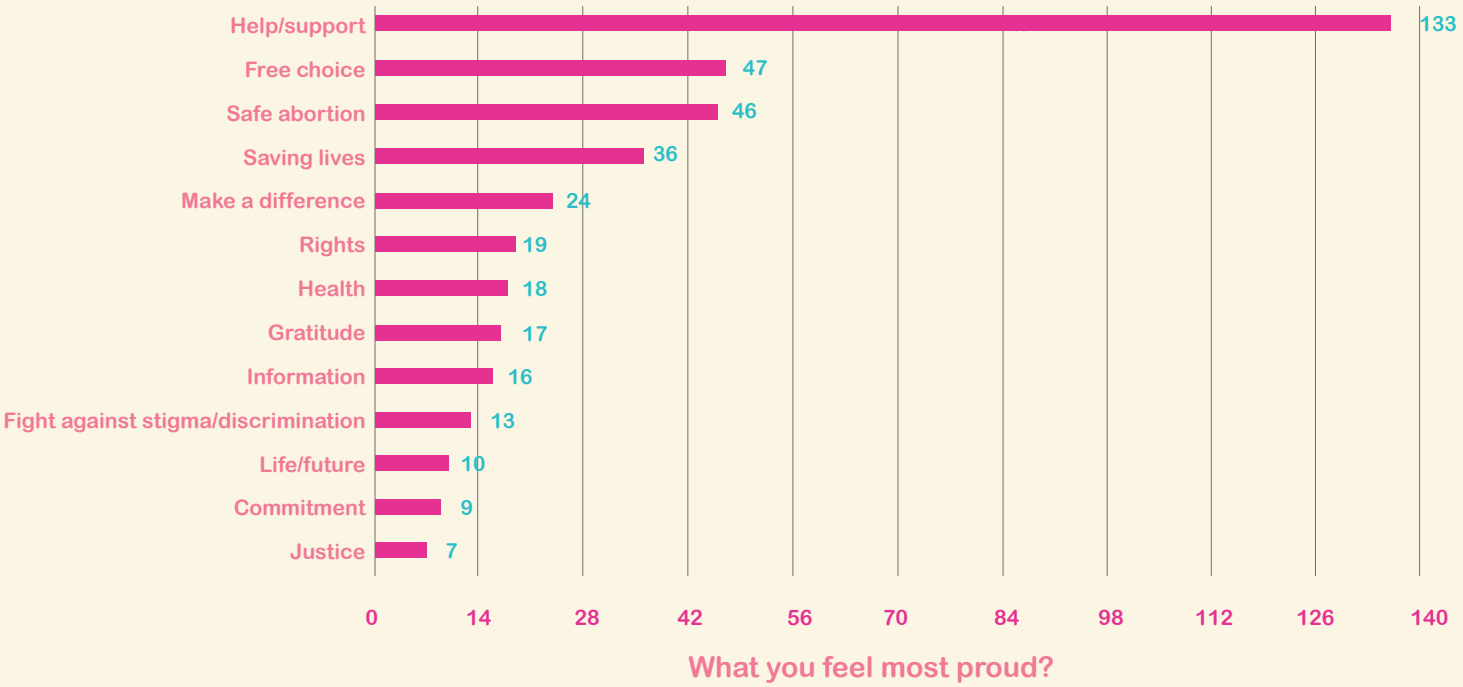
When asked whether they were proud of their job, almost 9 in 10 participants answered "yes" in all regions (87.5%). Something that stands out is the high rate that answered "sometimes" in Asia (25.9%) and "no" in Latin America and the Caribbean (5.4%) (Table 24).

Table 24. Rate of respondents who feel proud of their provision/companion job by region

	Pride in their job			
Region	**Yes**	**Sometimes**	**No**	**Total**
Latin America and the Caribbean	157	19	10	186
	84.4%	10.2%	5.4%	100.0%
Europe	46	2	0	48
	95.8%	4.2%	0.0%	100.0%
Africa	29	2	0	31
	93.5%	6.5%	0.0%	100.0%
North America	30	0	0	30
	100.0%	0.0%	0.0%	100.0%
Asia	19	7	1	27
	70.4%	25.9%	3.7%	100.0%
Oceania	7	0	0	7
	100.0%	0.0%	0.0%	100.0%
Total	288	30	11	329
	87.5%	9.1%	3.3%	100.0%

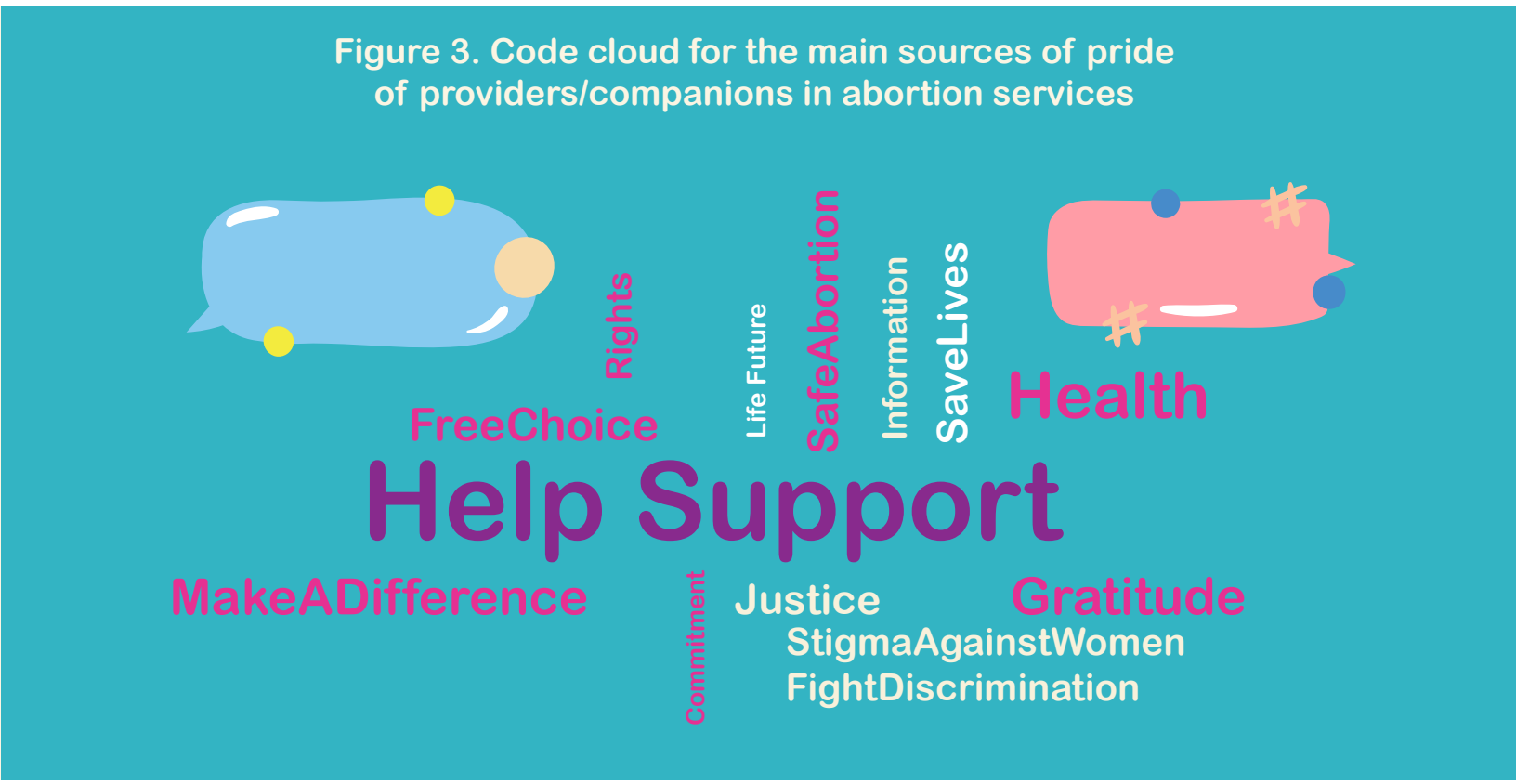
Respondents who feel proud of their job were asked to explain what they feel most proud (Q.31). This question was analyzed using qualitative methods. The 267 entries that were analyzable resulted in a total of 395 codified segments. The question regarding why they chose to be providers/companions of abortion services resulted in 13 codes (see Annex 1); the distribution is included below:

Graph 20. Distribution of frequencies of codes for item Q.31



The code cloud derived from the rates between codes shows that what abortion service providers are most proud of is the ability to help *(Help/Support)*, as well as the willingness to defend and exercise women's freedom to choose *(Free choice)*. Seeking justice *(Justice)* or the personal or political commitment to abortion *(Commitment)*, the feeling of saving lives *(Save lives)*, and the ability to give accurate and timely information *(Information)*. Other sources of pride included—although less frequently—the ability to affect women's prospects and future, the access to justice, and the work of destigmatizing women's health.

Figure 3. Code cloud for the main sources of pride of providers/companions in abortion services



In Latin America, Europe, and North America respondents listed *Help/Support* as a source of pride, followed by *Free choice* and *Safe abortion*. In contrast, in Africa, providers/companions were most proud of the ability to save lives. The access to justice was only mentioned in Africa and Asia as a reason for feeling proud of providing abortion services. Notably, in Oceania, a greater number of providers/companions were proud of fighting against the stigma faced by women who abort (Table 25).

Table 25. Distribution of frequencies and percentages of codified segments by region for Q.31

Reasons for pride	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Help/support	86	35%	17	39%	4	11%	15	47%	9	33%	2	20%	133	34%
Free choice	25	10%	10	23%	6	17%	4	13%	1	4%	1	10%	47	12%
Safe abortion	26	11%	2	5%	5	14%	6	19%	6	22%	1	10%	46	12%
Saving lives	23	9%	1	2%	9	26%	0	0%	2	7%	1	10%	36	9%
Make a difference	15	6%	1	2%	2	6%	3	9%	2	7%	1	10%	24	6%
Rights	13	5%	3	7%	1	3%	0	0%	1	4%	1	10%	19	5%
Health	10	4%	2	5%	1	3%	2	6%	2	7%	1	10%	18	5%
Gratitude	11	4%	2	5%	3	9%	0	0%	1	4%	0	0%	17	4%
Information	14	6%	1	2%	1	3%	0	0%	0	0%	0	0%	16	4%
Fight against stigma/ discrimination	9	4%	1	2%	0	0%	1	3%	0	0%	2	20%	13	3%
Life/future	6	2%	1	2%	2	6%	0	0%	1	4%	0	0%	10	3%
Commitment	5	2%	3	7%	0	0%	1	3%	0	0%	0	0%	9	2%
Justice	4	2%	0	0%	1	3%	0	0%	2	7%	0	0%	7	2%
Total	247		44		35		32		27		10		395	
N = Documents	191		48		32		31		30		7		339	

Close to 8 in 10 respondents answered that they feel connected to other colleagues with a similar job (77.2%). However, in Asia, this only occurs "sometimes" to 1 in 3 respondents, while in Latin America and Africa, this does not happen to 6.5% of respondents (Table 26).

Table 26. Rate of respondents that feel connected to colleagues with similar jobs by region

	Feeling of connection with colleagues with similar jobs			
Region	**Yes**	**Sometimes**	**No**	**Total**
Latin America and the Caribbean	138	35	12	185
	74.6%	18.9%	6.5%	100.0%
Europe	39	7	2	48
	81.3%	14.6%	4.2%	100.0%
Africa	24	5	2	31
	77.4%	16.1%	6.5%	100.0%
North America	27	3	0	30
	90.0%	10.0%	0.0%	100.0%
Asia	20	8	0	28
	71.4%	28.6%	0.0%	100.0%
Oceania	6	1	0	7
	85.7%	14.3%	0.0%	100.0%
Total	254	59	16	329
	77.2%	17.9%	4.9%	100.0%

What are the most significant stressors and stigmas?

Stressors

In total, 1 in 4 respondents said that their job is almost never a source of stress (25.5%), followed by 40% that believed it is sometimes. Globally, 3.6% considered that their provision/companionship job is a source of stress all the time. The majority of respondents that believed this to be the case are in Asia (10.3%), followed by those in Latin America (3.8%), North America (3.3%), and Africa (3.2%). The fact that in Oceania no respondent considered their job to be stressful all the time stands out (Table 27).

Table 27. Frequency with which participants considered their provision/companionship job a source of stress

Region	Frequency that their job is a source of stress					
	Never	Almost never	Sometimes	Frequently	All the	Total
Latin America and the Caribbean	time	Total	69	24	7	185
	21.6%	24.3%	37.3%	13.0%	3.8%	100.0%
Europe	5	12	21	10	0	48
	10.4%	25.0%	43.8%	20.8%	0.0%	100.0%
Africa	7	9	12	2	1	31
	22.6%	29.0%	38.7%	6.5%	3.2%	100.0%
North America	2	12	15	0	1	30
	6.7%	40.0%	50.0%	0.0%	3.3%	100.0%
Asia	0	3	16	7	3	29
	0.0%	10.3%	55.2%	24.1%	10.3%	100.0%
Oceania	1	3	2	1	0	7
	14.3%	42.9%	28.6%	14.3%	0.0%	100.0%
Total	55	84	135	44	12	330
	16.7%	25.5%	40.9%	13.3%	3.6%	100.0%

In general, the majority believed that they perceive the greatest load of stress only at work (61.8%). However, 1 in 3 respondents stated that they perceive stress both at work and at home (31.1%) By region, in Africa 1 in 5 respondents feel stress only at home (21.7%), while the rest of the regions report smaller rates. In Asia and Oceania, no respondent perceives stress only at home. Asia and Latin America report the greatest load of stress at work (69% and 67.8%, respectively). In contrast, North America (50%) and Europe (40.5%) reported higher rates of respondents who perceive stress in both places (Table 28).

Table 28. Place where they perceive the greatest load of stress by region

Region	Place where they perceive the greatest load of stress			
	Only at home	Only at work	Both	Total
Latin America and the Caribbean	9	78	28	115
	7.80%	67.80%	24.30%	100.00%
Europe	1	24	17	42
	2.40%	57.10%	40.50%	100.00%
Africa	5	10	8	23
	21.70%	43.50%	34.80%	100.00%
North America	2	11	13	26
	7.70%	42.30%	50.00%	100.00%
Asia	0	20	9	29
	0.00%	69.00%	31.00%	100.00%
Oceania	0	6	0	6
	0.00%	100.00%	0.00%	100.00%
Total	17	149	75	241
	7.10%	61.80%	31.10%	100.00%

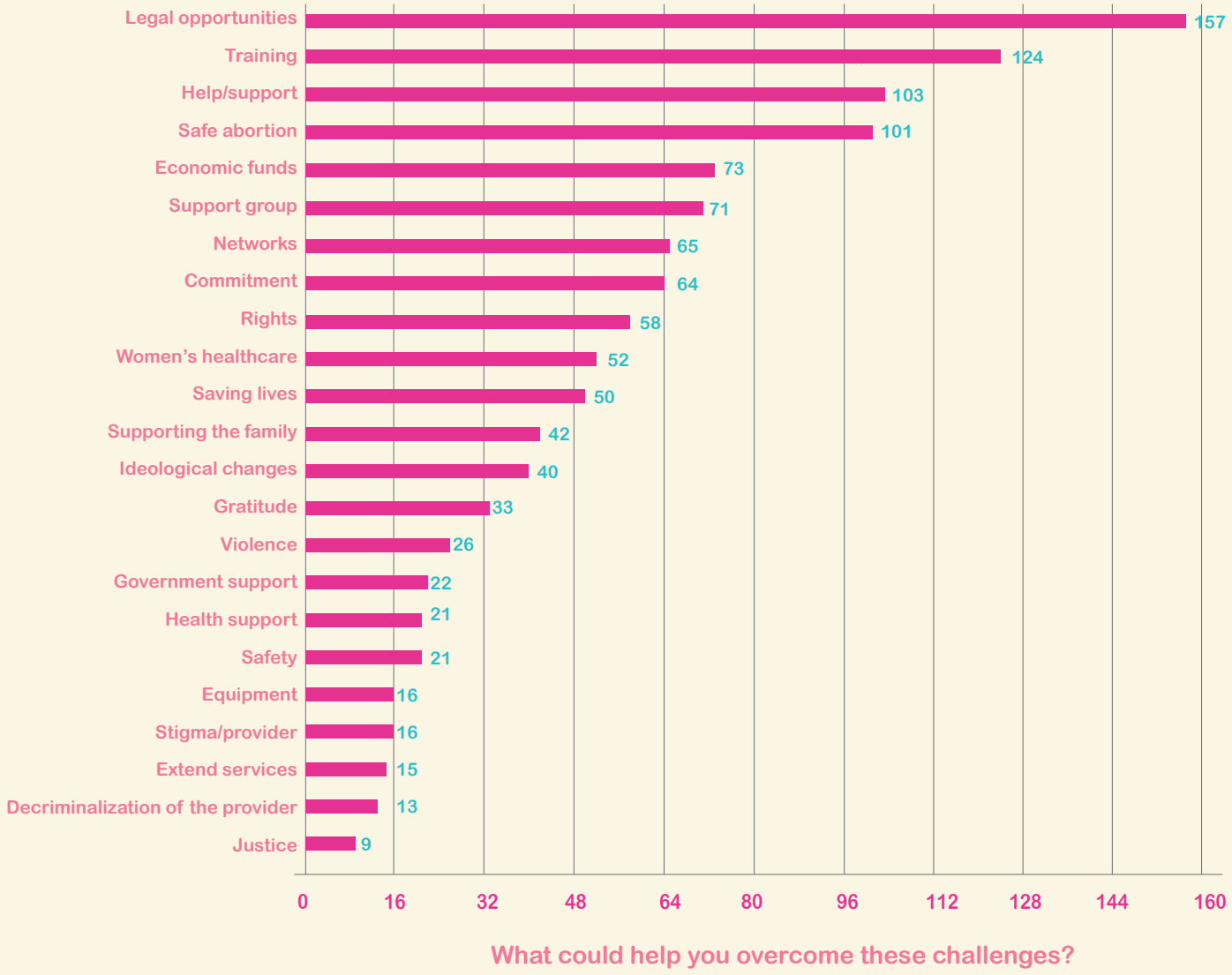
The majority of respondents reported that their main challenge is the discriminatory legislation and legal restrictions (49.7%), followed by the lack of funding, unequal access to resources, and economic pressure (48.2%). In third place is the scarcity of providers (38.3%); followed by the fear of persecution or what they consider the lack of government or legal protection and support to do their job (35.9%); the lack of support from other medical areas (32.2%); the hostile environment where they work (24.8%); and burnout or feeling overwhelmed (22.4%). Analyzing these stressors by region, legislation and legal restrictions are the most important in Oceania (85.7%) and Latin America (58.7%). In Europe (31.3%), Africa (74.2%) and North America (48.1%), a lack of funding is the greatest stressor. The most important challenge in Asia is the scarcity of providers (55.2%) (Table 29).

Table 29. Main challenges that providers/companions face by region

Stressor	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Discriminatory legislation and legal restrictions	108	58.7%	6	12.5%	20	64.5%	11	40.7%	11	37.9%	6	85.7%	162	49.7%
Lack of funding, unequal access to resources, economic pressure	94	51.1%	15	31.3%	23	74.2%	13	48.1%	8	27.6%	4	57.1%	157	48.2%
Scarcity of providers	81	44.0%	5	10.4%	11	35.5%	10	37.0%	16	55.2%	2	28.6%	125	38.3%
Fear of persecution/lack of government or legal protection and support	77	41.8%	4	8.3%	17	54.8%	7	25.9%	11	37.9%	1	14.3%	117	35.9%
Lack of support from other medical areas	69	37.5%	13	27.1%	11	35.5%	5	18.5%	3	10.3%	4	57.1%	105	32.2%
Hostile environment (threats, harassment, intimidation, violence)	41	22.3%	3	6.3%	14	45.2%	11	40.7%	9	31.0%	3	42.9%	81	24.8%
Burnout or feeling overwhelmed	39	21.2%	8	16.7%	6	19.4%	9	33.3%	11	37.9%	0	0.0%	73	22.4%
Risking my personal or professional reputation	32	17.4%	6	12.5%	6	19.4%	3	11.1%	9	31.0%	0	0.0%	56	17.2%
Lack of training	18	9.8%	3	6.3%	4	12.9%	0	0.0%	5	17.2%	0	0.0%	30	9.2%
Pressure from partners, family, or community	6	3.3%	4	8.3%	6	19.4%	2	7.4%	9	31.0%	0	0.0%	27	8.3%
Conflict with personal beliefs	7	3.8%	1	2.1%	4	12.9%	0	0.0%	14	48.3%	0	0.0%	26	8.0%
I don't feel I'm facing any challenges	10	5.4%	10	20.8%	1	3.2%	4	14.8%	0	0.0%	0	0.0%	25	7.7%
Feeling of despair or suffering	10	5.4%	1	2.1%	1	3.2%	4	14.8%	6	20.7%	0	0.0%	22	6.7%
High turnover	6	3.3%	2	4.2%	2	6.5%	3	11.1%	2	6.9%	0	0.0%	15	4.6%
Other	4	2.2%	3	6.3%	0	0.0%	2	7.4%	0	0.0%	0	0.0%	9	2.8%
Total	184	100%	48	100%	31	100%	27	100%	29	100%	7	100%	326	100%

Providers/companions were then asked "What could help you overcome these challenges?" (Q.36). The 233 entries that were analyzable resulted in a total of 1,192 codified segments. This question resulted in 23 codes (see Annex 1); the distribution is included below (Graph 21).

Graph 21. Distribution of frequencies of codes for item Q.36



The most significant answer to this question refers to ***Legal Changes***. This code groups reports suggesting the need to change laws and public policies that regulate and affect the access to legal and safe abortion services. ***Training*** also appeared as an element that would contribute to overcoming the challenges. ***Help/Support*** was also reported as an answer to this question; it implies the companionship, support, and ability to help women. Economic support ***(Economic Funds), Peer support***, and creating networks ***(Networks)*** were reported as aspects that could contribute to addressing the main concerns/challenges faced by providers. Other elements that could

help that were mentioned less frequently include the government's commitment to public services (*Government Support)*, strengthening of personal safety *(Security)*, providing the necessary resources or equipment for services *(Equipment)*, and decreasing stigma toward providers/companions *(Stigma Provider)*.

Figure 4. Code cloud for the changes that could help overcome challenges related to abortion provision/companionship

The differences become clear when analyzing answers by region. While Latin America and the Caribbean share the same general distribution, in Europe, *Training* and *Health care for women* are the most important elements that could help abortion service providers; i.e., greater awareness and access to health for women. In contrast, in Africa the main elements mentioned by respondents regarding help needs include legal changes *(Opportunities),* training *(Training)*, access to safe abortion *(Safe abortion)*, and concern in reducing mortality. In North America, the most important aspect to overcome concerns is the access to a safe abortion *(Safe abortion)*, followed by the exercise of commitment and political or social awareness, and feminism. In Asia, one of the most important needs is ideological changes, which refers to ceasing moral judgements or blaming abortion providers. In Oceania, respondents mentioned improving access to women's health *(Health care for women)* and state protection in terms of public policy *(Government support)*. It is important to note that decriminalizing the provider was only mentioned in Latin America and the Caribbean, and Oceania *(Decriminalization Provider)* (Table 30).

Table 30. Distribution of frequencies and percentages of codified segments by region for Q.36

	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Legal opportunities	113	14%	6	5%	26	17%	4	6.7%	4	6%	4	25%	157	13%
Training	90	11%	13	11%	13	9%	4	6.7%	3	5%	1	6%	124	10%
Help/support	79	10%	6	5%	6	4%	5	8.3%	7	11%	0	0%	103	9%
Safe abortion	67	9%	8	7%	13	9%	7	11.7%	5	8%	1	6%	101	8%
Economic funds	53	7%	6	5%	9	6%	3	5.0%	2	3%	0	0%	73	6%
Support group	42	5%	9	8%	10	7%	5	8.3%	5	8%	0	0%	71	6%
Networks	37	5%	4	3%	13	9%	5	8.3%	6	9%	0	0%	65	5%
Commitment	47	6%	2	2%	7	5%	6	10.0%	2	3%	0	0%	64	5%
Rights	43	5%	5	4%	8	5%	0	0.0%	1	2%	1	6%	58	5%
Women's healthcare	22	3%	12	10%	7	5%	5	8.3%	4	6%	2	13%	52	4%
Saving lives	35	4%	1	1%	12	8%	0	0.0%	2	3%	0	0%	50	4%
Supporting the family	24	3%	5	4%	5	3%	5	8.3%	3	5%	0	0%	42	4%
Ideological changes	22	3%	5	4%	2	1%	4	6.7%	7	11%	0	0%	40	3%
Gratitude	21	3%	3	3%	1	1%	2	3.3%	5	8%	1	6%	33	3%
Violence	14	2%	10	9%	0	0%	0	0.0%	2	3%	0	0%	26	2%
Government support	10	1%	2	2%	6	4%	1	1.7%	1	2%	2	13%	22	2%

	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Health support	12	2%	3	3%	2	1%	0	0.0%	3	5%	1	6%	21	2%
Safety	14	2%	4	3%	3	2%	0	0.0%	0	0%	0	0%	21	2%
Equipment	6	1%	4	3%	5	3%	0	0.0%	1	2%	0	0%	16	1%
Stigma/provider	11	1%	2	2%	1	1%	1	1.7%	0	0%	1	6%	16	1%
Extend services	6	1%	4	3%	3	2%	0	0.0%	1	2%	1	6%	15	1%
Decriminalization of the provider	12	2%	0	0%	0	0%	0	0.0%	0	0%	1	6%	13	1%
Justice	5	1%	1	1%	0	0%	3	5.0%	0	0%	0	0%	9	1%
SUM	785		115		152		60		64		16		1192	
N = Documents	191		48		32		31		30		7		339	

Stigma

The majority of respondents said they have never felt ashamed or guilty for doing their job (81.4%), and 13.1% said they almost never felt that way. However, 5.2% mentioned they felt that way sometimes, and one person said they frequently felt that way. The only person that selected "frequently" for this question works in Latin America and the Caribbean. In addition, 1 in every 4 respondents in Asia (25%) said they "sometimes" felt that way. On the other hand, the greatest number of respondents who felt ashamed or guilty the least were in North America; 90% said never and 10% said almost never (Table 31).

Stigma

81.4%
Said they have never felt ashamed or guilty for doing their job

13.1%
said they almost never felt shamed or guilty for doing their job

5.2%
mentioned they felt shamed or guilty for doing their job sometimes

Table 31. Frequency with which providers/companions have feelings of guilt or shame for doing their job

	Frequency with which they have feelings of guilt or shame				
Region	**Never**	**Almost never**	**Sometimes**	**Frequently**	**Total**
Latin America and the Caribbean	155	21	7	1	184
	84.2%	11.4%	3.8%	0.5%	100.0%
Europe	42	5	1	0	48
	87.5%	10.4%	2.1%	0.0%	100.0%
Africa	24	5	2	0	31
	77.4%	16.1%	6.5%	0.0%	100.0%
North America	27	3	0	0	30
	90.0%	10.0%	0.0%	0.0%	100.0%
Asia	15	6	7	0	28
	53.60%	21.40%	25.00%	0.00%	100.00%
Oceania	4	3	0	0	7
	57.1%	42.9%	0.0%	0.0%	100.0%
Total	267	43	17	1	328
	81.4%	13.1%	5.2%	0.3%	100.0%

However, the only person who said they frequently felt guilt or shame about their job did not answer why. Other answers could give clues that explain those feelings. The most common reasons in all regions relate to the judgement of others, in general, and specifically from colleagues and family members. Another recurring reason that leads providers to feel ashamed or guilty is the conflict of values. Two respondents stated they feel uncomfortable with advanced pregnancies (1 in Asia and 1 in Latin America), and two respondents stated they feel guilty due to women's lack of resources to pay for the procedure (Table 32).

Table 32. Reasons why abortion providers feel guilty or ashamed when doing their job

Region	Reasons (number of cases)
Latin America and the Caribbean	Conflict of values (4) Concern over the judgment from others (3) Concern over the judgment from colleagues (3) Concern over the judgment from family members (1) Emotional involvement in the cases (1) When dealing with a pregnancy close to the legal limit (1)
Europe	Concern over the judgment from colleagues (2) Concern over the judgment from others (1) Concern over the judgment from family members (1) Sensitive job (1)
Africa	Context of criminalization and legal restriction (1) Conflict of values (1) Lack of resources to pay for the medication (1)
North America	Concern over the judgement from family members
Asia	Conflict of values (2) Concern over the judgment from others (1) Lack of resources to pay for the medication (1)
Oceania	Advanced pregnancy and abortion due to reasons not related to fetal abnormalities (1)

One in ten respondents around the world considered it is difficult to comment on their work in abortion provision/companionship with others (11.8%). 1 in 3 considers that this is difficult only "sometimes" (29.4%). Latin America (14.6%), Asia (14.3%), and Oceania (14.3%) have the highest rate of respondents that do perceive it as difficult. In Europe, no respondent answered yes to this question. Oceania (57.1%) and North America (50%) have the highest rate of respondents who consider that "sometimes" it is difficult to comment on their job with others (Table 33).

One in ten respondents
considered it is difficult to comment on their work in abortion provision/companionship with others.

1 in 3
considers that this is difficult only "sometimes".

Table 33. Perception on the difficulty of commenting on their job as abortion providers/companions with others

Perception on the difficulty of commenting with others				
Region	**No**	**Sometimes**	**Yes**	**Total**
Latin America and the Caribbean	103	55	27	185
	55.7%	29.7%	14.6%	100.0%
Europe	38	10	0	48
	79.2%	20.8%	0.0%	100.0%
Africa	22	7	3	32
	68.8%	21.9%	9.4%	100.0%
North America	11	15	4	30
	36.7%	50.0%	13.3%	100.0%
Asia	18	6	4	28
	64.3%	21.4%	14.3%	100.0%
Oceania	2	4	1	7
	28.6%	57.1%	14.3%	100.0%
Total	194	97	39	330
	58.8%	29.4%	11.8%	100.0%

Regarding the reasons why it is difficult to talk to others about their work in abortion provision/companionship, the concern over judgement is in first place (43.8%), followed by having to justify themselves (39.2%) and, in third place, violence (30.8%). One in four respondents is worried about being treated differently (24.6%) and marginalized (22.3%) if they talk about their job with others. When observing rates per region, in Latin America and Asia, the most significant concerns are having to justify themselves (48.7% and 55.6%, respectively), followed by judgment (35.9% and 33.3%). In Europe, concerns over being marginalized are in second place (40%). In Africa, violence is in first place (50%), followed by judgement, being treated differently, and disappointment, with the same rates (40%). In Oceania, 7 in 10 respondents were concerned with judgement (75%), and, 1 in 4 with being treated differently (25%), marginalization (25%), and other reasons (25%) (Table 34).

The main concern included in "Other" is related to the context of illegality where provision/companionship takes place in Asia and in Latin America and the Caribbean. Some respondents even mentioned the fear of losing their professional license or facing a legal consequence as a result. In Europe and Oceania, respondents mostly referred to the emotional/moral burden that others might feel if they found out that they provide abortion/companionship services. In Africa and North America, respondents did not specify other reasons (Table 35).

Table 34. Rates for reasons why it is difficult to talk to others about their job

	Latin America and the Caribbean		Europe		frica		North America		Asia		Oceania		Total	
Reasons	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Judgement	28	35.9%	3	30.0%	4	40.0%	16	84.2%	3	33.3%	3	75.0%	57	43.8%
Having to justify myself	38	48.7%	7	70.0%	1	10.0%	2	10.5%	5	55.6%	0	0.0%	51	39.2%
Violence	25	32.1%	2	20.0%	5	50.0%	6	31.6%	2	22.2%	0	0.0%	40	30.8%
Being treated differently	17	21.8%	3	30.0%	2	20.0%	8	42.1%	1	11.1%	1	25.0%	32	24.6%
Being marginalized	14	17.9%	4	40.0%	4	40.0%	4	21.1%	2	22.2%	1	25.0%	29	22.3%
Other	9	11.5%	1	1.0%	2	20.0%	0	0.0%	1	11.1%	1	25.0%	17	13.1%
Disappointment	6	7.7%	3	30.0%	4	40.0%	3	15.7%	1	11.1%	0	0.0%	16	12.3%
Total	78	100%	10	100%	10	100%	19	100%	9	100%	4	100%	130	100.0%

Reasons why it is difficult to talk to others about their work in abortion provision/companionship:

43.8%
Concern over judgement

39.2%
Having to justify themselves

39.2%
Violence

One in four respondents is worried about being treated differently

One in four respondents is worried about being marginalized

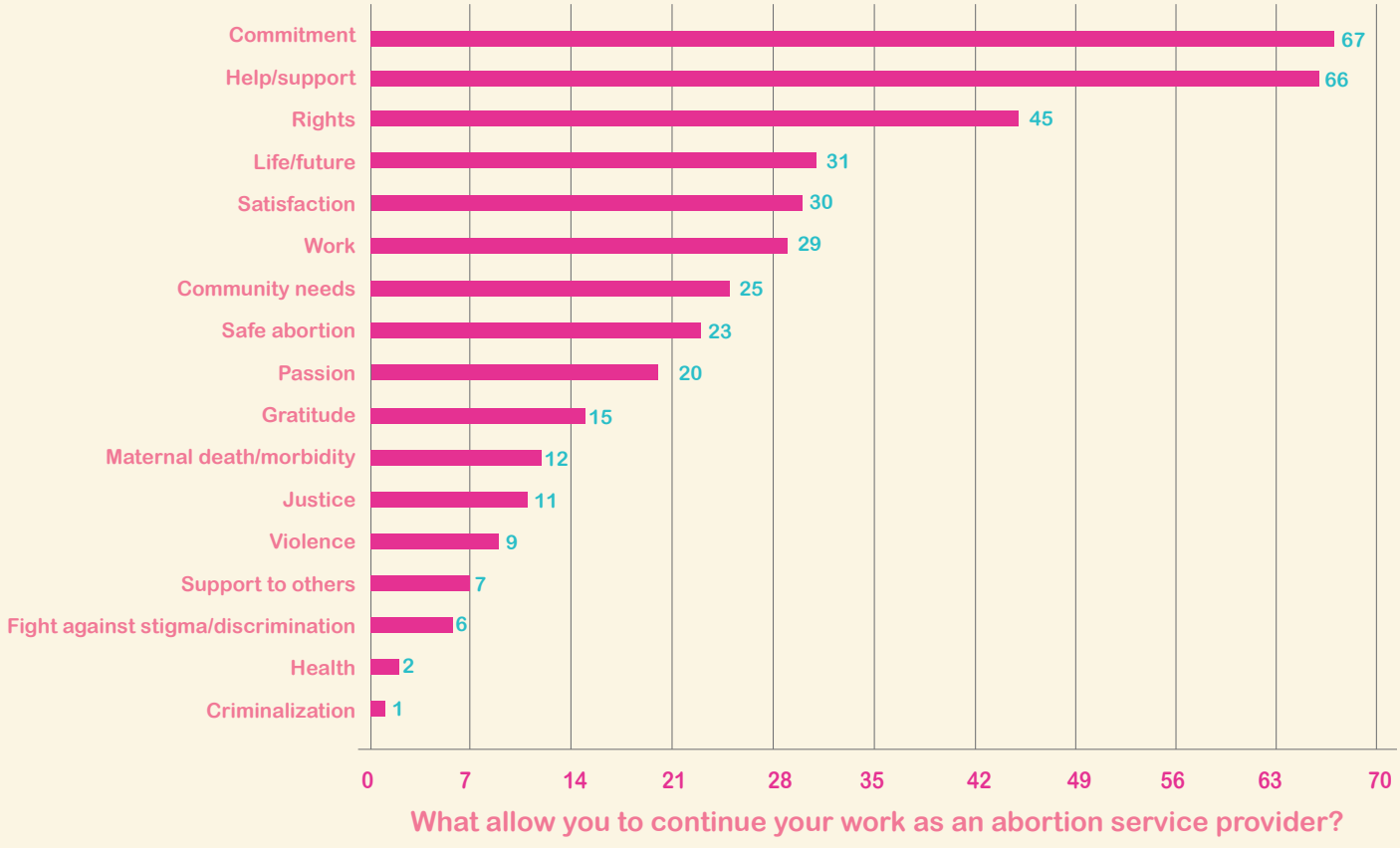
The concerns is related to the context of illegality where provision/companionship takes place in Asia and in Latin America and the Caribbean.

Table 35. Reasons why it is difficult to talk to others about their job

Region	Reasons (number of cases)
Latin America and the Caribbean	Singling out or aggressions toward their family (2) Concerns over the context of illegality/losing their license (8) Lack of importance given to pre- and post-abortion counseling (1)
Europe	Moral burden on others because of their job (1)
Africa	Not specified (2)
Asia	Concerns over the context of illegality/losing their license (1)
Oceania	Moral burden on others because of their job (1)

Later in the survey, providers/companions were asked about what would allow them to continue despite the stigmas they face (Q.41). The 266 entries that were analyzable resulted in a total of 399 codified segments and 17 codes were derived as well (see Annex 1); the distribution is included below:

Graph 22. Distribution of frequencies of codes for item Q.41



Respondents stated that the main reason for continuing to do their job is the conviction that their job makes a difference, and that it is necessary for women *(Commitment)* and the access to their rights *(Rights)*. Other aspects were reported at similar rates, including the ability to help and accompany women *(Help/Support)*, satisfaction with providing those services *(Satisfaction)*, and coverage or care of their community's needs *(Community needings)*. The need to reduce the number of deaths or morbidity (Maternal death/comorbility) and the stigma toward women who abort *(Stigma against women/Discrimination)*, and the gratitude of those they have been able to help *(Gratitude)* motivate them to continue providing abortion services. Respondents also mentioned the concern over women's prospects and future *(Life/Future)*, as well as their passion for the work they do *(Passion)*. These answers contrast with the rate of respondents who said they continued doing their job only because it was assigned to them *(Job)* (Figure 5).

Figure 5. Code cloud for the reasons that would allow them to continue with their work in abortion provision/companionship

In Latin America, the most important reason that would allow respondents to continue doing their job is commitment *(Commitment)*, followed by the ability to help women *(Help/Support)*. In addition, the codes related to stigma *(Fight against stigma/discrimination)* and violence *(Violence)* appear at higher rates in this region compared to the rest. Decriminalization *(Criminalization)* was only reported as a reason in these countries (Table 35).

In contrast, in Europe, Commitment and *Help/Support* are the most important motivator, followed by the assignment of tasks in their job *(Work)*. The most important reasons in Africa are seeking access to rights *(Rights)*, reducing maternal death and morbidity *(Maternal death/morbidity)*, and the concern over women's prospects and future *(Life/Future)*. In North America, the main reasons are the concern over access to rights *(Rights)* and social commitment *(Commitment)*. In Asia, covering community needs *(Community needs)* appears at the same rate as the ability to help and accompany women. Finally, in Oceania, the main reason why respondents continue doing their job is the satisfaction with the results *(Satisfaction)* (Table 36).

Table 36. Distribution of frequencies and percentages of codified segments by region for Q.41

Reasons for providing services	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Commitment	46	19%	8	22%	1	2%	6	16%	4	13%	2	29%	67	17%
Help/support	45	19%	8	22%	2	4%	4	11%	6	19%	1	14%	66	17%
Rights	26	11%	3	8%	10	21%	6	16%	0	0%	0	0%	45	11%
Life/future	22	9%	1	3%	5	11%	1	3%	2	6%	0	0%	31	8%
Satisfaction	16	7%	4	11%	1	2%	5	13%	1	3%	3	43%	30	8%
Work	13	5%	5	14%	4	9%	3	8%	4	13%	0	0%	29	7%
Community needs	15	6%	1	3%	3	6%	0	0%	6	19%	0	0%	25	6%
Safe abortion	14	6%	1	3%	4	9%	2	5%	2	6%	0	0%	23	6%
Passion	7	3%	2	6%	5	11%	5	13%	1	3%	0	0%	20	5%
Gratitude	9	4%	0	0%	1	2%	2	5%	2	6%	1	14%	15	4%
Maternal death/morbidity	3	1%	0	0%	8	17%	0	0%	1	3%	0	0%	12	3%
Justice	6	3%	0	0%	1	2%	3	8%	1	3%	0	0%	11	3%
Violence	8	3%	1	3%	0	0%	0	0%	0	0%	0	0%	9	2%
Support to others	2	1%	2	6%	2	4%	0	0%	1	3%	0	0%	7	2%
Fight against stigma/discrimination	6	3%	0	0%	0	0%	0	0%	0	0%	0	0%	6	2%
Health	1	0%	0	0%	0	0%	1	3%	0	0%	0	0%	2	1%
Criminalization	1	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
Total	240		36		47			38		31		7		399
N = Documents	191		48		32			31		30		7		339

Violence

A total of 13.4% of respondents has faced violent aggressions against them or their families due to their work as abortion providers/companions. It is especially noteworthy that the rate in Africa reaches 28.1%; in Asia, 21.4%; and in North America, 20.7%. Oceania and Europe report similar rates (14.3% and 12.5%, respectively). Latin America and the Caribbean report the lowest rate of respondents who have had these experiences (8.6%) (Table 37).

Table 37. Rate of respondents who have faced violent aggressions related to the provision/companionship of abortion services by region

	Experience of violence		
Region	**No**	**Yes**	**Total**
Latin America and the Caribbean	169	16	185
	91.4%	8.6%	100.0%
Europe	42	6	48
	87.5%	12.5%	100.0%
Africa	23	9	32
	71.9%	28.1%	100.0%
North America	23	6	29
	79.3%	20.7%	100.0%
Asia	22	6	28
	78.6%	21.4%	100.0%
Oceania	6	1	7
	85.7%	14.3%	100.0%
Total	285	44	329
	86.6%	13.4%	100.0%

Of the 44 respondents who stated that they have faced violence as a result of their job, they have most often faced verbal violence (77.3%), followed by harassment, intimidation, defamation, or attacks against their reputation (50%). The third most important aggression were threats against their life or personal safety (31.8%). One in three respondents also stated that they faced online harassment or protests (29.5%). One in five has faced legal investigations or law enforcement (20.5%). One in ten has faced physical violence (11.4%), and, to a lesser degree, other types of aggressions such as invasion of privacy (6.8%), threats to the life or safety of their loved ones (4.5%), discrimination (2.3%), economic retaliation (2.3%), and ostracism (2.3%) (Table 38).

On the other hand, it is important to note that in Latin America and the Caribbean, and North America, the most frequent type of aggression is verbal violence (75% and 100%), followed by harassment and intimidation (31.3% and 66.7%) and protests (31.3% and 50%). In Europe, the most frequent aggression is harassment-intimidation (50%) and reports to law enforcement (50%). In Africa, it is harassment and intimidation (100%), followed by verbal violence (88.9%) and threats to their life or personal safety (66.7%). In Asia, verbal violence (83.3%), protests (50%), and online harassment (33.3%) are the most frequent. These types of violence are not mutually exclusive, and a single person could have faced various aggressions (Table 38).

Aggressions related to the provision/companionship of abortion services

13.4% of respondents has faced violent aggressions:

77.3% Verbal violence

50% harassment, intimidation, defamation, or attacks against their reputation

31.8% Threats against their life or personal safety

One in three respondents
stated that they faced online harassment or protests

One in five
has faced legal investigations or law enforcement

One in ten
has faced physical violence

Other types of aggressions:

- Threats to the life or safety of their loved ones
- Discrimination
- Economic retaliation
- Ostracism

Table 38. Aggressions/violence faced by providers by region

Aggressions	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Verbal violence	12	75.0%	2	33.3%	8	88.9%	6	100.0%	5	83.3%	1	100.0%	34	77.3%
Harassment/intimidation/ defamation/attacks against their reputation	5	31.3%	3	50.0%	9	100.0%	4	66.7%	1	16.7%	0	0.0%	22	50.0%
Threats to my life or safety	3	18.8%	1	16.7%	6	66.7%	3	50.0%	1	16.7%	0	0.0%	14	31.8%
Online harassment	4	25.0%	1	16.7%	3	33.3%	2	33.3%	2	33.3%	1	100.0%	13	29.5%
Protests	5	31.3%	1	16.7%	0	0.0%	3	50.0%	3	50.0%	1	100.0%	13	29.5%
I was reported to law enforcement or I am under investigation	0	0.0%	3	50.0%	5	55.6%	0	0.0%	1	16.7%	0	0.0%	9	20.5%
Physical violence	0	0.0%	0	0.0%	2	22.2%	3	50.0%	0	0.0%	0	0.0%	5	11.4%
Invasion of privacy - harassment/stalking	1	6.3%	0	0.0%	1	11.1%	1	16.7%	0	0.0%	0	0.0%	3	6.8%
Threats to the life or safety of my loved ones	0	0.0%	0	0.0%	1	11.1%	1	16.7%	0	0.0%	0	0.0%	2	4.5%
Discrimination	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	16.7%	0	0.0%	1	2.3%
Economic retaliation	0	0.0%	0	0.0%	1	11.1%	0	0.0%	0	0.0%	0	0.0%	1	2.3%
Ostracism	1	6.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	2.3%
Total	16	100.0%	6	100.0%	9	100.0%	6	100.0%	6	100.0%	1	100.0%	44	100.0%

Discrimination

Half of respondents have never felt or never feel discriminated against in their professional life due to their provision/companionship job (50.5%). One in five (21.5%) said that they had almost never had discriminatory experiences, and a fourth said "sometimes". A total of 16 respondents (4.8%) said they frequently feel discriminated against in their professional life, and only 1 person in Africa said it always happens. In Latin America (53%), Europe (52.1%), North America (66.7%), and Asia (48.3%) the majority of respondents have never felt discriminated against in their professional life. However, in Africa and Oceania, the majority of respondents said they "sometimes" have had these experiences (43.8% and 42.9%, respectively) (Table 39).

Table 39. Frequency with which providers/companions have felt discriminated in their professional life by region

Region	Frequency					
	Never	Almost never	Sometimes	Frequently	All the time	Total
Latin America and the Caribbean	98	41	37	9	0	185
	53.0%	22.2%	20.0%	4.9%	0.0%	100.0%
Europe	25	12	9	2	0	48
	52.1%	25.0%	18.8%	4.2%	0.0%	100.0%
Africa	8	6	14	3	1	32
	25.0%	18.8%	43.8%	9.4%	3.1%	100.0%
North America	20	6	4	0	0	30
	66.7%	20.0%	13.3%	0.0%	0.0%	100.0%
Asia	14	4	9	2	0	29
	48.3%	13.8%	31.0%	6.9%	0.0%	100.0%
Oceania	2	2	3	0	0	7
	28.6%	28.6%	42.9%	0.0%	0.0%	100.0%
Total	167	71	76	16	1	331
	50.5%	21.5%	23.0%	4.8%	0.3%	100.0%

Only 153 respondents answered the type of experiences of discrimination they had faced. The majority mentioned that other colleagues who do not want to participate in the provision of services make their job more difficult (54.9%). This was followed by respondents who feel that their job faces greater legal restrictions than other health sectors (52.3%) and respondents who feel that other health professionals belittle their job (49.7%) or that they have less economic, material, and human resources compared to other health areas (42.5%). One in three respondents reported that they have felt that other professionals question their professional skills (33.3%) (Table 40).

Latin America and the Caribbean shared this hierarchy of experiences. In contrast, in Europe, the types of discrimination that providers faced most frequently are belittling (47.6%), lack of collaboration (42.9%), and questioning of their professional skills (38.1%). In Africa and North America, the most common experiences are legal restrictions (59.1% and 70%) and lack of resources (59.1% and 60%). In Asia, the most significant source of discrimination is lack of resources (53.8%), followed by lack of collaboration (46.2%), and belittling of their skills (46.2%). In Oceania, the most reported experience of discrimination that was reported was related to legal restrictions (100%) (Table 40).

Of the 5 respondents that reported other experiences of discrimination in their professional life, 2 did not specify, while the rest mentioned experiences related to stigma toward abortion service providers, for example, judgement or lack of acceptance.

Discrimination in professional life

50.5%
have never felt or never feel discriminated against in their professional life due to their provision/companionship job

One in five
said that they had almost never had discriminatory experiences

A fourth
sail "sometimes".

Table 40. Experiences of discrimination in the professional life of abortion service providers/companions

Experiences of discrimination	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Feels that other health areas do not want to collaborate with abortion providers and make their job more difficult.	50	61.0%	9	42.9%	12	54.5%	4	40.0%	6	46.2%	3	60.0%	84	54.9%
Feels their job is subjected to restrictive legislation more than other types of health services.	47	57.3%	4	19.0%	13	59.1%	7	70.0%	4	30.8%	5	100.0%	80	52.3%
Feels that other health professionals belittle them because of their work in abortion services.	42	51.2%	10	47.6%	11	50.0%	5	50.0%	6	46.2%	2	40.0%	76	49.7%
Feels their job is subjected to equipment, resource, and funding restrictions more than other health services.	33	40.2%	4	19.0%	13	59.1%	6	60.0%	7	53.8%	2	40.0%	65	42.5%
Feels that other professionals question their skills when they find out about their work related to abortion.	31	37.8%	8	38.1%	3	13.6%	5	50.0%	3	23.1%	1	20.0%	51	33.3%
Other	4	4.9%	0	0.0%	0	0.0%	1	10.0%	0	0.0%	0	0.0%	5	3.2%
Total	82	100.0%	21	100.0%	22	100.0%	10	100.0%	13	100.0%	5	100.0%	153	100.0%

Discrimination in personal life

64.3% said they had never felt discriminated against in their personal life because f their work in abortion services provision/companionship.

One in five respondents
said that they had almost never felt discriminated against.

13.7% said that “sometimes” they had felt discriminated against in their personal life.

The majority of respondents said they had never felt discriminated against in their personal life because of their work in abortion services provision/companionship (64.3%). In addition, 1 in 5 respondents said that they had almost never felt discriminated against (20.7%). However, 13.7% said that “sometimes” they had felt discriminated against in their personal life. Only 3 respondents said they frequently feel that way, and 1 respondent stated they feel that way all the time. Oceania had the highest rate of respondents that have never felt discriminated against (85.7%). In Africa, 1 in 3 respondents “sometimes” feels discriminated against in their personal life (28.1%), while others reported this occurs “frequently” (3.1%) and “all the time” (3.1%). In Asia, 1 in 5 reported “sometimes” feeling discriminated against (21.4%). North America had a slightly lower percentage for this frequency (17.2% for “sometimes”) (Table 41).

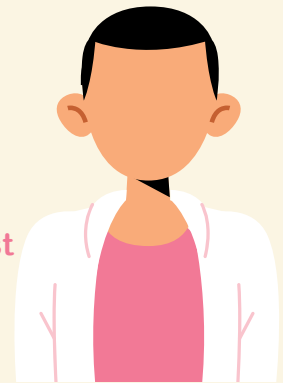
Table 41. Frequency with which providers/companions have felt discriminated against in their personal life by region

Region	Frequency					
	Never	Almost never	Sometimes	Frequently	All the time	Total
Latin America and the Caribbean	120	39	23	2	0	184
	65.2%	21.2%	12.5%	1.1%	0.0%	100.0%
Europe	34	12	2	0	0	48
	70.8%	25.0%	4.2%	0.0%	0.0%	100.0%
Africa	14	7	9	1	1	32
	43.8%	21.9%	28.1%	3.1%	3.1%	100.0%
North America	18	6	5	0	0	29
	62.1%	20.7%	17.2%	0.0%	0.0%	100.0%
Asia	19	3	6	0	0	28
	67.9%	10.7%	21.4%	0.0%	0.0%	100.0%
Oceania	6	1	0	0	0	7
	85.7%	14.3%	0.0%	0.0%	0.0%	100.0%
Total	211	68	45	3	1	328
	64.3%	20.7%	13.7%	0.9%	0.3%	100.0%

64.3% of respondents said they had never felt discriminated against in their personal life because of their work in abortion services provision/companionship.

One in five said that they had almost never felt discriminated against

13.7% said that "sometimes" they had felt discriminated against in their personal life



The most frequent experience of discrimination in respondents' personal life relates to the questioning of their moral values (74.3%), followed by a feeling that society in general does not value their job (39.4%), that family members and friends do not understand it (34.9%), and that they cannot reveal that they work in abortion services (23.9%). The discrimination they experience the least is that their family and friends would value them less if they spoke of the difficulties of their job (16.5%). This hierarchy was shared by Latin America and the Caribbean. Nevertheless, in Africa and Europe, the second most frequent experience of discrimination in respondents' personal life was that society in general does not value their job (46.2% and 43.8%). In fact, the latter is the most frequent experience in North America (60%). In contrast, in Asia the discrimination experienced most often is that others do not understand their job (60%), followed by the concern that their family or friends would value them less if they spoke of the difficulties of their job (50%). In addition, in Oceania only 1 person said they had experienced that type of discrimination and it was related to the questioning of their moral values. The respondents that selected "other" did not specify the reasons or the experiences of discrimination they had faced in their personal life (Table 42).

Experience of discrimination in respondents' personal life relates to:

74.3%
the questioning of their moral values

39.4%
feeling that society in general does not value their job

34.9%
family members and friends do not understand their job

34.9%
they cannot reveal that they work in abortion services

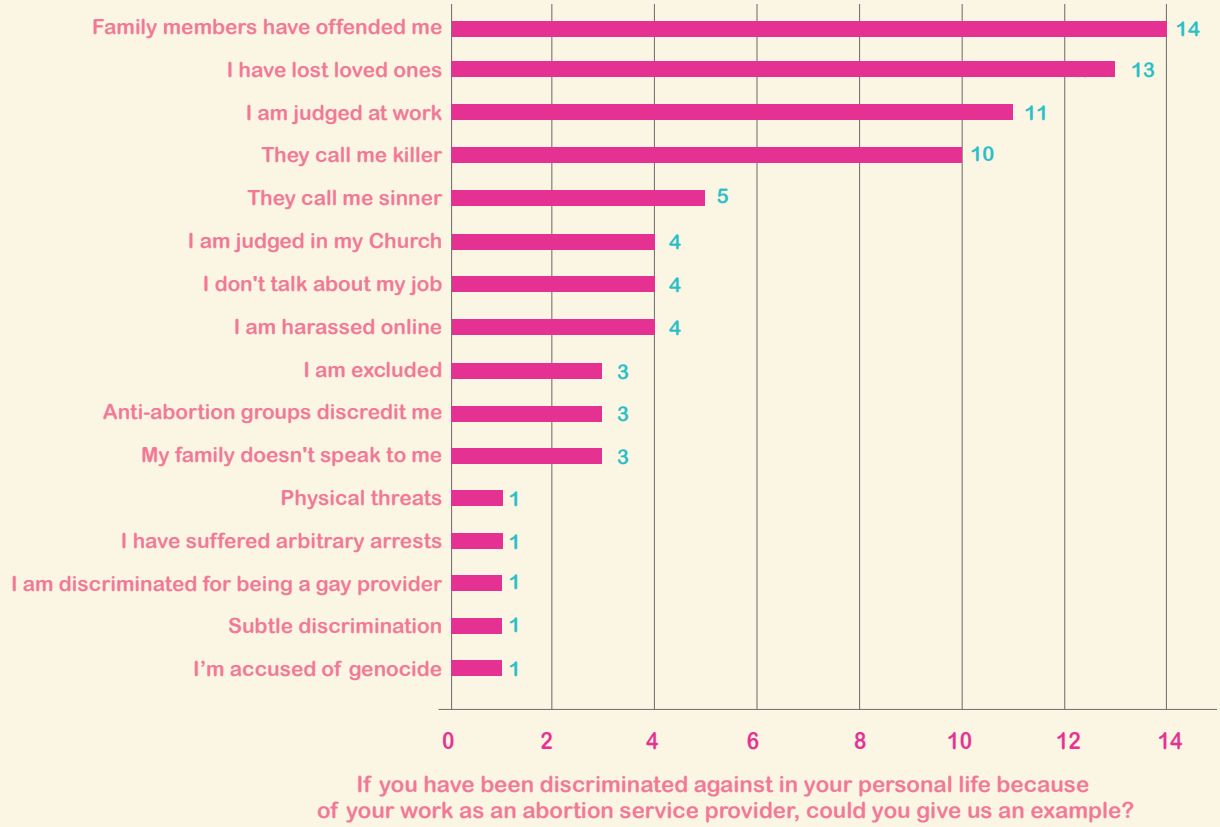
16.5%
their family and friends would value them less if they spoke of the difficulties of their job

Table 42. Experiences of discrimination in the personal life of abortion service providers/companions

Experiences	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Feels that others question their moral values when they find out that they work in abortion services.	50	84.7%	7	53.8%	15	93.8%	4	40.0%	4	40.0%	1	100.0%	81	74.3%
Feels that friends and family members who do not work in abortion services cannot understand their job.	21	32.2%	6	30.8%	7	31.3%	6	40.0%	3	60.0%	0	0.0%	43	39.4%
Feels that society in general does not value their job as abortion services providers/ companions.	19	35.6%	4	46.2%	5	43.8%	4	60.0%	6	30.0%	0	0.0%	38	34.9%
Feels that they cannot reveal that they work in abortion services or that they will not be able to access certain services or resources.	16	18.6%	2	0.0%	1	12.5%	2	10.0%	5	40.0%	0	0.0%	26	23.9%
Is concerned that their family or friends would value them less if they spoke about the difficulties or troubles in their work in abortion services.	11	27.1%	0	15.4%	2	6.3%	1	20.0%	4	50.0%	0	0.0%	18	16.5%
Other	0	0.0%	2	15.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	1.8%
Total	59	100%	13	100%	16	100%	10	100%	10	100%	1	100%	109	100.0%

Respondents who had at one point been discriminated against in their personal life or in their work in abortion provision/companionship were asked to give examples of their experiences (Q.48). Qualitative methods were used to analyze their comments. It is important to mention that for this case, the approach was to codify with more specific codes that would enable recording the general idea of the respondent's experience, even if the possibility of generalizing was lost. Examples where the main idea was similar were grouped together. The 86 entries that were analyzable resulted in a total of 80 codified segments, and 23 codes were derived as well (see Annex 1); the distribution is included below:

Graph 23. Distribution of frequencies of codes for item Q.48



The majority of respondents shared stories related to being offended by family members ***(Family members offended me).*** There were almost as many examples of respondents who mentioned that they lost friends or loved ones due to controversies related to their job or ideological position ***(Had lost friends)***. 11 answers were codified where respondents mentioned judgement or discrediting by colleagues or peers ***(Colleagues judge me)***. Another important code came from the examples of being called "murderers" or "genocides" ***(They call me killer/Was accused by genocide)***.

The ideological or religious insults occurred at similar rates ***(They call me sinner)***. Other examples included the inability of providers/companions of publicly speaking about their job ***(Can't talk about my work)***. Some people shared that they were excluded from family, social, and religious meetings ***(Being excluded/Judged in***

my Church). One service provider mentioned being arrested without a warrant *(Suffered arbitrary arrest)*, and another reported discrimination from members of their LGBTTT+ community as a result of providing abortion services *(Discriminated for being a gay provider)*. Only 1 respondent mentioned that the discrimination was subtle *(Discrimination is subtle)*.

Figure 6. Code cloud for examples of experiences of discrimination in the personal or professional life of abortion service providers/companions

In Latin America, Africa, and Asia, the examples of discrimination were more serious than in Europe, Oceania, and North America. In Asia, the religious-based discrimination stood out, while physical threats were reported only in Latin America and the Caribbean, where the rate of providers that have lost friends or family members due to their job is greater than in the other regions. Europe only reported two examples of discrimination (Table 43).

Table 43. Distribution of frequencies and percentages of codified segments by region for Q.48

Type of discrimination	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Family members have offended me	9	18%	0	0%	2	20%	3	33%	0	0%	0	0%	14	18%
I have lost loved ones	10	20%	1	50%	1	10%	1	11%	0	0%	0	0%	13	16%
I am judged at work	8	16%	0	0%	2	20%	0	0%	1	14%	0	0%	11	14%
They call me killer	7	14%	0	0%	1	10%	1	11%	0	0%	1	50%	10	13%
They call me sinner	2	4%	0	0%	0	0%	0	0%	3	43%	0	0%	5	6%
I am judged in my Church	0	0%	1	50%	2	20%	0	0%	1	14%	0	0%	4	5%
I don't talk about my job	2	4%	0	0%	1	10%	0	0%	1	14%	0	0%	4	5%
I am harassed online	3	6%	0	0%	0	0%	0	0%	0	0%	1	50%	4	5%
I am excluded	3	6%	0	0%	0	0%	0	0%	0	0%	0	0%	3	4%
Anti-abortion groups discredit me	3	6%	0	0%	0	0%	0	0%	0	0%	0	0%	3	4%
My family doesn't speak to me	1	2%	0	0%	0	0%	2	22%	0	0%	0	0%	3	4%
Physical threats	2	4%	0	0%	0	0%	0	0%	0	0%	0	0%	2	3%
I have suffered arbitrary arrests	0	0%	0	0%	1	10%	0	0%	0	0%	0	0%	1	1%
I am discriminated for being a gay provider	0	0%	0	0%	0	0%	0	0%	1	14%	0	0%	1	1%
Subtle discrimination	0	0%	0	0%	0	0%	1	11%	0	0%	0	0%	1	1%
I'm accused of genocide	0	0%	0	0%	0	0%	1	11%	0	0%	0	0%	1	1%
Total	50		2		10		9		7		2		80	
N = Documents	191		48		32		31		30		7		339	

Providers/companions were then asked whether they had difficulties discussing their job with others. Half of respondents feel that they have to hide their job from everyone (50.5%), followed by 1 in 4 who feel that they have to hide it from religious groups (26.2%) and strangers (24%). One in five respondents feel that they have to hide it from the government (17.9%) and 16.3%, from their family members. One in ten respondents stated that they have to hide their job from the media (13.7%), the community (11.5%), and their colleagues (10.5%). A lower number considered that they have to hide it from friends (6.7%), their partner (1.9%), and others (1%) (Table 44).

The distributions by region show differences. In Latin America, 43% feel that they have to hide their job from everyone and 1 in 3 (32.6%), from religious groups. In addition, a fourth (22.1%) feel they have to hide from government staff. In Europe, by contrast, 7 in 10 (71.7%) feel they have to hide from everyone and 1 in 5 (19.6%), from strangers. In Africa, the most important thing is to not reveal it to anyone (75%), followed by having to hide it from religious groups (12.5%), strangers (12.5%), government staff (12.5%), and even family members (12.5%). In North America, providers/companions felt like they needed to most commonly hide their work from strangers (46.4%), followed by anyone (35.7%), and religious groups (32.1%). In Asia, they hide their activities from anyone (57.1%), followed by strangers (25%) and family members (25%). Strangers (57.1%) are in first place in Oceania, followed by the community (28.6%). Respondents that chose "Other" were referring to not being able to reveal their job to almost anyone because it was "too forbidden". Another respondent explained that, in reality, she chose who to tell (Table 44).

Table 44. Rates of perception of the need to hide their work in abortion services from someone by region

Actor	Region											
	Latin America and the Caribbean		Europe		Africa		North America		Asia		Oceania		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Anyone	74	43.0%	33	71.7%	24	75.0%	10	35.7%	16	57.1%	1	14.3%	158	50.5%
Religious groups	56	32.6%	5	10.9%	4	12.5%	9	32.1%	6	21.4%	2	28.6%	82	26.2%
Strangers	38	22.1%	9	19.6%	4	12.5%	13	46.4%	7	25.0%	4	57.1%	75	24.0%
Government staff	42	24.4%	1	2.2%	4	12.5%	5	17.9%	4	14.3%	0	0.0%	56	17.9%
Family members	31	18.0%	2	4.3%	4	12.5%	7	25.0%	7	25.0%	0	0.0%	51	16.3%
Media	27	15.7%	1	2.2%	1	3.1%	7	25.0%	6	21.4%	1	14.3%	43	13.7%
Community	24	14.0%	2	4.3%	1	3.1%	2	7.1%	5	17.9%	2	28.6%	36	11.5%
Colleagues	25	14.5%	4	8.7%	0	0.0%	3	10.7%	1	3.6%	0	0.0%	33	10.5%
Friends	15	8.7%	0	0.0%	2	6.3%	0	0.0%	4	14.3%	0	0.0%	21	6.7%
Partner	5	2.9%	0	0.0%	0	0.0%	0	0.0%	1	3.6%	0	0.0%	6	1.9%
Other	2	1.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	14.3%	3	1.0%
Total	172	100.0%	46	100.0%	32	100.0%	28	100.0%	28	100.0%	7	100.0%	313	100.0%

Regarding the question of whether their personal values come into conflict with their work in abortion provision/companionship, 8.2% said sometimes and 3.3% said yes. The greatest number of respondents who said yes or sometimes, work in Asia; they represent 1 in 3 respondents (33.8%). In North America and Oceania, no respondent experienced a conflict in this regard (Table 45).

Table 45. Perception of the conflict between personal values and their work in abortion provision/companionship

	Perception of conflict			
Region	**No**	**Sometimes**	**Yes**	**Total**
Latin America and the Caribbean	163	16	5	184
	88.6%	8.7%	2.7%	100.0%
Europe	45	2	1	48
	93.8%	4.2%	2.1%	100.0%
Africa	28	3	1	32
	87.5%	9.4%	3.1%	100.0%
North America	30	0	0	30
	100.0%	0.0%	0.0%	100.0%
Asia	19	6	4	29
	65.5%	20.7%	13.8%	100.0%
Oceania	7	0	0	7
	100.0%	0.0%	0.0%	100.0%
Total	292	27	11	330
	88.5%	8.2%	3.3%	100.0%

In Latin America, Asia, and Africa, the main source of conflict were the religious values or morals. Many respondents stated that abortion is a sin; however, it was not clear if they were referring to this as a personal belief or that it was something they had to deal with at work. On the other hand, regarding the respect for life or the question on the fetus' rights, respondents—especially in Latin America and the Caribbean, and Asia—stated that they did not always feel comfortable with the reasons women gave to interrupt a pregnancy, believing them to be issues that women should resolve in therapy or personally and, therefore, they did not justify abortion (Table 46).

Table 46. Values that conflict with their provision/companionship job

Region	Reasons (number of cases)
América Latina y el Caribe	Religious/abortion is a sin (4) Respect for life/right to life (3) Prejudice about abortion (2) Not specified (2) Ethics (1) Illegality (1)
Europe	Respect for life/right to life (1) Not specified (1)
Africa	Religious/abortion is a sin (2) Prejudice about abortion (1)
Asia	Respect for life/right to life (2) Religious/abortion is a sin (2) Prejudice about abortion (1)

Personal values in the work in abortion provision/companionship

8.2%
of respondents said that "sometimes" their personal values come into conflict with their work in providing abortion care/counseling services

3.3%
of respondents said that their personal values come into conflict with their work

In North America and Oceania
no respondent experienced a conflict in this regard.

n Latin America, Asia, and Africa
the main source of conflict were the religious values or morals.

In Latin America and the Caribbean, and Asia
stated that they did not always feel comfortable with the reasons women gave to interrupt a pregnancy.

In what context do these stressors/stigmas occur? Grounds on which abortion is permitted

The most common legal ground for abortion amoung regions was the risk to the woman's life (60.7%), followed by rape (55.6%), and the risk to physical health (51.1%). This is common in Latin America and the Caribbean, Africa, and Asia. In contrast, Europe and North America have higher rates for the "Upon request under all circumstances" ground (95.8% and 73.3%, respectively). Respondents in North America, Latin America and the Caribbean, and Asia mentioned other reasons. The reasons correspond to the specificity of the legal frameworks. In reality, they refer to the same grounds, but they depended on the local legislation. One comment was repeated at least 3 times in Latin America: despite the fact that legal grounds exist, it is not very likely that they will be applied. They also mentioned that the legal grounds regarding the risk to a woman's life or physical or mental health is restricted by the opinion of a committee or doctor, and that in some places, the legal grounds regarding rape operates specifically for women with a disability (Table 47).

However, when analyzing these results, it is important to keep in mind that this corresponds to the perception or information of providers/companions regarding the legal restrictions in the countries where they work. The case of Mexico and the United States—where 40% of the sample comes from—stands out. Both countries have legislation regarding the grounds for abortion that differ depending on the state.

Yet, some providers in Mexico and the United States selected all grounds and at the same time included the option of completely prohibited. Other respondents also selected "Other" and specified that it depended on the state where they were. One provider mentioned that it was impossible to answer this question directly because the legislation was different. Finally, one respondent said that despite the existence of these legal grounds, they were seldom applied.

For those reasons, the decision was to not consider this variable as a filter for the qualitative answers on stressors and stigmas, and that these answers could not be the foundation to create an indicator on legal restriction. In any case, the finding regarding the differences in stressors or stigmas on the legal restrictions is related to the confusion associated with the local legislation in each country and what those restrictions imply in terms of the management of information of providers or companions.

The finding regarding the differences in stressors or stigmas on the legal restrictions is related to the confusion associated with the local legislation in each country and what those restrictions imply in terms of the management of information of

Table 47. Grounds for legal abortion by region

Grounds	Region						
	Latin America and the Caribbean	Europe	Africa	North America	Asia	Oceania	Total
Risk to the woman's life	138	9	28	4	19	3	201
	74.6%	18.8%	87.5%	13.3%	65.5%	42.9%	60.7%
Rape	137	7	13	4	22	1	184
	74.1%	14.6%	40.6%	13.3%	75.9%	14.3%	55.6%
Risk to the woman's physical health	109	8	21	4	22	5	169
		16.7%	65.6%	13.3%	75.9%	71.4%	51.1%
Fetal abnormality	107	10	15	3	21	2	158
	57.8%	20.8%	46.9%	10.0%	72.4%	28.6%	47.7%
Risk to the woman's mental health	62	7	13	3	18	5	108
	33.5%	14.6%	40.6%	10.0%	62.1%	71.4%	32.6%
Upon request under all circumstances	28	46	6	22	2	1	105
		95.8%	18.8%	73.3%	6.9%	14.3%	31.7%
Socioeconomic reasons	37	0	5	3	9	0	54
	20.0%	0.0%	15.6%	10.0%	31.0%	0.0%	16.3%
Other	19	1	0	7	0	2	29
	10.3%	2.1%	0.0%	23.3%	0.0%	28.6%	8.8%
Completely prohibited	14	0	1	0	1	0	16
		0.0%	3.1%	0.0%	3.4%	0.0%	4.8%
Total	185	48	32	30	29	7	331
	100%	100%	100%	100%	100%	100%	100%

Table 48 includes the legal limits that were specified for each ground for abortion by region. Not all respondents answered these questions, and there was also great variation among grounds and regions. On the one hand, this shows the great variation in country legislation, and on the other, the difficulties that providers/companions have in managing the related legal information. In fact, some participants openly recognized not knowing this information.

Table 48. Legal limit for each ground by region

Region	Grounds					
	Risk to the woman's life	Rape	Risk to the woman's physical health	Fetal abnormality	Risk to the woman's mental health	Upon request under all circumstances	Socioeconomic reasons
Latin America and the Caribbean	9 weeks (1) 12 weeks (62) 14 weeks (4) 16 weeks (1) 20 weeks (20) 21 weeks (1) 22 weeks (7) Different for each state (2) I don't know (4) No limit (47)	9 weeks (1) 11 weeks (1) 12 weeks (66) 13 weeks (7) 14 weeks (4) 16 weeks (1) 18 weeks (1) 20 weeks (21) 21 weeks (2) 22 weeks (4) 24 weeks (1) Different for each state (2) I don't know (4) No limit (47)	12 weeks (44) 13 weeks (5) 14 weeks (2) 16 weeks (1) 20 weeks (16) 21 weeks (1) 22 weeks (6) 24 weeks (1) Different for each state (1) I don't know (3) No limit (39)	12 weeks (45) 13 weeks (6) 14 weeks (2) 16 weeks (1) 20 weeks (22) 22 weeks (4) 24 weeks (1) Different for each state (2) I don't know (4) No limit (40)	12 weeks (21) 13 weeks (3) 14 weeks (1) 20 weeks (7) 22 weeks (2) 24 weeks (1) I don't know (1) No limit (29)	12 weeks (3) 13 weeks (1) 20 weeks (10) Different for each state (1) I don't know (2) No limit (7)	12 weeks (9) 13 weeks (1) 14 weeks (2) 20 weeks (9) 22 weeks (1) 24 weeks (1) I don't know (3) No limit (21)
Europe	10 weeks (1) 12 weeks (4) 14 weeks (1) 16 weeks (4) 22 weeks (4) 24 weeks (4) No limit (4)	10 weeks (1) 12 weeks (4) 14 weeks (1) 16 weeks (4) 18 weeks (1) 22 weeks (2) 24 weeks (4) No limit (3)	10 weeks (1) 12 weeks (2) 14 weeks (1) 16 weeks (3) 22 weeks (4) 24 weeks (3) No limit (5)	10 weeks (1) 12 weeks (4) 14 weeks (1) 16 weeks (4) 22 weeks (5) 24 weeks (4) No limit (5)	10 weeks (1) 12 weeks (3) 14 weeks (1) 16 weeks (4) 22 weeks (4) 24 weeks (3) No limit (4)	12 weeks (2) 14 weeks (1) 16 weeks (3) 22 weeks (3) 24 weeks (4) No limit (5)	
Africa	3 weeks (1) 8 weeks (1) 12 weeks (8) 16 weeks (1) 18 weeks (1) 20 weeks (6) 24 weeks (3) I don't know (3) No limit (5)	12 weeks (5) 16 weeks (1) 20 weeks (4) 24 weeks (2) I don't know (2) No limit (3)	3 weeks (1) 8 weeks (1) 12 weeks (6) 18 weeks (1) 20 weeks (6) 24 weeks (1) I don't know (2) No limit (3)	3 weeks (1) 12 weeks (5) 16 weeks (1) 18 weeks (1) 20 weeks (4) 24 weeks (2) I don't know (2) No limit (2)	12 weeks (5) 16 weeks (1) 20 weeks (5) 24 weeks (2) No limit (2)	12 weeks (1) 16 weeks (1) 20 weeks (2) 24 weeks (1) No limit (1)	12 weeks (1) 20 weeks (4) 24 weeks (1) No limit (2)
North America	20 weeks (1) 22 weeks (1) Different for each state (1)	20 weeks (1) 22 weeks (1) Different for each state (1)	20 weeks (1) 22 weeks (1) Different for each state (1)	20 weeks (1) Different for each state (1)	20 weeks (1) Different for each state (1)	Different for each state (1)	20 weeks (1) Different for each state (1)
Asia	8 weeks (1) 9 weeks (2) 12 weeks (5) 14 weeks (1) 16 weeks (2) 18 weeks (1) 20 weeks (1) 24 weeks (6) No limit (1)	8 weeks (1) 9 weeks (2) 10 weeks (1) 12 weeks (5) 14 weeks (1) 16 weeks (2) 18 weeks (1) 24 weeks (6)	8 weeks (1) 9 weeks (2) 12 weeks (5) 14 weeks (1) 16 weeks (2) 18 weeks (1) 20 weeks (1) 24 weeks (6) No limit (1)	8 weeks (2) 9 weeks (2) 10 weeks (1) 12 weeks (6) 14 weeks (1) 16 weeks (1) 18 weeks (1) 20 weeks (1) 24 weeks (4)	8 weeks (1) 9 weeks (2) 12 weeks (4) 14 weeks (1) 16 weeks (1) 18 weeks (1) 20 weeks (1) 24 weeks (4)	24 weeks (1)	8 weeks (1) 12 weeks (3) 14 weeks (1) 18 weeks (1) 20 weeks (1) 24 weeks (2)
Oceania	20 weeks (1) 24 weeks (3) No limit (3)	No limit (1)	20 weeks (1) 24 weeks (3) No limit (3)	20 weeks (1) 24 weeks (1) No limit (1)	20 weeks (1) 24 weeks (3) No limit (3)		

Differences in the stressors and stigma based on the characteristics of respondents

The outcomes used correspond to the main challenges abortion providers felt they faced; the reasons they felt it was difficult to tell others about their work in abortion services; the type of aggressions they faced; and the types of discrimination they had faced in their professional and personal life. A simple bivariate analysis between the different types of characteristics and the outcomes was used to complement the qualitative analysis. The final analysis included only those that showed significant statistical differences and that contributed to the development of a hypothesis on the differences in stress and stigma for the population at stake[1].

The majority of the differences occurred when the outcome relates to the challenges that abortion providers/companions considered to be the most important when doing their job. For some characteristics, there were also differences between the experiences of professional or personal discrimination.

Stressors and stigma based on demographic characteristics

What sociodemographic characteristics affect the experience of stress and stigma for abortion providers/companions? Differences occurred in relation to the main challenges they face when doing their job regarding age, schooling, ethnic identity, and religion (Table 49).

In terms of the three main challenges, younger respondents (25–34) were more worried about legislation and legal restrictions, funding, unequal access to resources, and the scarcity of providers. Respondents with less schooling (university or incomplete university vs. postgraduate studies) reported in higher rates that the most significant challenges they face are their job conflicting with their personal beliefs, restrictive legislation, and frequent feelings of despair (Table 49).

When compared to Hispanic and White respondents, those who identified as Asian are more worried about the conflict between their job and their personal beliefs, followed by Black respondents. Asian and Black respondents felt more pressure from their partner, family, or community compared to Hispanics. Indigenous respondents reported significantly higher rates of feeling worried or challenged because of the lack of support from other medical areas, compared to Asian respondents. Latino and White respondents reported higher rates of concern regarding restrictive legislation. Black respondents doubled the rate of White respondents when reporting fear of persecution or lack of government protection for their job. Also, along with Latino respondents, Black respondents feel more worried about lack of funding, unequal access to resources, or economic pressure toward their job, compared to Asian respondents (Table 49).

1 The report does not include the complete table with rates by characteristic because the goal of this analysis was to obtain information based on the observations that complement the qualitative information, not that delve on the magnitude or systematicity of the differences. On the other hand, the objective is to help decision-making and to disseminate the topic for more than purely scientific purposes.

Christian respondents feel much more worried about the hostile environment where they work, compared to Atheist or Catholic respondents. Compared to Christian respondents, Buddhist respondents feel more worried that their job conflicts with their personal beliefs; they also feel greater pressure from their partner, family, or community. In contrast, Agnostic respondents feel more worried about the legal restrictions, compared to Buddhist and Catholic respondents (Table 49).

Table 49. Differences in the stressors/stigmas for abortion service providers/companions based on their sociodemographic characteristics

Age	Discriminatory legislation and legal restrictions • 25-34 years (64.9%) • 35-44 years (38.2%) • 45-54 years (39.9%) Lack of funding, unequal access to resources, economic pressure • 25-34 years (64.9%) • 45-54 years (31.9%) Scarcity of providers • 25-34 years (49.5%) • 45-54 years (19.1%)
Education	Conflict with personal beliefs • University studies (15.9%) • Postgraduate (39.4%) Discriminatory legislation and legal restrictions • University studies (57.1%) • Posgrado (39.4%) Feeling of despair or suffering • Incomplete university studies (20%) • Postgraduate (3.8%)
Ethnic identity	Conflict with personal beliefs • Asian (48.3%) • Black (14.8%) • Hispanic (4%) • White (1.3%) Pressure from partners, family, or community • Asian (27.6%) • Hispanic (4.7%) • Black (22.2%)

Ethnic identity	Lack of support from other medical areas • Asian (6.9%) • Indigenous (75%) Discriminatory legislation and legal restrictions • Asian (31%) • Latino (58.4%) • White (33.8%) Fear of persecution/lack of government or legal protection and support • Black (59.3%) • White (21.3%) Lack of funding, unequal access to resources, economic pressure • Asian (27.6%) • Black (77.8%) • Hispanic (44.3%)
Religion	Hostile environment (threats, harassment, intimidation, violence) • Atheist (18.4%) • Catholics (19.2%) • Christians (evangelical, protestant) (50%) Conflict with personal beliefs • Buddhists (52%) • Christians (evangelical, protestant) (6.7%) Pressure from partners, family, or community • Atheist (5.3%) • Buddhists (28%) • Catholics (4%) Discriminatory legislation and legal restrictions • Agnostics (73.3%) • Buddhists (20%) • Catholics (39.4%)

Stressors and stigma based on professional characteristics

What professional characteristics affect the experience of stress and stigma for abortion providers/companions? Differences were found for the profession, experience in the field of reproduction, type of organization they work for and if it is part of the government, the type of abortion methods, the trimester they perform abortions, where they received training, and if they had enough training. Other characteristics included if they enjoy their job, if they are proud of it, and if they feel a connection with people that have similar jobs (Table 50).

Regarding the profession, respondents who said they are community advocates feel greater pressure from their partner, family, or community, compared to general physicians. On the other hand, psychologists and non-medical companions are more worried than midwives and gynecologists about legal restrictions. Likewise, non-medical companions are more worried about the lack of funding than providers with medical training (Table 50).

Respondents who have between 1 and 2 years of experience working in this field more often feel that one of the main challenges is that their job conflicts with their personal beliefs, compared to those with less experience in the field. Respondents with longer experience reported higher rates of feeling pressure from their partner or community, compared to those with less time working in the reproductive field. Respondents with more than six years of experience and those with less than one year showed greater fear that their families or friends would value them less if they spoke about the difficulties of their job, compared to respondents with three to five years of experience and those with more than 15 years of experience in the field (Table 50).

The respondents most worried about legal restrictions are those from civil organizations and autonomous networks, compared to those from abortion clinics, health centers, hospitals, or medical offices. These respondents also fear persecution at higher rates, compared to those who provide services in hospitals. Respondents who work for an NGO or autonomous networks considered that the lack of funding is one of the main challenges they face, compared to those who work in hospitals or medical offices. In addition, respondents in health centers and autonomous networks are more worried about the scarcity of providers than in abortion clinics. Also, respondents in health centers reported higher rates of challenges related to burnout and feeling overwhelmed, compared to medical offices (Table 50).

Respondents who work for the government—compared to those who work for other organizations—reported higher concern or challenges regarding the scarcity of providers, burnout, and collaboration with other medical areas. Those who do not work for the government face challenges such as fear of persecution, lack of funding, and aggressions such as harassment and intimidation (Table 50).

Respondents who work in post-abortion care and management of incomplete abortions more frequently stated that their challenges were legal restrictions, the lack of funding, and the lack of access to equipment and resources, compared to those who perform other surgical methods. In contrast, those who perform dilatation and evacuation procedures said that the challenge they face is the high turnover of providers (Table 50).

Finally, those who perform first trimester abortions believe a significant challenge they face is the lack of training, compared to respondents who perform second trimester abortions. Those respondents and the ones who perform second trimester abortions are more worried about staff turnover (Table 50).

Table 50. Differences in the stressors/stigmas for abortion service providers/companions based on their professional characteristics

Profession	Pressure from partners, family, or community • Community health promoters (44.4%) • General physician (5.6%) Discriminatory legislation and legal restrictions • Midwife or doula (27.3%) • Gynecologist/obstetrician (32.8%) • Non-medical companion (75%) • Psychologist (81) Lack of funding, unequal access to resources, economic pressure • Gynecologist/obstetrician (23.9%) • Non-medical companion (70.8%)
Experience in the area of reproduction	Conflict with personal beliefs • 1–12 months (7.7%) • 1–2 years (11.5%) • 3–5 years (5.7%) • 15 or more (15.3%) Pressure from partners, family, or community • 6–15 years (50%) • 3–5 years (8.8%) • 15 years or more (4.1%) They are concerned that their family or friends would value them less if they spoke about the difficulties or troubles in their work in abortion services (discrimination on a personal level). • 1–12 months (50%) • 3–5 years (10.8%) • 6–15 years (75%) • 15 years or more (10.7%)
Type of organization	Discriminatory legislation and legal restrictions • Abortion clinic (41.9%) • Health center (43.9%) • Hospital (30.9%) • Medical office (33.9%) • NGO (74.1%) • Autonomous network (73.1%) Fear of persecution/lack of government or legal protection and support • NGO (48.1%) • Hospital (24.7%) Lack of funding, unequal access to resources, economic pressure • Hospital (33%) • Medical office (30.6%) • NGO (63%) • Autonomous network (57.7%)

Type of organization	Scarcity of providers • Abortion clinic (18.9%) • Autonomous network (48.1%) • Health center (40.4%) Burnout or feeling overwhelmed • Health center (35.1%) • Medical office (11.3%)
Government organization	Fear of persecution/lack of government or legal protection and support • Government (26.3%) • Non-government (39%) Lack of funding, unequal access to resources, economic pressure • Government (38.2%) • Non-government (51.5%) Scarcity of providers • Government (52.6%) • Non-government (34.4%) Burnout or feeling overwhelmed • Government (34.2%) • Non-government (18.7%) Harassment, intimidation, attacks on their reputation, discrediting campaigns • Government (15.4%) • Non-government (64.5%) Feels that other medical departments do not collaborate with abortion services and they make their job more difficult. • Government (70.6%) • Non-government (50.9%)
Method	Discriminatory legislation and legal restrictions • Vacuum aspiration (43.7%) • Post-abortion care and management of incomplete abortions (54.6%) Lack of funding, unequal access to resources, economic pressure • Vacuum aspiration (40.7%) • Post-abortion care and management of incomplete abortions (52.1%) High turnover • Medical abortion (4.1%) • Dilatation and evacuation (18.5%) • Post-abortion care and management of incomplete abortions (4.3%) Feels their job is restricted when trying to access equipment, resources, and funding. • Medical abortion (41.5%) • Post-abortion care and management of incomplete abortions (53.9%)
Type of abortion	Lack of training • First trimester (8.9%) • Second trimester (4.7%) Scarcity of providers • Third trimester (37%) • Second trimester (41.1%) • First trimester (64.3%)

Stressors and stigma based on identity and commitment characteristics

What are the identity and commitment characteristics that modify the experience of stress and stigma for people who provide / accompany abortion services? Differences were found about where they had been trained, whether they considered their training sufficient and whether they enjoyed their work and were proud of it and, finally, whether they had a connection with colleagues who performed similar activities (Table 51).

Respondents who received training to provide abortion services/companionship from social movements, online, NGOs , and workshops are more worried about legislation and restrictions, compared to those with medical or clinical training. Also, respondents from social movements and those who received online training present greater rates of fear of persecution or lack of government/legal protection and lack of funding, unequal access to resources and economic pressure, than those who went to medical school (Table 51).

Respondents who believed that their training was insufficient reported that the most significant challenges they face are the lack of support from other medical areas, the hostile environment where they work, legislation and the legal restrictions, fear of persecution or lack of legal protection, lack of funding, and high staff turnover. They also reported higher rates of facing threats to their life or safety, compared to those who felt their training was sufficient (Table 51).

The reason respondents do not enjoy their job relates to the concern with the scarcity of providers and the feeling of despair. Not feeling proud of their job relates to the concern with conflicts with personal beliefs, risking their personal or professional reputation, and the feeling of despair. Respondents who "sometimes" share a connection with colleagues with similar jobs reported higher rates of fear of persecution or lack of legal protection, compared to those who do not feel a sense of connection (Table 51).

Table 51. Differences in the stressors/stigmas for abortion service providers/companions based on their identity and commitment characteristics

Place of training	Discriminatory legislation and legal restrictions • Medical school (24.6%) • Hospital residency program (41.4%) • Family planning clinic (46.7%) • Workshops (56.3%) • NGOs (63.9%) • Social movements (77.4%) • In their first job (55.8%) • Online (75%) Fear of persecution/lack of government or legal protection and support • Medical school (21.1%) • Social movements (54.8%) • Online (54.5%)

Place of training	Lack of funding, unequal access to resources, economic pressure • Medical school (38.6%) • Workshops (47.9%) • Social movements (67.7%) • Online (68.2%)
Perception on whether training is sufficient	Lack of support from other medical areas • No (47.5%) • Yes (26.7%) Hostile environment (threats, harassment, intimidation, violence) • No (32.3%) • Yes (19.8%) Discriminatory legislation and legal restrictions • No (58.6%) • Yes (45.6%) Fear of persecution/lack of government or legal protection and support • No (51.5%) • Yes (29%) Lack of funding, unequal access to resources, economic pressure • No (60.6%) • Yes (42.4%) Scarcity of providers • No (53.5%) • Yes (31.3%) High turnover • No (9.1%) • Yes (2.8%) Threats to my life or safety • No (64.3%) • Yes (19.2%)
Enjoys working in abortion services	Scarcity of providers • All the time (26.8%) • Frequently (30.8%) • Sometimes (70%) Feeling of despair • All the time (7%) • Frequently (5.8%) • Almost never (50%)
Feels proud	Conflict with personal beliefs • Sometimes (27.6%) • Yes (4.9%) Risking my personal or professional reputation • Sometimes (34.5%) • Yes (15.2%) Feeling of despair • Sometimes (20.7%) • Yes (4.6%)

Shares a connection with people with similar activities	Fear of persecution/lack of government or legal protection and support • No (6.3%) • Sometimes (43.9%)

Stressors and stigma according to the legal framework

How does the legal framework affect concerns over abortion provision/companionship? Although we know that the legal grounds for abortion are not mutually exclusive, each one was analyzed separately. Creating profiles was complex because the report on the legal framework did not correspond to the actual legislation of the region or country where they worked. Rather, it reflected the information that providers/companions had, and this did not always coincide. However, there were differences for the stressors and stigmas based on the answers regarding the legal framework they reported.

Respondents who reported that, in the country where they work, the legislation states that abortion is legal upon request under any circumstance reported being less concerned with the hostile environment, compared to those who work in countries where abortion is legal only on specific grounds. Respondents from countries where abortion is completely criminalized showed higher concern over legal restrictions, followed by those in countries where risk to the physical health or to life is valid ground (Table 52).

A higher rate of respondents from countries where abortion is legal in cases of risk to life or to the woman's health reported that the greatest challenge is the fear of persecution or lack of legal protection, compared to those in countries where abortion is legal in case of rape or upon request under all circumstances.

Respondents who work in countries where abortion is legal on the grounds of risk to mental health, physical health, rape, fetal abnormalities, or risk to the woman's life, reported more frequently that their main concern was the scarcity of providers, compared to respondents from countries where abortion is permitted upon request under any circumstance (Table 52).

Finally, respondents who feel that their work is restricted in terms of accessing equipment, resources, or funding, more often work in countries where abortion is legal on the grounds of risk to the woman's physical health or life. Compared to respondents who work in countries where abortion is legal upon request under any circumstance, respondents that lived in countries where it is legal when the woman's life is at risk more often feel that their moral values are questioned when others find out about their job (Table 52).

Table 52. Differences in the stressors/stigmas for abortion service providers/companions based on the legal framework

Grounds	Hostile environment (threats, harassment, intimidation, violence) •Upon request under any circumstance (20.8%) •Risk to the woman's physical health (23.6%) •Rape, sexual abuse, or incest (24.4%) •Fetal abnormalities (22.9%) •Socioeconomic reasons (23.1%) Discriminatory legislation and legal restrictions •Upon request under any circumstance (35.6%) •Risk to the woman's life (54.1%) •Risk to the woman's physical health (55.2%) •Completely criminalized (87.5%) Fear of persecution/lack of government or legal protection and support •Upon request under any circumstance (20.8%) •Risk to the woman's life (51%) •Risk to the woman's physical health (51.5%) •Rape, sexual abuse, or incest (38.9%) Scarcity of providers •Upon request under any circumstance (22.8%) •Risk to the woman's life (47.4%) •Risk to the woman's physical health (49.1%) •Risk to the woman's mental health (54.3%) •Rape, sexual abuse, or incest (48.9%) •Fetal abnormalities (48.4%) •Socioeconomic reasons (61.5%) Feels that their job is restricted when trying to access equipment, resources, and funding (discrimination on the professional level). •Upon request under any circumstance (30.6%) •Risk to the woman's life (58.1%) •Risk to the woman's physical health (58.8%) •Fetal abnormalities (46.8%) Feels that others question their moral values when they find out that they work in abortion services (discrimination on the personal level). •Upon request under any circumstance (54.8%) •Risk to the woman's life (83.3%)

Companionship experiences and/or advice for other companions

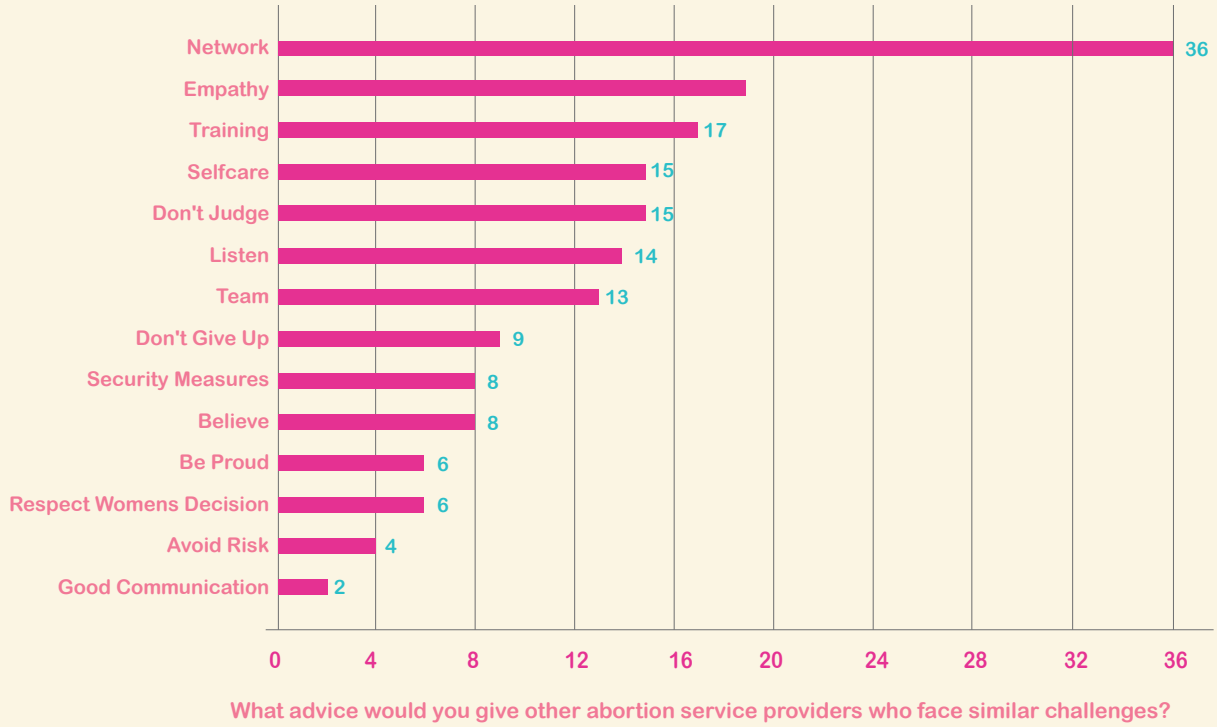
The final section of the survey addressed memories and everyday situations of respondents who wanted to share these experiences. Respondents were asked to share a memorable moment in their work as abortion providers/companions. 188 answers were retrieved for this question; the most representative examples per region are included. In Latin America, Africa, and Asia, respondents included examples where their experience as providers was affected by gender violence, unequal access to health services, criminalization, and even migration. In contrast, in North America and Europe, memories tend to be less stressful (Table 53).

Table 53. Memorable moments of abortion service providers/companions by region

Latin America and the Caribbean	Having accompanied an 11-year-old girl who was raped and was 22 weeks pregnant. While she watched cartoons and colored with watercolors, I performed the abortion. She gave me a drawing of him at the end; I still have it. After our report, a man was detained. We feel that with this, a girl received reparation. A girl called me, crying from joy because she was able to continue with her life plan thanks to my help. Seeing a smile on a patient who experienced gender violence, was a non-literate migrant, and who had no safety net.
Europe	The look, the smile of gratitude and, in particular, the appreciation from patients, while for me that is something so "normal"! When I performed an abortion on my wife. A woman's tears of relief when she found out she could have a safe and free abortion.
Africa	When I was harassed for more than 6 hours by the police in my workplace. For me, it was hard to begin providing abortion services. Losing a client in my unit. There have been many memorable moments; I have been working in this for over 40 years. I helped a 15-year-old girl with a disability to get an abortion. She became pregnant after a 55-year-old man from her community raped her. The pregnancy was terminated successfully. The man was detained after we advocated for his arrest. The man's family threatened me.
North America	A client who acknowledged our team's warmth (nurses and doctors). No moments standout. As a new abortion doula, I am still gathering and learning about each experience. I am always profoundly moved when I am able to be with a patient throughout the entire experience. Hearing them say "thank you" means everything. I provided support to a person during a D&C; they were all having a tough time. The radio was on and they began singing Adele songs softly. Her eyes met mine and I began to sing with them. At the end, the entire medical staff was singing.
Asia	Seeing my client with the possibility of continuing with their life. The majority of sexual victims do not come back or they skip the regular checkups. I feel proud and strong when they visit me regularly. Helping girls to continue their education and get a job.
Oceania	*Helping a woman decide to continue with her pregnancy and being a single mom of twins! Also... constantly being thanked for making a difficult process (abortion) a lot less stressful and not judging women. *Only entry

They were then asked what advice they would give other providers who face similar challenges. 175 analyzable documents were retrieved for this item, which resulted in 172 codified fragments. Answers were grouped into 14 codes based on their content. The distribution of frequencies of codes are shown below:

Gráfica 24. Distribution of frequencies of codes for Q.57



For providers/companions, the most important aspect to consider is the association with and creation of support networks *(Network)*. Establishing a network with other professionals and organizations was the main advice they would give other providers. Empathy *(Empathy)*, constant training and updating *(Training)*, and developing self-care strategies *(Self-care)* were also given as advice in the answers. The ability to not judge women who abort *(Don't judge)* and the importance of actively listening *(Listen)* to their needs was another aspect they considered important. The relevance of creating multidisciplinary teams *(Team)* and the willingness to work in them is another piece of advice worth highlighting. Answers also included concerns over the importance of preventing risks *(Avoid risks)* and establishing safety measures *(Security measures)* for the teams. On two occasions, respondents suggested caring for the quality of communication *(Communication)* within the framework of the patient-provider relationship.

Figure 7. Code cloud for the advice to other abortion providers/companions who face similar challenges

Providers/companions were then asked to briefly describe a day in their life. There were 172 answers in this item. Many highlighted the fact that abortion providers/companions do not work exclusively in this service. As a result, exhaustion and fatigue are constant aspects in their life. Some answers also included experiences related to feeling satisfied because they helped and accompanied women who requested an abortion, and to enjoying their job. Some examples are listed below (Table 54):

Table 54. Brief descriptions of a day in the life of abortion providers/companions

- *My day is a combination of administrative tasks and clinical care services.*
- *I have my day job. And, during breaks, at night, or on days when I don't work, I have the other job.*
- *I have a busy day because I work in the clinic all day, from 9 a.m. to 7 p.m.*
- *I need 30 hours a day to be up to date on my life and family.*
- *Sometimes, I want to cry because of the impunity when the girls' partners are the ones who decide whether or not to abort.*
- *It's busy because the unit offers other medical services.*
- *A day in my professional life is like a war against the enemy who wants to win at all costs.*
- *Strenuous.*
- *Difficult, but gratifying.*
- *I'm lucky to work with a good group of professionals, in addition to teaching classes. So, everything is good.*
- *It is wonderful to help others.*
- *We debated the legalization in Congress, and perhaps it will happen this year. Going forward, we will continue with the fight for respect, support, and feminist abortion!*
- *A lot of work, especially from my "home office" and in trainings.*
- *There are good, bad, and terrible days.*
- *The waiting room is filled with patients waiting to be seen.*
- *Very tired.*

Finally, providers/companions were asked if they wanted to add any other comment. The majority of these answers were comments of gratitude for the survey as a way to close their participation. Therefore, all sentiments of gratitude were considered; they resulted in subcodes that allowed the authors of this paper to organize the most common reasons and statements. This question includes the impact of the survey on respondents and it considers their experience in being questioned. An issue that stood out was the feeling of being recognized and the relevance that organizations have in the daily work of the respondents.

Figure 8. Code cloud for final comments

3. ANNEX 1. CODE BOOK FOR THE QUALITATIVE ANALYSIS

Code	Vocabulary
Believe	In patients In what you do In your job That you are doing the right thing
Commitment	Contribute to society Defend rights Believe Commitment to female patients Political commitment Social awareness Awareness Conviction Strengthen/empower Feminism Fight Hope Love work Social responsibility
Community needs	Lack of trained staff Lack of staff who are not conscientious objectors Lack of services in the city Lack of information Lack of providers Community needs Service needs Women's needs
Decriminalization	Decriminalize Stop criminalization
Provider of decriminalization	Decriminalization of abortion services
Not giving up	Persist Resist Wait Continue doing it Not giving up
Economic funds	Economic incentives Fund Economic funds Financial support*f* Economic resources
Empathy	Having empathy Being kind Continuing to have empathy Understand

Code	Vocabulary
Equipment	Misoprostol Infrastructure Medication Hospitals Physical space
Extend services	Extend services Reach more women Increase the number of procedures
Family support	Receive support from the family Respect from the family
Free choice	Anti-rights Freedom to choose Own decision Patient needs Pro-choice Right to choose
Good communication	Speak clearly Be specific with patients
Government support	Government support Government health departments Distribution of medication Improve public hospitals
Gratitude	Gratitude from patients Gratitude from women
Health	Contribute to health Exercise the right to health Healthcare Health Mental health Reproductive health Women's health
Provider of healthcare	Support to professionals Healthcare for providers Learn to establish limits Mental health for the provider Psychological health for the provider
Help/support	Accompany Support Help women Not being alone Sustain

Code	Vocabulary
Ideological changes	Juicio religioso Religious judgement Religious prejudice Moral judgement Religious beliefs Religious values Social changes Reduce the power of churches Evolution of mindsets Conscience
Information	Provide appropriate information Research Knowledge They asked me for information Receive information Look for information Raise awareness Became aware
Information	Provide information Inform women Appropriate information to make decisions
Work	Work Employment Obligation Part of my education
Justice	Access to justice Reduce inequity Reduce poverty Inequality Inequity Justice systems Marginalization Reproductive justice Social justice
Legal changes	Changes in the legal framework Legislation in favor of abortion Standardization of abortion Public policies
Life/future	Desires Future Prospects Life project Not continue with unwanted pregnancies because of life plans
Listen	Listen to anecdotes Listen to their stories Pay attention to what they say

Code	Vocabulary
Make a difference	Contribute Make a difference Develop citizenship
Maternal death/morbidity	Complication caused by abortion Incomplete abortion Maternal death Morbidity Dying patient Reduce
Networks	Activism Partnership Exchange experiences Not working alone Talking to other providers With feminists With an organization With other providers Work with other organizations
Does not provide	Do not provide more services Not in my case
Support from others	Others take care of it Family support
Own experience/seeing a death	Compassion Experience I aborted I had an abortion Based on my own experience Tired of seeing mistreatment/deaths
Passion	Passion Passionate Pride Love my work Love what I do
Support from peers	Support from colleagues Team With professional support
Respect women's decisions	
Restriction/legislation	Advocacy Legal framework

Code	Vocabulary
Rights	Access to human rights Right to choose Right to decide Right to self-determination To defend rights Ensure the access to rights Women's rights
Safe abortion	Dignity Freedom to decide Lack of appropriate services Reduce risks Safe abortion Safe services Safe space Space to make a decision Unsafe
Satisfacción	Enjoyment Satisfaction of doing the right thing
Save lives	Save women Save lives Avoid death Heal pain Reduce complications
Safety	Safety measures Physical measures
Safety measures	Online With your team
Self-care	Having the support of others Emotional support
Serendipity	Chance I didn't choose it Random Serendipity
Stigma against women	Destigmatizing women who abort Feeling guilty Other women/medical staff give you negative looks Stigmatizing women who abort Women who face judgement
Stigma against providers	Judgement on providers Stigma at work Moral judgment at work
Team	Working with an interdisciplinary team Teammates Teamwork Multidisciplinary team Lawyers, nurses, psychologists

Code	Vocabulary
Training	Improvement of the educational program Information Have the ability to inform others Technical support Workshops Reading Increase knowledge Develop a philosophical context
Violence	Gender-based violence Abuse of women Obstetric violence Rape Sexual abuse Rape Violence against women
Experiences of discrimination	Discrediting by anti-abortion groups I can't talk about my job Colleagues judge me Subtle discrimination I am discriminated for being a gay provider My family doesn't speak to me Family members offend me I have lost friends I am judged in my Church Online harassment I have suffered arbitrary arrests They call me killer They call me sinner I have been accused of genocide
Thanks	For the opportunity • To participate • To express myself • To share my experience For the support • Being there • Promoting For educating • Workshops • Education • Materials • Information For listening • Creating a space • Ask • Considering our opinion • For this research • Letting us speak • No one cares For your work • Share your work • Fight • Your commitment • Your documents

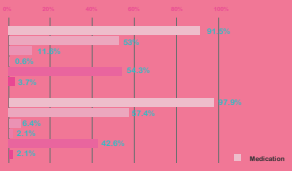
4. REFERENCES

Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., Eagen-Torkko, M., & Harris, L. (2012). Measurement of stigma in abortion provision: The abortion provider stigma scale. *Contraception*, 86(3), 302-303.

Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., & Harris, L. H. (2014). Abortion providers, stigma and professional quality of life. *Contraception*, 90, 581-587.

Martin, L. A., Hassinger, J. A., Seewald, M., & Harris, L. H. (2018). Evaluation of Abortion Stigma in the Workforce: Development of the Revised Abortion Providers Stigma Scale. *Women's Health Issues*, 28(1), 59-67.

safe2choose



International survey of abortion providers and companions

Report creation:
Pauline Diaz, Michell Mor, Fernanda Díaz de león, María Elena Collado and Laura Andrade.
Main writing: Karla Flores.
Original design: Ana Martha Sánchez.